CONCEPTS OF LEADERSHIP AND THE VALUE OF LEADERSHIP FOR HEALTH CARE PROFESSIONALS: PERSPECTIVES FROM DOCTOR OF PHYSICAL THERAPY STUDENTS

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CONCEPTS OF LEADERSHIP AND THE VALUE OF LEADERSHIP FOR HEALTH CARE PROFESSIONALS: PERSPECTIVES FROM DOCTOR OF PHYSICAL THERAPY STUDENTS

by

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A Dissertation Submitted in Partial Fulfillment of the

Requirements for the Degree of

DOCTOR OF EDUCATION

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March 2022
CONCEPTS OF LEADERSHIP AND THE VALUE OF LEADERSHIP FOR HEALTH CARE PROVIDERS: PERSPECTIVES FROM DOCTOR OF PHYSICAL THERAPY STUDENTS

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Dedication

This dissertation is dedicated to the village of people who have supported and encouraged me through the journey. First, to my husband, George, you are the most incredible life partner. Thank you for your commitment, support, and unending love through this journey. This accomplishment is not just mine but ours and an endeavor we weathered together. Second, to my amazing daughters: Libby, Kyla, and Maryn. You have been so patient and understanding as I spent many hours studying, researching, and writing. May my work make you proud and inspire you to be lifelong learners. Finally, to my extended family of supporters who have encouraged me and made this accomplishment possible by caring for our family through this journey. Thank you for your appreciation of my commitment to education and your willingness to support us in so many ways.
# Table of Contents

List of Figures ........................................................................................................... vii

List of Tables .............................................................................................................. viii

Chapter 1. Leadership Perspectives from Doctor of Physical Therapy Students .......... 1
  Summary of the Problem ................................................................. 4
  Problem Statement ........................................................................ 7
  Conceptual Framework .................................................................. 7
  Research Objectives ....................................................................... 8
  Research Questions ......................................................................... 10
  Research Methods ......................................................................... 10
  Purpose of the Study ...................................................................... 12
  Definition of Key Terms .................................................................. 12
  The Researcher .............................................................................. 14
  Limitations of the Study ................................................................. 14
  Significance of the Study ............................................................... 14
  Conclusion ...................................................................................... 15

Chapter 2. Literature Review ..................................................................................... 16
  Leadership ...................................................................................... 17
  Leadership in Health Care ......................................................... 21
  Leadership in Medicine & Medical Education ................................. 25
  Leadership in Nursing ................................................................... 26
  Leadership in Other Health Care Professions ................................. 29
  Physical Therapy .......................................................................... 31
  Leadership in Physical Therapy .................................................... 34
  Leadership in Physical Therapy Education .................................. 36
  Conclusion ...................................................................................... 42

Chapter 3. Methodology .............................................................................................. 43
  Purpose of the Study ...................................................................... 43
  Research Questions ....................................................................... 44
  Research Design ............................................................................ 44
  Procedures ..................................................................................... 49
    Participant Selection .................................................................... 50
    Protection of Participants ............................................................. 52
    Data Collection ........................................................................... 54
    Data Analysis ............................................................................. 57
    Validity ...................................................................................... 63
  Role of the Researcher ................................................................... 64
    Previous Knowledge and Bias ....................................................... 64
    Qualifications ............................................................................. 66
  Ethical Considerations ................................................................. 67
## List of Figures

<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Figure 1</td>
<td>Creswell and Poth (2018) Data Analysis Spiral</td>
<td>57</td>
</tr>
<tr>
<td>Figure 2</td>
<td>Concepts of Leadership from DPT Students: Themes and Codes</td>
<td>77</td>
</tr>
<tr>
<td>Figure 3</td>
<td>Leadership for Health Care Professionals</td>
<td>88</td>
</tr>
<tr>
<td>Figure 4</td>
<td>Research Question 1 Themes</td>
<td>100</td>
</tr>
<tr>
<td>Figure 5</td>
<td>Research Question 2 Themes</td>
<td>101</td>
</tr>
<tr>
<td>Figure 6</td>
<td>Themes for Research Question 1 (Concepts of Leadership) and Research Question 2 (Leadership for Health Care Professionals)</td>
<td>102</td>
</tr>
</tbody>
</table>
List of Tables

Table 1. Consensus Agreement (0.80 or greater) of “Very Important” Competencies (n = 37/76) for All Physical Therapists, Both Less Than and Greater Than 1 Year Post licensure (Sebelski et al., 2020, pp. 100-101) .................................................40
Table 2. Participant Demographics ........................................................................................................72
Table 3. Research Question 1 Theme 1 Summary: Connection ...............................................................79
Table 4. Research Question 1 Theme 2 Summary: Influence .................................................................81
Table 5. Research Question 1 Theme 3 Summary: Integrity .................................................................83
Table 6. Research Question 1 Theme 4 Summary: Experience ............................................................87
Table 7. Research Question 2 Theme 1 Summary: Connection ............................................................92
Table 8. Research Question 2 Theme 2 Summary: Integrity .................................................................94
Table 9. Research Question 2 Theme 3 Summary: Expertise ..............................................................96
Table 10. Alignment of Participant Responses with Leadership Competencies for Physical Therapists as Described by Sebelski et al. (2020) .........................................................110
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Abstract

The complex and rapidly changing environment of health care requires health care professionals with leadership knowledge and skills. Many health professional education programs have recognized the importance of developing the leadership abilities of students studying to be professionals in their field. There is emerging evidence of the need for leadership development for physical therapists, including a set of leadership competencies that has recently been identified by physical therapists. The perspective of Doctor of Physical Therapy (DPT) students regarding leadership and the value of leadership for health care professionals is unknown.

This qualitative phenomenological study utilizing semi-structured interviews was conducted to explore how DPT students conceptualize leadership and how they value leadership for health care professionals. The participants included five second-year DPT students and five third-year DPT students at one physical therapist professional education program. The findings yielded four themes for how DPT students conceptualize leadership: 1) Connection, 2) Integrity, 3) Influence, and 4) Experience. Participants described past leadership experiences through athletics, work experience, clinical rotations, and by parental role models. Participants’ concepts of leadership including leaders being able to connect with others through communication and compassion, leaders demonstrating integrity through honesty and accountability, and leaders having influence over others by being a guide and a role model. The participants’ responses aligned with the conceptual framework of leadership identified in this study.

The findings for the research question of how DPT students value leadership for health care professionals revealed three themes: 1) Connection, 2) Integrity, and 3) Expertise. Participants all stated that leadership knowledge, skills, and abilities are valuable for health care
professionals for various reasons. Connection described the importance of health care providers being able to connect with and share information with patients to set and achieve common goals. Integrity demonstrated participants’ views that health care professionals should lead through accountability and responsibility. Expertise revealed that DPT students believe that health care professionals should lead with confidence, knowledge, and patient advocacy efforts. The results aligned with studies on leadership in health care regarding communication and accountability, but did not include several other areas noted in recent literature, including health care quality and cost.
Chapter 1. Leadership Perspectives from Doctor of Physical Therapy Students

The health care system in the United States (U.S.) is a fast-paced, ever changing, and highly complex environment in which health care professionals need to adapt to be able to consistently provide high quality, effective patient care. Performance initiatives, insurance regulations, evolution of electronic health records, community assessment and outreach programs, and governmental policy changes all contribute to this complex environment and impact the work of health care professionals. Leadership skills are vital for all health care professionals to navigate this complex environment and provide quality patient care. There is a direct link between the quality of leadership and quality of care provided to patients (Blumenthal et al., 2012; Turnbull, 2018).

Leadership is holistic and requires leading laterally and collaboratively not just from the top down. Leadership entails leading people as well as the structures and processes of an organization. To become a leader, a person must have a strong academic education, be focused on taking care of both people and resources, and be confident in their own abilities. As stated by Ledlow and Stephens (2018), “A successful leader must have extraordinary critical thinking skills, be a life-long learner, and be willing to (graciously) accept information that may be counterintuitive to his or her sensibilities or current understanding” (p. 5). It is necessary for all health care professionals to be trained in leadership to be ready and equipped to make the right decisions at the right time. In health care, change is inevitable and needed. Change requires effective leadership.

Many health professions, including medicine and nursing, have identified the importance of developing leaders within their respective fields and have begun implementing leadership training in both professional and post-professional education programs (LoVasco et al., 2016).
As licensed health care professionals, leadership skills are important for all physical therapists. Recently, Sebelski and collaborators (2020) completed a Delphi study to identify leadership competency expectations in physical therapy. Consensus was reached on 37 leadership knowledge, skills, and behaviors for all physical therapists regardless of years of experience. The authors concluded that standardization of the definition of leadership and leadership competencies expected of physical therapists will provide opportunities for graduates to advance the transformation of health care to impact the overall patient experience (Sebelski et al., 2020).

Recent studies have shown the implementation of leadership training in Doctor of Physical Therapy (DPT) curricula with promising results of increasing student leadership abilities following leadership training activities (Eigsti & Davis, 2018; LoVasco et al., 2016; LoVasco et al., 2019).

Physical therapists work at the point of care with patients and have long contact time with patients across the health care system, from home to clinic to hospital services. Physical therapists are ideally positioned to identify areas for improvement, lead efforts to improve patient care, and bring necessary change to health organizations. The professional organization for physical therapists in the U.S., the American Physical Therapy Association (APTA) has established documents describing the Core Values for the Physical Therapist and the Code of Ethics for the Physical Therapist (APTA, 2020). These defined professional standards are required by the Commission on Accreditation in Physical Therapy Education (CAPTE) for the professional education of physical therapists in all accredited DPT programs across the U.S. (CAPTE, 2020). Within the Core Values for the Physical Therapist, there is crossover with leadership skills including accountability, collaboration, and excellence. Within the Code of
Ethics, there are several principles that align with leadership skills including Principles #6, #7, and #8:

Principle #6: Physical therapists shall enhance their expertise through the lifelong acquisition and refinement of knowledge, skills, abilities, and professional behaviors.

Principle #7: Physical therapists shall promote organizational behaviors and business practices that benefit patients and clients and society. Principle #8: Physical therapists shall participate in efforts to meet the health needs of people locally, nationally, or globally (APTA, 2020).

There is growing evidence of the importance of leadership for physical therapists and current DPT education requires core values and ethics education. Yet, there is no evidence of DPT students’ current perceptions of leadership or DPT students’ perception of the value of leadership for health care professionals.

Before implementing specific leadership training and development for DPT students, it is important to explore their current conceptualization of leadership: 1) How do DPT students conceptualize leadership? and 2) How do DPT students value leadership for health care professionals? Improved understanding of students’ current perspective of leadership would allow a DPT program to purposefully foster leadership development in curricula that meets those students’ needs. Leadership education and training should start with the students’ current conceptualization of leadership to provide the necessary knowledge and contextual foundation for leadership development. Regarding the value of leadership, if DPT students already indicate a high value of leadership as future health care professionals, then perhaps there is already enough emphasis on the importance of leadership explicit or implicit in the curriculum. If DPT students do not currently value leadership or have widely varied conceptions of leadership, then
the starting point for any curricular or programmatic changes would include education on leadership and the value of leadership in the profession before advancing to specific leadership training. These two questions must first be investigated to determine the current perspectives of leadership among DPT students and subsequently, what type of leadership development should then be introduced into the curriculum.

**Summary of the Problem**

A growing body of evidence emphasizes the importance of leadership abilities for health care professionals. Health care context requires all members of the interdisciplinary health care team to engage in leadership, not just those who identify as being in positions of leadership. There is a need for leadership across diverse health care professions, across shifts, and at every organizational level (Turnbull, 2011). Professionals in the fields of medicine, dentistry, nursing, and pharmacy have recognized the need to develop leaders in their professions (LoVasco et al., 2016). In a 2018 systematic review of leadership styles and outcomes in the nursing workforce, Cummings et al. (2018) provided strong support for the use of relational leadership styles to promote positive nursing workforce outcomes and related organizational outcomes. In another 2018 study, Boamah and collaborators concluded that transformational leaders in nursing play an important role in enhancing the quality of the work environment for nurses to produce better outcomes for patients. The task of leadership falls on physicians, nurses, and other health care professionals (i.e., physical therapists) who lead clinical teams in the course of their day-to-day work. Therefore, leadership is vital for improving the quality and efficiency of the core work of health care (Blumenthal et al. 2012).

Professionals in the fields of medicine and nursing have implemented leadership development in their respective professional education programs. In medicine, Sadowski et al. (2018) reported in their systematic review that graduate medical education leadership curricula
are variable and limited in effectiveness. The authors noted that interest in formalized graduate medical education leadership curricula is expanding, providing evidence that 65% of the articles included in the systematic review were published after 2010 (Sadowski et al., 2018). In nursing, following a critical review of leadership curricula in education, Morrow (2015) concluded that nursing education programs should encourage and support the study and development of creative, innovative teaching strategies to instill leadership ability in nursing students. The findings from medical and nursing education highlight the importance of leadership training across health care, including physical therapy.

Physical therapists are frontline professionals with direct contact with patients and an integral part of the health care team. Yet, there is little research regarding the impact of leadership behaviors on physical therapists’ patient outcomes, patient satisfaction, and teamwork with other health care professionals. A Delphi Study in 2004, investigating leadership in physical therapy, was undertaken to determine the knowledge and skills needed by new graduate physical therapists entering practice in the areas of leadership, administration, management, and professionalism (LAMP). At the conclusion of the study, the category ranked highest for importance for physical therapists overall was communication followed by leadership theory. In both the areas of knowledge needed and skills needed by a physical therapy graduate, communication was ranked highest, followed by professional involvement and ethical practice (Lopopolo et al., 2004). More recently, in 2020, Sebelski and collaborators completed a Delphi study to identify leadership competency expectations in physical therapy. Consensus was reached on 37 leadership knowledge, skills, and behaviors for all physical therapists regardless of years of experience. Examples of these items include accountable, authentic, collaborative, listening skills, relationship building, self-aware, and trustworthy. The authors concluded that
standardization of the definition of leadership and leadership competencies expected of physical therapists would provide opportunities for graduates to advance the transformation of health care to impact the overall patient experience (Sebelski et al., 2020).

In physical therapy professional education there are few studies on leadership behaviors and leadership development. Following a national study of innovation in physical therapist education, Jensen et al. (2017) recommended that physical therapy education “institute leadership development that reinforces the value of shared leadership, effective teams, innovation, and cultures of excellence. This development must begin in professional education and continue across a professional’s career” (Jensen et al., 2017, p. 878).

While Jensen and collaborators (2017) presented a reasoned and compelling call to action, there has been little follow up or action. The profession of physical therapy in the U.S. has limited evidence about the scale and scope of leadership knowledge and skills in physical therapists or DPT students, nor is there evidence about the number of physical therapy programs that have leadership competencies embedded in their professional programs. In three recent studies of leadership behaviors in DPT students, the Leadership Practices Inventory Self (LPI Self) was used as a measurement tool for assessing DPT student leadership behaviors in the five practices of exemplary leadership as developed by Kouzes and Posner (Kouzes & Posner, 2017). Lovasco and collaborators (2016) measured the leadership practices of year-one students enrolled in entry-level DPT programs. Eigsti and Davis (2018) investigated the impact of a leadership thread on DPT student education, and LoVasco et al. (2019) studied the impact of a leadership development program for students in a DPT program.

Despite these trends in research and emerging evidence for the importance of physical therapists having leadership skills, there are no explicitly defined leadership competencies
included in DPT program accreditation standards (CAPTE 2020). There are required accreditation standards which include the APTA Core Values and Code of Ethics. While these professional standards documents may have some crossover with some leadership knowledge and skills, they are not specifically labeled as such in accreditation requirements.

**Problem Statement**

Leadership is an increasingly important topic in physical therapy professional education; however, the evidence has been focused on measuring the leadership abilities of DPT students. As it stands, research has not been conducted to investigate the concept of leadership and the value of leadership from the students’ perspective. There is a recognized need for all physical therapists to have leadership knowledge and skills yet, there are no standards specifically related to leadership development in DPT curriculum. A set of leadership competencies has recently been identified by physical therapists as “very important” for all physical therapists regardless of years from licensure (Sebelski et al., 2020). DPT students’ current conceptualization of leadership is unknown and the value of leadership knowledge and skills to DPT students as future health care professionals are also unknown. Examining the current concepts and value levels of DPT students is the first step in considering implementation of a leadership development thread or course for DPT students as future health care professionals.

**Conceptual Framework**

According to Marion and Gonzales (2014), defining leadership is a complex and elusive task. Leadership is a process rather than an event, and one must decipher what that process, that dynamic, is. Leaders themselves are people who engage in the leadership process. Thus, one must get away from the notion that leaders are people in official roles and that mere authority is leadership (Marion & Gonzales, 2014). Kouzes and Posner (2017) agree that leadership is not about a position or title. Leadership is about developed behaviors and relationships and includes
an identifiable set of skills, abilities, and behaviors. Therefore, any person can advance their leadership behaviors by taking on leadership challenges. In agreement with Kouzes and Posner, Green-Wilson and Ziegler (2020) stated “Leadership is viewed today as a dynamic process through which a person influences a group of individuals to achieve a shared goal, and as a trait that can be developed” (p. 7).

Evidence indicates that leadership is a set of behaviors, knowledge, and skills that can be developed. When this evidence is coupled with the urgent need for health care professionals to have leadership capacities, there is a compelling argument to support further exploration of leadership in health care professional education programs, including DPT programs. How DPT students conceptualize the phenomenon of leadership is unknown.

**Research Objectives**

Physical therapists are essential members of interprofessional health care teams who impact quality of care delivered to patients and have a professional responsibility for transforming the health and wellness of society. Leadership competency is critical for DPT students to be able to navigate the complex world of health care, provide quality patient care, and transform society to better health.

Previous studies of leadership in the physical therapy profession in the U.S. have sought to identify leadership competencies and measure leadership abilities using standardized measures. The previous studies completed in DPT students used the Leadership Practices Inventory – Self (LPI Self) to measure leadership behaviors. This instrument was developed and validated by Posner (2016) based on the theoretical framework that leadership can be developed and practice of leadership skills is required to become an effective leader. Kouzes and Posner (2017) define five key leadership practices: 1) Model the Way, 2) Inspire a Shared Vision, 3) Challenge the Process, 4) Enable Others to Act, and 5) Encourage the Heart. The LPI Self is a
self-assessment of 30 leadership behaviors that results in a score for each of the five leadership practices. The higher the score for each practice, the more the person believes they use the behaviors of that practice (Lovesco et al., 2019). Sebelski et al. (2020) recently defined the leadership competencies necessary for physical therapists, which include but are not limited to accountable, authentic, collaborative, listening skills, relationship building, self-aware, and trustworthy (Sebelski et al., 2020).

The objectives of this research were to explore how DPT students conceptualize leadership and investigate if their perspectives align with existing leadership competencies or defined sets of leadership behaviors. Students’ current perspectives on leadership should be explored before implementing leadership development in DPT curricula. If DPT students’ view of leadership already aligns with the practices described by Kouzes and Posner (2017), then perhaps using the LPI Self as an instrument to measure leadership ability is appropriate to determine how much further leadership development should be implemented in a program. If DPT students’ view of leadership aligns well with the competencies defined by Sebelski et al. (2020) then perhaps the next step is to determine which competencies are not being developed effectively and then implement leadership training that compliments what is already being done. If DPT students’ understanding of leadership aligns well with the APTA Core Values and Code of Ethics, further exploration could be done to determine what leadership content training would complement these professional standards and would deepen students’ learning of the leadership competencies.

The goals of this qualitative phenomenological research study of the phenomenon of leadership among DPT students are: 1) explore DPT students’ perspectives on the concept of leadership, 2) determine if DPT students’ perspectives align with other defined leadership
definitions or competencies, and 3) investigate how DPT students value leadership knowledge and skills for health care professionals.

**Research Questions**

Question 1: How do DPT students conceptualize leadership?

Question 2: How do DPT students value leadership for health care professionals?

**Research Methods**

A thorough exploration of DPT students’ perspectives on the complex topic of leadership was needed to address the research questions in this study. Therefore, the researcher conducted a qualitative study using one-on-one interviews to complete the inquiry. This study adhered to the social constructivist (interpretive) paradigm, which is characterized by the presence of multiple realities that are constructed through each person’s lived experiences and interactions with others (Creswell & Poth, 2018).

The researcher used phenomenology as the specific method of qualitative research in this study. Phenomenology is the study of lived experiences of persons (Creswell & Poth, 2018). A phenomenological approach focuses on exploring how human beings make sense of experience and transform experience into consciousness, both individually, and as shared meaning. This requires thoroughly capturing and describing how people experience some phenomenon, in this case, leadership. This included studying how DPT students perceive it, describe it, feel about it, remember it, make sense of it, and talk about it with others (Patton, 2015). Phenomenology should be conducted with a specific group of people who have experienced the phenomenon and whose perspectives are needed for the purpose of the study. The researcher focused on DPT students’ perspectives in this study, so one-on-one interviews were conducted with second- and third-year DPT students enrolled in the DPT program at which the researcher is a faculty member.
The methods completed in this phenomenological study followed the recommendations of Moustakas (1994), Creswell and Poth (2018), and Patton (2015), including participant selection, data collection through interviews, and qualitative analysis. These methods are described in detail in Chapter 3 beginning on page 43.

Following IRB approval from Minnesota State University Moorhead, purposeful random sampling was completed to identify five DPT students in the second-year cohort and five DPT students in the third-year cohort at one DPT program. Students were invited to participate and given informed consent. The researcher conducted interviews with each participant in person, in a neutral space, using an interview guide (Appendix C) established according to the recommendations of Creswell and Poth (2018), Moustakas (1994), and Patton (2015). Each interview was audio-recorded and transcribed using NVivo transcription.

The researcher conducted qualitative data analysis of the transcripts using NVivo software following the five-step process described as a spiral by Creswell and Poth (2018), which included: 1) managing and organizing the data, 2) reading and memoing emergent ideas, 3) describing and classifying codes into themes, 4) developing and assessing interpretations, and 5) representing and visualizing the data. This process was integrated with phenomenological analysis and representation methods described by Moustakas (1994) and Patton (2015), which is described in detail in Chapter 3 (pp. 56-62). This process included a full description of the researcher’s personal experiences with leadership, then the development of significant statements about how DPT students experienced leadership, followed by grouping significant statements into broader units of information (themes), and then developing rich, thick descriptions of “what” the participants experienced and “how” the participants experienced leadership. The
analysis concluded with a composite description of the essence of leadership from the perspective of DPT students.

**Purpose of the Study**

The purpose of this qualitative phenomenological study was to explore the concept of leadership from a DPT student perspective: first, to assess the students’ current definition and description of leadership, and second, to examine if and in what ways DPT students value leadership for health care professionals and for themselves as future health care professionals.

**Definition of Key Terms**

**Doctor of Physical Therapy (DPT) Student or Student Physical Therapist**

Physical therapist professional education refers to the didactic and clinical education that prepares graduates for entry into practice of physical therapy. Professional (entry-level) physical therapist education programs in the United States only offer the Doctor of Physical Therapy (DPT) degree to all new students who enroll. Student physical therapist (SPT) is defined as a student enrolled in an accredited Doctor of Physical Therapy program (American Physical Therapy Association, 2019, September 12). Students enrolled in one Doctor of Physical Therapy program are the subjects of this study and meet the definition of DPT students as stated.

**Health Care Professional**

Health care professionals study, advise on, or provide preventive, curative, rehabilitative, and promotional health services based on an extensive body of theoretical and factual knowledge in diagnosis and treatment of disease and other health problems. They may conduct research on human disorders and illnesses and ways of treating them, and supervise other workers. The knowledge and skills required are usually obtained as the result of study at a higher educational institution in a health-related field for a period of
3–6 years leading to the award of a first degree or higher qualification (World Health Organization, 2020). Physical therapists are health care professionals.

**Interprofessional team**

Interprofessional team refers to a group consisting of members of different health professions who cooperate, coordinate, and collaborate in delivering patient-centered care collectively (American Nurse, 2014).

**Leadership**

Leadership is a dynamic process through which a person influences a group of individuals to achieve a shared goal and it is a trait that can be developed (Green-Wilson & Zeigler, 2020). Leadership is an observable pattern of practices and behaviors, and a definable set of skills and abilities (Kouzes & Posner, 2017). For the purposes of this study, leadership is viewed as a set of behaviors and skills that can be developed by anyone, and the definition of leadership is influencing others to work toward shared aspirations.

**Physical Therapist**

Physical therapists are licensed health care professionals and movement experts who optimize quality of life through prescribed exercise, hands-on care, and patient education (APTA, n.d.). Physical therapists are equivalent to physiotherapists.

**Physiotherapist**

Physiotherapists assess, plan, and implement rehabilitative programs that improve or restore human motor functions, maximize movement ability, relieve pain syndromes, and treat or prevent physical challenges associated with injuries, diseases, and other impairments. They apply a broad range of physical therapies and techniques such as movement, ultrasound, heating, laser, and other techniques. They may develop and
implement programs for screening and prevention of common physical ailments and disorders. Physiotherapists are health care professionals and equivalent to physical therapists in the U.S. (WHO, n.d.).

The Researcher

The researcher, Dr. Tara Haj, is employed as the Director of Clinical Education and an Associate Professor at a DPT program in the upper Midwest. She has 7 years of experience in higher education, is a licensed physical therapist, and has 10 years of experience in full-time patient care. She is a board-certified specialist in neurologic physical therapy and her patient care experience was with adults and children with neurologic diagnoses. The researcher teaches didactic courses and coordinates clinical education experiences for the DPT students who participated in this study. The role of the researcher in this qualitative study is thoroughly discussed in Chapter 3 (pp. 64-66).

Limitations of the Study

There is significant diversity in DPT programs across the United States (U.S.). They are housed in both private and public institutions with varied mission statements. The DPT student perspectives explored in this study are from one DPT program at a private institution only and therefore may not represent the perspectives of DPT students across the U.S.

Significance of the Study

In health care today and the foreseeable future, change is inevitable. Change requires leadership. Engaging all clinicians providing patient care in change process is necessary to reduce costs and improve patient outcomes. Therefore, all health care professionals, including physical therapists, must develop leadership skills. The vision statement of the American Physical Therapy Association is “Transforming society by optimizing movement to improve the human experience” (APTA, 2020). This professional responsibility to transform the health and
wellness of society can only be achieved with leadership—leadership in patient care, leadership in interprofessional teams, and leadership in communities. Yet, there are no defined leadership standards for DPT education programs.

Studies have examined the leadership competencies that practicing physical therapists identify as necessary and other studies have measured the self-assessed level of DPT students’ leadership abilities, but none have explored the concept of leadership from the student perspective. It is important to explore DPT students’ conceptualization of leadership and the value they place on leadership as future health care professionals so the physical therapy profession can move forward in advancing leadership development for future physical therapists.

**Conclusion**

Chapter 1 has introduced the study, including the significant importance of leadership skills for health care professionals. Change in health care is consistently needed for many reasons, including adapting to external pressures related to payment and policy, performance improvement, and enhancing patient outcomes. To thrive in this complex environment, health care professionals must be equipped to lead change. Physical therapists, as health care professionals, need to have leadership skills and there is emerging evidence for inclusion of leadership development in DPT curricula. Before implementing learning experiences to increase leadership development for students, a DPT program should determine the students’ current conceptualization of leadership and the value of leadership to these future health care professionals. A review of literature on leadership and leadership in various health professions will be presented next in Chapter 2, followed by the methodology and methods utilized in the study in Chapter 3. Chapter 4 will present the study findings, and Chapter 5 will discuss the implications of the study.
Chapter 2. Literature Review

Leadership is a complex topic that has evolved over time. Current understandings of leadership agree that it involves a set of skills and behaviors that can be developed by anyone. Many health professions have identified the importance of developing leaders within their respective health professions to meet the challenges of a constantly changing and complex health care environment (Boamah et al., 2018; Blumenthal et al., 2012; McGowan et al., 2020). Physicians, nurses, and other health care professionals have demonstrated the importance of developing leaders and have begun implementing leadership training in both professional and post-professional education programs (LoVasco et al., 2016). Blumenthal and colleagues (2012) succinctly summarize the importance of leadership in health care:

“Emerging evidence suggests that improving the leadership skills of practicing clinicians yields superior outcomes for patients and health care delivery organizations. Effective clinician leadership improves patient care by encouraging teamwork, facilitating the design and close monitoring of care processes, promoting a clinical culture that supports safe practices, and enabling innovation and continuous development of skills and outcomes” (Blumenthal et al., 2012, p. 513).

As licensed health care professionals who provide direct patient care, physical therapists must also rise to the challenges and complexities of health care today. Leadership skills are necessary for physical therapists to lead interprofessional teams, provide optimal patient care, and influence health organizations and systems for improving access and utilization. There are growing calls to action to include leadership development in physical therapy education (Green-Wilson et al., 2021; Jensen et al., 2017; Sebelski et al., 2020). Despite these calls to action, there is minimal evidence of successful leadership development programs for DPT students and no clear evidence
on best practices for implementation of leadership training in curricula. Currently DPT students’ perceptions of leadership or the value of leadership for health care professionals is unknown. Given the evolving theories of leadership, the evidence of the impact of leadership development in other health care professionals, and the rising push for leadership development in physical therapy, it is important to further explore the topic of leadership with DPT students. For a DPT program to implement appropriate and effective leadership development into the curriculum, it is important to first explore the current conceptualization of leadership held by DPT students and explore their perceptions of the value of leadership for health care professionals at all levels of health care.

This chapter will first include a discussion of leadership theory, followed by a review of studies on leadership in health care professional practice and education including physicians, nurses, and other health care providers. Lastly, the researcher will provide an in-depth review of the profession of physical therapy, physical therapy professional standards, and the current landscape of leadership in physical therapy and leadership in DPT education. This literature review includes leadership textbook references, studies published in peer-reviewed scientific journals, and perspective papers written by experts in their fields. Strategies used for searching the literature for studies related to leadership in health care included searches on CINHAL Complete, ProQuest, PubMed, Cochrane Database of Systematic Reviews, and APTA Article Search.

Leadership

There is no single construct unique to leadership theory. There is a range of theoretical perspectives available on leadership and subsequently the definitions of leadership have evolved over time. Ledlow and Stephens (2018) summarized this succinctly:
Within the refereed literature, leadership is said to be as much an art as a science. Leadership is also a cultural phenomenon, allowing for different traits and characteristics to emerge as successful parables across society. Lastly, leadership is a dynamic and evolving paradigm that takes on different literal and figurative definitions over the centuries. (p. 12)

Renowned leadership researchers Kouzes and Posner (2017) described leadership as “an identifiable set of skills and abilities that are available to anyone” (p. 25). They further stated that “leaders mobilize others to want to struggle for shared aspirations, and this means that, fundamentally, leadership is a relationship” (p. 26). Similarly, Vender (2014) defined leadership as “a combination of position, responsibilities, attitude, skills, and behaviors that allows someone to bring out the best in others and the best in their organization, in a sustainable manner” (Vender, 2014, as cited in Ledlow & Stephens, 2018, p. 18). In a more straightforward description, President Dwight Eisenhower once stated, “Leadership is the art of getting someone else to do something you want done because he wants to do it” (Zaleznick, 2004, as cited in Ledlow & Stephens, 2018, p. 12).

According to Marion and Gonzales (2014), leadership is a process rather than an event. Leaders themselves are people who engage in the leadership process. Thus, one must get away from the notion that leaders are people in official roles and that mere authority is leadership (Marion & Gonzales, 2014). There is a definite difference between leaders and managers and a different set of skills to be effective at each. Leaders must let vision, strategies, goals, and values be the guideposts for their actions and behaviors. In 2008, Ling and colleagues suggested that leadership requires an individual’s ability to motivate and instill pride in followers so that followers operate beyond self-interest and do what is necessary for the good of the organization.
LEADERSHIP PERSPECTIVES FROM DPT STUDENTS

(Ching et al., 2008). Whereas managers have an inherent obligation to know the daily duties and productivity of the people (human resources), finances and budgets (financial resources), and the materials under their control. A simple distinction between leadership and management is that people are led, and resources are managed. Historically, the terms leader and leadership have been culturally equated with terms that are not equivalent such as manager, supervisor, public figure, director, and other non-leadership designations. According to Ledlow and Stephens (2018), “this misapplication has had an adverse impact on health policy and planning, because the wrong caliber of individual is made responsible for areas of responsibility over and above his or her level of competence” (p. 13).

The age-old debate on whether the best leaders are born or made has been greatly discussed through history and leadership study. Today, many prominent leadership researchers agree that most behaviors of great leaders can be learned (Green-Wilson & Ziegler, 2020; Kouzes & Posner, 2017). Green-Wilson and Zeigler (2020) described leadership today as “a dynamic process through which a person influences a group of individuals to achieve a shared goal, and as a trait that can be developed” (p. 7). They further stated that leadership is about behavior and about what leaders do. Effective leadership focuses on the relationship between those who seek to lead and those who follow (Green-Wilson & Zeigler, 2020). For the purposes of this study, leadership is influencing others to work toward shared aspirations and is a set of behaviors and skills that can be developed by anyone.

Despite significant changes in the world and the evolution of the definition of leadership, what people most look for in a leader has remained stable. According to Kouzes & Posner (2017), for most people to follow someone willingly, they want a leader who they believe is honest, competent, inspiring, and forward-looking. People must be able to believe in their leaders
and willingly follow them. Therefore, credibility is the foundation of leadership. Leaders must do what they say they will do regardless of the times or their position and never take their credibility for granted (Kouzes & Posner, 2017).

“Leadership is not about personality. It’s about behavior” (Kouzes and Posner, 2017, p. 13). While the context of leadership has changed over the years, the components of leadership have not changed. The Five Practices of Exemplary Leadership described by Kouzes and Posner (2017) are: 1) Model the Way, 2) Inspire a Shared Vision, 3) Challenge the Process, 4) Enable Others to Act, and 5) Encourage the Heart. These practices are available to anyone who accepts the challenge to develop them. Embedded in the Five Practices of Exemplary Leadership are behaviors and skills that can serve as the basis of becoming a great leader. Model the Way includes first clarifying your own values and finding your voice to set the example. Inspire a Shared Vision includes envisioning the future and then enlisting others in a common vision by appealing to shared aspirations. Every great leadership success story involves a change from the status quo. Leaders must Challenge the Process by experimenting and taking risks and learning from experience. Big dreams and visions cannot become reality through the actions of just one person so leaders must Enable Others to Act by fostering collaboration, building trust, and facilitating relationships. To enable others to act leaders must foster self-determination and competence in others. The fifth and final Practice of Exemplary Leadership, Encourage the Heart, recognizes that people want to know that their leaders believe in them and in their ability to succeed. Exemplary leaders recognize contributions by showing appreciation for individual excellence and creating a culture of celebrating the values and victories by creating a spirit of community (Kouzes and Posner, 2017).
Leadership in Health Care

Change is inevitable, especially in health care. Change in health care is consistently needed for many reasons, including adapting to external pressures related to payment and policy, performance improvement, enhancing patient outcomes, and advancing research and technologies. Purposeful change requires leadership at all levels of health care.

Health care is a highly complex, rapidly evolving, and expensive enterprise. According to the World Health Organization, global spending on health continues to rise year after year. Global spending on health in 2017 was $7.8 trillion or about 10% GDP and $1080 per capita. Health care spending continues to expand faster than the economy. Between 2000 and 2017, global health spending grew by 3.9% a year while the economy grew 3.0% per year (World Health Organization, 2019). In the U.S. there are nearly 6,000 hospitals, more than 1 million physicians, and health care represents 18% of the total economy (Lerman & Jameson, 2018, p. 1862). Despite this significant spending, health institutions continue to struggle with patient safety and quality of care, indicating a more strategic and multifactional approach to health care is needed (Kohn et al., 2000).

The complexity of health care can be misunderstood or underestimated as there are many factors involved. This complexity is concisely described by William Kissick using The Iron Triangle of Health Care model. The Iron Triangle of Health Care model describes the relationship between cost, quality, and access to care as a triangle. In the triangle, if two of the components move in a positive direction, the third must move in a negative direction. For example, when cost and quality increase, access must decrease, or when quality and access increase, cost must decrease. Costs include any cost associated with providing care, including total costs charged to patients or insurance. Quality is measured in patient outcomes in which quality care leads to improved health status for the person receiving care. Access to health care is
the ease of obtaining care for a patient, which can be influenced by the number of physicians accepting patients, location of health care facilities, and availability of equipment or technology. The Iron Triangle is not always a rigid relationship but instead a general guideline as it can be impacted by increasing efficiency, decreasing regulation, and technology advances (Ledlow & Stephens, 2018). Despite its oversimplification, this model gives a broad understanding of the complexities of health care in the U.S.

Beyond access, quality, and costs, there continues to be evolution and complexities in health care that increases the dynamic elements of the industry. New health care technologies and pharmacological advances are shaping medical decision making and patient care. A diverse group of payers, including commercial insurances and government funded programs are continuously changing approval processes, quality oversight procedures, and payment levels. Health systems are implementing and updating electronic medical records, quality-improvement programs, and programs to improve community health. Health systems are also consolidating due to rising costs and increased administrative demands. The expanding complexity of health care presents challenges for communication, interdisciplinary coordination, and system level planning and organizing. These challenges are significant and point to the necessity for competent leadership throughout health organizations (Lerman & Jameson, 2018). Many of the more recent changes in health care in the U.S. can be contributed to the Affordable Care Act (ACA), which was passed in 2010. The ACA contains a triple aim of lower costs, improving the health of populations through better outcomes, and enhancing the patient care experience (Bronson & Ellison, 2015).

Bronson and Ellison (2015) stated that physicians must be leaders in our health system’s journey to be more just, more humane, more effective, more inclusive, and less costly. Health
care needs leaders who understand both patients and patient care while making decisions about legislation, government policy, capital expenditures, and the business of medicine (p. 1). The demand for health care accountability, quality of care, and patient satisfaction all require leadership training and professionalism at all levels of the health system. “To achieve the best outcomes in today’s health care system, all clinicians should be equipped with clinical leadership skills” (Blumenthal et al., 2012, p. 513).

Historically, the focus of leadership development in health care was for administrators and managers, but new evidence suggests the importance of clinical leadership with greater clinician involvement in governance and management roles. Ledlow and Stephens (2018) described leadership as holistic, meaning that leadership requires leading laterally or collaboratively and not just from the top down. They also stated that “leadership entails leading the people, the structure, and the processes of the organization” (Ledlow & Stephens, 2018, p. 5). Sarto & Veronesi’s 2016 review demonstrated the impact of clinician leadership on the efficiency and the effectiveness of health care organizations along several performance indicators, including the management of financial and operational resources and quality of patient care. The authors suggested that there are five reasons for the benefits of greater clinician involvement in leadership:

1) Greater provision of critical knowledge for the decision making process and consequent improvement of the overall decision making quality; 2) higher credibility of clinical leaders and related higher adoption of hospital policies by medical staff; 3) improved organizational credibility and reputation and therefore higher likelihood of attraction of talented personnel; 4) reinforcement of medical commitment to cost
containment; 5) greater attention to patients needs due to ethical beliefs and professional norms of clinicians. (Sarto & Veronesi, 2016, p. 94)

Blumenthal et al. (2012) stated, “now more than ever, patient safety, health care quality, and cost containment depend significantly on practicing physicians’ abilities not only to decide what care services to deliver but also to manage the delivery of those services” (p. 513). Evidence suggests that improving the clinical leadership skills of practicing clinicians yields superior clinical outcomes for patients and health care delivery organizations (Blumenthal et al. 2012).

Clinical outcomes are determined not only by individual professionals and organizational performance, but also by interprofessional team performance. The interprofessional health care team is the small group of clinicians from multiple professions, who are in direct contact with the patient. Leadership within each interprofessional team is a powerful determinant of clinical outcomes. In an interprofessional team, the leadership task does not fall on institutional leaders or administrators. The task of leadership falls on physicians, nurses, physical therapists, social workers, and other health care professionals who lead clinical teams in the course of their day-to-day work. Therefore, leadership is vital in improving the quality and efficiency of the core work of health care (Blumenthal et al. 2012).

Evidence from multiple health care professions regarding the value of leadership skills and leadership ability suggests effective leadership can improve organizational and patient outcomes (Blumenthal et al., 2012; Boamah et al., 2018; McGowan et al., 2020). High quality, high value health care cannot be achieved through the uncoordinated actions of individual health providers serving individual patients one at a time. All stakeholders in the health care system must work together toward a vision of excellent care for individuals, improved population health, and lower costs (Cochran et al., 2014).
Leadership in Medicine & Medical Education

To meet the demands of the complex and rapidly changing health care environment there have been numerous calls to increase leadership development for physicians (Sadowski, 2018). In 2018, Lerman and Jameson gave a compelling perspective on physician leadership in the *New England Journal of Medicine*:

> Our profession has been somewhat complacent in the face of these disruptive forces and hasn’t prioritized cultivation of leadership skills such as communication, team building, collaboration, and deliberative decision making that will position the next generation of physician leaders to succeed in this rapidly changing environment. (p. 1862)

Frontline physician leaders positively influence patient outcomes and patient satisfaction. Effective physician leadership has also been shown to facilitate open discussion of patient safety issues, implementation of quality improvement initiatives, and efforts to redesign health care organizations (Blumenthal et al., 2012).

The desire for more physician participation in health systems leadership has put pressure on educators to develop and implement leadership education programs across medical training and practice (Onyura et al., 2019). There is growing evidence of implementation of leadership training for physicians during graduate medical education. In a systematic review of leadership development programs for physicians by Frich et al. (2015), there were a total of 45 physician leadership programs studied and 26 of them were aimed at individuals in graduate medical education. The report concluded that there was a positive impact on knowledge, but that few studies explored behaviors or higher-level outcomes. The study also noted deficits in interprofessional and experiential learning methods (Frich et al., 2015). A 2018 systematic review published in the *Journal of Graduate Medical Education* by Sadowski and collaborators updated and expanded the work of Frich et al. by aiming to identify common elements, best
practices, and current gaps in graduate medical education leadership curricula. Their study extracted data from 52 articles published between 1991 and 2015. Evidence presented by Sadowski and collaborators suggested that small group teaching, project-based learning, mentoring, and coaching are valuable components of leadership curricula. In addition, the authors determined that longitudinal leadership curricula are more likely to be successful than brief or condensed training over a shorter period. The authors concluded that gaps exist in understanding the best ways to teach leadership and the value of leadership training (Sadowski, 2018).

There is evidence of the positive impact of physician leadership training throughout patient encounters and health systems. While there is emerging evidence of leadership development programs in graduate medical education, there is not yet an agreed upon set of behaviors and skills that should be included, nor is there evidence of a best way to teach and foster leadership in physicians.

**Leadership in Nursing**

Nursing has studied leadership extensively over the past decade. Many studies indicate that relationship focused nursing leadership practices contribute to positive outcomes for the nursing workforce, including job satisfaction, intention to stay in the nursing profession, and health and wellbeing of nurses (Cummings et al., 2018). Effective nursing leadership practices also have significant implications for improved health care quality and patient outcomes (Cummings et al., 2021; Wong et al., 2013). Cummings et al. (2021) suggested that nurses have leadership roles from bedside to the boardroom, so the strategic employment of effective leadership practices is necessary in a workforce critical to the future of changing health care. Having established the importance of leadership development for nurses, researchers are now moving forward to determine the most effective and impactful leadership development programs.
In 2014, Galuska posited that nurses must assume a transformational leadership role in increasing the quality, safety, access, and value in the health care system and to lead in these processes, nurses must be prepared for leadership roles.

In 2018, Cummings et al. completed a systematic review to examine the relationships between various styles or types of leadership (i.e., transformational leadership, empowering leadership, authentic leadership, transactional leadership, relational leadership) and outcomes for the nursing workforce. The systematic review included one hundred twenty-nine studies and the outcomes of the studies were grouped into six categories: 1) staff satisfaction with job factors, 2) staff relationships with work, 3) staff health and wellbeing, 4) relations among staff, 5) organizational environment factors, and 6) productivity and effectiveness. In their findings, relationally focused leadership styles led to positive outcomes in comparison to task focused leadership styles. The study concluded that there is strong support for relationship focused leadership practices in promoting positive nursing workforce outcomes and organizational outcomes.

More recently, Cummings et al. (2021) completed a subsequent systematic review to “determine whether certain nurse characteristics and contextual factors foster nursing leadership, and to examine the effectiveness of targeted interventions in improving nursing leadership” (p. 2). This review included ninety-three studies of nursing leadership, forty-four were correlational studies, and forty-nine were pre/post intervention studies. Studies from the author’s previous systematic review were also re-evaluated with the inclusion criteria. Results of this study demonstrated that targeted leadership development programs are an effective method for improving leadership among nurses. There was variability in the design, duration, and target of the intervention programs included in the review, but almost all reported significant increases in
leadership practices. The findings of this extensive review indicated that although research in nursing leadership has increased significantly, the factors contributing to leadership practices by nurses are still poorly characterized. Factors such as age, education, and experience have been assumed to contribute to leadership but no one individual factor had a direct influence on leadership practices. Also discussed are numerous contextual factors that contribute to the implementation and success of leadership development programs as what works for one organization, or one group of nurses, may not be as effective in another setting or with another group. The authors concluded that “the effectiveness of leadership development interventions is not dependent on program length or mode of delivery, but rather that most targeted approaches to improve leadership are successful” (Cummings et al., 2021, p. 11). The positive impact of leadership development for nurses has been clearly demonstrated. However, further research is warranted to determine which components of leadership development interventions are most effective for nurses in various contexts.

In nursing professional education, inclusion of leadership content in nursing curricula has been established as essential by the American Association of Colleges of Nursing (AACN, 2008). The Essentials of Baccalaureate Education for Professional Nursing Practice states that knowledge and skills in leadership, quality improvement, and patient safety are necessary to provide high quality health care. The document goes on to state that “patient advocacy is a hallmark of the professional nursing role and requires that nurses deliver high quality care, evaluate care outcomes, and provide leadership in improving care” (AACN, 2008, p. 8). Beyond leadership in clinical care, the AACN goes on to state that the development of leadership skills and acceptance of responsibility to promote social justice are expected outcomes of nursing education (AACN, 2008, p. 12).
Graduate nursing curricula have also been evolving to prepare transformational formal nurse leaders for complex systems (Galuska, 2014). Doctoral education in nursing is designed to prepare nurses for the highest level of leadership in practice and scientific inquiry. One of the fundamental essentials for Doctor of Nursing Practice (DNP) education programs is “Organizational and Systems Leadership for Quality Improvement and Systems Thinking” (AACN, 2006, p. 10). Advanced nursing practice includes an organizational and systems leadership component that emphasizes practice, ongoing improvement of health outcomes, and ensuring patient safety. DNP graduates are distinguished by their abilities to use information systems to support and improve patient care and health care systems, and provide leadership within health care systems (AACN, 2006).

There is clear evidence that leadership development for nurses has a positive impact on workforce outcomes such as job satisfaction and productivity but also on patient safety and quality initiatives within health organizations. Nursing education at both the baccalaureate and graduate levels includes leadership development in curricula. Nurses have the training and skills to become effective leaders in health care systems and health care teams.

**Leadership in Other Health Care Professions**

There is a recognized need to develop leaders across all levels of the health system and from a wide range of health care professions. Mental health professions, social work, pharmacy, and speech pathology are now consistently making investments to develop leadership within their workforce (McGowan et al., 2020). Given the increasing number of studies on leadership emerging in these health care professions, there was a need to evaluate these leadership development programs. McGowan et al. (2020) completed a systematic review on the effect of leadership development programs for health and social care professionals to investigate whether the stated objectives had been achieved. In this review, the authors included descriptive data
from nine studies of leadership development programs from across the globe that included professionals in mental health, social work, nursing, occupational therapy, physical therapy, speech pathology, dietetics, pharmacists, and medicine. Most of the studies were multidisciplinary and only two studies involved a single profession, which were social workers and physiotherapists. McGowan and collaborators (2020) concluded that because of the high variability between leadership development programs there cannot be definitive recommendations given for specific programs for health and social care professionals. Their results suggested that experiential learning and assigned project work or action learning should be included in leadership development programs and that mentoring may be beneficial.

In recent years, leadership in occupational therapy has attracted increasing attention in literature as the profession has sought to thrive and meet increasing global challenges (Brown et al., 2014; Davidson, 2012). A recently published cross sectional, descriptive study by Hitch et al. (2020) showed significant differences in leadership perceptions between junior and senior occupational therapy clinicians. In addition, a significant relationship was found between transformative leadership and patient outcomes.

Various health care professions such as medicine, nursing, and occupational therapy have developed expectations regarding leadership abilities within their profession. Schools of medicine and nursing have created curricula integrating leadership knowledge, skills, and abilities to produce competent health care professionals who can apply leadership knowledge, skills, and abilities in their daily decision making (Sebelski et al., 2021). Researchers from a variety of health care professions all agree that further study of interventions to best develop and promote viable leadership for the future are needed. Leadership is vital to achieve the goals of
developing healthy and efficient work environments for health care providers that optimize quality care for patients.

**Physical Therapy**

Over 100 years ago, the physical therapy profession originated within the societal events of the devastating rehabilitative needs of returning World War I soldiers and people who survived polio. Physical therapists today are health care professionals and movement experts who improve quality of life through prescribed exercise, hands-on care, and patient education.

Physical therapists practice in a wide range of settings, including hospitals, outpatient clinics, people’s homes, schools, sports and fitness facilities, workplaces, and nursing homes.

According to the American Physical Therapy Association (APTA):

Physical therapists and physical therapist assistants help people to maximize their quality of life. They work with people of all ages and abilities and in a variety of settings. They help people rehabilitate from devastating injuries, manage chronic conditions, avoid surgery and prescription drugs, and create healthy habits. (APTA Careers in physical therapy, n.d.)

To practice as a physical therapist in the U.S., a person must earn a Doctor of Physical Therapy (DPT) degree from an education program accredited by the Commission on Accreditation in Physical Therapy Education (CAPTE) and pass a national licensure exam. Most DPT programs require applicants to earn a bachelor’s degree prior to admission and the length of professional DPT programs is typically three years. Primary content areas in the DPT curriculum may include, but are not limited to, biology/anatomy, cellular histology, physiology, exercise physiology, biomechanics, kinesiology, neuroscience, pharmacology, pathology, behavioral sciences, communication, ethics/values, management sciences, finance, sociology, clinical
reasoning, evidence-based practice, cardiovascular and pulmonary, endocrine and metabolic, and musculoskeletal (APTA Becoming a PT, n.d.).

For education beyond graduation and licensure, licensed physical therapists may choose to pursue a residency or fellowship program to enhance their knowledge and practice. A clinical residency is designed to advance a physical therapist’s preparation as a provider of patient care services in a defined area of clinical practice such as sports medicine, neurology, or pediatrics. A clinical fellowship is a planned program of post professional clinical and didactic education for a physical therapist who demonstrates clinical expertise in an area of clinical practice related to the practice focus of the fellowship. Physical therapists can also become board-certified clinical specialists through the American Board of Physical Therapy Specialties. Specialization is the process by which a physical therapist builds on a broad base of professional education and practice to develop a greater depth of knowledge and skills related to a particular area of practice. Physical therapists are not required to be certified to practice in a specific area (APTA, Becoming a PT, n.d.).

The profession is guided by a set of core values and a code of ethics to provide the highest quality of physical therapist services. The core values for the physical therapist and physical therapist assistant include accountability, altruism, collaboration, compassion and caring, duty, excellence, integrity, and social responsibility (APTA, 2019). These core values retain the physical therapist as the person ultimately responsible for providing safe, accessible, cost-effective, and evidence-based services.

The Code of Ethics for the Physical Therapist (Code of Ethics) delineates the ethical obligations of all physical therapists as determined by the APTA. The purposes of the Code of Ethics include to define ethical principles that form the foundation of practice, provide standards
of behavior and performance, provide guidance for physical therapists facing ethical challenges, and establish standards by which the APTA can determine if a physical therapist has engaged in unethical conduct. These standards are used to educate physical therapists, students, other health care professionals, regulators, and the public regarding the core values, ethical principles, and standards that guide the professional conduct of physical therapists. The Code of Ethics describes the desired behavior of physical therapists in their multiple roles (e.g., management of patients and clients, consultation, education, research, and administration), addresses multiple aspects of ethical action (individual, organizational, and societal), and reflects the core values of the physical therapist (APTA, 2020). There are eight principles outlined in the Code of Ethics for the Physical Therapist (APTA Code of Ethics, 2020):

- Principle #1: Physical therapists shall respect the inherent dignity and rights of all individuals.
- Principle #2: Physical therapists shall be trustworthy and compassionate in addressing the rights and needs of patients and clients.
- Principle #3: Physical therapists shall be accountable for making sound professional judgments.
- Principle #4: Physical therapists shall demonstrate integrity in their relationships with patients and clients, families, colleagues, students, research participants, other health care providers, employers, payers, and the public.
- Principle #5: Physical therapists shall fulfill their legal and professional obligations.
- Principle #6: Physical therapists shall enhance their expertise through the lifelong acquisition and refinement of knowledge, skills, abilities, and professional behaviors.
• Principle #7: Physical therapists shall promote organizational behaviors and business practices that benefit patients and clients and society.

• Principle #8: Physical therapists shall participate in efforts to meet the health needs of people locally, nationally, or globally.

Leadership in Physical Therapy

Physical therapists are primary health care providers with direct contact with patients on a day-to-day basis and an integral part of the health care team at all levels of health care. The APTA’s current vision statement is “transforming society by optimizing movement to improve the human experience” (APTA, 2019, September). This vision is bold and compels physical therapists to transform society. To transform means to change and to change at the organization and society level requires effective leadership knowledge, skills, and abilities. Developing the ability to lead others and to work cooperatively is a top priority for leadership development in health care. There is emerging, but limited, evidence on leadership in physical therapy. Sebelski and colleagues (2021) argue, “as the profession approaches its centennial in the U.S., we have yet to realize fully our potential as movement system experts who embrace an identity as essential providers on primary care teams” (p. 1). The authors go on to say that the profession of physical therapy needs leadership at all levels by physical therapists in all settings and practices. Similarly, Green-Wilson and Ziegler (2020) stated, “As a future or current health care professional, you must understand how to be engaged as a valuable member on any team, and how to fuel and refuel collaborative and dynamic teamwork to ensure patient safety and quality outcomes and transform or advance clinical practice” (p. 95).

The current status of leadership development available for physical therapists in the U.S. includes the Leadership, Administration, Management and Professionalism (LAMP) Institute for
Leadership which is part of the Health Policy and Administration section of the APTA. In 2008, this institute was designed and began offering an evidence-based, experiential, multiple-component continuing education program to provide focused training in leadership for physical therapists and physical therapist assistants (Green-Wilson et al., 2020). This institute currently offers a three-step tiered leadership development program which focuses on personal and professional growth. The LAMP Institute of Leadership Certificate in Health Care Leadership is earned upon completion of the program. It is marketed as a powerful, game-changing leadership program designed for anyone in the health care field and has provided training to hundreds of professionals including physical therapists, physical therapist assistants, occupational therapists, speech language pathologists, physicians, nurses, human resource professionals, educators, and others in health care (Health Policy & Administration Section, n.d.). The LAMP Institute for Leadership website states, “with rapid changes in the dynamics of the health care work environment, leadership is now more important than ever before” (Health Policy & Administration Section, n.d.).

The first study to examine outcomes following the LAMP leadership development program was published in 2020. In this study, Green-Wilson and her colleagues qualitatively explored and evaluated the perceived outcomes of participants who completed the LAMP leadership development program from 2009 through 2015. From the data collected during focus group interviews of 25 participants, four essential themes emerged: 1) participants reframed their viewpoints of leadership development; 2) participants acknowledged that leadership development is a journey; 3) participants were inspired to act; and 4) participants confirmed that personal growth happened. From this preliminary work, the authors concluded that the participants in the LAMP leadership development program reported cognitive, affective, and
behavioral changes that were transformational for themselves, teams, and organizations (Green-Wilson et al., 2020).

**Leadership in Physical Therapy Education**

In physical therapy professional education there are few studies on leadership behaviors and leadership development occurring within entry-level DPT programs. Despite multiple calls for leadership at all levels of the physical therapy profession, there remains a lack of clear direction, emphasis, and integration in physical therapist education and practice on what leadership means and what leadership development should include (Sebelski et al. 2021).

Following a national study of innovation in physical therapist education, Jensen and renowned group of researchers (2017) recommended that physical therapy education “institute leadership development that reinforces the value of shared leadership, effective teams, innovation, and cultures of excellence. This development must begin in professional education and continue across a professional’s career” (Jensen et al., 2017, p. 878). While Jensen and her esteemed colleagues presented a reasoned and compelling call to action, there has been little follow up or action. The profession of physical therapy has little evidence about the scale and scope of leadership in physical therapists or DPT students, nor is there evidence about the number of physical therapy programs that have leadership integrated into their professional programs.

The Commission on Accreditation for Physical Therapy Education (CAPTE) has few references addressing leadership in the required academic standards and elements for entry-level physical therapists. The CAPTE standards do include some skills and behaviors found in leadership frameworks (i.e., communication) but they are not labelled as leadership skills or listed in the context of leadership ability. There is currently only one element required by CAPTE that explicitly mentions leadership in the DPT program accreditation standards, element
LEADERSHIP PERSPECTIVES FROM DPT STUDENTS

7D13 which reads, “participate in professional and community organizations that provide opportunities for volunteerism, advocacy and leadership” (CAPTE, 2020, p. 29). This required element is found in Standard 7, which states “the curriculum includes content, learning experiences, and student testing and evaluation processes designed to prepare students to achieve educational outcomes required for initial practice in physical therapy and for lifelong learning necessary for functioning within an ever-changing health care environment” (CAPTE, 2020, p. 26). Despite the acknowledgement that physical therapists will have to function in an ever-changing health care environment there is only one required element that mentions leadership throughout this standard. The concern here is described by Sebelski et al, (2020):

Given that the profession has not collectively defined leadership or the critical graduate competencies related to leadership, academic programs have little systematic and clear guidelines on which to develop leadership frameworks within curricula. There is wide variation among the APTA, APTA sections/academies of specialty practice, CAPTE, and entry-level education in addressing leadership that underscores the inconsistent expectations of leadership competencies for the entry-level graduate. (p. 97)

Currently, inclusion of leadership education in the DPT curriculum is variable across programs as it is not explicitly required by accreditation standards and is dependent on each institution’s mission and strategic priorities.

There is some evidence for the implementation of leadership development in DPT curricula in the U.S. There are three studies in which leadership behaviors of DPT students were measured, each study used the Leadership Practices Inventory Self (LPI Self) as a measurement tool for assessing DPT student leadership behaviors in the Five Practices of Exemplary Leadership as developed by Kouzes and Posner (2017). Lovasco and collaborators (2016)
measured the leadership practices of year-one students enrolled in entry-level DPT programs. The study provided a baseline description of how year-one students perceived their own leadership behaviors using the LPI Self (LoVasco et al., 2016). In 2019, LoVasco, Smith, Yorke, and Talley studied the impact of a leadership development program for students in a DPT program. This study was a pretest/posttest design in which the LPI Self was completed before and after a leadership development and education course. A significant increase was found in the total change score of the LPI Self from pre- to post-test in the experimental group compared to the control group. Their findings suggested that leadership development in DPT curriculum can increase leadership practices in new graduates (LoVasco et al., 2019).

A study by Eigsti et al. (2018) investigated the impact of leadership development threaded throughout a curriculum on DPT student education. In this study participants completed the LPI Self during their fourth semester of a DPT program and then again in the last semester of an eight-semester program. During the program, the students participated in various leadership development activities based on a transformational leadership framework. In agreement with LoVasco and collaborators work, there was a significant increase in leadership practices following a leadership thread in the curriculum which contained leadership development and education (Eigsti & Davis, 2018). Taken together, these two studies, LoVasco et al. (2019) and Eigsti & Davis (2018), provide noteworthy evidence of the impact of intentional leadership development and training in DPT professional education to advance the leadership behaviors in physical therapists. While these two studies included a measurement of students self-perceived leadership behaviors before and after a leadership training course or leadership thread in a curriculum, both were characterized by small sample sizes and limited to DPT students in only one program.
There is growing evidence defining leadership knowledge, skills, and abilities necessary for new graduate physical therapists. In 2004, Lopopolo and colleagues completed a Delphi to determine the knowledge and skills needed by new graduate physical therapists entering practice in the areas of leadership, administration, management, and professionalism. The panel of respondents in the study were physical therapists who were clinical managers. At the conclusion of the study the category ranked highest for overall importance was communication followed by leadership theory. Top-ranked component categories across the three scales used (importance, knowledge, and skill) were communication, professional involvement and ethical practice, delegation and supervision, stress management, reimbursement sources, time management, and health care industry scanning (Lopopolo, et al., 2004). This study provided a strong basis for which components of leadership, administration, management, and professionalism should be included in DPT curricula but there has been no follow up study on the implementation.

More recently, Sebelski and colleagues (2020) published a Delphi study to determine leadership competencies for physical therapists. Following two rounds of review by fourteen content experts who were physical therapists in the U.S., there were thirty-seven leadership competencies deemed “very important” for all physical therapists regardless of their years of experience. This list can be found in Table 1 (Sebelski et al., 2020). At the conclusion of the study, the authors stated “continued dialog on leadership competencies is essential to develop consensus on how physical therapists conceptualize leadership and to develop a standardized framework for preparation of the entry-level graduate and professional development of the more experienced point-of-care professional” (p. 99).
Table 1.

Consensus Agreement (0.80 or greater) of “Very Important” Competencies (n = 37/76) for All Physical Therapists, Both Less Than and Greater Than 1 Year Post licensure

(Sebelski et al., 2020, pp. 100-101)

<table>
<thead>
<tr>
<th>Competency</th>
<th>Definition Given</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accountable</td>
<td>Accepts ownership of the responsibility for decisions, roles, obligations, and actions.</td>
</tr>
<tr>
<td>Analyzes</td>
<td>Evaluates the individual pieces and the whole, to make meaning of the situation to make sound, evidence-based decisions.</td>
</tr>
<tr>
<td>Assesses</td>
<td>Evaluates performance against benchmarks, metrics of expectation, and new opportunities.</td>
</tr>
<tr>
<td>Authentic</td>
<td>Exhibits an ability to be true to one’s self, personality, spirit, or character despite external pressure.</td>
</tr>
<tr>
<td>Collaborative</td>
<td>Works together to allow a multitude of voices and ideas to be considered, an enhanced sense of group commitment and responsibility to intentionally bring people together.</td>
</tr>
<tr>
<td>Communication Skills</td>
<td>Exchanges information or ideas.</td>
</tr>
<tr>
<td>Cultural Humility</td>
<td>Demonstrates a perspective that is other oriented in relation to personal values, assumptions, and beliefs.</td>
</tr>
<tr>
<td>Diversity Orientation</td>
<td>Modifies interactions while engaging with individuals of different backgrounds, beliefs, or experiences that respects the boundaries, needs, and style of others.</td>
</tr>
<tr>
<td>Empathetic</td>
<td>Illustrates understanding, sensitivity, and awareness of another’s point of view or circumstances.</td>
</tr>
<tr>
<td>Ethical orientation</td>
<td>Aligns actions, beliefs, and values with moral standards and principles.</td>
</tr>
<tr>
<td>Evaluates</td>
<td>Determines significance, worth or condition by careful appraisal and paper.</td>
</tr>
<tr>
<td>Evidence informed practice</td>
<td>Distinguishes legitimacy of information use to match the unique needs of the situation.</td>
</tr>
<tr>
<td>Excellence orientation</td>
<td>Strives beyond an established standard to achieve the greatest outcome.</td>
</tr>
<tr>
<td>Follows through</td>
<td>Carries through to completion as promised.</td>
</tr>
<tr>
<td>Goal orientation</td>
<td>Strives for achievement of measurable outcomes with time frames for completion.</td>
</tr>
<tr>
<td>Health professional orientation</td>
<td>Articulates the roles, responsibilities, and values of the range of the health providers to foster effective relationships and promote an optimal care environment.</td>
</tr>
<tr>
<td>Implements</td>
<td>Executes the process of putting a decision or plan into effect.</td>
</tr>
<tr>
<td>Initiative</td>
<td>Self-motivates to act.</td>
</tr>
<tr>
<td>Integrity</td>
<td>Upholds one’s self to being honest with strong moral principles.</td>
</tr>
<tr>
<td>Leadership Perspectives</td>
<td>Description</td>
</tr>
<tr>
<td>------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Interpersonal relationship skills</td>
<td>Facilitates associations between 2 or more people.</td>
</tr>
<tr>
<td>Lifelong learning skills</td>
<td>Pursues knowledge, skills, and experiences for professional or personal behavior growth that is ongoing and self-motivated.</td>
</tr>
<tr>
<td>Listening skills</td>
<td>Processes spoken and unspoken messages actively to engage others.</td>
</tr>
<tr>
<td>Plans</td>
<td>Identifies tasks and deadlines to develop road maps for performance.</td>
</tr>
<tr>
<td>Problem solving skills</td>
<td>Uses a methodical analysis to find explanations or solutions.</td>
</tr>
<tr>
<td>Professionalism</td>
<td>Aligns personal conduct, aims, and values with standards, roles, responsibilities, and expectations of a profession.</td>
</tr>
<tr>
<td>Provides feedback</td>
<td>Offers advice to improve behaviors, decisions, performance and interactions with others in a constructive manner.</td>
</tr>
<tr>
<td>Receives feedback</td>
<td>Integrates critiques, affirmations, suggestions, or advice into future actions.</td>
</tr>
<tr>
<td>Reflects</td>
<td>Uses a thoughtful review of strengths, weaknesses, and outcomes.</td>
</tr>
<tr>
<td>Relationship building</td>
<td>Cultivates connections with others.</td>
</tr>
<tr>
<td>Scope of competence</td>
<td>Recognizes what one brings or does not bring to a situation.</td>
</tr>
<tr>
<td>Seeks information</td>
<td>Demonstrates curiosity and desire to know more about things, people, or issues.</td>
</tr>
<tr>
<td>Self aware</td>
<td>Identifies one’s own strengths, weaknesses, beliefs, motivations, emotions, and perceptions by others.</td>
</tr>
<tr>
<td>Self confidence</td>
<td>Believes in one’s own ability, success, and decisions or opinions.</td>
</tr>
<tr>
<td>Self-management</td>
<td>Regulates one’s own emotions and behavior.</td>
</tr>
<tr>
<td>Synthesizes</td>
<td>Integrates ideas and elements to form a coherent whole.</td>
</tr>
<tr>
<td>Team orientation</td>
<td>Uses a spirit of collaboration for action, decisions, and behaviors of groups.</td>
</tr>
<tr>
<td>Trustworthy</td>
<td>Demonstrates honesty in words and actions.</td>
</tr>
</tbody>
</table>

Given the available evidence, there is a need for leadership training for DPT students.

Emerging evidence suggests DPT students have self-assessed leadership abilities following leadership development within a curriculum. There is also recent evidence on which leadership knowledge, skills, and abilities should be included in DPT curricula but not yet a consensus on the best practices for implementing leadership development in physical therapist professional education.
Conclusion

To achieve the best outcomes in today’s health care environment, all health care professionals should be equipped with leadership skills. Leadership is a complex topic and the understanding and definitions of leadership have evolved over time.

If the profession of physical therapy is to live out the APTA’s vision statement “transforming society by optimizing movement to improve the human experience,” physical therapists must have the knowledge, skills, and abilities to lead organizational change in health care and communities to transform society. The emerging research completed in physical therapy to date demonstrates that there is a need for the inclusion of leadership development in DPT curricula. There is new evidence of which leadership competencies should be included in DPT education. Yet, there are no explicit leadership competencies included in DPT program accreditation standards and there is little evidence of best practices for implementation of leadership development in DPT curricula. Currently, inclusion of leadership education in the DPT curriculum is highly variable across programs as it is dependent on each institution’s mission and strategic priorities. Given the complexity of leadership and the current variability of including leadership development in DPT curricula, when looking to increase leadership development for students, a DPT program should first determine the students’ current conceptualization of leadership and its value to these future health care professionals.
Chapter 3. Methodology

Leadership is a complex topic, and the definition of leadership has changed over time. Current understandings of leadership concur that leadership is a process, and the knowledge, skills, and abilities necessary to lead can be developed by anyone. To navigate an ever-changing and highly complex health care environment, physical therapists must be able to lead change in organizations and communities. There is evidence for the inclusion of leadership development in Doctor of Physical Therapy (DPT) curricula, yet the current understanding of leadership from the perspective of DPT students is unknown. Given the complexity of leadership and the extent to which leadership definitions have evolved, it is important to examine DPT students’ current conceptualization of leadership. The purpose of this phenomenological study was to explore how DPT students have experienced and currently conceptualize leadership and their perception of the value of leadership for health care professionals. Current literature outlines the need for physical therapists to have leadership knowledge, skills, and abilities, but is void of describing the perceptions of leadership experienced by DPT students. The researcher chose a qualitative strategy to explore these perceptions of leadership.

This chapter will further define the purpose of the study and relate this purpose to the research design and phenomenological methodology. The design of the study will be detailed, including participant selection and the procedures for selecting and communicating with participants. Next, data collection procedures and instruments will be discussed. Data analysis methodologies will be described as outlined by Creswell and Poth (2018) and Patton (2015). Finally, ethical considerations concerning this study will be discussed.

Purpose of the Study

As described in Chapter 1 of this study (see p. 11), the purpose of the study was to investigate the perspectives of DPT students regarding the concepts of leadership and the value
of leadership for health care professionals. There is clear evidence of the need for health care professionals, including physical therapists, to have leadership knowledge, skills, and abilities. As further studies have indicated, there is emerging emphasis on the need for leadership development within DPT curricula. Despite the recent push for leadership development, there are no studies of DPT student perceptions of leadership or their understanding of the value of leadership. This study addressed a gap in the literature surrounding DPT students’ experience and perception of leadership and the value of leadership.

To collect meaningful data concerning a complex topic such as leadership, a quantitative survey might reveal that differences exist and the degree of variance of those differences for many participants; however, it does not allow individuals to detail their personal realities or reflect deeply to express their own understanding of leadership. Rather, a qualitative study comprised of interviews allows participants to divulge details, recount stories and events, and justify their perspectives. It is in these interviews that the researcher may find data that reveal how and why DPT students believe what they do about leadership and in what ways they value leadership. This type of inquiry is based on the interpretive paradigm and exemplifies social constructivism, the foundations of a phenomenological study.

**Research Questions**

1. How do DPT students conceptualize leadership?
2. How do DPT students value leadership for health care professionals?

**Research Design**

According to Creswell and Poth (2018), “we conduct qualitative research because a problem or issue needs to be explored. This exploration is needed, in turn, because of a need to study a group of population, identify variables that cannot easily be measured, or hear silenced voices” (p. 45). Qualitative research is conducted when a complex, detailed understanding of an
issue is needed. Leadership is a complex issue, and a detailed understanding of DPT students’ perspective of the issue is needed.

This study adhered to the social constructivist (interpretive) paradigm. In social constructivism, individuals seek understanding of the world in which they live. The social constructivist paradigm is characterized by the presence of “multiple realities constructed through our lived experiences and interactions with others” (Creswell & Poth, 2018, p. 35). This study investigated the perspectives and lived experiences of DPT students to interpret their constructions of meaning around leadership and the value of leadership knowledge, skills, and abilities for health care professionals.

There are many approaches to consider in qualitative research including narrative research, grounded theory research, case study research, ethnographic research, and phenomenological research. According to Creswell and Poth (2018):

We need to identify our approach to qualitative inquiry in order to present it as a sophisticated study; to offer it as a specific type so that reviewers can properly assess it; and, for the beginning researcher, who can profit from having a writing structure to follow, to offer some way of organizing ideas that can be grounding in the scholarly literature of qualitative research. (p. 65)

After establishing the need for identifying an approach, the next concern is deciding which approach is best suited to address the research focus (Creswell & Poth, 2018).

A researcher seeking to study a single individual may select the narrative research approach. Narrative studies tell of individual experiences, and they may shed light on the identities of individuals and how they see themselves. It is also an exploration of the social, cultural, and institutional narratives within which individuals’ experiences are shaped (Creswell
& Poth, 2018). Narrative research was not appropriate for this study of leadership given the goal of understanding multiple DPT student perceptions versus just one.

Regarding grounded theory research, Creswell and Poth (2018) noted, “while narrative research focuses on individual stories told by participants and phenomenology emphasizes the common experiences for a number of individuals, the intent of grounded theory study is to move beyond description and to generate or discover a theory, a unified explanation for a process or action” (p. 82). Grounded theory is an appropriate design to use when a theory is not available to explain or understand a process or the theories present are incomplete and do not address potentially valuable variables. The focus of the interview questions in grounded theory are on understanding how individuals experience a process and identify the steps in the process (Creswell & Poth, 2018). Given that there are existing, well-developed, theories of leadership, and the research questions for this study did not include process or steps in a process, grounded theory was eliminated as a potential research method.

Another potential qualitative research approach is case study research. As Creswell and Poth (2018) described,

Case study research is defined as a qualitative approach in which the investigator explores a real-life, contemporary bounded system (a case) or multiple bounded systems (cases) over time, through detailed, in-depth data collection involving multiple sources of information (e.g., observations, interviews, audiovisual material, and documents and reports), and reports a case description and case themes. (pp. 96-97)

The key to case identification for case study research is that it is bounded, meaning that it can be described within certain parameters such as a place or timeframe (Creswell & Poth, 2018). Case study research was not appropriate for the current research study of perspectives on leadership
due to the parameters, such as place or timeframe, required for a case study. The DPT students interviewed for the study brought experience from their entire life and not a bounded place or timeframe.

In the ethnographic research approach, the researcher focuses on an entire culture-sharing group. “The researcher describes and interprets the shared and learned patterns of values, behaviors, beliefs, and language of a culture-sharing group” (Creswell & Poth, 2018, p. 90). Ethnography involves engaging in extended fieldwork collecting data through observations and interviews of the group, and typically the researcher is immersed in the day-to-day lives of the participants. Ethnographic research was not appropriate for this study as it did not fit the research focus and was not the best approach to answer the research questions which were specific to leadership experience and not the entire culture of DPT students.

Phenomenological research was determined to be the most appropriate qualitative approach for this study. The core inquiry question of phenomenology as described by Patton (2015) is “what is the meaning, structure, and essence of the lived experience of this phenomenon for this person or group of people?” (p. 115). Phenomenology focuses on exploring how human beings make sense of experience and transform experience into consciousness, both individually, and as shared meaning. This requires methodologically and thoroughly capturing and describing how people experience some phenomenon including how they perceive it, describe it, feel about it, remember it, make sense of it, and talk about it with others (Patton, 2015).

One dimension that differentiates phenomenology from other qualitative approaches is the assumption that there is an essence or essences to shared experience. These essences are the core meanings mutually understood through a commonly experienced phenomenon. In
phenomenological research the experiences of different people are explored, analyzed, and compared to identify the essences of the phenomenon (Patton, 2015). Creswell and Poth (2018) agreed that phenomenology is the study of lived experiences of persons, that these experiences are conscious ones, and that it includes the development of descriptions of the essences of these experiences, not explanations or analyses.

Creswell and Poth (2018, p. 77) described several features that are typically included in all phenomenological studies:

- An emphasis on a phenomenon to be explored, phased in terms of a single concept or idea.
- The exploration of the phenomenon with a group of individuals who have all experienced the phenomenon.
- A philosophical discussion about the basic ideas involved in phenomenology which turns on the lived experiences of individuals.
- The researcher brackets themselves out of the study by discussing personal experiences with the phenomenon.
- Data collection procedures typically involve interviewing individuals who have experienced the phenomenon.
- Data analysis that can follow systematic procedures that move from narrow units of analysis such as significant statements and on to broader units or meaning units, and then on to detailed descriptions that summarize “what” the individuals have experienced and “how” they have experienced it.
- An ending with a descriptive passage that discusses the essence of the experience for individuals.
The researcher selected a phenomenological approach for this study as it focused on the single concept of leadership. The exploration of leadership occurred with a specific group of individuals, DPT students, who have experienced the phenomenon. The researcher bracketed herself out of the study with detailed description of her personal experience with leadership. Data collection procedures involved individual interviews with DPT students, and data analysis followed systematic procedures moving from narrow units to broad detailed descriptions that summarize how DPT students conceptualize leadership, how they have experienced it, and how they value it. Finally, as prescribed by the phenomenological approach, the study culminated with a description of the essence, or core meanings, of leadership, mutually understood by DPT students. According to Moustakas (1994), the aim of phenomenological research is to:

Determine what an experience means for the persons who have had the experience and are able to provide a comprehensive description of it. From the individual descriptions general or universal meanings are derived, in other words, the essence or structures of the experience. (p. 13)

In summary, the basic purpose of phenomenology is to reduce individual experiences with a phenomenon to a description of the universal essence (‘a grasp of the very nature of the thing’) (Creswell & Poth, 2018, p. 75). Thus, phenomenology was determined to be the most appropriate qualitative approach for this study.

**Procedures**

The procedures followed in this phenomenological study followed those outlined by Moustakas (1994) and Creswell and Poth (2018), which were in agreement with Patton (2015) and are described in detail later in this chapter. These procedures included participant selection, data collection through interviews, and qualitative data analysis. According to Creswell and Poth (2018), “the process of data collection, data analysis, and report writing are not distinct steps in
the process – they are interrelated and often go on simultaneously in a research project” (p. 185). The authors further described qualitative data analysis as a spiral with the researcher engaging in the process of moving in analytic circles rather than using a fixed linear approach. The researcher enters the spiral with data and exits with a detailed representation of the data (Creswell & Poth, 2018). Further details of this spiral are described later in this chapter, in the Data Analysis section (pp. 15-21).

**Participant Selection**

An important step in the data collection process for qualitative research is to find people or places to study and to gain access to and establish rapport with participants so that they will provide good data. Purposeful sampling was used in this study to target participants within the current cohorts of a DPT program. Purposeful sampling is used in qualitative research to intentionally sample a group of people that can best inform the researcher about the phenomenon being studied. According to Patton (2015), “the purpose of a purposeful sample is to focus case selection strategically in alignment with the inquiry’s purpose, primary questions, and data being collected” (p. 264). There are three considerations that go into the purposeful sampling approach in qualitative research: 1) the decision as to whom to select as participants for the study; 2) the specific type of sampling strategy; and 3) the size of the sample to be studied (Creswell & Poth, 2018).

The decision as to whom to select as participants for this study was driven by the researcher’s position and the purpose of the study data to be used in future program curricular decisions at the DPT program studied. The participants selected for this study were students in the second and third year of the DPT program. Each participant was enrolled in the DPT program and identified as a future physical therapist. Inclusion criteria included students in their
second or third year because they had context of the profession of physical therapy from completing multiple DPT courses and at least one full-time clinical education experience. At the time of the interviews, first-year students had not fully completed any DPT courses and had not completed a full-time clinical education experience, leaving their experience of the profession widely varied and quite limited. As a result, students in their first year of the DPT program were excluded from the study.

According to Patton (2015), “there are no rules for sample size in qualitative inquiry” (p. 311). Qualitative inquiry is full of ambiguities including determining sample size. Sample size depends on the purpose of the study and what can be done with the time and resources available. “In-depth information from a small number of people can be especially helpful in exploring a phenomenon and trying to document diversity or understand variation” (Patton, 2015, p. 311). There is a trade-off in depth versus breadth when it comes to sample size. There is an inverse relationship between the amount of useable data obtained from each participant and the number of participants, so the greater the amount of useable data obtained from each person, the fewer the number of participants needed. If the interviewer obtains a small amount of data per interview question, then to obtain the depth and richness of data required for qualitative analysis, the researcher needs many participants. Conversely, if a phenomenological study is conducted with multiple interviews of each person and there is a large amount of data obtained, fewer participants are needed in the study (Patton, 2015). In summary, Patton (2015) recommended that qualitative designs specify minimum samples based on expected reasonable coverage of the phenomenon given the purpose of the study and stakeholder interests. A researcher may add to the sample as fieldwork unfolds or change the sample if information emerges that indicates the value of change. “The design should be understood to be flexible and
emergent” (Patton, 2015, p. 314). Creswell and Poth (2018) recommended that researchers interview five to 25 individuals who have all experienced the phenomenon. The minimum sample size for this study of DPT students’ perspectives on leadership study was determined to be ten (five students from each cohort) based on the time and resources available to the researcher and the depth of data anticipated to be collected from each participant.

The specific type of sampling strategy used in this study was purposeful random sampling. According to Patton (2015), a purposeful random sample:

- Adds credibility to a qualitative study when those who will use the findings have a strong preference for random selection, evening for small samples; it can be perceived to reduce bias; purposeful random sampling is especially appropriate when the potential number of cases within a purposeful category is more than what can be studied within the available time and resources. (p. 268)

There were 35 students enrolled in the DPT program third-year cohort and 25 students enrolled in the second-year cohort. The time and resources allotted for this study were not sufficient to conduct interviews with all 60 DPT students. A purposeful random sample was selected to reduce perceived selection bias as those who will use the study results were primarily faculty members in the DPT program who have a strong preference for random selection. As Patton (2015) stated, “the purpose of a small random sample is credibility and manageability, not representativeness (p. 286).

The researcher completed the random selection of students from each cohort using a random number generator (Google, 2021). Each student in the second-year cohort was assigned a number on a spreadsheet. Then, five random numbers were selected using a random number generator to identify potential participants (Google, 2021). The researcher completed the same
process for the 35 students in the third-year cohort. The ten students randomly selected were then invited to participate in the study via email. If a selected student declined participation, then the random number generator was used again and the next randomly selected student in the same cohort was invited to participate via email. This process continued until there were ten students (five from each cohort) who agreed to participate in the study.

The researcher invited the randomly selected students to participate in the study via an email invitation that was sent to the student’s university email address. This email invitation included an invitation to participate (see Appendix A), the informed consent document (see Appendix B), and asked the student to respond to agree or decline participation within three days of receiving the invitation.

**Protection of Participants**

Each participant received an informed consent document from the researcher prior to the interviews (see Appendix B). This document was sent initially electronically via email for review and then signed prior to the interview. Signed consent forms were stored separately from transcripts and data to protect participant identity. The informed consent form outlined the rights of the individuals in regard to participation in the study, including the right to withdraw their participation at any time.

To protect the identity of participants, each participant was assigned a pseudonym, which was used to identify that participant throughout the data collection and in the analysis of the individual case record. In addition, to help protect confidentiality of participants, the storage of data and notes was kept in a secured location accessible only to the researcher.
Data Collection

Data collection for this project occurred through in-person qualitative interviews designed to explore the lived experience and perspectives of leadership of DPT students. According to Patton (2015), “an interview, when done well, takes us inside another person’s life and worldview” (p. 426). Qualitative interviewing starts with the assumption that the perspective of others is meaningful and knowable, and the purpose of interviewing is to allow the researcher to enter into another person’s perspective. According to Moustakas (1994), “the phenomenological interview involves an informal, interactive process…aimed at evoking a comprehensive account of the person’s experience of the phenomenon” (p. 114). By capturing a personal description of a lived experience, the researcher aimed to describe a phenomenon as it is lived through and understood without offering causal explanations or generalizations (Patton, 2015).

One-on-one interviews using an interview guide were used for data collection in this study. Moustakas (1994) indicated that typically the long interview is the format through which data is collected for phenomenological research and suggested that while not always necessary, a general interview guide, may facilitate the obtaining of rich vital, substantive descriptions of the participant’s experience of the phenomenon. Patton (2015) described three basic approaches to collecting qualitative data through interviews: 1) the informal conversational interview, 2) the interview guide, and 3) the standardized open-ended interview. An informal conversational interview relies entirely on spontaneous generation of questions in the natural flow of interaction, often as part of an observation. An interview guide lists the questions or issues that are to be explored during the interview. It is prepared to ensure that the same basic lines of inquiry are pursued with each person that is interviewed but the interviewer remains free to build
conversation within the subject area. The standardized open-ended interview approach requires
carefully and fully wording each question before the interview. It consists of a set of questions
specifically arranged to take each respondent through the same sequence and asking each
respondent the same questions with the same words. In this approach flexibility is limited. This
approach is beneficial when multiple interviewers are being used so that variation among
interviewers can be minimized (Patton, 2015).

In this study, using an interview guide, all participants were asked the same open-ended
questions about leadership, but the researcher had the freedom to ask follow-up questions to
probe the participant about responses or clarify concepts. The researcher conducted one in-
person interview with each participant following the established interview guide (see
Appendix C). One follow-up interview was conducted with a participant only if further
clarification of information was needed as determined during the data analysis process.

The questions that are asked in an interview depend on the purpose of the study and the
research questions guiding the study. According to Moustakas (1994), participants should be
asked two broad, general questions: 1) What have you experienced in terms of the phenomenon?
and 2) What contexts or situations have typically influenced or affected your experiences of the
phenomenon? Other open-ended questions may also be asked, but these two questions focus
attention on gathering data that will lead to a rich description of the experiences (Creswell &
Poth, 2018, p. 79). Creswell and Poth (2018) noted, “interview questions are often the sub
questions in the research study, phrased in a way that interviewees can understand” (p. 164). An
interview guide should be developed and include five to seven open-ended questions (Creswell
&Poth, 2018). The seven questions about leadership and the value of leadership that were used
in this study are presented in Appendix C.
Patton (2015) described the six types of questions that can be asked of people: 1) experience and behavior questions, 2) opinion and values questions, 3) feelings questions, 4) knowledge questions, 5) sensory questions, and 6) background/demographic questions. On any given topic, it is possible to ask any of these types of questions. Distinguishing the type of questions forces the researcher or interviewer to be clear about what is being asked and helps the interviewee respond appropriately (p. 444). Interview questions for this study were developed based on leadership literature and the context of leadership in health care as described in Chapter 2. Interview questions for this study, listed in the interview guide (see Appendix C), include knowledge questions about the concept of leadership, experience and behavior questions related to the participants experience with a leader or as a leader, and opinion and values questions regarding leadership for health care professionals.

Five second-year students and five third-year students were interviewed by the researcher between July and October 2021. The researcher conducted each interview in a conference room at the DPT Program. Creswell and Poth (2018) recommended “a distraction-free place for conducting the interview… and a physical setting where a private conversation can be held that lends itself to audiotaping” (p. 165). The identified conference room for this study met both of those recommendations. The interview guide was followed during each interview to ensure that the researcher pursued the same basic lines of inquiry with each participant (see Appendix C). The researcher recorded each interview using an audio-recording device. Following each interview, the researcher transferred the recorded audio and stored it on the hard drive of a password-protected laptop computer. Next, an audio-recording transcription was completed using NVivo web-based transcription service. Then the researcher checked the transcripts for accuracy by listening to the audio and editing any transcription errors.
Data Analysis

According to Patton (2015), “the analysis of qualitative data involves creativity, intellectual discipline, analytical rigor, and a great deal of hard work” (p. 529). In qualitative research, the process of data collection, data analysis, and writing are not separate steps in the process, they are interrelated and often happen simultaneously. Qualitative data analysis involves a five-step process described as spiral by Creswell and Poth (2018). The steps include: 1) managing and organizing the data, 2) reading and memoing emergent ideas, 3) describing and classifying codes into themes, 4) developing and assessing interpretations, and 5) representing and visualizing the data (see Figure 1).

Figure 1.

Creswell and Poth (2018) Data Analysis Spiral

For phenomenological analysis and representation specifically, Creswell and Poth (2018) described a simplified, six-step, version of the methods discussed by Moustakas (1994) that are in alignment with the methods described by Patton (2015) for phenomenological data analysis.
The steps for phenomenological analysis described by Creswell and Poth (2018), which are listed here, were incorporated into each step of the data analysis spiral as discussed above:

1. A full description of the researcher’s personal experiences with the studied phenomenon.
2. Develop a list of significant statements about how individuals are experiencing the topic.
3. Group significant statements into broader units of information (themes).
4. Develop textural description of “what” the participants experienced with the phenomenon.
5. Create a description of “how” the experience happened including the setting and context in which research participants experienced the phenomenon.
6. Report the essence of the phenomenon by writing a composite description. (p. 201)

The methods for data analysis used in this study followed Creswell and Poth’s (2018) five-step data analysis spiral (see Figure 1) as a general framework and Moustakas’ (1994) method as simplified by Creswell and Poth (2018), specifically.

Phenomenology includes the idea of Epoche, often referred to as bracketing, which means that the researchers attempt to, as much as possible, set their own experiences aside while attempting to gain knowledge. Moustakas (1994) provided a rich definition:

Epoche is a Greek word meaning to refrain from judgement, to abstain from or stay away from the everyday, ordinary way of perceiving things. In the natural attitude we hold knowledge judgmentally; we presuppose that what we perceive in nature is actually there and remains there as we perceive it. In contrast, Epoche requires a new way of looking at
things, a way that requires that we learn to see what stands before our eyes, what we can
distinguish and describe. (p. 33)

To achieve the recommended bracketing or Epoche, the researcher provided a full description of
the researcher’s previous experience with leadership, which is included later in this chapter.

First, to analyze qualitative interview data, the researcher must set up a system to manage
and organize the vast amount of data files that will be generated. “Data management, the first
loop in the spiral, begins the process” (Creswell and Poth, 2018, p. 185). A password protected
hard drive was used with the data from the study as well as a password protected NVivo
Software system on the researcher’s computer. Information from this study will be kept securely
until May 2024, at which point all information will be destroyed. The audio recordings of the
interviews were transcribed through NVivo Transcription a secure, automated transcription
service. After the automated transcription process was complete, the researcher read the
transcript while listening to the audio recording to ensure accuracy. Within the transcripts, each
line of text was numbered along with each interview question being numbered to ensure
information could easily be found during analysis.

Reading and memoing is the second step in Creswell and Poth’s (2018) data analysis
spiral after managing and organizing data. The researcher continued analysis by reading the
transcripts in their entirety, without memoing or note taking, to get a sense of the whole
database. This was recommended by Creswell and Poth (2018) in order be immersed in the
details to appraise the whole before breaking it into parts. Next, while reading the transcripts
again, the researcher began to document emergent ideas through memoing by documenting
phrases, words, ideas, or concepts that came to mind. From these written memos, initial codes
were developed. “Memos are short phrases, ideas, or key concepts that occur to the reader”
(Creswell and Poth, 2018, p. 188). Creswell and Poth (2018) recommended that memoing be prioritized throughout the analysis process; “begin memoing during the initial read of your data and continue all the way to the writing of the conclusions” (p. 188).

In the third step of the data analysis spiral, the researcher transitions from reading and memoing in the spiral to describing and classifying codes into themes (Creswell & Poth, 2018). Coding the data refers to the process of reducing data into meaningful segments and assigning names for the segments (Creswell & Poth, 2018). During the coding stage, Moustakas (1994) prescribed that the researcher lists all nonrepetitive and nonoverlapping statements, which he called meaning units of the experience. “Coding involves aggregating the text or visual data into small categories of information, seeking evidence for the code from different databases being used in a study, and then assigning a label to the code” (Creswell & Poth, 2018, p. 190). Creswell and Poth’s (2018) recommendation to practice lean coding was followed. Lean coding recommended that the researcher begin with just five or six initial codes and add additional codes as review and re-review of the database continued. According to Patton (2015), inductive analysis involves discovering patterns, themes, and categories in the data. Findings emerge out of the data. Oppositely, during deductive analysis, the data are analyzed according to an existing framework or existing set of ideas that the researcher is looking to find. Patton (2015) stated that qualitative analysis is typically inductive when developing a code book. This inductive analysis can also be called “open coding” (p. 542). Inductive analysis (open coding) was used in this study during the coding process.

Creswell and Poth (2018) recommended a code list of no more than 25 to 30 categories of information for qualitative studies. Because this process is repeated several times throughout the analysis process, a codebook was used to track codes. A codebook should contain the name of
each code and any shorthand labels used, described the boundaries for each code, and listed examples of each code from the study (Creswell & Poth 2018). The codebook for this study is provided in Appendix D.

Creswell and Poth (2018) discussed whether qualitative researchers should count codes. This issue is contentious among various researchers as it is considered a quantitative orientation of magnitude and frequency which is contrary to qualitative research. Creswell and Poth (2018) wrote that in their own work they have looked at the number of passages associated with each code as an indicator of participant interest in a code, but did not report code counts in published articles. For this study, the researcher counted codes only to understand the level of participant agreement on certain topics but did not report code counts.

Continuing the third step in the data analysis spiral, the researcher started to classify codes into general themes. These themes were refined and revised as more ideas emerged from the transcripts. According to Moustakas (1994), this is an important step in the process because it removes repetition and creates clusters of broader units from which the researcher can begin to regard as themes. Creswell and Poth (2018) recommended grouping the information into five to seven themes to work towards the final narrative. The researcher followed the recommendations that Creswell and Poth (2018) put forth for exploring and developing themes:

- Completed memoing to capture emerging thematic ideas.
- Highlighted noteworthy quotes during coding.
- Created diagrams representing relationships among codes or emerging concepts.
- Drafted summary statements reflective of recurring or striking aspects of the data. (p. 194)
Next, the fourth step in the data analysis spiral (Creswell & Poth, 2018) was developing and assessing interpretations. “Interpretation in qualitative research involves abstracting out beyond the codes and themes to the larger meaning of the data” (Creswell & Poth, 2018, p. 195). Patton (2015) described this interpretive process as requiring both creative and critical faculties of the researcher to make carefully considered judgements about what is meaningful in the patterns and themes generated by analysis. In this stage, the researcher worked to link interpretations to the larger literature surrounding leadership and the theoretical framework, if applicable, but with the understanding that these interpretations were tentative, inconclusive, and questioning (Creswell & Poth, 2018). The researcher remained “on guard” for alternate understandings and challenged her own interpretations through comparisons with existing data, relevant literature, or initial hypothesis.

In the fifth, and final, stage of the data analysis spiral, researchers represent the data, a packaging of what was found (Creswell & Poth, 2018). To complete this stage the researcher used tables and figures to present a visualization of the data and wrote rich, thick descriptions of the participants’ experience of leadership. During this step, in addition to member checking, three things should occur in a phenomenological study analysis according to Moustakas (1994):

1. A textual description is created of “what” the participants experienced with the phenomenon: referred to as textual description, this focuses on what the participants experienced and includes verbatim examples.

2. A structural description is drafted of “how the phenomenon was experienced”: referred to as structural description, whereas the researcher shares their reflection on the setting and context in which the phenomenon was experienced.
3. Using a composite description, the “essence” is developed: this is typically a long paragraph that includes both textual and structural descriptions and creates a universal description of the experience representing the whole group. (p. 121)

**Validity**

Validation is a judgement of the trustworthiness of a piece of research (Creswell & Poth, 2018). Creswell & Poth (2018) described nine strategies frequently used by qualitative researchers during the process of validation and recommend that researchers engage in at least two of the validation strategies in a study. From a researcher’s lens, validation can be done through corroborating evidence through triangulation of multiple data sources, discovering disconfirming evidence, or clarifying researcher bias. Participants can play a role in validation through member checking or seeking participant feedback, through a researcher’s prolonged engagement and persistent observation in the field, and by the researcher collaborating with participants. The final three validation strategies are from the reader’s or reviewer’s lens and include enabling external audits, the researcher generating a rich, thick description for the reader, and having a peer review or debriefing of the data and research process by someone familiar with the research or phenomenon explored (Creswell & Poth, 2018).

The two validation strategies used in this study were writing a detailed and thick description and member checking. Creswell and Poth (2018) note that writing with detailed and thick description and taking the entire written narrative back to participants in member checking are reasonably easy procedures to conduct and are the most popular and cost-effective procedures for validation. Other procedures, such as peer audits and external audits, were too time consuming and may have involved significant costs to the researcher. The detailed and thick description is included in Chapter 4. During the final stage of the data analysis spiral, the
researcher completed member checking by sending the written narrative and visual representations to each participant via email to review and confirm the accuracy of the representation.

**Role of the Researcher**

A characteristic of qualitative research is that the researcher is the key instrument for data collection and analysis. Because the researcher serves as the instrument for the study, they must position themselves within the study. Through reflexivity “the researchers convey their background, how it informs their interpretation of the information in a study, and what they have to gain from the study” (Creswell & Poth, 2018, p. 44). Using Moustakas’ (1994) concept of Epoche, the researcher must first seek to understand how their own background may influence the interpretations they will uncover and then must work to clear the prejudgments and biases in order to come to the phenomenon with an open consciousness. Moustakas (1994) contends researchers must not simply engage in the process of Epoche on the outset of the study, but instead that it should be a continuous process in which the researcher filters prejudgments and biases.

**Previous Knowledge and Bias**

To understand others’ experiences, the researcher must explore their own. In a phenomenological study, the process of Epoche, or bracketing, is done to attempt to not eliminate, but rather set aside one’s own judgements and beliefs and experience to be able to revisit the phenomenon in a fresh and open way (Moustakas, 1994). According to Creswell and Poth (2018), one way to place reflexive comments in a study is to include a discussion in the methods of a qualitative study in which the writer talks about her role in the study. This study did not limit bracketing to the analysis of the data, but rather, the researcher monitored biases and preconceptions throughout the entire research process.
The researcher is employed as a faculty member and the Director of Clinical Education (DCE) at the institution of higher education at which this study was conducted. She is responsible for both teaching didactic courses and coordinating clinical experiences for the DPT students who participated in this study. Her job duties as DCE include planning and directing the clinical education portion of the DPT curriculum. The researcher is responsible for teaching a variety of content in the DPT program including basic clinical assessment, professional values and ethics, advocacy, documentation in physical therapy, building therapeutic alliance, cultural competency, motivational interviewing, and leadership.

In one DPT course, the researcher was responsible for the development of leadership content that included three objectives related to personal leadership, community leadership, and professional leadership. At the time of this study, none of the participants had yet completed this course that included leadership objectives. During the design and preparation of this content unit, the researcher reviewed multiple studies and texts regarding leadership in physical therapy, many of which are referenced in this study. This immersion in leadership literature led to the researcher’s desire to increase the leadership knowledge, skills, and abilities of the DPT students in the DPT program. The need for leadership abilities for health care providers became evident, and she agreed with authors who recommended the addition of leadership learning, training, and development opportunities for DPT students (Green-Wilson et al., 2020; LoVasco et al., 2016). The inclusion of leadership learning objectives was the first step in a multi-layered process for implementing such opportunities in the DPT program.

The researcher’s biases include a high value placed on leadership abilities for all health care professionals, not just those in labeled leadership positions. Another bias includes an expectation that the experiences and descriptions of leadership provided by DPT students are
related to people in designated leadership positions or specific titles and that people in particular roles are meant to lead in health care. The researcher also anticipated finding some agreement from participants on the knowledge, skills, and abilities necessary for leadership including communication, dedication, and being a role model.

The researcher recognized her biases and strong beliefs regarding leadership, and it was imperative to allow the data collected from the interviews be the voices of the participants. The basis of social constructivism is that multiple realities are constructed through our experiences, and while the researcher had much experience studying leadership, she can also maintain the necessary objectivity knowing that each individual, including the study participants, experiences and interprets life events and meanings differently.

**Qualifications**

The researcher’s training and experience conducting interviews consisted of formal classes contained in the Doctor of Education program at Minnesota State University Moorhead. Within the program, interviews used for research were supervised and guided by course requirements and faculty. Specifically, coursework completed in the ED 705 Qualitative Research Methods course will help guide the interview process as well as the interviewing processes as outlined by Patton (2015), and Creswell and Poth (2018).

Additionally, the researcher has experience in the foundations of motivational interviewing through course design and teaching for DPT students. She has read multiple books on motivational interviewing and developed course content for DPT students based on the information in these texts (Berger & Villaume, 2020; Miller & Rollnick, 2013). One of the core skills of motivational interviewing is asking open questions and the researcher’s experience with motivational interviewing influenced the development of open questions in the interview guide.
used in this study. This research study was the first large-scale, formal study using interviews for the purpose of qualitative inquiry.

**Ethical Considerations**

Creswell and Poth’s (2018) framework was utilized for ethical considerations during each point in the research process starting prior to conducting the study, beginning the study, collecting data, analyzing data, reporting data, and publishing the study. Prior to conducting the study, the researcher obtained IRB approval from Minnesota State University Moorhead and written permission from the Program Director of the DPT program at which the study was conducted was obtained. In designing the study, the researcher considered the possibility of retaliation or embarrassment from the DPT student participants for giving candid responses during the interviews should their descriptions and experiences involve faculty members in the DPT program or physical therapists that the researcher knows personally or professionally. However, each participant gave informed consent, which outlined the intent of the study and that confidentiality of information would be maintained.

Prior to conducting the study, the researcher developed an informed consent form which also included information for the participants in their freedom to choose to participate or withdraw from the study at any time, explicitly detailed the purpose of the study and their role as participants, detailed interview procedures, and disclosed no harm. The form also ensured the protection of identities of the participants by using pseudonyms, storing the data in secure locations, and destroying data at the conclusion of the study.

During data analysis, reporting, and publishing phases of the study, the researcher adhered to ethical practices including using transparent language, reporting all findings, and maintaining confidentiality of the participants, and secure storage of data.
Summary

The purposes of this phenomenological qualitative study were to explore how DPT students have experienced and currently conceptualize leadership and their perception of the value of leadership for health care professionals. Perceptions of leadership are socially constructed and interpretive in nature, so a qualitative design was most appropriate for this study. To capture realities and interpretations of the participants, the researcher conducted one-on-one interviews. The design of this phenomenological study followed closely the guidance of Creswell and Poth (2018), Moustakas (1994), and Patton (2015).

The researcher used purposeful random sampling to identify DPT students to invite to participate in the study. The participants were DPT students in their second and third year of one DPT graduate program. The data analysis process followed a spiraling procedure as described by Creswell and Poth (2018), in which interviews were transcribed by the researcher and inductive analysis was completed using codes to identify patterns and significant statements. Further qualitative analysis led to themes and the researcher wrote rich, thick descriptions of the participants’ perspectives from the analysis. To validate findings, the initial analysis underwent member checking, providing an opportunity for the participants to offer feedback on the clarity, accuracy, and relevance.

Participants were protected through informed consent, which detailed the rights and safeguards in place including confidentiality of identities and revealing information, disclosing minimal risk, and the protection of the data on secure electronic devices. Following standards of ethical research practice, the researchers own bias have been disclosed and were held in check during interviews by following the interview guide to avoid asking leading questions or corroborating with the participants. This study received IRB approval from Minnesota State University Moorhead.
In Chapter 4, the researcher will provide details regarding the actual obtained sample will explain the methodology as it was specifically applied to the data collected during interviews. The researcher will also present the results of the qualitative analysis.
Chapter 4. Findings

The complex topic of leadership is understood as a process, and seemingly anyone who is willing can develop the knowledge, skills, and abilities necessary for leadership. In the frequently changing world of health care in the U.S., health care professionals must have the knowledge and abilities to lead change effectively and efficiently. As licensed health care professionals, physical therapists must have leadership knowledge, skills, and abilities to be successful in this ever-changing environment. While there is evidence for including leadership development in physical therapist education programs, there is no current literature documenting DPT students’ perceptions of leadership or the value of leadership for health care professionals. This phenomenological qualitative study was conducted to explore these perceptions of leadership and the value of leadership from the DPT student perspective through two research questions:

1. How do DPT students conceptualize leadership?
2. How do DPT students value leadership for health care professionals?

In this chapter, the steps of the research plan as described in Chapter 3 will be detailed. The data analysis method is explained as the findings unfold and the research questions are answered. Additionally, this chapter includes the researcher’s role and interest in the study, a description of participant demographics, and the resultant data and findings. The data and results presented in this chapter are organized by research question.

Researcher’s Role

A characteristic of qualitative research is that the researcher is the key instrument for data collection and analysis. Because the researcher serves as the instrument for the study, they must position themselves within the study and seek to understand how their background and interest may influence the results. The researcher became interested in studying leadership in physical
therapy as previously stated in Chapter 1, through her role as a faculty member in the DPT program included in this study. Through the design and development of DPT course content related to leadership, the researcher reviewed multiple studies and texts regarding leadership in physical therapy and health care. The evidence for the need for leadership development for future health care professionals was evident. This led the researcher to explore DPT students’ perspectives on leadership and the research questions formulated for this study.

The researcher’s biases included a high value placed on leadership abilities for all health care professionals. The researcher also had an expectation that the experiences and descriptions of leadership provided by DPT students would be related to people in designated leadership positions or specific titles and that people in particular roles are designed to lead. The researcher anticipated finding some agreement from participants on the knowledge, skills, and abilities necessary for leadership, including communication, dedication, and being a role model.

The researcher recognized her biases and strong beliefs regarding leadership and bracketed herself outside of the data. In a phenomenological study, the process of Epoché, or bracketing, is done to attempt to set aside one’s own judgements, beliefs, and experience to be able to revisit the phenomenon in a fresh and open way (Moustakas, 1994). This study did not limit bracketing to the analysis of the data, but the researcher monitored biases and preconceptions throughout the entire research process. Through the data analysis process, it was imperative to allow the data collected from the interviews be the participants’ voices. The basis of social constructivism is that multiple realities are constructed through our experiences. While the researcher had much experience studying leadership, she could also maintain the necessary objectivity knowing that everyone, including the study participants, experiences and interprets life events and meanings differently.
Description of the Sample

The participants in this study were from one DPT program at a private, not-for-profit institution of higher education located in the upper Midwest. The DPT program consists of eight semesters over the course of three years, and it is accredited by the Commission on Accreditation in Physical Therapy Education (CAPTE). Admission criteria for students to enter to this program include completion of a bachelor’s degree, cumulative and pre-requisite GPA standards, a written essay, performance in an interview, and letters of recommendation.

Purposeful sampling was used in this study to target participants within the current cohorts of a DPT program. At the time of this study, there were 35 students in the third-year cohort, 25 students in the second-year cohort, and 33 students in the first-year cohort of the DPT program. Participants were randomly selected from only the second-year and third-year cohorts because they had completed multiple DPT courses and at least one full-time clinical experience prior to participation in the study. The demographics of each of the students who participated in the study are outlined in Table 2.

Table 2.

Participant Demographics

<table>
<thead>
<tr>
<th>Year in DPT Program (# of participants)</th>
<th>Age Range in Years</th>
<th>Gender (# of participants)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2nd year (5)</td>
<td>24 - 28</td>
<td>Female (2) Male (3)</td>
</tr>
<tr>
<td>3rd year (5)</td>
<td>24 - 26</td>
<td>Female (3) Male (2)</td>
</tr>
</tbody>
</table>

Research Methodology Applied to Data Analysis

Purposeful sampling was used in this study to target participants within the current second- and third-year cohorts of the DPT program. Creswell and Poth (2018) recommended that
researchers interview five to 25 individuals who have all experienced the phenomenon when conducting qualitative interviews. Patton (2015) recommended that qualitative designs specify minimum samples based on expected reasonable coverage of the phenomenon given the purpose of the study and stakeholder interests and that a researcher may add to the sample as fieldwork unfolds or change the sample if information emerges that indicates the value of change. The initial targeted sample size determined for this study of DPT students’ perspectives on leadership study was 10 (five students from each cohort) based on the time and resources available to the researcher and the depth of data to be collected from each participant with the intent of continuing to add participants until saturation was reached. Saturation of information was noted during transcription and review of the interview of the ninth participant. At that point, the 10th interview had already been conducted and data from the 10th interview was included in data analysis.

The researcher completed the random selection of students from each cohort using a random number generator. Each student in the second-year cohort was assigned a number. Then, five random numbers were selected using the Google Chrome random number generator to identify potential participants (Google, 2021). The researcher invited the first five students identified to participate in the study. Of those identified, two declined and three agreed to participate. The Google Chrome random number generator was then used again to identify two more students in the second-year cohort. Those two identified students were invited to participate, and both agreed to participate in the study reaching the target goal of five participants from the second-year cohort. The same process was completed for the 35 students in the third-year cohort. The first five students randomly selected were then invited to participate in the study via email. Four of the five selected agreed to participate. The random number generator was then
used to identify one more student, and that student was invited to participate via email. The final student identified agreed to participate, reaching the target goal of five participants from each cohort.

The researcher invited the randomly selected students to participate in the study via an email invitation that was sent to the student’s university email address. This email invitation included an informed consent document (see Appendix A) and asked the student to respond to agree or decline participation within three days of receiving the invitation.

In-person interviews were conducted with each participant in a quiet conference room at the DPT program building. The audio was recorded during each interview using a voice memo app on the researcher’s iPhone. After the interview and recording process was completed, the audio recording was downloaded and saved on the researcher’s password-protected laptop in a password-protected OneDrive folder.

After all interviews were completed, the audio files were uploaded to NVivo software and automatic transcription was completed using NVivo’s online transcription service. Each transcription was reviewed and edited by the researcher to ensure accuracy and alignment with the audio file. After each written transcription was completed, the file was sent via email to the participant for verification of accuracy. Each participant read the transcript and confirmed the accuracy of the information in their transcript file. This member checking process of reviewing the transcripts allowed participants to play a role in the validation of the study findings.

Qualitative data analysis procedures were conducted as recommended by Creswell and Poth (2018), Moustakas (1994), and Patton (2015). The data analysis spiral was followed as described by Creswell and Poth (2018) with the first step of managing and organizing the data, second reading and memoing emergent ideas, third describing and classifying codes into themes,
fourth developing and assessing the interpretations, and finally representing and visualizing the data.

As described in detail in Chapter 3, the data analysis process began with reading the transcripts in their entirety. Next, initial memoing was completed on paper, and then further memoing was completed using the memo feature in NVivo software. The researcher documented emergent ideas by documenting phrases, words, ideas, or concepts that came to mind while reading the transcripts. This process is known as memoing. From these written memos, initial codes were developed. Creswell and Poth (2018) recommended that memoing be prioritized throughout the analysis process; “begin memoing during the initial read of your data and continue all the way to the writing of the conclusions” (p. 188). As recommended, the researcher continued memoing in NVivo software through the entire process of coding, grouping codes into themes, and during the writing process.

Using the information from initial memos, preliminary codes were developed and organized in NVivo. The coding process was inductive in which codes were developed from the information which emerged in the data. NVivo was used to document and organize all codes and memos written during the coding process. Codes were organized by research question, and definitions and descriptions were maintained in a code book (Appendix D).

The third step of the spiral was completed by simultaneously analyzing the interviews and collecting more data to classify codes into themes. The researcher went back through the interviews to find more data to support the developed codes and associated themes until nothing new emerged from the transcripts. At this point, the researcher felt a point of saturation had been reached. Additionally, participants consistently described similar realities and experiences with leadership. A draft of the results in the form of a codebook was sent to all participants to
complete the member checking process (Creswell & Poth, 2018). No revisions were recommended by any participants.

Next, in the fourth step of the data analysis spiral, the researcher developed and assessed interpretations of each theme and began the writing process. The fifth, and final, step was conducted simultaneously to organize and visually represent the data. This visual representation provided a framework for writing the results and discussion. The visual representation of the findings is provided below in this chapter for each research question and as a whole data set in Chapter 5 for further discussion of the results related to previous studies and leadership work.

**Presentation of Data and Results of the Analysis**

**Research Question 1: How do DPT students conceptualize leadership?**

To explore this research question, participants were asked several questions about defining leadership and their past experiences of leadership as a leader themselves and being led by others. These questions are listed in detail in the interview guide (Appendix C). From the data collected with these questions about leadership, four themes emerged: connection, influence, integrity, and experience (see Figure 2).
Connection.

When asked to define leadership and describe characteristics of great leaders, participants’ answers revealed a central theme of *connection*. Participants describe a leader as someone who connects to people, has compassion, and uses communication skills to develop a common goal and guide a group toward that goal. The codes associated with this theme and phrases within the codes are summarized in Table 3 at the end of this section. A full definition of each code and associated quotes are available in the codebook (Appendix D).

When describing someone they consider to be a great leader, multiple students commented about the person’s ability to build connections and connect to people. Student G stated:

He has a really good way of connecting with people. And professionally, he does that. In his job, I’ve seen him just work well with individuals. I would love to learn and have that
ability to just relate with people and have that emotional connection while maintaining professional status.

Another student, Student A, commented on a leader’s ability to build connection with a variety of people, “Just the ability to talk to anyone and adapt to them how they wanted to be approached. She could read personalities very well and then adapt her communication style to that.”

Participants noted compassion or caring as important characteristics of great leaders. Student C stated, “Just compassion and caring. I think all leaders should have that for employees or anyone that’s working for them. Because if you don’t care about them, why you want to lead them?” When describing someone he considered to a great leader, Student G stated, “He was compassionate, he’s always there for you, is understanding when things weren’t going the right way.”

Throughout the interviews, students described a common goal when defining or describing leadership and when discussing their past leadership experience. Student D summarized this succinctly stating, “Leadership to me means someone who either in a direct way or indirect way is helping to accomplish a certain goal.” Student A also stated, “They (leaders) just kind of guide to a shared vision or a shared goal.”

Tying this theme of connection all together were communication skills. From the interviews, it was clear that communication skills were a significant part of leadership and building connection. Communication skills were frequently mentioned by participants as important leadership skills both when describing characteristics of great leaders and in stating examples of a time that they experienced leadership. Student E stated, “To be an effective leader you have to be able to communicate to people and reach people.” Other students talked about
open lines of communication and great communicators who can talk to people individually and can also give an effective speech to a group.

Table 3.

Research Question 1 Theme 1 Summary: Connection

<table>
<thead>
<tr>
<th>Theme</th>
<th>Associated Codes</th>
<th>Phrases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connection</td>
<td>Connects to People</td>
<td>• Really good insight into other people</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Ability to talk to anyone and adapt to them</td>
</tr>
<tr>
<td>Compassion</td>
<td></td>
<td>• He was compassionate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• All leaders should have compassion</td>
</tr>
<tr>
<td>Common goal</td>
<td></td>
<td>• Willing to take others under their wing and help achieve a common goal</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Helping to accomplish a certain goal</td>
</tr>
<tr>
<td>Communication</td>
<td></td>
<td>• Listening and communication skills</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• A great communicator who is always able to talk to you</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Open lines of communication</td>
</tr>
</tbody>
</table>

Influence.

The second theme that emerged when participants were asked questions about defining leadership and their past leadership experiences was *influence*. Participants conceptualize leadership as having influence over others. Multiple associated codes emerged that were grouped to inform the theme of influence. These codes include encouraging, guiding, hardworking, influence, showing the way, and speaking up. A summary of the associated codes and phrases from participants for each code are listed in Table 4. A definition of each code and direct quotes from participants are available in the codebook (Appendix D).
Participants’ responses during interviews included many thoughts on leaders encouraging and guiding. Student I stated when describing leaders, “They’re very focused, very inspiring, encouraging.” Student B described a great leader in her life as “She was always nice to everybody and she encouraged everyone and if someone was struggling, she would take the time to go out of her way to help them get to where they needed to be.” Leaders were also described as being a guide or guiding others. Student C stated, “So that’s what leadership means to me as someone who’s not going to just tell someone what to do or go but guide them and help them along the way.” When defining leadership, Student H stated, “Leadership is guidance, direction, or influence.”

Regarding having influence over others, students also described experiences of leaders and leadership in which the person modeled behavior by being hardworking, showing the way, and speaking up. Student I stated this regarding leaders:

I think that they have to be very open-minded, very willing to work and kind of put themselves in the trenches as well as kind of having the go-getter attitude able to get things done and able to be willing to work.

Multiple students commented that leadership includes the ability to lead by example or that a leader must do the work to show others what to do. Student A described a quote she learned in a leadership course during her undergraduate education that she felt summarized leadership, “Leaders know the way, and they know how to show the way, and they know how to get people to come that way.” Student B also stated, “It (leadership) means leading and doing things by the rules and by example and helping others accomplish and reach their goals as well.”

In addition to leading by example in doing work or tasks, students described leaders as being willing to speak up or be vocal in situations. Student E stated:
To me, it means somebody who’s willing to take charge in tough situations, but also understands that they’re responsible for how the situation goes in a way and get somebody that’s not afraid to be vocal and really lead but listen at the same time.

Student F also stated, “Just the ability to just stand up for what they believe in and not be afraid to speak out.”

Lastly, in the theme of influence, students also specifically describe leaders as having influence over others, using the word influence directly. Student A stated, “Someone who I think just has influence over others and can guide people” when describing leadership and then went on to state, “She influenced a lot of my decisions throughout the whole process” when describing a great leader in her life.

Table 4.

Research Question 1 Theme 2 Summary: Influence

<table>
<thead>
<tr>
<th>Theme</th>
<th>Associated Codes</th>
<th>Phrases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influence</td>
<td>Encouraging</td>
<td>• To help encourage instead of just getting it done</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• She encouraged everyone</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Giving support</td>
</tr>
<tr>
<td></td>
<td>Guiding</td>
<td>• Guiding a group to a goal</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Leadership is guidance, direction, or influence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• She was my teacher, my guide, my mentor</td>
</tr>
<tr>
<td></td>
<td>Hardworking</td>
<td>• Put in extra work</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Willing to work</td>
</tr>
<tr>
<td></td>
<td>Show the Way</td>
<td>• Know how to show the way</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Doing things by the rules and by example</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Setting an example</td>
</tr>
<tr>
<td></td>
<td>Speaks Up</td>
<td>• Willing to take charge</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Not afraid to be vocal</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Stand up for what they believe</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Speak out</td>
</tr>
<tr>
<td></td>
<td>Influence</td>
<td>• Has influence over others</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Influenced a lot of my decisions</td>
</tr>
</tbody>
</table>
**Integrity.**

The third theme that emerged from the first research question about students’ conceptualization of leadership was *integrity*. Recurring descriptions of leaders being responsible, accountable, and having integrity were noted during the interviews. Each of these were coded throughout and then merged into this theme of integrity. A summary of the associated codes for this theme and phrases from participants for each code are listed in Table 5. A definition of each code and direct quotes from participants are available in the codebook (see Appendix D).

Students describe leaders as being accountable or able to be counted on. Student I said of leaders, “They’re respectful and reputable, accountable. Trustworthy.” Student A described a great leader in her life as having “Accountability not only for herself, but she held others accountable.”

Participants also describe leadership as having responsibility or a willingness to take on significant responsibilities. According to Student G, leaders are “able to kind of take on more responsibility and be someone who’s willing to have that responsibility on their shoulders.”

Overall, there were also comments directly on integrity in leadership. Student F mentioned integrity on several occasions throughout the interview and stated this when describing leadership:

*Not being afraid to maybe even make the unpopular decision, even if it’s the right one. Being able to live with those things and not be worried about what others are or what the kind of consequence, I guess, is going to be. But as long as you’re sticking by like what you believe in and having integrity to not back down, stick to your guns a little bit, even*
if it’s not popular or if it’s maybe not going to be the best for you if it’s the best for others or the best for the situation.

Table 5.

Research Question 1 Theme 3 Summary: Integrity

<table>
<thead>
<tr>
<th>Theme</th>
<th>Associated Codes</th>
<th>Phrases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrity</td>
<td>Accountability</td>
<td>• Accountability and responsibility make a leader</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Accountability for herself and held others accountable</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Doing the right thing all the time</td>
</tr>
<tr>
<td></td>
<td>Responsibility</td>
<td>• Willing to take up responsibility</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Willing to take charge</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Responsible for how it goes</td>
</tr>
<tr>
<td></td>
<td>Integrity</td>
<td>• Having integrity not to back down</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Doing what is best</td>
</tr>
</tbody>
</table>

Experience.

The final theme that emerged from participants’ responses to questions about how they conceptualize leadership was experience. Through the memoing and coding process, it became clear that specific experiences in life had shaped how DPT students understand leadership. There were common threads in the types of past experiences in which participants describe leadership and people they identified as leaders. This theme includes associated codes that describe the various types of past leadership experiences that students described, including athletics, clinical experiences, work experiences, parental mentors, and struggle. A summary of the associated codes and phrases from participants for each code are listed in Table 6. A definition of each code and direct quotes from participants are listed in the codebook (Appendix D).

One of the main life situations in which the DPT students who participated in this study had experienced leadership was through athletics. Nine of the 10 total participants described
team or game-time scenarios in high school or college sports. One participant’s response highlights this code directly; Student F said, “Up until this point in my life has pretty much been dominated by sports, and leadership is huge in sports obviously.” Leadership from coaches, team captains, and teammates was described, as well as game or season-related scenarios in which there was adversity or a need for change.

Multiple examples of great leaders that participants described were related to athletics. Student B stated, “When I played (a sport), one of the captains on the team, she was someone that everyone respected because she was really nice to everyone and showed you what you should be doing and how to do it.” When asked about experiencing leadership in the past, Student H stated:

So, I think some people when you look at a team, there are captains, there are coaches, there are people that are put in positions to guide you and show you and an end goal is to win a game. And I’ve had some really great experience with people in leadership roles.

It is evident that athletics and a having a role in team sports has provided many leadership experiences to DPT students and shaped their conceptualization of leadership.

Work experience also brought experiences of leadership to some participants. Situations involving a supervisor or coworkers at a job provided examples of leadership that helped shape their notions of leadership. Student C described several situations related to a job he had for several years during the summer months, and there was one boss whom he described as a manager, and another that he described as a leader. When describing one boss who he did not consider to be a leader, he stated, “When we had a (boss) that was very, very bossy. He would just give kind of hand out orders. He didn’t really show you or guide you.” Another participant, Student E, stated when asked for an example of a great leader:
It was when the former boss, he was just, he communicated with us and treated us as if we’re equals, even though it was clear that he had the authority on everything. He was the owner of the company, but he was always there to listen to us when we needed or just like I said, talk to us like we’re equals. He also understood that if we worked super hard, he was very good about putting in days where there was more fun involved.

For some participants, the example of a great leader in their lives was a parent. They described a parent as a mentor and leader in their own life but also in the lives of others in their career. Participants experienced leadership from a parent and some also witnessed them leading in other areas. Student C illustrates this, stating, “I’d say probably my dad. Yeah, so he I think he’s a great leader. I know for his work he’s kind of climbed the ladder and became pretty top end manager at his company he works at and stuff.” Student J described her mother as a great leader, stating:

Honestly, when I think of a leader like one of the top people, it comes to my mind is my mom. She is a very strong-willed person and I just think, she works at a school, and she would honestly do anything for, like, her students. And if she, like, sees or hears one of them being mistreated or she will not like let that go until she knows, she fights for them and helps them get back on what they deserve.

Another, more recent, area in which participants noted leadership experiences was during their DPT clinical experiences in which they were working in a clinic or hospital setting under the supervision of a licensed physical therapist. The supervising therapist is known as a clinical instructor. Student E stated:

I think the best example, at least recently, are probably clinical instructors because they are there to guide you, but they’re also there to listen and give advice when needed and
kind of steer you in the direction that they believe you should be going or that we should be going as clinicians.

The last code that emerged related to the theme of experience was that leadership is evident during times of struggle, and participants recalled this when asked for examples of times they had experienced leadership in life. Some participants described times when their sports team was struggling, and a coach or team captain led them to change or work together. Others described a work situation in which a leader had to get things organized or give directions to remedy a challenging situation. Student G described the following scenario from when he played a college sport when he asked about a time that he had experienced leadership:

I guess this was one if you go to one specific time, there’s one, um, our team was very good and this is in college and our team was very good. And we won our first few games and it kind of went on a little skid and he was not having it. So he kind of brought us aside and we had a little team meeting and he. I don’t know. He was just like a kind of a come to Jesus kind of thing. It’s like, yeah, all right, we’re better than this. Like, no, it’s not like yelling like here we are let’s go kind of thing. But, yeah, it’s like what do we need to do to figure this out and think it’s just a good approach to like kind of getting the team back together, getting us back on the right path to really start winning more games and be successful.

In summary, this theme of experience demonstrates that athletics and work provided helped shape participants’ concepts of leadership along with parental mentors and having leadership during times of struggle.
Research Question 1 Theme 4 Summary: Experience

<table>
<thead>
<tr>
<th>Theme</th>
<th>Codes</th>
<th>Phrases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experience</td>
<td>Athletics</td>
<td>• My life has pretty much been dominated by sports</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• There are captains and coaches and people in positions to guide you</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Watching coaches who I thought were good leaders</td>
</tr>
<tr>
<td>Work Experience</td>
<td></td>
<td>• Boss that was a manager and very bossy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Former boss who communicated with us and treated us as equals</td>
</tr>
<tr>
<td>Parental Mentors</td>
<td></td>
<td>• I think my dad is a great leader</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• I want to follow in a path similar to my dad</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• When I think of a leader, one of the top people who comes to my mind is my mom</td>
</tr>
<tr>
<td>Clinical Experiences</td>
<td></td>
<td>• Clinical instructors are there to guide you</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• My clinical instructor was my teacher, my guide, or mentor</td>
</tr>
<tr>
<td>Struggle</td>
<td></td>
<td>• Times when everything is falling apart</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Group of people working together to win a game or get an assignment done</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Getting the team back together and back on the right path</td>
</tr>
</tbody>
</table>

In summary, research Question 1 revealed four themes from the data collected with questions about leadership: connection, influence, integrity, and experience. It was evident that DPT student perspectives on the concept of leadership included many examples from their life, most prominently experience in athletics or on sports teams. The participants’ experiences including sports, paid work, clinical experience, or through parental mentors led them to ideas of leaders who can communicate and connect with people. Leaders are those who have integrity and lead by example to show the way for others were described by participants.
Research Question 2: How do DPT students value leadership for health care professionals?

To explore this research question, participants were asked several questions about the value of leadership for health care professionals and why or how leadership knowledge, skills, and abilities might be valuable. These questions are listed in detail in the interview guide (Appendix C). From the data collected with these questions on the value leadership for health care professionals, three themes emerged: connection, expertise, and integrity (see Figure 3). There is evidence that DPT students find leadership skills and abilities valuable for health care professionals, including physical therapists.

Figure 3.
Leadership for Health Care Professionals

Connection.
The first theme that emerged from the second research question about the value of leadership for health care professionals was connection. A health care professional’s ability to
communicate with patients, have empathy, empower patients, guide patients, and help patients reach goals were all noted within this theme. Additionally, communication with other health care professionals (interprofessional communication) and the importance of connection with other providers was also evident in the interviews. A summary of the associated codes for this theme and phrases from participants for each code are listed in Table 7. A definition of each code and direct quotes from participants are available in the codebook (Appendix D).

Communication skills, the ability to talk, listen, and relay information was mentioned frequently when discussing the value of leadership skills for health care professionals. Student H stated, “Communication is huge. Being able to talk and express your feelings, information with those patients is probably one of the bigger abilities of a health care professional needs.” Both the ability to listen and to communicate information were mentioned as valuable assets for a health care professional, which is noted in this statement from Student F:

I think just having the ability to, first of all, communicate things properly is a good leadership quality. But just being there to listen and do the right thing or direct them to the right service or doing our due diligence to make sure we’re offering the best care for that kind of goes across the board for all health care.

Next, in the theme of connection, students noted the importance of providers having empathy for patients. To have a connection and partnership with patients, students described being empathetic as a key to this partnership. Student H stated:

I think you need to be empathetic. So, understanding and relating to those patients and trying to put their goals, their values, their reasonings, their chief complaints before your own.
In response to a question about which leadership skills and abilities are important for physical therapists and why, Student B stated, “I think a big one is empathy because a lot of people are in so much pain and we really need to understand and make that connection with them to help them improve.”

Health care professionals having the ability to empower patients and guide patients were key elements in this theme of connection. Having an ability to connect in a way that builds a patient’s confidence in their ability to heal and participate in their care to achieve a common goal was noted in the interviews. Student J stated in response to a question about why she thought leadership skills were valuable for health care professionals and what that means for patients:

If they have a physical therapist where they can actually connect with and feel empowered by them and have like a real connection with them, I think it’s going to change the whole experience altogether in a more positive light.

Another student, Student I, stated when asked about which health care professionals would benefit from having leadership skills:

They all need to have leadership skills because, I mean, we’re taking care of other people. So, we have to be able to empower patients and help them believe our line of thinking to help achieve a goal.

Student H summarized her reason why health care professionals need to be a guide for patients when responding to why leadership skills are valuable for health care professionals:

I think health care is a very, it can be very intimate. So, you’re here at your worst times. You may be there at your best times, and you are looking for advice and guidance. So, leadership, you’re looking for someone to lead you or guide you.
Part of the reason that connection is important in health care is for reaching goals. When participants described interactions with patients and the value of leadership skills, they talked about health care professionals helping patients reach goals or creating a common goal.

Student B stated:

Encouraging others and helping them get to their goals. I think that’s really important for us, especially so we’re very focused on trying to get our patients to where they want to need to be, and we can’t do that if we don’t encourage and help them reach those goals.

In response to a question about which leadership skills and abilities you consider to be the most important for health care professionals, Student I stated, “I would say advocacy. For health care, empowering patients, helping others. Really, it is a common goal.”

Finally, in this theme of connection, student participants mentioned the importance of communication between health care providers in addition to communication with patients.

Student D discussed this specifically regarding physical therapists:

I think all of them should have, all aspects of health care team should have them (leadership skills), whether it’s one or two people doing it at each level, but. Obviously, being not necessarily the lower end of the health care team, but a different aspect of it, I can see physical therapists as a big leadership role because they, at least in the system where I was at they can kind of play a big, like middleman role between the athletic trainers who don’t have direct access to other doctors and between the medical doctors and orthopedic surgeons that are also sending their patients their way. So they need to, PTs need to have a bigger leadership aspect to it.
Table 7.

Research Question 2 Theme 1 Summary: Connection

<table>
<thead>
<tr>
<th>Theme</th>
<th>Codes</th>
<th>Phrases</th>
</tr>
</thead>
</table>
| Connection        | Communication        | • Communication is huge  
|                   |                      | • Being able to talk and express your feelings  
|                   |                      | • Ability to communicate between different people                      |
| Empathy           |                      | • Be empathetic  
|                   |                      | • Understanding and relating to patients                                |
| Empowering        |                      | • Empower patients                                                    |
| Guiding           |                      | • Patients are looking for a guide                                     |
| Reaching Goals    |                      | • Help them get to their goals                                         |
|                   |                      | • Establish a common goal                                              |
| Interprofessional| Communication        | • Communication between providers                                       |

Integrity.

The second theme that emerged from the second research question about the value of leadership for health care professionals was integrity. Health care professionals demonstrating accountability, integrity, managing responsibilities, and showing the way were all included in this theme. A summary of the associated codes for this theme and phrases from participants for each code are discussed below and listed in Table 8 at the end of this section. A definition of each code and direct quotes from participants are available in the codebook (Appendix D).

Participants discussed accountability or being able to be counted on as part of leadership skills and abilities for health care professionals. When asked about leadership skills and abilities that health care professionals should have, Student A stated, “Accountability. You need to be there and do what you say you’re going to do. Time management I think is huge and to juggle a lot of things.”
Integrity was mentioned by participants as something that health care professionals should demonstrate by doing what is right. Student A stated, “Integrity and honesty, abiding by all the HIPAA stuff and all patient confidentiality is huge.” When asked which, if any, health care professionals should have leadership skills and abilities and why, Student F stated:

I think all of them, even if we’re not necessarily in a position of leadership, I think we still need to possess some skills and the ability to first of all do what’s right all the time, not just when a matters, not just when it’s easy.

The next code in the theme of integrity was responsibility. Health care professionals needing to be organized or manage multiple responsibilities was noted by participants. Student D summarized this code with this quote:

Organization is a big thing. I know our clinic director had a lot of responsibilities regarding, not only their clinic, us athletic trainers, and they also had events with the overall company. And then, the other businesses in town that they cooperate with. So, because we also had a lot of traveling and PTs and PTAs and communicating, organizing between who’s going to be there, who’s going to be here. Especially when there is maternity leaves, you know, organizing and communicating, scheduling and all that.

The final code in the theme of integrity was show the way. Showing the way means health care professionals leading by example or modeling behavior. Multiple student participants mentioned this as important leadership behavior for health care professionals. Student B stated the importance of modeling behavior for patients:

Lead by example, by being like being healthy and doing your own things to make sure you’re taking care of yourself. Because I think that people look at us and think that, too, oh, if they I don’t take care of themselves why should I listen to what they’re saying?
Student G discussed showing the way to lead by example with colleagues or coworkers:

With your coworkers, if you’re always doing things and being responsive to your patients and calling the doctors, talking to parents, doing all the things necessary to ensure proper care for your patients and make sure you’re treating them the way that you’d want to be treated, you know? I think some of those other PTs they see you doing that, and they go, oh maybe I should be doing some of that kind of stuff. Maybe they’ll start to follow and do it, too.

Table 8.

Research Question 2 Theme 2 Summary: Integrity

<table>
<thead>
<tr>
<th>Theme</th>
<th>Codes</th>
<th>Phrases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrity</td>
<td>Accountability</td>
<td>• Do what you say you’re going to do</td>
</tr>
<tr>
<td></td>
<td>Integrity</td>
<td>• Integrity and honesty</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Confidentiality</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Do what’s right</td>
</tr>
<tr>
<td>Responsibility</td>
<td></td>
<td>• Organization</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Timely</td>
</tr>
<tr>
<td>Show the Way</td>
<td></td>
<td>• Lead by example for patients</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Be a good example to coworkers</td>
</tr>
</tbody>
</table>

Expertise.

The final theme that emerged from the second research question about the value of leadership for health care professionals was *expertise*. Within this theme, participants discussed health care professionals needing confidence, knowledge, and to be advocates for their patients. A summary of the associated codes for this theme and phrases from participants for each code are listed in Table 9. A definition of each code and direct quotes from participants are available in the codebook (Appendix D).
According to participants in this study, health care professionals need confidence or to be confident as part of being a leader. When asked which health care professionals, if any, should have leadership skills and abilities, Student C stated:

They should all have leadership. Because I think that, like I’ve said, that confidence is a huge trait that leaders should have. So in health care, because, I mean, you so if you’re a leader, or you want to be there or if you’re in a certain position where that confidence is key, like in health care, you go to the doctor, you go to the dentist or physical therapy, you want to know, you want to walk in, and you want them to come and kind of show them that I know what I’m doing.

Student E responded to a question about what leadership skills and abilities health care professionals should have with, “Confidence, number one, you have to be confident in your decisions and your abilities.”

The next code in the theme of expertise was knowledge. Student participants commented on the need for health care professionals to have knowledge as they are looked to as experts and also the need health care professionals to maintain their expertise through continued development. Student F stated, “People in general look to us as if we’re the experts pretty much. And that’s important even if even if we’re not necessarily experts, we have to come across as if we care and if we are.” Regarding continual development, Student A stated:

Continued development. I think if you’re a leader, you need to be current on what’s going on so that you can help guide others. I think that’s another huge quality of leaders as just the continued want to get better at whatever craft or art that you’re doing. And that way you can kind of show people the way of what you’re and the direction that is supposed to be going because health care is always advancing and there’s new things every day.
The final code in the theme of expertise was patient advocacy. Student participants discuss the need for health care professionals to advocate for their patients and be a voice for them when necessary. Student J stated, “I mean, every health care provider should be able to stand up for their patients, have empathy for their patients so they can actually kind of feel what they’re going through and use that as a way to fight for them.” Student I stated when discussing physical therapy:

I think we need to be leaders in really advocating for that patient-centered care, very holistic, open, and knowing what our scope of practice is, but also knowing that we are very large providers that can take care of musculoskeletal diseases and as well as other specialties as well.

Table 9.

Research Question 2 Theme 3 Summary: Expertise

<table>
<thead>
<tr>
<th>Theme</th>
<th>Codes</th>
<th>Phrases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expertise</td>
<td>Confidence</td>
<td>• Confidence is key</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Confident in your decisions and abilities</td>
</tr>
<tr>
<td>Knowledge</td>
<td></td>
<td>• Looked to as experts</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Continued development</td>
</tr>
<tr>
<td>Patient Advocacy</td>
<td></td>
<td>• Be their voice when needed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Patient-centered care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Stand up for their patients</td>
</tr>
</tbody>
</table>

From the data collected for research question 2 on the value leadership for health care professionals, there is evidence that DPT students find leadership skills and abilities for health care professionals valuable. There were three themes that emerged: connection, integrity, and expertise. Two of these themes, connection and integrity, were also evident in DPT students’ conceptualization of leadership.
Summary

Through this qualitative study utilizing individual interviews with DPT students, four themes emerged that define their conceptualization of leadership: 1) Connection, 2) Integrity, 3) Influence, and 4) Experience. In Chapter 5, there will be discussion of how these themes align with the conceptual framework of leadership in this study and previous literature on the topic.

Regarding the second research question about the value of leadership for health care professionals, the interviews with DPT students revealed three themes: 1) Connection, 2) Integrity, and 3) Expertise. It is evident in the results that DPT students perceive value in leadership skills and abilities for health care professionals. There is overlap in participants’ conceptualization of leadership and how leadership is valuable for health care professionals, with both having themes of connection and integrity. Chapter 5 will include visual representation and a detailed discussion of this overlap.
Chapter 5. Discussion, Implications, and Conclusion

This qualitative phenomenological research study was conducted to explore Doctor of Physical Therapy (DPT) students’ perspectives on leadership and the value of leadership for health care professionals. Leadership is necessary for professionals in health care to have successful patient outcomes by navigating a complex and rapidly changing environment (Blumenthal et al., 2012; Turnbull, 2018). Recent literature has demonstrated the importance of leadership knowledge, skills, and abilities for physical therapists (Sebelski et al., 2020). Yet, how current DPT students conceptualize leadership is unknown, and the value that DPT students place on leadership for health care professionals is not addressed in the literature. To explore these topics, the research questions addressed in this study include:

Question 1: How do DPT students conceptualize leadership?

Question 2: How do DPT students value leadership for health care professionals?

Ten semi-structured qualitative one-on-one interviews of randomly selected second- and third-year DPT students at one DPT program were conducted by the researcher. Each interview was transcribed, and member checking completed with each interviewee’s transcript to ensure accuracy of the data. Transcripts were analyzed following the qualitative data analysis spiral steps as described by Creswell and Poth (2018), including memoing, inductive coding, and thematic analysis as described in detail previously in Chapter 4.

The results of the study for the first research question revealed four themes: 1) Connection, 2) Integrity, 3) Influence, and 4) Experience. The codes for each theme demonstrate how DPT students conceptualize leadership in detail. Participants described past leadership experiences through athletics, work experience, clinical rotations, and by parental role models. Participants’ concepts of leadership included leaders being able to connect with others
through communication and compassion, leaders demonstrating integrity through honesty and accountability, and leaders having influence over others by being a guide and a role model.

The results of the study for the second research question revealed three themes: 1) Connection, 2) Integrity, and 3) Expertise. Participants all stated that leadership knowledge, skills, and abilities are valuable for health care professionals for various reasons. The codes in the first theme of connection describe the importance of health care providers being able to connect with and share information with patients to set and achieve common goals. The codes in the second theme of integrity demonstrate participants’ views that health care professionals should lead through accountability and responsibility. The codes in the final theme of expertise reveal that DPT students think health care professionals should lead with confidence, knowledge, and patient advocacy efforts.

**Interpretation of Findings**

In the qualitative data analysis spiral, as described by Creswell and Poth (2018), the fourth step is to develop interpretations of the data and assess those interpretations. The fifth and final step of the qualitative analysis spiral is to represent and visualize the data (Creswell & Poth, 2018). For the first research question exploring how DPT students conceptualize leadership, it was evident that various experiences in their lives had established their sense of what leadership is and who leaders had been in their lives. Leaders were people in their lives with influence over others and who helped others to work toward a common goal. These leaders had communication skills and led by example. These themes of DPT students’ concepts of leadership and their relationship to experience are illustrated in Figure 4.
For the second research question about how leadership is valuable for health care professionals, it was evident that DPT students value health care professionals having leadership knowledge, skills, and abilities for various reasons. Participants discussed the need for health care professionals to connect with patients to establish and work toward a common goal. Having empathy, being able to empower patients, and being able to guide patients were all leadership skills noted by participants in the theme of connection. The next theme was integrity. In the integrity theme, it was discussed that health care professionals should be accountable, responsible, and show the way for patients and other colleagues. The final theme was expertise, in which participants described the need for health care professionals to have knowledge and maintain knowledge in their field, have confidence in this knowledge to be seen as experts, and to use this knowledge to be advocates for their patients. These themes of how DPT students value leadership for health care professionals is illustrated in Figure 5.
The results of this study include considerable overlap between the themes from each research question. Themes of connection and integrity were revealed through the codes for DPT students’ conceptualization of leadership. Those same themes of connection and integrity were also observed in codes for the value of leadership for health care professionals from the DPT students’ perspective (see Figure 6).
DPT students conceptualize leaders as those who have communication skills and compassion to connect with other people, and these same abilities or skills were also noted by participants as valuable leadership abilities or skills for health care professionals.

**Findings Related to the Conceptual Framework of Leadership Described in this Study**

According to Marion and Gonzales (2014), leadership is a process rather than an event, and leaders themselves are people who engage in the leadership process. Kouzes and Posner (2017) agreed that leadership is about developed behaviors and relationships and includes an identifiable set of skills, abilities, and behaviors. Therefore, any person can advance their leadership behaviors by taking on leadership challenges or experiences. Similarly, Green-Wilson and Zeigler (2020) stated, “Leadership is viewed today as a dynamic process through which a person influences a group of individuals to achieve a shared goal, and as a trait that can be developed” (p. 7). The findings in this study aligned with several components of these...
descriptions of leadership: leadership is a process, leaders influence others, leadership is about relationships, and leadership involves shared goals. There is no clear evidence in this study that DPT students conceptualize leadership as a set of behaviors that can be developed by anyone through challenges or experience.

**Leadership is a Process.**

The themes revealed in this study regarding the concept of leadership align with leadership being a process and leaders being those who engage in this process. Participants described leaders who guided them through a situation or experience, thus engaging in the process of leadership. The processes described by participants included a variety of work or job scenarios. Multiple leadership processes described by participants were in the context of an athletic event or sports team situation. Coaches or team captains were described by participants as being leaders during a struggle or time of conflict on a team. Student G stated:

I guess this was one if you go to one specific time, our team was very good and, this is in college, and our team was very good. And we won our first few games and then kind of went on a little skid and he (coach) was not having it. So, he kind of brought us aside and we had a little team meeting and he, I don’t know, it was just like a kind of a come to Jesus kind of thing. It’s like, all right, we’re better than this. It’s not like yelling like here we are let’s go kind of thing but, it’s what do we need to do to figure this out and think it’s just a good approach to like kind of getting the team back together, getting us back on the right path to really start winning more games and be successful.

Some participants referred to past experiences in which they themselves engaged in the leadership process in athletics by mentoring or encouraging younger teammates. Student F described a time in high school in which he was a team captain but was injured so could not play.
Student F said, “I still had to fill my role as being a leader. And even though I wasn’t playing anymore for the year, that was really important to me.” When asked a follow-up question about how the role of a leader was filled, Student F stated:

Just by being supportive of my teammates and trying to keep a good attitude myself, even though it was a bad situation, just trying to make the most of it. Giving not only guidance as far as what they were doing in (the sport) but giving them support, like you guys are doing good and keeping the morale up.

**Leaders Influence Others.**

Influence is another important piece of Green-Wilson and Ziegler’s (2020) description of leadership: “Leadership is viewed today as a dynamic process through which a person influences a group of individuals to achieve a shared goal, and as a trait that can be developed” (p. 7). Influence was one of the main themes revealed by DPT students about leadership. Participants in this study described a leader as someone who has influence over others and can guide people. Student H stated, “Leadership is guidance, direction or influence.” Another student talked about someone considered to be a great leader by stating, “She influenced a lot of my decisions throughout the whole process.” The findings in this study align with previous researchers’ descriptions of leaders as a person who influences a group or individuals.

**Leadership and Relationships.**

Green-Wilson and Zeigler (2020) stated that leadership is about behavior and about what leaders do and that effective leadership focuses on the *relationship* between those who seek to lead and those who follow. The findings in this study align with this focus on relationships as revealed in the theme of connection. DPT students described leaders as having the ability to communicate and connect with people. They also described leaders as being compassionate and
LEADERSHIP PERSPECTIVES FROM DPT STUDENTS

Caring. All these codes (communication, connection, compassion) relate to the *relationship* that a leader has with those who follow them, and it aligns with Green-Wilson and colleagues’ description of effective leadership.

**Shared Goal.**

Multiple leadership researchers described leaders as a person who influences others to achieve a shared goal or work toward a shared vision (Green-Wilson & Ziegler, 2020; Kouzes & Posner, 2017). *Inspire a Shared Vision* is one of the five practices of exemplary leadership described by Kouzes and Posner (2017), which includes envisioning the future and then enlisting others in a common vision by appealing to shared aspirations. Green-Wilson and Zeigler (2020) described leadership today as “a dynamic process through which a person influences a group of individuals to achieve a shared goal, and as a trait that can be developed” (p. 7). Another code within the theme of connection that was revealed by participants in this study was common goal. This code was defined as “guiding or working toward a common goal” (see Appendix D). Student I described a leader as “A person who is willing to take others under their wing and help achieve a common goal.” Student A said about leaders, “They just kind of guide to a shared vision or a shared goal.” This idea of leaders helping others toward a shared goal was evident in the participants’ conceptualization of leadership which aligns with the work of Green-Wilson and Ziegler (2020) and Kouzes and Posner (2017).

**Leadership Can Be Developed.**

From the data in this study, it is not clear if DPT students conceptualized leadership as something that can be developed as described by Kouzes and Posner (2017) and Green-Wilson et al. (2020). Kouzes and Posner (2017) stated that leadership is not about a position or title. Rather, leadership is about developed behaviors and relationships and includes an identifiable set
of skills, abilities, and behaviors. Therefore, any person can advance their leadership behaviors by taking on leadership challenges or experiences. In agreement with Kouzes and Posner, Green-Wilson and Zeigler (2020) stated, “Leadership is viewed today as a dynamic process through which a person influences a group of individuals to achieve a shared goal, and as a trait that can be developed” (p. 7). The data in this study revealed that experience is what provided the context for their formations of the concept of leadership. For many students, this experience was specifically in athletics. Regarding the understanding that leadership can be developed by anyone, there were mixed comments regarding leaders being born or having natural tendencies or developing leadership skills. In response to a question asking how someone becomes a leader, Student I illustrated this by stating:

I think it’s one of those things, that part of it you’re born with, and part of it is learned. And so, I think some people are just born with personalities where they don’t like to be in front of people or don’t like to get things done whereas other people do. But at the same time, I think taking leadership courses in the past was really beneficial for me and helping develop my leadership skills, if that makes sense. Kind of learn the traits or techniques of what to do to help others follow you.

In summary, the findings in this study aligned with several components of recent researchers’ descriptions of leadership: leadership is a process, leaders influence others, leadership is about relationships, and leadership involves shared goals. However, there was not clear evidence from participants that DPT students conceptualize leadership as a set of behaviors that can be developed by anyone through challenges or experience, as there were mixed responses as to how a person becomes a leader.
Findings Related to Leadership in Health Care

Research in health care indicates the need for health care professionals to have leadership knowledge, skills, and abilities to navigate the complex and rapidly changing environment of health care, making this study quite significant for the profession of physical therapy. The demand for health care accountability, quality of care, and patient satisfaction all require leadership training and professionalism. According to Blumenthal et al. (2012), “To achieve the best outcomes in today’s health care system, all clinicians should be equipped with clinical leadership skills” (p. 513). The authors further stated, “now more than ever, patient safety, health care quality, and cost containment depend significantly on practicing physicians’ abilities not only to decide what care services to deliver but also to manage the delivery of those services” (Blumenthal et al., 2012, p. 513). Evidence from multiple health care professions on the value of leadership skills and abilities suggests that effective leadership can improve organizational and patient outcomes (Blumenthal et al., 2012; Boamah et al., 2018; McGowan et al., 2020).

Evidence indicates the overall need for leadership in patient care, on interprofessional teams, and in communities regarding health. Specific to physical therapy, in 2020, Sebelski and colleagues published a Delphi study about leadership competencies for physical therapists. There were 37 leadership competencies identified as “very important” for all physical therapists regardless of their years of experience (see Table 1).

The findings in this study revealed that DPT students recognize the importance of leadership skills and abilities related to direct patient care and establishing rapport with patients and some mention of interprofessional communication but did not indicate any sense of the need for leadership behaviors related directly to patient outcomes, health care quality, or the management of health care delivery. The DPT students in this study discussed many leadership
skills and abilities that align with the competencies for physical therapists identified by Sebelski et al. (2020), such as accountable, communication skills, empathetic, integrity, and self-confidence. However, there were many competencies, such as analyzes, assesses, initiative, and self-management, not noted by participants (see Table 10).

**Patient Interactions.**

One of the themes revealed in the findings of this study related to the value of leadership for health care professionals was connection. This theme includes codes of communication, empathy, empowering, guiding, and reaching goals that are directly related to patient care and patient interactions. Student F stated:

I think just having the ability to, first of all, communicate things properly is a good leadership quality. But just being there to listen and do the right thing or direct them to the right service or doing our due diligence to make sure we’re offering the best care for that kind of goes across the board for all health care.

Regarding empathy, Student H stated, “I think you need to be empathetic. So, understanding and relating to those patients and trying to put their goals, their values, their reasoning, their chief complaints before your own.” It is clear from the participants’ responses that DPT students value leadership knowledge, skills, and abilities for health care professionals because of what it brings to the patient relationship in health care.

**Interprofessional Communication.**

Within the theme of connection for research question two regarding the value of leadership for health care professionals, study findings include a code for interprofessional communication. Participants described how leadership skills could help physical therapists communicate between various other health care professionals and also among physical
therapists. When asked which health care professionals should have leadership skills, Student D stated:

I think all of them should have, all aspects of health care team should have them, whether it’s one or two people doing it at each level, but. Obviously, being not necessarily the lower end of the health care team, but a different aspect of it, I can see physical therapists as a big leadership role because they, at least in the system where I was at they can kind of play a big, like middleman role between the athletic trainers who don’t have direct access to other doctors and between the medical doctors and orthopedic surgeons that are also sending their patients their way. So, they need to, PTs need to have a bigger leadership aspect to it.

**Identified Leadership Competencies in Physical Therapy.**

Specific to physical therapy, in 2020, Sebelski and colleagues published a Delphi study examining leadership competencies for physical therapists. Following two rounds of review by content experts who were physical therapists in the U.S., there were 37 leadership competencies identified as “very important” for all physical therapists regardless of their years of experience (see Table 1). The DPT students in this study discussed many leadership skills and abilities that align with these competencies identified by Sebelski et al. (2020). This study includes codes that directly align to five of the 37 competencies identified, including: accountable, communication skills, empathetic, integrity, and self-confidence (see Table 10). Additionally, there was discussion of ten other competencies within the DPT students’ descriptions of leadership in health care, including: authentic, collaborative, evidence-informed practice, goal orientation, lifelong learning skills, listening skills, relationship building, team orientation, and trustworthy (see Table 10). Regarding trustworthy, for example, Student J stated, about what leadership skills
and abilities health care professionals should have, “I would say trust. Trust would be a big one. Always being loyal to your patients and doing the right thing.” Relationship building was noted by Student C, who stated, “Communication as a leader and just knowing how to connect with your patients; we’re talking about physical therapy, just how to connect and build that therapeutic alliance and relationship building skills.”

Table 10.

Alignment of Participant Responses with Leadership Competencies for Physical Therapists as Described by Sebelski et al. (2020)

<table>
<thead>
<tr>
<th>Competencies Aligned with Codes in Study</th>
<th>Additional Competencies Noted by Participants in Study</th>
<th>Competencies Not Noted by Participants in Study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accountable</td>
<td>Authentic</td>
<td>Analyzes</td>
</tr>
<tr>
<td>Communication Skills</td>
<td>Collaborative</td>
<td>Assesses</td>
</tr>
<tr>
<td>Empathetic</td>
<td>Evidence Informed Practice</td>
<td>Cultural Humility</td>
</tr>
<tr>
<td>Integrity</td>
<td>Goal Orientation</td>
<td>Diversity Orientation</td>
</tr>
<tr>
<td>Self-Confidence</td>
<td>Interpersonal Relationship Skills</td>
<td>Ethical Orientation</td>
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<tr>
<td></td>
<td>Listening Skills</td>
<td>Excellence Orientation</td>
</tr>
<tr>
<td></td>
<td>Lifelong Learning Skills</td>
<td>Evaluates</td>
</tr>
<tr>
<td></td>
<td>Relationship Building</td>
<td>Follows Through</td>
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<tr>
<td></td>
<td>Team Orientation</td>
<td>Health Professional Orientation</td>
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<tr>
<td></td>
<td>Trustworthy</td>
<td>Implements</td>
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<td></td>
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<td>Initiative</td>
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<td></td>
<td></td>
<td>Plans</td>
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<td></td>
<td></td>
<td>Problem Solving Skills</td>
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<td></td>
<td></td>
<td>Professionalism</td>
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<td></td>
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<td>Provides Feedback</td>
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<td>Scope of competence</td>
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<tr>
<td></td>
<td></td>
<td>Seeks information</td>
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<td></td>
<td></td>
<td>Self-aware</td>
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<tr>
<td></td>
<td></td>
<td>Self-management</td>
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<tr>
<td></td>
<td></td>
<td>Synthesizes</td>
</tr>
</tbody>
</table>

In summary, the findings in this study revealed that DPT students value leadership for health care professionals for several reasons, but not all the reasons identified in the literature.
DPT students recognize the importance of leadership skills and abilities related to direct patient care and establishing rapport with patients, and some mention interprofessional collaboration. However, participants did not indicate the need for leadership behaviors related directly to patient outcomes, health care quality, or the management of health care delivery. Many leadership skills and abilities that align with the competencies for physical therapists identified by Sebelski et al. (2020) were revealed by participants in the study.

**Implications of the Study**

This study provides vital information to direct the DPT program in the study regarding students’ current concepts of leadership and how they value leadership for health care professionals. There is a foundational understanding of leadership revealed in the interviews, and students value leadership skills and abilities in health care in some ways. The program can work to fill any gaps and further expand students’ leadership knowledge, skills, and abilities through the DPT curriculum and experiential learning opportunities. There does not appear to be a need to have formalized education for the basic concepts of leadership as described by Green-Wilson and Zeigler (2020), “Leadership is viewed today as a dynamic process through which a person influences a group of individuals to achieve a shared goal, and as a trait that can be developed” as students’ already have this conceptualization of leadership (p. 7).

Additionally, the in-depth understanding of the life experiences that DPT students described as being foundational to their conceptualization of leadership (e.g., athletics, work, parental influence) could be considered by the DPT program to inform admissions process. If having students with some leadership knowledge, skills, and abilities is preferred by the program, admissions criteria and admissions interview questions could be structured to ascertain this information from potential candidates. Having leadership experience could be valued in the
admissions process to attract DPT students with baseline conceptualization of leadership at the start of the program.

Furthermore, the lack of discussion by DPT students of several ways in which leadership has been identified as valuable in health care (e.g., patient outcomes, health care quality, and the cost of health care) identifies an area of growth for the program to foster continued learning and development. Interprofessional collaboration is certainly an area in which further leadership development would be beneficial as there was only limited discussion of this regarding communication between providers. More broadly addressing the organizations and systems of health care related to patient outcomes, cost of care, and efficiency of care delivery should be areas of interest to physical therapists and areas in which leadership knowledge, skills, and abilities are required. These areas warrant further learning and development for DPT students.

**Recommendations for Action**

The results of this study provide a basis for the DPT program involved in the study to make decisions regarding leadership content in the curriculum, but it also serves to inform the larger community in DPT education. Other DPT programs may be interested in the data and how it translates to their students. The study also provides a framework from which other DPT programs could explore their own student’s perspectives on leadership to determine how they align with recent evidence in the literature.

This study is appropriate for dissemination within the physical therapist professional education community and within the broader health care community. The perspectives of DPT students had not been investigated regarding leadership. It is important to include the perspectives of all stakeholders in the exploration of leadership development for health care professionals, including physical therapists. Additionally, the broader community of scholars in leadership, beyond health care, may be interested in this study design and results. Leadership is a
complex topic that has evolved over time, and having perspectives from multiple different groups on the conceptualization of leadership is highly valuable when exploring this concept.

**Recommendations for Further Study**

This study provides the basis for further research questions regarding leadership in the physical therapy profession and in DPT educational programs. The findings presented in this study are from the perspectives of DPT students in one program. Further studies should be conducted to explore the perspectives of DPT students in a variety of programs across the U.S. A broader perspective would inform the larger physical therapist professional education community about DPT students’ conceptualization of leadership.

For the program involved in the study, there is a need to now measure the students’ leadership abilities through standardized measurement tools. By knowing the students’ perspective on leadership and that students in the program studied do value leadership for health care professionals, the next logical step is to evaluate students’ leadership ability. Measuring students’ self-perceived or peer-assessed leadership abilities through a standardized tool will allow the leaders of the DPT program to make informed decisions about curricular content and leadership development opportunities in the program and then track the effectiveness of any implemented changes.

Another consideration for further research would be to explore the perspectives of licensed physical therapists with experience practicing in the profession. A similar phenomenological study could be conducted with individual interviews to determine professional physical therapists’ perspectives on leadership and the value of leadership for health care professionals. The findings of such a study could be compared with the findings in this study, but also with recent research on leadership in health care. Given the recent interest in leadership and
the continued push for further leadership development in physical therapy, exploring the perspectives of those practicing in the profession is imperative.

**Reflection on the Researcher’s Experience**

From the researcher’s perspective, much was gained in understanding how DPT students conceptualize leadership. The methods of this study were sufficient to gain the information necessary to explore and answer both research questions. Individual interviews proved to be the ideal way to collect the data as students seemed to be comfortable answering questions openly and honestly.

The researcher discovered that DPT students had a conceptualization of leadership that aligned closer to the study’s conceptual framework than she anticipated prior to conducting the study. The program that participated in the study did not have formally identified leadership education objectives or training within the DPT curriculum when the study was conducted. Given that DPT students did have some alignment in their conceptualization of leadership with recent literature, it would be worth investigating if there are components of the program’s curriculum that are related to leadership development, but not formally identified as such.

Additionally, this study has provided the researcher with some thought-provoking ideas and data to bring forward to the faculty in the DPT program studied, including the alignment of students’ conceptualization of leadership with recent literature and the experiences that participants indicated as crucial in their conceptualization of leadership. Identifying areas of the program’s existing curriculum that may already be fostering leadership development should be considered. Furthermore, discussion should be had by the faculty of the areas of leadership not identified by participants, such as leadership behaviors related directly to patient outcomes, health care quality, or the management of health care delivery. Additionally, this study has led the researcher to desire further study of the DPT students’ leadership knowledge, skills, and
abilities. Measuring students’ leadership knowledge, skills, and abilities is an important step in assessing the current curriculum and in assessing the outcomes of any implemented changes in the curriculum.

Conclusion

This study demonstrates DPT students’ conceptualization of leadership and their perspectives on the value of leadership for health care professionals. Participants conceptualized leadership through past experiences around four themes: 1) Connection, 2) Integrity, 3) Influence, and 4) Experience. Participants described past leadership experiences through athletics, work experience, clinical experience, and parental role models. Their concepts of leadership, including leaders being able to connect with others through communication and compassion, leaders demonstrating integrity through honesty and accountability, and leaders having influence over others by being a guide and a role model.

This study also demonstrates that DPT students value health care professionals having leadership knowledge, skills, and abilities as it enhances patient care and demonstrates professionalism. This is evident in three themes: 1) Connection, 2) Integrity, and 3) Expertise. Participants described the importance of health care providers being able to connect with and share information with patients to set and achieve common goals, lead through accountability and responsibility, and lead with confidence, knowledge, and patient advocacy efforts.

The findings of this study identified both areas of agreement with current research conceptualizations of leadership and areas of further development for DPT students. The value of leadership for health care professionals was evident in some respects (e.g., communication, accountability) as described in recent literature but was lacking in other areas (e.g., health care quality, health care costs). Overall, this study provides a firm foundation for the faculty within the program studied to have in-depth discussions regarding leadership development for DPT
students. The study findings provide a framework for researchers in physical therapy professional education to examine the perspectives of DPT students as part of the ongoing exploration and recommended implementation of leadership development in physical therapy professional education.
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Appendix A. Invitation to Participate

Dear Student,

You are invited to participate in an interview for a study of concepts of leadership and the value of leadership for health care providers. You were randomly selected as a possible participant in this study because you are currently enrolled in the upper Midwest university*. Participation in this study is voluntary. This study is for my dissertation for the completion of the Doctor of Education degree from Minnesota State University Moorhead.

If you decide to participate, I will conduct a one-on-one interview with you to ask several questions on the topic of leadership. We will schedule the interview at a date and time convenient for you. This interview will take place at the upper Midwest university* physical therapy program department and will last approximately 60 minutes. The interview will be audio-recorded, and I will take notes. There are no right or wrong answers to the interview questions. I want to hear all viewpoints and would like for you to contribute your thoughts.

You can choose whether or not to participate in the interview, and you may stop at any time. Your decision whether or not to participate will not affect your future relationships with the upper Midwest university* physical therapy program or me.

Please respond to this email to confirm if you choose to participate or would like to decline by [three days from date sent]. If you choose to participate, I will then send you an informed consent letter with further details and options for scheduling a time to complete the interview in the next two weeks.

Thank you for your consideration,
Dr. Tara Haj

*Actual name of the university was used on form in the study
Appendix B. Informed Consent Letter

Dear participant,

You are invited to participate in an interview for a study of concepts of leadership and the value of leadership for health care providers. You were selected as a possible participant in this study because you are currently enrolled in the upper Midwest university* Doctor of Physical Therapy Program.

If you decide to participate, the researcher will conduct a one-on-one interview with you to ask several questions on the topic of leadership. The researcher will contact you to schedule the interview at a date and time convenient for you. This interview will take place at the upper Midwest university* Physical Therapy department and will last approximately 60 minutes. The interview will be audio-recorded, and notes will be taken by the interviewer.

Please note that there are no right or wrong answers to the interview questions. The researcher wants to hear all viewpoints and would like for you to contribute your thoughts. Please be honest and open in your responses to the interview questions.

Any audio recordings and transcriptions of the interview will remain in secure storage in a locked file cabinet or on a computer that is password protected. No one will have access to these audio recordings and transcriptions except for the investigators in the study. The recordings will be destroyed two years after the study concludes.

Researchers will analyze the data, but your responses will remain confidential, and no names will be included in any reports or publications.

Your participation may benefit you and other DPT students and faculty by providing insight into DPT students’ concepts of leadership. However, no risks are anticipated beyond those experienced during an average conversation. Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will not be disclosed.

You can choose whether or not to participate in the interview, and you may stop at any time during the course of the study. Your decision whether or not to participate will not affect your future relationships with the upper Midwest university* Doctor of Physical Therapy Program or the researcher.

Please feel free to ask questions regarding this study. You may contact me later if you have any additional questions at tara.haj@uj.edu or 701-356-2136 Ext. 5915 or the principal investigator, Dr. Boyd Bradbury at bradbury@mnstate.edu or 218-477-2471. Any questions about your rights may be directed to Dr. Lisa I Karch, Chair of the MSUM Institutional Review Board, at 218-477-2699 or by email at: irb@mnstate.edu

You are making a decision whether or not to participate. Your signature indicates that you have read the information provided above and have decided to participate. You may withdraw at any time after signing this form should you choose to discontinue participation in this study. You will be offered a copy of this form to keep.

__________________________________________  __________________
Signature of Participant                          Date

*Actual name of the university was used on form in the study
Appendix C. Interview Guide

Date: 
Time: 
Place: 
Interviewer: 
Interviewee: 

Thank you for participating in this interview today. Remember that there are no right, or wrong answers and I welcome any of your thoughts on these questions, please be open and honest. This interview will be recorded using an audio-recording device and both the recording and the transcript will be kept confidential. Also remember that any information written or published for this research study will not contain identifying information of participants so your answers will remain confidential. You are free to stop the interview at any time as your participation is voluntary. Before we begin, do you have any questions?

Questions:

1. What does leadership mean to you?
2. How would you define or describe leadership?
3. What have you experienced in terms of leadership?
   a. What contexts or situations have influenced your experiences of leadership?
4. What makes a person a leader?
   a. How does a person become a leader?
5. If you think of someone that you consider to be a great leader; Why do you consider them a great leader?
   a. Can you describe the context of a time when you experienced great leadership from this person?
   b. What leadership skills and abilities did this person demonstrate?
6. In your opinion, which health care professionals should have leadership skills and abilities and why?
   a. What leadership skills and abilities do you consider to be most important for health care professionals?
7. What leadership skills and abilities, if any, are important for physical therapists and why?
8. Is there anything else that you would like to share about your experiences with leadership?

Thank you for your participation in this interview. I will contact you again so you can review the data I have collected to ensure accurate representation. If I need further clarification on anything we have discussed today, I may contact you to set up a brief follow-up interview. Thank you!
## Appendix D. Codebook

### Concepts of Leadership (Q1)

<table>
<thead>
<tr>
<th>Theme</th>
<th>Code</th>
<th>Definition</th>
<th>Quotes</th>
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<tbody>
<tr>
<td><strong>Connection</strong></td>
<td>Common goal</td>
<td>Guiding or working toward a shared or common goal</td>
<td>“A person who is willing to take others under their wing and help achieve a common goal.” (Student I) “…they just kind of guide to a shared vision or a shared goal.” (Student A) “Leadership to me means someone who either in a direct way or indirect way is helping to accomplish a certain goal.” (Student D)</td>
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<tr>
<td><strong>Communication</strong></td>
<td>Talking, listening, or relaying</td>
<td>“Listening and communication skills. To be an effective leader you have to be able to communicate to people and reach people.” (Student E) “He’s a great communicator who is always able to talk to you. He could give a speech.” (Student G) “Open lines of communication, able to communicate well.” (Student I)</td>
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<tr>
<td><strong>Compassion</strong></td>
<td>Compassion or caring</td>
<td>“Just compassion and caring. I think all leaders should have that for employees or anyone that’s working for them. Because if you don’t care about them, why you want to lead them?” (Student C) “He was compassionate, he’s always there for you, is understanding when things weren’t going the right way.” (Student G)</td>
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<tr>
<td><strong>Connects to People</strong></td>
<td>Connect or relate to different or a variety of people</td>
<td>“He had really good insight into other people.” (Student A) “Just the ability to talk to anyone and adapt to them how they wanted to be approached. She could read personalities very well and then adapt her communication style to that.” (Student A) “My dad, you know, he just knows how to, with every employee or between me and my brother, we’re very different people but he can communicate to both of us. So, I think communication as a leader and just knowing how to connect with your students or employees or your patient.” (Student C) “He has a really good way of connecting with people. And professionally, he does that. In his job I’ve seen him just work well with individuals. I would love to learn and have that ability to just relate with people and have that emotional connection while maintaining professional status.” (Student G)</td>
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<td><strong>Integrity</strong></td>
<td>Accountability</td>
<td>Accountability or being counted on</td>
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<td>“Yeah, accountability, responsibility. All of those traits can make up a leader.”</td>
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<td>“Accountability not only for herself, but she held others accountable.” (Student A)</td>
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<td>“I would say leadership to me means doing the right thing all the time, being somebody that others can always look to and someone that is always able to be counted on. In general, I guess, like being able to be counted on.” (Student F)</td>
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<td></td>
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<td>“They’re respectful and reputable, accountable. Trustworthy.” (Student I)</td>
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<td>Integrity</td>
<td>Integrity or honest or sticking to what a person believes in</td>
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<td>“Not being afraid to maybe even make the unpopular decision, even if it’s the right one, being able to live with those things and not be worried about what others are or what the kind of consequence, I guess, is going to be. But as long as you’re sticking by like what you believe in and having integrity to not back down, stick to your guns a little bit, even if it’s if it’s not popular or if it’s maybe not going to be the best for you if it’s the best for others or the best for the situation.” (Student F)</td>
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<td>Responsibility</td>
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<td>“A lot of responsibility, being willing to take up responsibility and speak up is one thing I know a lot of people are not comfortable doing that.” (Student D)</td>
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<td>“To me, it means somebody who’s willing to take charge in tough situations, but also understand that they’re responsible for how the situation goes.” (Student E)</td>
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<td>“They’re able to kind of take on more responsibility and be someone who’s willing to have that responsibility on their shoulders.” (Student G)</td>
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<tr>
<td>Influence</td>
<td>Encouraging</td>
<td>Encouraging others</td>
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<td>“…to help encourage instead of just getting it done and reaching your own goals, you can show that you help and encourage everybody else to get to their end goal as well.” (Student B)</td>
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<td>“She was always nice to everybody and she encouraged everyone and if someone was struggling, she would take the time to go out of her way to help them get to where they needed to be.” (Student B)</td>
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<td>“Not only giving guidance as far as what they were doing in (the sport) but giving support. Just like you guys are doing good, you know, like keeping the morale up.” (Student F)</td>
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<td>“They’re very focused, very inspiring, encouraging.” (Student I)</td>
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<tr>
<td>Guiding</td>
<td>Leaders guiding others or being a guide</td>
<td>“It [leadership] is guiding a group to a goal.” “So that’s what leadership means to me as someone who’s not going to just tell someone what to do or to go, but guide them and help them along the way.” (Student C) “Leadership is guidance, direction or influence.” “And I think I saw that a lot with clinical experience, like my C.I. was my teacher, my guide or my mentor.” (Student H)</td>
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<td>Hardworking</td>
<td>Doing hard work or putting in extra effort</td>
<td>“She went above and beyond what she needed to do all the time. She always put it extra work.” (Student B) “I think that they have to be very open minded, very willing to work and kind of put themselves in the trenches as well as kind of having the go getter attitude able to get things done and able to be willing to work.” (Student I)</td>
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<tr>
<td>Influence</td>
<td>Leaders having influence over others</td>
<td>“Someone who I think just has influence over others and can guide people.” “She influenced a lot of my decisions throughout the whole process.” (Student A) “Leadership is guidance, direction or influence.” (Student H)</td>
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<tr>
<td>Showing the Way</td>
<td>Leading by example or modeling behavior</td>
<td>“Leaders know the way. And they know how to show the way and they know how to get people to come that way.” (Student A) “It means leading and doing things by the rules and by example and helping others accomplish and reach their goals as well.” (Student B) “I think it’s someone or a group of people just kind of setting an example, example for others and kind of putting your foot in the door for others to do things.” (Student G)</td>
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<tr>
<td>Speaking Up</td>
<td>Leaders being vocal or speaking up in situations</td>
<td>“To me, it means somebody who’s willing to take charge in tough situations, but also understand that they’re responsible for how the situation goes in a way and get somebody that’s not afraid to be vocal and really lead but listen at the same time.” (Student E) “Just the ability to just stand up for what they believe in and not be afraid to speak out. Yeah. And because it’s so easy to just sit back and let things happen and...”</td>
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especially when it’s going to be an unpopular thing for possibly like yourself too. Yeah. Just like having the strength to even speak up.” (Student F)

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<tr>
<th>Experience</th>
<th>Athletics</th>
<th>Leadership experiences related to sports teams</th>
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<td>“When I played (a sport), one of the captains on the team, she was someone that everyone respected because she was really nice to everyone and showed you what you should be doing and how to do it.” (Student B)</td>
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<td>“Up until this point in my life has pretty much been dominated by sports and leadership is huge in sports obviously.” (Student F)</td>
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<td>“So I think some people when you look at a team, there are captains, there are coaches, there are people that are put in positions to guide you and show you and an end goal is to win a game. And I’ve had some really great experience with people in leadership roles.” (Student H)</td>
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<td>“Watching coaches who I thought were good leaders. Or who I was like, well, yeah, they really put the petal to the metal, helped us get this done or they’re really inspiring, encouraging, that kind of thing.” (Student I)</td>
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<th>Clinical Experiences</th>
<th>Leadership experiences related to clinical rotations while in DPT program</th>
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<td>“I think the best example, at least recently, are probably clinical instructors because they are there to guide you, but they’re also there to listen and give advice when needed and kind of steer you in the direction that they believe you should be going or that we should be going as clinicians.” (Student E)</td>
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<td>“And I think I saw that a lot on my clinical experience, like my clinical instructor was my teacher, my guide or my mentor.” (Student H)</td>
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<tr>
<th>Work Experience</th>
<th>Leadership experiences related to a job or work situation</th>
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<td>“I’ve worked a [job] the last few summers when we had a (boss) that was very, very bossy. He would just give kind of hand out orders. He didn’t really show you or guide you.” (Student C)</td>
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<td>“It was when the former boss, he was just he communicated with us and treated us as if we’re equals, even though it was clear that he had the authority on everything. He was the owner of the company, but he was always there to listen to us when we needed or just like I said, talk to us like we’re equals. He also understood that if we worked super hard, he was very good about putting in days where there was more fun involved.” (Student E)</td>
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### Parental Mentors

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<th>Leadership experiences related to a parent</th>
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<td>“I’d say probably my dad. Yeah, so he I think he’s a great leader. I know for his work he’s kind of climbed the ladder and became pretty top end manager at his company he works at and stuff.” (Student C)</td>
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<td>“I would say I consider my dad probably the person I look up to and follow and ask for direction. But that’s because I want to follow in a path similar to his. So, my core values, my goals, my aspirations all align with where he has taught me. But now that I’m older, too, it’s no longer following, it’s I get to go to him for advice.” (Student H)</td>
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<td>“OK, honestly, when I think of a leader like one of the top people, it comes to my mind is my mom. She is a very strong-willed person and I just think, she works at a school and she would honestly do anything for, like, her students. And if she, like, sees or hears one of them being mistreated or she will not like let that go until she knows, she fights for them and helps them get back on what they deserve.” (Student J)</td>
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### Struggle

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<th>Leadership experiences related to a challenging time or time of struggle</th>
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<td>“So, I think the biggest things that stand out for me are the times when everything is kind of falling apart per say. So, we have a group of people that are working together trying to. I don’t know win I game or try to get an assignment done together and when things are falling apart, they kind of knew how to rope us all in back together again and help us kind of focus on that bigger picture.” (Student I)</td>
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<td>“I guess this was one if you go to one specific time, our team was very good and, this is in college, and our team was very good. And we won our first few games and then kind of went on a little skid and he (coach) was not having it. So he kind of brought us aside and we had a little team meeting and he, I don’t know, it was just like a kind of a come to Jesus kind of thing. It’s like, all right, we’re better than this. It’s not like yelling like here we are let’s go kind of thing but, it’s what do we need to do to figure this out and think it’s just a good approach to like kind of getting the team back together, getting us back on the right path to really start winning more games and be successful.” (Student G)</td>
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<td>Theme</td>
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<td>Connection</td>
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<td>Guiding</td>
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<td>Reaching Goals</td>
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<td><strong>Leadership Perspectives From DPT Students</strong></td>
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<td>Interprofessional Communication</td>
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<td><strong>Integrity</strong></td>
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<td><strong>Responsibility</strong></td>
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<td>&quot;Organization is a big thing. I know our clinic director had a lot of responsibilities regarding, not only their clinic, us athletic trainers, and they also had events with the overall company. And then, the other businesses in town that they cooperate with. So because we also had a lot of traveling and PTs and PTAs and communicating, organizing between who’s going to be there, who’s going to be here. Especially when there is maternity leaves, you know, organizing and communicating, scheduling and all that.” (Student D)</td>
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<td>&quot;Be timely, be someone you know, that, you know, you can count on, um, just taking responsibility for the actions you take. I mean, all that kind of stuff, really. All that stuff that you feel like that a professional needs to have to get others to respect you and be someone that they look up to.” (Student G)</td>
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<tr>
<th><strong>Show the Way</strong></th>
<th>Health care professionals leading by example or modeling behavior</th>
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<tr>
<td>&quot;Lead by example, by being like being healthy and doing your own things to make sure you’re taking care of yourself. Because I think that people look at us and think that, too, like, oh, if they I don’t take care of themselves why should I listen to what they’re saying?” (Student B)</td>
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<td>&quot;But in the clinic, I like I said, you have to interact with the other staff members or co-workers, I think, in the community, too, because physical therapy doesn’t stop in the clinic, in the community. We have to be a good example and set a good example for the company we’re working for.” (Student E)</td>
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<td>&quot;With your co-workers, if you’re you’re always doing things and being responsive to your patients and calling the doctors, talking to parents, doing all the things necessary to ensure proper care for your patients and make sure you’re treating them the way that you’d want to be treated, you know? I think some of those other PTs they see you doing that and they go oh maybe I should be doing some of that kind of stuff. Maybe they’ll start to follow and do it, too.” (Student G)</td>
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<th><strong>Expertise</strong></th>
<th>Confidence</th>
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<td>Health care professionals need confidence or to be confident</td>
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<td>&quot;They should all have leadership. Because I think that, like I’ve said, that confidence is a huge is a huge trait that leaders should have. So in health care, because, I mean, you so if you’re a leader, or you want to be there or if you’re in a certain position where that confidence is key, like in health care, you go to the doctor, you go to the dentist or physical therapy, you want to know, you want to walk in and...&quot;</td>
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<tr>
<td>Leadership Perspectives</td>
<td>From DPT Students</td>
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<tr>
<td>Knowledge</td>
<td>Health care professionals need knowledge</td>
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<td>Patient Advocacy</td>
<td>Health care professionals advocating for patients</td>
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