

Hleb, Katja K.; Schara, Tomaž; Mirvis, Philip H.

Article

Responsible leadership: Strategic versus integrative practices in complex system transformation

Administrative Sciences

Provided in Cooperation with:

MDPI – Multidisciplinary Digital Publishing Institute, Basel

Suggested Citation: Hleb, Katja K.; Schara, Tomaž; Mirvis, Philip H. (2025) : Responsible leadership: Strategic versus integrative practices in complex system transformation, Administrative Sciences, ISSN 2076-3387, MDPI, Basel, Vol. 15, Iss. 4, pp. 1-18, <https://doi.org/10.3390/admsci15040145>

This Version is available at:

<https://hdl.handle.net/10419/321289>

Standard-Nutzungsbedingungen:

Die Dokumente auf EconStor dürfen zu eigenen wissenschaftlichen Zwecken und zum Privatgebrauch gespeichert und kopiert werden.

Sie dürfen die Dokumente nicht für öffentliche oder kommerzielle Zwecke vervielfältigen, öffentlich ausstellen, öffentlich zugänglich machen, vertreiben oder anderweitig nutzen.

Sofern die Verfasser die Dokumente unter Open-Content-Lizenzen (insbesondere CC-Lizenzen) zur Verfügung gestellt haben sollten, gelten abweichend von diesen Nutzungsbedingungen die in der dort genannten Lizenz gewährten Nutzungsrechte.

Terms of use:

Documents in EconStor may be saved and copied for your personal and scholarly purposes.

You are not to copy documents for public or commercial purposes, to exhibit the documents publicly, to make them publicly available on the internet, or to distribute or otherwise use the documents in public.




If the documents have been made available under an Open Content Licence (especially Creative Commons Licences), you may exercise further usage rights as specified in the indicated licence.



<https://creativecommons.org/licenses/by/4.0/>

Article

Responsible Leadership: Strategic Versus Integrative Practices in Complex System Transformation

Katja K. Hleb ^{1,*} , Tomaž Schara ²  and Philip H. Mirvis ³ ¹ School of Business and Economics, University of Ljubljana, 1000 Ljubljana, Slovenia² IEDC Bled School of Management, 4260 Bled, Slovenia³ Babson College, Park, MA 02457, USA

* Correspondence: katja@katjahleb.com

Abstract: Systems of national importance like national health care systems, even if historically and culturally diverse, are today facing similar problems. One way to address them is through responsible leadership orientations and practices that promote complex problem solving and multiple stakeholder relations. Here, we focus on challenges facing leaders in two historically distinct public health care systems, that of the UK (NHS) and the Republic of Slovenia (JZS), in terms of (a) costs versus care; (b) navigating regulations and bureaucracy; and (c) meeting the needs of staff versus patients. Then, we compare how responsible leadership, expressed in the form of the strategist versus integrator orientation of leader, could help to mitigate these problems. Analysing these two forms of responsible leadership, which successively express more mental maturity and practical acumen, illustrates their relative strengths in reconciling multiple economic and social interests, operational challenges, and public concerns in different national health system contexts. This highlights responsible leadership as a means to inform policy making and practice in public health care systems and opens up a vital discussion on the importance of leadership to ensure the human right to a healthy and fulfilling life.

Keywords: national health care system; complex system leadership; responsible leadership; constructive development of mind; health care; public system; policy making



Received: 21 December 2024

Revised: 2 April 2025

Accepted: 4 April 2025

Published: 17 April 2025

Citation: Hleb, K. K., Schara, T., & Mirvis, P. H. (2025). Responsible Leadership: Strategic Versus Integrative Practices in Complex System Transformation. *Administrative Sciences*, 15(4), 145. <https://doi.org/10.3390/admsci15040145>

Copyright: © 2025 by the authors. Licensee MDPI, Basel, Switzerland. This article is an open access article distributed under the terms and conditions of the Creative Commons Attribution (CC BY) license (<https://creativecommons.org/licenses/by/4.0/>).

1. Introduction

Addressing the problems facing national health care systems calls for highly responsible leadership. National health care systems in different nations are facing similar problems in the post-COVID-19 era, including ageing populations, critical shortages of health care professionals, gaps in investment that affect quality and availability, hierarchical and bureaucratic governance, and structures that yield disparities in care, long waiting periods for appointments, and less access to mental health services. Commonly utilised solutions to these problems, like increasing the pool of personnel, improving coordination between segmented health care functions and professionals, and implementing financial, legal, and political reforms, are all necessary, but not sufficient; they do not fully address the leader's everyday dilemmas involving the following: (a) costs versus care; (b) navigating regulations and bureaucracy; and (c) meeting the needs of staff versus patients. Could new types of health care system leadership make a difference?

Theorists have turned their attentions to the post-bureaucratic leadership mindsets and practices needed to address the complex multi-stakeholder problems facing large state and private organisations today (Mirvis, 2020b; Pless, 2023; Waldman et al., 2020). In both business school classrooms and executive offices, there are calls for authentic,

servant, ethical, and/or transformational leadership (Avolio & Gardner, 2005; Brown & Trevino, 2006; Bass & Riggio, 2005). Especially important is responsible leadership, since it takes a relational view of leadership and concerns attention and accountability to multiple stakeholders (Maak & Pless, 2006; Waldman & Siegel, 2008; Waldman et al., 2020). Recent research has highlighted two orientations of responsible leadership: that of the strategist and the integrator, who demonstrate different ways of leading an enterprise (Waldman et al., 2020; Voegtlin et al., 2020; Pless et al., 2012).

Here, we examine conceptually how responsible leadership, as practiced by the strategist versus the integrator, would be operationalised in national health care systems. On a macro scale, health care systems vary in different national, organisational, and socio-political contexts (Mintzberg, 2017; Johnson et al., 2017), but we have found that leaders of national systems in the UK and Slovenia face some common problems and operational dilemmas. Our analyses highlight how a responsible leader as a strategist versus an integrator would likely see and approach these challenges differently and engage in different kinds of problem solving.

We close with recommendations for national health systems with regard to leadership selection and development, system assessments and measurement, changing management, paying attention to quality, preventative maintenance and stress testing, and establishing humble, responsible leadership as a system norm.

2. Comparative Description of National Health Care Systems in the United Kingdom and Republic of Slovenia

The National health care service (NHS) in the United Kingdom (UK) and Javni zdravstveni sistem (JZS), (in English: Public Healthcare System) in the Republic of Slovenia (RS) were established in culturally and economically different societies. The NHS was formed in 1946 in a democratic monarchy with a liberal economy. JZS was formed at the same time after the second world war, but in a one political party republic with a centrally planned economy. JZS has further developed after the transition of the Republic of Slovenia into a democratic, social state with a liberal economy in the nineties of the previous century, becoming a part of the European Union in 2004.

In the NHS, every UK citizen makes a compulsory monthly contribution into public health care insurance, while in JZS, contributions are paid in by all employees, together with their employers. Comparing financial statistics and other statistics shows differences and similarities in the distribution of resources, but no major differences (Eurostat, 2024; OECD, 2023).

In the NHS, there are three groups of services: (a) general practitioner and dental, (b) hospital and specialist, and (c) local health authority. General practitioners give primary medical care to registered persons and are paid by the government on a per capita basis, in addition to having private patients. Hospital and specialist services are provided in government-owned hospitals and other facilities by professionals on government salaries. These are directed by regional authorities' hospital boards (Britannica, 2024). In JZS, by contrast, primary health care is organised into a network of community health care centres in 54 communities that secure funds and govern these centres. These are supplemented with twenty-five hospitals and two university clinical centres founded by the government. Funding for both levels comes from one public insurance company, ZZZS. There is provision for private practices and hospitals.

3. Challenges Facing National Health Care Systems in the United Kingdom and Republic of Slovenia

NHS founding principles are still appropriate today and provide a strong foundation for the future (Crisp et al., 2024). JZS founding principles are declared in the document Resolucija o nacionalnem planu zdravstvenega varstva 2016–2025 »Skupaj za družbo zdravja« (Vlada Republike Slovenije, 2016; ReNPZV16–25). The NHS and JZS are facing a multitude of challenges that are putting significant strain on the two systems. Despite differences in their funding and organisation, both the NHS and JZS face common problems that strain each system:

- a. Workforce shortages result in high levels of stress and burnout and hamper patient care.
- b. Funding and investment face significant gaps, particularly in infrastructure and equipment that affect the quality and availability of care.
- c. Long waiting periods for appointments, treatments, and surgeries, worsened by COVID-19, leading to delays in care and increased patient suffering.
- d. Ageing populations with complex health needs put additional pressure on the national health care systems and require more resources and specialised care.
- e. Mental health services are rising in demand with the availability of these services not keeping pace. Many people are unable to access the support they need in a timely manner.
- f. Wealth inequalities result in significant disparities in health outcomes between different regions and socioeconomic groups and are a crucial address for improving overall public health.
- g. Hierarchical and bureaucratic national health care systems hamper innovation and reduce efficiency, responsiveness, and adaptability.

The overarching problem facing health care leaders is how to best deliver appropriate services to patients with a promised quantity and quality, within the planned for and available budgets. What does responsible leadership theory have to offer national health care systems?¹

4. Responsible Leadership

Responsible leadership (RL) has been advanced to address critical issues in guiding complex, multi-relational, and multilevel organisations (Maak & Pless, 2006; Pless & Maak, 2022; Waldman & Galvin, 2008; Kempster & Carroll, 2021; Waldman et al., 2020; Mirvis, 2020a). Research (Marques et al., 2018; Shi & Ye, 2016; Javed et al., 2024) on the topic finds that roughly half the academic literature concerns its theoretical formulation (Maak & Pless, 2006; Waldman et al., 2020) and the rest is divided among empirical studies with CEOs (Pless & Maak, 2022) and methodological and measurement issues (Voegtlin et al., 2012, 2020).

Maak and Pless (2006) pioneered the definition of RL: *“responsible leadership is value based and thoroughly ethical principle driven relationship between leaders and stakeholders who are connected through a shared sense of meaning and purpose through which they raise one another to higher levels of motivation and commitment for achieving sustainable value creation and social change”*. The relational aspects of responsible leadership are emphasised. The core task of responsible leadership is to build and maintain trustful relationship with heterogeneous, often global stakeholders. A leader’s emotional intelligence and ethics are key. Emotional intelligence includes strong self-regulating capabilities and all forms of empathy (cognitive, behavioural, and emotional). Social abilities, skills, and trust building are the requisites for a responsible leader (Ardelt & Ferrari, 2014).

While many authors connect responsible leadership directly with corporate social responsibility, others take a more independent position. In Waldman et al. (2020), “responsible leadership is an orientation or mindset taken by people in executive level positions towards meeting the needs of a firm’s stakeholder(s). As such, it deals with defining those stakeholder(s), assessing the legitimacy of their claims, and determining how those needs, expectations or interests can and should be best served”.

Academic debates centre around the philosophical roots of core concepts of RL (Ciulla, 2022, p. 21), with a relative emphasis on responsibility, character, virtue, ethics, morality (Pless & Maak, 2022), and its link to supra-organisational relationality (Maak & Pless, 2006; Waldman & Galvin, 2008). Mirvis et al. (2022, pp. 350–354) divide it into four types: traditional (covered in classical leadership literature like Barnard), shareholder-centred, stakeholder-centred, and converging to co-responsibility. Further debate concerns its constituent properties of the mind (Waldman et al., 2017, 2020; Waldman & Galvin, 2008; Pless, 2023; Smith & Lewis, 2011) and its various political and social implications (Pless & Maak, 2022; Kempster et al., 2019; Stahl & Sully de Luque, 2014).

On the practical side, scholars and research have considered the applications of RL to a series of competing tensions: (a) responsibility to the stakeholder vs. shareholder, (b) economic vs. social value, and (c) fiduciary duty vs. social impact, and raised questions about its formulation as being (d) romantic vs. realistic and its use of (e) pseudo vs. authentic properties.

4.1. Responsible Leadership in Health Care-Related Literature

Responsible leadership theory has been widely adopted by scholars and practitioners alike (Pless, 2023). Many have employed a responsible leadership lens to health care systems governance (Batool et al., 2024; Haque, 2021; Molnár et al., 2021; Ogunyemi & Onaga, 2023; Khanam et al., 2024; Seray Özkan et al., 2024; Z. X. Zhang et al., 2023).

For instance, Haque (2021) suggests how organisations should utilise responsible leadership to protect and maintain employee well-being and organisational sustainability, with both having implications for health care policymakers’ initiatives. Z. X. Zhang et al. (2023) demonstrate how a responsible leader in China manages the process of balancing social and economic goals to contribute to the understanding of how a socially responsible firm can improve the health care industry, and contribute to the reform of China’s health care. In turn, Khanam et al. (2024) demonstrate a significant positive association between responsible leadership and organisational justice and a negative association between organisational justice and employee turnover intention in the health care sector. Results additionally confirm the mediating role of organisational justice between responsible leadership and employee turnover intention.

4.2. Two Variants of Responsible Leadership

Scholars have emphasised to various degrees that advanced development of the mind and the capacity to engage in complex thinking, “perform” or tackle paradoxes, operate relationally, behave morally, and take responsibility are all foundational characteristics of responsible leadership (Waldman et al., 2006, 2019, 2020; Maak & Pless, 2006; Y. Zhang et al., 2015; Miron-Spektor et al., 2018; Waldman & Bowen, 2016; Smith & Lewis, 2011).

Waldman et al. (2020) frame responsible leadership in two of its primary manifestations in the “real” world: the strategist and the integrator. Strategist and integrator orientations are proposed outlets of responsible leadership at different levels of sophistication and personal involvement. They differ in their type and quality of thinking, how they handle responsibilities and accountability to shareholders (or governing bodies) versus other stakeholders, in their personal involvement and commitments to social responsibility,

and in the relative emphasis they give to authenticity vs. image building. The two types also seem best suited in different contexts.

Briefly, leaders with a strategic orientation are more apt to be linear thinkers who see themselves as responsible primarily to share owners (or governing bodies in the public sector). Faced with a paradox or dilemma, they turn to the option that is favoured by those in power, causes the least disruption, and/or protects their own interests and position. They will settle for compromise rather than engage with others deeply to find a superordinate solution. They are often “institutionalists” whose sense of ethics and morals are anchored in existing rules and regulations and who respect the “system”. When it comes to CSR or other prosocial activities, they will favour whatever enhances their own image and their institution’s reputation but otherwise lack personal involvement and do not make these activities a high priority. When it comes to relationality, their emphases and social networks are based more so on instrumentality: who has the power, resources, and/or political connections needed to best help me fulfil my responsibilities to share owners (or governing bodies).

Leaders with an integrative orientation are more apt to have a both/and mindset and to see themselves as responsible to the full range of stakeholders inside and external to their organisation. Faced with a paradox or a dilemma, they look for a creative solution and to other’s ideas and influence to do so. As for ethics and morals, they operate in line with universal principles and will “buck the system” for the greater good. They also tend to personally lead CSR and other prosocial efforts for their organisation and strive to be authentic in their leadership overall. As for relationality, their emphases and social networks are more inclusive of all stakeholders and connect to those who will help to develop “win-win” solutions for all concerned.

In sum, both strategists and integrators have a commitment to and demonstrate responsibility and accountability in their leadership, but how they frame responsible leadership and implement it are decidedly different (see Table 1). How would these two types handle leadership in national health systems?

Table 1. Summary of foundational characteristics for strategist and integrator mindsets.

Strategist	Foundational Characteristic	Integrator
Linear either/or mindset	Mind	Both/and mindset
Strategist-specific meaning making		Integrator-specific meaning making
Uncomfortable with paradoxes and gives precedence to past practice or expediency	Handling Paradoxes	Embraces paradoxes and collaborates as needed for a “win-win” resolution
Favours shareholder (or governing body) vs. full range of stakeholders	Accountability	Considers both shareholders and stakeholders
Anchored in acknowledged system or institution of law and governance	Ethics	Anchored in universal law
No personal involvement in CSR efforts, delegates to others	Morals	
Lower concern for authenticity, higher concern for image building	Personal Responsibility	Serves as a role model for CSR and is likely to be personally involved
Instrumental—Whomever serves the prevailing interests	Authenticity vs. Image Building	Higher concern for the authenticity, no concern for image building
Liberal market economies	Relationality	Inclusive—Whomever is needed to serve the common good
	Context	Coordinated economy

Source: own work based on [Waldman et al. \(2020\)](#) and [Maak and Pless \(2006\)](#).

4.3. Applying Responsible Leadership to National Health Care System Leadership

To apply responsible leadership to national health care systems, we look at the foundational characteristics of RL in the context of their core application to leadership and their

operational application in a sample of three selected health care challenges in the national health care systems of the UK and RS.

We define an umbrella issue and three sub-issues as being cumulative listed problems of both national health care systems (a–g). In summary, a core pending issue of governance and responsibility in both national health care systems is that the two systems as a whole do not function adequately. Most of the urgent sub-pending issues of governance and responsibility, in both the NHS and JZS alike, are summarised as follows:

Sub-Issue 1: cost vs. care

Despite recent increases in funding in the NHS and a constant substantial proportion of GDP dedicated for health care in JZS, there are still gaps in investment, particularly in infrastructure and medical equipment. JZS also does not cover all the needs of the system. The quality and availability of care are affected.

Sub-Issue 2: dealing with rules, regulations, and bureaucracy

(A) Ageing populations with complex health needs and co-morbidities, (B) inequalities and disparities in health outcomes between different regions and socioeconomic groups, and (C) the hierarchical and bureaucratic nature of the respective national health care systems and obstacles to innovation, efficiency, responsiveness, and adaptability are key regulatory and bureaucratic issues.

Sub-Issue 3: meeting the needs of staff vs. patients

(A) The critical shortage of health care professionals is exacerbated by high levels of burnout and stress among existing staff. The expensive, liberalised labour market of doctors and medical staff in the EU is more of an RS problem. (B) Long waiting periods for appointments, treatments, and surgeries result in delays in care and prolonged patient suffering or even the worsening of the condition. Backlog is worsened after COVID-19. (C) Mental health care services are in high demand, and are insufficient in supply.

In what follows, we approach and address each of the three summarised sub-issues separately through the lens of responsible leadership. We offer examples that work with the three separate sub-issues and illustrate the takes of both responsible leadership orientations, the strategist and the integrator, on them.

4.4. The Responsible Leadership Mindset

The strategist mindset approaches complex problems in a partial fashion. As such, it focuses on a limited number of problems and their probable relatedness and tries to address those in linear fashion, while not addressing the issue as a whole or systemically. Such a mindset is focused on a narrowed, self-authored view and is informed predominantly by a singular domain and/or singular stance.

Sub-issue 1. Focuses, for example, on funding and investments and tries to mitigate the two for the purposes of solvent financial management, isolated from the realistic health-related needs of the population.

Sub-issue 2. Has singular views which are administration-driven and leave behind the assumed core purpose of the health care system, that is, the health of people subscribing to that given system. It is capacity-driven and not patient-requirement-driven (market-driven vs. patient-driven).

Sub-issue 3. Focuses on workforce shortages and ageing populations and tries to mitigate this one outcome, isolated from organisational properties, politics, or financial agreements.

By contrast, the integrator mindset approaches problems in a complex manner. It brings together and harmonises the needs of diverse stakeholders that seemingly contradict. It can deal with paradoxical tensions. As such, it focuses on meta problems and systemic views. Such a mindset applies a widened, (self) transformative view. Any comprehensive

number of issues are understood in line with complexity theory. The nonlinear dependency between boundary conditions and content is acknowledged. Such a view represents an integrator mindset.

Sub-issue 1. Focuses on funding and investments and tries to mitigate the two for the purposes of solvent financial management while first and foremost serving the realistic health-related needs of the population.

Sub-issue 2. Views the system as a whole, and is driven and led by an assumed core purpose of a health care system—that being the health of the people subscribing to that given system. Systemic solutions become a cane to a governing policy that is in service of actual health requirements in individual patients.

Sub-issue 3. Workforce shortages and the ageing population are juxtaposed in spite of high levels of discomfort and tension, until a meta solution is found, accepted, and applied. Such a solution distributes rights and responsibilities, in a manner which makes sense and is wise, among all stakeholders and adjusts to “what is” vs. “what should be”. As such, the integral approach does not isolate itself from organisational demands, politics, or financial agreements, but offers itself as a solution-seeking partner.

4.5. *Performing Paradox*

Strategists seek to resolve paradoxes by favouring the “side” most in line with past precedent and institutional traditions and interests. The stakeholder map is not developed. One or two stakeholders are picked in line with personal interests, proximity, pressure, or understanding. All the rest of the stakeholders are left out, deliberately or due to a lack of systemic knowledge, or are even seen as contradictory beneficiaries. The chosen stakeholders’ position is exaggerated and their possibly biased approach renders these more prominent than they would be in a wholesome mapping.

Sub-issue 1. Industry-specific pressures for the position on health care funding and budget, like digital, pharmaceutical, other medical material and equipment, education, food and beverages, etc., with a low ROI for basic units of care, hence, the patient. The strategist on-look can incorporate the interests of one group, while ignoring or opposing the interests of another equally important group.

Sub-issue 2. Intergenerational conflict, based on survival instinct, is left to be mitigated and shouldered by public policy and regulation. The strategic orientation leans in favour of one or the other and is short of the capacity to look for and eventually find a meta solution.

Sub-issue 3. The main characters of the health care story, the patient and the health care professional exhausted by the demands of the system in general, are both iron cuffed within it. The system is involuntarily co-dependent and in coalition with other governmental structures. A power play between basic two units is triggered due to the lack of preventive management. The status quo involves turning away, in hopes for the issue to solve itself.

Integrators are more comfortable with paradoxes or a dilemma and face them head on. No stakeholder’s position is exaggerated, and biases are actively brought to light and addressed. The stakeholder map is developed and all valid stakeholders are named, regardless of personal interest, proximity, pressure, understanding, or potential benefits (wholesome mapping). A both/and view is adopted. These responsible leaders look for creative “win-win” solutions.

Sub-issue 1. Industry-specific press for a position on health care funding and budget, like digital, pharmaceutical, other medical material and equipment, education, food and beverages, etc., with a low ROI for the basic unit of care, hence, the patient is addressed and withstood. The interests of all important groups are cross-negotiated to achieve a high ROI for the basic unit of care, hence, the patient outcome.

Sub-issue 2. Intergenerational conflict based on survival instincts is shared and shouldered by all relevant stakeholders, first and foremost, the juxtaposed interests of youth vs. age. Public policy and regulation is a mediating partner and a carrier of this process. An integrative orientation refuses to lean in favour of one or the other but leans into the process until a meta solution is found. Intergenerational cohabitation is the aim.

Sub-issue 3. The main characters of the health care story, the patient and the health care professional, are centre stage in an independent, value-driven sub-system of society. All involuntary co-dependency with other sub-systems is denied and as such enjoys the full support of governmental structures.

4.6. Accountability

Strategists tend to favour traditional interests (share owners or governing bodies and enlisted others) when in line with their institutional interests, pressure, or strategic advantages.

Sub-issue 1. A strategic on-look avails itself to certain stakeholders and not to others. For example, some technology providers have leeway into a partnering conversation and can count on agreements being made; however, another beneficiary, for example, a new unit builder contractor, cannot rely on agreements being made. Both are at the expense of better care for a final user.

Sub-issue 2. Some areas with better local management achieve better care, and others lacking quality in local management are lagging behind. Meta management, at the level of the state, is accountable to some but not equally to others.

Sub-issue 3. Physical illness is attended to and mental care is lagging behind due to less assertiveness or the lack of a comprehensive presentation of needs in the system as a whole.

Contrariwise, all relevant stakeholders can count on an integrator being accountable. Stakeholders are enveloped in a holistic point of view.

Sub-issue 1. An integral on-look envisions the systemic collaboration of all needed stakeholders for the system to be sustainable and in service of its main purpose—that being optimal care for a final user, hence a patient.

Sub-issue 2. Meta management, at the level of the state, is accountable to all.

Sub-issue 3. Mental health care is recognised as an area requiring attention in the wholesome design of health management and is seen as potentially rendering leverage in mitigating physical illness or harm, and as such, is a potential final cost cutter.

4.7. Personal Responsibility

Personal responsibility is not assumed by strategists; instead, it is delegated to others, or if problems are blamed upon the leader, to people above, people below, the system, or changes in policies; in short, to an external source, out of reach or not within managing power.

Sub-issue 1. Throwing a ball into another team's court; quality is not there due to a lack of facilities, facilities are not there because of a lack of funding, funding is not there due to insufficient contributions, and contribution is not sufficient due to excessive sick leave. Solving problems per partes.

Sub-issue 2. Delegation of power is withheld due to a lack of management skills in governing more sovereign and better schooled subordinates or distant subsidiaries with more granted autonomy.

Sub-issue 3. The relationship between patients and health care professionals is bubbled and left to its respective (rendering or dismissive) power dynamics, irrespective of admin-

istrative or financial management, quality control, or policy forming leverages, which are all left out of the equation.

Personal responsibility is assumed, managed, and not delegated by the integrator who serves as a role model for systemic (organisational and social) responsibility and is likely to be personally involved.

Sub-issue 1. Collaborative effort between relevant stakeholders is recognised and actively promoted, along with self-involvement and role modelling.

Sub-issue 2. Delegation of power is distributed in line with the mastered management skills needed for governing more sovereign and better schooled subordinates or distant subsidiaries with more granted autonomy.

Sub-issue 3. The relationship between patients and health care professionals is uncompromised but embedded in the system as a whole, respective of administrative or financial management, quality control, and policy forming leverages. Power issues are openly addressed in a developmental dialogue.

4.8. *Ethics and Morals*

Strategists take a calculated approach to ethical and moral concerns in health care delivery. They may defer to established policies and guidelines even when these seem to violate the Hippocratic Oath or go against their inner ethical standards. This is a big internal strain that is profession specific and, if not addressed with enough altitude, leads to internal turmoil and confusion.

Sub-issue 1. Pressing issues of applying standards that are investment-friendly and not in line with robust medical doctrines and ethics, but are rather backed up with current legislation, are not questioned, withstood, or refuted.

Sub-issue 2. Ethically sensitive and value-laden conversations of two-way intergenerational solidarity are not brought to the open and faced but are dealt with in a compromising manner and with “from behind closed doors” solutions.

Sub-issue 3. The standard of “doing good to oneself while doing good to others” is ignored and the potential sensitivity to guilt and the shaming of health care professionals is exploited. Boundaries are not communicated in an open, mature, and potentially difficult dialogue but are dealt with in a two-faced, passive aggressive, or self-destructive manner.

Ethical and moral concerns are paramount to the integrator who is prepared, when necessary, to “challenge” the system in line with universal laws.

Sub-issue 1. Pressing issues of applying standards that are investment friendly but not in line with robust medical doctrines or backed up with current legislation are thoroughly questioned, and if need be, withstood and refuted, with adjustments in the required legislation.

Sub-issue 2. Ethically sensitive and value-laden conversations of two-way intergenerational solidarity are brought to the open and are faced and dealt with in an honest and transparent manner. Potentially painful solutions for either stakeholder are sympathised with, lessened, or mourned collectively.

Sub-issue 3. The standard of “doing good to oneself while doing good to others” is applied and advocated for. Guilt shaming is refused and openly addressed in a radically honest manner. Boundaries are communicated in an open, mature, and potentially difficult dialogue and are properly negotiated. Difficult conversations are allowed to be had.

4.9. *Authenticity and Image*

In a contest between authenticity and image building, strategists favour whatever enhances their position and reputation. The medical profession has been assigned a high place in society and health care leaders are liable to fall prey to their own introjections or other people’s projections to fit the standard image.

Sub-issue 1. With accentuated care for one's image, simpler means of efficient care can be overlooked.

Sub-issue 2. Strategists care for high socioeconomic status groups and specialisations that carry more prominence and bring higher reputation, better paid work, and consequently a better image in the eye of an average observer. The gap between inequalities and disparities in health outcomes widens.

Sub-issue 3. Mental health care requirements do not foster a good image for an average observer and as such are ignored or pushed aside.

High concerns for image building are on equal fundamental standing with personal authenticity for the integrator who is more apt to withstand the pressures to conform with practices that violate personal value or threaten care.

Sub-issue 1. With concern for one's image left behind, posing no threat to one's identity, simpler means of efficient health care can be applied.

Sub-issue 2. Care for human health as a high standing value in society is a carrier of one's purpose and is an inner compass that renders a robust and integral identity to a health care professional. The gap between inequalities and disparities in health outcomes possibly narrows down due to the more natural distribution of resources.

Sub-issue 3. Mental health care requirements are reframed in their status for an average observer and as such are attended to appropriately. Extra caution is employed in order to avoid replacing neglect with an exaggeration, and placing mental health care as a status symbol or as an excuse for simpler versions of malfunction, like a poor up-bringing or basic personal discipline and maturation. Mental health as a tool for manipulation is strictly avoided.

4.10. Relationality

In forming relations, strategists have their relationships, roles, and values well defined and very carefully protect their boundaries. Well-controlled and self-possessed, believing they need to be "steel rods", they can show no display of weakness. The pursuit of a career or a cause is characterised with a driven, sometimes isolated and self-possessed manner, that shows a lack of need for others. Finality and sureness about holding the "right" theory about how to operate is exhibited, and as such one is possibly closed to, or unable to take in new information. A lot of focus is put on resolving conflicts or contradictions.

Sub-issue 1. The "steel rod" approach prefers to leverage human capability with excessive technological add ons in order to protect oneself from excessive relationality, which is taxing to one's self-authored psychological apparatus.

Sub-issue 2. They are capable of delegation and allow for the allocation of autonomy needed for innovation and adaptability. Collaboration, however, possibly becomes an issue.

Sub-issue 3. Insufficient management of excessive co-dependency between a health care professional and a patient, worsened by the ill condition of the patient, may be taxing to the medical care professional(s).

In forming relations, integral leaders are oriented toward relationships, dynamism, and tensions among systems of decision-making (e.g., relationships between quantitative and qualitative ways of knowing), rather than forcing decisions between one or the other, and they believe such relationships are prior to the systems themselves. These leaders become more tentative and less certain about their theory, seeing that any system of operating is temporary, preliminary, and self-constructed. They tolerate emotional conflict and even plurality within themselves and they return to connectedness (but not to fusion). Everyone's distinctiveness is preserved simultaneously. As such, it creates a context in which these separate identities "interpenetrate".

Sub-issue 1. Favours and can withstand honest, pristine relationality, using their self-transformative psychological apparatus.

Sub-issue 2. Capable of delegation and allows for the allocation of the autonomy needed for innovation and adaptability, and further, for the collaboration with synergic effects and/or significant cost-cutting consequences.

Sub-issue 3. There is sufficient management of excessive co-dependency between a health care professional and a patient, worsened by the ill condition of the patient, that may be taxing to the medical care professional(s). Connection is retained, while fusion is prevented and circumvented.

4.11. *Leading in Context*

Leaders operating in liberal market economies make a strategic commitment to maintain the organisation at all costs, sometimes at the expense of the larger purpose for which the organisation is only a temporary reflection.

Sub-issue 1. Boundaries of medical knowledge are increasingly being set by politics and capital and not by the inherent logic of the medical profession and science (Coburn & Willis, 2000), and if such is allowed, it risks an ultimate undermining of medical knowledge itself.

Sub-issue 2. Longevity, and at the same time a greater risk of co-morbidities, both concerning ageing populations, enter public discourse through bio-medical innovations and open ethical dilemmas, along with visions and utopias for the future society (Malnar et al., 2014).

Sub-issue 3. There is a growing disagreement between medicine and the ruling neoliberal capitalist system in Western societies; medicine is positioned as a modern instrument of social control (Malnar et al., 2014).

By comparison, leaders operating in a coordinated economy have the chance to integrate multiple interests and take responsibility for the system as a whole.

Sub-issue 1. Boundaries of medical knowledge are set by the inherent logic of the medical profession and science, and communication is used to look for meta solutions with politics and capital. Such an approach hedges the risk of an ultimate undermining of robust medical knowledge itself.

Sub-issue 2. Longevity, and at the same time a greater risk of co-morbidities, both concerning ageing populations, are openly discussed, including ethical dilemmas and innovations which make sense vs. those that do not.

Sub-issue 3. Medicine radically decouples itself from politics as an instrument of rulership in any society (Western or otherwise) and refrains itself from being any instrument of social control. It underlines its core purpose, aligned with universal values and historically reinforced acts like the Oath of Hippocrates, constitutional rights, and Les principes de la Croix-Rouge (Pictet, 1955, 1979; Haug, 1993; Melzer, 2016), those being humanity, impartiality, neutrality, independence, nonprofit orientation, unity, and universality.

5. Implications and Discussion

Health care systems are big, complex systems of national importance. We suggest that the key to successfully addressing pending issues of governance and responsibility in national health care systems is not limited to solutions involving more money, health care workers, etc., but to responsible leadership. The strategist orientation is a minimum requirement for sufficient management, and the integrator orientation represents a preferable level of leadership quality. Three important implications of applying responsible leadership as a tool for better policy making in regard to a national health care systems are

(a) hiring leaders, (b) developing leaders, and (c) putting integral responsible leadership into a system.

5.1. Hiring Leaders

Hiring appropriate leaders for a system of national importance is a delicate and in no way trivial matter. A team of experienced and specialised experts is needed in order to properly define (together with existing decision-makers), locate, and assess appropriate candidates. Such candidates are selected on the basis of educational background, previous experience, future aspirations, personal references, and a battery of psychological characteristics (Hill, 2018).

Educational background needs to testify a rigorous and demanding programme, which is not only an indicator of knowledge gained, but also of mental, emotional, and physical discipline, and of the habits required for such work. A university diploma is a minimum requirement, but a specialised MBA, MSc, or PhD are more suitable educational backgrounds. Preferable fields of education relevant for national health care system leadership are of a broad spectrum, and include natural sciences, humanistic studies, law, or economy. An interdisciplinary view is required.

Significant experience in best quality day to day management, including international settings, and preferably more than one line of production or service with appropriate certifications and hands on experience in sub-specialisations, standardisations, and quality regimes are entry-level requirements. Such basic experience has to be upgraded with demonstrable experience and successful leadership in big, complex systems of larger importance impacted by several stakeholders or, alternatively, a long-standing apprenticeship under the leadership of an experienced senior leader, in preparation to be a successor. Favourable, trustworthy, noteworthy, and detailed references shall be presented.

Psychological characteristics shall be measured with robust and standardised psychometrical tools, applying the best practice in such procedures, like expertise, ethics, and strict personal data protection. A battery of psychometrical tools includes personality inventories (like the big five questionnaire, Roccas et al., 2002), occupational interests (like the self-directed search; Holland, 1997), personal values (like Pogačnik, 2002), classical IQ (p.ex. Wechsler, 1955), emotional IQ (Gardner, 1983), moral reasoning (like the moral competence test, Lind, 2013), and meaning-making capacity (like the subject object interview, Lahey et al., 1988). Expected behaviours are anticipated from psychometrical results, references, and personal accounts.

5.2. Developing Leaders

Such leaders usually have a long history of successful participation in classic educational programmes, like post-degree studies, MBA, and specialised programmes, like ISO, EFQM, or similar programmes at internationally recognised institutions, and some form of formal interdisciplinary training. Presumably, there is a list of references to their written works and/or contributions at relevant conferences. Assuming that this is the case, further development of such leaders requires a possible missing skill or competence development, but more importantly, such leaders need to further build their complex leadership capability.

Complex leadership capability is first and foremost obtainable through the very high meaning-making capacity that also renders post-conventional moral development (Kegan, 1982, 1994; Avolio & Scott, 2021; Avolio, 2007; Björkman, 2018; Mc Cauley et al., 2006; Kohlberg, 1969, 1981). Complex leadership capability is usually the biggest gap in the system today. Further development shall offer a space in which broader contexts, stakeholder

logics, and ethical, moral, and virtuous conduct could be explored (Ciulla, 2022, p. 21; Parry & Jackson, 2021, p. 153; Pless, 2023; Avolio et al., 2004).

A worthy concern of business education is to agree to forward a message of benevolence, prudence, and courage (Parry & Jackson, 2021, p. 154). Teaching students about responsible leadership, for example, may balance out the (realistic) message of power, greed, control, and lust with (the romanticism of) charity, benevolence, and prudence. Self-interested behaviour is a learned behaviour and people learn it by studying economics and business. However, even the customers themselves, hence the students of business, yearn to hear more about the purpose (Porter & Kramer, 2011; Parry & Jackson, 2021, p. 154; Kempster, 2022, pp. 103, 105).

Such education is, in our view, obtainable through specialised courses for top executives in small peer circles, like round table discussions (Young, 2022, p. 373) moderated/mediated by experienced and internationally recognised professionals, usually members of academia or high-end senior practitioners.

Leader and leadership development, however, comes with its own issues. Wuffli (2022, p. 74) points out a pace change in our global era that is at odds with the long-term perspective required for systematic leadership development. Since top executives change positions on an average five-year cycle, this simply does not give enough time for serious personal and/or group developmental programmes.

5.3. Organisational Practices to Make Responsible Leadership a Systemic Way of Performing Health Care

We recognise a few important ways of intertwining responsible leadership principles into the daily practices of complex organisations or systems, like national health care systems. The aforementioned selection of able, educated, and experienced people for top positions is paramount. To select internally or externally should not be an overriding issue but should submit itself to the main goal of selecting for competence, knowledge, and expertise. Good quality differences among selected people shall be perceived as challenges as well as opportunities for growth, and should call for the preservation of mutual distinctiveness. Such selection allows for the system to invest all its energy in synergic collaboration and co-operation (Greiner, 1998). At the same time, the system frees itself from internal struggles of incompetency, internal politics, overactive survival instincts in individuals or selected groups, and from an absence of sophistication in organisational culture.

Further development of top people, as well as the systemic development of levels two and three, is a never-ending task, with cycles of more or less intense activity, respectful of its stages. The plateaued stage renders more time for operations, and the activity and progress stage requires substantial investment in development itself. Developmental dynamics within the organisation are a possible source of interpersonal teaching, mentoring, and guiding (Kegan et al., 2016). Such is well advised to be transferred to levels two and three in the organisation, preparing the system as a whole for an organisational developmental shift, when its time is due (Greiner, 1998; Mirvis, 2023).

External assessment on the progress made with established assessment tools applied to all areas that need constant measurement (in well-anticipated predefined periodicals) as a regular business practice helps in adopting appropriate and necessary changes. A delta between the measured and optimal state is to be taken as a sign for operational action, and considered “business as usual”. Improvements as the new norm, through, p.ex., the PDCA (plan do check act) cycle, shall be applied periodically (Shewhart & Deming, 1986; Deming, 1986). From time-to-time, a proactive, voluntary disruption of the system with “out of the box” creative thinking/thinkers should bring the least disruptiveness, and the least taxing adjustments.

To ground our theoretical reasoning in practice, we additionally present a sole personal take on strategist/integrator dilemma and directly quote one of the leaders of such a system. During the course of writing this article, we conversed about the relevance of our theoretical approach in practice. Here is what we obtained:

(Sic!) “If strategist leadership, one still has problems with paradox, conflicts, and ill-positioned interests of illegitimate stakeholders. These are not approachable with a strategist logic. This kind of lack of leadership tools leaves you frustrated to the highest degree. However, when one learns about integral leadership (integral orientation in responsible leadership), one sees this is “business as usual” and one can train oneself to some degree in this direction.

Prior to that you were a self-trained man dependent on trial and error. “Over one’s head” situation makes you nervous to the point of not finding the words, and just cursing. You wait for this storm to pass, and at the other end of this frustration is usually a solution. However, if you do not know of integral way of leading, you get confused and remain frustrated. Because you do know, the frustration slips off of your back”.²

6. Conclusions

National health care systems cater to versatile and multiple needs, with the central theme being providing health care for a patient. We have shown that while health care systems are different across nations, economies, and socio-political contexts, many share the same boundary conditions and common problems.

Responsible leadership theory with its two orientations, strategist and integrator, offers an approach to governing big, complex systems. It presents one answer to dealing with the boundary conditions of national health care systems for enhanced effectiveness, the diminishment of general frustration, and most importantly, the return of its initial function, that of preserving human health.

If the “top” of the organisation deploys and models responsible leadership, it is more likely to flourish throughout the health care system. This is not to be confused with “top-down” leadership. On the contrary, responsible leadership calls for the empowerment of everyone in an organisation and requires the continuous development of leaders in every function and at every level (Wuffli, 2022, p. 62; Farber & Wuffli, 2020; Lord & Hall, 2005; Day et al., 2009, 2014). Regular assessments, training, coaching, and self-development practices must become the new norm.

In its nascent state, the body of work on responsible leadership is obviously sparking huge interest among researchers and practitioners (Pless, 2023; Hodgkinson et al., 2025). Wide and globally spread momentum in responsible leadership research calls for further efforts to consolidate a core definition (Waldman et al., 2020) and accepted measurements (Voegtlin et al., 2012, 2020). Consequently, experimental applications to various settings, including systems of national importance like health care systems, can be executed.

Enveloping national health care systems and responsible leadership, if we are to follow supra-nationally recognised conventions like the Oath of Hippocrates, national constitutions, and Les principes de la Croix-Rouge that protect and preserve human life and human health in any circumstances, the medical system has to hold a sovereign position, independent from other governing systems of national importance. To be able to lead such a system, at its top, integral responsible leadership is paramount. The complexity of meaning making is an important antecedent to responsible leadership which requires theoretical attention, as well as serious consideration in the selection and training of responsible leaders. Carefully selected and well-trained integral responsible leaders are best suited to assure, negotiate, protect, and demand a sovereign position of health protection through national health care systems in any given nation.

Author Contributions: Conceptualisation, K.K.H. and T.S.; Methodology, K.K.H.; Validation, P.H.M.; Formal Analysis, K.K.H.; Resources, K.K.H. and T.S.; Data Curation, K.K.H. and T.S.; Writing—Original Draft Preparation, K.K.H.; Writing—Review & Editing, K.K.H. and P.H.M.; Visualisation, K.K.H.; Supervision, P.H.M.; Project Administration, K.K.H. All authors have read and agreed to the published version of the manuscript.

Funding: This research received no external funding.

Institutional Review Board Statement: Not applicable.

Informed Consent Statement: Not applicable.

Data Availability Statement: Data is contained within the article.

Conflicts of Interest: The authors declare no conflict of interest.

Notes

- ¹ We position an individual as a carrier of an attribute of health as well as a caretaker of one's health. In pursuit of this goal, the individual resorts to nature and health care workers that can help to maintain health and prevent or cure injury and diseases. Health care workers are individuals that can and are willing to deliver such care. This basic unit of a health care relationship is based on the assumption that an individual trusts health care workers and is willing to pay for health-related services. Reciprocally, it assumes that health care workers base their care on relevant knowledge, good care, and values aligned around the preservation and restoration of health under any circumstances. Every human (including all of the health care professionals) is a potential patient; health care workers are significantly lower in number. Thus, in society or a health care system, be it public, private, or both, binding the two parties is established.
- ² Anonymous, Personal Communication to Authors, 29th November 2024.

References

- Ardelt, M., & Ferrari, M. (2014). Wisdom and emotions. In *The Oxford handbook of emotion, social cognition, and problem solving in adulthood*. Oxford University Press.
- Avolio, B. J. (2007). Promoting more integrative strategies for leadership theory-building. *The American Psychologist*, 62(1), 25–33; discussion 43–47. [CrossRef] [PubMed]
- Avolio, B. J., & Gardner, W. L. (2005). Authentic leadership development: Getting to the root of positive forms of leadership. *The Leadership Quarterly*, 16, 315–338. [CrossRef]
- Avolio, B. J., Gardner, W. L., Walumbwa, F. O., Luthans, F., & May, D. R. (2004). Unlocking the mask: A look at the process by which authentic leaders impact follower attitudes and behaviors. *The Leadership Quarterly*, 15(6), 801–823. [CrossRef]
- Avolio, B. J., & Scott, A. (2021). *The Holly Grail of leadership development*. Podcast. 31.5.2021. Practical wisdom for leaders. Available online: <https://ilaglobalnetwork.org/podcasts/the-holy-grail-of-leadership-development/> (accessed on 20 December 2024).
- Bass, B. M., & Riggio, R. E. (2005). *Transformational leadership* (2nd ed.). Psychology Press.
- Batool, S., Ibrahim, H. I., & Adeel, A. (2024). How responsible leadership pays off: Role of organisational identification and organisational culture for creative idea sharing. *Sustainable Technology and Entrepreneurship*, 3(2), 100057. [CrossRef]
- Björkman, T. (2018). *The world we create: From god to market*. Perspectiva Press.
- Britannica. (2024). *National Health Service*. Available online: <https://www.britannica.com/topic/National-Health-Service> (accessed on 7 December 2024).
- Brown, E. M., & Trevino, L. K. (2006). Ethical leadership: A review and future directions. *The Leadership Quarterly*, 17, 595–616. [CrossRef]
- Ciulla, J. B. (2022). Why ethics is at the heart of leadership. In *Responsible Leadership* (2nd ed.). Routledge.
- Coburn, D., & Willis, E. (2000). The medical profession: Knowledge, power, and autonomy. In G. L. Albrecht, R. Fitzpatrick, & S. C. Scrimshaw (Eds.), *The medical profession: Knowledge, power, and autonomy* (pp. 377–393). SAGE Publications Ltd.
- Crisp, N., Bamrah, J. S., Morley, J., Augst, C., & Patel, K. (2024). The NHS founding principles are still appropriate today and provide a strong foundation for the future. *BMJ*, 384, e078903. [CrossRef]
- Day, D. V., Fleenor, J. W., Atwater, L. E., Sturm, R. E., & McKee, R. A. (2014). Advances in leader and leadership development: A review of 25 years of research and theory. *The Leadership Quarterly*, 25(1), 63–82. [CrossRef]
- Day, D. V., Harrison, M. M., & Halpin, S. M. (2009). *An integrative theory of leadership development: Connecting adult development, identity, and expertise*. Psychology Press.
- Deming, W. E. (1986). *Out of the Crisis*. MIT Press.

- Eurostat. (2024). *Healthcare expenditure statistics-overview*. Available online: https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Healthcare_expenditure_statistics_-_overview (accessed on 7 December 2024).
- Farber, V., & Wuffli, P. (2020). *The elea way. A learning journey toward sustainable impact* (1st ed.). Routledge.
- Gardner, H. (1983). *Frames of mind: A theory of multiple intelligences*. Basic Books.
- Greiner, L. E. (1998). Evolution and revolution as organizations grow. *Harvard Business Review*, 76(3), 55–64.
- Haque, A. (2021). The COVID-19 pandemic and the role of responsible leadership in health care: Thinking beyond employee well-being and organisational sustainability. *Leadership in Health Services*, 34(1), 52–68. [CrossRef]
- Haug, H. (1993). *The fundamental principles of the international red cross and red crescent movement*. Henry Dunant Institute. Paul Haupt Publishers.
- Hill, O. (2018). *Mein kompass für strömische zeiten*. Überreuter.
- Hodgkinson, G. P., Gazi, M. A., Hayward, S., & Laasch, O. (2025). Addressing the crises of modern-day capitalism through responsible management: A call for multidomain microfoundations research. *Academy of Management Discoveries*, 11(1), 9–16. [CrossRef]
- Holland, J. L. (1997). *Making vocational choices: A theory of vocational personalities and work environments* (3rd ed.). Psychological Assessment Resources.
- Javed, M., Pless, N., Waldman, D., Maak, T., Garavan, T., Sengupta, A., Gull, A. A., Akhtar, W., & Mouri, N. (2024). What, when, and how of responsible leadership: Taking stock of eighteen years of research and a future agenda. *Journal of Management Studies*. [CrossRef]
- Johnson, J. A., Stoskopf, C. H., & Shi, L. (2017). *Comparative health systems. A global perspective*. Jones & Bartlett Learning.
- Kegan, R. (1982). *The evolving self: Problem and process in human development*. Harvard University Press.
- Kegan, R. (1994). *In over our heads: The mental demands of modern life*. Harvard University Press.
- Kegan, R., Lahey, L., Miller, M. L., Fleming, A., & Helsing, D. (2016). *An everyone's culture: Becoming a deliberately developmental organization*. Harvard Business Review Press.
- Kempster, S. (2022). Responsible leadership and societal purpose. In *Responsible leadership* (2nd ed., pp. 97–116). Routledge.
- Kempster, S., & Carroll, B. (Eds.). (2021). *Responsible leadership. Realism and romanticism* (2nd ed.). Routledge.
- Kempster, S., Maak, T., & Parry, K. (2019). *Good dividends. Responsible leadership of business purpose*. Routledge.
- Khanam, Z., Khan, Z., Arwab, M., & Khan, A. (2024). Assessing the mediating role of organisational justice between the responsible leadership and employee turnover intention in health-care sector. *Leadership in Health Services*, 37(3), 342–358. [CrossRef] [PubMed]
- Kohlberg, L. (1969). Stage and sequence: The cognitive developmental approach to socialisation. In D. Goslin (Ed.), *Handbook of socialisation: Theory and research*. Rand McNally.
- Kohlberg, L. (1981). *The philosophy of moral development: Moral stages and the idea of justice*. Harper & Row.
- Lahey, L., Souvaine, E., Kegan, R., Goodman, R., & Felix, S. (1988). *A guide to the subject-object interview: Its administration and interpretation*. Cambridge.
- Lind, G. (2013). Thirty years of the moral judgment test—Support for the dual-aspect theory of moral development. In C. S. Hutz, & L. K. de Souza (Eds.), *Estudos e pesquisas em psicologia do desenvolvimento e da personalidade: Uma homenagem a Angela Biaggio* (pp. 143–170). Casa do Psicólogo.
- Lord, R. G., & Hall, R. J. (2005). Identity, deep structure and the development of leadership skill. *Leadership Quarterly*, 16, 591–615. [CrossRef]
- Maak, T., & Pless, N. (2006). Responsible leadership in a stakeholder society—A relational perspective. *Journal of Business Ethics*, 66, 99–115. [CrossRef]
- Malnar, B., Ule, M., & Kurdija, S. (2014). *Health and medicine in transition. Edition: Series: Sozialwissenschaften beobachten*. Echoraum.
- Marques, T., Reis, R. N., & Gomes, J. F. S. (2018). Responsible leadership research: A bibliometric review. *Brazilian Administration Review*, 15, e170112. [CrossRef]
- Mc Cauley, L., Drath, W. H., Palus, C. J., O'Connor, P. M., & Baker, B. A. (2006). The use of constructive-developmental theory to advance the understanding of leadership. *The Leadership Quarterly*, 17(6), 634–653. [CrossRef]
- Melzer, N. (2016). *International humanitarian law. A comprehensive introduction*. International Committee of the Red Cross.
- Mintzberg, H. (2017). *Managing the myths of health care*. Berrett-Koehler Publishers, Inc.
- Miron-Spektor, E., Ingram, A., Keller, J., Smith, W., & Lewis, M. W. (2018). Microfoundations of organizational paradox: The problem is how we think about the problem. *Academy of Management Journal*, 61, 26–45. [CrossRef]
- Mirvis, P. H. (2020a). Reflections: US coronavirus crisis management—Learning from failure January–April, 2020. *Journal of Change Management*, 20(4), 283–311. [CrossRef]
- Mirvis, P. H. (2020b). *Responsible global leadership Developing globally responsible leaders* (1st ed.). Routledge.
- Mirvis, P. H. (2023). Renewing the purpose of OD: From sustainability to leading social change. *Organization Development Review*, 54(1).
- Mirvis, P. H., Steenkamp, Y., & De Jongh, D. (2022). Responsible leadership in context. In *Responsible leadership* (2nd ed.). Routledge.

- Molnár, E., Mahmood, A., Ahmad, N., Ikram, A., & Murtaza, S. A. (2021). The interplay between corporate social responsibility at employee level, ethical leadership, quality of work life and employee pro-environmental behavior: The case of healthcare organizations. *International Journal of Environmental Research and Public Health*, 18(9), 4521. [CrossRef]
- OECD. (2023). *OECD data explorer. Health system characteristics survey—2023 round*. Available online: [https://data-explorer.oecd.org/vis?fs\[0\]=Topic,0%7CHealth#HEA#&pg=0&fc=Topic&bp=true&snb=33&df\[ds\]=dsDisseminateFinalDMZ&df\[id\]=DSD_HSCS2023@DF_HSCS2023&df\[ag\]=OECD.ELS.HD&df\[vs\]=1.0&dq=.&to\[TIME\]=false](https://data-explorer.oecd.org/vis?fs[0]=Topic,0%7CHealth#HEA#&pg=0&fc=Topic&bp=true&snb=33&df[ds]=dsDisseminateFinalDMZ&df[id]=DSD_HSCS2023@DF_HSCS2023&df[ag]=OECD.ELS.HD&df[vs]=1.0&dq=.&to[TIME]=false) (accessed on 7 December 2024).
- Ogunyemi, K., & Onaga, A. I. (2023). Responsible leadership for the new normal: Ensuring fairness in business and health. In *Responsible management of shifts in work modes—Values for post pandemic sustainability* (Vol. 2, pp. 1–19). Emerald Publishing Limited.
- Parry, K. W., & Jackson, B. (2021). Promoting responsibility, purpose, and romanticism in business schools. In *Responsible leadership. Romanticism and realism* (pp. 149–162). Routledge.
- Pictet, J. (1955). Les principes de la Croix Rouge, Geneva. *International Review of the Red Cross*, 37(440), 483–513.
- Pictet, J. (1979). *The fundamental principles of the Red Cross. International review of the Red Cross. International review of the Red Cross archive (1961–1997)*. Cambridge University Press. ISSN 0020-8604 (Print), 2059-9218 (Online).
- Pless, N. M. (2023). On the global emergence of responsible leadership: Purpose and social identity. *Emerald Open Research*, 1(11). [CrossRef]
- Pless, N. M., & Maak, T. (2022). *Responsible leadership* (2nd ed.). Routledge.
- Pless, N. M., Maak, T., & Waldman, D. A. (2012). Different approaches toward doing the right thing: Mapping the responsibility orientations of leaders. *Academy of Management Perspectives*, 26(4), 51–65. [CrossRef]
- Pogačnik, V. (2002). Pojmovanje in struktura osebnih vrednot. *Psiholoka Obzorja/Horizons of Psychology*, 11(1), 31–50. [CrossRef]
- Porter, M. E., & Kramer, M. R. (2011). The big idea: Creating shared value. *Harvard Business Review*, 89, 2–17.
- Roccas, S., Sagiv, L., Schwartz, S. H., & Knafo-Noam, A. (2002). The big five personality factors and personal values. *Personality and Social Psychology Bulletin*, 28(6), 789–801. [CrossRef]
- Seray Özkan, O., Üzümlü, B., & Aksoy Kürü, S. (2024). How does responsible leadership affect healthcare professionals' customer-oriented organizational citizenship behaviors? Mediating and moderating effect analysis. *Current Psychology*, 43(17), 15689–15704. [CrossRef]
- Shewhart, W. A., & Deming, W. E. (1986). *Statistical method from the viewpoint of quality control*. Courier Corporation.
- Shi, Y., & Ye, M. (2016). *Responsible leadership: Review and prospects*. School of Management, Jinan University.
- Smith, W. K., & Lewis, M. W. (2011). Toward a theory of paradox: A dynamic equilibrium model of organizing. *Academy of Management Review*, 36, 381–403.
- Stahl, G. K., & Sully de Luque, M. (2014). Antecedents of responsible leader behavior: A research synthesis, conceptual framework, and agenda for future research. *Academy of Management Perspectives*, 28, 235–254. [CrossRef]
- Vlada Republike Slovenije. (2016). *Resolucija o nacionalnem planu zdravstvenega varstva 2016–2025 »Skupaj za družbo zdravja«*; Vlada Republike Slovenije.
- Voegtlin, C., Frisch, C., & Walther, A. (2020). Theoretical development and empirical examination of a three-roles model of responsible leadership. *Journal of Business Ethics*, 167, 411–431. [CrossRef]
- Voegtlin, C., Patzer, M., & Scherer, A. G. (2012). Responsible leadership in global business: A new approach to leadership and its multi-level outcomes. *Journal of Business Ethics*, 105, 1–16. [CrossRef]
- Waldman, D. A., & Bowen, D. E. (2016). Learning to be a paradox-savvy leader. *Academy of Management Perspectives*, 30, 316–327. [CrossRef]
- Waldman, D. A., & Galvin, B. M. (2008). Alternative perspectives of responsible leadership. *Organizational Dynamics*, 37, 327–341. [CrossRef]
- Waldman, D. A., Putnam, L. L., Miron-Spektor, E., & Siegel, D. S. (2019). The role of paradox theory in decision making and management research. *Organizational Behavior and Human Decision Processes*, 155, 1–6. [CrossRef]
- Waldman, D. A., & Siegel, D. (2008). Defining the socially responsible leader. *Leadership Quarterly*, 19, 117–131. [CrossRef]
- Waldman, D. A., Siegel, D. S., & Stahl, G. H. (2020). Defining the socially responsible leader: Revisiting issues in responsible leadership. *Journal of Leadership & Organizational Studies*, 27(1), 5–20.
- Waldman, D. A., Sully de Luque, M., Washburn, N., & House, R. J. (2006). Cultural and leadership predictors of corporate social responsibility values of top management: A globe study of 15 countries. *Journal of International Business Studies*, 37, 823–837. [CrossRef]
- Waldman, D. A., Wang, D., Hannah, S. T., & Balthazard, P. A. (2017). A neurological and ideological perspective of ethical leadership. *Academy of Management Journal*, 60, 1285–1306. [CrossRef]
- Wechsler, D. (1955). *Manual for the wechsler adult intelligence scale*. Psychological Corp.
- Wuffli, P. (2022). Inclusive leadership for our global era. Chapter. In *Responsible leadership* (2nd ed.). Routledge.
- Young, S. B. (2022). Principle based leadership: Lessons from the Caux round table. Chapter. In *Responsible leadership* (2nd ed.). Routledge.

- Zhang, Y., Waldman, D. A., Han, Y., & Li, X. (2015). Paradoxical leader behaviours in people management: Antecedents and consequences. *Academy of Management Journal*, 58, 538–566. [[CrossRef](#)]
- Zhang, Z. X., Yi, X., & Dong, Y. (2023). Taking the path less traveled: How responsible leadership addresses a grand challenge in public health, a case study from China. *Management and Organization Review*, 19(4), 838–855. [[CrossRef](#)]

Disclaimer/Publisher’s Note: The statements, opinions and data contained in all publications are solely those of the individual author(s) and contributor(s) and not of MDPI and/or the editor(s). MDPI and/or the editor(s) disclaim responsibility for any injury to people or property resulting from any ideas, methods, instructions or products referred to in the content.