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A TALE OF TWO LEADERS: DYAD LEADERSHIP MODEL IN HEALTHCARE ORGANIZATIONS

By
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A DISSERTATION IN PRACTICE

Submitted to the faculty of the Graduate School of Creighton University in Partial Fulfillment of the Requirements for the degree of Doctor of Education in Interdisciplinary Leadership

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Omaha, NE
October 4, 2018

Abstract

As healthcare organizations evolve, experiencing market and technological changes, as well as pressure to reduce costs and become more efficient, leadership practices have not remained stagnant. In the healthcare context, a physician leader and a non-physician administrator have specialized skill sets and roles. The complexity of healthcare organizations necessitates collaborative arrangements between physicians and administrators for a better integration of clinical and administrative functions. These conditions have propelled healthcare organizations to implement emerging leadership models such as dyad leadership, to bridge the divide between these separate functions. Considering the novelty of the dyad model, healthcare organizations face challenges while transitioning to this leadership practice. With the focus on the dynamic between physician and administrator pairs, this study addressed how roles are practiced within a dyad leadership model as contextual forces evolve. A qualitative case study approach was used to explore the dyad leadership model. The study uncovered three salient themes: role clarity between administrative and physician leaders, leading together within the dyad model, and frequent interaction and communication. These themes revealed that sharing and practicing the role space in a dyad model is a dynamic, collective, and relational process that occurs between the dyad leaders. The proposed solution came in the form of an integrative framework for the dyad leadership model, as well as recommendations that leaders and leadership practitioners can use to implement the dyad leadership practice in their organizational settings.

Keywords: Dyad leadership model, healthcare leadership, dyad roles, leadership-as-practice

Dedication

With honor and pride, I dedicate this achievement to my parents, Valentina and Vladimir Vremes. I am grateful for their unconditional love and unwavering commitment to my education. My parents instilled in me a strong work ethic, an insatiable thirst for knowledge, and a relentless desire to pursue my dreams. Thank you for believing in me, Mom and Dad!

In the process of studying dyads, I have rediscovered the most important dyad of all—my marriage. For this reason, I want to dedicate this achievement to my marriage and to my husband, Josh Fritz. I am eternally grateful for his love, patience, and inspiration while I have pursued my doctoral journey. We have grown so much together and I cannot think of a better partner with whom to pursue my dreams and share my life. Thank you, Joshi, and I look forward to our next adventure!

Acknowledgements

Throughout my doctoral journey, I cultivated the belief that everyone can be a leader and everyone can lead all the time. My purpose through this journey was not only to acquire leadership skills, but also to grow as a leader. The Ed.D. in Leadership program was the gateway into the academic world, in which I immersed myself in exploring leadership theories and practices, engaging my mind, acquiring knowledge, and collaborating with colleagues, faculty members, organizations, and communities that aspire to transform the world for better. Partnering with Creighton University and adopting the Ed.D. program competencies gave me the confidence to face organizational challenges, undertake the most difficult initiatives, and implement effective and innovative solutions with proven erudition and poise.

This was not a solo journey and I want to acknowledge the individuals who have supported and encouraged my growth as a leader. My sincere gratitude goes to Dr. Jennifer Murnane for serving as my Dissertation Chair. Dr. Murnane supported and motivated me throughout the dissertation process and provided clarity in moments of ambiguity. I also owe a debt of gratitude to another committee member, Dr. Andy Noon, who provided great support through the process.

I want to acknowledge my team, my director, and the leaders of my organization. I am proud and honored to work with colleagues who supported me through my academic journey and my growth as a leader. I never felt alone and I am eternally grateful to family, friends, and colleagues for their support, guidance, and encouragement. Without all of you, I could not have done it.

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CHAPTER ONE: INTRODUCTION

Introduction and Background

If there is a constant defined in the healthcare industry, it is that the industry is continuously changing. The changes are driven by regulations, technology, consumer preferences, and socio-economic factors that impact the way patient care is delivered. These factors can be categorized as economic, technological, social, and political, and each has a unique impact on the behavior of key players in any given industry, including healthcare (Wells, 2011).

Economic forces impact reimbursement models that lead healthcare organizations to evaluate their financial practices and cost structures. With the proliferation of technology innovations (Baker & Bufka, 2011; LeRouge & Garfield, 2013; Spivack, 2011) and the adoption of electronic medical records (Angst, Agarwal, Sambamurthy, & Kelley, 2010), the industry has experienced and will continue to experience dramatic changes in the way care is delivered, pressing organizations to reengineer their processes and workflows to better meet patient needs. Social factors such as the aging population, chronic conditions, and geographic isolation increase the demand for health services and influence consumer preferences, leading the healthcare industry to redefine care models that shift the focus from care in the hospitals to care outside of hospitals in clinics, patient homes, or long-term facilities (Ferrara-Love, 1997).

In addition, healthcare is a heavily regulated industry. In the past few years, the industry has been affected by the passing of healthcare reform that impacted the payer system, as well as quality of care and access to care. Thus, political forces have a great

influence on how healthcare organizations operate, get reimbursed, and deliver care to patients.

Furthermore, healthcare organizations are complex and operate "in highly institutionalized environments that put substantial pressures on both their technical and managerial components" (Ruef & Scott, 1998, p. 882). Hospitals represent the "classic pluralistic domain" defined by divergent objectives, multiple actors, diffused power, and knowledge-based work processes (Denis, Lamothe, & Langley, 2001, p. 809; Denis, Langley, & Rouleau, 2007). Organizations, including healthcare organizations, are challenged with institutional complexity when faced with multiple institutional logics (Greenwood, Raynard, Kodeih, Micelotta, & Lounsbury, 2011). Institutional logics represent "a set of principles that prescribe how to interpret organizational reality, what constitutes appropriate behavior, and how to succeed" (Greenwood et al., 2011, p. 318; Thornton & Ocasio, 2008).

In response to institutional complexity and managing multiple logics, healthcare organizations traditionally created structural differences between technical and managerial levels, with technical tasks falling under the jurisdiction of clinical staff, while administrative tasks fell under the control of managers or administrators (Ruef & Scott, 1998). While the physicians focused on patient care, organizing medical staff, and clinical activities, the managers became more focused on cost containment, financial solvency, personnel management, and other administrative tasks (Kaissi, 2005). This organizational structure perpetuated a complex and dynamic relationship between physicians and administrators that was "built on the basic premise that each party is separate and independent" (Fiol & O'Connor, 2009, p. 17).

Collectively, the aforementioned contextual factors and constant industry changes created the perfect storm that altered and continues to alter the healthcare landscape; in addition, it eliminated and added new players and competitors, and influenced the nature of patient care. Furthermore, these forces not only incentivized healthcare organizations to redefine their models of patient care, but also propelled them to transform their organizational and leadership models and practices to better integrate clinical and administrative activities, in order to achieve economic efficiency and improve patient outcomes while remaining competitive.

Statement of the Problem

While industry changes and contextual factors have perpetuated the separation of clinical and administrative functions, they have also created the need for physicians and administrators to unite and foster an environment of collaboration. To effectively manage turbulent times and align the clinical and administrative functions, healthcare organizations have begun to implement dyad leadership models, in which "two individuals with different skill sets, education, and backgrounds are paired to better fulfill the mission of the organization" (Sanford & Moore, 2015, p. 7). Under the dyad model, a physician and a non-physician administrator collaborate and co-lead, either on a permanent basis at a given level, department, service line, division, or organization; or on a temporary basis to accomplish a project, pursue a strategic objective, or solve a particular organizational challenge (Sanford & Moore, 2015). The "suits" and the "coats" work together to achieve strategic goals and improve patient care (Sanford & Moore, 2015, p. 3). Furthermore, the dyad leadership model is viewed as a "solution for bridging healthcare's cultural gaps, combining different skills and knowledge for greater problem

solving and increasing the span of control and influence of leadership" (Sanford & Moore, 2015, p. 61).

While implementation of a dyad leadership model within healthcare organizations is trending upward (Sanford & Moore, 2015), issues regarding the dynamic of dyad leaders persist. In particular, both leadership researchers and practitioners are challenged by role enactment, distribution, and how leaders interact together and with other members around specific organizational issues (Denis, Langley, & Sergi, 2012). Particularly, for healthcare organizations that traditionally perpetuated functional silos, it is challenging to transition to a dyad model when the scope of the dyad roles is not clearly defined and structured, and when there is no established framework for the dyad leaders on how to interact and function with one another and with other organizational members.

Purpose of the Study

The purpose of this dissertation in practice study was to explore the dynamic between physicians and administrators working together in a dyad model to fulfill the mission of the organization, and how the model serves as a solution for bridging the divide between the clinical and administrative functions within a specific organizational setting. The focus was on developing an in-depth description and analysis of the dyad model—its dynamic, pattern of mutual action, and evolution as examined in a pluralistic organization such as an academic medical center.

Scope of the Study

In their research, Hodgson, Levinson, and Zaleznik (1965) described two types of professional duos that reflect different levels of power, partnership and hierarchical duos (as cited in Alvarez & Svejenova, 2005). While a hierarchical pattern is characterized by

a clear authority line of subordination, a partnership structure puts an emphasis on shared responsibility, wherein both members share roles and have equal power (Alvarez & Svejenova, 2005). Structural examples of partnerships include co-founders, co-chairs, co-CEOs, co-COOs, or physician-administrator dyads.

The dyad model suggests that two leaders come together as a group to achieve specific organizational objectives. For professional duos, Alvarez and Svejenova (2005) observed that a division of labor, task or emotional complementarity, as well as role differentiation is necessary for small-numbers structures to work effectively, which creates a dynamic process within the professional duos. A physician-administrator dyad would operate in a similar fashion, creating a dynamic group process as dyad leaders engage in mutual actions such as exchanging information, sharing knowledge, or collectively making decisions. Group dynamics influence not only the dyad leaders, but also their followers, in a vertical direction. Although it would be worth exploring how the dyad group dynamics influence followers, the scope of this study was limited to exploring the dyad as the unit of analysis, the group dynamics of the dyad model, its formative process, and its function, as displayed in Figure 1.

Considering the dyad as the unit of analysis for this study, the scope can be further refined by looking at the dyad leadership through two different yet interconnected lenses. The first lens is to consider the dyad model, as a leadership practice, in connection with its organizational context and its level of embeddedness within the institution that implemented this type of model. This constitutes a macro-level view of the dyad leadership practice within a specific organizational context. The second lens is viewing the dyad through the routine leadership interactions that occur between actors or dyad

leaders. This constitutes the micro-level view that shapes the dyad dynamic and puts emphasis on the "actual doing of leadership" (Endrissat & Arx, 2013, p. 280). While staying within the horizontal scope between dyad leaders, the study focused on both lenses, the macro- and micro-level analyses of the dyad leadership model.

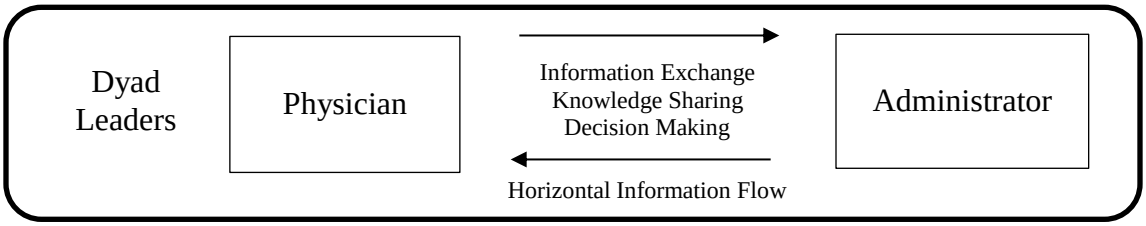

Figure 1. The dynamic between dyad leaders.

Research Question

Healthcare organizational structures and dynamics have evolved throughout the years, creating the need to effectively manage scarce resources, redefine models of care, and integrate clinical and administrative activities to achieve economic efficiency and improve quality outcomes. In the healthcare context, a physician leader and a non-physician administrator have specialized skill sets and roles. While a physician is trained to provide patient care, an administrator is trained to address organizational issues, which creates and perpetuates functional silos. Facing such challenges requires a better integration of clinical and administrative functions and a close collaboration between physicians and non-physician leaders. The dyad leadership model is implemented by healthcare organizations as a solution for bridging the divide between these separate functions. Thus, the following research question guided the proposed qualitative study: How is the role space shared and practiced within a dyad leadership model as contextual forces evolve?

The research question has two distinct parts worth deconstructing—context and dyad model as a leadership practice in a healthcare organization. Although a detailed examination of institutional pluralism and logics was not within scope of this study, it is difficult to ignore these concepts when examining leadership practices within healthcare organizations. Institutional context and its multitude of logics not only shape the entire health sector (Greenwood et al., 2011), but also influence how healthcare organizations respond internally. Leadership and leadership practices are placed at the intersection of external environment pressure and the internal organizational response to complex and competing demands.

The second part of the research question is regarding the dyad leadership model. A notable theme informs this part of the research question, and that is the dynamic and relational phenomenon of the dyad leadership model. Research indicates that in a multi-level structure such as a dyad, "roles cannot be viewed as static, but rather are fluid and dynamic in nature and depend on organizational and environmental demands and requirements" (Yammarino, Salas, Serban, Shirreffs, & Shuffler, 2012, p. 383). Additionally, as a relational phenomenon, the dyad leadership model involves a pattern of relationships and a mutual influence that occurs at a micro-level among the dyad leaders. At the same time, Denis, Langley, and Rouleau (2010) noted that "these micro-level manifestations of leadership do not occur in a vacuum" (p. 78). Thus, examining the dyad leadership model through the lens of institutional context and complexity provides a deeper understanding of the dyad dynamic and how dyad leaders exercise their roles in a complex environment.

Aim of the Study

The aim of the study was to propose a framework for dyad leadership. The framework evaluated the institutional context, determined the elements of the dyad structure, and identified the mechanisms for developing a successful dyad model.

Methodology Overview

Dyad leadership is an emergent model in healthcare organizations. Although the concept of shared leadership is not new, the application of this model is novel to healthcare organizations. Considering the novelty of dyad leadership models in healthcare organizations, using a case study approach for exploratory purposes to closely observe unit and within unit cases would yield new insights about this emerging leadership model in a specific context or setting.

For the purpose of this research, two methods were used to select a site and identify candidates to participate in the study, using purposeful selection and criterion sampling. Purposeful selection was employed to select a site for the study and determine the participants to be interviewed. In addition to purposeful selection, criterion sampling was employed to ensure that the participants represented people who are engaged in a leadership dyad and can meaningfully inform an understanding of the research question (Creswell, 2014).

There are many variations of dyads consisting of clinical pairings, such as a Chief Nurse Officer and a Chief Medical Officer, or a physician and a nurse manager managing a clinical unit. Another variation would be between a physician and non-physician operations or business manager. The scope of this study was limited to a dyad pairing between a physician and a non-physician leader. Thus, for the purpose of this study, the

researcher selected dyads from multiple service lines, with a total of eight dyad leaders or four dyad pairs who have been working together for a period of time, have experienced their own dynamic, and have made the dyad work.

Definition of Relevant Terms

The following terms are used operationally within this study:

Collective leadership: A dynamic leadership process in which a defined leader, or set of leaders, selectively utilizes skills and expertise within a network, effectively distributing elements of the leadership role as the situation or problem at hand requires (Friedrich et al., 2009).

Context: Context is traditionally viewed as a "situation that influences what kind of leadership will be effective" (Endrissat & Arx, 2013).

Dyad leadership: Two individuals with different skill sets, education, and backgrounds who are paired to better fulfill the mission of the organization (Sanford & Moore, 2015).

Institutional logics: Socially constructed, historical patterns of material practices, assumptions, values, beliefs, and rules by which individuals produce and reproduce their material subsistence, organize time and space, and provide meaning to their social reality (Thornton & Ocasio, 2008).

Leadership role constellation: Refers to the collective leadership group and implies multiple actors and a division of roles among them.

Organizational culture: A pattern of shared beliefs, behaviors, values, assumptions, rituals and symbols that uniquely identify an organization, and that produce norms that shape the behaviors of members and groups in an organization.

Pluralistic organization: An organization defined by divergent objectives, multiple actors, diffused power, and knowledge-based work processes (Denis et al., 2001, p. 809; Denis et al., 2007).

Shared leadership: A dynamic and interactive influence process among individuals in groups for which the objective is to lead one another to the achievement of group or organizational goals or both (Pearce & Conger, 2003).

Strategic planning: A deliberative, disciplined approach to producing fundamental decisions and actions that shapes and guides what an organization is, what it does, and why (Bryson, 2011).

Delimitations and Limitations

Limitations represent factors that are not under the control of the researcher and that impact the interpretations of the findings and the generalizability of the results (Lunenburg & Irby, 2008). A notable limitation with this qualitative research is the generalizability of the findings. Since the scope of study was limited to only physician and non-physician dyads within a healthcare organization, the chosen sample of dyads did not reflect the dyads across different types of healthcare organizations or even other industries.

Delimitations are "self-imposed boundaries" associated with the purpose and the scope of the study (Lunenburg & Irby, 2008, p. 134). The delimitations used in this study were determined by the need to explore the dynamic of the clinical and non-clinical dyad leaders within a healthcare setting. Thus, the following potential delimitations are noted with this case study:

1. The study focused only on dyad leaders within an academic medical center.

2. The study focused only on leaders engaged in a dyad structure.
3. The study focused only on dyads that consisted of physician leaders and non-physician administrators.

Having worked in a healthcare organization that recently implemented the dyad leadership model at the service line level, the researcher has had exposure to the model and has observed how the dyad was implemented in a real-life setting. This exposure allowed the researcher to observe the dyad model in practice, discuss the model with the current organizational leaders, and form assumptions and perceptions that could be potentially introduced in this study. Creswell (2013) introduced the concept of bracketing, which entails researchers setting aside their assumptions and personal experiences with a particular phenomenon in order to focus on the experiences of the study participants. Thus, while conducting the research and interviewing participants, the researcher of this study was acutely aware of instances when pre-existing assumptions and personal opinions permeated the overall research process.

Leader's Role and Responsibility in Relation to the Problem

Dyad leadership is an emergent model in healthcare organizations that generally possess a high degree of complexity and pluralism (Denis et al., 2007). On one hand, the study explored the dynamic between physicians and administrators working together in a dyad model and how the model served as a solution for bridging the divide between the clinical and administrative functions. On the other hand, this research introduced theoretical approaches central to the analysis of leadership within dynamic and pluralistic contexts.

At its initiation, this study was influenced by the notion that leadership is a collective or a group-level phenomenon (Pearce & Conger, 2003). The study examined leadership, not from an individual leader perspective, but from a collective leadership group perspective implying multiple actors, shared authority and accountability, and specific division of their roles. Furthermore, this study viewed leadership as a dynamic phenomenon with a particular focus on the role structure and how it is influenced by contextual factors.

Significance of the Study

Leadership research has been dominated by traditional models that focus on the "heroic" leaders at the top, their individual qualities and behaviors, and the leaders' downward unidirectional influence on teams through formal authority and power (Avolio, Walumbwa, & Weber, 2009; Gronn, 2002; Pearce & Conger, 2003; Yukl, 1999). In the past two decades, the heroic leader paradigm was challenged by emerging leadership research and practices such as shared leadership that goes beyond the command and control models, the properties of individual leaders and their qualities, and the vertical hierarchy between leaders and followers. In contrast to the traditional paradigm, shared leadership views "leadership as a shared process" between multiple team members assuming leadership roles in "potentially fluid" structures (Denis, Langley, & Sergi, 2012, p. 212; Pearce & Conger, 2003; Sergi, Denis, & Langley, 2012; Yukl, 1999, p. 292).

Gronn (1999) conceived that under certain contexts, classic or traditional leadership models might be substituted by alternative vehicles. Leadership couples or dyads, which imply that two individuals share one leadership role (Pearce & Conger,

2003), represent one example from a range of possible alternative models. Though limited, research on co-leadership models has increased, particularly between two executives sharing corporate governance roles (Alvarez & Svejenova, 2005; Pearce & Conger, 2003).

This study contributed to an emerging movement in leadership studies known leadership-as-practice. In contrast to the traditional models that focus on heroic leaders and their individual properties, leadership-as-practice "focuses on the everyday practice of leadership including its moral, emotional, and relational aspects" (Raelin, 2011, p. 195). As Raelin (2011) suggested, leadership-as-practice looks for leadership in its activity and is portrayed as a shared and collaborative process.

With the purpose of exploring the dynamic between physicians and administrators working together in a dyad model, the study focused specifically on routine interactions and how leadership is dynamically activated within the dyad model. Furthermore, under the premise that the shared role space of dyad leaders is dynamic rather than static, this study addressed how roles are practiced in a dyad leadership model as contextual forces evolve within a specific organizational setting.

Summary

As healthcare organizations evolve, experiencing market and technological changes, as well as pressure to reduce costs and become more efficient, leadership practices have not remained stagnant. In the healthcare context, a physician leader and a non-physician administrator have specialized skill sets and roles. The complexity of healthcare organizations necessitates collaborative arrangements between physicians and administrators for a better integration of clinical and administrative functions. These

conditions have propelled healthcare organizations to implement emerging leadership models such as dyad leadership, in order to bridge the divide between these separate functions.

Considering the novelty of the dyad model, healthcare organizations face challenges while transitioning to this leadership practice. With the focus on the dynamic between physician and administrator pairs, this study addressed how roles are practiced within a dyad leadership model as contextual forces evolve. This study uniquely contributed to the limited research on emerging leadership models, and paid close attention to the dynamic of leadership groups and how leaders interact and function with one another and with other organizational members.

CHAPTER TWO: LITERATURE REVIEW

Introduction

The purpose of the following chapter was to review the literature associated with the dyad leadership model as part of the collective leadership construct. This study intended to explore the dynamic between physicians and administrators working together in a dyad model to fulfill the mission of the organization.

First, the review provided a comprehensive analysis on the concept of collective leadership as an emerging phenomenon contrasting traditional leadership theories. The review compared the traditional and emergent leadership models and examined the evolving body of work on collective leadership. While collective leadership is a broad construct that encompasses concepts such as shared, distributed, and plural leadership, the scope of this review was limited to examining the concept of co-leadership represented by dyads or triads. The analysis focused on the definition and characteristics of leadership dyads, as well as on how this concept fits within the overall body of research on collective leadership.

Second, the review explored dyad leadership as an emergent model in healthcare organizations. Although the concept of shared leadership is not new, the application of this model is novel to healthcare organizations. The review provided a brief history and examined the context of the healthcare setting, its key actors, and the roles those actors play in healthcare organizations. The analysis explored physician and administrator dyads and their dynamic within pluralistic healthcare settings.

The majority of this literature review employed empirical, peer-reviewed studies in the identified topic areas. Additionally, some seminal research was also utilized to strengthen the review and build on topic analysis.

Healthcare Setting

Dyad leadership is an emergent model in healthcare organizations. Although the concept of shared leadership is not new, the application of this model is novel to healthcare organizations. The purpose of these section was to examine the healthcare context, its actors, and the functional roles these actors play within this context. The analysis explored physician leader and administrator dyad and the functional and cultural silos associated with these functions.

Pluralistic Organizations

Healthcare organizations are complex and operate "in highly institutionalized environments that put substantial pressures on both their technical and managerial components" (Ruef & Scott, 1998, p. 882). Hospitals represent the "classic pluralistic domain" defined by divergent objectives, multiple actors, diffused power, and knowledge-based work processes (Denis et al., 2001, p. 809; Denis et al., 2007). Displaying characteristics of professional bureaucracies, hospitals display decentralized decision-making, high levels of professional autonomy and power, and loose coupling of professional jurisdictions (Kitchener, 2002). Pluralistic organizations are characterized by bureaucratic processes and "enact administrative, managerial, and professional cultures and, within these broader groupings, subcultures and identities" (Jarzabkowski & Fenton, 2006, p. 632).

Traditionally, healthcare organizations have created structural differences between technical and managerial levels, with technical tasks falling under the jurisdiction of clinical staff, while administrative tasks fell under the control of managers or administrators (Ruef & Scott, 1998). While physicians focused on patient care, organizing medical staff, and clinical activities, managers became more focused on cost containment, financial solvency, personnel management, and other administrative tasks (Kaissi, 2005). This organizational structure perpetuated a complex relationship between physicians and administrators that was "built on the basic premise that each party is separate and independent" (Fiol & O'Connor, 2009, p. 17).

Healthcare organizations display pluralism through the presence of professional medical and administrative cultures, with their associated functions, identities, and interests (Jarzabkowski & Fenton, 2006). This pluralism represents a source of tension, which in turn gives rise to competing demands and conflicting goals that perpetuate ambiguity and fragmented functional practices in healthcare organizations.

Based on the above analysis, physicians and non-physician administrators represent two different subcultures with distinct values, assumptions, roles, identities, and interests. Furthermore, physicians and non-physicians administrators display opposing loyalties and commitments (Kaissi, 2005). Physician loyalty is directed toward the patient and the medical profession, and physicians are held accountable for clinical outcomes (Kaissi, 2005). Additionally, physicians display a preference for autonomy and are ambivalent "in exercising formal authority" with peer or subordinate physicians (Xirasagar, Samuels, & Stoskopf, 2005, p. 733). In contrast, administrators direct their

loyalty toward the organization and are held accountable for administrative functions and the financial performance of the organization.

Leadership as a Collective Phenomenon

This section of the literature review provides a comprehensive analysis on the concept of collective leadership as an emerging model contrasting the traditional leadership approaches. The review compares the traditional and collective leadership models and examines the emerging body of work on collective leadership. While collective leadership is a broad construct, the analysis focuses on examining the concept of co-leadership represented by dyads or triads, as well as where this concept fits within the overall research body on collective leadership.

Traditional Leadership and Emerging Models

As organizations have evolved, experiencing market and technological changes, as well as pressure to reduce costs and become more efficient, leadership research and practices have not remained stagnant throughout the years. Leadership theory and research have been dominated by traditional models that focus on the "heroic" leaders at the top, their individual qualities and behaviors, and the leaders' downward unidirectional influence on teams through formal authority and power (Avolio et al., 2009; D'Innocenzo, Mathieu, & Kukenberger, 2014; Gronn, 2002; Pearce & Conger, 2003; Yammarino et al., 2012; Yukl, 1999). Acknowledging that traditional leadership studies have validity, particularly in organizational settings in which hierarchical leadership is advisable, these studies were unable to capture team leadership dynamics and complexities (Vandewaerde, Voordeckers, Lambrechts, & Bammens, 2011).

In the past two decades, the heroic leader paradigm was challenged by emerging leadership research and practices such as collective, shared, or distributed leadership that goes beyond the command and control models, the properties of individual leaders and their qualities, and the vertical hierarchy between leaders and followers. In contrast to the traditional paradigm that views leadership as an individual level phenomenon, emergent models view leadership as a collective (Denis et al., 2012; Friedrich, Vessey, Schuelke, Ruark, & Mumford, 2009; Yammarino et al., 2012), shared (Pearce & Conger, 2003) or distributed phenomenon (Gronn, 2002). As an example, shared leadership views "leadership as a shared process" between multiple team members assuming leadership roles in "potentially fluid" structures (Denis et al., 2012, p. 212; Pearce & Conger, 2003; Sergi et al., 2012; Yammarino et al., 2012; Yukl, 1999, p. 292). Shared leadership implies that power is shared and influence is exercised "among a set of individuals rather than centralizing it in the hands of a single individual who acts in the clear role of a dominant superior" (Pearce et al., 2009, p. 234).

Collective leadership is not a novel concept, and scholars have flirted with the idea that peers could serve as a source of influence (Pearce & Conger, 2003). This emergent leadership model was explored approximately 60 years ago by C. A. Gibb, who viewed leadership in a "distributed pattern" (Contractor, DeChurch, Carson, Carter, & Keegan, 2012; Gronn, 2002, p. 424). Not until recently, however, did the concept start to gain popularity among emerging leadership theories, with room for advancing both theory and practice to conceptualize and operationalize collective engagement leadership (Cullen-Lester & Yammarino, 2016). As collective leadership practices gain traction, scholars have faced the challenge to define collective leadership.

Pearce and Conger (2003) defined shared leadership as "a dynamic, interactive influence process among individuals in groups for which the objective is to lead one another to the achievement of group or organizational goals or both" (p. 1). While examining leadership in teams, Day, Gronn, and Salas (2004) defined the construct as "an emergent state…that develops over the life of the team; is typically dynamic in nature; and varies as a function of team inputs, processes, and outcomes (p. 861). Along the same lines, Avolio, Sivasubramaniam, Murry, Jung, and Granger (2003) took the position that leadership is a social influence process and focused on how team members collectively influence one another to accomplish goals. Comparing traditional and contemporary leadership, Yammarino et al. (2012) viewed leadership "as a collectivistic phenomenon…where multiple individuals interact through a variety of formal and informal structures, [and] take on a variety of leadership roles, both formally and informally, over time" (p. 384).

Although each research stream—shared, distributed, or collective—has an overlap in definitions, there are also distinct elements that characterize each leadership theory (Friedrich, Griffith, & Mumford, 2016). The common elements emphasize the dynamic nature of collective leadership and the influence process between leaders and leaders, as well as between leaders and team members. In contrast, each leadership theory views the role of the leader differently. While shared and distributed leadership research focuses on leadership roles being shared or distributed among team members, collective leadership maintains the importance of the focal or formal leader, and integrates elements and processes from shared, distributed, and other collectivistic leadership theories (Friedrich et al., 2016).

Recognizing the variety of definitions, it is just as important to acknowledge the multitude of terms associated with collective leadership (Kocolowski, 2010). Collective leadership can be referred as "distributed," "shared," "plural," "collaborative," "relational," or "integrative" leadership (Denis et al., 2012). While some scholars have used these terms interchangeably, there have been inconsistencies in defining them (Avolio, et. al., 2009; Denis et al., 2012; Kocolowski, 2010). This research will adopt the terminology of collective leadership that encompasses multiple constructs, such as shared and distributed leadership. Furthermore, for the purposes of this research, collective leadership is defined as "a dynamic leadership process in which a defined leader, or set of leaders, selectively utilize skills and expertise within a network, effectively distributing elements of the leadership role as the situation or problem at hand requires" (Friedrich et al., 2009, p. 933).

Thus far, this section has explored the difference between traditional and emerging leadership models such as shared, distributed, or collective leadership. The scope of this dissertation in practice study was to explore the dyad leadership model and the dynamic between the dyad leaders. This leadership model aligns with the collective leadership definition, based on the premise that dyad leaders remain focal while enacting the collective and dynamic processes of leadership and activating specialized skill sets as circumstances dictate. The dyad leadership model is further explored in the following section.

Dyad Leadership

Characteristics of Dyads

In a sociological sense, dyads represent small groups comprised of two individuals or actors and can take on various forms, including friendship pairs, business partners, student-teacher dyads, or physician-patient pairs (Becker & Useem, 1942). While the scope of this study is focused on leadership dyads, it is worthwhile to examine such dyads and their dynamic through Becker and Useem's (1942) proposed frame of reference, which outlines the general characteristics of the dyad.

According to Becker and Useem (1942), a dyad is enacted when two individuals engage in intimate, face-to-face relations over a period of time through "patterned mutual action" (p. 14). The patterned mutual action is a unique characteristic of a dyad. Dyads are formed with a specific purpose of each member being "subordinated to ascribed roles" (Becker & Useem, 1942). Furthermore, Becker and Useem (1942) conceived that dyads display separation of roles, functions, and obligations, with role-taking manifesting through the unique qualities of the dyad members.

Another unique characteristic of dyads is the personalized pattern that makes it impossible for the dyad members "to shift blame, obligations, and responsibilities upon an impersonal structure when a crisis occurs, action is called for, or a decision is to be made" (Becker & Useem, 1942, p. 14). A similar attribute was noted by Simmel (1950), who emphasized the dyad's greater unity while preserving the individuality of each member and maintaining a degree of autonomy (as cited in Alvarez & Svejenova, 2005). In contrast to large groups that require conformity to the whole, dyad structures are characterized by the individual actors and their interaction (Alvarez & Svejenova, 2005).

The nature of exchange can be vertical or horizontal. A vertical exchange can be represented by teacher-student, physician-patient, or manager-subordinate pairs. A horizontal exchange can be represented by subordinate-subordinate, physician-physician, or physician leader-administrator pairs as explored in the scope of this dissertation in practice.

Co-Leadership and Leadership Couples

Gronn (1999) conceived that under certain contexts, classic or traditional, leadership models might be substituted by alternative vehicles. Leadership couples or dyads represent one example from a range of possible alternative models. Gronn (1999) defined a leadership couple or dyad as "an arrangement marked by a division of role tasks and responsibilities along specialized and complementary lines" (p. 44). Hodgson, Levinson, and Zaleznik (1965) coined the term "constellation" to refer to a collective leadership form, in which leaders exercise roles that are specialized in their areas of expertise, strongly differentiated to avoid overlap, and complementary (as cited in Denis et al., 2012). Alvarez and Svejenova (2005) viewed leadership dyads in a similar manner, asserting that commonality and complementarity are important elements in how professional duos function. While leadership dyads manifest role differentiation, specialization, and complementarity, to operate effectively, dyad leaders also need to have common backgrounds, values, and experiences (Alvarez & Svejenova, 2005).

While research has primarily focused on leadership being shared or distributed among team members, little attention has been given to small-number leadership structures such as dyads or triads (Alvarez & Svejenova, 2005). In spite of that, leadership role sharing is prevalent at the executive level in various organizational

contexts, such as healthcare (Chreim & MacNaughton, 2015; Denis et al., 2012), education (Gronn, 1999), small businesses and corporate organizations (Alvarez & Svejenova, 2005; Heenan & Bennis, 1999; O'Toole, Galbraith, & Lawler, 2002; Sally, 2002). As organizations become increasingly complex and dynamic, the role of single leaders is becoming more and more challenging as these individuals need to possess both the necessary knowledge and leadership competencies. Such circumstances lead to a greater demand for dyad leadership models that enable leaders to collaborate and effectively lead in complex and dynamic organizational environments.

Though limited, research on co-leadership models has increased, particularly between two executives sharing corporate governance roles (Alvarez & Svejenova, 2005; Heenan & Bennis, 1999). In their seminal work, Pearce and Conger (2003) have acknowledged six theoretical contributions that informed their understanding of the shared leadership concept. One of those contributions is represented by the concept of co-leadership or dyads, which implies that two individuals share one leadership role (Pearce & Conger, 2003). Pearce and Conger (2003) regarded co-leadership to be a related yet distinct concept under the concept of shared leadership.

An alternative way to portray the placement of the dyad leadership model within the collective leadership research is to consider Gibb's view on distributed leadership. Gibb (1954) proposed the idea of two forms of leadership—focused and distributed—as two end points of a continuum (as cited in Gronn, 2002). Focused leadership indicates the presence of a single individual in the role of a leader, whereas distributed leadership indicates the presence of two or more individuals who assume leadership roles (Carson et al., 2007; Gronn, 2002). The leadership concentration continuum is displayed in Figure 2.

Figure 2. Leadership concentration continuum.

Pearce and Conger (2003) focused on advancing their understanding of the shared leadership concept and its dimensions. Similarly, Denis et al. (2012) sought to review the growing body of research on plural leadership. In their comprehensive review, Denis et al. (2012) identified four streams of scholarship on plural leadership, each focusing on different phenomena, epistemology, and methodological assumptions. These streams focus on sharing leadership in teams, pooling leadership at the top of organizations, spreading leadership across boundaries over time, and producing leadership through interactions (Denis et al., 2012).

The first stream—sharing leadership in teams—placed emphasis on mutual leadership within groups, with team members leading each other (Denis et al., 2012). The second stream—pooling leadership at the top of organizations—emphasized research on co-leadership models that include dyads, triads, and constellations as joint leaders within an organization (Denis et al., 2012). While sharing leadership in teams implies that leadership is distributed among team members, in the context of dyads or triads, leadership is not shared beyond the constellation of leaders with top positions within an

organization. The third stream—spreading leadership across boundaries over time—examined research on how leadership roles are dispersed across organizations over a certain period of time (Denis et al., 2012). The fourth stream—producing leadership through interactions—is associated with relational leadership viewed as an emergent property, with leadership being collectively enacted through the interaction of team members (Denis et al., 2012).

Denis et al. (2012) provided a comprehensive overview of the plural leadership research, delineating the major streams that "vary according to their representations of plural leadership as structures or emergent and mutual or coalitional" (p. 211). Furthermore, the analysis also depicted where the dyad leadership model fits within the body of research dedicated to plural leadership. Considering that a dyad relationship implies role sharing between two leaders, the dyad leadership model aligns with the second stream on Denis et al.'s (2012) collective leadership continuum. Figure 3 illustrates where dyad leadership fits within the collective leadership construct.

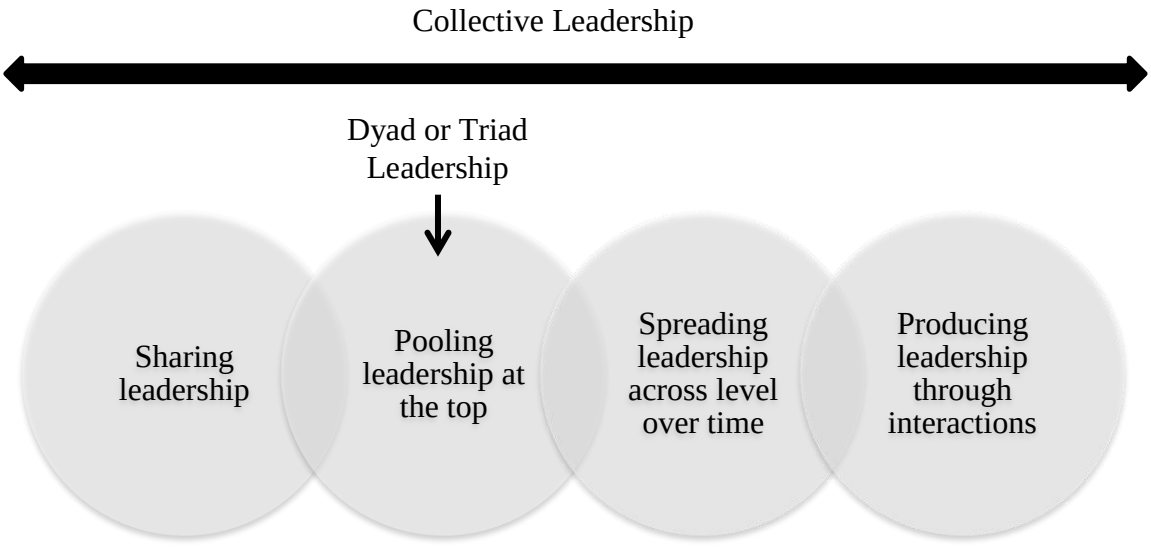

Figure 3. Four research streams on collective leadership.

Discussion of Dyad Leadership

Co-leadership practices such as dyad leadership are particularly suitable when two executives share corporate governance roles (Alvarez & Svejenova, 2005; Heenan & Bennis, 1999). Leadership role sharing is prevalent at the executive level in various organizational contexts, such as healthcare (Chreim & MacNaughton, 2015; Denis et al., 2012), education (Eckman, 2006; Gronn, 1999; Gronn & Hamilton, 2004), small businesses and corporate organizations (Alvarez & Svejenova, 2005; Heenan & Bennis, 1999; O'Toole, Galbraith, & Lawler, 2002; Sally, 2002). The limited research on dyad leadership provides an opportunity to explore the notion that multiple leaders "occupy a single leadership space" (Denis et al., 2012, p. 232). For example, Gronn and Hamilton (2004) and Eckman (2006) devoted their attention to studying co-principalship models in the field of education to explore the working dynamic between co-leaders and how the role space is shared.

With two leaders as a unit of analysis, Gronn and Hamilton (2004) argued that co-principalship is a form of shared role space filled by two or more leaders. Role performance manifests through division of labor governed by implicit or explicit norms. Additionally, Gronn and Hamilton (2004) acknowledged the interdependent nature of the relationship between the two leaders, and recognized interdependence within the co-principalship and within its role set. Within the co-principalship, role interdependence is exercised through role specialization, differentiation, and complementarity (Gronn & Hamilton, 2004). Within the co-principalship role set, role interdependence is exercised through shared cognitive tactics. Furthermore, Gronn and Hamilton's (2004) research emphasized the relational nature and the importance of trust between the "inhabitants of

the role space" (p. 15). The authors noted that trust develops over time as the co-leaders negotiate their expectations within the shared role space.

Examining the characteristics of co-principals and co-principalship role dimensions in the education field, Eckman (2006) described the strengths and weaknesses of the co-leadership model within the context of the selected institutions of the study. The majority of the study participants noted shared decision-making, problem solving, and workload as significant strengths of having a co-leader. The participants appreciated having exposure to multiple perspectives and recognized the value of "having collegial conversations" (Eckman, 2006, p. 12). The participants also acknowledged a reduction in stress associated with shared decision-making and job demands (Eckman, 2006). In contrast, the study participants noted communication challenges and the time required in joint meetings and in developing trust and shared values. Furthermore, the study participants acknowledged the challenge of sharing authority and having equitable responsibilities.

Dyad structures are unique. Dyads represent small groups, in which actors are allowed to preserve their individuality and maintain a degree of autonomy. Additionally, dyad structures are not only characterized by the individual actors, but also by the actors' interactions with one another in a dynamic organizational environment. The complexity of organizations and of the role of leaders results in greater demand for collective leadership models such as dyads, which enable leaders to collaborate, share roles, and effectively lead in dynamic organizational settings.

Leadership in Healthcare Organizations

While industry changes and contextual factors have perpetuated the separation of clinical and administrative functions, they have also created the need for physicians and administrators to unite and foster an environment of collaboration. The pluralistic and complex nature of healthcare organizations served as an impetus for introducing new leadership models. To effectively manage the turbulent times and align clinical and administrative functions, healthcare organizations have begun to implement dyad leadership models, in which "two individuals with different skill sets, education, and backgrounds are paired to better fulfill the mission of the organization" (Sanford & Moore, 2015, p. 7). Under a dyad model, a physician and a non-physician administrator collaborate and co-lead on a permanent basis at a given level, department, service line, division, or organization; or on a temporary basis in order to accomplish a project, pursue a strategic objective, or solve a particular organizational challenge (Sanford & Moore, 2015). The "suits" and the "coats" work together to achieve strategic goals and improve patient care (Sanford & Moore, 2015, p. 3). Furthermore, the dyad leadership model is viewed as a "solution for bridging healthcare's cultural gaps, combining different skills and knowledge for greater problem solving and increasing the span of control and influence of leadership" (Sanford & Moore, 2015, p. 61).

Considering Gronn's (1999) definition that dyads are characterized by a division of role tasks and responsibilities along specialized and complementary lines, physician and administrator dyads align with these outlined attributes. Physicians tend to focus on patient care and clinical activities. Managers, on the other hand, focus on administrative functions, cost containment, and financial solvency.

While leadership dyads manifest role differentiation, specialization, and complementarity, in order to operate effectively, dyad leaders also need to have common backgrounds, values, and experiences (Alvarez & Svejenova, 2005). The commonality element is not readily obvious, considering the contrast between physician and administrator subcultures. This is further complicated by a dyad's propensity for preserving the individuality of each member and maintaining a degree of autonomy. This particular detail emphasizes the unique and complex nature of a physician and administrator dyad within a pluralistic healthcare environment. The dissimilarities between the clinical and administrative functions and the contrasting cultures perpetuate a complex relationship and influence the dynamic between physicians and administrators.

Summary

Complex and dynamic organizations result in a greater demand for collective leadership models. While leadership role sharing is prevalent at the executive level in various organizational contexts such as healthcare, education, small businesses, and corporate organizations, little attention has been given to small-number leadership structures such as dyads or triads. This chapter reviewed the literature associated with the dyad leadership model as part of the collective leadership construct. The analysis focused on the definition of dyad leadership and determined the unique characteristics of leadership dyads, in addition to explaining how this concept fits within the overall research body on collective leadership.

Additionally, the review assessed dyad leadership as an emergent model in healthcare organizations. Although the concept of shared leadership is not new, the application of this model is novel to healthcare organizations and is largely under-

researched. The review explored the complex and pluralistic context of the healthcare setting to demonstrate how the clinical and administrative functions influence the dyad leaders represented by physician and administrators. Furthermore, the analysis examined physician and administrator dyads and the cultural influences of each group on the dynamic and on the relationship between physician and administrator dyad leaders.

CHAPTER THREE: METHODOLOGY

Introduction

The purpose of this dissertation in practice study was to explore the dynamic between physicians and administrators working together in a dyad model to fulfill the mission of the organization, as well as how the model serves as a solution for bridging the divide between the clinical and administrative functions within a specific organizational setting. The focus was on developing an in-depth description and analysis of the dyad model—its dynamic, pattern of relationships, and evolution—as examined in a pluralistic organization such as an academic medical center.

As leadership research has been primarily focused on the individual leader as the unit of analysis (Gronn, 2002), in the dyad leadership model, the dyad itself represents the unit of analysis to be examined. Under the premise that the shared role space of dyad leaders or actors is a dynamic and relational phenomenon, the research methodology focused on the pattern of relationships between the dyad leaders and how the dyad leaders exercise their roles. Data were gathered through interviews and organizational artifacts to examine the dynamic between a physician and administrator engaged in a dyad model.

Research Question

Healthcare organizational structures and dynamics have evolved throughout the years, creating the need to effectively manage scarce resources, redefine models of care, integrate clinical and administrative activities to achieve economic efficiency, and improve quality outcomes. In the healthcare context, a physician leader and a non-physician administrator have specialized skill sets and roles. While a physician is trained

to provide patient care, an administrator is trained to address organizational issues, which creates and perpetuates functional silos. Facing such challenges requires a better integration of clinical and administrative functions and a close collaboration between physicians and non-physician leaders. The dyad leadership model is implemented by healthcare organizations as a solution for bridging the divide between these separate functions. Thus, the following research question guides this qualitative study: How is the role space shared and practiced within a dyad leadership model as contextual forces evolve?

The research question has two distinct parts worth deconstructing—organizational context and the dyad model as a leadership practice in a healthcare organization. Although a detailed examination of institutional pluralism and logics is not within the scope of this study, it is difficult to ignore these concepts when examining leadership practices within healthcare organizations. Institutional context and its multitude of logics not only shape the entire health sector (Greenwood et al., 2011), but also influence how healthcare organizations respond internally. Leadership is placed at the intersection of external environmental pressures and the internal organizational response to complex and competing industry demands.

The second part of the research question concerns the dyad leadership model. A notable theme informs this part of research question—the dynamic and relational phenomenon of the dyad leadership model. Research indicates that in a multi-level structure such as a dyad, “roles cannot be viewed as static, but rather are fluid and dynamic in nature and depend on organizational and environmental demands and requirements” (Yammarino et al., 2012, p. 383). Additionally, as a relational

phenomenon, the dyad leadership model involves a pattern of relationships and a mutual influence among the dyad leaders. Examining the dyad leadership model through the lens of institutional pluralism and complexity provides a deeper understanding of the dyad dynamic and how dyad leaders exercise their roles in a complex environment.

Research Design

A case study is defined as an intense examination of single unit or instance with the purpose of describing or providing explanatory insights for a specific social phenomenon (Babbie, 2014; Gerring, 2004). Gerring (2004) noted that a unit, a "specially bounded phenomenon," is observed at a specific point in time or over a period of time (p. 342). Case study research represents a qualitative inquiry used to explore or develop an in-depth understanding of an issue or problem within its real-life context or setting (Creswell, 2013; Eisenhardt, 1989). Creswell (2013) noted that the main feature of a case study is the definition of a case that is bounded by time, place, or can be described within certain parameters.

A qualitative case study approach was appropriate to explore the dyad leadership model. One aspect to consider when deciding to pursue a case study research is the strategy of research, and Gerring (2004) noted two avenues—exploratory and confirmatory. While the purpose of confirmatory research is to test existing theories, the purpose of exploratory research is to examine a new theory (Gerring, 2004). Gerring (2004) found that case studies are particularly useful in exploratory research. Dyad leadership is an emergent model in healthcare organizations. Although the concept of shared leadership is not new, the application of this model is novel to healthcare organizations. Considering the novelty of dyad leadership models in healthcare

organizations, using a case study approach for exploratory purposes to closely observe unit and within-unit cases yielded unique insights about this emerging leadership model in a specific context or setting.

In addition, Creswell (2013) emphasized that intent is important conducting case study research. An intrinsic case illustrates a unique case that needs to be described and detailed. In the context of the dyad leadership topic, an intrinsic case study approach was particularly beneficial as the research focused on the dyad model, as well as on how the dyad was established and works within a specific organizational setting.

Participants/Data Sources

Creswell (2014) noted that the data collection phase consists of selecting a setting, collecting data through interviews, and determining the protocol for recording information. For the purpose of this research, two methods were used to select a site and identify candidates to participate in the study—purposeful selection and criterion sampling. Purposeful selection was employed to select a site for the study and to determine the participants to be interviewed. In addition to purposeful selection, criterion sampling was employed to ensure that the participants represent people who are engaged in a leadership dyad and can meaningfully inform an understanding of the research question (Creswell, 2014).

Research Site Description

Purposeful selection led to a desired research site that implemented and operationalized the dyad leadership model. The study was conducted at an academic medical center located in the Midwest region. In recent years, the organization announced a merger with other entities. The Midwest Medical Center, Heartland Community

Hospital, and Physician Practice Group, once three separate but inter-connected organizations, are currently operating under one name—Midwest Health System (MHS). MHS is a private, non-profit entity that provides effective and efficient care to patients and supports the academic mission of Midwest University, with which it is affiliated. MHS operates one of largest hospitals in Midwest, facilitating the clinical operations of private and academic physicians. The organization is known in the community for delivering high quality care and superior patient experience. Another unique aspect of the organization's business model is its close affiliation with Midwest University, which trains the best physicians, who would in turn elect to practice at MHS.

In parallel with the merger, the organization implemented the dyad leadership model at the service line level, recognizing the effectiveness of physician and administrator pairs in achieving an integrated health system. The chosen site for this study clearly reflects a pluralistic and complex environment to effectively observe and gather insights into the relational dynamic between the physician and administrator pairs.

Sample Size and Description

There are many variations of dyads consisting of clinical pairings, such as a Chief Nurse Officer and a Chief Medical Officer, or a physician and a nurse manager managing a clinical unit. Another variation would be a dyad consisting of a physician and non-physician operations or business manager. The scope of this study was limited to a dyad pairing of a physician and a non-physician leader. Thus, for the purpose of this study, the researcher selected dyads from multiple service lines, with a total of eight dyad leaders or four dyad pairs who have been working together for a period of time, have experienced their own dynamic and have made the dyad work.

The researcher engaged the selected site by contacting the CEO to obtain access and permission to conduct the research. The introductory letter to the research site was attached in Appendix B. Upon approval, the researcher reached out to the study participants with a letter as reflected in Appendix C, accompanied by the research participants' bill of rights attached in Appendix A.

Data Collection Tools

In case study research, researchers can combine multiple data collection methods such as interviews, observations, documents, physical artifacts, and audio visual materials that are both qualitative and quantitate in nature (Creswell, 2013; Eisenhardt, 1989). While quantitative evidence enables the researcher to uncover patterns and relationships between the variables explored, the qualitative evidence enables a researcher to understand "the rationale or theory underlying relationships revealed in the quantitative data" (Eisenhardt, 1989, p. 538). Using multiple data collection methods makes triangulation possible and allows for stronger validation for the research question or questions (Eisenhardt, 1989).

For the purpose of a case study exploring the dyad model, data collection methodology followed Yin's (2009) recommended types of information to collect: documents, archival records, interviews, direct observations, participant observation, and physical artifacts (as cited in Creswell, 2013). Therefore, data collection tools included organizational artifacts and reports, and interviews.

Organizational artifacts and reports. For qualitative evidence, the researcher collected organizational artifacts such as charts, documents, sample job descriptions, and internal and external press releases that depicted the existence and structure of dyad

models. The researcher sought not only evidence of dyad model existence, but also evidence of the dynamic between dyad leaders and how the dyads are currently structured and practiced within the research site.

In addition to gathering organizational documents, the researcher collected quantitative data available through community benefits and external annual financial reports. Though not salient to the research, these quantitative data were beneficial in evaluating the organizational complexity and economic impact that the research site has within the community.

Interviews. Data collection was performed through face-to-face participant interviews. Babbie (2014) noted that when asking questions, researchers have two options—open-ended questions and close-ended questions. With open-ended questions, the researcher seeks to obtain the respondents' own answers to the questions posed (Babbie, 2014). Closed-ended questions are popular with survey research and provide the respondents with uniform answers from which to choose (Babbie, 2014). Creswell (2013) noted different types of interviews, such as structured, semi-structured, and unstructured. Qualitative interviews tend to be unstructured and consist of open-ended questions to "elicit views and opinions from the participants" (Creswell, 2014, p. 190). Considering the novelty of dyad leadership models in healthcare organizations, using open-ended questions for exploratory purposes to get an in-depth understanding of the model yielded detailed insights about this emerging leadership model in a specific context or setting. A detailed interview protocol was attached in Appendix D.

Data Collection Procedures

Creswell (2014) noted that the data collection phase consists of selecting a setting, collecting data through interviews and observations, and determining the protocol for recording information. For the purpose of this research, two methods were used to select a site and identify candidates to participate in the study—purposeful selection and criterion sampling. Both methods were employed to ensure the selection of an appropriate research site and confirm that the participants represented people who are engaged in a leadership dyad and can meaningfully inform an understanding of the research question.

Prior to engaging the study participants, the researcher explained the interview process and advised that the interview could be conducted at a location chosen by the participant or at a mutually agreed upon location. All interviews were recorded with an audio recording device and were transcribed professionally for coding. The researcher ensured participant privacy and anonymity by removing individual participant names from data and replacing them with pseudonyms.

The data collection procedure consisted of the following steps:

1. Completed IRB process and procured approval. Since the research site was an academic medical center, it was necessary to comply with the organization's IRB processes. The researcher pursued the chosen site's IRB approval process.
2. Prepared and developed study artifacts, interview protocol, consent form, introductory emails, and follow-up emails.

3. Identified the chosen site and reached out to an authorized site leader to gain access to dyad leaders.
4. Collected organizational artifacts, documents, and charts that reflected dyad structures in departments, divisions, or service lines.
5. Identified the study participants and obtained their contact information.
6. Sent an introductory email to each study participant describing the study, the purpose and the nature of the study, and why the participants were selected.
7. Scheduled interviews with participants who agreed to participate in the study.
8. Conducted interviews and gathered data.
9. Completed the interviews and transcribed them.
10. Organized and stored the study artifacts and the data collected on a personal computer by creating password protected folders and files to ensure participant privacy.

Qualitative Research Validity

In contrast to quantitative research, which uses instruments, scores, or trend indicators, qualitative research is focused on human experience studied and observed in natural settings (Creswell & Miller, 2000; Sharts-Hopko, 2002). Similar to quantitative research, in qualitative work, researchers need to maintain rigor and demonstrate the credibility of a proposed study (Creswell & Miller, 2000; Sharts-Hopko, 2002). Creswell (2013) recommends a number of validity strategies to ensure accuracy and credibility of research findings. For the purpose of this study, validity strategies consisted of triangulation, member checking, an audit trail, and peer review and debriefing.

Triangulation. Triangulation consists of using various data sources to develop an understanding of the researched topic. There are four types of triangulation: method triangulation, investigator triangulation, theory triangulation, and data source triangulation (Carter, Bryant-Lukosius, DiCenso, Blythe, & Neville, 2014). This study used methodological triangulation consisting of interviews and organizational artifacts.

Member checking. Member checking used to determine the accuracy of findings serves as a critical validity strategy to enhance researcher accuracy and credibility (Creswell, 2013). Member checking allowed the study participants to review the interview transcripts, modify errors, and challenge researcher interpretations and findings. Once the researcher completed Chapter 4, a meeting was scheduled with each participant and the CEO of the research site, in order to present the findings. Participants had an opportunity to review the findings and provide additional feedback.

Audit trail. In addition to using triangulation and member checking, an audit trail approach was used to augment the credibility and trustworthiness of this research. An audit trail records a researcher's decisions and activities regarding the research development, interview coding, and data analysis (Babbie, 2014). Throughout the study, the researcher maintained a log of all research activities, developed analytical memos, and documented all data collection and analysis procedures.

Peer review and debrief. To enhance the validity of the study, the researcher engaged a peer reviewer (Creswell, 2013; Schwandt, Lincoln, & Guba, 2007). The researcher provided the peer reviewer with two interviews, the purpose statement, and the research question for the study. The researcher requested that the peer reviewer would code the interviews. The peer reviewer had a preference for in vivo coding, which allows

for the use of participant language in the codes. For the shared interviews, the researcher had between 70 and 80 unique codes. The peer reviewer had between 40 and 50 unique codes. Once the coding activity was completed, the researcher and peer reviewer met to compare the results, the coding process, and how granular the coding was.

Ethical Considerations

While conducting the case study research, there were a number of ethical considerations to acknowledge in regards to maintaining participant privacy and recognizing potential researcher bias. During the data collection phase, the researcher respected the research site without causing disruptions to the participants' daily responsibilities. The participants were engaged as collaborators in the study to ensure transparency into the study and to build rapport. The researcher thanked the study participants and followed up with them to validate the accuracy of the interview transcriptions and to review the findings. To ensure participant privacy and anonymity, the researcher removed individual participant names from data and replaced them with pseudonyms.

Working in a healthcare organization that recently implemented the dyad leadership model at the service line level, the researcher had previously had exposure to the model and had observed how the dyad was implemented in a real-life setting. During the interviews, the researcher exercised awareness when interviewees would share certain details about their lived experiences with the dyad model. Creswell (2013) introduced the concept of bracketing, which entails that researchers set aside their assumptions and personal experiences with a particular phenomenon to focus on the experiences of the study participants. Thus, while conducting the research and interviewing participants, the

researcher of this study was acutely aware when there was a slight indication that pre-existing assumptions might be introduced within research process. The researcher took note of those instances during the data collection and analysis phase to ensure that pre-existing assumptions would not permeate the overall research process.

Summary

This chapter discussed the methodological approach used for this qualitative study. Dyad leadership is an emergent model in healthcare organizations. Considering the novelty of dyad leadership models in healthcare organizations, using a case study approach for exploratory purposes to closely observe unit and within-unit cases yielded new insights about this emerging leadership model in a specific context or setting. Furthermore, this chapter outlined the approaches for participant selection, sampling, research procedures, data collection, strategies for validity and credibility, and ethical considerations.

CHAPTER FOUR: FINDINGS

Introduction

The purpose of this dissertation in practice was to explore the dynamic between physicians and administrators working together in a dyad model and how the model serves as a solution for bridging the divide between the clinical and administrative domains within a specific organizational setting. The focus was on developing an in-depth description and analysis of the dyad model—its dynamic and pattern of mutual action—as examined in a pluralistic organization such as an academic medical center. Thus, the following research question guided this qualitative study: How is the role space shared and practiced within a dyad leadership model as contextual forces evolve?

The purpose of the following chapter was to present the results of eight interviews conducted for this qualitative research. The chapter was organized in three major sections. The first section provided an overview of the participant demographics, as well as a description of the research site and why and how the dyad leadership model was implemented within the organization. The second section summarized the data analysis methodology. The third section provided a detailed description of each theme that emerged followed by the analysis and synthesis of the findings in support of the research question.

Presentation of the Findings

Overview of Participants

Considering that the scope of this study was limited to dyad pairings between physicians and non-physician leaders, criterion sampling was employed to ensure that the participants represented leaders engaged in the dyad model. At the time this research was

conducted, the organizational chart contained seventeen dyads. Three dyads were in the process of being dissolved due to dyad leaders' retirement and departure from the organization. As a result, criterion sampling led to selecting dyads from multiple service lines, with a total of eight dyad leaders or four dyad pairs. The selected dyads have been working together for a period of time, have experienced their own dynamic, and have made the dyad work. Five of the participants were female and three were male. While three of the four dyads were created in 2014 at the time of the merger, one dyad was created post merger in 2015. Additionally, five of the eight participants had over twenty years with the organization, one participant had ten years, and two participants had under five years of experience with the organization. To ensure anonymity and confidentiality, each dyad and dyad partner was given a pseudonym. These pseudonyms were used throughout the study to avoid referencing the participants by their real names. Table 1 illustrates participant demographics and reflects the given dyad name, participant pseudonym, participant gender, function, title, total years with the organization, and year when the dyad was established.

Table 1

Participant Demographics

Dyad name	**Participant pseudonym**	**Gender**	**Function**	**Title**	**Years with the organization**	**Year dyad was created**
Alpha	Mary Dr. Smith	F F	Administrator Physician	Vice President Division Chief	33 4	2014
Delta	Nancy Dr. Reed	F M	Administrator Physician	Executive Director Division Chief	4 20	2014
Sigma	Margaret Dr. Edwards	F F	Administrator Physician	Vice President Department Chair	31 28	2015
Omega	John Dr. Thompson	M M	Administrator Physician	Chief Operating Officer Chief Medical Officer	10 21	2014

Description of Research Site

The study was conducted at Midwest Health System, MHS, an academic medical center located in the Midwest region. In recent years, the organization announced a merger with other entities. The Midwest Medical Center, Heartland Community Hospital, and Physician Practice Group, once three separate but inter-connected organizations, are currently operating as one legal entity. MHS is a private, non-profit entity that provides effective and efficient care to patients and supports the academic mission of Midwest University, with which it is affiliated. MHS operates one of largest hospitals in Midwest facilitating the clinical operations of private and academic physicians. The organization is known in the community for delivering high quality care and superior patient experience. The system is also known for its services, which extend from a cancer center to heart and vascular services, transplantation, and general health services; and also include general surgery, pediatrics, orthopedics, emergency medicine, primary care, and other services that greatly benefit the community. Another unique aspect of the organization's business model is its close affiliation with Midwest University, which trains physicians who in turn elect to practice at MHS.

The organization is known for its tripartite mission of education, patient care, and research. The merger of the three organizations was a critical component in the organization's vision to achieve integration of clinical and education missions, as well as to bring alignment to clinical and operational functions. In parallel with the merger, the organization implemented the dyad leadership model at the service line level, recognizing the effectiveness of physician and administrator pairs to achieve an integrated health system. The chosen site for this study clearly reflects a complex environment in which to

effectively observe and gather insights into the relational dynamic between physician and administrator pairs.

Dyad Leadership Model at the Research Site

As the research site was transitioning into a new entity with the merger, the organization decided to evaluate its service lines to understand potential consolidation and organization re-design opportunities. At that point in time, the dyad leadership model was implemented at the clinical program level and the newly created dyads were charged with formulating strategic plans for their respective programs. Thus, the organization viewed strategy as an area better addressed by not just one leader, but by two leaders engaged in a dyad model. One study participant particularly noted that as the organization developed the strategic plans, "the hospital recognized the partnership with the physicians" (Margaret of the Sigma dyad). Another participant remarked on the importance of aligning an administrative person who knew operations and strategy with a physician who can help with alignment of physician groups, recruitment, and standardization.

In addition to pursuing a merger and formulating strategic plans, study participants noted the complexity of clinical operations at an academic medical center. In a hospital setting, the labor is highly specialized and necessitates constant coordination. At the clinical program level, the complexity and coordination requires not just one leader, but two leaders engaged in a dyad model.

Organizational dynamics through merger and strategy, as well as complex clinical operations, drove the need to implement the dyad leadership model at the research site. In addition to understanding this organizational context, it is important to reconcile

additional reasons for implementing the dyad leadership. The study participants shared specific factors that also provided impetus for implementing the dyad leadership model. One compelling reason was physician engagement. The organization had experienced a pattern of physician dissatisfaction, particularly at the decision-making level. The dyad leadership model was viewed as a solution for reversing this trend. For one thing, engaging physician leaders in the dyad model was a way to develop physician leaders in the organization. In addition to this benefit, physician leaders had credibility with the physician body within the organization and certainly understood physicians' needs, behaviors, and their way of thinking. This was a "philosophical driver" (Dr. Thompson of the Omega dyad) for implementing the dyad model to engage physicians in decision-making as well as to align the clinical and the business sides. Thus, a prevalent reason for implementing the dyad model was to get physician buy-in and involve physicians in decision-making. Additionally, a physician dyad noted that there was a lack of goal alignment and that the "feeling used to be that the hospital strategic goals were different than the doctors' goals and there was a perception that the two groups disagreed" (Margaret of Sigma dyad). The dyad model was viewed as a solution for reaching goal congruency between the administrative side and the physician side.

Data Analysis

The interviews were conducted between November of 2017 and February of 2018. Out of the total of ten interviews obtained, eight were used in this research to reflect the interviewed dyads as opposed to individual participants. The interviews were sent to a third-party transcription service and then reviewed by the researcher for accuracy. Upon final transcript review, each study participant was provided with his or

her individual transcript for review and feedback. This exercise was conducted to ensure that the researcher accurately captured the information provided by the study participants. Furthermore, sharing the transcripts with the study participants served as a member checking technique to enhance the validity and credibility of the research (Creswell, 2013).

In preparation for the data analysis phase, the interview data and research materials were gathered and organized on the researcher's personal computer, which was password and PIN code protected at all times. Subsequently, the transcribed interview data were thoroughly reviewed and formatted for consistency across interviews and imported into NVivo software, a data analysis program for qualitative studies. The data analysis phase of this research consisted of two main coding cycles as recommended by Saldaña (2016).

First Cycle Coding. Considering the exploratory nature of the study and the richness of the interview data, the first cycle coding required meticulous work and attention to detail. For that reason, the first cycle coding was conducted by employing in vivo coding methodology and splitting the data into smaller codable instances to capture valuable nuances of the data. The first cycle coding consisted of selecting the appropriate coding method and going through the process of initial interview coding. Furthermore, using in vivo coding and splitting the data at a more granular level allowed the researcher to capture the participants' voices and pay close attention to the words used when providing examples or describing participant experiences with the dyad model. The first cycle of coding resulted in 237 unique in vivo codes. As a concurrent activity, the researcher used analytic memos. Analytic memos document a researcher's reflections on

emergent patterns or coding process and choices (Saldaña, 2016). The researcher found it beneficial to use analytical memos to record thoughts and observations as they emerged during coding. The researcher reflected on the words that the participants used and the "ah-ha" moments that unexpectedly appeared while analyzing the data. NVivo software was used as a repository for all the analytic memos.

Second Cycle Coding. While the first cycle coding consisted of splitting the interview data at a granular level, the second cycle of coding consisted of collapsing the initial number of codes into broader categories (Saldaña, 2016). The second cycle of coding consisted of taking an inventory and reorganizing the codes created during the first cycle. Considering the exploratory nature of the study, axial coding was appropriate to meaningfully reconstruct the fractured data, eliminate redundant codes, and relabel and regroup the in vivo codes into broader categories. An additional step in this process was to carefully examine the relationships between categories. For that purpose, the researcher used one of Strauss and Corbin's (1990) proposed coding procedures called axial coding (as cited in Kendall, 1999). Axial coding was used to link the categories and identify the appropriate components by using Strauss and Corbin's (1990) paradigm, which includes context, conditions, interactions, and consequences (Kendall, 1999; Saldaña, 2016). Using Strauss and Corbin's (1990) paradigm allowed the researcher to assess the codes and categories and examine the relationships in a systematic way.

The process of coding resulted in an in-depth understanding of the institutional context, the drivers for implementing the dyad leadership practice, how the dyad model was operationalized after implementation, and the dynamic between the dyad leaders. Six broad themes emerged from the data. These were (a) Role clarity between administrative

and physician leaders; (b) Leading together; and (c) Frequent interaction and communication. Certain themes were supported by a number of references that participants made during their interviews, as well as by the secondary sources gathered through organizational documents. Table 2 illustrates the data triangulation across the primary and secondary sources that supported the themes from the interviews. A list of organizational artifacts obtained during the data gathering phase may be found in Appendix E.

Table 2

Data Triangulation across Primary and Secondary Sources

Themes	**Primary source**	**Secondary Sources**
	Interviews	**Organizational artifacts**
Role clarity between administrative and physician leaders	✓	Job description, organizational chart, consultant document shared by COO
Leading together	✓	Organizational chart, job description, co-signed internal communication, leading meetings jointly
Frequent interaction and communication	✓	Scheduled joint meetings, office proximity. Norms were not supported by secondary sources. Norms were implicit and not formally documented in organizational artifacts

Themes

The dyad leadership model is implemented by healthcare organizations as a solution for bridging the divide between the clinical and operational functions. For healthcare organizations that have traditionally perpetuated functional silos, it is challenging to transition to a dyad model when the scope of the dyad roles is not clearly defined and structured, and when there is no established framework for the dyad leaders on how to interact and function with one another and with other organizational members.

Thus, this study was guided by one main question: How is the role space shared and practiced within a dyad leadership model as contextual forces evolve?

The research question has two distinct parts worth deconstructing—organizational context and the dyad model as a leadership practice in a healthcare organization. Leadership is placed at the intersection of external environment pressures and the internal organizational response to complex and competing industry demands. Examining the dyad leadership model through the lens of organizational context provides a deeper understanding of the dyad dynamic and how dyad leaders exercise their roles in a complex environment.

The purpose of this study was to explore the dynamic between physicians and administrators working together in a dyad model, with the unit of analysis being the dyad and the routine leadership interactions between the dyad leaders. Considering the purpose and the scope of this research, the data collection and interview phase resulted in rich data that reflect the dynamism between contextual forces that impact an organization and the organizational response through the dyad leadership practice. In addition, the data provided invaluable insights into how leaders exercise their roles within the dyad practice. The process of coding and theming resulted in three salient themes: (a) Role clarity between administrative and physician leaders; (b) Leading together within the dyad model; and (c) Frequent interaction and communication. The themes and associated sub-themes are described in greater detail in the following section.

Theme 1: Role Clarity between Administrative and Physician Leaders

As two entities were coming together, the researched organization implemented the dyad leadership model at the clinical program level, recognizing the effectiveness of

physician and administrator pairs in achieving an integrated health system, as well as involving physicians at the decision-making level in the organization. The dyads were established and organization-wide announcements were made regarding the implementation of the dyad practice. The dyads were made public and were tasked with developing strategic plans for clinical programs and their growth. This leadership practice was reflected in organizational charts publicized on the organization's intranet.

There are two ways of looking how dyad leadership is operationalized. The first way is to consider the dyad model, as a leadership practice, in connection with its organizational context and its level of embeddedness within the institution that implemented this type of model. This constitutes a macro-level view of the dyad leadership practice within a specific organizational context. The second way is to view the dyad through the routine leadership interactions that occur between actors or dyad leaders. This constitutes the micro-level view that shapes the dyad dynamic.

A notable challenge to a co-leadership model such as the dyad is understanding how dyad roles are created and how leaders practice their respective roles within the dyad model. When specifically asked about how the dyad leadership model was implemented, two dyad leaders, while acknowledging that each dyad is unique, stated that job descriptions were created. A sample of one of these job descriptions was obtained for this research. In addition to the job description, the researcher was given a document that described the leadership structure for the clinical programs with the dyad leadership being shared between clinical and administrative leaders. The sample job description reflected a number of responsibilities, including patient satisfaction, operations, financial and human resource management, planning and development, and organizational

leadership. Each of these responsibilities contained specific tasks for which dyad leaders were accountable.

Structurally, two leaders representing separate functions and stakeholder groups were placed together. While job descriptions were created for the administrative leaders, physician leaders were not provided job descriptions. In addition to fulfilling their duties under the dyad model, the physician leaders practiced medicine and fulfilled their responsibilities as division chairs. Thus, while the administrative leaders exercised their dyad roles on a full-time basis, the physician leaders exercised their roles within the dyad model on a part-time basis.

A notable theme that the participants discussed was role clarity—differentiation of roles and how some aspects of the roles do not have discrete boundaries, which can be challenging to balance. In some instances, the roles had not been prescribed prior to engaging in a dyad, but were being developed as the relationship between the leaders evolved. Table 3 reflects the codes associated with the role clarity theme.

Table 3

Theme 1: Role Clarity between Administrative and Physician Leaders

Code
Accountability on administrator side
Administrative partner has better role clarity
Clarity on role and expectation
Dyad partners report to different leaders
Dyad partners with different clinical functions
Followers report to the administrative partner only
Job descriptions created for administrative leaders
No job description for physician dyad
No orientation for physician dyad
Physician as figurehead in dyad
Physician partner affinity for own specialty

(continued)

Code
Physician partners address physician issues
Practice role based on mission
Reporting structure
Role and task division/differentiation
Roles not clearly defined
Shared responsibility

When interviewed, the COO (John of the Omega dyad) shared a brief history of why the organization had considered the dyad model as a leadership practice. He shared that as the two organizations were coming together, a dyad model "made a lot of sense to us as we were bringing physicians into a historical hospital centric organization." Additionally, John remarked on the need of having strong physician engagement as a driver for implementing the dyad model. He further elaborated on the dyad model as a way of "elevating the right leaders, showing that they were recognized and supported to keep them engaged." In addition to discussing the organizational need for the dyad practice, John shared how the dyad was implemented by creating job descriptions and coordinating tasks to avoid duplication of work:

> Here's a position description that we used in general and was started at the senior vice president level, and then went more to a VP level that we looked at what we're asking them to do…. They chose their talents, because they're strongest [talents are] in leading physicians. It's not blocking, and tackling operational, how many staff do you need, what's the financial…that's the administrator's role. It's really using the physician leader in their clinical expertise, and in working with physicians and helping divide the work that way. So, you're not duplicating work the administrator partner is doing.

Another participant elaborated extensively on how she shares the role space with the dyad partner. While observing the lack of clear definition on roles, Mary of the Alpha dyad noted how task coordination occurs within the dyad. When issues emerge, the partners of the Alpha dyad explicitly divide what each partner needs to solve independently and what the partners need to solve together. Mary specifically noted that, in addition to having a job description, the essence was for the dyad partners to make the model work for them. This micro-level manifestation clearly showcases the dynamic nature of how the role space is shared within the dyad and how it intersects with context. Mary's narrative illustrates her view on role and task differentiation:

> Job descriptions were written. You know it was so long ago, I mean I'm sure that we had some activities and some scope of where there would be interception. But, to be honest with you, it was more about the two people in the model figuring out what worked best for them.… I would say, sometimes there's not enough clear definition about who should be doing what aspects of a particular thing. And, I would say my dyad partner has a tendency to creep into operations. She is really good about the fifty-thousand-foot view, but she also likes to get in the weeds, and so there's always this dynamic of that's really not yours to worry about, that clearly sits in my bucket. And so, some of it is coming to a compromise on here's where I really need you to be, or where I need you to be. And then having the trust or the kind of relationship to say: "That's not a decision you should make." Or "Thanks for your advice, but everything that you want to happen we're not going to act on." So, it's coming to that reasonableness around here are the areas we're going to intersect and we're going to work together. But, I'm going to bring

> you my concerns when it comes to the clinical program, but I'm going to trust that bringing you my concerns, or helping you create a pathway doesn't mean that I'm going to get into your business on how you interact with those physicians around those areas. And, in return, I don't want you telling me about how a receptionist should be answering the front desk phone of the clinic. You can bring me the complaints, but don't bring me a plan that you want implemented on how to do it better. Trust that we got this.

A different participant noted that at the time she was paired with a dyad partner, there was no job description that clearly delineated the dyad roles, particularly for department chairs. Dr. Edwards of the Sigma dyad presented a different perspective on how she practices her dyad role without a job description, taking the three organizational missions into consideration:

> I think at the level of the Senior Vice Presidents, there was sort of a general idea about what they were going to be, but they really did struggle writing that down. It wasn't like someone gave me a job description for that. At a certain point, there was a notion we need to have job descriptions with how much time is really supposed to be devoted to that activity as opposed to the other activities.… Now prior to creation of the organization, the department clearly had three missions—clinical, education, and research—and the department still has three missions.… So, for me, I would consider the clinical aspects of running the department fell mostly under the bucket of being a dyad leader, and the education and research aspects fell under the mission of being the department chair.

Acknowledging that the dyad roles and scope were not clearly defined, the dyad leaders stated that the structure developed over time, along with the natural evolution of the relationship between the dyad leaders. Pairing two leaders has the potential to create confusion among the dyad leaders; thus, having clear role boundaries is important. This aspect was emphasized by John of the Omega dyad:

> I think just when you look at the dyad leaders themselves, initially when we rolled it out there was confusion about who's doing what. You know, okay, here's my role, but what are you really asking me to do? Am I just a figurehead, and my name is trotted out here, so you can put a name of a physician on an org chart to satisfy things? Or are you really going to ask me to do things? So, I think early on it was those types of things where some people thought: "Okay, I'm just going to be a name out there, and I don't have to do anything." But that wasn't why we did it. We really wanted their thoughts, and ideas, and time.… One of the things we didn't do, and we're still struggling with a little bit, is how much are we going to fund for these roles? Some we fund, some we don't fund, and that creates some dynamic tension there as well. To do it right, we need to get dedicated FTE amount for this work, and fund it.

Role and task differentiation. Alvarez and Svejenova (2005) noted that a division of labor, specialization, differentiation are necessary for small-numbers structures to work effectively, which creates a dynamic process within the professional duos. In an administrator-physician dyad, specialization is manifested through the unique expertise each partner brings. In addition, differentiation is achieved when there is a clear division of labor to avoid overlap and duplication of work.

Role clarity was a salient theme that emerged, and the participants, particularly the administrative leaders, acknowledged the presence of job descriptions. Although job descriptions clearly stated the job requirements, duties, skills, and responsibilities to perform the administrative role, the job descriptions did not explicitly differentiate the roles between the dyad partners. Thus, it is worth exploring the intricacies of how the study participants exercise their roles and divide their respective tasks absent of clear job guideline.

When asked to discuss on how their roles are differentiated, Dr. Thompson of the Omega dyad stated that the administrative partner is responsible for the day-to-day operations, while the physician partner provides subject matter expertise. In addition, Dr. Thompson acknowledged that within the dyad, "the role of the physician leader in not fully defined," emphasizing the need to create more clarity. Dr. Thompson of the Omega dyad further elaborated:

> I would say that the day-to-day work is probably largely being done by the administrative dyad partner with subject matter expertise being provided by the physician dyad leader where that can be provided.… So, I think that the role of the physician leader is yet to be fully defined, which I think would also help make for a better functional unit. We, to be honest with you, we kind of built the plane as we were flying it. So, I think if we can create more clarity and focus around the roles then we can create clarity and focus around expectations and outcomes and we're still in the process of doing that, to be honest.

Another participant provided his perspective on how the dyad roles were created and divided. Dr. Reed of the Delta dyad noted that the dyad partners dictated how their

respective roles and tasks were divided. Dr. Reed elaborated on how he and his partner agreed to divide their roles:

> I think they left a lot of that up to my dyad partner and I. The dyad partner had experience as she was the Vice Chairman for Operations for Internal Medicine.… She had a lot of experience because she was also the head manager for anesthesia for the department in the past. I think she came in with some real ideas about how the dyad was going to work and I was grateful for her ideas. So, a lot of it came from the administrative dyad portion saying: "We want a physician-led organization with physician-led elements.… You go out and lead the physicians and I'll lead the administrators."

Within the organization, the dyad partners serve in roles that fall outside the dyad model. This applies particularly to the physician leaders, who serve dual roles as clinical chairs within their clinical divisions. This arrangement poses a challenge when exercising the roles within the dyad model. A participant described two types of scenarios, in which the role division was both clear and unclear. As a first scenario, Dr. Smith of the Alpha dyad described a specific operational example that necessitated the attention of the administrative dyad. In that particular example, Dr. Smith acknowledged that there was no role confusion and that it was the administrative partner's role to resolve the issue. As a second scenario, Dr. Smith recognized that division of roles is not always clear when it comes to a programmatic issue, which requires the engagement of both dyad partners. While discussing the topic of role division, Dr. Smith further elaborated on the reporting structure as a factor in how dyad roles are exercised:

> So there are clear divisions of tasks and there are certain things that need to happen. Sometimes, I think some of the challenges can be how we share this responsibility a little bit more robustly, especially when the dyad system is relatively new.… So, the reporting structure is very odd so you can see why the COO would pick up the phone and say to my dyad partner, "Hey, I need this done." Whereas, he might not pick up the phone and say that to me, because I don't report to him. Do you see what I mean? So, the org charts need to be a little streamlined so that there are similarities in reporting, but for the most part it has worked out very well and if I bring her a physician related issue, she would respond, "This is a physician issue you deal with it." But, I think that it has worked out well and I think that although there's no formal process…there used to be earlier on a more formal reporting structure to the dyad leadership.

In addition to describing how roles get practiced within the dyad, the study participants observed the changing nature of their roles. Dr. Edwards of the Sigma dyad noted that "the concept of the senior leadership team has gone from one sort of concept to another." The clinical chairs were made of the senior leadership teams and "the dyad piece kind of continues to change somewhat," noted Dr. Edwards of the Sigma dyad. As a result, the level of interaction between the Sigma dyads changed to a lesser frequency.

On the changing nature of the dyad, the Delta dyad provided a different perspective. As the functions were being divided between the administrative and the physician partners, Dr. Reed noted the absence of nursing. Thus, Dr. Reed proposed the addition of a nurse leader to the meetings. While not a formal structure, Dr. Reed saw the benefits of having a triad that included administrative, physician, and nurse leaders. As a

result, a nurse leader was incorporated at the meetings. Dr. Reed elaborated on his views in greater detail:

> So, a lot of it came from the administrative dyad portion saying: "We want a physician-led organization with physician-led elements…. And who is left out of that piece? The nurses. So, early on I would suggest to you that one of the faults or problems with dyad leadership is the nurses are not formerly represented well in the initial clinical programs, unless the administrative leader was also a nurse.… So, I would say one of the biggest changes we needed to have was to convince my dyad partner that we needed a triad, and that she and I were missing out, because the partners that had a nurse involved had a huge advantage.

In exercising roles and dividing tasks, the participants recognized the duality of their respective roles as reflected by the separate functional domains within the organization. The administrative dyad partners noted their focus on administrative functions, budgets, costs, and day-to-day operations. Physician partners, on the other hand, tended to focus on physician issues and exercise their role with the physician stakeholder groups. Furthermore, the participants observed that certain physician partners maintained an affinity for their clinical specialty. The data gathered from interviews and organizational artifacts reveal two types of dyad structures. One type of dyad structure reflects that the dyad partners report to the same leader, while another type reflects that the dyad partners report to two different leaders. One commonality is that each dyad partner has its own direct reports. Formally, the followers do not report to both dyad partners, but to each dyad partner separately. The upward and downward vertical

reporting structure represents a facilitating element in how dyad partners exercise their respective roles. The two types of dyad structures are displayed in Figure 4.

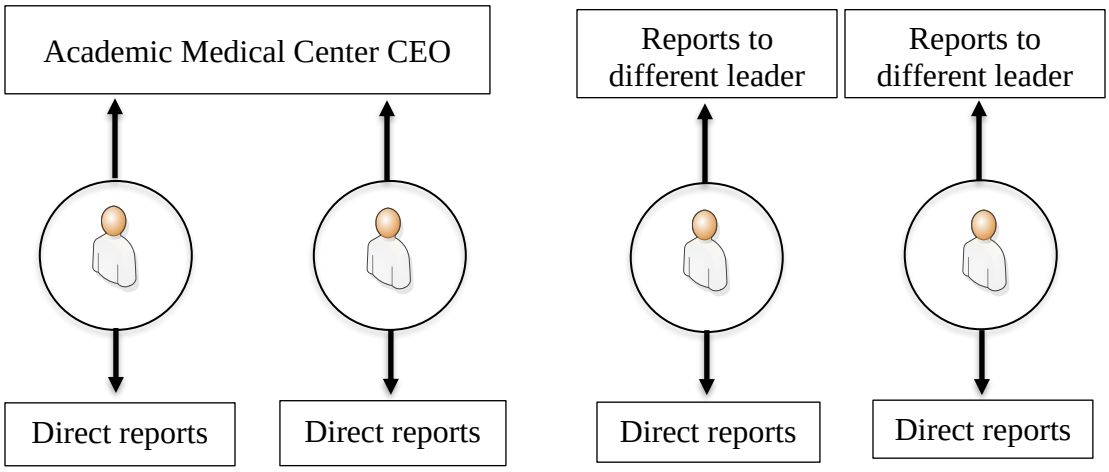

Figure 4. Two types of dyad structures.

The role clarity theme is indicative of the dynamic nature of how role space is practiced by the dyad leaders within the dyad model. At the macro-level, the dyad practice was established with the intent to engage physicians in decision-making, as well as align the clinical and the business sides. Structurally, two leaders representing separate functions and stakeholder groups were placed together within the dyad practice. While job descriptions were created for the administrative leaders, physician leaders were not provided job descriptions. In addition to fulfilling their duties under the dyad model, the physician leaders practiced medicine and fulfilled their responsibilities as division chairs. Thus, while the administrative leaders exercised their role on a full-time basis, the physician leaders exercised their role on a part-time basis within the dyad model.

At a micro-level, while consistently acknowledging the existence of role confusion and need for role definition and clarity, each dyad had its unique approach to role and task sharing. For example, the Alpha dyad reported a higher degree of task

differentiation, coordination, and frequent interactions when issues emerged. Both leaders of the Alpha dyad described a balanced initiative in dividing tasks by intentionally "discriminating what is hers and what is mine, and what is together" (Mary of the Alpha dyad). In the Alpha dyad, both leaders take an active role in enacting leadership within the dyad. In contrast, the administrative leader of the Delta dyad reported that she informs her partner of current issues and her partner selectively provides input or takes action. Thus, in the Delta dyad, one leader is more passive and one leader is more active within the dyad.

Combining the macro- and micro-level views, sharing and practicing the role space in a dyad model is a dynamic process that occurs between the dyad leaders. The role clarity theme demonstrated that in a dyad, roles are not static, but rather are dynamic in nature and morph over time based on organizational and situational requirements that arise. By contrasting the two dyads described above, it is clear that each dyad established its own "modus operandi" (Chia & MacKay, 2007, p. 231), with a more personalized rather than institutionalized approach to practicing roles within the dyad model. At the same time, within the dyad, the administrative partners displayed more confidence in their roles, while the physician leaders recognized that there was confusion around roles. Furthermore, the participants noted the need for role definition and clarity around expectations and outcomes, in order to make the dyad functionally better.

Theme 2: Leading Together Within the Dyad Model

A dyad is enacted when two individuals engage in a patterned mutual action over a period of time (Becker & Useem, 1942). A unique characteristic of a dyad is the personalized pattern that makes it impossible for the dyad members "to shift blame,

obligations, and responsibilities upon an impersonal structure when a crisis occurs, action is called for, or a decision is to be made" (Becker & Useem, 1942, p. 14). Another distinctive feature of the dyad leadership model is the mutual action that manifests itself through role sharing and leading together.

Role clarity within the dyad model, as explored in the previous section, is a challenging part of the dyad model. A notable theme that the participants discussed was the differentiation of roles and how some aspects of the roles do not have discrete boundaries. In some instances, the roles have not been prescribed prior to engaging in a dyad, but are being developed as the relationship between the leaders evolves.

Another aspect worth exploring is how the dyad leaders actually lead together within the dyad model. Leading together is a unique attribute of dyad leadership, and the data revealed two ways of how the model is manifested—horizontally and vertically. Horizontally, the dyad partners engage in a dynamic interaction that consists of decision-making, sharing information, and exercising influence. While the horizontal dynamic occurs between the two dyad leaders, the vertical dynamic occurs between the dyad partners as a leadership unit and their followers.

The scope of this research was to focus specifically on the horizontal dynamic between the dyad leaders. At the same time, it is worth noting that there is a vertical manifestation that the data revealed. However, this section is mainly focused on reporting the data that pertains to the horizontal dynamic between the dyad leaders—leading together as manifested through actions such as decision-making, information sharing, and exercising authority and influence. Exploring this theme in more depth serves as a continuation of the role clarity theme. Similar to the section addressing the previous

theme, this section focuses on the micro-level manifestations between the dyad leaders. Table 4 reflects the codes associated with the theme of leading together.

Table 4

Theme 2: Leading Together Within the Dyad

Code
Administrator the ultimate decision maker
Administrative dyad partner shares decisions and information within their domain
Agreement on decisions and goals
Authority as influence
Authority clearer on the administrative partner
Authority not clear for physician partner
Building relationships
Collaborative approach
Reaching consensus
Co-sign communication
Credibility with physicians
Dissemination of decisions
Dyad leaders on the same page/united front
Implement decisions together
Information shared in physician meetings
Decision-making process
Leading physician meetings together
Responsibility without authority
Share organizational data and information
Working together

Decision-making. An essential feature of leadership is decision-making (Westaby, Probst, & Lee, 2010). Leaders are expected to make decisions that impact strategy, performance, workforce, and various aspects of an organization. Thus, the concept of decision-making is an important area to explore, particularly in the context of a dyad leadership model. The study participants were specifically asked about decision-making with the purpose of understanding how two leaders engage in the process of decision-making and how their respective roles are exercised. In sharing his perspective on how decisions are made with his partner, John of the Omega dyad provided an

example of a current organization-wide decision. John described himself as the “ultimate decision-maker” while receiving support from his physician partner. In this particular example, the administrative leader of the dyad assumed the role of the decision-maker, while the physician partner played a supporting role by providing his thoughts and ideas to shape a better decision. John explicitly noted the importance of transparency and inclusion of his partner when making decisions. John reported the following:

> I think the joint decision is transparency and inclusion is the biggest thing to decide.… You know, it’s ultimately my decision on what we do, but my partner has been with me every step of the way asking questions, probing, because I have to have him on board when we make the change. He's going to be on board with the change, and speak positively about it as well. So, it's transparency, it's sharing the data, it's having discussions over, and getting his thoughts and ideas and opinions because I think it influences and shapes a better decision.

The physician partner of the Omega dyad elaborated that decision-making consists of using historical information or data and talking through the issue in question. Furthermore, when appropriate, the Omega dyad leaders involve operational leaders to solicit their input on the issue in question. A decision is ultimately made in a “collaborative and cooperative” manner.

In a similar fashion, one participant described the process for making a shared decision. Margaret of the Sigma dyad elaborated:

> I would say, so if we have to make decisions about things, I'm trying to think of an example. Say one of our strategic initiatives was to start the lung transparent program back up. Typically, what happens is, pretty much like any other

> initiative, we gather the data, we analyze the data and then together based on what the data says, based on what the opportunity is, we make a shared decision. Oftentimes, we will bring in other key stakeholders to get their input as well and show them the data and see if they are on board as well and those would be the subordinates just right below us.

While describing an equivalent experience with joint decision-making, another participant revealed a frequent interaction with her dyad partner and being intentional about "discriminating what is hers, what is mine, and what is together" (Mary of the Alpha dyad). This pattern of recognizing the areas in which the dyad is activated versus the areas in which each dyad partner acting individually can be detected in the role clarity theme. Additionally, when referring to making decisions with her partner, Mary noted that "because we are close in proximity we have the luxury of having some of this dialogue in real time."

When describing the decision-making process, the participants focused their discussion on the interaction between the dyad partners. One participant in particular also elaborated on organizational decision-making, indicating how decisions made above the dyad impacted the dyad itself. Dr. Edwards of the Sigma dyad reported:

> I think it is by conversation about bringing background information. I think sometimes we are beginning to get a little better at this, but sometimes a decision has really been made perhaps not even by the administrative dyad, but a level above that administrative dyad and said to that administrative dyad.… which is perfectly appropriate in an organization that there is a decision level and, in some sense, the Chiefs. At the very top is the CEO, so the CEO can make a decision

> and this goes down and needs to be enacted by, you know, whoever.… So, I think there's been a fair amount of that where a decision is implementing some decision that's been made.

Dr. Edwards explained in greater detail that organizational decisions are made at the Chief Officer level and subsequently disseminated to the dyad leaders. At that point, the dyad leaders jointly decide how to implement that decision. Thus, at a macro-level, the dyad receives a decision from the organization and at micro-level the dyad leaders have the latitude to decide on how to implement the decision.

Information sharing. Exploring the concept of decision-making, the data revealed that information sharing was an essential facilitator in the decision-making process between dyad leaders. The role clarity theme uncovered that physicians tended to focus on physician issues and clinical activities, while managers focused on administrative functions, budget, cost, and financial performance. In a similar fashion, the dyad partners possessed and had access to different types of information and organizational data that were shared to make a decision or take action.

The study participants acknowledged that sharing information was a regular occurrence during formal and informal interactions. When considering the concept of information sharing within the dyad model, it is worth paying attention to the sets of information that each dyad partner has access to and shares. While discussing this topic, one study participant noted the amount of information that she shares with her partner. The information is particularly focused on hospital operations, growth, revenue, and workforce. Margaret of the Sigma dyad remarked:

> It's any organizational updates. It could be any strategic initiatives. We might talk about what's going on in the healthcare industry, what's going on at a national level versus a local level. Are there opportunities that we're missing? A lot of times we talk about our teams and our teams performing well and if there's any safety issues or concerns. Typically, before any of the meetings end they always ask me, is there anything you would like me to do for you? So, I almost feel like sometimes that they see me as kind of the worker bee and I feel like that sometimes that they know that the real boots on the ground operations are being handled by me, but they are at the table to support those initiatives, and help with decision making, and provide advice.

Margaret's narrative revealed an intriguing detail about her feeling of being perceived as a "worker bee" by her physician partner. Based on this account, within the Sigma dyad, the administrative leader perceives her role as the "worker bee" and "boots on the ground," while physician leader plays a role in supporting organizational "initiatives and helping with decision making and providing advice" (Margaret of the Sigma dyad).

While Margaret elaborated on the type of information that she exchanges, such as operational and financial data, her physician partner explained the unique information that she shares. As a physician with past institutional knowledge, Dr. Edwards of the Sigma dyad ensures that her partner has exposure to historical background and how particular actions could impact aspects of the mission such as education. This positions Dr. Edwards in an advisory role, sharing her institutional knowledge, providing a

physician's perspective, and explaining the implications of a decision. Dr. Edwards further elaborated:

> I would say partly and certainly different aspects, my partner has brought data and that data might be volumes or it might be financial, some aspects of that. What I usually bring to the meeting is background in terms of how has this worked. So, background provider perspective and an impact on education I think is a big one that I have brought. So, helping my partner understand why somebody is asking for X, Y, or Z, and how that fits in, and who else would be involved with that and how that normally had gotten done before the merger. So, I would say, I was bringing sort of background information more only if she had a need for something very specific that would have been data that I would have brought to an interaction.

The Omega dyad expounded that the information the partners exchange relates to performance metrics, quality outcomes, safety, as well as patient relations issues. In addition, the dyad exchanges information about the overall health system and oversees the implementation of projects the partners co-sponsor.

Using a similar approach, the Alpha dyad leaders provided their perspective exchanging information. The dyad partners accountable for a service line share any information related to the service line, including financial performance, quality metrics, workforce, and physician recruitment to ensure program success. Mary of the Alpha dyad elaborated on the type of information shared with her partner:

> Everything that is important to grow the service line. Physician recruitment, strategic plan implementation, fiscally where we stand, volume where we stand,

> you know, critical deficiencies that we are experiencing, problems that need to be solved, staffing issues, outcomes, everything. I mean, we talk about everything, and she has a very good understanding, not only of cancer, but we have made it a point with her, in getting her to understand where cancer sits in a bigger picture. So, I don't only share the stuff about what's happening in our service line, but I will share the fiscal metrics of the organization, the quality metrics of the organization, so that she has some context of how it sits within a bigger system.

Mary's physician partner in the Alpha dyad shared her appreciation for getting exposed to the financial and patient volume information needed to build a service line program. Dr. Smith of the Alpha dyad expounded:

> When we are building a program a lot, so financial information, volume information, and metric information, and there are certain things that she won't bother me about and I won't bother her about. So, whether we are looking at programs or whether we are looking at pure physician and patient modeling, you know, I'll give her updates, but she doesn't need to go to the meeting. She's invited to the meetings but she doesn't want to go, but like today we had a meeting with all the physician leaders about what we do about our upcoming finances, and that's really appropriate to let us all know what's looming in the environment. Sometimes it's good information sometimes it's not so good information.

Nancy of the Delta dyad shared her perspective on information sharing with her dyad partner:

> Well, all sorts of things, depending on the issues of the day. Usually, we have the operational director there as well, so we can go through operational issues and concerns in various areas such as budgeting issues and concerns, contracting issues, recruitment issues, strategic initiative updates. He might have questions about various messages coming from senior leadership or he will share messages that have been delivered in various venues that he goes to, whether it be division meetings or meetings they have with the Dean. It's just trying to keep one another informed.

Information sharing is an essential mutual action that occurs between the dyad partners. Interview data revealed that each partner possesses unique information based on access to information sources, training, and knowledge. That unique information is exchanged through the interaction that happens within the dyad. Figure 5 is an illustration of information sharing that occurs between a physician and administrator dyad.

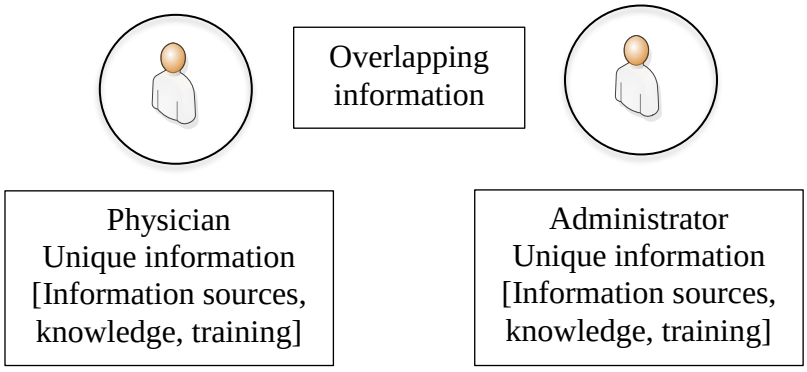

Figure 5. Information sharing in a dyad leadership model.

Authority and influence. As the definition suggests, dyad leadership consists of two individuals with different skill sets, education, and backgrounds who are paired to better fulfill the mission of the organization (Sanford & Moore, 2015). In addition to their

skill sets, education, and background, the two leaders are combining their expert power (Sanford & Moore, 2015). Exploring how authority is exercised, the data revealed the concepts of authority and influence to be different. When elaborating on how authority is exercised, Dr. Thompson of the Omega dyad elaborated:

> I would say that at least with me personally and my dyad partner, neither one of us view the other as having authoritative veto power and neither one of us believe that we ourselves have any authoritative veto power. We really try to be collaborative in how we approach things and if there is a discrepancy or a difference we always try to work that out prior to communicating anything. We want to have the appearance of a united front that I would say 99.9% of the time we do.

Dr. Thompson's partner provided his perspective on how the dyad structure between the physician and administrator influences the way authority is exercised. In his particular dyad, John of the Omega dyad explained that the partners are accountable to two different leaders. The administrator has authority and holds decision-making powers, while the physician holds clinical responsibilities and does not exercise authority within the dyad. John expounded:

> When you look at it administratively, I'm accountable to the CEO; the dyad partner is accountable to the Dean of the school. So, I say that tongue in cheek, but when rubber meets the road, I'm the one that if something's not performing well, the way we're structured, the physician can always go back to being a physician, and doing their leadership on the College of Medicine side. I'm the only one who would basically lose my job, you know, from that standpoint. So,

> the exercise of authority defaults to the administrator because that's all we do, whereas on the physician leadership side they have multiple responsibilities; the dyad leadership part is a component of that. We don't have anybody today that they're one hundred percent a physician leader. So, that's when you exercise authority, you have to have a little bit of that balance where the administrator does end up being I think the ultimate decision maker, but the physician is right there beside you. But that's how I see it.

Another participant noted that exercising authority is challenging. Nancy of the Delta dyad explained that she has authority over the hospital employees that work for the service line. While the physician partner has authority within his physician responsibilities, his authority is not "officially recognized" within the dyad. Nancy expounded:

> Well, it can be challenging. We obviously have authority over the people that are MHS employees that work for our programs. With the physicians it has been challenging, because I would argue there is not that authority officially recognized. That's part of the reason that I was hired—I'm good at working with physicians, try to be collaborative with them, and try to communicate with them.… I don't want to put everybody in the same huge group, but I think a lot of the physicians even till this day feel like decisions are made without their input. I think that's true. I'm sure many still are and there's probably reasons for that, but it is supposed to be a physician-led organization. So, I think they feel like sometimes it's more obvious than other times, and with certain things they still don't feel like they have much authority over.

A similar pattern was acknowledged by Dr. Edwards of the Sigma dyad, who saw herself in a supporting role for decisions that have already been made. Dr. Edwards shared her perspective:

> I would say that most of my authority has not really been authority as much as much as giving input and then supporting decisions that have been made, and then taking that support back over on the departmental side. I think it's a work in progress.… Is the dyad level a level where some of that decision-making is actually made obviously with accountability above that? I think that is being a little mushy. I think on the administrative side of the dyad piece of stuff there has been some authority and I think it's getting clearer as we continue to evolve this process, but I would say at the very beginning it was less clear.

When describing how she exercises authority, Dr. Smith of the Alpha dyad noted the difference between her authority within the division and within the dyad, which is not as clear. Dr. Smith elaborated:

> I don't know if we all have any authority really unless we have financial leverages. For example, many of us that run our divisions, so we have authority of our divisions, be it citizen, doctor, or do what you get hired to do; obviously the authority comes in as reimbursements, as well as your ability to hire and fire. So, that's authority, but for the majority of what we do we are not given clear authority. We are given a set of leadership skills that allow us to say, "Hey, by the way this would be in your best interest to do." For example, here are some you're looking at cost reducing by X, Y, and Z and here would be some mechanisms that you could do so. It's not like we have authority to say, "Hey, by the way, we're

not going to do a 10% reduction." Of course we have to do a 10% reduction, but how we do that 10% reduction may be within our scope of what we do.

The leading together theme has revealed the dynamic and collective nature of the dyad model. Leading together is a unique attribute of the dyad model, as the source of leadership comes not from a single leader, but from two leaders. To lead together, the dyad leaders engage in joint decision-making, keep each other informed, and exercise influence within the dyad model. Nevertheless, the leading together theme revealed how leaders practice their roles, along with challenges that the leaders encountered. When it comes to leading together, the administrative leaders appeared to have more clarity around decision-making and authority. While physician leaders retained their decision-making power and authority within their respective clinical divisions, within the dyad model they played supporting and advisory roles. Physician leaders exercised their roles by providing input and showing support for organizational decisions disseminated to the dyad.

Theme 3: Frequent Communication and Interaction

In contrast to large groups that require conformity to the whole, dyad structures are characterized by the individual actors who engage in a patterned mutual action over a period of time. As reported in the previous sections, leading together occurs through activities such as joint decision-making and information sharing. In addition, exercising roles within a dyad dynamically happen through role division and task coordination. Within a dyad, leading together and exercising different roles does not happen without a relational mechanism. The study participants consistently noted the importance of communication and the frequent interaction between the dyad leaders. Communication

and interaction serve as the relational mechanisms within the dyad. This theme has four strands that are worth noting: access to partner, formal and informal interaction, addressing disagreements, and norms that guide the dyads. Table 5 reflects the codes associated with the theme of frequent communication and interaction.

Table 5

Theme 3: Frequent Communication and Interaction

Code
Access to dyad partner
Address disagreement-consider different perspectives
Address disagreements with discussion
Close proximity
Communicate expectation
Communicate intent
Constant communication
Face-to-face dialogue
Formal meetings
Frequent interaction
Honesty-communication
Improved communication between partners
Informal meetings and touch points
Keep physician partner informed
Multiple modes of communication-text, phone, email
No blindsiding rule
Open-door policy with partner
Respect and respectful to other person
Transparency in communication
Have trust and support/build trust

Access to Partner. When exploring the dyads interviewed for the study, the researcher observed that certain dyad partners had offices next to one another, while other dyad partners were dispersed throughout the campus. Two dyads explicitly remarked on their frequent interaction due to the close proximity of their offices. Thus, access to the dyad partner was noted as an important element in making the dyad model work. Recognizing the importance of having access to her partner and being in close proximity,

Mary of the Alpha dyad noted the need for "dialogue in real time," particularly when facing an issue or needing input from her partner. Mary noted that the "exchange makes decision-making, and problem solving a lot easier" and is a better way to run the service line. The participant further elaborated:

> I think it is constant communication. I think you have to have regular meetings, I think you have to have informal touch bases, I think you have to be within close proximity to each other. My dyad partner's office is right next to mine. I cannot tell you how many times we run into each other's office to say something, or I'll be in the middle of a meeting and, I'll say, "Wait a minute, this is something my partner should hear, and I will run and get her." I have her cell phone number on speed dial. It is about access. If you want this to work, you have to create consistent points of access, and it just can't be a weekly meeting, a quarterly meeting. I've got to tell you, the value of her being next to me or on my floor is huge. And, you have to have someone who answers their email in a timely manner.

The Omega dyad, with its dyad partners in close proximity to one another, remarked on having an "open door policy." Dr. Thompson noted in particular his preference for face-to-face communication with his dyad partner. Furthermore, his partner confirmed the benefit of being "next door," which facilitates the dyad leaders' daily interaction.

Formal and informal interaction. While two dyads explicitly noted the benefits of being in close proximity, all of the dyads interviewed for this research remarked on the frequency of the interaction between the dyad partners. The interactions described were

formal and informal, and both types of interaction served their unique purposes, depending on the need of the partner. On one hand, the dyads recognized the need to interact with partners in formal meetings with specific agenda items to discuss, share information, and make decisions. The scheduled interactions would occur once a week or once a month. On the other hand, the dyad partners also had frequent informal interactions. The informal interactions occurred face-to-face, as well as via various modes of communication such as email, phone calls, or text messages.

A participant discussed the frequency of the interactions, emphasizing the importance of developing a good relationship with his partner. John of the Omega dyad described his interaction with the dyad partner:

> I interact with him every day, multiple times every day. We have formal weekly meetings, and then we're in various other committee meetings jointly, but I interact with him every day. And a lot of times, even on the weekends, we exchange texts, or notes, or something like that if something is popping up that we need to talk about. So, I mean, we just have to develop a really good relationship. My dyad partner's office is through the wall right there next door, which makes it really easy to see him every day.

Another participant, Mary of the Omega dyad, also described her interactions with her partner. The participant emphasized the benefits of developing a personal connection with the partner, which, in turn, leads to creating trust between the partners. She elaborated:

> In person daily, except on the days that she’s in surgery. So, I would say, on average, I interact with her at least three to four days a week, multiple times a

> day. And it might just be “Hey!” “Hi!” “How are you?” Or, it could a very non-related hospital thing. The other thing that I think is important with the dyad model is to understand that, in order to really create trust, you have to have some kind of personal connection with that person. So, my partner knows all about my family. She’s met my husband. We’ve gone out. I know what my partner’s family situation is. I know what she loves to do. I know her favorite kind of wine. She knows how I’m wired. But, that is, that’s important from a trust standpoint. So, when you make a connection with somebody personally, your investment in them escalates pretty dramatically.

A different dyad described the mix of formal and informal interactions. The physician partner of the Delta dyad (Dr. Reed) confirmed that the partners meet on a weekly basis in a formal setting. At the same time, he also noted informal interactions via alternative modes of communication, such as sending text messages to contact one another when needed:

> We text, and I talk to her almost every day by text. We are very informal. She will text me at 5 o’clock in the morning or 10:30 or 11:00 o’clock at night occasionally.… I’ll call her or I’ll text her and say: “I really need to talk to you today for 15 minutes.” Or she’ll say: “I need to come and see you” and I will be in clinic.

The Sigma dyad described in detail the formal and informal interaction that occurs between the partners. Both dyad leaders noted the formal meetings that are scheduled with one another as well as other leaders. Margaret of the Sigma dyad noted the multiple meetings that both partners attend together. Additionally, in case of an

urgency, the partner elects to use technology such as sending text messages or emails to connect. Margaret of the Sigma dyad expounded on the nature of the formal and informal meetings:

> Okay, so formally we have with all of them I meet with them once a month in a formal meeting where it's just me and them sharing information, talking about any issues, any concerns, any things we need to move on, but that would be formally. Informally, for the acute care structure, we have an acute care advisory team that me and the dyad partner lead and then we have three sub groups that report up to us. The sub groups are all related to operations, quality and patient safety, and professional development and succession planning. All of that was identified in our original strategic plan.

Address disagreements. Leaders engaged in a dyad model are bound together based on organizational structure and the interaction that is occurring between the two leaders. Similar to any group dynamic, the leaders' actions have an effect on one another, and conflict or disagreement can arise. Thus, understanding how the dyad leaders dealt with arising disagreements was an important aspect to explore as part of the overall dyad leadership model. When inquiring about how the dyad leaders faced disagreements, John of the Omega dyad described his perspective:

> Honestly, when we do have differences we just talk it out. We don't have really "disagreements" per se very often, but, you know, if we have, "Do I go left, or right?" And I say, "Left." And he says, "Right." We talk about it, and just say, listen to each other's side, and point of view, and then we come to a mutual decision. One thing we do is that once we decide on a direction, we leave the

> room decided united. Whether it was my idea at first, or his idea, it doesn't matter, once we decide the direction we decide, and we go, and we support each other, and outside the room we don't share our disagreements. Yeah, that is because that's one of our mantras in some of our meetings is that we're going to come to the meetings prepared, and we're going to actively participate, and when we decide something we leave it united.

The physician partner of the Omega dyad stated that few disagreements arise with his partner. When disagreements emerge, Dr. Thompson explained that they get resolved "through conversation and I can honestly say that we have never walked out of a conversation, in which there may have been a disagreement or different thoughts about something to begin with where we haven't walked out united."

The Omega dyad leaders emphasized the concept of being "united" once a resolution or a decision was reached. A similar sentiment was shared by Margaret of the Sigma dyad:

> So, if there's a disagreement all of the partners are very, very good at listening to each other. If we disagree, we'll say: "Now, I respectfully disagree and here's why." And typically, we come to a consensus, but when it's all said and done we walk away and we support whatever the decision is moving forward.

When facing a disagreement with her dyad partner, Mary of the Alpha dyad takes the physician's mindset into consideration. Mary prefers to be direct with the dyad partner, to "leave the emotion" out of the discussion, and to use data to demonstrate an opportunity for improvement. In addition, Mary has developed an understanding of how

to speak with a physician, particularly her dyad partner, without placing blame for a specific issue. Mary shared her perspective in greater detail:

> Head on. And, she's a very data driven person so I try to leave the emotion out of it, because she can get very defensive, and so I always come with an objective data perspective. And I always coach it in terms of "Here's an opportunity for improvement." I've learned long ago that, physicians particularly, have difficulty accepting criticism, they automatically go to problem solving, instead of just thinking kind of through things. They jump over a lot of steps from a process standpoint, but I do it two ways. Number one, I'm direct with her, and I also coach things in terms of "I." "It is my understanding." "I see it this way." Because when you get into this "you," like, "You need to get your surgeons in line because they don't come to clinic on time and its screwing up our ability to get patients done." When I said the word "you" to her she has shut down. So, it's about, "I feel it's about we need to find a way to a way together to fix the problem of surgeons not coming to clinic on time." And, "Here's the data from five of the surgeons on when they show up for clinic and when their first appointment was scheduled." So, that's a way for me to say, "Here's the data." "I want to help you with this" and, "It's not just your problem."

Norms. Dyads represent small groups comprised of two individuals or actors. A small group such as a dyad is characterized by structure and cultural traits (Bonifacio, 1961). While status and role are attributes of structure within a small group, culture traits are manifested through material elements such as property or books, and non-material elements that consist of oral and written codes of behavior (Bonifacio, 1961). In the

healthcare setting, one form of a dyad represents the pairing between an administrator and a physician leader. Similar to any group setting, a dyad is subject to an "unwritten code of behavioral rules or norms that guide the interaction of the group" (Miles, Paquin, & Kivlighan, 2011).

In addition to exploring the communication patterns between the dyad leaders, it is worth exploring the norms that guide their interaction. The study participants consistently noted that while some norms were established, some norms emerged as the dyad evolved. Dr. Thompson of the Omega dyad remarked that his dyad has not "drafted anything," confirming that there were no formal norms that guided the dyad. At the same time, John of the Omega dyad elaborated:

> The norm is I over-invite him to everything, and not for fear of missing out, but I want total transparency. And that's the norm we've developed is total transparency between us that, you know, he'll get contacted on some things and he'll mention it to me in case I haven't heard about it, and vice versa; so that way we're not surprised walking down the hallway and somebody mentions something that will have gotten an advance notice on it from one or the other, and we can say, "Hey, we got it, we're on it." That type of thing, because that's one thing we want to do as a united front.… The other norm we developed is we go on open forum tours, we went to every academic department chair, and some of the chiefs even as well, too, and just had no set agenda, just come in and talk for a half hour, hour, about what's working, what's not working, and what we can do to help type of thing.… Some of them organically emerged just based on how some of the work evolved. And we didn't intentionally set out to say, "We're going to do these

> open forums.' But as we looked at how we strengthen position, and engagement, and communicate better, and have more visibility out to the physicians.

Another dyad reflected a similar pattern, with the physician partner stating that there are no rules, while the administrative partner articulated emergent norms that guide the dyad. Mary of the Alpha dyad provided a few examples of norms:

> A couple things. I think we're both very respectful if we're, number one, keeping people informed of what we say we're going to do; keeping each other informed about what we say we're going to do. I think number two is that, if I am unable to make a meeting or do something that she wants me to do, or I said I'd be involved in something and I can't, to be very respectful about letting her know that.… When I text her, I know that she will call me back quickly. So, if I'm texting her about something, she knows I need her now. And, I know if she's texting me, she needs me now. So, the text is like the alert. So, one of our norms is, if you're getting a text from me, I really need your advice, I really need you input, I need something from you. The other rule is when we've gotten into a good rhythm of when we get emails sent to both of us, it's like "Hey, you need to help me with this." Before we respond, we either send an email to each other to say, "Are we going to talk about this first before we respond?" "What are you thinking?" Or, "This is in your camp." Or, "I've got this." So, when I see that something has been sent to both of us, we're both really good about not, like, acting on it on our own. And, sometimes it's just like "That's mine" or "That's yours."

Another dyad described that the norms of the Sigma dyad emerged around the pattern of communication. Dr. Edwards described the following norm: "Having some

standing meetings involving me when there was a task for the dyad that was sort of a strategic planning task." Margaret of the Sigma dyad confirmed the same norm and elaborated on a few other norms:

> I think really the norms I should say that any time there is an issue or concern we either text each other or we simply pick up the phone and we talk to each other. So, I would tell you that on any given week, I probably talk to my partner at least three times. And it could be little things, like "We have a couple new interview candidates that are coming in to interview for different jobs, why don't you sit down with me so that they see the partnership between administration and the college?" So that could be it. There may be patient care issues or quality issues and so we just kind of go back and forth that way. I think more than anything it's just that the norm is that we are both on the same page in terms of sharing information so that at any given time we both know what's going on.

The frequent communication and interaction theme revealed the relational nature of the dyad model. Similar to the other themes, the dyads developed their own way of operating that dictated the frequency and depth of interaction. Emphasizing the importance of constant communication, dyads are subject to codes of behavioral rules or norms that guide the interaction of the group. The study participants particularly noted that while the dyads abide by certain norms, the norms emerged only after the dyads were established and continued to evolve as the dyad evolved. While the dyad partners did not deliberately established group norms, the norms that guided the dyads were implicit in nature and were not documented in any organizational artifact. In addition, these themes revealed the dynamic nature of the dyad. Building relational pathways requires time and

mutually satisfactory interactions that occur over time. Two dyads that reported close proximity and frequent formal and informal interactions appeared more confident in their dyad and noted the presence of a close and personalized relationship between the dyad partners. Two other dyads, while still displaying mutual respect for their respective partners, reported a lesser frequency of interaction, and there was little to no indication of a close relationship.

Analysis and Synthesis of Findings

Healthcare organizational structures and dynamics have evolved throughout the years, creating the need to effectively manage scarce resources, redefine the models of care, and integrate clinical and administrative activities to achieve economic efficiency and improve quality outcomes. In the healthcare context, a physician leader and a non-physician administrator have specialized skill sets and roles. While a physician is trained to provide patient care, an administrator is trained to address organizational issues. This disparity in skill sets and roles creates and perpetuates functional silos. Facing such challenges requires a better integration of clinical and administrative functions and a close collaboration between physicians and non-physician leaders. The dyad leadership model is implemented by healthcare organizations as a solution for bridging the divide between these separate functions. Thus, the following research question guided this qualitative study: How is the role space shared and practiced within a dyad leadership model as contextual forces evolve?

The research question has two distinct parts worth deconstructing—organizational context and dyad model as a leadership practice in a healthcare organization. A detailed examination of institutional pluralism and logics was not within scope of this study. At

the same time, it is worth recognizing that institutional context and its multitude of logics not only shape the entire health sector (Greenwood et al., 2011), but also influence how healthcare organizations respond internally. Leadership is placed at the intersection of external environment pressure and the internal organizational response to complex and competing industry demands.

There were external and internal contextual forces that led the researched organization to consider its leadership practices. The external forces were represented by industry dynamics that propelled the organization to transform its leadership practices to better align clinical and administrative activities. In addition to the forces located outside the organizational boundaries, there were internal organizational dynamics that served as triggers to adoption of the dyad leadership model. As the research site was transitioning into a new entity with the merger, the organization decided to evaluate its service lines to understand potential consolidation and organization re-design opportunities. At that point in time, the dyad leadership model was implemented at the clinical program level and the newly created dyads were charged with formulating strategic plans for their respective programs. Thus, the organization viewed strategy as an area better addressed by not just one leader, but by two leaders engaged in a dyad model.

External and internal organizational dynamics drove the need to implement the dyad leadership model at the research site. In addition to understanding organizational context, it is important to reconcile additional reasons for implementing dyad leadership. The study participants shared specific factors that also provided impetus for implementing the dyad leadership model. One compelling reason was physician engagement. The organization had experienced a pattern of physician dissatisfaction,

particularly at the decision-making level. The dyad leadership model was viewed as a solution for reversing this trend. For one thing, engaging physician leaders in the dyad model was a way to develop physician leaders in the organization. In addition to this benefit, physician leaders had credibility with the physician body within the organization and certainly understood physicians' needs, behaviors, and their way of thinking. This was a "philosophical driver" (Dr. Thompson of the Omega dyad) for implementing the dyad model to engage physicians in decision-making, as well as aligning the clinical and business sides. External and internal organizational dynamics represented macro-level manifestations that led to the decision to implement the dyad model as a practice at the selected research site.

The second part of the research question is regarding the dyad leadership model and how the role space is practiced within the model. A notable theme informed this part of research question, and that was the dynamic, collective, and relational phenomenon of the dyad leadership model. A dyad is enacted when two individuals engage in a patterned mutual action over a period of time (Becker & Useem, 1942). A unique characteristic of a dyad is the personalized pattern that makes it impossible for the dyad members "to shift blame, obligations, and responsibilities upon an impersonal structure when a crisis occurs, action is called for, or a decision is to be made" (Becker & Useem, 1942, p. 14). Data collected through interviews and organizational artifacts revealed three salient themes: (a) Role clarity between administrative and physician leaders; (b) Leading together within the dyad model; and (c) Frequent interaction and communication.

Role clarity was a challenging part of the dyad model. This theme demonstrated that at a micro-level within a dyad, roles are not static, but rather are dynamic in nature

and morph over time based on the organizational and situational requirements that arise. Each dyad established its own "modus operandi" (Chia & MacKay, 2007, p. 231) with a more personalized rather than institutionalized approach to practicing roles within the dyad model. Participants noted the differentiation of roles and how some aspects of the roles did not have discrete boundaries. In some instances, the roles had not been prescribed prior to engaging in a dyad, but were being developed as the relationship between the leaders evolved. The role clarity theme uncovered that physicians tended to focus on physician issues and clinical activities, while managers focused on administrative functions, cost containment, and financial solvency.

Leading together is a unique attribute of the dyad model, as the source of leadership comes not from a single leader, but rather from two leaders. To lead together, the dyad leaders engage in joint decision-making, keep each other informed, and exercise influence within the dyad model. Nevertheless, the leading together theme revealed both how leaders practice their roles, as well as challenges that the leaders encountered. When it comes to leading together, the administrative leaders appeared to have more clarity around decision-making and authority. While physician leaders retained their decision-making power and authority within their respective clinical divisions, within the dyad model, they played supporting and advisory roles. Physician leaders exercised their roles by providing input and showing support for organizational decisions disseminated to the dyad.

In addition to leading together, study participants consistently noted the importance of frequent communication and interaction between the dyad leaders. As in the other themes, the dyads developed their own modus operandi dictating the frequency

and depth of interaction. Communication did not manifest as a discrete activity, but rather as a continuous activity around managerial aspects such as decision-making, strategic planning, or problem-solving, as well as around the interpersonal relationship between the dyad leaders. Furthermore, the communication between the dyad leaders was facilitated by proximity, frequency of formal and informal interactions, and dyad leaders' ability to address emerging disagreements. In addition to emphasizing the importance of constant communication, dyads are subject to codes of behavioral rules or norms that guide the interaction of the group. The study participants particularly noted that while the dyads abide by certain norms, the norms emerged only after the dyads were established, and continued to evolve as the dyad evolved. While the dyad partners had not deliberately established group norms, the norms that guided the dyads were implicit in nature and were not documented in any organizational artifact.

The following research question guided this qualitative study: How is the role space shared and practiced within a dyad leadership model as contextual forces evolve? The three salient themes revealed that sharing and practicing the role space in a dyad model is a dynamic, collective, and relational process that occurs between the dyad leaders. The dynamic nature manifested through the constant negotiation between organizational context and the dyad leaders' unique way of operating within the dyad. The data revealed that while structurally, the dyads might appear static through job descriptions and reporting hierarchies, the roles within the dyad model were fluid and dynamic.

Sharing and practicing the role space within a dyad is also a collective process. The data revealed that while managers focused on administrative functions, budgets, cost

containment, and financial performance; physicians tended to focus on physician issues and clinical activities. The roles within the dyad are exercised through differentiation and specialization. In an administrator-physician dyad, specialization is manifested through the unique expertise each partner brings—clinical versus business. In addition, differentiation is achieved when there is a clear division of labor to avoid overlap and duplication of work. As an area for improvement, study participants noted the need for role definition and clarity around expectations and outcomes to make the dyad functionally better.

In addition, sharing and practicing the role space is a relational process. Within a dyad, leading together and exercising different roles does not happen without a relational mechanism. The study participants consistently noted the importance of communication and the frequent interaction between the dyad leaders. Communication and interaction serve as the relational mechanisms within the dyad. Building relational pathways requires time and mutually satisfactory interactions that occur over time. Each dyad developed its own way of sharing the role space through a relational process. Two dyads appeared to rely on a close and personalized relationship. In contrast, two other dyads were content with a more formal and less intimate relationship, while still maintaining mutual respect between the dyad leaders.

Dyad structures are unique, each with its own established modus operandi. Even though dyads represent small groups of two actors and require greater unity, actors are allowed to preserve their individuality and maintain a degree of autonomy. Additionally, dyad structures are not only characterized by the individual actors, but also by the actors' interaction with one another in a dynamic organizational environment. The complexity of

organizations and the role of leaders result in greater demand for dynamic, collective, and relational processes that enable leaders to collaborate, exercise their roles, and jointly lead in dynamic organizational settings.

Summary

This chapter reviewed the research methodology, introduced the study participants, outlined data analysis procedures and coding, and discussed the findings Through the analysis, the researcher was able to address the main research question: How is the role space shared and practiced within a dyad leadership model as contextual forces evolve? Data collected through interviews and organizational artifacts revealed three salient themes: role clarity between administrative and physician leaders, leading together within the dyad model, and frequent interaction and communication. These themes revealed that sharing and practicing the role space in a dyad model is a dynamic, collective, and relational process that occurs between the dyad leaders.

The chapter presented the results of eight interviews organized in three major sections. The first section provided an overview of the research site and participant demographics. The second section summarized the data analysis methodology. The third section contained a detailed description of the three central themes that emerged. The next and final chapter will address the proposed solution; implications for implementation; practical, research and leadership implications; and final conclusions.

CHAPTER FIVE: CONCLUSIONS AND RECOMMENDATIONS

Introduction

The focus of this research was on developing an in-depth analysis of the dyad model—its dynamic, pattern of mutual action, and evolution—as examined within an organizational context. This study contributed to the body of knowledge concerning emerging leadership models such as the dyad model by addressing the dynamic nature of two leaders engaged in a dyad structure. Under the premise that the shared role space of dyad leaders is dynamic rather than static, this study addressed how roles are practiced in a dyad leadership model as contextual forces evolve within a specific organizational setting.

The purpose of this chapter was to provide a summary of the entire study. The following discussion focused on the research question and purpose statement, and presented an integrative framework for the dyad leadership practice. Additionally, this chapter offered concrete recommendations that organizational leaders can use to implement or optimize the dyad leadership model. Furthermore, the chapter outlined research and leadership implications, as well as avenues for future research.

Purpose of the Study

The purpose of this dissertation in practice was to explore the dynamic between physicians and administrators working together in a dyad model, and how the model serves as a solution for bridging the divide between the clinical and administrative functions within a specific organizational setting. The focus was on developing an in-depth description and analysis of the dyad model—its dynamic, pattern of mutual action, and evolution—as examined in a pluralistic organization such as an academic medical

center. Thus, the following research question guided this qualitative study: How is the role space shared and practiced within a dyad leadership model as contextual forces evolve?

Aim of the Study

The aim of the study was to propose a framework for dyad leadership. The framework evaluated the institutional context, determined the elements of the dyad structure, and identified the mechanisms for developing a successful dyad model.

Proposed Solution

To effectively manage the turbulent times and align clinical and administrative functions, healthcare organizations have started to implement dyad leadership models in which "two individuals with different skill sets, education, and backgrounds are paired to better fulfill the mission of the organization" (Sanford & Moore, 2015, p. 7). Additionally, the dyad leadership model is viewed as a "solution for bridging healthcare's cultural gaps, combining different skills and knowledge for greater problem solving and increasing the span of control and influence of leadership" (Sanford & Moore, 2015, p. 61).

While implementation of the dyad leadership model within healthcare organizations is trending upward (Sanford & Moore, 2015), issues regarding the dynamic of dyad leaders persist. In particular, role sharing and how leaders interact together and with other members around specific organizational issues challenge both leadership researchers and practitioners (Denis, Langley, & Sergi, 2012). For healthcare organizations that have traditionally perpetuated functional silos, it is challenging to transition to a dyad model when the scope of the dyad roles is not clearly defined and

there is no established framework for the dyad leaders on how to interact and function with one another. Thus, the proposed solution emanating from the study comes in the form of an integrative framework and recommendations for the actual practice of dyad leadership in healthcare organizations.

The framework was established based on the data gathered from the study interviews and artifacts collected from the research site. The proposed framework integrates key dimensions and elements for the organizational leaders to consider in order to best facilitate the development of long-lasting and effective dyad leaders. Those dimensions are represented by organizational context and the dyad leadership practice, followed by the dynamic and mutual action between the dyad leaders.

The study participants noted reasons for implementing the dyad that were unique to the research site. The interview data uncovered that the dyad leadership practice was established as a result of multiple organizations coming together. Furthermore, this leadership model was instituted with the intent of engaging physicians in decision-making, as well as aligning the clinical and the business sides together in a complex clinical environment. The data collected indicated that structurally, two leaders representing separate functions and stakeholder groups were placed together within the dyad practice. At the dyad practice level, the study participants noted the need to select the right dyad leaders and the importance of having clear role definition and structure. In addition, the study participants shared the unique dynamic of each dyad that guided the dyad leaders when exercising their respective roles and leading together. Within a dyad, leading together and exercising different roles does not happen without a relational

mechanism. The study participants consistently noted the importance of communication and frequent interaction between the dyad leaders.

The proposed framework is intended for healthcare executives, clinical operations leaders, and physician leaders interested in implementing or optimizing the dyad leadership practice in their organizations. The intent is for organizational leaders to use the integrative framework in combination with the proposed recommendations described in the next section. Organizational leaders may use the framework and recommendations as resources for implementing the dyad model and for creating orientation guides for the dyad leaders. The proposed integrative framework for the dyad leadership model is depicted in Figure 6 and highlights key dimensions uncovered during the data collection phase.

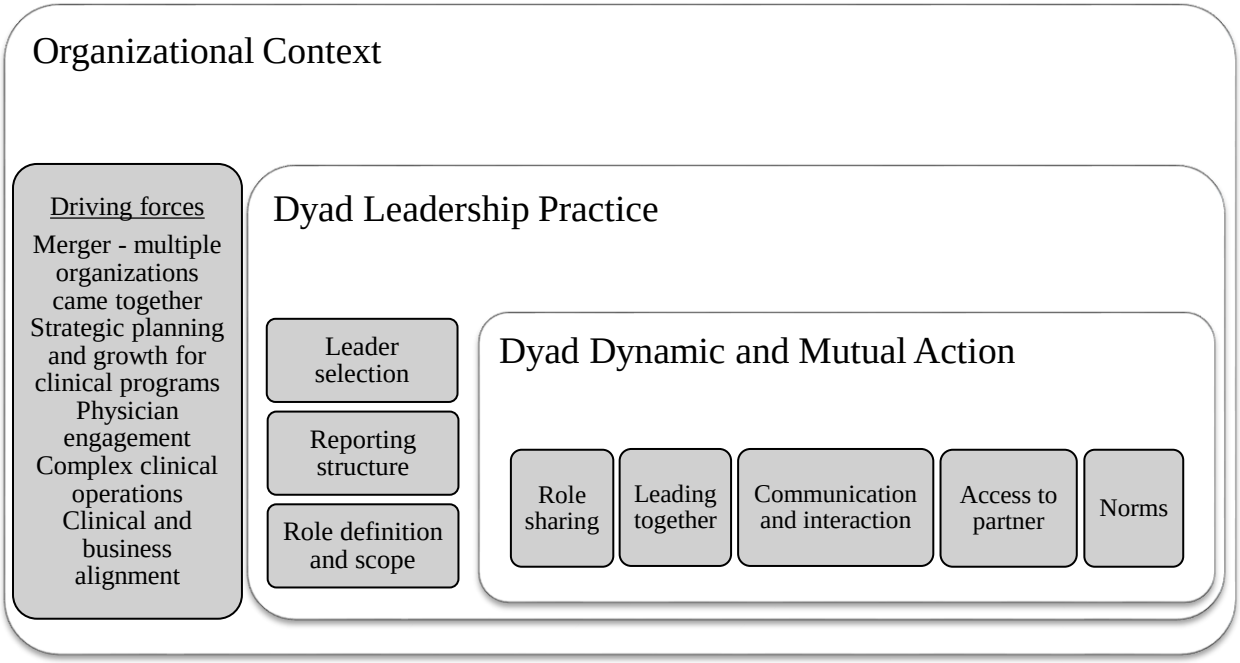

Figure 6. Dyad leadership model integrative framework.

As described previously, the proposed framework integrates key dimensions and elements for organizational leaders to consider in facilitating the development of long-

lasting and effective dyad leaders. Those dimensions are represented by organizational context and dyad leadership practice, followed by the dynamic and mutual action between dyad leaders.

Context. The leadership discipline has recognized the role that context plays in understanding leadership in organizations (Endrissat & Arx, 2013). Context is defined as a situation that "influences what kind of leadership will be effective" in an organizational setting (Endrissat & Arx, 2013, p. 279). Additionally, leadership scholars have proposed that the relationship between leadership and context is recursive (Endrissat & Arx, 2013; Denis, Langley, & Rouleau, 2010). A recursive relationship implies that leadership is produced by context and is contextually influenced, but is also viewed as a context-producing practice (Denis et al., 2010). The recursive relationship between leadership and context is particularly apparent in a healthcare setting. As described above, healthcare organizations represent complex environments that are fraught with ambiguity created by divergent interests, knowledge bases, and power. Leadership practice constantly intersects with contextual factors, and thus, no leadership practice can be implemented in a vacuum. Examining the dyad leadership model through the lens of institutional context and complexity provides a deeper understanding of the dyad dynamic, the mutual action between the dyad leaders, and how dyad leaders practice their roles in a complex environment.

Dyad Leadership Practice. The dyad leadership model represents an organizational leadership practice and can be viewed through two different yet interconnected lenses. The first lens is to consider the dyad model, as a leadership practice, in connection with its organizational context and its level of embeddedness

within the institution that implemented this type of model. This constitutes a macro-level view of the dyad leadership practice within a specific organizational context. At the practice level, the interview data uncovered three critical areas that organizations and their executives need to consider when implementing a dyad model. Those areas are leader selection, reporting structure, and role definition and scope. These are foundational activities that need to occur with the support of organizational leaders. In addition, the proper configuration of these activities can facilitate a more optimal dynamic and mutual action, as described below.

Dyad Dynamic and Mutual Action. As previously described, the first lens, through which the dyad leadership model may be viewed, represents the macro-level activities that need to occur to develop the structure of the dyad practice. The second lens is viewing the dyad through the routine leadership interactions that occur between actors or dyad leaders. This constitutes the micro-level view that shapes the dyad dynamic and puts emphasis on the "actual doing of leadership" (Endrissat & Arx, 2013, p. 280). The interview data uncovered that at the micro-level, there are five main actions that facilitate the dynamic between the dyad partners. These actions include role sharing, leading together, communication and interaction, access to dyad partner, and norms. Organizational leaders who wish to implement a dyad leadership model need to carefully consider the dynamic and the mutual action within the dyad model, which in turn can facilitate how dyad leaders effectively practice their dyad roles.

The relationship between the macro- and the micro-level view is complex (Carroll, Levy, & Richmond, 2008). Thus, when an organization decides to implement the dyad leadership model, it has to consider both the macro- and micro-level views.

Organizational leaders and dyad practitioners should be careful not to prioritize the practice over the actors or vice versa. Organizational leaders and dyad practitioners should focus on both and appreciate the intricacies and the relevance of both practice and the dynamic that happens within it.

Support for the Solution

The proposed solution represents a framework for dyad leadership and is integrative in several ways. The framework integrates organizational context and the dyad leadership practice, followed by the dynamic and mutual action between the dyad leaders. The framework incorporates key dimensions for organizations and leaders to consider when implementing dyad models. Furthermore, the data collected and analyzed from the participant interviews uncovered concrete recommendations that support the proposed integrative framework for the dyad leadership practice. The intent is for organizational executives and dyad leaders to use the integrative framework in combination with the proposed recommendations described in this section. Predicated on the building blocks of the framework, the recommendations to consider for implementing a dyad leadership practice include the following:

- Leader selection
- Role definition and clarity
- Dyad leadership charter
- Dyad induction
- Compensation for physician time
- Access to dyad partner
- Access to information

- Measure outcomes and monitor progress
- Institutionalizing the dyad leadership practice

Leader Selection. The dynamic between dyad leaders is just as important at the individuals within the dyad. Thus, the leaders who enter the dyad represent a critical factor in making the dyad successful. In their seminal works, Sanford and Moore (2015) and Pearce and Conger (2003) found that groups of dyads and co-leaders failed due to poor selection of leaders. In particular, Sanford and Moore (2015) looked at arranged dyads versus selected partnerships and metaphorically compared the dyad partnership to marriage. While acknowledging that dyads are not actually marriages, the authors emphasized the importance of compatibility and complementarity. In a similar fashion, Pearce and Conger (2003) highlighted the importance of rapport, complementarity, and chemistry when selecting a team of co-leaders. One study participant specifically addressed the topic of leader selection in his interview. The participant noted that "somebody who is a great clinician and a really bright thinker does not necessarily make a great leader and vice versa" (Dr. Thompson of the Omega dyad). Thus, leader selection is a critical step in a successful implementation of the dyad leadership practice.

Recognizing the importance of selecting the right leaders, the implementation plan should incorporate a selection system and process. Selection should be based not only on individual attributes of the leaders and their positions within the organization, but also on their interpersonal skills and ability to work together with the dyad partner.

Role Definition and Clarity. In exercising roles and dividing tasks, the participants recognized the duality of their respective roles as reflected by their separate functional domains within the organization. The administrative dyad partners noted their

focus on administrative functions, cost containment, and financial solvency. Physician partners, on the other hand, tended to focus on physician issues. The study participants consistently noted the need for role definition and clarity around expectations and outcomes to make the dyad functionally better.

Dyads represent small groups comprised of two individuals or actors. A small group such as a dyad is characterized by structure and cultural traits (Bonifacio, 1961). Additionally, research indicates that in a multi-level structure such as a dyad, "roles cannot be viewed as static, but rather are fluid and dynamic in nature and depend on organizational and environmental demands and requirements" (Yammarino et al., 2012, p. 383). Thus, roles serve as crucial elements within the structure and performance of a small group and represent a set of defined activities expected from an individual member in a particular position (Bray & Brawley, 2002; Hassan, 2013). Mabry and Barnes (1980) noted that there are two types of roles within a group—formal and informal (as cited in Bray & Brawley, 2002). According to Mabry and Barnes (1980), while formal roles are prescribed to members, informal roles "develop through a process of interpersonal interaction within the group" (as cited in Bray & Brawley, 2002). Pearce and Conger (2003) found that role ambiguity is associated with disfunction in groups. Role ambiguity ensues when roles are not "sufficiently articulated in terms of domain, methods of fulfillment, and consequences of role performance" (Hassan, 2013, p. 717). Kahn and colleagues (1964) explored three factors that influence role ambiguity, organizational complexity, organizational change, and managerial communication (as cited in Hassan, 2013). All three factors can be recognized in the organizational context of the researched site, thus contributing to the lack of role clarity and expectations. The study findings

revealed that the dyad roles were articulated in terms of domain, clinical versus administrative. At the same time, more clarity was required around fulfillment and consequences.

When implementing a dyad leadership practice, organizational leaders should carefully evaluate the role aspect within the dyad. Organizational leaders should determine a scope of responsibilities and sphere of influence that transcend the traditional functional silos. The dyad leaders should have clear division of roles and tasks, while still be given the latitude to coordinate and communicate with one another to avoid duplication. In addition, organizational leaders should set clear role expectations and establish performance outcomes, for which dyad leaders are jointly accountable.

Dyad Leadership Charter. In the healthcare setting, one form of dyad represents the pairing of an administrator and a physician leader. Similar to any group interaction setting, a dyad is subject to a code of behavioral rules or norms that guide the interaction of the group (Miles et al., 2011). One approach to formalizing the norms and processes that would guide dyad partners is creating a dyad leadership charter. Using Mathieu and Rapp's (2009) definition, team charters represent "codified plans for how the team will manage teamwork activities" (p. 90). Literature on team charters have found that teams benefit from having charters that serve as tools for facilitating effective teamwork (Mathieu & Rapp, 2009; Sverdrup, Schei, & Tjølsen, 2017). In addition, in their longitudinal study, Mathieu and Rapp (2009) found that developing and using charters resulted in better performance over a team's lifespan. Thus, it is recommended that upon formation, dyad partners develop a dyad leadership charter. The charter should define the purpose of the dyad, as well as roles, scope of responsibilities, expectations, norms, and

meeting cadence. Furthermore, the charter should outline measurable outcomes and reporting mechanisms for progress and ongoing organization-wide initiatives that dyads are managing.

Dyad Induction. The development of a dyad leadership charter should be followed by the establishment of an induction process for the dyad leaders. This induction process should not be equated with traditional onboarding processes that seek to inculcate new employees into the organization. The premise for dyad induction is to introduce the leaders to a new way of leading. Using the dyad leadership charter as a guide, the induction process should get the dyad leaders acclimated to their roles, responsibilities, and expectations within the dyad. The induction process should introduce the dyad leaders to the organization's governance and decision-making entities, and should further provide an orientation for financial and decision-support systems. In addition, the induction process could also be used to address areas of conflict and how to address conflicts as they emerge.

Compensation for Physician Time. In addition to fulfilling their duties under the dyad model, the interview data indicated that the physician leaders practiced medicine and fulfilled their responsibilities as division chairs. While the administrative leaders exercised their role on a full-time basis, the physician leaders exercised their role on a part-time basis within the dyad model, without being compensated for the role. Therefore, a compensation model should be developed for the time a physician leader dedicates to fulfilling the role of a dyad leader. While it may not be necessary to engage the physician partner on a full-time basis, the physician's time within the dyad should be

compensated accordingly. Fulfilling the dyad role takes physician leaders away from their clinical practices and thus, away from income-earning activities.

Access to Dyad Partner. When exploring the dyads interviewed for the study, the researcher observed that certain dyad partners had offices next to one another, while other dyad partners were dispersed throughout the campus. Two dyads explicitly remarked on their frequent interaction due to the close proximity of their offices. Recognizing the importance of having access to her partner and being in close proximity, Mary of the Alpha dyad noted the need for "dialogue in real time," particularly when facing an issue or needing input from her partner. Thus, proximity and access to the dyad partner was noted as an important element in facilitating the frequency of interaction between the dyad leaders.

Access to Information. This study revealed that information sharing was an essential action that occurs between the dyad partners. Each partner possesses unique information based on access to information sources, training, and knowledge. That unique information is exchanged through frequent interaction that happens within the dyad. Additionally, through the dyad partnership, the interviewed physician leaders appreciated gaining exposure to the financial side of the organization. While each dyad partner serves as a point through which information is shared, it is recommended that both dyad partners are given the same access to information, particularly to the financial and decision-support systems. Giving both of the dyad partners access to the same information and information systems will maximize the information sharing interactions.

Measure outcomes and monitor progress. A leadership practice should not be implemented without an end goal in mind. Thus, implementing the dyad leadership

practice should lead to expected improvements and desired outcomes that can be measured. In their interviews, the study participants shared concrete examples of outcomes that materialized as a result of working closely with their dyad partner. For example, there were reported accounts of improved communication and transparency between the dyad leaders. Alignment between the clinical and administrative domains and exposure to different perspectives were also cited as outcomes of being engaged in a dyad model. When implementing the dyad leadership practice, organizational leaders should make a compelling case for deciding to lead differently, develop and measure concrete and organization specific outcomes, and continuously monitor progress.

Institutionalizing the Dyad Leadership Practice. The interview data and organizational artifacts indicated that the research site implemented the dyad leadership model at the service line level. Additionally, an interim dyad was established at the CEO level that was later dissolved. There was no evidence that indicated the level of embeddedness of the dyad leadership practice beyond the service line level.

At a fundamental level, one of the reasons for implementing the dyad leadership model at the research site was to increase physician engagement and decrease the divide between clinical and administrative functions. Studies also suggest that there has been an increased focus on engaging physicians in the managerial domain (Kippist & Fitzgerald, 2012; Spehar, Frich, & Kjekshus, 2014). Additionally, studies on clinician engagement have emphasized the importance of clinical and administrative leaders creating a culture that “encourages and fosters engagement” (Kippist & Fitzgerald, 2012, p. 40).

The dyad leadership model is viewed as a solution for increased physician engagement. Furthermore, the dyad leadership practice represents a new way to lead

within an organization. To make it successful and long-lasting, the dyad leadership philosophy should permeate the entire organization. Pearce and Conger (2003) asserted that a shared leadership philosophy "is not just an issue at the top of corporations" (p. 260). When they conducted a survey of thousands of managers in a dozen corporations, Pearce and Conger (2013) discovered that the shared leadership practices were institutionalized in the systems, policies, and cultures of the organization. Organizations that wish to implement the dyad leadership model should consider institutionalizing the practice and embedding it in the organization's systems and culture.

Factors and Stakeholders Related to the Solution

Implementing a new leadership practice such as a dyad model requires organizational commitment and careful planning. Organizational leaders have to align the medical and administrative groups to build support for implementing a new way of leading. In addition, leaders have to be acutely aware of their organizational cultures and internal dynamics, and must understand the financial demands associated with implementing the dyad leadership practice. The implementation of the proposed framework and recommendations requires a concrete plan for change management. Thus, an organization wishing to implement a dyad leadership model or optimize an already implemented dyad model should plan and initiate a change management process following the change path model described later in this section.

Potential Barriers and Obstacles to Proposed Solution. Organizational leaders who wish to explore the dyad leadership practice should consider organizational culture as a potential barrier to the proposed solution. Healthcare organizations display pluralism through the presence of professional medical and administrative cultures, with their

associated functions, identities, and interests (Jarzabkowski & Fenton, 2006). This presence represents a source of tension, which in turn gives rise to competing demands and conflicting goals that perpetuate ambiguity and fragmented functional practices in healthcare organizations.

Physicians and non-physician administrators represent two different subcultures with distinct values, assumptions, roles, identities, and interests. Furthermore, physicians and non-physicians administrators display opposing loyalties and commitments (Kaissi, 2005). Physician loyalty is directed toward the patient and the medical profession, and physicians are held accountable for clinical outcomes (Kaissi, 2005). Additionally, physicians have a preference for autonomy and are ambivalent "in exercising formal authority" with peer or subordinate physicians (Xirasagar, Samuels, & Stoskopf, 2005, p. 733). In contrast, administrators direct their loyalty toward the organization and are held accountable for administrative functions and the financial performance of the organization. This creates a natural tension that can, in turn, pose as a barrier to implementing the dyad leadership practice within an organization.

Financial/Budget Issues Related to Proposed Solution. When the dyad leadership model was implemented at the research site, study participants noted role definition and clarity as an area for improvement. Structurally, within the dyad model, two leaders representing separate functions and stakeholder groups were placed together. While job descriptions were created for the administrative leaders, physician leaders were not provided with job descriptions. In addition to fulfilling their duties under the dyad model, the physician leaders practiced medicine and fulfilled their responsibilities as division chairs. Thus, while the administrative leaders exercised their role on a full-time

basis, the physician leaders exercised their role on a part-time basis within the dyad model.

Within an organization that desires to implement a dyad leadership model, part of the change process for the proposed recommendations should include considering the potential financial demands (Baldwin, Dimunation, & Alexander, 2011). First, a compensation model should be developed for the time a physician leader dedicates to fulfilling the role of a dyad leader. While it may not be necessary to engage the physician partner on a full-time basis, the physician's time within the dyad should be compensated accordingly. Fulfilling the dyad role takes the physician leaders away from their clinical practices and thus, away from income-earning activities. Second, an organization should consider investing in the education and training of physician and administrative leaders. Investing in leadership training, particularly for physician leaders, would be beneficial in "elevating the right leaders" (John of the Omega dyad) and ensuring a path for leadership growth within the organization.

Other Issues or Stakeholders Related to Proposed Solution. In addition to considering the cultural aspects and financial demands associated with implementing or optimizing the dyad leadership practice, organizational leaders should be keenly aware of the complexity of the relationship between the managerial and the clinical domains, as well as the political nature of this relationship. In addition, organizational leaders should be aware of the interplay and potential conflicts between the clinical and managerial domains, and effectively manage these conflicts as they arise.

As described earlier, healthcare organizations are complex and operate "in highly institutionalized environments that put substantial pressures on both their technical and

managerial components" (Ruef & Scott, 1998, p. 882). Hospitals represent the "classic pluralistic domain" defined by divergent objectives, multiple actors, diffused power, and knowledge-based work processes (Denis, Lamothe, & Langley, 2001, p. 809; Denis, Langley, & Rouleau, 2007). Organizations, including healthcare organizations, are challenged with institutional complexity when faced with multiple institutional logics (Greenwood, Raynard, Kodeih, Micelotta, & Lounsbury, 2011). Institutional logics represent "a set of principles that prescribe how to interpret organizational reality, what constitutes appropriate behavior, and how to succeed" (Greenwood et al., 2011, p. 318; Thornton & Ocasio, 2008).

In response to institutional complexity and managing multiple logics, healthcare organizations traditionally created structural differences between technical and managerial levels, with technical tasks falling under the jurisdiction of clinical staff while administrative tasks fell under the control of managers or administrators (Ruef & Scott, 1998). While physicians focused on patient care, organizing medical staff, and clinical activities, managers became more focused on cost containment, financial solvency, personnel management, and other administrative tasks (Kaissi, 2005). This organizational structure perpetuated a complex and dynamic relationship between physicians and administrators that was "built on the basic premise that each party is separate and independent" (Fiol & O'Connor, 2009, p. 17).

Change Theory. Implementation of the proposed framework and recommendations requires a concrete plan for change management. An organization wishing to implement a dyad leadership model or optimize an already implemented dyad model should initiate a change process by using the change path model established by

Cawsey, Deszca, and Ingols (2016). The change path model denotes the four main steps of awakening, mobilization, acceleration, and institutionalization (Cawsey et al., 2016). The change path model provides a practical approach to change management, highlighting a linear process of change that can be adapted by any organization.

Awakening. Before initiating change, Cawsey et al. (2016) emphasized the need to understand the current state of the system as a whole, as well as its individual parts. The awakening phase begins with "critical organizational analysis" (Cawsey et al., 2016, p. 53). Organizational leaders need to initiate a detailed assessment of the organization, its systems, human resources, culture, and environmental shifts, in order to understand the internal and external dynamics of the institution. In the awakening phase, leaders spread awareness of the new challenges, develop a vision for change, and disseminate the vision to the entire organization.

Mobilization. The mobilization phase entails communicating the need for a change and involves preparing the organization and its leaders for the potential alterations to the status quo. When deciding to implement or optimize a dyad leadership practice, organizational leaders need to develop a convincing case, emphasizing organizational reasons for needing a new leadership philosophy. In addition, organizational leaders should create a "shared need" (Sanford & Moore, 2015, p. 322). The concept of a shared need should focus on creating collaborative relationships between the clinical and administrative domains.

***Acceleration*.** The acceleration phase involves action planning and implementation (Cawsey et al., 2016). A critical phase of change is its implementation, during which organizations put ideas and visions to work (Russ, 2008). Communication

plays an important role in the implementation phase (Russ, 2008). Additionally, communication is critical in several aspects of organizational change, including creating and articulating a vision, providing feedback between change agents, and garnering social support (Lewis, 1999). Russ (2008) asserted that change is implemented through human communication rather than automation, and further synthesized conceptual treatments of organizational change communication into two broad themes—programmatic and participatory.

The programmatic approach focuses on the top-down dissemination of information, in order to generate the desired positive attitudes and stakeholder compliance, minimize resistance, and achieve a successful change implementation (Russ, 2008). By contrast, participatory approaches involve the stakeholders in the change process and solicit input to shape organizational change (Russ, 2008). The objective of this approach is to gather consensus and support, as well as to give stakeholders a voice and allow their active participation in establishing and implementing change (Russ, 2008). Participatory communication activities include open forums, working groups, informal conversations, focus groups, and morale and opinion surveys. These participatory approaches can be used to build momentum, and to engage and empower stakeholders in the change process.

In the acceleration phase, it is recommended that organizational leaders develop a communication plan for transitioning to the dyad leadership practice. The communication plan needs to be disseminated to stakeholder groups in meetings and through internal press releases. Both the clinical and administrative leaders need to be engaged in transitioning to a new leadership model. The transition needs to be balanced carefully

with minimal disruption to current operations. In addition, the organization needs to celebrate milestones and share success stories and outcomes that were accomplished as a result of transitioning to the dyad leadership practice.

Institutionalization. Once the acceleration phase is completed, institutionalization entails periodic monitoring of progress. Cawsey et al. (2016) asserted that measurement plays an important role in this phase. In addition, institutionalization implies that the new structures, beliefs, or behaviors take place in the organization and will continue to be measured, in order to ensure sustainability of the implemented change (Cawsey et al., 2016).

Implementation of the Proposed Solution

Migrating to a new leadership practice that is philosophically different than hierarchical leadership models takes time and organizational commitment. The researcher intends to present the integrative framework and the recommendations to the executives of the research site. In addition to discussing the framework and the recommendations, the researcher seeks to propose an implementation plan as outlined in Table 6. The plan follows the change path model as described in the previous section. The plan identifies concrete milestones with associated timelines. In addition, the plan outlines the stakeholder groups and the change owners involved in the implementation phase.

Table 6

Timeline for implementation and assessment

Change Path Model	Milestone	Stakeholder group	Change owner	Timeline
Awakening	Assess current state	Healthcare executives, administrative and physician leaders	Change leaders	1-3 months
Mobilization	Initiate dyad leadership practice change	Healthcare executives, administrative and physician leaders	Change leaders	2 months
Mobilization	Select dyad leaders	Healthcare executives, administrative and physician leaders	Executives and change leaders	2 months
Mobilization	Develop dyad leadership charter: Determine role scope Define roles Define responsibilities Define meeting cadence Develop measurable outcomes Establish reporting mechanism	Selected dyad leaders	Change leaders and selected dyads	3 months
Acceleration	Dyad induction and implementation	Administrative and physician leaders	Change leaders and facilitator	3 months
Institutionalization	Measure outcomes and monitor progress	Administrative and physician leaders	Change leaders and facilitator	6-9 months

Leader's Role in Implementing Proposed Solution

Change in leadership practices cannot occur without leadership support. Organizations that wish to implement the dyad leadership practice will benefit from assigning two change leaders—an administrative leader and a physician leader—both of whom will serve as champions for the implementation of the dyad model. A change leader can take on multiple roles, from change initiator to change implementer or change

facilitator (Cawsey et al., 2016). The change leaders' roles will be to frame a vision, ignite inspiration, and garner support for the dyad leadership practice.

Selecting the right change leaders is equal in importance to leading change initiatives. The selected change leaders need to possess credibility within their functional domains. The literature review emphasized the pluralistic nature of healthcare organizations. Additionally, Mintzberg (1979) stated that hospitals represent professional bureaucracies, with power residing in expertise through knowledge and skills brought by the clinical domain (as cited in Spehar et al., 2014). The physicians possess the understanding of the clinical domain and the "cultural capital" (Witman, Smid, Meurs, & Willems, 2010, p. 482) that can be used as a source of influence. This source of influence can be leveraged by selecting a physician change leader who can garner support for the dyad leadership practice. Similarly, the selected administrative change leader should possess in-depth knowledge of the business domain and the necessary credibility that can be leveraged to promote and implement the dyad leadership model.

Together the change leaders should create an "us" culture that nurtures collaboration and engagement across functional domains. Considering the barriers described in the previous section, the change leaders should address resistance and work actively to overcome any issues that emerge, using their influence within their respective domains. In addition, change leaders should focus on measuring outcomes and monitoring progress of the implementation.

Evaluation and Timeline for Implementation and Assessment

A leadership practice should not be implemented without an end goal in mind and a plan for measuring outcomes. Implementing the dyad leadership practice should lead to

expected improvements and desired outcomes that can be measured. Although there are few studies that explore the outcomes of shared leadership (Pearce & Conger, 2003), the participants of this study shared concrete examples of outcomes that materialized as a result of working closely with their dyad partner. For example, there were accounts of improved communication and transparency between the dyad leaders. Alignment between the clinical and administrative domains and exposure to different perspectives were also cited as outcomes of being engaged in a dyad model. In addition to using qualitative approaches such as interviews to measure outcomes, there is an opportunity to explore approaches to quantify outcomes. Outcomes should be organization-specific and reconciled with the internal organizational reasons for implementing the dyad practice. For example, if the reason for implementing the dyad model is to engage physicians, the outcomes should be measured around physician engagement in decision-making. When implementing the dyad leadership practice, organizational leaders should make a compelling case for deciding to lead differently, establish and measure concrete outcomes, and continuously monitor progress.

Implications

Practical Implications

The focus of this research was on developing an in-depth analysis of the dyad leadership model—its dynamic, pattern of mutual action, and evolution—as examined within an organizational context. This study contributes to the body of knowledge concerning emerging leadership models such as the dyad model by addressing the dynamic nature of two leaders engaged in a dyad structure. Under the premise that the shared role space of dyad leaders is dynamic rather than static, this study addressed how

roles are practiced in a dyad leadership model as contextual forces evolve within a specific organizational setting. The study findings will be of relevance to future analyses of dyad leadership practices and dyad leaders in healthcare organizations. Furthermore, the study findings can provide a basis from which to examine the dynamic, collective, and relational processes between the dyad leaders. Therefore, this study offers several practical implications for leaders and leadership practitioners.

Leadership research has been dominated by traditional models that focus on the "heroic" leaders at the top, their individual qualities and behaviors, and the leaders' downward unidirectional influence on teams through formal authority and power (Avolio, Walumbwa, & Weber, 2009; Gronn, 2002; Pearce & Conger, 2003; Yukl, 1999). Thus, the leadership source originates with a single leader and the leadership role is contained within that single leader. Nevertheless, leadership literature conceived that under certain contexts, classic or traditional leadership models might be substituted by alternative vehicles.

Leadership couples or dyads, which imply that two individuals share one leadership role (Pearce & Conger, 2003), represent one example among a range of possible alternative models. This study revealed that the source of leadership in a dyad model rests within two leaders. Furthermore, the sharing and practicing of the role space is a dynamic, collective, and relational process that occurs between the dyad leaders. The findings represent a departure from traditional leadership research.

Organizations that desire to transition to a co-leadership model need to appreciate the dynamic, collective, and relational nature of leadership. Thus, leadership should not originate with an individual leader and be viewed "as an external authority or symbol

influencing others from outside" (Denis et al., 2010, p. 84). Rather, the locus of leadership is embedded in organizational networks (Denis et al., 2010). Based on this premise, leaders need to be in tune with the day-to-day interactions that dynamically shape leadership.

This study also has practical implications for leadership development. Classic leadership development is primarily focused on individual leaders and their attributes. Raelin (2011) has noted the decrease in interest for "teaching about leadership or teaching lists of traits to aspiring leaders" (p. 204). Rather, leadership development should be brought back "into the group where the lessons of experience can be truly assessed" (Raelin, 2011, p. 204). This is a departure from traditional approaches to leadership development.

Implications for Future Research

While the study contributed to the leadership-as-practice movement and to healthcare leadership, it also opened the opportunity for future research. In light of the findings presented in Chapter 4, this study could be augmented by looking at variations in methodology and extensions of this research predicated on its findings.

Methodology. Interviewing participants for this study provided invaluable perspectives by using participants' own narratives of how they practiced leadership within the dyad model. While interviewing is a useful source of data, another source of data is observations of leaders in action. This can be obtained by using two approaches—leadership sociograms and ethnographic methods (Pearce & Conger, 2003). According to Pearce and Conger (2003), the leadership sociogram approach uses observation of "group meetings and recording of interaction patterns" (p. 298). This approach results in a deep

understanding of group dynamics (Pearce & Conger, 2003). The ethnographic approach uses extensive, long-term observations of a group in its natural environment, providing "the richest possible understanding of ongoing group dynamics" (Pearce & Conger, 2003, p. 299). A common weakness of these approaches is the extensive time commitment for the researcher to be onsite for data collection. Another obstacle is gaining extended access to organizations that have implemented the dyad leadership model, as well as to dyad leaders, to be able to observe them for a longer period of time without disturbing them.

Extension of This Research. The dyad model suggests that two leaders come together as a group to achieve specific organizational objectives. For professional duos, Alvarez and Svejenova (2005) observed that the division of labor, task or emotional complementarity, and role differentiation is necessary for small-numbers structures to work effectively, which creates a dynamic process within the professional duos. A physician-administrator dyad would operate in a similar fashion, creating a dynamic group process as dyad leaders engage in mutual action such as exchanging information, sharing knowledge, or collectively making decisions. Group dynamics influence not only the dyad leaders themselves, but also their followers in a vertical direction. The scope of this research was intentionally narrowed to explore the horizontal dynamic between the dyad leaders, with the dyad being the unit of analysis. As an extension of this research, it would be worth exploring how the dyad group dynamics influence followers.

Another opportunity to extend this research is to evaluate the intervening conditions that facilitate the dyad leadership model. In addition to uncovering salient themes, the data revealed specific conditions that facilitated the dyad leadership model

and how the dyad leaders exercised their role within the model. For example, in two of the four interviewed dyads, access and close proximity to the dyad partner facilitated the frequent interaction, which in turn facilitated the overall communication pattern between the dyad partners. Thus, an extension of this research would be to explore the specific intervening elements and how they influence the dyad leadership practice.

Implications for Leadership Theory and Practice

Dyad leadership is an emergent model in healthcare organizations that generally possess a high degree of complexity and pluralism (Denis et al., 2007). On one hand, the study explored the dynamic between physicians and administrators working together in a dyad model, and how the model served as a solution for bridging the divide between the clinical and administrative functions. On the other hand, this research introduced theoretical and practice approaches central to the analysis of leadership within dynamic and pluralistic contexts.

At its initiation, this study was influenced by the notion that leadership is a collective or a group-level phenomenon (Pearce & Conger, 2003). The study examined leadership, not from an individual leader perspective, but from a collective leadership group perspective, implying multiple actors, shared authority and accountability, and certain division of roles. Furthermore, this study viewed leadership as a dynamic phenomenon, with a particular focus on the role structure and how it is influenced by contextual factors.

This study contributes to an emerging movement in leadership studies known as leadership-as-practice. In contrast to the traditional models that focus on heroic leaders and their individual properties, leadership-as-practice “focuses on the everyday practice

of leadership including its moral, emotional, and relational aspects" (Raelin, 2011, p. 195). As Raelin (2011) has suggested, leadership-as-practice looks for leadership in its activity and is portrayed as a shared and collaborative process.

With its purpose of exploring the dynamic between physicians and administrators working together in a dyad model, the study focused specifically on the routine interactions and how leadership is dynamically activated within the dyad model. Furthermore, under the premise that the shared role space of dyad leaders is dynamic rather than static, this study addressed how roles are practiced in a dyad leadership model as contextual forces evolve within a specific organizational setting. By examining leadership as a practical activity, the study added value to the leadership-as-practice body of literature.

Summary of the Study

As healthcare organizations evolve, experiencing market and technological changes, as well as pressure to reduce costs and become more efficient, leadership practices have not remained stagnant. In the healthcare context, a physician leader and a non-physician administrator have specialized skill sets and roles. The complexity of healthcare organizations necessitates collaborative arrangements between physicians and administrators for a better integration of clinical and administrative functions. These conditions have propelled healthcare organizations to implement emerging leadership models such as dyad leadership to bridge the divide between these separate functions.

Considering the novelty of the dyad model, healthcare organizations face challenges while transitioning to this leadership practice. With the focus on the dynamic between physician and administrator pairs, this study addressed how roles are practiced

within a dyad leadership model as contextual forces evolve. A qualitative case study approach was appropriate to explore the dyad leadership model. Data were collected by interviewing eight participants or four dyads and by obtaining organizational artifacts. Three salient themes emerged during the data collection and analysis phase: role clarity between administrative and physician leaders, leading together within the dyad model, and frequent communication and interaction. These themes revealed that sharing and practicing the role space in a dyad model is a dynamic, collective, and relational process that occurs between the dyad leaders.

The proposed solution represents a framework for dyad leadership and is integrative in several ways. The framework integrates organizational context and the dyad leadership practice, followed by the dynamic and mutual action between the dyad leaders. The framework incorporates key dimensions for organizations and leaders to consider when implementing dyad models. The proposed framework and implementation plan can be used to guide organizational and system change for implementing the dyad leadership practice. Additionally, the proposed framework and implementation plan are intended for organizational leaders, administrative and physician leaders, as well as leadership practitioners and researchers who are interested in exploring emerging leadership practices.

This study uniquely contributes to an emerging movement in leadership studies known as leadership-as-practice. In contrast to the traditional models that focus on heroic leaders and their individual properties, leadership-as-practice focuses on the everyday practice of leadership, looks for leadership in its activity, and is portrayed as a shared and collaborative process. By exploring the macro- and micro-level views that shape the dyad

dynamic and putting emphasis on the actual doing of leadership, the study advances not only the leadership-as-practice movement, but also leadership research in the healthcare field.

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Appendix A

Bill of Rights for Research Participants

As a participant in a research study, you have the right:

1. To have enough time to decide whether or not to be in the research study, and to make that decision without any pressure from the people who are conducting the research.
2. To refuse to be in the study at all, or to stop participating at any time after you begin the study.
3. To be told what the study is trying to find out, what will happen to you, and what you will be asked to do if you are in the study.
4. To be told about the reasonably foreseeable risks of being in the study.
5. To be told about the possible benefits of being in the study.
6. To be told whether there are any costs associated with being in the study and whether you will be compensated for participating in the study.
7. To be told who will have access to information collected about you and how your confidentiality will be protected.
8. To be told whom to contact with questions about the research, about research-related injury, and about your rights as a research subject.
9. If the study involves treatment or therapy:
    a. To be told about the other non-research treatment choices you have.
    b. To be told where treatment is available should you have a research-related injury, and who will pay for research-related treatment.

Appendix B

Request for permission to conduct research at the selected site

Dear Dr. Williams,

My name is Cornelia Vremes and I am a doctoral student at Creighton University located in Omaha, Nebraska. The research I wish to conduct for my Doctoral Dissertation involves exploring the dynamic between physicians and administrators working together in a dyad model. The focus will be on developing an in-depth description and analysis of the dyad model at a chosen site to understand the dyad dynamic and how the dyad role space is created and practiced in a particular organizational context. This project will be conducted under the supervision of committee chair Dr. Jennifer Murnane, PhD, and co-chair Dr. Andy Noon, PhD.

I am hereby seeking your permission to conduct research at your organizations. I have provided you with a copy of my dissertation proposal which includes copies of the participant letter and the consent forms to be used in the research process, as well as a copy of the approval letter from Creighton University IRB and the organization's IRB. If you require any further information, please do not hesitate to contact me at 402-779-6809 or cvr91781@creighton.edu. Thank you for your time and consideration in this matter.

Sincerely,

Cornelia Vremes

Creighton University

Appendix C

Letter to study participants

Dear Participant,

This study is being conducted as a part of my dissertation in practice to explore the dynamic between physicians and administrators working together in a dyad model. The focus will be on developing an in-depth description and analysis of the dyad model at a chosen site to understand the dyad dynamic and how the dyad role space is created and practiced in a particular organizational context.

You have been selected to participate in this study because of your experience with being engaged in a dyad leadership model. You will be asked approximately 18 to 20 standard questions. Your participation in the study will involve a face-to-face interview with me that is anticipated to last approximately 60 minutes. I may have additional periodic follow-up regarding your responses but the time commitment is expected to be minimal. You will be provided with a copy of your interview transcript should you wish to make clarifying or additional comments.

It is not anticipated that you will experience risks any greater than you may experience in everyday life by participating in this study. You are able to withdraw from the study at any time prior to the interview and there will be no consequences for withdrawal.

The interviews completed for this study will not identify you by name and will ensure your confidentiality and anonymity. The interview data will remain unspecified and in no way attributable to a single individual. As soon as the interviews are completed and transcribed, your responses will be coded and subsequently destroyed.

You will not receive any monetary compensation for participating in this qualitative research study. There are no costs associated with this study other than the time spent during the discussion.

You may ask questions pertaining to this research and have those questions answered before agreeing to participate. If you have any questions about your rights as a participant in this study that were not sufficiently answered by the researcher, please feel free to contact the Institutional Review Board at 402-280-2126 or via email at IRB@creighton.edu.

Sincerely,

Cornelia Vremes

Creighton University

Appendix D

Interview Protocol

Interview Protocol: Dyad leadership model in a healthcare organization
Time of Interview:
Date:
Place:
Interviewer:
Dyad:
Role of Interviewee:

Purpose: The purpose of this dissertation in practice study will be to explore the dynamic between physicians and administrators working together in a dyad model to fulfill the mission of the organization, and how the model serves as a solution for bridging the divide between the clinical and administrative functions within a specific healthcare setting. The focus will be on developing an in-depth description and analysis of the dyad model at a chosen site to understand the dyad dynamic and how the dyad role space is created and practiced in a particular organizational context.

Introduction:
Thank you for agreeing to be interviewed for this research project on the dyad leadership model.
I want to remind you that your comments will remain confidential and anonymous.

***Note to interviewer: Let them know they can take a break at any time and that they can ask you if they have any questions, etc.)

Questions:

1. How long have you worked for the organization and what has been your career trajectory?

2. What is your role within the organization?

3. When was your dyad established?

4. Why did you decide to implement the dyad leadership model?

5. What were the business drivers that served as the impetus to implement a dyad leadership model within the organization?

6. Describe the experiences you have encountered since being paired with a physician/or administrator?

7. Describe the benefits of implementing the dyad leadership model.

8. Describe the challenges of the dyad leadership model.

9. How are the dyad roles created and shared?

10. How are the roles differentiated in the dyad model?

    a. Did the roles ever create any confusion among the dyad leaders and subordinates?

11. How do you exercise authority in the dyad model?

12. How often do you interact with your dyad leader?

13. What norms have been developed in the dyad model?

14. Which rules were established by the dyad leaders versus which ones emerged?

15. How do you communicate with your dyad leader? Are the lines of communication clear and direct?

    a. Do you have scheduled time with one another?

16. What type of information do you exchange during the interactions with your dyad leader?

17. How much information do you exchange?

18. How do you address disagreements when they occur?

19. Describe the decision making process? How do decisions get made?

20. How are decisions being disseminated to teams and subordinates?

Final question

21. If there is anything more you would like to add about your experience with the dyad model that I have not asked please describe that for me.

***Note to interviewer: Additional questions for depth and breadth to the above questions:
Would you expound on that?
Tell me more.
How would you describe that in a different way?
I would like to hear more about that.

Would you clarify that for me? What was the effect of that incident? What were the consequences? What was your reaction to that behavior? Take me through your thought processes during that time.

Appendix E

Research site organizational artifacts

1. Organizational chart
2. Research site website
3. Internal communication, emails, and press releases
4. External press releases
5. Job description for the administrative leader
6. Job description examples used as a model for the job description created
7. Research site community benefit report
8. Research site annual report