LEADERSHIP STYLES OF FEMALE HEALTHCARE EXECUTIVES: COMPARISON OF TRANSFORMATIONAL, TRANSACTIONAL, AND PASSIVE-AVOIDANT LEADERSHIP STYLES

by

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Abstract

The healthcare industry has experienced a myriad of leadership challenges that continue to evolve with the economy, technology, access to care, organizational structure, and dynamics of the work force. Each year since 1987, *Modern Healthcare* magazine has recognized 12 healthcare executives for their significant impact in the healthcare industry by awarding them the Up & Comers award. There is a need for leaders with a vision who can gain the trust of their followers, instill confidence, create a positive atmosphere, stimulate creativity, and motivate followers to work together as a team to overcome the obstacles encountered in today's healthcare industry; these characteristics are found in transformational leaders. This study and quantitative methodology were based on Wheatley's 2010 study and Avolio and Bass's 2004 full range leadership model: transformational, transactional, and passive-avoidant leadership. The researcher collected data on 55 female healthcare executives to examine if there was a significant difference in leadership styles and outcomes of leadership between female Up & Comers healthcare executives and other female healthcare executives as measured by the Multifactor Leadership Questionnaire (MLQ) 5X Short, developed by Avolio and Bass in 2004. Findings indicated there were no significant differences between female Up & Comers healthcare executives' and other female healthcare executives' leadership styles or outcomes of leadership as measured by the MLQ 5X Short. Limitations associated with methodology, response rate, electronic survey distribution, and participants are discussed, along with recommendations for future research.

Dedication

Life choices are influenced by many things. My choices in life have been and will continue to be influenced by my experiences and the people in my life. The most influential people in my life are my family members. This milestone in my life would not have been possible without my parents. I dedicate this achievement to my mother and father, George and Mary, for being there for me in my early years. Their guidance and discipline, and watching my mother earn her graduate degree as a wife and mother all while working full-time, left an everlasting impression that nothing is impossible. To my younger brother, Kevin, who looked up to me, I always wanted to set the example for him, but I soon found myself admiring his accomplishments and academic success. You, my brother, were an inspiration to me.

Among my life choices, I entered the Navy, married, and had children. To my wife, thank you for your support during my 29 years of military service and multiple deployments. You inspired me to go back and pursue my education while on active duty. Fulfilling multiple roles as a wife, friend, mother, and full-time employee, you made it possible for me to work toward personal and professional goals. To my daughters, Cristen, Chesaré, and Candice, you are the greatest gift a parent could ask for, and I want to make you proud to call me your father. You can be whatever you want and accomplish any goal; the secret is to never give up.

To all my family and friends who have supported and believed in me, I dedicate this dissertation to you.

Acknowledgments

My academic journey presented many challenges. There were obstacles I encountered, and when I lost focus and considered quitting, I received words of encouragement and guidance that put me back on track. An individual whom I would like to acknowledge and thank is Cheryl McConnaughey, EdD, my mentor. I cannot put into words the impact she had and what she provided me through this journey. Her words and guidance were always thought-provoking and insightful; I attribute her efforts to my successful completion of my dissertation. I would also like to acknowledge my dissertation committee members, John Klocinski, PhD, and Geoffrey Laendner, PhD. I appreciated the honest feedback and challenging questions; without your insight and time, I would not have achieved this milestone.

Designing my research project and collecting data required coordination and assistance. I want to acknowledge the team at Medical Marketing Service for their assistance in recruiting participants and Chris at Mind Garden, whose expertise allowed me to use an electronic survey and centralized data collection. The assistance of Andrea McGlynn, followed by Dr. Lani's team at Statistic Solutions, with a special thank you to Ed King, were instrumental in helping me understand and present my statistical findings. A very special acknowledgment of Linda Carter, editor, for her time and attention to detail that allowed me to present a finished project.

Finally, I must acknowledge my wife and daughters for always believing in me. Thank you all for putting up with me and understanding my academic mood swings. Your words, smiles, and laughter always kept me grounded. Thank you all for being there

for me! It will take the rest of my life to show you my appreciation for all that you have done for me.

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CHAPTER 1. INTRODUCTION

Introduction to the Problem

The healthcare industry has experienced a myriad of leadership challenges that continue to evolve with the economy, technology, access to care, organizational structure, and dynamics of the work force (Lantz & Maryland, 2008; Wheatley, 2010). Wheatley (2010) noted that observers view these challenges as disruptive and impede organizational performance that is further complicated by "high turnover among healthcare executive leaders" (p. 3). Vance and Larson's (2002) review of business and healthcare studies revealed that leadership influences an organization's performance, profits, and employee turnover. The focal point of several studies and leadership literature by Avolio and Bass (2004), Bass (1985, 1997), Bass and Riggio (2006), Burns (1978), Gilmartin and D'Aunno (2007), Lantz and Maryland (2008), Spinelli (2006), Wheatley (2010), and Wikström and Dellve (2009) is transformational leadership and how it impacts organizational outcomes. There is a need for leaders with a vision who can gain the trust of their followers, instill confidence, create a positive atmosphere, stimulate creativity, and motivate them to work together as a team to overcome the obstacles encountered in the healthcare industry today (Carless, 1998; Lantz & Maryland, 2008; Parry & Proctor-Thomson, 2002; Tucker & Russell, 2004; Wheatley, 2010); these characteristics are found in transformational leaders.

Background of the Study

The success of an organization is dependent on effective leadership (Defee, Stank, Esper, & Mentzer, 2009). There is no one perfect leadership approach for all situations or organizations. Leadership is seen through many different lenses and influenced by various factors ranging from personal to environmental. Perceptions of leaders and followers alike define what style of leadership they believe is more effective, promotes satisfaction, and motivates followers to go the extra mile. Definitions of *leadership* have varied through the centuries, contributing to different theories with styles that varied in approach and execution. Characteristically, leadership is a process of influencing a group of people to work toward a common goal (Hersey, Blanchard, & Johnson, 2001; Hersey, Blanchard, & Natemeyer, 1979). As Hersey et al. (2001) noted, "Leadership and management are full-time responsibilities that must be practiced every hour of every day" (p. 7). Scholars and practitioners have long recognized and acknowledged the intricacies associated with people and the evolving art of leadership. The focus of this study was leadership styles among female healthcare executives.

A series of studies conducted by American College Healthcare Executives (ACHE, 1997, 2006, 2012), along with academic research from 1990 to 2012 (Athey, 2014; Carnes & Bland, 2007; Fontenot, 2012; Gilmartin & D'Aunno, 2007; Lantz & Maryland, 2008; Pounder & Coleman, 2002; Weil & Mattis, 2001), compared male and female healthcare executives. Despite the increasing presence of women in leadership positions, there remains a lack of representation of women in the upper echelons of healthcare leadership (Athey, 2014; Lantz & Maryland, 2008; Weil & Mattis, 2001; Weil & Zimmerman, 2007). A traditional leadership approach would not meet future political,

economic, and increasing diverse demographic challenges in the healthcare industry (Athey, 2014; Fontenot, 2012; Lantz & Maryland, 2008; Wheatley, 2010). Wheatley (2010) postulated a leader who possesses transformational characteristics is more likely to align healthcare organizations with government policies and healthcare reform. Over the past 10 years, transformational leadership has been integrated into healthcare organizations to support that vision.

Transformational leadership is common in business organizations and desired in the healthcare industry (Carless, 1998; Carnes & Bland, 2007; Wheatley, 2010). Historically, men ruled the economic system while women tended to domestic duties (ACHE, 1997, 2006, 2012; Barbara, 1987; Bass & Riggio, 2006; Kwolek-Folland, 2007; LaPierre & Zimmerman, 2012). Over the years, women entered the work force and, through socialization, the business landscape evolved, presenting greater opportunities for women. The presence of women in business, marketing, services, and health care is increasing (ACHE, 1997, 2006, 2012; Athey, 2014; Pounder & Coleman, 2002). The focus of this study was on female executives in the healthcare industry.

Each year *Modern Healthcare* magazine recognizes young talented managers who have made a significant impact in the healthcare industry, through an awards program titled Up & Comers. The Up & Comers awards were first introduced in 1987 (Burda, 2007a, 2007b). Since the inception of the award program to 2013, there have been 328 Up & Comers healthcare executives—204 men and 124 women. This study was based on Wheatley's (2010) recommendation for future research to identify "whether female Up & Comer healthcare executives have a greater tendency to practice transformational leadership than male colleagues" (p. 151).

Statement of the Problem

Wheatley's (2010) assumptions were the premise for conducting a study that focused on healthcare executives, comparing leadership styles based on Bass's full range of leadership (FRL) model: transformational, transactional, and passive-avoidant/laissez-faire leadership styles (Avolio & Bass, 2004). The healthcare executives were divided into two groups: Up & Comers award recipients and other healthcare executives. Wheatley's research provided valuable insight on leadership styles among healthcare executives, with a recommendation for future research to identify if there is a statistical relationship between leadership style and gender. B. A. Wheatley (personal communication, January 25, 2013) clarified the scope of his recommended future research, noting it should compare leadership styles of female Up & Comers healthcare executives and other female healthcare executives.

Wheatley's (2010) findings indicated transactional leadership style was more prominent among Up & Comers healthcare executives. For the current study, the researcher examined the leadership styles of female healthcare executives to determine if a significant difference exists between female Up & Comers healthcare executives and other female healthcare executives. This study contributes to the field of organization and management by investigating the relationship between female healthcare executives and leadership styles.

Purpose of the Study

The purpose of this causal-comparative survey study was to evaluate the FRL model that relates the leader to leadership style and outcomes of leadership, controlling

for gender of healthcare executives at medical facilities across the United States. The independent variables are defined as female Up & Comers healthcare executives and other female healthcare executives. The dependent variables are generally defined as leadership styles—transformational, transactional, and passive-avoidant. Leadership styles mediate outcomes identified as the leader's ability to motivate followers to exert extra effort, leader's effectiveness, and followers' satisfaction with the leader. The control and intervening variables—gender and leadership characteristics—were statistically controlled in this study.

Over the past two decades practitioners and researchers have voiced their concern and interest regarding the existing gap between gender and goal attainment in the healthcare industry (ACHE, 1997, 2006, 2012; Athey, 2014; Fontenot, 2012; Weil & Mattis, 2001, Weil & Zimmerman, 2007). The interest in the gender gap in health care coupled with leadership studies that identified transformational leadership as the desired leadership style in health care (Avolio & Bass, 2004; Pounder & Coleman, 2002; Wheatley, 2010) gives relevance to this study of female healthcare executives' leadership styles.

Wheatley (2010) noted a transformational leader is needed to lead healthcare organizations through 21st-century challenges. Leadership studies conducted in other industries revealed that men rated higher as transactional leaders and women rated higher as transformational leaders (Bass & Riggio, 2006; Carless, 1998; Lantz & Maryland, 2008; Pounder & Coleman, 2002). As of 2013, there were 328 Up & Comers award recipients: 204 men and 124 women. The intent of this study was to capture data to

identify if there is a statically significant difference in leadership styles between female Up & Comers healthcare executives and other female healthcare executives.

Rationale

This study was based on Wheatley's (2010) recommendation for future research to focus on female healthcare executives. Wheatley's dissertation involved male and female Up & Comers healthcare executives and other male and female healthcare executives. Wheatley found that Up & Comers healthcare executives' characteristics were more transactional compared to other healthcare executives' characteristics. Pounder and Coleman (2002) noted, "There is a line of argument in leadership literature contending that female leaders tend to be more transformational than male leaders" (p. 123). Based on research addressing gender and leadership, it is generally assumed that female healthcare executives' leadership characteristics are highly transformational. The researcher collected data to determine if female Up & Comers healthcare executives and other female healthcare executives' leadership styles were similar. Wheatley suggested future research that would "determine if female Up & Comer healthcare executives have a greater tendency to practice transformational leadership than male colleagues" (p. 151).

The annual Up & Comers award recognizes managers who have made a significant impact in their organizations (Burda, 2007a, 2007b). Based on Wheatley's (2010) findings, Up & Comers healthcare executives with a transactional leadership style made a significant impact in health care from 1987 to 2009. The data from Wheatley's study do not align with data from other researchers and authors (Avolio & Bass, 2004; Bass, 1985, 1997; Bass & Riggio, 2006; Burns, 1978; Carless, 1998; Carnes & Bland,

2007; Gilmartin & D'Aunno, 2007; Lantz & Maryland, 2008; Parry & Proctor-Thomson, 2002; Spinelli, 2004, 2006; Tucker & Russell, 2004; Wikström & Dellve, 2009) who have identified transformational leadership as the desired leadership style to promote positive organization outcomes needed in the healthcare industry.

The MLQ 5X Short (Avolio & Bass, 2004) was used to measure how female healthcare executives rate their leadership style. Various instruments can be used to collect data associated with leadership that include styles categorized as transformational and transactional. The MLQ 5X Short was used for this research to capture the rater's self-assessment of her leadership style and outcomes. The foundation of this study was based on Avolio and Bass's (2004) FRL model. The research questions and independent and dependent variables fit a quantitative methodology approach (Arbnor & Bjerke, 1997; Cooper & Schindler, 2006; Fowler, 2002; Robson, 2002). The MLQ 5X Short was used to measure factors that construct and identify leadership styles. Permission to use the MLQ 5X Short was received through Mind Garden's website.

Studies associated with Avolio and Bass's (2004) FRL were quantitative and used the MLQ to collect data. The MLQ examines leadership behavior as perceived by the leader, followers, colleagues, peers, and/or superiors (Avolio & Bass, 2004). Over the past two decades, the MLQ has been challenged and revised in response to concerns raised by scholars and practitioners. The revisions and ongoing testing have been instrumental in reinforcing the instrument's reliability and validity (Avolio & Bass, 2004; Muenjohn & Armstrong, 2008; Spinelli, 2004; Wheatley, 2010).

Avolio and Bass (2004) conducted a confirmatory factor analysis (CFA) using the initial set of data and eight alternative models, ranging from a single factor to nine

factors, employed by researchers using the MLQ. Factors are the characteristics associated with each leadership style. Results in 1999 revealed the six-factor model exceeded the minimum cutoff for goodness of fit (providing the best fit) as compared to the alternative models (Avolio & Bass, 2004).

In 2003, the nine-factor model proved to be the best fit, demonstrating consistency across regions and by rater (Avolio & Bass, 2004). As the factors increased, the goodness of fit improved (Avolio & Bass, 2004; Spinelli, 2004, 2006), covering the FRL: transformational, transactional, and laissez-faire. For the purpose of this study, the nine-factor model was applied, capturing data related to factors associated with transformational leadership (inspirational motivation, idealized influence behavior, idealized influence attributed, intellectual stimulation, and individualized consideration), transactional leadership (contingent reward and management by exception-active), and passive-avoidant (management by exception-passive) coupled with laissez-faire leadership (voidance or absence of leadership; Avolio & Bass, 2004; Bass, 1985; Firestone, 2010; Muenjohn & Armstrong, 2008; Wheatley, 2010).

This study used homogeneous samples with similar demographics. In reference to the MLQ, Antonakis, Avolio, and Sivasubramaniam (2003) wrote, "One would expect the factor structure to be invariant only within homogeneous contexts" (p. 268). Heinitz, Liepmann, and Felfe (2005) shared that the empirical rationale supported the three-factor model among the samples used in their study. The meta-analysis conducted by Muenjohn and Armstrong (2008) revealed a positive correlation between all the factors associated with transformational leadership. Muenjohn and Armstrong found the MLQ 5X to be statistically significant. The researchers conducted a CFA to test the structural validity of

three MLQ models using an analysis of moment structure. Multiple data sources were used that involved 138 cases. Their findings suggested that transformational leaders were more effective than transactional leaders.

Research Questions

The research questions were based on the FRL model (Avolio & Bass, 2004) to determine if a significant difference exists between female Up & Comers healthcare executives and other female healthcare executives. Additionally, a question was added to capture the outcomes of leadership, which include the leader's ability to motivate followers to exert extra effort, leader's effectiveness, and satisfaction with the leader.

ResQ1: To what extent does leadership style vary between female Up & Comers healthcare executives and other female healthcare executives as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004)?

ResQ2: To what extent do female Up & Comers healthcare executives and other female healthcare executives vary in terms of the outcomes of leadership as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004)?

The research questions for this study were based on Bass's (1985) leadership theory and Wheatley's (2010) dissertation. Leadership styles identified in Avolio and Bass's (2004) FRL model encompass the charismatic role model, who inspires followers through a shared vision, meaningful work, and recognizing followers as individuals. The FRL also encompasses the bargaining leader, who offers rewards for good performance and punishes for poor performance. At the other end of the spectrum is the leader who only gets involved when followers or processes deviate from the status quo, and, finally,

the absence of leadership. Avolio and Bass (2004), Bass (1985), and Wheatley (2010) categorized these leadership styles as transformational, transactional, and passive-avoidant.

Significance of the Study

Since the early 1990s, women have made significant progress in fields historically dominated by men (Carnes & Bland, 2007; Lantz & Maryland, 2008; Pounder & Coleman, 2002). Carnes and Bland (2007) noted a gap still exists, identifying elite leadership positions in America's largest corporations, universities, and the healthcare industry were still dominated by men. Several studies and leadership literature (Avolio & Bass, 2004; Bass, 1985, 1997; Bass & Riggio, 2006; Burns, 1978; Carnes & Bland, 2007; Gilmartin & D'Aunno, 2007; Lantz & Maryland, 2008; Spinelli, 2004, 2006; Vance & Larson, 2002; Wheatley, 2010; Wikström & Dellve, 2009) have explained how transformational leadership has had a positive influence on organizational outcomes. There is a need for visionary leaders who will gain the trust of their followers, instill confidence, stimulate creativity, and motivate followers to work together as a team to overcome the obstacles encountered in today's healthcare industry (Carless, 1998; Lantz & Maryland, 2008; Parry & Proctor-Thomson, 2002; Tucker & Russell, 2004; Wheatley, 2010).

Wheatley (2010) examined the FRL, comparing similarities and differences between two groups of healthcare executives, and found there were no differences between Up & Comers healthcare executives and other healthcare executives in relation to transformational and passive-avoidant leadership. There was a significant difference in

MLQ scores for transactional leadership traits, with the Up & Comers healthcare executives rating themselves higher than did other healthcare executives.

Empirical research and meta-analysis of leadership and gender studies provided data that revealed female leaders were more transformational than male leaders (Appelbaum, Audet, & Miller, 2003; Bass & Riggio, 2006; Eagly, Johannesen-Schmidt, & van Engen 2003; Pounder & Coleman, 2002). Women also were rated higher as possessing the characteristics associated with contingent reward under transactional leadership (Eagly et al., 2003). Although there were differences in the outcomes, these studies supported Bass's (1985) FRL and augmentation effect of transformational leadership, as identified from data collected using the MLQ 5X (Avolio & Bass, 2004; Bass & Bass, 2008; Hater & Bass, 1988).

When appropriate, a transformational leader may employ transactional behavior, establishing an agreement with followers to accomplish a task (Avolio & Bass, 2004). Avolio and Bass (2004) noted that previous studies indicated that government, religious, and military leaders are transactional when followers demonstrate "lower levels of performance or non-significant change" (p. 21). The difference between these two leadership styles is the leader's expectation for level of performance. Transactional leaders inspire followers to perform as expected, whereas transformational leaders motivate followers to do more, exceeding their own expectations (Hartog, Van Muijen, & Koopman, 1997).

One would expect that Up & Comers would score higher than other healthcare executives on the scale of transformational leadership, but Wheatley's (2010) findings showed the opposite. Wheatley's population consisted of 73 men and 52 women, among

49 Up & Comers and 76 other healthcare executives. The self-perception of leadership style by gender was not analyzed.

Wheatley (2010) cited studies by Gabbert; Gasper; Janssen; Longenecker; Spinelli; and Xirasagar, Samuels, and Stoskopf, noting their findings were different than his. The studies cited by Wheatley indicated personnel in high-level executive leadership and management positions in health care were more transformational. These studies also highlighted the positive influence transformational leadership had on the healthcare organizations' outcomes. Wheatley posited several reasons for the imbalance of his findings of Up & Comers' self-perception as transactional leaders in comparison to the aforementioned studies. He posited that in order for an organization to achieve the desired leadership, time and money would be required to train the current leadership. Wheatley noted that training leaders to be transformational is hindered by negative connotations associated with other change initiatives that have failed. Wheatley further noted defining leadership is complicated, but recognizing it is easy.

Wheatley (2010) recommended that future research be focused on transformational leadership and suggested that female healthcare executives be studied specifically to identify their leadership style. The intent of this current study was to contribute to the field of organization and management by investigating the relationship between female healthcare executives and their leadership styles.

Definition of Terms

For the purpose of this study, the definitions for the following terms are provided.

Active management by exception. The act of a proactive leader monitoring processes and enforcing the rules to ensure his or her followers' performance is within the guidelines. If there is any deviation in performance or process, the leader implements corrective measures in a timely manner (Avolio & Bass, 2004; Bass, 1997; Bass & Riggio, 2006; Spinelli, 2004, 2006; Wheatley, 2010).

Augmentation effect. The relationship between transformational and transactional leadership styles. It is possible to achieve a "greater amount of extra effort, effectiveness and satisfaction" (Avolio & Bass, 2004, p. 22) when transformational leadership behaviors augment transactional leadership.

Contingent reward/reinforcement. An agreement between the leader and follower in which the leader rewards the follower for achieving established goals based on effort and performance (Avolio & Bass, 2004; Bass, 1985, 1990a, 1990b; Bass & Riggio, 2006; Bycio, Hackett, & Allen, 1995; Hartog et al., 1997).

Laissez-faire leadership. The absence of leadership, in which the leader fails to provide an active presence among followers or resources to meet the organization's goals and mission (Bass, 1997; Bass & Riggio, 2006; Spinelli, 2004, 2006; Wheatley, 2010).

Passive-avoidant leadership. The act of a reactive leader who is not active in monitoring followers' performance and processes. Unaddressed problems intensify and no action is taken until the problem is brought to the leader's attention (Bass, 1997; Bass & Riggio, 2006; Spinelli, 2004, 2006; Wheatley, 2010).

Transactional leadership. A leadership style based on a reward system that encourages followers to meet goals and discourages them from failing to do so (Avolio & Bass, 2004; Bass, 1997; Bass & Riggio, 2006; Spinelli, 2004, 2006; Wheatley, 2010); also known as "quid pro quo" (Kent, Crotts, & Azziz, 2001, p. 222), or *this for that*.

Transformational leadership. Refers to visionary leaders who communicate how the followers' efforts contribute to the overall organization and goals of the team versus those of the individual. Transformational leaders motivate followers to work beyond expectations and do the right thing (Avolio & Bass, 2004; Bass, 1997; Bass & Riggio, 2006; Bycio et al., 1995; Spinelli, 2004, 2006; Wheatley, 2010) by instilling confidence, creating a positive atmosphere, stimulating creativity, and recognizing that each individual is unique.

Up & Comers healthcare executive. Each year *Modern Healthcare* recognizes young talented managers who have made a significant impact in administration, management, or policy in the healthcare industry, through an awards program titled Up & Comers. The Up & Comers award program was first introduced in 1987 (Burda, 2007a, 2007b). The Up & Comers award is sponsored by an executive search firm, Witt and Kieffer, that specializes in health care, education, and not-for-profit organizations.

Assumptions and Limitations

Assumptions

This study compared leadership styles between two groups of female healthcare executives identified as female Up & Comer healthcare executives and other female healthcare executives. Using Avolio and Bass's (2004) FRL model, leadership styles

were identified as transformational, transactional, and passive-avoidant. Based on the researcher's literature review and previous studies (Appelbaum et al., 2003; Avolio & Bass, 2004; Bass & Riggio, 2006; Eagly et al., 2003; Lantz & Maryland, 2008; Pounder & Coleman, 2002), the researcher assumed female healthcare executives' leadership characteristics would be highly transformational.

From 1987 to 2013, *Modern Healthcare* identified 328 Up & Comer award recipients, 124 of whom were women (Burda, 2007, 2008, 2009, 2010, 2011, 2012; *Modern Healthcare,* n.d.). With a target population of 7,300 female healthcare executives, identified by Medical Marketing Service, and a sample population of 500, the researcher assumed the minimal required sample size would include a sufficient number of Up & Comers to conduct the study.

The researcher assumed an electronic survey would be convenient based on the assumption that all potential participants listed with Medical Marketing Service would have access to a computer, cell phone, or other electronic mobile device. The researcher also assumed that conducting the study during the holiday season would impact response rate. With no way of validating demographics, the researcher assumed all responses were accurate, truthful, and answered by the intended e-mail recipient.

Limitations

Limitations associated with this research are associated with the quantitative methodology using an electronically distributed questionnaire for data collection, such as response rate, from the target population that represented both groups of female healthcare executives (Fowler, 2002). Medical Marketing Service identified a large population and sample size of female healthcare executives but did not segment the list to

identify Up & Comers. Responses to the demographic questionnaire identified the group with which the participants were associated: Up & Comers or other healthcare executives. However, there was no way for the researcher to validate demographic responses. Incorrect responses compromise data integrity, which impacts the overall findings of the study.

Following Wheatley's (2010) methodological approach, several limitations were identified with the current research. Excluding organizational and situational factors does not provide insight to the effects that such dynamics would have on leadership styles. Restricting data collection to capture only the rater's self-assessment does not offer a well-rounded view of the leader's characteristics as perceived by supervisors, peers, and/or followers that would provide a better understanding of the female healthcare executive's leadership style (Wheatley, 2010).

Nature of the Study

For the purpose of this study, the target population consisted of female healthcare executives that were divided into two groups: female Up & Comers healthcare executives and other female healthcare executives. Medical Marketing Service, a mailing list broker, assisted in identifying 12,484 female healthcare executives. A sample frame of 3,000 was contacted to participate in the study. Among the female healthcare executive population, there are 124 female Up & Comers healthcare executives (Burda, 2007a, 2007b, 2008, 2009, 2010, 2011, 2012; *Modern Healthcare,* n.d.).

Female healthcare executives answered a series of questions from Avolio and Bass's (2004) MLQ that are associated with one of the following leadership styles:

transformational, transactional, or passive-avoidant. Additional questions provided insight of their views related to outcomes of their leadership. Findings identified if there was a statistical difference between female Up & Comers healthcare executives and other female healthcare executives. The findings built upon Wheatley's (2010) study identifying "whether female Up & Comers healthcare executives have a greater tendency to practice transformational leadership than male colleagues" (p. 151).

Prior researchers who examined biological sex and gender and its influence on leadership style argued that transformational leadership relates more to female characteristics than to male characteristics (Appelbaum et al., 2003; Pounder & Coleman, 2002). The issue of whether female leaders are more transformational than male leaders has been discussed in other industries (Pounder & Coleman, 2002), with limited mention of the healthcare industry.

The focus of the study was based on the theoretical framework of Avolio and Bass's (2004) FRL theory (see Figure 1). Further literature review of scholarly journals revealed the different views associated with leadership styles, gender, leadership in health care, charisma, followership, and organizational culture.

A quantitative methodology was used to conduct the research. The research instrument of choice is the MLQ 5X Short (Avolio & Bass, 2004). The MLQ identifies leadership style and measures leadership effectiveness, employee satisfaction, and leader's ability to motivate employees to exert extra effort.

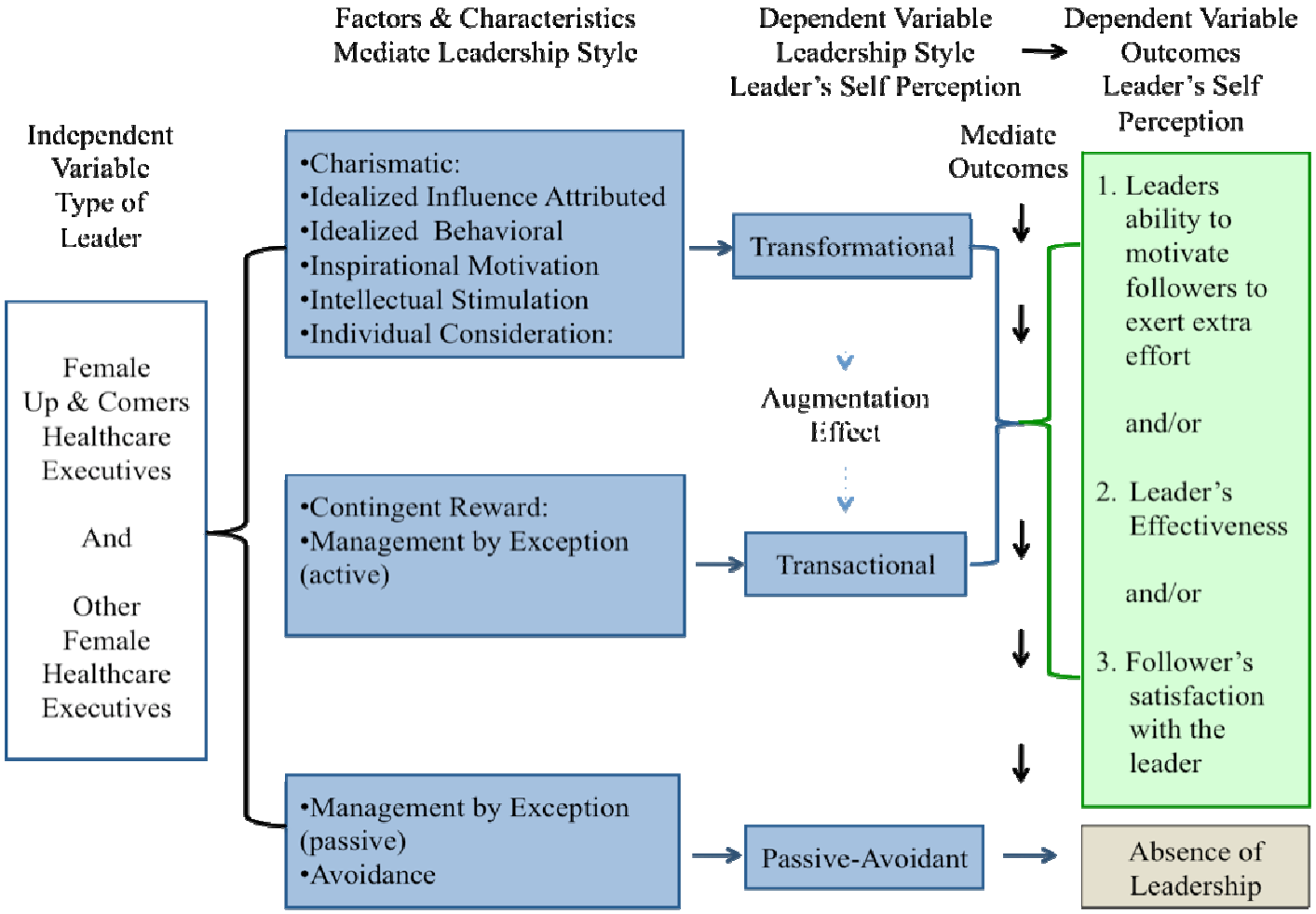

Figure 1. Conceptual model of female healthcare executives' self-perception of leadership styles and outcomes.

Organization of the Remainder of the Study

Chapter 2, the literature review, discusses leadership styles and FRL—specifically transformational, transactional, and passive-avoidant/laissez-faire (Avolio & Bass, 2004; Bass, 1985)—dating from the early 1970s to the present. Chapter 3, the methodology, identifies the conceptual framework, research hypothesis, questionnaire used for data collection, and analysis. Chapter 4 presents the demographic data, quantitative data, and data analysis. Chapter 5 provides the findings and summary, conclusion, and recommendations for further research.

CHAPTER 2. LITERATURE REVIEW

Introduction

This chapter is divided into six sections: leadership overview, differences between male and female leadership styles, female leadership in health care, charisma, methodology, and the MLQ. Academic research has focused on specific periods of time, generating leadership theories that did not illustrate integration with one another. As new variables were introduced, leadership theories evolved and became more multifaceted. The more complex leadership theories became, the more criticism they drew (Barker, 2001; Burns, 1978; Ionescu & Negrusa, 2007; Yukl, 1999).

The focus of this study was based on Bass's FRL model: transformational, transactional, and passive-avoidant leadership (Avolio & Bass, 2004; Bass, 1985, 1997; Bass & Riggio, 2006; Burns, 1978; Spinelli, 2004, 2006; Wheatley, 2010). Bass's (1985) seminal work captured leadership styles under the FRL model between male and female leaders. Avolio and Bass (2004), along with Bass's earlier studies, captured data and addressed findings associated with political, corporate, industrial, religious, and military environments; the current study focused on female executives in the healthcare industry. Spinelli's (2004, 2006) and Wheatley's (2010) studies were influential in the researcher's methodological approach in the current study.

Wheatley's (2010) causal-comparative study of two groups of healthcare executives' leadership styles was adapted for this study. Wheatley wrote, "Healthcare is in need of effective leadership" (p. 4). He discussed the need for leadership development in healthcare organizations, noting the traditional leadership approach would not meet future political, economic, and increasing diverse demographic challenges. Wheatley identified a need for leaders who possess transformational characteristics to align healthcare organizations with government policies and healthcare reform. Over the past 10 years, transformational leadership has been integrated into healthcare organizations (Spinelli, 2004, 2006; Wheatley, 2010).

It is important to understand the power associated with leadership and the definitions of leadership styles, theories of leadership, and how these theories are integrated within Bass's FRL model. Transformational, transactional, and passive-avoidant leadership are identified and separated by dimensions that characterize the behavior perceived by the leaders themselves, their peers, supervisors, and followers under Bass's FRL model, discussed later in this chapter.

According to Hersey et al. (1979), there are seven bases of power: coercive, reward, legitimate, expertise, referent, connection, and information. Coercive power describes a leader who persuades through fear. Followers strive to accomplish their goals to avoid punishment. A more effective base of power is reward power, in which the leader can reward followers for completing assignments and complying with policies and guidelines. The power to reward others stems from legitimate power. Legitimate power is recognized through positional authority that is related to and recognized by where an individual is positioned within the organizational structure, such as chief executive

officer (CEO), division manager, department manager, or floor manager. Certain abilities and authority are assigned to positions that are recognized as having formal power (Longest & Darr, 1993).

Personnel viewed as having connections with influential people, such as those with legitimate power, possess connection power. Followers are inclined to comply with a leader who is perceived to be well connected with powerful people so they may gain approval or avoid disapproval from those within the powerful network (Hersey et al., 1979).

The technical expert, or the go-to person, in an organization possesses expert power. This type of power is different from coercive, reward, and legitimate power, which are derived from delegation. An individual with technical expertise in a specific area may be granted the previously discussed bases of power (Hersey et al., 1979; Longest & Darr, 1993).

Unlike expert power, employees who have corporate knowledge or any source of information that is of value to others are recognized as having informational power. Possessing such information that others need or want gives the holder of such information influential power (Hersey et al., 1979). Finally, referent power is a source of power stimulated by the confidence of a leader who exudes charisma and inspires loyalty with followers who desire to be like that leader.

Over a decade later, Longest and Darr (1993) focused on five of the seven bases of power associated with leaders: coercive, reward, legitimate, expertise, and referent. The five bases of power are evident throughout the history of leadership and in Bass's FRL model (Longest & Darr, 1993).

Leadership Styles

Discussions of leadership can be traced back to before Christ and appeared in Greek and Roman writings, such as Homer's *The Iliad* (Bass & Bass, 2008). Discussions involving leadership continued through the ages, contributing to as well as challenging the growing philosophies that have defined leadership. During the Renaissance, Machiavelli believed that leaders needed to be coercive (Longest & Darr, 1993)—firm, authoritative, powerful, and existing in an orderly and functional government. Machiavelli also believed that if followers did not accept and support their leader, they could be persuaded through manipulation, threats, or acts of violence (Bass, 1990a; Bass & Bass, 2008; Lang, 1991; Skinner & Price, 2007; Yukl, 1999).

Further evaluation of Machiavelli's philosophy revealed that a leader's approach should be based on the situation. Machiavelli's leadership studies focused on ancient Greek, Roman, and European rulers; during this period—1400s to 1500s—there were two ways an individual could become a ruler: Power could be inherited or established through favor. *Favor* referred to a leader's selection by one of his own, be it a noble or one who came up through the ranks (Skinner & Price, 2007).

Rulers, no matter how they arrived at their position, faced many obstacles. The reign of rulers was dependent on their ability to keep their promises, influencing followers' trust and belief in them. As rulers jockeyed for position in the political arena, a common survival strategy was to kill or be killed (Bass, 1990a; Bass & Bass, 2008; Skinner & Price, 2007). Machiavelli's basic assumption was that "rulers must always be prepared to do evil if good will come of it" (as cited in Skinner & Price, 2007, p. xxiv). He expounded on this statement by noting that one must know when to use laws and

when to use force. When following the law did not achieve expected results, rulers would use barbaric methods to achieve order. Understanding who to trust and when to apply forceful tactics was important in achieving success. Rulers had to possess the animal-like instincts of a fox, to recognize traps, and those of a lion, to ward off predators (Bass, 1990a; Bass & Bass, 2008; Skinner & Price, 2007).

Machiavelli's writings promoted situational awareness and adjusted leadership tactics to appropriately address the existing environmental climate (Skinner & Price, 2007). He further emphasized that if force or evil acts must be used, they should be done at once and not over an extended period of time so followers would not live in fear of the ruler. One cannot always lead with an iron fist; fear breeds animosity that will inevitably lead to a ruler's demise (Skinner & Price, 2007).

Herman (2000) discussed the evolution of leadership, evaluating past practices and looking ahead to what a leader's role would become in the future, to include higher education programs to prepare future business leaders. The autocratic leader, with a top-down approach, used coercive and reward power (Longest & Darr, 1993) to motivate followers with rewards for meeting established goals or punishment for failure to meet established goals.

The way people were managed and led shifted, transitioning to a style at the other end of the spectrum, labeled participative or democratic leadership, displaying legitimate and reward power (Longest & Darr, 1993). Followers were treated as equals, being rewarded and encouraged for their participation and input in the decision-making process (Bass & Bass, 2008; Herman, 2000; Weiskittel, 1999).

Researchers in leadership began to recognize the value and importance of those doing the work, with followers working together as a team. The team approach established leadership at different levels, reinforcing a hierarchical structure. As the focus shifted from teams to individuals, the leadership role moved to a facilitative function. A leader, as a facilitator, possessed legitimate and reward power (Longest & Darr, 1993) that allowed teams to remain intact while encouraging equality and valuing individual input and collaboration to achieve innovation (Herman, 2000).

Weiskittel (1999) highlighted another leadership approach that involved groups, identified as blended leadership. Blended leadership recognized the strengths of group members and the environment in which they operate. This style of leadership had a blended base of power—legitimate and reward (Longest & Darr, 1993)—allowing a group to work with minimal to no supervision by providing training and coaching to personnel, much like a facilitator would do.

As views and theories of leadership continued to evolve, the concept of servant leadership was identified in the 1970s, originating from Robert K. Greenleaf's management research (Spears, 2004). Servant leadership focused on followers, with the leader as a servant. Greenleaf posited, "True leadership emerges from those whose primary motivation is a deep desire to help others" (as cited in Spears, 2004, p. 8). Through the study of Greenleaf's work, Spears (2004) identified 10 characteristics associated with servant leadership that focus on the follower.

The first characteristic of servant leadership involves listening (Spears, 2004). A leader must be an effective listener and be able to reflect on the follower's input and past experiences. Second is the ability of the leader to empathize and understand what people

have been through, recognizing followers as individuals who are unique (Spears, 2004). Healing is the third characteristic, in which leaders focus on helping others and themselves emotionally (Spears, 2004). The fourth characteristic is awareness (Spears, 2004). Leaders must possess self-awareness along with a general awareness of the internal and external environments that involve but are not limited to ethics and values. The fifth characteristic is persuasion (Spears, 2004). Servant leadership does not rely on legitimate power (Longest & Darr, 1993) established through positional authority. Servant leaders seek to influence and stimulate intrinsic motivation among followers.

Spears's (2004) sixth characteristic notes the servant leader must also be a visionary, with the capability to identify and share thoughts about day-to-day, short-term, and long-term goals known as conceptualization. Closely related to conceptualization is foresight, the seventh characteristic (Spears, 2004). Servant leaders incorporate reflection, learning from experience and past mistakes as well as successes to identify future outcomes (Spears, 2004).

Stewardship is the eighth characteristic (Spears, 2004). A servant leader must trust others and earn the trust of others. Servant leaders promote and emphasize the use of openness and persuasion rather than control over followers. The ninth characteristic is commitment to the personal and professional growth of followers (Spears, 2004). Under commitment, the servant leader recognizes followers' uniqueness as individuals and that they are a valuable resource to the organization beyond their tangible contributions (Spears, 2004).

The last characteristic Spears (2004) addressed is community: leading and teaching followers to come together and assist one another as coworkers, most

importantly getting involved and understanding the needs of the internal and external community. “At its core, servant-leadership is a long-term, transformational approach to life and work” (Spears, 2004, p. 8).

Finally, leadership that adapts and adjusts to the situation at hand and maturity of the follower is defined as situational leadership (Hersey et al., 2001; Hersey et al., 1979). A practitioner of situational leadership is one who understands and acknowledges that one style of leadership does not fit all (Vecchio, 1987; Weiskittel, 1999). The five bases of power are aligned with situational leadership, adjusting and shifting as it applies to relationship behavior, task, and follower’s maturity level (Hersey et al., 2001; Hersey et al., 1979). The acknowledgment of generational differences, organizational systems, technology, and globalization are variables that present current and future leadership challenges (Herman, 2000).

Full Range of Leadership

Hierarchy of power and respect are learned as one transitions through the stages of life and identifies with role models (Burns, 1978). Leadership is present and portrayed in the home by parents; in the schools by teachers; in sports by team captains and coaches; in organizations by supervisors; and in the community by law officials and religious, military, and political figures. Among these leaders, many have motivated and inspired followers to achieve goals beyond their expectations, goals that supported and benefited the majority rather than the few. These leaders transformed people, communities, organizations, and nations (Bass, 1990a, 1990b).

According to Burns (1978), one's genetic makeup plays an integral part of who one is and the role one takes in society as a follower and leader. Furthermore, the influence of one's surroundings contributes to the behaviors one accepts or rejects through observation and personal experiences with failure and success. How followers are led is influenced by the leader's assumptions and experiences (Burns, 1978).

As noted, leadership is perceived to be many things by different people: practitioners, scholars, leaders, and followers. During the 1970s, research concentrated on behavioral theories such as the path-goal theory (Georgopoulos, Mahoney, & Jones, 1957; House, 1971), expectancy theory (Behling & Starke, 1973; House, 1971), leader–member exchange (LMX) theory (Graen & Uhl-Bien, 1995), and normative decision theory (Jago & Vroom, 1980; Vroom, 2000) in order to analyze leadership effectiveness.

Burns presented transactional leadership in 1978 in association with his seminal work on political leaders (Avolio & Bass, 2004; Burns, 1978). Based on the concept of using leadership as a resource to enhance the maturity level among followers, a shift in the level of need was predicted to be a result of the maturity level, which allowed followers to move beyond the lower half of Maslow's hierarchy of needs (physiological, safety, and belonging) to experience achievement, recognition, and self-actualization (Burns, 1978; Maslow, 1943). Burns (1978) postulated a leader would meet followers' needs through an exchange process between the leader and followers, based on established performance goals in which a reward is provided in order to reach the stated goals. Increasing challenges that involve greater change require a more notable exchange relationship.

Transformational leadership came to the forefront a decade later in the late 1980s. A new interest in individual differences as predictors of effective leadership was the result of the formulation of Burns's (1978) theories on charismatic and transformational leadership. The differences between the transactional and transformational leadership styles were identified first by Downton (as cited in Avolio & Bass, 2004) and Zaleznik (1977), who further elaborated on a difference between leaders and managers. Managers identify employees' needs, set realistic goals, and establish an exchange for achieving such agreed-upon goals (Zaleznik, 1977). Downton's abstract philosophy was not supported until 1978, when Burns's research involving political leaders was published.

Bass and his colleagues conducted research that addressed a full range of leadership. Bass's theory covers transformational, transactional, and laissez-faire leadership (Avolio, 2002; Avolio & Bass, 2004; Bass, 1985, 1990a; Bass & Bass, 2008; Bass & Riggio, 2006; Bycio et al., 1995). Transformational leadership is recognized by followers' emotional attachment to the leader. The leader's involvement and acceptance by followers establishes trust and a willingness to perform beyond expectations (Avolio & Bass, 2004; Hartog et al., 1997; Weiskittel, 1999). The transformational leader is a visionary who communicates and promotes a shared vision, raising followers' confidence as well as awareness of overall outcomes and value of organizational success. Followers admire and emulate transformational leaders and are driven to do what is right for the group rather than for their personal gain (Avolio, 2002; Avolio & Bass, 2004; Bass, 1985, 1990a, 1990b; Bass & Riggio, 2006; Bycio et al., 1995; Spinelli, 2004, 2006; Wheatley, 2010).

The following factors of transformational leadership enhance motivation among followers (Avolio & Bass, 2004; Bass, 1997; Bass & Riggio, 2006; Bycio et al., 1995; Hartog et al., 1997; Spinelli, 2004, 2006; Wheatley, 2010):

1. Idealized influence/charisma (attributed)—the leader is admired by followers, builds confidence, instills pride, and establishes trust.
2. Idealized influence/charisma (behavior)—the leader's actions, such as making sacrifices and putting the followers' needs before his or her own. Inspirational motivation and charisma were once viewed as a single factor, but different behaviors were implied: Charisma requires the follower to identify with the leader, whereas inspirational motivation does not.
3. Inspirational motivation—a leader who is an infectious optimist and successfully communicates visions and goals.
4. Intellectual stimulation—encourages taking risks and not settling for the status quo; viewing mistakes as part of the learning process.
5. Individualized consideration—a leader who knows his or her personnel, recognizing followers as individuals and being aware of their needs.

Transactional leaders seek to identify and understand what task is to be accomplished and the roles required in meeting that goal. As noted earlier, the transactional leader becomes familiar with followers' needs to set up an exchange for doing what the leader wants, arranged through an agreement or a contract, known as contingent reward (Avolio & Bass, 2004; Bass, 1997; Bass & Riggio, 2006; Bycio et al., 1995; Hartog et al., 1997; Spinelli, 2004, 2006; Wheatley, 2010).

Transactional leadership also incorporates two forms of management by exception identified as active and passive. Leaders practicing active management by exception monitor followers and processes, getting involved only when there are indications of a problem. When problems are foreseen, the leader provides proactive intervention to circumvent potential problems (Avolio & Bass, 2004; Bass, 1997; Bass & Riggio, 2006; Bycio et al., 1995; Hartog et al., 1997; Spinelli, 2004, 2006; Wheatley, 2010). Under passive management by exception, the leader does not actively monitor followers and ongoing work. When a follower or a team encounters a problem, the leader gets involved. The leader is reactive rather than proactive (Avolio, 2002; Avolio & Bass, 2004; Bass, 1997; Bass & Riggio, 2006; Bycio et al., 1995; Hartog et al., 1997; Spinelli, 2004, 2006; Wheatley, 2010).

When appropriate, a transformational leader may employ transactional behavior, establishing an agreement with followers to accomplish a task. Avolio and Bass (2004) noted that previous studies indicated that government, religious, and military leaders are transactional when followers demonstrate "lower levels of performance or non-significant change" (p. 21). The difference between these two leadership styles is the leader's expectation for level of performance. Transactional leadership inspires followers to perform as expected, whereas transformational leadership motivates followers to do more, exceeding their own expectations (Hartog et al., 1997).

Finally, the nonexistence of leadership (passive-avoidant/laissez-faire) describes the person who carries the title of leader but chooses not to lead (Avolio & Bass, 2004; Bass, 1985, 1997; Bass & Riggio, 2006; Burns, 1978; Spinelli, 2004, 2006; Wheatley, 2010). The lack of a relationship between the leader and followers is evident through the

absence of communication, involvement, and knowledge and understanding of followers' needs.

Bass and Riggio (2006) noted that laissez-faire leadership may be suitable in a rare instance in which the issue has no bearing on the leader, such as two employees' work schedules with conflicting flex hours, which requires someone to switch. The situation provides greater benefit and understanding if the coworkers work together to gain an understanding of each other's needs to develop a solution rather than the leader getting involved and making the decision. Bass and Riggio further emphasized this practice is not to be confused with empowerment, normally practiced under transformational leadership. The sincerity and caring experienced under transformational leadership is nonexistent under laissez-faire leadership.

For decades, researchers in the field of leadership studied characteristics of personnel in leadership positions. The focus and findings identified whether the leader was effective or ineffective based on the leader's behavior traits, leadership style, and approach to different scenarios (Graen & Uhl-Bien, 1995). Among all the leadership studies, Graen and Uhl-Bien (1995) noted the findings were vague, leading to a lack of understanding of how they interrelate, as each theory addressed a different aspect of leadership.

Yukl (1999) scrutinized the label Bass (1985) used to classify his theory known as full range of leadership—FRL—noting that the theory was plagued with conceptual weaknesses. Yukl's reference to studies involving transformational and transactional leadership styles were directed to findings by Bass that identified positive-reward behavior as a factor within transformational rather than transactional leadership. Other

concerns were the conflicting findings related to passive management by exception, indicating this leadership approach was identified as a factor linked to laissez-faire rather than transactional leadership (Yukl, 1999).

The realization that those being led are humans presented unique variables and sparked the interest of scholars and practitioners. With a new focus, research in leadership expanded, involving several domains: charisma, the follower, and the dyadic leader–member relationship (Graen & Uhl-Bien, 1995). When the focus is primarily on the leader, under the leader-based domain, leadership effectiveness is measured by the leader's characteristics and behaviors. The application of different scenarios provided data to analyze factors associated with the different outcomes (Graen & Uhl-Bien, 1995). Under a follower-based domain, the follower becomes the main focus. Much like the leader-based domain, the follower's perception, expectations, behaviors, traits, attitude, and other characteristics are a contributing factor to what a follower determines to be an effective leadership style or a leader's effectiveness (Graen & Uhl-Bien, 1995).

With a relation-based approach, the focus is on the relationship characteristics between leader and follower outcomes. These characteristics involve but are not limited to trust, respect, and mutual obligation (Graen & Uhl-Bien, 1995). The development and ability to maintain leadership effectiveness is evaluated based on the link between the dyadic relationship and organizational variables of interest. J. Howell and Hall-Merenda (1999) emphasized the importance of understanding the influence each leader and follower brings into a relationship. Understanding the dyadic relationship provides an explanation of leader behavior and follower outcomes, along with how a leader develops

and adapts to the relationships with different followers (J. Howell & Hall-Merenda, 1999).

J. Howell and Hall-Merenda (1999) conducted a study involving different dimensions of leadership by testing the link between Bass's transformational–transactional leadership model, which is based on behavior, and a relationship-based model identified as LMX. The study brought these two models together to test the joint impact on predicting follower performance, focusing on how physical distance over time would affect followers' performance. This was the first leadership study of such magnitude to empirically test these two leadership models. Howell and Hall-Merenda's study provided empirical support demonstrating the quality of the relationship between leaders and followers, based on how a leader's behavior influences follower performance.

The transformational leader articulates a vision that inspires and includes followers, encouraging their input, transforming the leader's vision into a shared vision. This leadership approach stimulates individuals' creativity and intellect, recognizes the unique contribution of each individual, and motivates followers to work toward a common goal (Hater & Bass, 1988). Followers identify with the transformational leader, and the relationship dynamics contribute to a high-quality leader–follower relationship, resulting in higher levels of follower performance (Graen & Uhl-Bien, 1995; J. Howell & Hall-Merenda, 1999).

Contingent reward provides a type of recognition or feedback that influences the quality of relationship between transactional leaders and their followers. The contingent reward approach provides positive reinforcement by recognizing or rewarding a follower when he or she accomplishes agreed-upon goals (Bass, 1985; Hater & Bass, 1988). When

the environment in which followers work does not induce motivation, leaders are faced with the challenge of motivating followers. Transactional leaders work with followers, establishing an exchange of reward or recognition for completing a task or reaching a goal, reflecting a vertical dyad linkage (Graen & Uhl-Bien, 1995) or path-goal theory (House, 1971). Constructive influence inspires followers to perform as expected and provides a high-quality relationship between leaders and followers (Graen & Uhl-Bien, 1995; Hater & Bass, 1988). Unlike transformational leadership, which motivates followers to work beyond what was originally expected, followers under transactional leadership are motivated to work toward set goals. The level of the relationship and performance is higher in transformational leadership (Hater & Bass, 1988; J. Howell & Hall-Merenda, 1999).

Transactional leaders' behavior and approach involve the application of active and passive management by exception in which negative connotations are introduced in the LMX. Unlike the contingent reward approach, in which a relationship exists between leader and follower and is viewed under a positive lens, active and passive management by exception hinder the relationship. The leader's presence comes into play when problems are about to occur or have already occurred, resulting in negative feedback. The minimal involvement of the leader, along with the basis in which interaction is stimulated between the leader and follower, results in a low-quality LMX, associated with lower levels of follower performance (Graen & Uhl-Bien, 1995; J. Howell & Hall-Merenda, 1999).

The aforementioned studies revealed how the two leadership models—behaviors and relationships—contribute to leadership effectiveness, motivating employees, and

employees exerting extra effort. Yukl (1999) argued these studies focused on the interaction and influence among individuals—leader and followers—rather than groups. Many transformational theories failed to address the working dynamics that take place in groups and organizations, along with the leader's influence on their processes (Yukl, 1999). Yukl also noted that another area from which transformational theory would benefit is the role of leadership in increasing efficiency: the leader's impact on culture, structure, management systems, and technology. Leadership research revealed transformational leadership is needed to be successful in the healthcare industry (Wheatley, 2010).

Gilmartin and D'Aunno (2007) postulated the healthcare industry is different from other business industries and more complex, making up a significant portion of the U.S. economy. As the business landscape and technology evolves in health care, there is a need for strong leadership to navigate through the increasing economic challenges in an unpredictable environment (Gilmartin & D'Aunno, 2007; Lantz & Maryland, 2008).

Over the past 10 years, practitioners, scholars, and researchers postulated that female leaders demonstrate more of a transformational leadership style than male leaders (*Modern Healthcare,* 2013; Pounder & Coleman, 2002). Vecchio (2007) noted the data revealed in U.S. Department of Labor reports 15 years ago indicated an increasing presence of women in leadership positions. Women were advancing to executive positions in the administrative and managerial realm, but there was still a low representation of women among corporate executive positions (Lantz & Maryland, 2008; Vecchio, 2007).

Differences Between Male and Female Leadership Styles

Stereotypical views that linked masculine characteristics to men and feminine characteristics to women are based on historical research that stems back to theorists such as Freud (Appelbaum et al., 2003; Bass & Riggio, 2006; Bem, 1974; Eagly et al., 2003; Gilligan, 1982; R. L. Kent & Moss, 1994; Megargee, 1969; Riger, 2000). Gilligan (1982) noted that women feared the way theorists depicted masculinity. Freud's 1905 reference to the male's "Oedipus complex" (as cited in Gilligan, 1982, p. 6) did not address females and the differences that existed between the sexes. Over a decade later, Freud addressed the composition of females. He posited that females' "pre-Oedipal attachment to their mothers" (as cited in Gilligan, 1982, p. 7) and "castration anxiety" (p. 11) made them more susceptible to making decisions based on their feelings and their perception of being inferior to males. Females were perceived as less capable, in comparison to males, of handling life's challenges and demands (Freud, as cited in Gilligan, 1982). Psychological theorists and researchers posited that childhood development influenced thought and behavior among the sexes, along with perceptions of their behavioral characteristics (Gilligan, 1982).

An example of how childhood development influenced thought and behavior is portrayed in organized sports. Common perception was that organized sports provided early training to boys in the concepts of competition, leadership, teamwork, and developing strategies—the game plan. It was not as common for little girls to participate in organized sports 50 years ago. Girls were at a disadvantage because they missed out on the opportunity to be exposed to this environment, and as a result, they would have to wait to learn about teamwork, management, and leadership later in life (Riger, 2000).

Studies of gender differences and sex roles provided a foundation of how women and men were perceived as leaders (Appelbaum et al., 2003; Bem, 1974; Eagly et al., 2003; Gilligan, 1982; Lantz & Maryland, 2008; Pounder & Coleman, 2002; Riger, 2000). Women's abilities and effectiveness as leaders were plagued with biased views based on research that consisted of unbalanced populations made up predominantly of men (Gilligan, 1982; Korabik, 1990). Masculine characteristics associated with males were favored by developmental researchers and considered the standard. Men were believed to have an innate ability to lead, whereas women were viewed as docile, lacking the necessary attributes to fulfill a leadership role (Bem, 1974; Gilligan, 1982).

Socialization is based on traditional perceptions in which men were perceived to be better suited as leaders because of their masculine characteristics; feminine characteristics were perceived unfavorable, putting women at a disadvantage. Separating gender and sex set the stage that permitted both groups to display masculine and feminine characteristics that are not stereotypically expected from one another (R. L. Kent & Moss, 1994; Pounder & Coleman, 2002). Appelbaum et al. (2003) identified the mixed or shared characteristics between men and women as a balance, referred to as the third gender: "androgynous" (p. 45).

Bem (1974) developed the Bem Sex-Role Inventory (BSRI), a self-rating questionnaire that identified the respondent's sex type as masculine, feminine, or androgynous. One scale measured masculine items, another measured feminine items, and a third measured neutral items identified as social desirability. The BSRI's separate scales of measurement set it apart from existing survey instruments such as the California Psychological Inventory that used a single masculinity–femininity scale (Bem, 1974).

The BSRI consisted of 60 decisive factors that were evenly divided among the three groups, 20 in each. These factors were based on traditional beliefs and views of opposing sex roles that linked masculinity with one who thinks and approaches a task with determination and completion in mind to achieve a goal, referred to as "instrumental orientation" (Bem, 1974, p. 156). Femininity was related more to interpersonal and emotional attributes recognized as "expressive orientation" (Bem, 1974, p. 156). Many factors can be used to describe masculinity and femininity, however, so to streamline the selection process and choose positive factors that would be incorporated into the BSRI, Bem, along with a number of students, put together a list of 200 personality characteristics that related to masculinity and 200 related to femininity. Another 100 positive and 100 negative factors that were not directly related to masculinity or femininity were identified as neutral (Bem, 1974).

Forty undergraduate students, 20 men and 20 women, from Stanford assisted Bem (1974) in narrowing down the factors. These students also completed a questionnaire, and a year later another group of students, 30 men and 30 women, completed the questionnaire. Based on the responses and statistical analysis, the final 60 characteristics were identified. The following year, Bem conducted a psychometric analysis in which normative data were established based on the questionnaire results of 917 students from Stanford University and Foothill Junior College, 61% of whom were male and 39% female; these percentages mirrored the sample from each location.

The results of the BSRI completed by an individual would identify if he or she rated him- or herself high as possessing masculine or feminine characteristics. Bem (1974) noted the androgyny score is derived from the difference in an individual's score

between masculine characteristics and feminine characteristics. Bem hoped the BSRI would promote androgyny to a level of awareness among investigators and be recognized as the norm.

Stereotypical views of how men and women are expected to behave and the nature of their temperament is a byproduct of socialization (Appelbaum et al., 2003; Gilligan, 1982; Riger, 2000). Gilligan's (1982) research consisted of observation, scholarly literature, and studies of various thoughts about women and the challenges that hindered the understanding of female development. The lack of representation of women in seminal work in psychological studies was highlighted along with the need to incorporate women in psychological research to gain a holistic view of human development.

Riger (2000) also questioned the traditional theories related to women and the conventional research practices used in psychology. In her writings, she brought feministic views about equal rights for women to the forefront by addressing "feminism in psychology" (p. 4). Secreted beliefs about women being equal to men suggested that women needed to possess characteristics customarily linked to men by being unique, having the ability to stand out among others, and possessing self-control. Based on this underlying belief and ridicule, feminists argued that research in social science has been derelict in reference to women and inaccurate (Riger, 2000). The motivating factor behind Riger's writings were prompted by the pressure from the media for women to change and be more like men to succeed in business and management. Riger's intent of sharing her thoughts and essays, along with her views on interviews and literature reviews, was to educate the public on equality for women.

"Several experimental studies revealed that men and woman prefer male leaders even when the credentials of candidates are the same" (Lantz & Maryland, 2008, p. 296). The stereotypical views that associated task orientation with masculine characteristics linked to males and relations orientation with feminine characteristics linked to females were a common theme in leadership research conducted between the 1960s and 1980s (Appelbaum et al., 2003; Bass & Riggio, 2006; Bem, 1974; Eagly et al., 2003; R. L. Kent & Moss, 1994; Megargee, 1969). Preconceived notions instilled through socialization in reference to males' and females' behaviors skewed findings of studies based on where data were collected through visual surveillance (Gilligan, 1982).

Seminal research provided the foundation for how sex roles were perceived to determine human behavior. Earlier studies identified by Gilligan (1982) focused on sex roles and success between males and females. While a male's incentive to be successful is to evade failure, a female's desire to be successful over a male is suppressed to avoid the stigma it carries with it. A female does not want to be viewed as a social outcast or be perceived as lacking feminine qualities, especially if her success resulted in someone else's failure.

Riger (2000) maintained that males were willing to take risks to succeed even if they failed, whereas females were hesitant to take risks for fear of failure. Males focused on future career goals; placing value in what they do in their current position would benefit and assist them in climbing the corporate ladder—a means to an end. Females lived in the moment, making the best out of the current situation; their aspirations to move to higher-level positions were limited based on the male-dominated environment in

which they existed. Young boys were taught they will be the breadwinners in the family and young girls were groomed to raise a family (Riger, 2000).

Characteristics desired for leadership roles call for one to be responsible, think independently, and make decisions that are associated with masculinity, expected of males, recognized as instrumental abilities; these same attributes were considered unattractive when associated with females (Bem, 1974; Eagly et al., 2003; Gilligan, 1982). Expressive capacities such as caring and loving were expected of females, while males possessed the instrumental abilities (Bem, 1974). While a female's emotional and compassionate ways were often confined in a domestic state, the male displayed his masculine attributes publicly in order to gain power. Females were not viewed as having the knowledge or credentials to possess the power held by males and therefore were unwilling to speak publicly (Riger, 2000).

Leadership studies conducted in a controlled setting with students fulfilling leadership roles reflected the conventional views of males and females. Studies in reference to leadership in organizations failed to show differences among leadership styles between genders (Eagly et al., 2003). Some studies revealed that females were "more democratic or participatory" (Riger, 2000, p. 109), while males were "more autocratic or directive" (p. 109). It was believed that females who exhibited masculine traits and led with authority, giving directions and orders, were devalued (Riger, 2000) because they stepped out of the stereotypical role in which they were expected to be more interpersonally oriented and sensitive (Eagly et al., 2003; Riger, 2000).

Studies have identified that leadership attributes may differ between males and females, with females taking less risk, but overall, the outcomes for males and females

were the same (Riger, 2000). Males and females adopted alternative leadership styles because they believed they would receive recognition for their particular actions rather than being categorized and stereotyped by their biological makeup (Riger, 2000). Overall, effectiveness as a leader appeared to be the same between males and females, with the exception of their organization's environmental makeup. Effectiveness is diminished when the environment is heavily populated by the opposite gender. For example, men are not as effective in a predominantly female environment such as the healthcare industry or education, and women are not as effective in a predominantly male environment such as the military or construction (Riger, 2000).

Appelbaum et al. (2003) used prior leadership studies to answer the following questions: "Are women's leadership styles truly different from men's? Are these styles less likely to be effective? Is the determination of women's' effectiveness as a leaders [*sic*] fact-based or perception that has become a reality?" (p. 43). The theories Appelbaum et al. explored were founded on biological sex and gender role, socialization, and environmental factors. Based on sex and gender, effective leadership was perceived to be predominantly related to males (Appelbaum et al., 2003). The studies that supported these findings were a reflection of the sample population that routinely excluded females (Gilligan, 1982; Korabik, 1990). This practice is a reflection of earlier studies involving sex roles where males designed the studies and the scales of measurement with males in mind. Psychologists considered male conduct as the standard, putting females at a disadvantage, and failure to meet the standard resulted in negative perceptions of their conduct (Gilligan, 1982). Korabik (1990) and Appelbaum et al. noted there was insufficient data to support the concept that differences exist between male and female

leadership styles and suggested that continued research would assist in identifying leadership emergence if similarities existed between males and females.

Korabik (1990) presented "Bale's theory of leadership and Bem's theory of androgyny" (p. 286), highlighting that both theories were based on "instrumentality" (p. 286) linked to masculine characteristics and "expressiveness" (p. 286) linked to feminine characteristics. Bem (1974) posited that androgyny provides flexibility for males and females to engage in both masculine and feminine behaviors.

Females faced environmental challenges that stemmed from socialization, where they were conditioned to restrain their behavior, in which they were perceived as being passive, rendering them unsuitable for leadership positions: This state of mind is referred to as the "culture trap" (Appelbaum et al., 2003, p. 46). Socialization also contributed to females' lack of self-confidence and feeling they were not equal to males or capable of achieving leadership roles. Passive behavior and lack of confidence normally resulted in women taking a back seat to male coworkers, resulting in missed opportunities to gain experience to hone their leadership skills (Appelbaum et al., 2003).

Other environmental factors existed in the workplace. Corporations owned and operated by men did not value female attributes and believed women's way of thinking did not align with organizational values. With men in leadership positions and making decisions that identified who received training and promotions, women were at a disadvantage. Young male executives received mentoring and other professional development opportunities that were not made available to women, enhancing the perception that the "good ole boy" network exists. While men benefited from training opportunities and advancement in the corporation, women's professional growth was

stymied. Feeling unwelcomed, women would often seek employment elsewhere (Appelbaum et al., 2003).

During the 1980s and 1990s, research focused on leaders' ability to motivate and develop followers as well as enhance the organization's overall performance (Eagly et al., 2003). Appelbaum et al.'s (2003) review of prior studies revealed there was a difference between male and female leadership styles. The belief that the female leadership style is not as effective as the male leadership style is not fact-based but a perception developed through socialization. Findings indicated men were more business oriented with a quasi-Machiavelli approach, preferred to work within a structured environment, leading from the top, directing personnel on what to do and how to do it, motivating personnel by offering employees rewards for completing tasks. Men displayed characteristics associated with transactional leadership (Appelbaum et al., 2003; Lantz & Maryland, 2008). Women were people oriented, instilled trust, communicated how and why tasks were necessary, encouraged as well as welcomed followers' input, and promoted teamwork and group decisions. Female attributes reflected transformational leadership. Based on their meta-analysis of 45 studies, Eagly et al. (2003) noted that not only were women more transformational than men, they also were more transactional, using contingent reward, thus reflecting Avolio and Bass's (2004) augmentation effect.

When followers are not motivated by intrinsic rewards and are satisfied with the status quo, contingent reward is required to assist in achieving established goals (Avolio & Bass, 2004). The difference between transformational and transactional leadership styles is the leader's expectation for level of performance. Transactional leadership

inspires followers to perform as expected, whereas transformational leadership motivates followers to do more, exceeding their own expectations (Hartog et al., 1997).

Studies have revealed transformational leadership to be an effective leadership style in an organizational setting (Appelbaum et al., 2003; Avolio & Bass, 2004; Bass & Avolio, 1993; Bass & Bass, 2008; Bass & Riggio, 2006; Lantz & Maryland, 2008; Pounder & Coleman, 2002; Soares, 2012; Vecchio, 2007). The characteristics associated with transformational leadership and women are what organizations are seeking to achieve success and become change-resilient. Despite research data indicating women possess characteristics that are transformational, they are still struggling to ascend to high-level executive positions (Appelbaum et al., 2003; Bass & Riggio, 2006; Lantz & Maryland, 2008; Pounder & Coleman, 2002; Soares, 2012; Vecchio, 2007).

In 2012, the labor force was 47% female, and out of this 47%, only 4% were CEOs (Soares, 2012). Over half of the female population in business (51%) maintained management positions (Soares, 2012). Data from two recent reports, the U.S. Bureau of Labor Statistics for 2011 and 2012 and the Catalyst 2012 Census for *Fortune* 500 companies, indicated that women's representation among executive-level leadership is still low, with very little change over the past several years (as cited in Soares, 2012).

Female Leaders in the Healthcare Industry

Historically, men monopolized leadership positions in corporate America and the healthcare industry (Bass & Riggio, 2006; Lantz & Maryland, 2008). The same was true in the Catholic Religious Order, with the exception of Catholic hospitals in America, where Catholic sisters provided administrative support and were supervisors, trustees,

nurses, and pharmacists (Fontenot, 2012; Wall, 2011). Catholic sisters, unlike most women in America, held executive-level leadership positions and were more influential in their healthcare organizations. “In 1980, half of the Catholic hospitals’ CEOs were sisters” (Wall, 2011, p. 4). When the stability of Catholic hospitals was threatened as the healthcare industry entered turbulent times—dealing with government regulations, unions, healthcare insurance, authority issues, and concerns with the working atmosphere—it altered Catholic hospitals administration and a transition between genders in leadership positions occurred. By the 1990s, only 15% of Catholic hospital CEO positions were occupied by Catholic sisters (Wall, 2011). Fontenot (2012) noted the accomplishments made by nuns, referred to as Catholic sisters by Wall (2011), as administrators and leaders “paved the way for future female healthcare leaders and helped make healthcare a comparatively female-friendly field” (p. 12).

Weil and Mattis (2001) and Weil and Zimmerman (2007) noted there were more male than female healthcare executives in upper-level positions, to include CEO positions. In comparison, there are more men and women in the healthcare industry who achieve executive-level position than in the business sector. In both the healthcare industry and business sector, however, men are more likely than women to be CEOs (Weil & Mattis, 2001).

Lantz and Maryland (2008) emphasized the need for strong leadership in the healthcare industry. In a review of surveys conducted by ACHE between 1990 and 2012 that compared career attainments of male and female healthcare executives with 5–19 years of experience, the data reflected that men still maintained a strong hold on

executive-level positions in health care (Athey, 2014; Fontenot, 2012; Lantz & Maryland, 2008; Weil & Mattis, 2001; Weil & Zimmerman, 2007).

Based on surveys conducted in 1990, findings indicated that 59% of 498 male respondents were CEOs and chief operations officers (COOs)/associate vice presidents in comparison to 35% of 521 female respondents holding these positions (ACHE, 2012). Follow-up surveys in 1995 revealed the gap between genders had decreased, with 45% of 600 male respondents and 30% of 600 female respondents in executive-level positions (ACHE, 1997, 2006, 2012; Athey, 2014; Weil & Mattis, 2001). However, data from surveys conducted in 2000, 2006, and 2012 indicated inequities still exist between men's and women's promotion opportunities to executive leadership positions, salaries, compensation, and equitable treatment (ACHE, 2012; Athey, 2014; Weil & Mattis, 2001).

ACHE (1997, 2006, 2012) quantitative and qualitative data provided insight to the factors that have contributed to the gap between male and female healthcare executives. Men have more managerial experience and education, which contributes to the disparity in career attainment between men and women (Weil & Mattis, 2001). Other factors associated with women that give men an advantage in ascending to high-level executive positions are related to the conflicts of work and family. In dual-income households with children, women are routinely the primary caregivers. Between genders, it is usually the woman who focuses on family needs, choosing to forgo her own professional goals to afford her husband an opportunity to pursue his professional milestones (ACHE, 1997, 2006, 2012, n.d.).

Vance and Larson's (2002) review of business and healthcare studies revealed that leadership influences an organization's performance, profits, and employee turnover. Several studies and leadership literature by authors such as Avolio and Bass (2004), Bass (1985, 1997), Bass and Riggio (2006), Burns (1978), Gilmartin and D'Aunno (2007), Lantz and Maryland (2008), Spinelli (2004, 2006), Wheatley (2010), and Wikström and Dellve (2009) have focused on transformational leadership and how it impacts organizational outcomes. There is a need for leaders with a vision who can gain the trust of their followers, instill confidence, create a positive atmosphere, stimulate creativity, and motivate them to work together as a team to overcome the obstacles encountered in the healthcare industry (Carless, 1998; Lantz & Maryland, 2008; Parry & Proctor-Thomson, 2002; Tucker & Russell, 2004; Wheatley, 2010). These characteristics align with feminine characteristics and transformational leadership described by Avolio and Bass (2004), Bass and Riggio (2006), Bem (1974), R. L. Kent and Moss (1994), Lantz and Maryland (2008), Megargee (1969), Pounder and Coleman (2002), and Vecchio (2007).

Due to the healthcare industry's bureaucratic hierarchical structure, as members ascend to leadership positions, they fulfill the roles of a manager and a leader, depending on their position and purpose (Longest & Darr, 1993; Stack & Harrison, 2010). Bass and Riggio (2006) translated the approach as being either transformational or transactional. Management takes a rational approach to completing organizational goals. A manager oversees and ensures the efficient use of resources, which includes but is not limited to people, information, technology, funds, and equipment, to meet identified goals. Leadership involves a vision, a way of doing things differently, and the ability to

motivate a group of people to work through change toward a common goal (T. W. Kent, Crotts, & Azziz, 2001; Northouse, 2010; Zaleznik, 1977, 1992).

The major distinction between managers and leaders is their personal history, motivation, human relations, and how they think and act (Zaleznik, 1977). Managers are reactive and relate to the task at hand as maintaining the status quo, getting the job done, and motivating followers through a transactional approach—masculine characteristics normally related to males (Appelbaum et al., 2003; Bass & Riggio, 2006; Eagly et al., 2003; Gilligan, 1982; Vecchio, 2007). Leaders are proactive, welcoming challenges and looking for new and efficient ways to do business. Leaders infuse intrinsic motivation among followers by getting them involved and instilling ownership in the process—reflecting leadership attributes linked to females and in health care (Athey, 2014; Fontenot, 2012; Lantz & Maryland, 2008).

The actions of managers and leaders also illustrate a difference in relationships with their followers. Managers guide people through an existing process, getting involved only when followers stray from routine procedures; this approach displays transactional management by exception (Avolio & Bass, 2004; Bass & Riggio, 2006; Spinelli, 2004, 2006; Vecchio, 2007; Wheatley, 2010). Eagly et al.'s (2003) study indicated men had a greater tendency to practice management by exception. Leaders create an environment that is transformational. They get to know their people personally, mentoring, coaching, and empowering followers to use their strengths and improve their weaknesses to build confidence (Zaleznik, 1977). Zaleznik (1977) further noted that grooming and developing managers may hold back the development of leaders.

Research revealed that leadership styles and philosophies in the healthcare industry evolved through the years (Avolio & Bass, 2004; Bass, 1985; Bass, Avolio, Jung, & Berson, 2003; Spinelli, 2004, 2006; Yukl & Van Fleet, 1982; Wheatley, 2010). Leadership training and awareness continue to incorporate literature, research, case studies, mentoring, sharing of knowledge, and practical applications to assist in educating healthcare leaders. Studies involving healthcare leaders, administrators, physicians, and nurses provided a foundation of knowledge for healthcare leaders (Avolio & Bass, 2004; Bass, 1985; Bass et al., 2003; Spinelli, 2004, 2006; Yukl & Van Fleet, 1982). As leaders in the healthcare industry realized the need to train and mentor leaders, the presence of women in leadership roles increased, but women are still underrepresented in executive-level positions (Athey, 2014; Lantz & Maryland, 2008).

Health care exists in an unstable environment that requires flexibility. The challenge of healthcare leaders and followers to adapt and overcome the evolving challenges of technology, policies, and healthcare reform affects daily work routines involving healthcare services and the work atmosphere (Athey, 2014; Lantz & Maryland, 2008; Longest & Darr, 1993; Wheatley, 2010). Bass (1985) conducted research that revealed transformational and transactional leadership exist in the healthcare industry.

Transformational leadership is synonymous with adaptive leadership and contributes to the development of leaders, followers, and organizational performance (Waldman & Yammarino, 1999). Bass et al. (2003) noted that building trust and commitment boosts morale and contributes to teamwork, influencing organizational performance. The concept of effective leadership, identified as transformational leadership, is known as the "augmentation hypothesis" (Eid, Johnsen, Bartone, &

Nissestad, 2008, p. 5), based on the seminal work of earlier scholars and practitioners. Transformational leaders instill confidence and a shared vision among followers, motivating them to sacrifice personal goals to achieve team, unit, and organizational goals (Avolio, 2002; Avolio & Bass, 2004; Bass, 1985, 1990a, 1990b; Bass et al., 2003; Bass & Riggio, 2006; Bycio et al., 1995; Spinelli, 2004, 2006; Wheatley, 2010).

One of the most overlooked behaviors is inspiration, a behavior illustrated in writings that address iconic political, religious, civil rights, military, and cult leaders. Yukl and Van Fleet (1982) referred to a charismatic transformational leader as one who can inspire followers to make the ultimate sacrifice to accomplish a goal, even if it means giving one's life.

Charisma

Charisma, Greek for *gift* (Choi, 2006), is recognized as an exceptional personality characteristic that sets some people apart from others. Bass (1990b) identified charisma as one of the four characteristics associated with transformational leadership. This personality trait attracts followers and poses an implied, unwritten authority that allows the member to take on the role of leader (Bass & Bass, 2008; Choi, 2006).

Choi's (2006) study of charismatic leadership analyzed how a leader's behavior impacts the relationship between a leader and follower. Lang (1991) noted the similarities between charismatic and transformational leadership, discussing how each inspires and motivates followers. The concern Lang presented related to the moral and ethical issues surrounding charismatic leadership. Reference to early leadership and motivational theories highlighted by Lang addressed the mathematical link between charismatic and

transformational leadership identified by Fiedler and House. Bass (1985) and Lang both referred to House's theory of charismatic leadership as a crucial factor that gives faith and respect to the leader who inspires and encourages followers.

Other theorists had opposing views, arguing there was no connection between transformational and charismatic leaders. Theorists have discussed the level of communication the leader uses and to what extent he or she shares information to reveal one's true intent (the root of charisma). Contrary to Bass's (1985) and Lang's (1991) views, charisma is believed to be based on the quality of communication rather than personality traits (T. W. Kent et al., 2001).

Conger and Kanungo (1987) and T. W. Kent et al. (2001) shared their views on charismatic leadership. The authors noted that articulation and impression management are characteristics that make charismatic leaders stand out. The charismatic leader motivates others through self-expression, achieving buy-in to new ideas by articulating a picture of the future that includes followers, separating them from other leaders.

Charismatic leadership may or may not be viewed as an admirable factor based on ethical and moral issues (Lang, 1991). Socialized charisma describes a leadership style that motivates followers to see the big picture and work together to meet the overall goal rather than striving to meet personal goals (Bass & Bass, 2008; Burns, 1978; Choi, 2006). An example of socialized charisma is John F. Kennedy's charismatic leadership that inspired patriotism among Americans toward the goals of domestic reform and an international presence (Burns, 1978). Kennedy ignited pride among Americans and reached out to the world during his inauguration speech, stating, "Ask not what your country can do for you; ask what you can do for your country" (as cited in Barnes, 2005,

p. 17). This famous quote communicated the need for people to recognize there is a greater reward in sacrifice for the majority than one's own desires and needs. The list of charismatic leaders also includes Martin Luther King Jr. and Jessie Jackson for inspiring others to work toward a greater cause to reshape American society, as did Mahatma Gandhi in India (Burns, 1978; Kets de Vries, Loper, & Doyle, 1994).

Adolf Hitler displayed the dark side of charisma. He seduced a nation, articulating a vision of his thousand-year Reich to create a better Germany (Kets de Vries et al., 1994). Hitler's vision involved unethical practices encouraging gross mistreatment of humans and genocide. Personal goals and a distorted vision ultimately led to his demise and the fall of Germany (Bass & Bass, 2008; Burns, 1978; Yukl, 1999).

Other leaders, such as Charles Manson, Jim Jones, and David Koresh, possessed charismatic qualities that were used to exploit their followers. Manson's followers committed crimes ranging from petty theft to murder to prove their loyalty and gain Manson's approval. Jim Jones's followers were emotionally and spiritually attracted to his charismatic presence. He took the time to personally get to know his followers, demonstrating individualized consideration, coaching them and giving them a sense of belonging. He convinced his followers to commit suicide rather than surrender their religious beliefs (Bass, 1985; Bass & Bass, 2008; Choi, 2006; Hartog, House, Hanges, & Ruiz-Quintanilla, 1999).

On April 19, 1993, the death of 54 adults and 21 children were the result of David Koresh's personalized charisma. Koresh led a religious sect known as the Branch Davidians; he viewed himself and persuaded others to believe he was the last prophet. Koresh communicated his beliefs and vision to his followers, convincing them the

government was evil and working for Satan. As the Branch Davidians' activities grew more and more suspicious, several federal agencies became alarmed, resulting in a raid. During the raid, Koresh's followers gave their lives in support of his beliefs. Koresh's followers believed that in order to get into the Millennial Kingdom, they had to obey what is in the Bible; therefore, under his guidance, they sacrificed their lives for what they believed rather than give in to the government (Ramsland, 2009).

Charismatic leaders are likely to emerge in an organization going through change (Bass, 1985). When organizational culture is disrupted, it creates fear of the unknown among employees. The absence of traditional leadership and legal authority creates a void that welcomes a charismatic leader who can relate to the followers' needs and fears and satisfy their motives (Bass, 1985; Lang, 1991). Choi (2006) identified three factors associated with socialized charismatic leadership: empathy, envisioning, and empowerment. Leaders use the three factors to motivate followers. These factors reflect the upper half of Maslow's hierarchy of needs and his theory of human motivation (Graham & Balloun, 1973; Kets de Vries et al., 1994; Maslow, 1943).

Empathy meets followers' social and affiliation needs of belonging. Envisioning provides followers with an opportunity to satisfy their desire for respect and self-esteem through achievement. Finally, empowerment allows for self-fulfillment in conjunction with personal and professional development to achieve power (Choi, 2006; Graham & Balloun, 1973; Kets de Vries et al., 1994; Maslow, 1943).

Charismatic leaders are rare in organizations that are well structured and successful. When there is a shift in organizational management systems or structure, the

charismatic leader appears in the midst of unrest as the knight in shining armor, fulfilling followers' immediate needs (Bass & Riggio, 2006; Choi, 2006).

Conger and Kanungo (1987) discussed Weber's views surrounding charisma and the authority associated with it. As followers watch and listen to leaders, they judge them on their behavior. Leaders who discuss organizational goals with followers, addressing followers' needs rather than their own and demonstrating personal sacrifices, are appealing and recognized as being trustworthy. Another trait that followers find attractive about such leaders is their ability to think outside the box and do things differently. Charismatic leaders are recognized as subject-matter experts, with the ability to motivate followers and bring about radical change (Bass & Bass, 2008; Longest & Darr, 1993).

Charismatic leaders' longevity is dependent on their effectiveness. As long as their actions and contributions benefit followers and contribute to the community, they will remain successful. Over time, in a volatile environment, the reign of a charismatic leader's influence can end as followers lose interest and belief in the leader (Bass, 1985).

Charismatic leaders exist at different levels throughout organizations. These complex organizational structures may exist in different industries and businesses, including the healthcare industry. Authority is required to establish coordination in an organization. Although Bass (1985) and Lang (1991) viewed charisma as a significant characteristic of transformational leadership, charismatic leaders influence bureaucratic structure that operates under traditional management and thrives on transactional leadership. Bass and Bass (2008) stated, "The charismatic [leader] formulated the basic purpose and principles for bureaucratic administrators to live by" (p. 575).

The various leadership styles and leadership models illustrate that leadership is a diverse approach to a complex process (Avolio & Bass, 2004; Bass & Bass, 2008; Ionescu & Negrusa, 2007; Weiskittel, 1999). Among the leadership styles and models, Bass (1985), Burns (1978), Lang (1991), and Weiskittel (1999) identified factors associated with leadership that incite intrinsic and extrinsic motivation; align people to achieve a common goal; and inspire creativity, innovation, and stewardship, to include rewarding success as well as punishing failure. Seminal researchers noted that leaders have different views on what motivates a person to work and the nature of work itself (Ionescu & Negrusa, 2007; Ryan & Deci, 2000). A full range of leadership complements and influences organizational culture, providing followers with intrinsic and/or extrinsic motivation to perform (Avolio & Bass, 2004; Bass, 1985; Bass & Bass, 2008). For this study, characteristics of FRL were captured and measured using the MLQ 5X Short (Avolio & Bass, 2004).

Methodology

Seminal leadership studies involving Bass's FRL model used a "fixed design" (Robson, 2002, p. 96) that links "research to theory" (p. 96). Quantitative data were collected to identify leaders' leadership styles and outcomes of leadership along the spectrum of FRL. Over the years, different variables were introduced and data were analyzed for causal effects (Avolio & Bass, 2004; Carless, 1998; Cooper & Schindler, 2006; Muenjohn & Armstrong, 2008).

Researchers who conducted quantitative studies involving leadership styles of the FRL model and their outcomes collected data using a survey instrument (Arbnor &

Bjerke, 1997; Avolio & Bass, 2004; Bass, 1985, 1990a, 1990b, 1997; Bass & Avolio, 1993; Bass, Avolio, & Atwater, 1996; Bass et al., 2003; Carless, 1998; Muenjohn & Armstrong, 2008). The most commonly used survey instrument was the MLQ (Avolio & Bass, 2004; Avolio, Bass, & Jung, 1999; Bass, 1985, 1990a, 1990b; Bass et al., 1996; Bass et al., 2003; Carless, 1998; Muenjohn & Armstrong, 2008; Yukl, 1999). The MLQ has undergone several revisions and continues to be used in current studies, as demonstrated by Spinelli (2004, 2006), Jones and Rudd (2008), and Wheatley (2010).

Using a survey instrument to collect data ensures all participants are presented with the same questions with no deviation of verbiage and thus ensures reliability (Robson, 2002). Over three decades ago, data collection was conducted face-to-face or by filling out a paper questionnaire received via mail, fax, or over the telephone (Frippiat & Marquis, 2010; Griffis, Goldsby, & Cooper, 2003; Oppermann, 1995). The introduction of technology and integrating it with research offered another method of data collection with the use of computers (Cooper & Schindler, 2006; Couper, 2000; Couper & Miller, 2008; Fowler, 2002; Frippiat & Marquis, 2010).

Technology in its infancy was not the primary choice for data collection due to access limitations, geographical location, cost to own a personal computer, and end users' lack of knowledge of computers (Dommeyer & Moriarty, 2000; Oppermann, 1995). Thirty years ago, few individuals had a computer, e-mail, or Internet access, thus presenting challenges that would exclude potential participants (Evans & Mathur, 2005; Frippiat & Marquis, 2010). As technology matured, there was greater exposure in educational facilities, work environments, and commercial environments. Computers

became more affordable, along with user-friendly applications, and people were becoming more computer-savvy.

Over the years, technology introduced mobile devices such as laptops, cell phones, tablets, and iPads, allowing greater access to the Internet as well as convenience. The U.S. Department of Commerce (2013) reported a 56% increase in homes with broadband Internet access between 2000 and 2011. The World Wide Web provided international communication that was no longer limited to the government and large organizations (Cooper & Schindler, 2006).

Advancements in technology made web-based surveys more applicable and cost effective. The web-based survey grew popular and highly integrated in research, thus offering several advantages. Some of these advantages consisted of a more efficient vehicle for developing and distributing the survey; recruiting and attracting potential participants who would normally be difficult to contact by traditional mail or telephone, and a more cost-efficient way to distribute a survey over a wide geographical area (Evans & Mathur, 2005; Frippiat & Marquis, 2010). Web-based surveys also offer participants anonymity, thus encouraging participation. For the researcher, the web-based survey offers real-time tracking of results with quicker turnaround time from survey distribution to data collection (Cooper & Schindler, 2006; Couper, 2000; Dommeyer & Moriarty, 2000; Griffis et al., 2003; Kaplowitz, Hadlock, & Levine, 2004; Oppermann, 1995).

Disadvantages related to surveys are e-mail sorting; e-mails surveys or links to surveys may be placed in junk mail and eventually deleted. Web-based surveys or e-mail surveys may be viewed as impersonal, consist of unclear instructions, and difficult to

access due to systems or applications being incompatible (Evans & Mathur, 2005; Kaplowitz et al., 2004).

Web-based surveys also present disadvantages linked to cost for the researcher for small samples (Griffis et al., 2003). Costs are endured for services to assist with designing a web-based survey or converting a survey for use online, for services to obtain e-mail listings and distribution, and data collection. These services are not always required or desired and can present vulnerabilities, as well as enhance protection of personal identifiable information and storage of data (Evans & Mathur, 2005; Griffis et al., 2003; Oppermann, 1995).

As a researcher, understanding the Digital Divide Index (DIDIX) is important when preparing to conduct a web-based survey (Couper, 2000; Frippiat & Marquis, 2010). The DIDIX identifies groups that are more likely to have a computer and Internet access based on demographic variables such as household income, ethnicity, race, and education in comparison to the national average (Frippiat & Marquis, 2010).

A quantitative methodology, the MLQ, and Web-based distribution are not appropriate for all research projects. Based on the literature review and the focus of this research project, a quantitative methodology was used and data were collected using the MLQ 5X Short. Respondents were contacted via e-mail with an embedded link that provided access to the consent form, web-based MLQ, and demographic questionnaire.

Multifactor Leadership Questionnaire

Various instruments can be used to collect data associated with leadership that include styles categorized as transformational and transactional. The decision to use the

MLQ 5X Short for this research was to capture the leader's self-perception of her leadership style and the outcomes of her leadership. The premise for the study was based on Bass's (1985) FRL theory and Wheatley's (2010) study. The research questions and independent and dependent variables fit a quantitative methodology approach (Arbnor & Bjerke, 1997; Cooper & Schindler, 2006; Fowler, 2002; Robson, 2002). The MLQ 5X Short (Avolio & Bass, 2004) was used to measure factors that construct and identify leadership styles. Permission to use the MLQ 5X Short was received through Mind Garden's website.

Avolio and Bass (2004) first introduced the MLQ in the early 1980s. Previous studies had focused on behavior traits and areas such as leaders versus managers, using different survey instruments to capture data. Bass and his colleagues conducted research that addressed the FRL, which included transformational, transactional, and laissez-faire styles of leadership. Application of the MLQ made significant contributions to the field of study in capturing the FRL.

The MLQ 5X Short (Avolio & Bass, 2004) was used to measure factors that construct and identify leadership styles for Research Question 1 to include outcomes of leadership for Research Question 2. The MLQ 5X Short was designed to capture quantitative data to measure behaviors and characteristics associated with the three leadership styles and outcomes identified in Bass's FRL theory (Antonakis et al., 2003; Avolio & Bass, 2004; Casida & Pinto-Zipp, 2008; Muenjohn & Armstrong, 2008).

Female healthcare executives provided responses to a series of questions identifying their behavior characteristics and outcomes of leadership. Scores depict how a leader's behaviors relate to leadership factors that categorize the leader's leadership style

(dependent variable) as transformational, transactional, or passive-avoidant. Outcomes of leadership (dependent variable) were determined based on the leader's responses identifying the leader's behavior and ability to motivate followers to exert extra effort, the leader's behavior and effectiveness, and the leader's influence on the follower's satisfaction with the leader (Avolio & Bass, 2004).

Studies associated with Avolio and Bass's (2004) FRL were quantitative and used the MLQ to collect data. The MLQ examines leadership behavior as perceived by the leader, followers, colleagues, peers, and/or superiors (Avolio & Bass, 2004). Over the past two decades, the MLQ has been challenged and revised in response to concerns raised by scholars and practitioners. The revisions and ongoing testing have been instrumental in reinforcing the instrument's reliability and validity (Avolio & Bass, 2004; Muenjohn & Armstrong, 2008; Spinelli, 2004, 2006; Wheatley, 2010).

The MLQ is among other instruments used to measure transformational leadership. Previous studies using the MLQ captured data on military leaders within Army units and Navy and Air Force academies, leadership within healthcare, CEOS in the corporate realm and private organizations, as well as nonsupervisory project leaders (Avolio & Bass, 2004; Bass, 1997; Bass & Avolio, 1993; Bass et al., 2003). The MLQ gradually developed into a concise and inclusive instrument that has been widely used to measure transformational leadership and was applied in this study to measure transformational leadership between female Up & Comers healthcare executives and other female healthcare executives.

Data collected in seminal studies using the MLQ were used to determine if there was a correlation between transformational, transactional, and laissez-faire leadership

styles among various leaders in different environments to analyze followers' satisfaction with the leader, leader's effectiveness, and followers' willingness to exert extra effort (Avolio & Bass, 2004; Avolio et al., 1999; Heinitz et al., 2005). Bycio et al. (1995) noted that various versions of the MLQ have been applied to capture data to test other areas, such as questioning the difference between active and passive management by exception. Incidentally, various versions of the MLQ have been used to target different populations, offering varying numbers of items and content. MLQ forms with more than five factors contributed to research identifying differences between active and passive management by exception (Bycio et al., 1995). Bycio et al. noted the various forms of the MLQ also were used to assess organizational outcomes, leadership performance, and follower satisfaction that cannot be measured using transactional scales.

Avolio and Bass (2004) conducted a CFA using the initial set of data and eight alternative models, ranging from a single factor to nine factors, employed by researchers using the MLQ. Results from 1999 revealed the six-factor model exceeded the minimum cutoff for goodness of fit, providing the best fit, as compared to the alternative models (see Table 1).

In 2003, the nine-factor model proved to be the best fit, demonstrating consistency across regions and by rater (Avolio & Bass, 2004), as shown in Table 2. As the factors increased, the goodness of fit improved (Avolio & Bass, 2004; Spinelli, 2004, 2006), covering the FRL: transformational, transactional, and laissez-faire.

Table 1. *Comparison of Goodness-of-Fit Index and Root Mean Square: Residuals for the MLQ 5X 1999 Normative Samples Summary of CFA Results*

Test	One-factor model	Two-factor model: active vs. passive	Two-factor model: transformational vs. nontransformational	Three-factor model	Four-factor model	Five-factor model	Six-factor model	Seven-factor model
Goodness-of-Fit Index	75 (67)	86 (85)	77 (77)	86 (82)	89 (88)	89 (88)	91 (91)	90 (91)
Root mean square residual	07 (09)	05 (06)	08 (11)	05 (07)	04 (06)	04 (06)	04 (05)	04 (05)

Note. Values in parentheses are for the replication sample. From *Multifactor Leadership Questionnaire (3rd ed.) Manual and Sampler Set* (p. 55) by B. Avolio and B. Bass, 2004, Menlo Park, CA: Mind Garden. Copyright 2004 by Bernard Bass and Bruce Avolio. Adapted with permission.

Table 2. *Comparison of Goodness-of-Fit Index and Root Mean Square: Overall Fit Measures Among Several Factor Models*

Test	One-factor model	Two-factor model	Three-factor model	Nine-factor model
Goodness-of-Fit Index	.74	.78	.78	.92
Root mean square residual	.08	.08	.08	.05

Note. From *Multifactor Leadership Questionnaire (3rd ed.) Manual and Sampler Set* (p. 75) by B. Avolio and B. Bass, 2004, Menlo Park, CA: Mind Garden. Copyright 2004 by Bernard Bass and Bruce Avolio. Adapted with permission.

Today, the design of the MLQ 5X Short is a user-friendly format, written at a ninth-grade level, with 45 questions that take an average of 20 minutes to complete. Responses are rated on a 5-point Likert scale (0 = *not at all*, 1 = *once in a while*, 2 = *sometimes*, 3 = *fairly often*, and 4 = *frequently, if not always*; Avolio & Bass, 2004; Casida & Pinto-Zipp, 2008; Spinelli, 2004, 2006; Wheatley, 2010). Scores depict how a leader's behaviors relate to leadership factors (Avolio & Bass, 2004).

For the purpose of this study, the nine-factor model was used to capture data related to factors associated with transformational leadership: inspirational motivation, idealized influence behavior, idealized influence attributed, intellectual stimulation, and individualized consideration (Avolio & Bass, 2004; Bass, 1985; Firestone, 2010).

Factors for transactional leadership consist of contingent reward and management by exception active. In this study, management by exception passive and absence of leadership aligned with passive-avoidant/laissez-faire (Avolio & Bass, 2004; Bass, 1985; Firestone, 2010; Wheatley, 2010).

The MLQ rater form was used to collect data from female healthcare executives. For this research, there were two groups of female healthcare executives, one identified as Up & Comers, an annual award issued by *Modern Healthcare*, and the other as female healthcare executives. The MLQ self-rater form is written in first person so leaders can rate their actions as it relates to questions focused on leadership and outcomes in their organization.

Leaders' profiles are generated through the MLQ's descriptive statements, rated by the leader using the MLQ 5X scoring key. In this study, the leaders rated themselves to identify if there was a significant difference in Bass's leadership styles

(transformational, transactional, and passive-avoidant/laissez-faire) between the two groups of leaders (female Up & Comers healthcare executives and other female healthcare executives, to include the outcomes of leadership. The data also revealed whether the five factors associated with transformational leadership and two factors associated with transactional leadership can be clearly identified. Finally, the data either accepted or rejected the stated hypotheses.

Chapter Summary

Strong leadership is needed for the healthcare industry to be successful as it encounters the environmental challenges associated with the economy, government policies and regulations, technology, and personnel. Characteristics identified to fit the profile of the type of leader desired in the healthcare industry are those associated with the transformational leadership style.

Socialization and stereotypical views play a significant role in how male and female leaders are perceived and treated. Variables that were not discussed in this study (e.g., age, education level, and time with the organization) may play a significant role in how a leader's effectiveness may be affected.

Studies indicated men reflect more of a transactional style of leadership than do women. In the past, the stereotypical view of men and women led to the belief that men had an innate ability to lead. This belief was further supported by studies that were based on male-only populations. Later studies incorporated the female population, thus providing insight in regard to how men and women viewed themselves as leaders and how they were viewed as leaders by their supervisors, peers, and followers. Empirical

research revealed women were found to be more transformational than men. As society views of gender evolve, opportunities regarding mentoring, training, and leadership positions will increase, narrowing the gap between genders.

The recognition of young healthcare executives who make a significant contribution in their healthcare organizations and industry are awarded the Up & Comers award. This annual recognition was established by *Modern Healthcare* (Burda, 2007a, 2007b), and since the inception of the award in 1987, 38% of the recipients have been women. Wheatley's (2010) findings identified Up & Comers as being more transactional than other healthcare executives. With men making up 62% of the Up & Comers, the intent of this research was to separate the genders and focus on female healthcare executives to isolate and identify their leadership style.

This study examined Avolio and Bass's (2004) FRL to discover how female healthcare executives identified their leadership characteristics in response to the MLQ 5X Short. According to Avolio and Bass, previous studies based on their FRL research associated with the military and civilian and private organizations have used the MLQ, identifying leadership behavior as perceived by followers, colleagues, peers, and superiors. The current research explored and revealed leadership styles and their outcomes, identifying similarities and differences between female Up & Comers healthcare executives and other female healthcare executives.

CHAPTER 3. METHODOLOGY

Introduction

In this chapter, the methodological approach appropriate for conducting the study of female healthcare executives' leadership styles and the outcomes of their leadership is presented. The research design for this study is identified in this chapter, the research questions are revisited, and hypotheses identified. Other topics addressed in this chapter are research design, sample population, appropriateness of design, instrumentation, data collection and analysis, validity and reliability, and ethical considerations.

Research Design

Based on a review of the literature on research design (Arbnor & Bjerke, 1997; Cooper & Schindler, 2006; Fowler, 2002; Robson, 2002), the research study was based on a fixed approach, using a quantitative methodology adapted from Wheatley's (2010) study. The research questions and hypotheses reflect Wheatley's methodological framework with the focus of this study on female healthcare executives' self-perceptions of their leadership styles and outcomes of their leadership.

Robson (2002) identified traditional research strategies for fixed designs. Fixed designs are theory-driven, using numeric data and encompassing experimental and nonexperimental strategies. Nonexperimental strategies are used to understand the current

state of behavior and what caused the behavior or outcome. Because the focus of this study was to understand the current state of behavior and outcomes of female healthcare executives' leadership, the fixed, nonexperimental, quantitative research design was chosen.

The MLQ 5X Short was designed to capture quantitative data to measure behaviors and characteristics associated with transformational, transactional, and passive-avoidant leadership styles and outcomes identified in Bass's FRL model (Antonakis et al., 2003; Avolio & Bass, 2004; Casida & Pinto-Zipp, 2008; Muenjohn & Armstrong, 2008). Antonakis et al. (2003) stated, "The MLQ (Form 5X) can be used to represent the full-range model of leadership and its underlying theory" (p. 283). The questionnaire consists of 45 questions, 36 of which may be rated by the leader, supervisor, follower, and/or peers to indicate how often each statement fits characteristics the leader believes he or she possesses or is perceived to possess by others. The last nine questions address how the rater perceives the outcomes of leadership and how it affects their followers. Responses were gathered from a five point Likert scale (Avolio & Bass, 2004).

Bass's (1985) seminal work, along with studies and meta analyses by Antonakis et al. (2003), Avolio and Bass (2004), Casida and Pinto-Zipp (2008), and Muenjohn and Armstrong (2008), captured data associated with leadership styles under the FRL using the MLQ in various organizations and organizational structures. Organizational structures introduced various dynamics such as bureaucratic hierarchical structures with multiple leaders traditionally associated with the military, health care, and education to a flat organizational structure linked to private, nonprofit, and for-profit organizations.

Spinelli's (2004, 2006) and Wheatley's (2010) studies associated with the healthcare industry were influential in the current researcher's methodological approach.

Population and Sample

The target population for this study was healthcare executives. ACHE (n.d.) identified there are over 100,000 people in healthcare management positions ranging from department heads to CEOs. Skills such as planning and execution, vision, and strategy formulation and implementation are required to succeed in today's healthcare industry (Fontenot, 2012; Hartman & Crow, 2002; Longenecker, Longenecker, & Gering, 2014; Wheatley, 2010). With all the changes occurring in health care, the role of healthcare executives is becoming more diverse, taking on new roles beyond those of the traditional hospital setting and taking leadership roles in other medical treatment facilities and administrative support facilities, such as

- Ambulatory care facilities
- Consulting firms
- Healthcare associations
- Home health agencies
- Hospices
- Hospitals and hospital systems
- Integrated delivery systems
- Long-term care facilities
- Managed care organizations (such as HMOs and PPOs)
- Medical group practices
- Mental health organizations
- Public health departments
- University or research institutions. (ACHE, n.d., "Career Opportunities for Healthcare Executives," para. 3)

The sample frame was designed specifically to focus on female healthcare executives awarded the Up & Comers award and other female healthcare executives

between the ages of 25 and 70 with an undergraduate degree or higher, working in a medical facility for more than a year, fulfilling one of the following positions: CEO, vice president, COO, chief financial officer (CFO), chief information officer (CIO), director of human resources, clinic director, or other senior executive position.

Based on available data from *Modern Healthcare*, from 1987 to 2013, a total of 328 young leaders in the healthcare industry have received the Up & Comers healthcare executive award (Burda, 2007a, 2007b, 2008, 2009, 2010, 2011, 2012; *Modern Healthcare,* n.d.). Among the Up & Comers healthcare executive awardees were 204 men and 124 women who held various positions in the healthcare industry. A list of female healthcare executives obtained from *Modern Healthcare*'s Up & Comers listings (Burda, 2007a, 2007b, 2008, 2009, 2010, 2011, 2012; *Modern Healthcare,* n.d.) along with other female healthcare executives identified by Medical Marketing Service, a mailing list broker that provided contact information for healthcare executives, was used to identify the sample frame.

The sampling method for this study was a probability sampling. There are four alternate sampling approaches associated with probability sampling: systemic, stratified, cluster, and multiple (Cooper & Schindler, 2006). A stratified random sample was selected from among the probability samples to provide good representation of female Up & Comers healthcare executives and other female healthcare executives. Cooper and Schindler (2006) noted that stratified sampling would be more efficient, provide sufficient data for analyzing the diverse subpopulations, and permit different research methods to be applied to the different groups.

The targeted sample population consisted of women identified in *Modern Healthcare*'s annual Up & Comers supplemental special feature (Burda, 2007a, 2007b, 2008, 2009, 2010, 2011, 2012; *Modern Healthcare,* n.d.) and other female healthcare executives identified by Medical Marketing Service. The total population consisted of 7,300 female healthcare executives.

Using G*Power 3 and Prajapati, Dunne, and Armstrong's (2010) guidance on calculating sample size and statistical power analyses, the researcher calculated a sufficient sample size. The sample size was based on a diverse population and supports the research questions. Prior studies such as that of Jones and Rudd (2008) reflected the suggested sample used in a study based on Avolio and Bass's (2004) FRL. Sample size for this research was identified as 40.

Calculations using G*Power 3 were based on a one-tailed analysis of the difference between two independent means (two groups). The means (*M*) and standard deviations (*SD*) for Groups 1 and 2 were based on the difference between the highest and lowest means of leadership style scores by gender found in Jones and Rudd's (2008) study. Effect size was calculated as 0.8008475 with power of .80; the degree of freedom (*df*) was calculated as 38. The minimum sample size for each group was 20 for a total sample size of 40. Groups excluded were all male healthcare executives. Other business executives and Up & Comers outside of the healthcare industry also were excluded.

Research Questions

The research questions for this study were based on Bass's (1985) leadership theory and Wheatley's (2010) dissertation. The research questions provided insight to the

FRL to assess female healthcare executives' self-perceptions to determine if a significant difference exists between female Up & Comers healthcare executives' and other female healthcare executives' leadership styles and outcomes. Leadership style outcomes include the leader's ability to motivate her followers to exert extra effort, their perception of the leader's effectiveness, and their satisfaction with the leader (Avolio & Bass, 2004; Wheatley, 2010).

ResQ1: To what extent does leadership style vary between female Up & Comers healthcare executives and other female healthcare executives as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004)?

Sub-ResQ1: To what extent does leadership style vary between female Up & Comers healthcare executives and other female healthcare executives using transformational leadership as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004)?

Sub-ResQ2: To what extent does leadership style vary between female Up & Comers healthcare executives and other female healthcare executives using transactional leadership as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004)?

Sub-ResQ3: To what extent does leadership style vary between female Up & Comers healthcare executives and other female healthcare executives using passive-avoidant leadership as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004)?

ResQ2: To what extent do female Up & Comers healthcare executives and other female healthcare executives vary in terms of the outcomes of leadership as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004)?

Sub-ResQ4: To what extent do female Up & Comers healthcare executives and other female healthcare executives vary in terms of a leader's ability to motivate followers to exert extra effort?

Sub-ResQ5: To what extent do female Up & Comers healthcare executives and other female healthcare executives vary in terms of a leader's effectiveness?

Sub-ResQ6: To what extent do female Up & Comers healthcare executives and other female healthcare executive vary in terms of followers' satisfaction with the leader?

Research Hypotheses

The research hypotheses were based on Avolio and Bass's (2004) FRL model and Wheatley's (2010) study. Based on the data analyses, the researcher rejected or failed to reject the following hypotheses of female Up & Comers healthcare executives' and other female healthcare executives' leadership styles.

Research Hypothesis 1

H_o1: No statistically significant difference exists between female Up & Comers healthcare executives' and other female healthcare executives' leadership styles as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004).

H_a1: A statistically significant difference exists between female Up & Comers healthcare executives' and other female healthcare executives' leadership styles as

measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004).

Subhypotheses were created for Hypothesis 1 to fully examine the hypothesis:

$SubH_o1$: Female Up & Comers healthcare executives do not have statistically greater transformational leadership characteristics than other female healthcare executives as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004).

$SubH_a1$: Female Up & Comers healthcare executives have statistically greater transformational leadership characteristics than other female healthcare executives as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004).

$SubH_o2$: Female Up & Comers healthcare executives do not have statistically lower transactional leadership characteristics than other female healthcare executives as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004).

$SubH_a2$: Female Up & Comers healthcare executives have statistically lower transactional leadership characteristics than other female healthcare executives as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004).

$SubH_o3$: Female Up & Comers healthcare executives do not have statistically lower passive-avoidant leadership characteristics than other female healthcare executives as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004).

$SubH_a3$: Female Up & Comers healthcare executives have statistically lower passive-avoidant leadership characteristics than other female healthcare executives as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004).

Research Hypothesis 2

H_o2: No statistically significant difference exists between female Up & Comers healthcare executives' and other female healthcare executives' outcomes of leadership as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004).

H_a2: A statistically significant difference exists between female Up & Comers healthcare executives' and other female healthcare executives' outcomes of leadership as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004).

Subhypotheses were created for Hypothesis 2 to fully examine the hypothesis:

$SubH_o4$: Female Up & Comers healthcare executives do not have statistically greater abilities to motivate followers to exert extra effort than other female healthcare executives as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004).

$SubH_a4$: Female Up & Comers healthcare executives have statistically greater abilities to motivate followers to exert extra effort than other female healthcare executives as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004).

$SubH_o5$: Female Up & Comers healthcare executives do not have statistically greater abilities to enhance a leader's effectiveness than other female healthcare executives as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004).

$SubH_a5$: Female Up & Comers healthcare executives have statistically greater abilities to enhance a leader's effectiveness than other female healthcare executives as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004).

$SubH_o6$: Female Up & Comers healthcare executives do not have statistically greater abilities to enhance followers' satisfaction with the leader than other female healthcare executives as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004).

$SubH_a6$: Female Up & Comers healthcare executives have statistically greater abilities to enhance followers' satisfaction with the leader than other female healthcare executives as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004).

To examine the three subhypotheses of Hypothesis 1, the researcher conducted three independent sample *t* tests. According to Pagano (2010), the independent sample *t* test is a suitable statistical analysis when the researcher is assessing for the existence of differences on a scale- or ratio-level dependent variable when grouped by a dichotomous independent variable. The continuous dependent variables in this research were the three leadership styles: transformational for $SubH_o1$, transactional leadership for $SubH_o2$, and passive-avoidant leadership for $SubH_o3$. Hypothesis 2 also consisted of continuous

dependent variables: the ability to motivate followers to exert extra effort for $SubH_o4$, leadership effectiveness for $SubH_o5$, and follower's satisfaction with the leader for $SubH_o6$. Each of these dependent variables contained continuous-level data. The independent variable grouped participants into one of the two groups: female Up & Comers healthcare executives or other female healthcare executives. Because the grouping variable was dichotomous and was used to assess differences in a continuous-level score, the *t* test was an appropriate statistical test. The *t* tests were one-tailed, with alpha levels set at $\alpha = .05$; this ensured 95% confidence that differences were not the result of random chance.

Instrumentation

MLQ 5X Short

The MLQ 5X Short was designed to capture quantitative data to measure behaviors and characteristics associated with the three leadership styles and outcomes identified in Avolio and Bass's FRL model (Antonakis et al., 2003; Avolio & Bass, 2004; Casida & Pinto-Zipp, 2008; Muenjohn & Armstrong, 2008). The questionnaire is written at a ninth-grade level and takes approximately 15–20 minutes to complete.

Female healthcare executives provided responses to 45 questions identifying their behavior characteristics and outcomes of leadership that were rated on a 5-point Likert scale (0 = *not at all*, 1 = *once in a while*, 2 = *sometimes*, 3 = *fairly often*, and 4 = *frequently, if not always*; Avolio & Bass, 2004; Spinelli, 2006; Wheatley, 2010). Scores depicted how a leader's behaviors related to leadership factors that categorized the leader's leadership style (dependent variable) as transformational, transactional, or

passive-avoidant (Avolio & Bass, 2004; Spinelli, 2004, 2006; Wheatley, 2010). Outcomes of leadership (dependent variable) were determined based on the leader's response to the MLQ 5X Short identifying the leader's behavior and ability to motivate followers to apply extra effort, the leader's behavior and effectiveness, and the leader's influence on followers' satisfaction with the leader (Avolio & Bass, 2004). Demographic data were captured by a questionnaire designed by the researcher that allowed him to view additional variables that may influence outcomes.

Permission to use Avolio and Bass's (2004) MLQ 5X Short was received through Mind Garden's website. Mind Garden is an independent publisher of psychological assessments and instruments located in Menlo Park, California. The MLQ 5X Short was used to collect and analyze data to determine if there was a difference in female Up & Comers healthcare executives' and other female healthcare executives' leadership styles and outcomes in terms of female healthcare executives' self-perceptions. Hypotheses and theoretical background were provided to illustrate the choice of sample population and instrument used to collect data.

Origin of the MLQ

In 1985, Bass established the MLQ as a measure to evaluate transformational and transactional leadership. The original instrument captured an era in which Bass viewed transformational leadership using a six-factor model. Since the original design in 1985, alternative models have been used in studies of transformational and transactional leadership; as a result, additional factors were revealed. These new factors contributed to Avolio and Bass's (2004) MLQ 5X Short based on the FRL; the nine-factor model

contributed to the study and knowledge of transformational and transactional leadership (Avolio & Bass, 2004; Spinelli, 2004, 2006; Wheatley, 2010).

The MLQ 5X Short was used to measure transformational leadership. Previous studies using the MLQ captured data on military leaders in Army units and Navy and Air Force academies, leadership in health care, CEOs in the corporate realm and private organizations, as well as nonsupervisory project leaders (Avolio & Bass, 2004; Bass, 1997; Bass & Avolio, 1993; Bass et al., 2003). The MLQ gradually developed into a concise and inclusive instrument that is widely used to measure transformational leadership despite the negative connotations of other researchers who challenged and criticized the instrument, questioning the factor structure (Bass & Riggio, 2006; Carless, 1998; Heinitz et al., 2005; Muenjohn & Armstrong, 2008; Parry & Proctor-Thomas, 2002). These researchers and scholars have viewed the MLQ as a hindrance in the research of leadership.

Applications of various versions of the MLQ have been used to target different populations and offered varying numbers of items and content. MLQ forms offering more than five factors contributed to research identifying differences between active and passive management by exception (Avolio et al., 1999; Bycio et al., 1995; Heinitz et al., 2005). Bycio et al. (1995) highlighted how the various forms of the MLQ have been used to assess organizational outcomes, leadership performance, and follower satisfaction that could not be measured using transactional scales.

Data Collection

The sample population was contacted via e-mail. E-mail was used to capture data from the identified sample population of female healthcare executives over a wide geographical area in the United States (Fowler, 2002). The researcher hired Medical Marketing Service, a mailing list broker agency with the capability to identify and contact the target population by recruiting potential participants across the United States through the use of e-mail. The services of Mind Garden, an independent publisher of psychological assessments and instruments, were purchased to set up the link to access the online consent form with an embedded link to the survey (Evans & Mathur, 2005). The e-mail with the embedded link minimized turnaround time for results and centralized data collection directly to a character-separated values (.csv) file that was maintained on a secure server through Mind Garden.

Once the target population of 7,300 female healthcare executives was identified, a random sample of 3,000 female healthcare executives was targeted by the mailing list broker by selecting every other person on the list. The random sample was further randomized through the purchase of 501 licenses through Mind Garden to use the MLQ 5X Short. With total sample identified at 40, the researcher monitored and planned to close data collection after the first 501 participant licenses were used. A license was used when a potential participant clicked *agree* on the consent form, which automatically opened the link to the MLQ 5X Short. The decision of potential participants to complete the questionnaire and be among the first 501 participants out of 3,000 e-mail recipients further randomized the sample. The researcher had the ability to purchase additional licenses if needed, but it was not necessary.

The publishing company customized a link that provided direct access to the consent form with an option to exit the study or continue on to the MLQ 5X Short. The link was embedded in the recruitment e-mail and forwarded to the mailing list broker for dissemination. The first 501 participants who clicked to open the embedded link in the recruitment e-mail used an MLQ license. Only those who completed the survey were included in the study. Recipients who volunteered to participate in the survey acknowledged their understanding of the survey and risk associated with the study by accessing the link and reading the consent form. After reading the consent form, the subject clicked either *disagree*, to opt out, ending her participation in the study, or *agree*, to be connected directly to the MLQ 5X Short so she could complete it and demographic questions. The link to the consent form allowed potential participants and those who completed the survey to remain anonymous; no personal identifiable information was requested or collected. Subjects could stop participating in the study at any time.

Mind Garden collected all responses to the consent form, MLQ 5X Short, and demographic questionnaire. The researcher monitored responses daily through a .csv data file maintained on Mind Garden's secured website. The link to access the consent form, MLQ 5X Short, and demographic data remained active from December 26, 2013, to March 7, 2014. Following the closing of the data collection, the final .csv file was downloaded and exported to SPSS 22.0 for data analysis.

Data Analysis

Descriptive statistics were performed to detail the demographics in the sample as well as the research variables used in the study. For any categorical data of interest, the

researcher calculated frequencies and percentages, for example, the proportion of Up & Comers healthcare executives versus other healthcare executives. Means and standard deviations were calculated for continuous data, such as transactional scores (D. C. Howell, 2010).

Preanalysis data screening consisted of screening for accuracy, missing responses, and research variable outliers. Descriptive statistics, such as frequency distributions, were conducted to determine whether responses were within the range of values appropriate for the MLQ and whether outliers distorted the data. To assess for outliers, standardized values were calculated for each subscale score; responses were inspected for any standardized value above 3.29 or below –3.29 (Tabachnick & Fidell, 2012). All responses were reviewed to identify if there were any missing data. Participants with nonrandom missing data were excluded from analysis if large portions of the MLQ 5X Short were left incomplete.

Validity and Reliability

Creating a valid and reliable questionnaire is challenging. This study was based on a quantitative design; one of the disadvantages with this methodological approach is illustrating cause and effect (Adcock & Collier, 2001; Arbnor & Bjerke, 1997; Robson, 2002). The ultimate goal of a researcher is to illustrate validity by creating a questionnaire that captures the information associated with and/or that contributes to the research (Deming, 1947; Robson, 2002). The questionnaire used to conduct this research, the MLQ 5X Short, has been in active circulation for over two decades. The MLQ was designed to capture specific variables that directly contribute to the subject matter

identified in the area of research, providing consistency along the scale of measurement, making the instrument reliable (Avolio & Bass, 2004; Bass, 1985; Robson, 2002).

The MLQ initially consisted of 142 items based on literature and content analysis that incorporated open-ended questions. This approach invited 70 senior executives to participate in identifying what they considered to be factors that described transformational and transactional leaders based on their personal experiences and observations of leaders they knew and with whom they worked. As a result of the response allocation, the 142 items were reduced to 73 (Avolio et al., 1999; Bass, 1985; Lowe & Kroeck, 1996). Eleven graduate students classified these responses as either transformational, transactional, or "can't say" (Spinelli, 2004, p. 83), an area that lacked factors associated with leadership. These findings provided the foundation for the initial instrument (Bass, 1985; Hater & Bass, 1988; Spinelli, 2004, 2006; Waldman, Bass, & Yammarino, 1990).

Bass and his colleagues conducted a pilot study to illustrate the MLQ's validity among a sample of military officers (Avolio et al., 1999; Bass, 1985). A principal component analysis of the 73 items using the MLQ identified three transformational leadership factors and two transactional leadership factors. Factors related to transformational leadership were (a) charismatic leadership, where leaders are idealized, respected, and inspire followers; (b) individualized consideration, for leaders who take time to know and understand their followers; and (c) intellectual stimulation, indicating leaders who encourage innovation and creativity, risk taking, and doing things differently. Factors related to transactional leadership were (a) contingent reward, where leaders establish what is to be done and offer a material reward for completing the task;

and (b) management by exception, where leaders get involved only when there is a potential problem or after a problem has occurred (Avolio & Bass, 2004; Bass & Riggio, 2006; Bycio et al., 1995; Spinelli, 2004, 2006).

The MLQ's reliability was confirmed through the development of scales that ensured consistency (Avolio & Bass, 2004; Bycio et al., 1995; Spinelli, 2004, 2006). Evidence of inconsistent measurement would nullify reliability, producing what is known as random error. Avolio and Bass (2004); Avolio et al. (1999); and Tejeda, Scandura, and Pillai (2001) highlighted inconsistencies as researchers modified the instrument using various forms of the MLQ to conduct their studies. Variations of the form focused on different facets and dimensions drawn from transformational and transactional leadership, identified as alternative factor models. Over the years, the models changed, introducing different combinations, progressing from a model with one factor to a model with nine factors. As studies of the models progressed, they grew less restrictive, resulting in a better fit (Avolio & Bass, 2004; Tejeda et al., 2001). In the absence of reliability, the instrument is not valid, but reliability alone does not render the instrument valid (Adcock & Collier, 2001; Robson, 2002).

From the questionnaire's infancy to the current format used in this study, the MLQ has undergone much scrutiny, questioning of internal, external, and construct validity. Internal validity refers to cause and effect, while external validity refers to outcome as a result of or reaction to a certain variable or multiple variables tested over time, in a specific environment or group of people (Avolio & Bass, 2004; Bass, 1985; Scandura & Williams, 2000).

The instrument's validity is jeopardized if the questionnaire is poorly designed (Adcock & Collier, 2001; Aiman-Smith & Markham, 2004). Particular attention was devoted in designing questions for the MLQ so all participants could understand them, as improper question design would result in inaccurate responses and thus affect data (Deming, 1947). Revisions made by Avolio and Bass's colleagues do not invalidate seminal work (Spinelli, 2004, 2006); furthermore, Avolio and Bass (2004) acknowledged the importance of incorporating cognitive and personality traits to evaluate the impact of leadership behavior.

Over the years, the maturity of the MLQ revealed an instrument that encompassed the FRL. The MLQ 5X further defined the characteristics of the factors associated with transformational leadership: charismatic, idealized influence behavioral, and idealized influence attributed. Management by exception was reevaluated and identified as being either active or passive under transactional leadership. Other instruments for leadership expanded their measures of transformational leadership, incorporating factors addressing inspiration, charisma, and visionary leadership. These instruments did not capture the FRL currently related to transformational and transactional leadership (Avolio & Bass, 2004; Avolio et al., 1999; Heinitz et al., 2005; Spinelli, 2004, 2006).

The MLQ's reliability and validity as a data collection instrument have shown significant improvement over the years. The MLQ is recognized for identifying factors that capture the FRL associated with transformational, transactional, and passive/avoidant leadership (Avolio & Bass, 2004). The questionnaire's consistency faced challenges that incited further testing in the late 1990s and early 2000s. Avolio and Bass (2004) conducted a CFA using the initial set of data and eight alternative models, ranging from a

single factor to nine factors, employed by researchers using the MLQ. Results in 1999 indicated the six-factor model exceeded the minimum cutoff for goodness of fit, providing the best fit as compared to the alternative models (as was shown in Table 1). In 2003, the nine-factor model proved to be the best fit, demonstrating consistency across regions and by rater (Avolio & Bass, 2004; as was shown in Table 2). As the factors increased, the goodness of fit improved, covering the FRL (Avolio & Bass, 2004).

Studies over the past decade have provided additional evidence of the validity and reliability of the MLQ 5X. Researchers have conducted meta-analyses that reviewed the scales designed by Avolio and Bass (2004) used to measure the factors associated with the full range of transformational leadership (charisma, consisting of idealized influence attributed and idealized influence behavior; individualized consideration; inspirational motivation; and intellectual stimulation) as well as transactional leadership (contingent reward, management by exception active, management by exception passive) and laissez-faire leadership.

Researchers voiced their concerns with the high correlation among several items used to characterize the leadership styles identified by Bass's FRL (Avolio & Bass, 2004; Avolio et al., 1999; Bass, 1985). Questions surrounding the factor structure of the MLQ have been addressed through research over the years, several of which include Avolio et al. (1999), Carless (1998), Heinitz et al. (2005), Muenjohn and Armstrong (2008), Spinelli (2004, 2006), and Wheatley (2010). These studies entailed multiple reviews of the questionnaire that incorporated various factor structures and factor analyses, testing the construct and discriminant validity.

Carless (1998) conducted a study using the MLQ 5X that compared three models of transformational leadership, using a CFA. The target population consisted of employees from an international banking organization in Australia. Data were collected from 1,440 employees with a 54% response rate. The employees, 69% female and 31% male, with an average age of 31, rated their supervisors. The first three-factor first-order model consisted of charisma, intellectual stimulation, and individualized consideration, aligning with Bass's theory of transformational leadership. Carless noted that transformational leadership behaviors are indistinguishable, and because of the close relation, these behaviors can be viewed as one and the same and therefore were grouped together as a single factor in the second model. For the third model, transformational leadership was viewed as a "hierarchical concept" (Carless, 1998, p. 354). The hierarchical concept made reference to the transformational leadership behaviors identified in the first model. In this model, the behaviors were viewed as being different from one another, with a mutual connection to a higher-order construct.

Carless (1998) found that a change to the Likert scale was required to assure a standard layout for other leadership items on the questionnaire. Due to alternate models, modifications of the MLQ were necessary; the MLQ 5-point Likert scale was altered during this study. The revisions consisted of altering the numbering: changing 0 to 1 and 4 to 5. The wording was changed for the lowest scale response from 0 = *not at all* to 1 = *rarely or never* and from 4 = *frequently* to 5 = *very frequently, if not always* (Carless, 1998).

Findings of Carless's (1998) study for goodness of fit are presented in Table 3. Comparison of the models indicated the first model was a better fit than the second model

based on the chi-square. Goodness of fit was also confirmed by the root mean square residual, root mean square error of approximation, Goodness-of-Fit Index (GFI), Adjusted GFI (AGFI), Nonnormed Fit Indexes (NNFI), and Relative Noncentrality Index. Table 3 also showed that the first and third models were identical.

Table 3. *Goodness of Fit for the MLQ Based on Carless's (1988) Study*

Model	χ^2	*df*	*p*	RMSEA	RMSR	GFI	AGFI	NNFI	RNI
Model 1 3 factors (1st order)	3317	320	< .001	.08	.04	.82	.78	.89	.90
Model 2 1 factor	4079	324	< .001	.09	.05	.78	.74	.86	.86
Model 3 3 1st-order factors & 2nd-order factors	3317	320	< .001	.08	.04	.82	.78	.89	.90

Note. RMSEA = root mean square error of approximation, RMSR = root mean square residual, GFI = Goodness-of-Fit Index, AGFI = Adjusted GFI, NNFI = Nonnormed Fit Indexes, RNI = Relative Noncentrality Index. From "Assessing the Discriminant Validity of Transformational Leader Behaviour as Measured by the MLQ," by S. A. Carless, 1998, *Journal of Occupational and Organizational Psychology, 71,* p. 355. Copyright 1998 by John Wiley and Sons. Reprinted with permission.

Carless (1998) conducted further testing of the first and third model using the "Lee–Hershberger replacement rule" (p. 356), confirming that the two models were similar. Further comparisons of the two models were carried out based on substantive meaning versus goodness of fit. Based on the findings, the third model was identified as lacking discriminant validity due to the high covariation that existed among the first-order factors due to a higher-order construct. These results indicated there was an overarching transformational leadership factor, suggesting the MLQ 5X measures a

single higher construct of transformational leadership behavior instead of separate transformational leadership behaviors (Carless, 1998).

The overall findings of Carless's (1998) study revealed the two alternate models, first-order model and third hierarchical order model, aligned with Bass's (1985) theory that defined transformational leadership constructs as being markedly different and provided a better fit to the data over the second one-factor model. Carless highlighted that the goodness of fit for the third model was weak, with < .90 GFI, AGFI, and NNFI and > .05 RMSEA. Avolio and Bass (2004) identified acceptable measures for GFI as > .90 and root mean residual < .05.

Through her study, Carless (1998) demonstrated there was a high correlation of MLQ subscales with high proportion of variance. She divided the variance of the MLQ into three elements: common variance, unique variance, and error variance. Division of variance revealed there was a significant measure of common and error variance, leading to the belief there is an overarching, second-order construct. Carless concluded that at the time of the study, there was insufficient data to support individual subscale scores for transformational leadership, therefore recognizing the version of the MLQ 5X used for the study as assessing transformational leadership as a single, hierarchical construct. Several implications related to the study were presented suggesting the need for additional research to look at what influenced the perceptions of rating leadership behaviors associated with charismatic leadership.

Avolio et al. (1999) revisited the six-factor MLQ 5X consisting of 80 items used to measure leadership behavior, and conducted a study to test the factor structure of the questionnaire. Eight alternate models, a null model, and their factor structures were

discussed, and then compared using a CFA. Researchers voiced a concern in reference to the different MLQ models that focused on the items associated with transformational leadership. Questions addressed characteristics related to transformational leadership compared to one another and whether these items should be considered separate from contingent reward or if contingent reward should be considered as a factor in itself. Researchers also argued there was a lack of experimental evidence to differentiate the components of transformational leadership (Avolio et al., 1999).

The study conducted by Avolio et al. (1999) involved 14 samples consisting of a total of 3,786 respondents capturing followers' responses regarding their leaders. Nine of the 14 samples represented the U.S. Army and U.S. and international organizations that provided responses using the original six-factor MLQ form. To establish the model used in the first nine samples, the study was replicated using the second remaining five samples that represented a larger sample size from five U.S. organizations. Avolio et al. assumed that using a larger and more diverse population would establish a theoretically and empirically replicable structure.

A CFA was performed including all 80 items on the data collected from both sets of samples to validate the proposed six-factor model of leadership. The six-factor model was further evaluated by means of a covariance matrix using the maximum likelihood estimation method. The six-factor model proved not to be a sufficient fit, with the CFA illustrating that transformational factors did not differentiate from one another and contingent reward items were closely related to transformational leadership factors. Values for the GFI at .73, root mean square residual at .10, and chi-square with 2889

degrees of freedom of 13,378 ($p < .0001$) confirmed that the six-factor model was not a good fit (Avolio et al., 1999).

Avolio et al. (1999) explained the Modification Indices were used to reduce items by eliminating those that were highly correlated or redundant in the questionnaire, known as "item trimming" (p. 449); this method did not change the original model and assisted in shortening the form for future studies. The final product resulted in 36 items to be included on the MLQ 5X. A CFA was run again on all 14 samples using the 36 items, along with the eight alternative models and the null model. The six-factor model proved to be the best fit among all models, based on the chi-square difference tests, with a minor decrease in the level of fit associated with the replication test for the six-factor model involving the five samples. Avolio et al. noted that no difference was found between the six-factor model and alternative seven-factor model.

Although the six-factor model was a good fit, the discriminant validity was still in question. Avolio et al. (1999) explained that latent correlations existed with the scales associated with the factors and that hierarchical factors may influence lower-order factors, accounting for the high correlations.

The higher-order factors were examined to clarify the covariation among the first-order factors. Three post hoc hierarchical models were tested to see if the discriminant validity could be enhanced using what Avolio et al. (1999) identified as Marsh and Hocevar's "target coefficient (T)" (p. 454). Each model consisted of correlated and uncorrelated higher-order factors:

- Model 1 consisted of the six lower-order factors along with two uncorrelated higher-order factors: active constructive and passive corrective leadership.

Active constructive leadership was defined by charisma/individualized consideration and contingent reward, while passive corrective leadership was defined by management by exception and laissez-faire (Avolio et al., 1999).

- Model 2 consisted of three uncorrelated higher-order factors: transformational leadership, defined by charismatic/inspirational and intellectual stimulation; developmental/transactional, defined by individualized consideration and contingent reward; and passive corrective leadership, as defined in Model 1 (Avolio et al., 1999).
- Model 3 consisted of two correlated higher-order factors—transformational leadership and developmental/transactional—and a third uncorrelated corrective avoidant factor that included management by exception and laissez-faire leadership (Avolio et al., 1999).

GFIs for the three models were comparable to the six-factor model. The target coefficient indicated that "Model 3 exceeded the minimum cutoffs recommended by Marsh and Hocevar" (Avolio et al., 1999, p. 455). Model 3 was found to be the best fit among the three models, and review of the latent correlations revealed discriminant validity.

Heinitz et al. (2005) conducted three studies, two of which consisted of German-speaking participants, that spanned a 4-year period, 2000–2004. Their research reexamined the MLQ 5X Short's factor structure associated with transformational leadership. The study involved 2,840 participants similar in age, gender, and occupation from organizations comparable in structure. The MLQ 5X was translated for the German-speaking participants involved with Studies 1 and 2.

Burn's and Bass's concepts of transformational and transactional leadership were discussed, and Heinitz et al. (2005) highlighted Bass's views on transformational leadership as a more effective variation of leadership style. Additionally, the augmentation effect was brought forward and considered in their study. The MLQ 5X scale of measurement for the nine facets of leadership was addressed, along with the criticism of the instrument's lack of discriminant validity due to the alignment of the factor structure.

In Heinitz et al.'s (2005) study, the categorization of the nine facets related to transformational, transactional, and laissez-faire leadership were addressed, presenting the following arguments: (a) contingent reward should be associated with transformational leadership rather than transactional leadership based on the high correlations with transformational scales, (b) management by exception passive portrayed absence of leadership and should be associated with laissez-faire leadership, and (c) the isolation of management by exception active would be classified in a category of its own. The categories of leadership style would be as follows: charismatic goal-oriented, management by exception active, and passive-avoidant, thus reducing the nine factors.

The first study was a translated copy of the MLQ 5X that included all nine factors (Heinitz et al., 2005). The study involved 1,311 participants, with a rejection rate of 53.2%. The study indicated there were acceptable internal consistencies of the scales, but the fit for the nine-factor model was insufficient (see Table 4). To confirm these findings and to identify how many factors can be removed, Heinitz et al. (2005) conducted a parallel analysis along with eigenvalues. The parallel analysis computed data using a correlation matrix that identified data that were larger than the eigenvalues from the

factor analysis, indicating which factors were false (Dinno, 2009). The results of the comparison indicated three factors that could be extracted from the nine-factor model.

Heinitz et al. (2005) used the results from the first study as a basis for the second study, which had 879 participants, with a 55.3% rejection rate. The questionnaire was modified to represent the following three factors consisting of nine items: charismatic goal orientation based on idealized influence (behavior), inspirational motivation, and contingent reward. Intellectual stimulation, idealized influence attributed, and individual consideration were the three factors removed and not included in this scale. The second factor identified as passive-avoidant leadership was characterized by management by exception passive and laissez-faire leadership. With management by exception passive falling under the second factor, passive-avoidant leadership, management by exception active stood alone as the third factor, simply identified as management by exception. This second study failed to meet the fit indices (see Table 4).

Table 4. *Goodness of Fit for the MLQ Based on Heinitz et al.'s (2005) Study*

Model	χ^2	*df*	*p*	AGFI	CFI	RMR
Study 1: Replication of Bass & Avolio's (1985) nine-factor model, German-speaking participants	5030	558	< .001	.79	.86	.89
Study 2: 3-factor, German-speaking participants	3569	558	< .001	.78	.84	.78
Study 3: 3-factor with independent sample	217	62	< .001	.93	.95	.042

Note. AGFI = Adjusted Goodness-of-Fit Index, CFI = Comparative Fit Index, RMR = root mean residual. Data from "Examining the Factor Structure of the MLQ: Recommendation for a Reduced Set of Factors," by K. Heinitz, D. Liepmann, and J. Felfe, 2005, *European Journal of Psychological Assessment, 21*(3), p. 186. Copyright 2005 by Hogrefe & Huber Publishers.

A CFA was used in the next step of the investigation with the three-factor model used in the second study among an independent sample. Findings of this model met the criteria for a good fit. Following these results, another analysis was completed on the first sample from the second study that provided good fit indices ($\chi^2 = 263$, $df = 62$, $p = < .001$, AGFI = 0.91, Comparative Fit Index = 0.93, and root mean residual = 0.0061; Heinitz et al., 2005).

Heinitz et al. (2005) noted that researchers normally reduced items in order for their model to achieve a good fit. It was further acknowledged that reducing items excluded behaviors associated with the transformational scale and had a significant impact on outcomes verified through a regression analysis. The elimination of the three items in the second study resulted in a loss of information in comparison to the nine-factor model.

The study used homogeneous samples with similar demographics. In reference to the MLQ, Antonakis et al. (2003) wrote, "One would expect the factor structure to be invariant only within homogeneous contexts" (p. 268). Heinitz et al. (2005) indicated the empirical rationale supported the three-factor model among the samples used in the study.

A meta-analysis conducted by Muenjohn and Armstrong (2008) revealed a positive significant correlation between each of the factors associated with transformational leadership. The researchers found the MLQ 5X to be statistically significant. Muenjohn and Armstrong conducted a CFA to test the structural validity of three MLQ models using an analysis of moment structure. Multiple data sources were

used that involved 138 cases. Their findings suggested that transformational leaders were more effective than transactional leaders.

Muenjohn and Armstrong (2008) shared the analysis of the three models. The fit measures indicated the ratio of the chi-square was significant at $p < .01$. Statistically, the nine-factor model proved to be a "reasonable fit" (Muenjohn & Armstrong, 2008, p. 9) among the models in the study, with an "overall chi-square" (p. 9) with a probability of .01, $\chi^2 = 540.18$, and $df = 474$; the ratio of the chi-square to the degrees of freedom ($\chi^2 \div df$) was 1.14, RMSEA 0.03, GFI .84, and AGFI .78.

Muenjohn and Armstrong's (2008) analysis suggested the nine-factor model was the best theoretical construct representing the MLQ form at the time the study was published in 2008. Based on Muenjohn and Armstrong's findings, the MLQ 5X is suitable for measuring the nine leadership factors representing the FRL.

Within the last 10 years, leadership studies have been conducted in various departments in the healthcare environment that focused on Avolio and Bass's FRL. Spinelli (2004, 2006) and Wheatley (2010) used the nine-factor model to collect and analyze data to determine the difference in leadership styles and outcomes of leadership among healthcare executives as perceived by their followers.

Spinelli (2004, 2006) applied multivariate correlation analysis with multiple regressions to test the three leadership factors and outcomes of healthcare CEOs viewed by subordinate managers. This study of hospital CEOs and subordinate managers in an administrative setting provided empirical support that there is a significant relationship between independent variables—transformational, transactional, and passive-avoidant

leadership styles—and dependent variables—satisfaction with the leader, leadership effectiveness, and motivation to exert extra effort.

Wheatley (2010) conducted a causal-comparative study between two executive groups—Up & Comers award recipients and other healthcare executives—to determine if their leadership styles and outcomes were comparable. Statistical tests used were the *t* test, *F* test for equality of variances, Satterthwaite method to calculate an approximate linear combination of independent sample variances to the effective degrees of freedom, and Cohen *d* to test the standardized difference between two means that is expressed in standard deviation units.

The independent variable for Wheatley's (2010) study was executive type, with executives who received the Up & Comers award and executives who were nonrecipients of the award as the nominal variables. "The multiple interval-scale dependent variables" (Wheatley, 2010, p. 118) were the three leadership styles—transformational, transactional, and passive-avoidant leadership—to include outcomes—satisfaction with the leader, leadership effectiveness, and motivation to exert extra effort.

Wheatley (2010) noted there were previous studies consistent with his findings as well as dissimilarities among other studies conducted in the healthcare industry. Several studies had indicated high scores among transformational leadership styles among executives, whereas Wheatley's findings identified high scores among transactional leadership. Although there were differences in outcomes, these studies supported Bass's FRL and the augment theory, as identified from data collected using the MLQ 5X (Avolio & Bass, 2004; Bass & Bass, 2008; Hater & Bass, 1988).

For the purpose of the current study, the nine-factor model was applied capturing data related to factors associated with transformational leadership characterized by idealized influence attributed, idealized influence behavior, inspirational motivation, intellectual stimulation, and individualized consideration (Avolio & Bass, 2004; Bass, 1985). Factors for transactional leadership consisted of contingent reward, management by exception active, and management by exception passive, associated with the absence of leadership, referred to as passive-avoidant in the context of this study, known as laissez-faire, introduced as the ninth factor (Avolio & Bass, 2004; Bass, 1985).

The MLQ rater form was used to collect data from research participants: healthcare executives. For this research, healthcare executives were identified as female Up & Comers healthcare executives and other female healthcare executives. The MLQ self-rater form is written in the first person and leaders' profiles are generated through the MLQ's descriptive statements rated by respondents using the MLQ 5X scoring key. The participants' ratings identified whether Bass's concept of leadership—transformational, transactional, and passive avoidant—exists among Up & Comer healthcare executives and other female healthcare executives. The researcher also used the data to determine if there was a significant difference between Up & Comers healthcare executives' and other female healthcare executives' leadership styles and their outcomes. Finally, the data were used to accept or reject the stated hypotheses based on Avolio and Bass's (2004) theory of FRL.

The researcher used data to provide insight to how the raters perceived their leadership style according to Avolio and Bass's (2004) FRL. The dependent variables were measured using the MLQ 5X Short to determine how a rater perceived her

effectiveness as a leader, motivating her followers to exert extra effort, and how satisfied her followers are with her. The MLQ has been validated and found to be reliable, as illustrated in previous studies over the past 20 years (Avolio & Bass, 2004).

The MLQ measures a leader's effectiveness based on several areas: a leader's ability to meet others' job-related needs, how effective the leader is in representing his or her group to higher authority, effectiveness in meeting the organization's requirements, and the leader's ability to lead a group that is effective (Avolio & Bass, 2004). Motivating personnel to exert extra effort is measured by the MLQ by focusing on three areas. Female healthcare executives rated how well they are able to encourage others to do more than expected, heighten others' aspiration to succeed, and increase others' inclination to exert effort (Avolio & Bass, 2004). Finally, the female healthcare leaders measured their perceptions of their followers' satisfaction with them. The MLQ measured this area based on how female healthcare executives viewed their leadership methods and how well they worked with others (Avolio & Bass, 2004).

Ethical Considerations

The research presented minimal risk to participants. Participants were randomly selected from the mailing list broker's database and contacted via e-mail. The e-mail contained an embedded link that redirected potential participants to the consent form. Participation was voluntary and participants were informed about potential Internet practices that may put them at risk, such as network security, shared networks, sharing passwords, and hackers. Recipients who decided to participate in the study acknowledged this agreement by clicking the *agree* link at the bottom of the consent form, which then

provided access to the MLQ. Names were not required. All voluntary participants were asked for demographic data, not to include name, social security number, or any information that can be used to identify participants. The surveys were returned to Mind Garden's website secure server, where they will be maintained for 1 year. Mind Garden implements security measures to protect electronic data using industry standard Secure Sockets Layer (SSL) encryption.

Only the researcher and the statistics advisors had access to the raw data when the study was completed. Data were reviewed and desensitized to ensure there was no identifying information. Demographic data captured the following information: level of education, current position, length of time in current position, specialty area in which the participant worked, size of organization, class of Up & Comer, age, ethnicity, and race.

This study presented no conflict of interest for the researcher or participants. This research was not related to any organization or business. There was no direct or indirect monetary gain or business advantage for the researcher or participants.

Data are being stored for 1 year following the end of data collection (March 7, 2014). The researcher will store data in a locked fireproof safe for 7 years following the dissertation approval date. All data will be destroyed with a cross-cut shredder and all digital files erased.

Chapter Summary

The methodological approach discussed in this chapter identified a fixed quantitative design that was used to test the stated hypotheses for the study. The study involved female healthcare executives between the age of 25 and 70 with an

undergraduate degree or higher who worked in a medical facility for at least a year. Services were purchased through outside agencies to assist with identifying and capturing the desired targeted and sample population. Another service provided license to use 501 questionnaires and customized a link that was embedded in the e-mail to provide access to the consent form with the option to agree or disagree to participate in the study.

Recipients who chose not to participate clicked *disagree* to exit the study. Participants who agreed to participate were redirected to the demographic data questionnaire, followed by the MLQ 5X Short. Participants could discontinue the study at any time by exiting at any stage of the process. Only questionnaires that were completed were included in the study. The first 501 completed questionnaires were used in the study. Data were collected and maintained by Mind Garden and made available to the researcher during data collection.

Research questions and hypotheses were provided to highlight the variables involved in the study. The research design illustrated the researcher's approach to communicating with potential participants, collecting data, the questionnaire, data collection, and analysis.

A review of the MLQ highlighted the instrument's validity and reliability and how the instrument evolved over the past two decades, highlighting studies conducted by Avolio et al. (1999), Carless (1998), Heinitz et al. (2005), Muenjohn and Armstrong (2008), Spinelli (2004, 2006), and Wheatley (2010). The CFA and GFI verified that the six-factor and nine-factor models improved over the years. The six-factor model was identified in earlier studies as the model of choice; for the current research, the nine-

factor model was used. Discussion on how the researcher used the data analysis to accept or reject the null hypotheses was provided.

Finally, ethical considerations were identified as a minimal risk to participants based on the nature of questions and demographics. Data were collected by Mind Garden and maintained on a secure server to which the researcher had access for monitoring throughout the data collection process. The data were turned over to the researcher at the end of the data collection and will be maintained by Mind Garden for 1 year.

Only the researcher and the statistical advisors reviewed the raw data. SPSS 22.0 was used to conduct statistical tests for data analysis. Findings are presented in Chapter 4, and discussion, conclusions, and recommendations for further research are addressed in Chapter 5.

CHAPTER 4. RESULTS

Introduction

The researcher conducted a quantitative study to examine leadership styles of female healthcare executives. Female healthcare executives were separated into two groups identified as female Up & Comers healthcare executives and other female healthcare executives. The intent of the study was to identify if a statistically significant difference exists between the two groups in reference to leadership style and the outcomes of their leadership as measured by the MLQ 5X Short (Avolio & Bass, 2004). Based on the data analyses, the researcher rejected or failed to reject the following null hypotheses:

H_o1: No statistically significant difference exists between female Up & Comers healthcare executives' and other female healthcare executives' leadership styles as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004).

H_a1: A statistically significant difference exists between female Up & Comers healthcare executives' and other female healthcare executives' leadership styles as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004).

Subhypotheses were created for Hypothesis 1 to fully examine the hypothesis:

$SubH_o1$: Female Up & Comers healthcare executives do not have statistically greater transformational leadership characteristics than other female healthcare executives as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004).

$SubH_a1$: Female Up & Comers healthcare executives have statistically greater transformational leadership characteristics than other female healthcare executives as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004).

$SubH_o2$: Female Up & Comers healthcare executives do not have statistically lower transactional leadership characteristics than other female healthcare executives as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004).

$SubH_a2$: Female Up & Comers healthcare executives have statistically lower transactional leadership characteristics than other female healthcare executives as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004).

$SubH_o3$: Female Up & Comers healthcare executives do not have statistically lower passive-avoidant leadership characteristics than other female healthcare executives as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004).

$SubH_a3$: Female Up & Comers healthcare executives have statistically lower passive-avoidant leadership characteristics than other female healthcare executives as

measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004).

H_o2: No statistically significant difference exists between female Up & Comers healthcare executives' and other female healthcare executives' outcomes of leadership as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004).

H_a2: A statistically significant difference exists between female Up & Comers healthcare executives' and other female healthcare executives' outcomes of leadership as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004).

Subhypotheses were created for Hypothesis 2 to fully examine the hypothesis:

$SubH_o4$: Female Up & Comers healthcare executives do not have statistically greater abilities to motivate followers to exert extra effort than other female healthcare executives as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004).

$SubH_a4$: Female Up & Comers healthcare executives have statistically greater abilities to motivate followers to exert extra effort than other female healthcare executives as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004).

$SubH_o5$: Female Up & Comers healthcare executives do not have statistically greater abilities to enhance a leader's effectiveness than other female healthcare executives as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004).

$SubH_a5$: Female Up & Comers healthcare executives have statistically greater abilities to enhance a leader's effectiveness than other female healthcare executives as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004).

$SubH_o6$: Female Up & Comers healthcare executives do not have statistically greater abilities to enhance followers' satisfaction with the leader than other female healthcare executives as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004).

$SubH_a6$: Female Up & Comers healthcare executives have statistically greater abilities to enhance followers' satisfaction with the leader than other female healthcare executives as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004).

Description of Population and Sample

With a focus on healthcare executives, the services of an e-mail broker, Medical Marketing Service, were used to capture the female healthcare executive population. Medical Marketing Service identified the target population of female healthcare executives. The target population was identified by the following demographics: women who were 25–70 years of age with a undergraduate degree or higher, working in a medical facility for more than a year, fulfilling one of the following positions: CEO, vice president, COO, CFO, CIO, director of human resources, clinic director, or other senior executive position. Medical Marketing Service identified 7,300 female healthcare executives, with a targeted random sample of 3,000 female healthcare executives.

Selection of participants was based on the following file types: only records meeting the aforementioned criteria with an e-mail address.

The recruitment e-mail with a link to the consent form, demographic questionnaire, and MLQ 5X Short was distributed electronically through the services of Medical Marketing Service and Mind Garden. All data were collected through Mind Garden's website and saved on a secure server using industry-standard SSL encryption. Access to the data was limited through Mind Garden's additional security measures. The researcher was granted permission to access the data using a personalized encrypted password that was viewable in a .csv data file.

The researcher initially purchased 501 MLQ licenses from Mind Garden with the option to purchase additional licenses as needed. The initial e-mail was sent on December 26, 2013, with reminder e-mails sent on January 16, 2014, and February 12, 2014. The total sample required was calculated using G*Power 3 based on a one-tailed analysis to examine the differences between two groups (independent variables). Effect size was calculated as 0.8008475 with power of .80; the degree of freedom was calculated as 38. The minimum sample size for each group was 20, for a total sample size of 40. Groups excluded were all male healthcare executives as well as other business executives and Up & Comers outside of the healthcare industry. A total of 55 participants completed the survey: 21 female Up & Comers healthcare executives and 34 other female healthcare executives; however, one was dropped because a couple of her responses were identified as outliers. Only the data from 54 respondents were used. With the minimum sample size achieved, the survey was closed on March 7, 2014.

Descriptive Statistics

The sample consisted of 54 female healthcare executives, 20 Up & Comers and 34 non-Up & Comers. Many of the Up & Comers reported being from the Classes of 1987–1990. A large number of the sampled executives were in the age ranges of 40–49, 50–59, or 60–65. The sample was mostly White, with only three Black participants and one American Indian/Alaska Native participant. A majority reported earning up to a master's degree. Many were CEOs or COOs. Most of the participants had held their current position for either 1–5 years, 6–10 years, or 11–15 years. The largest number of participants reported working at an organization of 99 beds or less, though many also reported working at an organization of 501 beds or more. Frequencies and percentages for sample demographics are provided in Table 5.

Table 5. *Demographics for Female Healthcare Executive Participants*

Variable	*n*	%
Up & Comer		
Yes	20	37
No	34	63
Up & comer class year		
1987–1990	9	17
1991–1994	4	7
1995–1999	2	4
2000–2004	4	7
2005–2009	1	2
Not applicable	34	63
Age		
30–39	3	6
40–49	11	20
50–59	22	41
60–65	17	32
66–70	1	2

Table 5. *Demographics for Female Healthcare Executive Participants* (*continued*)

Variable	*n*	%
Race		
American Indian/Alaska Native	1	2
Black	3	6
White	50	93
Education		
Bachelor's degree	8	15
Master's degree	37	69
Doctoral degree	5	9
Other	3	6
Prefer not to answer	1	2
Job position		
Business office director	3	6
Chief executive officer	15	28
Chief operations officer	13	24
Chief financial officer	3	6
Chief administrator	2	4
Human resource director	5	9
Other	13	24
Years in position		
1–5	18	33
6–10	21	39
11–15	10	19
16–20	3	6
21 or more	2	4
Specialty area		
Single hospital system	15	28
Multihospital system	28	52
Rural health system	5	9
Group practice	1	2
Other	5	9
Size of organization		
99 beds or less	21	39
100–300 beds	8	15
301–500 beds	9	17
501 beds or larger	15	28
Prefer not to answer	1	2

Note. Due to rounding error, some percentages may not sum to 100%.

Means and standard deviations were calculated to determine the average scores for the three leadership styles and three leadership outcomes. The lowest average leadership score in the sample was passive-avoidant. Participants tended to score highest on the transformational leadership scale. The lowest outcome of leadership score in the sample was on the extra effort scale. Participants tended to score highest on the effectiveness scale. Means and standard deviations for the scores of interest in the sample are presented in Table 6.

Table 6. *Means and Standard Deviations for Sample's Scores*

Variable	Min	Max	*M*	*SD*
Leadership style				
Transformational leadership	2.40	4.00	3.46	0.37
Transactional leadership	0.90	3.40	2.47	0.50
Passive-avoidant leadership	0.00	1.50	0.48	0.42
Outcome of leadership				
Extra effort	1.30	4.00	3.34	0.53
Effectiveness	2.30	4.00	3.62	0.36
Satisfaction with the leadership	2.50	4.00	3.57	0.43

Summary of Results

Data were collected on 55 participants who completed the survey that was made available to the first 501 participants out of the 3,000 who received the recruitment e-mail. Based on data results, one participant's responses were removed as an outlier on one of the dependent variable scales. Based on the data collected on the remaining 54 participants, the researcher answered the following research questions and research subquestions.

Research Question 1

ResQ1: To what extent does leadership style vary between female Up & Comers healthcare executives and other female healthcare executives as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004)?

Sub-ResQ1: To what extent does leadership style vary between female Up & Comers healthcare executives and other female healthcare executives using transformational leadership as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004)?

Sub-ResQ2: To what extent does leadership style vary between female Up & Comers healthcare executives and other female healthcare executives using transactional leadership as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004)?

Sub-ResQ3: To what extent does leadership style vary between female Up & Comers healthcare executives and other female healthcare executives using passive-avoidant leadership as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004)?

Findings indicated that female Up & Comers healthcare executives and other female healthcare executives share common leadership characteristics. The one-tail *t*-test scores were not statistically different for the three leadership styles: transformational, transactional, and passive-avoidant. Leadership styles did not vary between female Up & Comers healthcare executives and other female healthcare executives.

Research Question 2

ResQ2: To what extent do female Up & Comers healthcare executives and other female healthcare executives vary in terms of the outcomes of leadership as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004)?

Sub-ResQ4: To what extent do female Up & Comers healthcare executives and other female healthcare executives vary in terms of a leader's ability to motivate followers to exert extra effort?

Sub-ResQ5: To what extent do female Up & Comers healthcare executives and other female healthcare executives vary in terms of a leader's effectiveness?

Sub-ResQ6: To what extent do female Up & Comers healthcare executives and other female healthcare executives vary in terms of followers' satisfaction with the leader?

Findings associated with outcomes of leadership indicated there were no significant differences between female Up & Comers healthcare executives and other female healthcare executives. Outcomes of leadership were identified as the ability to motivate an employee to exert extra effort, leader's effectiveness, and satisfaction with the leader.

Details of Analysis and Results

Preanalysis Data Cleaning

Data were collected from 58 female healthcare executives. Three participants did not provide consent to be used in the study, and were dropped from the data set. Next, each participant's dependent variable scores were assessed for outliers. To determine

outliers, standardized scores were calculated for each participant's scores of interest. Standardized scores indicate how many standard deviations an individual's score is from the sample's mean on that score. Participants with a score 3.29 standard deviations or more from the mean were indicated as outliers and were removed from the data set. One participant was removed for an outlier on the Passive-avoidant scale (4.85 *SD* from the mean). Thus, final analyses were conducted on a sample of 54 participants.

Hypotheses for Research Question 1

H_o1: No statistically significant difference exists between female Up & Comers healthcare executives' and other female healthcare executives' leadership styles as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004).

H_a1: A statistically significant difference exists between female Up & Comers healthcare executives' and other female healthcare executives' leadership styles as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004).

SubH_o1: Female Up & Comers healthcare executives do not have statistically greater transformational leadership characteristics than other female healthcare executives as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004).

SubH_a1: Female Up & Comers healthcare executives have statistically greater transformational leadership characteristics than other female healthcare executives as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004).

$SubH_o2$: Female Up & Comers healthcare executives do not have statistically lower transactional leadership characteristics than other female healthcare executives as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004).

$SubH_a2$: Female Up & Comers healthcare executives have statistically lower transactional leadership characteristics than other female healthcare executives as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004).

$SubH_o3$: Female Up & Comers healthcare executives do not have statistically lower passive-avoidant leadership characteristics than other female healthcare executives as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004).

$SubH_a3$: Female Up & Comers healthcare executives have statistically lower passive-avoidant leadership characteristics than other female healthcare executives as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004).

To examine the three subhypotheses of Research Question 1, three independent sample *t* tests were conducted. The researcher conducted one analysis for each of the three leadership styles of interest: transformational, transactional, and passive-avoidant. Prior to analysis, the assumptions of the independent sample *t* test were assessed. Normality was assessed using three one-sample Kolmogorov–Smirnov (KS) tests, one for each dependent variable. The results of the KS tests indicated that transformational and transactional leadership scores followed normal distributions ($p > .05$); however, passive-

avoidant did not follow a normal distribution ($p < .001$). Though the assumption of normality was violated for the passive-avoidant scale, Stevens (2009) stated this assumption may be violated with relatively little harm in the *t* family of tests. The assumption of homogeneity of variance was assessed using three Levene's tests, one for each *t* test. Results did not indicate significant differences in variance between the two groups, and the assumption was met for all three analyses ($p > .05$).

Results indicated no significant differences in any of the three leadership styles between female Up & Comers and non-Up & Comers. Transformational leadership ($t(52) = 0.50$, $p = .618$), transactional leadership ($t(52) = 0.59$, $p = .558$), and passive-avoidant leadership ($t(52) = –0.33$, $p = .973$) scores were not statistically different for either Up & Comers or other healthcare executives. Thus, no further interpretation could be made. Results of the three independent sample *t* tests are presented in Table 7.

Table 7. *Independent Sample* t *Tests for Three Leadership Styles of Interest*

			Up & Comers		Others	
Leadership style	*t*(52)	*p*	*M*	*SD*	*M*	*SD*
Transformational	0.50	.618	3.43	0.39	3.48	0.36
Transactional	0.59	.558	2.42	0.60	2.50	0.44
Passive-avoidant	–0.33	.973	0.48	0.45	0.47	0.41

Hypotheses for Research Question 2

H_o2: No statistically significant difference exists between female Up & Comers healthcare executives' and other female healthcare executives' outcomes of leadership as

measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004).

H_a2: A statistically significant difference exists between female Up & Comers healthcare executives' and other female healthcare executives' outcomes of leadership as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004).

$SubH_o4$: Female Up & Comers healthcare executives do not have statistically greater abilities to motivate followers to exert extra effort than other female healthcare executives as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004).

$SubH_a4$: Female Up & Comers healthcare executives have statistically greater abilities to motivate followers to exert extra effort than other female healthcare executives as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004).

$SubH_o5$: Female Up & Comers healthcare executives do not have statistically greater abilities to enhance a leader's effectiveness than other female healthcare executives as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004).

$SubH_a5$: Female Up & Comers healthcare executives have statistically greater abilities to enhance a leader's effectiveness than other female healthcare executives as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004).

$SubH_o6$: Female Up & Comers healthcare executives do not have statistically greater abilities to enhance followers' satisfaction with the leader than other female healthcare executives as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004).

$SubH_a6$: Female Up & Comers healthcare executives have statistically greater abilities to enhance followers' satisfaction with the leader than other female healthcare executives as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004).

To examine the three subhypotheses of Research Question 2, three independent sample *t* tests were conducted. The researcher conducted one analysis for each of the three outcomes of leadership: extra effort, effectiveness, and leadership satisfaction. Prior to analysis, the assumptions of the independent sample *t* test were assessed. Normality was assessed using three one-sample KS tests, one for each dependent variable. The results of the KS tests indicated that none of the scores for the outcomes of leadership followed a normal distribution ($p < .05$ for all). However, Stevens (2009) stated that, in the *t* family of tests, this assumption may be violated with relatively little harm. The assumption of homogeneity of variance was assessed using three Levene's tests, one for each *t* test. Results did not indicate significant differences in variance between the two groups, and the assumption was met for all three analyses ($p > .05$).

Results indicated no significant differences in any of the three outcomes of leadership between female Up & Comers and female non-Up & Comers. Extra effort ($t(52) = 1.05$, $p = .298$), effectiveness ($t(52) = 0.79$, $p = .558$), and satisfaction with leadership ($t(52) = –0.34$, $p = .736$) scores were not statistically different for either Up &

Comers or other healthcare executives. Thus, no further interpretation could be made. Results of the three independent sample *t* tests for outcomes of leadership are presented in Table 8.

Table 8. *Independent Sample* t *Tests for Three Outcomes of Leadership*

			Up & Comers		Others	
Outcome	*t*(52)	*p*	*M*	*SD*	*M*	*SD*
Extra effort	1.05	.298	3.24	0.63	3.40	0.47
Effectiveness	0.79	.436	3.57	0.41	3.65	0.33
Satisfaction with leadership	–0.34	.736	3.60	0.48	3.56	0.40

Chapter Summary

The intent of this study was to capture data to identify if there was a statically significant difference in leadership styles between female Up & Comers healthcare executives and other female healthcare executives. Based on the data collected and the statistical tests conducted, the researcher made the following conclusions.

For Research Question 1 and Research Subquestions 1–3, there were no significant differences in the three leadership styles between female Up & Comers healthcare executives and other female healthcare executives. Based on the data analysis, the researcher failed to reject the null hypotheses for Research Question 1 and all Subhypotheses 1–3. Findings indicated that female Up & Comers healthcare executives and other female healthcare executives share common leadership characteristics.

For Research Question 2 and Subresearch Questions 4–6, there were no significant differences in the three outcomes of leadership between female Up & Comers healthcare executives and other female healthcare executives. Based on the data collected, the researcher failed to reject the null hypotheses for Hypothesis 2 and all Subhypotheses 4–6. Findings indicated that female Up & Comers healthcare executives' and other female healthcare executives' outcomes of leadership were similar.

Unlike Wheatley's (2010) study that included male and female Up & Comers healthcare executives and other healthcare executives, this study focused on women in the two groups. The researcher did not find any significant differences between Up & Comers healthcare executives and other female healthcare executives regarding leadership style or leadership outcomes. The difference between the results obtained in the current study and Wheatley's study may be due to the homogeneous groups and the argument that women are generally considered to have a more transformational leadership style than men (Appelbaum et al., 2003; Bass & Riggio, 2006; Eagly et al., 2003; Pounder & Coleman, 2002).

Details of findings are further discussed in Chapter 5, as are the implications and limitations of the study, along with recommendations for further research.

CHAPTER 5. DISCUSSION, IMPLICATIONS, RECOMMENDATIONS

Introduction

As the final chapter of this study, Chapter 5 reiterates the purpose of the study. A summary and discussion of the results is also covered in this chapter, along with the significance of the study. The researcher also highlights seminal work that focused on the FRL model that provided the theoretical foundation for the study. Recent research that inspired the methodology and target population with a focus on healthcare executives, to include leadership behaviors linked to gender differences, is discussed by the researcher in a summary of the results. Limitations encountered with this research and recommendations for further research also are provided in this chapter. The researcher closes the chapter with a statement addressing the study's contribution to the field of organization and management.

The purpose of this study was to evaluate the FRL model that relates the leader to leadership style and outcomes of leadership, controlling for gender of healthcare executives at medical facilities across the United States. The independent variables were defined as female Up & Comers healthcare executives and other female healthcare executives. The dependent variables are generally defined as leadership styles—transformational, transactional, and passive-avoidant. Leadership styles mediate outcomes identified as the leader's ability to motivate followers to exert extra effort,

leader's effectiveness, and followers' satisfaction with the leader. The control and intervening variables—gender and leadership characteristics—were statistically controlled in this study.

Summary of Results

This quantitative study was based on Wheatley's (2010) study of healthcare executives, who were divided into two groups of male and female Up & Comers award recipients and non-award recipients. Wheatley compared the two groups' leadership styles based on Bass's FRL model of transformational, transactional, and passive-avoidant/laissez-faire leadership styles (Avolio & Bass, 2004). The target population of this study was inspired by Wheatley's recommendation for future research that focused on female healthcare executives and the examination of their leadership styles that compared two groups of female healthcare executives: Up & Comers award recipients & non-Up & Comers award recipients.

The researcher identified two groups of female healthcare executives: Up & Comers award recipients and other female healthcare executives (non-Up & Comers award recipients). Wheatley's (2010) research provided valuable insight on leadership styles among healthcare executives and outcomes, with a recommendation for future research to identify if there is a statistical relationship between leadership style and gender. B. A. Wheatley (personal communication, January 25, 2013) clarified the scope of his recommended future research, noting the suggested research compare leadership styles of female Up & Comers healthcare executives and other female healthcare executives.

Wheatley (2010) noted a transformational leader is needed to lead healthcare organizations through 21st-century challenges. Leadership studies conducted among other industries revealed men rated higher as transactional leaders and women rated higher as transformational leaders (Bass & Riggio, 2006; Carless, 1998; Lantz & Maryland, 2008; Pounder & Coleman, 2002). During the time this study was conducted, 7,300 female healthcare executives were identified by Medical Marketing Service, 124 of whom were female Up & Comers, identified through *Modern Healthcare* (Burda, 2007a, 2007b, 2008, 2009, 2010, 2011, 2012; *Modern Healthcare,* n.d.).

The intent of this quantitative study was to capture data and identify if there is a statistically significant difference in leadership styles between female Up & Comers healthcare executives and other female healthcare executives. Findings of the study indicated there were no statistically significant differences in leadership style and outcomes of leadership between female Up & Comers healthcare executives and other female healthcare executives.

Discussion of Results

Leadership Style

Based on Avolio and Bass's (2004) FRL model, two groups of female healthcare executives—Up & Comers healthcare executives and other female healthcare executives—rated their leadership style using the MLQ 5X Short. Responding to 45 questions using a 5-point Likert scale, 55 participants rated 36 of the 45 questions that identified factors associated with Avolio and Bass's FRL model: transformational, transactional, and passive-avoidant. The responses were recorded on the MLQ scoring

key used to measure responses for each leadership style associated with the FRL model (Avolio & Bass, 2004).

The responses from both groups of female healthcare executives had similar score averages (as was shown in Table 6). One participant's responses were outside the standardized value identified by Tabachnick and Fidell (2012), with a score greater than 3.29 or less than –3.29. The response identified as an outlier was removed from the data set, decreasing the total participants to 54. The researcher answered Research Question 1 based on the data collected and measured using the MLQ scoring key and statistical analysis.

ResQ1: To what extent does leadership style vary between female Up & Comers healthcare executives and other female healthcare executives as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004)?

There were no significant differences between female Up & Comers healthcare executives and other female healthcare executives regarding the three leadership styles. Transformational leadership was rated highest and passive-avoidant leadership was rated lowest between both groups (as was shown in Table 7). Based on the data analysis, the researcher failed to reject the null hypotheses for Hypothesis 1:

H_o1: No statistically significant difference exists between female Up & Comers healthcare executives' and other female healthcare executives' leadership styles as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004).

Outcomes of Leadership

The MLQ (Avolio & Bass, 2004) consists of 45 questions, 36 of which measure factors associated with leadership styles and nine that measure outcomes of leadership. Female Up & Comers healthcare executives and other female healthcare executives responded to the questions using a 5-point Likert scale that identified factors associated with outcomes of leadership: leader's ability to motivate followers to exert extra effort, leader's effectiveness, and followers' satisfaction with the leader (Avolio & Bass, 2004). The responses were recorded on the MLQ scoring key and measured for outcomes.

The responses from both groups of female healthcare executives had similar averages. The highest outcome of leadership score was the effectiveness scale; the lowest outcome of leadership score was the extra effort scale (as was shown in Table 8). The measurements using the MLQ scoring key and findings provided the response to Research Question 2:

ResQ2: To what extent do female Up & Comers healthcare executives and other female healthcare executives vary in terms of the outcomes of leadership as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004)?

There were no significant differences between female Up & Comers healthcare executives and other female healthcare executives regarding leadership outcomes. Based on the data analysis, the researcher failed to reject the null hypotheses for Hypothesis 2:

H_o2: No statistically significant difference exists between female Up & Comers healthcare executives' and other female healthcare executives' outcomes of leadership as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004).

Implications of the Study Results

The statistical analysis of the data collected for this study indicated there were no significant differences of leadership styles or outcomes between the two groups of female healthcare executives. Findings of the study may be a reflection of the demographic make up of participants. A majority of the participants from both groups were white females between the ages of 50 and 65. The similarities in self-perception of leadership characteristics may be associated with race and age influenced by socialization and environmental factors, a reflection of the era in which the participants were raised.

The researcher thought the convenience of accessing an online survey would generate greater participation among the younger technical-savvy healthcare executives. The researcher expected a higher response rate among recent Up & Comers award recipients based on curiosity about the study, their recent success as healthcare executives, and their comfort with technology. However, there was no representation of Up & Comer award recipients between 2010 and 2013.

One style of leadership does not fit all (Vecchio, 1987; Weiskittel, 1999). The current research implies that a specific leadership style is not necessary in hospital administration. The dynamics associated with human relations such as, interactions between leaders and followers, co-workers, providers and patients; to include customer relations need a leader that can adapt to varying situations and challenges. According to Eagly, et al., (2003) and Lantz & Maryland (2008) women are people oriented, instill trust, communicate how and why task are necessary, they encourage as well as welcomed followers' input, and promote teamwork and group decisions.

Isolating women in the two groups as Wheatley (2010) suggested for the current study provided different findings than revealed in his own study. The current study indicated no significant differences between the two groups of female healthcare executives regarding leadership style. In the absence of male participants, it may be implied or considered anecdotal evidence that female Up & Comers healthcare executives have a greater tendency to practice transformational leadership than their male colleagues.

The two groups of female healthcare executives are separated by those awarded the Up & Comer Award and non-award recipients. One thing the two groups have in common is gender that may account for similar responses on the MLQ that identified leadership style and leadership outcomes. The similarities in leadership styles may be a result of a female's ability to adapt to changing situations, a reflection of situational leadership (Hersey, Blanchard, & Johnson, 2001; Hersey, Blanchard, & Natemeyer, 1979). Riger (2000, p.109) noted, females tend to be "more democratic or participatory", understanding the needs and desires of others (Eagly, et al., 2003; Riger, 2000) that would enhance leadership outcomes.

Organizational Implications

Receiving the Up & Comer Award does not mean the individual is a better leader or the answer to leading an organization to success. The organization's challenge is to find the best fit for their organization. Based on these findings the researcher would question if the organization is looking for a leader to fit into their existing culture or a leader that possesses transformational leadership skills.

Limitations

Limitations with this research were associated with the quantitative methodology, response rate, electronic survey distribution, and participants. As technology has evolved over the past 20 years, so have the threats and challenges associated with network security that subject the method of electronic distribution to limitations. The researcher had no guarantee that female Up & Comers would be included in the sample population due to the inability to differentiate between the two targeted groups in the sample. Finally, the human factor associated with participants that may be due to social desirability, culture, values, experience, or fear of being identified could have influenced participation and responses.

Methodology

Following Wheatley's (2010) methodological approach, several limitations were identified that existed with the current research. Wheatley stated that excluding organizational and situational factors would not provide insight to the effects that such dynamics would have on leadership styles. Restricting data collection to capture only the rater's self-assessment does not offer a well-rounded view of the leader's characteristics as perceived by supervisors, peers, and/or followers that might provide a better understanding of the female healthcare executive's leadership style (Wheatley, 2010).

Medical Marketing Service identified a large population and sample size of female healthcare executives, but did not have the ability to segment the list to identify Up & Comers. Each participants self-identified as an Up & Comers award recipient by her response on the demographic questionnaire. The researcher relied on accurate responses, but there was no process to validate them. The responses were anonymous,

rendering it impossible to identify who was responding or to cross-reference to determine if the participant was an Up & Comers award recipient or not. No sources were available to identify Up & Comers' contact information. *Modern Healthcare* used to provide an e-mail addresses in the annual issue that announced the current year's Up & Comers award recipients. However, this practice was discontinued years ago. LinkedIn has an Up & Comers group exclusive to Up & Comers; one must be an award recipient to join the group. Requests to submit surveys via LinkedIn to the Up & Comers group were denied by the site. Recruiting Up & Comers was done blindly and created concern with the recruiting methodology that there would not be enough participants to move forward with the research.

Response Rate

A low response rate contributed to the study's limitations. The survey instrument was disseminated via e-mail with a link to access the consent form, MLQ 5X Short, and demographic questionnaire. The survey link remained active for approximately 72 days: December 26, 2013, to March 7, 2014. Two reminder e-mails were sent on January 16, 2014, and February 12, 2014. The researcher identified two factors that may have contributed to the low response rate: the time the survey was initiated (during the holiday season) and the verbiage used in the recruitment letter. The consent form was identified in the recruitment e-mail as an informed consent form. In the healthcare industry, an informed consent is given to patients addressing potential risk prior to a medical procedure. With a targeted population of medical professionals, the incorrect identification of the consent form may have caused disinterest, resulting in potential participants deciding to opt out by not clicking the link to access the consent form and

participating in the study. Medical Marketing Service provided a report that indicated there had been numerous clicks that opened the recruitment e-mail, with lower results of clicking the link and even lower results for recipients completing the survey. Cost and time further limited the researcher's ability to correct and redistribute the recruitment e-mail.

The low response rate may not provide a good representation of the total population of female Up & Comers healthcare executives and other female healthcare executives. The majority of respondents (73%) were between the ages of 50 and 65, and one was between the ages of 66 and 70, representing an era that influenced perceptions of which types of leadership behaviors were acceptable among women (Appelbaum et al., 2003; Bem, 1974; Eagly et al., 2003; Gilligan, 1982; Lantz & Maryland, 2008; Pounder & Coleman, 2002; Riger, 2000). A mixed methodology may have afforded the researcher an opportunity to conduct interviews to gain a better understanding of the quantitative data.

The average response rate in reference to the healthcare industry is 53.8%, according to Baruch and Holtom (2008). Baruch and Holtom examined existing data from 463 studies to identify return rates between 2000 and 2005. Return rates were based on several distribution methods, to include e-mail. Wheatley's (2010) study had a 42% return rate based on a similar population as the current research that involved Up & Comers healthcare executives and other healthcare executives. Wheatley used the same survey instrument (MLQ 5X Short) and used e-mail as the method of survey distribution. For the current study, the researcher used an e-mail broker whose response rates for hospital personnel and executives is 7.9% (J. Stormzand, personal communication,

November 10, 2014). The lack of interest to participate in this study may have been enhanced through offering some type of incentive to participants.

Electronic Survey Distribution

Limitations encountered with electronic survey distribution were related to recipients not opening the e-mail and recipients deleting the e-mail. A report provided by Medical Marketing Service identified activity associated with the e-mail, total clicks, clicks that open the e-mail, and clicks on the embedded link. Participants may not want to click on the link in fear of a virus. Although reminder e-mails were sent to potential participants, the researcher did not have the ability to identify returned e-mails returned if an e-mail account was no longer valid or rejected for other reasons. The e-mail was initially sent out during the Christmas and New Year's holiday, so with the possibility of recipients being away on vacation, the e-mail may have been buried among all the other incoming e-mails and deleted or not received due to a full inbox. Connectivity or network security may have interfered with the delivery of the e-mail and not allowed the e-mail to go through or disabled the link embedded in the e-mail.

Recipients may have decided not to participate or to discontinue the process after they started. There is the potential that someone other than the intended recipient responded to the survey; this happens if the recipient is too busy or the e-mail is delegated to an alternate in the recipient's absence. The process of having to click through several links, reading and acknowledging the consent form, and responding to survey questions followed by demographic questions may have been viewed as too time consuming (Dommeyer & Moriarty, 2000; Evans & Mathur, 2005; Frippiat & Marquis,

2010; Griffis et al., 2003; Hirt-Marchand, 2005; Kaplowitz et al., 2004; Oppermann, 1995).

Participants

As noted in the Implications of the Study section, the majority of respondents were baby boomers, ages 50 to 65. These women were born and raised during a time when behaviors associated with femininity were expected. Femininity was related more to interpersonal and emotional attributes recognized as "expressive orientation" (Bem, 1974, p. 156), and female leadership styles were perceived to be "more democratic or participatory" (Riger, 2000, p. 109). Thus, this age group's self-rating of leadership behaviors may have been influenced by what they believed to be acceptable behavior as a reflection of the era in which they grew up.

Finally, the participants provided a self-assessment of their leadership behaviors and the outcomes their leadership had on followers. These results may not be accurate if participants are too critical of their performance or, at the other end of the spectrum, they overrate their behavior and outcomes. Having the leaders as well as their peers, supervisors, and followers rate their leadership behaviors and perceived outcomes of leadership would have provided feedback from different levels that could offer opportunities for further research.

Recommendations for Further Research

Following this study, areas of concerns and different approaches were identified by the researcher that may provide a greater insight to leadership in the healthcare industry and among Up & Comers healthcare executives. Further research should include

peers, supervisors, and followers, as previously noted, in addition to the leader's self-assessment. A mixed methodology or qualitative approach may provide greater insight to the dynamics of the leader–follower relationship in the healthcare industry.

Participants should consist of followers in different layers of the organizational structure (e.g., directors, middle managers, care providers, administrators, and personnel working in the treatment facility such as technicians). The different levels of raters could assist in capturing data associated with leadership style and outcomes. Further research could examine if leadership styles and outcomes are perceived differently by followers at different levels in the organizational structure or layers of leadership between the healthcare executive and follower.

A recommendation for future research might focus exclusively on Up & Comers healthcare executives and their followers to examine if there is a difference between the two groups' perceptions of leadership styles and outcomes. Another area of study to be considered among this target population might be to examine if there is a correlation between gender and leadership styles and outcomes and/or age and leadership styles and outcomes. Additional research may also be able to examine if differences between men and women exist by age category regarding leadership styles and outcomes among Up & Comers healthcare executives.

Wheatley (2010) found that Up & Comers healthcare executives were more transactional than the other healthcare executives. Thus, another recommendation for further research is a qualitative study to examine the organizational culture. Is there a correlation between organizational culture and executive leadership style in a healthcare

organization? Does organizational culture influence the leadership style or does leadership style influence the culture?

The recommended future research could contribute to the existing body of knowledge of organizational management with a focus on leadership in the healthcare industry.

Conclusion

This study examined the leadership styles and perceived outcomes of leadership of female healthcare executives. Female healthcare executives were divided into two groups, Up & Comers award recipients and non-award recipients, referred to as other female healthcare executives. The analysis of data generated for this study indicated there were no significant differences in leadership styles or perceived outcomes of leadership between female Up & Comers healthcare executives and other female healthcare executives as measured by the MLQ 5X Short (Avolio & Bass, 2004). The findings answered the following research questions:

ResQ1: To what extent does leadership style vary between female Up & Comers healthcare executives and other female healthcare executives as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004)?

ResQ2: To what extent do female Up & Comers healthcare executives and other female healthcare executives vary in terms of the outcomes of leadership as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004)?

Based on the findings the researcher failed to reject the null hypotheses for research question one and two. Findings indicated that female Up & Comers healthcare

executives and other female healthcare executives share common leadership characteristics and perceived outcomes of their leadership.

H_o1: No statistically significant difference exists between female Up & Comers healthcare executives and other female healthcare executives' leadership styles as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004).

H_o2: No statistically significant difference exists between female Up & Comers healthcare executives and other female healthcare executives' leadership in terms of the outcomes of leadership as measured by the Multifactor Leadership Questionnaire 5X–Revised (Avolio & Bass, 2004).

The similarities between Up & Comers healthcare executives and the other female healthcare executives may be associated with the age and race of the respondents; 93 percent of the respondents were White women with 74 percent between 50 and 70 years of age. This age group grew up during an era when socialization through childhood, education, the work environment, and politics may have influenced their self-perceptions of what behaviors are acceptable. Participants in this age group may have identified with traditional perceptions that identified behaviors associated with masculinity and femininity, what was and was not acceptable leadership behavior for women (Appelbaum et al., 2003; Bem, 1974; Eagly et al., 2003; Gilligan, 1982; Korabik, 1990; Lantz & Maryland, 2008; Pounder & Coleman, 2002; Riger, 2000).

Wheatley's (2010) study revealed there were no significant differences between Up & Comers healthcare executives and the other healthcare executives associated with transformational and laissez-faire leadership styles and perceived outcomes. Wheatley's

study, however, did reveal a significant difference between the two groups in relation to transactional leadership style and outcomes. Wheatley's sample population consisted of both men and women. The data collected and analyzed provided additional comparisons based on demographic data, but did not identify leadership styles associated with gender. Men made up roughly 62% of the Up & Comers who participated in Wheatley's study. Previous leadership studies that indicated female behaviors tend to be more transformational than do male behaviors (Appelbaum et al., 2003; Eagly et al., 2003; Lantz & Maryland, 2008; Pounder & Coleman, 2002), coupled with Wheatley's sample population and findings, were factors that motivated the researcher to focus on female Up & Comers healthcare executives.

The researcher posits there is more to learn about leadership in health care as it relates to the relationship between leader and follower. The recommendations for further research may provide insight of female and male healthcare leaders through a different lens, the follower's perception. Age and gender of the follower may also be another variable that influences perception of the leader's leadership style and outcomes of the leadership. The challenge is to gain access to this private group of Up & Comers and examine their behaviors to determine if there is a significant difference in leadership styles associated with gender and age. Ongoing research could contribute to the field of organization and management in health care.

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APPENDIX. STATEMENT OF ORIGINAL WORK

Academic Honesty Policy

Capella University's Academic Honesty Policy (3.01.01) holds learners accountable for the integrity of work they submit, which includes but is not limited to discussion postings, assignments, comprehensive exams, and the dissertation or capstone project.

Established in the Policy are the expectations for original work, rationale for the policy, definition of terms that pertain to academic honesty and original work, and disciplinary consequences of academic dishonesty. Also stated in the Policy is the expectation that learners will follow APA rules for citing another person's ideas or works.
The following standards for original work and definition of *plagiarism* are discussed in the Policy:

> Learners are expected to be the sole authors of their work and to acknowledge the authorship of others' work through proper citation and reference. Use of another person's ideas, including another learner's, without proper reference or citation constitutes plagiarism and academic dishonesty and is prohibited conduct. (p. 1)
>
> Plagiarism is one example of academic dishonesty. Plagiarism is presenting someone else's ideas or work as your own. Plagiarism also includes copying verbatim or rephrasing ideas without properly acknowledging the source by author, date, and publication medium. (p. 2)

Capella University's Research Misconduct Policy (3.03.06) holds learners accountable for research integrity. What constitutes research misconduct is discussed in the Policy:

> Research misconduct includes but is not limited to falsification, fabrication, plagiarism, misappropriation, or other practices that seriously deviate from those that are commonly accepted within the academic community for proposing, conducting, or reviewing research, or in reporting research results. (p. 1)

Learners failing to abide by these policies are subject to consequences, including but not limited to dismissal or revocation of the degree.

Statement of Original Work and Signature

I have read, understood, and abided by Capella University's Academic Honesty Policy (3.01.01) and Research Misconduct Policy (3.03.06), including the Policy Statements, Rationale, and Definitions.

I attest that this dissertation or capstone project is my own work. Where I have used the ideas or words of others, I have paraphrased, summarized, or used direct quotes following the guidelines set forth in the APA *Publication Manual*.

Learner name and date	Gregory A. Bullock, January 20, 2015
Mentor name and school	Cheryl McConnaughey, EdD, School of Business and Technology