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Enhancing Care Quality Through Effective Leadership in Multidisciplinary Healthcare Teams

Monica Elisa Meneses-La-Riva[1*], Víctor Hugo Fernández-Bedoya[1], Josefina Amanda Suyo-Vega[1], Hitler Giovanni Ocupa-Cabrera[1], Rosario Violeta Grijalva-Salazar[1], Giovanni di Deus Ocupa-Meneses[1]

1. Grupo de Investigación "Innovación Humanizadora", Universidad César Vallejo, Av. Alfredo Mendiola, Trujillo 13600, Peru.

Abstract

This paper examines the internal dynamics of healthcare professional workgroups and highlights leadership behaviors that maximize the benefits of professional diversity to enhance the quality of care. A review of recent literature on leadership, diversity in healthcare teams, and performance outcomes—particularly regarding quality of care—provides valuable insights. Findings suggest that sub-group categorization is a key process that shapes diversity in these teams. However, when leaders cultivate a shared perception of inclusiveness, they can mitigate the prominence of these sub-groups, fostering a psychologically safe environment and promoting workgroup inclusion. This approach enables team members to contribute more effectively and ultimately improve the quality of care. By identifying critical diversity-related processes within healthcare teams and examining the role of inclusive leadership, this paper provides a new framework for future research on leadership and quality of care. The proposed model provides a strategic foundation for leaders to harness professional diversity within healthcare teams to enhance patient care.

Keywords: Quality of care, Professional diversity, Inclusive leadership, Workgroup inclusion, Psychological safety climate

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Corresponding author: Monica Elisa Meneses-La-Riva
E-mail ✉ mmenesesl@ucv.edu.pe

Introduction

The process of delivering care is intricate and involves multiple dimensions, which often leads to its division into tasks and delegation across various healthcare professionals [1, 2]. Due to this complexity, contemporary scholars view the quality of care as a result of collaborative efforts within workgroups of professionals from various disciplines [3-5]. These teams, whether they emerge organically or are purposefully structured, inherently reflect the diversity found in combining multiple professions [6]. Effective communication and knowledge sharing are essential for these teams to provide high-quality care [7, 8], but the internal structure of these teams often complicates such efforts [7]. The presence of professional hierarchy [9] and strong professional identities [10] pose challenges for leaders aiming to enhance the flow of information among team members. This has prompted calls for research to identify strategies that can improve leadership in multidisciplinary healthcare teams, thereby boosting care quality [11-13].

This study addresses these issues by examining the internal dynamics of multidisciplinary healthcare teams and exploring how effective leadership can enhance care quality, using the categorization-elaboration model as a framework. This model provides insight into how professional diversity within a team can have both positive and negative impacts on performance outcomes, such as care quality. It also helps identify the key diversity processes that influence team dynamics and guide

leadership behaviors aimed at improving care. The study makes several contributions to the literature. First, it answers the call for research into leadership strategies that can effectively guide diverse healthcare teams to improve care quality [11-13]. Second, it identifies the primary diversity processes that shape the internal workings of these teams. Third, it offers a refined conceptualization of leader inclusiveness within these teams. Finally, the study contributes to the theory of care quality, diversity, and the categorization-elaboration model by proposing how diverse teams can be led to improve care outcomes. It also expands the categorization-elaboration model by examining its effects at both individual and group levels. This research not only addresses the internal dynamics of healthcare teams but also provides insights into improving care quality on a broader scale.

The first part of the study explores the primary diversity dynamics within healthcare professional workgroups and reviews existing research on leadership's impact in the context of multidisciplinary or professionally diverse teams. It then presents a theoretical framework **(Figure 1)**, which illustrates how a shared perception of inclusiveness from a workgroup leader can improve care quality by fostering psychological safety at the group level and promoting individual perceptions of inclusion within diverse healthcare teams.

Multilevel influence of professional diversity: uncovering key processes

The influence of multi-professional team membership on group behavior can be explained using the Categorization-Elaboration Model (CEM) [14]. CEM suggests that diversity in teams is shaped by two processes—information elaboration and subgroup categorization—that interact to influence team performance. Information elaboration refers to the exchange and integration of diverse perspectives, which is considered a beneficial cognitive outcome of diversity and a positive aspect of group performance. This exchange of knowledge becomes a collective asset at the group level. In contrast, subgroup categorization is the tendency of individuals to divide themselves and others into in-groups and out-groups, which can result in negative consequences such as bias and reduced cooperation. This process typically operates at the individual level and can impede the overall effectiveness of the team. Both processes need to be managed effectively to maximize the advantages of diversity within teams [14]. Homan *et al.* [15] argue that understanding the dominant diversity processes is crucial to effectively managing their impact.

In the context of healthcare workgroups, where professional identity plays a significant role [16], subgroup categorization is especially prominent. Over time, distinct professional identities have developed, often reinforced by hierarchical structures [9, 17]. These status-based differences often lead to subgroup categorization, which diminishes the positive effects of information elaboration. This happens for two primary reasons: first, individuals in these teams strongly identify with their specific profession and feel their perspectives are undervalued within the broader team; second, subgroup categorization leads to a reluctance to share information due to fears of judgment or disapproval [15]. These factors limit the ability to communicate effectively, which is critical for sharing information and providing high-quality care [7, 14].

As a result, identifying leadership behaviors that can mitigate the salience of subgroup categorization is essential. Leaders who promote inclusiveness and create a psychologically safe environment can reduce communication barriers and encourage the exchange of care-related information across professional boundaries. The following section delves into the literature on the connection between leadership, professional diversity, and team performance, with a particular focus on quality of care.

Materials and Methods

To gather relevant information for this study, we carried out a manual review of recent publications [13, 15, 18]. Using the forward and backward snowballing technique, we explored the reference lists of these papers [19]. We also searched databases like PubMed and Google Scholar to locate studies examining leadership's impact on diversity-related processes within multidisciplinary and inter-professional healthcare teams and their outcomes, with a particular focus on quality of care. Additionally, research addressing the connection between leadership and the quality of care was included in the review.

Results and Discussion

The importance of leadership in enhancing the quality of care within healthcare teams has been well-documented [11, 20]. Literature reviews by various writers (e.g., Kossaify *et al*. [21]; Rosen *et al.* [12]; Salas *et al*. [22]) highlight that strong leadership and communication are key drivers of improved care quality. According to McKean and Snyderman [23], leaders in multi-professional teams can advance safety and care by cultivating a culture of quality improvement through effective and clear communication of goals. Likewise, Havig and Hollister [24] found that workgroups with proactive leadership demonstrate better care quality due to a stronger sense of psychological ownership, insider status, and shared mental models, all of which are promoted through effective communication. However, challenges persist, as leaders of frontline teams often struggle with integrating members from various professions [20], and some leadership styles, such as directive leadership, can hinder the free exchange of information necessary for quality care.

The literature also reveals that a variety of leadership styles have been explored in the context of multidisciplinary healthcare teams, including collective leadership [25], transformational leadership [16], shared leadership [26, 27], directive and participative leadership [8], approachability of leaders [28], inclusive leadership [14], and active leadership [24]. However, few studies have focused specifically on the diversity-generated processes (e.g., Nembhard & Edmondson [17]; Hirak *et al.* [29]; Mitchell *et al*. [16]; Mitchell *et al*. [10]; Zijl *et al*. [8]), and even fewer have explored the link between these processes and quality of care outcomes [23, 24, 30]. This paper demonstrates that leaders in healthcare workgroups can leverage diversity by fostering an environment where various viewpoints and experiences can contribute to improved health results. It also underscores the importance of factors such as interpersonal relationships, information sharing, communication, team identity, and psychological safety, which mediate the connection between leadership behaviors and team outcomes. These elements are crucial for delivering high-quality care [11, 12, 31, 32].

The impact of subgroup categorization within healthcare teams is well documented, particularly in how it diminishes the effectiveness of information exchange. However, there has been little exploration of how leaders can effectively manage subgroup categorization to foster both the recognition of individual contributions and a sense of team cohesion [33, 34]. While much of the existing literature emphasizes that a sense of inclusion within teams can diminish subgroup categorization [35] and that an individual's perception of being an insider can improve the quality of care [24], no study has specifically addressed how leaders can create an inclusive environment that reduces subgroup categorization and enhances care delivery.

Key studies by Nembhard and Edmondson [17], Hirak *et al*. [29], and Mitchell *et al.* [10] have explored the potential of inclusive leadership in linking diverse perspectives and capabilities to enhance team performance. They have shown that inclusive leadership behaviors can help bridge status differences by enhancing psychological safety and strengthening team identity. Their work, based on the conceptualization of Nembhard and Edmondson [17], focuses on how leaders can actively invite input from all members, fostering a climate where members feel valued and their voices heard. This view of inclusive leadership primarily highlights the importance of leaders valuing individual uniqueness to overcome status variations but does not provide a clear set of actionable leader behaviors. In contrast, research examining how the perception of inclusion varies based on members' professional identities [29, 36] suggests that inclusivity is more likely to reduce subgroup categorization. Although inclusive leadership is considered essential for maximizing the benefits of diversity and improving care quality [37], there remains a need for a more detailed exploration of inclusive leadership [34]. This should not only focus on reducing subgroup categorization but also on balancing the need for both individuality and a sense of belonging while ensuring a safe interpersonal climate that promotes the quality of care **(Table 1)**.

Table 1. Leadership style and subgroup categorization

Leadership styles	Characteristics	Effects on subgroup categorization
Directive and Participative leadership [8]	• Directive leadership enhances communication through inquiry and questioning. • Participative leadership emphasizes transparent communication and collaborative decision-making.	• Directive leadership might discourage communication from lower-status members regarding errors or adverse events, as it restricts the flow of information within the group [38]. • While participative leadership can improve communication among group members, its emphasis on shared decision-making is less effective in the presence of status hierarchies and subgroup categorization.
Transformational leadership [16]	• Viewed as a hierarchical leadership approach, where leaders leverage their charisma to inspire individuals to exceed expectations and prioritize collective goals over personal interests [39]	In healthcare settings, this approach is often seen as leader-focused and is frequently associated with a directive leadership style [40], which may not effectively address sub-group categorization or status hierarchy.
*Shared and collective leadership [27, 30, 41]	This approach emphasizes adapting leadership based on the situation to enhance group performance or the quality of care [30].	• Shared leadership is more likely to be effective in mature teams. • It thrives in environments where social interactions are encouraged [27]. • Effective communication and psychological safety among group members is key to fostering shared leadership [26]. • Clear leadership is necessary for promoting safety and openness within teams [42], and it may not be effective in the presence of subgroup categorization and status hierarchy.
Leaders' approachability [28]	The easy access to and frequent visibility of leaders support team members in participating in decision-making, foster a sense	It is more effective in addressing sub-group categorization and status hierarchy.

	of inclusion, and lower the barriers to asking questions or voicing concerns.	
Inclusive leadership [10, 17, 29]	• At the group level, encouraging participation in decision-making by actively seeking and valuing the input of others. • At the individual level, the leader's openness, approachability, and availability during interactions [29].	Inclusive leadership holds greater potential to diminish subgroup categorization and status hierarchies, ultimately enhancing the quality of care in multidisciplinary or professionally diverse teams [37].

*These three leadership behaviors are conceptually distinct but the way they are described in the literature seems to have more similarities [42]. Source: Multiple sources from the literature

Theory and propositions

In this part, we present propositions related to the proposed theoretical framework.

Creating a shared understanding of inclusive leadership to enhance quality of care

To address the prominence of subgroup categorization, this study proposes fostering a collective perception of leadership inclusiveness within workgroups. This shared view is based on the assumption that a leader treats all group members equally [43], leading to a similar perception of the leader's actions among members, thereby creating a more inclusive group climate. Leaders can foster this shared perception through behaviors such as accessibility, openness, and availability during interactions. According to social information processing theory (SIP) [44], when a workgroup member perceives a leader as approachable, available, and open to all, regardless of rank or professional role [10, 45], it signals the leader's willingness to listen to ideas and engage with input. This behavior encourages members to consult the leader more frequently, promoting social interaction [28], which, in turn, aligns their interpretations and results in a collective understanding of the leader's inclusivity. It also facilitates the flow of information and resources needed to efficiently accomplish tasks [28]. When professionals from different backgrounds share insights, it leads to a comprehensive understanding of patient needs, improving diagnosis and treatment accuracy [22], which ultimately enhances the quality of care. Based on this reasoning, the following proposition is put forward:

Proposition 1: The leader's accessibility, openness, and availability contribute to creating a shared perception of inclusiveness, improving the overall quality of care.

Mitigating sub-group categorization: promoting the sense of inclusion

The collective perception of leadership inclusiveness (i.e., accessibility, openness, and availability) also plays a role in balancing members' need for belonging and distinctiveness, fostering a deeper sense of inclusion within the group [46]. By creating a work environment that encourages the sharing of ideas and a sense of belonging, the leader nurtures individual inclusion within the workgroup. SIP theory suggests that employees are likely to adjust their perceptions based on cues, such as the perceived hierarchy within the group. When inclusive cues are provided by the leader, individuals reassess their self-image and feel valued and meaningful as part of the group. This boosts their sense of uniqueness and enhances participation, which is crucial for the effective functioning of multi-professional teams [22] and the successful delivery of healthcare services [12]. When all group members, regardless of their status, feel they can easily approach the leader, it encourages active engagement and interaction, fostering feelings of fairness, support, and equality that fulfill the need for belonging [34]. These leadership behaviors promote a sense of group unity [28], leading to improved care delivery [24].

Proposition 2: A shared perception of inclusive leadership will positively correlate with the sense of workgroup inclusion, ultimately enhancing the quality of care provided by healthcare professional teams.

Addressing the saliency of sub-group categorization: fostering a climate of psychological safety

A significant amount of crucial care-related information often goes unshared because members of the team perceive the work environment as unsafe for interpersonal risks. The shared perception of an inclusive leadership approach helps to reduce this barrier by cultivating a collective understanding of psychological safety. According to social information processing (SIP) theory, individuals interpret cues from their environment to make sense of events in the workplace and decide how to act [44]. Workgroup leaders, who typically occupy higher-status roles, engage directly with team members. Through these interactions, group members receive important informational cues that shape their views of the work environment, influencing their subsequent behaviors. When leaders offer clear verbal assurances that all group members are encouraged to share their unique perspectives and ideas without fear of criticism, it fosters an inclusive climate. This approach encourages involvement from individuals across various disciplines and hierarchical positions, resulting in increased participation and engagement. As a

result, this leads to more frequent reports of treatment errors [47], better communication, and an overall improvement in the quality of care [12, 26, 31, 48]. Therefore, this study suggests the following proposition:

Proposition 3: When workgroup leaders exhibit inclusiveness, it positively influences the development of a psychological safety climate that subsequently enhances the quality of care delivered by healthcare teams.

Furthermore, creating a psychological safety climate not only boosts the flow of information, improving care quality but also works to reduce subgroup categorization within different groups. This climate supports the fulfillment of the psychological needs of employees and limits instances of discrimination within the group [49]. It encourages proactive behaviors and improves the visibility of team members. A psychological safety climate is a vital factor in fostering perceived workplace inclusion [46]. It helps group members feel that they are treated fairly, recognized individually, and have access to the necessary resources, while also feeling included. This environment strengthens interpersonal relationships within the team, creating a stronger sense of belonging. Moreover, when individuals feel safe to express their unique views without fear of reprisal, it balances their need for both belonging and uniqueness [46, 50]. Increased trust and acceptance among team members naturally amplify feelings of inclusion. As a result, individuals who feel included tend to experience greater job satisfaction [4, 5], leading to enhanced performance and improved quality of care.

Proposition 4: A psychological safety climate promotes a sense of inclusion within the workgroup, which in turn enhances the quality of care provided by healthcare teams.

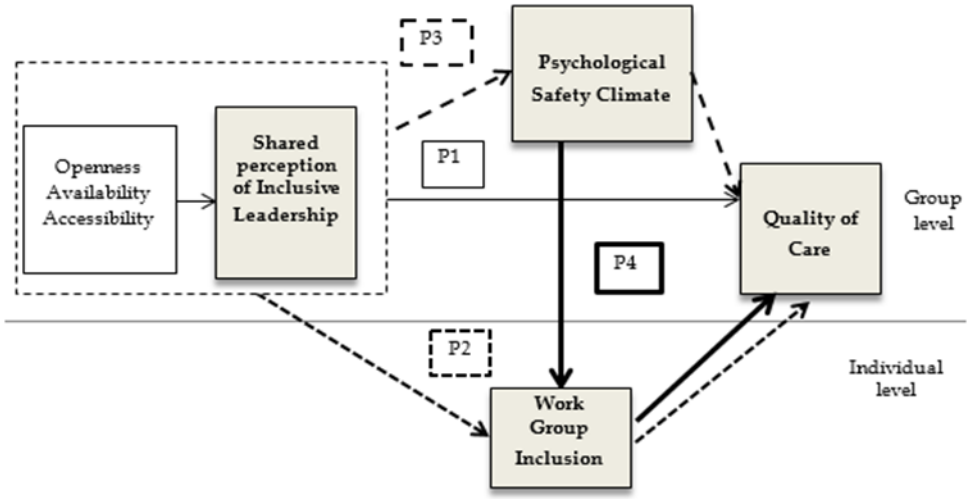

Figure 1. Multilevel impacts of inclusive leadership on healthcare quality of care in functionally diverse teams.

In response to the call by numerous scholars (e.g., Sfantou *et al.* [11]; Rosen *et al.* [12]; Smith *et al.* [13]; Fojlaley *et al.* [51]) for further research to explore leadership behaviors in the unique context of functionally or multidisciplinary diverse healthcare workgroups to enhance care quality, this paper argues that subgroup categorization is a dominant factor that reduces the benefits of integrating diverse perspectives in healthcare teams. To address this, it suggests that a shared perception of inclusive leadership is necessary to diminish subgroup categorization by promoting inclusion and creating a climate of psychological safety.

Theoretical implications

The study makes a valuable contribution to the ongoing discussion on leadership and diversity by identifying key diversity-driven processes within multidisciplinary healthcare teams [15]. It further argues that subgroup categorization is particularly prominent in healthcare settings and introduces a theoretically grounded model that explores how a shared perception of inclusive leadership can strengthen communication and interpersonal relationships within diverse healthcare teams, ultimately improving care quality. Additionally, the proposed framework enriches the theory of quality of care by specifying its antecedents and conceptualizing psychological safety climate as a determinant of the perception of inclusion, shedding light on the factors influencing care quality.

Practical implications

The model presented in this study demonstrates that a shared perception of inclusive leadership can enhance the performance outcomes of healthcare teams, particularly in complex and dynamic environments. It provides leaders with a framework for reducing subgroup categorization by cultivating an atmosphere that encourages interpersonal risk-taking and promotes problem-solving during care delivery. Additionally, this model highlights the importance of fostering a supportive work

environment by enhancing the perception of inclusion among team members. It offers guidance to leaders on how to develop and sustain strong relationships with their teams through openness, accessibility, and availability, ultimately contributing to the improvement of care quality even in resource-constrained settings.

Research implications

The proposed model warrants empirical testing through both quantitative and qualitative approaches. Qualitative studies could utilize case study methodology to examine how inclusive leadership influences care quality in various healthcare organizations. Quantitative studies could employ surveys or questionnaires to assess the propositions. Future studies should also explore the role of cultural factors, such as the power-distance orientation of leaders, in shaping leadership behaviors. Additionally, further studies could investigate how organizational characteristics impact the inclusiveness of psychological safety and leadership, as well as the perception of inclusion at both the group and individual levels.

Conclusion

Healthcare organizations often function with multidisciplinary teams in complex and dynamic environments, facing challenges in improving care quality. This creates a need for further research to examine the role of leadership in managing the effects of functional diversity on team processes and outcomes. This research argues that leadership behaviors can form the foundation for a psychological safety climate, fostering a supportive environment where team members feel safe to take interpersonal risks and contribute their unique perspectives to the work process. This, in turn, enhances the overall quality of care provided. The study proposes testable hypotheses and outlines future research directions aimed at understanding the interaction between inclusive leadership, group dynamics, and care quality.

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References

1. Hanawi SA, Saat NZM, Zulkafly M, Hazlenah H, Taibukahn NH, Yoganathan D, et al. Impact of a healthy lifestyle on the psychological well-being of university students. Int J Pharmaceutical Res & Allied Sci. 2020;9(2):1-7.
2. Ren-Zhang L, Chee-Lan L, Hui-Yin Y. The awareness and perception on Antimicrobial Stewardship among healthcare professionals in a tertiary teaching hospital Malaysia. Arch of Pharm Pract. 2020;11(2):50-9.
3. West M, Lyubovnikova J. Why teamwork matters: enabling health care team effectiveness for the delivery of high quality patient care. In: Salas E, Tannenbaum S, Cohen D, Latham G, eds. Developing and enhancing teamwork in organizations. Jossey-Bass: San Francisco; 2013. p. 331-72.
4. Brimhall KC, Mor Barak ME. The critical role of workplace inclusion in fostering innovation, job satisfaction, and quality of care in a diverse human service organization. Hum Serv Organ: Management publisher. 2018;42(5):474-92.
5. Brimhall KC. Inclusion Is Important... But How Do I Include? Examining the Effects of Leader Engagement on Inclusion, Innovation, Job Satisfaction, and Perceived Quality of Care in a Diverse Nonprofit Health Care Organization. Nonprofit Volunt Sect Q. 2019;48(4):716-37.
6. Harrison DA, Klein KJ. 'What's the difference? Diversity constructs as separation, variety, or disparity in organizations. Acad Manag Rev. 2007;32(4):1199-228.
7. Kreps GL. Communication and effective interprofessional health care teams. Int Arch Nurs Health Care. 2016;2(3):051.
8. Zijl ALV, Vermeeren B, Koster F, Steijn B. Interprofessional teamwork in primary care: the effect of functional heterogeneity on performance and the role of leadership. J Interprofessional Care. 2021;35(1):10-20.
9. Gergerich E, Boland D, Scott MA. Hierarchies in interprofessional training. J Interprof Care. 2019;33(5):528-35.
10. Mitchell R, Boyle B, Parker V, Giles M, Chiang V, Joyce P. Managing inclusiveness and diversity in teams: How leader inclusiveness affects performance through status and team identity. Hum Resourc Manag. 2015;54(2):217-39.
11. Sfantou DF, Laliotis A, Patelarou AE, Sifaki-Pistolla D, Matalliotakis M, Patelarou E. Importance of leadership style towards quality of care measures in healthcare settings: a systematic review. Healthcare. 2017;5(4):73.
12. Rosen MA, DiazGranados D, Dietz AS, Benishek LE, Thompson D, Pronovost PJ, et al. Teamwork in healthcare: key discoveries enabling safer, high-quality care. Am Psycho. 2018;73(4):433.

13. Smith T, Fowler-Davis S, Nancarrow S, Ariss SMB, Enderby P. Leadership in interprofessional health and social care teams: a literature review. Leadership in Health Services. 2018;31(4):452-67.
14. Van Knippenberg D, De Dreu CK, Homan AC. Work group diversity and group performance: an integrative model and research agenda. J Appl Psychol. 2004;89(6):1008.
15. Homan AC, Gündemir S, Buengeler C, Van Kleef G. A. Leading diversity: Towards a theory of functional leadership in diverse teams. J Appl Psychology, Advance online Publication [Internet]. 2020;105(10):1101. doi:10. 1037/apl0000482
16. Mitchell R, Boyle B, Parker V, Giles M, Joyce P, Chiang V. Transformation through tension: the moderating impact of negative affect on transformational leadership in teams. Hum Relat. 2014;67(9):1095-121.
17. Nembhard IM, Edmondson AC. Making it safe: the effects of leader inclusiveness and professional status on psychological safety and improvement efforts in health care teams. J Organ Behav. 2006;27(7) 941-66.
18. Dinh JV, Traylor AM, Kilcullen MP, Perez JA, Schweissing EJ, Venkatesh A, et al. Cross-disciplinary care: a systematic review on teamwork processes in health care. Small-Group Res. 2020;51(1):125-66.
19. Greenhalgh T, Peacock R. Effectiveness and efficiency of search methods in systematic reviews of complex evidence: audit of primary sources. BMJ. 2005;331(7524):1064-5.
20. Folkman AK, Tveit B, Sverdrup S. Leadership in interprofessional collaboration in health care. J Multidisciplinary Healthcare. 2019;12: 97-107.
21. Kossaify A, Hleihel W, Lahoud JC. Team-based efforts to improve quality of care, the fundamental role of ethics, and the responsibility of health managers: monitoring and management strategies to enhance teamwork. Pub Health. 2017;153:91-8.
22. Salas E, Zajac S, Marlow SL. Transforming health care one team at a time: ten observations and the trail ahead. Group Organ Manag. 2018;43(3):357-81.
23. McKean EL, Snyderman CH. Leadership driving safety and quality. Otolaryngol Clin North Am. 2019;52(1):11-22.
24. Havig AK, Hollister B. How does leadership influence quality of care? Towards a model of leadership and the organization of work in nursing homes. Ageing Int. 2018;43(3):366-89.
25. Silva JAM, Agreli HF, Harrison R, Peduzzi M, Mininel VA, Xyrichis A. Collective leadership to improve professional practice, healthcare outcomes, and staff well-being. Cochrane Database Syst Rev. 2021;(1).
26. Aufegger L, Shariq O, Bicknell C, Ashrafian H, Darzi A. Can shared leadership enhance clinical team management? A systematic review. Leadersh Health Serv. 2019;32(2):309-35.
27. Ong YH, Koh MYH, Lim WS. Shared leadership in interprofessional teams: beyond team characteristics to team conditions. J Inter Professional Care. 2020;34(4):444-52.
28. Swani J, Isherwood P. The approachable team leader: front line perspectives on leadership in critical care. J Patient Saf Risk Manag. 2020;25(1):29-34.
29. Hirak R, Peng AC, Carmeli A, Schaubroeck JM. Linking leader inclusiveness to work unit performance: the importance of psychological safety and learning from failures. Leadership Q. 2012;23(1):107-17.
30. West MA, Lyubovnikova J, Eckert R, Denis JL. Collective leadership for cultures of high quality health care. J Organ Eff People Perf. 2014;1:240-60.
31. Aranzamendez G, James D, Toms R. Finding antecedents of psychological safety: a step toward quality improvement. Nursing Forum. 2015;50(3):171-8.
32. Koopmans L, Damen N, Wagner C. Does diverse staff and skill mix of teams impact quality of care in long-term elderly health care? An exploratory case study. BMC Health Serv Res. 2018;18(1):988.
33. Shore LM, Cleveland JN, Sanchez D. Inclusive workplaces: a review and model. Hum Resour Manag Rev. 2018;28(2):176-89.
34. Randel AE, Galvin BM, Shore LM, Ehrhart KH, Chung BG, Dean MA et al. Inclusive leadership: realizing positive outcomes through belongingness and being valued for uniqueness. Hum Resource Manag Rev. 2018;28(2):190-203.
35. Ferdman BM. The practice of inclusion in diverse organizations. In: Ferdman BM, Deane BR, eds. In Diversity at work: the practice of inclusion San Francisco. CA: Jossey-Bass; 2014. p. 3-54.
36. Carmeli A, Reiter-Palmon R, Ziv E. Inclusive leadership and employee involvement in creative tasks in the workplace: The mediating role of psychological safety. Creat Res J. 2010;22(3):250-60.
37. Bradley EH. Diversity, inclusive leadership, and health outcomes. Int J Health Policy Manag. 2020;9(7):266-8.
38. Armstrong JH. Leadership and team-based care. AMA J Ethics. 2013;13(6):534-7.
39. Nieuwboer MS, Van der Sande R, Van der Marck MA. Olde Rikkert MG, Perry M. Clinical leadership and integrated primary care: a systematic literature review. Eur J Gen Pract. 2019;25(1):7-18.
40. Orchard C, Rykhoff M. Collaborative leadership within interprofessional practice. In: Forman D, Jones M, Thistlewaite J, eds. Leadership and collaboration: further developments for interprofessional education. New York: Palgrave Macmillan; 2015. p. 71-94.

41. Forsyth C, Mason B. Shared leadership and group identification in healthcare: the leadership beliefs of clinicians working in interprofessional teams. J Interprof Care. 2017;31(3):291-9.
42. Smith T, Fowler Davis S, Nancarrow S, Ariss S, Enderby P. Towards a theoretical framework for integrated team leadership (IgTL). J Interprof Care. 2020;34(6):726-36.
43. Dansereau F, Alutto J, Yammarino F. Theory testing in organizational behavior: the variant approach. Englewood Cliffs. NJ: Prentice-Hall; 1984.
44. Salancik GR, Pfeffer J. A social information processing approach to job attitudes and task design. Adm Sci Q. 1978;23(2):224-53.
45. Algarni EH A. Extraction of natural pigments from food-industrial waste and their use in the manufacture of jelly candy for a child. World J Environ Biosci. 2020;9(4-2020):33-40.
46. Shore LM, Randel AE, Chung BG, Dean MA, Ehrhart KH, Singh G. Inclusion and diversity in work groups: a review and model for future research. J Manag. 2012;37(4):1262-89.
47. Appelbaum NP, Dow A, Mazmanian PE, Jundt DK, Appelbaum EN. The effects of power, leadership, and psychological safety on resident event reporting. Med Educ. 2016;50(3):343-50.
48. O'Donovan R, Ward M, De Brún A, Mc Auliffe E. Safety culture in health care teams: a narrative review of the literature. J Nurs Manag. 2019;27(5):871-83.
49. McLinton SS, Dollard MF, Tuckey MR. New perspectives on psychosocial safety climate in healthcare: a mixed methods approach. Saf Sci. 2018;109:236-45.
50. Chung BG, Ehrhart KH, Shore LM, Randel AE, Dean MA, Kedharnath U. Workgroup inclusion: a test of a scale and model. Group Organ Manag. 2020;45(1):75-102.
51. Fojlaley M, Kalkan F, Ranji A. Drying process of garlic and allicin potential-a review. World J Environ Biosci. 2020;9(4-2020):50-4.