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Informal Leadership in the Clinical Setting: Occupational Therapist Perspectives

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Abstract

Background: Leadership is vital to clinical, organizational, and professional success. This has compelled a high volume of research primarily related to formal leadership concepts. However, as organizations flatten, eliminate departmental structures, or decentralize leadership structures the relevance of informal leaders has markedly enhanced.

Methods: Using a qualitative phenomenological methodology consistent with interpretative phenomenological analysis, this study examines the impact of informal leadership in the clinical setting for occupational therapists. Data was collected through the completion of semi-structured interviews with 10 peer-identified informal occupational therapy leaders in Ontario, Canada. Collected data was transcribed verbatim and coded for themes by multiple coders. Several methods were employed to support trustworthiness.

Results: The results identify that informal leaders are collaborative, accessible, and considered the “go to” staff. They demonstrate professional competence knowledge, experience, and accountability and are inspirational and creative. Practically, informal leaders organically shape the practice environment while building strength and capacity among their peers.

Conclusion: Recommendations for supporting informal leaders include acknowledgement of the role and its centrality, enabling informal leaders time to undertake the role, and supporting consideration of informal leadership concepts at the curriculum and professional level.

Comments

The authors have no conflicts of interest to disclose.

Keywords

leadership, occupational therapy, qualitative method

Cover Page Footnote

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Credentials Display

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Strong leadership is the oil in the engine of an organizational machine; it is vital for a smooth ride. Leaders prepare organizations for change and help them to cope with the related challenges (Kotter, 2001; Maxwell, 2011). This centrality to organizational success has compelled a high volume of scholarly analysis on leadership concepts. Typically, this work has focused on traditional and more formal concepts of leadership involving conferred authority and title (Day, Fleenor, Atwater, Sturm, & McKee, 2014; Dinh et al., 2014). Practically, the leaders studied in this type of work would be referred to as formal leaders. Perhaps not surprisingly, leadership research in health care has largely mirrored this focus on the more formally defined and titled leaders (Brown, Williams, & Jolliffe, 2014; Heard, 2014; Wong & Laschinger, 2013). While formal leadership has compelled significant and ongoing scholarly attention, it appears that shifts in workplace environments and cultures are influencing the centrality of new approaches. Specifically, as the modern work environment evolves and becomes flatter and with formal leadership more organizationally distributed and less directly accessible, an enhanced autonomy is expected of employees (Avolio, Walumbwa, & Weber, 2009; Martin & Waring, 2013; Smart, 2005). This new autonomy frequently enables or requires decision-making, influence, and enhanced responsibility for many individuals who may not be formally titled leaders (Lawson, 2016; Ross, 2014). A different kind of accountability is, accordingly, required and a culture of informal leadership that emphasizes collaboration and communication evolves. These individuals do not possess authoritative power like their more formally titled counterparts; however, they play a key role in enabling, influencing, and guiding others in the work environment (Zhang, Waldman, & Wang, 2012).

Literature Review

Over the past several decades there has been significant attention paid to enhancing health care quality while concurrently minimizing costs (Healthcare Financial Management Association, 2012; Robinson et al., 2014; VanLare & Conway, 2012). One strategy that has been broadly employed in working to meet these targets has involved decentralizing leadership (Kim et al., 2014; Meier, 2015). In many facilities, this has meant a move from centralized and hierarchical departmental structures for occupational therapists to more decentralized program-based assignments for clinicians (Salvatori, Simonavicius, Moore, Rimmer, & Patterson, 2008). Smart (2005) refers to this type of change as creating “flatter” organizational leadership (p. 120). While such approaches can reduce or eliminate departmental leadership costs, the impacts involve less direct or less immediate access to formal professional leadership and support (Rappolt, Mitra, & Murphy, 2002). With access to formal professional leadership more limited, the potential influence of informal leaders in clinical settings is markedly enhanced (Downey, Parslow, & Smart, 2011).

To date, the study of informal leadership concepts in the health care professions has been limited (Chávez & Yoder, 2014; Lawson, 2016; Ross, 2014). The occupational therapy context reflects this trend, and leadership research in the profession has almost exclusively focused on formal leadership and related leadership behaviors (Braveman, 2016; Dillon, 2001; Fleming-Castaldy & Patro, 2012; Heard, 2014; Snodgrass, Douthitt, Ellis, Wade, & Plemons, 2008). While informal leadership has not been a focus of significant academic consideration in the health care milieu, its practical implications, particularly for occupational therapists, appear significant (Downey et al., 2011; Gabel, 2014).

Method

Design

This study employed a qualitative research method consistent with Interpretive Phenomenological Analysis (IPA) to explore the research question: What is the meaning of participation

in the role of informal leadership in occupational therapy practice (Smith, Flowers, & Larkin, 2009)? A phenomenological approach appeared reasonable as the study focused on exploring the unique meaning and experience of the participants (Creswell, 2009). In further considering the design, Smith (2011) noted that “IPA is concerned with the detailed examination of personal lived experience, the meaning of experience to participants and how participants make sense of that experience” (p. 9). The Western University Research Ethics Board approved this study prior to implementation.

Participants

IPA takes an idiographic approach in understanding phenomena in context: “Given the complexity of most human phenomena, IPA studies usually benefit from a concentrated focus on a small number of cases” (Smith et al., 2009, p. 51). For this study, the researchers recruited participants practicing in both community and hospital settings in a large hospital system in Southwestern, Ontario, Canada. This hospital system employed occupational therapists in both urban and affiliated rural settings across five campuses and in a diverse range of practice areas, including physical health/rehabilitation, specialized mental health, forensic mental health, specialized geriatric care, veterans care, and long-term care. The hospital system also supported the management of seven Assertive Community Treatment teams for community-based mental health also encompassing both urban and rural environments.

In order to identify informal occupational therapy leaders across such a diverse health care organization, we employed a two-stage sampling process. In the first stage, all occupational therapists working in clinical roles across the organization were invited to participate in a brief survey through which they could anonymously identify occupational therapist peers or coworkers who they perceived as informal leaders. All occupational therapists ($n = 99$) employed by the health care organization in direct care provision were contacted regarding potential survey participation. After the participants completed the survey, those who consented were provided the option to either opt-in or opt-out of the second stage of the sampling process: being contacted for a follow-up interview if they were identified by their peers as an informal leader. A convenience sample ($n = 49$) indicated a willingness to participate in the first stage involving survey completion. It is notable that of these participants, four indicated a preference to opt-out of being contacted for potential participation in the second stage of the sampling process.

In the second stage of the sampling process, a follow-up interview, occupational therapists that had been identified as informal leaders by at least three of their peers were contacted for potential interview. In employing an approach that required interview participants to be identified by multiple peers, the potential credibility of the data set was enhanced. At the same time, this approach also supported a reasonable limitation of the total number of interview participants, which is consistent with IPA methodology. An interview sample of 10 ($n = 10$) was established. Demographically, this interview sample ($n = 10$) included 9 women and 1 man. The participants’ mean age was 41.8 years with a range from 29 to 52 years. The participants averaged 16 years of experience and 12.5 years with tenure in their current role. Two participants practiced in mental health and eight practiced in physical health. Three participants worked in community-based care while seven worked in hospital settings. Demographically, the ratio of women and men and mean age were in line with national data for Canada. In area of practice, in-hospital practice for the sample at 70% significantly exceeded the national data (45.6%), while the community practice data at 30% was in line with current national demographic data (Canadian Institute for Health Information, 2011). Variance in hospital employment participation in this

study versus the national norms appears related to formal occupational therapist health care leaders (managers, coordinators), educators, and researchers not being included in the sample.

Data Collection

The occupational therapist coinvestigator supported the completion of the survey component of the sampling process while the principal investigator conducted all follow-up interviews. All survey completion and interview participation was completed in person and at a hospital or in community facilities operated by the health care organization.

All of the interviews occurred during regular therapist working hours. After obtaining consent from each participant, limited demographic data were collected. No identifying data or information linking the research to the participant were included on the interview form. Once informed consent was obtained, a semi-structured interview was conducted using the following three questions:

1. As a peer-identified informal leader in occupational therapy, how would you describe your perceptions of participation in that role?
2. How do you feel that informal leadership influences occupational therapy practice?
3. How do you feel that informal leaders might be best supported or enabled in the occupational therapy profession?

Interview responses were transcribed verbatim immediately following interview completion using word processing software.

Data Analysis

Following data collection, the results from the 10 participants were coded and analyzed. The coding team consisted of the primary investigator (an occupational therapist), a spiritual care professional, and a social worker. The coding process employed an editing style of analysis wherein each independent coder repeatedly analyzed interview text in order to identify meaningful sections and potential themes (Jongbloed, 2000; Krefting, 1991). Following this step, the coding team met to consider each team member's independently developed preliminary codes and to identify potential connections. Thereafter, the coding team identified overarching themes generated from these results (Smith et al., 2009). After completion of the data analysis process, the coding scheme was tested for consistency and each coding team member independently coded one transcript using the overarching themes developed in the coding process. Final coding agreement was found to be 85.03%.

Trustworthiness

The researchers employed several methods in this study to enhance trustworthiness and reduce potential systemic bias. The first was triangulation of data. This involved the collection of data at different times, in different locations and settings, and from varied informers. In working to understand the meaning of the collected data, triangulation by analyst (three health care professionals in the coding team) was also employed. Accordingly, multiple researchers (the coding team) engaged in the coding process. By using multiple researchers from different health care backgrounds (i.e., occupational therapy, social work, and spiritual care) triangulation by theory or perspective was also supported.

Two other methods were employed to further enhance trustworthiness. The first of these involved the collection of informant feedback from several participants. In this process, the final codes were reviewed with these individuals for their feedback. No changes were advised. Doyle (2007) has identified that this type of engagement supports "credibility and the ability for participants to meaningfully contribute to the research process" (p. 894). The second supplemental method employed to enhance trustworthiness involved peer review of the developed codes and related themes by an

experienced qualitative researcher and formal nurse leader employed in the health care organization. Hammell and Carpenter (2000) have noted that this type of peer review supports “a further instance of triangulation” (p. 111).

Results

The coding team identified several unique overarching themes for each interview question (see Table 1).

Table 1

Overarching Themes

Question	Overarching Themes
1. As a peer-identified informal leader in occupational therapy, how would you describe your perceptions of participation in that role?	<ul style="list-style-type: none"> ● Informal leaders are accessible and demonstrate professional competence, knowledge, experience, and accountability ● The experience of informal leadership is both assertive and receptive ● Informal leaders work collaboratively; they are perceived as “go to” staff
2. How do you feel that informal leadership influences occupational therapy practice?	<ul style="list-style-type: none"> ● Informal leaders organically shape and define practice as supportive mentors, coaches, and educators ● Informal leaders are inspirational and creative in building strength and capacity
3. How do you feel that informal leaders might be best supported or enabled in the occupational therapy profession?	<ul style="list-style-type: none"> ● Informal leaders are validated by having the freedom to realize their vision ● Acknowledgement of informal leaders’ unique contribution by organizations enables and supports that role participation ● The provision of time and opportunity to connect with peers is key

Question 1: The Role of Informal Leaders

Data analysis identified three interrelated overarching themes that describe participation in the role of informal leader. The first theme noted that informal leaders are accessible and demonstrate professional competence, knowledge, experience, and accountability. The importance of this accessibility was highlighted in the participants’ responses. A common understanding about accessibility was “someone available to be approached with questions” (Participant 6). Aside from the accountability that comes with being accessible, the participants identified the need to demonstrate professional competence, knowledge, experience, and accountability. Several of the participants voiced that their professional experience contributed to their role as an informal leader; one noted: “Because I’ve worked on a variety of areas around here, colleagues would approach me with certain questions about OT” (Participant 2). Another posited: “I think part of it is also that I had a role that involved acting in a bit more of a formally recognized leader in the past, so other OTs had the opportunity to reach out to me and work with me in that role as a leader” (Participant 10).

A second overarching theme was that the experience of informal leadership is both assertive and receptive. Several of the participants indicated that they believed that they were identified as informal leaders because they often took initiative in various contexts. One noted: “I’d guess because I’m okay to speak up for clients and [for] more efficient protocol” (Participant 3). Another indicated: “I’ll speak for the group, that happens a lot. When it comes to a meeting, I’ll speak up and professionally and respectfully speak up for what the group has in mind” (Participant 5). Of interest is that one participant simply described a receptiveness to discussion, noting: “I talk a lot, it just ends up being a lot of discussion . . . there is a lot of conversation” (Participant 1). The participants also spoke about how they are open and receptive to their colleagues’ questions: “A lot of times when people have questions they come [and ask] who should I ask questions, what should I do next?” (Participant 4).

A third overarching theme identified that informal leaders work collaboratively but, more powerfully, that they are perceived as “go to” staff. When issues or uncertainties emerge in practice, clinicians often seek out guidance from their most trusted and available peers. This reality was expressed several times in participant responses. One stated: “I think when issues like that come up, people come to me because they know I’ll take it up” (Participant 9). The same participant further explained: “I think it’s my willingness to help out with people that keeps them [occupational therapists] coming back” (Participant 9). Those identified as “go to” individuals also tend to work collaboratively with others and assist in finding a solution. The participants identified how they acted as collaborators by helping their colleagues with questions that come up in practice: “Someone to help with questions occurring for OT’s in the organization” (Participant 6). Finally, the participants talked about how their collaboration in other contexts contributed to their role as informal leaders: “And I think just the role in this program, which has advanced knowledge so I’m often sought out for education and consultation, that would support that role as informal leader” (Participant 10).

Question 2: Informal Leadership Influencing Practice

In considering the relationship between informal leadership and practice, the participants identified a unique and powerful influence. This was described through two related themes. The first identified that informal leaders organically shape and define practice as supportive mentors, coaches, and educators. The second identified that informal leaders are inspirational and creative in building strength and capacity.

The participants identified multiple ways in which informal leaders organically shape and define the practice as supportive mentors, coaches, and educators. One participant described the influence of informal leaders on their experience in transitioning from school to practice, stating: “Coming out of school I felt unprepared, I had a lot of jobs. I was mentored by informal leaders, not constantly going to my professional practice leader” (Participant 6). The participants were more likely to turn to informal leaders than more formally recognized leaders for advice relating to everyday practice. As one participant put it: “From a personal practice I’d say I’m probably influenced more by informal leadership than what I’m required to answer to my boss for” (Participant 1). Many of the participants described informal leaders as helping colleagues work through concerns without the same power relationship dynamics that may be involved between an employee and formal leader. One participant illustrated this by stating: “If they [occupational therapists] didn’t feel safe to come to a manager, etcetera, they come to the leader who will help them diffuse the concern” (Participant 5). Another noted: “A lot of people are afraid of management; a lot of people don’t always have a manager who is supportive and [would] rather talk to a colleague without the same kind of intimidation” (Participant 4).

Beyond the role of mentor, the participants described informal leaders as inspirational or creative in building strength and capacity in the profession. One spoke of informal leaders as creative problem solvers, noting, “I think some of those characteristics would also include creative thinking, problem solving, approachability, someone you can trust, and you know they will keep things confidential” (Participant 10). Other participants identified that when informal leaders speak up they have an impact on the profession: “It may inspire, helps you take control in an ever changing system” (Participant 3). Another noted, relatedly: “Good leaders reflect the profession in a positive light” (Participant 5).

Other participants highlighted how informal leaders strengthen and support the profession: “I think OTs are outstanding informal leaders. I’ve been lucky to have been with OTs who are informal leaders or have that capacity” (Participant 7). Another noted that informal leaders are action oriented: “I think the leaders are the ones who are heard and are the representatives of the practice. No leaders’ practices go silent” (Participant 5). The participants further discussed how occupational therapists use their advocacy skills to promote the profession and to build capacity in individuals: “I feel in OT we’re advocating for things we do. We’re overlapping with some disciplines, we’re explaining to people what we can offer them . . . when you help someone you’re building capacity for that professional, for that therapist, to help them do it on their own” (Participant 9).

Question 3: Supporting Informal Leaders in Occupational Therapy Practice

In considering how to best support or enable informal leaders in occupational therapy, the participants’ responses supported the development of three unique themes. The first of these indicated that informal leaders are validated when they are given the autonomy to realize their vision. The second theme focused on organizational acknowledgement of the unique contribution of informal leaders as an important enabler and support for the role. The final theme highlighted the importance of providing informal leaders with the time and opportunity to connect with their peers.

In supporting informal occupational therapist leaders in practice, the participants highlighted the importance of having the autonomy to realize their vision. Several indicated that they valued the opportunity and time to share their knowledge and vision with others. One participant indicated that “being asked to lecture, share your knowledge, is a good way to support informal leadership” (Participant 2). Another participant spoke of the relevance of creativity in their practice and the value “that freedom to play and tinker and make changes for the team [can have]” (Participant 6). These efforts require more formally recognized leaders to enable the resources to support the informal leader’s vision. This extended, for another participant, to day-to-day practice in supporting clinical peers, as they noted: “I think independence and autonomy with your day is important to enable . . . then I’m free to do, to discuss something [with another OT] that’s bothering them” (Participant 4).

A second overarching theme related to organizational acknowledgement of the unique contribution made by informal leaders. Recognition of their unique efforts in helping others, in teaching, and in mentoring was evident in the participants’ responses. One noted: “Management needs to see the value of it, to identify it as . . . right now the weight is in visits, patients seen. It needs to be valued . . . right now people educate on their lunches” (Participant 5). That same participant stated further on the topic: “if not listened to, there is no incentive . . . [informal leadership] . . . needs to be taken seriously. If not, what will go away is the leadership” (Participant 5). Another participant reflected similarly on the need to value, organizationally, the importance of the role, plainly indicating: “I think it is recognition and recognized time dedicated” (Participant 8). Finally, one participant discussed the relevance of organizational support as a key enabler:

I know that people will choose to step up to the plate when it's on work time. Less will when it goes over. When opportunities come, people around you will make things difficult. As an informal leader, you need to be confident . . . strong enough to work through that. There are lots of people who may want to but can't stand up to that. As an organization, there needs to be better leadership to stop that sort of blocking. (Participant 7)

Beyond autonomy and organizational support, the participants clearly identified that the provision of time and opportunity to connect with peers was central to supporting and enabling informal occupational therapy leaders. One participant noted: "A basic would be giving people the time to have conversations" (Participant 2). Another noted the impacts of such time:

Time is the enabler; [we] need time to [have] creative, brainstorming, informal discussions about things. I think Google has it right, they give staff a day to a day and a half a week to work on their own projects . . . to take a step away from their day-to-day grind and have those brainstorming moments. (Participant 4)

Another participant highlighted the importance of providing time, stating, "as an organization, if they allowed more time you would hear amazing ideas. It takes time. People need the time to think and process ideas. It's been cut, cut, cut over years" (Participant 7). Of note, eight of the 10 participants voiced the relevance of supporting time for informal leadership participation with a focus on connecting, conversation, and discussion of ideas.

Discussion

The results of this qualitative study consider the meaning of participation in the role of informal leader for occupational therapists. The results also provide some insight into those conditions that can support or inhibit informal leaders in the role. The results of the study identified that informal leaders in occupational therapy strongly valued the role and found it professionally important. Indeed, the participants repeatedly identified the relevance of the informal leader as a "go to" team member and often as a more comfortable, safe, and trusted option for peers to consult than more formally recognized leaders. At the same time, the results indicated that clinicians benefited from both the time to participate in their role as informal leader and the recognition from formally recognized leadership of the relevance, importance, and impact of their work in that role.

Maxwell (2011) equates leadership with influence, and it is compelling to capture that narrative in consideration of the results of this study. That is, the peer-identified informal leaders participating in this study quite significantly influence a number of domains in the practice setting. Among those identified by the participants in the interviews were clinical practice, communication with formal leadership, student education, team function, peer mentoring, professional and organizational culture, and innovation. In participating in these roles, informal leaders organically shape and define the practice as mentors, coaches, and educators.

These results appear in line with those in other disciplines where concepts of informal leadership have been considered. In the nursing context, Downey et al. (2011) noted that informal nurse leaders are recognized for "standing up, speaking out, actively listening and creating a safe comfortable environment for others" (p. 519). Lawson (2016) also spoke to the nursing context, noting that "informal leaders are forced to exert influence, not from positional authority granted by a third party, but instead from a position of power granted by their followers" (p. 40). McCallin and McCallin (2009) considered the influence of informal leaders on team function from a physical therapy lens finding them to enhance communication and understanding. Peters and O'Connor (2001), as physicians, offered a

perception that the informal leader “will always shape opinions, decisions, and actions, and, as a result, will have a strong impact” (p. 38).

It is compelling, given the influence of informal leaders as identified in this study and in the related literature, that only limited scholarly attention has been paid to the role. A vast majority of the current leadership scholarship appears to target those who are more formally titled and who lead via an assigned authority. In this study, none of the peer-identified informal leaders had any such assigned authority and yet they were thematically the “go to” staff if there was any concern or issue. Downey et al. (2011) came to a similar conclusion in their analysis of informal leaders in nursing, noting that such individuals pull their teams together and that others “migrate towards them” (p. 518).

The participants in this study spoke about their perceptions of the value of the informal leader role and this seems consistent with analysis by other disciplines in the health care space. External study considering the impact and value of informal leaders has also been considered. In athletics, Crozier, Loughead, and Munroe-Chandler (2013) related the informal leader role as potentially enhancing performance. In the manufacturing context, Neubert (1999) considered the impact of informal leaders on team function and noted: “Informal leadership dispersion (the proportion of informal leaders within the team) was positively related to team members’ perceptions of cohesiveness” (p. 643). Smart (2005) referred to informal leaders as an enabling value creation and competitive advantage.

Although not explicitly stated, key principles of current occupational therapy theory appeared consistent with the participants’ discussion of informal leadership concepts. That is, when the participants in this study captured participation in the informal leader role, it was voiced as impacting persons (fellow occupational therapists, team members, students), environments (health care settings, clinical teams), and occupations (client care, teaching, mentoring, advocating). This is consistent with core occupational therapy theory in the Person-Environment-Occupation Model (Law et al., 1996).

Perhaps more compellingly, the actions undertaken by informal leaders in occupational therapy also appeared consistent with current occupational therapy theory in practice. Specifically, the participants in this study identified that informal leaders in the clinical setting consistently employ those enablement skills that define application of the Canadian Practice Performance Framework (Townsend & Polatajko, 2007). These skills, including adapt, advocate, coach, collaborate, consult, design-build, educate, engage, and specialize define enablement in the clinical relationship. It appears that they may also define elements of informal leadership in practice. Townsend and Polatajko (2007) note that supporting enablement is a collaborative process and one that is attentive to power inequities and diversity and that is charged with visions of possibility for change. This appears to reasonably define the participation of informal occupational therapy leaders in the clinical setting.

While occupational therapy theory appears to potentially influence and possibly support the definition of informal leaders in the clinical setting, it also appears that leadership theory may have similarly informed the participants’ responses. That is, the participants often identified a perception that their own traits and attributes informed their informal leadership participation (Zaccaro, 2007). The concept of trait and attributes as potentially informing leadership participation appears consistent with Heard’s (2014) analysis of more formally titled occupational therapist leaders. This appears a somewhat compelling point in that the formal leaders studied by Heard (2014) purposively chose the path of leadership, whereas the current participants in this study were peer identified. Indeed, it seems that occupational therapists globally participating in leadership tasks may well be significantly informed by trait and attribute concepts (DeRue, Nahrgang, Wellman, & Humphrey, 2011; Zaccaro, 2007).

At a practical level, the participants in this study offered clear instruction on how to best support informal leaders in the profession and in care settings. They spoke to several specific conditions necessary to enable informal leadership participation. First, informal leaders need to be validated by having the freedom to realize their vision. This is notable because vision is often emphasized as a core component of leadership globally and in the occupational therapy profession (Archbald, 2013; Copolillo, Shepherd, Anzalone, & Lane, 2010). It is also consistent with Townsend and Polatajko's (2007) enablement concepts of design-build and specialize. It is compelling that the same concepts that inform macro thinking in leadership similarly inform those who informally participate in more informal leadership roles as a professional task. In both instances, it is about the necessity of having the freedom "to play and tinker and make changes for the team" (Participant 6). Bakker and Demerouti (2008) further speak to this concept of freedom to create in their research related to worker engagement, noting that engaged workers are more creative, productive, and willing to "go the extra mile" (p. 209). This is what informal leaders do.

The participants in this study spoke about concepts of validation in the informal leader role and the necessity of the same. In part, this appeared to speak to concepts of recognition and the need for some organizational acknowledgement of the importance/value of their role. Consistent with this recognition was the provision of performance capital in terms of time supported to enable participation in informal leadership tasks. In this study, the participants noted that informal leadership was not explicitly recognized, nor was time prioritized by their employer and, as such, they were not provided with time to carry out that role. Despite this lack of formally recognized time to undertake informal leadership tasks, the sample participants nonetheless persisted in undertaking the role. Marion, Christiansen, Klar, Schreiber, and Erdener (2016) speak to the importance of "complexity-aware administrators" enabling informal leaders:

By structuring physical facilities that passively encourage interaction (e.g., open work areas with clustered seating), and by organizing schedules, work, and meetings to foster interaction. They use their access to resources and to organizational authority to enable interaction among diverse agents and groups. (p. 257)

It appears that the participants in this study highly value both their participation in the role of informal leader and the potential for outcome achievement in that role. It is also evident from the participants' responses that much of that role participation occurs before or after work, in informal discussions, at lunches, and on an "as needed" basis depending on the personal, clinical, or professional need. While a number of studies (Fransen et al., 2015; Marion et al., 2016; Pielstick, 2000) speak to the value and relevance of informal leadership, it does not yet seem to be supported in provision of time or via recognition metrics and continues both in the literature and in practice to take a second place to more formally defined, titled, and recognized leadership structures.

Implications for Occupational Therapy Practice

Formally titled and recognized occupational therapy leaders can be found in clinics; hospitals; and community care, professional, and academic settings (Braveman, 2016). Each day there are thousands of individuals occupying these roles and enabling professional influence (Heard, 2014). At the same time, a far higher number of occupational therapists are working in similar settings in the role of informal leader. These individuals are the "go to" staff, the problem solvers, the voices of reason, and the shoulders to cry on (Krueger, 2013; Pescosolido, 2001). They support critical thinking, the dissemination of ideas, and innovation in practice. They inform the workplace culture. Despite their

influence and quiet primacy, their presence has been hardly acknowledged in the professional literature. The results of this study offer several implications for occupational therapy practice:

- In order to authentically consider leadership in the profession it is paramount to engage, or at minimum acknowledge, those participating as informal leaders. While formally recognized leaders create policy, informal leaders guide its application and influence. Given these practice implications, it would be reasonable to significantly enhance the focus on informal leadership concepts in both curriculum material and professional guidance and development documentation. The current focus on formally recognized leaders is inadequate and does not speak to the day-to-day realities of the professional milieu.
- Developing or supporting informal leaders is an organic process. It does, however, require the provision of time for conversation and meaningful dialogue. Those who have vision and who create and innovate need the time and autonomy to enable that work. Moorley and Chin (2016) have identified unique roles for social media application in both formal and informal leadership concepts in the nursing profession. It is this type of innovative approach that could support informal leaders and followers in the OT profession, given the constraints that currently surround the role participation.
- The results of this study speak to the centrality of informal leaders across a variety of practice and professional settings. As organizations continue to flatten and decentralize their leadership structures, the relevance of informal leaders will only enhance. In supporting a culture of mentorship in professional practice, occupational therapists can position the profession to be at the fore in not only adjusting but also thriving during this cultural change.

Limitations and Directions for Future Research

While the sample in this study offers demographic correlation with nationally collected data for occupational therapy practice in Canada, it may not be representative of occupational therapists in other locations or jurisdictions (Canadian Institute for Health Information, 2011). Further, the nature of the sampling process across one large health care organization offers some challenges. The first of these relates to occupational therapists who may participate in the role of informal leader but who may have been limited in peer contact due to role or geographic diversity in the practice environment. This may have limited their identification as an informal leader by their peers. A second challenge related to the nature of the sampling process across one large health care organization potentially limiting study generalizability. Given the results of this study, it may be relevant to consider if the same value that this sample voiced regarding the role of informal leadership is consistent.

When using a design consistent with IPA, it is required that the sample be more or less homogeneous. Concepts of bracketing, more traditionally employed in methods of qualitative inquiry, were not used as they are not associated with IPA (Smith et al., 2009). It is important to acknowledge this variance as it describes a fundamental difference among designs consistent with IPA and more traditional phenomenological approaches.

Conclusion

To date, informal leadership has been studied in a variety of contexts and in varied academic fields. It has not, however, received the volume or intensity of scholarly attention of more formal leadership concepts. In health care, and more specifically in the occupational therapy context, study has been limited. In considering the results of this research, it appears that participation in the role of the informal leader in occupational therapy influences practice and the provision of health care significantly.

Further, this study identified a significant influence for informal leadership as an occupational therapy practice informer.

Informal leaders are the “go to” staff and demonstrate a high level of competence, knowledge, and accountability in their work. The findings of this study identify that informal leaders in occupational therapy seem to view themselves more modestly as therapists who are open to discussion and willing to help. While occupational therapist informal leaders are supportive of their peers, they also significantly influence and shape occupational therapy practice. They do this by mentoring students and peers, coaching team members, and sharing knowledge through scholarship and teaching.

To support and enable the emergence and growth of informal leaders in the occupational therapy profession, several factors must be considered. First, informal leaders need to be given the autonomy and time to develop those skills, abilities, research, or innovations that they prioritize. As well, they require an organizational commitment of time to meaningfully connect with their peers. Recognition and acknowledgement of their contributions also supports this role participation. While it appears that informal leaders may offer a particularly unique value to organizations, it seems that they may be somewhat undervalued assets. In the current milieu they are key contributors, but it seems that this work most often occurs at lunches, breaks, before or after work, or on personal time. Taking a long view, it appears that there is a sleeping giant of capacity in occupational therapy informal leadership available to organizations; those that can engage, recognize, and enable these individuals will support enhanced environments for care, research, and education.

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