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Leadership Dynamics in Primary Healthcare Delivery: A Case of Rural GP Practice in Northeast England

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Due to ongoing debates on evidence-based management (EBMgt) in healthcare, there is an increasing research interest in the relationship between leadership support and operational excellence in the health care sector. The purpose of this study is to critically evaluate the ethical leadership behaviour of the general practitioners (GPs) and their practice manager (PM) in a health centre in the United Kingdom (UK). We adopted a mixed method and used five theoretical lenses – manipulation, putting self above others, responsibility avoidance, lack of flexibility, and belittling others – to examine these medical leaders' ethical behaviour and to match their ethical behaviours with their employees' expectations. Although there is strong evidence of ethical behaviour, which reflects the National Health Service (NHS) core values, there are strong evidence of unethical behaviours too. We therefore analysed the impact of these leaders' (un)ethical practices on their employees' motivation. The findings from this study could be used to improve ethical decision making, leadership support, and leadership development in healthcare. The paper's findings also contribute to the application of EBMgt in healthcare sector.

Keywords: Ethical leadership, empowering leadership, medical leadership, organisational performance, National Health Service

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There have been ongoing debates on evidence-based management (EBMgt) in healthcare (Aloini *et al.*, 2018) and the relationship between leadership support and operational excellence in health care sector (Nair and Thomas, 2020). Despite a recurrent call for research that examines ethical leadership behaviour in various sectors (Dion, 2012), with a few notable exceptions (e.g., Mishra and Tikoria, 2021); research on the problematic sides of leadership in the health sector, remain limited. Yet, with a growing imbalance in doctor–patient ratio (Mishra and Tikoria, 2021), doctors are facing increasing ethical dilemmas regarding compliance with policy changes (Baum *et al.*, 2009), which results in burnout, exhaustion (Mansour and Abu Sharour, 2021) and psychological distress (Kekesi and Agyemang, 2014). These aspects have been found to also reduce commitment from these medical professionals (Purohit and Wadhwa, 2012). Hence, further research to foster an understanding of the

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ethical leadership dynamics in the healthcare sector, becomes critical.

Earlier studies on ethical and empowering leadership (e.g., Freeman, 1994) have examined the moral nature of organisations. Drawing on Brown and Trevino's (2006) stakeholder theory, Hill (2017) also examined the moral rights and ethical responsibilities of leadership, and in relation to the expectations of various stakeholders. Indeed, work-related interactions with stakeholders and the management of complex resources can create difficult leadership situations which require novel leadership solutions that also test the leader's boundaries between ethics and immorality (Hill, 2017). Such leadership ethical dilemma is common in the NHS due to its diverse workforce along with constant changes and reforms (See BMA, 2021; Bohmer, 2012; Gerada *et al.*, 2013; Department of Health [DoH] 2010; Giordano, 2011; King's Fund, 2021; Royal College of General Practitioners, 2013).

The 21st century ethical leadership literature has flourished (Hassan *et al.*, 2013), with a new strand that links ethical behaviour with person-organisation-fit (POF) (Al Halbusi *et al.*, 2021). This new aspect encourages top management to train middle managers and supervisors on ethical conducts, and to motivate them to communicate and practice ethical values because they directly influence employees' ethical behaviour at the workplace (Al Halbusi *et al.*, 2021). Prior research also links ethical and empowering leadership with high quality leader member exchange (LMX) relationship (Brown and Trevinõ, 2006; Kalyar *et al.*, 2020), subordinate affective commitment, and subordinates' perception of leader effectiveness (Hassan *et al.*, 2013). For instance, a perceived organisational support (POS) (Loi *et al.*, 2015) triggers employee motivation, job satisfaction, improved performance and pro-social behaviours (Ehrich *et al.*, 2015; Hassan, *et al.*, 2013), and thus High-Performance Work Systems (HPWS) (Marchington and Wilkinson, 2005). Yet, several questions relating to the social exchange view on ethical leadership still remain unanswered (Loi *et al.*, 2015). For instance, *how* do leaders' ethical behaviours compare with their employees' expectations? Second, *how* can empirical evidence help us understand whether ethical leaders do put themselves above followers in relation to reward and benefits? Given the ***'how'*** in these questions, a thorough understanding of these issues demand an open-ended qualitative interview approach to facilitate an in-depth exploration of participants' opinions, behaviours and experiences. Given the paucity of empirical data examining how ethical leadership behaviour may trigger employee-organisation social exchange process (Loi *et al.*, 2015), our study makes a distinctive contribution to the ethical leadership, medical leadership, and social exchange literatures. It is one of the few studies to critically evaluate the ethical behaviour of general practitioners (GPs) and their practice manager (PM) by undertaking a case study in a rural GP practice in Northeast of England in the United Kingdom's (UK) national health service (NHS). We focus upon employees' awareness and expectations of the ethical behaviours of healthcare leaders. The

analysis further matches these leaders' ethical behaviours with their employees' expectations and consider the impacts of their ethical practices on the employees' motivation. Hence, our paper strengthens the understanding of this important phenomenon by incorporating insights from multiple respondents.

The rest of our paper is organised so that the next section presents literature review on ethical leadership, followed by the discussion on research methodology. After that data analysis is presented followed by a discussion of findings, and practical and theoretical implications. The paper concludes with a presentation of limitations of the study, and future research directions.

LITERATURE REVIEW

Theorising Ethical Leadership

At the heart of the current theorising on ethical leadership is the Brown *et al*. (2005) definition of ethical leadership, as "the demonstration of normatively appropriate conduct through personal actions and interpersonal relationships, and the advancement of such conduct to the followers through two-way communication, reinforcement, and decision making" (p. 120). Here, the central argument is that ethical behaviours are key to fostering a performance-driven accountability (Ehrich *et al*., 2015) and ethical climate (Al Halbusi, 2021; Aryati, 2018). This implies that ethical leadership behaviour embodies integrity, fairness, trustworthiness, and having concern for others (Toor and Ofori, 2009).

Although ethical behaviours are at the heart of the 21st century leadership literature (Al Halbusi *et al*., 2021; Mishra and Tikoria, 2021), leaders are still faced with competing priorities – leadership's understandings of ethical tensions and dilemmas, but which sometimes contradicts stakeholders' expectations (Rhodes, 2012). This is why practising in an ethical manner is still complex and challenging in the current context (Ehrich *et al*., 2015). This also highlights the need for more research that examines the role of ethical leadership in fostering a performance-driven accountability and ethical climate in various sectors.

However, Brown *et al*. (2005) has identified the distinguishing traits of ethical leadership – fairness, honesty, and trustworthiness – which have been linked to the tendency to make fair and balanced decisions (Mishra and Tikoria, 2021) and followers' ethical conducts (Al Halbusi and Amir Hammad Hamid, 2018). Zoghbi-Manrique-de-Lara and Viera-Armas (2019) also found these distinguishing traits of ethical leadership to inspire followers to become sensitive to peers' setbacks and misfortunes, and thus acting to reduce their peers' suffering. Four compassionate feelings that explain such a relationship between ethical leadership and interpersonal citizenship behaviour directed at peers have been identified. These include (a) empathic concern (*an emotional response provoked*

by and corresponds with the perceived welfare of a peer in need); (b) mindfulness (*a state of awareness where attention is focused on present-moment phenomena*); (c) kindness (*the tendency to understand the pain or suffering of peers*); and (d) common humanity (*perception of peers' experiences as part of the larger human experience*) (Zoghbi-Manrique-de-Lara and Viera-Armas, 2019). These four compassionate feelings also link to the 6 core values of the NHS, which include (1) working together for patients, as patients come first in everything NHS do; (2) respect and dignity; (3) commitment to quality of care; (4) compassion; (5) improving lives; (6) everyone counts. Yet, there are lack of empirical data that examine these four compassionate feelings in the UK health sector, although compassion is among the 6 core values of the NHS (Wattis *et al.*, 2018).

Selflessness

The role of ethical leadership behaviour in stimulating empathy at workplace through moral elevation – the emotional reaction to moral excellence or moral beauty (Diessner *et al.*, 2013) – has also been emphasised. A leader's moral excellence (the interpersonal fairness and self-sacrifice of the leader, cf. Zoghbi-Manrique-de-Lara and Viera-Armas, 2019) fosters follower's organisational citizenship behaviour (OCB) (Vianello *et al.*, 2010). Through a demonstrable positive regard for others (Dutton and Ragins, 2007), high quality LMX relationships can be built (Zoghbi-Manrique-de-Lara and Viera-Armas, 2019). For instance, by demonstrating compassion in the discharge of their duties (Dickson *et al.*, 2001), the NHS leadership can inspire the *'moral obligation'* of the healthcare workers to follow suit (Folger *et al.*, 2005; Zoghbi-Manrique-de-Lara and Viera-Armas, 2019). Therefore, ethical leadership can shape both the ethical and care standards of the NHS.

Honesty, Trust, Fairness, and Reciprocity

As a group phenomenon (Zoghbi-Manrique-de-Lara and Viera-Armas, 2019) and social relationship (Dulebohn *et al.*, 2012), leadership also has a direct influence on the attitudes and behaviours of the follower in a leader-follower dyad (Holmvall *et al.*, 2019). Blau's (1964) social exchange theory also emphasises the creation of personal obligation and trust among the dyadic partners, such that followers of an ethical leader will view themselves as having an obligation to return any fair and caring treatment received from the leader (Nangoli *et al.,* 2020). For instance, when a leader shows ethical guidance and fairness to the team (Trevino *et al.*, 2006), and compassion to the pains and sufferings of others (Folger, 2001), employees return such an ethical conduct to, not just their leader, but co-workers. Through vicarious reinforcement (Bandura, 1977, 2001), ethical leadership can therefore create an effective (Engelbrecht *et al.*, 2017) and well-functioning organisational climate (Zhang and Zhang, 2016), which impacts followers' work attitudes (Al Halbusi *et al.*, 2021) and turnover intents (Demirtas and Akdogan, 2015), which is crucial in the healthcare sector (Aryati *et al.*, 2018).

Respecting Others

By fostering an employee voice system (Zhu *et al.*, 2004), ethical leadership also fosters consistency in ethical behaviour, commitment among employees (Nangoli *et al.*, 2020), and fosters innovation (Van der Wal and Demircioglu, 2020). This is crucial in the healthcare sector where consistency in the provision of high-quality health care, employee commitment and high turnover of medical doctors have been an issue (Mishra and Tikoria, 2021). Yet, given increasing challenges (e.g., work overload and staff shortages amidst a shrinking budget) (Mishra and Tikoria, 2021), to facilitate commitment, job satisfaction and innovative behaviour, healthcare workers globally demand sustained motivation (Zappalà and Toscano, 2020). This highlights the need for research that examines the role of ethical leadership in fostering an organisational climate for sustained motivation, commitment, job satisfaction and innovative behaviour in the healthcare sector.

GPs' Ethical Leadership: The NHS Perspective

To deliver high quality medical care in an ethical manner Department of Health (DoH, 2010), and to steer the ship of the NHS under this new arrangement (Giordano, 2011), GPs are encouraged to understand the changing health and social care system and their position within it, including the knowledge, skills and awareness needed (King's Fund, 2016). Consequently, the GPs ethical conducts has been at the heart of policy frameworks issued by regulatory bodies, such as the Royal College of General Practitioners (2013), where, as generalists, GPs are advised never to forget their core values which is to consider their patients as people, to be moved by their sufferings, and to be their companions on difficult and life-changing journeys (p. 2).

Although the delivery of primary care under this new arrangement entails sophisticated leadership and managerial approaches, doctors are often not imbued with such qualities (Bohmer, 2012). The debate on the type of leadership required for a modern NHS focuses on designated clinical leadership roles being held by the doctors (BMA, 2021), and development of leadership skills through enhanced and extended training programmes (Gerada *et al.*, 2013), which should clearly focus on the NHS vision for 2022. The 6 point NHS vision for 2022 GP Action plan includes, to: promote greater understanding of the value that generalist care brings to the health service; develop new generalist-led integrated services to deliver personalised, cost-effective care; expand the capacity of the general practice workforce to meet population and service needs; enhance the skills and flexibility of the general practice workforce to provide complex care; support the organisational development of community-based practices, teams and networks; and increase community based academic activity to improve effectiveness, research and quality (Royal College of General Practitioners, 2013). While such qualities might be lacking in some cases in NHS, they are at the very heart of higher quality prim-

ary care delivery (Bohmer, 2012).

Manipulation

Theoretically, a myriad of ethical based theories can help us explain the leadership styles associated with manipulation. These include abusive (Tepper, 2000), tyrannical (Ashforth, 1994), destructive (Einarsen *et al.*, 2007), bullying (Namie and Namie, 2000), unethical or bad (Kellerman, 2004), toxic (Chua and Murray, 2015) and the overlaps and distinct differences between them (Pelletier, 2010). Drawing from these theories, two main types of leaders have been identified in the ethical leadership literature. These include those who use impression management to accurately convey information to build positive interpersonal relationships, facilitating good decisions and promoting sound teamwork. Then there are those who distort information by sending deceptive messages, leading to poor conclusions and wrong decisions which undermine relationships and ruin group goals and aspirations (Johnson, 2012). An example of this latter category of leadership behaviour is evidenced in the management culture in NHS Lothian according to an independent report (Bowles and Associates, 2012). Here, a bullying culture was considered by many as 'acceptable and something to emulate' (Bowles and Associates, 2012: 26), and thus a toxic culture (Pelletier, 2010: 377) quickly spreading over the thrust, and thus a low quality LMX relationship (Avolio *et al.*, 2009; Moberg, 2006; Wong *et al.*, 2009). To avoid such toxic culture, scholars have suggested ethical frameworks for fostering ethical values including inclusion, collaboration, achievement, social justice (Ehrich *et al.*, 2015) and the ethics of care, critique, and justice (Starratt, 1996), are emphasised in the literature. Yet, there is lack of empirical data examining these ethical frameworks in the healthcare sector settings.

Responsibility Avoidance and Lack of Flexibility

Given the leadership challenges facing effective GP practice (Giordano, 2011: 10), shared leadership (between medical and non-medical colleagues) have been recommended in multidisciplinary teams (General Medical Council, 2012a, 2012b). Although interactions among diverse work groups could lead to new and enhanced ways of working (Giordano, 2011; DoH, 2010), given the multiple interests involved in such working arrangement (Pearce *et al.*, 2007), this idea (of shared leadership) may not work in practice. For instance, Waring and Wainwright (2008) study of a Northeast of England GP practice found a wide variation in the perceptions of the GPs, nurses and practice managers, even when the three are from the same unit. Yet, historically, medical doctors have always been labelled as – authoritarians, and who may sometimes have to face their own latent arrogance (Giordano, 2011: 8). Rhodes (2012) also highlights some of the confusions that has characterised this new generation of GPs services.

> *"This portends an ongoing oscillation between ethics and politics… where leaders are caught up in contexts where they might try at once to be responsible to one other (say an employee) only to find that they face demands from others (say another employee, a boss or a customer) and that these demands are not commensurable"* (Rhodes, 2012: 1324).

Given such challenges facing this new generation of GPs services; GPs are required to think and behave like leaders, i.e., by formulating their visions, sharing such visions, and positively influencing others to actualise such visions while leading across the various groups (Lynch and McFetridge, 2011; DoH, 2010). Moreover, the need for ethical conduct by the GPs as leaders in health care provision is essential now than ever (Coleman *et al.*, 2015). Therefore, by examining the impacts of the GPs ethical leadership behaviours on employees' motivation within the defined context of this study, this study provides valuable insights for the GP partners at this centre to promote effective health care delivery.

The main research questions of this study are:

How can empirical evidence help us understand whether the GPs and the PM are honest or manipulative in communicating with staff? (NHS Core values No. 1 & 6).

How can empirical evidence help us understand whether these leaders are fair or are putting self above followers? (NHS Core values No. 2).

How can empirical data help us understand if these leaders are demonstrating accountability or are avoiding responsibility in discharge of their duties? (NHS Core values No. 1 & 3).

How can empirical evidence help us establish whether these leaders are demonstrating flexibility in their relationship with followers? (NHS Core values No. 1 & 6).

How do the (un)ethical behaviours of these leaders compare with their followers' expectations? (NHS Core values No. 4, 5 & 6).

How do the (un)ethical practices of these leaders' impact on their followers' motivation? (NHS Core values No. 6).

Given the theoretical argument required to address the above research questions, ethical theories by Johnson (2012), Lipman-Blumen (2005) and Moberg (2006), are used in our paper. Table 1 (see Appendix-I) shows the linkages between Johnson (2012), Lipman-Blumen (2005) and Moberg (2006) ethical leadership theories.

METHODOLOGY

This study adopts a mixed method approach. By providing a detailed account of the actual research

activities we undertook during the data collection and analysis process (Gibbert and Ruigrok, 2010), this section shows the level of rigour, validity and reliability of our research (Creswell, 2007; Gioia *et al.*, 2012; O'Reilly *et al.*, 2012). As our target participants are well-defined (i.e., healthcare professionals in chosen healthcare centre), the purposive sampling technique is used. A single case-study-qualitative type was chosen, and the medical industry was selected as this industry best fits both the design and the structure of this study (Ben Jacob, 2020). This study is designed to identify and explore the (un)ethical behaviours of GPs and their PM in a health centre in the UK, to match these medical leaders' ethical behaviours with their employees' expectations, and to consider the impact of their (un)ethical practices on their employees' motivation. For an in-depth understanding of complexities and contexts – including individuals, their actions, interactions, residues and artefacts of their behaviours – an instrumental case study is appropriate (Punch, 2014).

However, due to the size of the organisation, there were only 15 staff (i.e., 1 PM, 3 GPs, and 11 staff) employed by the healthcare centre. Although the interviews were designed for the GPs and PM only, due to staff availability, only two interviews were conducted (i.e., with one available GP and the PM). Therefore, based on participants' ability, availability and/or willingness to participate (Jupp, 2006), a convenience sampling approach of interviewing the one (available) GP and the PM, was used. In choosing a sample size in a qualitative study, two factors – what is ideal and what is practical – must be considered (Robinson, 2014). Similarly, Saunders and Townsend (2016) review of 798 articles on qualitative interview shows that the participant numbers were contingent on characteristics of the population from which they were chosen. Therefore, contingent on the population of our study, 2 participants are practical.

Initial access was gained via the PM, as one of the researchers was a patient at the centre during the time of this study. Following the semi-structured interview, a Likert scale type questionnaire was used to measure the perception of staff. This provided an additional rich data, which complements the qualitative data and ensures triangulation (Bryman and Bell, 2011). Ritchie *et al.* (2013) argue that this process is needed to produce better-quality data. Overall, 10 questionnaires were distributed to the 10 staff available at the time of this research, while only 8 were returned, and due to the nature of their services, the case GP practice allowed only a limited timescale for the researchers to conduct this research.

Data Collection

GP and the PM, and both were asked the same series of questions which address the six research questions mentioned above. The interviews were semi-structured, and the questions consist of a set of guided questions, follow up questions, and multiple probes. This approach has helped us ascertain

each individual healthcare professional's experience regarding what constitutes ethical leadership in detail (McConville *et al.*, 2018). The interviews were structured around the following five themes: manipulation, putting self above others, responsibility avoidance, lack of flexibility, and belittling others. The focus of the conversations was to ascertain, if, and how, each of these five themes can help to answer any of our research questions. Based on Liu and Rong's (2015) recommendation, each participant was allowed enough time to elaborate on their views on each of the questions asked. Each interview lasted approximately 45 minutes. The data collection occurred in March 2015. The data collection and analysis process are illustrated in Table 2 (See Appendix-II).

Data Analysis: Procedures and Steps

Given the theoretical argument and rigour involved in addressing our research questions, we followed Alo (2020) and Braun and Clarke (2006) suggestions on the six-stage process of the thematic data analysis as explained below.

-*Data Familiarisation*

The researchers begun the data analysis process by listening to the recorded audio interviews a few times. This had to be done a few times, so we are familiar with our raw data. Following familiarisation with the raw data, data transcription commenced – i.e., the conversion of the recorded audio files into written files. For a thorough transcription of the data, we doublechecked all the written text against their original (audio interview) files. This helped to ensure accuracy in data transcription.

-*Generating the Initial Codes*

Having completed all the data transcription at this stage, data coding commenced. Based on similarities in meaning of the data collected, we began the coding process by separating the transcribed data into categories. The data coding process was reiterative, which continued until sufficient distinguishing characteristics were evident among the categories of data (Eisenhardt, 1989; Goulding, 2002), and thus has helped the researchers associate each relevant raw interview data with their matching themes (Goulding, 2002), which has helped to boost the validity of the study (Alo, 2020). We returned to the raw interview data on a few occasions to amend and recode some of the data and to ensure they are aligned with the appropriate content-themes.

-*Searching for Themes*

At this third stage, based on the corresponding theories and similarities in meanings of our data sets, we generated a more logical expression of the data sets, bearing in mind the five themes that informed our interview questions.

-*Thematic Coding*

Table 3 (see Appendix-III) presents an analysis and coding of the theories of Johnson (2012) and Lip-

man-Blumen (2005) into broad themes that form the basis for both the interviews and the questionnaire. These analyses also provide a broader understanding of these theories, especially from a comparative perspective, and in relation to the key issues addressed in this study.

-Reviewing the Themes

At this stage, it was necessary that the data analysis process was assessed by a team of experienced qualitative researchers. The expertise of a team of three well-experienced qualitative researchers who acted as both critical friends (Kember *et al.*, 1997) and research auditors (Filho and Rettig, 2016) were utilised to conduct the expert checks. In a few cases, we had to recode and regroup some data units.

-Re-Definition and Re-Naming of Themes

Based on recommendations by our critical friends, this fifth step required redefining and renaming a few of the themes to enhance clarity. This step (in our data analysis process) has helped us maximize the themes to enhance the readers understanding of the relationships among the various constructs in the study (Alo, 2020), and thus enhances our study's validity.

-Report Writing

A comprehensive report writing involves a methodical interpretation and explanation of the links between the data collected, their matching themes, and the corresponding literature. Accordingly, our thorough report writing effort has helped us to further clarify the connections between the quantitative data, the interview responses, their matching themes, and the related literature, which is consistent with Liu and Rong (2015) recommendation on making exhaustive linkages between the dominant theory and research findings. To make a robust connection between the results and the dominant theories, Liu and Rong (2015) suggest repeatedly moving forward and backward within the empirical data and the literature review sections to enable a comprehensive analysis of the data, which we followed. Moreover, as we compared our results with 2 theories, we also adopted a deductive approach in our report writing.

RESULTS

Qualitative Findings

This section presents the analysis and interpretation of answers to the open-ended interview questions. A GP and the PM participated in the interview, and the interviews were conducted following standard interview protocol. The interview questions were adopted from initial questionnaire used in the quantitative study (Macfarlane, 2009), which was targeted to the employees of the case GP practice.

-Coding

Short phrases or single words that recap in the interviewees' statements (Saldaña, 2013), result in variance in the coding (Anwar, 2019). The role of effective coding is to assign data chunks of importance to relevant themes (Anwar, 2019) and align the interview questions with their relevant research questions (Castillo, 2016). The coding helps to strengthen both the reliability and the validity of the interview. Based on the number of interviews conducted, it was convenient to do a manual coding, and five clusters were identified, which we termed *manipulation, putting self above others, responsibility avoidance, lack of flexibility, and belittling others*.

-Interpretation

Based on the similarities in the raw interview data, the researchers were able to arrange the data in clusters and align them with the codes. This has helped the study to unpack, understand, interpret and explain the leadership dynamics in primary healthcare

-Qualitative Interview Analysis

This section uses the raw interview data to critically examine the ethical behaviour of the GP and the PM in the case study. This has helped the researchers to match these leaders' (un)ethical behaviours with their employees' expectations, to consider the impact of their ethical practices on their employees' motivation, and in relation to the core values of the NHS. This section uses the SQC (set up, quote and comment) strategy for analysing the qualitative data. This section offers fresh insight into the link between (un)ethical leadership behaviour, employees' expectations and employees' motivation.

Theme 1: Manipulation

This theme examined whether the leader present, misrepresent or withhold information to enable the leader control outcomes. The response of the 2 participants varied. The GP said she does not give information to staff just to keep them compliant, rather that she maintains honesty in communication with staff. The GP said: "I don't think this happens. We make sure everyone gets the same information." "I tell them how it is, and I try to explain the reasons and the rationale. I don't tell them to keep them sweet I just tell them how it is." This was contrary to the PM's response. When alerted by the interviewer that the staff feel they are told information just to keep them compliant, the PM suggested that this perception was based on salary increases alone. As empathic concern is among the four compassionate feelings that link ethical leadership with interpersonal citizenship behaviour directed at followers (e.g., Zoghbi-Manrique-de-Lara and Viera-Armas, 2019), therefore, a lack of emotional response to a perceived welfare of a peer in need raises some questions around ethics.

Theme 2: Lack of flexibility

This theme examined the level of willingness or ability to accept another's point of view, take risks,

foster entrepreneurial behaviours or empower employees in the health centre. The researchers asked questions to determine if the Centre's leadership involve staff in developing a service quality. The GP said: "…flexibility would be about the structures and how this works. "It is not trying to give staff what they want, it's about trying to run a business with those staff." Despite this Centre's business-focused approach to flexibility, data from the questionnaire indicate that staff are sought after by their managers with regards to knowledge and experience they might have, and which demonstrates staff involvement and flexibility in developing a quality service within the Centre. Also, both interviewees explained that they have monthly meetings where all staff are invited to share their views and ideas. The GP spoke about: "practice learning time to share ideas, where we encourage staff feedback; so, if something is not working well, we need to know", while the PM noted that: "we have monthly meetings where staff can bring up anything, and we encourage people to be involved." Regular interaction (around service standards) between a leader and the staffs shapes employees' perception around the moral rights and ethical responsibilities of the leader (Hill, 2017), and which typifies the moral nature of the organisation. Yet, the moral nature of an organisation (Freeman, 1994) links ethical and empowering leadership with LMX relationship quality (Brown and Trevino, 2006; Kalyar *et al.*, 2020), the level of subordinate affective commitment, and subordinates' perception of leader effectiveness (Hassan *et al.*, 2013).

Theme 3: Belittling others

This theme examined whether the leadership at the Centre demonstrates behaviours which undermine, threaten or erode the self-esteem and confidence of others. The interviewer wanted to know why some staff feel that the reaction to problems depends upon who you are. The GP said: "I would hope this would not happen; you might get feedback to say it does but we would need to be made aware of that. We take complaints, abuse etc. very seriously". This indicates she is unaware of such issues, as she does advocate equality and fairness to all. The PM said: "We have a member of staff who has a little bit of an edge to her voice regarding their relationships with certain patients or certain members of staff. And, sometimes (I will say to her) it's not what you say it's how you say it, as you probably aren't trying to offend somebody but it's not right." Questions were also asked to know how the Centre's values are communicated to staff. The GP declined from answering this question and insisted that it is the PM's question. The PM said: the Centre has "appraisals, and regular meetings where people get credit where it is due". The PM also noted that there is a sense of mutual support amongst the team e.g., "if anybody is verbally or physically aggressive towards anybody be it a doctor, a nurse or an admin person then they (the victim) know they have the support of everybody else, and it is a part of our values. We really expect people to treat each other as they would like to be treated themse-

lves." Although the stakeholder theory (Brown and Trevino, 2006) helps us understand the moral rights and ethical responsibilities of leadership in relation to the various stakeholders' expectations, work-related interactions and the management of complex resources can create difficult leadership situations which test the leader's boundaries between ethics and immorality (Hill, 2017).

Theme 4: Responsibility avoidance

This theme examines whether the leadership (of this health centre) ensures that their actions or omissions leading to misdeeds can always be attributed to someone else. The GP said: "we try to include everybody in everything we do but there are certain groups whom we have tried over the years to segregate them, but they just go back but it is not noticeable. If you walked in there you wouldn't know it was going on. Although when people leave, I always interview them to see if there is any problem with the staffing and there's only one thing they have ever said, "I feel there was a very strong them and us". When asked whether there are in-groups and out-groups, to avoid speaking further, the GP abdicated to the PM saying "Ask the (PM). Anything major would come to me; I am the lead for staff issues but (she) would have strategies for things like this." The PM said: "…We don't have a great turnover of staff. People stay for years, although I do feel sorry for new people coming in. Even though I do try [regardless of their position] to make them feel included and very welcomed but it all depends on how they take it; if they take it as "Oh God there's a clique here" then it becomes more difficult for them to fit in. She also mentioned that monthly meetings are held with new staff, where everyone is included and "they are still here so I must be doing something right." When asked their views on why the Government is pushing for GPs to be trained to be leaders, the GP said: "One GP is involved with leadership… (and) she is being encouraged to do GP leadership training, but no GPs here have done this already." The GP also stated: "we have to do it but a lot of us feel it is difficult to be combined with our job roles. So, you get one or two partners who are leaders the others are clinical… as we employ GPs for their clinical skills and not leadership skills…" The PM said: "This is a question for the GP". Despite the growing imbalance in doctor-patient ratio (Mishra and Tikoria, 2021), doctors are today facing increasing ethical dilemmas regarding compliance with policy changes (Baum *et al.,* 2009), which result in burnout and exhaustion (Mansour and Abu Sharour, 2021), and higher error rates due to missed treatments (Metcalf *et al*., 2018). These can also reduce the level of commitment from these medical professionals (Purohit and Wadhwa, 2012).

Theme 5: Putting self above others

This theme examined whether the leaders prioritise and control events and resources to meet personal agendas, and at the expense of group goals. In terms of how they empower their staff, the GP revealed that clear boundaries were evident. The GP said: "…even though they know their limitations

and what level they can go to, we also do teach them to be aware that when they have been here a bit longer, then they ought to get to another level and they can start doing additional this, or that; and some are quite happy to take on more responsibility, while others simply don't want any at all." The PM said: "…We have team building (and) the best thing we do here is to have coffee/lunch daily around the coffee table. It is not like a hospital here, there is no clear hierarchy; we are aware of the strengths, weaknesses, skills. We value people for what they are good at." Among the suggested ethical frameworks for fostering ethical values include inclusion, collaboration, achievement, social justice (Ehrich *et al.*, 2015) and the ethics of care, critique, and justice (Starratt, 1996). Also, the social exchange theory highlights the importance of exchanging both economic and social resources (Blau, 1964; Shore *et al.*, 2006), as key to performance-driven accountability (Ehrich *et al.*, 2015) and ethical climate (Al Halbusi, 2021; Aryati, 2018; Demirtas and Akdogan, 2015; Zhang and Zhang, 2016).

Quantitative Findings

Given the small sample size, 8 questionnaires were returned from the 10 issued, representing an 80% response rate, and of which two (i.e., 25%) were clinical staff and six (i.e., 75%) administrative staff. The quantitative data results are presented in Table 4 (see Appendix-IV).

DISCUSSION

This study sought to critically examine how the ethical behaviours of GPs and their PM in the case study match their employees' expectations and to establish the impact of these practices on their employees' motivation, and in relation to the NHS core values. We found that in terms of exchange of information, the employees are happy, as they rated the Centre's leadership practice very highly in terms of genuine ethical commitment and values. In fact, most of the staff agree that their managers do not hide the truth, or distort facts to maintain compliance, or with-hold information that others need. This answers our research questions 1 and 2. Ethical and empowering leadership has been associated with a range of organisation outcomes, such as, employee motivation, job satisfaction, improved performance, and pro-social behaviours (Ehrich *et al.*, 2015; Chen *et al.*, 2011).

Furthermore, majority of the respondents also believe that standards are set, and role modelled by their managers, while resources are fairly allocated, as the GPs do not put themselves before others in relation to rewards and benefits. This answers our research question 2. However, about 38 percent believe there are in-groups and out-groups in the centre, and which could cause some internal strife among the workgroups. This answers our research question 3. Allowing in-groups to develop is not only a reflection of moral blind-spots, but leaders who are culpable of such an act would normally

blame others for leaders' mistakes, i.e., scapegoating and pitting in-groups against out-groups (Johnson, 2012; Lipman-Blumen, 2005).

However, majority believe the information they are given is complete and truthful, and that ethical issues are discussed openly between clinical and non-clinical staff. This answers our research question 4. Although in-groups do exist, but 75 percent indicate they do not feel blamed when it is not their fault, while many believe that when there are problems, actions taken do not depend upon 'who you are'. Yet, 75 percent feel their views are as important as their manager's when their performance is reviewed. This answers our research question 5, and also indicates a high LMX relationship. Gerstner and Day (1997) found that leaders with positive LMX relationships are more effective in their leadership approaches, as they foster employee commitment than those with poor exchange LMX relationships. The results also indicate a high level of involvement and flexibility within the Centre. For instance, with 87.5 percent of staff acknowledging they feel safe raising issues with their managers, and 75 percent saying they are listened to by their managers as their views are as important as their manager's when their performances are reviewed, which reflects a high level of flexibility, employee involvement and participation. This answers our research questions 4 and 6. Employee involvement and participation has been linked to increased services quality, which are responsive to the needs of patients (DoH, 2010; Giordano, 2011: 7, 10).

While all the respondents believe their managers seek them out for information when they have knowledge or experience, 75 percent agree to be having a regular face to face meetings with their managers to share ideas on service improvement, which is consistent with the NHS perspective on GPs' ethical leadership and also answers our research questions 4 and 6. GPs are required to think and behave like leaders by formulating their visions, sharing such visions by positively energizing others to actualise the visions, while leading across the various groups (Lynch and McFetridge, 2011; DoH, 2010).

Although all employees who participated in the survey believe they are sought after by their managers with regards to knowledge and experience they might have, which are positive indications of staff involvement and empowerment, there are also evidence of unethical behaviours by these leaders. For instance, with only 50 percent of staff believing that actions taken in response to problems do not depend upon who you are and coupled with the existence of in-group and out groups, there are perceptions of disregard, favouritism, harassment and ridicule, which could potentially lead to a lack of trust in the centre (Wong *et al.*, 2009). This answers our research question 6. Good working environment which includes management support – which epitomises ethical leadership – has been linked to employee retention (Vasquez, 2014) and innovation diffusion (Chiu *et al.*, 2017).

Although our data were collected in 2015, recent research linking ethical leadership, patient safety,

effective healthcare delivery and organisational effectiveness resonates with our findings. For instance, employee's perception of supervisor's ethical and transparent behaviour pattern has been linked to patient care quality, positive work environment, authentic leadership promotion, and well-being of Canadian nurses in acute care hospitals (Malila *et al.*, 2018). Staff motivation, fairness, team cohesion, reorganization of care, task redistribution, transparency and capacity building – an ethos which epitomises the ethical leadership style (Brown *et al.*, 2005) – has been linked to successful implementation of team-based care at primary care clinics in India (Lall *et al.*, 2020). In Scotland, Allbutt *et al.* (2017) has found supervisor's ethical behaviour – personal reflection, planned action, constructive challenge, respectful relationships and processes tailored to employees' circumstances – as key to successful health and social care practice in Scotland, as these ethical values foster employees' willingness and commitment. Zappalà and Toscano (2020) study of 637 healthcare workers in 48 centres in Italy found that ethical leadership fosters employees' work engagement, job satisfaction and higher-quality LMX relationship. In Uganda, Mayende and Musenze (2018) study of 214 healthcare workers found that ethical leadership positively affects staff retention, moderated by the role of job resources. In health information management, ethical leadership has been linked to successful ethical coding and ethical use of the coded information. For instance, Shepheard (2019) study of Australian health information managers (HIMs) and clinical coders (CCs) found that, by fostering a complete, accurate coding for every episode of care, ethical leadership tenets – honesty, commitment to compassion, commitment to equity and respect for variation – are key to uninterrupted communication and forming partnerships in the Australian healthcare arena.

Through proactive planning, careful consideration, open dialogue, active listening, ethical vigilance, value driven behaviour, demonstrable empathy, compassion, empowering and supporting behaviour and a collective commitment to safe and quality care, nurse managers have been found to support physically and emotionally exhausted nurses' recovery from Covid-19 (Markey *et al.*, 2021). As ethical role models (Aryati *et al.*, 2018), these nurse managers raise ethical standards in everyday practice (Markey *et al.*, 2021), as they influence employees' conduct and perception regarding organizational policies and practices, embodied in the organizational climate (Mishra and Tikoria, 2021). Yet, given the current complex healthcare challenges resulting from the raging COVID-19 pandemic, and coupled with the resultant surge in ethical burdens on healthcare workers (Keselman and Saxe-Braithwaite, 2021), ethical principles of care are needed to positively impact patient outcomes in the current climate.

Furthermore, followers' perception of ethical principles – ethical awareness, modelled ethical behaviour and effective two-way communication – fosters employees' willingness to raise ethical concerns that relates to patients' safety (Foglia and Cohen, 2019). This is particularly

crucial in an era of Covid-19, where healthcare workers are expected to continually voice out safety concerns to ensure patients' and healthcare workers' safety. Research has also found ethical leadership a key factor in successful healthcare delivery through a facilitated ethical voice – employees' willingness to proactively voice out their concern – which is critical in fostering integrity and high-quality patient care (Foglia and Cohen, 2019). To inspire employees' positive work attitudes and to promote organisational service climate, healthcare leaders, must, therefore, encourage ethical behaviour (Zappalà and Toscano, 2020) and ethical voice. Although employees in higher positions feel safer raising ethical concerns than lower ranked employees, a culture of trust, follow-through and fair treatment has been found to encourage employees to raise ethical concerns with their managers (Foglia and Cohen, 2019). Ethical leadership behaviour – respect, empathy, role modelling and genuine conscientiousness – has also been linked to a facilitated job performance and ethical workplace (Markey *et al.*, 2021). This highlights the role of ethical leadership in building an organisational climate for ethical behaviour in the healthcare settings.

CONCLUSION

This paper has offered a critical evaluation of the ethical behaviour of GPs and their practice manager in a UK's health centre. We have unpacked the extent that the behaviours of the GPs and their PM in a UK's healthcare organisation reflect the ethical values as required by the NHS. With evidence such as, employee involvement and employee voice system, communication, meetings, staff empowerment, sense of 'family values', staff motivation, knowledge creation, perceived fairness and equity, there are strong evidence to suggest that ethical leadership is pursued by the health centre studied. This epitomizes the NHS core values and echoes the NHS Constitution. The NHS strive to value every individual, respect individual aspirations, needs, ability and limits and is committed to providing rewarding and worthwhile jobs, trusting and listening to every stakeholder and providing meaningful feedback, in the interest of the patients (NHS Constitution, 2015).

Although our study has found ample evidence to suggest that ethical leadership behaviour is pursued by the centre, there are evidence of unethical behaviours in the centre, which is consistent with Dion (2012) view that ethicality is not observed in the real world of work as much as it is acclaimed in the literature. For instance, the interview with the GP revealed discrimination between the various staff-groups in the centre, which spiralled out of her control, and thus is impacting staff retention in the centre. Apart from a potential damage on the Centre's 'family culture', this could result in a decline in the quality of care provided. Similarly, the King's Fund (2016) research also found the difficulty in combining clinical leadership responsibilities with the responsibilities for direct care delivery. King's Fund study therefore suggests that clinical leadership development should be a major

priority throughout the NHS.

IMPLICATIONS

This study offers insights to further the ongoing debate around evidence-based management (EBMgt) in healthcare and the relationship between leadership support and operational excellence in health care sector. Due to a recent rise in ethical scandals in organisations (Al Halbusi *et al.*, 2017; Brown and Trevino, 2014; Trevino *et al.*, 2014), to help doctors balance the complex range of responsibilities demanded of them, King's Fund (2016) has emphasised the need for medical leadership development to be taken more seriously. This will help to improve doctors' abilities to make ethical decisions, improve their teams' effectiveness, influence changes within their organisations, and increase their confidence and resilience as leaders. This also highlights the need for integrating leadership development curriculum in the GPs development portfolio, especially, as the primary health care in England is now under significant strain and a crucial phase in its development. For instance, GP practices now face tensions between patient needs and the administration of care delivery, hence the need for leadership development (Smith *et al.,* 2013), especially in the light of resource constraints, on the one hand, and higher demand, on the other (Giordano, 2011).

LIMITATIONS AND FUTURE DIRECTIONS

One major limitation to GPs' leadership development is the contradictions between the leadership development pathways for medical leadership and the leadership development guidelines as recommended in the academic literature (King's Fund, 2016), which is due to the differences between the perspective of managers and those of the doctors. For instance, despite their common goal of delivering quality care to patients, the priorities of 'doctors as clinicians' differ from those of 'doctors as clinical leaders', and which often culminate in conflicts and resentments. It is not surprising therefore that once doctors reach senior management positions, they are likely to be far removed from direct care delivery, hence restraining them from having frontline experience of health care. This reflects the difficulty in combining the responsibilities of direct care delivery and clinical leadership.

In the light of these constraints and conflicts, further research, is, therefore, needed to explore ways of making the doctors leadership development more effective so when participants return to their duty, they can combine their responsibilities as professional clinicians with their leadership responsibilities as clinical leaders. Future research can examine the effectiveness of collaborations between senior clinicians and leadership development consultants in both the design and implementation of the GPs leadership development curriculum. This study will motivate theoretically

such future study, as the theoretical ideas and themes in this study can be replicated and be broadly applied to such future research, it, therefore, contributes to the theoretical development of both the medical leadership and the ethical leadership literatures. Although our study adopts a mixed method approach, given the small size of our sample, future studies should draw from a relatively larger sample size to help enhance the generalisability of such studies. Such studies should also examine leadership dynamics in primary healthcare delivery from an emerging economy. This will offer the much-needed data to compare leadership dynamics in primary healthcare delivery across diverse organizational, cultural and economic settings. Finally, our data was collected in 2015, though still valid, further studies can utilise more recent data.

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Appendix–I

Theory	Main principles suggested
Toxic Leadership (Lipman-Blumen, 2005)	• based on followers' perceptions of the leader regardless of the leader's intentions or organisational outcomes.
Competence/morality (Moberg, 2006)	• Managers expect competency over ethics by followers while followers seek morality in managers. • managers who come from a competency stance may perceive themselves to be ethical if they meet the aims of the organization • Followers are looking for the softer skills and perceive the leader to be unethical.
Shadow casting (Johnson, 2012)	• Shadow of Power • Shadow of Privilege • Shadow of Mismanaged Information • Shadow of Inconsistency • Shadow of Misplaced and Broken Loyalty • Shadow of Irresponsibility

Source: Authors' Presentation

Table 1. The Main Premises of Johnson (2012), Lipman-Blumen (2005) and Moberg (2006) Theories

Appendix–II

Case Study Steps	Activities
Step 1	Establish the focus and scope of the research
Step 2	Develop the research questions: The research questions were tailored along the 6 core values of the NHS.
Step 3	Decide the appropriate research instruments and protocols, e.g., the data gathering techniques, and in this case, the mixed-method approach.
Step 4	Decide the location of the study and the individual participants to include in the case study: To ensure proximity of the case study to the researchers, the North East of England was chosen.
Step 5	Select a GP practice: 12 GP practices were contacted in the North East of England, but due to the nature of their services, only one of them agreed to participate in this research.
Step 6	Ask Participants: Through the PM, participants' consent was sought, and they all agreed to participate.
Step 7	Decide how many participants to be included in the survey and those for the interview, and the criteria for selection: The idea was to sample only staff with no leadership/line-management responsibilities to participate in the survey. Due to the size of the health centre, only 8 questionnaires were collated. To supplement this small sample size, the leaders in the centre were also interviewed.
Step 8	Determine the 'suitable' leaders to select for the interview: a vertical and horizontal slice of the GP practice to ensure that each prospective GP-participant and the PM has a line management responsibility.
Step 9	Data collection period – March 2015
Step 10	Data analysis commences (See below for the steps involved)
Step 11	Dissemination: report and article development

Source: Authors' Presentation

Table 2. Data Collection and Analysis Process

Appendix–III

Thematic codes	Johnson	Lipman-Blumen
Manipulation	Lying, using information for personal benefit, role playing impression management, preventing employees passing on information others have a right to, hiding the truth, with-holding information others need, deceit.	Lying, misleading, distorting facts to maintain compliance, presenting toxic agendas as noble visions, emotional volatility.
Putting self above others	Don't accept responsibility, deification, expect higher standards from followers than themselves, selfishness, pay and higher bonuses for managers, betraying employees to benefit the bottom line	Using scarce resources to build monuments to themselves, lack of integrity
Responsibility avoidance	Denying issues exist which may negatively impact on employees/customers, ignore or deny ethical problems, hiding wrong-doings, overlooking mismanagement of expenses, failure to prevent followers' misdeeds, developing in-groups and out-groups.	Moral blind-spots, blaming others for leaders' mistakes, scapegoating, pitting in-groups against out-groups.
Lack of flexibility	Coercion, constraint.	Being rigid, forced hardship, ignoring ideas.
Belittling others	Disregard, favouritism, violating the privacy of others, cruelty.	Ostracizing, demeaning, harassment, direct attack on follower character / ability / wellbeing, undermining, ridicule.

Source: Authors' Presentation

Table 3. Thematic Coding and Analysis of Johnson (2012) and Lipman-Blumen (2005) Theories

Appendix–IV

Question	**Analysis (%)**					**Interpretation**
	SA	**A**	**U**	**D**	**SD**	
Question 1 – "I feel safe raising issues with my manager relating to my role at work."	75	12.5	0	0	12.5	The results indicate that 87.5% of staff feels safe raising issues with their manager, while 12.5% do not.
Question 2 – "I am given the information I need to do my job."	62.5	12.5	12.5	12.5	0	The results indicate that 75% of staff feel the information they are provided with is appropriate for them to carry out their job roles, while 12.5% are undecided and 12.5% disagree.
Question 3 – "I believe the information I am given is complete and truthful."	62.5	12.5	12.5	0	0	25% of respondents indicate they are undecided on whether the information they are given is complete and truthful, while 75% believe it is and none believe it is not.
Question 4 – "My employer tells me what he/she thinks I want to hear in order to keep me compliant."	25	12.5	12.5	12.5	37.5	50% of staff believe they are not told information only to keep them compliant, 37.5% do agree they are and 12.5% are undecided.
Question 5 – "My manager sets standards and demonstrates these in his/her behaviours."	62.5	12.5	0	12.5	12.5	75% of staff believe standards are set and role modeled by their manager, while 25% disagree and none were undecided.
Question 6 – "Resources are not fairly allocated across organisational need."	0	12.5	12.5	25	50	75% of staff believe resources are fairly allocated across the organisation, with 12.5% indicating they are not and 12.5% undecided.
Question 7 – "GP salary/benefits are put ahead of staff salary/benefits."	25	0	12.5	25	37.5	62.5% said GPs do not put themselves above others in relation to reward and benefits with 25% believing they do and 12.5% being undecided.
Question 8 – "Ethical issues are openly discussed (clinical and non-clinical)."	62.5	25	12.5	0	0	87.5% agree ethical issues are openly discussed while 12.5% are undecided, and none disagree. As 12.5% represents one person there is the possibility that they did not understand the question fully or feel ethics is not a part of their role.
Question 9 – "In-groups and out-groups exist in my organisation."	0	37.5	50	12.5	0	With 50% undecided and zero strongly agree or strongly disagree, the agree and disagree responses represent a 3:1 situation, showing there could be internal strife among the work-groups.
Question 10 – "I feel blamed when it is not my fault."	12.5	0	12.5	62.5	12.5	While 75% indicate they do not feel blamed when it is not their fault, and with 12.5% strongly believe they do feel blamed, and 12.5% undecided, this gives a 6:1 ratio of staff who do not feel blamed to those who do when something goes wrong, and it is not their fault.
Question 11 – "When there are problems, actions taken depend upon 'who you are'."	25	0	25	25	25	25% of staff indicate that actions taken following problems depend upon who you are, however, 50% feel this is not the case and 25% are undecided.

Question 12 – "My ideas are listened to by my manager."	37.5	37.5	12.5	0	12.5	75% of staff feel listened to by their managers with 12.5% undecided and 12.5% strongly disagreeing.
Question 13 – "My manager seeks out information from me where I have specific knowledge and experience."	50	50	0	0	0	100% of staff feels their manager seeks out information from them when they have particular knowledge or experience.
Question 14 – "My views are as important as my manager's when my performance is reviewed."	12.5	62.5	12.5	0	12.5	75% of staff feels their views are as important as their manager's when their performance is reviewed with 12.5% undecided and 12.5% strongly disagreeing.
Question 15 – "I have regular face to face meetings with my employer to share ideas on service improvement."	37.5	37.5	0	12.5	12.5	75% agree, while 25% disagree to be having regular face to face meetings and sharing ideas on service improvement with their managers. However, as explored through the interviews, the Centre's policy on supervision is not known, so depending upon the individual respondent's role within the Centre this may well have a bearing on the results.
Question 16 – "I feel empowered to do my job and make decisions within my role."	25	50	0	12.5	12.5	There are no responses for undecided in this question, indicating staff have clear views. As indicated, 75% feel empowered while 25% do not feel empowered.

Source: Authors' Presentation
Key: Strongly Agree (SA); Agree (A); Undecided (U); Disagree (D); Strongly Disagree (SD)

Table 4. Quantitative Data Analysis