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Physician Authentic Leadership as Health Care Managers and Its Impact on Subordinates' Ethical Strength

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Abstract

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MA, Middle Tennessee State University, 1998

BA, University of Texas Permian Basin, 1984

Dissertation Submitted in Partial Fulfillment

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Doctor of Philosophy

Industrial/Organizational Psychology

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Abstract

Physicians exercising the characteristics of authentic leaders may be better equipped to affect the ethical strength of health care staff and provide a vehicle for reducing corruption in the health care industry. This position suggests that physicians practicing with these particular qualities are more effective than those who are not genuine, transparent, or committed to maintaining emotional balance in their work relations. The purpose of this quantitative correlational study was to determine whether physician authentic leadership (AL) moderated the relationship between physician emotional intelligence (EI) and the moral potency of their billing and codes managers. Survey data were collected from 105 medical staff who completed measures of ethical strength, EI, and AL. Regression analyses were conducted to evaluate the relationships among these measures. Findings indicated physician EI had a significant positive relationship with the billing/codes managers' ethical strength. Physician EI also had a significant positive relationship with physician AL. The moderation regression was not statistically significant, nor was the effect for EI in the regression. However, analyses yielded a significant effect for AL. Although physician AL did not significantly interact with physician EI and managers' ethical strength, results indicated that managers' ethical strength was influenced by the physician's AL. Results may be used for positive social change to raise awareness about a potential means of reducing corruption in the health care industry.

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Dedication

This achievement was only made possible by my Lord, God, Almighty. It is Him to whom I first dedicate this incredible undertaking. His words from Isaiah 41:10 have been my mantra: “Fear thou not; for I am with thee: be not dismayed; for I am thy God: I will strengthen thee; yea, I will help thee; yea, I will uphold thee with the right hand of my righteousness.” Praise the Lord for his unwavering faithfulness.

Secondly, I dedicate this project to my parents, Peggy and Bernice Christian. You both left this world too soon, but you’ve never been forgotten. I’m grateful for being raised in a home where love and hard work were taught by example. I cannot wait to see you again, and introduce you to your granddaughter, Hannah.

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Chapter 1: Introduction to the Study

Corporate malfeasance and the magnitude of corrupt activities within organizations has drawn a great deal of attention over the last decade (Liu et al., 2018). Landay et al. (2019) reported that recent scandals had facilitated broad concern regarding the character and ethical behavior of corporate executives. Moreover, Kimeu (2014) reported that International Transparency defined systemic corruption as "the abuse of entrusted power for private gain" (p. 231). Although a great deal of the literature has focused on the criminal activities and has viewed some companies as victims in false claims cases (Sanford Heisler, 2012), Arellano-Gault (2019) examined the internal organizational processes that often dictate the misconduct and serve to steady or secure corrupt demands. Arellano-Gault found one side of the issue centered on corruption from the perspective of it being a decision of profit and risk calculations, and the other side viewed it as a social relationship that is normalized within the firm. Moreover, having a greater awareness of the detrimental effects of corruption has generated increased strategies for countering its sustenance (Persson et al., 2013).

Sullivan and Hull (2019) reported that "healthcare fraud, waste, and abuse losses were estimated to be as much as $700 billion per year" (p. 48). The researchers claimed that these deficits contribute to the rapid escalation in health care costs for all Americans. Sullivan and Hull reported that although health care costs rose, so did the number of health care fraud activities. This problem affects everyone from patients to health care insurance providers to health care professionals and spans a variety of unethical behaviors. Sullivan and Hull listed some of the most common types of health care fraud

as kickbacks paid in the form of cash and billing for medically unnecessary prescription drugs. Moreover, the researchers found doctors who had billed health insurance providers for patient visits coded as "evaluation and management" and had at the same time billed for "preventative counseling" for the same patient visit. In addition to these types of misconduct, other researchers reported the following examples: sexual coercion (d'Oronzio, 2015; Melo et al., 2019; Swiggart et al., 2016), upcoding (Bauder et al., 2017; Jürges & Köberlein, 2013), hospital profiteering (Derlet et al., 2016), criminal prescribing of opioids and unnecessary surgeries (DuBois et al., 2019), and withholding potentially life-prolonging medical treatment (Landry et al., 2019).

This chapter introduces the current study's problem under investigation, the research questions and hypotheses, and the quantitative design used to measure the constructs. Relevant terms used throughout the current study are defined as well as pertinent assumptions made prior to the current study. In addition, the current study's scope, delimitations, and limitations are reviewed.

Background

Trending in recent years has been a focus on ethics and morality in leadership (Liu et al., 2018). Covelli and Mason (2017) explained that this has been partly attributed to organizational corruption leading to distrust among people for their leaders across the United States and around the world. DuBois et al. (2019) reported that in a study analyzing 280 cases in the United States between 2008 and 2016 concerning ethical violations in medicine, most involved repeated wrongdoing that was overlooked. DuBois et al. also found that systems failed to identify, track, or prevent repeated offenses.

DuBois et al.'s study also revealed that most cases involved males with selfish motives, and over half involved either a personality disorder or a substance use disorder.

Wiernik and Ones (2018) found that employee corruption typically included "lying, misrepresentation, cheating, bribery, operating with a conflict of interest, abusing one's position for personal ends, and breaking or subverting laws, rules, or regulations" (p. 37). Wiernik and Ones concluded that some organizations promote unethical behaviors or blatantly require it from their employees. One of the examples cited was the Wells Fargo scandal of 2016, in which the authors reported that employees were instructed to commit fraudulent banking and set goals so high that others would act unethically to reach them. With the increased publicity of global corruption and the arrival of the 21st century, George (2003), a former chair and CEO of a leading medical technology company, wrote, "we need authentic leaders to run our organizations, people of the highest integrity, committed to building enduring organizations" (p. 5). During this same period, Luthans and Avolio (2003) were formulating a new approach to leadership, which they called authentic leadership (AL). In their development of AL theory, Luthans and Avolio's aim was to identify constructs and relationships that would assist in the reestablishment of confidence and integrity in leaders. Duncan et al. (2017) reported that, over the years, AL gained a large degree of attention. Walumbwa et al. (2008) provided the four key dimensions of the leadership construct: "self-awareness, relational transparency, balanced processing, and internalized moral perspective" (p. 95).

Malila et al. (2018) claimed theirs was the first literature review to examine original peer-reviewed research on AL applied in health care, dating back to 2009. The

purpose of the review was to identify potential gaps and make suggestions for future research. Four themes were noted in their research which included well-being at work, patient care quality, work environment, and AL promotion. Moreover, they highlighted the fact that well-being at work was the most common among the themes reporting that this must be addressed properly to avoid potential burnout and high turnover. In their research they found that AL actually influenced health care staff in a number of positive ways, that it could impact patient outcomes, that it enhanced healthy work environments, and yet was found to be the smallest research theme among their review. Wong and Cummings (2009) implemented the AL model using secondary analysis procedures examining health care employees. Their study included physicians, nurses, pharmacists, and administrative and support staff. Results indicated a positive effect of AL behaviors on work outcomes, as leaders who were perceived as relationally transparent also generated greater trust in followers.

The concept of emotional intelligence (EI) was brought into public awareness by Goleman (1995), who described EI in terms of understanding and controlling emotions in oneself. Goleman argued that EI was developed by learning appropriate emotional skills over time. Moreover, Goleman maintained that because EI was an ability form of intelligence, it could be enhanced through training. Mayer and Salovey (1997) defined EI as:

> the ability to perceive, appraise, and express emotions accurately; the ability to access and generate feelings to facilitate cognitive activities; the ability to understand affect-laden information and use emotion-relevant knowledge; and the

> ability to manage one's own emotions and the emotions of others to promote emotional and intellectual growth, well-being, and adaptive social relations. (p. 10)

Panait and Bucinschi (2018) asserted that to be seen as having AL was to exhibit high EI. While investigating the relationship between EI and variance in ethical behavior, Jeffries and Lu (2018) collected data using an experimental economics lab in which they issued cash payoffs for decisions made in an ultimatum game. While assessing moral reasoning in combination with EI, Jeffries and Lu found support for their hypothesis that higher scores on both constructs yielded more ethical behavior.

Previous research addressed ethical behavior using moral development measures (Jeffries & Lu, 2018). Jeffries and Lu (2018) focused on the gap in the knowledge involving whether there were variances in ethical behavior and a link to EI. Their findings indicated that EI was attributed to some of the variance in ethical behavior. Rather than using traditional self-report data, Jeffries and Lu created a simulation in which participants were required to make decisions and experience the consequences for their decisions. Another gap in the knowledge was identified by Panait and Bucinschi (2018) who reported EI to be crucial for effective leaders. The current study was needed to determine EI's role in physician leaders, combined with their authenticity in the workplace, and the impact they have on medical staff's moral integrity.

The current study was needed to address health care corruption and the need for greater ethics in the field. This study was needed to determine to what extent AL among physicians may moderate the relationship between physician EI and ethical strength in

medical staff. In addition, the intent was to provide relevant information to physicians and health care administrators as evidence toward mitigating corruption and its destructive repercussions in the health care industry. The intent was to create greater awareness of an important social issue and promote new strategies toward positive social change in health care, which may impact individuals, organizations, and communities.

Problem Statement

At the time of the current study, the research problem was the unethical and corrupt upcoding of patient fees in health care (Spika & Zweifel, 2019). Previous research also addressed these concerns (Alilyyani et al., 2018; Candy, 2014; Malila et al., 2018; Nica, 2015; Swiggart et al., 2016). Ionescu (2018) reviewed recent literature regarding health care corruption and found that it was a significant factor in the cost and stability of services. The analysis also revealed that one of the most important tools in curtailing corruption was transparency. Ionescu argued that corruption played a relevant role in determining health care costs, interfering with delivery of services, and causing resources to be misused. Ionescu found that some of the key factors contributing to corruption included not having an effective corruption reporting system, political interference, and a lack of ethical and moral integrity within health care staff.

Because AL and EI are still relatively young constructs in the social and behavioral sciences, gaps in the literature were identified, which had overlapping associations with each other and the current study. First, a gap was noted regarding the impact leadership style has on corruption in health care (Malila et al., 2018). The objective in conducting the current quantitative study was to determine to what extent, if

any, AL among physicians moderated the relationship between physician EI and ethical strength behavior, which was intended to address this gap. Malila et al. (2018) reported that despite the studies indicating the positive effects of AL, there was little empirical research on AL in health care. The current study was conducted to add to the knowledge base regarding potential methods for reducing misconduct in health care.

Cianci et al. (2014) also noted that they were not able to investigate all pertinent antecedents that linked AL to subordinate ethical decision making. Alilyyani et al. (2018) reported that future studies needed to include a bigger variety of health care professionals. Eisenbeiß and Giessner (2012) indicated the need to investigate the depth of ethical leadership by examining overlooked contextual factors. One example from the literature in which AL constructs were missing in health care was reported by Vasquez (2018) concerning Sutter Health. California's attorney general filed a lawsuit alleging that Sutter engaged in anticompetitive contractual practices, raising the fees for health care services above what it would have been able to charge against competition. Due to cases like this throughout the corporate world, Avolio and Walumbwa (2014) maintained that interest in AL had grown rapidly due to the deterioration of trust among leaders throughout the world.

Candy (2014) explained how more demands were being issued from government for health care organizations to comply with greater ethical conduct and demonstrate greater levels of integrity. Melo et al. (2019) conducted a study with physicians in Rhode Island and found that physician boundary violations were serious breaches of professional conduct. Such incidents jeopardize the relationship between doctors and

patients because professional relationships between doctors and patients are built on trust (Melo et al., 2019). Lopes (2016) reported that ability EI had been positively related with supervisor performance ratings. Lopes asserted that supervisors must regulate their own and subordinates' emotions to be able to motivate employees. In addition, Lopes claimed that health care staff must manage their feelings and expression of emotion to help patients and comply with organizational policies. Lopes echoed the theory of several authors who claimed that effective leadership relied on high levels of EI.

Purpose of the Study

The purpose of this quantitative correlational study was to investigate whether physician AL and EI were significant factors in helping reduce corrupt and unethical behavior in health care. Also, the intention was to determine whether EI predicted ethical strength in employees, as well as whether AL moderated the relationship between physician EI and ethical strength in their employees. Finally, an intent of the current study was to provide results to physicians and health care administrators with the potential for promoting greater ethical behavior within individual medical practices.

Research Questions and Hypotheses

The following research questions and associated hypotheses were used to address the identified gap in the literature:

RQ1: Does perceived EI in physicians, as provided by staff members and assessed by the Wong-Law Emotional Intelligence Scale (WLEIS), predict employee ethical strength, as assessed by the Moral Potency Questionnaire (MPQ)?

H_{01}: Physician EI does not predict employee ethical strength.

H_{a1}: Physician EI predicts employee ethical strength.

Physician EI, as assessed by the WLEIS, was evaluated to determine whether it may be used to predict employee ethical strength, as measured by the MPQ. Statistical Package for Social Sciences (SPSS) analysis of EI on employee ethical strength was conducted to assess whether the predictor variable of EI was a significant predictor of the criterion variable.

RQ2: Does perceived physician EI, as provided by staff members and assessed by the WLEIS, predict physician AL, as assessed by the Authentic Leadership Questionnaire (ALQ)?

H_{02}: Physician EI does not predict their AL.

H_{a2}: Physician EI predicts their AL.

Physician EI, as assessed by the WLEIS, was evaluated to determine whether it may be used to predict AL, as assessed by the ALQ. SPSS analysis of EI on AL was conducted to confirm whether the predictor variable of EI was a significant predictor of the criterion variable.

RQ3: Does perceived physician AL, as provided by staff members, moderate the relationship between physician EI and employee ethical strength, as measured by the MPQ?

H_{03}: Physician AL does not moderate the relationship between physician EI and employee ethical strength, as measured by the MPQ.

H_{a3}: Physician AL moderates the relationship between physician EI and employee ethical strength, as measured by the MPQ.

Physician AL, as assessed by the ALQ, was evaluated to determine whether there was a moderation effect between physician EI and employee ethical strength, as measured by the MPQ.

Theoretical Framework

Authentic Leadership Theory

The current study was anchored in three theories. The principle theory was AL theory (Luthans & Avolio, 2003). Gardner et al. (2011) reported the first literature writings describing AL were by Hoy and Henderson (1983), which consisted of references to individuals taking ownership for actions, not taking advantage of others, and not prioritizing their own affairs. However, more recently, Avolio and Gardner (2005) put forward this theory asserting that the key constructs pertained to self-awareness, moral character, and openness with others. Due to the extent of mistrust and corruption being publicized over the past decade, Covelli and Mason (2017) asserted that AL had been optimistically approached with the hopeful intent to serve as a significant influence toward affecting organizational challenges.

Avolio and Walumbwa (2014) claimed that interest in authenticity and AL theory had expanded quickly due to the decay of trust among world leaders. Avolio and Walumbwa referred to data produced by Harvard University that showed how the American people had lost a significant degree of trust in their leaders. In addition, Ghoshal (2005) argued that business schools had failed to include the importance of ethical practice, which Ghoshal believed had served to allow students to be more ethically noncompliant after they graduate. The enhanced awareness of unethical conduct

has generated more literature calling for AL to speak to the crisis (Avolio & Walumbwa, 2014). Avolio and Walumbwa described this leadership style as one that does not involve self-deception, but rather involves individuals who are honest about who they are as people.

AL theory posits that the person has a heightened awareness of themselves and conducts their behavior according to who they really are rather than any image they might wish to portray (Luthans & Avolio, 2003). Also, Walumbwa et al. (2008) described the authentic leader as one who is transparent with their thoughts as they interact among colleagues. Finally, AL theory proposes that trust between leaders and their subordinates promotes more positive behavior outcomes as well (Avolio & Gardner, 2005). Although AL theory has grown in drive and strength over the last few years, the literature review suggested there had been a slower pace in research demonstrating its connection to key outcomes of the organization, and especially in reference to the health care industry (Alilyyani et al., 2018).

Emotional Intelligence Theory

The second theoretical framework applied in the current study was EI theory (Mayer & Salovey, 1997). Sternberg (2016) reported that Thorndike, a pioneer in the development of mental measurements, was focused on academic performance and military aptitude. According to Sternberg, Thorndike hypothesized the concept of social intelligence, which consisted of two domains beyond traditional intelligence abilities: (a) managing others and (b) acting wisely in relationships. Sternberg went on to explain that

decades later, researchers would be inspired to investigate these concepts well beyond traditional perspectives of intelligence.

Goleman (1995) reported first learning about the term EI coined by Mayer and Salovey in 1990. Goleman perceived EI to consist of five components: self-awareness, self-regulation, internal motivation, empathy, and social skills. Although Goleman popularized these concepts, Mayer and Salovey (1990) had previously theorized how other skill sets served to determine individual success, leadership, and effective interpersonal relationships.

In contrast to some of the popularizations that had been compared and related to EI, Mayer and Salovey (1997) asserted their theory (distinguished from personality characteristics) was more practical and personal (Mayer et al., 2004). Specifically, Mayer and Salovey (1997) defined EI as:

> the ability to perceive, appraise, and express emotions accurately; the ability to access and generate feelings to facilitate cognitive activities; the ability to understand affect-laden information and use emotion-relevant knowledge; and the ability to manage one's own emotions and the emotions of others to promote emotional and intellectual growth, well-being, and adaptive social relations. (p. 10)

The theory was developed from the view that EI was a part of what Mayer et al. (2004) called hot intelligences: those cognitions that pertain to personal matters and those that are emotionally important to the person. Following their review of the literature, Mayer et al. (2004) determined that the abilities and skills of EI could be divided into

four parts: "(a) the ability to perceive emotion, (b) use emotion to facilitate thought, (c) understand emotions, and (d) manage emotion" (p. 199). A central claim regarding EI theory is that it includes the ability to use sophisticated information processing to navigate one's own and others' emotions, and then to use the information to guide thought and behavior (Mayer et al., 2004).

In a study involving EI, Lopes (2016) reported that ability EI had been positively related with supervisor performance ratings. Lopes asserted that supervisors must regulate their own and subordinates' emotions to be able to motivate employees. In addition, Lopes claimed that health care staff have to manage their feelings and expressions of emotion to help patients and comply with organizational policies. Lopes echoed the theory of several authors who claimed that effective leadership relied on high levels of EI.

Deontological Ethics Theory

The third theoretical framework in the current study was the deontological ethics theory developed by Immanuel Kant, born in 1724 in East Prussia (Rohlf, 2020). Lefkowitz (2017) reported that Kant was probably the most influential philosopher in the American culture due to his practical view of ethics. Lefkowitz explained how Kant saw moral behavior through the lens of duty, or people doing what they ought to. For example, Lefkowitz stated that Kant's idea of morals did not hinge on one's behavior being neither ineffective nor yielding a negative outcome. Rather, supporters of Kant's theory would argue morality is about the person's good intentions (i.e., their duty to conduct themselves out of honor for the moral principle). Kant's theory maintains that

whatever moral obligations one assigns to others, they must also accept for themselves (Lefkowitz, 2017). Following deontological ethics, individuals realize they do not violate the rights of others to achieve their own objectives (Lefkowitz, 2017).

In research concerning business ethics and whistleblowing, Mpho (2017) reported that deontological ethics was founded on careful thoughtfulness toward other people. Mpho explained Kant's position that if the individual acted in a way as to satisfy, then the behavior did not come from a moral motive. Deontological theory argues that a person should examine their actions first and figure out whether they can be established as universal law (Mpho, 2017). The concern with deontology is not only the individual, but all people.

Avella (2017) reported that deontological theory places obligation and duty as the first order of business with ethical dilemmas. Avella explained that the theory also extends to contracts between individuals and their organizations, meaning ethical behavior is dictated by the agreed upon contract between the two parties. White (2015) described Kant's moral philosophy as based on the idea that humans are capable of autonomy: the ability to function cognitively free of outside influence or their own inner wishes. White explained that Kant's theory asserts individuals do what is right regardless of whether it opposes authority or their own preferences. Moreover, deontological ethics theory involves compliance to moral rules and official orders within a society (Chan, 2019).

Nature of the Study

The nature of the current study was quantitative to examine whether AL in physicians and their EI influences a trusting relationship with individuals and staff as a group, and their subsequent ethical strength. To assess the association of the constructs, the ALQ (Version 1.0 Rater; Avolio et al., 2007) was administered to the physicians' employees, along with an employee MPQ (Hannah & Avolio, 2010). A WLEIS was also administered to each physician's staff members to rate the doctor's EI. For the current study, ethical strength in billing and codes managers was assessed in each practice, using the MPQ. A bivariate regression analysis was performed to assess whether levels of ethical strength (moral potency) in medical billings managers could be predicted from physician EI in health care settings. A second analysis was completed to determine whether physician EI predicted AL. A third analysis was completed to determine whether physician AL moderated the relationship between physician EI and employee ethical strength. Each of the three analyses was completed using SPSS. The predictor variable was EI, the criterion variable was ethical strength, and the moderating variable was AL. Each instrument in the current study had been used in the past with organizational research. Regression analysis was chosen to analyze the impact of the hypothesized constructs in the health care industry. The goal was to determine whether the relationship between EI and ethical strength depended on AL.

Definitions

The following terms were operationally defined for the purpose of the current study:

Authentic leader: People strong in self-awareness and who impact others through their genuineness and transparency, always striving to be objective and emotionally balanced in their dealings with others (Avolio et al., 2004; Lussier & Achua, 2016).

Authentic leadership: A consistent behavior pattern exhibited by one of high moral character, which facilitates followers who aspire to operate with integrity themselves (Walumbwa et al., 2008).

Authenticity: Being real, genuine, trustworthy, and legitimately true to oneself (Harter, 2002).

Corporate corruption: Fraudulent behavior conducted within an organization by individuals who intend to generate illegal dollars for themselves (Rose-Ackerman, 1999).

Corruption: Misconduct of one's power and authority for self-interests (Hope, 2019).

Emotion regulation: Healthy management of one's emotions through identifying feelings and expressing them appropriately (Gross, 1998).

Emotional intelligence: The ability to recognize and understand information regarding affect in oneself and others, utilizing the information to navigate social relations well (Mayer & Salovey, 1997).

Ethical erosion: Small acts of repeated misconduct that serve to gradually deteriorate an ethical climate within an organization (Hartman & Ramamoorti, 2016).

Ethical strength/moral potency: A moral mindset within one who exercises the ability to conduct business ethically even in the face of inevitable challenge (Hannah & Avolio, 2010).

Health care ethics: The practical application of practicing medicine from a moral perspective (Candy, 2014).

Hot intelligences: The abilities associated with an individual's emotional makeup rather than thought processes (Mayer et al., 2016).

Kleptocracy: Members of a governing body who exploit the people they hold power over, stealing for personal gain (Moorman, 2018).

Medical professionalism: The high standard exercised in health care that represents the quality and ethics that patients expect from physicians and staff members (American Board of Family Medicine, 2018).

Systemic corruption: A variety of dishonest activities that negatively affect an organization (Stefes, 2007).

Upcoding: The act of charging patients a higher fee than the one typically associated with the service delivered at the time (Bauder et al., 2017).

Assumptions

I assumed that the current study participants would be truthful in their responses to the survey questions. For example, I assumed as the participants rated their colleagues, their responses would be genuine. I also assumed that the current study participants would be appropriate representatives of the population. For example, I assumed that the medical staff to be surveyed would reflect employees with similar job duties in the health care industry, who were employed with similar job titles such as office manager, appointment scheduler, nurse, physician assistant, lab technician, and billing/codes manager.

These assumptions were necessary because they aligned with the social science paradigm referred to as postpositivist (Babbie, 2017). This viewpoint, according to Babbie (2017), represents belief in the reality of an objective and logical order of things based on observation and empirical evidence. The current study was conducted from the belief that participants would respond to questions logically, and that data collected would be assessed quantitatively using descriptive and inferential statistics.

Scope and Delimitations

This study was designed to address health care corruption with the focus on practicing family physicians and their staff members. The sample included doctors and staff employed in a variety of work settings such as private practice, hospitals, and medical clinics. This population was chosen with the assumption that more Americans can identify with their primary care family physician rather than other medical specialists. Moreover, the population was chosen from the viewpoint of family physician practices being the hub of the health care sector, and with the objective that study results could be generalized from that hub outward toward the broader medical community.

Although the overall research problem was health care corruption, the current study focused on specific aspects of that arena. The aim was to include the most common types of ethical violations in the health care industry reported in the literature. The following list represents such violations: sexual misconduct (Samenow et al., 2012), overcharges (Jürges & Köberlein, 2015), boundary violations (Melo et al., 2019), confidentiality breaches (Muhammed et al., 2018), inappropriate use of social media in health care (Moses et al., 2014), accepting gifts from pharmaceutical reps (Kelly, 2016),

physician-assisted suicide (Sulmasy et al., 2018), Medicare fraud (Gordon & Siegal, 2020), kickbacks for patient referrals to surgeons/hospitals (King, 2017), improper prescribing of controlled substances (DuBois et al., 2016), violation of patient dignity in psychiatric hospitals (Gustafsson et al., 2014), fraudulent bookkeeping (Alonazi, 2020), and payment of bribes (Kaptein, 2008).

Family physicians were chosen for the current study to generate greater awareness of these activities and to determine whether the key constructs hypothesized positively affected ethical behavior in their billing and codes managers. No other staff in the practice were evaluated for their ethical behavior. The study included only physicians and staff who used computers in the medical practice and those who could access online surveys. Because the research problem was health care corruption, and upcoding is a significant form of the misconduct, the focus in the current study was chosen to evaluate whether physician AL and EI influenced the billing/codes manager's moral integrity.

Other factors not investigated in the current study included theories that were related to the primary constructs. For example, the core emphasis of transformational leadership is on encouraging staff members to move beyond their self-interests for the good of the team and organization (Sanford, 2016). Transformational leadership emphasizes the influence leaders project including their positive vision, openness to new ways of doing things, coaching individuals, and caring for employees in a manner that encourages them to become leaders themselves (Arnold, 2017). Another theory, transactional leadership, stresses things such as order, structure, and results, asserting that

the important issue is aligning a staff culture with priorities using a carefully executed strategy and specifying leader roles and expectations (Hemker & Solomon, 2016).

Also, concerning EI, three additional theories were identified. The trait model indicated EI was a trait that was made up of a group of emotional self-perceptions associated with one's personality (Petrides & Furnham, 2001). The performance model described EI in terms of understanding and controlling emotion in oneself (Goleman, 1995). Finally, the mixed-model viewed EI as capabilities, competencies, and skills that affect an individual's way of coping with demands and stressors (Bar-On, 1997). Other ethics theories related to but not investigated in the current study were egoism and utilitarian ethics (Mpho, 2017).

Limitations

A potential limitation of the current study was the possible barrier for collecting data using surveys and the recruitment of participants. There may also have been limitations in the reliability of the survey data due to its structure through implementing the rater version, with employees evaluating the physicians and billing and codes managers. To mitigate these limitations, I used instruments designed with a forced choice format. The surveys were made accessible online, and the participants self-administered each one. The participants completed the surveys with me being absent. Also, the surveys provided clear scoring instructions to minimize researcher bias.

Significance

The results of the current study could provide insights into the relationship between physician AL, physician EI, and the ethical strength of billing and codes

managers. The study could also add to the extant literature while addressing the omissions left in the medical community research (see Wong & Cummings, 2009). Wong and Cummings (2009) noted a gap in the literature on understanding the impact of leadership styles and their correlation with subordinates in health care. In response to this gap, the intent of my research was to examine the relationship between physician EI and the billing and code manager's ethical strength, and to examine any moderating effect of AL on this relationship.

Although leaders are crucial in any organization to ensure safe and healthy work environments, there is a fresh interest to understand how AL affects health care staff outcomes (Alilyyani et al., 2018). Recent research indicated that corruption is a serious impropriety that breaks down and interferes with quality health care services (Ionescu, 2018). Ionescu (2018) reported that being unambiguous is a vital instrument in decreasing health care corruption.

Corporate corruption has long been an issue needing some type of real deterrent, and the context of the corrupt activity is important for understanding how to prevent it (Zyglidopoulos et al., 2017). Zyglidopoulos et al. (2017) explained how easy it was to reject or dismiss unethical actions without understanding how they developed. However, as health care premiums skyrocket and plan participation is modified, greater fear escalates concerning the consumer's ability to obtain adequate and affordable health care coverage (McKillop et al., 2018).

The current study may positively impact the medical practices of the participants because the findings may support part of the hypotheses presented. Moreover, other

professionals in the field may recognize the importance of physicians' AL and EI in relation to their staff members' ethical behavior. The objectives of the current study aligned with the problem stated regarding health care corruption. Although the key proponents of AL maintain that the model represents an individual's character (George, 2003), the intent is for physicians and staff to identify a positive relationship between these variables, thereby serving to promote positive social change in which physicians and staff may choose to operate with greater moral integrity in their day-to-day practice.

Summary and Transition

"Healthcare fraud, waste, and abuse losses were estimated to be as much as $700 billion per year" (Sullivan & Hull, 2019, p. 48). After the turn of the century, academic and business scholars began to collaborate on the need for "authentic leaders to run our organizations; people of the highest integrity, committed to building enduring organizations" (George, 2003, p. 5). Luthans and Avolio (2003) formulated a new approach called AL with the intent to identify constructs and relationships to assist in the reestablishment of confidence and integrity in leaders.

The objective in conducting the current study was to provide data regarding the relationships between AL, EI, and employee ethical strength in the health care community. The study was designed to determine whether physician AL moderated the relationship between physician EI and employee ethical strength. Moreover, the aim was to promote awareness of these constructs and their potential benefits if implemented within medical practices, with the hope of reducing some of the unethical behavior, if applicable.

Creating an ideal approach to reduce corruption is not simple, yet the stakes of ignoring health care ethics violations are high (Vian, 2019). Clarke (2020) argued that the legalistic maneuvers in place and designed to lessen the misconduct have been ineffective. DuBois et al. (2019) reported that in a study analyzing 280 cases in the United States between 2008 and 2016 concerning ethical violations in medicine, most involved repeated wrongdoing that were overlooked. Witvliet (2019) asserted it would take a global anticorruption movement to facilitate the collective action necessary for significant change. Vian (2019) maintained that if the appropriate steps are taken to fight corruption and strengthen health systems, lives can be saved.

Chapter 1 summarized the attention that corporate scandals have received over the last decade and some of the devasting costs that the misconduct has yielded to individuals, companies, communities, and societies (Ionescu, 2018). Moreover, the literature indicated the need for an effective deterrent to reduce unethical behavior. Several examples from the literature were presented of the most common types of health care fraud. Luthans and Avolio's (2003) model of AL was introduced, as was the plan to use the ALQ in the current study to assess physician AL, and the WLEIS to assess physician EI. Finally, Hannah and Avolio's (2010) MPQ was introduced, with the plan to use the instrument to assess billing and codes managers' ethical strength. In addition, pertinent definitions of terms used throughout the current study were included along with limitations and significance of the current study.

Chapter 2 includes a review of the current literature regarding corporate corruption, unethical conduct in health care, AL, and EI. I also describe the common

fraudulent acts committed by individuals attempting to access money illegally. Leaders exhibiting high moral character and integrity are discussed, along with those who excel in managing emotions in themselves and their subordinates. This chapter also includes the literature search strategy, databases, and key search terms used. The theoretical foundation involving the three major theoretical propositions appropriate to the current study is also discussed.

Chapter 2: Literature Review

Large-scale corruption throughout various industries during the beginning of the 21st century led to distrust of corporations across the United States and around the world (Covelli & Mason, 2017). DuBois et al. (2019) reported that in a study analyzing 280 cases in the United States between 2008 and 2016 concerning ethical violations in medicine, most involved repeated wrongdoing that was overlooked. DuBois et al. also found that systems failed to identify, track, or prevent repeated offenses. Ionescu (2018) reviewed recent literature regarding health care corruption and found that it was a significant factor in the cost and stability of services. The analysis also revealed that one of the most important tools in curtailing corruption was transparency. Ionescu contended that corruption plays a relevant part in determining health care costs, interfering with sufficient delivery of services, and causing resources to be misused. Through this research, Ionescu found that some of the key factors contributing to corruption included not having an effective corruption reporting system, political interference, and a lack of ethical and moral integrity within health care staff.

Moreover, there was a gap noted in the literature regarding the impact leadership style has on corruption in health care. The objective in conducting the current quantitative study was to determine to what extent, if any, did AL among physicians moderate the relationship between EI and employee ethical behavior. The study was conducted to provide relevant information to physicians and health care administrators as evidence toward proactively affecting corruption and its destructive repercussions in the industry.

Findings from the current study may serve to promote positive social change throughout the health care field.

This chapter contains a literature review of the theoretical foundations, conceptual framework, and descriptions of key concepts. From these theoretical perspectives, a review is presented regarding authentic AL, EI, and deontological ethics as related to professional health care. Conceptually, the focus is the combination of AL and EI among physicians and the ethical impact the two constructs have on patient billing being conducted by medical staff.

Literature Search Strategy

Selected articles relating to AL of physicians and the correlational effects with EI and ethical behavior are reported. The keywords searched were *physician ethics*, *healthcare corruption*, *physician trust*, *authentic leadership*, *medical malfeasance*, *healthcare leadership*, *physician overcharge*, *healthcare upcoding*, *ethics compliance*, *medical boundary violations*, and *healthcare integrity*. The terms were searched using the following databases: PsycINFO, PsycARTICLES, PILOTS, ABI/INFORM, Business & Management Practices, MEDLINE, Academic Search Complete, ProQuest Health & Medical Collection, Psychology Databases Combined Search, Wiley Online Library, Business Source Complete, and Thoreau multi-database. All searches were conducted for the publication years of 1983 through 2021. In addition to these sources, reference sections of peer-reviewed articles were examined as well as seminal works and tables of contents within recent research articles. Although the scope of the literature review ranged from the early 1980s to 2021, the largest number of searches spanned the past 5

years from 2016 through 2021. The literature searches included areas such as organizational and business ethics, corporate scandals, common types of health care ethics violations, and the effect that AL and EI have within organizations. Searches also involved seminal literature as well as recent peer-reviewed literature.

Theoretical Framework

AL Theory

The central theory on which the current study was anchored was AL theory (Luthans & Avolio, 2003). Original writings pertaining to AL date back to research by Hoy and Henderson (1983). While surveying nearly 600 teachers regarding school principal behavior, Luthans and Avolio (2003) found that authentic leaders accepted responsibility; did not abuse their authority; and nurtured cooperation, self-discipline, and fair relations. Luthans and Avolio worked from academic backgrounds: Avolio from transformational leadership and Luthans from positive organizational behavior. They joined efforts to develop their approach, launching a new paradigm they called AL.

Luthans and Avolio (2003) reported that earlier perspectives of AL were given by Harter (2002) and Erickson (1995). In addition, Avolio and Gardner (2005) explained that the previous work by Rogers (1959) and Maslow (1968) was relevant given their inclusion of concepts focused on an individual's self-awareness, moral perspectives, and self-regulation. These two humanistic psychologists had been pioneers in the study of people who were fully functioning and closely connected with their basic qualities and character. Maslow (1971) viewed self-actualized people as being ethically strong, which also helped in the development of AL. Instead of continuing to focus on negative features

of previous corporate failures, Luthans and Avolio (2003) resolved to develop a theory-driven approach drawing from positive organizational behavior as well as transformational and ethical leadership theories.

More recently, Avolio and Gardner (2005) put forward this theory asserting that the key constructs pertained to self-awareness, moral character, and openness with others. Avolio and Gardner reported that part of the rationale for developing an instrument to assess AL was that current theory did not emphasize facets of leader EI. Due to the extent of mistrust and corruption being publicized over the previous decade, Covelli and Mason (2017) contended that AL had been optimistically approached, with the hopeful intent to serve as a significant influence toward affecting these organizational challenges.

Avolio and Walumbwa (2014) asserted that interest in authenticity and AL theory had expanded quickly due to the decay of trust among world leaders. The enhanced awareness of unethical conduct had generated more literature calling for AL to address the crisis (Avolio & Walumbwa, 2018). Avolio and Walumbwa described this leadership style as one that does not involve self-deception but rather honesty about who people are.

AL theory posits that the person has a heightened awareness of themselves and conducts their behavior according to who they really are rather than any image they might wish to portray (Luthans & Avolio, 2003). Although AL theory has grown in drive and strength over the last 5 years, my literature review suggested there has been a slower pace in research demonstrating its connection to key outcomes of the organization, especially in reference to the health care industry (see Alilyyani et al., 2018). The rationale for choosing AL theory for the current study was its underlying principle

regarding genuine trust between leaders and their subordinates. The idea was that this attribute would serve as a key component in deterring unethical behavior.

Deontological Ethics

The second theoretical framework applied in the current study was the deontological ethics theory developed by Kant (1724-1804). Lefkowitz (2017) reported that Kant was the most influential philosopher in Western culture due to his practical view of ethics. Lefkowitz explained how Kant saw moral behavior through the lens of duty or doing what should be done. Lefkowitz stated that Kant's idea of morals did not depend on one's behavior being ineffective or yielding a negative outcome. Rather, supporters of Kant's theory argued that morality is about the person's good intentions (i.e., their duty to conduct themselves out of honor for the moral principle). Kant's theory maintained that whatever moral obligations are assigned to others must also be accepted for oneself (Lefkowitz, 2017). According to deontological ethics, one realizes they do not violate the rights of others in an attempt to achieve their own objectives (Lefkowitz, 2017).

In research concerning business ethics and whistleblowing, Mpho (2017) reported that deontological ethics was founded on careful thoughtfulness toward other people. Mpho explained Kant's position that if the individual acted in a way as to satisfy, then the behavior did not come from a moral motive. The argument employing deontological theory underscores that people should examine their actions first and figure out if they can be established as universal law (Mpho, 2017). The concern with deontology is not only the individual, but all people.

Avella (2017) reported that deontological theory places obligation and duty as the first order of business with ethical dilemmas. Avella explained that the theory also extends to contracts between individuals and their organizations, meaning ethical behavior is dictated by the agreed upon contract between the two parties. White (2015) explained that Kant's theory asserts individuals do what is right regardless of whether it opposes authority or their own preferences. Moreover, deontological ethics theory involves compliance with moral rules and official orders within a society (Chan, 2019). My rationale for choosing this theory was its core principle regarding the duty to do what one knows is right, while not violating the rights of others.

EI Theory

To be seen as an authentic leader is to exhibit high EI (Panait & Bucinschi, 2018). EI consists of a group of adaptive skills or mental abilities involving emotions and is thought to be a different construct than cognitive ability or personality (Yip et al., 2020). Kanesan and Fauzan (2019) reported that Thorndike was considered an early pioneer in the work of EI as he viewed intelligence through the lens of social intelligence. Thorndike (1920) described social intelligence as "the ability to understand and manage men and women, boys and girls, to act wisely in human relations" (p. 228). The term EI was used in the 1960s amid literary criticism and psychiatry (Mayer et al., 2004). In 1986, the concept of developing EI was investigated in a doctoral dissertation by Payne (Panait & Bucinschi, 2018). Four years later, Salovey and Mayer (1990) published their milestone research. This was the beginning of researchers developing a systematic approach to measure emotional differences from a human abilities perspective (Panait &

Bucinschi, 2018). Salovey and Mayer defined EI as "a form of social intelligence that involves the ability to monitor one's own and others' feelings and emotions, to discriminate among them, and to use this information to guide one's thinking and action" (p. 185).

Kanesan and Fauzan (2019) reported that EI had been distinguished by three types or models: ability, mixed, and trait. This was the result of theorists defining EI differently. For example, Salovey and Mayer (1990) referred to EI as an ability to be conscious of one's own and others' emotions and then use the information to think and act. Goleman (1995) described EI as the capacity to recognize feelings and to motivate and manage emotions. Goleman saw EI more as a personal characteristic than a cognitive ability. In a mixed model, Bar-On (1997) viewed EI as capabilities, competencies, and skills that affect an individual's way of coping with demands and stressors. Petrides and Furnham (2001) said that EI was a trait that was made up of a group of emotional self-perceptions associated with one's personality.

Mayer and Salovey's (1997) ability model consisted of four areas or branches: (a) perceiving emotion, (b) using emotion to facilitate thought, (c) understanding emotion, and (d) managing emotion. First, EI was regarded as a mental ability in which the individual could manage abstract reasoning (Antonakis & Dietz, 2010; Cherniss, 2010; Côté & Miners, 2006; Jordan et al., 2010; McClesky, 2012). This also included an individual's motives, social style, and self-control (Mayer et al., 2016). When measuring mental abilities, the problem-solving area must be specified in advance (Joint Committee, 2014). Tests with high validity consist of well-defined subject matter that facilitates the

demonstration of mental abilities (Wai et al., 2009). My rationale for choosing this theory was its stance on composure of one's emotions in human relations. The idea was that this could be a key ability in encouraging ethical integrity among subordinates.

EI

The concept of EI is broad, which means human thinking can be divided into several areas representing various skills within the individual (Flanagan et al., 2000; McGrew, 2009). Mayer et al. (2016) explained how EI is focused on what is referred to as hot information processing (Gutiérrez-Cobo et al., 2016; Kret & Bocanegra, 2016; Markiewicz & Kubinska, 2015). Mayer et al. (2016) argued this involved matters that are personal, practical, and socially important to the individual (Dvorak et al., 2016; Lane, 2020; Luo et al., 2012; Stevenson et al., 2018). These included things such as "their sense of social acceptance, identity coherence, and emotional well-being" (Mayer et al., 2016, p. 292).

Based on research since their original 1997 four-branch model, Mayer et al. (2016) revised the model. This revision included several other areas of problem solving; the revision indicated that some of the mental abilities involved in EI are yet to be identified, and Mayer et al. argued EI is a member of a group of hot intelligences. Schneider et al. (2016) defined hot intelligences as "abilities involving emotionally-salient information" (p. 1). These refer to noncognitive traits such as when one interacts with others in social situations in contrast to the typical cognitive tasks (cool intelligences) such as when one solves an abstract mathematical problem (Schneider et al., 2016). In their revision, Mayer et al. posited that EI brings to bear specific forms of

problem solving. Mayer et al. argued that individuals encounter a problem they want to solve and make a space mentally to resolve the problem. Other researchers have supported this argument (Beauducel & Kersting, 2002; Newell & Simon, 1972; Ohira, 2020; Samsonovich & Kuznetsova, 2018; Shen et al., 2016).

While investigating the relationship between EI and variance in ethical behavior, Jeffries and Lu (2018) collected data using an experimental economics lab in which they issued cash payoffs for decisions made in an ultimatum game. While assessing moral reasoning in combination with EI, Jeffries and Lu found support for their hypothesis that higher scores on both constructs yielded more ethical behavior. However, results were mixed regarding their counterhypothesis that low scores in both moral reasoning and EI would yield less ethical behavior. Skarbaliene (2019) reported that personal EI was found to be an effective tool for addressing the main issues in health care. Skarbaliene argued that people scoring high in EI were usually motivated, highly productive, and effective in their work. In contrast, Skarbaliene found that low EI correlated with deviant behavior, substance abuse, and poor relationships. Skarbaliene also reported that surveys showed the highest burnout rate and stress among health care personnel.

Corporate Corruption in America

The results of corruption have been seen throughout much of the world (Zyglidopoulos et al., 2017). Often, the aftermath and chronic damages have a severe impact on societal and individual well-being (Zyglidopoulos et al., 2017). Zyglidopoulos et al. (2017) described the routes that researchers have taken to study the many facets of corruption. Zyglidopoulos et al. reviewed four research paths, then provided

recommendations for further research on corruption. Zyglidopoulos et al. reported that various organizations acted with the intent to reduce business corruption.

Zyglidopoulos et al. (2017) have found corruption increases the cost of doing business. Also, Zyglidopoulos et al. reported an increase in fines and regulations being issued, in addition to a significant number of firms creating new compliance departments. However, Zyglidopoulos et al. claimed that even though efforts to reduce corruption had increases, the improprieties have appeared to persist. Zyglidopoulos et al. explained how corruption manifests in different cultures and activities. For example, Zyglidopoulos et al. found individuals within organizations typically have used rationalizations for their corrupt behavior. Further, the misconduct with many firms becomes so prevalent that it transpires into the default way of doing business. Zyglidopoulos et al. named the most common corrupt activities to include bribery, fraud, exaggerating expenses, modifying financial statements, and discriminating behaviors.

Corruption was also found to be an existential issue that can devastate not only organizations but debilitate whole communities (Koven, 2019). According to Koven (2019), corruption slowly erodes the underpinning of the body it thrives within. The author argued more attention needs to be given to the magnitude of the dishonest or illegal misconduct. Moreover, a serious inquiry needs to be made addressing the dangers of such unscrupulous acts, and how to significantly reduce corruption in our society. Koven reported that the ethics literature had addressed corruption indirectly, presenting several different views and philosophies. Koven argued that despite the broad span of ethics literature, it has been too general and incomplete concerning ways to combat

corruption. In other words, Koven suggested there must be universal guidelines and distinct penalties for violations, because often, the reward for unethical behavior may outweigh the risk or sanction involved. Koven added what makes corruption even more complex is that actions are always open to a variety of interpretations. Finally, Koven (2019) reported that ethics literature has not addressed the progression of kleptocracy, which refers to "a government of corrupt leaders who use their power to exploit their people and the nation's power" (p. 681).

While corruption is certainly not a new phenomenon to the 21st century, Koven (2019) argued, to make a real difference within organizations, leaders have to have a strategy to combat it. He presented a three-part approach for such an objective: (a) educate people within the organization concerning what is acceptable vs. unacceptable behavior. This, Koven declared, would involve having administrators establish clear guidelines concerning company policies and procedures, (b) informing employees of the exact consequences they will face whenever guidelines are violated, and (c) following through with the punishment documented for misbehavior. Koven pointed out how organizations have guidelines in place, employees are adequately informed of the policy, but administration fails to provide said punishment for violations. This only enables the dilemma to thrive and maintain the risks and costs for all parties (Koven, 2019).

Cuervo-Cazurra (2016) further discussed the effects of corruption such as this in other areas. Countries with more corruption have less growth, less investment, less effective public policy, and fewer resources for education and health care (Cuervo-Cazurra, 2016). Further, Cuervo-Cazurra reported that while most countries have laws

governing corruption, it is still prevalent, and many in leadership positions do not see it as a problem but are willing to engage it to seek a competitive edge. Other research showed that corruption yields a decrease in employment with companies (Beltrán, 2016). Beltrán (2016) found that firms chose not to pursue new hires but preferred to seek more capital than personnel. Beltrán's research involved firm-level surveys that were completed by business owners and top management from 14,200 firms from 28 countries from Latin America and the Caribbean. The survey questions addressed several key areas of operations including bribery, access to finance, performance measures, gender participation, annual sales, work force composition, and costs of inputs. These findings from Beltrán's study aligned with the position that staying small and restricting new hires allows firms to continue their activities inconspicuously. Moreover, Beltrán asserted this strategy also reduces the risk of being exposed to bribes from public officials.

Ding and Wu (2014) used data from the Survey of Small Business Finances to investigate fraud and unethical business practices. Arellano-Gault (2019) found that both public and private organizations, while experiencing systemic corruption, often tend to develop strategies to normalize the process, which lead to further corruption. Similarly, Persson et al. (2013) had reported earlier that most strategies enacted to fight corruption had resulted in few successes. While using surveys and a set of interviews with two companies in a major Mexican city, Arellano-Gault (2019) learned that organizations develop conditions internally that allow employees to accept bribes from public officials. In a study investigating the effects of bribery by developers on a local community for a new wind farm, participants who were informed that the project was both a benefit and

requirement showed much greater support for the project (Walker et al., 2015). Arellano-Gault (2019) explained how companies can easily get caught up in corrupt acts due to the advantages presented to them for such actions.

Ailon (2015) suggested the two top executives involved in the Enron scandal were classic examples of this demise. Arellano-Gault (2019) described two real scenarios regarding corruption. The first maintained that companies were being victimized by government. The second indicated corruption was simply an organizational process where individuals justified their behavior through the responses they created to normalize them. The results indicated that 84.6% of participants reported that government was corrupt, while 90.8% stated they had encountered at least one bribe within the year in question. The study also indicated "24.4% of the companies reported that they recorded the bribes as special expenses, and 56.4% said they listed them as sundry expenses, while 17.6% reported that they did not have a specific internal accounting process for bribery" (Arellano-Gault, 2019, p. 149).

Organizational Ethics

Leading from the impacts of corporate corruption into organizational ethics, Levine and Boaks (2014) argued that having values and good character were clearly not enough for leadership. They maintained that despite the vast array of positive character traits emphasized in leadership literature, successful leadership did not necessarily have to always include them. Levine and Boaks maintained that although some people might wish for their leaders to be more moral, oftentimes they are not. Thus, Levine and Boaks supported the position that good leadership in organizations is about being effective

rather than moral. They described the relationship between leadership and ethics as complex but fundamentally connected.

Effelsberg and Solga (2015) reported ethical standards and moral conduct are a central component of transformational leaders. This form of leadership typically involves attempts to empathize with employees and understand their emotional reactions as well as the leader exhibiting a great deal of extroversion that stimulates and motivates the employee (Arnold et al., 2015). Also, Levine and Boaks (2014) maintained that other forms of leadership have been used to focus on striving to help employees reach consensus in solving problems or completing job tasks. Levine and Boaks (2014) cited several references to various leadership styles that do not necessarily emphasize ethics as their central theme yet have proven adequate.

Previous research suggested that leaders may behave in an ethical manner simply to promote the enhancement of follower performance rather than because their ethics is intrinsic to leading others (Liden et al., 2008). Also, Levine and Boaks (2014) continued to state their case that ethical values are not a requirement for sound leadership. The emphasis was more concerning the leader's judgment (Levine & Boaks, 2014). Levine and Boaks argued that the leader must determine which goals are most important and how to go about accomplishing them in a way that parallels virtue ethics. Levine and Boaks also acknowledged how this differs with others, such as Kouzes and Posner (2010), who placed values at the very center of leadership and highlighting how so often the most admired leaders are those viewed as holding solid positions with reputable principles.

Levine and Boaks (2014) insisted that leadership encompasses much more than character and ethics. Utilizing more than 250 employees from a variety of industries, (Moore et al., 2019) examined how employees interpreted morally difficult decisions while affected by ethical leaders. Over the course of four studies, Moore et al. (2019) found that ethical leadership decreased employees' tendencies to behave immorally. Three findings emerged from the studies. First, there was a lack of correlation between ethical leadership and moral disengagement. Second, there was evidence that explained how rejecting ethical standards serves as a mechanism for describing the association between an ethical leader and their employees' unethical behavior. Third, the studies showed how an employee's moral identity had an impact on the employee's unethical decisions. Moore et al. also noted the oversimplification that faulty behaviors are exhibited by deviant people. Instead, Moore et al. found employee moral misconduct was greatly impacted by both work environment and interpersonal relations on the job.

Building on the findings of Moore et al. (2019), research conducted by Jurkiewicz and Giacalone (2016) posited ethical dysfunction hinged upon the way an organization functions more than on individual employee behaviors. Jurkiewicz and Giacalone reported the task of avoiding corruption was a more difficult process because people have become more skillful at concealing their infractions. Jurkiewicz and Giacalone argued that ethics violations within organizations were more prevalent and damaging to both individuals and their communities. A few examples of detrimental impacts included the excessive expense in health care, higher turnover, dissatisfied employees, and poor commitment to the firm. Jurkiewicz and Giacalone also added serious financial

consequences and the overall economic decline in society. Jurkiewicz and Gacalone also reported "based upon longitudinal studies, the World Bank has determined that the greatest deterrent to global economic and social development is organizational unethicality" (p. 2). Jurkiewicz and Gacalone identified several negative consequences suffered by employees such as psychological alienation, poor motivation, deteriorated health (in Moore et al., 2004 & Promislo et al., 2013); insomnia (in Elovainio et al., 2003 & Thomas et al. 2006); theft (in Greenberg, 2002); depression (in Schneider et al., 2000 & Sheridan, 2006); and suicide (in Promislo et al., 2013). Based on these findings, an organization's greatest asset is its reputation, which yields just how much stakeholders place their trust in the company. It was argued that if an organization attempts to function amid scandal or negative media attention, employees tend to internalize the tension and are more likely to behave unethically. If an organization notices that another organization appears to not receive any consequences for unethical behavior, they too are more prone to ethical violations (Jurkiewicz & Giacalone, 2016).

Jurkiewicz and Giacalone (2016) reported that these behaviors are cultivated in an organization's culture and manifested through its leadership. At the same time, Jurkiewicz & Giacalone also suggested that employees act according to how they are rewarded and will behave unethically if there is a significant advantage to them. As important as accountability programs are in combating ethical violations, there must be consistent consequences enacted with leaders who fail to enforce the firm's code of ethics. Jurkiewicz and Gacalone also asserted that although many companies have reacted to unethical behavior by enhancing their ethical codes, it has not proven to be an effective

deterrent. Jurkiewicz and Giacalone argued part of the problem is because significant repercussions for unethical acts are rarely invoked. Furthermore, they asserted that when employees sense that their behavior will not be reprimanded, they are more prone to act unethically.

Health Care Ethical Violations and Physician Boundaries

Following corporate corruption and organizational ethics, ethical violations and physician boundaries must be observed. Today's business research often includes the examination of employee ethical behavior (Wiernik & Ones, 2018). Wiernik and Ones (2018) declared that the trend among societies and governments was moving toward greater responsibility. Despite the numerous corporate scandals over the past two decades, there have been very few empirical measures developed for assessing employees' unethical behavior (Kaptein, 2008). Wiernik and Ones identified the measures currently available and presented a summary of their key differences. Wiernik and Ones reported that over the years, the research on what constitutes "ethical behavior" has suffered due to the variance in its definition. Following the examination of various descriptions, Wiernik and Ones maintained that "unethical behaviors include lying, misrepresentation, cheating, bribery, operating with a conflict of interest, abusing one's position for personal ends, and breaking or subverting laws, rules, or regulations" (p. 37). In their research, Wiernik and Ones concluded that some organizations promote unethical behaviors or blatantly require it from their employees. One of the examples cited was the Wells Fargo scandal of 2016, where it was reported that employees were instructed to

commit fraudulent banking, as well as set goals so high that others would act unethically to reach them.

DuBois et al. (2019) argued that ethical violations in health care, such as sexual misconduct, prescribing of opioids criminally, and surgeries that are not necessary, undermine trust in the field and directly harm patients. DuBois et al. reported that after reviewing the literature and analyzing 280 cases in the United States between 2008 and 2016 concerning ethical violations in medicine, most involved repeated wrongdoing that was overlooked. DuBois et al. found that systems failed to identify, track, or prevent repeated offenses. The study also revealed most cases involved males with selfish motives, and over half involved either a personality disorder or a substance use disorder. Moreover, 97% of the cases involved repeated instances of intentional wrongdoing, 95% in nonacademic medical facilities, and 90% involving either attempted financial gain or sex.

Boundary violations represent a significant focus in the health care industry, with sexual misconduct ranking most prevalent (Melo et al., 2019). Melo et al. (2019) found that sexual violations made up 94% of those investigated between 2012 and 2018 (Melo et al., 2019). Melo et al. also identified the top three specialties that made up the violations: psychiatrists (31.3%), internists (25%), and family medicine physicians (18.8%). The study revealed that all practitioners who had sex with their patients lost their licenses, with the possibility of being reinstated following a forensic psychiatric evaluation. Melo et al. asserted that for patients to thrive, there must be a trusting relationship between them and the physician. Melo et al. explained how trust is

developed, as patients disclose delicate information to their doctors. Crossing professional boundaries is a serious breach of this trust. Melo et al. concluded their remarks by emphasizing how these types of violations were quite preventable, and when situations were handled in an ethically appropriate manner, everyone benefited, including the health care industry overall.

Another common health care ethics issue has been patient overcharges (Terhune, 2018). Terhune (2018) reported a lawsuit had been filed against California's biggest hospital, Sutter Health, with charges of anticompetitive pricing. According to Terhune, Sutter allegedly had increased the price of the services above what they could have typically charged in a competitive market. Terhune elaborated on the lawsuit, reporting that Sutter allegedly created a practice wherein prices were not disclosed, prohibiting consumers from the ability to compare with other providers, which could have involved hundreds of millions of dollars in overcharges.

Schonberger et al. (2016) suggested that an increase in billing accuracy does not always explain some of the connections between payment incentives and billing operations. Using a quasi-experimental regression design, Schonberger et al. analyzed data regarding age, ASA (drug caution code for aspirin) physical status scores, sex, and type of surgery. The data were retrieved to learn if patients who became Medicare eligible at age 65 would experience any pattern of decreased upcoding. This fraudulent act was described by Bauder et al. (2017) as "billing for a more expensive service than the one actually performed, occurring when physicians or medical claims staff enter codes that indicate either services not rendered, or services not fully rendered" (p. 34).

A total of 49,850 records were reviewed by Schonberger et al. (2016) and did not reveal any evidence of deliberate upcoding with patients becoming Medicare eligible. Schonberger et al. claimed, however, that previous investigations suggested billing patterns that corresponded with upcoding. For example, outpatient office visits covered under Medicare Part B were found, through forensic investigation, to indicate intentional upcoding, possibly for the purpose of gaining higher reimbursements (Stuckey, 2012). Hospitals can take advantage of their patients and maximize reimbursements by upcoding the patients' severity of illness (Spika & Zweifel, 2019). Spika and Zweifel (2019) argued that fraudulent charges can be made by the doctor and hospital management, hinging upon the facility's internal decision-making process (Jürges & Köberlein, 2013; Silverman & Skinner, 2004).

Spika and Zweifel (2019) explained a very critical fact wherein upcoding may occur at two possible areas along the information chain of a typical hospital: within central management and within the various clinical departments. Spika and Zweifel emphasized that the severity of the patient's condition was only assessed by clinical personnel, which involves diagnostics and treatment. Afterward, that information is sent to management's coding division and documented as the patient's medical record. The diagnoses and treatments are coded according to classification systems such as International Classification of Diseases (ICD-10). Special software then assigns a diagnosis-related group classification for prospective payment to the hospital, covering all charges. Finally, the diagnostic-related group is reported to the patient's health insurer that determines the charges due.

The first opportunity for upcoding, according to Spika and Zweifel (2019), was in the clinical department. Spika and Zweifel reported that clinical staff may overstate the severity of the patient's illness at this stage of the process. The second opportunity is through management personnel, who have the flexibility in their interpretation of patient medical reports, which also allows them to encode additional diagnoses or treatments. In addition, Spika and Zweifel reported that upcoding occurs because there are incentives that prompt staff members to misrepresent or give a false account of the severity of illness. These types of practices lead to increased hospital revenue (Derlet et al., 2016; Drabiak & Wolfson, 2020).

Melo et al. (2019) reiterated the American Psychiatric Association's position stating that these types of boundary violations are never acceptable. d'Oronzio (2015) discussed how unethical behavior in health care undermines the integrity of the field. However, d'Oronzio cited other examples of boundary violations in the practice of medicine, such as being attached to patients socially or emotionally, favoring patients, or forming dual relationships such as business collaborations. d'Oronzio argued that any motive not related to patient care is an interference of professional objectivity and a breach of trust, highlighting that the primary sources of physician boundary violations are state disciplinary records. These records typically contain greater data concerning sex-related misconduct rather than other common types of violations.

Swiggart et al. (2016) insisted part of the problem can be attributed to lack of education and training, which involved physicians who had been referred for education and remediation by their state board of medical examiners. Results of the investigation

revealed that training after the fact did not have a significant impact on changing the number of incidents among physicians. Results from Swiggart et al. indicated training should occur during medical school and residency. A total of 27 of the 29 respondents from the first group (in 2001) reported they had not received any information regarding sexual boundaries while in training. The second group (in 2014) indicated a slight change in boundary training as they reported having some ethics instruction during medical school. Still, Swiggart et al. reported very little had changed during the 13-year period.

DuBois et al. (2019) concurred, as their research involving 280 ethical violations revealed most were repeated offenses that had gone undetected. These authors found most violations were intentional and, in 51% of cases, either personality disorder or substance use disorder was suspected. DuBois et al. highlighted this point by citing the case of Larry Nassar, who served as medical staff director with USA gymnastics and Michigan State athletics, abusing over 250 women and girls before he was stopped. Unfortunately, according to DuBois et al., there are no symptoms or signs that indicate clear red flags and thus, making prevention more difficult.

Vidal et al. (2015) investigated why medical schools tolerate unethical behavior of faculty. Their findings included at least four reasons: (a) obstacles to reporting, such as the fear of retaliation while no certainty of anonymity, (b) faculty not wanting to observe it in colleagues, (c) people simply learn to take it for granted, and (d) school accreditation does not cover it. Vidal et al. referenced Zimbardo (2007), who explained how particular situations can easily influence upright people to detour from ethical paths through mechanisms such as authority directives, deindividuation, and rationalization, all of

which are found to be common in medical school. Vidal et al. argued that leaders need to be more aware as they endeavor to prevent unethical acts.

Moreover, Aultman et al. (2016) declared that most physicians who are reported to the National Practitioner Data Bank for sexual violations have never been disciplined by their state medical board (d'Oronzio, 2015; DuBois et al., 2019; Melo et al., 2019; Swiggart et al., 2016). Aultman et al. believed this lack of discipline is a failure to protect the public and enables the unethical behavior to persist. Moreover, it was reported that the state medical board, as well as the integrity of health care, is compromised. Aultman et al. reported that only 11 states require cases of sexual misconduct to be reported. Despite these findings, four medical facilities that have implemented new professionalism programs were presented: "Brigham and Women's Hospital, Mount Sinai Medical Center, the University of Pennsylvania Health System, and Vanderbilt University School of Medicine" (Aultman et al., 201, p. 178). Each of these programs incorporated a centralized reporting system, including the ability to report anonymously and a structured means of handling professionalism issues in a dignified way.

AL in Health Care

Deriving from the impacts of ethical violation and corruption, AL emerged to assist researchers address these concerns. Of the various leadership styles being researched, AL has gained a great deal of attention (Duncan et al., 2017; Iszatt-White & Kempster, 2019; Legutko, 2020). Part of the rationale for this was to add the importance of various facets of leader EI found in existing research, such as self-awareness (Avolio & Gardner, 2005; Mayer et al., 2004). The prevailing instrument used to assess AL, the

AL Questionnaire (ALQ; Walumba et al., 2008) evaluates four components of leadership: relational transparency, internal moral perspective, balanced processing (objective and unbiased), and self-awareness. Duncan et al. (2017) described each of the components: Relational transparency is the extent to which a leader allows subordinates to see and experience their true selves, with no distortions. The leaders share information and communicate thoughts and feelings openly while welcoming others' ideas and opinions. Other leadership researchers supported this principle (Avolio & Gardner, 2005; Gardner et al., 2005; Walumbwa et al., 2008). Self-awareness is the degree to which leaders are cognizant of their strengths and abilities and how they impact others (Kernis, 2003; Walumbwa et al., 2008). Balanced processing is the leaders' objectivity and lack of bias while reviewing data and other people's positions that differ from their own (Gardner et al., 2005; Walumbwa et al., 2008). Internal moral perspective pertains to the leader's level of moral and ethical conduct and the degree to which he or she allows them to direct their decisions and behavior (Avolio & Gardner, 2005; Gardner et al., 2005; Walumbwa et al., 2008).

The identification of AL was specifically positioned as a result of the excessive amount of corporate corruption across various industries, as well as political unrest at the beginning of the 21st century (Covelli & Mason, 2017; Iszatt-White & Kempster, 2019). The disillusionment with previous forms of leadership and an ethical business meltdown led scholars and concerned leaders to begin pursuing answers to what factors actually influence ethical decisions and behavior (Iszatt-White & Kempster, 2019). By the 1990s, dramatic economic downturn had inundated most of the crucial world economies (Iszatt-

White & Kempster, 2019). Avolio and Gardner (2005) indicated how the stage was set for the inaugural summit on AL development in 2004 at the University of Nebraska-Lincoln, hosted by the Gallup Leadership Institute. Avolio and Gardner provided their description of the key components of AL theory. Medtronic's former CEO, Bill George (2003, as cited by Avolio & Gardner, 2005), stated "we need leaders who lead with purpose, values, and integrity; leaders who build enduring organizations, motivate their employees to provide superior customer service, and create long-term value for shareholders" (p. 316). Thus, Avolio and Gardner reported the purpose for the Gallup Summit was to generate a dialogue among scholars and practitioners from various domains toward developing AL theory. Avolio and Gardner also reported that after more than 80 manuscripts were presented, seven were selected as contributors to the theory development.

Avolio and Gardner (2005) highlighted a key foundational idea, reporting that authenticity itself originated from Greek philosophy wherein the term meant "to thine own self be true" (p. 319). This concept became a central theme throughout the development of AL. Authenticity became the term used to describe an individual's awareness and ability to act according to his or her true self (Knoll et al., 2015; Metin et al., 2016). It is important to keep in mind previous research and the early definition of authentic leaders set forth by Avolio et al. (2004) as they described them as:

> those who are deeply aware of how they think and behave and are perceived by others as being aware of their own and others' values/moral perspectives,

> knowledge, and strengths; aware of the context in which they operate; and who are confident, hopeful, optimistic, resilient, and of high moral character. (p. 4)

In studying how AL influences employee behavior, Avolio et al. (2004) found a positive significant correlation between AL and the subordinates' identification with their supervisors ($r = 0.47$, $p < 0.01$). In other words, the extent that employees believed their supervisor had the ability to lead them was measured. Second, a positive significant correlation was found between AL and psychological safety ($r = 0.46$, $p < 0.01$). Third, a positive significant correlation was identified between AL and job engagement ($r = 0.46$, $p < 0.01$), which means the level of intensity, enthusiasm, and mental focus of employees was measured. Finally, results from the current study revealed a negative correlation (nonsignificant) between AL and the employees' deviant behavior due to job engagement ($r = -0.07$, $p > 0.05$).

Ethical and Professional Health Care

Professionalism in health care involves people who are conscious of their own and others' emotions and exhibit "a set of values, behaviors, and relationships that underpins the trust the public has in doctors" (Jowsey, 2018, p. 996). Many of these characteristics are representative of EI (Kanesan & Fauzan, 2019). For example, certification and licensure now require professionalism as part of the core competency in surgical education (Hultman & Wagner, 2015). Anthony-Pillai (2016) reported three prominent perspectives of medical professionalism in the United Kingdom. One common denominator encompassing each viewpoint was honesty. Anthony-Pillai explained how

this key characteristic was dependent on the doctors' behaviors and sound judgment. This was manifested in the doctors' abilities to communicate and manage conflict.

Anthony-Pillai (2016) reported Picker Institute's (2008) distinction between a profession and an occupation using four aspects:

> First, reference to a register of members; second, the existence of a special skill or learning; third, standards of ethical conduct beyond those of society at large; and fourth, an acceptance of personal responsibility for the practitioner's actions towards those served, so that public confidence can be maintained. (p. 586)

The first stance on medical professionalism Anthony-Pillai (2016) presented was that of the Royal College of Physicians, who argued it is a moral contract where the medical community and society both accept responsibility for health care's wellbeing. Other research reflected this same principle (see d'Oronzio, 2015; Ionescu, 2018; Mannion et al., 2018; Price et al., 2018). Anthony-Pillai pointed out how the desire for higher ethical standards alone has not proven to be a significant counter to the many scandals. Various writers reported similar viewpoints (Jurkiewicz & Giacalone, 2016; Koven, 2019; Rydon-Grange, 2015; Slawotsky, 2015; Zyglidopoulos et al., 2017). Next, Anthony-Pillai presented the General Medical Council perspective regarding medical professionalism. It stated that professionalism in health care involved doctors who make patient care top priority, are competent, are honest, and act with integrity. Nigro (2018) echoed these same sentiments and added those operating through deception and manipulation negatively impact health care systems. Anthony-Pillai added the council believed unethical behavior in health care would not be seriously impacted without

individual commitment to professionalism. The final description reported by Anthony-Pillai was by the National Health Service of England. The view of the service reflected similarities of the other two concerning medical professionalism, with the addition that it involved humility, respect, and a commitment to excellence.

Elrod and Fortenberry (2017) reported that some health care institutions were seeking to spotlight their efforts for exceptional care and treatment with specific diagnoses. Part of the endeavor, the authors maintained, revolved around things such as innovation, technologies, and their enhanced recruitment strategies. An additional point highlighted in their research was the importance of health care organizations and physicians demonstrating just how much they supported and valued their employees. This was found to be a key component in the organizations' abilities to excel in professionalism (Enke, 2019; Koskiniemi et al., 2019; Sng et al., 2017).

Sanford (2016) reported that health care systems of the next era will require distinct physician leadership, mentioning that several factors could help shape the landscape in health care for the coming years. Sanford argued some of these facets will include how leadership itself is defined, how people feel their careers will be affected by possible changes in health care systems, and how doctors and hospital executives make the necessary adjustments in their relationships. Hemker and Solomon (2016), as cited in Sanford (2016), argued that for some time now administrators and hospital staff have been operating in silos. In other words, Hemker and Solomon concluded employees had been working in their separate departments independent of each other rather than collaboratively. Hemker and Solomon (2016) insisted that medical personnel had to start

examining various ways to ensure that physicians were not being excluded from the pertinent business operating procedures. Moreover, this would involve physicians and staff being treated with respect and genuine care. The authors suggested there needed to be a paradigm shift toward developing an integrated culture.

While investigating the effect organizational leadership had on physician satisfaction and burnout, Shanafelt et al. (2015) found that physicians' well-being and contentment was impacted by their supervisors. In addition, Shanafelt and colleagues noted other organizational factors that impacted physician well-being included "the efficiency of the practice environment, the level of flexibility/autonomy provided to physicians, and workload expectations" (p. 436). According to Sanford (2016), physicians have failed to make significant commitments to their health care organizations. Sanford argued that 21st-century health care success would certainly hinge on physician leadership. Sanford explained how properly going forward with the health care industry would involve not only a paradigm shift concerning its leadership but solid planning and change management. It was also highlighted that those traditional models of physician leadership have not yielded strong collaboration between hospitals and medical personnel such that organizational missions and visions were adequately achieved. Also, Sanford stated part of the lack of progress stems from the tendency for health care organizations to simply follow the current business trends, arguing that one size does not fit all or not all business practices are appropriate for every hospital.

Hemker and Solomon (2016) argued that effective physician leadership must be guided by several leader characteristics. Pertinent keys they mentioned included having a

primary allegiance to patients and the medical profession, the ability to facilitate a diverse medical staff and relevant administrative priorities, serving as advocates for their own profession, navigating bureaucratic realities, and implementing strong work teams. Moreover, they asserted that effective leaders need five essential competencies: "leading oneself, leading others, leading change, leading for results, and leading for collaboration" (Hemker & Solomon, 2016, p. 41). Furthermore, Legutko (2020) indicated various benefits of a variety of leadership styles that have been implemented within organizations.

Transactional leadership is an effective strategy that involves providing rewards or withholding punishment. In contrast, Sanford (2016) highlighted transformational leadership techniques wherein the emphasis was on encouraging staff members to move beyond their own self-interests for the good of the team and organization. Beck and Harter (2014) reported how organizations err in 82% of decisions to hire managers because many are not competent to lead. Sanford posited a given doctor may present as highly skilled with great respect from colleagues, yet not necessarily an outstanding leader. Sanford concluded by reporting a newer leadership model called AL that was derived from transformational theory. AL has also gradually been implemented in health care (see Alilyyani et al., 2018; Koskiniemi et al., 2015; Malila et al., 2018; & Waite et al., 2014). Sanford stated authentic leaders are intently aware of their own thoughts and behaviors, they behave according to their ethics and personal values, and they exhibit great integrity in their relationships with staff, as well as with people outside of the

organization. These types of characteristics, Sanford argued, will be crucial in selecting the most appropriate leaders for the 21st century health care industry.

Koskiniemi et al. (2015) investigated the authenticity construct in health care leader identity. These researchers also argued that having expertise in each medical profession does not guarantee leadership success in health care. In their discussion regarding the use of AL principles in health care, Koskiniemi et al. indicated most of the previous research has examined the effect of AL with nurses. They cited the first reference of using AL in health care in 2005 when the American Association of Critical Nurses found it to be relevant toward cultivating healthy work environments. In addition, Koskiniemi et al. argued there has been a lack of research on doctor leaders and that implementing AL has been viewed as promising for the future enhancement of leadership in the health care industry.

Koskiniemi et al. (2015) also found that nurses and doctors typically develop varying professional identities that define them in their roles as professionals. Koskiniemi et al. maintained that health care workers can advance and shift from being professionals to being leaders. For this reason, the authors argued the main objective should not be in finding leadership traits or skills, but rather on cultivating meaningful, internal leader behaviors. They concluded by stating whenever people experience themselves as leaders, they typically sense a greater motivation to lead, and they tend to seek out further opportunities that enable their leadership skills to be utilized.

Summary and Transition

The impact of corporate corruption is being observed throughout the world. Some organizations are attempting to put systems in place to help reduce the unethical acts. While research indicates that corruption increases the cost of doing business, the misconduct appears to have persisted (Cuervo-Cazurra, 2016; Zyglidopoulos et al., 2017). As an existential issue, corruption has proven to destroy not just individuals or companies, but entire communities (Koven, 2019; Zyglidopoulos et al, 2017). Historical ethics models have not addressed how to manage employee improprieties (Koven, 2019; Slawotsky, 2015).

The research reviewed elaborated on the various positions that experts have taken regarding best practices for addressing the dilemma. An increasing number of countries have adopted stricter laws, with more solid consequences for engaging in corrupt activities. Other researchers investigating global organizational misconduct provided similar findings (Hannah & Zatzick, 2008; Koven, 2019). Some suggested there must be a greater account kept concerning requests for bribes from public officials.

Of the various leadership styles that have been researched, AL has gained a great deal of attention by scholars in the field. Despite all the attention regarding leaders' deceit, manipulation, and secret wrongdoing, Luthans and Avolio's (2003) real intent for AL was to view the positive side of the construct, which promoted leaders who were genuine, trustworthy, and values driven. Similarly, research has exhibited how EI consisted of a group of adaptive skills or mental abilities. Some of the early research associated with the construct was viewed through the lens of social intelligence. This

concept was defined in the literature to involve monitoring one's own as well as others' emotions (Goleman, 1995; Salovey & Mayer, 1990). EI was found to be an effective tool for addressing some of the main issues in health care. Skarbaliene (2019) explained how, in health care, staff must be competent in more than just medicine. To be effective, one must be able to communicate, exercise flexibility, regulate their emotions well, and exhibit high levels of tolerance with patients as well as colleagues. Weakness in any of these areas could result in negative work outcomes for health care staff.

Anthony-Pillai (2016) argued that doctors must make patient care top priority, along with being competent, being honest, and acting with integrity. Other perspectives include physicians must support and value their staffs and that physician leadership will be required in the next era of health care systems. Current literature proposed that administrators and hospital staff have to begin creating various ways to bring physicians in and nurture a more integrated culture, wherein the focus is not so much on leadership traits or skills, but rather on cultivating meaningful, internal leader behaviors. The current study will help fill the gap in the literature regarding how physician AL and EI can impact ethical integrity among health care subordinates.

In Chapter 3, a description of the quantitative research method and rationale are provided, along with their connection to the research questions. The target population is discussed as well as sampling and recruiting procedures. Descriptions of the three survey instruments used in the current study are presented as well as the data analysis plan to investigate AL in physicians, their EI, and the interaction that may impact ethical strength among health care staff.

Chapter 3: Research Method

The purpose of the current study was to address health care corruption and the lack of ethical and moral integrity in the field as reported in the literature (Candy, 2014; Ionescu, 2018; Melo et al., 2019; Vasquez, 2018). Due to the gap in the literature regarding the impact leadership style has on corruption in health care (Malila et al. 2018), the objective in the current study was to determine the extent, if any, to which AL among physicians moderates the relationship between physician EI and ethical strength in medical staff. The aim was to provide relevant information to physicians and health care administrators as evidence toward proactively affecting corruption and its destructive repercussions in the industry. Leadership is the key determining factor in setting up and arranging an organization's culture (Nica, 2015). Further, Koven (2019) argued that the ethics literature did not address the magnitude of the challenges that corruption posed.

The three primary constructs in the current study, AL, EI, and employee ethical strength, were measured using validated assessment instruments. The operational definitions for each of the three variables were as follows: AL is a consistent behavior pattern exhibited by a person of high moral character, which facilitates followers who aspire to operate with integrity themselves (Walumbwa et al., 2008). EI is the ability to recognize and understand information regarding affect in oneself and others, and using the information to navigate social relations (Mayer & Salovey, 1997). Ethical strength/moral potency refers to an individual's moral mindset and the ability to conduct business ethically in the face of inevitable challenge (Hannah & Avolio, 2010). For each staff member participating in the current study, AL and EI was evaluated using the rater

version of the survey instruments to avoid any self-report biases. Also, medical staff members evaluated the ethical strength of their billing and codes managers using the instruments' rater version. A report regarding how all data were collected and the cleaning processes pertinent to them is provided. The data analysis using the SPSS software is also explained, as well as the interpretation of results. Included is a discussion concerning critical issues in research such as validity, sample size, ethics, and human protection. A summary is also presented at the end of the chapter.

Research Design and Rationale

Imperative to scholarly investigation is the understanding that the research problem informs the research design, and not the reverse (De Vaus, 2001). The quantitative correlational research design was appropriate for the current study due to its alignment with the research problem. Creswell and Creswell (2018) explained that a correlational design is chosen when the researcher aims to observe two variables (at least one independent and at least one dependent, without controlling either) and determine whether there is a statistically significant corresponding relationship between them. Further, Creswell and Creswell emphasized the importance of choosing the design according to the research questions and objectives of the current study. I conducted an analysis of AL, EI, and employee ethical strength once approval was received from the Walden University Institutional Review Board (approval #03-28-22-0730634). AL was the moderating variable, EI was the independent variable, and ethical strength was the dependent variable.

Leary (2004) reported that the main constraint in a correlational design is the researcher cannot make any conclusions regarding a cause-and-effect relationship occurring between the variables measured. Leary emphasized another limitation in correlational research designs, stating that results from the current study are possibly due to some other unrecognized source. The problem statement in the current study highlighted the magnitude of health care corruption in the United States. I then proposed measurable constructs as potential deterrents to unethical acts. Quantitative assessments were used with selected physicians and their staff members, who included billing and codes managers, to assess the relationship among the three constructs: AL, EI, and ethical strength. Constraints of this research design included potential participant bias concerning how medical staff rate the physicians' AL and EI, as well as how the staff rate ethical strength in their billing and codes managers. Another possible limitation was the response rate by the participants in completing the current study surveys. The time restriction with regard to data collection was another possible constraint. Finally, the use of only recent published literature may have been a limitation.

In the current study, each physician was assessed for AL style and EI within work relations among staff. In each physician's office, staff members rated the physician's AL and EI using the ALQ and WLEIS surveys. The physician's employees then rated the ethical strength of the billing and codes manager. A bivariate linear regression was used to analyze the relationship between physician EI and the billing and code manager's ethical strength. Next, a bivariate linear regression was used to analyze the relationship between physician EI and physician AL. Finally, a multiple regression model was used to

test whether physician AL affected the relationship between physician EI and the billing and codes manager's ethical strength.

Population

The participants for the current study consisted of medical staff members employed within family physician practices. Eligible staff members included office managers, nurses, front-desk receptionists, laboratory staff, radiology staff, and billing and codes managers. Projections regarding primary care physicians (Health Resources and Services Administration, 2016) indicated that family physicians would likely grow from 216,580 in 2013 to 239,460 by 2025. The role of family physicians usually involves treating patients of all ages and most health care needs (Phillips et al., 2014). Other researchers asserted that family physicians practice prevention, understanding, and management of illnesses, and use science to provide patient services for promoting health (Katon et al., 2001). Moreover, the key job responsibilities for family physicians' staff require a variety of different people. Family physicians are typically the first point of contact for patients in the health care system and may refer patients to specialists as indicated (Phillips et al., 2014). Physician employees are involved in assisting with the implementation of the services the medical practice offers as well as the business functions related to treatment (Ladouceur, 2011). Front-desk staff confirm appointments, check patients in or out, and assist patients with using a patient check-in kiosk (Miner, 2020). Nurses take patients' vitals assessing crucial bodily functions, administer shots, and assist the doctors during patient exams (Josi & Bianchi, 2019). Laboratory staff take specimens and draw blood for testing (Blau et al., 2007) while radiology staff take X-rays

to assist in diagnostics (Birchall, 2010). The office manager supervises the daily operations, provides guidance for staff members' job tasks, and keeps track of all pertinent records regarding the medical practice (Lowes, 2007). Finally, the billing and codes manager receives patient exam paperwork, inputs medical codes for patient treatment charges, and manages patient account balances including health insurance payments (Muse et al., 2022). These duties are essential to the business success of medical practices.

Sampling Procedures and Recruitment Strategy

The research sample in the current study was drawn using a nonprobability convenience sampling method. Recruitment of participants occurred through the Medscape web portal. The sampling frame was concentrated on family physicians licensed and practicing in the United States. Nonprobability convenience sampling was the sampling method chosen because a relatively large number of family physicians was conveniently accessible through the Medscape web portal. Also, the sampling was nonprobability because it did not involve random selection of participants. A recruitment email announcement (see Appendix A) about the current study was designed and circulated among potential participants throughout the United States. No other materials were distributed concerning the current study other than the announcement through the partner organization.

For staff to participate in the current study, they were asked to access the Survey Monkey web address from the announcement email through their web browser. As participants accessed the link, they were allowed to ask any questions they might have

had prior to the current study. I responded directly to any questions presented prior to participants engaging the current study. Afterward, a brief description of informed consent and the directions for providing that consent were presented. These directions explained how all participants would engage the current study voluntarily, and anyone could withdraw and terminate their involvement at any time.

Each participant then completed a brief demographic questionnaire (see Appendix B) followed by the three surveys designed to assess the physicians' AL using the ALQ (see Appendix C), physicians' EI using the WLEIS (see Appendix D), and the billing and codes managers' ethical strength using the MPQ (see Appendix E). The entire process was conducted online and took approximately 17 minutes to complete. Once all data were collected, all participants' names and email addresses were removed to de-identify the data. No additional emails were provided to any of the participants. However, all participants were informed that a summary of the current study results would be provided for their review using a specified link once the current study was completed.

Data Collection

Participants were recruited over a 7-day period with the assistance of the Medscape, LLC web portal firm headquartered in New York. Data were collected between April 12 and April 19, 2022. Medscape provided participant recruitment by distributing my study invitation to 2,818 medical practices throughout the United States. The invitation provided details regarding the current study's purpose and brief instructions for participating in the current study. From this outreach, there were 325 participants who started the survey. Of the 325 surveys, 194 participants failed to meet

the current study's inclusion criteria and were excluded from the current study. The inclusion criteria for the current study specified that participants must be health care staff members employed in primary care physician practices. In addition, 26 participants started the survey but did not finish. The survey was closed after 105 participants completed the survey, which exceeded the G*Power analysis that suggested a minimum of 84 participants were needed for the current study.

Discrepancies

I had planned to obtain each participant's email address after they responded to the current study invitation, indicating their interest in participating. However, before data collection began, I determined that I would not receive any participant email addresses or other identifying information. Rather, Medscape agreed to provide each respondent a unique ID number that enabled Medscape to track participants until the close of data collection. The agreement was that the ID numbers would then be destroyed. Participants were provided my name, email, and phone number for anyone interested in asking questions before or during the current study. Second, rather than surveying respondents only from the middle Tennessee region, Medscape enabled the sample to be spread across the United States due to the large membership of health care providers. This provided substantial assistance in obtaining the needed participants for the minimum sample size in a timely manner.

Sample Size

Two major factors in any quantitative study are sample size and effect size (Gravetter & Wallnau, 2009). Lakens (2013) reported that to determine an appropriate

sample size to yield a statistically significant result, an a priori power analysis is recommended. Cohen (1988) argued that the power of a statistical test was the probability of correctly rejecting the null hypothesis. In the current study, power was set at 0.80 because Cohen (1988) suggested this as the typical minimum level of power in behavioral science research. In addition, the effect size is important to understand whether the predictor variables in the current study have an effect greater than zero (Lakens, 2013). Cohen (1988) categorized effect sizes (Cohen's *d*), indicating the standardized mean difference between two groups. In the current study, a medium effect was chosen as Field (2009) suggested; with multiple regression studies, this is appropriate for identifying how large the effect is, or how well the predictors predict the outcome. Cohen (1992) suggested that when conducting multiple regression for a medium effect with two independent variables, researchers can Cohen's f^2, which is calculated from the R^2 correlation coefficient. Using this measure, Cohen (1988) identified 0.02 as small, 0.15 as medium, and 0.35 as large effect sizes.

The rationale for the current study's effect size and power level stemmed from Cohen's (1988) recommended formula: $f^2 = R^2$ divided by $1 - R^2$. Moreover, Selya et al. (2012) reported that Cohen's f^2 was appropriate for multiple regression models in which the independent and dependent variables were both continuous. In this calculation, R^2 represents the part of the variance for the dependent variable that is explained by the independent variable (Selya et al., 2012). Further, Cohen (1992) recommended sample sizes in behavioral research necessary for various power levels to detect small, medium, and large effects (.02, .15, and .35, respectively). The sample size pertains to the current

study's total number of participants and is indicated by the letter *N.* Also, the sample size affects the current study's power. Moreover, "power is the probability of obtaining a test statistic such as a *t* ratio that is large enough to reject the null hypothesis when the null hypothesis is actually false" (Warner, 2008, p. 1032). Power is the probability that statistical analyses will detect a treatment effect if there is one (Gravetter & Wallnau, 2009).

Effect size refers to a statistic that indicates the strength of relationships (Leary, 2004). In the current study, the concern was not only whether variables were related significantly to the participants' responses, but also the strength of the relationship. To determine an appropriate sample size for this project, I identified similar studies from the literature to ascertain effect sizes. Cohen (1992) suggested that for multiple regression tests with alpha of .05, a medium effect, and two independent variables, the recommended sample size should be 67. G*Power (Faul et al., 2009) was used to determine the effect and sample size for Adigüzel and Kuloglu's (2019) and Lanciano and Curci's (2015) studies. For these analyses, power was set at .80 and alpha at .05. Adigüzel and Kuloglu investigated the effects of EI and AL on employees in the organization, including the proportion of the variation in organizational identity (dependent variable) explained by EI (independent variable) = .19 (adjusted R^2). Using Cohen's calculated f^2 yielded a medium effect of 0.234567. Adigüzel and Kuloglu entered this number (f^2) into the G*Power input parameter box, along with alpha at .05, power at 0.80, and number of predictors at three. The G*Power calculation using these coefficients generated a total sample size of 51.

This process was repeated in a study by Lanciano and Curci (2015) who investigated the relationship between emotions communication ability in terms of EI and psychological well-being. Their aim was to explore the moderating effect of gender on this relationship. When gender of participants was analyzed as the moderator, the model and the incremental change were significant; $F = 5.79$, $p < .001$, $R^2 = .12$, $p = .001$. When computing Cohen's f^2, a medium effect of 0.136363 was found. When Lanciano and Curci entered this result into the G*Power analysis, the output generated a sample size of 84. The sample size estimates (51–84) from the Adigüzel and Kuloglu (2019) and Lanciano and Curci studies suggested a minimum sample size of 84 for the current study.

Instrumentation and Operationalization of Constructs

In the current study, the plan was to create a nine-question demographic survey (See Appendix B) and administer three standardized survey instruments: ALQ, WLEIS, and MPQ. After the raw data were collected, they were stored on an external hard drive in a locked safe. In accordance with Walden University (2022) guidelines, the data will be stored for 5 years. Afterward, all data will be destroyed.

Authentic Leadership Questionnaire

The moderator variable for this research study was AL, as measured by the ALQ Version 1.0 Rater. The ALQ is a 16-statement self-report or rater assessment that takes approximately 6–12 minutes to complete, utilizing a 5-point Likert-type scale ranging between zero and four. According to Avolio et al. (2007), the scale reflects participant response choices as follows: 0 indicates not at all, 1 indicates once in a while, 2 indicates sometimes, 3 indicates fairly often, and 4 indicates frequently, if not always. The

instrument was developed and designed to measure the components of AL. Mind Garden, the administrator of the questionnaire, granted permission to use the instrument in this research study. The ALQ was chosen because it was designed to measure four major components of AL: self-awareness, transparency, ethics/morals, and balanced processing. Avolio et al. provided a brief synopsis of each factor. Self-awareness: the degree to which the leader is aware of their strengths, limitations, how others see them, and how they impact others; transparency: the degree to which the leader reinforces a level of openness with others that provides them the opportunity to be forthcoming with their ideas, challenges, and opinions; ethics/morals (ethical/moral): the degree to which the leader sets a high standard for moral and ethical conduct; balanced processing: the degree to which the leader solicits sufficient opinions and viewpoints prior to making important decisions. The ALQ was appropriate for the current study as the research questions address whether there is any significant correlation between leader authenticity and leader EI, and whether AL moderates the relationship between EI and employee ethical strength.

In developing the ALQ, a confirmatory factor analysis was conducted with separate studies to examine AL's four main components and demonstrate their content and convergent validity (Walumbwa et al., 2008). In addition, structural equation modeling (SEM) analysis was used, which confirmed the predictive validity of the instrument toward work-related attitudes and behaviors (Walumbwa et al., 2008). A diverse cultural context was chosen using data collected from Kenya, the People's Republic of China, and the United States. The U.S. sample was made up of 224

employees from a northeastern high-tech manufacturer, who rated their supervisors' AL behaviors. The Chinese sample involved 212 employees from a Beijing state-owned company. Results indicated Cronbach's alpha for each of the four AL factors at acceptable levels: self-awareness = .92, transparency = .87, ethical/moral = .76, and balanced processing = .91 (Walumbwa et al., 2008).

Wei et al. (2016) used 248 subordinate-supervisor pairs to test interaction between AL and follower job performance through work engagement in the following numbers: 53% of the employees were male, 90% were college educated, average age was 28.4 years, and the average job tenure was 37.8 months. Supervisors were 72% male, 89% with college degrees, an average age of 33.2 years, and 72.8 months was the average job tenure. In using the ALQ to assess supervisor AL, results yielded Cronbach's alpha at 0.92.

In another study, Liu et al. (2018) investigated how AL influenced employees' workplace behavior. More than 500 employees were surveyed at a large health care organization. Using the ALQ, Cronbach's alpha reliability was 0.93. A confirmatory factor analysis affirmed content and convergent validity, with the following statistical results regarding key factors of the current study: supervisor identification = Cronbach's alpha, 0.85 ($r = 0.47$, $p < 0.01$), psychological safety = Cronbach's alpha, 0.78 ($r = 0.46$, $p < 0.01$), job engagement = Cronbach's alpha, 0.95 ($r = 0.46$, $p < 0.01$) proactive behavior = Cronbach's alpha, 0.96 ($r = -0.07$, $p > 0.05$), and workplace deviant behavior = Cronbach's alpha, 0.83 ($r = -0.23$, $p < 0.05$).

Wong-Law Emotional Intelligence Scale

The independent or predictor valuable for this research study was EI, as measured by the WLEIS (rater version). The WLEIS is a 16-statement self-report or rater assessment that takes approximately 5–10 minutes to complete. The instrument was developed in 2002 by Wong and Law to create a brief assessment of EI appropriate for research involving employees in the workplace (Wong & Law, 2002). One of the authors granted permission to use the instrument in this research study. The WLEIS was chosen because it was designed to incorporate the Mayer and Salovey (1997) definition of EI as an ability measure. Mayer et al. (2004) argued that EI involved a set of skills "to perceive accurately, appraise, and express emotion; the ability to access and/or generate feelings when they facilitate thought; the ability to understand emotion and emotional knowledge; and the ability to regulate emotions to promote emotional and intellectual growth" (p. 197). Within this framework, Mayer and Salovey (1990) generated four key dimensions of EI: self-emotion appraisal (SEA), others' emotional appraisal (OEA), use of emotion to facilitate performance (UOE), and regulation of emotion in the self (ROE). Initially, a 36-item pool was created after an exploratory factor analysis was conducted. Mayer and Salovey (1990) identified the four major elements as mentioned above that represented the overall EI construct. Internal consistency reliability for the four factors ranged from .83 to .90 (Wong & Law, 2002). Rathore et al. (2017) reported that previous research had also shown a positive correlation between strong EI and helping behavior in public-sector organizations.

The WLEIS was appropriate for the current study because the research questions address whether there is any significant correlation between EI and AL. The instrument should also help determine whether the relationship between EI and employee ethical strength was moderated by AL. Wong and Law (2002) reported that the research was deficient concerning the association among three variables: EI with leaders, EI with followers, and job outcomes. This was a large impetus for developing the WLEIS. Wong and Law argued that after leaders and subordinates begin to interact, emotional awareness and emotion regulation become major factors that influence the relationship. Three groups of independent samples were used to create the survey items and test psychometric properties. Quantitative evidence confirmed the factorial structure of the four EI dimensions (Wong & Law, 2002). The samples included managers as well as MBA and undergraduate students at a large Hong Kong university. Survey items were developed using a 7-point Likert-type scale that ranged from strongly agree to strongly disagree. Examples from each of the four dimensions include the following: self-emotion appraisal = "I have good understanding of my own emotions," others' emotion appraisal = "I am sensitive to the feelings and emotions of others," use of emotion = "I am a self-motivated person," and regulation of emotion = "I am quite capable of controlling my own emotions." Listing the four factors resulted in an average loading of .80 for the 16 items on their individual EI dimensions. Internal consistency reliability for the four dimensions ranged between .83 and .90. Correlations with the four dimensions were within reasonable limits ranging from $r = .13$ to $r = .42$.

Sears and Holmvall (2010) investigated EI in the relationship of supervisors and their subordinates along with leader-member exchange, and a significant association was found. Analysis indicated the subordinates' EI was significantly correlated with leader-member exchange. To measure the EI of the supervision and subordinates, Sears and Holmvall used the WLEIS. They also concurred with Wong and Law that the WLEIS was a good predictor for life satisfaction and job performance. In their study, the reliability coefficient alpha was .90 for subordinates and .81 for supervisors.

Moral Potency Questionnaire

The dependent or criterion variable for this research study was moral potency (ethical strength), as measured by the MPQ 360 Multi-Rater version (Hannah & Avolio, 2010). The MPQ is a 12-item measure created as a self-report or rater assessment that takes approximately 5–10 minutes to complete. The instrument was developed in 2010 by Hannah and Avolio to assist with organizational research and practice in evaluating employee moral strength (Hannah & Avolio, 2010). Permission to use the instrument in this research study was granted by Mind Garden, the administrator of the questionnaire. Hannah and Avolio's preliminary research involved collecting input from dynamic organizational practitioners regarding their original three moral potency constructs: (a) moral ownership, (b) moral courage, and (c) moral efficacy. In addition, with the help of four leadership scholars, lists of items were generated for each of the three dimensions. Following their randomizing a list and asking observers to sort them based on the dimension descriptions, a final list of items was subjected to a content validity assessment by senior faculty members. The 12-item measure was then created. Hannah and Avolio

explained that four items measured moral courage (e.g., “I will always state my views about ethical issues to my leaders”), three items measured moral ownership (e.g., “I will not accept anyone in my group behaving unethically”), and five items measured moral efficacy (e.g., “I am confident that I can take decisive action when addressing a moral/ethical decision.” The first seven items were rated on a 5-point Likert scale ranging from 1 = strongly disagree to 5 = strongly agree. The last five items were rated on a 5-point Likert scale ranging from 1 = not at all confident to 5 = totally confident.

Hannah and Avolio (2010) used a convenience sample of 309 soldiers from an Army base in the southwestern United States. The average participant age was 24.94 years; 96% were men and had served in the Army for an average of 4.25 years. All internal reliabilities were satisfactory for each scale independently as well as combined. Hannah and Avolio reported sufficient evidence for convergent validity. “Item factor loadings for moral courage were .60 - .80, for moral ownership .80 - .82, and moral efficacy .66 - .94” (Hannah & Avolio, 2010, p. 300).

In another study investigating brain activity associated with security breaches of digital information, West et al. (2019) found that about half of the breaches occurred by people on the inside of the organizations. While specifically focusing on self-control, moral potency, and the brain activity around decision making concerning information security, results showed an increase in neural activity associated with higher moral potency. During the current study, the MPQ was administered to 48 individuals composed of students and staff from a private liberal arts university in the Midwest. Results specified Cronbach’s alpha at .72; in addition, the reliability for the subscales

were below alpha .70: moral courage = .67, moral efficacy = .62, and moral ownership = .35 (West et al., 2019). West et al. concluded that while higher moral potency may be associated with fewer security violations, it appeared to have separate influences on brain activity involving security breaches.

Data Analysis Plan

The data analysis plan for the current study involved specifying the research objectives and hypotheses, as well as establishing parameters regarding participant inclusion and exclusion criteria. The study's three key constructs were identified along with the three research questions, which included null and alternative hypotheses. Specific statistical tests to be used in the analysis were identified including the statistical assumptions for each test. A report of the findings was provided including effect sizes and pertinent tables and figures.

The study's research questions and hypotheses were stated as follows:

RQ1: Does perceived EI in physicians, as provided by staff members and assessed by the Wong-Law Emotional Intelligence Scale (WLEIS), predict employee ethical strength, as assessed by the Moral Potency Questionnaire (MPQ)?

H_{01}: Physician EI does not predict employee ethical strength.

H_{a1}: Physician EI predicts employee ethical strength.

Physician EI, as assessed by the WLEIS, will be evaluated to determine whether it may be used to predict employee ethical strength, as measured by the MPQ. SPSS analysis of EI on employee ethical strength will be conducted to confirm whether the predictor variable of EI is a significant predictor of the criterion variable.

RQ2: Does perceived physician EI, as provided by staff members and assessed by the WLEIS, predict physician AL, as assessed by the Authentic Leadership Questionnaire (ALQ)?

H_{02}: Physician EI does not predict their AL.

H_{a2}: Physician EI predicts their AL.

Physician EI, as assessed by the WLEIS will be evaluated to determine whether it may be used to predict AL, as assessed by the ALQ. SPSS analysis of EI on AL will be conducted to confirm whether the predictor variable of EI is a significant predictor of the criterion variable.

RQ3: Does perceived physician AL, as provided by staff members, moderate the relationship between physician EI and employee ethical strength?

H_{03}: Physician AL does not moderate the relationship between physician EI and employee ethical strength.

H_{a3}: Physician AL moderates the relationship between physician EI and employee ethical strength.

Physician AL, as assessed by the ALQ, will be evaluated to determine whether there is a moderation effect between physician EI and employee ethical strength, as measured by the MPQ.

Validity may be threatened in several potential circumstances that can raise questions regarding a study's outcomes (Creswell & Creswell, 2018). Such threats may be internal or external and require specific actions to minimize their effects. Babbie (2017) referred to internal validity issues as those where anything other than the

experimental stimulus influences the dependent variable. In addition, researchers must guard against potential external validity concerns, which Babbie explained pertain to how generalizable the current study's findings are to groups beyond the sample investigated. Examples listed as threats to internal validity include history, maturation, selection, attrition, cross contamination, compensatory/resentful demoralization, compensatory rivalry, testing, and instrumentation (Creswell & Creswell, 2018). Creswell and Crreswell (2018) also identified three examples of threats to external validity: interaction of selection and treatment, interaction of setting and treatment, and interaction of history and treatment.

A specific external validity threat for the current study was selection-treatment interaction (see Creswell & Creswell, 2018) because the physicians and medical staff members all participated in the current study voluntarily. This could have also limited the current study's outcome generalizability to other groups. Further, interaction of setting may be another potential threat as most of the current study participants were from hospitals and medical clinics.

Because the current study involved using the rater version of each survey, there was the possibility for participant bias toward the physician, as well as the billing and codes manager (another threat to internal validity). In addition, mortality could occur (internal validity threat), wherein some individuals might have failed to participate in the current study or began the process without completing all steps. Also, there could have been an interaction effect of testing (external validity) where participants completed the first survey and then became either more or less sensitive to the experiment, thus

affecting the outcomes. Finally, design contamination could have been possible in terms of participants having a reason to want to make the research outcome result in a preferred manner (internal validity threat).

Ethical Procedures

In compliance with the American Psychological Association (2017) and Walden University (2022) ethical research guidelines, specific precautionary steps were taken. This included completing the "Protecting Human Research Participants" course, previously offered by the National Institutes of Health (2018). All participants were informed in the preliminary email regarding the purpose of the research, the expected time to complete each survey, and the instructions for how to complete them. Upon initial contact with the participants, each person was informed that involvement in the current study would be strictly voluntary. Also, each participant was apprised of the option to decline participation or withdraw from the study at any time. An explanation regarding informed consent was presented with initial instructions at the beginning of the demographic questionnaire. The objective was to facilitate a trusting relationship with each participant, assuring their confidentiality. Participants were informed that all email addresses would only be used for the research study, and all would be stored on an external hard drive.

After all data were collected, each participant was de-identified prior to data analysis. Intellectual property was also discussed in the introductory email, informing participants that I would provide the results of the research study through a linkafter the study was completed. Regarding dissemination of study results, the primary target

audiences included physicians, members of the medical staff, and health care administrators. These professional target groups and other scholars who may study similar research topics will have access to the findings. Access to the findings will also include dissertation committee members and members of the Walden University community. Finally, dissemination might include the general public, wherein an organization might request an informal presentation of study results. I will retain all data researcher for 5 years. After that period, all data will be destroyed through erasing records stored on the computer hard drive.

Summary and Transition

Chapter 3 describes the quantitative research method and rationale for addressing the current study's three research questions. These involved physician AL, physician EI, and billing and codes staff ethical strength. A description of the population is provided regarding specific medical staff members who were employed with primary care physician practices. Sampling procedures and the recruitment strategy are presented with an explanation of the nonprobability convenience sample generated through the Medscape web portal of New York. The rationale for the sample size and effect size are provided with a brief report of similar studies that were identified as relevant models in helping determine an appropriate sample size while incorporating G*Power (Faul et al., 2009). Instrumentation and operationalization of constructs are presented with pertinent details of the ALQ, WLEIS, and MPQ. Finally, ethical procedures for the current study are explained as directed by Walden University (2022) guidelines.

Chapter 4 provides a detailed description for the current study's data analysis. The exact time frame for data collection is stated and the discrepancies that occurred in the data collection process are provided. The demographic characteristics of the sample are provided as well as descriptive statistics. Also included is a report of statistical findings, including tables and figures relevant to the statistical results.

Chapter 4: Results

The purpose of this quantitative study was to investigate whether physician AL and EI were significant factors in helping reduce corrupt and unethical behavior in health care. In addition, the objective was to determine whether EI predicted ethical strength in employees, as well as whether AL moderated the relationship between EI and ethical strength in employees. Three research questions and hypotheses guided this investigation. The first research question addressed the relationship between physicians' EI and their billing/codes managers' ethical strength (moral potency). The second research question addressed the relationship between physicians' EI and AL. The third research question addressed whether physicians' AL moderated the relationship between their EI and the billing/codes managers' ethical strength.

In this chapter, a summary of the statistical analyses and findings related to the research questions and hypotheses is presented. Analyses are summarized relevant to each research question. Descriptive statistics for the measures are provided, and tests of the assumptions for the analyses are summarized. Finally, findings for each research questions are presented.

Demographic Sample Characteristics

Baseline descriptive characteristics of the current study sample included health care staff members at least 18 years of age employed with primary care physicians who were licensed in the United States (see Table 1). Respondents had to be employed in their current position for at least 6 months. Their job titles included office manager, front-desk administrator, nurse, appointment scheduler, billing/codes manager, physician assistant,

radiology technician, and lab technician. Each physician practice had to employ a billing/codes person, and each respondent had to have been associated with the physician and billing/codes manager for at least 6 months to participate in the current study.

Table 1 indicates that most participants were women (84.8%). Men made up 15.2% of the sample. The ages of the participants were dispersed: 23% ranged between 34 and 41, 24% ranged between 50 and 57, and 24% ranged between 58 and 65. In terms of ethnicity, 80% of the participants were White, almost 9% were Latino or Hispanic, and almost 6% were African American. Slightly more than 97% of participants were employed full-time. Finally, the participants' job titles included 38% billing/codes staff, almost 29% front-desk administrator, and slightly more than 15% nurses (see Table 2). These demographic characteristics were comparable to the larger population of health care staff members, as noted by the Bureau of Labor Statistics (2022) report stating women in health care made up 77.6% of employees. In contrast, the Bureau of Labor Statistics reported that men accounted for approximately 23%. In addition, Salsberg et al. (2021) reported that nationally health care staff consisted of 61% White, 18.2% Hispanic, 12.1% African American, and 6.3% Asian. In 2017, over half of U.S. nurses were age 50 or older and almost 30% were 60 or older (American Hospital Association, 2021).

Descriptive Statistics, Cronbach's Alpha, and Bivariate Correlation

Descriptive statistics were computed for the predictor variable, criterion variable, and moderator variable (see Table 3). In addition, Cronbach's alpha and the bivariate correlation for the variables were calculated.

Statistical Assumptions for Regression

The primary methods used to analyze the data were bivariate linear regression and multiple linear regression. Linear regression is a statistical method involving a linear prediction model in which one or more independent variables are used to predict the value of a dependent variable (Frankfort-Nachmias & Leon-Guerrero, 2018). Multiple linear regression is a statistical method involving a regression model examining how several independent variables effect the value of one dependent variable (Frankfort-Nachmias & Leon-Guerrero, 2018). Certain assumptions have to be met concerning the variables in the model for the regression analysis to yield valid results. These assumptions involve variable type, linearity, multicollinearity, independence, homoscedasticity, and normality (Warner, 2013).

The assumptions for regression were tested prior to analyzing the data in the current study. The first assumption for regression is that there is a linear relationship between the two variables. To test this assumption, I produced a scatterplot in SPSS illustrating the relationship between the independent and dependent variables. Figure 1 shows that this assumption was met.

Table 1

Demographic Characteristics of Sample

Gender	Frequency	Percentage
Male	16	15.2
Female	89	84.8
Total	105	100.0
Age		
26-33	10	9.5
34-41	24	22.9
42-49	17	16.2
50-57	25	23.8
58-65	25	23.8
66-73	4	3.8
Total	105	100.0
Ethnicity		
White	84	80.0
African American	6	5.7
Latino or Hispanic	9	8.6
Asian	3	2.9
Prefer not to say	3	2.9
Total	105	100.0
Highest education level completed		
High school	20	19.0
Bachelor's degree	44	41.9
Master's degree	31	29.5
PhD or higher	1	1.0
Prefer not to say	9	8.6
Total	105	100.0

Table 2

Demographic Characteristics of Sample Concerning Employment History

Employment	Number	Percentage
Full-time	102	97.1
Part-time	3	2.9
Total	105	100.0
Duration in the health care field		
1-3 years	1	1.0
4-6 years	5	4.8
7-10 years	11	10.5
1-15 years	24	22.9
16+ years	64	61.0
Total	105	100.0
Job title of current position		
Front desk administrative	30	28.6
Nurse	16	15.2
Billing/codes manager	40	38.1
Radiology technician	1	1.0
Physician assistant	18	17.1
Total	105	100.0
Time you have had a working relationship with the physician you are rating		
1-3 years	14	13.3
4-8 years	35	33.3
9-12 years	15	14.3
13-15 years	10	9.5
16+ years	31	29.5
Total	105	100.0
Time you have had a working relationship with the billing/code manager you are rating		
Less than 1 year	2	1.9
1-3 years	13	12.4
4-8 years	37	35.2
9-12 years	20	19.0
13-15 years	8	7.6
16+ years	25	23.8
Total	105	100.0

Table 3

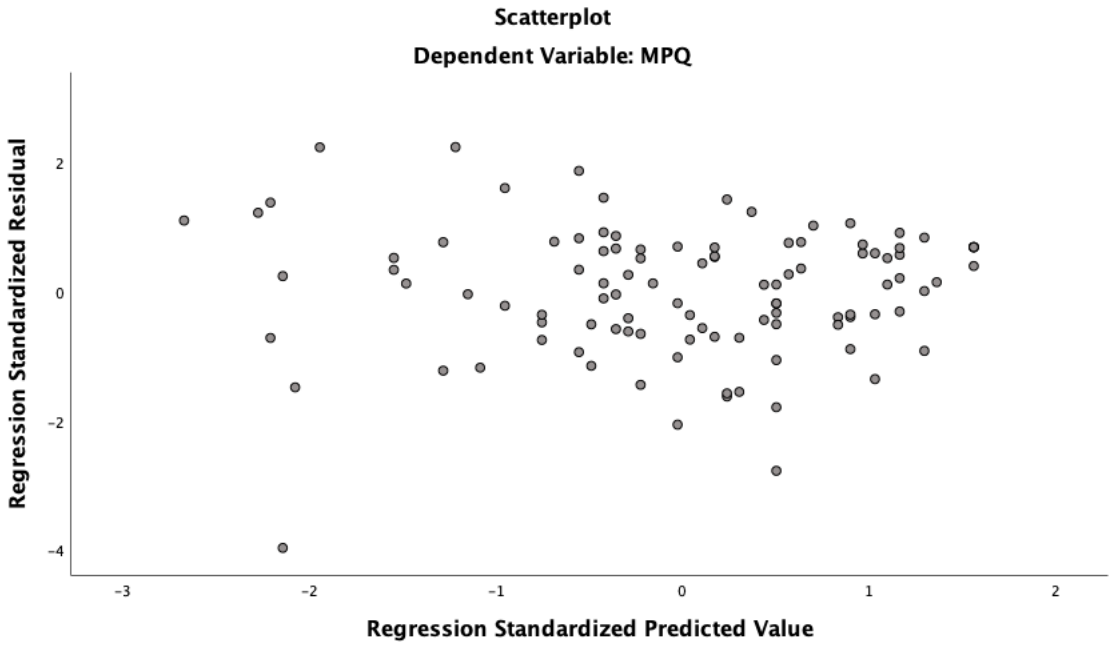
Descriptive Statistics, Cronbach's Alpha, and Bivariate Correlations

	Descriptive statistics		Reliability estimates	Bivariate correlations		
	Mean	*SD*	Alpha	AL	EI	MP
Authentic leadership	11.74	3.06	.94	--	.76	.60
Emotional intelligence	5.53	.95	.95		--	.49
Moral potency	12.34	1.95	.93			--
	Min	Max				
Cook's distance	.00	.47	.01	.05		

The second assumption for regression is no multicollinearity (i.e., none of the predictor variables are highly correlated with each other). In the current study, there was only one predictor variable. However, the predictor variable (EI) was highly correlated with the moderator variable (AL). Table 3 indicates the bivariate correlation of .760 between the two variables. This was expected, as the literature review indicated (Jeffries & Lu, 2018; Moore et al., 2019; Panait & Bucinschi, 2018). The two constructs had overlapping characteristics. Moreover, McClelland et al. (2017) argued that multicollinearity with regard to moderators is not a concern and tends to distract from true moderator relationships.

Figure 1

Scatterplot Between the Total EI, AL, and Moral Potency Scores



The third assumption for regression is independence (i.e., the observations are independent). This assumption indicates that individual data points are uncorrelated. The Durbin-Watson statistic, as illustrated in Table 4, showed that this assumption was met, as the obtained value was 1.783.

The fourth assumption for regression is homoscedasticity (i.e., the residuals have constant variance at every point in the linear model). The P-P plot of regression standardized residuals versus standardized predicted values (see Figure 2) showed no signs of funneling, suggesting that the assumption was met.

The fifth assumption for regression is multivariate normality (i.e., the residuals of the model are normally distributed). The P-P plot for the model showed that this assumption was met. Histograms for each of the three measures (see Figure 3, Figure 4,

and Figure 5) also reflected normality. The sixth assumption for regression states there are no standardized residuals versus standardized predicted values. There were no signs of funneling, suggesting that the assumption was met (see Figure 2). The seventh assumption for regression states there are no influential cases biasing the model. In Table 3, which illustrates Cook's distance, values were all under 1, suggesting individual cases were not unduly influencing the model.

Table 4

Regression Summary for the Three Research Questions

RQ	Predictor	Predicted	*df*	β	Adjusted R^2	*F*	Durbin-Watson	
1	WLEIS	MPQ	1,104	1.01	<.001	.23	32.30	1.78
2	WLEIS	ALQ	1,104	2.46	<.001	.57	140.66	
3	ALQ- WLEIS	MPQ	3,101	.02	.65	.34	19.20	

Statistical Analysis Findings

The following paragraphs include the results of the SPSS statistical analyses with a description of the research questions, as well as the null and alternative hypotheses. The data include results of the bivariate linear regressions and correlations among the variables. In addition, results of the moderation regression analysis are presented with explanations of statistically significant and nonsignificant findings. Figures of regression plots, frequencies of the key constructs, and tables displaying statistical coefficients are also presented.

Figure 2

Normal P-P Plot of Regression Standardized Residual

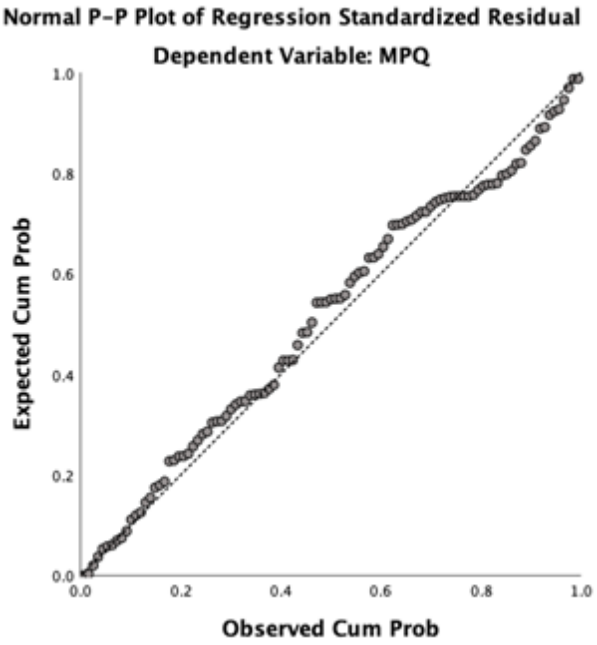


Figure 3

Frequencies of Authentic Leadership

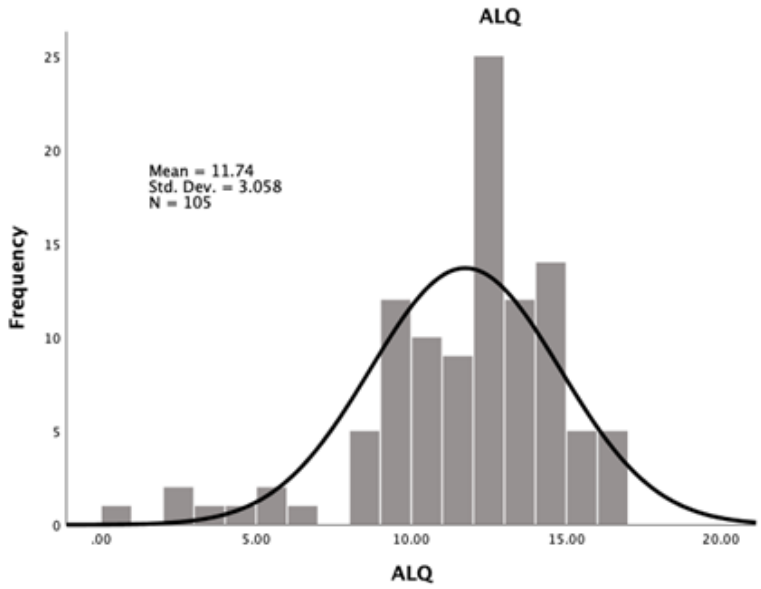


Figure 4

Frequencies of Emotional Intelligence

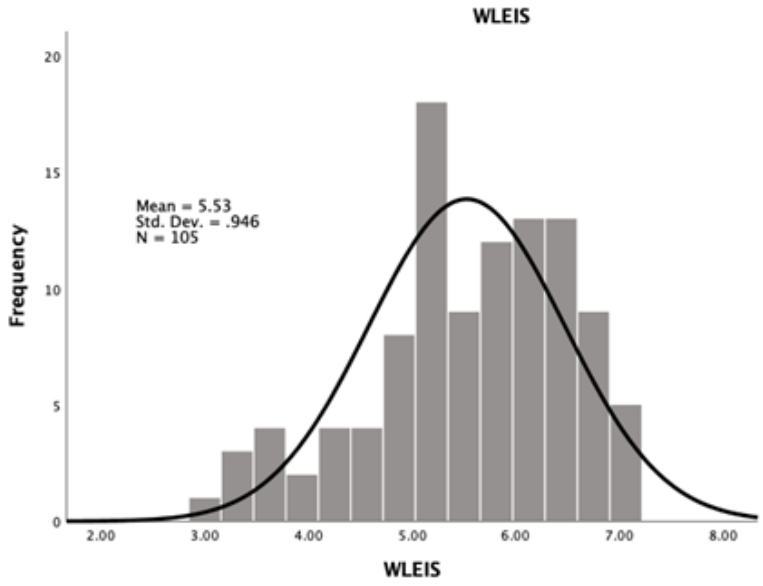
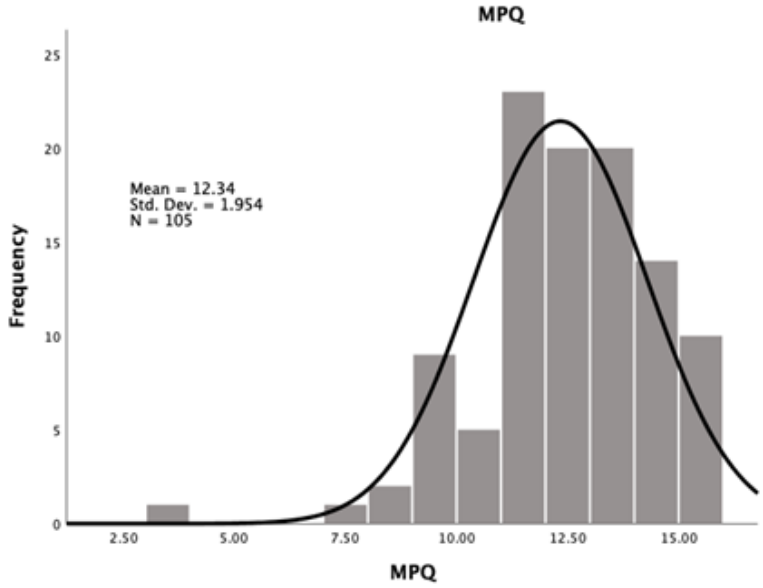


Figure 5

Frequencies of Moral Potency



Research Question 1 and Hypothesis

RQ1: Does perceived EI in physicians, as provided by staff members and assessed by the WLEIS, predict employee ethical strength, as assessed by the MPQ?

H_{01}: Physician EI does not predict employee ethical strength.

H_{a1}: Physician EI predicts employee ethical strength.

The first research question was addressed by conducting a bivariate linear regression analysis. The predictor variable was EI and the predicted variable was moral potency. The intent was to determine whether physician EI predicted the billing/codes manager's ethical strength. Table 4 illustrates the statistical results for this regression.

Warner (2013) explained the adjusted R^2 value as the part of the variance accounted for by the regression equation. Therefore, downward adjustments reflect a more conservative estimate of the amount of true variance in the dependent variable that can be predicted from the independent variable. In regression analysis, the caution is to avoid including too many IVs in the model and getting results cannot be trusted.

With regard to the first research question, does WLEIS predict MPQ, and the bivariate linear regression, the analysis indicated that the model containing EI as the independent variable significantly predicted change in the staff member's moral potency (dependent variable). Adjusted $R^2 = .231$; $F\,(1,104) = 32.302$, $p < .001$ (see Table 4). The model explained 24% of the variance in moral potency, using adjusted R^2.

The regression coefficient reflects the difference in the predicted value of moral potency for each one-unit change in EI. Based on the analysis, the null hypothesis--physician EI does not predict employee ethical strength--can be rejected. The analysis

suggests that physician EI does have a significant positive relationship with the billing/codes manager's moral potency.

Research Question 2 and Hypothesis

RQ2: Does perceived physician EI, as provided by staff members and assessed by the WLEIS, predict physician AL, as assessed by the ALQ?

$H_{02:}$ Physician EI does not predict their AL.

$H_{a2:}$ Physician EI predicts their AL.

The second research question was addressed by conducting a bivariate linear regression analysis. The predictor variable was EI and the predicted variable was AL. The intent was to determine whether physician EI predicted physician AL. Table 4 illustrates the statistical results for this regression. With regard to the second research question, does WLEIS predict physician AL, and the bivariate linear regression, the analysis indicated that the model containing EI as the independent variable significantly predicted change in the physician's AL (dependent variable).

Adjusted $R^2 = .577$; $F\,(1,104) = 140.655$, $p < .001$ (see Table 4). The model explained 58% of the variance in AL, using the adjusted $R^{2.}$ The regression coefficient reflects the difference in the predicted value of AL for each one-unit of change in EI. Based on the analysis, the null hypothesis that physician EI does not predict AL can be rejected. The analysis suggests that physician EI does have a significant positive relationship with physician AL.

Research Question 3 and Hypothesis

RQ3: Does perceived physician AL, as provided by staff members, moderate the relationship between physician EI and employee ethical strength?

$H_{03:}$ Physician AL does not moderate the relationship between physician EI and employee ethical strength.

$H_{a3:}$ Physician AL moderates the relationship between physician EI and employee ethical strength.

The third research question was addressed by conducting a multiple linear regression analysis to test whether physician AL moderated the relationship between physician EI and billing/codes manager moral potency. Table 4 illustrates the statistical results for this regression. Warner (2008) stated that moderation was a term synonymous with interaction, and involved a model where the slope to predict Y from X_1 differs across scores on the X_2 variable. This is illustrated more clearly by Frankfort-Nachmias and Leon-Guerrero (2018) who reported how regression models are displayed showing two variables comprising the vertical and horizontal axes of a graph. The independent variable, X, is displayed along the horizontal axis and the dependent variable, Y, along the vertical axis. Gravetter and Wallnau (2009) explained that for moderation regression models, the two predictor (independent) variables are identified using the notation X_1 and $X_{2.}$ For the current study's third research question, it refers to the observed effect of the moderator variable, physician AL, on the relationship between physician EI and billing/codes manager moral potency. The effect sizes with the Pearson *r* correlations between variables are provided in Table 5. First, the correlation between moral potency

and EI = .489 (large effect). Second, the correlation between AL and moral potency = .599 (large effect). Third, the correlation between EI and AL = .760 (large effect). Table 5 illustrates the model summary and pertinent coefficients regarding the moderation regression.

A product term was created to represent an interaction between EI and moral potency scores on both variables. Warner (2013) emphasized the importance of incorporating a notation to represent interactions between the two predictor variables. The regression included EI, AL, and an interaction term as predictors of moral potency.

The regression in Table 5 was not statistically significant, as adjusted $R^2 = .021$, $F(3, 102) = 19.202$, $p = .647$. Unstandardized regression coefficients are reported, unless otherwise specified. There was also a nonsignificant effect for EI in the moderation regression, as adjusted $R^2 = .163$, $F(1, 101) = .647$, $p = .519$. However, there was a significant effect for AL, as the adjusted $R^2 = .358$, $F(1, 101) = 4.312$, $p < .001$. Because the interaction term was not statistically significant, the interaction was not retained in the model. Thus, the null hypothesis is not rejected.

In summary, the analysis indicated that when combined, physician EI and physician AL have a significant effect on the billing/codes manager's ethical strength. Yet, the moderation regression indicated that physician AL did not significantly interact with physician EI and ethical strength. With the significant effect of AL, it appears that the health care staff member's ethical strength is influenced more by the physician's AL than his/her EI.

Table 5

Results of Linear and Moderation Regressions Predicting Moral Potency

Moral Potency	*B*	*SE B*	β	*t*	*p*
Results of linear regression with EI total predicting moral potency and AL					
EI total	6.76	1.00		6.79	< .001
		.18	.49	5.68	
AL	-1.84	1.16	.60	-1.58	.117
EI total	2.46	.21	.76	11.86	< .001
Results of moderation regression with EI and AL total predicting moral potency					
EI–AL	.02	.05	.04	.46	.647
EI total	.16	.25	.08	.65	.519
AL total	.36	.08	.56	4.31	<.001

Summary and Transition

The purpose of this quantitative study was to determine whether physician AL moderated the relationship between physician EI and billing/codes manager moral potency. With regard to Research Question 1, the analysis showed a significant positive relationship between physician EI and billing/codes manager moral potency. With the second research question, the analysis also resulted in a significant positive relationship between physician EI and physician AL. Finally, with regard to Research Question 3, the moderation regression analysis indicated that physician AL did not have a significant interaction with physician EI to influence billing/codes manager moral potency. Therefore, the null hypothesis was not rejected.

In Chapter 5 of the current study, I reiterate the purpose of the current study and why it was conducted. A summary of the key findings are presented along with how the findings compare with what has been found in the literature review of Chapter 2. Next, a description of the current study's limitations is provided, as well as implications for social change. Finally, the chapter concludes with recommendations for further research, and a "take home" message that captures the key essence of the current study.

Chapter 5: Conclusions and Recommendations

The purpose of this quantitative study was to investigate whether AL and EI might play a significant role in positively impacting ethical integrity among employees in the health care field. This study focused on corruption in the health care industry. Sullivan and Hull (2019) reported "healthcare fraud, waste, and abuse losses were estimated to be as much as $700 billion per year" (p. 48). Higher ethical standards have not proven to be a significant deterrent to scandals or misconduct (Jurkiewicz & Giacalone, 2016). Researchers argued doctors must make patient care a top priority, along with being competent, being honest, and acting with integrity (Candy, 2014).

The impetus for the current study was the realization of the magnitude of the lack of trust people have in their leaders (see George, 2003) and the personal belief despite all the deterioration in integrity, there must be something a society can do to affect such a trend. Although a large number of researchers have explored the impact leadership approaches have in business, the intent in the current study was to address the gap regarding the possible impact AL might have on corruption in health care (see Malila et al., 2018). The intent was to focus on primary care physician practices. The hypothesis was the physician's AL would interact with their EI and positively affect the medical staff's ethical strength. The study was conducted to provide relevant information to physicians and health care administrators and to add to the knowledge base regarding methods for reducing unethical conduct in health care.

Results of the first bivariate linear regression yielded a statistically significant correlation suggesting that physician EI predicts employee ethical strength. The second

bivariate linear regression also yielded a statistically significant correlation suggesting that physician EI predicts physician AL. The third multiple regression analysis indicated that physician AL did not significantly moderate the relationship between physician EI and employee ethical strength. However, the overall regression yielded a statistically significant result, suggesting a meaningful association between the three constructs.

The participants included health care staff members at least 18 years of age who were employed with primary care physicians who were licensed and practicing in the United States. Three research questions dictated the data collection method and the statistical analysis design. Three surveys were used to collect the data: the ALQ (Walumbwa, 2008), the WLEIS (Wong & Law, 2002), and the MPQ (Hannah & Avolio, 2010). The Survey Monkey platform was used for volunteer participants to access the combined surveys and allowed for the three main constructs of the current study (AL, EI, and moral potency) to be assessed. Statistical analyses involved two bivariate linear regressions and one moderated regression to determine the relationships and interaction between variables. In this chapter, the conclusions, limitations of the current study, implications for positive social change, and recommendations for future research are presented.

Interpretation of the Findings

The research questions and hypotheses were designed to examine whether a relationship existed between the physician's EI and their billing/codes manager's ethical strength. Second, the intent was to determine whether there was a relationship between the physician's EI and AL. Third, the intent was to determine whether the physician's AL

moderated the relationship between their EI and staff's ethical strength. The first bivariate regression analysis resulted in a statistically significant correlation, which suggested EI predicts ethical strength in employees. The second bivariate regression analysis also resulted in a statistically significant correlation, suggesting EI predicts AL. The third analysis, with a multiple regression model, yielded an overall statistical significance among the three constructs. However, there was not a significant interaction effect for AL with EI to predict ethical strength.

The findings aligned with the peer-reviewed literature reviewed in Chapter 2. Historical ethics models had not addressed how to manage employee improprieties (Koven, 2019; Slawotsky, 2015). Some research suggested having values and good character were not the most important attributes in successful organizations (Alvesson & Einola, 2019), although other studies showed ethical leadership to have a positive influence on decreasing unethical conduct in employees (Moore et al., 2019). Although the existing research indicated numerous types of ethical violations in health care (Schonberger et al., 2016), the current study focused on upcoding charges by the billing/codes managers within primary care physician practices. The findings showed EI significantly predicted moral potency, confirming findings in the existing literature. For example, in an experimental economics lab in which cash payoffs were issued for decisions made, Jeffries and Lu (2018) found higher scores in EI yielded more ethical behavior. In addition, Skarbaliene (2019) reported EI was found to be an effective tool for addressing issues in health care, and low EI scores were correlated with more deviant behavior.

In a study investigating the relationship between EI character strengths and virtues, Ros-Morente et al. (2018) evaluated 419 undergraduate students and found a significant positive correlation between ethical strength and EI scale constructs such as positive affect, temperance, and humanity virtues. In a study exploring the role of EI in individual ethics and how participants viewed others' ethics, Cabral and de Oliveira Carvalho (2014) conducted multiple regression analyses using questionnaires and found that EI not only predicted individual ethics but significantly correlated with self-esteem and social desirability.

A second finding in the current study also confirmed findings in the literature pertaining to the significant correlation between EI and AL. Panait and Bucinschi (2018) reported that to be seen as an authentic leader was to exhibit high EI. This principle was validated further in the research pertaining to specific components that make up each construct. For example, with regard to EI, Mayer and Salovey (1997) asserted the construct included "one's ability to perceive, appraise, and express emotions accurately, to understand affect-laden information and use it to manage one's own and others' emotions to promote growth, well-being, and adaptive social relations" (p. 10). While integrating some of these characteristics with AL, Avolio et al. (2004) described the authentic leader as "one who is deeply aware of how they think and behave and are perceived by others, as being aware of their own and others' values/moral perspectives, and who are themselves of high moral character" (p. 4). Walumbwa et al. (2008) highlighted the four key components of AL: relational transparency, internal moral

perspective, balanced processing, and self-awareness. The current study's findings confirmed the significant relationship between the two constructs.

In a cross-cultural study, Rahim et al. (2006) investigated the relationship between EI and transformational leadership. Previous research indicated that the authors of AL based their theoretical framework on dynamics of the transformational leadership style (Sanford, 2016). Rahim et al. reported that although studies exploring EI's effect in organizations were limited, scholars were starting to stress the importance of EI on leader effectiveness. With data collected from 685 dyads consisting of MBA students and their colleagues across the United States and four other countries, Rahim et al. found that individual perceptions of leader EI were associated with transformational leadership actions in all five countries.

The unexpected finding in the current study, which extends knowledge in the discipline, was physician AL did not significantly moderate the relationship between physician EI and moral potency in billing/codes managers. However, a linear relationship was evident in the scatterplots between EI and both moral potency and AL. The first bivariate regression containing EI as the independent variable significantly predicted change in staff members' moral potency (dependent variable). This means that as EI increases, so does moral potency, and it was a large effect. The second bivariate regression containing EI as the independent variable and AL as the dependent variable predicted change in physician AL. These results indicate that as EI increases, there is a corresponding increase in AL. In the third analysis, a multiple linear regression indicated no significant moderation of AL between EI and moral potency. Findings indicated that

AL does not moderate the relationship between EI and moral potency. Instead, there were direct effects for AL and EI on the outcome measure.

Limitations of the Study

Leary (2004) stated that generalizability is determined by how participants are selected. In addition, Leary asserted that generalizability refers to the current study's external validity, meaning the extent the results can be replicated in other samples. In the current study, one potential limitation to generalizability was the nonprobability voluntary response sampling method used. According to Leary, with most studies it is impossible or unnecessary to obtain a probability sample. With nonprobability samples in which researchers cannot know who will be selected, this limitation prohibits calculating the error of estimation, resulting in less certainty regarding how representative the sample is of the larger population.

In the current study, participants were all health care staff employed with primary care physicians across the United States. Each participant voluntarily responded to the current study invitation without any determination made by me. Although internal validity appeared to be strong from the statistical significance found in the relationships tested among the variables, there may have been other factors that influenced the results.

Another possible limitation was data collection occurred through online surveys using standardized questionnaires. The participant responses were the perceptions of the physicians and billing/codes managers' behaviors. An employee's perception of a colleague could be different from the actual character of that colleague. Therefore, data could have been skewed by the bias of the respondent. Finally, Babbie (2017) highlighted

another possible limitation with using surveys. In contrast to field research in which the researcher may become aware of some new variable emerging and may be able to observe it, surveys do not afford the researcher this opportunity. Some potentially valuable data may have been missed in the current study.

Recommendations for Future Research

Researchers should contemplate other relevant independent variables to predict ethical integrity in organizational employees. Further studies could identify more impactful strategies for reducing corruption across corporate America. Researchers might incorporate a different sampling method such as random sampling in which the sample would be a more significant representation of the target population. This might eliminate sampling bias and reduce error. Researchers could also investigate the same hypotheses but incorporate a different data collection method than standardized surveys conducted online. A qualitative study including face-to-face interviews in which participants are able to communicate their work experiences with physicians and other staff members may be beneficial. Such an approach could afford the researcher the opportunity to observe new phenomena that may occur during the data collection.

Even though the intent of the current study was not to survey the physicians themselves, researchers might consider having physicians rate themselves regarding their AL and EI, and then compare their scores to staff who also rate them on the same constructs. Moreover, the current study could be repeated in a different culture outside of the United States to determine whether cultural differences affect study outcomes.

Researchers could also explore fields beyond health care to determine whether the current constructs, as well as others, yield similar results regarding ethical integrity in employees. The current study was conducted to address the unethical and corrupt activities in health care and the lack of quantitative research examining the effects of leadership style in the industry. Because the current study showed the relevance of AL, additional research could be conducted to learn the most effective ways to develop AL skills and characteristics.

Implications

Potential Impact for Positive Social Change

The potential impact for positive social change the current study provides is physicians and health care administrators accepting that their leadership and ability to manage emotion can have a significant impact on the ethical integrity of their colleagues. Authentic leaders have a heightened awareness of themselves and conduct their behavior according to who they are rather than any image they might wish to portray (Luthans & Avolio, 2003). Subsequently, the trust between leaders and their subordinates promotes more positive behavior outcomes (Avolio & Gardner, 2005). These characteristics in addition to the abilities of EI could impact families as well. There is a potential transformation in family dynamics in which these principles are implemented (e.g., where parents have the "ability to perceive, appraise, and express emotions accurately, to understand affect-laden information" [Mayer & Salovey, 1997, p. 10]) and use it for the well-being of themselves and their children.

Within organizations, leaders could train to develop their authenticity and emotion management so they might become the change they wish to see in their subordinates. They could develop transparency by being aware of their values and more accepting of their coworkers' values. Moreover, they might enhance their ability to manage their emotions and navigate their colleagues' emotions more effectively. This could yield significant benefits and reduce unethical and corrupt activities. With this type of initiative adopted by CEOs, trust in leaders might be restored and the billions of dollars typically lost each year in fraud (Sullivan & Hull, 2019) could be used to bolster the American economy.

If more government officials chose to operate within the principles of the current study, the positive social change effect could be substantial. Leaders across the nation could come together and act not as opponents but as partners striving to promote the well-being of society. If this knowledge was promoted in local schools and communities, it might cause citizens to carefully choose the leaders they elect, meaning more organizations might be led by people with ethical integrity, thereby reducing a significant amount of corruption.

Methodological and Theoretical Implications

I incorporated a quantitative method using standardized online surveys to gather data. One of the biggest disadvantages of using surveys is participants who are not willing to answer all of the questions (Babbie, 2017). In the current study, only those who completed the surveys were included. In addition, using surveys cannot guarantee truthfulness in participant responses. In the current study, participants were informed of

the confidentiality of their participation and had no obvious benefit of responding untruthfully. Survey research yields a quantitative/numeric description of the participants' thoughts and attitudes so researchers can examine a sample of the target population (Creswell & Creswell, 2018). The current study yielded statistically significant results, and the findings may be generalized to broader health care populations, as well as other organizations in which leaders affect subordinate behavior.

Because the participants in the current study were all registered members of a large health care firm and included primary care physician practices across the United States, time was saved collecting data. One important implication for health care research is the ability to obtain data promptly. Also, there was no need to employ other people to conduct face-to-face interviews to complete the current study. The identity of participants was protected with this method, and the data collection was straightforward without complication. Another presumption to be noted was the ease and access to the surveys through the participants' electronic devices. This study affirmed Babbie's (2017) position that survey formats have to align with participants' device preferences. It can be assumed that smartphones, tablets, and laptops will all be part of future research involving online surveys. While this method has several advantages, a possible disadvantage Babbie highlighted was the researchers' inability to completely grasp the participants' total life situations in regard to their work experiences.

The conclusions drawn from the results of the current study also support the theoretical framework for both AL and EI. Moreover, the current study's results further confirm each construct's validity. For example, as previous research indicated, the key

components to AL pertained to relational transparency, self-awareness, internal moral perspective, and balanced processing (Avolio & Gardner, 2005). With the growing awareness of unethical business conduct, Avolio and Walumbwa (2014) argued the AL elements were essential toward addressing the organizational crisis. While there have been few studies investigating the effect of AL on health care staff and work outcomes, Wong and Laschinger (2013) found AL was significantly and positively related to job satisfaction and performance through its effect on staff empowerment. In another study investigating the relationship between AL and subordinate behaviors, Liu et al. (2018) found AL was positively related to employee proactive behavior and negatively related to workplace deviant behavior. Their findings, like the current study, suggest organizations can be more confident in hiring authentic people and placing them in leadership positions.

The second key theoretical framework of the current study was EI theory. Mayer and Salovey's (1997) ability model consists of four areas: (a) perceiving emotion, (b) using emotion to facilitate thought, (c) understanding emotions, and (d) managing emotions. The authors asserted these abilities were essential in one's social interaction to guide one's thinking and actions. In addition, they maintained because EI was an ability, it could be developed by learning appropriate emotional skills over time and strengthened through training. Jeffries and Lu's (2018) investigation of EI attempted to explain the variance in organizational ethical behavior. Their findings from data collected in an experimental economics lab confirmed the significant relationship between EI and ethical behavior. In addition, Angelidis and Ibrahim (2011) found a correlation between

subjects' EI and their ethical mindsets, in which those with high EI scores believed their behaviors should not be deceptive or harmful to others. Those with low EI scores indicated they would willingly act in ways that could result in negative outcomes for others. These findings align with the current study and support the theory that EI does predict moral potency in subordinates.

Recommendations for Practice

The findings of the current study provided evidence of a very unique type of leadership that can be added to extant research in the industrial/organizational (I/O) psychology field. Individuals who work in I/O may choose to incorporate both AL and EI in their daily business management activities. While I/O psychologists focus on employee behavior in the organization (Lefkowitz, 2019), they may use the results of the current study in their efforts to improve their overall work environments, communications between management and employees, job satisfaction, and workplace safety. A large portion of the job responsibilities for persons employed in the I/O field revolve around interpersonal work relations. This study's findings can be utilized in both the development and ongoing cultivation of these relationships.

Conclusion

This dissertation study was an investigation concerning three central questions: (a) did physician EI predict employee moral potency/ethical strength? (b) did physician EI predict physician AL? and (c) did physician AL moderate the relationship between physician EI and employee moral potency? A significant positive correlation was found between physician EI and employee moral potency, indicating what may be an important

association between them. A significant positive correlation was also found between physician EI and physician AL. This finding confirmed what the previous research had revealed regarding the positive association between the two. Most importantly, the current study found both physician AL and EI to be positively associated with the staff members' ethical strength.

A final look at the key components of an authentic leader will demonstrate the current study's strongest takeaways. According to Avolio et al. (2004), the characteristics that best describe the authentic leader are self-awareness and being cognizant of their own and others' values/moral perspective. Walumbwa et al. (2008) added the following to these key features: relational transparency, balanced processing wherein they objectively consider all relevant information including others' viewpoints, and the positive development of followers.

If enough people in the United States are serious about reducing unethical, corrupt behaviors, then these are the types of leaders organizations must be committed to placing at the top of organizations: those who will set the example. Finally, Lussier and Achua (2016) described the authentic leader as one who "holds him or herself to a higher standard of integrity and accountability, and whose character provides the moral compass for decision making" (p. 375). Based on the results of the current study, this is the ideal gold standard to be promoted in organizations in order to effectively reduce corruption.

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Appendix A: Participant Recruitment Email

Dear _____

As a valued Medscape member, we are inviting you to participate in the following online market research survey on behalf of our client.

Details: Quick Paid Research on Health Care Management
Length: 15 minutes
Honorarium: $18 Amazon.com Gift card*

START SURVEY >

Please note that you will be asked to complete a series of screener questions in order to determine if you meet the survey eligibility criteria.

Questions about the survey? Email:

We look forward to your participation!

Sincerely,

The Medscape Market Research Team

Appendix B: Demographic Information About You

1. Gender: male___ female___ prefer not to say ___

2. Age: 18–25 ___
   26–33 ___
   34–41 ___
   42–49 ___
   50–57 ___
   58–65 ___
   66–73 ___
   74–81 ___

3. Ethnicity:
   Caucasian
   African American
   Latino or Hispanic
   Asian
   Native American
   Other
   Prefer not to say

4. Highest education level completed:
   High school
   Bachelor's degree
   Master's degree
   PhD or higher
   Prefer not to say

5. Employment:
   Full-time
   Part-time
   PRN

6. Duration in the health care field:
   0–11 months
   1–3 years
   4–6 years
   7–10 years
   11–15 years
   16+ years
7. Job title of current position:
   Front desk administrative
   Appointment scheduler

Billing/Codes manager
Nurse
Radiology technician
Physician assistant
Other

8. Time you've had a working relationship with the physician you're rating:

   Less than 1 year
   1–3 years
   4–8 years
   9–15+ years

9. Describe the extent of your working relationship with the billing/codes manager you're rating:

   Less than 1 year
   1–3 years
   4–8 years
   9–15+ years

Appendix C: ALQ Permission Letter

Eddie Christian

mind garden

To whom it may concern,

This letter is to grant permission for Eddie Christian to use the following copyright material for his/her research:

Instrument: ***Authentic Leadership Questionnaire (ALQ)***

Authors: ***Bruce J. Avolio, William L. Gardner, and Fred O. Walumbwa***

Copyright: ***2007 by Bruce J. Avolio, William L. Gardner, and Fred O. Walumbwa***

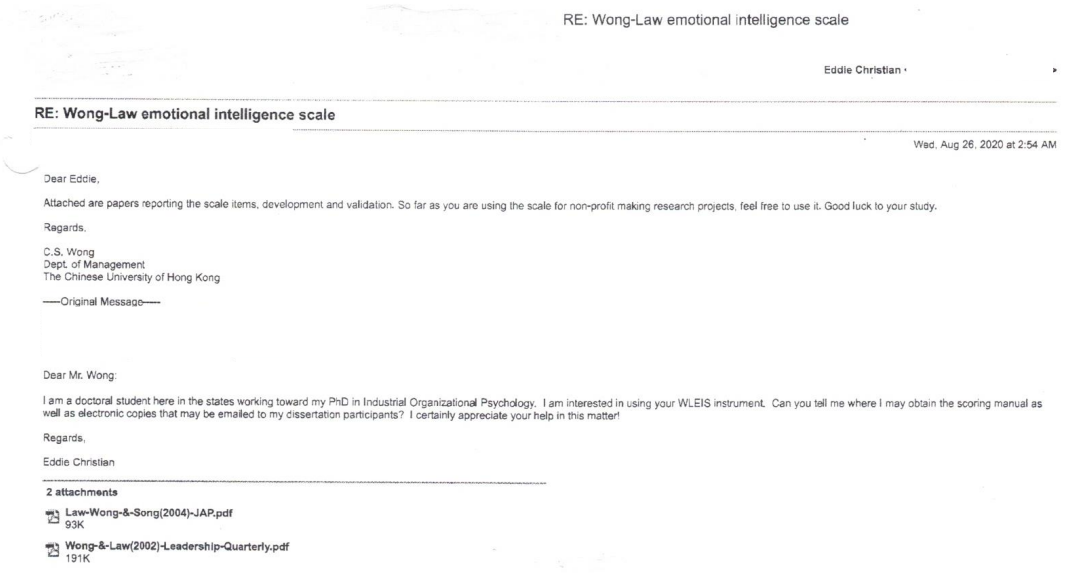
Three sample items from this instrument may be reproduced for inclusion in a proposal, thesis, or dissertation.

The entire instrument may not be included or reproduced at any time in any published material.

Sincerely,

Mind Garden, Inc.
www.mindgarden.com

Appendix D: WLEIS Permission Letter



RE: Wong-Law emotional intelligence scale

Eddie Christian

RE: Wong-Law emotional intelligence scale

Wed, Aug 26, 2020 at 2:54 AM

Dear Eddie,

Attached are papers reporting the scale items, development and validation. So far as you are using the scale for non-profit making research projects, feel free to use it. Good luck to your study.

Regards,

C.S. Wong
Dept. of Management
The Chinese University of Hong Kong

-----Original Message-----

Dear Mr. Wong:

I am a doctoral student here in the states working toward my PhD in Industrial Organizational Psychology. I am interested in using your WLEIS instrument. Can you tell me where I may obtain the scoring manual as well as electronic copies that may be emailed to my dissertation participants? I certainly appreciate your help in this matter!

Regards,

Eddie Christian

2 attachments

Law-Wong-&-Song(2004)-JAP.pdf
93K

Wong-&-Law(2002)-Leadership-Quarterly.pdf
191K

Appendix E: MPQ Permission Letter

Eddie Christian

mind garden

To whom it may concern,

This letter is to grant permission for Eddie Christian to use the following copyright material for his/her research:

Instrument: **Moral Potency Questionnaire**

Authors: **Sean T. Hannah and Bruce J. Avolio.**

Copyright: **2007 by Sean T. Hannah and Bruce J. Avolio.**

Five sample items from this instrument may be reproduced for inclusion in a proposal, thesis, or dissertation.

The entire instrument may not be included or reproduced at any time in any other published material.

Sincerely,

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