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RESEARCH ARTICLE

BEING AN WHOLISTIC AND DEVELOPMENTAL HEALTHCARE LEADER: INSIGHTS FROM A GROUNDED THEORY RESEARCH STUDY

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ABSTRACT

BACKGROUND

Healthcare is becoming increasingly complex, requiring leaders to cope with a significant degree of uncertainty, change and ambiguity. In this environment, the healthcare leader's ability to make sense of their experiences and thrive as a leader, is crucial to the efficient functioning of the healthcare system.

OBJECTIVE

To explore how the healthcare leader understands and makes sense of their leadership experiences and to develop a theoretical model which reflects contemporary leadership in a complex healthcare environment.

METHODS

A constructivist grounded theory methodology provided a comprehensive and rigorous model for the flexible exploration and analysis of the personal experiences and perspectives of the participant healthcare leaders. The rich and varied data was co-created through researcher interviews with participants, where participants engaged in two, one-hour interviews. Memo writing throughout the data collection and analysis process afforded additional valuable data.

RESULTS

Coding of data using constant comparative analysis rendered six key categories: Broadening perspectives and abilities as a leader, Creating the best possible healthcare environment, Experiencing and making sense of the bad times, Leading in alignment with personal values, Communicating and building relationships, Experiencing and making sense of the rewarding times. An overarching core category emerged of Being an wholistic and developmental leader, which connected all the categories.

CONCLUSION

This research provides an understanding of how healthcare leaders make meaning from their leadership experiences. A comprehensive model has been constructed to describe how contemporary healthcare leaders make sense of their leadership experiences in complex environments both wholistically and developmentally. This is useful for both informing and supporting the developmental growth of healthcare leaders.

KEYWORDS

leadership. healthcare leader, developmental, wholistic, complex, complexity

INTRODUCTION

Healthcare systems represent a substantial investment in human and economic resources, while also increasing in complexity [1]. Healthcare systems and the healthcare leaders within them are required to deliver an expanding range of technologically enabled healthcare to an aging population, with chronic and complicated health conditions. All in the context of a politically influenced environment [2].

Healthcare leaders at all levels are required to function with a significant degree of complexity, uncertainty, change and ambiguity. Testament to this was the recent COVID-19 global pandemic where rapid transformation of healthcare services presented critical leadership challenges [3]. Additional complexity is afforded by the highly professionalised nature of the healthcare workforce. To effectively manage this complexity, leaders require more than proficiency in technical skills and the attainment of base-level competencies [4, 5]. Given the complexity and fluid nature of the management and leadership role in healthcare, some of the growth capabilities needed to thrive in this variable environment include adaptation, innovation, collaboration and transformational change management [[5-7].

It is unclear how contemporary healthcare leaders understand and make sense of their leadership experiences and how this understanding influences their leadership behaviours [8]. A scoping review was conducted to identify this gap in the literature [9]. The scoping review was then used to inform this exploratory grounded theory study to answer the research questions: 1.“How does the healthcare leader understand and makes sense of their leadership experiences? 2. “What are the leadership behaviours manifested by the healthcare leader?

METHODS

RESEARCHER POSITIONALITY

A constructivist ontology and epistemology [10-12] underpinned this research, where it was held that reality is mediated and shaped by the individuals' social environment and cultural context, and knowledge is constructed through their experiences and interactions. In this research, the meaning of the healthcare leaders' experiences was interpreted through their own sense-making, where they determined what is truth and knowledge. The data was co-constructed through the lens of both the researcher and the participant. Each of the researchers were health professionals who have worked in health leadership roles. Acknowledging the philosophical position guiding the study, the primary researcher also undertook bracketing and reflective strategies including memo writing, prior to and post interviews to advance the trustworthiness of the conclusions [13].

STUDY POPULATION

Participants included both doctors and nurses working in large acute care hospitals. The participants occupied leadership roles where they managed or led other clinicians and provided direction, guidance, co-ordination or planning in the allocation of resources for medical and health services in accordance with the objectives of the health care organisation. They may or may not have had fiscal or administrative responsibilities [14-16]

SAMPLING STRATEGY

A purposeful snowball sampling strategy was used to recruit a heterogeneous sample of healthcare leaders who presented with a mix of leadership experience and organisational environments. Participants were recruited through introduction and referral. A total of 24 participants were invited via email to interview, of which 17 were recruited and 16 completed both interviews with one participant completing interview one[17]. Data saturation was reached at approximately 14 participants. However, an additional three participants were already recruited.

CONTEXT AND STUDY SETTING

The study setting was in acute care hospitals within Australia, with one participant working in both the UK and Australian settings. Where possible, interviews were conducted face-to-face within the participant's office or meeting room, otherwise, interviews were conducted virtually via Microsoft Teams (version 1.7.00.1864). Data collection was from January to October 2022. Noting that at this time the COVID-19 global pandemic was still very much top of mind.

RESEARCH DESIGN

Constructivist grounded theory

Constructivist Grounded Theory (CGT) as developed by Charmaz [17] provided an appropriate methodology where the research process was inductive and cyclical. What is real and what is true was distinguished by the assumption that “what we take as real, as objective

knowledge and truth, is based upon our perspective" [18] The concept of emergence was a central concept and was predicated on the idea that outcomes or theory emerge from the data,[19]. The researchers' flexible exploration and analysis of the personal experiences and perspectives of the selected participants provided rich and co-created data [20]

DATA COLLECTION METHODS

Leadership Interviews

Two in-depth, semi-structured, one on one interviews with leaders were conducted to explore how the healthcare leader understands and makes sense of their leadership experiences, and how these leadership experiences manifested in their leadership behaviours. Open-ended questions were asked, for example, "How would you describe yourself as a leader? What would you describe as some of the most challenging/most rewarding aspects of your leadership? Questions were informed, in part, by research from an initial scoping study performed by the researchers [9]. Based on the ongoing analysis, as interviews progressed, additional questions and concepts were included to better explore and understand leaders' experiences on emergent topics or themes, such as [21] the notion of conflict and how this manifested in leaders' behaviours. The second interview was usually conducted within two weeks of interview one. The data from both interviews were combined and analysed. Further analysis of the data from the second interview using constructive development theory will be reported elsewhere.

All interviews were recorded and transcribed by the researcher. Data collection and analysis were undertaken concurrently, thereby allowing for the integration of insights, and pursuit of additional data on promising themes.

Memos

Memos written before and after the interview captured a self-reflective noticing of key elements of the interaction. In between sessions, memos captured assumptions, observations or tenuous linkages that could be explored further. Memos played a pivotal role in the creation of theoretical categories [17].

ANALYSIS METHODS

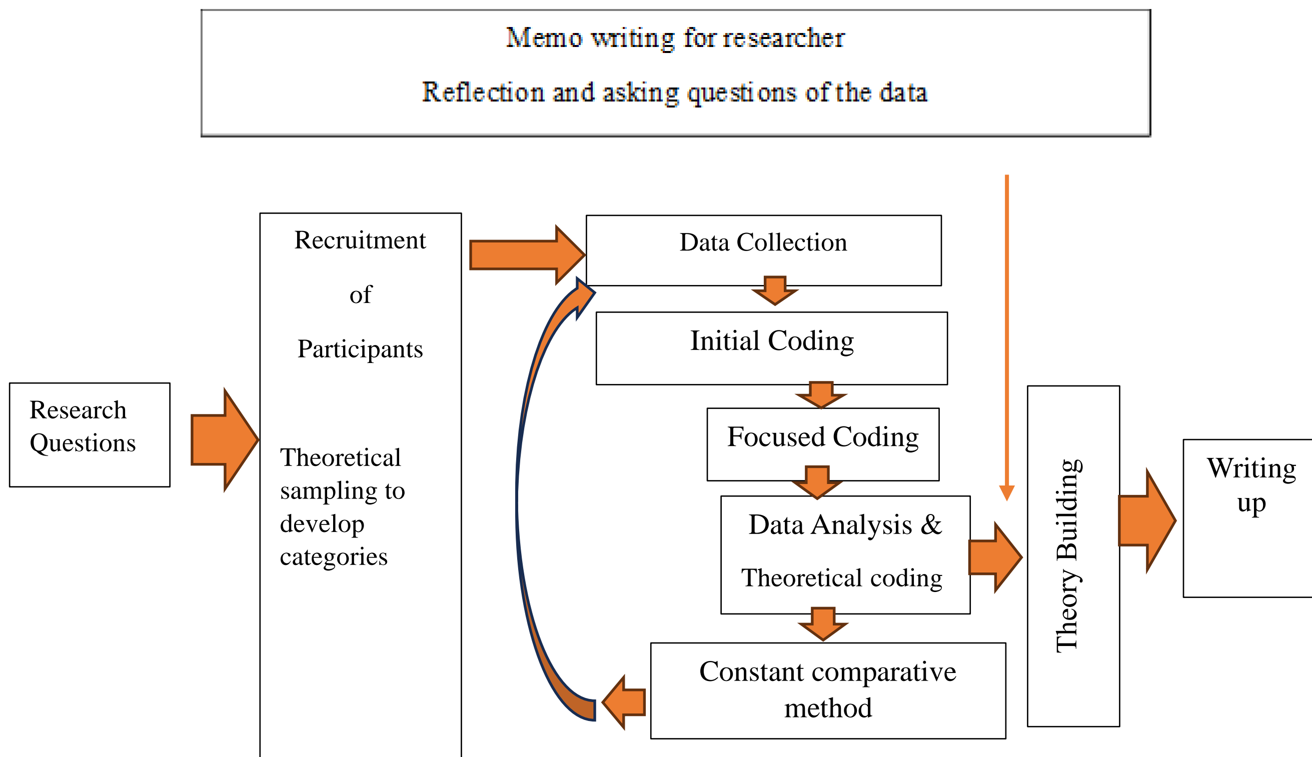
Coding assigned meaning to segments of the data[22] and commenced with line-by-line coding of interview transcripts. It then progressed to focused coding by asking questions of the data, such as "What larger story are these codes conveying"? Following an iterative comparative process which continued throughout the analysis of both interviews, focused codes were then grouped into sub-categories which represented the emergence of key categories. Table 1 defines the CGT coding strategy used in the study.

The following figure 1 provides insight into how the elements of grounded theory aligned with the research.

TABLE 1. CONSTRUCTIVIST GROUNDED THEORY CODING STRATEGY

Coding	Description
Initial line-by-line coding	Initial codes were developed through line-by-line hand coding where each line or relevant segment of the data was interrogated for meaning and assigned a code which attempted to explicate the meaning of the segment [17]. Coding began on the data from interview one.
Focused coding	Focused coding took the process one-step further by comparing data with data, codes with codes, codes with categories, categories with new data and comparing codes between participants and within participants. The aim was to delineate the most representative codes as focused codes [23]. To this end, codes were often collapsed or merged into each other where it was considered that a more expansive code encompassed the extent of the data.
Theoretical coding	Theoretical coding involved abstracting the data to create a broader code which had both analytical and "explanatory power" [12].

FIGURE 1. GROUNDED THEORY ELEMENTS AS THEY ALIGNED WITH THE RESEARCH



Adapted from Charmaz (2014, p.18) [17]

ETHICS

Bond University Human Research Ethics Committee (BUHREC) granted ethical approval on 05/05/2021 for project # SR00236.

RESULTS /FINDINGS

The demographics of the 17 participants are presented in Table 2.

TABLE 2. PARTICIPANT DEMOGRAPHICS

		Frequency (%) N=17
Gender	Female	10 (59)
	Male	7 (41)
Age	30-40	1 (6)
	40-50	5 (29)
	50-60	6 (36)
	60+	5 (29)
Profession	Registered Nurses	13 (76)
	Doctors	4 (24)
Years of leadership experience	5-10	7 (41)
	11-20	3 (18)
	21-30	5 (29)
	30+	2 (12)

*Percentages are rounded to a whole number

FINDINGS

Leaders described their behaviours at the same time as they described how they understood and made sense of their leadership experiences. Therefore, results for both research questions were integrated together. For example when discussing, how a leader understood and expressed the emotion of anger in the workplace, one participant commented, "This person basically went against everything that we as a team stood for and instantly, I was enraged, not just angry, I was absolutely fuming to the point where I could not talk to that person that day because I knew if I did, I would not come across the way a leader should"(P6).

Initial codes or sub-categories were created first and preceded the emergent development of the key categories. Following extensive line-by-line, focused and iterative coding of the data, six key categories emerged which represented the diverse plethora of leaders' perspectives. In addition, a seventh overarching or core category emerged, which connected and linked all the categories. By exploring each of the key categories in turn, there is a gradual unfurling of the leaders' understanding, sense making and associated behaviours.

Key category 1: Broadening perspectives and abilities as a leader

TABLE 3. PARTICIPANT QUOTES ILLUSTRATIVE OF THE KEY CATEGORY AND SUB-CATEGORIES

Broadening perspectives and abilities as a leader			
Description	**Sub-categories**		**Participant Quotes**
This category explained how the leaders viewed their leadership experiences and how their leadership had changed over time. It detailed how developing their emotional intelligence, increasing their self-belief and having environmental scaffolding supports influenced their leadership and how this manifested in their leadership behaviours.	1.1	Changing experience of leadership over time	"Be vulnerable and humble, just because I am in a leadership position doesn't mean I know everything" (P9).
	1.2	Developing emotional intelligence	"I have started to reflect recently on how I engage with others, what can I do differently?" (P16).
	1.3	Having self-belief	"Sometimes you realise that you are in the exact right position and point in your life to do this job" (P6)
	1.4	Providing and receiving scaffolding support	"My boss is an amazing listener" (P13) "You look at the negative behaviours, [and think], I am not going to touch that" (P15).

As participants progressed in their roles, their experience of leadership changed to a position where they learnt to navigate uncertainties, value diversity of thought, devolve power and responsibility, sponsor innovation, and manage risk more strategically. For some, there was a shift from operational to more strategic roles, where their leadership influenced on a broader scale. While 24% of leaders had post-graduate leadership qualifications, leaders noted that their leadership skills were primarily acquired or honed through practical on-the-job experiences rather than formal leadership training. "It has been a long journey…I am practical, I've learned along the way "(P3)

In developing their emotional intelligence, participants used reflection as a valuable tool for enhancing their self-awareness, including identifying their values. This enabled participants to recognise the impact of their emotions on themselves and others. For some participants, there was the reflection that over time they became better at managing their emotions more effectively. Participants' self-belief grew as they embraced their vulnerabilities, set boundaries, and faced their fear of failure. They experienced a movement away from seeking constant approval and focussed on developing their personal authenticity, even if it meant not conforming to others' expectations. One participant recounted their experience with a more senior colleague, "He had a narcissistic injury and just got really defensive, condescending and unprofessional with me…I had to stand up for myself" (P1).

Scaffolding support in the form of role models, mentors, and supportive teams played a pivotal role in the participant leaders' growth. Both positive and negative role models influenced their behaviour, while mentors provided guidance and encouragement. Mentoring others and practicing self-care were also components of the leaders' development, even though self-care was often overlooked. As one participant commented, "I'm a wee bit desensitised, nurturing myself, I've never really thought about it" (P15). The scaffolding support which helped in their growth was also a factor in participants' developing confidence in their abilities and learning from failures. As one participant wryly observed, "You learn from your scars" (P13).

Key category 2: Creating the best possible healthcare environment.

TABLE 4. PARTICIPANT QUOTES ILLUSTRATIVE OF THE KEY CATEGORY AND SUB-CATEGORIES

Creating the best possible healthcare environment			
This category described the leaders' focus on prioritising patient safety, care, and advocacy. Demonstrating agility in managing rapid change and having a bias for action, in addition to creating a team environment where staff were safe, engaged, valued, and respected. This contributed to creating the best possible healthcare environment.	2.1	Prioritising patient safety, care and advocacy	"There are a few times when you need to stand by the patient and be a strong advocate" (P17).
	2.2	Demonstrating agility and getting things done	"At one stage there was a new thing you had to bring in on a daily basis" (P3).
	2.3	Creating a team environment	"By creating connection and building a sense of trust and respecting what people say…there are a lot more people feeling brave enough to speak up and speak out" (P16).

In creating the best possible healthcare environment, all participants expressed the view that prioritising patient safety, care and advocacy was integral to their role. To this end, participants' commitment involved addressing competency issues, making tough decisions, and investing in staff training and education. Several participants stated that advocating for the patient included mitigating the unintended consequences of budget cuts to services.

Demonstrating agility and getting things done, were key ingredients in the participants' aim of creating the best possible healthcare environment. This agility involved the practice of open communication with stakeholders, and the encouragement of innovation, underpinned by a commitment to professionalism and respect for both patients and staff "We didn't have to push back if something came up, you could just talk to each other…it was a really good dynamic" (P12).

Creating a team environment which was both cohesive and safe for staff and patients revolved around fostering an atmosphere that prioritised connection, active engagement, psychological safety, credible advocacy, and the embracing of diversity. There was an acknowledgement of the need to learn from failures and the importance of cultivating a culture of continuous improvement.

Key category 3: Experiencing and making sense of the bad times.

TABLE 5. PARTICIPANT QUOTES ILLUSTRATIVE OF THE KEY CATEGORY AND SUB-CATEGORIES

Experiencing and making sense of the bad times			
This category explored how leaders defined for themselves what challenges constituted the bad times, and how they	3.1	Experiencing and dealing with conflict	"No one likes to confront or have challenging conversations, I will have them though, I never shy away because I think that is also respectful to the other person"(P2).

dealt with and made meaning from them. Conflict and exposure to negative leadership was challenging for leaders, however, it also provided opportunities. Building resilience, involved learning from and building strength from the challenges of bad times.	3.2	Accumulating exposure to negative leadership	"No matter what you did they just didn't listen" (P12) "You can only put up with it for so long"(P4).
	3.3	Building resilient healthcare leaders	"Let us try and understand how we got to this unexpected point in the road"(P9)

As participants discussed how they made sense of challenging leadership situations and experiences, they emphasised a requirement for reflecting on and aligning with their core values. Addressing conflict directly in a timely manner was seen as a way to pre-empt escalated disputes and improve relationships. The ability to engage in contentious dialogue was in part driven by values of making a difference and respect for themselves and others. Some participants avoided conflictual situations due to personal discomfort and a perceived potential threat to relationships: "I don't like conflict or upsetting people; I find that a challenge" (P3).

The toll of addressing conflicts and exposure to negative leadership behaviours was linked to undervalued staff contributions and the existence of toxic cultures. Having continued exposure to negative leadership behaviours, took a toll on participants, with some reporting stress responses and burnout. "It has probably just been too long and too many strikes" (P12). Participants also identified a lack of values alignment, frustration with organisational processes, a lack of work/life balance, and overwhelming job commitments as contributing to burnout. For several participants there was a decision to leave their positions due to experiencing these bad times. Leaders recounted that building resilience involved learning from mistakes, understanding their values, prioritising effectively, maintaining a curious outlook, taking a systems view, advocating for oneself, and building mutually supportive partnerships.

Key category 4: Leading in alignment with personal values.

TABLE 6. PARTICIPANT QUOTES ILLUSTRATIVE OF THE KEY CATEGORY AND SUB-CATEGORIES

Leading in alignment with personal values			
For leaders, being aware of, and aligning with their core values was fundamental in supporting them to flourish in their roles. Many felt a sense of vocation. Where there was a misalignment with their values the leader experienced a sense of cognitive dissonance, manifesting in various ways, such as burnout.	4.1	Being authentic and true to myself	"I am honest in the way I deal with things, and people either like it or they don't…I am never scared to say I disagree with something"(P10).
	4.2	Doing the job I was meant to do	"This is who I was meant to be"(P3).
	4.3	Having compassion, courage, honesty and integrity	"I think compassion is not just about patience, it is about being compassionate to everyone, even the people that you don't like(P11).

For participants, being aware of, and aligning with their core values was fundamental in supporting them to flourish in their roles. A majority of participants regarded the value of authenticity as a key element of their leadership. This value involved knowing themselves deeply and aligning their actions with their core values. Being authentic allowed participants to take risks, build confidence, set clear priorities and be reflective. It also empowered them to act when their values were compromised, even at a personal cost to themselves. Leaders' values were interwoven with behaviours around making a difference, helping others, supporting staff, and ensuring patient care, quality and advocacy.

Leaders perceived themselves as having an integral role to play in the patient's journey often describing this in the context of a 'vocation' or 'doing the job I was meant to do'. Values such as respect, positivity, clinical competence, and compassion guided leaders to positively impact colleagues, staff and patients and make decisions aligned with their principles.

Participants nominated values of fairness, honesty, positivity, commitment, trustworthiness, compassion, courage, integrity and competency. For many, cultivating an atmosphere of openness, respect, and trust within the workplace, promoted staff engagement and a culture of accountability. "You just need to be honest with people, whether it is actually going to be challenging or a positive thing for them" (P8).

Key category 5: Communicating and building relationships.

TABLE 7. PARTICIPANT QUOTES ILLUSTRATIVE OF THE KEY CATEGORY AND SUB-CATEGORIES

Communicating and building relationships			
Leaders' emphasis on communicating and building relationships was supported by their ability to listen and have difficult conversations. Leaders had multiple approaches to getting the best out of people, which all involved facilitating communication.	5.1	Listening and having the difficult conversations	"If it is out of character for my team member, it raises a red flag for me, just to make sure that they are okay"(P7).
	5.2	Building networks, partnerships and strategic alliances	"My strategy is always to get to know the people and the personalities and to build relationships and to find the common ground that has nothing to do with work…Trust is something that is not transactional, it is something that is built"(P5)
	5.3	Getting the best out of people	"They know that they are going to get support from you when they need it and then that creates loyalty"(P6) "I like to think that empowering people is not about making them like you it is about saying, good for you for having an opinion on this and hopefully the way I respond will help them have an opinion next time"(P11).

Leaders recognised that building relationships involved attentive listening, understanding others' emotions and being willing to have the difficult conversations. "Some of the conversations had to be fairly gnarly because they [the team] had a bunch of blind spots" (P5). Honesty, courage, preparation, and a willingness to learn, were key elements in creating successful outcomes during difficult conversations and in developing professional relationships.

Participants in senior leadership roles emphasised the importance of building networks, partnerships and strategic alliances. Open communication supported organisational change, staff development, empowerment, patient-centered care, and an efficient workplace. Past clinical experience was seen as valuable in helping participant leaders to understand their team's environment and advocate for the profession.

Getting the best out of people involved engagement, active listening, letting go of perfection, building trust, and ensuring individuals feel valued and heard. As one participant commented, "Facilitating execution through others…I think that is something that has been a big learning for me (P2). Failure to listen actively or understand the emotional makeup of others led to misunderstandings and unexpected behaviours.

Key category 6: Experiencing and making sense of the rewarding times

TABLE 8. PARTICIPANT QUOTES ILLUSTRATIVE OF THE KEY CATEGORY AND SUB-CATEGORIES

Experiencing and making sense of the rewarding times			
Healthcare leaders explained how experiencing rewarding times was integrally allied to their ability to make a difference for their patient's, their staff, and the organisation. Developing individuals and teams was seen to be a significantly rewarding and worthwhile element of their leadership. Their role also provided a diverse range of opportunities for them to learn and engage with different and novel challenges. This variety was seen to be both advantageous and rewarding.	6.1	Making a difference	"I come in every day and even if it is only one small thing that makes a difference or makes the service even a snippet kinder or more responsive, then I have achieved something"(P14). "I know that I am creating a level of significant influence in the position I am in, where I can now shape what is happening, it is really rewarding" (P11).
	6.2	Growing and developing individuals and teams	"Part of the legacy will be around people, growing the team"(P13)
	6.3	Exploring new challenges and novelty	"What I value is the opportunity to explore and expand and go, I wonder if we could do that?...I don't do well with humdrum"(P9).

For healthcare leaders, the rewarding aspects of their roles were derived from making a meaningful difference where they coped with challenges and could feel a sense of achievement through positively impacting the lives of others. As one participant commented, "There is a lot of good you can do in this role and that is probably what keeps me in it" (P17). Leaders also found fulfillment in growing and developing individuals and teams, irrespective of whether it was appreciated or not. Knowing that they had helped others was the reward. "Making a difference for each and every nurse on each and every shift" (P16). Having opportunities for exploring diverse areas, engaging in challenging circumstances and exposure to novel situations were all rewarding aspects of the participant's leadership role. Leaders also mentioned the importance of collaborating with like-minded individuals within an intellectually stimulating and professionally rewarding environment.

In the following Figure 2, the emergent model is represented by the overarching category "Being an wholistic-developmental leader" (innermost ring), this category emerged to connect and link all the categories. The six key categories, (middle ring), emerged to describe the diversity of leaders' perspectives. The sub-categories emerged to describe detailed behaviours, (outermost ring).

FIGURE 2 THIS SUNBURST DIAGRAM REPRESENTS THE QUALITATIVE FINDINGS. CORE CATEGORY (INNER RING), KEY CATEGORIES (MIDDLE RING) AND SUB-CATEGORIES (OUTER RING)

DISCUSSION

STATEMENT OF PRINCIPAL FINDINGS

For the healthcare leader, understanding and making sense of their healthcare leadership involves a constellation of thinking and behaviours. Leaders recognised that their perspectives and abilities broadened over time, as they focused on creating the best possible healthcare environment. They described the importance of leading in alignment with their personal values and fostering communication and relationships. They also described recognising and making sense of the bad and the rewarding times.

From these six key categories, a unifying theme of being an wholistic-developmental leader emerged to describe both the perspectives and behaviours of contemporary health leaders. These categories embody the wholistic elements of this cohort of healthcare leaders, in both the development of the self and a focus on others and the environment. As evidenced from alignment with the existing literature referenced in Table 9, a focus on these elements creates the conditions for effective leadership. Each category is intrinsically linked in an ecosystem such that the absence of one category impacts the whole.

Staying close to the data through interviewing, transcribing and hand-coding provided the researchers with a front row seat in observing and defining how the healthcare leader makes sense of their leadership experiences. Looking at the data from different perspectives allowed an integrated approach and assumed that "what we take as real, as objective knowledge and truth, is based upon our perspective" [18].

DISCUSS THE MAIN RESULTS WITH REFERENCE TO PREVIOUS RESEARCH

This study builds on previous research which found that healthcare leadership is multifaceted and complex [5-7]. Hearing from the leader's themselves has outlined a much broader and integrative landscape for the leader than the nomination of adherence to a specific leadership theory, process or system. The grounded theory, "Being an wholistic-developmental leader" model, aligns with the extant leadership literature by capturing elements of Authentic, Adaptive, Transformational, Complexity and Caring Science leadership theory as outlined in Table 9. [Do not delete section break]

TABLE 9 LINKING AND INTEGRATION OF LEADERSHIP THEORIES WITH THE BEING AN WHOLISTIC-DEVELOPMENTAL LEADER MODEL

Leadership theory	Elements of the Theory	Links with Being an Wholistic Developmental Leader Model
Authentic Leadership	"A pattern of leadership behavior that draws upon and promotes both positive psychological capacities and a positive ethical climate, to foster greater self-awareness, an internalized moral perspective, balanced processing of information, and relational transparency on the part of leaders working with followers, fostering positive self-development" [24]	Being Authentic and true to myself Developing emotional intelligence Leading in alignment with personal values Communicating and building relationships
Adaptive leadership	This theory highlights the ability of a leader to adapt to changing circumstances in complex and uncertain environments, elements include; communication, relational leadership, providing purpose, empowering team members, conflict resolution, resilience, mobilizing and inspiring action [25].	Demonstrating agility, and getting things done Communicating and building relationships Making a difference Changing experience of leadership over time Creating a team environment Growing and developing individual and teams Listening and having the difficult conversations

Transformational leadership	Transformational leadership is a leadership style that focuses on inspiring and motivating followers to achieve their full potential and exceed their own expectations [26]	Communicating and building relationships Creating the best possible healthcare environment Getting the best out of people Emotional intelligence Changing experience of leadership over time
Complexity Leadership Theory	Complexity leadership includes a number of key elements which align with the model where leaders need to adapt to changing circumstances, learn from experience as well as promoting self-organising of teams Understanding, leveraging and navigating dynamic interactions within the organisation [27, 28]	Demonstrating agility and getting things done Changing experience of leadership over time Creating a team environment Providing and receiving scaffolding support Making sense of the bad times Experiencing and making sense of the rewarding times Broadening perspectives and abilities
Caring science leadership theory	This model emphasises a holistic and humanistic approach to leadership, elements include; Fostering caring relationships, Developing self-awareness and knowing one's values, cultivating empathy and compassion, encouraging stress-reduction and resilience, prioritising a positive work environment, service to others, Creating a culture of innovation, Authentic presence, Supporting the growth and development of team members [29]	Providing and receiving scaffolding support Broadening perspectives and abilities as a leader Developing emotional intelligence Making a difference Exploring new challenges and novelty Building resilient healthcare leaders Creating the best possible healthcare environment Being authentic and true to myself Growing and developing individuals and teams

CONCLUSION AND RECOMMENDATION: MEANING (IMPLICATIONS) OF THE STUDY FOR HEALTHCARE LEADERS

The aim of this research was to explore how the healthcare leader understands and makes sense of their leadership experiences, and to develop a theoretical model which reflects contemporary leadership in complex healthcare environments. The "Being an wholistic-developmental leader" model gives a powerful rendition of the key elements which are essential to being an effective healthcare leader. These provide a valuable foundation on which to build scaffolding supports for healthcare leaders to grow and thrive in highly complex and dynamic workplace environments.

Having a leadership model specifically developed from healthcare leader's experiences, captures shared priorities such as caring, compassion, and a focus on the safety of both patients and staff. Effective healthcare leadership in highly complex environments, is critical for the safety, care and wellbeing of patients, staff and the community.

STRENGTHS AND WEAKNESSES OF THE STUDY

The application and coherence of the study design using a constructivist ontology and epistemology and a constructivist grounded theory methodology, provided a comprehensive and rigorous real-world exploration of how the healthcare leader understands and makes sense of their leadership experiences. The resulting emergence of the "Being an wholistic-developmental leader" model is grounded in the data and supported by adherence to the evaluative concepts of credibility, originality, resonance and usefulness [17]

Credibility was achieved through in-depth data collection and analysis involving a significant range, number and depth of observations. A comprehensive audit trail was maintained throughout using NVivo V12, memos and hard copies of the data. Originality was demonstrated by the uniqueness of the model which has a dual focus, on both the development of the self and leading and developing others. Resonance was attained through incorporating the data from comprehensive memos written throughout the research process that sought to move beyond surface meaning and interrogate meaning from what is not readily visible. Usefulness is demonstrated by the importance of healthcare leaders to the efficient functioning of the healthcare system. For healthcare leaders to survive and thrive in their complex daily working environment and to be an effective healthcare leader requires attention to each of the key categories.

These results represent a small group of healthcare leaders at a certain time and place (i.e. the acute hospital setting) and may not be easily transferable to other healthcare systems.

FUTURE RESEARCH

Applying the model more broadly with other professions a more diverse group of leaders both within healthcare and outside the healthcare industry could determine the transferability of the theory.

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