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Leading consciously: examining global leadership self-awareness across healthcare executives

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LEADING CONSCIOUSLY: EXAMINING GLOBAL LEADERSHIP SELF-AWARENESS ACROSS HEALTHCARE EXECUTIVES

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TABLE OF CONTENTS

Page

LIST OF TABLES vi

LIST OF FIGURES vii

DEDICATION viii

ACKNOWLEDGMENTS ix

ABSTRACT x

Chapter 1: Introduction 1

- Problem Statement 4
- Purpose of the Study 4
- Importance of the Study 5
- Theoretical Framework 5
- Research Questions 8
- Scope of the Study 8
- Clarification of Terms 9
- Organization of the Study 12

Chapter 2: Literature Review 13

- 21st Century Leadership – The Future 14
- Leadership in Healthcare 18
- Global Leadership Competencies 24
- Self-Awareness in Leadership 37
- Conscious Leadership in the Literature 51
- The Self Aware Future Healthcare Executive 54
- Summary 55

Chapter 3: Methodology 57

- Research Approach and Design 57
- Research Setting 58
- Data Collection Strategies and Procedures 58
- Instrumentation 62
- Data Process and Analysis 68
- Statistical Analysis Process 69
- Summary 71

Chapter 4: Results 72

Overview 72
Descriptive Statistics 73
Comparisons of Means 81
Examining Relationships Between Variables 84
Predicting Self-awareness and Effectiveness 85
Summary 92

Chapter 5: Conclusion 95

Study Overview 95
Summary of Findings 98
Implications for Practice and Future Study 105
Global Conscious Leadership in Healthcare 109

REFERENCES 111

APPENDIX A: Pepperdine IRB Exemption Notification 127

LIST OF TABLES

Page

Table 1. Leadership Futurists Themes 15

Table 2. Healthcare SPELIT Quick View 19

Table 3. Healthcare Leadership Competency Models for the Future 22

Table 4. Global Leadership Levels 28

Table 5. Competencies Mapped to GL Competency Levels 33

Table 6. Kegan's (1994) Adult Stages of Development 48

Table 7. Variables for Data Analysis Procedures 60

Table 8. Definitions of Healthcare Core Competencies (Lombardo, 2017) 65

Table 9. Descriptive Summaries of Variables 74

Table 10. Descriptive Outcomes for Self-Awareness and Effectiveness Variables 79

Table 11. SPSS Results of Independent Samples t-tests – Gender 82

Table 12. SPSS Result of Independent Samples t-tests – Minority 83

Table 13. SPSS Result of Independent Samples t-tests – Clinical 83

Table 14. Correlation Matrix Between Self-Importance (SI) and Self-Awareness (SA) 85

Table 15. Analysis of L1 Self-Awareness and Gender, Minority, Profession 87

Table 16. Analysis of Level 1 Self-Awareness and Predictor Variables Including Age and Importance 88

Table 17. Regression Analysis on Self-Awareness (TotalSA) and Effectiveness 90

Table 18. Regression Analysis of Level 1 Self-Awareness (L1 SA) and Leadership Effectiveness 91

Table 19. Analysis of L1 SA and Leadership Effectiveness with Covariates 91

LIST OF FIGURES

Page

Figure 1. Literature review framework. 13

Figure 2. Histogram of courage self-awareness. 77

Figure 3. Histogram of integrity self-awareness. 78

Figure 4. Histogram of resiliency self-awareness. 78

DEDICATION

For my children

and the wisdom within them

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Who looking outside dreams; who looks inside, awakes. – Carl Jung

ABSTRACT

The well-being of people around the world and in every community depend on healthcare. Yet, exponential shifts in globalization, technology and the environment have destabilized healthcare systems across the globe. Hence, the future of healthcare is forecast to be volatile, uncertain, complex and ambiguous (Porter & Teisberg, 2006). To face current and future challenges, healthcare leaders will be expected to operate consciously and effectively while under extreme pressure. While a number of inter- and intra-personal characteristics and traits are associated with effective leadership through volatility, chief among them is self-awareness (Hernandez, Luthanen, Ramsel, & Osatuke, 2015). Unfortunately, however, no study has yet examined the degree to which self-awareness is associated with leadership effectiveness among healthcare leaders.

The purpose of this study was to address a clear gap in the existing literature by modeling global leadership self-awareness among healthcare executives using a sample of healthcare executives. The results of the empirical analysis will provide insight into the following questions: What factors predict self-awareness on Level 1 Global Leadership competencies of integrity, courage and resiliency? Is self-awareness on Level 1 Global Leadership competencies associated with leadership effectiveness?

A series of descriptive statistics and multiple linear regression analysis were conducted, leveraging 360-degree assessment data for nearly 100 executives in healthcare. The assessment measured 24 leadership effectiveness competencies and provided three scores: self, other and importance. The focus of the research was on the Level 1 competencies of integrity, courage and resiliency, as the foundational skills for global leadership. The effect of gender, minority status, age and professional background were included as covariates in the regression models.

In summary, the importance score was positively correlated with self-awareness. Age was found to have a positive relationship with effectiveness. Minority status showed a negative relationship with self-awareness scores, indicating higher over-claiming. Of the competencies, integrity self-awareness was found to be the most significantly related to leadership effectiveness. As integrity self-awareness decreased (higher over-claiming), effectiveness also decreased. Finally, the research highlighted the positive effect humility (under-claiming) has on effectiveness. The findings have fascinating implications for both practice and research for conscious global leaders in healthcare.

Chapter 1: Introduction

During one of his final official foreign affairs addresses, President Barack Obama issued a passionate call to action for the 21st century, calling for visionary leadership by American leaders in order to lift and lead the world (Obama, 2010). Rapid changes in technology, globalization, and the environment have made it difficult to predict what transformations may occur in the 21st century and beyond (Friedman, 2017). Governments around the world depend upon influential organizations to help tackle the challenges that rapid transformations may present (McQuivey, 2013). Organizations need to look beyond their own bottom line and become conscious of broader social and environmental impacts alongside organizational success (Pillay & Sisodia, 2011). The field of healthcare is likely to be particularly affected by these future shifts.

Healthcare leadership is currently facing extreme complexity, volatility, and regulatory pressure (Porter & Teisberg, 2006). This is in large part due to political shifts, payment model changes, and patients presenting with multiple morbidities (Porter & Teisberg, 2006). The goal of healthcare in the U.S. is to serve the needs of patients and communities, leading to health and wellbeing for communities. Therefore, executive leaders of large healthcare organizations hold a role which has a broad social impact beyond the organization's bottom line. This complexity requires effective leadership. Effective executive leaders shape the strategy and vision of an organization. They set the direction and align resources designed to meet the goals of the organization (Collins, McKinnies, & Collins, 2015).

Gawande (2010, 2014), renowned physician, leader and writer, argued that the increase in information has burdened leadership with an overabundance of knowledge, especially in healthcare. The Patient Protection and Affordable Care Act (ACA) shifted the payment models

of healthcare from fee-for-service to value-based purchasing (Love & Ayadi, 2016). This created a shared risk model and led to the evolution of the vertically integrated delivery system (Love & Ayadi, 2016). The demand that the market makes on healthcare is to provide high-quality, cost-effective, and patient-centric service delivery (Madden, 2015).

The patient population is another challenge facing the healthcare industry. As the "baby boomers" age, they are anticipated to increase the volume on the healthcare system (Wells & Hejna, 2009). Additional pressures result from evolving technology and the need for "meaningful use" of the electronic healthcare record as mandated by the American Reinvestment and Recovery Act, HITECH (Baker, 2001). These ambiguous and complex changes have created experiences of stress, confusion, and intensity for healthcare employees and leaders (Glasberg, Eriksson, & Norberg, 2007). Healthcare organizations have an opportunity to transform healthcare by leveraging this data and evolving technology for quality, patient-focused, system-oriented care (Love & Ayadi, 2016).

Because leaders in healthcare are responsible for the health of their communities, not just their organizations, they are required to lead in what can be considered a complex global context. Healthcare leaders, like other leaders of large matrixed organizations, cross a variety of relational boundaries in their leadership, not only by engaging with policymakers and government organizations, but also by engaging with other practitioners within their fields and across professional fields. They are responsible for the health and welfare of people living in the United States and those who culturally identify with countries around the world. To meet this challenge, healthcare organizations have begun to answer the former President Obama's call for visionary leadership and recognize the need to develop leaders who lead effectively, with wisdom and

purpose (Blouin, McDonagh, Neistadt, & Helfand, 2006). However, a challenge facing the field of healthcare is high rates of burnout.

Burnout rates in healthcare are at an all-time high, with 60% of physicians considering leaving the profession. With increasing demands on their personal energy, time and resources, physicians are reporting burnout at a rate of 54% (Perlo & Feeley, 2018). The challenges facing healthcare organizations are all factors in this increasing rate of burnout. Burnout leads to organizational turnover and reduces productivity, impacting an organizations ability to meet its mission (Glasberg et al., 2007). Development of self-awareness has been shown to reduce burnout syndrome and increase well-being (Hernandez et al., 2015). In order to succeed in achieving the conscious mission of healthcare, organizations need to support the development of self-awareness in executives.

Self-awareness has been identified as a global leadership competency model that is foundational for emotional intelligence (Osland, 2000). However, research indicates that many executives experience a lack of self-awareness regarding their leadership capabilities (Sala, 2003). In the ADKAR model, an individual change model used for organizational transformation (Hiatt, 2006), the first stage of all change is awareness. Internal self-awareness is an individual's understanding of their own personal goals, needs, purpose, and beliefs. External self-awareness is an individual's understanding of how others perceive them, including their strengths and weaknesses (Silvia & Duval, 2001).

Leaders show various levels of capability to lead in exponentially evolving environments due to factors such as previous experience and personality (Osland, Bird, & Mendenhall, 2006). Moreover, executives do not fit a singular archetype; their experiences, beliefs, values, and professional backgrounds are as diverse as they are (VanVactor, 2015). This variation in

background and training means that at the executive level, development is highly individualized ("Executive coaching: optimizing the potential of healthcare leaders," 2002). Narrowing the developmental focus to self-awareness allows for development at the individual level, meeting each executive where they are with the development support required to lead at a higher level and maximize leadership effectiveness.

Problem Statement

Due to exponential shifts in globalization, technology, and the environment, the future of healthcare is volatile, uncertain, and complex (Porter & Teisberg, 2006). To face these future challenges, healthcare executives will be asked to lead with greater wisdom and purpose. The field of healthcare is burdened with a high rate of burnout and decreased wellbeing (Glasberg et al., 2007). Research shows that developing self-awareness can result in higher rates of effectiveness, well-being and resiliency (Hernandez et al., 2015)**.**

Purpose of the Study

The purpose of this descriptive quantitative study was to model global leadership self-awareness across healthcare executives. Leadership self-awareness is difficult to identify and measure (Silvia & Duval, 2001). The literature is replete with evidence that executive development, such as executive coaching, is effective in the development of self-awareness and leads to greater leadership effectiveness ("Executive coaching," 2002). However, gaps in the literature exist regarding the factors that impact self-awareness in leadership and the relationship between self-awareness and leadership effectiveness (Showry & Manasa, 2014). Scholars have called for additional research to address these gaps and attain a deeper understanding of what constitutes conscious leadership (Hofman, 2008). This study was designed to advance the body

of knowledge about leadership self-awareness and effectiveness, which are defined as "conscious leadership" for the purposes of this study.

Importance of the Study

Currently, there is no universal agreement on the definitions of competent leadership or global leadership in healthcare. The findings of this study contribute to the literature on healthcare and global leadership development, conscious leadership, and self-awareness in leadership. From a practitioner's standpoint, the field of human resources and talent management needs to respond to the pressures of the business by deepening the evidence-based practice of executive leadership development. In addition, by adding to the academic canon on the development of self-awareness, this study advances the field of professional executive coaching. This study provides information that may enable practitioners in the fields of human resources, talent management, leadership development, and executive coaching to deepen their programmatic approach to the field of business and organizational development.

Theoretical Framework

The study is founded on a worldview which acknowledges that the researcher's background, experience and beliefs may influence what is observed. Therefore, the study is grounded in the global leadership competency framework developed by Cumberland, Herd, Alagaraja, and Kerrick (2016), in Silvia and Duval's (2001) objective self-awareness theory, and in Robert Kegan's (1994) constructive-development theory.

Global leadership competency framework. Cumberland et al. (2016) identified three key global leadership competency levels through an exhaustive literature review on global leadership: personality traits, knowledge and skills, and behaviors. These competencies can only develop through a concentrated focus in four areas: self-awareness, didactic training, experiential

opportunities, and immersion (Cumberland et al., 2016). The competencies vary from traditional leadership models, as they focus not only organizational skills but also on emotional and cognitive intelligences. By looking at these additional dimensions, a picture of the effective global leadership that is required for successful healthcare leadership can be assessed (Cumberland et al., 2016). The focus of this study is on development in the area of self-awareness, specifically in competencies of level 1, personality traits.

Objective self-awareness theory. What a leader knows intellectually—skills and knowledge—may be less important than how they know themselves, as well as the impact they have on others. Self-awareness is the ability to recognize oneself as separate from others and the environment (Wicklund & Duval, 1971). The process by which an individual comes to understand their own drives, needs, desires, and character is known as internal self-awareness. The ability to evaluate oneself based on the perceptions of others is external self-awareness (Wicklund & Duval, 1971). In the early 1970s, Wicklund and Duval (1971) introduced a theory of objective self-awareness and analyzed the conditions that cause the consciousness to focus on the self as an object. This self-focus allows for self-evaluation. If an individual has reasonable self-standards and optimism about achieving their goal, then increased self-awareness leads to success (Silvia & Duval, 2001). Low self-awareness promotes arrogance, whereas high self-awareness promotes a foundation for developing competencies and skills. Self-awareness has been shown to lead to perspective-taking, self-control, and pride (Silvia & Duval, 2001).

Self-awareness is often cited as a key component of effective leadership (Eurich, 2017). Self-awareness as a leadership construct refers to the extent to which a leader is aware of their own strengths and weakness and how others perceive them in the workplace (Avolio & Gardner, 2005). Research suggests that when leaders see themselves clearly, they are more effective. They

make more ethical decisions, build stronger teams, and communicate more effectively (Silvia & Duval, 2001). Executives who lack self-awareness perceive themselves differently than others do. People tend to judge themselves by intent, while others judge their effectiveness by their actions. The self-serving bias leads individuals to misjudge their own weaknesses; consequently, it can result in destructive behaviors and career derailment (Tang, Dai, & De Meuse, 2013). As an individual's self-awareness develops, their world-view shifts to an expanded understanding of consciousness.

Constructive development theory. In Kegan's (1994) constructive-development theory , adults continue to grow beyond childhood; specifically, this theory outlines a process of five stages of consciousness. Adults learn and grow through their ability to construct meaning based on experiences (Kegan, 1994). Like children, adults move through these stages at different rates, and they can become arrested at one stage such that they become unable to move onto the next phase. Becoming a more conscious adult means developing a more independent sense of self, as measured by relationship to others. Transitioning between levels requires continued expansion of self-awareness as the individual's approach to meaning-making expands. Expanded self-awareness leads people to greater sense of the world around them and the social and cultural factors that impact them (Kegan, 1994).

These three connected theories of global leadership competency, self-awareness in leadership, and constructive-development theory create a framework for conscious leadership development. The study is founded on these theories to address research questions, which examine the relationship between Level 1 Global Leadership competency, self-awareness and leadership effectiveness

Research Questions

This study addressed the following main research questions:

RQ1: What factors predict self-awareness on Level 1 Global Leadership competencies of integrity, courage and resiliency?

RQ2: Is self-awareness on Level 1 Global Leadership competencies associated with leadership effectiveness?

These questions were addressed through an analysis of executive leadership competency data collected from a healthcare organization. Based upon 24 leadership competencies, participants received a score on a 5-point Likert scale in three different areas: how important they believe the competency is, their self-reported skill level on that competency, and a combination score of all other raters who provided input on effectiveness related to each competency.

Scope of the Study

This study is focused on leadership in a non-profit healthcare system geographically located in Northern California, serving patients in the local communities. The 97 leaders who participated in the survey were currently holding executive level roles in the organization. Survey respondents varied by location, profession, and level of executive power, as well as demographic characteristics such as gender, ethnicity, and age.

Delimitations. Delimitations are decisions made to set boundaries for the study, including the research questions, variables, and objectives of the study (Creswell, 2012). The population of the study was constrained to healthcare leaders in Northern California in order to situate the study in the field of healthcare as a primary objective. A large healthcare system was selected to represent healthcare leaders who lead across organizational, economic, and cultural

boundaries within a complex environment. The research questions were selected to focus on the concept of self-awareness in leadership. The data were previously collected by the talent management department of the organization, which enabled the researcher to leverage existing data, reducing time and effort of data collection.

Limitations of the study. The research is limited by the population of leaders who participated in the original survey, which was initially administered for leadership development purposes. The participants' responses may have been affected by the stress or discomfort of responding to questions related to their own leadership competencies. Bias and judgement are also inherent in any subjective cognitive process, such as assessing one's own or others effectiveness (Kruger & Dunning, 1999). This study is specifically scoped to one organization in one large geographic area and a specific industry. The findings of this study will not be generalizable but will be transferable, and similar studies can be conducted with other data sets, including data from other industries and locations. This study is also limited to the United States and could be repeated to include an international population.

Assumptions of the study. The researcher made the following assumptions within the study:

1. The organization was willing to provide the data for analysis.
2. Participants were forthright in their original assessments of self and importance.
3. Raters accurately identified participants' skill levels.

Clarification of Terms

In this section, terms used throughout the study are defined in order to clarify their meanings within the context of healthcare leadership.

Constructive development. "Constructive" refers to building meaning through interpretation of one's experiences. "Development" refers to changes that occur in biological and psychological human life and become more complex over time. This study is concerned with adult development, defined as human development that occurs beyond adolescence. There are few adult development models found in the literature that have been applied to leadership studies; Robert Kegan (1994) was the first to coin the term, which was determined to be applicable for this study. The Kegan model of adult development is broken into five stages.

Courage in leadership. A courageous leader provides constructive feedback to others, faces up to people problems quickly, takes action when needed, and does not hold back what needs to be said (Eichinger & Lombardo, 2003).

Conscious leadership. Conscious leadership refers to the purpose-driven practice of leadership by individuals who lead with awareness of self (intrapersonal), others (interpersonal), and the environment (cognitive).

Executive level. Defined as an organizational level of director or above. A director is a leader who has responsibility for budgets and management covering more than one function or location.

Factors/characteristics. These terms are used interchangeably to describe the various demographic factors of the participating leaders, i.e. gender, ethnicity, profession and age.

Global leadership. For the purposes of this study, global leaders are defined as those with an impact beyond their immediate responsibilities. Global leaders lead in a socially, politically, environmentally, legally, interculturally, and technologically complex environment. Therefore, global leaders are not only responsible for outcomes within their chain of command; they also make decisions that are not confined by organizational boundaries.

Importance score. How important individuals believe a competency to be in the context of their leadership role.

Integrity in leadership. A leader with integrity is seen as direct and truthful, is widely trusted, presents the truth appropriately, keeps confidences, admits mistakes, and does not misrepresent herself for personal gain (Eichinger & Lombardo, 2003).

Leadership competency. Competency in leadership is defined as those skills and behaviors that lead to effectiveness. Competency models allow organizations to determine what skills are needed in specific roles and make informed decisions regarding hiring, developing, and promoting leaders into more senior roles (Boyatzis, 2008a).

Leadership effectiveness. Leadership effectiveness is defined as overall leadership competency, measured by the total others-score across all 24 global leadership competencies.

Level 1 Global Leadership competency. Cumberland et al. (2016) defined these competencies as personality traits. They reflect work conducted by Mendenhall et al. (2017), who described these traits as the threshold for a global leader. They are seen as necessary and traditionally regarded as hiring challenges, as opposed to development opportunities (Mendenhall et al., 2017).

Other-score. The rating per competency of an individual by all others selected, including managers, peers, customers, and direct reports.

Resiliency. A resilient leader is comfortable dealing with ambiguity; can effectively cope with change and change gears; can act without the total picture; and comfortably handles risk and uncertainty (Eichinger & Lombardo, 2003).

Self-awareness. Self-awareness is defined as the conscious knowledge of one's own character, emotions, behaviors, motives, and needs. External self-awareness is an individual's

awareness of how others perceive them and how their personal behavior impacts others (Silvia & Duval, 2001).

Self-score. An individual's rating of his or her level of skill in each competency, indicated on a Likert scale from 1 (*serious issue*) to 5 (*towering strength*).

Organization of the Study

The study is organized by a traditional research framework and divided into five chapters. Chapter 1 begins with the premise of the study. It includes an overview, the purpose of the study, and the theoretical framework. It also includes the background of the issue and the situational context for the study. Chapter 2 provides a description of healthcare leadership, global leadership competency, and self-awareness. It reviews the most current and relevant literature the topic of conscious leadership, along with a review of related concepts and research. Chapter 3 details the methodology of the study, including the research design and descriptions of the instrument and procedures used. Chapter 4 presents the research findings, including the statistical analysis and the interpretation of the data. Finally, Chapter 5 provides a concluding overview of the entire study, a discussion of the findings, and recommendations for practical application and future research.

Chapter 2: Literature Review

The purpose of this descriptive quantitative study was to model global leadership self-awareness across healthcare executives. In a rapidly changing environment, the world's future is unknown and unpredictable (Johansen & Euchner, 2013). As these changes compound, 21st-century leadership is required. While all industries are impacted by this evolution, the field of healthcare is particularly important to communities (Delmatoff & Lazarus, 2014). Therefore, identifying, assessing, and developing effective and competent leadership in healthcare is crucial for individuals, communities, and the world.

The framework of this literature review begins with the foundations of 21st-century leadership, leadership in healthcare, and global leadership competency. This is followed by a review of literature on self-awareness in leadership studies and the concept of conscious leadership. This time-bound literature review examines these issues by focusing on the most relevant and recent literature related to each concept. The purpose of this literature review is to situate the research within the scholarly conversation on the future of healthcare leadership—specifically global leadership, self-awareness in leadership, and conscious leadership. Gaps in the literature will be identified, and a justification for the study will be discussed. Figure 1 illustrates the thought framework for this study.

The FUTURE of Leadership

➔ 21st century leadership ➔ healthcare leadership ➔ global leadership competencies

➔ self-awareness in leadership ➔ conscious leadership

Figure 1. Literature review framework.

21st Century Leadership – The Future

Futurology can simply be defined as the study of the future (Singh & Singh, 2018). Futurists are social scientists who explore predictions and possibilities of the future by drawing on trends and relying upon systems thinking (Potts, 2018). An understanding of the current state and a consideration of the past is required in order to predict future scenarios and determine their plausibility (Bierman, Jette, Silverman, Splaine, & Wasson, 1998). As the years move on, the present state evolves, and a better understanding of the past is constructed. Therefore, when considering a future state of leadership, the most recent literature will be grounded in the most current present moment. For this reason, literature published post-2014 is primarily considered in this review.

Futurist Thomas Freidman defined the year of 2007 as a cataclysmic year of change in our world due to the launch of the iPhone (Friedman, 2017). Since that time, the world has experienced an accelerating pace of change. Evolutionary psychologist Yuval Harari (2016) proposed that for the first time in history, the changes in people's surroundings outpace people's ability to evolve with those changes. To understand the complexity of the environment, Freidman (2017) theorized that there are three key forces: Moore's law (technology), the Market (globalization), and Mother Nature (climate change and biodiversity) (Friedman, 2017). In order to fully realize the potential this evolution is unveiling and to make sense of the chaos it may entail, leaders around the world will be looked to as a source of grounding and inspiration. Future leaders will be called to reimagine work, politics, and community (Harari, 2016).

A search on Google Scholar and Pepperdine University's EBSCO Host search engines for *leadership* following the year 2014 returns over 1,000,000 results between the two. The *future of leadership development* provides 566,000 results, and *21st century leadership* provides

62,100. Many of these, however, were too broad or too limited to specific instances and applications; they were not meaningfully illustrative of a modern approach to leadership in the 21st century. Therefore, narrowing the search to *leadership futurist(s)* illuminates 5,620 responses. By focusing on the most often cited (50+) authors published as leadership futurists, eliminating specific audiences or industries beginning in 2014, the most modern future thinking is unveiled. Table 1 lists the futurists identified by this search, summarizes the key leadership construct in their concept, and describes their vision of future-focused leadership.

Table 1

Leadership Futurists Themes

Futurist	Key Leadership Construct	Future-Focused Leadership
Reframing Organizations (Bolman & Deal, 2017)	Leadership theories and studies are oversimplified; reframing is needed. Development is needed at the individual level using the 4 theoretical frames: structural, human resources, political and symbolic.	Wise leaders understand their own strengths, work to expand them, and build diverse teams.

(continued)

Futurist	Key Leadership Construct	Future-Focused Leadership
"Reviewing leadership styles: Overlaps and the need for a new 'full-range' theory" (Anderson & Sun, 2015)	A review of the most recently studied leadership styles: ideological, pragmatic, servant, authentic, ethical, spiritual, integrative, shared/distributed, transformational, charismatic, and transactional. The analysis leads to a discussion of the need for a "full-range" concept of leadership.	The behaviors of leadership can be aligned to identities. These identities are tied to ego development.
Leading with Wisdom (Pruzan, Mikkelsen, & Miller, 2007)	Research focused on the spiritual life of leaders, including purpose, values, growth, and personal evolution. This volume draws on many religious backgrounds.	Lead with integrity and the confidence in order to be a joyful leader. In this way, life and leadership unfold from a conscious life.
Leading with Meaning (Pava, 2015)	Drawing on the Jewish tradition and ancient texts, this book illustrates that traditional resources can help solve current and future problems. Pava defined success beyond financial wellbeing, including social responsibility, ethical behavior, and concern for the environment.	The future leader is not a servant but a teacher, who shows students how to use yesterday's lessons to solve tomorrow's problems.

(continued)

Futurist	Key Leadership Construct	Future-Focused Leadership
Competing Values Leadership (Cameron, Quinn, DeGraff, & Thakor, 2014)	Core dimensions of a competing values framework. Values can be illustrated on a quadrant framework showing a continuum from internal to external, flexibility to control. Leaders and organizations span this model; the right approach depends on the situation.	There is not just one effective leadership strategy; leaders must be aware of their environment and the needs of the organization. To do this, they must also be aware of how they impact this values framework.
The New Leadership Literacies (Johansen, 2017)	Through a futurist lens, Johansen provides a framework for "thriving in a future of extreme disruption and distributed everything." This suggests a future leadership practice of foresight, insight and action. Leadership is about clarity and flexibility.	The future must focus on skills combined with discipline, practice, perspective, and worldview.

Leadership futurists support the themes described by Friedman (2017), agreeing that the future will continue to be experienced as volatile, uncertain, complex, and ambiguous (VUCA) (Johansen & Euchner, 2013). The futurists speak to leadership behaviors which will become more important in this shifting environment. This does not mean that traditional leadership competencies are not important or valid; it just means that a more evolved approach should also

focus on the interpretation of meaning, rather than focusing only on skills and behaviors. These futurists do not point to a single clear way forward for the future of leadership. They agree, however, that to successfully navigate the complexities of the future, leadership development is an essential element worthy of future study.

Leadership in Healthcare

A search of the terms *healthcare executives, healthcare executive competencies,* and *healthcare leadership* on Pepperdine's EBSCO host and Google Scholar reveal a wealth of information and emerging research. The majority of the reviewed articles begin by situating the conversation in the current environment of healthcare and specifically addressing the challenges that face executives. These challenges highlight the need to focus on healthcare leadership to create solutions.

A scan of the healthcare environment through the organizational environmental tool, the SPELIT power matrix themes emerges (Schmieder-Ramirez & Mallette, 2007). The SPELIT framework examines the environment through the lens of social, political, environmental, legal, intercultural, and technological issues. The environmental scan gives a frame through which to examine the various issues that face healthcare and as a field and the problems through which healthcare executives are being asked to lead. In Table 2 below, a SPELIT quick view is offered, providing the overview of the issues through the model.

Table 2

Healthcare SPELIT Quick View

S: The patient and employee population are changing. Patients are aging and presenting with co-morbidities.	I: The interaction between the employee, the community and the caregiver grow in importance and complexity.
P: The Affordable Care Act (ACA) and intense cost pressures are a continuing focus of the political landscape.	L: Organizations are under pressure to meet the ACA mandated rules; they also face pressure to comply with Health Insurance Portability and Accountability Act (HIPPA) regulations.
E: The environment is shifting and causing changes in population health and wellbeing.	T: The electronic healthcare record mandated by the Health Information Technology for Economic and Clinical Health Act (HITECH), is complex and expensive.

Note. Adapted from *Redefining Healthcare* by M. Porter, M., & E. Teisberg, 2006, Cambridge, MA: Harvard Business School Press. Copyright 2006 by Harvard Business School Press. Reprinted with permission.

Burnout among healthcare leaders. Burnout syndrome (BOS) is an unintended consequence of the environment of healthcare (Embriaco, Papazian, Kentish-Barnes, Pochard, & Azoulay, 2007). Burnout increases costs and decreases effectiveness due to turnover. However, a significant amount of BOS is preventable, and strategies can be deployed to reduce or eliminate this condition (Embriaco et al., 2007). Studies have shown that personal changes, organizational changes, or a combination of the two have positive impacts on decreasing dimensions of burnout (Awa, Plaumann, & Walter, 2010).

In a study conducted by researchers at the Mayo Clinic, nine strategies to address burnout were discussed: (a) acknowledge the problem, (b) harness the power of leadership, (c) develop interventions, (d) cultivate community at work, (e) use rewards wisely, (f) align values and strengthen culture, (g) promote work-life integration and flexibility, (h) promote resilience and self-care, and (i) fund research (Shanafelt & Noseworthy, 2017). Research has shown that the development of self-awareness develops leadership, leads to internal alignment of values, and promotes resiliency (Hernandez et al., 2015).

Studies have illustrated the positive impact of self-care practices, including mindfulness-based interventions (MBI), on burnout and stress. Mindfulness is primarily a practice of the development of self-awareness (Siegel, 2007). One study focused on healthcare providers who attended a mindfulness-based education program. The attendees spanned the healthcare employees of one organization, including a cross-section of all employees (Goodman & Schorling, 2012). The pre-post observations study at a university medical center used the MBI and a self-perceived mental and physical well-being measure. The results showed that MBI was associated with improvement across all three factors of burnout: emotional exhaustion, depersonalization, and personal accomplishment (Goodman & Schorling, 2012).

The organization can provide other preventative strategies through communication structures or leadership and organizational support. Because emotional exhaustion is related to interpersonal relationships, key support strategies for reducing this form of burnout include improving interpersonal communication, providing space for sharing experiences, and establishing a direct connection to the value provided (Embriaco et al., 2007). Studies have shown that providing structures which encourage communication between peers, employees,

managers, and social networks can contribute to lower levels of burnout and higher levels of wellbeing (Awa et al., 2010).

The Mayo Clinic has issued a call to reduce burnout by "harnessing the power of leadership" (Shanafelt & Noseworthy, 2017). In a 2013 study of Mayo Clinic physicians, a 1-point increase in the leadership score (60-point scale) of a physician's direct manager resulted in a 3.3% reduction in burnout ($p < .001$) and a 9% increase in satisfaction ($P < .001$), adjusting for specialty, gender, and age. The way to harness leadership power is to hire and promote leaders who can engage, develop ,and lead physicians (Shanafelt & Noseworthy, 2017). It is also paramount that these leaders must also seek to continuously improve and develop themselves.

In an Institute of Healthcare Improvement (IHI) study, researchers call for the reframing of burnout, turning the focus to finding meaning and satisfying work. The IHI has proposed this reframing as a renewed focus on the "Joy of Work" (Perlo & Feeley, 2018). Developing a culture of joy (or management practices that support joy) within the workplace results in benefits that increase engagement, reduce burnout, and increase quality (Perlo & Feeley, 2018). To do this, the IHI is drawing on literature from positive organizational scholarship and positive psychology, among other fields. This is also supported by the development of internal self-awareness, which leads to greater joy and reduced burnout (Hernandez et al., 2015).

Healthcare leadership competencies. A competency is a skill that prepares an individual to perform a task, in this case leadership (Lievens, Sanchez, & De Corte, 2004). Competencies can be viewed as external or internally focused skills. Cognitive skills are skills that can be taught, repeated and measured and are therefore externally visible. Internal skills are skills that are intra- and interpersonal. These skills are often cited as components of emotional

intelligence (Goleman, Boyatzis, & McKee, 2013). Traditional competency models and management skill models focus on cognitive skills.

However, emerging competencies are needed in order to manage in a complex environment, across hospitals, ambulatory centers, ancillary providers, and physician practices (Love & Ayadi, 2016). The competencies required for future of healthcare leadership are beginning to include both internal and external skills. Five models for future skills of healthcare leadership are illustrated below in Table 3. The competency buckets and the skills are listed as either external (something a leader knows or does) or internal (something a leader has as a personality trait or an emotional skill).

Table 3

Healthcare Leadership Competency Models for the Future

	Love & Ayadi (2015)	Stefl (2008)	Madden (2015)	Wells & Hejna (2009)	Hargett et al. (2017)
I	Comfort with change	Leading the way	Agility	Self-awareness	Emotional intelligence
	Way of leading	Relationships	Passion	Compelling vision	Selfless
		Professionalism	Influence	Real way with people	Integrity
			Integrity & Drive		

(continued)

	Love & Ayadi (2015)	Stefl (2008)	Madden (2015)	Wells & Hejna (2009)	Hargett et al. (2017)
E	Quality and finance	Knowledge of healthcare	Business skills	Knowledge healthcare	Teamwork
	Practice management	Business skills and knowledge	Communication	Masterful execution	Critical thinking

The majority of these future-focused competencies are internal, or trait-based. Love and Ayadi (2015) interviewed 12 senior executives in healthcare to understand the skills needed for the future in this industry, leadership was ranked as number one. Stefl (2008) described leadership as the ability to inspire excellence in individuals and organizational to create and attain a shared vision and to successfully manage change to attain the organization's strategy. Madden (2015) varied from a traditional business-oriented model by including personal leadership traits such as passion. Wells and Hejna (2009) specifically called out self-awareness as a key competency. Hargett et al. (2017) used a mixed method study to describe 300 competencies in five buckets, now referred to as the Duke Healthcare Leadership model, including the patient at the center. As different as the language in these models may be, what is clear is that skills beyond the cognitive are a threaded throughout as a key focus area for healthcare leadership in the future.

Healthcare leadership of the future. To meet the complex demands of the future and lead with wisdom and purpose, healthcare leaders will require an evolved set of skills, including both cognitive and emotional skill sets. Leadership is seen as pivotal for compassionate and

quality healthcare. Delmatoff and Lazarus (2014) wrote that self-awareness and social awareness are leaders' most valuable tools in the changing environment of healthcare. This emerging, humanistic approach to leadership will need to be supported by a coherent philosophical framework and leverage modern leadership and organizational theories (Delmatoff & Lazarus, 2014). The field of global leadership provides such a framework by providing a competency model which addresses not only external cognitive skills, but also internal emotional competencies.

Global Leadership Competencies

The global leadership framework is a competency framework that combines an internal focus with the more traditional external focus. Global leadership competencies are the skills and competencies required to lead in a global environment. Global leadership is differentiated from domestic leadership in the level of skill and skill deployment it requires (Mendenhall, Reiche, Bird, & Osland, 2012). Mendenhall et al. (2012) identified complexity, flow, and presence as the defining features of global leadership. Complexity refers to the highly variable and complex environment in which leadership operates. Flow refers to the boundary-spanning required to navigate the complex system through interdependent relationships and interactions. Presence refers to the need to be physically and emotionally available to people in various geographic locations.

The field of global leadership. Global leadership emerged as a concept in the 1980s as the business field began a dynamic shift in technology, economics, and world politics (MacIntyre & Souvestre, 2017). Executives, politicians, and business owners began to see that a strategic focus both within and beyond the organization was necessary for future leaders. Leading in a global context requires flexibility, adaptability, and agility in response to rapid changes

(Biermeier-Hanson, Liu, & Dickson, 2014). Global leadership is often defined as "a process of influencing the thinking, attitudes and behaviors of a global community to work together synergistically towards a common vision and common goals" (Mendenhall et al., 2012, p. 123).

A global mindset is defined as the ability to interpret and perform across cross-cultural contexts; it is a way of being, as distinct from a set of skills (Osland et al., 2006). The field is moving towards the development of this mindset to define developmental aspects of global leadership. The Hofstede (2011) model is one well-regarded and researched approach to global mindset and cross-cultural interactions. The Hofstede model comprises six dimensions that can be measured across cultures: power distance, uncertainty avoidance, individualism, masculinity, long-term orientation, and indulgence. However, while this is a useful and validated cross-cultural tool, Hofstede does not indicate whether it supports development at the individual level.

The Global Leadership and Organizational Behavior Effectiveness (GLOBE, 2004) research study is a comprehensive cross-cultural study examining leadership and organizational cultures around the world (House, Hanges, Javidan, Dorfman, & Gupta, 2004). The 62 countries were clustered on dimensions drawing on the Hofstede (2011) model. The findings are applicable to many aspects of organizational behavior; specifically, they indicated that the effectiveness of a given leadership style depends on cultural context.

Global leadership can be viewed as a leadership style. There are many styles of leadership that have been emerging and are well-studied in the 21st century. Leadership theories that are seen as working styles and are considered supportive of the conscious leadership context are values-based, ethical, authentic, charismatic, and transformational (Biermeier-Hanson et al., 2014). Findings from the GLOBE study show that these various styles are perceived differently across cultures (House et al., 2004). Additional research is needed to determine the impact of

various leadership styles in global contexts and cross-culturally. In general, the field has moved away from seeking a universal approach to leadership within the global context.

Global leadership competency models. Organizations are struggling to determine what sorts of knowledge, skills, and abilities are necessary for global leadership competence (Caligiuri & Santo, 2001). Research on skills overseas began to emerge as early as 1978. Multiple theories and competency models have since evolved. The most recent research began on the foundation of international leadership and global mindset. Since then, the field of global leadership has grown, and a few key theorists have continued to develop the construct.

Caligiuri and Santo (2001) approached the competency issue from an organizational perspective and defined eight developmental dimensions tied to the personality. Caligiuri and Sinha (2010) defined global leadership as having an international component and regards success as highly dependent on personality. However, along with personality, self-awareness is particularly important. Caligiuri (2012) continued to advance this approach and focused it on developmental programming, thereby narrowing down to three competencies: (a) valuing of cultural differences, (b) cultural flexibility, and (c) tolerance of resiliency.

Boyatzis (2008b) suggested that emotional intelligence was the key factor in global leadership, with self- and social awareness at the core of distinguishing effective global leaders from other leaders. Meldrum and Atkinson (1998) consider global leadership as a set of meta-abilities, defined as the application of knowing how and when knowledge will be used. They identify three components of global leadership: (a) cognitive skills including self-knowledge, (b) emotional resilience, and (c) personal drive (Meldrum & Atkinson, 1998).

In 2005, Jokinen attempted to create an integrated global leadership competency model. This model comprised three levels: (a) core GL competencies, (b) desired mental characteristics,

and (c) behavioral GL competencies. The core competencies defined by Jokinen include self-awareness, engagement in personal transformation, and inquisitiveness. Like other researchers, Jokinen placed little emphasis on the technical skills of a global leader. Rather, this study argues that the distinguishing features of a global leader are qualities of self-awareness, flexibility, self-mastery, and social skills.

Most recently, Park, Jeong, Jang, Yoon, and Lim (2018) published a literature review on global leadership competency. Five research themes were identified, and a framework was proposed. The themes found are: (a) intercultural, (b) interpersonal, (c) global, (d) change and vision, and (e) personal traits and values. Flexibility, self-authorship, and openness are among the factors within the last category ("personal traits and values"), and these are considered especially important in the selection and development of global leaders (Park et al., 2018).

Bird, Mendenhall, and Osland have published prolifically and collaboratively on the subject of global leadership competence. These researchers have identified hundreds of global leadership competencies (Bird & Stevens, 2017). In 2014, Bird and Osland developed a pyramid-style framework arguing that global leadership competence is built and evolves in levels. Each level is built upon the next, Level 1 being the foundation for all of the remaining levels (Mendenhall et al., 2017). Through this four-level competency framework, development opportunities can be identified. Table 4 illustrates the four levels in detail.

Table 4

Global Leadership Levels

Level 1	Threshold traits: integrity, humility, inquisitiveness, and resilience
Level 2	Global mindset: attitudes and orientations
Level 3	Interpersonal skills: communication and building relationships
Level 4	System skills: decision making, boundary spanning, change management

Note. Adapted from *Global Leadership: Research, Practice, and Development* by M. Mendenhall et al., 2017, New York, NY: Pearson. Copyright 2017 by Pearson. Reprinted with permission.

Global leadership development. As stated, awareness is the foundation of leadership and leadership development. Leadership development is defined as an internal change process that consists of moving from awareness to application and finally to adoption (Quinn, Anderson, & Finkelstein, 1996). This process is cyclical and ongoing as one becomes more and more aware of themselves and of others' perceptions. Development does not happen in one event; it takes place over a period of time with intentional effort (Biermeier-Hanson et al., 2014). Therefore, when speaking about development, the field is referring to a long-term process, not a course or program.

Leadership is a process of transforming oneself and others through continuous learning and shifting identity. Leading others requires the development and maintenance of relationship with followers (Northouse, 2015). Global leadership development requires not only skill development, but also development focus on meta-cognitive skills such as self-knowledge and self-reflection. Others' awareness requires cross-cultural intelligence. Cross-cultural intelligence, as described by Mendenhall et al. (2017), is essential for global leadership. Developing cross-cultural intelligence is a continuous process of awareness, planning, and checking.

The field of Global Leadership seems to provide a framework which can support the complexity of healthcare in the 21st-century environment. A standard or agreed-upon competency model does not yet exist. However, there is agreement across scholars that both external and internal competencies are essential. Global leadership, then, begins with self-awareness. Leadership competency assessments are an evidence-based process with which to begin the process of developing self-awareness.

Global leadership assessments. There are a number of global leadership assessments in today's marketplace. Most focus on the traditional skills of global leadership and global mindset. Bird and Stevens (2017) reviewed the available global leadership assessments and found three types of assessments. The identified cultural difference assessments and intercultural adaptability assessments are not relevant to this study. Both of these were found to be in use and effective for the purposes of which they are defined. The final category of assessments are focused on global leadership competencies (Bird & Stevens, 2017), which are discussed below.

O'Keefe (2018) compares assessments for global leadership competencies. Four of these were identified as competency-focused and appropriate for an organizational context. The Global Leadership Life Inventory (GlobeInvent) by Kets de Vries, Vrignaud, and Florent-Treacy (2004) is a 360-degree assessment designed to assess leadership behavior in executives with a clinical view and across professions. The other three identified as reliable and valid include the GlobeSmart Leadership Assessment, the Global Competencies Inventory, and the Global Mindset Inventory (O'Keefe, 2018). Each of these was found to be narrowly focused and not applicable to the wider conversation on global leadership competency development.

However, in combination with traditional leadership competency assessments and emotional intelligence aspects, a more comprehensive assessment is possible. There are noted

limitations of competency models. These models can create conformity and can restrain thinking. They may also disassociate leadership behavior from contextual elements (Biermeier-Hanson et al., 2014). However, there is agreement that competency models used for developmental purposes have merit, but that assessments should be conducted by multiple raters.

360-Degree assessment. Today, the 360-degree assessment is one of the most prevalent management tools in management history, though only a few decades ago, few managers had exposure to the process (Toegel & Conger, 2003). In the 1990s, as organizations began to restructure and work became more complex, managers began to rely more heavily on collaboration for results. This created a need for feedback beyond the manager, as the direct line boss no longer had a clear picture of the effectiveness of a leader. A 360-degree feedback evaluation takes into consideration confidential feedback spanning all of the relationships a leader might have: peers, bosses, customers, subordinates, and others. This is seen as one of the most effective ways to increase self-awareness in leaders (Atwater, Ostroff, Yammarino, & Fleenor, 1998).

At the core of a 360-degree assessment (hereafter abbreviated to "360") is the cognitive process of self-reflection with the goal of developing self-awareness (Toegel & Conger, 2003). A typical 360 requires an individual to rate themselves on each competency or skill (self-score). It then asks the participant to rate the importance of the skill (importance-score). Finally, the combination of ratings from the participant's boss, peers, manager, and customers is calculated (others-score). Through this feedback, the participant attains a picture of how important they perceive a skill to be, how well they are performing that skill, and how others see them performing the skill. Self-awareness through this feedback tool has been shown to lead to effectiveness improvement (Toegel & Conger, 2003).

Kluger and DeNisi (1996) conducted a meta-analysis on feedback interventions and found that feedback sometimes improves effectiveness by up to .4 of a standard deviation; however, in over one third of the interventions, effectiveness decreased. In their resulting feedback interventions theory (FI), the researchers found three levels of attention: the task learning level, then the task motivation level, and finally meta-tasks, or the self-level. After an analysis of 23,663 observations, Kluger and DeNisi concluded that the higher the attention is on self, the lower the effectiveness. By focusing on the task or learning level, leaders can focus their attention on growth (rather than on their own emotional reactions), and effectiveness will consequently improve. This study resulted in deeper research into the 360 process and will be further discussed in the Limitations section below.

The growth of the 360 tools has been attributed to three main driving forces. First, the rise of leadership development programs centered around leadership competencies, which led the 360 assessment to become the primary measuring tool. Second, as hierarchies flattened and matrix organizations created a need for cross-function work, a need for holistic assessment emerged. Finally, measurement in general has become a priority, and the quantitative data yielded by 360 assessments appeals to organizations seeking to increase their effectiveness and results (Toegel & Conger, 2003).

A 360 is designed to foster personal development and continuous learning. It is assumed to be a psychologically safe environment, focused on development (as distinct from effectiveness evaluation). In this reframing, an individual is more likely to experience the data as a growth opportunity, rather than a personal attack. This leaves raters in a better position to rate participants honestly and makes participants more open to the feedback. There has been a recent

movement to include the 360 data in the effectiveness appraisal processes of an organization (Toegel & Conger, 2003). There are many studies arguing for either side of this shift.

Drawing on existing and longitudinal data. The emerging global leadership assessment field provides tools for those entering into global leadership endeavors. However, most large organizations currently have leadership competency frameworks and 360 feedback assessments in place. There are many benefits of drawing on existing traditional frameworks. Due to the limitations described above, a 360-degree feedback provides incomplete data. The traditional tools have longitudinal results and multiple revisions behind them to decrease the limiting factors mentioned. Companies often have decades' worth of data, providing a deep view into the issues. The data can be better utilized by looking at them from a more holistic perspective, making a new tool unnecessary. By leveraging the current, traditional competency models and using a conceptual framework of global leadership, existing data can be analyzed with a view toward an expanded definition of leadership.

Korn Ferry 360 assessment. The Korn Ferry Voices 360 Feedback Assessment (KF 360), the tool leveraged in this study, is an industry leader in leadership assessments, drawing on the leading leadership competency model. Korn Ferry is an organizational consulting company that integrates talent and strategy to drive effectiveness. Korn Ferry partners with 98% of the Fortune 100 companies and has over 120 million talent data points on global professionals (Korn Ferry Website: https://www.kornferry.com/about-us).

In the absence of an agreed-upon GL competency model and 360 assessment, the global leadership (GL) competency pyramid framework proposed by Mendenhall et al. (2017) can be mapped onto the KF 360 competencies. Each of the named competencies from the KF 360 fits into one of the four levels names by the GL competency framework (described previously). A

mapping strategy is proposed below in Table 5. The table lists each of the 24 competencies in alphabetical order. The global leadership levels 1-4 are then mapped to each competency based on the global leadership pyramid described above. Some competencies directly match the GL model; the researcher decided to match each remaining competency to the closest GL concept.

Table 5

Competencies Mapped to GL Competency Levels

Leadership Competency	Mapped to GL Levels 1-4
Building Effective Teams	L3
Business Acumen	L4
Comfort Around Higher Management	L2
Compassion	L2
Creativity	L2
Customer Focus	L2
Resiliency	L1
Decision Quality	L4
Drive for Results	L4
Ethics and Values	L2
Innovation in Management	L3
Integrity and	L1
Interpersonal Savvy	L2
Learning on the Fly	L2

(continued)

Leadership Competency	Mapped to GL Levels 1-4
Courage	L1
Managing and Measuring Work	L4
Managing Diversity	L3
Managing Vision and Purpose	L4
Motivating Others	L3
Planning	L4
Political Savvy	L2
Priority Setting	L4
Strategic Agility	L2
Timely Decision-Making	L4

Note. Adapted from *Global Leadership: Research, Practice, and Development* by M. Mendenhall et al., 2017, New York, NY: Pearson. Copyright 2017 by Pearson. Reprinted with permission.

Integrity, courage, and resiliency map onto level (threshold traits or internal processing) of the global leadership competency pyramid by Osland et al. (2006). They are all related to the call for 21st-century leadership, which is described as a focus on self-management and wisdom. The threshold traits also support the healthcare leadership gap, supporting physicians, diversity, and burnout syndrome prevention. These internally focused skills of emotional intelligence are the foundation for the other skills.

Bias and judgement in assessments. Despite the popularity of 360 tools, the process has limitations. These challenges are often cited as an argument to keep the tool focused on development, rather than assessment of effectiveness. A core issue with 360 feedback is the individual subjectivity of the rater. Differences between raters impact how they view and

experience the participant. Paths to leadership, gender, minority status, profession, age, and organizational culture can all impact how a rater perceives the competency of the participants. Because of this variance, an aggregate "others" number is often provided to reduce the effect of bias (Toegel & Conger, 2003).

"Real knowledge means knowing the extent of one's own ignorance" is a philosophical idea, coined by Confucius, that has permeated the modern zeitgeist. This idea, posed throughout the centuries, has found its way into various fields of research, including psychology, sociology, and leadership. Dunning and Helzer (2014) explored this idea by analyzing studies of correlations between self-prediction and actual effectiveness. These studies showed a significant correlation; however, they did not show an enhancement when comparing self to all others (or average). The researchers concluded through analysis of multiple studies that the correlation coefficient does not allow for consideration of discrimination and bias in self-assessment and others score (Dunning & Helzer, 2014).

The most apparent bias in effect is optimistic bias. People tend to overestimate their own ability. Kruger and Dunning (1999) found that people scoring in the 12th percentile on a skills study estimated their skills to be in the 62nd percentile. Interestingly, the higher an individual's actual effectiveness, the lower their overconfidence bias. As effectiveness increases, the gap between self-assessment and effectiveness decreases; in the literature, this trend is now known as the Dunning Kruger effect. It can be concluded that those with higher effectiveness have a higher level of self-awareness (Kruger & Dunning, 1999) and vice versa; those with higher self-awareness have higher effectiveness.

In a meta-analysis of 725 articles by Davis et al. (2006), this finding on self-assessment was validated through a specific sample of physicians. This analysis verified that physicians who

received the lowest ratings on skills gave themselves the highest ratings on competency (in other words, the least skilled participants felt most confident) (Davis et al., 2006). The literature is replete with agreement that self-assessment does not provide an adequate assessment of knowledge or ability. In order to have a more complete picture of developmental opportunity, an external assessment is required.

The central premise of a 360-feedback assessment is that people other than the participants provide information that allows for a different perspective. It is then assumed that there will be discrepancies between other-scores and self-scores. The others score in a 360 refers to the mean score of all others who are providing input—typically the manager, peers, customers, and employees.

The Dunning-Kruger effect is also in play while assessing others' competence. In some cases, a reviewer (a) is not an expert on the competency, (b) does not know that they are not an expert, and (c) rates another individual as if they are an expert. This effect impacts how one individual rates and reviews another. Interestingly, stereotypes help offset this effect, but they also create other issues of perception when rating others (Dunning & Helzer, 2014).

Campbell and Lee (1998) attributed differences between self and other score to three differences: (a) different perceptions on the job and the competency, (b) different cognitive processing, and (c) different affective processing. These individual perception differences compromise reliability between individuals.

Unconscious bias is also a factor in evaluation of others' competence. The reality of implicit bias has been demonstrated by numerous studies indicating that people of all backgrounds have preferences on the basis of gender, race and other factors of identity. This bias is usually favorable toward those who belong to one's own group. Unconscious bias can also

lead to cognitive dissonance. Not only is bias favorable toward the groups of which one is a member; it is also favorable to groups that are considered the most culturally valuable (Morin, 2015). Unconscious bias is not deliberate, which makes it difficult to change. However, when people become more aware of their bias, they can see it for what it is and therefore act from their true values and lived experience (Fiarman, 2016).

Because unconscious bias is an inherent human factor during the assessment process, the differences between self-other is also reflective of the other who is rating, as much it is reflective of the participant. Therefore, it becomes important to look at demographic information, such as age, gender, minority status, and profession of the raters, to explore the unconscious bias impact. These limitations of the 360 assessment do not make them useless, but they do point to the importance of the intention behind the use of the tool.

Assessment final thoughts. A 360-feedback assessment is a subjective process that raises risks of biased judgements, but it still provides valuable data and insight into how others perceive an individual's leadership. Self-assessment is biased towards overconfidence and provides little value on its own. By adding other viewpoints, gaps in an individual's perception can be identified. Other assessments also contain bias, unconscious and conscious, and distort outcomes. By combining data across raters, the bias error can be reduced; however, it is still a subjective process. The most powerful use of the 360 tools, then, occurs through reflection on the data on input from others than self. This reflection allows for increased self-awareness, and through this process, development opportunities are identified.

Self-Awareness in Leadership

Today, a Google Scholar search on *self-awareness* turns up over 3 million responses. Narrowing this to *self-awareness in leadership* returns half that number. This sheer quantity of

research shows a high level of interest and suggests the importance of continued study on self-awareness and what it means to leadership. This review is not an exhaustive search of the literature; rather, it focuses specifically on factors of self-awareness in leadership, self-other agreement, and the development of self-awareness in an organizational context. The following section concludes with an expanded discussion of levels of self-awareness development through adult developmental stages.

Self-other agreement as a measure of self-awareness. According to Wicklund and Duval (1972), when the focus of attention is on the self, individuals evaluate and compare current behavior to internal standards and values. People judge themselves based on their intentions, while others judge them based on their actions. Leadership literature seems to agree that self-awareness is key to competent leadership. Self-other agreement (SOA) is associated in the literature with better effectiveness, promotions, and success (Church, 2014; Yammarino & Atwater, 1993). SOA is a measure of external self-awareness using 360 assessment data, and it is the primary measurement of self-awareness available in the leadership and management literature to date.

According to multiple studies on leadership and self-awareness, leaders tend to over or underestimate their effectiveness when compared to ratings from other sources (Atwater et al., 1998). Accuracy in self-awareness when self-assessing skills was found to be related to leader effectiveness. Studies have found that over-claimers of skills (or those with lower self-awareness) had lower effectiveness (Yammarino & Atwater, 1993).

Interestingly, the more experience and power a leader has, the less self-awareness he or she is likely to have. Atir, Rosenzweig, and Dunning (2015) found that the more expertise an individual believes they have, the more likely they are to overclaim their ability. The research

was conducted over three studies, each one leading to overclaiming. The statistical analysis showed self-perceived knowledge ($b = 0.09$, t [198] = 11.73, $p < .001$) and genuine knowledge ($b = .02$, t [198] = 2.14, $p = .033$) had a significant effect on overclaiming (Atir et al., 2015). Therefore, the more expertise individuals have, the more likely they are to overclaim (lower self-awareness) and therefore, the lower their effectiveness is likely to be.

Van Velsor, Taylor, and Leslie (1993) also found that individuals who rated themselves lower in a competency were rated higher by direct reports in terms of their leadership effectiveness. Those who rated themselves higher than the others rating group were found to have the lowest level of effectiveness. Congruence between the self and other reported rating was found to be the highest predictor of effectiveness. This is supportive of both studies related above, adding the additional result on congruence.

Bratton, Dodd, and Brown (2011) found similar outcomes in a study finding that under-claimers earn higher effectiveness scores from raters, while over-claimers earn lower scores. These researchers found a significant relationship between the EQ scale and underestimating ($B = 0.351$, $p < 0.05$). The study concluded that there is a negative relationship between self-awareness and leader effectiveness for managers who overestimate their own leadership abilities (Bratton et al., 2011). These studies did not examine the differences between individuals, but the authors pointed out a need for further research to explore those differences.

Studies have shown that people tend to prefer for their workplace to be homogeneous in terms of race and gender. This preference may influence their ratings of others (Tajfel & Turner, 2004). Ostroff, Atwater, and Feinberg (2004) examined the importance of biographical and contextual data with regard to leader self-other agreement on effectiveness across over 3,600 leaders. The researchers expected to find women underestimating themselves and men

overestimating themselves. They expected non-whites to under-rate themselves, whites to over-rate themselves, and older workers to over-rate themselves.

Gender of the manager was found to be significantly related to the others score; other significant relationships included self to subordinate (F [2,3203] = 7.04, $p < .01$), self to peer (F [2,3203] = 4.35, $p < .05$), and self to supervisor (F [2,2587] = 7.23, $p < .01$). Race was significantly related to self-score, with white participants rating themselves significantly higher than non-white participants. The main effects were found in found in self-subordinate (F[2,3203] = 9.32, $p < .001$), self-peer (F [2,2597] = 15.23, $p < .001$) and self-supervisor (F [2,2597] = 15.23, $p < .001$) comparisons. A correlation indicated that variables of race, gender, and age accounted for 3.4% of the variance in the self-subordinate ratings (F [30,6400] = 7.59, $p < .001$). The self-peer rating relationship was also significant (F [30,6400] = 8.76, $p < .001$). The self-supervisor analysis showed that the variables of supervisor and self scores accounted for 5.1% of the variance and a significant relationship existed between them (F [28,5188] = 9.89, $p < .001$). Finally, through multivariate regression, the study confirmed the hypotheses; women, non-whites, and new managers underestimate themselves more often than their counterparts (Ostroff et al., 2004).

Hernandez and colleagues (2015) connected leadership to self-awareness as measured through self-other agreement, burnout syndrome (BOS), and organizational environment. BOS has been shown to have a negative impact on the culture of a team and perceptions of psychological safety (Deckard, Meterko, & Field, 1994; Northouse, 2015). The study found that self-awareness is a mediator between burnout and environment; as self-awareness was introduced, the model fit was improved. A significant relationship was found between workforce civility and self-awareness: $B = -.019$, $p = .006$.

The components of burnout syndrome on the tool used included emotional exhaustion, depersonalization, and personal accomplishment. These components were analyzed to define the relationship between self-awareness and burnout syndrome. Under-raters (M = 19.43, SD = 10.24) reported higher levels of emotional exhaustion than over-raters (M = 16.01, SD = 10.29). Under-raters (M = 5.73, SD = 4.63) reported experiencing significantly higher levels of depersonalization than over-raters (M = 4.23, SD = 4.80). Finally, under-raters (M = 4.72, SD = 4.09) reported significantly lower levels of personal accomplishment than over-raters (M = 40.080, SD = 6.07) As a leader faces burnout, high levels of self-awareness allow the leader to navigate the challenge and provide positive leadership to their teams. Interestingly, the study also showed significantly higher rates of burnout in under-raters. Level of self-awareness was found to predict psychological safety. Leaders have a direct impact on the environment of their team. When under stress, the higher a leader's self-awareness is, the better that leader becomes, and the more positive the organizational culture becomes (Hernandez et al., 2015).

It can be concluded from these and other studies that level of self-awareness, measured by SOA, has an impact on leadership and team effectiveness. The direction of the relationship contributes to a positive or negative outcome in leadership effectiveness. From a developmental perspective, understanding of self-other agreement begins a process of growth. Research on developing leadership self-awareness centers on a few key concepts: feedback, executive coaching, and mindfulness.

Developing self-awareness. The current literature points to three main developmental focus areas for developing self-awareness: feedback, executive coaching, and mindfulness. Each of these interventions can be leveraged organizationally and is finding its way into organizational literature and research. Each can be studied independently, though in a review of the research,

they are often cited as contributing or outcome factors to each other. For instance, executive coaching often begins with a 360-feedback process and offers mindfulness practices as a recommendation for development of self-awareness. For the purposes of this review, foundational information is offered for each developmental tool.

Feedback intervention. A feedback intervention is defined as actions taken by an external agent to provide information regarding another's effectiveness on a task (Kluger & DeNisi, 1996). Feedback has been studied as an important factor in behavior and effectiveness for nearly 100 years. Early on, the field centered on behavioral research and the law of effect (Thorndike, 1927). Thorndike's Law of Effect found that both positive and negative feedback caused an increase in effectiveness. In 1956, social scientist Ammons expanded this general theory of cause and effect into knowledge acquisition, concluding that knowledge of effectiveness (KP) increases learning and motivation.

The use of feedback as a theoretical component has expanded into leadership studies through the decades, giving rise to concepts such as goal-setting theory (Latham & Locke, 2018), control theory (Carver, 2018), and self-awareness theory (Yammarino & Atwater, 1993), among others. A meta-analysis on feedback found that studies were inconsistent, and feedback did not always improve effectiveness (Kluger & DeNisi, 1996). It was determined that while positive and negative directional feedback did increase effectiveness, praise as a form of feedback alone did not. Positive directional feedback was found to be the most effective at improving effectiveness (Kluger & DeNisi, 1996).

The most successful leaders solicit frequent and comprehensive feedback. To develop a learning organization, systems and process must be in place to develop and increase awareness (Senge, 1991). In the organizational context, this happens both quantitatively and qualitatively.

For the purposes of leadership development, the previously discussed 360 assessment system is the most common form of quantitative feedback for development. The 360 review is designed to broaden a leader's awareness of their strengths and weaknesses with the intent to grow and develop (Atwater et al., 1998). This process is also possible qualitatively, where a series of questions are asked in a narrative form. These narrative responses provide more information on reasons and can help shed light on the bias and judgments mentioned in the 360-assessment section of this review.

An effectiveness feedback system is also a common organizational method for developing awareness related to leadership competency. Effectiveness appraisal is burdened by the same bias and judgement described in the 360-assessment section (DeNisi, Cafferty, & Meglino, 1984). The most recent literature on effectiveness feedback proposes a movement towards developmental feedback (Bizzi, 2018), as there is little data to show that effectiveness feedback improves effectiveness. The research does not support a positive relationship between feedback and effectiveness, which may be related to the negative nature of some feedback.

The overriding recommendation for using feedback sources to support development is to focus on a small number of areas for improvement (Antonioni, 1996). Focusing on the most important but bottom-ranked area is a common practice. In a longitudinal study of multi-source feedback (Dai, De Meuse, & Peterson, 2010), both developmentally and effectiveness-focused, it was found that managers improved across 67 competencies selected. However, the researchers found that there was significant improvement on competencies selected as focus areas, in comparison to those not selected (Dai et al., 2010).

Coaching for developing self-awareness. Executive coaching as a management tool has become increasingly popular over the last two decades (Kombarakaran, Yang, Baker, &

Fernandes, 2008). The goal of executive coaching is to provide a process and opportunity for developing self-awareness (Bozer & Joo, 2015). Coaching, as a cognitive behavioral approach, is defined by Bozer and Joo (2015) as a 1:1 relationship for the purposes of enhancing self-awareness and leading to behavioral change which ultimately, leads to both individual and organizational success.

Executive coaching has been shown to have positive organizational outcomes, which are directly related to the development of self-awareness (Kombarakaran et al., 2008). Through the process of coaching, a leader draws on the awareness created through SOA and creates a plan for behavior change with the support and encouragement of the coach (Whitworth, 2007). This process deepens external self-awareness and integrates internal self-awareness components of values, beliefs, needs, and interests.

Mindfulness at work. While mindfulness is often associated with the philosophy of Buddhism, the roots of mindfulness can also be found in Greek philosophy, phenomenology, existentialism, transcendentalism, and humanism (Brown, Ryan, & Creswell, 2007). Mindfulness is central to the human experience and is rooted in consciousness, specifically attention and awareness. Awareness is the registration of stimulus through the senses, the mind and the environment. The ancient practice of mindfulness is growing in interest and application.

A search on *mindfulness at work* turns up 249,000 results, 12,500 published in 2018 alone. Mindfulness can be defined as present-centered attention and awareness (Brown et al., 2007). Mindfulness has been shown to have positive impacts on the effectiveness and functioning of an individual (Brown et al., 2007). Organizations such as Google, the Mayo Clinic, and the U.S. Army use mindfulness programs to enhance effectiveness in the workplace

(Good et al., 2016). Mindfulness when applied to work has also been shown to improve leadership and team effectiveness (Glomb, Duffy, Bono, & Yang, 2011).

Mindfulness has been described as a state of consciousness where attention and awareness of the present moment is focused without evaluation, cognitive filters, or judgement (Glomb et al., 2011). It is the practice of focusing attention on stimuli, either internal (sensations, thoughts, emotions) or external (physical or social environment), as distinct from applying an interpretation onto said stimuli. The recognition of an emotion, judgment, self-talk, or impulse can be observed, but not acted upon (Siegel, 2007). By observing these thoughts as they move across the consciousness, an individual can develop an awareness of the internal landscape of the mind.

Through this attention and awareness of the mind, human functioning is improved. Research has shown that mindfulness is associated with improvements in attention, cognition, emotion, behavior, and physiology (Good et al., 2016). These improvements translate to better workplace outcomes in the areas of effectiveness, relationships, and resiliency (Glomb et al., 2011). Mindfulness has also begun to be studied through the lens of neuroscience. Neuroscientist Dan Siegal has proposed a complex systems approach to mindfulness that allows an integrated state of brain chemistry to produce a state of well-being (Siegel, 2007).

Mindfulness can be seen as similar to Wicklund and Duval's (1971) self-awareness theory; however, it expands the experience of self-awareness to a broader developmental process through the strength, direction, and quality of mind (Brown et al., 2007). The practice of mindfulness begins with internal or external self-awareness but continues through a sustained and focused state of mind. A mindfulness practice ensures that self-awareness does not create a

focus solely on ego enhancement or self-identity and develop into maladaptive behaviors. Mindful awareness moves from self-esteem to a focus on right action.

A mindful practice has been shown to deepen an individual's understanding of self by interrupting the narrative self. What is experienced as self is described in organizational theories as a narrative identity constructed by a fabric of prior experiences. These experiences shape an individual's interpretation of reality (Duvall, 1971). In order to maintain the constructed self, the typical reaction is maintaining self-consistence or self-enhancement. Through mindfulness, the narrative self gives way to the experiential self, which provides openness to change and greater acceptance of self and others (Good et al., 2016). Mindfulness can be descried as a practice of development of self-awareness, both external and internal, or integrated self-awareness.

Evolving self-awareness. The literature supports the idea that through assessments, coaching, and mindfulness, self-awareness can be developed. Scholars also agree that leadership effectiveness, well-being, and effectiveness can also be improved through these processes. The literature mainly focuses on the measurement, processes, and organizational outcomes of developing self-awareness, not the purpose or goal of the development. The application and purpose of expanded leadership self-awareness can be viewed through the constructive development framework created by educational psychologist Robert Kegan (1994). Since publishing, Kegan's model of development has been cited in multiple studies in the fields of psychology, sociology and recently, leadership.

In 1982, Kegan published *The Evolving Self*. In this seminal work, Kegan put forth an alternative to traditional psychological approaches to meaning-making and personality. While drawing on the founders of psychology, he focused this new approach on the theories of James Mark Baldwin, John Dewey, George Herbert Mead, and, most significantly, Jean Piaget (1936).

By leveraging these various philosophical approaches to the development of self-awareness to childhood, Kegan (1982) proposed a model expanding beyond childhood to further explore the development of self through adulthood.

Kegan's (1982) constructive developmental framework describes the levels of self-awareness that occur between levels of development. These levels are also referred to as levels of consciousness in the literature. Each mind-level differs in the way the mind processes, understands, and gives meaning to the external stimuli presented. Consciousness is constructed through meaning-making and continues to develop and evolve through life (hence the label "constructive development"). The key underlying understanding of each level is the relationship between self and other, or the subject-object relationship. As mindset and self-awareness expand, meaning making grows in complexity. In each stage, the relationship between subject and object shifts as meaning-making changes and consciousness evolves (Kegan, 1982).

The initial incorporative self (0) and impulsive self (1) stages are found in childhood. The remaining stages occur during adulthood. These include: imperial self (2), interpersonal self (3), institutional self (4), and inter-individual self (5) (Kegan, 1982). Each of these stages is defined by the orientation of self-awareness and how the mind interacts with the concept of self. For adults, these correlate to mind states of self-sovereign mind (2), socialized mind (3), self-authoring mind (4), and self-transforming mind (5) (Kegan, 1995). Table 6 describes each mind state and the corresponding subject-object relationship.

Table 6

Kegan's (1994) Adult Stages of Development

	Object of "I HAVE"	Subject to "I AM"
Stage 1 Impulsive mind childhood	Reflexes	Impulses and perceptions
Stage 2 Self-sovereign mind Adolescence, 6% of adults	Impulses and perceptions	Needs, interests, desires
Stage 3 Socialized mind 58% of adults	One's needs, interests, desires	Interpersonal relationships
Stage 4 Self-authoring mind 35% of adults	Interpersonal relationships	Self-authorship, identity, ideology
Stage 5 Self-transforming mind 1% of adults	Self-authorship, identity, ideology	Dialectic between ideologies

The imperial self-sovereign mind begins in adolescence. In this stage of development, the individual begins to see herself as having a separate self-concept and favors independence. The subject (I am) is defined by needs, interests, and wishes. The object (I have) is experienced as impulses and perceptions. It is at this stage that the reactions of others become a consideration,

and the impact of those reactions on the self becomes highly important. At this stage, individuals evaluate experiences and others solely based on how these affect their own personal goals and interests. According to Kegan (1982), 6% of adults remain in this stage of development. The behaviors of leaders in this stage could be experienced as narcissistic.

The interpersonal socialized mind comprises the majority of the adult population, estimated by Kegan (1982) to be 58%. In this stage, adults now heavily favor interaction with others. The subject (I am) becomes focused on relationships, and the object (I have) becomes defined by needs, interests, and desires. Individuals in this category define themselves based on the roles they play in relationship to others, i.e. mother, daughter, etc. There is no self to share with another; rather, the other brings the self into being (Kegan, 1982). In this stage, promises, expectations, and support are the primary focus. In a leadership context, this can mean that a leader only sees themselves as a leader when in relationship with followers.

In the institutional self-authoring mind, an individual is no longer defined by their relationships, they realize that they have (object) relationships and that they change over time. This moves back to a focus on independence, where individuals see themselves as self-dependent and own their experience and development. They see themselves as defined by their ideology and operate from that premise; 35% of individuals make meaning from this perspective. In an organizational context, the leader sees themselves as part of the organization, and strongly relate to personal values and ideology (Kegan, 1982).

In the inter-individual self-transforming mind, the focus moves back from the individualistic to inclusion, but in an evolved and integrated way. The object (I have) becomes self-authorship, identity and ideology, and the subject becomes the dialect between ideologies (I am). Only 1% of adults and 5-8% of people aged 40-60 can be found at this level (Kegan, 1994).

In this space, a leader sees themselves as deriving meaning from their organization and work. "Should" is no longer in the vocabulary of a self-transforming mind (Kegan, 1982). The individual leads from their own internal compass, wisdom, and sense of purpose. They give their work, time and dedication to the well-being of others, the organization, or even the greater society. They remain grounded in their own personal values but are respectful and open to the perspectives of others. The leader at this level is leading from a place of internal and external self-awareness and leading at the highest level of consciousness.

Kegan followed up this early work by providing organizational tools that apply these levels of consciousness to overcoming change resistance and creating a developmental organizational culture. In *Immunity to Change*, Kegan and Lahey (2009) claimed that hidden mindsets are a leading barrier to change, both personally and organizationally. In order to change, these mindsets must be made clear, and intentional action must be taken (Kegan & Lahey, 2009). The structure put forth in this book is intended specifically to develop self-awareness and uncover blind spots.

Developmental psychology describes the process of adult growth as either *horizontal* or *vertical* (Cook-Greuter, 2004). Horizontal development is the accumulation of new knowledge and measurable skills, this is the most common type of development. Vertical development is a transformation in worldview, an expanded awareness or level of consciousness (Cook-Greuter, 2004). In vertical development, the way an individual sees the world shifts and grows, allowing for more complexity. Vertical development happens through the development of awareness, interpersonally, interpersonally, and cognitively. Through the constructive development model and process, Kegan and Lahey (2009) proposed that self-awareness can be purposely developed, leading to transformation of consciousness.

Kegan (1994) described consciousness as a dynamic and fluid process of growth. A large enough life event or personal development practice can result in a transformation to a new worldview. As leaders move to a higher level of consciousness, they have the capacity to lead and influence those at a lower level, as they can adopt the perspectives of each. Kegan argued that in order to meet the demands of the 21st century, leaders must move from a socialized mind through a self-authoring mind and ultimately to a self-transforming mind (Kegan & Lahey, 2009). The final transition to self-transforming mind is aligned to the global mindset described as the most important perquisite of global leadership.

A global mindset is defined in the literature as a way of being, which manifests itself in something other than a skillset (Osland et al., 2006). The global mindset is seen in the majority of global leadership frameworks as a primary indicator of success, but the question of how to define or identify it has been identified as a gap in research (Osland et al., 2006). The self-transforming mind, as one that is not tied to its ideology and can comfortably move between groups and ideas, fits the future-focused concept of a global mindset way of being. It is then through the vertical evolution of consciousness that leaders will have the capacity to lead globally with greater wisdom and purpose.

Conscious Leadership in the Literature

Conscious leadership is simply defined as leading with awareness of self, others, and the environment (Kegan, 1994). Leading consciously, then, is leading with a developed internal and external self-awareness. Developing self-awareness is a vertical development process, moving from one level of consciousness to the next. Conscious leadership is found emerging as a term and concept in the current literature.

A search on Google Scholar turns up 1,960 references on the term *conscious leadership*, and 1,570 of those were published since the year 2000. A review of the literature points to two main themes. Many articles use the term to describe leadership for the future and leading with awareness; however, some focus on other business concepts. Much of the research uses the term as a description of leadership within the context of conscious business models, which emphasize a triple aim: people, the planet, and profit. For the focus of this research, we will examine articles on conscious leadership practice as defined by level of consciousness and greater awareness.

Conscious leadership is described as a leadership practice that is accountable, collective, cooperative and responsible (Jones, 2012). Effectively, conscious leaders are aware, and this awareness leads to collaboration and connection (Jones, 2012). Through a qualitative study of 12 global leaders, Jones et al. (2012) found that leaders make sense of conscious leadership through their own awareness and self-knowledge. The leaders studied demonstrated conscious leadership through cooperation and collaboration. The conclusion of the study indicated that a conscious leadership framework could aid in the development of leaders who are prepared for complex and changing organizations. Through the practice of conscious leadership, institutions reflect their highest values (Jones, 2012).

In a dissertation and later research examining the relationship between level of leadership (consciousness) and behavioral measures of effectiveness, Harris and Kuhnert (2008) found a significant relationship. The model for the hierarchical multiple regression analysis was significant for all rating sources (self and others), F (5, 69), $p < 0.01$. Interesting, the self-score was not shown to have a significant effect. This could be because the level of leadership was self-reported, as was the self-score for effectiveness. This study was later repeated, and a significant relationship between level of leadership and effectiveness was found. Baker (2001)

concluded that additional research was needed to understand the catalysts for moving between levels of leadership in order to provide development programming.

Studies have shown that higher levels of consciousness lead to higher levels of effectiveness. In a study by Eigel and Kuhnert (2005) examining 21 CEOs of successful organizations as compared to a control group of leaders, a significant difference in level of consciousness was found at $p < .000$. The study found that leader effectiveness for CEOs begins at Level 4, with exceptional effectiveness at Level 5. The researchers concluded that a leader's level of consciousness is the source of what is described as their leadership style. For example, Level 3 leaders are transactional, whereas Level 4 leaders are transformational. The conclusion is that Level 5 is most closely aligned to an authentic leadership style. The work of Eigel and Kuhnert led to a theory of Leadership Development Level (LDL) which is aligned to the constructive development levels and is defined as a capacity to understand oneself, others, and situations—or, essentially, self-awareness as defined in this study.

Based on the literature, one challenge associated with the use of constructive development theory of conscious leadership is to identify where one is within the levels of development and how to move to the next level. The research on levels of leadership has relied on self-reported level of leadership. Self-reported assessments alone are considered unreliable; adding ratings of others through a 360 process has been shown to lead to higher reliability (Craig & Hannum, 2006). As a leader moves from an externally focused sense of self to an internally focused sense of self, effectiveness is shown to increase (Eigel & Kuhnert, 2005; Kegan, 1994; Harris & Kuhnert, 2008).

However, in the research, the triggering event creating movement from one level to the next is not fully understood (Harris, 2008). Research exists on the development of self-

awareness, and valid development options have been researched and validated, such as mindfulness training, executive coaching, and feedback (see the section on self-awareness development above). The research questions of this study are based on the premise that the use of the self-other agreement (SOA) measurement of self-awareness can contribute additional perspective and rigor to research on the vertical development of consciousness.

The Self-Aware Future Healthcare Executive

This literature review synthesizes available research on 21st century leadership, healthcare leadership, global leadership competencies, self-awareness in leadership, and conscious leadership. These subjects build upon one another conceptually in order to provide background and context of the existing research specifically related to this study.

The futurists' research point to a future that continues to evolve at an exponential rate. As these changes in the markets, technology, and global environments continue, the 21st century leader must lead in a way that reflects the future. Leaders in healthcare are being asked to lead with greater wisdom and purpose as the field becomes more complex, volatile, and ambiguous. This rapid pace of change leads to high rates of burnout and decreased well-being, which have negative impacts on organizations. The future of healthcare leadership requires a focus on developing leaders with factors of internal leadership and emotional intelligence. A global leadership competency framework provides a skill model that addresses the needs of future by expanding beyond external cognitive skills to encompass internal emotional skills. The development of these skills begins with self-awareness, which is shown in the literature to have a positive relationship to effectiveness and a negative relationship to burnout. Methods for developing self-awareness described in the literature include feedback, executive coaching, and mindfulness practices. As a leader develops self-awareness, their level of consciousness

increases, which allows for a greater ability to lead through complexity. The future of leadership development requires a focus on cultivating self-awareness and becoming a conscious leader.

The purpose of the literature review was to provide an examination of the current research related to the research study. Ultimately, the complex futurist consideration of 21st-century leadership becomes concrete when grounded through the research on healthcare leadership and global leadership competencies. By analyzing existing studies on self-awareness and conscious leadership, individual development opportunities can be planned. This literature review reveals gaps in literature and illustrates the need for further research on self-awareness and conscious leadership for executives in healthcare.

Summary

What we know. The world is changing at a pace more rapid than the human ability to evolve (Harari, 2016). To prepare for future challenges, leaders must lead with greater purpose and wisdom. This challenge requires a dedication to learning, growing, and drawing on internal resources. Global leadership competencies provide a framework for leading in the evolving complex environment of healthcare. It is important that executives in healthcare are given opportunities to assess and develop individual self-awareness. Through an understanding of self-other agreement, self-awareness can be examined.

Leadership and self-awareness have both an external and an internal process. The external factors can be measured by skills-based leadership competencies found in the research with 360-degree assessments. The global leadership threshold traits related to competencies of integrity, resiliency and courage are components of an inner process. Inner and external self-awareness lead to development and increased effectiveness. More importantly, expanded self-awareness can contribute to the development and expansion of a global mindset.

What we do not know. There are a few significant gaps identified through this literature review. First, there are disparate opinions on a definition, competency model, or assessment process for 21st-century global leadership in healthcare. It is unlikely that researchers across this expansive conversation will reach a common agreement. However, scholars in relevant fields of study agree that there is a need for more research on external and internal self-awareness in leadership. A gap in the literature exists for a competency model on conscious leadership, as described by Kegan's (1994) constructive development framework. Research on conscious leadership as an application of developing self-awareness, through levels of adult development as described by Kegan is needed.

Justification of the study. The purpose of this descriptive quantitative study is to model global leadership self-awareness across healthcare executives. By leveraging 360-assessment data, relationships between variables can be analyzed and predictions can be made, leading to recommendations for future research. Beginning with what is known and what gaps exist, the dissertation examines two research questions: What factors predict self-awareness on Level 1 Global Leadership competencies of integrity, courage and resiliency? Is self-awareness on Level 1 Global Leadership competencies associated with leadership effectiveness?

The outcomes of this research will contribute to scholarly discussions on 21st-century leadership, healthcare leadership, and global leadership development. Most practically, this study's findings will deepen the research on self-awareness in leadership and provide a focus on the importance of leading consciously. This will provide a foundation for practitioners to evolve identification, assessment, and development programs and practices for global leaders, thereby supporting executives who can lead the future with wisdom and purpose.

Chapter 3: Methodology

The purpose of this descriptive quantitative study was to model global leadership self-awareness across healthcare executives. This chapter lists the research questions and describes the rationale for the research design. The research setting, data collection strategies and procedures used are then explained. Following this, the tools and instruments used as well as the analysis methods will be described. This includes limitations of the study. Finally, a summary of the methodology and preview of the study are offered.

The following research questions were addressed in this study:

RQ1. What factors predict self-awareness on Level 1 Global Leadership competencies of integrity, courage and resiliency?

RQ2. Is self-awareness on Level 1 Global Leadership competencies associated with leadership effectiveness?

Research Approach and Design

To add to the field of research on executive leadership in healthcare, a quantitative, non-experimental approach was selected. Quantitative research is a deductive process that uses primarily numerical data to explain phenomena or test hypotheses. This is in contrast to qualitative research, an inductive process that focuses on gaining insight on phenomena through primarily narrative data (Creswell, 2012). A quantitative design was selected to examine the relationships between variables and account for multiple interactions while utilizing available numerical data.

Quantitative research can take many forms, including experimental, quasi-experimental, and correlational (Urdan, 2011). In a non-experimental correlational design, the goal is to uncover quantitative associations or relationships between two or more variables. The benefit of

a non-experimental approach is that it leverages statistical analysis to test the theory or hypothesis. Also, a random sample is not required (Creswell, 2012). The drawback of this design is that careful controls are not in place; therefore, causal associations are not reliable (Urdan, 2011).

Research Setting

The research setting for this study was a large healthcare system, headquartered in Northern California. It operates as a not-for-profit network, which includes acute care hospitals, physician organizations, home health, shared services, medical foundations, surgery centers, and the business office. Including the physician networks, the organization has nearly 65,000 employees and 16 billion dollars in revenue. This system network model supports the entire continuum of care and therefore serves the nonprofit mission of serving the community and patients of Northern California. The system's size, scope, and patient population require the leaders in the system to lead across geography, location, field, and profession.

Data Collection Strategies and Procedures

This study used existing, secondary data. This is in contrast to original data personally collected by the researcher through a survey or experimental design. The benefit of using secondary data was that the data already existed at the time of the study, allowing for immediate analysis. Also, because the data had been collected previously, the organization was invested in leveraging the data. Through examination of the data, organizational leaders are in the position to make informed decisions on resources relating to leadership effectiveness designed to enhance self-awareness.

The drawbacks of using secondary data include a lack of controls on the data collection process and procedures. The data used in this study were cross-sectional, which is to say that the

data were captured at one point in time. This is in contrast to panel or longitudinal data, which are collected over a period of time (Creswell, 2012).

The first research question focused on the factors that predict self-awareness on three leadership competencies, integrity, courage and resiliency. These variables are aligned with the global leadership competency framework as Level 1 threshold traits. Threshold traits are considered foundational competencies for effective global leadership (Mendenhall et al., 2017). The outcome or dependent variable for this first question was a calculated score of self-awareness, shown as negative or positive. The self-awareness score was calculated by subtracting the "other-score" from the "self-score" for each of the three competencies described above. A negative self-awareness score indicates an underestimate of effectiveness; positive self-awareness scores are those who over-claimed effectiveness. Perfect self-awareness is at zero and called congruent self-awareness.

The second research question addressed the relationship between self-awareness on Level 1 Global Leadership competencies and leadership effectiveness. The independent, predictor variable was self-awareness, and the dependent, outcome variable was leadership effectiveness. Leadership effectiveness was calculated by combining the scores on each of the 24 competencies determined to be the core competencies for healthcare executive leadership.

For both questions, demographic factors of gender, minority status, age, and profession were included as control variables. Profession indicates if a participant was either a clinical or administrative leader. An administrative leader is not a board-certified physician or nurse; a clinical leader is either a licensed physician or a nurse. The self-reported importance score of each competency was also included as a covariate. Importance score per competency was

included. This score indicates how important the competency is to the participant. Table 7 more clearly defines the variables and the approach.

Table 7

Variables for Data Analysis Procedures

RQ	Dependent Variable	Ind Variable	Control Variable
RQ1: What factors predict self-awareness on L1 GL competencies	integritySA courageSA resiliencySA	female, minority, clinical, age	female, minority, clinical, age and integritySI, courageSI, resiliencySI
RQ2: Is Self-awareness on L1 GL competencies associated with leadership effectiveness?	effectiveness* *calculated*	TotalSA* L1SA* *calculated*	female, minority, clinical, age and integritySI, courageSI, resiliencySI

The study's targeted participant group represented a population of full-time executives working in a large healthcare system. The sample of the 97 high-potential executives were a subset of a population of 450 executive leaders. These leaders were selected to participate in the assessment by their managers. The assessment was a prerequisite to entrance into an executive

leadership program. Therefore, each of the leaders who participated in the assessment were determined to be a leader with potential to lead at a higher level.

An executive was defined as a leader at the organizational level of director or above. Director refers to a leader who has responsibility for budgets and management covering more than one function or location. The participants operated across the footprint of the organization, leading in corporate positions, physician organizations, acute care hospitals, surgery centers, home health programs, medical research facilities, or specialty services.

Protection of human subjects. The Institutional Review Board (IRB) application was submitted through eProtocol, Pepperdine University's Graduate School for Education and Psychology's IRB electronic management system. The data was existing at the time of the study, and the study was determined to pose minimal risk to participants. The study was therefore submitted to IRB and approved on exempt review. Beyond contact information on the principal investigator and administrative contact, required documentation for submission included proof of human subjects training and information on the study, including setting, type, funding and purpose. Detailed information on the population, risks, benefits, consent process, confidentiality, and qualifications was also required.

Anonymity and confidentiality. Data were previously collected by the organization for a leadership development program and was existing at the time of the study. Site approval was obtained by the Vice President of Talent Management, the responsible party for the data. All personally identifiable information was removed prior to the researcher obtaining the data. The data was blinded and contained no identifying information, therefore it was anonymous. The data was stored and collected on internal servers prior to being shared with the researcher

electronically. The data was then pulled from the internal organizational database and input into IBM Statistics SPSS for analysis.

Risks and benefits. Minimal risks were anticipated, including a possible increased concern about personal leadership practices. There were no proposed benefits of participation. Conflicts of interest were not anticipated or known. All data collection instruments that were not developed by the researcher had the correct reference. Data will continue to be securely stored for at least three years after the study's completion.

Instrumentation

The instrument the organization used for the competency assessment was the Korn Ferry 360-feedback assessment (Ferry, 2015). Korn Ferry is an industry leader in global organizational consulting, focused on syncing strategy and talent to drive effectiveness (Ferry, 2015). This tool has the capability to assesses effectiveness on 67 different leadership competencies based on Korn Ferry's Leadership Architect, a reliable and validated global competency framework (Tang, De Meuse, & Dai, 2007).

The report included a self-score, an importance-score, and an other-score. The other-score raters are selected by the participant and include manager, peers, customers, and employees. This multiple rater approach is referred to as a 360-degree assessment (Antonioni, 1996). The other-score represents the mean of all others who rated the participant. The instrument was administered through an online system stored on Korn Ferry's server system and accessed through a link on an email sent from the Korn Ferry assessment server to each individual rater. The rater, including the participant, logged in with an individual login ID accessed from the link provided directly by Korn Ferry.

The data was then transferred by Korn Ferry to the organization and stored on an internal database matching the employee data to the results. The organization collected demographic data through the human resource system which was connected to the employee record. Gender and minority status were recorded as nominal variables. Clinical, also a nominal variable, indicated if the leader was a licensed clinician (either a physician or nurse).

Validity and reliability. Reliability is the consistency of measures over time and accuracy in representation of a population (Golafshani, 2003). Research in business, military, and education settings has shown that 360 instruments have up to .90 reliability (Dai et al., 2010). Validity is the degree to which any inference from the assessment score can be seen as reasonable. An instrument is considered valid if it measures what it was intended to measure. Validity for the Korn Ferry instrument is described in relationship to effectiveness and rated per competency (Ferry, 2015).

Eichinger and Lombardo (2004) originally developed the competency and assessment tool and established its reliability and validity. Test-retest reliability was found to be 0.75 for self-score and 0.82 for other-score. Across the competencies, internal consistency ranged from 0.77 to 0.93 (Eichinger & Lombardo, 2004). Dai et al. (2010) further validated the tool and found an average internal consistency of 0.70 across the original 67 competencies. Other researchers have used the model and assessment in their studies (Lievens et al., 2004; Tett, Guterman, Bleier, & Murphy, 2000).

Self, importance, and other scores. Each individual has a score for self, importance and other. The "self-score" was the score that each individual gave themselves, prompted by "rate your individual skill in this competency." Using a Likert scale, each participant provided a score

for each skill, from *a serious issue* (1), *a weakness* (2), *skilled/ok* (3), *talented* (4), to *towering strength* (5).

After rating themselves on each of the competencies, respondents then rated how important each skill was for the job. The Likert scale categories included *mission critical* (5), *very important* (4), *nice to have* (3), *less important* (2) and *least important* (1), resulting in an "importance-score". The importance scoring happens after the self-scoring to mitigate optimism bias, where a leader is more likely to rate themselves higher on a competency they believe is important (Silvia & Duval, 2001).

The other rater category included manager, peers, customers, and direct reports. Other than the manager, the raters are selected by the individual. The manager was the individual in the organizational structure to whom an employee reports and who was responsible for the employee's effectiveness. At least four other raters are required for a score to be given, in order to provide confidentiality for the participant when they review the responses. The mean of the other rater sources was called the "other-score". The calculation of an average score across raters has been shown to reduce the effect of low inter-rater reliability (Dai et al., 2010).

Healthcare executive core competencies. To define core competencies of healthcare executive leadership, the senior leadership team was engaged in an evidence-based selection method. The senior leadership of the organization was asked to filter the 67 competencies in the database down to a subset the most important skills for the future healthcare executive. The process used to select the core group of healthcare competencies was a Q-sort activity (Eichinger & Lombardo, 2003). A Q-sort method is a common methodology in psychological research. The Q-sort method assesses the reliability and construct validity of a questionnaire through an iterative process (Nahm, Rao, Solis-Galvan, & Ragu-Nathan, 2002).

The senior executive team met with certified professional coaches to conduct a Q-sort on the 67 competencies. The senior executive team consisted of senior leaders in operations, finance, legal, human resources, and nursing, as well as the chief medical officer. This was intended to represent an interprofessional viewpoint. The question prompt to the senior leadership was "What are the most important competencies for executive leadership in healthcare for the future?".

The cards were then sorted into five rating categories: (*a) essential for success, (b) very important, (c) nice to have, (d) less important, and (e) not important*. The process included a forced distribution to limit inflation. Only six cards could be in the top (1) and bottom (5) category. The middle (3) could have 23 cards included, leaving the maximum cards allowed in (2) and (4) at 16. Means were calculated and divided into top, middle, and bottom third.

The results of this executive leadership team process were repeated and verified through a random panel of certified coaches and human resources directors. Through a confirmation Q-sort, the resulting top 24 healthcare core competencies were selected. The total of these 24 healthcare core competencies are determined to measure leadership effectiveness for executives in a healthcare system. The definition of each core competency is listed in Table 8.

Table 8

Definitions of Healthcare Core Competencies (Lombardo, 2017)

Leadership Competency	Skilled Performance
Building Effective Teams	Creates a strong morale and spirit, shares wins, foster open dialogue and creates a feeling of belonging
Business Acumen	Knowledgeable on the business, current and future trends, competition, strategy and the marketplace

Leadership Competency	Skilled Performance
Comfort Around Higher Management	Deals comfortably with senior managers, can present effectively and understand how senior managers think and work
Compassion	Genuinely cares about people and their work and non-work problems. Demonstrates empathy and is available and willing to help
Creativity	Comes up with new and unique ideas, makes connections among unique ideas
Customer Focus	Dedicated to meeting expectations and requirement of customers, maintains effective customer relationships
Resiliency	Can effectively cope with change and change gears, can act without the total picture, comfortably handles risk
Decision Quality	Makes good decisions, suggestions turn out to be accurate over time, sought out by others for advice and solutions
Drive for Results	Can be counted on to exceed goals, consistent top performer, pushes self and others for results
Ethics and Values	Rewards the right values and disapproves of others, acts in line with values
Innovation Management	Facilitate effective brainstorming, can make good judgement about creative ideas

(continued)

Leadership Competency	Skilled Performance
Integrity	Seen as direct and truthful, is widely trusted, presents the truth appropriately, keeps confidences and admits mistakes, doesn't misrepresent self for personal gain
Interpersonal Savvy	Relates well to others, builds rapport and effective relationships
Learning on the Fly	Learns quickly, open to change, analyzes successes and failures, enjoys the challenge of new tasks
Courage	Provides constructive feedback to others, faces up to people problems quickly, takes action when needed, doesn't hold back what needs to be said
Managing and Measuring Work	Clearly assigns responsibilities and sets clear objectives, monitors progress and results, builds feedback loops
Managing Diversity	Hire, manages and supports people equitably and deals effectively with races, cultures, ages, disabilities, sexes, nationalities
Managing Vision and Purpose	Communicates an inspired vision and core purpose, is optimistic and can inspire and motivate others to the vision

(continued)

Leadership Competency	Skilled Performance
Motivating Others	Creates an environment where people want to do their best, empowers and invites others to share responsibility and visibility
Planning	Scopes projects and sets achievable objectives and goals, anticipates problems, and measures and evaluates results
Political Savvy	Deals with complex political situations and is sensitive to how people organize, anticipates relational challenges, and views politics as a responsibility
Priority Setting	Spends time on what's important and narrows in on critical few, can eliminate road blocks
Strategic Agility	Anticipates future consequences and trends, broad knowledge and perspective, breakthrough strategies and plans
Timely Decision-Making	Makes decisions timely, with possibly incomplete information and tight deadlines

Data Process and Analysis

The survey data were exported from the Korn Ferry system and collected in an internal database, which was then blinded and shared with the researcher. The data were then imported into IBM SPSS Statistics Version 25. Self-awareness was calculated by subtracting other-score from self-score per competency. The effectiveness score was calculated by summing the other-score from the total of the 24 competencies in the framework.

By subtracting other-score from self-score, a numerical rating of self-awareness was provided; this was referred to as self-other agreement (SOA) in the literature (Atwater et al., 1998). Negative numbers indicated under-claiming, meaning an individual rated themselves as lower than their perceived effectiveness (other-score). Positive numbers indicate over-claiming, an individual rated themselves as higher than perceived effectiveness (other-score). For example, a participant with scores of -0.125, -1.025 and .050 on the courage, resiliency and integrity competencies would have an overall self-awareness score of -1.10. A participant with an overall self-awareness score of 0 would have congruent self-awareness, or agreement between self and other-score.

Leadership effectiveness was calculated as the sum of the other-score across all competencies. The other-score gives an overall indication of the perception of leadership effectiveness. Each competency in the framework had been validated against effectiveness, the outcome the assessment was designed to measure (Eichinger & Lombardo, 2003). The combined competency validation in relationship to effectiveness was shown to be 0.46 at the executive level. This means that 46% of executive effectiveness could be attributed to leadership competence as measured through the instrument.

Statistical Analysis Process

Initially, descriptive statistics, including mean, standard deviation, and ranges of scores, were calculated for each of the variables. Multiple linear regression was then leveraged for both research questions to examine the nature and strength of the relationships between variables. A regression analysis assumes that two variables have a linear relationship and are measured on an interval/ratio scale. It also assumes that the variables have a normal distribution and are not too closely correlated to each other (Urdan, 2011).

The purpose of regression analysis is to predict the values of the dependent, or outcome, variables (DV) based on variations in the independent, or predictor, variable (IV). Multiple regression allows for covariate relationships to be examined. Covariates are other factors that can contribute to variations in the outcome variables. For instance, by including the effects of demographic information the researcher could assess how much these variables are related to self-awareness. The outcome also provides the strength of the relationship of each factor while controlling for the others.

A multiple linear regression was selected over a standard correlation because it provides more information and allows for a predicted value to be calculated. A correlation coefficient provides a number on the relationship between two variables. However, in a regression, a slope line can also be calculated, and predictions can be made.

The regression line provided by the analysis allowed for predicting the outcome variable, based on changes to the predictor(s). For instance, for every one-use increase in IV, a calculated increase/decrease in DV was possible. The more closely correlated these variables were, the stronger the relationship, and the greater the slope of the line. The regression slope line translates to an equation. Using this equation, predictions can be made through mathematical calculations, based on changes in the IV and covariates. To clarify, even with this information, causality was not determined, only relationships and effects.

Research Question 1: What factors predict self-awareness on Level 1 Global Leadership competencies of integrity, courage, and resiliency? In order to answer the first question, the current study used multiple linear regression. The dependent variable was self-awareness on the three Level 1 Global Leadership competencies of integrity, courage, and resiliency. Three regression models were conducted, one for the L1 Global Leadership

competencies as the independent variables. To control for the potential confounding effects of multiple individual factors, the study controlled for binary indicators of gender, minority status, and professional background. Importance score was also considered a covariate and included the regression models.

Research Question 2: Is self-awareness on Level 1 Global Leadership competencies associated with leadership effectiveness? Multiple linear regression was again leveraged. In this model the dependent variable was leadership effectiveness. The independent variable was Level 1 Global Leadership self-awareness on each competency. Again, controlling for gender, minority status, profession, age, and importance.

Summary

The purpose of this quantitative, non-experimental study was to model leadership self-awareness among executives in healthcare. Chapter 3 reviewed the purpose and research questions for the study, described the research design and rationale, and reviewed the research setting and data collection strategies and procedures. Also, the instruments for data collection were described. The chapter concluded with an explanation of the statistical analysis that was conducted in the study. The following chapter, Chapter 4, will restate the purpose and research questions, provide descriptive analysis of the participants, and summarize the inferential analysis findings.

Chapter 4: Results

Overview

The purpose of this study was to explore the relationship between self-awareness on Level 1 Global Leadership competencies and leadership effectiveness for executives in healthcare. Chapter 4 details the results of the descriptive and inferential statistics used to address the following research questions:

RQ1: What factors predict self-awareness on Level 1 Global Leadership competencies of integrity, courage, and resiliency?

RQ2: Is self-awareness on Level 1 Global Leadership competencies associated with leadership effectiveness?

A series of statistical tests were conducted, designed to examine the data in depth. To begin, descriptive statistics were run on the sample to categorize the data for each variable. The outcomes are presented in table format showing the average score per variable. This allows for a quick view of the sample. A histogram, an overall picture of the results, was then created to show the distribution of scores for each variable. This level of analysis allows for assumptions to be made, about the overall population of executives in healthcare.

Next, independent sample *t*-tests compared the variables to each other to determine if there were significant differences between them. This led to a need to determine the direction and strength of the relationship. Therefore, multiple linear regression models were conducted in order to create a slope line. This line provided information utilized to predict changes to the dependent variable, based on changes on the independent variable. Finally, the chapter concludes with a synopsis of the analysis and provides a preview of the next chapter.

Descriptive Statistics

The analysis began with a descriptive analysis of the sample data. Descriptive statistics allow for large data sets to be consumed in a way that is easier to understand. Instead of viewing the entire data set, descriptive statistics create a picture of the overall composite of the sample. This was important to do in order to assess the distributional qualities of the variables used in the empirical analyses, which would then inform the researcher whether necessary assumptions of the linear model were satisfied.

Demographic and professional variables. Table 9 describes the results of demographic descriptive statistics on the sample. As the data in this table show, the participants in the sample varied across demographic and personal identifiers. The sample of 97 participants included 62 (i.e., 64%) females and 35 (36%) males. This female to male ratio aligns with the general population of healthcare practitioners; however, it does not align with known gender ratios in leadership. For example, studies indicate that women dominate the healthcare industry overall, but this dominance is not reflected in top roles in leadership (McDonagh, Bobrowski, Hoss, Paris, & Schulte, 2014).

Race/ethnicity was an important consideration in this study since it was plausible that self-awareness can be moderated by one's racial/ethnic identity. Consequently, participants in the study were asked to report their racial/ethnic identification. Thirty participants identified as "White" and the remaining participants self-identified as "Black," Asian," "Latino" or "other." Because the numbers of participants who identified as being non-White were too small to allow for meaningful disaggregated statistical analysis, the researcher collapsed all participants into either White or minority status. Descriptive analysis in Table 9 also shows that of the participants

in the current study, 67 (i.e., roughly 70%) self-identified as "White" while the remaining participants (30 or 30%) self-identified as "minority."

Descriptive analysis in Table 9 also shows that of the total participants in the study, 38 (39%) identified as clinical leaders. This means that nearly 40% worked as licensed physicians, nurses, or pharmacists. As with race, the distinction between the clinical professions did not represent a large enough sample; therefore, they were included in a group named "clinical," to represent all leaders with a clinical license. The remaining 59 participants (~ 60%) worked as administrative leaders with no clinical background. Sample administrative positions include attorneys; administrative directors; and personnel in finance, support services, or human resources.

Data in Table 9 also show tremendous variation in the age of the sample participants. While the average age of participants in the study was 42, the standard deviation was nearly 10 years. This suggests that roughly 95% of the sample participants were within 22 and 62 years of age. Indeed, the youngest participant was 25 and the oldest was 59.

Table 9

Descriptive Summaries of Variables

	Variable	Mean	Standard Deviation
Demographic and	Female	0.64	--
Professional	Clinical	0.39	--
	Minority	0.31	--
	Age	42.0	9.72

(continued)

Variable	Mean	Standard Deviation	Variable
Level 1 self-awareness	CourageSA	-0.35	0.86
	IntegritySA	-0.05	0.76
	ResiliencySA	-0.28	0.79
	Effectiveness	95.06	5.52
Importance scores	CourageSI	4.12	0.63
	IntegritySI	4.47	0.54
	ResiliencySI	4.03	0.71

Level 1 self-awareness. Outcome variables include self-awareness scores for the Level 1 Global Leadership competencies: courage, integrity, and resiliency. The self-awareness score was calculated through self-other agreement (SOA), as described in detail in Chapter 3. The other-rating was subtracted from the self-score to provide a self-awareness score. A positive number indicates over-claiming, and a negative number indicates under-claiming. For example, a self-score of 4.5 with the other-score of 4.0 would result in a self-awareness score of positive .50. This participant therefore over-claimed their skill in this specific competency. A score of 0 indicated perfect self-awareness, referred to as congruence.

Descriptive statistics of the remaining self-awareness variables are found in Table 9. Each of the competencies resulted in over-claiming as a theme. Courage had a mean of -.35 (*SD* = .86), meaning that the average of participants underestimated their capability by .35 of a unit. For integrity, participants had an average under-claiming score of .05 (*SD* = .76). For resiliency, the mean was found to be -.28 (*SD* = .79). In each of these competencies, there is a disparity between what leaders intend and how others experience their actions.

Leadership effectiveness. The 24 leadership competencies as a total represent leadership effectiveness for healthcare executives. By totaling the other-scores of the 24 skills, a composite score was calculated. The composite score evens out an individual leader's strengths and weaknesses and reports a numerical rating of how others view the leader's total effectiveness. The average effectiveness score for the group was 95.06 (*SD* = 5.52). The total possible was 120. Therefore, the average skill of this group was 80% of total effectiveness.

Importance scores. The study included a control variable of importance on each competency. This was done to account for potential bias that might have occurred. It was hypothesized that the more important an individual believed a competency to be, the more likely they were to over-claim their skill in that competency. The possible scores for importance per skill ranged on a Likert scale from 5 (critical to success) to 0 (nice to have but not necessary).

The courage importance score average was 4.12 (*SD* = .63); integrity was seen as slightly higher in importance (*M* = 4.47, *SD* = .54). Resiliency was seen as the least important of the three (*M* = 4.03, *SD* = .71). Because there are the 24 industry best practices for executive healthcare leadership effectiveness, it was expected that most competencies would be over a score of 4. However, while the difference between skill importance was slight, it indicates which skills respondents regarded as most and least important. The focus for this study was on how this number related to leaders' personal self-awareness.

Central tendency. Figure 2 shows the distribution of data within each outcome variable. A histogram for each of the outcome variables related to self-awareness was created to test for a central tendency. A histogram compiles the data on a bar chart to highlight the number of results within a range. The central tendency was defined by both the median, or true middle, and the mean, which was the calculated average. The variance was shown on either side of the mean.

In the distribution for courage self-awareness, the mean (M = -.35) was slightly below the median (P_{97} = -.33), indicating a slightly negative skew. This means that the average score for self-awareness was negative more than it was positive. In other words, more people under-claimed, versus over-claimed their skill. Because the true middle was close to the number, the overall data set was only slightly heavier on the negative side. The same held true for integrity self-awareness; however, the mean was (M = -.05) above the median of (P_{97} = -.16), resulting in a slight positive skew. The skew means that while the average score was just under 0, the middle point was actually lower than that. Finally, resiliency had a slight negative skew with a mean of (M = -.28) in comparison to (P_{97} = -.18). In this competency, the mean was smaller than the true middle, making the overall weight of the scores leans towards under-claiming.

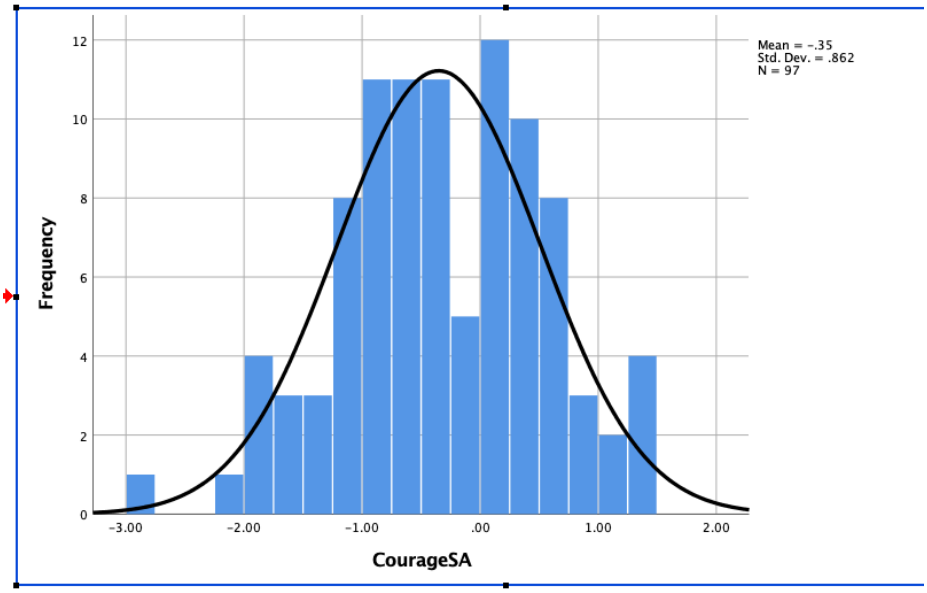

Figure 2. Histogram of courage self-awareness.

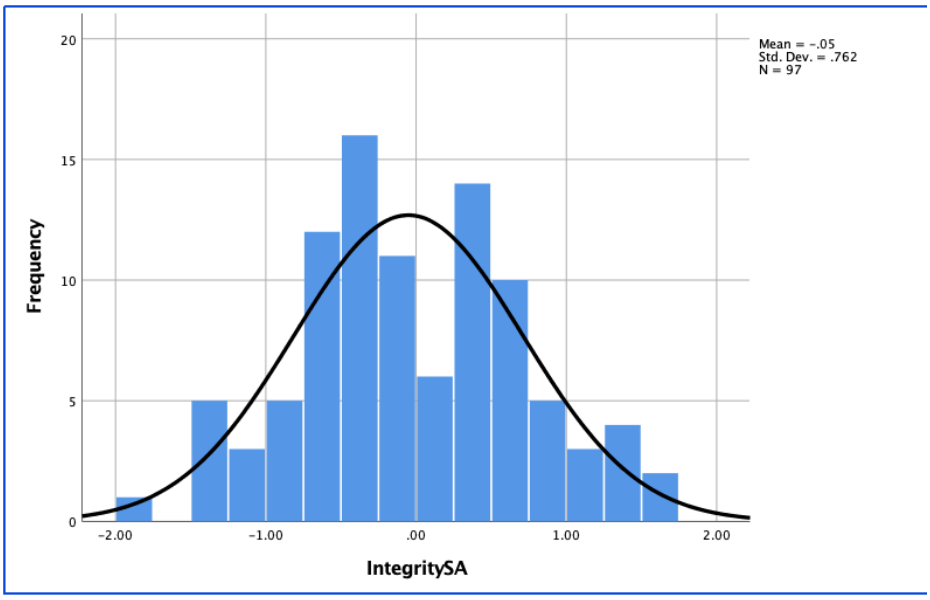

Figure 3. Histogram of integrity self-awareness.

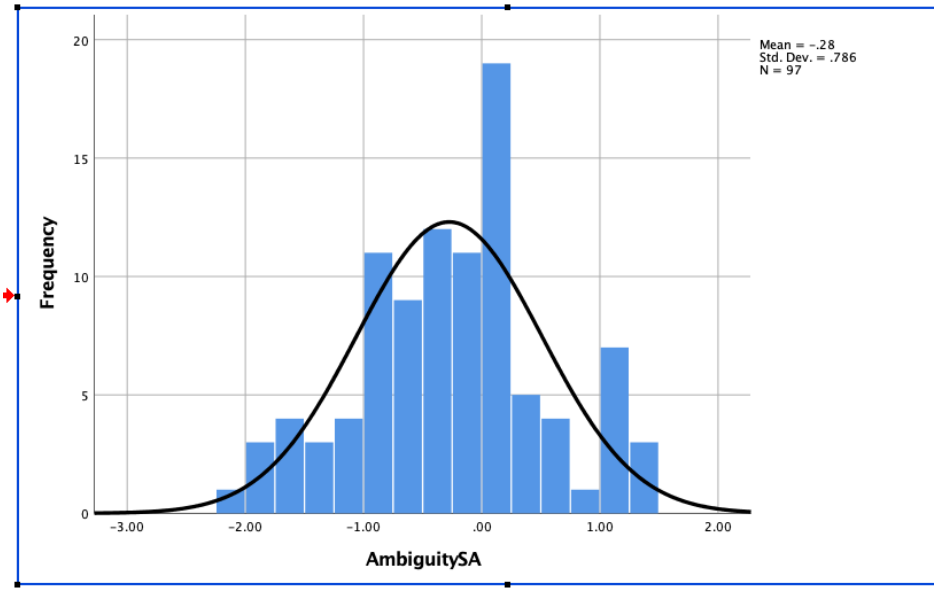

Figure 4. Histogram of resiliency self-awareness.

Due to the normal distribution of data, the following data analysis can be conducted with relative confidence. The normal distribution, though not a perfect bell-shaped curve, is only slightly skewed; this proves that the data is useful for inferential, parametric statistical analysis. This further supports the possibility that the sample could potentially represent the population.

Variances by outcome variable. Table 10 describes the distribution of the outcome variables disaggregated by demographic factors. Literature indicates that demographic and professional information effects skill on a competency and also how individuals rate themselves. For instance, women and minorities were shown in the literature to be more likely to under-claim their competency, whereas clinical leaders were more likely to over-claim their ability, due to the Dunning-Kruger effect (Kruger & Dunning, 1999). In this effect, experts are more likely to be less aware of the perceptions of others and therefore overestimate their competence. The study examined this relationship across the three Level 1 Global Leadership competencies; courage, integrity, and resiliency.

Table 10

Descriptive Outcomes for Self-Awareness and Effectiveness Variables

	Female		Male		Minority		White		Clinical		Admin	
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
Courage	-0.41	0.80	-0.25	0.96	-0.35	0.80	-0.35	0.89	-0.10	0.80	-0.51	0.87
Integrity	-0.08	0.78	-0.01	0.74	0.31	0.73	-0.21	0.73	-0.02	0.88	-0.07	0.69
Resiliency	-0.35	0.79	-0.14	0.78	-0.40	0.85	-0.22	0.76	-0.21	0.76	-0.32	0.81
Effectiveness	95.18	5.50	94.83	5.64	92.67	6.23	95.94	5.00	96.70	5.29	93.95	5.44

Courage self-awareness, or the ability to speak up when needed, varied across demographics. Females under-claimed their competence by .41 (*SD* = .80) and males by .25 (*SD* = .96). This competency showed no difference in averages between minority (*M* = -.35, *SD* = .80) and white participants (*M* = -.35, *SD* = .89). Administrators had higher levels of courage self-awareness (*M* = -.10, *SD* = .80) than clinical leaders (*M* = -.51, *SD* = .87), as they under-

claimed their skill at a lower rate. Even if an individual under-claimed their skill by a higher degree, they lacked as much self-awareness as an individual who over-claimed their skill at the same level. The closer to zero on either side, the more self-aware the individual was. In summary, for courage, females had lower self-awareness, minority status showed no difference, and clinical leaders had lower self-awareness in regard to this competency.

Self-awareness in integrity, meaning acting in a trustworthy and consistent manner, varied as well. When individuals rated themselves higher than others, it indicated that they intend to be trustworthy, but others don't experience their actions in this way. Females were less self-aware in this competence, under-claiming (M = -.08, SD = .78) their competence more than males (M = -.01, SD = .74). Minorities over-claimed their competency in this skill (M = .31, SD = .73), meaning that minorities rated themselves higher than others perceived their skill. Their non-minority counterparts under-claimed this skill (M = -.21, SD = .73). Clinical leaders' self-awareness score in integrity was nearly congruent (M = -.02, SD = .88). This indicates that a clinical leader sees themselves as acting with integrity in roughly the same way that others perceive their actions.

Scores for resiliency self-awareness, the ability to handle ambiguity and change, showed similar differences. Females, again, under-claimed their skill (M = -.35, SD = .79) more than males (M = -.14, SD = .78). Minorities (M = -.40, SD = .85) under-claimed this skill nearly twice as much as white participants (M = -.22, SD = .76). The clinical leaders (M = -.21, SD = .76) and administrative leaders (M = -.32, SD = .81) also had negative self-awareness scores. All participants under-claimed their level of resiliency. Participants internal processing of change is not reflected in how others perceive their ability to deal with change.

Leadership effectiveness. Examination of the leadership effectiveness variable revealed the following results. Female, white, and clinician participants showed higher effectiveness than their counterparts. The difference between female (M = 95.18, SD = 5.5) and male (M = 94.83, SD = 5.64) was slight. Minority (M = 92.67, SD = 6.23) leaders showed nearly a 3.3-point difference in effectiveness from white leaders (M = 95.94, SD = 5.00). Clinicians' (M = 96.70, SD = 5.29) effectiveness was higher than that of administrative leaders (M = 93.95, SD = 5.44).

In summary, females and minorities under-claimed their competence more than their counterparts, meaning they were less self-aware and humbler. The Dunning-Kruger effect did not seem to be in effect for clinical leaders. Clinicians showed more congruency in self-awareness than administrators. To further examine the compounded relationships between variables, *t*-tests were conducted.

Comparisons of Means

Independent samples *t*-tests were conducted to assess differences on outcome variables by the three factors of gender, minority status, and profession. These tests indicated whether an observed difference between the two means is large relative to the standard error of the difference of the means. While the means of the outcome variable appeared to be different across demographics and professional groups, it is important to test the degree to which these differences were attributable to the sampling error. Consequently, a series of independent samples *t*-tests were run to test for mean differences in the outcome variables. Results for these tests are found in Tables 11-13.

The three tables below show the difference between group by outcome variable. The gender *t*-tests didn't reveal any significant differences between genders. However, the minority group independent *t*-tests showed significant differences in integrity self-awareness. The

minority group showed an over-claiming of self-awareness for integrity (*M*= .31, *SD*= .73) as well as further from congruency than the non-minority group (*M*= -.21, *SD*= .73); *t*(.06) = 3.25, *p* < .01. Leadership effectiveness was also lower for the minority group (*M*= 92.67, *SD*= 6.22) than non-minority group (*M*= 95.94, *SD*= 5.00) by nearly three points; *t*(2.84) = -2.55, *p* < .05. These results suggest that minorities are over-claiming on integrity and this over-claiming may be having an effect on effectiveness.

Significant differences were also found to exist between clinical and administrative leaders. On courage self-awareness, clinical leaders were greater under-claimers (*M*= -.10, *SD*= .80) than administrative leaders (*M*=-.51, *SD*= -.87) and further from congruency; *t*(.39) = 2.35, *p* < .05. Leadership effectiveness for the clinical group (*M*= 96.68, *SD*=5.93) was higher than the non-clinical group (*M*=93.95, *SD*= 5.44); *t*(.70) = 2.35, *p* < .05. These results suggest that clinical leaders are more self-aware regarding courage and therefore more effective in that competency than administrative leaders.

Table 11.

SPSS Results of Independent Samples t-tests – Gender

GENDER	Mean			t Statistic
	Female	*Male*	*Difference*	
Courage	-0.41	-0.25	-0.16	-0.88
Integrity	-0.08	-0.01	-0.07	-0.40
Resiliency	-0.35	-0.14	-0.21	-1.28
Effectiveness	95.18	94.83	0.35	0.29

If significant at the *p<0.05, **p<0.01, ***p<0.001

Table 12

SPSS Result of Independent Samples t-tests – Minority

MINORITY	Mean			t statistic
Variables	*Minority*	*White*	*Difference*	
Courage	-0.35	-0.35	0.01	0.04
Integrity	0.31	-0.21	0.52	3.25*
Resiliency	-0.40	-0.22	-0.18	-1.03
Effectiveness	92.67	95.94	-3.26	-2.55*

If significant at the *p<0.05, **p<0.01, ***p<0.001

Table 13

SPSS Result of Independent Samples t-tests – Clinical

PROFESSION	Mean			*t* statistic
Variables	*Clinician*	*Admin*	*Difference*	
Courage	-0.10	-0.51	0.41	2.35*
Integrity	-0.02	-0.07	0.05	0.30
Resiliency	-0.21	-0.32	0.12	0.70
Effectiveness	96.69	93.95	2.73	2.35*

If significant at the *p<0.05, **p<0.01, ***p<0.001

The independent sample *t*-test showed significant differences between the binary variable of minority status in the sample for integrity self-awareness and leadership effectiveness. The minority group significantly over-claimed their skill, compared to the non-minority, white group.

This difference was also reflected on the effectiveness variable, with the minority group showing over three points lower. Significant differences were also found between clinical and administrative leaders in courage self-awareness and leadership effectiveness. Clinical leaders were much closer to congruence, with administrative leaders under-claiming on courage significantly. This was reflected in a gap in effectiveness as well, with clinical leaders outperforming the administrators. These findings support the hypothesis that there is a relationship between self-awareness and effectiveness. We could expect that significant differences would be found in a repeated test with another sample within the population of executives in healthcare.

The independent sample *t*-test allowed for a comparison of means, and several significant differences were found. However, a *t*-test does not allow for taking into effect variables in the environment. Confounding variables, or covariates, are variables that could have an effect on the outcomes of the analysis. For instance, age could be a factor on level of self-awareness and skew the outcome variable results reported above. To examine these results in more depth, correlation and multiple linear regression analysis was conducted.

Examining Relationships Between Variables

The impact of importance-score per competency could be contributing to the differences suggested in the *t*-tests. The literature suggested a connection between an individual's values and their reported self-awareness (Dunning & Heltzer, 2014). A correlation analysis was conducted in order to account for this potential impact. To investigate the idea that importance ranking is correlated with self-awareness, a bivariate correlation coefficient was calculated. Table 14 is a correlation matrix describing the relationship between importance and self-awareness. The correlation coefficient for each was shown to be significant. Courage self-awareness had a

moderate positive correlation coefficient of $r = .36$ with importance on the same competency. Integrity self-awareness $r = .23$ and resiliency self-awareness $r = .18$ were also found to be moderately correlated. The significant relationships indicate that for every increase in importance, we could expect to see an increase in self-awareness. Therefore, courage and integrity importance scores are both correlated with self-awareness. The more important they are to a rater, the higher they rate themselves on the competency.

Table 14

Correlation Matrix Between Self-Importance (SI) and Self-Awareness (SA)

	CourageSI	IntegritySI	ResiliencySI
CourageSA	.358***		
IntegritySA		0.227*	
ResiliencySA			0.178

If significant at the *p<0.05, **p<0.01, ***p<0.001

This test shows that the importance score for two competencies are associated with self-awareness; however, this result does not demonstrate a causal association. It also does not provide information of the nature or strength between variables. To answer the research question, a prediction across variables controlling for the unique contributions of covariates was required. For this deeper examination, simple linear and multiple regression analyses were conducted to address each of the two research questions.

Predicting Self-awareness and Effectiveness

The purpose of a regression analysis is to make predictions about the value of a dependent variable based on a predictor valuable. Multiple regression allows the analysis to

control for variables that could potentially cause an effect. By controlling for variables, multiple regression allows researchers to compare individuals of similar traits and characteristics. The results of a regression analysis indicate (a) how the group of predictor variables are related to the dependent variable, (b) the strength of the relationship between the predictor variables and the dependent variables while controlling for the other predictor variables, and (c) the predictor variables' relative strengths.

RQ1: What factors predict self-awareness on Level 1 Global Leadership competencies of integrity, courage and resiliency? Multiple regression was utilized to address the first research question. It was designed to predict self-awareness on integrity, courage and resiliency. Three individual models were conducted to address this question, one per dependent variable. Previous analysis indicated that gender, minority status, and profession have an impact on self-awareness. Initially, these three factors only were entered into the model as predictor variables.

Table 15 shows the results per variable. Together gender, minority status, and profession account for 4% of the variance in resiliency self-awareness, 10% for integrity self-awareness and 7% for courage self-awareness. Two significant findings were found. Minority status had a significant impact on integrity ($B = .52$, $p < .01$) and profession on courage ($B = .43$, $p < .05$). Meaning, minorities are more likely to over-claim their competency on integrity than the non-minority group and clinical leaders are more likely to over-claim on courage. To take it one step further, this result shows that other raters saw the demonstrable skills of the participants to be lower than they rated themselves.

Table 15

Analysis of L1 Self-Awareness and Gender, Minority, Profession

	R^2	Variable	β	SE
Resiliency	.037	Female	-0.23	0.17
		Minority	-0.19	0.17
		Profession	0.14	0.16
Integrity	.102	Female	-0.04	0.16
		Minority	0.52**	0.16
		Profession	0.05	0.15
Courage	.067	Female	-0.39	0.18
		Minority	-0.01	0.19
		Profession	0.43*	0.18

Significant at *p<0.05, **p<0.01, ***p<0.001

The analysis indicated that no one demographic or professional variable accounted for variance in self-awareness across the three competencies. However, minority status and clinical leaders were show to significantly over-claim their competency. Therefore, additional multiple regressions were conducted to include additional co-variates, age and importance-score.

The analysis yields additional significant relationships when the covariates of age and importance are added to the model. Table 16 shows the results of the expanded regression analysis. The five predictor variables, taken together, account for 19% of the variance for resiliency self-awareness, 17% for integrity and 23% for courage. As expected, this addition of two covariates resulted in improvement to the model.

Table 16

Analysis of Level 1 Self-Awareness and Predictor Variables Including Age and Importance

	R^2	Variable	β	SE
Resiliency	.187	Female	-0.19	0.16
		Minority	-0.02	0.17
		Profession	-0.15	0.17
		Age	0.30**	0.01
		Resiliency SI	0.31**	0.11
Integrity	.169	Female	-0.03	0.15
		Minority	0.59**	0.17
		Profession	-0.07	0.17
		Age	0.01	0.01
		Integrity SI	0.36**	0.14
Courage	.233	Female	-0.14	0.17
		Minority	0.19	0.18
		Profession	0.04	0.18
		Age	0.03**	0.01
		Courage SI	0.34*	0.13

If significant *p<0.05, **p<0.01, ***p<0.001

Importance per competency is found to be a significant predictor of self-awareness for each competency. The factor of importance has an effect on self-awareness even when considered with other covariates. The importance effect on resiliency self-awareness (B = .31, p

< .01), integrity self-awareness (B = .36, p < .01), and courage self-awareness (B= .34, p < .05) were all significant. The results suggest that importance score predicts the self-awareness score on each competency.

Age was also found to have a significant effect on self-awareness for both resiliency (B= .30, p < .01) and courage (B= .03, p < .01). Factoring in age, a significant relationship still exists between minority status and integrity (B = .36, p < .01). Meaning, minorities are shown to significantly over-claim the skill of integrity. However, the relationship between profession and courage self-awareness is no longer significant (B = .04, p = .18). With age taken into account, a clinical leader is no longer predicted to have significantly higher self-awareness on courage. However, as age increases, self-awareness score could be predicted to increase.

The multiple regression models indicate that the factors of importance score, age and minority status significantly predict self-awareness on global leadership competencies. Specifically, as importance score increases, self-awareness score increases. Minority status leads to over-claiming on integrity. Age increases self-awareness on both courage and resiliency. The results suggest that the most important factors to consider in relationship to how they contribute to self-awareness score are age, importance and minority status.

RQ 2: Is self-awareness on Level 1 Global Leadership competencies associated with leadership effectiveness? The next research question examined the relationship between self-awareness and leadership effectiveness. Integrity, courage and resiliency self-awareness were anticipated to have an effect on effectiveness. To begin the analysis, self-awareness scores on integrity, courage, and resiliency were combined to result in a Level 1 self-awareness (L1 SA) score. As stated, a leadership effectiveness score was calculated as the total other-score across all 24 leadership competencies determined to be the core skill set for healthcare executives.

The literature indicated that self-awareness is related to effectiveness, therefore it was an anticipated outcome of the analysis. Table 17 depicts the results of a simple linear regression utilized to determine whether self-awareness across all global leadership competencies was associated with overall effectiveness. Total self-awareness was calculated across all 24 competencies. The relationship was found to be negatively correlated and significant (B = -.19, p < .001). This is an interesting result, indicating that under-claimers have significantly higher leadership effectiveness than over-claimers. As total self-awareness moves beyond zero, or congruence, effectiveness declines by .19 points.

Table 17

Regression Analysis on Self-Awareness (TotalSA) and Effectiveness

	R^2	Variable	β	SE
Effectiveness	.151	TotalSA	-.185***	0.048
If significant *p<0.05, **p<0.01, ***p<0.001				

However, this study is concerned with the Level 1 Global Leadership competency threshold traits. A linear regression was then run to determine if Level 1 (L1) self-awareness has an effect on effectiveness, without taking any co-variates into account. Table 18 indicates the results. The predictor of Level 1 self-awareness accounted for 2.2% of the variance in leadership in effectiveness. A negative relationship between Level 1 self-awareness and leadership effectiveness remained (B = -.51, p = .09). However, the findings are not significant.

Table 18

Regression Analysis of Level 1 Self-Awareness (L1 SA) and Leadership Effectiveness

	R^2	Variable	β	SE
Effectiveness	.033	L1 SA	-0.51	0.34
If significant at the *p<0.05, **p<0.01, ***p<0.001				

Variables in the environment were hypothesized to be causing an effect. This is considering the significant findings on total self-awareness relationship to effectiveness reported above. Therefore, additional models including control variables were again conducted. Table 19 outlines the results of the multiple linear regression analysis holding constant for gender, minority status, profession, age and importance.

Table 19

Analysis of L1 SA and Leadership Effectiveness with Covariates

	R^2	Variable	β	SE
Effectiveness	.276	L1SA	-0.93**	0.33
		Female	-0.06	1.09
		Minority	-1.81	1.25
		Profession	1.37	1.17
		Age	0.22**	0.07
		L1Importance	0.67	0.41
If significant *p<0.05, **p<0.01, ***p<0.001				

The six variables were simultaneously entered into a new model: L1 self-awareness, L1 importance, female, minority, profession, and age. The predictors together accounted for 27.6% of the variance in leadership effectiveness. L1 self-awareness was found to be significant (B = -.93, $p < .01$). Results indicated a negative association between the Level 1 self-awareness measure and leadership effectiveness. More specifically, for a one unit increase on the self-awareness measure, we would expect job effectiveness to fall by .93 points. In other words, as participants moved from lower self-awareness scores (under-claiming) to higher self-awareness scores (over-claiming) their effectiveness decreased. This finding confirms the findings of a prior analysis conducted by Bratton et al. (2011) who found that under-claimers perform better than over-claimers. Age was found to be positively associated with effectiveness, (B = .22 $p < .05$) such that as age increased, so did leadership effectiveness.

The hypothesis of the research was that self-awareness on Level 1 Global Leadership competencies would have an effect on leadership effectiveness. When run as only two variables, the results were found to have no significant relationship. However, when covariates were added to the model, significant relationships were discovered. By holding constant for gender, minority status, profession, age, and importance, the relationship between self-awareness on Level 1 Global Leadership competencies and leadership effectiveness was shown to be significant. As individuals age, so does leadership effectiveness. Most interestingly, the higher the self-awareness score (over-claiming), the lower the effectiveness.

Summary

The purpose of this study was to model global leadership self-awareness across healthcare executives. Beginning with an analysis of demographic information through descriptive statistics, the sample was examined. Independent sample *t*-tests were then leveraged

to examine relationships between variables. The tests showed significant differences for the minority status group in the area of integrity self-awareness, indicating higher over-claiming (or lower self-awareness) than the non-minority counterpart. Significant differences were also found between clinical and administrative leaders in courage self-awareness with clinical leaders showing closer to congruent self-awareness for courage. Inferential statistics were then leveraged to answer the research questions.

A correlation coefficient calculation was conducted for the first research question. A moderate relationship between Level 1 Global Leadership competencies self-awareness and importance score of each competency was found, validating the importance of the variable as a covariate. The regression models indicated that the factors of importance, age, minority status, and profession significantly predict self-awareness on Level 1 Global Leadership competencies. Specifically, as importance increased, self-awareness scores increased across all competencies. Minority status was found to have lower self-awareness (higher over-claiming) in integrity. Finally, as the age variable increased, courage and resiliency self-awareness scores increased.

Multiple linear regression analysis was then utilized to address the second research question and surprising results were found. Initially, no relationship was found between the two variables. However, when the covariates of age, importance, gender, minority status, and profession were added to the model, the hypothesis was validated. The finding of a significant relationship between both age and self-awareness on Level 1 Global Leadership competencies was identified. Not surprisingly, but interestingly, as age increases, leadership effectiveness was shown to increase. A more nuanced finding was that as an individual move from humility (under-claiming skill) to over-claiming skills on Level 1 Global Leadership competencies, leadership effectiveness decreases. This is a significant finding for practitioners in human

resources and talent management, highlighting the importance of self-awareness, self-development and humility.

These findings and the implications support a conscious leadership theory and will be discussed in detail in the next chapter. Chapter 5 will review the primary results discussed here and in the literature review. It will then cover an interpretation of the results in relationship to the research questions. Finally, a discussion on the implications of this research, application recommendations, and suggestions for future research will be provided.

Chapter 5: Conclusion

The purpose of this study was to examine global leadership self-awareness and the effect on leadership effectiveness of healthcare executives. This chapter provides a review of the background and an orientation to the study. It also provides a synopsis of the findings and proposes applications for practice and suggestions for future research. The chapter concludes with a call to action for all leaders who will lead the future of healthcare.

Study Overview

As previously stated, the future of healthcare is highly complex, contains unknown uncertainty and is constantly changing (Porter & Teisberg, 2006). Due to exponential shifts in the regulatory, technological and global environment, the rate of change is accelerating, and executive leadership is forced to evolve their practices for the future (Love & Ayadi, 2016). The success of leaders within healthcare impact the health of the communities in which they operate and individuals within the community (Love & Ayadi, 2016).

Non-profit healthcare operates closely to what is referred to as a conscious business model, focused on three targets; profit, people and the planet (Hofman, 2008). In other words, non-profit healthcare must sustain operations financially (profit), as well as function as an employer in the community (people) and the provider of healthcare to the citizens (Harris, 2008). Clinicians, such as physicians and nurses, make patient decisions every day, impacting the health of each individual they treat. However, healthcare leaders also make decisions which impact care at the patient level as well as the community level, impacting more people and patients with every decision. For example, decisions to enter or exit service lines, impact patients and caregivers across the continuum of care. Healthcare leadership has far a reaching impact for the

planet, beyond the local community, even effecting policy at the local, national and global level (Harris, 2008).

Decisions at the regulatory or policy level, influenced by healthcare executives, affect not only the present but also the future. For instance, the effects of the Affordable Care Act (ACA) impacted the way care was delivered by encouraging the development of healthcare systems, needing to provide care beyond the individual hospital stay or office visit. The ACA limited Medicare payments on readmissions, which meant, patients needed to stay healthy when they left the visit (Kocher, Emanuel, & DeParle, 2010). The way patients took care of themselves at home became a problem of the healthcare provider to solve. This required a move towards hospital system integration, aimed at expanding the continuum of care (Waring et al., 2018). Therefore, healthcare executives are required to lead beyond their original scope and into a more complicated systems approach.

As more people were taking advantage of these new care delivery models, new approaches to managing health also began emerging (Rak & Janis Coffin DO, 2013). A move towards virtual health was made possible by the HITECH act, which demanded meaningful use of the electronic healthcare record (Harris, 2008). Once patient information was made available and shareable digitally, providing care virtually, became a possibility. This has far reaching impacts, beyond the local community to people around the globe. For instance, if a famous heart surgeon at Stanford University can provide care virtually anywhere, possibilities for excellence in healthcare are exponential. Managing this type of access and information is delicate and complex. The dynamic environment in which healthcare organizations operate requires not only excellence within leadership but also the ability to lead with careful action and clear purpose (Love & Ayadi, 2006).

Global leadership competency models have been designed to identify, measure and develop the skills needed to lead effectively in a complex and ambiguous environment (Mendenhall et al., 2017). So-called intrapersonal skills - integrity, courage and resiliency – are foundational to global leadership effectiveness (Mendenhall et al., 2017). Competency in these skills is considered essential, however development typically focuses on cognitive and inter-personal skills (Osland et al., 2006). The three competencies of integrity, courage and resiliency are referred to in this study as Level 1 Global Leadership competencies and are identified as a foundational requirement for leadership effectiveness.

As the environment evolves and executives are asked to work at peak effectiveness, they are facing more burnout and decreased well-being (Glasberg et al., 2007). Increased self-awareness has been shown to result in increased well-being and therefore decreased burn out (Hernandez et al., 2015). Greater self-awareness has also been shown to be related to higher leadership effectiveness (Van Velsor et al., 1993). Leading with wisdom and purpose requires internal and external self-awareness. Internal self-awareness is an understanding of personal needs, drives and beliefs. External self-awareness is understanding impact on others and the ability to respond to others effectively (Wicklund & Duval, 1971). Self-awareness is the beginning stage of growth and development.

However, self-awareness is difficult to identify and measure and has traditionally relied on research based on self-report (Tang et al., 2013). The literature indicates that the higher an individual rate their self-awareness, the lower others perceive it to be. The effect, referred to as the Dunning-Kruger effect, calls into question the use of self-report alone (Kruger & Dunning, 1999). Through the use of 360 assessments, which includes the input of others, self-awareness can be more accurately measured. Also, as a mitigating factor, evidence indicates that leveraging

feedback through assessments and methodologies such as mindfulness and executive coaching are effective in developing self-awareness (Kress, 2008).

Leading consciously is purposefully leading with awareness of self, others and the environment, focusing on not only profits but also people and the planet (Pillay & Sisodia, 2011). Conscious leadership models are emerging in the field; however, it is identified not as a style of leadership, but as an internal way of being while leading. Through the conscious development of awareness, or the application of wisdom, a leader is prepared as an individual to face the challenges of the future (Ward, 2016).

Gaps in the literature exist on the relationship between factors that affect global leadership self-awareness and leadership effectiveness. This study seeks to address this gap by leveraging three theoretical frameworks which bring together the concepts of global leadership competency, self-awareness and conscious leadership. Through an analysis of the existing literature and a quantitative non-experimental research study, the researcher sought to address to the following two research questions:

RQ1: What factors predict self-awareness on Level 1 Global Leadership competencies; integrity, courage and resiliency?

RQ2: Is self-awareness on Level 1 Global Leadership competencies associated with leadership effectiveness?

Summary of Findings

The study was conducted in a large non-profit healthcare system located in Northern California. The sample included 97 healthcare executives and included demographic information of gender, minority status, and age, as well as profession for each participant. Gender was included as either male or female. Race was recorded as binary as well, comprised of those who

selected white on the employee forms and all other responses included in the category of minority. The variable coded as profession, refers to leaders who are board-certified clinicians. This group included physicians, nurses and pharmacists. The alternative to this designation was an administrative leader, whom is not a certified clinician. These factors were considered important, as literature indicated that each factor can have effect on both self-awareness and leadership effectiveness.

Data sample. The competency data was comprised of secondary data, leveraging existing 360 assessment findings gathered by the company for other purposes. The 360 data set included three scores per participant, a self-score, importance-score and other-score across 24 global leadership competencies. Each of these competencies were rated by the participant on a Likert scale from 1 to 5. The self-score indicated personal level of competency per skill. Next, an important-score noted how necessary they felt the skill was for healthcare leadership effectiveness. The participant competency level was then rated by a group of participant-selected raters including manager, peers, employees, and customers. The average composite score of this group was referred to as the other-score.

The researcher initially calculated three scores using this data. For each of the three competencies, integrity, courage, and resiliency, a self-awareness score was calculated. The method used was referred to in the literature as self-other agreement. This score was calculated by subtracting the other-score from the self-score. For example, if an individual rated themselves a 4 on courage, but others said they were a 4.5, they then under-claimed their competency by .5, this was shown as a self-awareness score of -0.5. A Level 1 self-awareness score was calculated by averaging the three competencies self-awareness scores. Finally, leadership effectiveness was calculated as a total of the other-scores, across all 24 competencies. These skills were identified

by the organization and supported in research as the critical leadership competencies required for executives in healthcare.

Demographic analysis overview. The analysis began by conducting descriptive statistics, utilizing the demographic and professional data of the participants. The average of each variable was calculated resulting in interesting results. For instance, this sample was 64 percent female, indicating that this group of executives was represented by women more so than the literature predicted would be seen at this level of leadership. The group was 71 percent white, the remaining 31 percent indicating one of the minority categories on employee forms. The average age of the group was 42; however, there was large dispersion in the sample, the youngest at 25 and the oldest at 59 years old.

The average self-awareness score for each of the three competencies, courage, integrity and resiliency, were all underestimated, with courage being the closest to congruency (perfect self-awareness). This indicates that on average, participants under-claimed their capability on intra-personal leadership skills. The three competencies were all rated over 4.00 in importance, ranging from 4.03 to 4.47, with integrity being identified as the most important competency. The average effectiveness score for the group as 95.06, which was approximately 80% of the total possible score.

The differences in self-awareness and effectiveness became even more interesting when disaggregated by the variables of female, minority and profession. Females and minorities were shown to be less self-aware than their counterparts on all three competencies. Perfect self-awareness was at zero, where self and other scores are equal. Therefore, negative or positive results, away from zero, indicate lower self-awareness. On one side is humility, under-claiming and the other side over zero is over-claiming. Female, white and clinician groups showed higher

overall effectiveness scores. However, while interesting, the descriptive analysis alone doesn't indicate if these differences were significant enough to consider if they could be reflected in the overall population of healthcare executives.

Significance overview. In order to further examine the relationship between variables, independent *t*-tests were conducted to test for mean differences that were statistically significant at conventional levels. The initial tests indicated a significant relationship between minority and integrity self-awareness, as well as effectiveness. Minorities slowing lower self-awareness and effectiveness. Leadership effectiveness and courage self-awareness was found to be significantly related to profession, with the clinical leaders showing significantly higher outcomes than administrators.

Literature pointed to bias in the rating process due to cognitive processing that could impact results. Importance-score was found through a correlation test to be positively correlated to each of the three competencies. Courage was found to have the strongest correlation. The more important a participant found courage, we could expect their self-awareness on courage to be closer to congruency, or perfect self-awareness. Interestingly, as pointed out before, courage was found be very close to congruent and therefore, this was supported in the findings.

The analysis also indicated that there were factors which contribute to self-awareness on Level 1 Global Leadership competencies and leadership effectiveness, with varying strengths and directions. Multiple liner regression analysis was leveraged to determine the relationships between variables including covariates. The analysis provided a prediction of effectiveness based on self-awareness. These tests are the final step in answering the research questions.

RQ 1: What factors predict self-awareness on the Level 1 Global Leadership competencies of integrity, courage and resiliency? The proceeding analysis indicated that

gender, minority, and profession were associated with self-awareness and therefore were included in the regression models. The model was originally conducted with only the three factors of gender, minority status and profession. Together they accounted for an average of 7 percent of the variation. However, when adding age and importance to the model, the five variables together now accounted for an average of nearly 20 percent of the variance on self-awareness. The stronger model is the center of the implications discussion.

Importance effect. Importance score was found to have a significant effect on self-awareness for all three competencies. The results suggest that leaders are more self-aware, the more they find the skill important. This more specifically indicates that personal values are related to self-awareness on intra-personal competencies. This an interesting finding and worth further study, having implications for leadership development and value alignment research.

Surprisingly, an unanticipated finding related to authentic leadership was identified which could contribute to future research on the style leadership. The literature defines authentic leadership was a leader who leads with self-knowledge and aligned values (Hofman, 2008). The research on authentic leadership is largely qualitative and a gap in research exists for empirical evidence linking the style to leadership effectives. This finding potentially provides support of the style and should be further explored in future studies.

The factor of age. Age was expected to have an impact on leadership effectiveness; however, it was also shown to have an impact on self-awareness for both courage and resiliency. The effect was not found to be significant for integrity, a competency that was shown to remain nearly constant as a leader continues to age. This means that for every year older a leader grows, courage and resiliency self-awareness increase. In summary, younger leaders exhibit lower self-awareness on both courage and resiliency.

Minority status and integrity. Interestingly, with age and importance factored in, minority status and integrity self-awareness indicate a significant relationship. A leader who self-identified as a non-white minority was found to more likely to over-claim their competency on integrity. Meaning, a minority executive leader sees their personal integrity as significantly higher than others perceive it to be. Multiple effects found in the literature could be impacting this outcome, for instance, the cultural background of the raters. It could be estimated through the demographic analysis that at least 60 percent of the raters were white. Therefore, it could be that unconscious bias on the part of the rater was in effect. Because this study was not focused on skill rating, but internal and external self-awareness, the finding is important and worth discussion in the summary.

RQ 1 summary. As an answer to the research question, the factors of importance score, age and minority status all predict Level 1 Global Leadership competency self-awareness. Importance score has a positive linear effect on all three. As importance-score increases, self-awareness increases. Also, as leaders age, self-awareness for courage and resiliency increase. Finally, minority status seems to be related to lower integrity self-awareness. These findings are supported, though not before shown specifically, in the literature. This is also in alignment with the cognitive development framework of consciousness levels. The implications of minority status and integrity are interesting and potentially concerning. Both will be discussed in the implications for practice and future study section.

RQ2: Is self-awareness on Level 1 Global Leadership competencies associated with leadership effectiveness? A multiple regression was conducted to determine the relationship between Level 1 global leadership competencies and leadership effectiveness. The two were determined to be correlated with self-awareness, accounting for 15 percent of the variance in

effectiveness between leaders on total self-awareness. As total self-awareness moves away from congruence, leadership effectiveness decreases.

The variance was reduced to 3.3 percent when the regression was conducted with only Level 1 Global Leadership competencies. This was very low and not a promising model. Not surprisingly, the relationship between Level 1 Global Leadership competencies and leadership effectiveness was not found to be significant. An expanded model was conducted, as the finding contradicted the literature. Covariates were added in the model to determine what effect variables in the environment may be having.

The power of humility. The covariates included in the expanded model were importance, gender, minority status, profession and age. These were previously determined to be important factors in self-awareness and effectiveness. With these covariates taken into account, the relationship between Level 1 self-awareness and leadership effectiveness was found to be significant. The model in entirety was shown to account for over 27 percent of the variance in the model. Therefore, an association between L1 self-awareness and leadership effectiveness can be said to exist. The relationship was negative, as self-awareness moves above zero, by one point, effectiveness will decrease by .23 points. This finding was interesting, as it illustrates a connection between humility and effectiveness. Under-claimers were determined to have higher effectiveness. The higher a leader believed a skill to be in relationship to lower other-scores, the lower the effectiveness. Therefore, the humbler a leader is perceived to be, the more effective.

Integrity and effectiveness. A negative relationship was shown to exist between total self-awareness and leadership effectiveness. Meaning, the humbler a leader, the higher the effectiveness. The three Level 1 competencies, out of the total of 24 total possible competencies account for nearly 50 percent of that effect. This validates the focus on integrity, courage and

resiliency self-awareness, as foundational competencies related to self-awareness. Surprisingly, when disaggregating the three of the Level 1 competencies, integrity was found to be the most significant of the three variables. Integrity self-awareness resulted in a significant relationship to effectiveness. When a leader over-claims their integrity by one point, their effectiveness decreases by .37 of a point.

RQ2 summary. Humility was shown to have a significant effect on leadership effectiveness, the less humble, the lower the effectiveness. Of the competencies, integrity self-awareness was the most significant predictor of leadership effectiveness. Interestingly, integrity was also seen as the most important competency for executive leadership in healthcare by the raters. These findings were a nuanced confirmation of the original hypothesis. They address the overall problem of the study, providing insight into what is needed to lead in a future of complexity.

Implications for Practice and Future Study

This study has a number of important implications for academic and professional fields including, but not limited to, human resources and talent development. The findings also have direct implications for healthcare leadership studies. Specific implications for - and contributions to - these fields and areas of study are detailed in what follows.

The study was focused on executives leading in the complex environment of healthcare. The relationship between personal factors, self-awareness and leadership effectiveness were analyzed. Specifically, the study narrows in on self-awareness on the competencies of integrity, courage and resiliency. The findings for the first research question indicates that age and minority status are important considerations. The second research question confirms that self-awareness and leadership effectiveness are significantly related. These findings, specifically on

age and integrity self-awareness have significant implications for practitioners in healthcare leadership, human resources and talent management. These are discussed below.

With age comes wisdom. Age was found to be a significant predictor of both self-awareness and leadership effectiveness. As a leader ages, self-awareness and effectiveness were shown to increase. This finding can be understood through the constructive development model. In this model, the level of adult development continues to evolve as individuals age. Therefore, it would be expected that a younger leader would be at a lower level of development. By identifying the level of development, leaders at lower levels of development can be paired with those at higher levels as managers or mentors. Through this relationship, the developing leader can be supported in their growth and therefore more effective when leading in complexity.

The findings on age point to the conscious leadership model as a potential developmental solution for practitioners in human resources and talent management. Traditional leadership development is focused on external skills such as inter-personal and cognitive competency sets, which can be learned at any age. However, this research points to a need to focus on intra-personal skills, or who a leader is internally. This internal skill development points to a need to provide developmental time and resources focused on growing self-awareness.

The constructive development theory of conscious leadership provides a personal development path for executive leadership at every age. By identifying where an executive is on the continuum and leveraging evidence-based self-awareness development interventions, such as executive coaching and mindfulness training, self-awareness can be development. Through these types of interventions, designed to increase level of development, an executive can ultimately reach the self-transforming mindset. This mental model, closely related to a global mindset, is determined to be the most effective mindset for leading complexity (Kegan & Lahey, 2009). In

summary, the finding of age confirms the importance of leveraging the constructive development framework for developing self-awareness with the intention of self-development designed to increase leadership effectiveness.

Leading with integrity. Integrity was found to be the most significant and important of the competencies, in relationship to leadership effectiveness. The behaviors relating to integrity in the competency model were defined as being truthful, admitting mistakes and providing a realistic representation of self. This could be summarized to mean an integration of internal and external self-awareness. This finding points to the importance of organizational support for development of integrity. The challenge for the human resources and talent management is designing and developing programs that support integrity development.

Like with age, when considering the findings within the constructive development framework, levels of integrity can be mapped to levels of consciousness. A level 3 or socialized mind will act as others see as important, defining themselves through others' needs and desires. Levels 4 and 5 are the levels where integrity, defined as internal and external integration, grows and develops. It is in these levels where individuals start to have greater self-awareness and take accountability for the alignment of their actions with their values and beliefs. In the self-transforming mind, an individual has great knowledge of who they are and have an understanding that this doesn't change when the environment around them shifts. They are comfortable being with people who differ greatly in background or ideology. This model again provides a framework which an organization can leverage to create opportunities for development through programs which focus on personal growth and self-development.

Challengingly, minorities, or non-whites, were more likely to overestimate their personal integrity in relationship to how others rate them on this ability. What is unknown in this study is

the cultural background of the raters. It is possible that bias and cultural competence is affecting the other score. What is apparent is that minorities are rated lower on integrity, a predictor of effectiveness. The literature indicated a need for more diversity in leadership in healthcare (Silver, 2017). This finding is problematic in that minorities are seen as less effective and less self-aware, especially on the competency seen as the most important. This could be a barrier to selection and promotion to higher levels of leadership. This information provides insight and continues to support the need for diversity and inclusion programming within healthcare organizations. By helping the organization become aware of unconscious bias through diversity programming, leaders can take a more thoughtful approach to assessing others.

Global healthcare leadership. It was pointed out at the beginning of the study that a specific competency model for healthcare leadership has not been adopted across the field. This study indicates that this is not necessary, however, the findings suggest that those in the filed consider applying the global leadership competency model to the field. The evolution of the environment is beginning to break the artificial location barriers of healthcare and becoming more complex.

The global leadership model includes an additional focus on intra-personal skills required for leading in a complex environment. It also includes a mindset factor, not included in traditional models of healthcare leadership. The leadership field would be served by additional scholarly research, including longitudinal studies, on the application of global leadership competency models. More research is also needed on the efficacy of self-development programming on executive effectiveness in healthcare.

Healthcare policy implications. The findings of this study indicate that patients and communities benefit from the self-awareness of executives in healthcare. The leaders in this field

have responsibility and impact outside of the organizational bottom line. The more self-aware and humble a leader is perceived to be, the more effective. Following, the more effective leaders in healthcare are at leading, the healthier the communities they operate within. As the government seeks to care for the health of the people in the community, essential policy could begin to address healthcare leadership gaps.

Healthcare reform and government policy contribute to the challenges facing healthcare. Existing programs are focused on quality, access and affordability with a goal of improving the overall health of patients and communities (Rak & Janis Coffin DO, 2013). However, employee well-being was not part of that equation. Therefore, should policy be introduced to include leadership development programming, this study would suggest focusing efforts towards not only the development of inter-personal and cognitive skills, but also intra-personal skills. By leveraging a conscious leadership development model, healthcare leadership can be effective in leading the triple aim of people, profits, and the planet.

Global Conscious Leadership in Healthcare

The conscious global leader leads with awareness of self, others and the environment. This study concludes that the development of congruent self-awareness, humility and integrity leads to increased leadership effectiveness when leading in complex and volatile environments. It has been proven many times before that increased leadership effectiveness leads to better organizational outcomes. With this expanded awareness, conscious leaders lead with the profits of the organization as well as for the people of the community and the health of the planet.

Futurists are predicting exponential change and ambiguity ahead. As technology continues to evolve and the world continues to change in response, leaders are asked to rise to the challenge of leading in complexity. How leadership reacts to these changes will shape the

future for their employees, organizations and communities. Through insight of self, others and the environment leading with wisdom and purpose becomes possible. Through awareness, wise action can be taken.

It the truest sense, integrity is defined as being whole and undivided. Being in integrity is therefore being in awareness of self, others and the environment, the very foundation of conscious leadership. Conscious leaders bring the whole of who they are to what they do. Through the development of self-awareness, executives will be prepared to lead the future of healthcare and beyond, with greater wisdom and purpose.

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APPENDIX A:

Pepperdine IRB Exemption Notification

PEPPERDINE

Pepperdine University
24255 Pacific Coast Highway
Malibu, CA 90263
TEL: 310-506-4000

NOTICE OF APPROVAL FOR HUMAN RESEARCH

Date: October 05, 2018

Protocol Investigator Name: Carole Bennett

Protocol #: 18-09-870

Project Title: Leading Consciously: Modeling Global Leadership Blind Spots Across Healthcare Executives

School: Graduate School of Education and Psychology

Dear Carole Bennett:

Thank you for submitting your application for exempt review to Pepperdine University's Institutional Review Board (IRB). We appreciate the work you have done on your proposal. The IRB has reviewed your submitted IRB application and all ancillary materials. Upon review, the IRB has determined that the above entitled project meets the requirements for exemption under the federal regulations 45 CFR 46.101 that govern the protections of human subjects.

Your research must be conducted according to the proposal that was submitted to the IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For any proposed changes in your research protocol, please submit an amendment to the IRB. Since your study falls under exemption, there is no requirement for continuing IRB review of your project. Please be aware that changes to your protocol may prevent the research from qualifying for exemption from 45 CFR 46.101 and require submission of a new IRB application or other materials to the IRB.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite the best intent, unforeseen circumstances or events may arise during the research. If an unexpected situation or adverse event happens during your investigation, please notify the IRB as soon as possible. We will ask for a complete written explanation of the event and your written response. Other actions also may be required depending on the nature of the event. Details regarding the timeframe in which adverse events must be reported to the IRB and documenting the adverse event can be found in the *Pepperdine University Protection of Human Participants in Research: Policies and Procedures Manual* at community.pepperdine.edu/irb.

Please refer to the protocol number denoted above in all communication or correspondence related to your application and this approval. Should you have additional questions or require clarification of the contents of this letter, please contact the IRB Office. On behalf of the IRB, I wish you success in this scholarly pursuit.

Sincerely,

Judy Ho, Ph.D., IRB Chair

cc: Mrs. Katy Carr, Assistant Provost for Research