"EXPLORING LEADERSHIP STYLES ADOPTED BY THE TOP AND MIDDLE LEVEL LEADERS FROM THE HOSPITAL INDUSTRY IN PUNE CITY"

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SUBMITTED BY

BHAGYASHREE SUDHAKAR JOSHI

UNDER THE GUIDANCE OF

PROF. DR. ERACH BHARUCHA

RESEARCH CENTRE

CENTRE FOR HEALTH MANAGEMENT STUDIES AND RESEARCH,

BHARATI VIDYAPEETH UNIVERSITY. PUNE - 411043.

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CERTIFICATE

This is to certify that the work incorporated in the thesis entitled "Exploring leadership styles adopted by the top and middle level leaders from the hospital industry in Pune city" for the degree of 'Doctor of Philosophy' in the subject of Hospital Administration under the Faculty of Interdisciplinary Studies has been carried out by Ms. Bhagyashree Sudhakar Joshi in the Department of Center for Health Management Studies and Research at Bharati Vidyapeeth University, Pune 411043 during the period from 1st November 2012 to October 2015, under the guidance of Prof. Dr. Erach Bharucha

Place: Pune (Signature of Head of the Institute with seal)

Date: Director

Prof. Dr. Erach Bharucha

CERTIFICATION OF GUIDE

This is to certify that the work incorporated in the thesis entitled "Exploring leadership styles adopted by the top and middle level leaders from the hospital industry in Pune city" submitted by Ms. Bhagyashree Sudhakar Joshi for the degree of 'Doctor of Philosophy' in the subject of Hospital Administration under the Faculty of Interdisciplinary Studies has been carried out in the Department of the Center for Health Management Studies and Research at Bharati Vidyapeeth University, Pune 411043, during the period from 1st November 2012 to October 2015, under my supervision and guidance.

Place: Pune (Signature of Research Guide)

Date:

Prof. Dr. Erach Bharucha

Director
Center for Health Management
Studies and Research

DECLARATION BY THE CANDIDATE

I hereby declare that the thesis entitled “Exploring leadership styles adopted by the top and middle level leaders from the hospital industry in Pune city” submitted by me to the Bharati Vidyapeeth University, Pune, for the degree of Doctor of Philosophy (Ph. D) in Hospital Administration, under the Faculty of Interdisciplinary Studies is original piece of work carried out by me under the supervision of Prof. Dr. Erach Bharucha. I further declare that it has not been submitted to any other university or institution for the award of any degree or diploma.

I also confirm that all the material which I have borrowed from other sources and incorporated in this thesis is duly acknowledged. If any material is not duly acknowledged and found incorporated in this thesis, it is entirely my responsibility. I am fully aware of the implications of any such act which might have been committed by me advertently or inadvertently.

Place: Name and signature of Research Student

Date:

Dedication

I dedicate this dissertation to the memory of my father who always wanted me to hold the doctoral degree. He always encouraged me to study as much as I wanted and kept an example in front of me that an individual could study till the end of the life in spite of any obstacles of any magnitude. I believe if soul exist then his soul will now rest in peace.

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Abstract

The aim of the study was to examine the leadership styles adopted by the top and middle level leaders of the hospitals in Pune city, and provide inputs to enhance the leadership style of the hospital leaders**.** Five research questions were addressed in this study. Mixed method study design was used for this study. The top and middle level leaders from the hospital and hotel industry participated in this study. Quantitative data was obtained by 41 top and middle level leaders from both the industries by self reporting techniques and qualitative data was obtained by face to face interview technique from 20 leaders. Quantitative data was analyzed with the help of percentages and chi square test. Qualitative data was analyzed by thematic analysis and results were mixed during the interpretation and reporting phase of the study.

Results showed mixed leadership style need to be adopted by the hospital top and middle level leaders. The Hospital industry lack leadership training and development of their top and middle level leaders as compared to the hotel industry. Medical curriculum also needed to inculcate leadership components in their undergraduate or postgraduate courses.

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Chapter 1: Introduction

Chapter 1 includes a historical overview of leadership, types of leadership styles, background of the research topic, a statement of the research study, and gives brief about how the study was carried out.

1.1 Historical overview of leadership:

A leader, follower, and leadership terms are different from each other. Louis Allen reported that “A leader is one who guides and directs other people”. People who engage in leadership are called as leaders, and those toward whom leadership is directed are called as followers. Both leaders and followers are involved together in the leadership process. Leaders need followers and followers need leaders (Burns, 1978, Heller & Van Til 1982, Hollander, 1992, Jago, 1982). Leader cannot be called as a ‘leader’ without having followers.

Rost (1991) defined leadership as the art or process of influencing people so that they will strive willingly and enthusiastically towards the achievement of group goals. Whereas, Chester Barnard reported that, “leadership is the quality of behavior of individuals whereby they guide people or their activities in organizing efforts.” According to Antonakis, et al. (2003) leadership can be defined as, " the nature of the influencing process—and its resultant outcomes— that occurs between a leader and followers and how this influencing process is explained by the leader’s dispositional characteristics and behaviors, follower perceptions and attributions of the leader, and the context in which the influencing process occurs" (Antonakis, et al. 2003, Pg 5). Bennis (1959) stated that “of all the hazy and confounding areas in social psychology, leadership theory undoubtedly contends for top nomination. And, ironically, probably more has been written and less is known about leadership than about any other topic in the behavioral sciences” (pp. 259-301) (as cited by Antonakis, et al., 2003 pg 4). "A common belief is that leadership is vital for effective organizational and societal

functioning. Leadership is easy to identify in situ; however, it is difficult to define precisely. Given the complex nature of leadership, a specific and widely accepted definition of leadership does not exist and might never be found" (Antonakis, et al., 2003, pg. 5).

Above mentioned definitions of leadership was typically defined by the traits, qualities, and behaviors of a leader. Another important aspect of leadership is that leadership and power are connected. Different powers lead to different leadership and leadership style. Power can be divided mainly under two categories, one personal power and other is positional power. Figure 1 represents the power and it's relation of it to the leader and his/her leadership. When followers like the leader and they follow the leader it is called as a 'referent power'. When knowledge and skills of the leader influence people it is called as 'expert power'. 'Legitimate power' comes from the position leader holds in the society, or in the organization. 'Reward power' means individual has power to reward others. 'Coercive power' is capacity of the leader to punish others. Figure 1 describes power and its relation to the leader and leadership.

Figure 1: Leadership and the power

Type of power	Description of leaders and their leadership
Referent power Personal Power	Based on followers' identification and liking for the leader e.g. a teacher who is adored by students has referent power
Expert power	Based on followers' perception of the leader's competence, knowledge and skills e.g. other surgeons will listen to a surgeon who did 10,000/- surgeries on 'X' organ as they consider him/her subject expert.
Legitimate power Position Power	Associated with having status or formal job authority. e.g. A judge who administers sentences in the courtroom exhibits legitimate power.
Reward power	Derived from having the capacity to provide rewards to others. e.g. A supervisor who gives rewards to employees who work hard is using reward power
Coercive power	Derived from having the capacity to penalize or punish others. e.g. A supervisor penalizes employees for being late to work is using coercive power.

Source: Adapted from " The bases of social power," by J.R. French Jr. and B. Raven, 1962, in D. Cartwright (Ed.), Group Dynamics: Research and Theory (PP. 259-269), New York: Harper & Row.

These powers are reflected even in the history. There is a long standing history of human behavior linked to leadership. It is part of team building and understanding. Leadership has an ancient historical context.

Table 1 presents a natural history of leadership described by Vugt, et al. (2008). These authors have presented a hypothetical description of how leadership practices evolved over the course of non- human to human primate history. They have described four stages of history of leadership: stage1- pre-human leadership, stage 2-Band and tribal leadership, stage 3-Chiefs, kings, and warlords, stage 4- State and business leadership.

Vugt et al (2008) cited that the "*first (and by far the longest) phase extended from the emergence of early humans around 2.5 million years ago until the end of the last ice age, about 13,000 years ago. During this stage, the Pleistocene era, humans lived in seminomadic hunter-*

gatherer bands and clans consisting of 50–150 mostly genetically related individuals. Extrapolating from hunter-gatherer evidence, authors inferred that living conditions in the environment of evolutionary adaptedness (EEA) were fundamentally egalitarian, with no formalized leadership role. The best hunters and warriors, so-called Big Men, exercise disproportionate influence on group decision making, but their power is limited to their domain of expertise and accumulated degree of trust" (pg187). "Dominance hierarchies were the norm in primate groups; for early humans, collaboration among subordinates reversed this dominance hierarchy and resulted in a democratic leadership style that may have existed for nearly 2.5 million years (Vugt, et al.,2008, pg 188).

Table 1: A natural history of leadership

Stage	Time period	Society	Group size	Leadership structure	Leader	Leader-follower relations
1	>2.5 million years ago	Prehuman	Any size	Situational or dominance hierarchy	Any individual or alpha	Democratic or despotic
2	2.5 milion to 13,000 years ago	Hominid bands, clans, tribes	Dozens to hundreads	Informal, situational, prestige based	Big man, head man	Egalitarian and consensual
3	13,000 to 250 years ago	Chiefdoms, kingdoms, warlord societies	Thousands	Formal, centralized, hereditary	Chiefs, kings, warlords	Hierarchial and unilateral
4	250 years ago to the present	Nations, states, businesses	Thousands to millions	Strutural, centralized, democratic	Heads of state, mangers, executives	Hierarchial but participatory

Adopted from Vugt, et al.(2008) "Leadership, followership, and evolution- some lessons from the past" American Psychologist, 63(3), 187.

Later, "*social structures changed dramatically beginning with the development of agriculture at the end of the last ice age some 13,000 years ago. Agriculture and dependable food supplies enabled groups to settle and populations to grow exponentially. For the first time in human history, communities accumulated surplus resources, and leaders played a key role in their redistribution. As communities grew, so did the potential for within- and between-groups conflict. Leaders acquired extra power to deal with such threats, which resulted in more formalized authority structures that paved the way for the first chiefdoms and kingdoms*" (Vugt, et al. 2008, pg 188).

"*The fourth leadership period corresponds roughly to the beginning of the Industrial Revolution some 250 years ago. Communities merged into states and nations, and large businesses developed, all of which had implications for leadership practices. Citizens of states and employees in organizations are relatively free from the predations of their leaders and may defect*

to other states or organizations. This freedom shifts the balance of power away from lead- ers and produces conditions more akin, but not equivalent, to the reverse dominance hierarchy of the environment of evolutionary adaptation" (Vugt, et al. 2008, pg 188).

To recap, "*Leadership became more refined during the environment of evolutionary adaptation in response to challenges associated with the growing size and complexity of groups and the inevitability of conflict both within and between groups. The development of cognitive capacities notably language, theory of mind, and culture facilitated large- scale leadership. Hunter-gatherer data suggested that leadership in the environment of evolutionary adaptation was consensual, democratic, and transitory. The formalized leadership structures that emerged after the agricultural revolution are novel and potentially conflict with our evolved leadership psychology. The Industrial Revolution helped free people from tyrannical warlords, but the scale, complexity, and form of contemporary organizations pose novel challenges to our innate leadership psychology*" (Vugt, et al. 2008, pg 189).

It means leadership began with the cave dwellers who had an alpha male and a small hierarchical system. Later, leadership began to have a political role with small rulers of independent societies. In India, this was evidently present in the 2-3rd century BC with powerful rulers creating large empires such as the Guptas and Moryas. The leadership in India required mentors and rulers had mentorship of priest and sages who prescribed religious ceremonies. This led to the caste system in Hinduism. Religious leadership came from Buddha and Mahavir.

In modern India, leadership led to the removal of the British and Independent democracy. This was led by Mahatma Gandhi, one of the world's greatest thinkers. Political leadership came from charismatic rulers such as Indira Gandhi.

A new form of leadership came from the Industrial management needs of a growing economy in India. While this was usually selected by a process in the Board of different industries, it was frequently a family based outcome. Thus, the House of Tatas, Ambanis, Birlas had leaders from within the initiating family. Hospital leadership in a small hospital was frequently a medical professional who had to learn management and leading his team on the job by trial and error. It

was only with corporations and the growth of public hospitals that became necessary to have well trained leaders.

In nineteen century focus was on the leader and their leadership. Many scholars have worked in their life on exploring more about leadership. Historical perspective of leadership and leadership theories of nineteenth century is as follows:

In 1922, Max Weber mentioned that leaders possessed power by virtue of position. In the nineteenth century the notion of the “great man” theory dominated leadership field of work. Its core belief was that only a few men possessed certain characteristics which made a historical impact (Maslanka, 2004). For example, leadership was explained by the internal qualities with which a person is born (Bernard, 1926 as cited by Horner, 1997, pg 270). "*A second major thrust looked at leader behaviors in an attempt to determine what successful leaders do, not, how they look to others. These studies began to look at leaders in the context of the organization, identifying the behaviors leaders' exhibit, that increase the effectiveness of the company* "(*Halpin and Winer, 1957; Hemphill and Coons, 1957* as cited by Horner, 1997, pg 270).

In the 1920-1930s trait theory was dominating the understanding of leadership. According to this theory, it focused on the trait individuals' posses to differentiate him/her as a leader from non leaders. These involve inherent traits that individuals possess for example, personal, physical, and social attributes. It raised the questions as to whether leaders are born, or individuals can develop themselves to be leaders.

In 1938, Chester Bernard defined leadership as “The ability of a superior to influence the behavior of subordinates and persuade them to follow a particular course of action”. Lewin, Lippitt and White (1939) discussed the difference between autocratic, democratic and laissez-faire leadership. Later Robert

Tannenbaum and Warren Schmidt came out with a classic Harvard Business Review article entitled ‘How to Choose Your Leadership Style’.

In 1948, Ralph Stodgill and his team conducted Ohio State and University of Michigan studies, which reported two aspects of leadership behavior i.e. initiating structure and consideration. In 1964, Robert Blake, Shephard and Jane Mouton’s developed a Managerial Grid model. They changed the dimensions from initiating structure and consideration to concern for production and concern for people.

In 1967, Fred Fiedler developed the Contingency Theory of Leadership which talks about leader’s behavior according to situations. In 1972, Hersey and Blanchard used the term ‘Situational Leadership’. The Vroom-Yetton theory (1973) described how a leader makes a decision in a given circumstances in spite of the followers involvement, their capability and capacity.

In 1974, House and Mitchell proposed Path goal theory, which stresses how leader interact with their followers to reach their personal, professional and organizational goals. In 1976, Linden and Graen, initiated leader-member exchange theory. This theory explains the nature of the relationship between leaders and followers and how this relationship impacts the leadership process (Horner, 1997, pg 272). Burns, in 1978 proposed transactional leadership theory which was based on exchange of reward for the work. Whereas, in 1985, Bass further developed the work of Burns and proposed transformational leadership which emphasis on motivation of followers to meet the goals.

Gardner (1990)" *begins to challenge the idea that leadership exists within a single designated person and a situation. Instead, he positions leadership as moving toward and achieving a group goal, not necessarily because of the work of one skilled individual (i.e. the leader) but because of the work of multiple members of the group. Not only does leadership require someone who helps set the direction and move the group forward while serving as a resource, but it*

involves the contributions of other great thinkers and doers, access to the right resources, and the social composition of the group. Manz and Sims also offer a revised, integrative perspective on leadership. Using the term "Super Leadership," they challenged the traditional paradigm of leadership as one person doing something to other people (Manz and Sims, 1991). Instead, they suggested that another model exists for leadership today: "the most appropriate leader is one who can lead others to lead themselves" (Horner, 1997, pg 274-275).

In short, Antonakis, et al. (2003) presented eight schools of leadership theories namely: Trait, Behavioral, Contingency, Contextual, Skeptics, Rational, New Leadership, and Information - Processing. According to Trait school of leadership individual possesses some inherited characteristics which differentiated leaders from non leaders (pg.6). In 1950s, Behavioral school of leadership emerged. This highlighted leader's behavior for their followers. University of Michigan and Ohio State researches boosted this idea of behavioral leadership. Late the 1960s and early 1970s Contingency school of leadership took over. This school of thought emphasized that leadership is based on the situation (pg 7). Later, Relational school of Leadership took over. This stresses relationship between the leader and their followers (pg8). In late 1980s, Skeptics of Leadership school emerged with the idea that what leaders do is largely irrelevant and that leader ratings may reflect simply the implicit leadership theories that individuals carry "in their heads" (Eden and Leviatan, 1975, p. 740 as cited in the Antonakis, et al.1990, pg 8). This school of thought also pointed out that leadership rating is based on the items consisted in the data collection tool which is designed by the researcher based on the leaders attributes rather than focusing on the outcome of the leadership. In early 1980s, Information- Processing school of leadership emerged. "The focus of this school was primarily on understanding why a leader is legitimized by virtue of the fact that his or her characteristics match the prototypical expectation that followers have of the leader" (Antonakis, et al. 1990, pg 9). The New Leadership School, is also known as Neo-charismatic/

Transformational / Visionary Leadership. Bass (1985) worked on transformational/ visionary leadership thought of school and further this work was carried on by his associate Avolio. This school of thought highlights visionary, inspiring leader's behavior, transforms their followers' behavior, which encourages followers to exhibit their potential to do their best.

Historical perspective of leadership shows many leadership styles have been emerged. Caimir 2001 (as cited in Johnson and Klee, 2007, pg 130) defined leadership styles as "a pattern of emphases, indexed by the frequency or intensity of specific leadership behavior or attitudes, which a leader places on the different leadership functions". The technical knowledge of leadership styles helps a leader to understand characteristics and differences of each style; however it is up to the leader to choose an appropriate leadership style and implement that effectively in practice. Types of leadership styles are discussed in the next section.

1.2 Types of Leadership styles:

A numbers of leadership styles are reported in the literature however this section mainly focuses on ten leadership styles including autocratic, democratic, bureaucratic, charismatic, leissez faire, transactional, transformational, situational, coaching, and visionary leadership styles. This section mainly informs characteristics, advantages, disadvantages of these styles.

1.2.1 Autocratic leadership style:

A leader who practices an autocratic leadership style dominates decision making and give very little scope for others to give any inputs. The leader dictates at every step and followers have to follow it without any question or argument. This style is commonly used in the military setting and where others' inputs are not expected or needed. However, there are many disadvantages of this style. Autocratic leadership usually leads to high levels of absenteeism and staff turnover and less satisfaction among employees. On the other hand, autocratic leadership can be beneficial when employees are unskilled and need control because it is argued that the advantages of control may outweigh the disadvantages. This style is also important when work needs to be done fast or in a limited time.

1.2.2 Democratic leadership style:

Democratic leadership style is also known as participative leadership style (Arab, A.; Tajvar, M.; Akbari, F., 2006). Democratic leadership exhibits a completely contrasting framework than that of autocratic leadership. The democratic leader encourages others to share their ideas and views and then the leader makes the decision. Because others are valued in this style, satisfaction of followers is greater as compared to autocratic leadership. Additionally followers feel that they are in control of their own destiny, so they are motivated to work hard by more than just a financial reward. It is argued that democratic leadership style is

beneficial when one has part of the information, and others have other parts. So when you do not know everything, you can take help of others knowledge and skills to understand a better picture or the phenomena. Thus, it is of mutual benefit; it allows team members to feel important and become part of decision making and allows the leader to understand different perspectives and make better decisions. The disadvantage is because others views are encouraged, decision making may take a longer time and there may be chaos and conflict in decision making.

1.2.3 Bureaucratic leadership style:

Bureaucratic leadership style follows rules and regulation. Bureaucratic leaders strictly adhere to policies and procedures by themselves and make others do the same. In short they 'work by the book'. It can be argued that this style is rigid in the sense policies and norms must have been written in the past, as circumstances changes policies and norms need to be modified accordingly. However literature reports that this style is beneficial to follow safety procedure, handling equipments and large financial outlays.

1.2.4 Charismatic leadership style:

Charismatic leaders have an aura around them. This may be due to their personality, their dedication, their vision, their sincerity, their communication, their knowledge and skills or expertise in the field and the way they present themselves in front of people. Charismatic leaders inspire, motivate interest and passion in their teams and they are the driving force in the organization. Charismatic leaders believe more in themselves than in their teams. They take responsibility, and are committed to their work. In the eyes of the followers, success is directly connected to the presence of the charismatic leader. Other attributes highlighted about charismatic leadership are this leadership style wins

the support and enhances devotion of followers. They are visionary, inspirational and confident. Such leaders can convince and negotiate better. They take care of followers needs, treat followers with respect and create enthusiasm in the employees. Charismatic leadership influences followers emotionally (Gibson, J.W., Hannon, J.C., Blackwell, C.W., 1998). The downside of this leadership style is that leaders believe more in themselves rather than their followers thus there may be a trust issue.

Four types of charismatic leadership have been discussed by Steyer, J. (1998): For example, hero (heroic charisma), father (paternalistic charisma), savior (missionary charisma), and king (majestic charisma). Charisma can be looked from both the angles from the leaders point of view i.e. qualities displayed by the leaders, or behavior of the leader (objective perception) and from the followers point of view i.e. perception of the leader by the followers (subjective perception). Thus Steyer has discussed four approaches of charismatic leadership: “i) leader centered, ii) follower centered, iii) interdependency oriented, and iv) context centered” (Steyer, 1998 pg 809). It is important to note that charisma has to be evaluated from both the sides. Interdependency model of charismatic leadership discusses interaction from leaders as well as followers sides for charismatic interaction. It is related to the relationship between leader and followers.

Evidence shows that charismatic leaders reported in the literature need not be charismatic. This is showed in the survey conducted by Gibson, J.W., Hannon, J.C., and Blackwell, C.W. (1998). Survey was conducted to explore whether 23 well- known personalities had charisma or not. These personalities were from politics, military, corporate world, religion, sports and entertainment. Survey was conducted on 111 respondents including faculty and students from USA. The result confirmed that the majority of respondents scored, only half of the personalities were charismatic. When authors asked a question whether charismatic leadership is always a good thing only 30% responded to this as being ‘True’. That means the majority (70%) disagreed with the statement. Not all

leaders adopt charismatic leadership style as reported in the literature. For example, American CEOs do not possess charismatic leadership style (Gibson, Hannon, and Blackwell, 1998).

Is the 'charisma' inherited or charismatic attributes be acquired? Gibson, Hannon, and Blackwell, (1998) feel it stands in the middle, some personality traits need to be inherited whereas other attributes can be acquired. Further they add that 70% of respondents from their study felt that charismatic leadership attributes can be learned. These authors cites that an individual has to develop charismatic attributes like speech patterns of a charismatic leader, and be more emotionally expressive, use neurolinguistic programming and use humor (Gibson, Hannon, and Blackwell, 1998, pg 22).

When can charismatic leadership be useful? Gibson, Hannon, and Blackwell (1998) cites that "according to House (1992), charisma matters most in startups, turnarounds, or whenever a business (or team) is going through rapid, unpredictable change. House believes that when conditions are uncertain, charismatic bosses spur subordinates to work above and beyond the call of duty. Charismatic leaders can be classified as corporate heroes capable of performing miracles; they are often responsible for orchestrating corporate turnarounds, launching new enterprises, inspiring organizational renewal, and influencing individuals to achieve maximum performance levels" (pg 20).

1.2.5 Leissez fairy leadership style:

Leissez-faire leaders allow others to make decisions. These leaders neither give any input nor interfere in decision making, but they are still held responsible for the decisions. Leissez faire leader decentralizes authority in hands of experts. Essence of this leadership is that leader trusts team members and has confidence in the capability and capacity of the team to achieve the goal. This

leadership style is effective when the team is highly competent, knowledgeable, self motivated, skilled, and who does not need close monitoring or supervision. On the other hand, leissez faire style is misinterpreted as the leader who follows this style is lazy, but it is not the fact. It is argued that this is not a style to be used so that the leader can blame others when things go wrong, rather this is a style to be used when the leader fully trusts and has confidence in others.

1.2.6 Transactional leadership style:

In transactional leadership the “transaction” or a ‘deal’ means that the organization pays the team members in return for their effort and compliance. Transactional leadership style is mainly focused on getting work done by people and in return they will get the reward for completing the task. If reward is monetary in nature then the followers have control over their income. So transactional style of leadership uses reward system for motivating employees (Frey, et.al. 2009). Disadvantage of transactional leadership is it does not give importance to developing relationships and team work. It is argued that transactional leadership is a type of management, not a true leadership style, because the focus is on short-term tasks. It has serious limitations for knowledge-based or creative work.

1.2.7 Transformational leadership style:

The transformational leader was coined by Downton (1973). Later it was fully described by Burns in 1978 and Bass (1985) coined the concept of transformational leadership (as cited in Gill, R., Levine,N., and Pitt, D.C.,1998). Transformational leadership inspires team members with a shared vision of the future, focus on values and develops a win – win approach.

1.2.8 Situational Leadership Style:

Hersey-Blanchard coined the term ‘situational leadership style’. Different styles are needed for different situations or in other words ‘one single style fit’ is not applicable for all situations. This style is based on the contingency theory which emphasis that there is no best leadership style, but it depends on the situation. This style encourages leaders to choose a leadership style that best fits into a given situation, people, time, task in hand, and at the same time considers other factors. However in order to use situational leadership style, firstly the leader needs to be aware of all leadership styles, then the leader needs to be well versed with the organizational culture, team, resources available, demands of time, internal and external environment and so on. Once the leader is competent on these aspects then only it is possible for a leader to use situational leadership style.

1.2.9 Coaching Leadership style:

Hicks and McCracken (2011) reported that coaching leadership makes employees learn new ways of thinking and behaving. Coaching leadership inspires hope in others to accept challenges, overcome barriers, and create a positive vision of the future. Coaching leadership leader or coaches show genuine interest, openness and honesty towards others. (Hicks, R., and McCracken, J., 2011). Goleman,D., Boyatzis, R., and McKee,A., (2001) reported that the coaching style is really the art of the one-on-one. Coaches help people identify their unique strengths and weaknesses, tying those to their personal and career aspirations. Effective coaching exemplifies the emotional intelligence competency of developing others, which lets a leader act as a counselor. It works hand in hand with two other competencies: emotional awareness and empathy (Goleman,D., Boyatzis, R., and McKee,A., 2001) .

1.2.10 Visionary Leadership style:

Goleman,D., Boyatzis, R., and McKee,A., (2001) reported that the visionary leader articulates where a group is going, but not how it gets there — setting people free to innovate, experiment and take calculated risks. Inspirational leadership, emotional intelligence, transparency, empathy are that most strongly undergirds the visionary style. The ability to sense what others feel and understand their perspectives helps a leader to articulate a truly inspirational vision (Goleman,D., Boyatzis, R., and McKee,A.,2001).

In 1939, Lewin, Lippert and White introduced the term ‘Leadership styles’. From the time of its introduction till date, work on leadership styles have been evolving. Literature has reported that leadership styles differ with generations and age of the leader. Each generation had adopted different leadership styles suitable for that generation (Table 1). Kao, Craven, and Kao, (2006) discussed three eras of leadership- Trait era, Behavior era and Contingency era (Table 1). Trait era of leadership (late 1800- mid 1940) focused on physical, psychological, and personality traits of leaders. Behavior era (late 1940) focused on effectiveness of the leader’s behavior on employees and organization as a whole. Contingency era (1960s) examined the leaders and their followers’ behavior to find out the effectiveness of external environment on the behavior of both.

Table 1: Leadership styles as per the era and generations

Name of the Era	Years of the Era	Generation	Individuals born between years	Leadership style as per the generation
Trait Era	**Late 1800-mid 1940**	Veterans	1922-1943	Command and control leadership
Behavior Era	**Late 1940 onwards**	Baby boomers	1943-1960	Participative leadership style
Contingency Era	**1960 onwards**	Generation Xers (baby busters)	1960-1980	Lead by challenging the thinking and ideas of others, involving people in the decision-making process.
Modern Era	**1980 onwards**	Nexters (DOT com generation)	1980-2000	Competence as the top characteristic.

Reference: Above table information is based on the Kao, Craven and Kao (2006) and Salahuddin (2010) study.

Table 1 presents unique behavioral characteristics of each generation and leadership style adopted by those generations. Each generation is named according to the year they were born in. For example, the reason for the veterans (born between1922-1943) behavior might have been due to their struggle to survive the world war and the recession that they faced during the youth. Thus, they exhibited more work focus and work values. They used the “command and control” leadership style i.e. an autocratic leadership style. Likewise, the baby boomers (born between1943-1960) also exhibited a high degree of work value. Traditionally forming close friendships at work; the boomers were part of a crowded generation and thus, they had to “play well with others” (Kennedy, M., 2003). Thus baby boomers demonstrated participative leadership styles.

On the other hand, generation Xers (born between1960-1980) want to work alone; they are not interested in workplace relationships, rather they focused on family and leisure activities outside the organization. Generation xers known as hunters are committed fully to the organizations to gain knowledge and skills and

exhibit their excellence and technical expertise. They do not mind changing jobs and do it often even without an intimation. They give more importance to their satisfaction, family and friends, before the organization and organizational goals. Generation Xers exhibit a democratic leadership style. On the other hand, The Nexters (born between1980-2000) rank competences as their top characteristics. However, research studies are still to explore leaders from this era, or in other words these young individuals may still be on their path to leadership positions.

1.3 Background of the research topic:

Leadership style is a complex phenomenon. Management researchers and other scholars have spent more than four decades to study leadership styles. Leadership style is a core component for any organizational growth. The main goal of leadership style is to establish positive, healthy relationships in the organization and motivate enthusiasm in employees to achieve organizational goals. A leader needs to be well trained and experienced for using appropriate leadership styles because studies have shown a positive relationship between leadership style and effectiveness of management (Hazy, 2006). Effective leadership depends on technical, human and conceptual skills of the leader and its relation to various leadership styles (Katz, Robert L., 1974). A leader needs to be well versed with various leadership styles so that he/she can choose an appropriate leadership style as per the circumstances, people, task, time and resources available. A number of leadership styles are reported in the literature including autocratic, bureaucratic, charismatic, democratic, leissez faire, transactional and transformational styles, paternalistic, coaching, visionary, and situational leadership styles.

Although many leadership styles are reported in literature, there is a wide agreement that there is no single leadership style which is the best (Ahn, et al., 2004). Many authors have supported this statement. For example Yu, H. and Miller, P (2005) cite that "… traditional criteria used to define successful leadership no longer fit into today's modern workplace. The new science of leadership requires a mixture of skills, such as professional skills, experience, education and a leadership styles" (pg 6).

There is no leadership style which will best fit into all circumstances. Thus, a leader has to be aware of multiple leadership styles as well as he/she needs to understand that there are multiple factors which need to be considered while adopting a particular leadership style. A leader has to understand which factors

are in favor or against the needs of an organization so that he/she can choose the appropriate leadership style. Leadership style is not merely skills that the leader possesses, or behavior he/she exhibits, or attitude he/she shows, or influence he/she has on others; but it is a permutation and combination of multiple factors and right judgments made at the right time and for the right circumstances. For example, the leadership style needs to be changed as per the trend of economy, organization, technology, work characteristics of employees, and organizational climate. Similarly Frey, et al., (2009) supported this argument by stating that leadership is influenced by internal and external environment of the organization along with the personality of the leader.

Good leaders often switch instinctively between styles as needed. Thus, leadership styles overlap with each other to a certain extent. Thus, it is difficult to point out that a leader demonstrates only a single leadership style. Leaders may use leadership styles concurrently or sequentially. It means leaders use a single leadership style in a particular circumstance and may use another appropriate leadership style in other circumstances; or leaders may use more than one leadership style under a particular circumstance concurrently, (or at the same time) or follow one leadership style after another (i.e. sequentially).

A lot of research was carried out to understand leadership and leadership styles of leaders working in multiple industries. However, literature lacks industry wise understanding of the leadership styles.

1.4 Statement of the research study:

A review of literature showed that scholars had studied leaders from multiple industries like education, manufacturing, banking, finance, information technology, and communication rather than focusing on leaders from similar types and nature of the industry. No study had explored and focused on the possible links among leadership styles from different industries and compared them with each other. It is also important to understand whether one industry leader can learn leadership from another industry especially when the industries are of similar nature. In other words it is essential to understand which leadership styles are suitable in a particular industry and why? Thus, there is a need to explore whether any link exists between leadership style(s) and the type of industry. Snaebjornsson and Edvardsson (2013) supported the need for exploring leadership among different industries. However, the review of literature done for this study showed lack of comparative studies on leadership styles adopted by the leaders in a similar functional industry say for example the hospital and hotel industry.

Leadership styles adopted by the top and middle level leaders in any industry influence not only their employees but the entire work processes of an organization. Thus, it is important to understand the leadership styles of the top and middle level leaders. Very few articles were focused on determining the leadership styles of the top and middle level leaders within an industry. It is important to know whether leaders are aware of their own leadership styles. This self perception helps to guide the leader to develop the desired skills and behavior to strengthen his/her leadership style. However, there is a dearth of literature on leadership styles adopted by the leaders from various levels of leadership within an industry in general and the hospital and the hotel industry in particular. Current leaders from hospital industry struggle to find the ideal leadership style to fit into a situation to overcome the challenges posed and to

carry out day - to - day operations. Above this, limited literature and lack of evidence on leadership styles related to hospital and healthcare industries leaves hospital leaders with a lack of direction (Janssen, 2004). Additionally, scarcity of trained leaders in hospitals from the leadership point of view and lack of leadership models in the hospital industry increases the need for the current study. Lack of evidence on leadership style suitable and beneficial to the hospital industry, especially from an Indian perspective, increases the need and importance of this study. Thus, this study was focused on exploring the leadership styles adopted by the top and middle level leaders from the hospital and the hotel industry.

1.5 Brief about the study:

Due to the complex nature of leadership styles, this study used a mixed method research design. Mixed method means combining qualitative and quantitative methods in a single study (Tashakkori and Creswell 2007). This study used qualitative and quantitative methods to obtain answers for the key questions mentioned in the next chapter. Qualitative data was collected by face to face interviews and quantitative data was collected by a survey method. Two separate tools were thus used for obtaining data from qualitative and quantitative methods. Results of these two methods were merged during interpretation and the reporting phase of the study. This has provided a large complex data set on which it has been possible to examine how hospital leaders perceived their leadership style and provided inputs into what needs to be done to enhance leadership skills and leadership style of the hospital leaders.

Chapter 2: Aim and objectives

2.1 Title of the study:

"Exploring leadership styles adopted by the top and middle level leaders from the hospital industry in Pune city."

2.2 Aim of the study:

The aim of the study was to examine the leadership styles adopted by the top and middle level leaders of the hospitals in Pune city, and provide inputs to enhance the leadership style of the hospital leaders**.**

2.3 Objectives of the study:

The objectives were embedded in the complex nature of hospital management strategies that are either directly or indirectly dependent on leadership patterns and the structural and functional characteristics of the top and middle strata of the leaders. The objectives relate to the leadership styles and the perception of leaders on how they function within their organization. Hospitals are a part of the service industrial sector, but by the nature of what they do; they require a variety of specific leadership styles. As they deal with human life and wellbeing, leadership is a critical concern of hospital management. Some of these issues are best dealt with, through a qualitative approach, while others bring out a variety of concerns that are best appreciated through a quantitative study. Thus the objectives have been designed and studied through a dual set of methodological approaches best suited to the different objectives and managerial requirements for hospitals as critical organizations.

Objectives of the study were as follows:

1) To assess the leadership styles adopted by the top and middle level leaders from the hospital industry and the hotel industry.
2) To explore the selected demographic details of the top and middle level leaders from the hospital and the hotel industry.

3) To evaluate similarities and differences between leadership styles of leaders from the hospitals and the hotel industry.
4) To obtain the views of the top and middle level leaders from the hospital and the hotel industry related to leadership and leadership style.
5) To suggest recommendations based on the study findings.

2.4 Research Questions:

Research questions addressed in this study were:

1. Which leadership styles are adopted by the top and middle level leaders from the hospital and the hotel industry from Pune city?
2. Is there any association between leadership styles of the leaders from the hospital and the hotel industry?
3. Is there any association between demographic variables of the top and middle level leaders with the leadership styles?
4. What are the perceptions of the leaders from the hospital and the hotel industry regarding leadership training and development?
5. What are the other views of the top and middle level leaders from the hospital and the hotel industry related to leadership styles?

2.5 Assumptions:

Assumption according to Oxford advanced learner's dictionary means 'a thing that is accepted as true without proof'. Researcher had following assumptions in relation to the respondents participated in this study.

1. It is assumed that all respondents provide honest responses.
2. It is assumed that all respondents have knowledge of their leadership styles.

Although researcher had above mentioned assumptions, it is not necessary that respondent will give honest response to the research questions posed in the study or they may have knowledge on the leadership style in general or leadership style related to self. However, this research study was not focused on leader's knowledge related to leadership style.

2.6 Scope of the study:

- Studying leadership styles of the top and the middle level leaders from the hospital industry sheds light on leadership styles adopted by these leaders and appreciate similarities and differences with the leadership styles adopted by the leaders from the hotel industry. By providing this valuable information the gap in leadership styles adopted within the hospital industry helps to plan strategies to develop and strengthen the leadership styles of hospital leaders. This study will serve as a means to develop the appropriate leadership style best fitted to the hospital industry.
- It also serves as a means to develop a leadership training program for the leaders including leadership training components and teaching methodologies to develop future leaders as well as to strengthen leadership styles of current leaders from the hospital industry.

2.7 Delimitations of the study:

- Geographically, the study focused only on the hospital and the hotel industries from Pune city.
- The study focused on the top and middle level leaders from the hospital and the hotel industries from Pune city.

Chapter 3: Review of literature

The goal of this review of literature was to explore available literature on the leadership styles in a general context and especially from service industries such as the hospital and hotel industry. Studies which were focused on leadership styles were the main interest of the review. This review of literature has obtained the answers to the following questions:

1) Which leadership styles are reported commonly in the literature from various industries?
2) Is there any association between demographic data of the leader like age, gender, leadership position, educational level, and the type of industry with leadership style?
3) What are the gaps in the existing literature?

Literature was searched from Proquest PhD dissertation, Gale one library (from British library), and Google scholar database as well as hand search of articles from these sites. Search key term was used for the literature search was mainly 'leadership style'. More than 50,000 articles were reported the limitations such as peer review, full text, English language and articles were used to narrow the literature search.

After reviewing the literature, five themes were derived to report the findings from the literature, which are as follows:

1) Leadership style and industry
2) Leadership style and leadership position
3) Leadership style training and development
4) Leadership style and age
5) Leadership style and gender

Based on above mentioned themes the review of literature has focused attention on key concerns which includes following sections:

3.1 Leadership style and industry

3.2 Leadership style and leadership position

3.3 Leadership style training and development

3.4 Leadership style and age

3.5 Leadership style and gender

3.1 Leadership style and industry:

Scholars have studied various leaders from different industries to explore leadership style. Although studies have included leaders from different industries; no author had emphasized why they had chosen a particular industry. It was observed that the samples of the study varied by chance rather than for a specific purpose. No strong purpose was found in the majority of existing literature in relation to leadership style and the nature of the industry.

Table 3: Authors included various industries in their leadership studies

Education industry	Manufacturing industry	Finance industry	Business industry	Communication Industry	Transport Industry
• Eagly and Johnson, 1990 • Yu and Miller, 2005 • Benjamin and Flynn, 2006 • Handsome, 2009 • Frey, et al. 2009 • Avolio et al., 2009	•Gibson and Marcoulides, 1995 •Yu and Miller, 2005 •Matsa and Miller, 2012	• Gibson and Marcoulides, 1995 • Benjamin and Flynn, 2006 • Handsome, 2009	• Eagly and Johnson, 1990 • Frey, et al., 2009	• Gibson and Marcoulides, 1995 • Matsa and Miller, 2012; • Giri and Santra, 2009	• Gibson and Marcoulides, 1995 • Matsa and Miller, 2012 • Giri and Santra, 2009 • Handsome, 2009

Table 3 provides the information about various authors who included different industries in their leadership studies. For example, scholars focused on leadership from education industry (Eagly and Johnson, 1990; Yu and Miller, 2005; Benjamin and Flynn, 2006; Handsome, 2009; Frey, et al. 2009; Avolio et al., 2009); manufacturing industry (Gibson and Marcoulides, 1995; Yu and Miller, 2005; Matsa and Miller, 2012); finance industry (Gibson and Marcoulides, 1995; Benjamin and Flynn, 2006; Handsome, 2009); and business industry (Eagly and

Johnson, 1990 ; Frey, et al., 2009). Gibson and Marcoulides (1995) study targeted agriculture, forestry, fishing, mining, construction, insurance, real estate, banking, transport, communication, service industries, and public administration. It was also reported that service industries were health services, legal services, and educational services (Gibson and Marcoulides, 1995). Firms involved in the Matsa and Miller (2012) study were transport, storage, and communication; or real estate, renting, and business firms. Avolio et al. (2009) included leaders holding managerial positions in healthcare, human resource, community services. On the other hand, the Giri and Santra (2009) study included 324 employees from top, middle and junior level of management from various organizations like, manufacturers, dredging corporations, airlines, real estate, bankers, R&D, telecommunications, and information technology firms (Giri and Santra, 2009). The Frey, et al. (2009) study included students who were from business (68%), education (12%), health care (9%) industries, and others were from government and religious organizations. There were 51 students from Walden University who participated in Handsome's study who were from: consulting industry, education industry, finance and government, healthcare, retail, technology, and transport industry (Handsome, 2009). Arab, et al. (2006) cross sectional study in Qom Province study focused on managers, chiefs, and hospital staff. On the other hand, few scholars focused on technology industry (Benjamin and Flynn, 2006; Handsome, 2009).

Likewise, several studies focused on different industries and reported varied leadership styles. For example, Derakhshandeh and Gholami, (2011) focused on agricultural directors and managers in Iran and reported a positive relationship between autocratic leadership style and effectiveness of management. Looking at sports industry, Chen (2013) reported that there was a significant correlation between soccer coaches who demonstrated paternalistic leadership style. Frey, et al. (2009) focused on the business industry, education industry and healthcare industry and reported the relationship between lifestyle and transformational leadership style. Whereas Benjamin and Flynn (2006)

conducted three separate studies on MBA and undergraduate students from industries like financial services, consulting, high technology, education, pharmaceuticals, and media. They also focused on transactional and transformational leadership styles but lacked industry wise results.

Bhattacharyya (2006) studied how leadership makes a difference. Samples were from the information technology industry like Infosys, Wipro, Tata consultancies, and telecommunication industry like Reliance, Bharati telecom, Tata telecom. However Bhattacharya (2006) did not report any type of leadership style.

It is evident that the above studies had included leaders from different industries but none of these studies reported the reasons for selecting a particular industry and particular level of the leader. Additionally literature did not report leadership styles according to industry. Thus, it can be concluded that samples as well as industries included in above mentioned studies varied by 'chance' rather than by purposeful reason.

In the above mentioned studies, neither any authors mentioned their purpose to understand leadership style according to the nature of the industry, nor was their study aimed at comparing leadership styles in different industries. Thus, there is a clear evidence of the scarcity of documentation on the leadership styles adopted by the leaders in a particular industry and its reasons are conspicuously absent.

Service industries like hotel and hospital industry had almost a similar picture. A majority of studies from the hotel industry focused on transformational leadership styles. For example, Gill, Flaschner, and Bhutani (2010) examined the effect of managers through transformational leadership styles on hotel employee's empowerment and on the job stress in the hotel industry in Punjab, India. A negative relationship was reported between transformational leadership style and

job stress whereas transformational leadership style was correlated with employee's empowerment. Likewise, a qualitative study by Huhtala, N. (2013), reported that restaurant managers' behavior represented transformational and transactional leadership style. However this study had only three samples, thus the results cannot be generalized. Similarly, Parry and Proctor-Thomson (2002) reported strong positive relationship between perceived integrity and transformational leadership styles. Above examples from the hotel industry mainly focused on the transactional and transformational leadership styles rather than looking at the other leadership styles.

However, the 'Hospital' or the 'Healthcare' industries are different from other industries. The main difference is that the hospital industry is highly complex in nature which deals with life and care of an individual. Thus, the hospital environment is fragile and extremely dynamic and the managerial processes change every minute as per the needs of patient care; hence the leader and employees need to adopt fast and act accordingly. Various types of hospitals exist in the Indian scenario: government, private, corporate, mission hospitals, nonprofit organizations etc. and each has its unique leadership requirements. Leadership in the hospital industry is crucial as the leader has to constantly balance between quality care of patients, their satisfaction and cost management. Scholars have reported the urgent, effective and visionary leadership for health care organizations (Nurse, E. 2010). Scarcity of literature was found on leadership styles adopted in the hospital sector. "It has been postulated that the changing environment of health care industry needs a mixture of leadership styles to lead the organizations" (Heever, 2009, pg 98).

Literature review showed that the hospital industry mainly reported autocratic, transactional and transformational leadership styles. The results of the Arab, et al. (2006) study reveal that more than 70 % hospital managers perceived that they used consultative leadership styles in their practice; however the number of hospital managers that participated in this study was only eight. Thus, the results

cannot be generalized. In contrast, Hicks, R. and McCracken, reported that directive style is not suitable in the hospital industry as directive style of management increases medical professionals' dissatisfaction and conflict as well as disengagement (Hicks, R. and McCracken, 2011).

No significant difference was found between transactional leadership style of CEOs from USA and Canadian hospitals (Nurse, 2010). Transactional leadership style of CEOs in the 'not-for-profit' hospitals in Canadian public healthcare system was significantly different from that of CEOs in the 'not-for-profit' hospitals in the American private healthcare system (Nurse, 2010).

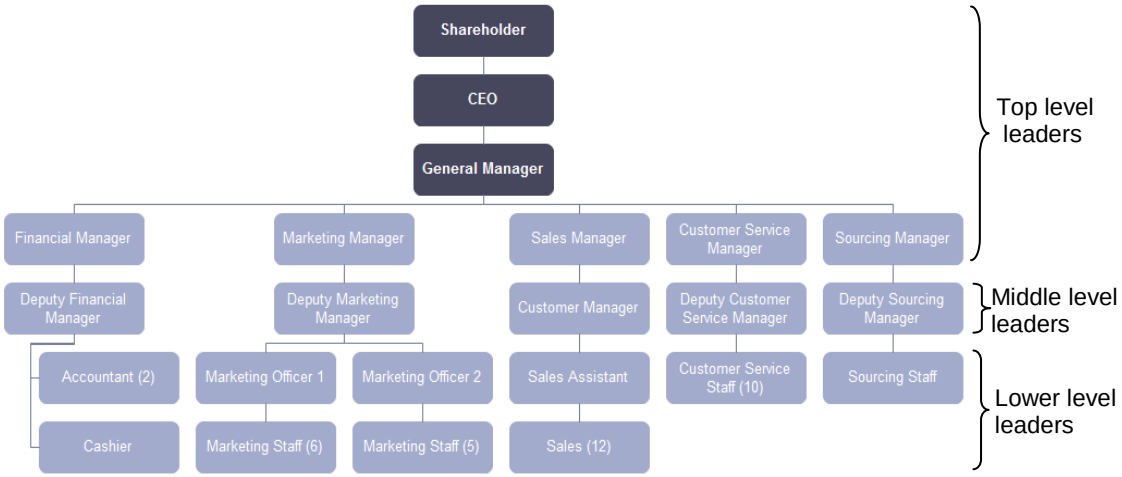
Few scholars have studied transformational leadership from the hospital industry. For example, The CEOs in the USA private healthcare system practiced more transformational leadership than CEOs in the Canadian public system (Nurse, 2010). Xirasagar, et al. (2006) reports 269 executive directors of community health centers wherein they evaluated perception of the medical directors' leadership. The results confirmed that transformational leadership had higher mean scores compared to transactional leadership styles. Nurse (2010) study also indicated that the CEOs from Florida hospitals reported transformational leadership style than that of the CEOs in Ontario hospitals (Nurse, 2010, pg 155-156).

Thus, leadership literature, although reported from many industries, it has not studied all types of leadership styles in a specific industry. It also lacked comparative studies on the leadership styles from similar industries, for example, the hospital and the hotel industry. Thus, exploring leadership styles adopted by the leaders from hospital and hotel industry is an essential component in exploring leadership patterns of behavior at the top and middle level in the organizational structure.

3.2 Leadership style and leadership position:

Leaders are everywhere in the organization, that is to say at the top level, middle level and lower level and they play their roles to achieve organizational goals. The Chief Executive Officer (CEO) plays a major role to set an image in front of other leaders to follow and imitate. However, the organization which has hierarchical structure has only a few top level leaders as compared to the number of lower level leaders (Hayes 1999). In horizontal or flat organization structure leaders are more. Figure 2 and Figure 3 displays the same. The hierarchical relationship between different people is visualized clearly in the Figures related to organizational charts. For example, Figure 2 displays vertical or hierarchical organizational structure and level of leadership.

Figure 2: Vertical organizational chart and leadership level



The vertical organizational structure has top down hierarchical structure. Legitimate power displays from the each layer as well as their leadership positions. With chain of command well defined, decisions usually move from top down through layer by layer, and people at the bottom have the least autonomy. In the structure, each person is supervised by the one directly above him.

On the other hand, horizontal or flat organizational structure is much flatter in terms of leadership levels and hierarchy. Figure 3 displays the example of flat structure.

Figure 3: Flat hierarchical structure

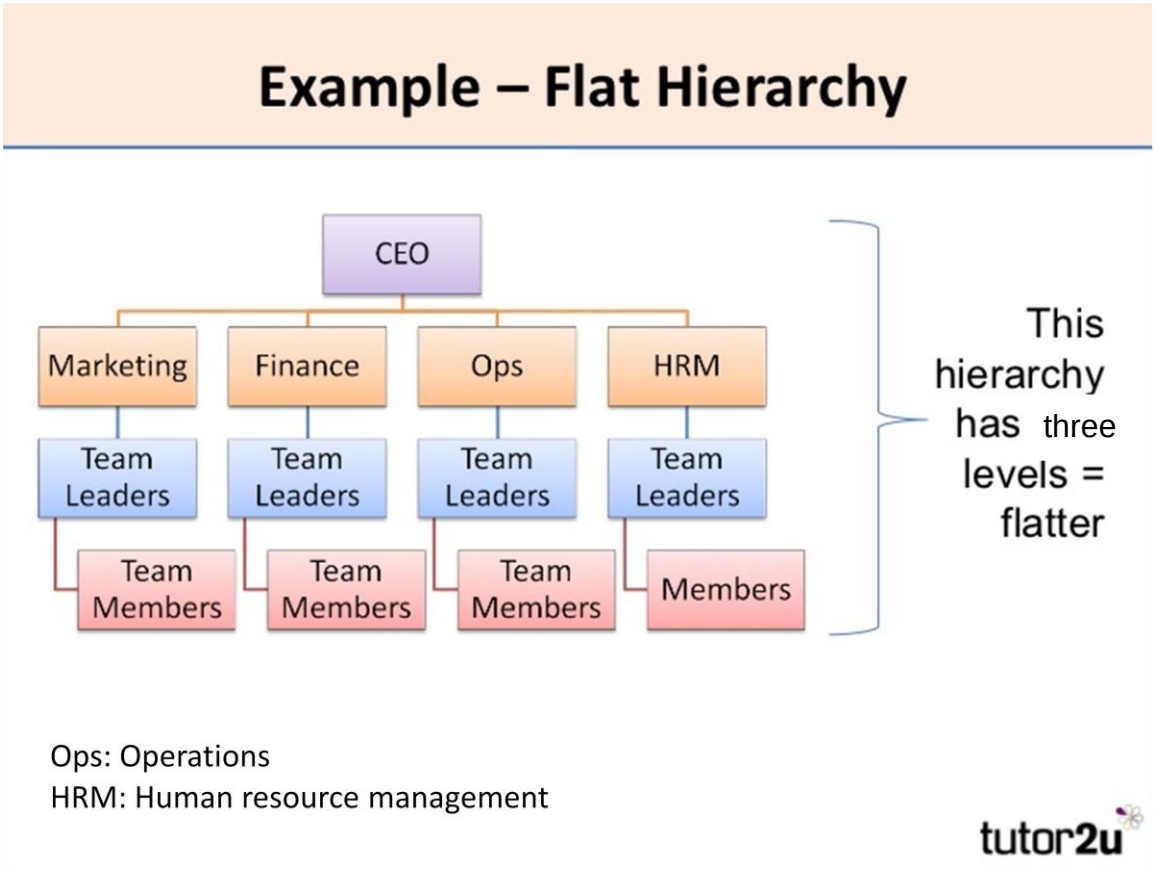


Figure 2 shows that organization which has hierarchical structure and example of number of people on such positions. It shows the top level leaders are less in numbers as compared to the leaders at the middle and lower level. If we see the Figure 2 from lower level then we see number of lower level leaders. As we go up the ladder i.e. at the middle level, the number of leaders decreases and further at the higher level only a few leaders hold positions. Likewise, Giri and Santra (2009) reported that their study showed 47% employees to be at the junior level, and only 3% leaders were from the top level.

In general the hierarchical structure mentioned above is seen everywhere. For example, in Indian scenario, organization may have one CEO per hospital, one president, one medical director etc. On the other hand, if an organization adopts

a horizontal leadership structure, then there can be a larger number of leaders at every level. For example, leaders at each department/ ward of the hospital, floor in-charge etc. to name a few. Such horizontal structure in the organization may help people to learn, understand, support, develop, motivate and to have a win-win situation for everyone while reaching the vision and mission of the organization. Such a structure needs to be developed intentionally which will help to develop leadership at all levels in the organizations. “It behooves organizations to establish a leadership framework that ensures a participative, cooperative, and collaborative culture….Leadership framework has to come from all corners of the organizations and all professionals, teams, levels and titles and done so purposely” (Pontefract, D., 2012, pg 56).

Different levels of leaders from the top level to the lower level leaders were included in the literature. For example, Snaebjornsson and Edvardsson (2013) study focused on the top level leaders. Frey, et al. (2009) study, focused on management students; 63 % were holding first level managerial positions. On other hand the Arab, et al. (2006) study focused on managers, chiefs, and hospital staffs. Heever‘s (2009) goal of the study was to identify the ideal leadership style for unit managers. Heever‘s (2009) survey consisted of nurses and unit managers working in the C.C.U.s of eleven private health institutions in the Cape Metropolitan Area. More than two thousand female and male managers from middle level to senior level positions in NHS (National Health Service), UK, participated in the Alimo-Metcalfe, B., (2004) study. Gibson and Marcoulides (1995) study samples consisted of managers from Norway (47), Sweden (53), Australia (64) and USA (54) and majority (41%) of leaders were working as middle level managers.

Some author’s operationally defined their samples. For example, in Kao, et al. (2006) the aim of correlational study was to address the relationship between the leadership styles and demographic characteristics of the Taiwanese executives. 163 executives from 151 companies participated in the Kao et al. study; a wide

range of executives included were: chairman, vice chairman, chief executive officer, president, vice president, in charge of a principal business unit/ division, or function such as sales, administration, finance, or any other officer who performed policy making functions excluding the human resource department.

Hiller, et al. (2011) study included six subcategories of the leaders, for example: top management team, middle management, lower level, mixed, NR, and laboratory. Hiller, et al. (2011) operationally defined middle and lower level leaders as follows: “Unlike supervisors at lower levels who interact directly with employees at the lowest end, middle managers typically attend to higher-level goals of their business units, manage significant projects, and manage multiple organizational levels below their level …Although managers at lower levels closely supervise and support the lowest level employees, they do not have to manage multiple hierarchical levels below them.” (Hiller, et al., 2011, Pg 1149).

Apart from the examples mentioned above, other studies did not operationally define the top, middle and lower level leaders. Additionally authors did not report the leadership styles of the leaders participated in their study according to their leadership positions in the organization. Thus, it creates a need to explore the leadership style according to the top, middle or lower level leaders.

Although literature showed variation in the samples, settings of the study and leadership levels; it is important to develop leadership from lower level to the top level in the organization. To develop leadership of an individual, it is important to know whether an individual that has leadership capacity and capability; then the organization can plan leadership training including leadership styles and leadership skills etc. for such individuals. This aspect has been discussed in the next section on leadership training and development.

3.3 Leadership training and development:

This section includes overview of leadership development and focuses on leadership development in relation to learners. A brief presentation is given on objectives of leadership development programmes and leadership development methods used in the study. An attempt is made to report the evidences on relationship between leadership style, duration and outcome of leadership training and development. The gap in leadership training and development from the hospital and the hotel industry has been reported.

3.3.1 Overview of leadership training and development:

Parry described leadership training being more skill based (Psychomotor skills), whereas, leadership development is more conceptual (Cognitive) based (Parry, K.W., 1998, pg 92). Leadership development definition has been cited in Lynham's study "as every form of growth or stage of development in the life-cycle that promotes, encourages, and assists the expansion of knowledge and expertise required to optimize one's leadership potential and performance (pg 285)." This definition shows that leadership development is a continuous process. Leadership is a complex and continuous phenomena (Snaebjornsson and Edvardsson, 2013), thus the leadership development may require a long time to imbibe the nuances in leadership knowledge, skills, and attitude. Leadership development is not a single task or a single day activity by which a leader can learn everything about leadership. It is a set of multiple activities over one's lifetime (Hartley and Hinksman 2003). Due to its prolonged nature, people are reluctant to be learners (for leadership) throughout their life. Once an individual holds a leadership position, then he/she tends to postpone or stop learning. We need to change this attitude of most of the leaders. "Probably the most important attitude change is to get people excited about learning … and about changing, relearning, so that the excitement energizes change rewarding those involved and decreases resistance to change, unleashing still more human

potential" (Harris et al., 2004, pg 11). "To address the demands of this highly tumultuous context, leadership development needs to be grounded in the notion of deep change in one's self, as well as in the organization" (Kritskaya, O. and Dirkx, J., 2000, pg 415). Leadership development programs need to be focused on change in an individual's fundamental belief and learning. In short, the individual has to work on his/her self (Kritskaya and Dirkx, 2000). Quinn feels that "to develop an effective leader, firstly the leader has to develop a new self" (as cited in Kritskaya, O. and Dirkx, J., 2000, pg 416), and change his/her inner self (Kritskaya and Dirkx, 2000; Short and Jarvis, 2000). Changing inner self means changing one's own assumptions and beliefs and learning, relearning different perspectives of the same phenomena.

Many organizations are investing time, money and resources in developing leaders and their leadership (Hartley and Hinksman, 2003). However "there is no clear and consistent answer to the question of what leadership development is and isn't" (Lynham, 2000 pg 289). Lynham's (2000) review highlighted what we know and do not know about leadership development. Lynham (2000) highlighted seven 'knows' about leadership development (pg 287). These are:
"1) Leadership development occurs in early childhood and adolescent development. 2) Formal education plays a key role in leadership development.
3) On-the-job experiences are important for the development of leadership.
4) Leadership development also occurs through specialized leadership education. 5) Leadership education focuses on three specific areas (namely improving a leader's attitudes, skills and knowledge, training in success and effectiveness as a leader, and training and education on leadership styles.
6) There are a number of factors that can act as potential barriers to the effectiveness of leadership development. 7) Leadership development is a lifelong process".

Due to the long leadership development process and shortage of top and middle level leaders, currently organizations have developed a 'fast track' option for

developing leaders. “Fast-track programmes are sometimes established with the express purpose of creating the leaders of tomorrow” (Hartley and Hinksman, 2003, pg 35). However literature lacks longitudinal studies which explored the effectiveness of leadership training in the long run. Additionally literature lacks the scholarly knowledge on leadership training, education, its effect on leadership etc. “It would appear that the body of knowledge on leadership development has some distinct voids, some troublesome gaps, and that both may be well served by further purposeful and scholarly inquiry and study” (Lynham, S., 2000 , pg 285).

Developed countries are taking initiatives and a lead in leadership development of their leaders. For example, Hartley and Hinksman (2003) conducted systematic review from six databases from 1997-2003 which was focused on leadership development; however the number of articles reviewed were not clearly reported in this study. Results show that a majority of articles were from developed countries like USA, Canada, Australia and UK. Likewise Collin’s (2002) study also confirmed similar findings. USA (67%) was the leading country focusing on leadership development (Collins, 2002) as compared to European and Asian countries. However demand of leadership development remains the same in all countries and in all industries.

Although all industries need strong, positive leadership; hospital industry needs it the most due to the limited number of well trained and experienced leaders to handle the complex nature of the hospital. Chuwattannakul (1993) emphasized that health care leaders lack leadership qualities and need training to develop leadership styles and people management skills (Chuwattannakul, P., 1993).

3.3.2 Contents of the leadership training and development programs:

The main focus of leadership training and development is developing conceptual, human and technical leadership aspects of leaders. A few studies focused on content of leadership development programs like developing leader's capability (Steinert, et al., 2012) and man management strategies (Collins, 2002). For example, Steinert, et al., (2012) review over nineteen years, reported 14 interventions that focused on leadership : conflict management and negotiation; budgeting and financial management; leadership theory and concepts; people management and performance issues; networking, team-building and mentoring; organizational structure and culture; change management; strategic planning and problem-solving; time management; and personal leadership styles. Collin's meta- analysis showed that content of leadership development program was mainly focused on human relation (53%), general management (32%), employee performance and strategic stewardship (4% each), and problem solving and job/ work design (3% respectively) (Collin, 2002).

3.3.3 Methods of leadership training and development:

Studies show differences on the training content and teaching methodology required for leadership development programs. Some argue that to develop leadership hands-on or real time experience is important and on the other hand scholars feel mentoring can be used for this purpose rather than mere classroom learning.

Literature provides multiple methods of delivering contents of leadership development, or leadership training, or leadership education programmes. Methods of training vary as per the developmental stages of human beings and leadership levels in the organization. For example Lynham (2000) reported four areas of leadership development: early childhood and adolescents; role of formal education; adult and on the- job experiences; and specialized leadership

education programs. A number of different leadership development approaches are reported in the literature. For example, Hartley, and Hinksman (2003) review listed a number of leadership development approaches including 360 degree feedback, mentoring, coaching, networking, action learning, job challenge, secondments, succession planning, formal programmes, fast track cohorts, organizational development, and partnership working. On the other hand, Collin's (2002) meta- analysis showed that formal training (80%) was a common method of leadership development followed by feedback intervention (13%).

Although leadership training and development is essential, formal education is not supported by some scholars. For example, Kao, et al. reported that leadership styles had a negative correlation with the educational level of executives (Kao, et al., 2006). Likewise Kritskaya and Dirkx (2000) reported that degree programs are not successful in developing effective leaders. These two arguments support the reasons for a general decreasing trend that was found in leaders holding Masters Degree or Doctorate Degree from 1990 till 2012 among female leaders (95%, 86%) and male leaders (95%, 87% respectively) (ACHE report 2012). The Giri and Santra (2009) study of the top, middle and junior level leaders also reported that 55% of leaders were graduates, 39% were postgraduates and only 4% held doctorate degrees (Giri, V. and Santra, T. (2009).

Collin's (2002) meta-analysis showed that only 2% studies used on the job intervention for developing leadership. In contrast, the argument from Kritskaya and Dirkx (2000) was that people learn best from their own experience rather than formal education. Likewise, Lynham (2000) had pointed out that 'on the job training' and learning from events and other people on the job, actually enhances leadership development. However, they claimed that they have multiple issues. For example, learning from experience is time consuming. Secondly, resources like men, money, material, etc. may be wasted in adopting trial and error method for learning sake. Thirdly, the leadership focus may change in a wrong direction

while learning with own experiences. Leader may not understand or confirmed whether they made right or wrong decisions because of lack of proper guidance or lack of educative discussions with an expert.

3.3.4 Duration of leadership training and development:

Can the leader learn from few hours of training or do we need to plan long term training for leadership development? Literature lacks evidence to answer this question. Paucity of literature was found on the duration of training and its effectiveness on leadership development.

Time duration of leadership training varied from a few hours to one year as reported in a review by Steinert, et al. (2012). For example, for leadership training or development programs and part-time fellowships, the period ranged from 6 months to 1 year. Leadership workshops lasted from 8 hours to 3.5 days; seminar series duration was only for 6-hours (Steinert, et al., 2012). On the other hand, mean hours of leadership training received by hospital CEOs was around 98 hours (Janssen, 2004). Xirasagar, et al. (2006) reported more than 60% of medical directors had 'in-service education training' on management (not on the leadership) between 1- 30 days; 7% had training between 30-90 days and only 2% of medical directors had for more than 90 days. However, the major drawback of Xirasagar, et al. (2006) study was that it did not report whether this management training had any component of leadership. Hence, the study findings are not useful for understanding leadership as such.

Lack of evidence related to duration of leadership training and development period created confusion on how much time needs to be allotted for the leadership development programmes and its effectiveness in actual leadership practices. For example, Lynham's (2000) review concluded that long term training on leadership development is more effective than short term training. Longitudinal leadership development study was done by Lafferty, B., and

Lafferty, C. (2000) in military leadership school, USA. Although results showed an increase in leadership assessment score at the end of 3 years of the study, it could not be claimed exclusively that these results were due to leadership training only. This is because of extraneous variables like maturity of samples, experience and other factors might have affected this Lafferty and Lafferty's study. Although Lynham (2000) agreed that leadership development is a lifelong process, literature lacks the understanding on how long and how to go about it. Leadership is supposed to be a continuous learning process, so is leadership development. Thus, a leader needs to have leadership training after specific interval, either to get acquainted with new techniques, or update previous knowledge and skills possessed by the leader.

3.3.5 Outcome of leadership training and development:

No clear indication was given in the literature related to the outcome of leadership development. Confusion, contradictions, and controversies prevail on how to evaluate the effectiveness of leadership development. Whether the focus should be on individual development and/or team development and/or relationship development and/or organizational development and/or something else? Although all organizations understand the importance of investment on leadership development of their leaders; organizations are still falling short on implementation aspect of leadership development programmes. Very few hospitals from India actually 'invest' in the leadership development of their leaders. Due to intangible outcomes of leadership training, hospital authorities may be hesitant to spend their resources on leadership development.

In spite of this, quite a few studies tried to report on the outcome of leadership development programmes. Leadership training outcome can be evaluated on two aspects i.e. from participants themselves (by subjective evaluation) and secondly by objective assessment of training (Hartley and Hinksman, 2003). Steinert, et al. (2012) systematic review reported that training outcomes were measured in

terms of increase in satisfaction, increase in knowledge, or skills of leadership, attitudinal change, and behavioral changes. Likewise, Collin's study focused on expertise, knowledge, system and financial outcome. Collin (2002) conducted a meta- analysis of 103 studies from the year 1982-2001, from three databases and hand search articles to evaluate effectiveness of leadership development programs. This meta- analysis explored leadership development in relation to system, financial, expertise, and knowledge outcomes. 75% of studies focused on expertise outcome whereas only 16% studies focused on knowledge outcome, 7% studies focused on system outcome and 1% of studies focused on financial outcome in this meta- analysis (Collin, 2002).

Evaluation of attachment styles of leaders may help to understand training needs of leaders to develop positive attitude and relationship competencies. Lynham, (2000) thought effectiveness of leadership development programme can be evaluated with the help of 360-degree feedback systems. It may help to evaluate behavior and attitudes of the leaders.

Literature, thus, lacks the evidence on leadership training and its outcome. Authors and organizations are still struggling to evaluate leadership training outcomes either in the form of actual leadership style of individuals, their own performance, or performance of followers, organizational culture, organizational development or relationship development. Most importantly, "Organizational outcomes must be the driving force and energy behind the design and implementation of all leadership development interventions" (Collins 2002, pg 4).

3.3.6 Leadership training and development in the hospital industry:

Hospitals are well-known for their complex organizational structure and nature of functioning. Every hospital has a dynamic environment where multi specialty, multi-ethnicity, multi-culture, multi- dimensional and multi- operational work comes under one umbrella called the 'hospital' which needs a unique leadership

style. Training to handle and lead such a diverse workforce in a specialized environment requires special training skills. Majority of Western hospital administrators (from USA, and European countries) reported training in management and leadership. These administrators hold Masters in Hospital administration (MHA) or Masters Degree in Business Administration (Chuwattannakul, P. 1993). Xirasagar, et al. (2006) conducted a cross sectional survey of 269 executive directors of community health centers and evaluated perception of the medical director's leadership. This study revealed that only 31% of directors had a formal postgraduate degree in the management either in MHA, MPH (Masters in Public Health), or MBA (Masters in Business Administration). Other executive directors had in-service training. American college of healthcare executives (ACHE) reported that less number of female leaders obtained health administration (43%) and business (26%) as their major subject as compared to male leaders (46% and 31% respectively) (ACHE report 2012).

Along with management and leadership training the Western organizations also focused on leadership development research. For example, Steinert, et al. (2012) conducted a review from 1980-2009 from six data bases and selected 48 articles for critical appraisal of studies. Out of 48 articles only 19 articles mainly focused on leadership from 1985-2010. Out of 19, 14 studies were conducted either in medical school or academic health centers from developed countries. 12 studies were from USA, 1 from Canada and another from UK.

In contrast, Asian countries like Thailand (Chuwattannakul, 1993), India, Pakistan, and Malaysia etc. do not have trained hospital administrators in all hospitals or research initiatives in leadership development, especially in the hospital industry. In Thailand, a majority of hospital administrators are males and are chosen from physicians not formally trained to be professionally hospital administrators (Chuwattannakul, 1993). Similarly in India, a majority of hospital administrators have been basically clinicians in origin and given the post of leader in the organization either due to their seniority and experience in their

respective fields or due to their family legacy and ownership of the hospital. Thus, majority of these leaders neither hold a formal degree or leadership training, nor an administration or management degree. Lack of leadership training is noted in health and hospital industry in the Indian context as well as worldwide as compared to the business industry. For example Collin's (2002) meta- analysis reported that 24% of the leadership development programs were conducted in the business industry and only 8% leadership development programs were conducted in the hospital industry. Thus leadership training and development of the hospital leaders is a need of the time.

3.3.7 Leadership training and development in the hotel industry:

Labor intensive nature of the hospitality industry need high manpower and labor in comparison to other industries. Turnover of employees in the hospitality industry is very high, it ranged from 70% to 100% and also cited sometimes it is 300% (Ho,J., 2001). The average turnover time is less than 2 years in the hospitality industry in the USA and UK (Ho,J., 2001). Ho, J. (2001) thinks appropriate leadership training can reduce turnover rate in the hospitality industry. Leadership training benefits for both the organization and the employee. Organizations benefit from the reduced turnover, increased productivity and improved dedication. On the other hand, leadership training helps the employees to develop skills, self-esteem and job satisfaction (Ho, J., 2001, pg4).

The Hospitality industry spent the least amount on leadership training and development. "VanBuren and King (2000) studied training practices of more than 900 organizations in Europe, Canada, Australia, the United States (U.S.), Japan and Asia. The European organizations spent the highest percentage on employee training in comparison to employee payroll in other countries. The U.S. respondents averaged the most amount spent on training per employee. Asia spent the least amount on employee training in comparison to the percent of their total annual payroll" (as cited in the Ho, J., 2001, pg 10). Janes (2000) found that

the top five reasons why hospitality or lodging organizations failed to provide employee training were namely a lack of time, high employee turnover, high business demands, cost and lastly a lack of resources (as cited in Ho, J., 2001, pg.13).

Ho, J., (2001) emphasized that "the key to provide effective hospitality leadership training is to first reduce or eliminate the training barriers for each organization and ensuring organizational culture that is committed to training as well as training design and delivery" (pg 22). However literature reported that formal education is not needed in the hospitality industry. According to the International Labour Organization (2001), the operational skills can be easily achieved on the job without a certificate (as cited in Ho, J., 2001, pg 9). Similarly, Saunders, R. (2004) highlighted gap in the leadership knowledge and skills offered by the academic organization and actual requirements in the hospitality field. He stated that, "The fact that while a lot is said about leadership, comparatively little is done to actually prepare those who will assume leadership roles in the hospitality industry: (Saunders, R., S. 2004, pg 33).

Saunders, R. suggested narrowing this gap, as author stated that, “Hospitality programs may also partner with industry to afford students the opportunity to gain insight about success of leadership practices through internships or mentoring." Working on a one-on- one basis with industry leaders and having the chance to implement theoretical knowledge practically in the workplace provide students with invaluable insight into their own” (Saunders, R., S. 2004,pg 37). Saunders, R., S. (2004) reported seven steps to establishing a foundation for leadership development:

1)Commit to investing the time, resources and money needed to create a culture that supports leadership development.
2)Identify and communicate the skills associated with leadership abilities
3)Develop the tools and measures necessary to support leadership skills
4)Make leadership skills a focus of management training: communication, team-

building, and planning.
5) Implement ongoing programs that focus on leadership skills, such as managing multiple priorities and creating change.
6) Know that in the right culture, leaders can be found at every level.
7) Recognize, reward, and celebrate leaders for their passion, dedication, and results (Saunders, R., S. 2004, pg 39).

Hospitality industry has well structured leadership training programs designed for their employees as compared to the hospital industry. Ho, J., (2001) gave examples of the hospitality organizations which conducts leadership training programs. For example, Raffles International offers Total Performance Management System (TPMS), the Four Seasons training program has their new employees go through two days of classroom orientation, one day of shadowing and then they begin to learn the specific standards of their job (Ho, pg21). At Ritz Carlton has well structured training certification for every position. It is a structured process that typically takes about twenty one days to complete (Ho, pg 22).

To recapitulate this section showed gaps in leadership training and development from various angles and gaps in leadership training in the hospital industry as compared to hotel industry. Literature also showed that hotel industry has more knowledge and work done on the leadership training and development as compared to the hospital industry. Literature also reported examples of leadership training programs existing in the hotel industry.

3.4 Leadership style, generation and age:

Historical perspective on leadership reported that leadership styles differ as per the generation (Table 2) and age of the leader. Each generation has adopted different leadership styles suitable for that generation as mentioned in Table 2. Leaders need to understand generation gaps along with lifestyles, culture and ethnicity related to their own leadership style as well as that of their employees; 'Cross generational harmony' in workplace is a crucial task for the leader. According to Kennedy (2003), cross generational harmony means: "Boomers can learn to manage, motivate and retain generation Xers and generation Xers can try to appreciate the boomers' knowledge of organizational history and culture and their work ethics" (Kennedy, M., 2003, pg. 23). Boomers can mentor generation Xers and in return generation Xers can update boomers with technological advances (Kennedy, M., 2003).

However, healthcare industry is struggling to maintain this cross generational harmony. The generation Xers are criticized by the baby boomer physicians for their laid- back work habits, lack of motivation and commitment (Kennedy, M., 2003). Majority of current CEOs (ages between 50-60 years) in health care are from 'baby boomers era'. These experienced top level leaders have knowledge and experience of leadership but we hardly observe the transfer of this knowledge and skills related to leadership from these baby boomer CEOs to the next generation. Janssen emphasize that the current leaders from the healthcare field need to mentor the next generation health care leaders (Janssen, 2004, pg 3).

Many reasons have been reported in the literature for why organizations need to prepare young leaders. For example, Crainer and Dearlove (1999) mentioned that — "demographic predictions in the United States suggest that the number of 35 to 44 year olds - the traditional executive talent pool- will fall by 15 percent between 2000 and 2015. At the same time, the number of 45 to 54 year olds- the

current senior executive population-will rise" (as cited in Kao, et al., 2006, pg. 22). When these executives retire then who is the successor/ who takes over? Thus, it is important to train the nexters for future leadership positions. Currently "Companies are about to be engaged in a war for senior executive talent that will remain defining characteristics of their competitive landscape for decades to come" (Barner, R. 2000, pg 47). Another reason is that currently employees want to receive guidance and support, rather than the use of traditional ways of management done by their leaders. They need to be valued and supported in decision making within the organization than merely having had to follow the orders of their superiors. Leaders need to enhance creativity and innovation in their organization. This will satisfy the needs of the younger generation and help to engage them and groom them for future leadership positions.

The above mentioned claim of Crainer and Dearlove (1999); and Kao, et al., (2006) is supported with further evidence. For example, Frey, et al. (2009) reported the median age of management graduate students was 34 years. In Benjamin, L. and Flynn, F. (2006) studies on leadership styles of students reported in their first study sample (MBA students) mean age was 35 years. In the second and third study samples mean age of participants was 22 and 21 years respectively (Benjamin and Flynn, 2006). Janssen (2004), and Xirasagar, et al., (2006) studies also reported that mean age of hospital CEOs and executive directors was around 50 and 52 years respectively. In short, evidence showed that individuals may possess top and middle level leadership positions approximately above the 45 years of age. If organization does not prepare youngsters for future leadership positions; organization may face competition to appoint new top level leaders or many have to retain the existing top level leaders.

Age influences the leadership styles of the leaders. However, findings reported in the literature are contradictory to each other. For example, in Janssen's (2004) study, the younger CEO reported higher mean score on the transformational

leadership style as compared to older CEOs (Janssen, 2004). In contrast, Nurse (2010) reported that transformational and laissez-faire leadership styles were not significantly correlating with the age of CEOs of Ontario and Florida hospitals. On the other hand, the transactional leadership style was positively correlated with age of CEOs of Ontario as well as Florida hospitals (Nurse, 2010).

Apart from age, other demographics like gender also influence leadership style of the leader.

3.5 Leadership style and gender:

Leadership style and gender is a much debated topic. This debate is highlighted at the beginning of this section followed by a discussion of various factors resulting in gender bias. Various solutions have been adopted by countries to narrow gender and leadership gaps. At the end, this section has discussed gender in relation to the leadership positions in the hospital and the hotel industry.

3.5.1 Debate on Leadership Style and Gender:

Leadership style and gender is a much debated topic in the literature. Debate starts with the terminology itself. Common terminologies used in the literature on leadership style were “gender”, “sex”, “women”, “men”, “feminine”, and “masculine” (Eagly and Johnson, 1990; Alimo - Metcalfe, B. 2004; Snaebjornsson and Edvardsson, 2013). Whether these different words represented gender or differ in understanding was not clear from the literature.

Alimo-Metcalfe, B. (2004) reported that most of the studies from the “Great Man / Trait Theories” to the most recent ones on leadership have highlighted gender difference in relation to leadership. It can be argued that leadership theories also have gender difference within it. For example: the 'Great Man Theory' is biased as it is focused on male rather than female. There is no mention of a “women” in this theory.

Currently, leadership demographics are skewed towards male leadership compared to female leaders. Traditionally, when the word ‘leader’ is stated, an individual imagines a masculine image of a leader; even female leaders perceive the same. Snaebjornsson, and Edvardsson, (2013) stated that women are more convinced than men that a successful manager is a “male”. One third of women and men perceived a successful manager’s leadership style to be masculine. A

high level of agreement between male and female perceptions was noted as to the levels of instrumental traits which successful leader should possess. Interestingly, both male and female managers tended to use the pronoun "he" when describing a “successful manager/ leader” (Snaebjornsson and Edvardsson, 2013, pg 96). “…women see themselves as either androgynous or feminine, but they see top managers as more masculine than themselves” (Snaebjornsson and Edvardsson, 2013 pg 97).

Apart from the perception of leadership and gender; gender also influences leadership roles, hiring and promotional activities within the organization. Although, proportion of male and female leaders on managerial or leadership position within an organization is equally important (Alimo-Metcalfe, B., 2004), evidence shows contradictory findings. Significant relationship has been established by the scholars; between gender, leadership style and leadership position within an organization from 1990 till date (Eagly and Johnson, 1990; Janssen 2004; Snaebjornsson and Edvardsson, 2013).

For example, The American College of Healthcare Executives (ACHE) conducted periodic surveys on leadership and gender. Total five studies have been reported on gender and leadership position during the year 1990, 1995, 2000, 2006, and 2012. These reports showed that the number of male CEOs doubled (22%) as compared to the number of female CEOs (11%) from 1990 till 2012. It showed that the female leaders were fewer in number and held less CEO’s positions as compared to male leaders in 2012 in USA. In contrast, 33% of departmental head positions were held by females as compared to males (26%) (ACHE report 2012). Likewise, Alimo-Metcalfe, B., (2004) reported that in UK, 90% of top management posts were held by men and they were the ones who recruited the people for the top level positions.

Gibson, C.B., and Marcoulides, G.A., (1995) study was done across four countries namely Australia, United States, Norway and Sweden. In their study,

55% were males and 45% were female leaders. Norway had equal percentage of male and female leaders. Sweden had higher number of female leaders (55%) as compared to the male counterpart (45%). Australia had an opposite picture with male (59%) leaders outnumbering female (41%) leaders. Likewise, USA had the highest number of male leaders (69%) among these other three countries as compared to female leaders (31%). Thus, this study supports that gender difference was present in developed countries.

However, Eagly and Johnson, (1990) reported that stereotypic gendered difference is lesser in the organizational studies as compared to studies conducted in the laboratory settings. However, the evidence put forth in the above paragraphs does not report whether studies were conducted in the laboratory settings or in the organizational settings. Thus, the debate on "gender difference and leadership" continues in the literature. There is a continuous need to study "gender and leadership" from time to time to evaluate any change in the stereotypic leadership styles (Eagly and Johnson, 1990).

People need to understand that males and females are different in their biological, mental, social and spiritual aspects. Eagly and Johnson (1990); and Rosener, J. (1990) argued that individual personality is unique, thus, a male or a female chosen for certain leadership position may not manifest the same behavior. Their roles and leadership styles also differ significantly from each other. Eagly and Johnson, (1990) differentiated the belief or general tendency of male versus female. Male being aggressive, dominant and independent, are thus considered masculine; whereas, females are supposedly kind, helpful, understanding and aware of others' feelings are thus labeled feminine. Female leaders tend to focus on interpersonal relationship whereas male leaders focus on organizational goals. However, both the patterns are important in leadership and in the organization.

These characteristics reflect in the leadership style chosen by male and female leaders. Janssen's (2004) study reported a significant relationship between gender and leadership style. Eagly and Johnson, (1990) and Rosener, J., (1990) reported that women tend to adapt democratic or participative style as against the men who adopt autocratic and directive style. Ivan (2012) disagreed with these findings because in Ivan's study masculine sex orientation type showed lower score on transformational leadership style (Ivan, 2012). Male leaders use power in their execution of leadership and also use transactional leadership styles whereas female leaders use transformational leadership style and use their charismatic influence and interrelationship skills while dealing with others (Rosener, 1990). Snaebjornsson and Edvardsson reported similar results. Women leaders scored higher on social, emotional skills, and charismatic leadership as compared to men (Snaebjornsson and Edvardsson, 2013). On the other hand, Janssen's study (2004) findings indicated that in the hospital industry, male CEOs had lower mean scores for transformational behaviors and traits than their female counterparts.

Many more characteristics of female leaders have been highlighted in the literature. Female directors 'care' more for their employees compared to male directors. Female directors are more independent in their decision making and self motivating compared to male directors (Matsa and Miller, 2012). These aspects of female leadership are going to favor the appointment of female leaders in the future because one of the predictions is that, interactive and relational leadership styles of women will be more valued in the near future due to increased corporate and cultural diversity and globalization.

It is important to understand why gender difference exists for the leadership positions in the organizations. Multiple factors have been highlighted in the literature in relation to the gender differences for leadership positions.

3.5.2 Factors resulting in gender bias:

Multiple factors have resulted in skewing the discussion on “gender and leadership”. For example, doubt on the capacity and capability of female leaders, social stigma, biased attitude of the followers, policies of the top management in selecting and recruiting female leaders, and want of proper assessment checklist to evaluate competency of existing leaders and prospective male and female leadership candidates etc.

According to Glass Ceiling Theory, gender difference in leadership position is due to social stigma, and doubt and disbelief on capacity and capability of a woman. This undermines women’s attempts to gain leadership roles. It can be argued that the capacity and capability, although vary from physical, mental, psychological or other aspects, currently women have shown that they can be at par with their male counterpart. In fact, females are much stronger and they handle certain situations in a much better way, thus masculinity is not always necessary for the leadership positions. But female leaders are always compared by masculinity rather than their capacity and capability for leadership positions. When a woman leader adopts a tough and authoritative position which is a masculine style of leadership, she receives a lot of criticism.

On the other hand, when an organization is aware of the leadership capacity and capability of a female leader, the male from the top management positions are hesitant to offer the leadership positions to their female counter parts (Alimo-Metcalfe, B., 2004). Many psychological aspects have been studied in this regard. One of the major apprehensions that the males have, is competition from the female leaders and difficulty to work under the female head of the organization due to “male ego”. Lucas and Lovaglia (1998 as cited in Stelter, 2002) reported that subordinates expect higher performance from female leaders as compared to male leaders. Thus, above mentioned factors create an obstacle for female leaders to reach the top leadership positions.

This is a major road block for female leaders who have the capacity and capability to be on the higher management positions. Although women have the potential for leadership they are unable to express their desire due to societal, cultural, political, educational, economical, personal, organizational, and industrial obstacles. It can be argued that one cannot evaluate an individual's efficiency merely based on her gender and restrict her from holding the top positions in the organizations, because, studies have reported no significant difference between gender and efficiency (Snaebjornsson and Edvardsson 2013).

Another important factor which has created confusion in relation to gender dependent leadership abilities is lack of a reliable assessment tool. There is no universal check list to evaluate leadership styles for male and female leaders. Additionally there is a lack of bench marks for evaluating leadership styles for gender. Usually leadership is evaluated by traditional stereotyped leadership expectations. Lack of a universal method of assessing leadership styles makes it difficult to integrate studies on leadership styles and gender (Eagly and Johnson, 1990).

One more factor for gender differences is the 'spillover' concept. Spillover concept states "gender based expectation" for behavior (Eagly and Johnson, 1990). In certain cultures (society / organization), people expect traditional or stereotyped leadership behavior from the leaders. Thus, in order to 'fit into' the environment of an organization woman leaders may adopt masculine leadership styles which shadows their original leadership styles. Gender influences the leadership role as well as hiring and promotional activities of the organization. This pressurizes women leaders to adopt masculine leadership styles in order to get accepted in the organization. Eagly and Johnson have caught the very core of this dichotomy in the following quote: "Female leaders and managers experience conflict between their gender role and their leadership role. Another reason for spillover of gender role into organizational role is that people who hold

positions in organizations tend to have negative attitudes towards women occupying managerial roles. Reflecting the subordinate status of women in the society… studies have shown that people are often reluctant to have a female supervisor and think that women are somewhat less qualified for leadership and that female managers would have negative effects on morale" (Eagly and Johnson, 1990 pg 235) as well as male leaders doubt the capacity and capability of female leaders. Although currently multiple factors have resulted in the gender difference and leadership position, the future is much brighter for the female leaders.

3.5.3 Future female leadership:

Although, currently there is a gender difference in leadership positions nationally and internationally, this scenario is going to change and be much more favorable to support women leaders in near future. It has been forecasted that, in the coming decades, female leaders will outnumber their male counterparts; this is so because it has been observed that the number of female students are greater than male students in postgraduate management programs in India and abroad, like Masters in Business Administration (MBA), Masters in Hospital Administration (MHA). For example, Ivan's (2012) study reported that female students were admitted in double number (88) in similar postgraduate studies as compared to male students (42). This trend may change leadership positions in the future. Further, this will increase the talent pool of females for leadership positions in the near future. Hayes, A. (1999) stated that "leadership is not a new phenomenon; but women leaders are" (Hayes, A., 1999, pg 113).

3.5.4 Solutions adopted to resolve gender bias:

Snaebjornsson and Edvardsson (2013) stressed that the number of females in the leadership position is increasing. Many reasons have been stated for this. For example, it may be due to the pro-female policies like maternity leave, tax

benefits, quota system, social feminine movements (Snaebjornsson and Edvardsson, 2013). Hayes felt this change was due to the women attaining political power, economic independence, and influence either by virtue of their property, status, or experience (Hayes, A., 1999, pg 116).

On the other hand, every organization is obliged to make sure that their organizational policies give equal opportunity for male and female leaders to handle the diverse workforce (Stelter, N. 2002). In order to equalize the gender ratio, Europe has adopted the policy of gender quota (reservation on the basis of gender) for corporate boards of directors (Matsa and Miller, 2012). Law has enforced the gender equality (Snaebjornsson and Edvardsson, 2013) in various nations like Norway, Europe, and United States (Matsa and Miller, 2012). Female director ratio has doubled within three years because of mandatory quota requirements (Matsa and Miller, 2012).

3.5.5 Gender and hospital industry:

Gender and leadership is a much-researched area in various business industries, however, literature lacked evidence when it comes to leadership in the hospital industry. Only a few studies highlighted leadership in the hospital industry and the majority of studies were on the “nurse leader” rather than other leadership positions in the hospital. Xirasagar, et al. (2006) reported marginal difference in the number of male (52%) and female (48%) executive directors from the hospitals. Gender disparity was observed in giving responsibility in hospital areas in USA (ACHE report 2012). According to ACHE report (2012), female leaders were working in nursing, human resource and continuum care areas, whereas male leaders were given general management, clinical services and ancillary service areas. Disparity in salary was observed between female leaders and their male counterparts (Rosener, 1990; ACHE report, 2012). Significant pro-male gender bias was observed in promotion policy at work place in the healthcare industry (ACHE report 2012). These studies have focused on the fact that

gender bias is still a critical area in the hospital industry in this 21st century. Although laws are forcing organizations to reduce this bias, female leadership has a long way to go, especially in the hospital industry.

3.5.6 Gender and hotel industry:

The hotel industry also had similar picture in relation to gender. For example, purpose of the study by Boone, et al (2013) was to explore perceptions on women and leadership in the hospitality industry. 99 executives (54 males and 45 women) participated in the study. Although women are ambitious to achieve higher ladder in the organization their family commitments hold them from reaching it (Mooney, S., 2007; Boone, et al, 2013). Majority women reported that barriers for climbing the higher position were related to the family commitments, pregnancy, and small children (Mooney, S., 2007). Boone, et al. (2013) reported seven workplace barriers for females to upgrade themselves in the hotel industry were: Lack of mentoring, Lack of careful career planning and planned job assignments, Stereotyping, Social exclusion (ostracized from informal networks of communication), Managers do not offer good opportunities, Counterproductive behavior of male coworkers, and Inhospitable corporate culture (Boone, et al 2013). Likewise, Mooney, S. (2007) studied barriers related to gender in Australia and New Zealand's hotel industry. Mooney (2007) reported that organizational barriers prevent women from advancing within the structures of the hotel company.

Pinar, et al. (2009) studied gender diversity in the hospitality industry in Turkey. Turkish hospitality is men dominated industry. Although no relationship was observed between gender and job position in Turkish hospitality industry, results showed that 69 % males were holding the middle level position as compared to females (32%). Likewise, 67% males were holding the top level position as compared to females (33%) in the Turkey hospitality industry (Pinar, et al 2009).

This result shows males dominated top level positions in the hotel industry in Turkey as compared to females.

To conclude, this section presented themes related to leadership style and gender, factors resulting in gender bias, future female leadership, and solutions adopted to resolve gender bias were discussed in this section. Although laws are forcing organizations to reduce the bias, female leadership has a long way to go in all the industries worldwide and especially so in the hospital industry. Scarcity of information on female leadership in the hospital industry was evident during this review.

3.6 Gaps in the literature:

1) The review of literature showed that a majority of leadership style studies focused on multiple industries like manufacturing, banking, finance, information technology, communication rather than focusing on similar types and nature of industries. No study had explored and focused on the possible links among leadership styles from similar industries and compared them with each other. For example, the hospital and the hotel industry being service industries, it is important to understand preferred leadership styles in these industries. This is also a current need because one industry leader can learn leadership from the other industry leader. Thus, there is a need to explore whether any link exists between leadership style and the type of industry. Snaebjornsson and Edvardsson (2013) supported the need for exploring leadership among different industries. This has thus been addressed in this study. This research will try to narrow the gap by exploring the leadership styles adopted by the leaders from the hospital industry and then looking at the similarities and differences in leadership styles adopted by the leaders from the hotel industry.

2) Top and middle level leaders in any industry influence other employees. Thus it is important to understand the top and middle level leader's leadership styles. Very few articles were actually focused on determining the leadership styles of the top and middle level leaders within an industry. Thus it is important to explore such area in the research. To narrow this gap the current study focuses on the top and middle level leaders from the hospital and the hotel industry.

3) It is important to know whether leaders are aware of their own leadership styles. This self perception helps to guide the leader to develop desired skills and behavior to strengthen their leadership styles in the future. However,

dearth of literature was found on the self perception of different types of leadership styles adopted by the top, middle, and lower levels of the leaders within industries in general and the hospital and the hotel industry in particular. Current leaders from the hospital industry struggle to find exact leadership style to face the challenges present in the organization. Additionally, limited literature and lack of evidence on leadership styles related to the hospital and healthcare industry leave the hospital leaders with lack of direction (Janssen, 2004). Additionally, scarcity of trained leaders in the hospitals from the leadership point of view and a lack of leadership models in the hospital industry increase the need for the current study. Lack of evidence on which leadership style is most suitable and beneficial in hospital industry especially from an Indian perspective increases the need and importance of this study. Thus this study has focused on perceptions of the top and middle level leaders from the hospital and the hotel industry on ten leadership styles.

4) Literature showed a wide gap between methodologies used in leadership studies. Majority of studies had used a survey instrument for their data collection. Leadership being a complex subject it is difficult to understand leadership merely with a structured survey tool, or a quantitative design; it needs to obtain data from multiple methods of data collection techniques like interview and survey, or focus group studies, and review of documents. Thus, this study explored leadership styles adopted by the top and middle level leaders from the hospital industry and also obtained information by the leaders on leadership style in a broader sense by the mixed method study design, that is to say quantitative data was collected by the survey method and qualitative data was collected by the ‘face to face’ interview method.

5) Janssen, L. (2004) expressed that training hospital leaders for developing and strengthening leadership skills would benefit the hospital industry to face 21st centuries challenges. Literature lacks an understanding of specific leadership

training and development content or the methodology to be used for training and development of leadership. Thus, it is important to explore leaders' perception on training components and methodology which can be incorporated in the leadership training and development courses in the future especially for developing the leadership in the hospital industry. This study narrows this gap by obtaining views of the top and middle level leaders from the hospital as well as the hotel industry on leadership training and development. This may serve as guide for leadership training and development for future hospital leaders.

Chapter 4: Research Methodology

The research methodology used for this study has been designed to address complex nature of leadership in relation to the hospital industry. This study aimed at examining the leadership styles adopted by the top and middle level leaders from the hospital industry in the Pune city. This study has dealt with a comprehensive set of objectives, each of which required specific methodological approach.

To answer the below mentioned questions, this study had used a ‘mixed’ method research design, which was most suited to the context of leadership and the self perception of leaders within the hospital environments. This is supported by Marshall who stated that "...the choice between quantitative and qualitative research methods should be determined by the research question, not by the preference of the researcher" (Marshall, MN., 1996, pg 522).

Table 4 presents objectives of the study, research question, and data collection technique and method. Details of these points are described in this chapter.

Table 4: Objective, research question, data collection technique and data collection method used in this study

Objectives	Research Question	Data collection technique and data collection method
1.To assess the leadership styles adopted by the top and middle level leaders from the hospital industry and the hotel industry.	1.Which leadership styles are adopted by the top and middle level leaders from the hospital and the hotel industry from Pune city?	**Mixed method-** **Survey-** Quantitative data on 10 leadership style **Interview-** Perception of leaders regarding leadership style.
2.To explore the selected demographic details of the top and middle level leaders from the hospital and the hotel industry.	2.Is there any association between leadership styles of leaders from the hospital and the hotel industry? 3.Is there any association between demographic variables of the top and middle level leaders with the leadership styles?	**Survey-** Quantitative data on 10 leadership style **Interview-** Perception of leaders regarding leadership style.
3.To evaluate similarities and differences between leadership styles of leaders from the hospital and the hotel industry.		**Survey-** Quantitative data Demographic data sheet
4.To obtain the views of the top and middle level leaders from the hospital and the hotel industry related to leadership, and leadership style.	4.What are the perceptions of the leaders from the hospital and the hotel industry regarding leadership training and development? 5.What are the other views of the top and middle level leaders from the hospital and the hotel industry related to leadership styles?	**Mixed method-** **Survey-** Part of demographic data sheet related to leadership training. **Interview**- Qualitative data
5.To suggest recommendations based on the study findings.		

4.1 Mixed method research design:

This study used mixed method design. Mixed method requires combining qualitative and quantitative methods in a single study (Tashakkori and Creswell 2007) rather than using both methods in different studies. Both leadership and hospital as an organization is complex in nature, thus understanding leadership within a hospital industry requires data from both perspectives i.e. qualitative as well as quantitative. Greene, Caracelli, and Graham (1989) reported that phenomena can be studied by using either qualitative or quantitative methods separately or together with the same set of questions or different questions to assess the issue/ topic/ problem. Further Greene, Caracelli, and Graham (1989) strengthen this statement by reporting that qualitative and quantitative methods respond differently for different questions. This means mixed method helps to study the phenomenon from multiple angles, multiple perspectives, multiple positions and standpoints (Johnson, Onwuegbuzie, Turner, 2007).

Authors have debated on the definition of mixed method. Homogeneity and heterogeneity can be seen in the definitions of mixed method. This can be observed in agreements and differences in the definitions of mixed method. A couple of definitions are highlighted here to understand what is included in a mixed method framework. “Mixed methods research is a systematic integration of quantitative and qualitative methods in a single study for purposes of obtaining a fuller picture and deeper understanding of a phenomenon” (Huey Chen as cited in Johnson, et al., 2007, pg 119). After critically analyzing 19 definitions of mixed methods, Johnson, et al. (2007) proposed the following definition, “Mixed methods research is the type of research in which a researcher or team of researchers combines elements of qualitative and quantitative research approaches (e.g., use of qualitative and quantitative viewpoints, data collection, analysis, inference techniques) for the broad purposes of breadth and depth of understanding and corroboration” (pg 123). These authors have derived five themes from the definitions: 1) What is mixed? 2) Mixing stage (when and where

the mixing is carried out), 3) Breadth of mixed research, 4) Why mixing is carried out in the research, and 5) Orientation of the mixed methods research. Out of these five questions three questions suitable for the context of the current study are discussed below:

4.1.1 What is 'mixed'?

In the mixed method study, qualitative data and quantitative data are mixed to draw strong results and conclusions at the end of the study. Although mixed method research is commonly used today, one cannot deny the fact that the debate still exists on how to collect and integrate qualitative and quantitative data in mixed method studies. "Mixed method research embraces much more than the traditional dichotomy between qualitative and quantitative research" (Yin, R. 2007, pg 41). Sale, Lohfeld, and Brazil (2002) argued that qualitative and quantitative methods cannot be mixed for validation purpose or triangulation purpose but it can be combined for complementary purpose. The argument was, each method (qualitative and quantitative) studies have different perspectives; thus, it can be combined for complementary purposes, but each phenomena needs to be examined and written separately in the study (Sale, et.al., 2002). Although scholars are still debating on this point they also strongly agree that mixed method is important and there are many genuine reasons to use this method in this research study.

Similarly, in this leadership style study, it was difficult to obtain answers by merely a single method. Hence, in this study qualitative and quantitative methods were used to obtain the answers for the questions mentioned earlier. Quantitative data was obtained from the participants on ten leadership styles (namely autocratic, democratic, bureaucratic, charismatic, laissez-faire, paternalistic, transactional, transformational, visionary, and coaching leadership styles). Qualitative data was reported by the participants on eleven open ended questions related to leadership and leadership styles. These Quantitative and

Qualitative data were mixed to understand a complete picture of leadership in relation to hospital industry from the Pune city.

4.1.2 Why mixed method?

The goal of mixed method research is to draw strengths and minimize the weaknesses of both qualitative and quantitative designs (Johnson and Onwuegbuzie, 2004). Yin (2007) reported that mixed method design broadens and strengthens the research study. Number of authors reported reasons to use mixed method design (Greene, et al., 1989; Caracelli and Greene, 1993; Sale, et al., 2002; Tashakkori and Teddlie,2003; Creswell, 2003; Johnson and Onwuegbuzie, 2004; Johnson, et al., 2007; Doyle, et al., 2009). Four main reasons of mixed method can be concluded from the literature: Triangulation (greater validity), understand complete and comprehensive picture of the phenomena, draw stronger inferences (by combining and supporting results of each method), and best fit to study complex research question, and enhance rigor of the study (by overcoming limitations of single method).

In this study, mixed method design was used because of specific reasons. Main reason was to provide a better and in depth understanding of the phenomena of leadership style. Second reason was to enhance description of leadership from the hospital and the hotel industry leaders' perspectives. Third reason was to provide richer and more meaningful and complete answers to the research questions posed in this study. Due to complex nature of leadership styles, this study needed qualitative and quantitative data to understand leadership styles from various angles and give a chance to the top and middle level leaders from the hospital and the hotel industry to express their views on leadership styles which could not be otherwise captured by a single method design. Also it would have been a challenge to catch experience and expressions of individual leaders within quantitative boundaries. Collins, et al. (2007) supported this statement by stating that "In mixed methods studies, the challenge of representation refers to

the difficulty in capturing (i.e., representing) the lived experience using text in general and words and numbers in particular" (pg 268).

4.1.3 When and where the mixing was carried out?

In mixed method study, the researcher draws inferences by mixing the qualitative and quantitative approaches in a single study (Tashakkori and Creswell 2007). Many mixing strategies are reported in the literature. Mixing can occur at data collection stage, data analysis stage, or data interpretation stage. In this study mixing was carried out during the "results and data interpretation" phase of the study which has been represented mainly in the results and discussion chapters. Because this study had qualitative data and quantitative data, it needed to be analyzed separately as it was not possible to analyze these two different data by a single method of analysis. Once the analysis was done separately, then bringing the results under particular research question was easy. Thus, in this study mixing was carried out during the results and data interpretation phase.

4.2 Sample, Sampling technique and Sample size:

4.2.1 Sample:

Samples are the subset of the population researcher wants to study. To understand the sample for this study, it is important to understand the organizational structure of the hospital and the hotel industry in general.

Organizational structure:

Figure 4 and Figure 5 displays example of organizational structure of hospital industry. Figure 4 displays corporate sector hierarchy, and Figure 5 displays Armed Forces Medical College organizational structure. Organizational structure varies according to type or category of organization. For example organizational structure of the hospital for government hospital, trust hospital, private hospital, and medical college hospital varies. Leadership level in these hospitals also varies. Figure 4 and Figure 5 are examples of the top, middle and lower level leadership in the corporate hospital and the Armed Forces Medical College. In India government hospitals have complicated organizational structure. Figure 6 shows hierarchical structure of Government hospital, i.e. Civil hospital, Ahmadabad. Please note the hierarchical differences. The hierarchical differences, changes the leadership position in the organization.

Annexure 1a) presents the organogram of the Indian government hospital and medical college. This annexure 1a) is from the revised organizational structure and staffing standards for Indian government hospitals, 2013. Annexure 1 b) presents organizational chart of the government medical college and hospital, Chandigarh.

Organizational structure

Figure 4: Example of organizational structure of the corporate hospital

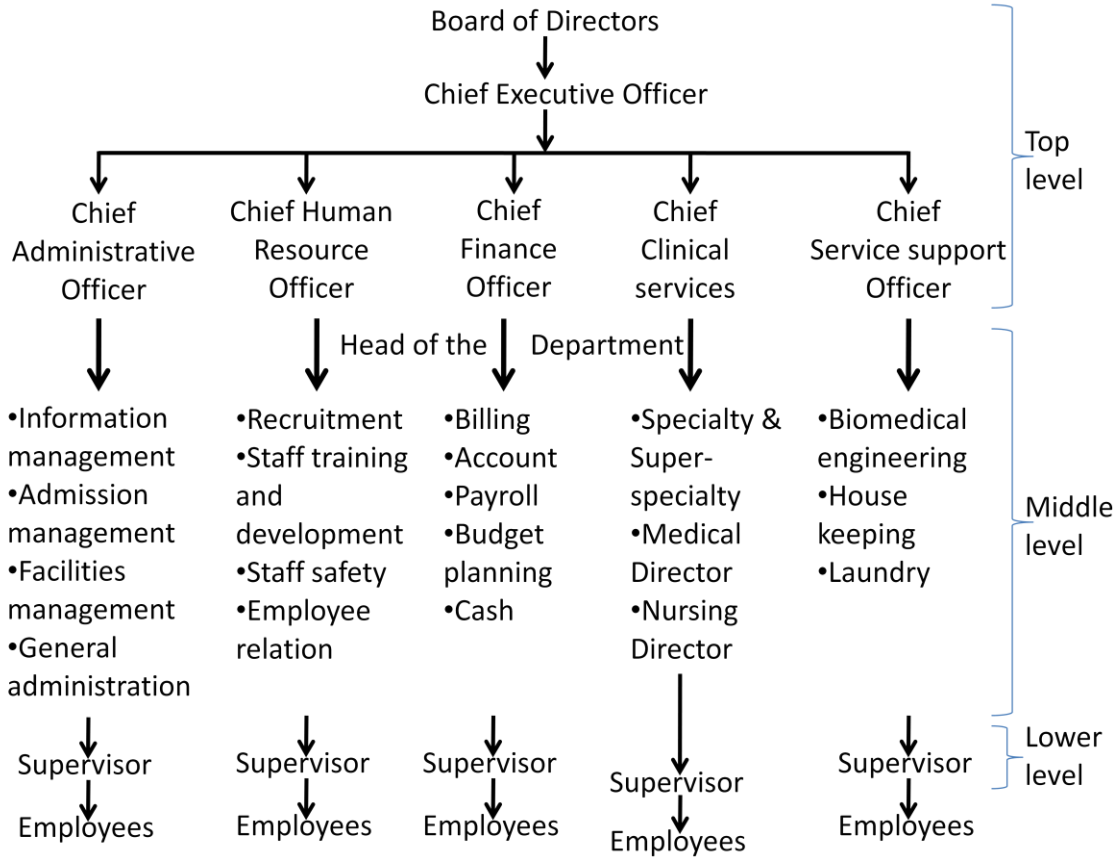
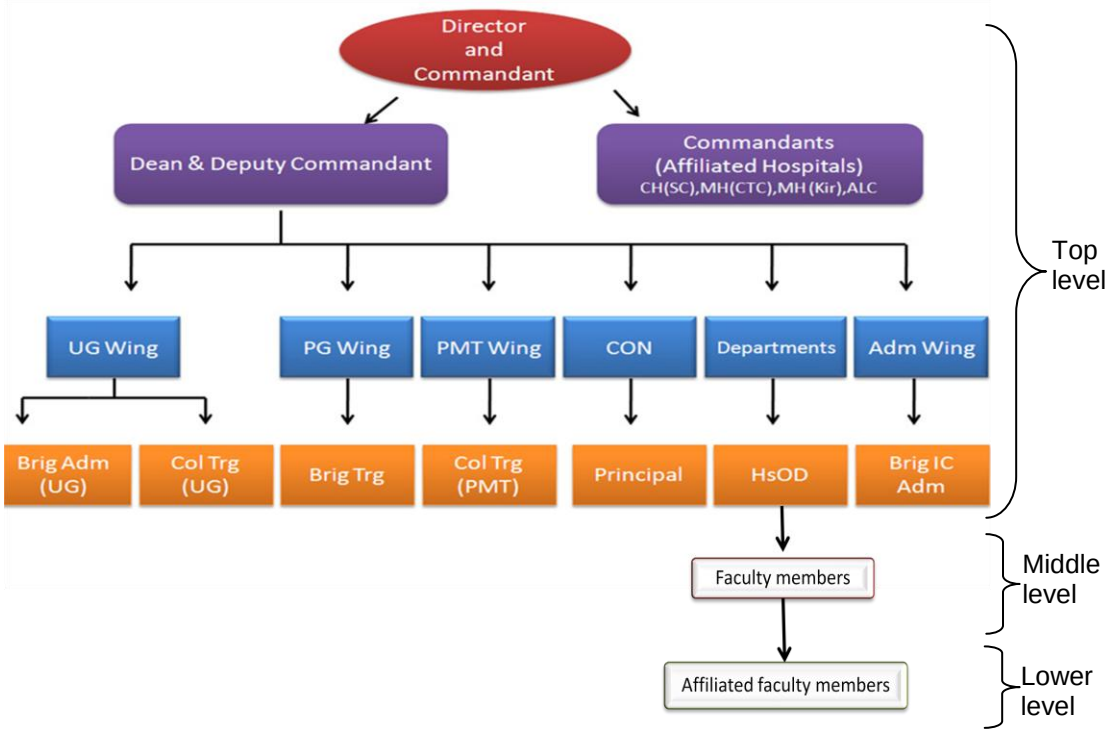
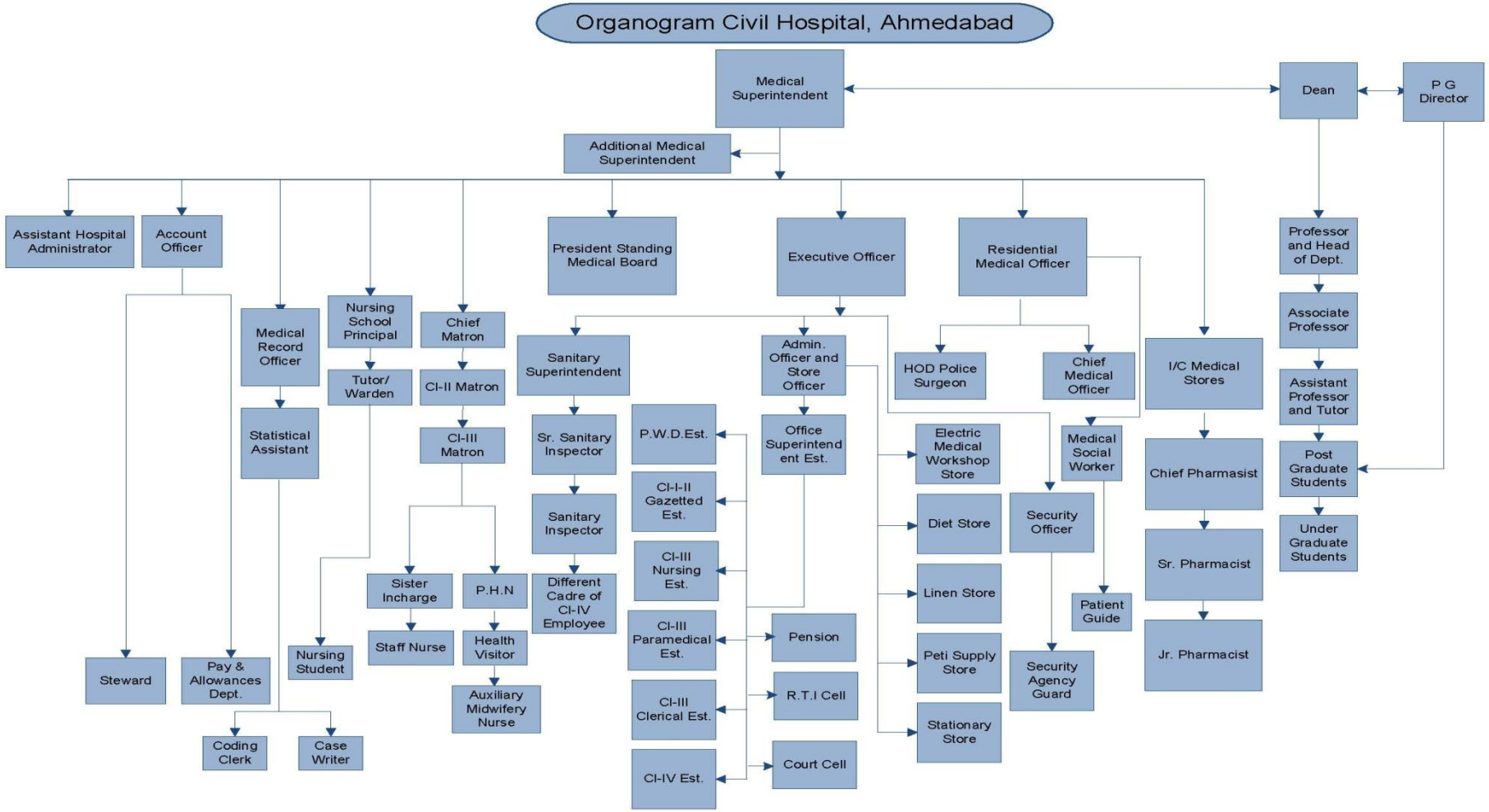


Figure 5: Organizational chart of Armed Forces Medical College



Administration Structure of Armed Forces Medical College
Source: http://www.afmc.nic.in/Departments/Administration/administrationchart.html

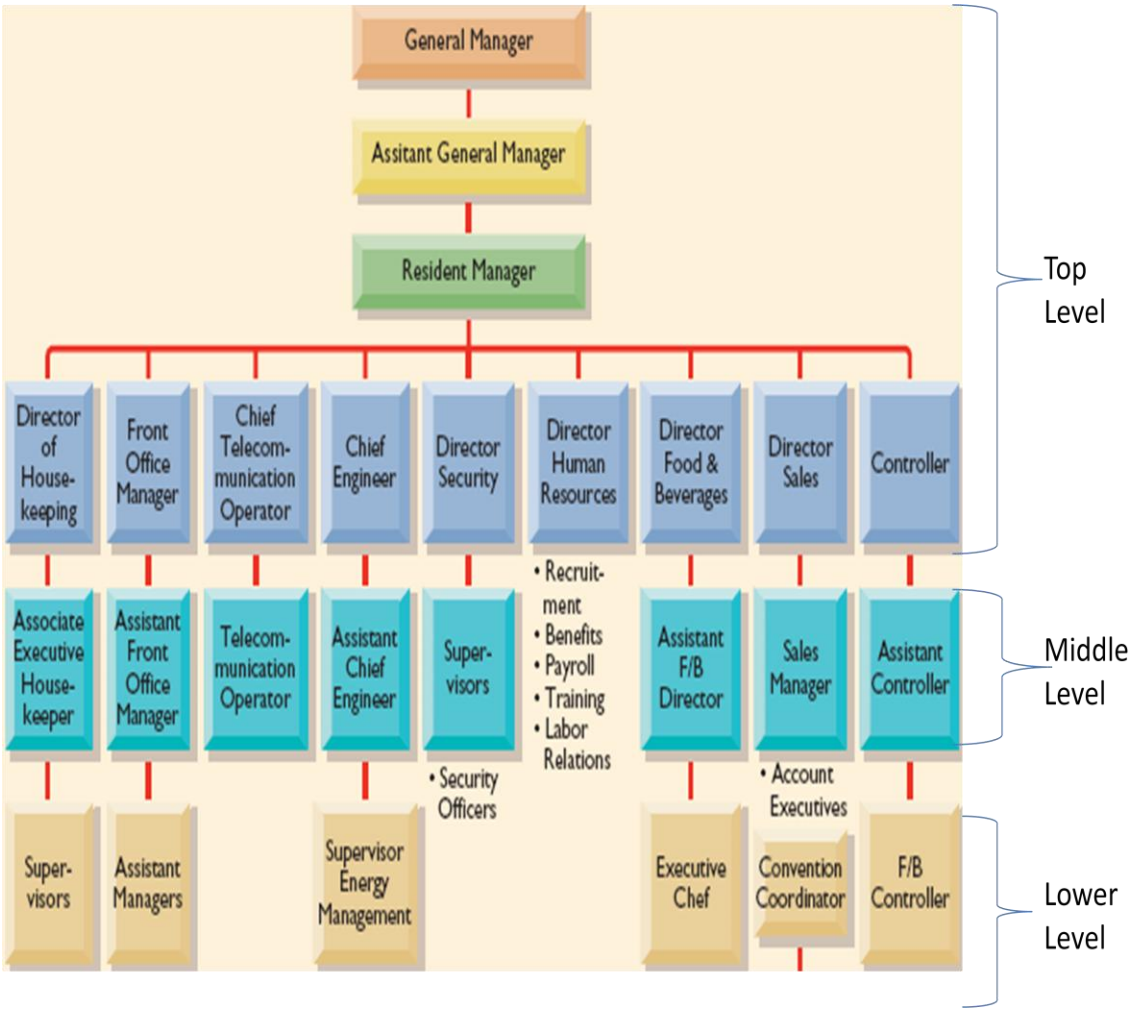


Source: http://civilhospitalamdavad.org/wp-content/uploads/2012/04/Organogram.jpg

Figure 6: Organogram of Civil hospital, Ahmadabad.

Likewise five star, four star, three star, two star, budget hotel, and international chain of hotels have different organizational structures. Looking at the hotel industry, organizational chart in general is displayed in Figure 8 as follows:

Figure 8: Example of Organizational structure of the hotel industry



Source: http://www.orgcharting.com/category/examples/ retrieved on 11th October 2015

Kvaerner et al. (1999) defined a leader as follows in their study: “Leaders were defined as chief executive officers, senior consultants, clinical department full time or part time professors, principal research officers, central and local government medical officers. Within private healthcare, and industrial concerns chief medical physicians and medical directors in research departments were defined as leaders" (Kvaerner, et al.,1999, pg 92).

This study was focused on the top and middle level leaders from the hospital and the hotel industry. Thus the top and the middle level leader’s operational definitions are as follows:

- **Top level leaders**= are the leader who hold following positions in the organizations: Chief Executive Officer, Chief operation officer, Chief finance officer, Chief quality assurance officer, Chief marketing officer, Executive Director, Director, Medical Director, General manager, Civil Surgeon.
- **Middle level leaders=** are the leader who hold following positions in the organizations: Medical Superintendent, Manager, Assistant manager, Deputy Director, Assistant director, Professor, Assistant Professor, Assistant Director.

Option was also kept open for the leaders to write their designation in the ‘any other’ category if it was not included under current job title in the tool. Leaders added following current job titles:

Top level leaders: Director Food and Beverages, Deputy General Manager, President, Trustee, Vice Dean, Professor and Head of the Department, Chief of medical services, etc.

Middle level leaders= Executive Assistant Manager, Sr. Divisional medical officer, Section in charge, Deputy Dean, Professor, Assistant Professor, etc.

4.2.2 Sampling Techniques and Sample size:

Collins, Onwuegbuzie, and Jiao (2007) suggested different sampling techniques for the mixed method study design. They reported that 'Convenience sampling' can be used by choosing settings, groups, and/or individuals that are conveniently available and willing to participate in the study (Collins, Onwuegbuzie, and Jiao, 2007). Likewise convenient sampling technique was used in this study.

This study focused on the top and middle level leaders from the hospital and the hotel industry. The reasons for selecting the top and middle level leaders from the hospital and the hotel industry was that it is the top and middle level leaders who influence the entire organization's outcome, output and behavior of their employees. Additionally, these leaders are supposed to play major roles in decision making, policies, procedure; and organization of the smooth functioning of the hospital or the hotels.

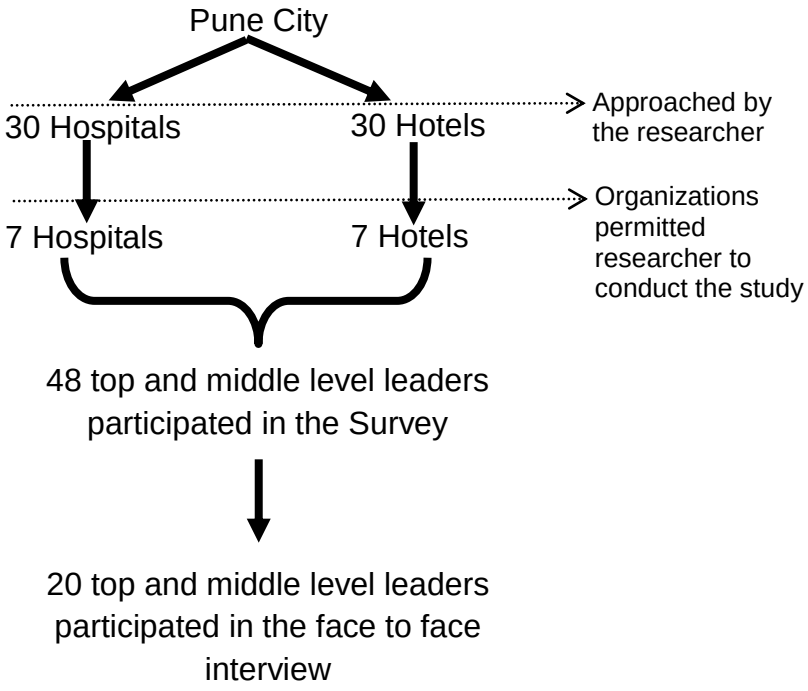
The researcher faced a few obstacles while approaching the top and middle level leaders from the hospital and the hotel industry. Mainly due to the sensitive nature of the top and middle level positions of the leaders in the hospital and the hotel industry; it was difficult to obtain appointments either to talk directly or indirectly or to obtain the permission for conducting this research study. Many organizations refused to give permission to conduct the research on their employees due to their organizational policy which restricted their employees to participate in a research study conducted by an outsider.

Another reason was obtaining appointments of the top and middle level industry leaders were rather difficult due to their busy schedule, non availability, out of station appointments, need to attend VIP guests etc. After repeated 4-5 reminder calls and/or visits, the leaders who were not responding were not included in the current study.

Majority of the organizations from the hospital and the hotel industry in Pune have hierarchical organizational structure; thus, the number of the top and middle level leaders were lesser. Therefore, the number of the top and middle level leaders from the hospital and the hotels were relatively less for this survey.

There is no defined sample size for qualitative research study however researcher is expected to study the detail phenomena with small sample size (Tuckett, A. 2004). As mentioned earlier the researcher approached 30 hospitals and 30 hotels from Pune city to obtain permission for this study. Out of these, 7 hospitals and 7 hotels permitted the researcher to visit their organizations and also allowed their employees to participate in the research. Out of this, total 48 top and middle level leaders agreed to participate in the survey (for quantitative data) and total 20 top and middle level leaders participated for the face to face interview (for qualitative data). Data saturation was reached after 18th interview but two more interviews were conducted to confirm that no new information yielded during the face to face interviews. Figure 8 presents the sample size according to the data collection techniques.

Figure 8: Sample size for the survey and face to face interview in this study.



Leaders who met the inclusion criteria (see inclusion and exclusion criteria mentioned later in this section) and gave informed written consent were included in this study. However a few leaders expressed that they were more comfortable to participate in this study by giving a verbal consent and refused to sign the written consent form. Such leaders were allowed to do so and permitted to participate in this study with verbal consent.

4.2.3 Inclusion and exclusion criteria of samples:

Due to small number of the leaders on the top and middle level positions in the hospital and the hotel industries in Pune city, it was decided to use convenient sampling method. Convenience sampling means researcher included the sample who met the inclusion criteria and who gave the consent to participate in the study and was present during the data collection period. This helped to reduce the bias in the sample selection because researcher did not select the samples purposefully. Availability and participation of the leaders in the study was the main concern of the researcher.

Inclusion criteria:

The following inclusion criteria were used for selecting leaders in the study:

- Age: above 21 years
- Both genders were included
- Industry: Hospital and Hotel only
- Designation: Top and middle level leaders.
- Those who voluntarily participated and gave a written/verbal consent to participate in the study.

Exclusion criteria of samples:

- Age less than 21 years
- Leaders from other industries
- Lower level leaders.
- Leaders who refused to participate and who did not give consent

.

4.3 Study settings:

Literature showed that authors had included various industries in their leadership studies. However, no study was focused an exploring leadership styles between these industries. Literature did not focused on leadership styles from the similar industries. The hospital and the hotel industry are similar in nature to a certain extent. For example, both industries have ongoing customers from varied backgrounds. Both industries have employees from different cultural, socioeconomic, ethnicity, nationality, educational backgrounds. Both industries have many similar natures of departments like housekeeping, food and beverages, front desk, finance and purchasing, maintenance, technology etc. Both the industries give importance to quality and satisfactions of their customers. Turnover of customers is also quiet similar in these industries. Some customer may stay in a hotel for a day or two, or some may stay longer. Hospital also has a similar pattern for example some patients may be admitted for a day care whereas other patients may stay longer. These are some of the similarities in the hospital and the hotel industry. Both the industries have people as their stakeholders. However, hospitals have sick patients whereas hotel industry may not handle sick people. The purpose of getting admission in a hospital is different as compared to ‘check in’ in the hotels. Thus, looking at the above mentioned many similarities and little dissimilarity, current study had chosen the hospital and the hotel industry from the Pune city as study settings.

4.4 Data collection methods:

Leadership research has been a central topic in management literature. Due to complex nature of leadership phenomena, it is difficult to capture the holistic picture of leadership styles in a single study by a single method (i.e. either qualitative or quantitative method) of data collection; therefore, data on leadership styles can be collected by multiple methods. For example, data on leadership styles can be collected by combination of survey, interview, observation, company records etc. (Hiller, et al. 2011). In Kao, et al. study, primary data on leadership was collected by survey method and secondary data was collected from reports, books, essays, dissertations, periodicals, and academic journals, encyclopedias, dictionaries, yearbooks, and bibliographies (Kao, et al., 2006). Although many methods have been used by the research scholars, one cannot deny the fact that each data collection method has its strength and weaknesses. Thus, using one particular method may limit particular type of information especially when studying leadership style.

Extensive review was conducted from 1985-2010 to explore which data collection method was used by the researchers to study the complex phenomena of leadership. Hiller, et al. (2011) reviewed 1,161 empirical studies from 11 journals over 25 years from January 1985 till December 2009. It was interesting to observe the preferred data collection methods by various authors reported in this literature review. Hiller, et al. (2011) study reported that survey (63%) was the most common method used by the scholars, followed by the database/company records (23%), followed by experimental manipulations accounted for 9%. Further Hiller reported that very few preferred observations and interviews together which make up less than 5% (Hiller, et al. 2011). The same study reported that survey was the most preferred method of data collection and preference rose as the years passed, from 57% (1985) to 70% (2009). This review also showed that interview method was used by only 2% of studies in 1985 which minimally rose by 1% in 2009. On the other hand, observation

method decreased from 4% to 1% during the period from 1985 to 2009. Thus, the method of data collection in a span of 25 years from 1985 till 2009 was Survey (63%), Interview (3%) and Observation (2%) and Company records and Databases 23% (Hiller, et al., 2011).

Similar trend continued after 2009. Snaebjornsson and Edvardsson (2013) showed similar findings in their literature review on leadership. Snaebjornsson and Edvardsson (2013) conducted a review for the period of 12 years from 2000-2012. This review was from a single database i.e. ProQuest data base and selected 27 articles for the final review. Out of 27 studies 11 studies used survey method, 4 studies used mixed method and 2 studies used only interview method. Thus, it can be concluded that survey was the most common method to study leadership styles for almost 27 years from 1985 till 2012.

Scholars have rationalized why authors used particular methods of data collection for studying leadership research. For example, Hiller, et al. (2011) reasoned that survey method is the easiest way to collect the data which consumes less time. However, authors encouraged using other methods of data collection like observation and interview methods to collect the data which may shed light on different perspectives of leadership. It was interesting to understand why authors did not prefer other methods of data collection for example, interview method, or mixed methods study. It can be argued that collecting qualitative data by the interview method is time consuming. In case of mixed methods study, integration of qualitative data with quantitative data is challenging. Thus, very few authors were keen to obtain the data by mixed method study i.e. by using interview and survey method together. Moreover, each researcher may have limitations of resources while conducting the study; for example, money and man power to conduct the extensive research study by using various methods of data collection for a single study.

This study has accepted such a challenge in spite of limited resources and has used mixed method study design. Data was collected by the interview method as well as the survey method. Although it was time consuming; but combining these two methods revealed very interesting findings which emerged out of this study. Thus, it was worth spending time and giving importance for different data collection methods like interview and survey together in this study.

4.5. Data collection tools:

As mentioned above, different data collection techniques i.e. interview and survey methods were used in this mixed method study; thus two separate tools were used for collecting qualitative and quantitative data. One tool was used to obtain data by the face to face interview method i.e. qualitative data and another tool was used to obtain quantitative data by the survey method.

4.5.1 Tool for collecting qualitative data:

As mentioned in the previous section the purpose of face to face interview was to obtain views of leaders in relation to leadership styles. Thus, the tool used for the interview purpose consisted of open ended questions. These questions were designed by the researcher based on the knowledge gained from the review of literature related on leadership and leadership styles. Interview questions were focused on leadership styles, need of leadership training and development, availability of leadership training and development programs within the organization, leadership styles adopted while dealing with the top, middle and lower level of employees, etc. Table 5 represents the details of the tool used for the face to face interview of the leaders. Although research questions were structured, the researcher also kept a room during the interview to probe deeper to obtain some additional information from the individual leader.

Table 5: Tool used for the face to face interview of the leaders

Number	Content of Interview Question
1	Which leadership style would be most suitable and beneficial in your organization in particular and your industry in general?
2	Do you think your leadership style has changed over the years? Explain in detail.
3	Describe your leadership style when you deal with employees from top levels.
4	Describe your leadership style when you deal with employees from middle levels.
5	Describe your leadership style when you deal with employees from lower levels.
6	Describe your leadership style when you handle a specific situation?
7	Do you think leaders are trained well in order to hold the leadership position in your industry?
8	What needs to be included in the leadership training?
9	What is your opinion on training grass root employees related to leadership?
10	Does your organization have training for developing and strengthening one's leadership styles?
11	Which factors are affecting in developing or strengthening individual's leadership style?

Table 5 consists of 11 questions which were posed to the respondents during the face to face interview. These questions were actually targeted on three areas, i.e. leadership style, leadership training, and factors affecting leadership development of an individual. For example, Interview question number Q1, Q2, Q3, Q4, Q5, Q6 focused on leadership styles. Interview questions number 7, 8, 9, 10 focused on leadership training, and Q. 11 was focused on factors affecting leadership.

4.5.2 Tool for collecting quantitative data:

The purpose of the survey technique in this study was to obtain data from the leaders by self reporting survey methods related to their own demographic details and leadership styles. The tool used for the survey consisted two separate sections: one on demographic data of the leader and another based on ten leadership styles. Details of these tools are as follows:

4.5.2.1: Demographic data sheet:

Demographic data sheet consisted items on the industry, age, gender, education, and experience of leaders (see the demographic data sheet on the next page). These items were alphabetically named as Item A to Item E. Sub items were numbered with roman number, for example D-I, D-II, D-III etc. Majority of the items in the demographic data sheet were structured with multiple choice answer options. Few items had open ended responses to elicit any other information provided by the respondent.

Demographic data sheet

Code No.

Please note: You are requested to read each item carefully and tick (√) on the appropriate box for each item that you are most agree with.

A) Industry: Which industry do you belong?

1) Hospital☐, 2) Hotel☐

B) Age in years:

1) 21- 30 years☐, 2) 31-40 years☐, 3) 41-50 years☐, 4) 51-60 years☐,

5) 61- 70 years☐, 6) above 70 years☐.

C) Gender: 1) Female☐, 2) Male☐.

D) Education:

D- I. Your highest educational status is:

1) Diploma☐, 2) Graduation degree☐, 3) Post Graduation degree☐,

4) Post graduate diploma☐, 5) PhD☐,

6) Any other, please specify☐ …….....….....……

D- II. Basic Graduation degree was in:

1) Commerce☐, 2) Arts☐, 3) Science☐, 4) Management☐, 5) Law☐,

6) Engineering☐, 7) Social sciences☐, 8) Allopathy☐, 9) Homeopathy☐, 10) Ayurveda ☐, 11) Dental☐, 12) Nursing☐, 13) Pharmacy☐, 14) Physiotherapy☐,

15) Hotel management☐, 16) Any other please specify☐ .....…

D- III. Have you had Management training? 1) Yes☐, 2) No☐

(If no skip the D- IV question and go to question D-V).

D- IV. If you had management training what was it called as?

1) Diploma in Management Administration☐,
2) Bachelor in Business Administration (BBA)☐,
3) Masters in Business Administration (MBA)☐,
4) Masters in Administration☐,
5) Masters in Business administration in Healthcare (MBAHC)☐,
6) Masters in Hospital Administration (MHA)☐,
7) Any other please specify☐.....
8) Not applicable ☐

D- V. Have you had any leadership training? 1) Yes☐, 2) No☐

(If answer is no then skip the D- VI to D-XI questions and answer question E).

D- VI. Type of leadership training: 1) Formal☐, 2) Informal☐, 3) Both formal and Informal☐,

4) On the job☐, 5) any other please specify☐ .....,

6) Not applicable☐

D- VII. If Yes, When did you have Leadership training?

1) During graduation degree☐, 2) During Post graduation degree☐,

3) During diploma☐, 4) During In-service education☐, 5) during workshop☐,

6) Any other please specify☐.....,

7) Not applicable☐

D- VIII. When was your last leadership training? 1) Before 3 months☐, 2) 3-6 months☐,

3) 6-9 months☐, 4) 9months- 12 months☐, 5) 1-3 years☐, 6) 3-5 years☐,

7) 5 years and more☐, 8) Not applicable☐

D- IX. How many <u>Total</u> days of leadership training you had?

1) Half a day☐, 2) one day☐, 3) 2-4 days☐, 4) 5-7 days☐, 5) 7-15 days☐,

6)15 days – one month☐, 7) 1 -3 Months☐, 8) 3 - 6 month☐, 9) 6-9 months☐,

10) 9months - 1year☐, 11) 1-2 years☐, 12) more than 2 years☐, 13) Not applicable☐

D- X. Do you feel leadership training you received was adequate to carry your job as a leader?

1) Yes☐, 2) No☐, 3) Not applicable☐

D- XI. If leadership training was not adequate then what needs to be included in the leadership training in the future ....…….....

……

……..……

……..……

……

E) <u>Experience:</u>

E- I. How many (total) years are you holding a leadership position?

1) less than 1 year☐, 2) 1-5 years☐, 3) 5-10 years☐, 4)10-15 years☐, 5)15-20 years☐,

6) More than15 years☐

E- II. Since how long are you holding <u>current</u> leadership position?

1) less than 1 year☐, 2) 1-5 years☐, 3) 5-10 years☐, 4)10-15 years☐, 5)15-20 years☐,

6) More than15 years☐

E- III. What is your <u>current</u> leadership position in your organization?

1) Top level☐, 2) Middle level☐, 3) Lower level☐, 4) Consultant☐

E- IV. What is your <u>current</u> job title?

1) Chief Executive Officer☐, 2) Chief operation officer☐, 3) Chief finance officer☐,
4) Chief quality assurance officer, 5) Chief marketing officer☐, 6) Executive Director☐,
7) Director☐, 8) Deputy Director☐, 9) Assistant director☐, 10) Medical Director☐,
11) Medical Superintendent☐, 12) Civil Surgeon☐, 13) Manager☐,
14) General Manager☐, 15) Any other, please specify☐ .....
.....

E- V. How many employees are working in your organization?

1) 1-100☐, 2)101-200☐, 3)201-300☐, 4) 301-400☐, 5) 401-500☐,
6)More than 501☐, 7) Not applicable☐

E- VI. How many employees are working under you?

1) 1- 25☐, 2) 26-50☐, 2) 51-100☐, 3)101-200☐, 3)201-300☐, 4) 301-400☐,
5) 401-500☐, 6) More than 501☐, 7) Not applicable☐

4.5.2.2 Leadership style assessment tool:

The second part of the survey tool was focused on ten leadership styles namely autocratic, bureaucratic, democratic, charismatic, laissez faire, paternalistic, transactional, transformational, visionary, and coaching leadership styles. The reasons for selecting these ten leadership styles were:

Literature reported that transactional, transformational and laissez faire leadership styles were studied more than other leadership styles like autocratic, bureaucratic, democratic and paternalistic. Commonly, in the Indian scenario, autocratic, bureaucratic, democratic, paternalistic leadership styles are well known by the general public and are commonly utilized in the system within the organization which was observed by the researcher. These styles are also commonly expressed in management books. On the other hand, visionary and coaching leadership styles are not commonly utilized, or known, in general industry. However, these leadership styles are also equally important. Scarcity of literature was noted on the coaching and visionary leadership styles. Some of the characteristics of leadership style are overlapping within different leadership styles. For example: transformational and visionary, paternalistic and coaching have strong overlaps. Democratic leadership style has certain components of the transformational type. Autocratic and bureaucratic have a few similarities. Mainly, none of the available tools in the literature were covering all the ten styles of leadership mentioned above. Thus, a survey tool was developed as an innovative one which represented all ten leadership styles. This survey tool was developed by the researcher based on the knowledge and description of these ten leadership styles from the existing literature. Table 6 represents leadership style assessment tool. Table 7 presents additional information on leadership style.

Each leadership style was represented by seven items (see quantitative data analysis section for detail distribution of items according to the leadership style). Thus, in total seventy items were presented in the survey tool representing ten leadership styles. With the help of computer generated table for random order, these items were randomly ordered in the survey tool thus, mixed the order of items related to leadership styles. The reason for doing this mix was to minimize the bias when the respondents self report related to these items. Five point rating scale i.e. never, rarely, sometimes, often and always which ranged from 1-5 respectively, was used to obtain answers from the top and middle level leaders. Experts including educationist, psychology research experts and academicians were consulted before finalizing the above mentioned five point rating scale.

The time period of “Leadership” (years of leadership experience was taken into consideration while obtaining answers from the leader on items mentioned in leadership style tool) required for this survey tool which was another tricky issue that emerged during the development of this survey tool. As mentioned in the review chapter, leadership is a lifelong process; thus, it was difficult and probably not appropriate to mention the time period to express leader’s leadership style. For example “express your leadership style in the last five years, or ten years” etc. So no time period was specified by the researcher in the tool, instead one question was added at the end of the survey tool to shed light on this aspect. The question was an open ended so that the leader could use his/her judgment to spontaneously respond to the question as regards the time period he/she had taken into consideration while answering items related to his/her own leadership styles through introspection.

Table 6: Leadership style assessment tool Code No:

You are requested to read following descriptive statements listed below on your leadership style as you perceive it. The word "others or people" may mean your collogues or employees or subordinates. Judge how frequently each statement fits you and **Tick '✓'** the appropriate rating scale. Rating scale is as follows: **1= Never, 2= Rarely, 3=Sometimes, 4= Often, and 5=Always**.

You are requested to answer all the items. Please do not leave any item unanswered.

No	Item	Never	Rarely	Sometimes	Often	Always
1	I challenge others to do things differently					
2	I create a cooperative environment for others					
3	I provide a good working environment					
4	I talk enthusiastically about the future					
5	I make final decision after obtaining views from others					
6	I strictly adhere to my role					
7	I am open to criticism					
8	I pay attention to complaints, failures and errors					
9	I feel everyone must follow my orders implicitly					
10	I micromanage					
11	I look after my employees professional and personal growth					
12	I strictly follow policies of my organization					
13	I believe more in myself rather than others					
14	I take calculated risk while implementing new ideas					
15	I penalize for errors/ mistakes					
16	I give regular praise and recognition					
17	I don't like others questioning my judgment					
18	I give rewards when individuals achieve their targets					
19	I take immediate action when I sense things may go wrong					
20	My employees must follow the line of authority					
21	I respect individual differences					
22	I am optimistic about the future					
23	I encourage ideas for future development					
24	I spend time in coaching others					
25	I am committed to my work.					
26	I create excitement and commitment in others					
27	I give frequent feedback					
28	I dictate how to do the tasks					
29	I like to maintain good relationship with others					
30	I wait until issues become critical					
31	I believe employees should obey the leader					
32	I help others to set clear developmental goals					

No	Item	Never	Rarely	Sometimes	Often	Always
33	I believe teams operate best within a clear, structured instructions					
34	I motivate and energize others					
35	I play a fatherly/ motherly role in the organization					
36	I encourage others to challenge my ideas					
37	I work as a facilitator					
38	I treat others like a family member					
39	I don't trust others while handling important tasks					
40	I work at the pace of the individual					
41	I expect everyone must do exactly what is told to them					
42	I expect everyone must follow procedures precisely					
43	I do not make myself available when needed					
44	I encourage creativity and innovation of ideas from others					
45	I give importance to rules and regulations					
46	People repeatedly seek advice and support from me					
47	I motivate others to use their creativity					
48	I communicate my vision at all levels					
49	My employees are dependent on me for task accomplishment					
50	I think long term and beyond the current problem set					
51	I inspire enthusiasm in others					
52	I make decisions independently					
53	I assign jobs and responsibilities to specific individuals					
54	I help others to improve their strengths					
55	I create hope in others					
56	I wait for others to initiate moves to meet me					
57	I avoid making important decisions					
58	I decide what is best for others					
59	I focus more on the people than the job					
60	I focus on the future rather than the past					
61	I take responsibility for my employees					
62	I participate in the task given to others					
63	I trust others					
64	I do not micro manage					
65	I am satisfied when employees achieve targets					
66	I empower others					
67	I focus more on the job output than people					
68	I believe people work best when given minimal instructions					
69	I listen to the needs of others					
70	I delegate complete authority to others					

Table 7: Additional information on leadership style Code No:

No	Item	Never	Rarely	Sometimes	Often	Always
1	I take responsibility whatever I do					
2	I believe in having transparency in all my actions					
3	I look at the problem through others perspective					
4	I believe in analyzing rationally for every decision making					
5	I share my knowledge and skills with my team					
6	I believe in accepting that there is a problem so that a solution can emerge					

4.6 Data collection protocol:

Figure 5 gives a complete framework of this study process from planning phase till reporting the results. The list of the hospital and hotels was prepared from the Pune city with the help of Internet and telephone directory. Leaders from the top and middle levels from the hospital and hotel industry were identified by contacting them on telephone, or by email or direct contact. Initially, permission from the authority of the organization was sought and then written/ verbal consents of the participants were obtained to participate in the face to face interview and survey. First face to face interviews were conducted. The interviews were tape recorded and subsequently transcribed. The interviews ranged from 20 minutes to 40 minutes, a few interviews exceeded an hour. Thus the average time spent for each interview was around 40 minutes. This ensured that a sufficient amount of time was used to be able to obtain in depth understanding of each respondents views.

Followed by the face to face interview, these leaders were given the demographic data sheet and leadership style assessment tool for self rating. Other leaders who did not participate in the interview were directly handed over the survey tool sheets for self reporting which includes the demographic data sheet and tool sheet on the ten leadership styles. The researcher collected these tool sheets from the leaders. On a few occasions the researcher had to visit the organization to collect the tool sheets repeatedly as leaders could not get time to fill up the tools after the first visit.

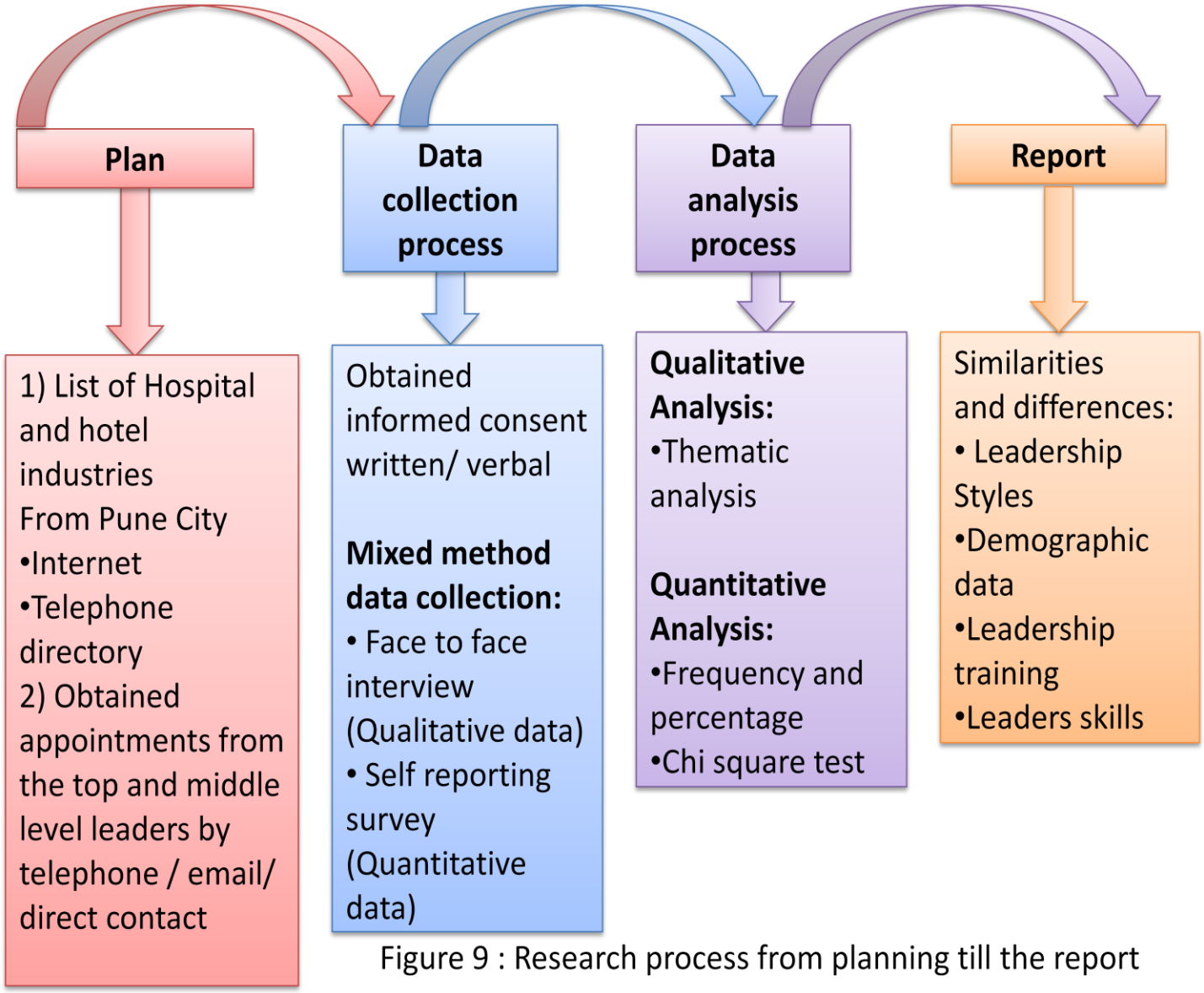


Figure 9 : Research process from planning till the report

4.7 Validity and reliability of the tool: Leadership style assessment tool was tested for validity and reliability.

Validity of tool:

Validity is the extent to which a test measures what it is intended to measure. Content, construct and face validity of the tool was done by eight experts in the field. These experts were working as leaders in the hospital industry from the clinical areas as well as from the health academia. After receiving the feedback from the experts, necessary corrections were made in the tool. For example, six items on the additional information on leadership style was added in the survey tool after the validity. The letter for the experts and evaluation Criteria for validation of the tool is presented below:

Letter for validation of demographic data sheet

and

leadership style assessment tool

To Date:

Subject: Request for validity of the tool

Respected Sir/ Madam,

I Ms. Bhagyashree Joshi, registered for PhD in Hospital Administration in Bharati Vidyapeeth University, Pune. My study is focused on exploring leadership styles adopted by the top and middle level leaders from the hospital and hospitality industry in Pune city. Kindly see the attachment for details of my research study. I request you to assess the validity of attached tool and give your valuable suggestion for any modification of the tool.

Thanking you

With regards

Bhagyashree Joshi

Attachments:

1) Brief about research study
2) Demographic data sheet
3) Leadership style assessment tool

Validity of the tool

I declare that I have read and critically assessed the demographic data sheet and leadership style assessment tool of Bhagyashree Joshi for her PhD study on “Exploratory study on leadership styles adopted by the leaders from hospital and hospitality industry from Pune city”.

I hereby report that:

☐ Both the tools are relevant to the study
☐ Language is appropriate in the tool
☐ Item content is appropriate
☐ Items construction is appropriate
☐ Rating scale is relevant to the study
☐ Score calculation for each leadership style is acceptable

The tool is:

☐Completely valid
☐Valid with minor modification
☐Valid with major modification
☐Rejected

Any other remark:

Signature of the Expert:

Name of the Expert:

Date:

Reliability of the tool:

Reliability is defined as the consistency of results from a test. Korb, K.A. stated that, if researcher administer a Likert Scale or have another measure that does not have just one correct answer, the preferable statistic to calculate the split-half reliability is coefficient alpha (otherwise called Cronbach's alpha). "Coefficient alpha (also known as "Cronbach's alpha") is perhaps the most widely used reliability coefficient. It estimates test-score reliability from a single test administration using information from the relationship among test items. That is, it provides an estimate of reliability based on the covariation among items internal to the test; hence it is also called an internal-consistency coefficient" (Webb, et al. 2006, pg 1).

In other words, estimating the reliability of test scores is to use the split-half reliability method. The test is divided into two halves selected to be as parallel as possible. "The problem with the split half reliability method is that there are several ways in which a set of data can be split into two and so the results could be a product of the way in which the data were split. To overcome this problem, Cronbach (1951) came up with a measure that is loosely equivalent to splitting data in two in every possible way and computing the correlation coefficient for each split. The average of these values is equivalent to Cronbach's alpha, a, which is the most common measure of scale reliability (Dr. Andy Field, 2006, pg.1). Value of 0.7- 0.8 is an acceptable value for Cronbach's alpha (Dr. Andy Field, 2006, pg.1).

In this study reliability test of the leadership assessment tool was done on 10 top and middle level leaders from the selected hospital and academia. "Split half method" was used to test the reliability of the survey tool. Leadership style assessment tool appeared to have more than accepted value of Cronbach's alpha reliability which is 0.881, and Spearman- Brown coefficient is 0.866 (as

mentioned above recommended acceptable value for Cronbach's alpha is 0.7-0.8) thus leadership style assessment tool is reliable. See the Table 8 for details:

Table 8: Reliability Statistics of leadership style assessment tool

Cronbach's Alpha	Part 1	Value	.769
		N of Items	5[a]
	Part 2	Value	.606
		N of Items	5[b]
		Total N of Items	10
		Correlation Between Forms	.881
Spearman-Brown		Equal Length	.937
Coefficient		Unequal Length	.937
		Guttman Split-Half Coefficient	.866

a. The items are: Autocratic, Bureaucratic, Democratic, Charismatic, Lassiez Faire.

b. The items are: Paternalistic , Transactional, Transformational, Visionary, Coaching.

4.8 Data analysis method:

This study has used ‘mixed’ method design, thus the study consisted qualitative and quantitative data. Qualitative data was collected by face to face interview method whereas quantitative data was collected by survey method. Qualitative data was in the form of quotes whereas quantitative data was mostly categorical. Because of the difference in the nature of data i.e. qualitative and quantitative data, different analysis methods were used. Qualitative data was analyzed by ‘Thematic’ analysis, whereas quantitative data was analyzed by using ‘descriptive statistical methods’ including frequency and percentage and Chi square test. Qualitative and quantitative data analysis methods are discussed in detail on next pages. Result of the quantitative and qualitative analysis has been presented together, answering each research question in the results chapter.

4.8.1 Qualitative data analysis method:

Qualitative data was obtained by the face to face interviews of the top and middle level leaders from the hospital and the hotel industry. Once the data saturation was reached interviews were stopped. Data saturation means no new concepts emerged from the interview data. Data saturation was reached around 18th interview. However to be on a safer side two more interviews were conducted to reconfirm that no new ideas emerged from the interview data. Thus, interviews were stopped after interviewing the 20th participant. A total of 20 top and middle level leaders participated in the face to face interview from which 13 leaders were from the hospital industry and 7 were from the hotel industry. Out of twenty, only 3 were female leaders as compared to 17 male leaders. Average time spent for each interview was around 40 minutes.

Interviews were preferably recorded with the permission of the respondents. Respondents who refused to record the interviews, allowed the researcher to take “hand written notes” of the interview. Thus, the researcher wrote the dialogues immediately during the interview and checked with the respondents to confirm what was written was the same as what was shared by the respondents. Interviews were transcribed ‘word to word’ by the researcher. After transcribing each interview; the interviews were read many times to develop themes, sub themes, codes and sub codes. The process of thematic analysis followed in this study was as follows:

The purpose of face to face interview was to obtain views of the leaders on 11 research questions mentioned in the tool section. Analysis of these 11 research questions was carried out by a four-step analysis approach recommended by Creswell: 1) Organizing the data, 2) Reading and understanding, 3) Categorizing and describing the data, 4) Representing and reporting (Creswell, 2007). These steps lead to ‘Thematic analysis’ (Creswell, 2007) which was used for analysis of the qualitative data in this study. Thematic analysis includes examining the data

and looking for similar patterns or themes and presenting data in figures, tables or narrative discussion (Creswell, 2007). Thematic analysis allows the researcher to determine frequency of a particular theme as well as helping to understand the meaning beyond the theme. In this study the researcher adopted an inductive approach (entering the study without pre-assumptions) to understand the meaning of themes emerged from the raw data.

In this study the researcher read scripts many times and observed emerging patterns in responses, and dimensions of expressions and experiences of respondents in the qualitative data. Based on the interview questions and data obtained from the respondents, tree structure was formulated while developing thematic analysis. In the beginning, the researcher picked up the reasonable evidences from the raw interview data and organized and tagged the ideas on the tree structure diagrams. These ideas were then labeled individually and each concept named and given a code. Thus, primarily 270 such codes were formulated. Later, these codes were refined to group them according to their similarity and relationships. After that these 270 codes were reorganized under three themes, twelve sub themes, eight codes and six sub-codes. Three main themes were developed from the interview data were as follows:

1) Leadership style
2) Leadership training
3) Leaders skills

Figures 10 shows schema of the first main theme, their codes and sub codes.

Figures 11 shows schema of the second main theme, their sub themes.

Figures 12 shows schema of the third main theme, their sub themes.

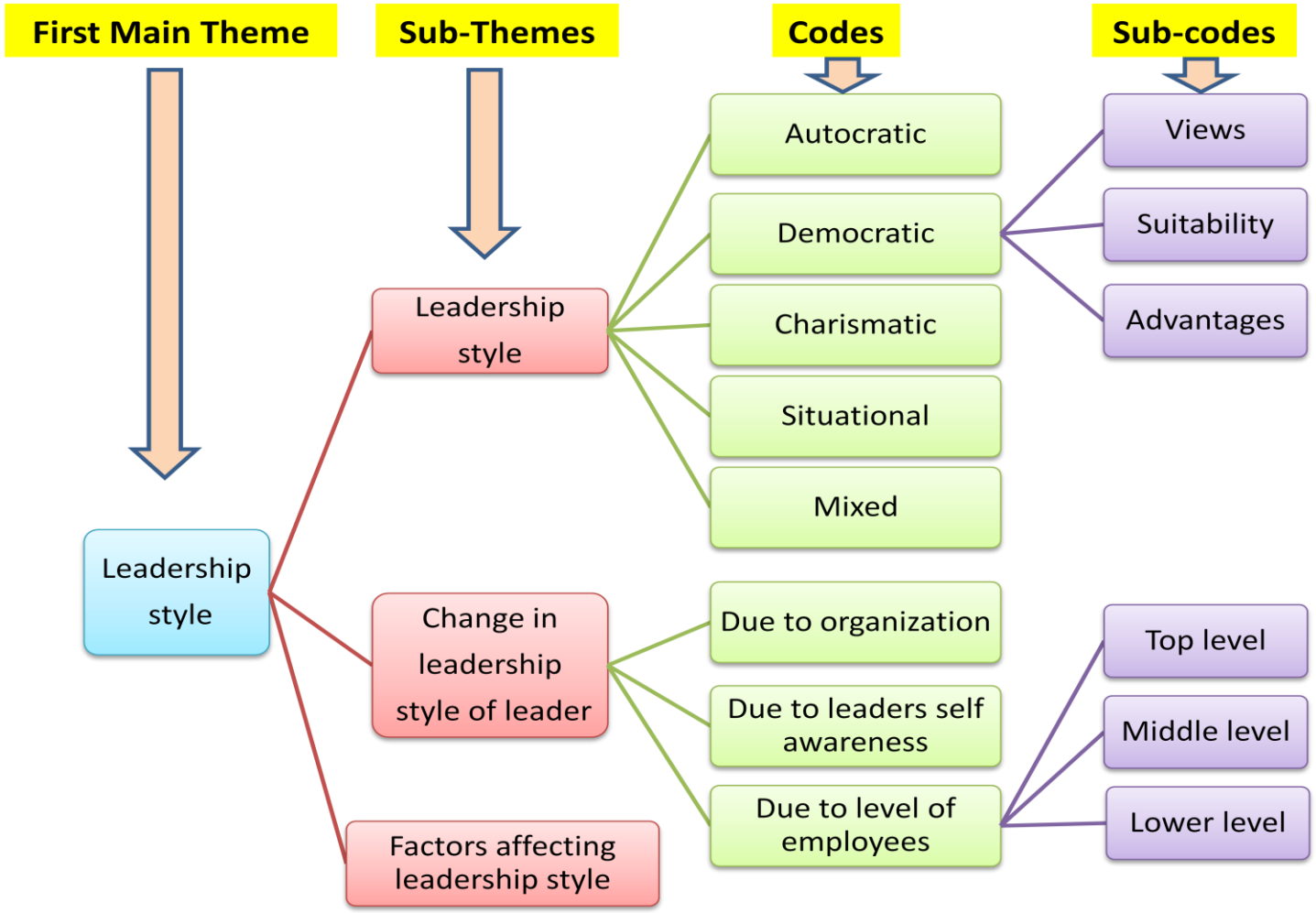


Figure 10: Thematic schema including first main theme, its sub themes, codes and sub- codes

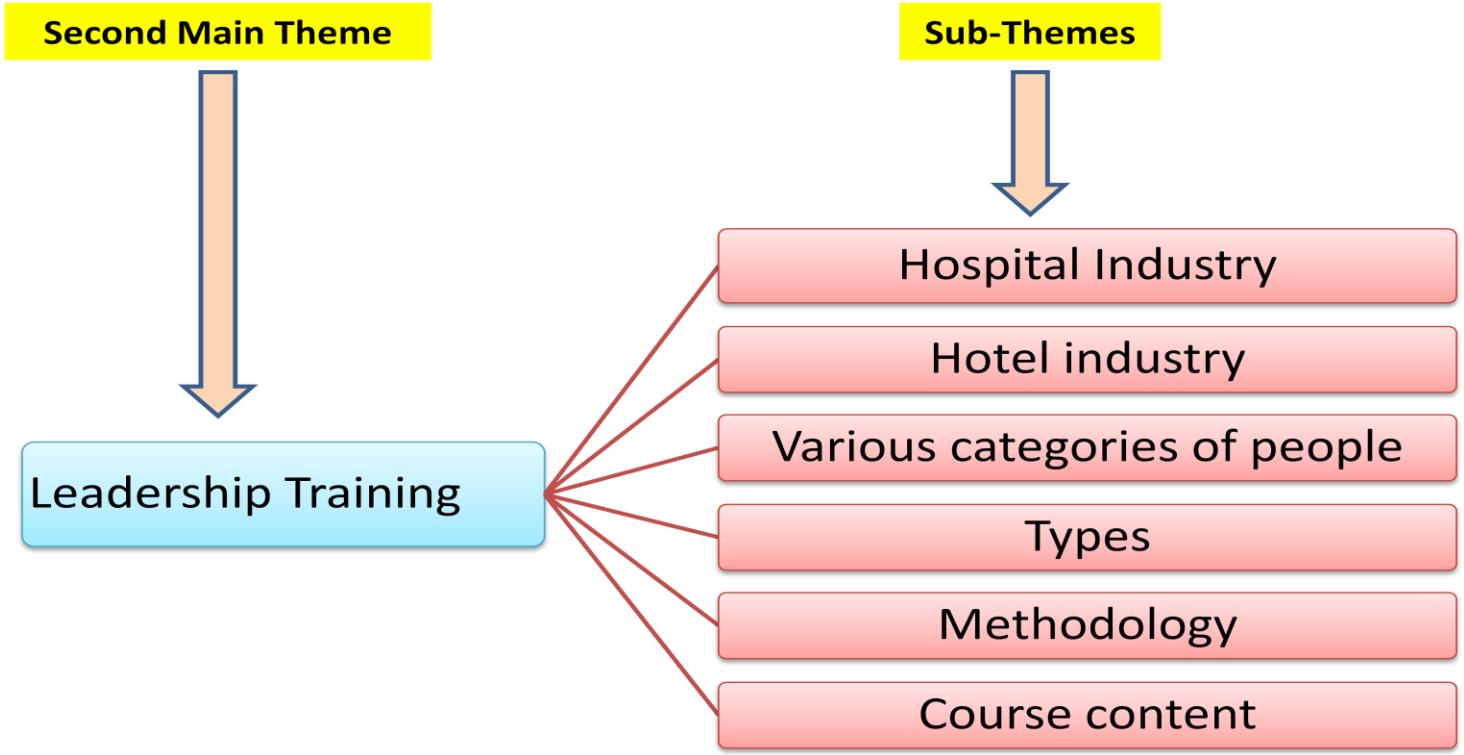


Figure 11: Thematic schema including second main theme and its sub theme

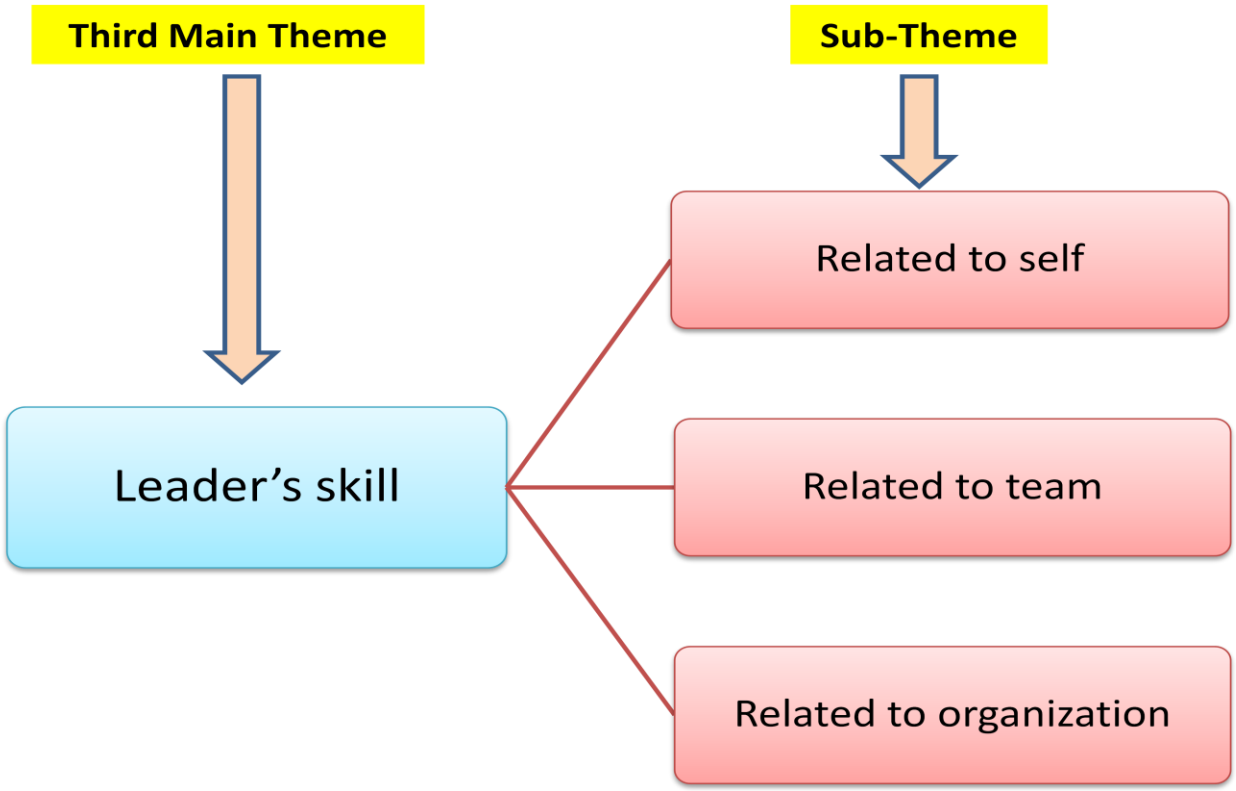


Figure 12: Thematic schema including third main theme and its sub themes

Each of the above mentioned main themes, subthemes, codes and their sub codes is presented in detail in the “results chapter”. The researcher described each ‘theme’ in the results chapter followed by the evidence from the interview data i.e. representative quotes of leaders. **Quotes mentioned in this study are direct quotes of the leaders, that is to say they were not modified or altered by the researcher**. However, in case of repetitive quotes only representative quotes were used in this study which gave a better picture of the themes, sub themes, codes and sub codes. Each leader was given unique identification such as ***‘P’ (Bold)*** for participant with numerical numbers for maintaining anonymity and confidentiality, for example, ***P5, P25,*** and ***P44*** etc. This was followed by the industry and the level of leadership of that leader. For example: ***P5 [hotel top leader].***

4.8.2 Quantitative data analysis method:

Quantitative data was collected by “self reporting survey method” from the top and middle level leaders from the hospital and the hotel industry. A total of 48 top and middle level leaders participated in self reporting survey and completed the survey tool. After survey tools were obtained by the researcher, the data was cleaned for incomplete responses. Seven respondents did not attempt more than 2-3 items in the survey tool thus these responses were rejected from the final analysis. Thus, the responses of 41 leaders’ were usable for the final data analysis giving a response rate of 85.42% for leadership style survey. This response rate is within acceptable range as per the literature for example Anseel, et al. (2010). Anseel et al. conducted a meta analysis of survey studies over 13 years, reported that expected response rate for personally distributed surveys for managerial respondents is 83 and above and for top management it is 79% at 80 percentile respectively (pg 342). Another review was conducted by Baruch and Holtom (2008) on 1607 studies from 2000-2005. They reported 53% response rate for survey studies. Thus, current study response rate is higher (>85%) as compared to these two reviews. Out of these 41leaders who participated in this study, 22 leaders were from the hospital industry and 19 leaders were from the hotel industry.

Quantitative data was entered in excel as well as SPSS version 17 for analysis purposes. As mentioned earlier, self reporting survey instrument had two sections. Section one focused on demographic data of the participants and section two was focused on ten leadership styles. After the final data sheet was ready, the demographic data was analyzed by frequency and percentages according to the top and middle level leadership in the hospital and the hotel industry and presented in the results chapter with the help of graphs and tables.

Second section focused on ten leadership styles. Each leadership style had seven items. Thus, in total there were seventy items in the survey tool representing ten leadership styles. Each leadership style had seven items.
Table 9 presents seven items for each leadership style.

Table 9: Leadership style according to their item numbers in the survey tool

No	Leadership style	Item number	Raw Scoring
1	Autocratic leadership style	6,15,17,28,39,52,67	**Total the scores of items for each leadership style.**
2	Bureaucratic leadership style	9,12,20,33,41,42,45	
3	Democratic leadership style	5,7,29,36,47,59,62	
4	Charismatic leadership style	13,25,26,34,51,55,61	
5	Laissez Faire leadership style	30,43,56,57,64,68,70	
6	Paternalistic/motherly leadership style	3,11,35,38,46,49,58	
7	Transactional leadership style	8,10,18,19,31,53,65	
8	Transformational leadership style	2,21,37,44,54,63,66	
9	Visionary leadership style	4,14,22,23,48,50,60	
10	Coaching leadership style	1,16,24,27,32,40,69	

Five point Likert Scale was used for to obtain answers related to this survey tool. All seven items for each leadership style were grouped to provide the final score for each leadership style (7 items×5 point likert scale= Total score of
35 / leadership style). Thus, for each leadership style the raw scores were out of maximum 35. Later, these raw scores were further divided under three categories as follows:
Raw scores ranging from 1-11.66 represent low score.
Raw score ranging from 11.67-23.33 represent moderate score.
Raw score ranging from 23.34-35 represent high score.

Same has been presented in the Table 10.

Table 10: Raw scores according to categories of leadership score

Raw score	Three categories of leadership score
1-11.66	Low score
11.67-23.33	Moderate score
23.34-35	High score

Additional six items were added after the validity of the tool. These items also have been same rating scale like other seventy items. Only difference is analysis of these items. These six items are presented according to percentages of top and middle level leaders from the hospital and hotel industry according to the five point rating scale. Each item was considered as individual thus the score of these six items were not combined.

These leadership style results have been presented according to percentage of leaders that obtained these scores. The results chapter also presents association of leadership style according to the top and middle level leaders from the hospital and hotel industry which has been demonstrated with the help of chi square test value.

Chi Square Test: Chi square test was used to find out the association between the selected demographic variables and leadership styles of the hospital and hotel industry leaders.

The term `chi square' (pronounced with a hard `ch') is used because the Greek letter χ is used to define this distribution. It will be seen that the elements on which this distribution is based are squared, so that the symbol $\chi 2$ is used to denote the distribution (Chapter 10, pg 704-706). Chi-square, is a non-parametric test of significance appropriate when the data is in form of frequency counts occurring in two or more mutually exclusive categories (Onchiri, S., 2013).

“There are various types of statistical relationships which can exist among variables. Each of these types of relationship involves some form of connection or association between the variables. The connection may be a causal one, so that when one variable changes, this causes changes in another variable or variables. Other associations among variables are no less real, but the causal nature of the connection may be obscure or unknown. Other variables may be related statistically, even though there is no causal or real connection among them. The chi square test provides a means of testing whether or not a relationship between two variables exists” (Chapter 10, pg 732). In other words, “Whether the calculated Chi-square value is significant is determined by comparing it with the value from table. If the calculated value exceeds the table value, then it is taken as significant otherwise it is considered insignificant (as cited in Onchiri, S., 2013, pg 18). In this study 0.05 significance levels was taken into consideration while interpreting association between variables.

The Results chapter answers the research questions posed for this study. Answers are supported with the quantitative and qualitative results together, to understand a complete picture related to the questions posed for the study.

4.9 Ethical consideration:

The researcher had obtained approval from the ethical committee organized by the University under the Faculty of Interdisciplinary Studies to conduct this study. Informed written consent was obtained from leaders before obtaining their views during the face to face interview as well as self reporting survey technique (see the information sheet and the informed consent form at the end of this section). All the leaders participating in this study gave informed written consent except seven leaders who gave a verbal consent for the same. Out of these seven leaders two were top leaders from two separate hospitals and five were the top level leaders from the hotel industry (four leaders were from one hotel and the fifth one was from another hotel) who gave verbal consent and participated in this study. The following ethical aspects were taken into consideration in this study:

Voluntary participation and withdrawal from study: Participation in the study was completely voluntary. When a leader agreed to participate in this research he/she was requested to sign the informed written consent form or give a verbal consent. Even after the agreement to participate in the study, the leader had the option to withdraw before the study commences or discontinue during the data collection process.

Confidentiality and anonymity: Researcher ensured that no clues of leaders' identity appeared in the data collection tools, thesis or any other publication. Signed informed written consent form was separated from the tool and stored in a locked cupboard; rest of the tool was coded. Information obtained by leaders was held in confidence and was safely stored in a locked facility and only the researcher had access to this information on hard copy. Confidentiality was provided to the fullest extent. No name or identity was required to be filled in the demographic data sheet and leadership styles assessment tool. These tools were coded. Data received from the participants was entered in the computer and was password protected. The hard copy of the data was saved under lock.

Written consent forms were separated from the tool and secured under lock. No identity was disclosed in the thesis or in the article publication. Data collected from the interview were coded separately and quotations of the participants were mentioned without any name or identity.

No risk/ harm to the participants: This study did not involve any physical, psychological or mental risk/ harm to the individual respondent. Possible effect on the participants was that they could reflect on their own leadership style while answering the questions. No personal data except the demographics as mentioned in the tool was collected from the participants. Thus no disclosure of any personal information was done or no sensitive data was collected in this study.

See the information sheet for the participants and the informed consent form below:

Code No:

Information Sheet for participants

Study Title: Exploring leadership styles adopted by the top and middle level leaders from selected industries in Pune city.

Researcher: Bhagyashree Joshi, PhD student in Hospital Administration, Bharati Vidyapeeth University, Pune.

Purpose of the Study: As part of the requirements for PhD in Hospital Administration at Bharati Vidyapeeth University, I have to carry out a research study. The study is concerned with leadership styles adopted by the top and middle level leaders from selected industries from Pune city.

What will the study involve? The study will involve reporting self perception about leadership styles adopted by the top and middle level leaders from hospital and hospitality industry from Pune city. It will take approximately 15 minutes for the participants to tick the sentences related to their demographics and own leadership styles, however you will be given 30 minutes to complete the forms.

Why have you been asked to take part? You have been asked because you are holding the leadership position in your organization and manage number of resources including human, money, material and time. You are suitable to provide data on my study to understand the leadership styles you have adopted in your position.

Do you have to take part? Your participation in the study is completely voluntary. If you agree to participate in this research you are requested to sign the informed written consent form. You have the option of withdrawing before the study commences (even if you have agreed to participate) or discontinuing during data collection period.

Will participation in the study be kept confidential? Yes. I will ensure that no clues of your identity appear in the thesis or any other publication. All information you

supply during the research will be held in confidence. Your information will be safely stored in a locked facility and only the researcher will have access to this information. Confidentiality will be provided to the fullest extent.

What will happen to the information which you give? Information given by you will be kept confidential from your superiors and other members of your organization. The data will be kept confidential for the duration of the study. On completion of the thesis, information will be retained for a further one year period and then destroyed.

What will happen to the results? The results will be presented in the thesis. They will be seen by my guide, statistician and the external examiner. The thesis may be read by future students on the course. The study may be published in a research journal.

What are the possible disadvantages of taking part? There are no disadvantages for participating in this study.

Who has reviewed this study? This research has been reviewed and approved for compliance with research ethics protocols by the Ethics Committee under the Faculty of Interdisciplinary Studies, Bharati Vidyapeeth University, Pune-411043.

Any further queries? If you need any further information, you can contact me: Bhagyashree Joshi, Center for Health Management Studies and Research, Bharati Vidyapeeth University, Pune-411043. Or by email address: bhagyashree.joshi@bharatividyapeeth.edu

If you agree to take part in the study, please sign the attached consent form

Informed Written Consent to participate in research Code No:

If you agree to take part in the study, please Tick (√) in the given box in front of the each sentence.

☐ I ……..agree to participate in Bhagyashree Joshi's research study.

☐ The purpose and nature of the study has been explained to me in writing.

☐ I am participating voluntarily.

☐ I understand that I can withdraw from the study, at any time, whether before it starts or while I am participating.

☐ I understand that anonymity will be ensured in the write-up by disguising my identity.

☐ I understand that my information may be used in the thesis and any subsequent publications disguising my identity.

I....., consent to participate in the research study on "Exploring leadership styles adopted by the top and middle level leaders from selected Industries in Pune city" conducted by Bhagyashree Joshi. I have understood the nature of this project and wish to participate. I am not waiving any of my legal rights by signing this form. My signature below indicates my consent.

Signature…….
Date……..
Name……

Chapter 5: Results

This study had used mixed method research design. Thus quantitative and qualitative data was generated by this method. As mentioned earlier in section 4.8 qualitative and quantitative data was analyzed accordingly. This chapter presents the combined results of quantitative and qualitative data to answer the research questions posed in this study. Each research question has been highlighted in the beginning followed by quantitative and qualitative data results. Quantitative data results are displayed in the form of percentages and chi square test results, whereas, qualitative data results are displayed with the theme, subtheme, code or *sub code* in the form of the quotes of the leaders. These quotes are direct quotes without any modification/ alteration by the researcher and these respondents quotes are displayed in *italics.* For example ***P5 [hotel top leader]*** …..

This chapter presents the results of following research questions which were posed in this study:

1. Which leadership styles are adopted by the top and middle level leaders from the hospital and the hotel industry from Pune city?
2. Is there any association between leadership styles of the leaders from the hospital and the hotel industry?

   Question 1 and 2 results are related to ten leadership styles and qualitative data related to leadership style. It also presents the results of association between leadership styles and leaders according to their industry.
3. Is there any association between demographic variables of the top and middle level leaders with the leadership styles?

   In this results show association of demographic variables (like age, gender, educational background, experience) and leadership styles of the leaders.

4. What are the perceptions of the leaders from the hospital and the hotel industry regarding leadership training and development?

   In this quantitative and qualitative results are displayed in relation to leadership training.

5. What are the other views of the top and middle level leaders from the hospital and the hotel industry related to leadership styles?

   In this qualitative results related to leadership skills are displayed.

5.1 Research Question 1 and 2

Research Question 1: Which leadership styles are adopted by the top and middle level leaders from the hospital and the hotel industry from Pune city?

Research question 2: Is there any association between leadership styles of the leaders from the hospital and the hotel industry?

Main Theme 1: Leadership style:

This section presents results related to the research questions one and two. Although researcher has presented results of quantitative and qualitative data together; researcher also has highlighted as quantitative data results and qualitative data results before describing it. Researcher felt that presenting results in this manner will help to understand the answer from both the perspectives (quantitative and qualitative) at the same time.

This study demonstrated that various leadership styles were adopted by the leaders from the hospital and the hotel industry. The hospital and the hotel industry are changing dramatically in the present era. ***P5 [hotel top leader]*** expressed that "*All hotel industry is evolving. There are new developments, new concepts, and new designs which take place almost every day in this industry. Thus, the needs of leadership and management constantly keep on evolving*". The same phenomenon is happening in the hospital industry probably much more rapidly. Thus, choosing an appropriate leadership style to handle such vibrant industries is a challenge for current leaders.

A number of different leadership styles adopted by the leader became evident from the interview (qualitative) data. All those styles which were similar were grouped under a particular code. For example, a total of five codes were created namely autocratic (or dictatorial), democratic (including participative, people oriented, collaborative and servant leadership), charismatic, situational, and mixed leadership styles. On the other hand, ten leadership styles of the top and

middle level leaders from hospital and hotel industry were assessed using quantitative data obtained by the survey method. These ten leadership styles were namely, autocratic, democratic, bureaucratic, paternalistic, laissez faire, transactional, transformational, charismatic, visionary and coaching leadership styles. Total raw score obtained by the leader related to particular leadership style are presented under three categories as low, moderate and high score:

Raw scores ranging from 1-11.66 represent low score.

Raw score ranging from 11.67-23.33 represent moderate score.

Raw score ranging from 23.34-35 represent high score.

Autocratic Leadership Style:

Quantitative data results and qualitative data results are presented in relation to autocratic leadership style.

Quantitative data results:

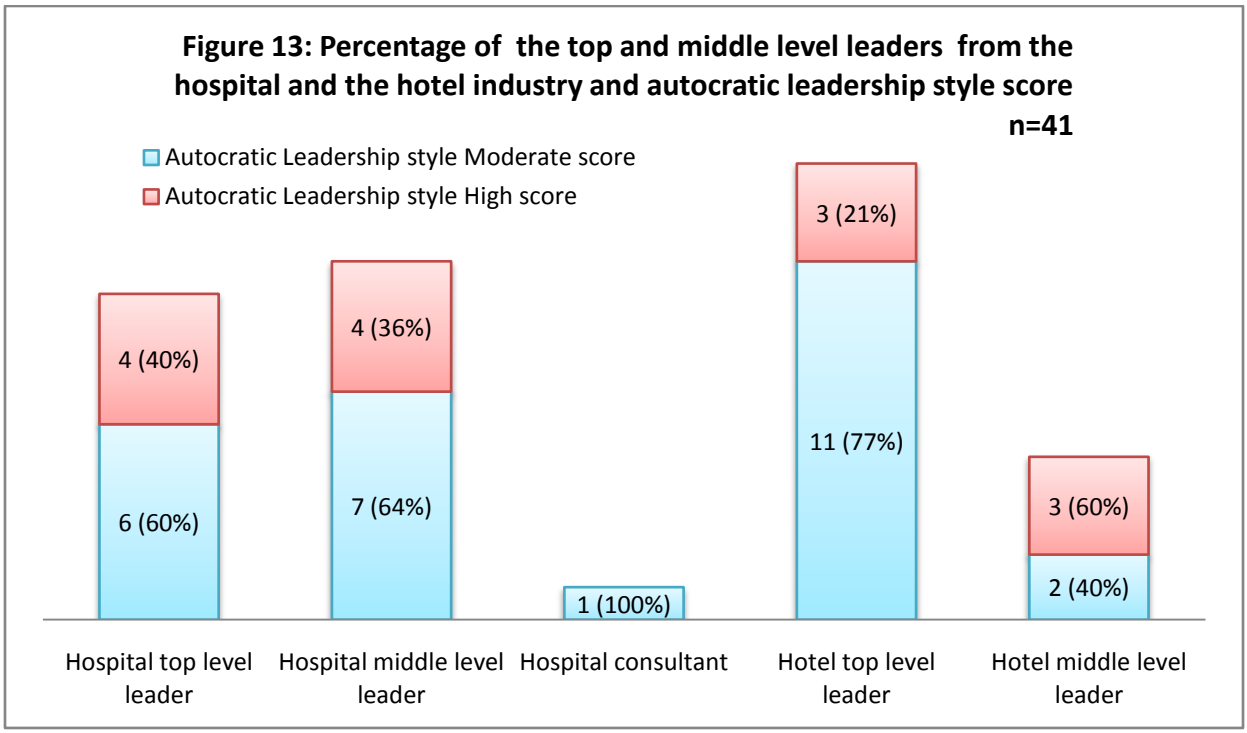


Table 11 : Association between autocratic leadership style of the top and middle level leaders among the hospital and the hotel industry		
	Top level leader	**Middle level leader**
$\chi 2$ value	.974	0.780
p value	.324	0.377
Association	**NS**	**NS**

NS= No Significant association

Figure 13 presents the results obtained from the top and middle level leaders from the hospital and the hotel industry in relation to autocratic leadership styles. Overall minimal difference was found between number of the top and middle level leaders from the hospital industry who scored high and moderate scores on autocratic leadership style. Percentage of the top and middle level leaders with

high score on autocratic leadership style was lesser in the hospital and hotel industry as compared to moderate score. No association was noted between autocratic leadership style and the top and middle level leaders from the hospital and the hotel industry as depicted in Table 11.

Qualitative data results:

Sub theme: Type of Leadership Style:

Code 1: Autocratic Leadership Style:

In contrast to quantitative data, qualitative data obtained by the interview revealed that autocratic leadership style was adopted and supported by mainly the top level leaders from the hospital as compared to the hotel industry leaders in this study. Leaders used different terminologies in order to express autocratic leadership style, like dictatorial and directional leadership style. Six leaders from the hospital industry and two leaders from the hotel industry reported that authoritative style was appropriate in their industry. Results reported that autocratic leadership style is commonly practiced in the military organizations and by the individuals handling operations of the organization. For example, leaders expressed the following:

> ***P27 [hospital top leader]****: "…you have to be autocratic only, where you have to pass the order because this is organization's requirement."*
>
> ***P6 [hotel top leader]:*** *"Where you are managing only operations or core operations... the style remains to be very directional. You give clear directions; give clear picture to people what you want from them to deliver to guest".*

Few leaders strongly expressed that autocratic leadership style should be used mainly to control the lower level employees or front line workers as well as for the employees who do not listen to the leader. For example:

> ***P28 [hospital middle leader]:*** *"…you have to keep a control. You have to show that who the boss is, so that feeling has to be there".*

> ***P6 [hotel top leader]:*** *"At the bottom level, it is more directional, where they are told 'on day today basis' what is their role…"*
>
> ***P5 [hotel top leader]:*** *"In hotel industry you have a mix of mature and immature people. You have a mix of educated, semi educated and uneducated people. It is a test of your leadership skills that you are able to understand how to handle a situation depending on whom you are dealing with. Sometimes you have extremely demanding people who would not listen. So then your leadership style should be wherein you straight away establish 'who is the boss'. Listening to them is not going to be useful. In a minute person knows I am speaking to the boss."*

In contrast, other leaders from the hospital industry also supported that autocratic leadership is not at all suitable in the hospital industry and for the current era. One leader portrayed it as follows:

> ***P27 [hospital top leader]:*** *"autocratic leadership in no way can help in healthcare industry" because "in hospital each group is different. One group would require participative leadership style whereas another group would require authoritative and directional leadership style".*

Democratic leadership style:

Quantitative data results:

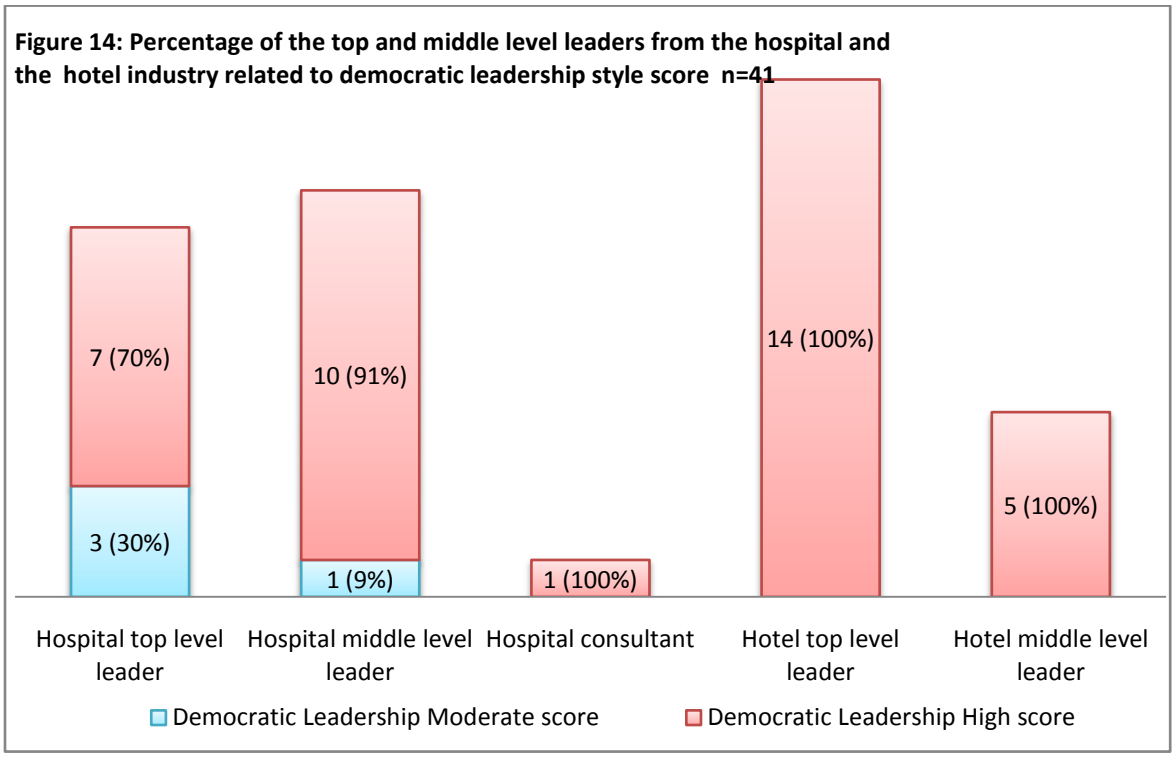


Table 12 : Association between democratic leadership style and the top and middle level leaders from the hospital and the hotel industry

	Top level leader	Middle level leader
χ2 value	4.800	.485
p value	.028	.486
Association	S	NS

S= significant association NS= No Significant association

Figure 14 depicts that 100 percent top and middle level leaders from the hotel industry gave high scores on democratic leadership style as compared to leaders from the hospital industry. Percentage of hospital middle level leaders gave higher (91%) scores for the democratic leadership style, than 70% top level leaders. Table 12 shows significant association between democratic leadership

style and the top level leaders from the hospital and the hotel industry with $\chi 2$ value 4.800 and p value 0.028.

Qualitative data results:

Code 2: Democratic leadership:

In this study various terminologies and synonyms were used by the respondent leaders for democratic leadership style. For example, participative, collaborative, people oriented and servant leadership styles. Because the expressions and meaning given by the leaders for above mentioned terminologies depict the democratic leadership style, these terminologies were merged under 'democratic leadership style'.

Three sub codes were developed from the Interview data. For example, views on democratic leadership style, suitability of democratic leadership style in the hospital and the hotel industry, and advantages of democratic leadership style. Each sub code has been described below:

Sub code I: Views on democratic leadership

Leaders from the hospital and the hotel industries expressed their views on the democratic leadership style. Empowerment and participation in decision making were two main ideas which surfaced from leaders' views on democratic leadership style. For example:

> ***P6 [hotel top leader]:*** *"I call it servant leadership model, I think it is highly successful in the hotel industry, where entire empowerment is given to the team to manage and senior team is largely positioned to take care of the support, basically to the people delivering at front end; support in terms of product, service, equipment whatever they need. This is the kind of support that leadership largely gives to these people. That is the most successful style in the hotel industry".*
>
> ***P6 [hotel top leader]:*** *"Collaborative style has been the most successful style. It brings lot of clarity to the whole team about what we are talking*

about. Lot of discussions are done with the team so that they feel they are part of the whole decision making process. In case there is any initiative …responsibility is given to respective HODs (Head of the Department), so that they feel that they are responsible to drive".

Sub code II: Suitability of democratic style in the hospital as well as the hotel industry

Leaders from the hospital and the hotel industry had similar views on democratic or participative leadership style. Both industry leaders agreed that this is the most beneficial and suitable leadership style in their industries. Various reasons were reported by the leaders to justify its suitability. For example: If the top leader uses participative style it goes down to the grass root level and followers start practicing in the same way.

P31 [hospital top leader]: *"If you are using participative style then it is definitely important to everybody on the board, not only top leadership. What happens is that it percolates down and just goes into complete organization. If I am doing participative management, immediately my immediate subordinates adopt the same style. Same is passed on throughout. So permeation starts everywhere and that permeation helps you at every level".*

P44 [hotel top level]: *"One of the key things you are talking about leaders, is they fail in people management. People management, people development is the key. All industries are same in this manner. As you grow up you realize you are not alone. You have to develop the set of people. Every level you realize whatever you do there are people watching, there are people learning, there are people looking up to you".*

Another reason reported by the leaders was, current employees have diverse backgrounds. Employees come from a higher socioeconomic strata and cultures than in earlier time. Employees have higher educational levels and richer work experience. Thus, employees expect to be treated as professionals rather than

laborers. Therefore, the leader has to understand this difference and handle them sensitively.

> ***P5 [hotel top leader]:*** *"We have employees coming in from practically every region of the country, whether it is south, north, east or west. So, obliviously they come from different cultural background, from different kind of upbringing, and from different educational background…Industry has become more people focused in terms of the understanding which requires more sensitive handling. As the people coming from grass root level are coming from good family, good backgrounds and getting training as hotel management professionals, hotel management institutes definitely need to handle them carefully because these individuals are not ready to be treated as laborer. Thus, last few decades have a lot of improvement in terms of man management skill. I believe person needs to be treated as human being first. That's very important leadership training that you do not treat different people differently because they are occupying different positions…"*
>
> ***P27 [hospital top leader]:*** *"You have to have participative style…because even subordinates working under you they are well read, they may be having better ideas, and better methodology to do what you want to do. So why not to use participative leadership style? So their views are more important than what I am having today…Yes, participative is more effective as far as long term planning and organizing is concerned".*
>
> ***P28 [hospital middle leader]:*** *"You have to know how to touch the right chord with each category of person. So if you are a 'people person' then you know what affects whom and what you can do about. You know getting the work done or getting the results from any particular category of employees, then that is how it works. That is leadership. That is how you can make a difference".*

P11 [hotel top leader]: *"You should know how to tackle people. You should have good skill of handling people. That's all is required to be a leader".*

Caring for people and treating them equally gives better results. An industry leader expressed this concept as follows:

P10 [hotel middle leader]: *"Hotel is more challenging business. If your people are happy to work in your organization, they will give 100% to that particular company, their best services. If people are not happy, working for long hours, they may not produce their potentials. As a leader I believe you have to take care of your people. It helps to win the race and they are on the top. I never differentiate people. Equality is very important to the organization. It is important to place right people at right place".*

Sub code III: Advantages of democratic leadership style

Various advantages of democratic leadership style were discussed by the leaders from both the industries. These advantages are skewed towards individual aspects rather than organizational aspects. Advantages are discussed under five sub codes as follows:

i. ***Employees learn how to think and develop participative management.*** For example:

P44 [hotel top level]*: "Why do you make participative because there are people who are looking up to you for leadership style. They get to learn when they become participative. They start thinking, "this is how my manager thinks in the situation so he/she can ask you a question why did you take a call, why didn't you think like this". One of the key things we are facing is people development. That happens only in participative".*

P45 [hotel top level]: *"People perspectives are different from others. I will be having some other perspective; you will be having some other perspective. Basically you have to teach him/ her in a particular way which fits in his/her learning. Ultimate motto is giving them particular knowledge".*

ii. ***Democratic leadership is a two way process. It empowers people, increases self importance, self image and self esteem of an individual. It involves people in decision making and at the same time it enhances individual's right to voice their own opinions.*** For example:

P27 [hospital top leader]: *"So once you go in for participative then it should be top bottom and bottom top approach".*

P28 [hospital middle leader]: *"…has to be something where people feel like empowered. They feel like that they are contributing and their inputs are given due importance and things like that. That is what probably something more inclusive where junior most people feel that they are contributing".*

P5 [hotel top leader]: *"Wherein you are very clear that you are in a leadership position wherein you listen to people and yet at the same time you are quite assertive and quite clear about vision and mission which is clearly communicated to everyone and you are also open to understanding the views of your people who are with you and also do not isolate the people".*

P11 [hotel top leader]: *"You have to take ideas from others also. You cannot only tell I want this and this, it does not work that way in today's scenario. You have to ask people to participate because their views make lot of changes".*

P31 [hospital top leader]: *"In participative leadership everybody has right to say what they feel good or bad. They have every right to voice it. If they are permitted to do so they will not have hesitation to call me or my colleagues".*

iii. ***Democratic leadership style helps to solve complex problem easily because of inputs from various people and from various angles*.**

One leader expressed:

P38 [hospital top leader]: *"Whenever you make a participative leadership possibly different people with different capabilities can solve a complex problem together rather than one person solving it. Whenever you are going to make any decision you have to take all parties into consideration. You must collect ideas from all people, screen them, even if your own opinion is different, you find that someone else is suggesting better. You must be flexible to allow that to come in and tried and ultimately there is scope for improvement. All the ideas that click your mind may not be suitable so there is always a scope for change".*

iv. ***Democratic leadership style helps to give weightage to benefit the majority rather than provide individual benefits***. For example a leader expressed as follows:

P44 [hotel top level]*: "(*When you understand others' views, you come to know that*)…eighty other employees who are not affected so you have to give that sort of weightage while making a decision. Majority benefit is taken into consideration in decision making than individual benefit".*

Bureaucratic, Laissez-faire, Paternalistic and Transactional leadership styles:

Quantitative results:

Table 13 represents more than 80% of the top and middle level leaders from the hospital and the hotel industry scored high on bureaucratic, laissez faire, and transactional leadership style. Equal percent (50%) of the top leaders from the hospital industry scored moderate and high score on paternalistic leadership style.

Table 13: Percentage of the top and middle level leaders from the hospital and the hotel industry according to leadership style (count,%) n=41

Leadership level according to industry	Bureaucratic Leadership style		Laissez-faire Leadership style		Paternalistic Leadership style		Transactional leadership style	
	Moderate score	High score	Low score	Moderate score	Moderate score	High score	Moderate score	High score
Hospital top level leader	1(10%)	9(90%)	1(10%)	9(90%)	5(50%)	5(50%)	1(10%)	9(90%)
Hospital middle level leader	2(18%)	9(82%)		11(100%)	1(9%)	10(91%)	1(9%)	10(91%)
Hospital consultant		1(100%)		1(100%)		1(100%)		1(100%)
Hotel top level leader	2(14%)	12(86%)	1(7%)	13(93%)	1(7%)	13(93%)		14(100%)
Hotel middle level leader		5(100%)	1(20%)	4(80%)	1(20%)	4(80%)		5(100%)

Table 14: Association between four leadership style of the top and middle level leaders from the hospital and the hotel industry

	Bureaucratic Leadership style		**Laissez-faire Leadership style p**		**Paternalistic Leadership style**		**Transactional Leadership style**	
	Top level leader	Middle level leader	Top level leader	Middle level leader	Top level leader	Middle level leader	Top level leader	Middle level leader
χ2 value	.098	1.039	.062	2.347	5.714	0.374	1.461	0.485
p value	.754	.308	.803	.126	0.017	0.541	0.227	0.486
Association	NS	NS	NS	NS	S	NS	NS	NS

S= significant association NS= No Significant association

Chi square test results did not show association between bureaucratic, lassiez faire, and transactional leadership style with the top and middle level leaders from the hospital and the hotel industry as showed in Table 14. However, significant association was demonstrated among the top level leaders from the hospital and the hotel industry in relation to paternalistic leadership style with the χ^2 value of 5.714 and p value 0.017.

Charismatic, Transformational, Visionary and Coaching leadership styles:

Quantitative results:

Table 15: Percentage of the top and middle level leaders from the hospital and the hotel industry according to leadership style (count, %) n=41

Leadership level according to industry	Charismatic Leadership style	Transformational Leadership style	Visionary Leadership style	Coaching Leadership style
	High score	High score	High score	High score
Hospital top level leader	10(100%)	10(100%)	10(100%)	10(100%)
Hospital middle level leader	11(100%)	11(100%)	11(100%)	11(100%)
Hospital consultant	1(100%)	1(100%)	1(100%)	1(100%)
Hotel top level leader	14(100%)	14(100%)	14(100%)	14(100%)
Hotel middle level leader	5(100%)	5(100%)	5(100%)	5(100%)

Table 15 is quite revealing. Unlike other tables this table shows that all 100 percent top and middle level leaders from the hospital and the hotel industry scored high in charismatic, transformational, visionary and coaching leadership styles.

Qualitative results:

Code 3: Charismatic leadership style:

Only one respondent from the hospital industry mentioned about charismatic leadership style. He expressed charisma comes along with the individual's expertise in the field rather than merely by leadership position. For example:

> ***P25 [hospital middle leader]:*** *"If you have to have a certain amount of leadership rising from expert or domain knowledge, certain amount I would say would be charismatic leadership. And certain amount should be through referent powers. In the sense, doctors would appreciate*

charismatic leadership or expert leadership i.e. referent leadership arising from an individual's knowledge or status. We respect a man who states I have done 10,000 surgeries that means he is an expert in the field and we listen to him even if he is not a leader of the group. But we listen to him…expertise".

None of the top and middle level leaders from the hospital as well as the hotel industry reported about bureaucratic, laissez faire, paternalistic, transformational, visionary and coaching leadership styles during the face to face interview.

Qualitative results:

Code 4: Situational Leadership style:

Half of the leaders supported that leaders should practice situational leadership style. In fact, one of the leaders felt leadership style evolves as per the situation because there are different situations and different areas across the organization. Whereas, another leader expressed that leadership style depends on the time in hand and the context of the situation.

> ***P5 [hotel top leader]:*** *"… tradition of leadership in let's say within 10 hours of work leadership role on daily basis what you put in different situations demands different management styles and it should be able to change yourself every five minutes without it affecting you".*

On the other hand, one leader expressed that it is difficult to label an individual with a particular leadership style as the individual has to demonstrate or use different styles in different situations. For example:

> ***P6 [hotel top leader]:*** *"I would say style should be known predominantly in terms of how you look at situations, both in house and on a guest front. Though styles may change as per the situations more or less very difficult to bracket somebody say his leadership style; this is how he is always going to respond but largely what is the tendency. I think we should know how we are going to react to the situations, so it is important to know whether I need to change somewhere on in the position that I am in a given situation. Is it right way or do I need to incorporate something else? I should know my style for sure in the terms of preferences of what I take most of the situations, but largely I think leaders should be able to change his functioning as per the situations. It does change according to situation, but I think since we are handling large human workforce, it has to because each one is different one".*

Various situations demands different leadership styles. In other terms effectiveness of a particular leadership style depends on the situation.

P38 [hospital top leader]: reported that, *"Actually many styles would be effective and different styles would be effective in different situations."*

P5 [hotel top leader] represented situational leadership style as:

"You have to actually wear multiple hats at multiple times. It is extremely important that a good leadership can only be provided when you are able to visualize yourself as donning different hats, depending on the different circumstances and situations we face on daily basis".

Code 5: Mixed leadership style:

Only six leaders mentioned the name of mixed leadership style. Among them one hospital top level leader expressed the essence of mixed leadership style. For example:

> ***P27 [hospital top leader]:*** *"See very difficult to say because it is going to be mixed of all… It is very difficult to answer this …because no one leadership style is 100% successful. So if you can adopt few of them, then things can definitely happen… It is kind of mix… May be different in the morning, different in the evening and may be different with different kind of people. You have to behave like that. You have to develop that kind of leadership style."*

Quantitative results:

Additional data related to leadership style:

Six items were added to the leadership style tool for obtaining additional information on the leadership styles. Results of these six items are as follows. Also see the Table 16 for details.

Item 1: Table16 shows 70% top level leaders and 82% middle level leaders from the hospital industry reported that they always take the responsibility of whatever they do. On the other hand, all 100% top and the middle level leaders from the hotel industry reported that they always take responsibility of whatever they do.

Item 2: 70% hospital top level leaders and 86% hotel top level leaders believed in transparency in their actions. Whereas, all 100 percent middle level leaders from the hospital as well as the hotel industry believed in transparency in their actions.

Item 3: Minimal variation was found in the percentages of top and middle level leaders related to the item 3 (See the Table16 for details). However, the top and the middle level leaders from the hotel industry always look at the problem through others perspectives (50 % and 40% respectively). On the other hand majority of the middle level leaders (60%) reported they often look at the problem from others perspectives as compared to the middle level leaders (46%) from the hospital industry. Only 40% top level leaders from the hospital industry always look at the problem from others perspective

Item 4: Minimal difference was found between the top and the middle level leaders from the hospital industry who reported that they often and always analyzed rationally for every decision the made. On the other hand 7 percent top level leaders never analyzed rationally and other 7 percent hotel top leaders reported that they sometimes analyze rationally for every decision making. On the contrary, the middle level leaders reported they always (40%) and often (60%) analyzed rationally before they made their decisions.

Item 5: All 100 percent top and middle level leaders from the hospital industry reported that they always share their knowledge and skills with their team

members. In contrast, 60% top level leaders and 82% middle level leaders from the hospital industry always share their knowledge and skills with their team members.

Item 6: More than 70% top and middle level leaders from both the industries reported that they always accept that there is a problem so that a solution can emerge.

Table 16:Percentages of the top and middle level leaders from the hospital and the hotel industry and additional data related to leadership style

count, (%) n=41

Current leadership level according to Industry	Item1 Take Responsibility		Item2 Believe in Transparency		Item3 Look at the problem from others perspective			Item4 Analyze rationally				Item5 Share knowledge and skills		Item 6 Accept the problem		
	Often	Always	Often	Always	Sometimes	Often	Always	Never	Sometimes	Often	Always	Often	Always	Sometimes	Often	Always
Top level Hospital Industry	3 (30%)	7 (70%)	3 (30%)	7 (70%)	1 (10%)	5 (50%)	4 (40%)			5 (50%)	5 (50%)	4 (40%)	6 (60%)		3 (30%)	7 (70%)
Middle level Hospital Industry	2 (18.2%)	9 (81.8%)		11 (100%)	2 (18.2%)	5 (45.5%)	4 (36.4%)			5 (45.5%)	6 (54.5%)	2 (18.2%)	9 (81.8%)		3 (27.3%)	8 (72.7%)
Consultant Hospital Industry		1 (100%)		1 (100%)			1 (100%)				1 (100%)		1 (100%)			1 (100%)
Top level Hotel Industry		14 (100%)	2 (14.3%)	12 (85.7%)	2 (14.3%)	5 (35.7%)	7 (50%)	1 (7.1%)	1 (7.1%)	3 (21.4%)	9 (64.3%)		14 (100%)	1 (7.1%)	2 (14.3%)	11 (78.6%)
Middle level Hotel Industry		5 (100%)		5 (100%)		3 (60%)	2 (40%)			3 (60%)	2 (40%)		5 (100%)		1 (20%)	4 (80%)

5.2 Research Question 3

Research question 3: Is there any association between demographic variables of the top and middle level leaders with the leadership styles?

Details of the demographic data sheet have been discussed in the research methodology chapter. This demographic data sheet consisted items from Item A till Item E. This section describes the quantitative results of these items in the form of graphs and tables.

Item A: Industry, and Item E III: Current leadership level

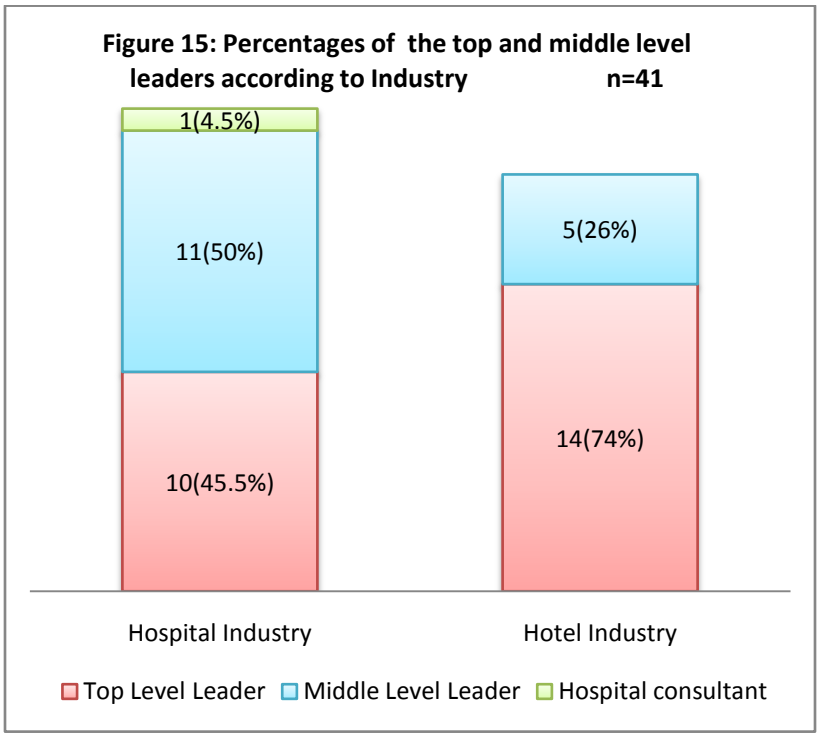


Figure 15 shows percentages of the top and middle level leaders according to the industry. Total 22 leaders from the hospital industry and 19 leaders from the hotel industry participated in this leadership survey. Top and middle level leaders were equal in numbers (50% each) within the hospital industry whereas in the hotel industry majority were top leaders (74%) as compared to middle level leaders (26%) (Figure15).

Item B: Age in years:

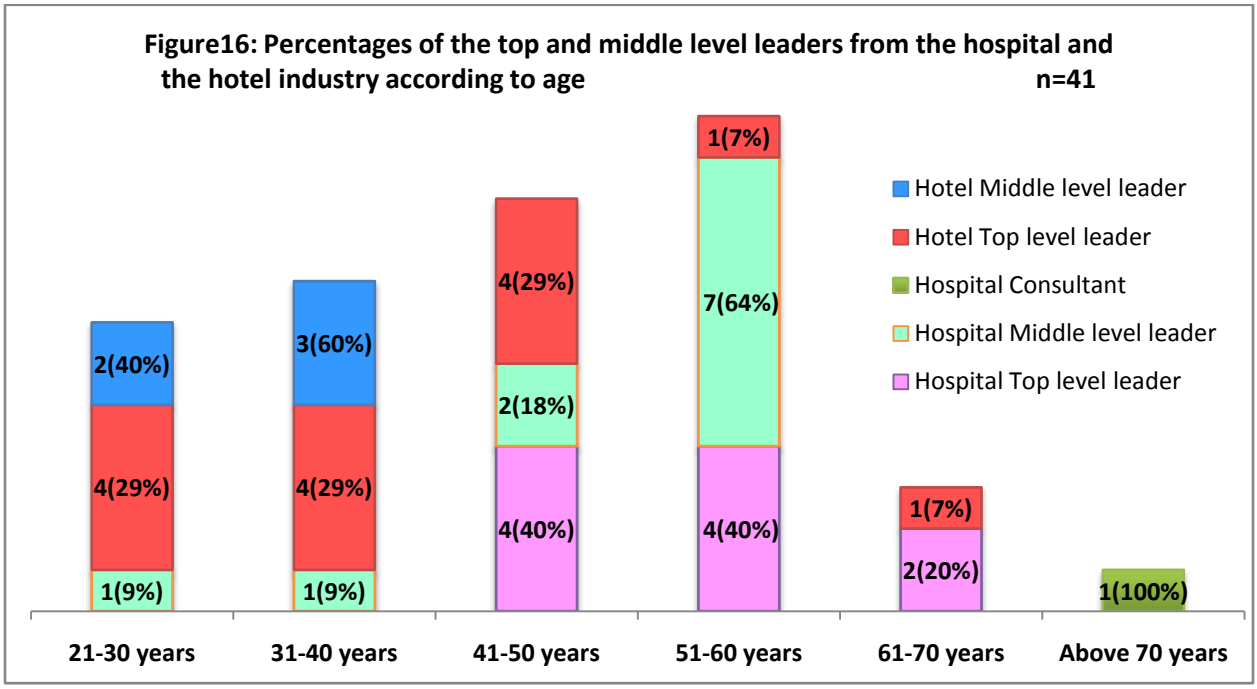


Figure 16 shows percentages of the top and middle level leaders from the hospital and the hotel industry according to their ages. Figure 16 shows all 10 (100%) top leaders and one consultant from the hospital industry were more than 41 years of age, whereas, 8 (58%) top leaders from the hotel industry were below 40 years of age and other 6 (43%) top leaders were above 40years of age from the hotel industry. Nine (82%) middle level leaders were above 41 years of age in the hospital industry as compared with only 2 (18%) middle level leaders were younger (between 21-40 years of age) from the hospital industry. In contrast all five (100%) middle level leaders from the hotel industry were younger i.e. below 40 years of age.

Chi square test result showed significant association between the hospital top and middle level leaders with χ^2 Value 27.709 and p value 0.002 as showed in Table 17 below.

Table17: Pearson Chi-Square Tests results related to age of the top and middle level leaders among the hospital and the hotel industry

Industry		χ^2Value	df	Asymp. Sig. (2-sided)	Association
Hospital	Pearson Chi-Square	27.709	10	.002	Significant
Hotel	Pearson Chi-Square	3.283	4	.512	Non significant

S= Significant association NS= Non significant association

Table 17 shows association between Democratic Leadership of the top level leaders from the hospital and the hotel industry and age (41-50 years) as Chi Square (χ^2) Value 4.800 and p value 0.028.

Table 18: Chi-Square Tests results related to Democratic Leadership style of the top and middle level leaders among the hospital and the hotel industry and their age in years

Age in years	Current leadership level		χ^2 Value	df	Asymp. Sig. (2-sided)	Association
21-30	Top level	Pearson Chi-Square				
		N of Valid Cases	4			
	Middle level	Pearson Chi-Square				
		N of Valid Cases	3			
31-40	Top level	Pearson Chi-Square				
		N of Valid Cases	4			
	Middle level	Pearson Chi-Square				
		N of Valid Cases	4			
41-50	Top level	Pearson Chi-Square	4.800	1	.028	Significant
		N of Valid Cases	8			
	Middle level	Pearson Chi-Square				
		N of Valid Cases	2			
51-60	Top level	Pearson Chi-Square				
		N of Valid Cases	5			
	Middle level	Pearson Chi-Square				
		N of Valid Cases	7			
61-70	Top level	Pearson Chi-Square				
		N of Valid Cases	3			
Above 70	Any other	Pearson Chi-Square				
		N of Valid Cases	1			

S= Significant association

Item C: Gender:

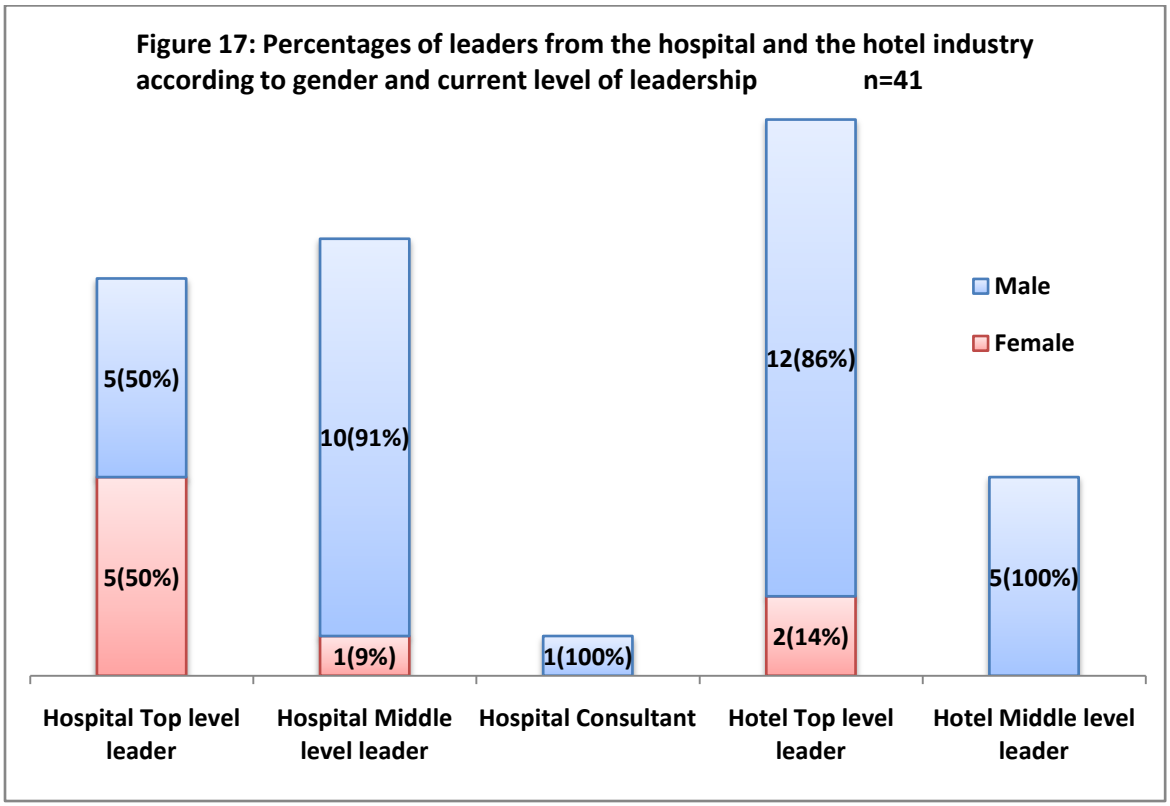


Figure 17 depicts that the hospital industry had three times higher the number of female leaders (6) as compared to the female leaders (2) from the hotel industry. Equal percentages of male and female leaders held the top level leadership position in the hospital industry. In contrast, 91% of middle level leaders were males as compared to 9% of middle level female leaders in the hospital industry. Majority (86%) of the top level leaders were male with only 14% top leaders were females in the hotel industry. On the other hand, all 100% middle level leaders from the hotel industry were males.

Table 19: Chi-Square Tests results related to Democratic Leadership style of the top and middle level leaders among the hospital and the hotel industry and their gender						
Gender	**Current leadership level**		**χ^2 Value**	**df**	**Asymp. Sig. (2-sided)**	**Association**
Female	Top level	Pearson Chi-Square	.467	1	.495	
		N of Valid Cases	7			
	Middle level	Pearson Chi-Square				
		N of Valid Cases	1			
Male	Top level	Pearson Chi-Square	5.440	1	.020	Significant
		N of Valid Cases	17			
	Middle level	Pearson Chi-Square	.536	1	.464	
		N of Valid Cases	15			
	Any other	Pearson Chi-Square				
		N of Valid Cases	1			

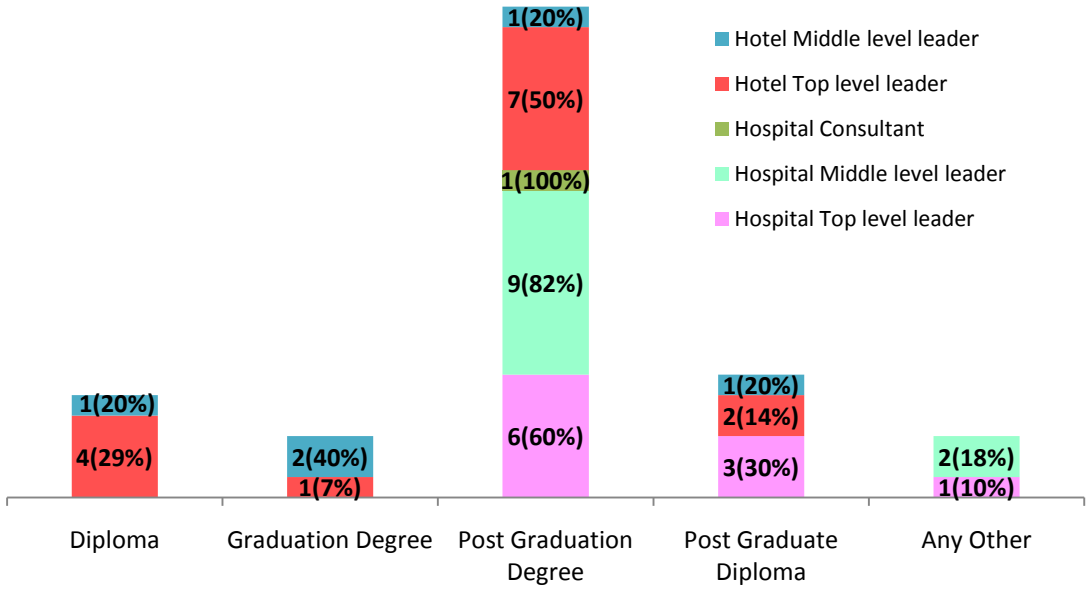
Table 20: Chi-Square Tests results related to Paternalistic Leadership style of the top and middle level leaders among the hospital and the hotel industry and their gender						
Gender	**Current leadership level**		**χ^2 Value**	**df**	**Asymp. Sig. (2-sided)**	**Association**
Female	Top level	Pearson Chi-Square	1.120	1	.290	
		N of Valid Cases	7			
	Middle level	Pearson Chi-Square				
		N of Valid Cases	1			
Male	Top level	Pearson Chi-Square	5.236	1	.022	Significant
		N of Valid Cases	17			
	Middle level	Pearson Chi-Square	.288	1	.591	
		N of Valid Cases	15			
	Any other	Pearson Chi-Square				
		N of Valid Cases	1			

Table 19 showed significant association between the top level male leaders from the hospital and hotel industry and democratic leadership style with chi square value of 5.440 and p value 0.020. The top level male leaders from both the industries also showed association with paternalistic leadership style with the chi square value of 5.236, and p value 0.022 (Table 20).

Item: D Education: This item consisted many other items such as Item D-I to Item D- XI. Results related to these items are as follows:

Item D-I: Highest educational status of the leader:

Figure 18: Percentages of the top and middle level leaders from the hospital and the hotel industry and their Highest Education (Count, %) n=41



The hospital industry leaders were double in number (16) as compared to the hotel industry leaders (8) who had post graduation degree. In other words Figure 18 reveals that all top and middle level leaders from the hospital industry had post graduation degrees or post graduation diplomas. On the other hand, three leaders from the hotel industry held graduation degree and 4 top leaders and one middle level leader held diploma as their highest educational qualification.

Item D- II: Basic graduation degree:

Table 21 :Percentages of the top and middle level leaders from the hospital and the hotel industry and their basic graduation degree n=41

Level of leadership within Industry	Commerce	Arts	Science	Management	Allopathy	Pharmacy	Hotel Management
Hospital Top level leader		1 (10%)			8 (80%)	1(10%)	
Hospital Middle level leader			2(18%)		9(82%)		
Hospital Consultant					1(100%)		
Hotel Top level leader	2(14%)	1(7%)	1(7%)	1(7%)			9(64%)
Hotel Middle level leader	2(40%)						3(60%)

Hospital $\chi 2$ value= 4.444; p value= 0.617 (NS) NS= No Significance

Hotel $\chi 2$ value= 2.239; p value= 0.692 (NS) $\chi 2$ = Chi Square

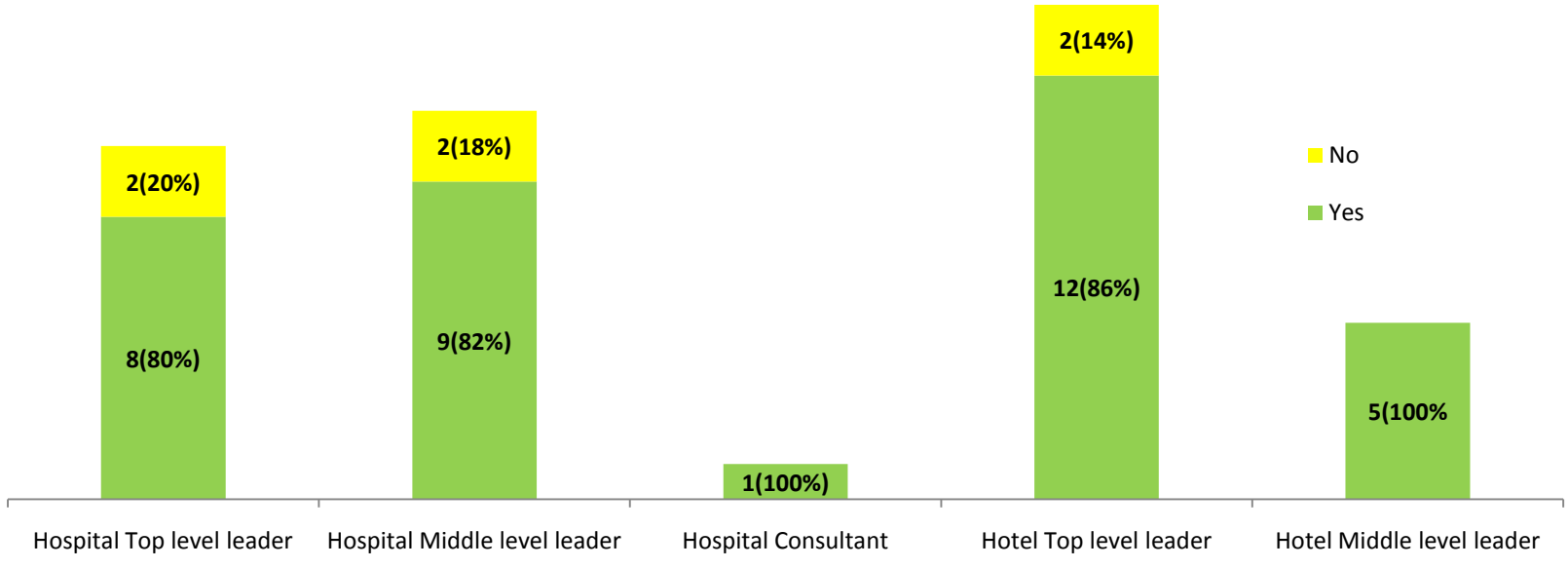
Table 21 showed that more than eighty percent of the top and middle level leaders from the hospital industry had their basic graduation degree from Allopathy (modern medicine). Only one top level leader (10%) was holding Arts degree and another one pharmacy degree. Two middle level leaders (18%) were from science background. None of the leaders from the hospital industry had basic graduation degree from the management background.

Unlike this, majority of the top (64%) and the middle (60%) level leaders from the hotel industry were holding basic degree related to the hotel management (table 16). Rests of the top level leaders from the hotel industry were holding arts (7%), commerce (14%), science (7%) and management (7%) degrees. Table 16 does not show association between the top and middle level leaders among the hospital and the hotel industry and their basic graduation degrees.

Item D-III: Management training of leaders:

Figure 19 demonstrates that more than 80% of the top and middle level leaders from the hospital and the hotel industry reported that they had management training. Two (20%) top level leaders and two (18%) middle level leaders from the hospital industry reported that they did not have any management training. Likewise two (14%) top level leaders from the hotel industry also reported that they did not have management training.

Figure 19: Percentages of the top and middle level leaders from the hospital and the hotel industry and whether they had any Managment training (count, %) n=41



Item D-IV: Name of the management training:

More than 80 % of top and middle level leaders from the hospital and the hotel industry reported that they had management training. Whereas, other 20% top level leaders and 18 % middle level leaders from the hospital industry reported that they did not undergo any management training. The Table 22 depicts the same.

Out of 22 leaders from the hospital industry, majority of the top level leaders (60%) either held MD in hospital administration (30%), or Masters in Business Administration in Healthcare (MBA HC) (20%), or Masters Degree in hospital administration (10%) degree. None of the top level leaders were holding Masters in Business Administration (MBA) degree. On the other hand 64% of the middle level leaders were holding MD in hospital administration degree. One middle level leader (9%) from the hospital industry was holding MBA degree as depicted in the Table 22.

On the other hand, Table 22 also shows that 36% top leaders and 40 % middle level leaders had Bachelors and/or masters degree in the hotel management, or diploma in the hotel management. Likewise, 36% of the top level leaders and 20% middle level leaders from the hotel industry were holding Masters Degree in Business Administration. Equal number (2) of top and middle level leaders from the hotel industry reported that they were holding diploma in management/ administration.

No association was found between the leadership level and name of the management training in the hospital and the hotel industry (Table 22).

Table 22: Percentages of the top and middle level leaders from the hospital and the hotel industry and name of the management training (count, %) n=41

Level of leadership within Industry	**Diploma in Management Administration**	**Masters in Business Administration**	**Masters in Business Administration in Healthcare**	**Masters in Hospital Administration**	**Any Other**	**Not Applicable [as leaders did not have management training]**
Hospital Top level leader	2(20%)		2(20%)	1(10%)	3(30%)	2(20%)
Hospital Middle level leader		1(9%)	1(9%)		7(64%)	2(18%)
Hospital Consultant				1(100%)		
Hotel Top level leader	2(14%)	5(36%)			5(36%)	2(14%)
Hotel Middle level leader	2(40%)	1(20%)			2(40%)	

Any other= includes MD in hospital administration, Bachelors and/or masters in hotel management, diploma in hotel management.

Hospital χ^2 value= 16.080; p value= 0.097 (NS) NS= No Significance

Hotel χ^2 value= 2.178; p value= 0.536 (NS) χ^2 = Chi Square

Item E Experience:

Item E-I: Total years of leadership position held by the leaders:

Table 23: Percentages of the top and middle level leaders from the hospital and the hotel industry and total years of leadership position they held. N=41

Level of leadership within Industry	Less than one year	1-5 years	5-10 years	10-15 years	15-20 years	More than 20 years
Hospital Top level leader		4(40%)		4(40%)	1(10%)	1(10%)
Hospital Middle level leader	1(9%)	1(9%)	2(18%)	1(9%)		6(55%)
Hospital Consultant						1(100%)
Hotel Top level leader		5(36%)	5(36%)	3(21%)		1(7%)
Hotel Middle level leader		2(40%)	3(60%)			
Hospital χ^2 value= 13.105; p value= 0.218 (NS)					NS= No Significance	
Hotel χ^2 value= 1.963; p value= 0.580 (NS)					χ^2 = Chi Square	

Table 23 shows that 60% of the top level leaders from the hospital industry were holding leadership position for more than ten years whereas remaining 40% top level leaders from the hospital industry held leadership position between 1-5 years.

On the other hand, above table also shows the middle level leaders in the hospital industry were holding leadership positions as follows: More than 60

percent meddle level leaders were holding their leadership position for more than 10 years, 9% middle level leaders were holding leadership position for less than one year, another 9% between 1-5 years, and 18 % between 5-10 years. On the contrary in the hotel industry 72 % top level leaders and 100% middle level leaders were holding leadership position from one year to ten years.

No association was observed between total years of leadership position and the top and middle level leaders from the hospital and the hotel industry (Table 23).

Item E-II: Period of current leadership position held by the leader:

Table 24: Percentages of the top and middle level leaders from the hospital and the hotel industry and period of current leadership position n=41

Level of leadership within Industry	Less than one year	1-5 years	5-10 years	10-15 years	More than 15 years
Hospital Top level leader		7(70%)	1(10%)	2(20%)	
Hospital Middle level leader	3(27%)	4(36%)	3(27%)		1(9%)
Hospital Consultant					1(100%)
Hotel Top level leader	2(14%)	7(50%)	2(14%)	2(14%)	1(7%)
Hotel Middle level leader	1(20%	3(60%)	1(20%)		
Hospital χ^2 value= 18.159; p value= 0.020 (S)					
Hotel χ^2 value= 1.294; p value= 0.862 (NS)					
NS= No Significance		S= Significance		χ^2 = Chi Square	

Table 24 shows that 70 % leaders from the hospital industry were holding the top level position in the current organization between 1-5 years, 10 % between 5-10 years, and remaining 20 % between 10-15 years. On the other hand, 36% of middle level leaders from the hospital industry were holding leadership position in the current organization between 1-5 years, and 27% from 5 – 10 years. Only 27% middle level leaders recently joined the hospital organization, as they

reported holding the middle level position for less than a year. Hospital consultant and one middle level leader held their positions for more than 15 years in the same organization.

Chi square test result (χ^2 value= 18.159; p value= 0.020) shows strong association between period of current leadership position and level of leadership among hospital industry (Table 24).

The hotel industry showed different picture in the same Table 24. More than 50% top and middle level leaders from the hotel industry were holding the current leadership position for the period of 1-5 years. 14 % of top level leaders and 20% of middle level leaders from the hotel industry were holding current leadership position for less than one year and between 5-10 years respectively.

Table 25 presents Chi square test result which displays χ^2 Value 3.818 and p value .051 showing significant association between autocratic leadership style of the top level leaders in the hospital and the hotel industry who were holding current leadership position for 1-5 years. Table 25 also presents Chi square test result which displays χ^2 Value 4.000and p value .046 showing significant association between autocratic leadership style of the top level leaders in the hospital and the hotel who were holding current leadership position for 10-15 years. Similar p value (0.046) was found with laissez faire leadership style and the middle level leaders from both the industries who held current leadership position for less than one year (Table 26). Likewise, middle level leaders from both the industries who held current leadership positions between 5-10 years also showed association with paternalistic leadership style with similar chi square value 4.000 and p value 0.046 (Table 27).

Table 25: Chi- Square tests results related to the Autocratic leadership style of the top and middle level leaders from the hospital and the hotel industry and period of current leadership position

Period of current leadership position	Current leadership level		χ^2 Value	df	Asymp. Sig. (2-sided)	Association
Less than one year	Top level	Pearson Chi-Square				
		N of Valid Cases	2			
	Middle level	Pearson Chi-Square	.444	1	.505	
		N of Valid Cases	4			
1-5 years	Top level	Pearson Chi-Square	3.818	1	.051	Significant
		N of Valid Cases	14			
	Middle level	Pearson Chi-Square	.194	1	.659	
		N of Valid Cases	7			
5-10 years	Top level	Pearson Chi-Square	3.000	1	.083	
		N of Valid Cases	3			
	Middle level	Pearson Chi-Square				
		N of Valid Cases	4			
10-15 years	Top level	Pearson Chi-Square	4.000	1	.046	Significant
		N of Valid Cases	4			
More than 15 years	Top level	Pearson Chi-Square				
		N of Valid Cases	1			
	Middle level	Pearson Chi-Square				
		N of Valid Cases	1			
	Any other	Pearson Chi-Square				
		N of Valid Cases	1			

Table 26: Chi- Square tests results related to the Laissez faire leadership style of the top and middle level leaders from the hospital and the hotel industry and period of current leadership position						
Period of current leadership position	**Current leadership level**		**χ^2Value**	**df**	**Asymp. Sig. (2-sided)**	**Association**
Less than one year	Top level	Pearson Chi-Square				
		N of Valid Cases	2			
	Middle level	Pearson Chi-Square	4.000	1	.046	Significant
		N of Valid Cases	4			
1-5 years	Top level	Pearson Chi-Square	1.077	1	.299	
		N of Valid Cases	14			
	Middle level	Pearson Chi-Square				
		N of Valid Cases	7			
5-10 years	Top level	Pearson Chi-Square				
		N of Valid Cases	3			
	Middle level	Pearson Chi-Square				
		N of Valid Cases	4			
10-15 years	Top level	Pearson Chi-Square	1.333	1	.248	
		N of Valid Cases	4			
More than 15 years	Top level	Pearson Chi-Square				
		N of Valid Cases	1			
	Middle level	Pearson Chi-Square				
		N of Valid Cases	1			
	Any other	Pearson Chi-Square				
		N of Valid Cases	1			

Table 27: Chi- Square tests results related to the Paternalistic leadership style of the top and middle level leaders from the hospital and the hotel industry and period of current leadership position						
Period of current leadership position	**Current leadership level**		**χ^2Value**	**df**	**Asymp. Sig. (2-sided)**	**Association**
Less than one year	Top level	Pearson Chi-Square				
		N of Valid Cases	2			
	Middle level	Pearson Chi-Square				
		N of Valid Cases	4			
1-5 years	Top level	Pearson Chi-Square	2.800	1	.094	
		N of Valid Cases	14			
	Middle level	Pearson Chi-Square	.875	1	.350	
		N of Valid Cases	7			
5-10 years	Top level	Pearson Chi-Square				
		N of Valid Cases	3			
	Middle level	Pearson Chi-Square	4.000	1	.046	Significant
		N of Valid Cases	4			
10-15 years	Top level	Pearson Chi-Square	1.333	1	.248	
		N of Valid Cases	4			
More than 15 years	Top level	Pearson Chi-Square				
		N of Valid Cases	1			
	Middle level	Pearson Chi-Square				
		N of Valid Cases	1			
	Any other	Pearson Chi-Square				
		N of Valid Cases	1			

Item E-IV: Current job title:

The top and middle level leaders from the hospital and the hotel industry were asked to report their current job title. When leader's current job title was compared with their self reporting of their leadership positions following results were observed.

Table 28 shows leaders current job title according to their leadership position in their respective industries. Results revealed that 30% of the Hospital top level leaders were chief executive officers, 20% were general manager, 10 percent were medical director and 40% ticked the option 'any other' and gave their details of current job titles.

Study also kept the "any other" option open for the participants, in case leader's current job title was not mentioned in the demographic data sheet. Respondents have added their current job titles in the "any other" option. 40%top level leaders and 73% middle level leaders ticked on 'any other' option under the heading current job title. Responses are as follows:

Four (40%) top level leaders from hospital industry reported their current job title as follows: Chief of Medical Services (1), Director- Overall in – charge (1), Professor and Head of the Department (1), and another top level leader reported the many job title as Vice Dean PG, Deputy Director and Professor and Head of the Department (1).

Assistant Director (1), Medical Superintendent (1), and Manger (1) post were held by the middle level leaders from the hospital. Whereas, 8 (73%) middle level leaders from the hospital industry ticked 'any other' option for their current job title. Out of eight middle level leaders: Professor and Instructor (1), Associate Professor (1), Professor and Head of the Department (1), Head of the

Department (1), Deputy Dean (1), Professor (1), Section In-charge (1), Senior Divisional Medical Officer (1).

On the other hand, majority of the top level leaders held the Manager (5, 36%) post; other top leaders were General Managers (29%), Director (14%), and Executive Director (7%). From Hotel industry only two (14%) top level leaders ticked the option as ‘any other’ which they reported as AVP (1), Deputy General Manager (2) as their current job titles which were not present in the options given in the tool. All hundred percent middle level leaders from the hotel industry were working as Managers.

Table 28: Percentages of the top and middle level from the hospital and the hotel industry and their current job title (count, %) n=41

Industry		Current job title									Total
		Chief executive officer	Executive director	Director	Assistant director	Medical director	Medical superintendent	Manager	General manager	Any other	
Hospital	Top level	3 (30%)				1 (10%)			2 (20%)	4 (40%)	10 (100%)
	Middle level				1 (9.1%)		1 (9.1%)	1 (9.1%)		8 (72.7%)	11 (100%)
	Consultant									1 (100%)	1 (100%)
Hotel	Top level		1 (7.1%)	2 (14.3%)				5 (35.7%)	4 (28.6%)	2 (14.3%)	14 (100%)
	Middle level							5 (100%)			5 (100%)

Any other means:

Hospital Top level: Chief of Medical Services (1), Director- Overall in – charge (1), Professor and Head of the Department (1), and another top level leader reported the many job title as Vice Dean PG, Deputy Director and Professor and Head of the Department (1).

Hospital Middle level: Professor and Instructor (1), Associate Professor (1), Professor and Head of the Department (1), Head of the Department (1), Deputy Dean (1), Professor (1), Section In-charge (1), Senior Divisional Medical Officer (1).

Hospital any other- **Consultant** (1)

Hotel top level: AVP (1), Deputy General Manager(1)

Item E-V: Number of employees working in the organization:

Table 29: Percentages of the top and middle level leaders from the hospital and the hotel industry and number of employees working in the organization n=41

Level of leadership within Industry	101-200 Employees	201-300 Employees	301-400 Employees	401-500 Employees	More than 501 Employees	Not applicable [as leader was consultant]
Hospital Top level leader		1(10%)	3(30%)		6(60%)	
Hospital Middle level leader					11(100%)	
Hospital Consultant						1(100%)
Hotel Top level leader	1(7%)	1(7%)	4(29%)	5(36%)	3(21%)	
Hotel Middle level leader	1(20%)	2(40%)	1(20%)	1(20%)		
Hospital χ^2 value= 27.694; p value= 0.000 (S)						
Hotel χ^2 value= 4.560; p value= 0.335 (NS)						
NS= No Significance S= Significance χ^2 = Chi Square						

Tale 29 represents higher number of employees in the hospital industry as compared to the hotel industry. The number ranged from more than 200 – more than 501 employees. Whereas majority of the hotel industry leaders reported that their organization had less than 500 employees. Chi square result (χ^2 value=

27.694; p value= 0.000) shows association between number of employees in the hospital industry and leadership level of the leader (Table 29).

Item E-VI: Number of employees working for the leader:

Table 30 depicts that more than 80% of hospital top leaders were dealing with more than 200 employees. In contrast 82 % of hospital middle level leaders were dealing with less than 200 employees. 100 percent of middle level leaders from the hotel industry were dealing less than 100 employees. Almost equal percentages (49%) of the top level leaders from the hotel industry were dealing with less than 200 and more than 200 employees. Same Table 30 reveals Chi square result (χ^2 value= 34.550; p value= 0.005) which shows strong association between number of employees working under the leadership of the top and middle level leaders from the hospital industry.

Table 31 depicts middle level leaders from the hospital and the hotel industry had association between autocratic leadership style and number of employees (1-25) working under these leaders. Chi square value for these results was 7.000, and p value was 0.008.

In contrast, paternalistic leadership style has showed association with the top level leaders and number of employees (51-100) working under these leaders. Chi square value for this result was 4.000 and p value was 0.046 (Table 32).

Table 30: Percentages of the top and middle level leaders from the hospital and the hotel industry and number of employees working for the leader n=41

Level of leadership within Industry	**1 to 25**	**26-50**	**51-100**	**101-200**	**201-300**	**301-400**	**401-500**	**More than 501**	**Not applicable [as leader was consultant]**
Hospital Top level leader			2(20%)		1(10%)	3(30%)	1(10%)	3(30%	
Hospital Middle level leader	5(46%)	1(9%)	2(18%)	1(9%)	1(9%)	1(9%)			
Hospital Consultant									1(100%)
Hotel Top level leader	1(7%)	2(14%)	2(14%)	2(14%)	1(7%)	2(14%)	2(14%)	2(14%)	
Hotel Middle level leader	2(40%)	2(40%)	1(20%)						

Hospital χ^2 value= 34.550; p value= 0.005 (S)

Hotel χ^2 value= 6.967; p value= 0.432 (NS)

NS= No Significance

S= Significance

χ^2 = Chi Square

Table 31: Chi- Square tests results related to the Autocratic leadership style of the top and middle level leaders from the hospital and the hotel industry and number of employees working for the leader						
Number of employees working under you	**Current leadership level**		**χ^2Value**	**df**	**Asymp. Sig. (2-sided)**	**Association**
1-25	Top level	Pearson Chi-Square				
		N of Valid Cases	1			
	Middle level	Pearson Chi-Square	7.000	1	.008	Significant
		N of Valid Cases	7			
26-50	Top level	Pearson Chi-Square				
		N of Valid Cases	2			
	Middle level	Pearson Chi-Square				
		N of Valid Cases	3			
51-100	Top level	Pearson Chi-Square	1.333	1	.248	
		N of Valid Cases	4			
	Middle level	Pearson Chi-Square				
		N of Valid Cases	3			
101-200	Top level	Pearson Chi-Square				
		N of Valid Cases	2			
	Middle level	Pearson Chi-Square				
		N of Valid Cases	1			
201-300	Top level	Pearson Chi-Square	2.000	1	.157	
		N of Valid Cases	2			
	Middle level	Pearson Chi-Square				
		N of Valid Cases	1			
301-400	Top level	Pearson Chi-Square	2.222	1	.136	
		N of Valid Cases	5			
	Middle level	Pearson Chi-Square				
		N of Valid Cases	1			
401-500	Top level	Pearson Chi-Square	.750	1	.386	
		N of Valid Cases	3			
More than 500	Top level	Pearson Chi-Square	2.222	1	.136	
		N of Valid Cases	5			
Not applicable	Any other	Pearson Chi-Square				
		N of Valid Cases	1			

Table 32: Chi- Square tests results related to the Paternalistic leadership style of the top and middle level leaders from the hospital and the hotel industry and number of employees working for the leader

Number of employees working under you	Current leadership level		χ^2 Value	df	Asymp. Sig. (2-sided)	Association
1-25	Top level	Pearson Chi-Square				
		N of Valid Cases	1			
	Middle level	Pearson Chi-Square	.467	1	.495	
		N of Valid Cases	7			
26-50	Top level	Pearson Chi-Square				
		N of Valid Cases	2			
	Middle level	Pearson Chi-Square	.750	1	.386	
		N of Valid Cases	3			
51-100	Top level	Pearson Chi-Square	4.000	1	.046	Significant
		N of Valid Cases	4			
	Middle level	Pearson Chi-Square				
		N of Valid Cases	3			
101-200	Top level	Pearson Chi-Square				
		N of Valid Cases	2			
	Middle level	Pearson Chi-Square				
		N of Valid Cases	1			
201-300	Top level	Pearson Chi-Square	2.000	1	.157	
		N of Valid Cases	2			
	Middle level	Pearson Chi-Square				
		N of Valid Cases	1			
301-400	Top level	Pearson Chi-Square	.833	1	.361	
		N of Valid Cases	5			
	Middle level	Pearson Chi-Square				
		N of Valid Cases	1			
401-500	Top level	Pearson Chi-Square				
		N of Valid Cases	3			
More than 500	Top level	Pearson Chi-Square	.139	1	.709	
		N of Valid Cases	5			
Not applicable	Any other	Pearson Chi-Square				
		N of Valid Cases	1			

Qualitative data obtained by the face to face interview revealed that leaders change their leadership styles because of various reasons. Sub Theme 2 represents it as follows:

Sub Theme 2: Change in leadership style:

100% respondents expressed that their leadership style has changed over the years. Total 3 codes were developed to represent the change in the leadership style; for example 1) change in the leadership style due to organization, 2) change in the leadership style due to awareness of own leadership style and 3) change in the leadership style according to the level of employees that the leader has to deal with. The third code was further divided into three sub codes i.e. leadership style while dealing with the top level, middle level and the lower level employees.

Code 1: Change in the leadership style due to organization:

Two leaders expressed that leadership style changed according to the organization i.e. type of organization, type of employees, type of customer, geographic location of the organization, ownership of the organization, etc. For example:

> ***P25 [hospital middle leader]:*** *"Leadership style according to organization. In the service in military setting, we have both medical duties and military duties. So the military duties require a strict hierarchical chain of command and we can't afford to violet that. In military setting the hospital administration needs to be little more directorial or authoritative and may be just little participative with the top…doctors".*
>
> ***P29 [hospital middle leader]:*** *"leadership style changes according to type of organization. As I told you, corporate sector, government sector, and trust organizations need different leadership style. Additionally, type of patients which your hospital caters (for example, rural people, urban people or mixed crowd in the hospital), specialty you cater in the hospital that also changes the leadership style of individual. Even what type of*

employees you have that is also one point where your leadership changes accordingly".

Code 2: Change in leadership style due to awareness of own leadership style:

All leaders agreed that leaders need to be aware of their own leadership style. The awareness comes either by introspection, results or outcome of the leadership styles adopted in a given situation, experience, or evaluation of leadership styles by others like supervisors or colleagues or by 360^0 evaluation. Bias needs to be minimized during evaluating the self. Or leader can ask for evaluation by others which may help to certain extent. But finally, leadership style of the leader needs a balanced evaluation of objective and subjective data. For example:

P29 [hospital middle leader]: *"Well, he should be aware of his leadership style. Otherwise how he will know the consequences of his leadership? He should be aware. Someone should tell him. Top management should tell I think. Superior should tell how you work, right things to practice in a particular situation or need some change in the leadership style. I think some senior people should tell. Periodic review of leadership according to situation and incident handled by the person will help to be aware of the leadership style suitable in that situation".*

P25 [hospital middle leader]: *"I might have slightly changed but I think slight change is more due to increase in self efficacy and self esteem than actually change in my leadership style. As I have grown, the problems I faced and challenges I faced due to the problem and the way I solved the problems, my sense of self efficacy improved, my sense of self esteem is improved. I came to understand how I fit in and what is my role and , how I play my role in such a huge organization".*

P37 [hospital middle leader]: *"When I introspect I feel I have changed lot with an experience. Initially I was like an autocratic leader. Because results I was getting due to autocratic leadership, I have changed myself.*

Because of experience I have changed. It was the outcome that made me change my style. In autocratic leadership so many problems were there and it was difficult. When I introspected why this has happened then I came to know that I was using dictator type of working style that was not suitable. Later on I understood giving order is not sufficient, what difficulties they are facing while completing the task given to them is equally important. So I learned I should have more interpersonal relationship which I developed over the years. Now I am participative leader and I found it very successful compared to autocratic style. It's my experience".

P38 [hospital top leader]: *"When I started working and people around me, they gave and shared their thoughts with me. Thus, I come to know what to be done and I learned some techniques and become more and more perfect. There are always changes because one goes on improving".*

P28 [hospital middle leader]: *"Yes, It does change. No matter what we say in perceptively only it does change. Because you learn how effectively you can handle them (*people*), sometimes some things works and then you take a mental note that this is the point that you should be incorporating little more. Sometimes you fall short. You think next time I do better by doing this. Things like that".*

Code 3: Change in leadership style according to levels of employees:

Leadership style changes according to the levels of employees the leader is dealing with. Data shows that leadership style differs while handling the top bosses, the middle level as well as the lower level employees. It has been observed that majority of the leaders, although they held top positions in the organization, they adopted passive leadership style or played submissive role and do not exhibit their leadership style in front of their superiors. In contrast, they play authoritative leadership style while handling lower level employees and participative leadership style with their colleagues or the middle level employees.

Sub code 1: Leadership style with the top bosses:

Few leaders reported to adopt submissive role or subordinate role while dealing with the top bosses. For example:

> ***P25 [hospital middle leader]:*** *"When I deal with my bosses, with my superiors I do not get too many opportunities to deploy my leadership because I am usually in a subordinates role or at the most I am be in a advisory role, as a staff role. So as a staff or an advisor I prefer to think that giving the honest picture first and painting the big picture clearly is important for the staff. So I play that role. I don't have in our set up as I told you since we have hierarchy driven we don't have much role of displaying leadership when we are dealing with our seniors. So at the most what we show is our personal traits or characteristics so I am upfront, honest and behave forward. I don't participate in sycophancy so that may be the personality I am which is also ok".*
>
> ***P6 [hotel middle leader]:*** *"When we talk about senior leadership team which is for them I am more of a coach and a mentor than being a boss. So for them it is always going to be supporting them, giving them initiative, taking their thoughts, ideas and giving them guidance how to change things or deliver…"*

On the other hand one leader expressed to be bold enough and not to be afraid of the top bosses.

> ***P37 [hospital middle leader]:*** *"Dealing with top bosses, I give my priority, not according to them I work. I know whatever I did; I did with full devotion, good intention. Sometimes I broke rules for people. I don't bother for that. Only staffs need to be convinced and result should be proper. So I do not have problem to handle boss. I put straight way to my boss. I believe one human should not be afraid of another human being, though that other human being is your boss. It is not because of pressure of boss I should hide things and project him that how I am a good person. Where I felt*

there are difficulties I accepted and accordingly I worked. I never hide anything".

Leaders have less opportunity to express their leadership style in front of the top bosses because the top bosses do not have more time to spend with an individual. So an important concept emerged i.e. **effective time management while handling the top bosses** to show your leadership skills in the shortest possible time. Leaders reported that talking with accurate and objective data works with the top bosses, and settles the issue of time constraint. For example:

P28 [hospital middle leader]: *"With top leaders, one would have actually show the evidence based data, if you have right data available that is how you will be able to impact change in ideas or whatever it is to bring particular kind of".*

P44 [hotel top level]: *"When it comes to the top bosses you have to realize one thing, the top bosses do not have time only for you. So they are there. Within short span of time you get, you communicate precisely. I have to be clear and go with the solution. For example, I have a problem, this is what it is, and I have a solution. I feel this is what should be done. Then the top bosses automatically start relating to you. If you don't do it they will not take you seriously. So it is important that you have to be precise and understand whole thing because when they give a solution, you should be in a position to understand whether it is possible or not. You should be in a position to debate that situation. That's how you deal with the top bosses because they don't have time. For them you are their representative and they only expect you to produce. They expect you to implement and they expect you to nurture. Their expectation also the same in turn they are nurturing me so all three things goes to everybody".*

Sub code 2: Leadership style with the middle level employees:

Interview data revealed that leaders use a friendly approach, develop good interpersonal relationships with their colleagues, with the middle level leaders,

treat them as their equivalent, groom them, boost their energy, and provide supportive leadership. They also thought of sharing their ideas and obtaining feedback from the middle level colleagues whenever necessary for making decisions. Interview data revealed that all leaders wanted a support from their colleagues thus making efforts to establish a good relationship with them which is not seen with the top bosses as well as the lower level employees. Few quotes are as follows:

> ***P27 [hospital top leader]:*** *"Colleagues are equivalent to you. You must learn from them. Because they may be having their own views so definitely it should be a consultative".*
>
> ***P29 [hospital middle leader]:*** *"To the colleagues and middle level I think leadership should be friendly one".*
>
> ***P37 [hospital middle leader]:*** *"Colleagues I always try to maintain interpersonal relationship. I always try to understand their difficulties. I always make them feel free to ask me, any time they can approach to me. I keep myself in his place and then I realize what his problems are and then it becomes easy to give solutions for that".*

One leader from the hospital industry elaborated on spiritual context and on how to deal with educated employees especially with an objective data.

> ***P25 [hospital middle leader]:*** *"I think when you are dealing with doctors or clinicians who are educated and have their internal drives and motivations, it would be best to have a participative leadership style which will be inclusive where you deal with them. When I am dealing with my peers and subordinates then I work you know at 'spiritual context' of human being, is major role to play. How he or she relates to anyone. When we talk about leadership we talk often the management science or organizational behavior science, we talk on that bracket or literature as a science. What is that individual's spirituality, his emotional integrity, his emotional intelligence and how that affects his leadership roles those don't get deliberated upon. But personally, I think it's the way my spiritual*

growth is that I recognize every other human being as a human being , as a element of godliness and part of the nature and earth. So my leadership style is participative. As a personality by nature it is a participative. It is a default setting. The situation may change it, requires different handling so with my peers and subordinates I have default setting of democratic participative."

Further this leader added *"…Let's say you get to know that your clinical services there are some complaints coming in about cardiothoracic or cardiology department. These logical responses should be, to first investigate that complaint. When you investigate you have multiple choices of investigations. The first is to ask head of the department that I received this complaint from your department, and you look into it and give us the feedback. The other is also deploying test cases. Anonymous patients from your own service and let them run as testers to the system. You will get the information about what is actually happening at the grass root level. If you find the truth emerging from multiple ways you investigated and you need to counsel or rain in that department you have to call the senior most clinician or group of them and you have to base your response of counseling them with data. It can't be subjective when you talk; you need to talk to them with data. That I have 5 complaints, I have investigated five. 3 of them I found waiting time was more than 3 hours and when I looked into this it happened because doctor so and so did not arrive his OPD at 9^{o} clock. He arrived at 12^{o} clock …you have to have that data and it has to be objective, factual and without any embellishment. So objectively dealing with clinicians in difficult situations with data, in my experience works the best because then it does not give them place to, you know tell you that you are making an acquisition which is anecdotal in nature. 90% of times patient have in 15 minutes and one person must have complaint it. But when I talk with data, I say I have 5 complaints and out of them three i.e. 60% of them are saying this, that puts them down…I think when you are dealing with educated group which*

can analyze and reflect, you should be objective in dealing with them. As a leader you should have your facts right. You must have your data right and you must put that data in by which that it cannot back out of it. As a leader your doctors, junior doctors, senior doctors, senior nurses, you need to deal with them very carefully and objective base and data base".

Sub code 3: Leadership style with the lower level employees:

Overall, there was some discrepancy in dealing with the lower level employees. Some leaders argued to use authoritative leadership style whereas other leaders supported democratic or participative leadership style for the lower level employees.

Following few quotes support authoritative leadership style while handling the lower level employees.

P25 [hospital middle leader]: *"Whereas, if you go on to dealing with the lower level of education training or skill then you may need to have more directional style. Subordinate staffs are not looking for data. They are not looking objective change. I tell them I have complaints arising from poor behavior of technician. See you hereby put on warning. He knows it that he has behaved poorly more often than not and now the matter has come to the head and he is being warned. Dealing with subordinate staffs with power; at the lower level I don't think you need to put so much effort. It will just take away your time. So you as a leader know how much time to deal with which situation. But let's say junior nurse you shouldn't be getting into that role because you employed nursing superintendent and the assistant nursing superintendent to look up to these issues. If they are not able to solve it, only then it should come to you and when it comes to you…with subordinates use democratic participative leadership and authoritative and directional as needed".*

P28 [hospital middle leader]: *"Yes, you have to keep a control. You have to show that 'who is the boss' so that feeling has to be there."*

P6 [hotel top leader]: *"At the bottom level, it is more directional, where they are told on day today basis what is their role…"*

P44 [hotel top level]: *"In a situation, when other party is not in a position to listen and argue, If I see that is happening in front of group of people I would take this person aside and speak to him. I would say this is how the style of function would be, if you feel this is not right you give me justifiable reason. This is because how you learn then currently learn from me because I am your current boss. Where you have to put your foot down you have to put your foot down".*

Some of the leaders suggested that democratic leadership style is useful for lower level employees. Leaders are supported to use friendly approach while handling the lower level employees. Further, it was emphasized that the leader should treat the lower level employees as human beings and he/she must provides support to them. For example:

P37 [hospital middle leader]: *"For lower level, keeping strict attitude does not help. Some freedom needs to be given to them. One thing is that, don't differentiate person because of his lower status. He is also human being. Even he is lower level employee here in the office, but at his home he is a boss. His children respect him as a boss or head of the family and he has that type of attitude at home. Here all of a sudden I start treating him as a peon, it will be difficult for him. So always consider human being irrespective of his cadre or economical status."*

P28 [hospital middle leader]: *"Even with the lower level employees one has to create enthusiasm in them. So you have to show them what difference it is going to make and how it is going to make a difference and if you are able to do that then orders are not always necessary. If they feel yes, they are making difference then the output is that much better."*

P45 [hotel top level]: *"For lower level I am friendly to them. I really want my staff not to scare of me. Perhaps they should be very much friendly with me because once they are friendly with me they can be open to me.*

They can discuss and understand what I actually want as a manager from your part of the hotel and I also understand what they expect from me. So it basically a deal. Understand each other well."

Sub Theme 3: Factors affecting leadership style:

Multiple factors were reported by the leaders from the hospital and the hotel industries which affect leadership style of individual leader. After reading the scripts, researcher divided these factors under two headings i.e. factors related to the self in which individual's traits, family, etc. affect the leadership style of an individual leader. Whereas, factors related to the organization in which internal aspects of the organization affect the individual leader's leadership style. Table 33 and Table 34 enlist the factors related to self and the factors related to the organization affecting the leadership style of the leader.

Table 33: Factors related to self which affect leadership style of an individual:

- Family background and upbringing of the individual
- Training, knowledge, attitude and skills
- Socioeconomic strata and status in the society
- Position held in the organization
- Previous experience
- Personality
- Ready to change and flexibility

Table 34: Factors related to the organization which affect leadership style of an individual:

- Organizational culture, climate, and structure
- Organizational socio-economic condition
- Ownership of the organization
- Type of organization
- Organizational Philosophy, Vision and mission
- Type of employees/ team/ bosses

Following quotes depict self and organizational factors mentioned in Table 33 and 34 which affect leadership styles of an individual. For example:

> ***P31 [hospital top leader]:*** *"…It goes back to the individual also. How they have come up through their life. How they have been brought up, their colleagues, institutions, the way they have been trained. Everything matters in terms of leadership style because that's how they have been brought up. If they have been cursed every time, they understand that language only… Organization culture may affect them a bit, they understand so and so person is also behaving like this, but that is temporary factor. How they have been brought up, their attitude, their knowledge everything definitely come to play… If it is politically driven organization, so style and functioning will be totally different. They do not consult anybody. It is autocratic organization. From time to time one mould themselves in that organization...Board of directors functioning, culture of the organization, philosophy of the organization affect the leadership style … Many times when it is singly owned organization (ownership of the organization), most of the hospitals are, for example, it is my money, I have started this hospital then such leadership automatically becomes an autocratic. People develop fear in such organization in result they tend to obey, they tend to display master servant relationship, and they get into that. They know this is the only person who is going to make decisions either bad or good whatever it is and that's how organizational culture changes."*
>
> ***P29 [hospital middle leader]:*** *"Education does matter. Experience does matter. What position he held matters, which background he comes from that does matter, many things. Leaders own family background does matter from which social economic strata he has come that also matters. Previously with whom and which organization he worked that also matter, because he has developed the culture over there. That is replicated in his next subsequent appointments that also affects. I think these are the things. The climate, type of employees, type of organization matters. As I*

told you corporate sector, government sector, trust. Type of patients which you cater: rural people, urban people or mixed crowd in the hospital. Which specialty you cater in the hospital that also matter. Even type of employees you have that is also one point where your leadership change accordingly."

P27 [hospital top leader]: *"I always feel the amount of money you earned definitely give you status in the society. So, after few years when you become kind of an expert in that field then you definitely look forward for good position and good salary…Organizations economic status affects the leadership of an individual. You have to make decisions accordingly. If you got lot of innovative ideas in which you want to bring up to date and latest technology in healthcare; there may be constrained because of budget available to you. You will always think of bringing in the cheap technology which your organization can afford and once your economy of an organization is too good then you look forward to kind of medical tourism or look for clientele who afford any kind of state of art medical care and you will like to attract that segment of people rather than going lower segment of people."*

P27 [hospital top leader]: *"Number one, it depends on what kind of hierarchy is there, then, you have what kind of orders you have to pass so it depends on that. Then you also look into who are available with you and what kind of outputs you can expect from those people depending on their qualifications, skills who are available to you. If there is a chap too good then you basically delegate your authority and responsibility and let him do the job. But if you feel that the individual working under you are going to be exposed for particular task first time definitely you will like to supervise throughout. Another factor is that he always should be ready for change. That is very important. He should not be stubborn; he should not stick that I will follow my own ways and all. He has to change along the society".*

P25 [hospital middle leader]: *"I think the stated mission of the hospital will affect the leadership style. Provided like you say culture is one of*

healthy, open growing organization culture. In such a situation having a well defined mission and vision will enhance a leadership. Leadership is didactic leadership. For example, my leadership style or ability will get enhance if my subordinates are highly skilled, very motivated, lot of initiatives, looking for growth. So when you have subordinates as a group who can motivate the leader to achieve higher level of achievement that will enhance. So it is not the leader who is motivating the subordinates, it is also nature and kind of subordinates you have which will enhance leadership."

P6 [hotel top leader]: *"Having very open work style in terms of sharing with the team, taking their feedback, leaving them with right information at right time, giving them trainings and having a lot of fun, celebrations around all the time because industry is very labor intensive, work schedules are very tough, very difficult, so it is always important to have some activities for the staffs. They are kept motivated somebody who has that kind of capability. People focused definitely have to have very strong aspect somebody should have a guest focus. Ownership that is what we drive. We say everybody in whatever work area you are, you are not defined as per your role. We always look upon you as you are responsible for what is happening around so we would largely shift towards organization towards the human rather than the only ownership what you are doing today. So we believe…giving that kind of empowerment to the people so that built in lot of capabilities in them that becomes their own I would say managers to manage themselves."*

P29 [hospital middle leader]: *"Good condition actually good working conditions, healthy competitions. You should be allowed in free environment, healthy environment, periodic trainings, and periodic incentives to the leaders also because many people work on the same position and same incentives, regular salaries, they are not motivated. There should be some motivating factor. Something should be done for his family also. For example cultural programs because see this is very*

stressful position you are holding and if your spouse does not know what you are doing there then again you will enter next stress level when you go home. So his/ her spouse should be known and should be aware what his/ her spouse doing exactly, the job in the organization and appreciate employees hard work in front of their family. Give due recognition in front of family. In that way also organization should think."

P5 [hotel top leader]: *"To enhance the leadership one is trust. Trust is vital factor. That if organization trusts you that is the greatest feeling. Integrity, trust, and faith these are the three key factors where when the organization understands your abilities, have the trust that yes, you are going to make it happen. And yes, this is the person of integrity. We have the trust and the faith that this person is going to achieve a great thing which we really are looking forward to and need to make it success. Any organization which stands behind the leader helps you to stand. These three traits will automatically propel anyone who does best."*

If the leader has bird's eye view or holistic understanding about the phenomena then it also enhances leadership style. For example:

P25 [hospital middle leader]: *"I think for a leader especially about middle and senior leadership understanding the big picture context is I think is the most important factor for a leader to be able to decide which style to move to. If the big picture context is clear to him and he can understand that my targets can be met by comfortable collegiate style then he need not shift to an authoritarian style."*

5.3 Research Question 4

Research Question 4: What are the perceptions of leaders regarding leadership training and development?

Quantitative data results:

Item D-V: Leadership training:

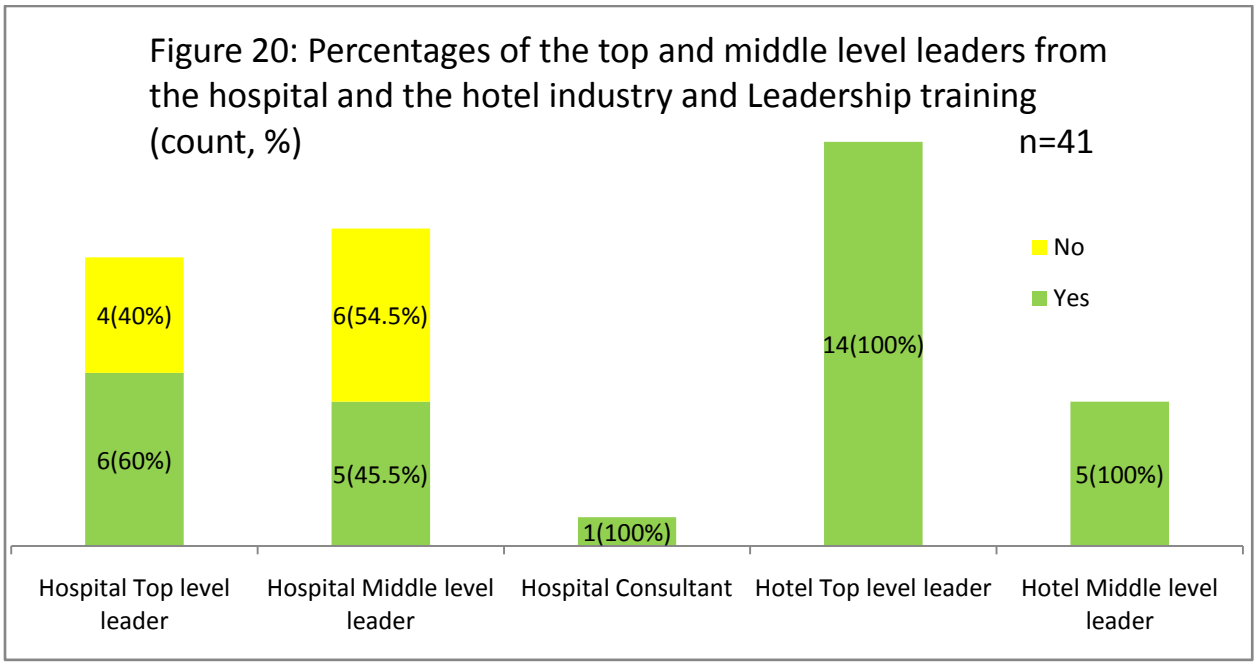


Figure 20 indicated that 100% top and middle level leaders from the hotel industry had leadership training whereas only around 50% of the top and middle leaders from the hospital industry reported they had leadership training.

Table 35: Chi- Square tests results related to the Democratic leadership style of the top and middle level leaders from the hospital and the hotel industry and leadership training						
Leadership training	**Current leadership level**		**χ^2Value**	**df**	**Asymp. Sig. (2-sided)**	**Association**
Yes	Top level	Pearson Chi-Square	5.185	1	.023	Significant
		N of Valid Cases	20			
	Middle level	Pearson Chi-Square	1.111	1	.292	
		N of Valid Cases	10			
	Any other	Pearson Chi-Square				
		N of Valid Cases	1			
No	Top level	Pearson Chi-Square				
		N of Valid Cases	4			
	Middle level	Pearson Chi-Square				
		N of Valid Cases	6			

Table 36: Chi- Square tests results related to the Paternalistic leadership style of the top and middle level leaders from the hospital and the hotel industry and leadership training

Leadership training	Current leadership level		χ^2 Value	df	Asymp. Sig. (2-sided)	Association
Yes	Top level	Pearson Chi-Square	4.821	1	.028	Significant
		N of Valid Cases	20			
	Middle level	Pearson Chi-Square	.000	1	1.000	
		N of Valid Cases	10			
	Any other	Pearson Chi-Square				
		N of Valid Cases	1			
No	Top level	Pearson Chi-Square				
		N of Valid Cases	4			
	Middle level	Pearson Chi-Square				
		N of Valid Cases	6			

Tables 35 and 36 showed chi square test results which showed that the top level leaders from the hospital and the hotel industry who had leadership training had association with the democratic leadership style (χ^2 Value 5.185, and p value was 0.023) and with paternalistic leadership style (χ^2 Value 4.821, and p value was 0.028).

Item D- VI: Type of leadership training:

Table 37: Percentages of the top and middle level leaders from the hospital and the hotel industry and type of leadership training n=41

Level of leadership within Industry	Formal	Informal	Both Formal & Informal	On the Job	Not applicable [as leaders did not have leadership training]
Hospital Top level leader	3(30%)		1(10%)	2(20%)	4(40%)
Hospital Middle level leader	1(9%)		4(36%)		6(55%)
Hospital Consultant			1(100%)		
Hotel Top level leader	3(21%)		9(64%)	2(14%)	
Hotel Middle level leader	3(60%)	1(20%)		1(20%)	
Hospital χ^2 value= 7.937; p value= 0.243 (NS)					
Hotel χ^2 value= 7.826; p value= 0.050 (S)					
NS= No Significance; S= Significance; χ^2 = Chi Square					

The results obtained from the leaders on types of leadership training are presented in Table 37. Ten percent hospital top level leaders and one hospital consultant had both formal and informal leadership training as compared to the hospital top level leaders who had only formal leadership training (30%). Twenty percent of the hospital top level leaders reported that they had on the job leadership training.

Middle level leaders from the hospital industry who had both formal and informal leadership training were four times greater (36%) than the middle level hospital leaders who had only formal leadership training (9%). As reported earlier, around fifty percent of the top and middle level leaders from the hospital industry did not have any leadership training.

On the other hand, Table 37 reveals that the top level leaders from the hotel industry who had both formal and informal leadership training were three times higher (64%) than the top level leaders who had only formal leadership training (21%). Only 14% hotel top level leaders reported that they had on the job leadership training.

Chi square test result shows association (χ2 value= 7.826; p value= 0.050) between the top and middle level leaders from the hotel industry and type of leadership training (Table 37).

Item D-VII: When did the leader undergo leadership training?

Table 38: Percentages of the top and middle level leaders from the hospital and the hotel industry and time period when the leader had leadership training n=41

Level of leadership within Industry	**During Graduation Degree**	**During Post Graduation Degree**	**During In-service Education**	**During Workshop**	**Not applicable [as leaders did not have leadership training]**
Hospital Top level leader	1(10%)	1(10%)	2(20%)	2(20%)	4(40%)
Hospital Middle level leader		2(18%)	3(27%)		6(55%)
Hospital Consultant		1(100%)			
Hotel Top level leader	1(7%)	2(14%)	6(43%)	5(36%)	
Hotel Middle level leader		1(20%)	2(40%)	2(40%)	

Hospital χ^2 value= 8.730; p value= 0.366 (NS)

Hotel χ^2 value= 0.459; p value= 0.928 (NS)

NS= No Significance; χ^2 = Chi Square

Table 38 displayed that the hotel industry leaders reported significantly more leadership training during in service education and during the workshop than the hospital industry leaders. Forty percent of the hospital top leaders expressed that

they had leadership training during in service education and during workshop. On the other hand, 20% of the top leaders and the hospital consultant reported that they had leadership training during graduation and postgraduate degree. Majority (27%) middle level leaders from the hospital industry reported that they had leadership training during in service education and 18% middle level leaders from the hospital industry had leadership training during post graduation degree.

Similar trend was reported by the top level leaders from the hotel industry. Around 80% of the top and middle level leaders from the hotel industry reported that they had leadership training during in service education or during workshop. Remaining 20% top and middle level leaders informed that they had leadership training during graduation or post graduation degree.

No association was observed between the top and middle level leaders from the hospital and the hotel industry regarding when did they have leadership training (Table 38).

Table 39: Percentages of the top and middle level leaders from the hospital and the hotel industry and last leadership training period

n=41

Level of leadership within Industry	**Before 3 months**	**3-6 months**	**6-9 months**	**9-12 months**	**1-3 years**	**3-5 years**	**5 years and more**	**Not applicable [as leaders did not have leadership training]**
Hospital Top level leader			1(10%)	1(10%)	2(20%)	1(10%)	1(10%)	4(40%)
Hospital Middle level leader		1(9%)			1(9%)	1(9%)	2(18%)	6(55%)
Hospital Consultant							1(100%)	
Hotel Top level leader	2(14%)	6(43%)		1(7%)	2(14%)		3(21%)	
Hotel Middle level leader	1(20%)	1(20%)		1(20%)		1(20%)	1(20%)	

Hospital χ^2 value= 8.870; p value= 0.714 (NS)

Hotel χ^2 value= 4.695; p value= 0.454 (NS)

NS= No Significance

χ^2 = Chi Square

Item D- VIII: Last leadership training period of the leaders:

It is obvious from the Table 39 that percentage of leadership training within last one year was greater in the hotel industry leaders as compared to the hospital industry leaders. On the other hand, almost 40 percent of the top and middle level leaders from both the industries reported that they had last leadership training ≥ 1 year ago. Chi square test shows no association between last leadership training of leaders from both the industries.

Table 40: Percentages of the top and middle level leaders from the hospital and the hotel industry and total days of leadership training

N=41

Level of leadership within Industry	**One day**	**2-4 days**	**5-7 days**	**7-15 days**	**15 days-1 month**	**1-3 months**	**3-6 months**	**9 months-1 year**	**More than 2 year**	**Not applicable(as leader did not undergo leadership training)**
Hospital Top level leader		2(20%)	2(20%)		1(10%)		1(10%)			4(40%)
Hospital Middle level leader			1(9%)		1(9%)	2(18%)		1(9%)		6(55%)
Hospital Consultant			1(100%)							
Hotel Top level leader		2(14%)	2(14%)	4(29%)	3(21%)	1(7%)	1(7%)		1(7%)	
Hotel Middle level leader	1(20%)	2(40%)	2(40%)							

Hospital χ^2 value= 11.620; p value= 0.477 (NS)

Hotel χ^2 value= 8.686; p value= 0.276 (NS)

NS= No Significance

χ^2 = Chi Square

Item D- IX: Total days of leadership training:

Table 40 shows total days of leadership training among the top level leaders from the hospital industry were: 40% had 2-7days, 10% had 15 days to one month, and another 10% top level leaders had 3-6 months of leadership training. Middle level leaders from the hospital industry reported leadership training between 5-7 days, 15 days – one month, and 9 months – one year leadership training (9% each) and 1-3 months (18%).

Total days of leadership training among the top level leaders from the hotel industry were as follows: 57% had 2-15 days, 21% had 15 days – one month, 7% had 1-3 months, 7% had 3-6 months, and 7% had more than 2 years of leadership training. On the contrary, 100 % middle level leaders from the hotel industry had 1-7 days of leadership training.

No association was observed between total days of leadership training and the top and middle level leaders from the hospital and the hotel industry (Table 40).

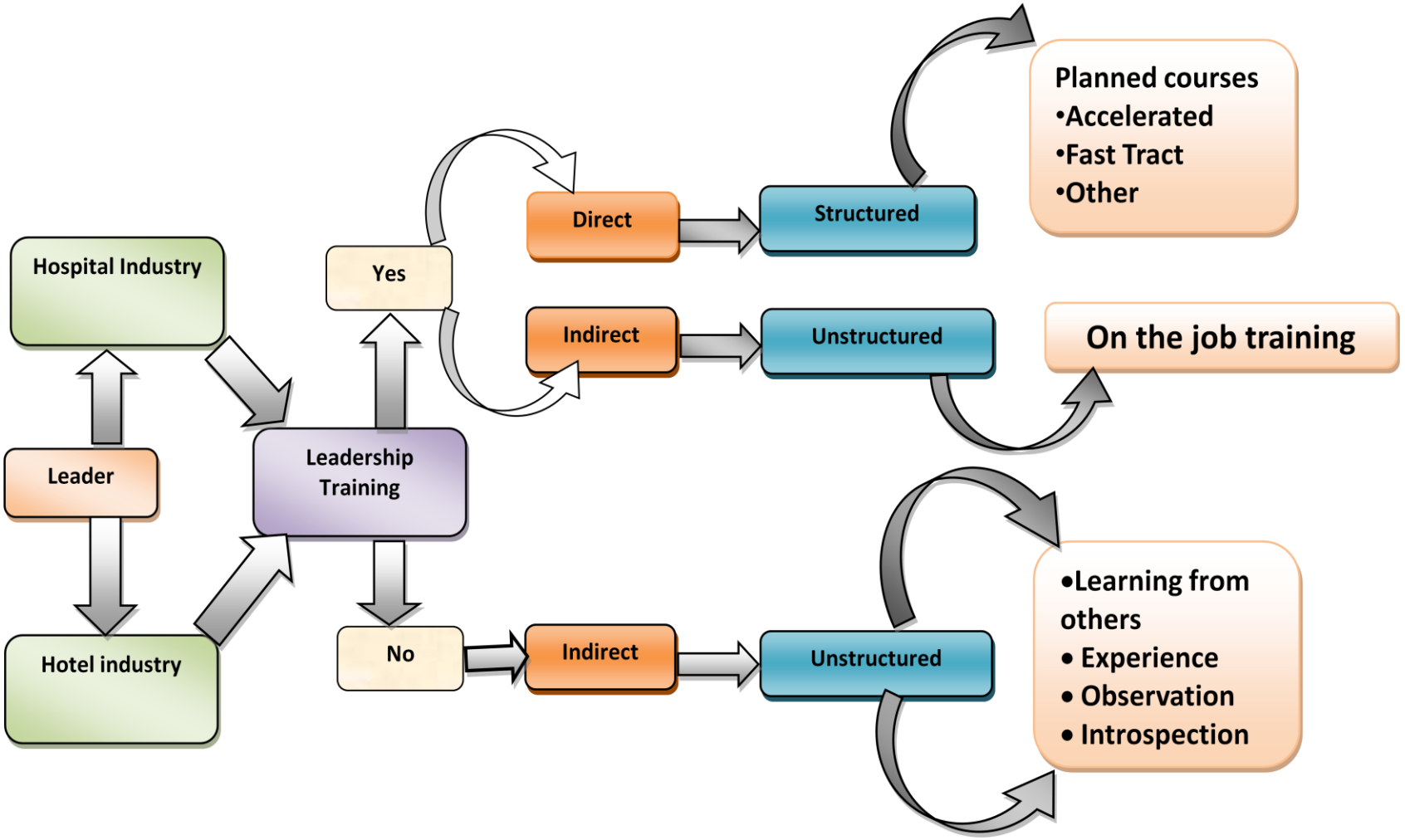
Item D-X: Adequacy of leadership training:

Table 41: Percentages of the top and middle level leaders from the hospital and the hotel industry and adequacy of leadership training n=41

Level of leadership within Industry	Yes	No	Not applicable [as leaders did not have leadership training]
Hospital Top level leader	3(30%)	3(30%)	4(40%)
Hospital Middle level leader	2(18%)	3(27%)	6(55%)
Hospital Consultant	1(100%)		
Hotel Top level leader	13(93%)	1(7%)	
Hotel Middle level leader	4(80%)	1(20%)	
Hospital χ^2 value= 3.320; p value= 0.506 (NS) Hotel χ^2 value= 0.647; p value= 0.421 (NS) NS= No Significance; χ^2 = Chi Square			

Table 41 depicts equal percent (30 %) of the top level leaders from the hospital industry expressed that leadership training was adequate and not adequate. Whereas 18% middle level leaders from the hospital industry felt leadership training was adequate and 27% expressed it was not adequate. On the other hand majority (93%) of the top level leaders from the hotel industry reported that leadership training was adequate, with only 7% leaders from same group stated that it was not adequate. 80 % of middle level leaders from the hotel industry reported leadership training to be adequate. No association was observed between adequacy of leadership training and the top and middle level leaders from the hospital and the hotel industry (Table 41).

Figure 21: Overview of leadership training in the hospital and the hotel industry



Qualitative results:

Theme 3: Leadership training:

Leadership training theme emerged during the analysis of qualitative data obtained from the face to face interviews. Many codes are illustrated under this theme such as overview of leadership training in industry, leadership training according to category of employees, types of leadership training, leadership training methodology, and leadership training course content.

Figure 21 illustrated overview of leadership training for both the industries i.e. hospital as well as hotel industry. Data revealed that the hospitals and the hotels may or may not have in-house leadership training. Interview data confirmed that some organizations had the leadership training delivered either by a structured program or in an unstructured delivery system. Leaders learned leadership by "on the job" training or learned by experience and/or observation and/or introspection. After analyzing interviews of leaders from the hospital and the hotel industries, it has been observed that the hospital industry lacks leadership training as compared to the hotel industry. Following codes described leadership training in the hospital as well as the hotel industry.

Code 1: Leadership training in the hospital industry:

All leaders from the hospital industry unanimously accepted that there was no leadership training in the hospital industry. Individuals who hold leadership positions in the hospital were either in their position by chance, or by virtue or by experience, or by ownership of the institution.

> ***P31 [hospital top leader]:*** *"Current leaders are not trained well for leadership. Many of them do not have the background which is required for a leader. There is no formal* (leadership) *training as such. Most of them have become leaders because of their experience in medical field, not because they had management education or leadership training specific. I don't think 90% of leaders in our healthcare industry are all by…you know because they are there holding leadership positions, they have their own*

money (ownership) *or they have reasons to that through experience* (or seniority) *in medical field".*

P37 [hospital middle leader]: *"In the present situation there is no specific training for leadership. You have to learn by experience. HRD department is there but they do not develop such skills in my opinion".*

P27 [hospital top leader]: *"As far as defense organization is concerned after the merger of specialty and admin cadre there is no leadership training is imparted to specialist who take over as an administrator in any position in defense service".*

P28 [hospital middle leader]: *"It is not given so much importance as it should be, particularly in the management person so that part yes we can stress more on the leadership aspect. Little more to be done on that…There is little touching upon leadership aspect but I don't think it is well understood and that much detail in healthcare industry".*

P25 [hospital middle leader]: *"No, I don't think the leadership is very well trained in the function of leadership. Even though the healthcare industry has for most of the historical purposes it is always been laid by clinicians. However, clinician's role today has become very specialty centric and the quantum of knowledge which is available does not allow them to participate in administrative management of hospitals. So overtime the complexity of hospital has become menace. The knowledge of clinical field has become huge and if you expect good clinician to be able to administer hospital on full time basis very difficult without professional qualification or training of the administration (and leadership). So at least in India we haven't moved on to training our hospital leadership in administer or running hospitals. And those who are grown into this field have grown in by experience".*

Few leaders from the hospital industry debated on clinicians holding the leadership position as an administrator without any leadership or management training. Hospital leadership and management are dominated by the clinicians.

However, few leaders agreed that the scenario is changing and individuals who are trained either as an administrator and/or manager will hold the leadership positions in the healthcare in the near future. However, currently leadership positions and job descriptions mainly depend on the leader's medical and non medical background. One of the quotes denotes this fact as follows:

> ***P25 [hospital middle leader]:*** *"In hospitals unfortunately the hierarchy is such hospitals will by enlarge remain the domain of doctors as the leaders. And as long as clinicians remain as leaders they will not accept anyone who is not equivalent to him, his educational status to take decisions which affects him... So very typically you see that hospitals are divided into direct operations and clinical roles. The operations roles are now being offered to the MBA graduates from other industries, other colleges. I have seen people coming from automotive industries, from hotels and hospitality, from tourism. I have seen people come over and they are doing…but the director medical services are always clinicians who are remained or shown some propensity towards administration. They have been put there as medical directors".*

Some leaders made efforts to learn about leadership and management during their work experience, interacting with others, participating in extracurricular activities during student life. For example:

> ***P38 [hospital top leader]:*** *"I did not have any formal leadership training. When I started working and people around you give and share thoughts you come to know what to be done and you learn some techniques and you become more and more perfect."*
>
> ***P27 [hospital top leader]:*** *"It is kind of on the job training. It is kind of learning on the job. So I don't think there is any structured course laid down where individual can always look forward to undergo any such kind of courses. I don't think there is any. Its individual's own wish how exactly he wants to grow how he learns medico legal aspects and go and learn the soft skills also but as such it is not available in the organization".*

> ***P37 [hospital middle leader]:*** *"When person gets admitted to medical college he remains here for four and half years during that time he is exposed to student council and many activities are organized in the college through these activities they learn the leadership qualities".*

When asked about availability of leadership training within the current organization, only two organizations from hospital industry reported they had some sort of training for developing individual's leadership abilities. Organizations which had leadership training were: one was a defense organization and other was a corporate hospital. Following quotes clarify the same:

> ***P27 [hospital top leader]:*** *"As far as our organization is concerned we do undergo various types of courses which do teach us leadership qualities, management qualities. There are courses which every medical officer has to undergo. They are compulsory".*
>
> ***P25 [hospital middle leader]:*** *"Yah, we have in our service organization we have multiple training courses particular seniority of officer's growth. So we are trained to undergo courses like junior command and senior command and then there is something called senior officer's course. Then we are exposed to national defense college and long defense management course. These are actually leadership courses".*
>
> ***P31 [hospital top leader]:*** *"Yes, there is a systematic grooming of people. They have to undergo certain defined training. They also have cycle of personal development training. We call it PDT. We do that for every person".*

Result revealed that apart from these two organizations rest of the hospitals neither had any leadership training for their employees to train or update or strengthen leadership ability of an individual; nor did they have trained hospital administrator.

Code 2: Leadership training in the hotel industry:

In contrast to the hospital industry, a majority of leaders from the hotel industry reported that their leaders are trained well for leadership and they also have leadership training facilities in their organizations. Only one hotel top leader expressed that *"I don't think there is any kind of coaching, grooming in terms of leadership" (**P15**).* Sub code emerged was experience helps to refine the leadership styles. Leaders from the hotel industry polished their leadership style and leadership skills with experience. Experience under the supervision of the mentor helped others to develop their leadership in similar fashion. For example:

> ***P44 [hotel top level]:*** *"Lot of leaders in hotel industry who are actually fit enough to be mentors. I would say majority of them earned their positions. They evolved their leadership style based on the different people they worked with. They adopt different way of handling the situation depending on whomever they worked under. So, it is not just one person. So person who comes out through hard work happens to be a better leader than the person who finishes in a one year and get the position".*
>
> ***P45 [hotel top level]:*** *"Yes. Current top leaders in industry are experienced from other parts of hotels, internationally and heading the current departments. We really see the confidence in them and how to plan the department so that they can ensure the smooth operations".*

It was reported that the majority of the leadership training took place on the job. Class room learning is limited and not enough to cater the needs in actual field operations. Practical training is equally important. Thus, there are a number of training programs available for an individual to develop his or her knowledge and skills and help to climb up the ladder in the hotel industry. Majority of times the individual is supported by the mentor.

> ***P11 [hotel top leader]:*** *"Theory does not teach you much of leadership qualities. You have to be in frying pan then you learn your leadership skills".*

P6 [hotel top leader]: *"Overall development of leadership skills that level I think it is only about 10% at that level. 90% does happen on the job".*

P15 [hotel top leader]: *"There is no classroom set up for coaching. It is all on the job, on the field kind of it and you are attached to somebody to learn these parts. So there are these modules which are available".*

Leaders from the hotel industry reported that leadership training and grooming occurred according to the type of organizations. For example, in large chain of hotels or hotels having an international brand has such training facility but small hotels do not have any leadership training facility.

P6 [hotel top leader]: *"It largely depends on which organization we are looking at. See, hotels largely divided in structured segment and unstructured segment. If we talk about large group or chain hotels, I think trainings are very structured in a way. There is sufficient planning which is done. Training is very well taken care of on the leadership aspect as well. If you come to unorganized structure, it is more of …ownership or proprietorship concern".*

Few hotel leaders discussed training programs they have in their organizations such as accelerated leadership development program (ALDP) and fast track programs to uplift junior employees on the leadership positions in the shortest possible time due to scarcity of human resource on leadership post in the hotel industry.

P45 [hotel top level]: *"We do have accelerated leadership development program (ALDP). We do it over here. There are certain modules like think ahead, celebrate difference. These are the things which leaders should do. Why we think ahead, because as a leader one has to think beyond what associate is thinking".*

P15 [hotel top leader] : *"…Hyatt does the corporate leadership training program, Taj has TNV, TO programs, Oberoi has OCD".*

> ***P44 [hotel top level]:*** *"…Only 1- 2 % people may succeed and that to they are pushed to achieve whatever positions. We just give due consideration whether they are comfortable in that positions or not, nobody is really known, so this becomes an area of concern in many places. Even any of the international companies they think ten times (before appointing a leader). This is why in International companies they have programs within to promote people, put them on a fast track or select them as a corporate…stuffs like that. We have fast track programs things like that from associate to team leaders, from team leaders to Assistant Manager. Every level you have fast track. If I have 200 associate here then I have to look at each department how many are stars. So by creating this program one, you are recognizing his/ her skills because one of the key things is recognition and two, you are allowing the person to imbibe the responsibility because he has given specific responsibility not relating to his specific department. He will be asked to go and work in different department, interact with them, then they recreate entire thing in front of you. So we choose people not only based on appraisal but on continuous basis".*

The above mentioned differences showed wide gap in the leadership training between the hospital and the hotel industry. The hotel industry has leadership training whereas the hospital industry still has to go a long way to develop leadership training for their current as well as future leaders. One way to develop the leadership is, the hospital industry can study the way hotel industry is molding their leaders before giving them leadership position and transfer that knowledge and skills into the hospital industry as appropriate.

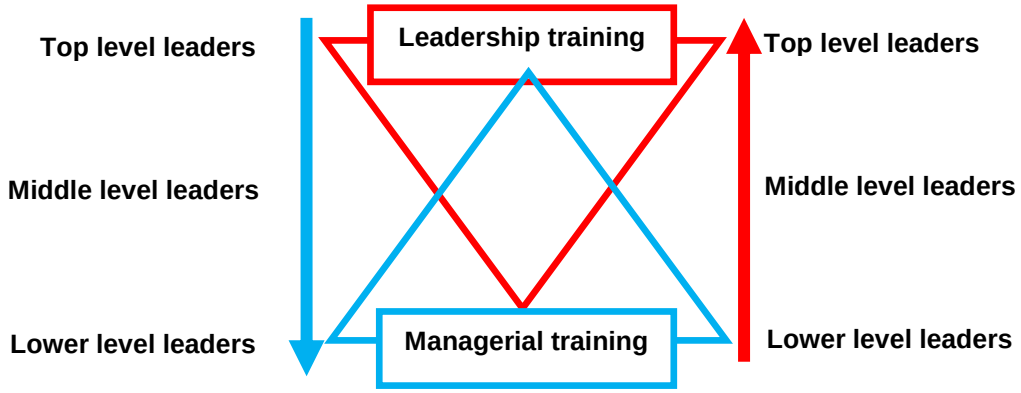
Code 3: Leadership training according to categories of people:

From the interview scripts, another code that emerged was the leadership training to various categories of people. This is further divided under three sub codes namely leadership training to all employees, leadership training to selected

employees and leadership training for students. In this section, only first two sub codes will be discussed here and the last sub code i.e. leadership training for students will be discussed in the next section.

Interview data showed that the need of leadership training to all the employees is necessary in the hospital as well as in the hotel industry. However, significant difference was found in the suggestions given by the leaders from both these industries. Leaders suggested that lower level employees need more management training and less leadership training (Figure 22). On the other hand, inverted pyramid in Figure 22 shows that as you go up on the ladder, more leadership training is needed as compared to management training. Figure 23 shows leadership training according to level of people from the top level to the lower levels as well as students. Following statements of various leaders also represent the same:

Figure 22: Leadership and managerial training for the leaders



P25 [hospital middle leader]: *"I am very certain that certain amount of leadership exposure needs to be provided right down to the grass root level. It could be a combination certain amount of leadership training and certain amount of managerial training. So may be at lower level you have a smaller quantum of leadership and larger supervisory managerial training. As you go up the chain the quantum changes to more leadership and smaller managerial. But it should be there".*

P37 [hospital middle leader]: *"Higher post people go for leadership training but lower level people do not get opportunity to go for leadership training. So if some communication skills, leadership qualities that type of workshop or activities are organized, it will be always beneficial for all."*

P27 [hospital top leader]: *"If leadership is taught from the day one in our healthcare sector, Why not? They are going to hold the position in the future or may choose to become an administrator rather than staying as clinician. And every specialist also is a leader by himself; because he has to take decision at various levels, may be at junior level, and may be at middle level or later on in his life at higher level. So if one really gets exposed to kind of management and the leadership, procedures, policies, or precedents being present there, definitely it will help them… At every level why not you must at least make them aware of various leadership styles available and how exactly which style is going to principally fitting in that kind of decision making position they are holding. Even receptionist has to make decision over there. If she is forced on to consult every time there is no point. So she must have some kind of leadership style. She is the first contact in any organization. So she has to take decision on her own. She has to have leadership skills. She is dealing with public and she is dealing with public who are going to meet her may be at first time or may be at last time. So that kind of leadership style has to be taught to everyone, because everyone does not have their own ways and means to do it. Thus some kinds of education, training, or small workshops need to be there to sensitize them."*

P25 [hospital middle leader]: *"Yah, we have in our service organization we have multiple training courses particular seniority of officer's growth. So we are trained to undergo courses like junior command and senior command and then there is something called senior officer's course. Then we are exposed to national defense college and long defense management course. These are actually leadership courses. So it's progressive. It is based on age and seniority of the doctors up to the*

senior command courses is compulsory... So you might find some training regarding leadership roles for handling coworkers or colleagues. The senior technicians out of the rest of technicians may be put through a certain amount of training as to how to handle his colleagues as co workers and he will be speaker of that group but I don't think there is formal training as part of their curriculum. I don't think there is formal training for lower functionaries."

P31 [hospital top leader]: *"Leadership for supervisors, leadership for budding supervisors or communication training for certain people that we have to ensure that build into our system."*

Figure 23 presents overview of leadership training to various categories of people.

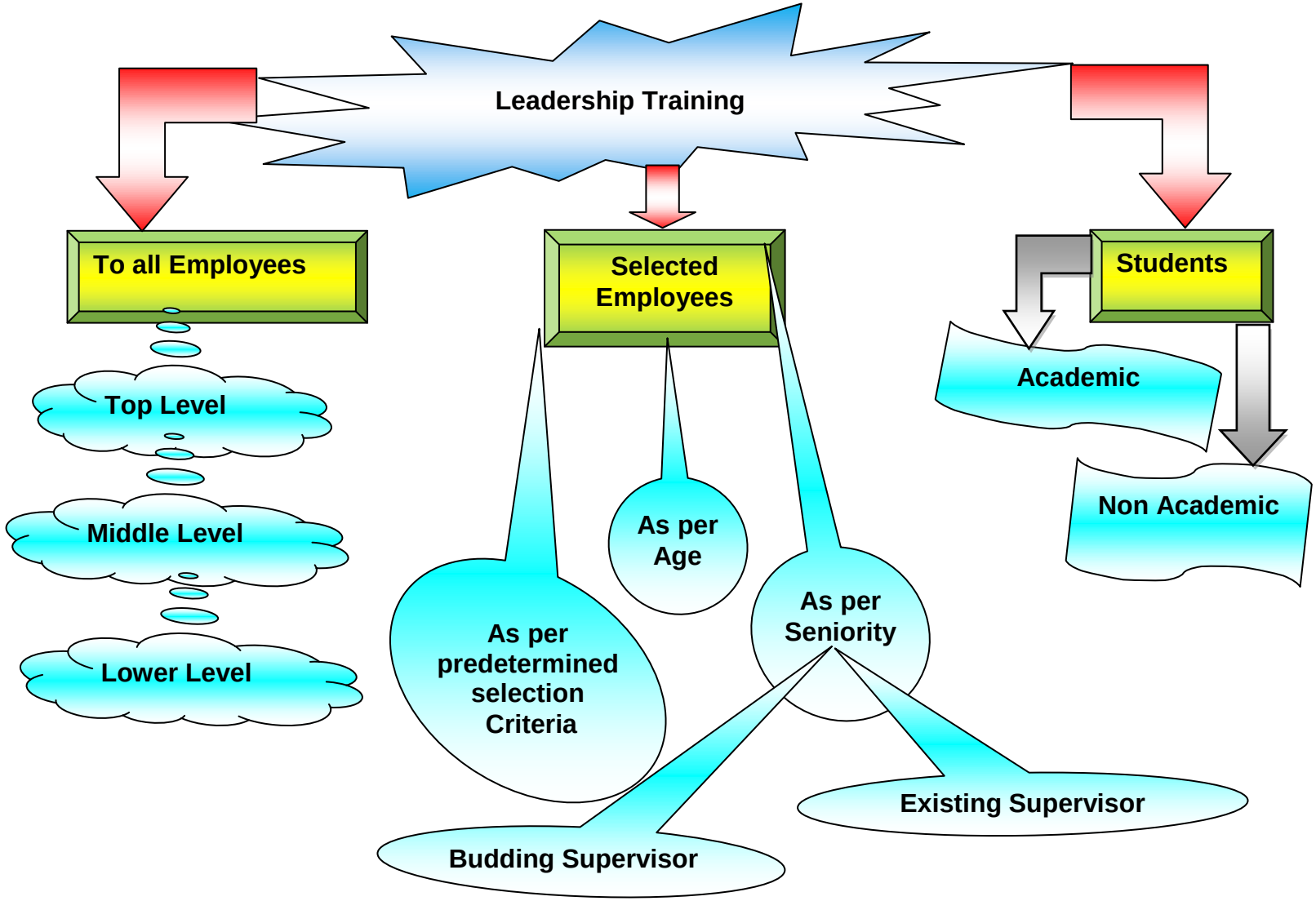


Figure 23: Leadership training to various categories of people

Code 4: Types of leadership training:

The third sub code i.e. leadership training for students is equally important which has been merged with this section. Leaders from the hospital and the hotel industries suggested various types of leadership training which includes academic courses as well as non academic courses. Figure 24 gives schematic presentation of types of leadership training. To undergo academic courses individual needs to enroll herself / himself for the course either by full time, part time, or by distance learning or online student position in any academic institution.

Current academic courses do not have leadership components in their curriculum. Thus, there is a need to include leadership concept in the curriculum. Leaders from hospital industries have expressed the weaknesses in the curriculum as follows:

> ***P27 [hospital top leader]:*** *"Not at all. There is hardly any course, any specialty course because whosoever is doing either it is MBBS followed by a specialist course in that particular subject, they don't cover at all."*
>
> ***P25 [hospital middle leader]:*** *"In fact syllabus I have seen of MBA programs in health even the MD program, there is a small element of leadership which is concerned on the organization behavior subject but it is no where preparatory to assuming role of a leader. It's only giving you a theoretical knowledge component which is not enough."*

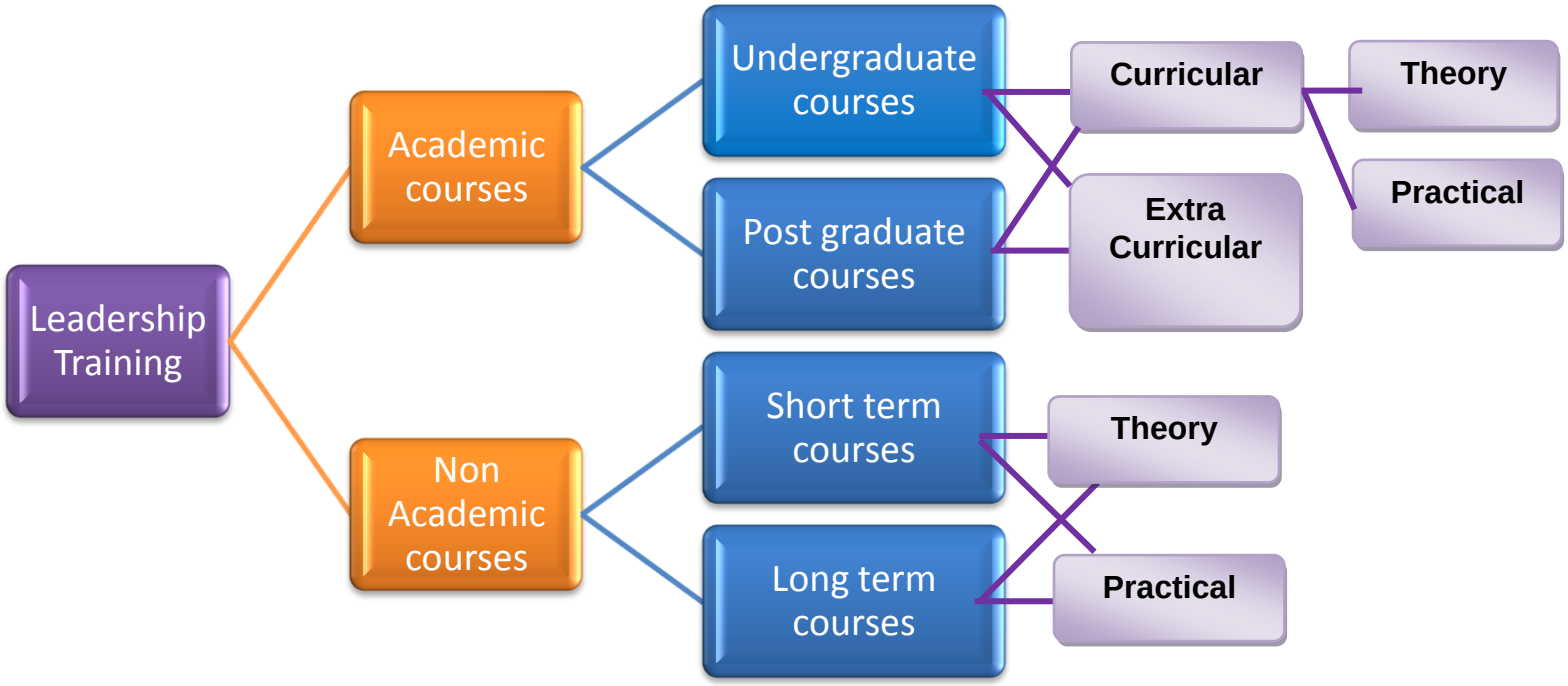


Figure 24: Types of Leadership Training

P29 [hospital middle leader]: *"I did my MBA, M.Phil from…, many diplomas…but I have never seen any course which gives you direct practical exposure for leadership. So that is I think it should be included in whatever they are taught in the classroom. Whatever I learned in classrooms I hardly can practice here. Day to day dealing with people is basically different."*

P31 [hospital top leader]: *"…probably what is lacking is they are never exposed to hospital leadership. What happens is everything is in theory. When it comes to practical aspect of observing people, understanding what leadership styles they are undergoing, implementing that in your day today scenario is again a challenge. That's what is required. That's why there is a requirement of understanding these things from hospital point of view."*

Code 5: Leadership training methodologies: Various leadership training methodologies (see Table 42) are in vogue especially in the hotel industry, e.g. buddy system, mentoring, on the job or field training as compared to the hospital industry. With the help of different training methods, teacher / mentor/ supervisor can develop individual's leadership styles and leadership abilities. These training methodologies reported by the leaders are: competency based training, field work, constant exposure in relation to leadership, hands on training, role playing and trigger survival tactic methods while teaching leadership to any individual (see Table 42).

Table 42: Leadership Training Methodologies:
• Competency based
• Field work
• Constant exposure
• Hands on training
• Role Playing
• Trigger survival tactics

P25 [hospital middle leader]: *"Harvard case study has reported that among all the traits now the trait leader demonstrated consistently during the period something called resilience. So how will we train our leadership to understand that you are going to be tested for resilience when you are leading your hospital so how do you take place? How do you test an individual for resilience? Unless we have test for that whether psychometric evaluation or role playing or game theory etc. either we do something of that or we just put through stress situation and allow them to build in like we do in the army for our officers of the arms and services; So that there is a breaking down the normal restrains and the emergence of survival tactics, survival instincts which business leaders and healthcare leaders must demonstrate."*

One of the leader's quotes reflects on how he was trained for his leadership:

P45 [hotel top level]: *"I had started my career as an associate over Taj. I was trained under somebody. We do have buddy system. In this buddy system the associate who is older in the organization they club together him with associate who is new in the organization. Older associate gives start known as 'March start' so he gives start to new fellow. He takes care like a father, guardian. It is like mentoring. I think person has to be mentor, guide for own first before guiding others."*

Code 6: Leadership training course content: Hospital leaders agreed to have practical components and field training or hands on experience for developing leadership of individual leader (Table 43).

P37 [hospital middle leader]: *"I think theoretical things are not enough (need practical leadership training). Constant exposure, constant counseling is important. Field work is important. With experience only they become good leader. Workshop or activities organized will be beneficial for all."*

P25 [hospital middle leader]: *"So the curriculum of training whether it is MBA, whether it is masters program or MD program should include hands on, role playing."*

P28 [hospital middle leader]: *"It is good to have little grounding but ... every person is not the same... So it basically understands the grammar of things is good but how you translate it into actions (practical aspect) is what matters at the end of the day."*

Table 43: Leadership Training Course Contents

Human skills	Conceptual skills	Technical skills
• Communication Skills • Counseling • Develop teams • Develop ability to give importance to others than self • Developing Inter-personal relationship	• Creative Problem solving • Decision making • Survival tactics • Bird's eye view • Look beyond the surface/ problem • Develop ability to drill deeper for solution/ Answer	• Technical competencies
Other leadership training course contents are: • Leadership styles • Leadership versus management • Forecasting • Global perspective • Holistic approach		

Various leadership training course contents were suggested by the leaders from both the industries. Leadership training course contents are compiled in the Table 43. These skills can be divided under three headings: human, conceptual and technical skills. Following quotes depicts the same:

P25 [hospital middle leader]: *"If you want to improve the quantum and quality of a leadership in healthcare we have to have means and ways of*

more creative problem solving, more ability to drill deeper for solutions and answers, more ability to built teams and more ability to lesser their own importance and give importance to front line workers. All these cannot happen just by theory. Individual has to work. Experience that the leadership, relationship is developing from it's called didactic relationship in the sense you will accept me as a leader so to me to be a leader I need you, right? By in isolation I am no one… I have a belief that the leadership role requires two essential components. One is personal competencies. You could say integrity, honesty, knowledge, empathy which is part of the individual's personality which is in born or inculcated. The other part is training to manage an institution. It is like saying can someone who is administering the auto industry be suddenly asked to administer health industry. I don't think so. So there need to be a part may be at a higher level of specialization where you need to train people in the leadership role functions… Training in content of leadership theory is, as well as training in how to modify your style when the context changes. Harvard case study has reported that among all the traits now the trait he demonstrated consistently during the period something called resilience. So how will we train our leadership to understand that you are going to be tested for resilience when you are leading your hospital so how do you take place? How do you test an individual for resilience? Unless we have test for that whether psychometric evaluation or role playing or game theory etc. either we do something of that or we just put through stress situation and allow them to build in like we do in the army for our officers of the arms and services; So that there is a breaking down the normal restrains and the emergence of survival tactics, survival instincts which business leaders and healthcare leaders must demonstrate."

5.4 Research Question 5

Research Question 5: What are the other views of top and middle level leaders from the hospital and hotel industry related to leadership styles?

Qualitative data results:

Theme 3: Leader's skills:

No specific question was posed to the leaders on the skills a leader needs to possess. However, many leaders spontaneously added information related to skills that need to be possessed by the leader while expressing about leadership styles. Because these skills directly or indirectly support various leadership styles; a separate 'leader's skills' theme was developed and incorporated in this study under the research question 5. This theme is divided under three sub-headings. For example leader's skills related to self, leader's skills related to team and leader's skills related to the organization. Leader's skills as listed under these subthemes are as follows:

Code 1: Leader's skills related to self: Leaders listed following "skills of leader related to self" like commitment, resilience, to be able to see 'out of the box', good common sense, cool head, positive thinking, immense faith in self, positive attitude, focus, integrity, honesty. Do not give any excuses either for yourself or for anyone else. Do not show an aggression. Keep open and willing to learn new skills and to adapt to the changing scenario and understand that what an individual knew yesterday is not going to sustain today, so one must constantly keep on evolving.

Code 2: Leader's skills related to team: Leaders reported that a leader needs to posses various skills in order to handle teams effectively. These skills reported by them are empathy, compassion, and cheerful complement, communication, creating sense of belonging in the entire team, being with the people, being one among them, straight forwardness, non corrupt attitude, no vested interest attitude, emotional intelligence, and agility.

Code 3: Leader's skills related to the organization: A leader is the key person in any organization and he/she plays a role model for the followers and employees. Thus, a leader needs to demonstrate certain skills related to the needs of the organization. To name a few: being loyal to the organization and the customers, develop vibrant work culture, clarity of management decisions, update with technology and knowledge, keep watch globally, and keep your competitors position.

5.5 Time period leader had taken into consideration while answering the tool:

All top and middle level leaders were asked which time period they took into consideration while answering the leadership style items. Leaders were asked this question at the end of the self reporting survey. This was open ended question to obtain better understanding from the leaders related to their leadership style. Result reveals that all the top and middle level leaders reported that they considered entire leadership experience while answering items posed in the survey tool. For example, if leader had 1-5 years total experience as a leadership including leadership in the current organization those leaders mentioned they took 1-5 years into consideration. Whereas, leaders who had more than 20 years of leadership experience they reported that they took entire leadership experience into consideration.

Surprisingly, leaders who reported that during student period curricular and extracurricular activities prepare an individual for the leadership position, did not report that they took their student period also into consideration when asked which time period they took into consideration. Thus, it made researcher wonder that the information given during the face to face interview by those leaders was misleading to certain extends in relation to preparation of an individual for their leadership position.

5.6 Field notes result: A majority of leaders were open and willing to participate in the interview, but the hotel industry leaders were friendlier and wanted to share more information as compared to the hospital leaders. Researcher also observed that a 50 percent of hospital leaders lacked the basic concepts of leadership styles, or had a limited understanding of leadership styles mainly autocratic, democratic and participative leadership styles. On the other hand, the hotel industry leaders shared recent trends in leadership including emotional intelligence, current leadership training etc. and correlated with their experiences. The hotel leaders were more enthusiastic to share their personal experience and how they developed their leadership style as compared to the hospital leaders.

Looking at customer care, the hotel industry leaders had made the researcher comfortable and made sitting arrangements whenever necessary. One of the senior leader from the hotel industry even apologized for making the researcher visit their organization for the second time and felt sorry for delay in meeting time due to front desk communication issue and expressed that he would take care of it and pointed out that he would take care that no visitors should have such issue next time in his organization. Majority of the leaders from the hotel industry offered tea/ coffee and few leaders even offered snacks to the researcher. On the other hand, three leaders from the hospital industry offered coffee to the researcher and one leader also offered a lunch. Apart from this, although the interviews were scheduled in advance, majority of the hospital leaders did not bother to make comfortable sitting arrangements and not even offered a glassful of water to the researcher.

It was observed that few hospital leaders did not maintain eye to eye contact with the researcher while talking. In contrast, all the hotel leaders had eye to eye contact with the researcher. Another fact was the number of hospital leaders who did not allow recording of interviews was higher in number as compared to the hotel industry leaders. Discomfort was observed among the hospital leaders

when the researcher asked permission to record; but the hotel leaders were comfortable and easily gave permission to record the interview and no hesitation was observed among them.

To recap this result chapter illustrated qualitative and quantitative results in relation to each research question posed in this study. Next chapter discusses these questions and their results in details along with other literature which support the findings of this study.

Chapter 6: Discussion

Currently the hospital industry from the Pune city is going through a paradigm shift bringing corporate chains of hospitals into Pune. This is dramatically changing the structure and functions of the hospital industry. Therefore to suit such diverse, dynamic and complex needs of the hospital industry, hospital leaders need to adopt suitable leadership styles to reach the organizational goals. However, literature reviewed did not shed light on which leadership styles need to be adopted by the top and middle level leaders from the hospital industry, or whether there is a need to learn leadership and leadership styles from other industry leaders especially for example from the hotel industry. This was not clear from the reviewed literature. Hence the aim of the study was to examine the leadership styles adopted by the top and middle level leaders from the hospital industry from Pune city. This study is the first of its kind to study ten leadership styles of the top and middle level leaders from the hospital and the hotel industry from the Pune city. The study findings augment the current body of knowledge available regarding leadership styles adopted by the top and middle level leaders from the hospital industry from India and especially from the Pune city.

This section discusses each research question posed in this study.

6.1 Research question 1 and 2

Research Question 1: Which leadership styles are adopted by the top and middle level leaders from the hospital and the hotel industry from Pune city?

Research Question 2: Is there any association between leadership styles of the leaders from the hospital and the hotel industry?

Discussion related to research question 1 and 2:

Survey was conducted on ten leadership styles, namely autocratic, democratic, bureaucratic, paternalistic, laissez faire, transactional, transformational, charismatic, visionary and coaching leadership styles of the top and middle level leaders from the hospital industry in the Pune city and compared them with the leaders from the hotel industry. Additionally, face to face interviews were conducted to obtain more qualitative information related to the leadership styles. Such combination could not be revealed from literature. No single study from literature had actually focused on ten leadership styles and also obtained data from the interviews as was done in this study. Thus, this is a unique study.

Autocratic leadership style:

The leaders from both the industries supported autocratic leadership style during face to face interview as against to survey results. Survey results showed that percentage of the top and middle level leaders with high score in relation to autocratic leadership style was lesser in the hospital industry and hotel industry as compared to moderate score. Whereas, during interview six leaders from the hospital industry and two leaders from the hotel industry reported that authoritative style was appropriate in their industry. For example,

> ***P27 [hospital top leader]****: "…you have to be autocratic only, where you have to pass the order because this is organization's requirement."*

This means leaders gave a different picture during the survey as compared to face to face interviews. The reason for this is, as leaders were free to express their views and perception during the face to face interview. Another reason was, face to face interviews were conducted before the survey method; thus, leaders have become conscious while answering the items presented in the survey tool.
Arab et al. (2006) studied 385 hospital staffs and their perception related to their manager and chiefs. Most of the staff (77.4%) believed that manager and chief's leadership style was authoritative whereas leaders perceived that they were following democratic leadership style. This study did not test leadership style of the leader from their followers' perspectives to confirm or reject these findings.

Democratic leadership style:

Leaders from the hospital and the hotel industry expressed similar picture as presented in the literature in relation to democratic leadership style. All hotel industry leaders reported they use democratic leadership style. Whereas, 70% top and 90% middle level leaders reported they use democratic leadership style. These study finding are supported by Arab et al. (2006) who studied 8 managers and 8 chiefs along with their hospital staffs. Most of managers and chiefs (75%) believed that their leadership style was consultative. In this study qualitative data revealed advantages and importance of democratic leadership. For example:

> ***P45 [hotel top level]:*** *"People perspectives are different from others. I will be having some other perspective; you will be having some other perspective. Basically you have to teach him/ her in a particular way which fits in his/her learning. Ultimate motto is giving them particular knowledge".*
>
> ***P27 [hospital top leader]:*** *"You have to have participative style…because even subordinates working under you they are well read, they may be having better ideas, and better methodology to do what you want to do.*

> ***P38 [hospital top leader]:*** *"Whenever you make a participative leadership possibly different people with different capabilities can solve a complex problem together rather than one person solving it.*

These findings are in line with Arab et al. (2006), and Heever (2009). The reason for supporting democratic leadership was employees coming from different cultures, ethnicity, educational and socioeconomic strata in the organization. Such employees may possess better knowledge and experiences than the leader which directly or indirectly pressurizes leaders to use democratic leadership style. Moreover, qualitative results supports that leaders who used autocratic leadership style in their life did not get better results and they had many bad experiences, thus they changed their leadership style from autocratic to democratic.

Transactional leadership style:

Survey result shows more than 90 percent top and middle level leaders from the hospital industry and 100 percent top and middle level leaders from the hotel industry scored high on transactional leadership style. These findings are in line with Janssen's study. Janssen also reported that hospital CEOs showed strong transactional leadership behavior (Janssen, L. 2004). However this needs more in depth attention. Transactional leadership stresses reward for the work done or goal achieved by the follower (Frey et al., 2009; Janssen, 2004)). But giving a reward every time when employee achieves something is a real concern; verbal reward is acceptable, but other rewards which involve money (e.g. buying gift for employees), unnecessarily increase financial burden on the part of organization. Another risk is employees may become habituated of this extrinsic motivation which may hamper their intrinsic motivation to work for the organization. No single leader from both the industries mentioned about transactional leadership style.

Bureaucratic leadership style:

A majority of the top and middle level leaders gave high scores on bureaucratic leadership style. This reflects Indian culture of bureaucracy. The researcher indicates that, the leader uses this style as a safety precaution to remain in their current position, or retain future positions. Either leaders are pressurized from the organizations to follow such leadership styles or in other cases, leaders may not feel confident to take the risk while making decisions, or in healthcare, legal suits forces leaders to use bureaucratic leadership style to keep themselves away from legal matters. Whiting, C. (2005) cited that healthcare organizations are structured to be bureaucratic thus decisions in such organizations are sequential (pg7). Whiting (2005) also gave examples of hospital leaders who uses bureaucratic leadership style.

Leissez Faire leadership style:

Majority of the leaders gave moderate scores on this leadership style which is another concern. In this leadership style leader gives freedom for their employees to carry on the functions on their own. In the Indian scenario we see this picture frequently. The top and middle level leaders are never there in the organization when needed and thus other middle level leaders have to make their decisions to carry on day to day functions, this lowers productivity, motivation, as well as increases piles of workload. Hospital leaders support this style which worried the researcher as in the hospital, one has to minimize the use of leissez faire leadership style i.e. leaving decision making on the next line of management. Very few hospitals and very few units in the hospitals have competent personnel where such leadership may work to a certain extend. However, the researcher feels it needs more exploration to understand why hospital leader follow lassiez faire leadership styles.

Charismatic, transformational, visionary, and coaching leadership style:

To be a leader one need to posses characteristics of charismatic, transformational, visionary, and coaching leadership style. Although quantitative data shows 100 percent top and middle level leaders from both the industries gave high scores on these leadership styles, the researcher doubts if this is true. While analyzing results the researcher felt that follower's perception related to their leader's style would have benefitted to shed light on this phenomenon. After interacting with the few leaders during the face to face interview, the researcher did not feel that any charisma was present in several leaders. Majority of the leaders participated in the face to face interview but did not even mention the charismatic, transformational, visionary, and coaching leadership styles, nor did they give any hint related to the characteristics of these leadership styles while sharing their thoughts with the researcher. Only one hospital middle level leader highlighted the charismatic leadership style related to referent power of the leader in relation to leaders' expertise. This difference in information may be due to either unawareness of the technical nomenclature on the part of the leaders, or lack of knowledge of these leadership styles. None of the leaders talked about their vision while dealing with their followers. Vision is an important component in the transformational leadership style, and surprisingly, no leader mentioned about their vision, or the organizational vision and how he/she works towards it along with the employees. Thus, this results needs to be interpreted cautiously.

The national survey conducted by Xirasagar, et al., (2006) found that transformational leadership of 269 medical directors from community health centers (USA) had higher mean score compared to transactional leadership style. However, Xirasagar, et al., (2006) study focused only on the leaders from the hospital industry and focused on transactional, transformational and laissez-faire leadership styles of the medical directors. Results from this study did not show any association between leadership styles and the top and middle level leaders from the hospital and the hotel industry especially transformational, and

laissez- faire leadership styles. However, these results cannot be generalized due to small sample size and caution needs to be exercised while interpreting these results because it is possible that above mentioned results are due to self reporting bias on the part of the leaders who have participated in this study. Janssen, (2004) cited that managers, while describing their own leadership, self-inflate or rate themselves higher than those who rate them. However, further research is needed to generalize the findings of the current study.

Situational leadership style:

Only 50% hospital leaders supported this style. This means other leaders do not change their leadership style according to the situation which is again a major concern. In the hospital industry, situations change every minute as it depends on the patient's health and patient's response to the treatment offered and care given by the employees. Thus, the research provided an impression that situational leadership needs to be adopted by hospital leaders. One style fits all situations do not seem to be relevant in the hospital industry. Quotes from respondent are as follows:

> ***P38 [hospital top leader]:*** reported that, *"Actually many styles would be effective and different styles would be effective in different situations."*
>
> ***P5 [hotel top leader]*** represented situational leadership style as:
>
> *"You have to actually wear multiple hats at multiple times. It is extremely important that a good leadership can only be provided when you are able to visualize yourself as donning different hats, depending on the different circumstances and situations we face on daily basis".*

Mixed leadership style:

Only one third of the leaders from both the industries mentioned that they used this style. The researcher outlines that this is the best style suitable in the hospital industry. The researcher doubts whether leader emphasized situational

leadership as a mixed leadership style, however, the researcher did not have any way to confirm this concept. The research findings provide the impression that every hospital leader needs to possess certain characteristics of each leadership style to develop a mixed leadership style, so that the hospital leader will be capable of using mixed leadership style appropriately.

Interview data from the current study confirmed that leaders need to adopt multiple leadership styles. Each situation in the hospital demands a different leadership style. Hospital being a complex industry dealing with the life of patients, deals with employees who have different skills and knowledge, have different cultural backgrounds, multi linguistic, multi ethnicity, multi-diversity and multi-complexity of the hospital organization need a mixed leadership style where leaders have to understand the holistic picture of the scenario before making any decision. Thus, the hospital leader cannot focus on a single leadership style. Rather the hospital leader needs to adopt multiple leadership styles based on the context of the situation, task in hand, people and other resources available at a given time.

Results from this study reinforce the need for adopting multiple leadership styles in the top and middle level leaders in the hospital industry. Literature strongly supports these findings. Ahn, et al(2004) and Yu and Miller (2005) reported that ‘although many leadership styles are reported in the literature there is a wide agreement that there is no single leadership style which is the best’. Tannenbaum and Schmidt (1998) stated that, “Successful leader will not rely on only one decision making style, but will alter their leadership “pattern” along the leadership scale using varying amounts of leader control and group input according to the specific situation or problem, the organizational and societal environments, and other factors” (Tannenbaum and Schmidt pg 170-172 as cited in Strohmeier, B. 1998 pg 35). Northouse stated, “It would be misleading to say that one type of leadership style is better than the next. Each style has advantages and disadvantages, and not all constructs of style work in every

situation (Northouse, 2004). A leader who is flexible and able to manage challenging environments should assess each situation and adopt an appropriate leadership style" (Northouse, 2004 as cited in Chiabotti, D.J., 2006, pg 23). Heever stated that "it has been postulated that the changing environment of health care industry needs a mixture of leadership styles to lead the organizations" (pg 98).

Additional data on leadership style:

Results reveal that the top leaders take 70% and the middle level take 80% responsibility in whatever they do. The researcher has shown that this is not acceptable and the hospital leaders need to take 100 percent responsibility of their actions as they are dealing with the life and death of patients. In order to maintain quality in the hospital organization the leader has to take 100 percent responsibility of their actions. Leaders cannot shift their responsibility on others. Leaders need to constantly monitor their fellow workers and other employees who are working under their supervision or guidance. In other words leaders' who do not take responsibility, actually support lassiez faire results mentioned earlier.

Only 40 percent of the top level leaders always look at the problems from other perspective which is contradictory to the high scores they have given to democratic, paternalistic, transformational, visionary, and coaching leadership styles. This is another concern where the researcher saw that the leaders have overrated themselves on these leadership styles.

Sixty percent top level leaders and 82% middle level leaders, from the hospital industry said that they always shared their knowledge and skills with their team members. However, during the face to face interview, none of the hospital leaders expressed about knowledge sharing. Tieman, 2002 as cited in the Janssen, 2004 reported that despite CEOs wealth of experience in healthcare,

CEOs are doing little to train and develop the next generation of leaders (Tieman, 2002 as cited in Janssen, 2004). Researcher's gives three reasons for this is that, the hospital leaders are not comfortable in sharing their knowledge and skills with their followers either due to time constrains, or due to their own workload. The second reason for this is that, the hospitals leaders feel threaten that juniors will take their position if they share their knowledge or skills. The third reason is that, the hospital leaders may not possess more information or unique knowledge related to the field in which they could share knowledge with others.

Change in the leadership style:

In this study, leaders reported that their leadership styles metamorphosed over the years either due to the needs of the organization they worked for, employees they handled, or due to self awareness or introspection of their own leadership style and its outcome that made them change their leadership style. Likewise, Avolio (2005), as cited in Avolio and Hannah (2008) described that the leader development process is a lifelong in which the individual interprets and makes meaning out of own experiences which enhance the individual's understanding of self and their own development as a leader. The hospital leaders also expressed that geographical area of the organization, type of patients and employees they dealt with in those geographical zones influenced them to change the leadership style adopted by the leader; for example, in a military setting, or a super specialty hospital. However, Janssen (2004) and Nurse (2010) study showed opposite findings. Janssen and Nurse reported that no significant difference was found between type of the organization and geographical location of the hospital and the leadership style of the leader. Leaders from current study also reported that they adopt different leadership styles while dealing with their top bosses, their colleagues and their lower level employees.

Leadership style and the period of current leadership position held by the leader:

Results show another remarkable finding that the top level leaders with 10-15 years experience showed significant association with the autocratic leadership style. One of the justifications for this result is that the leaders hold the leadership position for a longer time in the organization and it is expected that they know better than others which may contribute in increasing their ego state. As the hospital and the hotel industry face the problem of employee turnover, the top level leaders have to use this style to direct the new employees and teach them the way to do their functions in their organizations. Another justification is as leaders remain for a number of years in the same organization his / her ego may develop in such a way that they may not be able to listen to the junior leaders as they look down on these junior leaders, although junior leaders may have knowledge and skills required to carry on managerial and leadership tasks more effectively.

On the other hand, middle level leaders who had less than one year of experience showed significant association with the lassiez faire leadership style. Similarly, middle level leaders with 5-10 years experience showed significant association with paternalistic leadership style (see the Item E-II results for details).

Leadership style and number of employees working for the leader:

It shows strong association between number of employees working under the leadership of the top and middle level leaders from the hospital industry. This study showed that the number of employees (1-25) working under the middle level leaders from the hospital and the hotel industry showed strong association between autocratic leadership style. Number of employees (51-100) working

under the top level leaders from both the industries showed association with the paternalistic leadership style.

6.2 Research question 3:

Research question 3: Is there any association between demographic variables of the top and middle level leaders with the leadership styles?

Discussion related to research question 3:

Research question three dealt with the demographic data of the top and middle level leaders from the hospital and the hotel industry (especially age, gender, educational status, leader's experience, number of employees working within their organization) and its association with the leadership styles of the leaders. The researcher observed some interesting differences among demographic data of the hospital and the hotel industry leaders as mentioned below:

Age:

None of the hospital top level leaders were below 40 years of age in this study as compared to the top leaders from the hotel industry. The researcher offers three possible explanations for this difference in age. The first possible explanation is that this difference may be due to the total years spent by the individual hospital leader to obtain health care degree and complete his/her post graduation degree, as well as obtaining required experience before holding the top level position in the industry. In India, on an average, the hospital leader spends a minimum of five years for obtaining Bachelor's degree in the health care either in Allopathy / Homeopathy/ Ayurveda or dental field. Another 3-4 years are needed to be spent by the healthcare professionals to obtain post graduate degree in selected stream of specialization. An individual also needs related experience before reaching higher positions in the organizations having a hierarchical structure. Thus, when the leader actually holds the leadership position in the hospital industry he/ she has already crossed the age of forty years. Nurse, E. (2010) and Xirasagar, et al., (2006) study also had similar reports. The Nurse (2010) study

reported that more than 50% of hospital CEOs aged around 51-60 years. In the Xirasagar, et al., (2006) study the mean age of hospital CEOs was 50 years, executive directors were 52 years whereas mean age of medical directors was 45 years. This study results are in line with the Nurse (2010) and Xirasagar, et al., (2006) findings.

This study found that the hotel industry leaders were younger as compared to the hospital leaders. The reason for this was that fewer years are required to obtain post graduation degree in non medical fields especially in the Indian context. For example, students spend three years to obtain bachelors degree either in hotel management / arts / commerce streams of education. Further two years are needed to complete post graduation degree, thus a total of five years of formal education after completing higher secondary level of education is necessary. Approximately age of the student at the end of obtaining Bachelors' degree is around 20 years. Adding two more years for the Post Graduation degree makes an individual 22 years of age. When this individual starts working in the hotel industry he/she is taken as trainee, then promoted as a junior manager, then as a senior manager and so on. Thus, their journey from the lower level to the top level positions is much faster in the hotel industry as compared to that in the hospital industry.

The second possible explanation is that hotel industry reported constant turnover of their employees including the top and middle level leaders due to opportunities available in the hotel industry in India and abroad. Therefore the hotel industry needs to upgrade their lower level employee to the middle or the top level positions with the help of 'Fast track' system. "Fast-track programmes are sometimes established with the express purpose of creating the leaders of tomorrow" (Hartley, J. and Hinksman, B., 2003, pg 35). This opportunity benefits the young employees to reach the top level position in the hotel industry at an early age. Thus, hotel industry top level leaders are younger as compared to the hospital top level leaders. At the same time in the hospital industry, especially the

leaders from the clinical side cannot have a fast track system because these leaders are supposed to make important decisions related to patient's lives and they are directly responsible for the life and wellbeing of their patients. Thus, fast track system is not suitable for the leaders from the clinical side in the hospital industry. However, fast track system may be possible for the leaders dealing with the non clinical areas of the hospital like finance, human resource, information technology, etc. However, further study is needed to be carried out in the area of fast track system in the hospital scenario.

Third possible explanation is that leader's age is also reflected in their total years of leadership experience. The hospital top and middle level leaders were more experienced as compared to the hotel industry leaders in this study. This finding is consistent with those of Janssen (2004) and Nurse (2010) study. For example, Janssen's (2004) study reported mean experience of hospital CEOs was 11 years. Similar findings were shown in Nurse (2010) study that majority CEOs from Ontario worked for 26-30 years whereas 11 CEOs from Florida worked for 31-35 years (Nurse, 2010). This study also shows that the top level leaders from the hospital industry had longer years of experience as compared to leaders from the hotel industry. This is because, in India, a leader working in the hospital, which has hierarchical structure may have to wait for a longer duration to reach the middle and the top level position due to scarcity of the top level positions in the hierarchical organization as compared to a matrix organization. Exceptions to this are those hospital leaders who hold the leadership position either by chance, or by virtue of ownership of the organization.

Experience:

Hospital leaders were older and experienced as compared to hotel leaders. Janssen's (2004) study reported mean experience of hospital CEOs was 11 years. Similar findings were shown in Nurse (2010) study that majority CEOs from Ontario worked for 26-30 years whereas 11 CEOs from Florida worked for

31-35 years (Nurse, 2010). Avolio (2005), as cited in Avolio and Hannah (2008) described that the leader development process is a lifelong in which the individual interprets and makes meaning out of own experiences which enhance the individual's understanding of self and their own development as a leader.

Gender:

This study revealed that there were four times more males leaders as compared to female leaders. Overall, male leaders outnumbered female leaders in both the industries i.e. hospital and hotel industry. However, the number of male and female leaders at the top level positions was equal in the hospital industry as against the hotel industry in this study. One of the reasons postulated for this gender disparity in the hospital and the hotel industry could be sampling technique and the sample size chosen for this study. Thus sampling bias could have influenced this result. This study is different from previous findings in terms of gender difference at the top level especially from the hospital industry. For example Xirasagar, et al., 2006; Nurse, E. 2010; ACHE reports 1990, 1995, 2000, 2006, and 2012 reported that gender difference was present at the top level positions in healthcare. The number of male CEOs was higher (38) compared to female CEOs (11) in the hospitals from USA and Canada (Nurse, E. 2010). Likewise in Xirasagar, et al. (2006) study, 72 % of medical directors were males compared to female directors (28%). Five survey reports (1990, 1995, 2000, 2006, and 2012) published by the American College of Healthcare Executives (ACHE) on leadership and gender also support similar findings. These reports showed that the number of male CEOs doubled (22%) as compared to the number of female CEOs (11%) from 1990 till 2012. Likewise, Norwegian data shows women were not given the top level medical administrative positions (Kvaerner, et al. 1999, pg 94). Further, Kvaerner, et al. (1999) postulated that men have significantly higher probability for all leadership positions as compared to females in healthcare.

Education:

It is apparent from this study that all the top and middle level leaders from the hospital industry reported that they were holding post graduate degree or post graduate diplomas as their highest qualification as compared to the hotel industry leaders. The reason for this can be that, in the Indian scenario, an individual has to compete for the top and middle level leadership positions in the hospital industry because of the less number of posts for the top and middle positions especially in the hospitals which have hierarchical organizational structure.

Additionally, in India quota system, reservations for an individual belonging to the minority groups, or on the basis of casts and religions, further reduces the chances for the general category individuals to reach the top and middle level positions in the organization. This may be one of the strong reasons why an individual leader obtains a post graduation degree, it may add value to his/her curriculum vitae and help the leader to sustain in the competitive market especially in the hospital industry. This study produced results which corroborate the findings of Nurse (2010) who reported that master degree holder CEOs were higher in Florida hospital. In contrast, Kritskaya and Dirkx (2000) reported that degree programs are not successful in developing effective leaders. This may be the reason for a generalized decreasing trend that was observed in leaders holding masters degree or doctorate degree from 1990 till 2012 among female leaders (95%, 86%) and male leaders (95%, 87% respectively) in United States of America (ACHE report 2012).

The findings of this study revealed that a majority of the top and middle level leaders hold their basic graduation degree from their own field of expertise that is to say, the hospital leaders held Allopathy degree i.e. MBBS degree and the hotel management leaders held hotel management degree as their basic graduation degree. As a leader, it is important to hold basic graduation degree from the respective field as it adds weightage to their curriculum vitae while

applying for the top and middle level leadership position in the organization. In other words, in Indian scenario, an employer believes in holding a basic graduation degree from the respective field of specializations. This means an individual has a basic understanding of that particular system and the employer also assumes that this basic degree helps the leader to make decisions and carry out the operations and lead effectively as a top or middle level leader within the organization. It is surprising to observe that none of the hospital leaders had basic graduation degree from the management field. It is important for the leader to understand basic management principles to carry on smooth operations because to be an effective leader one has to be an effective manager. Another justification for this is that in the Indian scenario, healthcare field is dominated by the medical professionals. As mentioned earlier, the selection and recruitment for the top and middle level positions is also based on the basic graduation degree along with an individual's post graduation degree and experience. This is one of the major barriers for the leaders from the non medical background to enter and hold the top level leadership positions in the Indian hospitals. An individual with non medical background may get the top level position in the non clinical areas like finance, human resource, stores and inventory departments to name a few, but not in the clinical areas.

Division of leadership in Indian hospitals:

Currently, in several Indian hospitals, leadership has been divided under two headings i.e. non clinical administration and clinical administration. Assumption behind this division is obvious. Medical professionals are reluctant to hand over the leadership of clinical fields to a person with non- medical background. This is because they are skeptical about the non medical person's competency to handle, or control the clinical domain. Another assumption is that medical professionals from India are uncomfortable to work under the non medical professionals.

Developed or Western countries show a totally different picture. In developed countries, non medical person holding the CEOs post in the hospital is commonly seen and surprisingly, the medical professionals also support the same. Although this scenario is percolating slowly in Indian healthcare scenario, the change is very slow. Indian healthcare has to go a long way to offer a top leadership position to an individual with non medical background and selecting the candidate for the top level positions based on the capacity, capability and competency of the individual, than merely based on the basic graduation degree. Today, in few corporate hospitals the top most position is not necessarily held by a medical professional. However, future study is needed to determine the reasons why Indian medical professionals hesitate/ resist an offer of the top level positions to be given to the non medical individuals.

Management Training:

This study found that the majority of the top and middle level leaders from the hospital and the hotel industry reported that they had management training in their respective fields; for example, either in the hospital administration or hotel management. However, qualitative data from this study showed that a majority leaders from the hospital industry reported that the curriculum lacked management and leadership components. A majority of the hospital organizations do not have programs or facilities to develop and strengthen an individual's management and leadership. In case this claim is true, the research has indicated that all the leaders should undergo management and leadership training as an essential requirement to hold leadership positions in the hospital and the hotel industry. In the current study, 60% of the top level leaders were holding Masters Degree in healthcare like MD in hospital administration or MBA in Healthcare management. This finding is in line with other literature. A majority of Western hospital administrators (from USA, and European countries) are trained and leaders hold Masters in Hospital administration or Masters in Business Administration degrees (Chuwattannakul, 1993). Chuwattannakul, et al.

study was on the hospital administrator and their supervisors from Thailand. Likewise, Xirasagar, et al. (2006) study revealed that only 31 % of executive directors of community health centers had formal postgraduate degree in the management i.e. MHA, MPH, or MBA which is fifty percent lower than in this study.

6.3 Research question 4:

Research question 4: What are the perceptions of the leaders from the hospital and the hotel industry regarding leadership training and development?

Discussion related to research question 4:

Leadership training is essential in order to develop and strengthen leadership styles of the leaders. The research emphasizes that individuals who want to be an effective leaders must understand leadership as a whole. Training is more skill based (man management skills) whereas development is more conceptually based (problem solving, policy making, decision making) as described by Parry, K.W. (1998, pg 92).

Leadership Training and Development:

The findings of this study indicated that all 100 percent top and middle level leaders from the hotel industry reported that they had some level of leadership training. On the other hand, fifty percent of top and middle level leaders from the hospital industry did not undergo any leadership training. This finding is consistent with Rodriguez, et al. (2003) study which revealed that 70% of leaders did not have leadership training. On the other hand, systematic review result showed that although studies targeted medical professional for leadership training, these studies targeted either resident physicians with no formal leadership roles or physicians in mid-level management positions. No top-level leadership positions were involved in the studies for leadership training (Frich, et al, 2014, pg 671). Thus, lack of literature on leadership training in the hospital industry creates a need to explore this area in the future.

As mentioned above although the hospital leaders were holding leadership positions as the top and middle level leaders, 50% of these leaders did not have any leadership training. The current research offers three possible explanations for the difference in the leadership training and development between the hospital and the hotel industry leaders. The first explanation is that in a majority of the hospitals, individuals get to the top level position as per their seniority in the field. Thus, an individual may not take the extra effort to undergo leadership training. The second possible explanation is that there is a lack of interest on the part of the hospital leader to learn more about leadership. The third possible explanation is that the hospital management is not keen on developing leaders within the organization itself either due to lack of resources or lack of need from the hospital side, or they are not inclined to invest on the leadership training and development due to its intangible outcome. Avolio and Luthans (2006) as cited in Avolio, et al. 2010, reported that a review of the leadership intervention literature from the last hundred years only produced 201 articles on studies examining the impact of leadership interventions, and less than half were focused on leadership development (pg 634). Avolio and Hannah (2008) also cited that in 2007, organizations in the United States spent $12 billion on leader development.

Avolio et al. (2010) advocate that leadership development should be analyzed like other investment decisions (pg 635). This type of thinking will make the organizations invest on their leaders' development. Further authors described that return on development investment include the number of people going through training, the costs of training, the expected effect of training and duration of that effect, as well as the estimated dollar value impact for those who have gone and not gone through the leadership training (Avolio, et al., 2010, pg 635). Avolio, et al., (2010) reported that in house leadership training and development for the employees is economical than sending leaders outside for the training; this will help the organization to assess its impact in terms on 'return on development investment'.

The hospital leaders do not give importance to leadership training and development. This is because leaders from the hospital industry overweigh clinical training and expertise as compared to the leadership training. The researcher pointed that the hospital leaders believe that their clinical expertise can sustain them throughout the leadership tenure. However, “acquiring the skills needed for strong and effective clinical leadership is rarely seen as part of the clinical training and professional development of doctors” (Olsen,S. and Neale,G., 2005, pg 1219). “Clinical leadership is needed at all levels, not least in the clinical teams delivering day to day care in hospital wards. Traditionally, junior doctors absorb hierarchical leadership skills "by osmosis" from their chiefs, a model that is no longer appropriate “(Olsen,S. and Neale,G., 2005, pg 1220). Thus, Festa and Walmsley (2005) expressed that “Competent practitioners must learn to interact in and eventually lead teams of healthcare workers, yet little or no formal teaching is aimed at developing individual doctors' leadership skills or to helping them to understand the impact of their behavior and actions on the team” (pg 7).

Ah-kee, Elliott and Khan, Amir (2015) wrote in the letter to the editor that they strongly believed that leadership and management skills are crucial within the NHS and have been shown to positively impact the overall performance of doctors appointed to hospital boards of directors and clinical outcomes (pg 507).

It has been observed that there is a huge gap between the medical professionals and leadership development of these professionals in Indian scenario especially in hospitals from Pune. One of the reasons for this is the lack of training on leadership aspects in the medical curriculum. Medical professionals have not fully understood and are not convinced about the special needs for the management training and the leadership training. Few medical professionals however argued that medical professionals need only clinical competencies rather than leadership and management competencies. These competencies are: selection of leadership style appropriate to the institution, flexibility, team

building, understanding finance and financial planning, problem solving, and handling emergency situations to name few. Medical professionals are forgetting that they are the key players in the organization working for their unit and their department areas, or for a group of patients and their relatives, working with nursing staffs and other paramedical staff; thus, handling this diverse group of people needs a suitable leadership style. Because medical professionals do not feel the need for the leadership training, they resist spending time on the leadership training and development. LeBrasseur, et al. (2002) supported the notion that physicians resist leadership development. Similarly Cherry, et al. (2010) felt that there was a need to develop physicians' leadership program to educate physicians to work collaboratively across and beyond professional boundaries. Additionally "health care executives need to engage in direct, hands-on process to identify leadership capabilities needed by the organization, and to identify and develop physician leaders who exemplify these capabilities" (Cherry, et al., 2010, pg 39).

A majority of the top and middle level leaders from the hotel industry reported that they had undergone leadership training, as compared to the hospital industry leaders. Collin's (2002) meta- analysis is consistent with these findings by reporting that business industry conducted more (24%) leadership development programs as compared to medical industry (8%).

Leadership training and Development methodology:

The findings of the study support the argument that the top and middle level leaders from the hospital and the hotel industry had leadership training either during in service education or during workshops as compared to during graduation or post graduation studies. This is a very interesting finding which reflects upon lack of curriculum structure related to leadership training. Qualitative data results also reported lack of leadership components in the medical curriculum. Allopathy (modern medicine) syllabus for under graduation

degree from the Maharashtra University of Health Sciences (MUHS) was explored for evaluating contents of the curriculum in relation to leadership. Surprisingly, this exploration did not reveal any striking patterns that would change the interpretation of this study finding of lack of leadership component in the medical curriculum.

Communication word was observed at number of places in the Third MBBS syllabus of MUHS. For example, Psychiatry, Pediatric, Community medicines including humanities (preventive and social medicine), Surgery, and Ophthalmology subjects mentioned the word communication. Communication word in these subjects is mentioned mainly in their objectives and at some places in their contents. However, the communication in this syllabus is in relation to the diagnosis, or treatment / management of patient's diseases. Communication is not at all related to man management or leadership aspects in the MBBS syllabus.

Under IIIrd MBBS Community medicine including humanities (preventive and social medicine) subject it has mentioned especially under the skills **objectives** to "*develop capabilities of synthesis between cause of illness in the environment or community and individual health and respond with* ***leadership qualities*** *to institute remedial measures for this*". This objective had used the word' leadership qualities for disease diagnosis and management, however illustration of leadership qualities in the course content is missing. This objective highlights leadership for diagnosis purpose and its management not for developing leadership qualities in order to lead people and lead the organization. It can be argued that if students are supposed to learn leadership qualities for patient management, then why not to transfer these leadership qualities to manage and lead the organization from administration and man management angle. It is important to note that although leadership qualities are mentioned in the objectives, details of leadership qualities are missing in the syllabus content of theory as well as practical. Thus, it leaves the wide gap between objectives and course content of the MUHS syllabus, especially on how to teach leadership qualities to the students.

During the interview, leaders also expressed that a small component present in the syllabus does not prepare the candidate enough to hold a leadership position in a hospital. This evidence from the Indian scenario increases the need to include leadership training in the medical curriculum for medical professionals either in their undergraduate or post graduate course contents, but preferably both. Similar dilemma was observed in the Ah-kee, Elliott and Khan, Amir (2015) study. Ah-kee, Elliott and Khan, Amir (2015) highlighted the importance of Medical Leadership and Management within the UK undergraduate medical curriculum. However they reported that medical leadership and management education lacks consistency and current literature on how to incorporate this into the undergraduate curriculum, is scarce (pg 507). Thus, they suggested further work is required to implement a nationally cohesive Medical Leadership and Management program that is evidence-based, in UK medical schools (pg 507).

The above observation confirms the need of adding a leadership component in the under graduation and post graduation syllabus of allopathic system of medicine. During the face to face interview many hospital leaders reported that leadership training is not needed for the medical students because medical syllabus is already too heavy or packed and there is no room and time to add non medical subject or component like leadership and management. Additionally hospital leaders also expressed that adding a leadership component will increase burden on the teachers as well as the students. Likewise, Ah-kee, Elliott and Khan, Amir (2015) also raised the same concern that a mandatory year studying leadership and management within an already overcrowded undergraduate curriculum for medical students is not realistic and feasible (pg 507). However, few hospital leaders agreed that leadership training is important, but at the same time they expressed that doctors do not need leadership training as a separate component in the syllabus. Moreover, several identified barriers to the implementation of such education, including negative attitudes held by both doctors and students toward medical leadership and management still need to be addressed (Ah-kee, Elliott and Khan, Amir, 2015, pg 507). Observations from

this study, concludes that the hospital leaders devalue leadership training and felt that the clinical competency is more than enough for sustaining them during their leadership tenure.

On the other hand, the hotel management syllabus was explored to understand whether their syllabus has any leadership component. It showed that the hotel management syllabus has basic leadership components like developing communication, human relationship etc. in their syllabus (see the Annexure 3 for the same). Another important observation was that the hotel industry had strong leadership training programs and systems within an organization to develop an individual leader which is unfortunately lacking in the hospital industry. Thus firstly, the hospital industry has to understand and accept the need for leadership training and then include it in the formal curriculum of either graduation or post graduation degree or both.

This study confirms that leadership training needs more practical components to develop leadership skills and leadership styles required to carry out their work as a leader. This study supports “on the job” training which is equally important for leadership development. The argument from Kritskaya and Dirkx (2000) was that people learn best from their own experience. Likewise Lynham (2000) had pointed out that on the job training and learning from events and other people on the job actually enhances leadership development.

This study confirms that academic and non academic courses can be offered for developing leadership of individuals at all levels of management. Many training methodologies were reported in this study, for example, competency based training, field work, hands on training, role playing, and mentoring. Likewise, Ah-kee, Elliott and Khan, Amir (2015) suggested that although preferred methods for medical leadership and management education included experiential learning or simulation, quality improvement projects, and student audits; however, this could require inputs from professional bodies, including the General Medical Council,

Faculty of Medical Leadership and Management, and NHS Leadership Academy (pg 507). Frich, et. al, reported that “leadership development programs largely employed lectures, seminars, and group work rather than the broader set of teaching tools available for leadership development, including developmental relationships (mentors, coaching, peer learning partners), assignments (job moves and rotations, action-based learning projects), feedback processes (performance appraisal, 360° feedback), and self-developmental activities (Frich, et. al, 2014, pg 671-672).

Frich et al. (2014) examined the leadership programs from 45 studies and showed the use of multiple learning methods. Teaching methods were specified in 43 articles out of 45 articles studied in this systematic review. Of the 43 programs, 36 used didactic lectures/interactive plenary seminars, 32 involved group work (case-based discussions, exercises, group reflections), 16 included project work (action- based learning, project planning), and 12 reported the use of simulation exercises (simulated practice and role play) (Frich, et al, 2014, pg 671). Further, Frich, et al. (2014) suggested that interdisciplinary leadership development programs need to be designed to facilitate interaction between other leaders and giving the opportunities for developing the capacity to collaborate across professional lines, which may be important for team-based leadership (pg671).

However, Frich, et al., also cautioned the risk of interdisciplinary leadership development programs and using multiple methods in leadership training and development. They stated that "greater investment in programs using teamwork and multiple learning methods is likely to have the largest impact in the area of leadership development for physicians. And while these may be more expensive and time-consuming to undertake, real progress will likely require such resources, and lower-level efforts may continue to have a limited effect" (Frich, et al., 2014,pg 672).

Leadership training and development course content:

Various leadership course contents were suggested by the leaders from both industries (see Table related to training course contents). Communications, leader's skills, leadership style, conceptual skills, development of teams, technical competency were the contents highlighted for the leadership course. The findings of this study are in line with the Frich, et al. study, who conducted systematic reviews and found that content of the leadership development program found that 35 out of 45 studies, were focused on leadership development, 26 studies included teamwork, 13 studies included conflict management, 12 studies included communication as their major program contents (Frich et al. 2014, pg 658). Self awareness is a core of leadership; however this aspect was given less importance in the studies addressed in the systematic review (Frich, et al., 2014).

This study also pointed out trigger survival tactic as one of the course content. Likewise, Luthans and Avolio as cited in Avolio and Hannah (2008), expressed that trigger events in one's life contribute to changing the individual's leadership potential (pg 334). Further authors expressed that these trigger events in the life, create a state of disequilibrium which leads to an introspection and help the leader to change in his or her leadership style (Avolio and Hannah, 2008). Thus authors proposed to plan triggers which will help the leaders to develop their potential as a leader.

Duration of Leadership Training:

The current study showed that respondents had varied durations of leadership training. The study findings are in line with the other studies. Frich et al. (2014) reported that out of 45 studies they reviewed systematically showed that the duration of leadership training ranged from a half-day workshop to a three-year program. Most programs (n=32) were delivered as an extended course, most

often over a period of 12 months; fewer (n=13) were one-time events (such as a single workshop, conference, or a course) (pg 658).

On the other hand, although literature showed a few scholars had studied leadership, they did not report total days of leadership training in their studies; rather they reported management training of their leaders. For example, Xirasagar, et al. (2006) raveled that medical directors' management training ranged as follows: 11% had no management training, 37% had 1-7 days, 31% had 8-29 days, 7% had 30-89 days, 2% had more than 90 days training. 13% had MPH, MH, or MBA as well as >30 days of in service management training (Xirasagar, et.al. 2006). This research strongly suggests that leadership development is a continuous process. Leadership cannot be developed within a day, or within few days of training. Thus, leadership training needs to be planned for short durations but such short courses need to be organized, reorganized and offered after specific time intervals to either update or strengthen leadership styles of the leader. How many total days of leadership training is needed to develop and strengthen the leadership and leadership style of the hospital leader is not yet explored in detail. Thus this area can be a topic for the future research.

In short, the researcher strongly recommends that the hospital industry in Pune needs to follow the footsteps of the hotel industry on leadership training aspects, to develop current and future leaders in the hospitals to begin with. Later, each hospital can modify leadership training content, methodology etc. according to the needs of the hospital. Compared to the hotel industry the hospital industry needs to go a long way to develop leadership training facilities within the organization. Although this study suggests multiple methods to deliver the leadership training course content, however, the aim of all this training must be to give the best possible leadership exposure and live experiences to the individual leader.

Leadership development, training or education must focus on selecting the appropriate 'would be leader(s)' who have a potential to grow as a leader (Hartley and Hinksman, (2003). There is a need to select the right time, right resources, right outcome and right evaluation strategies. Two studies emphasize this aspect: "A good leadership development program may be thought of from two perspectives: the organizational and the individual" (London, 2002). "At the individual level, there must be an assessment of the leader's (or potential leader's) talents and a way of determining areas that need further development. The organization then provides the resources to enable the individual development as well as support the ongoing development of leaders" (Smith, et al., 2004. pg 64). Avolio and Hannah (2008) reported many factors which affect leadership training and development. It includes leaders readiness, organizational readiness, leaders motivation, funding allotted for leadership training, time and duration of the training, and experience of the leader.

Factors need to be taken care before implementing Leadership training and development program:

Organizational factors play a major role in leadership development. Smith et al. reported that "*The authors believe organizations must consider several factors before implementing a leadership development program. For example, an analysis of the organizational culture for evidence of covert or overt gender bias, formal programs that provide support for both female and male leaders, examination of organizational policies and benefits for presence or absence of particular policies that affect female leaders (e.g., child care, maternity leave, flexible working schedules)"* (Smith et al., 2004. pg 64).

This study had reported multiple factors which affect leadership style of individuals either they are related to individuals themselves, their family background, their socioeconomic and cultural background or factors related to

the organization. The research strongly recommends the need to evaluate factors affecting leadership training before implementing leadership training to maximize the outcome and results of the leadership training programs. This result of this study appeared to be more in line with the research performed by Janssen, 2004, Avolio and Hannah (2008), who reported multiple factors affect leadership development and leadership style of the leader.

6.4 Research question 5:

Research question 5: What are the other views of top and middle level leaders from the hospital and hotel industry related to leadership styles?

Discussion related to research question 5:

Results of this study revealed that leaders reported a number of skills related to self, team and the organization. These skills are in line with the Frich et al. (2014) study which also mentioned leader's skills as human, conceptual and technical skills. Frich et al. (2014), conducted a systematic review on 35 studies from Ovid Medline from 1950 till 2013. Results of this systematic review reported that leadership development programs for physicians were focused more on skills training, technical and conceptual knowledge rather than personal growth and awareness. Frich et al. (2014) reported that the studies aimed to develop leadership skills (64%), develop technical and conceptual knowledge (60%), and developing personal growth and self awareness (20%) of physicians.

"Improving leadership skills among today's doctors is obviously important and necessary. We must also consider, however, how best to educate the next generation of doctors. Moreover, with the expansion of medical training and increasing numbers of students, there is the risk that clinical training will become less personal and bedside teaching will suffer" (Olsen,S. and Neale,G., 2005, pg 1220).

Chapter 7

7.1 Limitations of the study:

The following limitations of the research were noted and should be considered in the wider interpretation of the results. This study included several limitations in order to generalize the results of the study to other industries or other hospitals outside the Pune city.

The main limitation was inclusion of only the hospital and the hotel industry from a single city. This limits the generalization of results, conclusions to be applied to other industries in other geographical areas. The foremost limitation was that this study focused only on the leaders' self perception of leadership style rather than understanding their followers' perception with respect to the leadership styles of these leaders. Self reported bias cannot be avoided with this technique. Further study is needed to explore both sides i.e. from leaders' perspectives and from their followers' perspective related to the leadership style which will help to eliminate this bias.

Another limitation was related to the sampling technique used in this study. Study participants were selected by convenient sampling technique. Therefore, the results of this study are applicable to the leaders and organizations identified in this study. Study samples were small in this study due to availability and accessibility of the top and middle level leaders from the hospital and the hotel industry. However, this was sufficient as both quantitative and qualitative assessments have been used.

The study respondents were interviewed and surveyed only once. Leadership style is a complex phenomenon and may not be thoroughly assessed by the

solitary interview and survey instruments used in this study, even though the analysis has been comprehensive.

Though these have been some of these limitations, statistical analyses and a comparative review of other work has shown that the sample size and quality of outputs has adequately met stringent parameters to validate the outcome of the study.

7.2 Implications of the study:

Although the study entailed some limitations, the results of the study have several implications:

- Since there is no one single style which is considered the best for the hospital industry; hospital leaders have to adopt multiple styles and use them appropriately in the given circumstances.

- The findings of the study can provide information to develop leadership training programs. Knowledge generated from this study will enable the leaders and administrators to plan leadership training to train, develop and strengthen leaders for multiple leadership styles.

- Academic advisors will also find this new knowledge useful in inculcating leadership components in their syllabus to develop knowledge and skills related to leadership in general and leadership style in particular, with respect to the hospital industry.

7.3 Recommendations for future research:

Based on the results of the study, additional research is needed to enhance the understanding of leadership styles adopted by the leaders from the hospital industry. Given the findings of the study, recommendations for future studies are as follows:

- The sample for this study was selected from two industries i.e. the hospital and the hotel industries from the Pune city. Therefore, the findings of the study have limitations to generalize results to other industries and industries from other cities and States in India. Further studies need to select random samples of leaders and followers from various hospitals and from various levels including lower level leaders; and comparative studies can be done on the leadership styles of the leaders from outside the Pune city.

- Future studies need to investigate leadership training in relation to the hospital industry. Based upon the experience gained from this study, further research into the leadership training or leadership development and its effects on leadership styles would benefit future leaders in the hospital industry.

- It would be particularly beneficial to replicate this study in more than one hospital organization from different regions for two reasons. The first reason would be to test the survey tool reliability among different and more diverse populations. The second reason would be to generate additional leader self rating data sets for the purpose of evaluating leadership styles of leaders and supporting findings of this study.

- Replication of this study is possible on all levels i.e. top, middle, and lower level leaders within the hospital. This will help to understand applicability

of survey tool on the lower level of leaders. It can be a population study of all leaders within selected hospital.

- If other researcher wanted to compare leaders and followers perception then refinement of the instrument may be needed to obtain the data from the followers' point of view. Future study needs to be done from followers' point of view. Moreover, this additional quantitative data from both followers' rating and leaders' self – rating would help to enhance the evidence about the leadership styles adopted by the leaders from the followers' perspective, as opposed to a leaders' self- perception.

7.4 Significant contributions of the study:

This study makes four major contributions to the enhancement of the understanding of leadership styles adopted by the leaders from the hospital industry.

- This study showed that the hospital leaders cannot restrict themselves to one leadership style; rather this study proposes that the hospital leaders need to adopt mixed leadership styles which are the most suitable leadership style for the hospital industry.

- The results of this study showed that the hospital leaders lack leadership training. Conversely, the results show that the hotel industry has well organized leadership training for their leaders. Thus, most importantly, the results strongly suggest academicians and current hospital leaders to develop leadership training programmes for their leaders from the lower level to the top level, either to develop or enhance the leadership styles of their leaders.

- The results of this study report that multiple factors affect the leadership development of the leaders. Thus, this study pointed out that the hospital as an organization has to pay attention to these factors and minimize or take care of these factors before planning and implementing leadership development programs for their organization.

- Finally, the researcher is confident that each of these significant contributions adds to the existing body of knowledge about leadership style in the hospital industry.

Chapter 8 Summary and conclusion

This chapter provides a summary of the chapters and conclusion of this study.

Chapter1: Chapter 1 has provided brief historical overview of leadership from ancient period till 1990. Ten leadership styles are presented with their brief understanding, advantages, and disadvantages as well as when it has been commonly used. These ten leadership styles included in this chapter were: autocratic, democratic, bureaucratic, charismatic, leissez faire, transactional and transformational, situational, coaching, and visionary leadership styles. Chapter one also gives a review of background of the research topic, statement of the research study, and brief information about the study.

Chapter 2: This chapter presented the aim and objectives of the study. Research questions posed in the study, assumptions, scope of the study and delimitations of the study.

Chapter 3: The third chapter presented a comprehensive literature review of the primary research components. The literature review discussed leadership in relation to industry, leadership position, training and development, age, and gender. The gaps in literature reviewed have been presented. The researcher has attempted to narrow these gaps in this study.

Chapter 4: Chapter 4 described the methodology used in the research study, the appropriateness of the methodology to the study, the study's specific research design, the appropriateness of the research design. The chapter also described samples, sampling technique and sample size for quantitative and qualitative part of the study, sample selection. Study settings, data collection methods, data collection tools, and protocols were explained in this chapter. It provided a discussion of the reliability and validity of the research tool used in this study.

The chapter also described the data analysis process and ethical consideration.

Chapter 5: The chapter provided a discussion of the survey results and face to face interview. The discussion was carried out under each research question.

Chapter 6: The chapter included a detailed discussion under each research question.

Chapter 7: This chapter describes limitations, implications, and significant contribution of the study. This chapter also describes recommendations.

Chapter 8: This final chapter discusses summary and conclusion. It gives overview of chapters included in the study and conclusions of all five questions posed in the study.

Conclusion

The aim of the study was to examine the leadership styles adopted by the top and middle level leaders of the hospitals in Pune city, and provide inputs to enhance the leadership style of the hospital leaders**.**

Although many leadership styles are reported in literature, there is a wide agreement that there is no single leadership style which is the best (Ahn, et al., 2004). Many authors have supported this statement. For example Yu, H. and Miller, P (2005) cite that "… *traditional criteria used to define successful leadership no longer fit into today's modern workplace. The new science of leadership requires a mixture of skills, such as professional skills, experience, education and a leadership styles*". There is no leadership style which will best fit into all circumstances.

A review of literature showed that scholars had studied leaders from multiple industries but no study had explored and focused on the possible links among leadership styles from different industries and compared them with each other. Snaebjornsson and Edvardsson (2013) supported the need for exploring leadership among different industries. Very few articles were focused on determining the leadership styles of the top and middle level leaders within an industry. A dearth of literature on leadership styles adopted by the leaders from various levels of leadership within an industry in general and the hospital and the hotel industry in particular. Current leaders from hospital industry struggle to find the ideal leadership style to fit into a situation to overcome the challenges posed and to carry out day - to - day operations. Thus this study had focused on the top and middle level leaders from the hospital industry and compared them with the top and middle level leaders from the hotel industry which is also a service oriented industry.

Due to the complex nature of leadership style and complex nature of the hospital industry the study required to use a unique approach to study the leadership styles of the top and middle level leaders. Thus, this study had used mixed method research design. This study used qualitative and quantitative methods to obtain answers for the key questions mentioned in the study. Qualitative data was collected by face to face interviews and quantitative data was collected by a survey method. Two separate tools were thus used for obtaining data from qualitative and quantitative methods. The results of these two methods were merged during interpretation and the reporting phase of the study. The top and middle level leaders from the hospital and the hotel industry participated in the survey (41), and in the face to face interview (20). The results of quantitative and qualitative data have been presented together in this study, to be able to maximize the quality of the results.

Results and discussion in relation to research questions posed in this tudy are briefly presented below:

Research question 1: Which leadership styles are adopted by the top and middle level leaders from the hospital and the hotel industry from Pune city?

Research question 2: Is there any association between leadership styles of the leaders from the hospital and the hotel industry?

Results for the research question 1 and 2 are combined below:

Autocratic leadership style: The percentage of the top and middle level leaders who provided a high score on autocratic leadership style was rated lower in the hospital and hotel industry, as compared to moderate scores provided by the leaders. No association was noted between autocratic leadership style and the top and middle level leaders from the hospital and the hotel industry. Interview results however showed that six leaders from the hospital industry and two leaders from the hotel industry reported that authoritative style was appropriate in their industry.

Democratic leadership style: A hundred percent of the top and middle level leaders from the hotel industry had given high score on democratic leadership style used by them as compared to leaders from the hospital industry. The percentage of hospital middle level leaders was higher (91%) who chose on democratic leadership style, than 70% top level leaders. Empowerment and participation in decision making were two main ideas which surfaced from leaders' views on democratic leadership style. Both industry leaders agreed that this is the most beneficial and suitable leadership style in their industries.

Bureaucratic, Laissez-faire, Paternalistic and Transactional leadership styles: More than 80% of the top and middle level leaders from the hospital and

the hotel industry provided a high preference for bureaucratic, laissez faire, and transactional leadership styles. Equal percent (50%) of the top leaders from the hospital industry provided moderate and high scores on paternalistic leadership style. Significant association was demonstrated among the top level leaders from the hospital and the hotel industry in relation to paternalistic leadership style.

Charismatic, Transformational, Visionary and Coaching leadership styles:
A hundred percent top and middle level leaders from the hospital and the hotel industry provided high scores in charismatic, transformational, visionary and coaching leadership styles. Only one middle level leader form the hospital reported referent power in relation to charismatic leadership style.

Situational Leadership style: Ten leaders from the hospital and the hotel industry supported that leaders should practice situational leadership style.

Mixed leadership style: Six leaders mentioned the name of mixed leadership style during their face to face interview.

To summarize discussion of Q.1 and Q.2 this study reinforces the need for adopting multiple leadership styles in the top and middle level leaders in the hospital industry. Tannenbaum and Schmidt (1998) stated that, “Successful leader will not rely on only one decision making style, but will alter their leadership “pattern” along the leadership scale using varying amounts of leader control and group input according to the specific situation or problem, the organizational and societal environments, and other factors” (Tannenbaum and Schmidt pg 170-172 as cited in Strohmeier, B. 1998 pg 35). Heever stated that “it has been postulated that the changing environment of health care industry needs a mixture of leadership styles to lead the organizations” (pg 98).

Research question 3: Is there any association between demographic variables of the top and middle level leaders with the leadership styles?

Industry: A total of 22 leaders from the hospital industry and 19 leaders from the hotel industry participated in this leadership survey. Top and middle level leaders were equal in numbers (11, 50% each) within the hospital industry whereas in the hotel industry a majority was top leaders (14, 74%) as compared to middle level leaders (5, 26%). A total of 20 leaders participated in face to face interviews, from which 13 leaders were from the hospital industry and 7 were from the hotel industry.

Age: Majority of hospital industry leaders' age was above 41 years. Chi square test result showed significant association between the hospital top and middle level leaders. On the contrary hotel industry reported having younger leaders. Democratic leadership style of the top level leaders from the hospital and the hotel industry showed association with leaders' age (41-50 years).

Gender: Out of twenty leaders in face to face interviews, only 3 were female leaders as compared to 17 male leaders in this study. The hospital industry had three times higher number of female leaders (6) as compared to the female leaders (2) from the hotel industry. Equal percentages of male and female leaders held the top level leadership position in the hospital industry. In contrast, 91% of middle level leaders were males as compared to 9% of middle level female leaders in the hospital industry. A majority (86%) of the top level leaders were males with only 14% top leaders were females in the hotel industry. On the other hand, all 100% middle level leaders from the hotel industry were males. A significant association between the top level male leaders from the hospital and hotel industry in relation to choosing democratic, and paternalistic leadership style was observed.

Management training: More than 80% of the top and middle level leaders from the hospital and the hotel industry reported that they had management training. No association was found between the leadership level and name of the management training in the hospital and the hotel industry.

Period of current leadership position held by the leader: In this study 70 % of leaders from the hospital industry were holding the top level position in the current organization for between 1 to 5 years, 10 % between 5 to10 years, and the remaining 20 % between 10 and15 years. On the other hand, 36% of middle level leaders from the hospital industry were holding leadership positions in the current organization between 1 to 5 years, and 27% from 5 to 10 years. Only 27% middle level leaders had recently joined the hospital organization, as they reported holding the middle level position for less than a year. Strong association between period of current leadership position and level of leadership in the hospital industry was reported. Results showed significant association between selecting autocratic leadership style of the top level leaders in the hospital and in the hotel industry, who were holding current leadership position for 1 to 5, and 10 to 15 years. Middle level leaders from both the industries who held current leadership positions showed an association between 5 to 10 years for the paternalistic leadership style.

Number of employees working in the organization: Results showed a higher number of employees in the hospital industry as compared to the hotel industry. The number ranged from more than 200 to more than 501 employees. Result also showed an association between numbers of employees in the hospital industry and leadership level of the leader.

Number of employees working for the leader: More than 80% of hospital top leaders were dealing with more than 200 employees. In contrast 82 % of hospital middle level leaders were dealing with less than 200 employees. A strong

association was found between number of employees working under the leadership of the top and middle level leaders from the hospital industry. Results depict that middle level leaders from the hospital and the hotel industry showed that there is an association between selecting an autocratic leadership style with the number of employees (1 to 25) working under these leaders. In contrast, paternalistic leadership style was associated with the top level leaders and number of employees (51 to 100) working under these leaders.

Change in the leadership style: All the respondents expressed that their leadership style has changed over the years. This change was due to organization, or awareness of their own leadership style, or due to the top, middle and lower level of employees that the leader had to deal with.

Factors affecting leadership style: Result showed that factors related to self, and factors related to the organization affect the leadership style of the leader.

Research question 4: What are the perceptions of the leaders from the hospital and the hotel industry regarding leadership training and development?

Leadership training: Fifty percent of the top and middle leaders from the hospital industry reported they had leadership training as compared to 100 percent top and middle level leaders from the hotel industry who reported that they had leadership training. chi square test results showed that the top level leaders from the hospital and the hotel industry who had leadership training had association with the democratic leadership style and with paternalistic leadership style.

Total days of leadership training: The total days of leadership training among the top level leaders from the hospital industry indicated that 40% had 2 to 7days, 10% had 15 days to one month, and 10% top level leaders had 3 to 6 months of leadership training. Middle level leaders from the hospital industry reported leadership training between 5 to 7 days, 15 days to one month, and 9 months to one year leadership training (9% each) and 1 to 3 months (18%). No association was observed between total days of leadership training and the top and middle level leaders from the hospital and the hotel industry.

Leadership training themes that emerged during the analysis of qualitative data obtained from the face to face interviews provide a closer look at training. Many codes are illustrated under this theme such as overview of leadership training in industry, leadership training according to category of employees, types of leadership training, leadership training methodology, and leadership training course content.

Hospital leaders lacked leadership training comes out strongly from this study. It has been observed that there is a huge gap between the medical professionals

and leadership development of these professionals in an Indian scenario, especially in hospitals from Pune. LeBrasseur, et al. (2002) supported the notion that physicians resist leadership development. Similarly Cherry, et al. (2010) felt that there was a need to develop physicians' leadership program to educate physicians to work collaboratively across and beyond professional boundaries.

The medical undergraduate and postgraduate curriculum lacked leadership and management components in Indian scenario. Likewise, Ah-kee, Elliott and Khan, Amir (2015) highlighted the importance of Medical Leadership and Management within the UK undergraduate medical curriculum. Many leadership training, methodology and course content, and duration, was discussed and supported with the literature in discussion chapter.

Research question 5: What are the other views of the top and middle level leaders from the hospital and the hotel industry related to leadership styles?

This research question illustrates the leader's skills related to self, leader's skills related to their team and leader's skills related to the organization, or human, conceptual and technical skills of a leader. These skills are in line with the Frich et al. (2014) study.

To conclude, this study has brought out remarkable findings in terms of leadership styles, and leadership training. This mixed method study reinforces current hospital leaders to use mixed leadership style. Leadership training was lacking wide spread in the hospital industry as well as in the medical curriculum. Thus, this study highlights the need for leadership training and development of leaders in the hospital industry and also recommends inculcating leadership components in the undergraduate and postgraduate curriculum.

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Annexure

Annexure 1a): Organogram of the Indian Government hospital and medical college.

Annexure 1b): Organizational chart of the government medical college and hospital, Chandigarh.

Annexure 2: Syllabus from MUHS- MBBS (Allopathy (Modern medicine undergraduate syllabus).

Annexure 3: Syllabus from Bharati Vidyapeeth University- Hotel management undergraduate syllabus).