v1: 18 December 2025

Commentary

When Ambition Overshadows Patients: Reflections on Three Pharmaceutical Leadership Personas and the Role of Integrity

Preprinted: 13 September 2025
Peer-approved: 18 December 2025

Qeios, Vol. 7 (2025)
ISSN: 2632-3834

Alexandros Sagkriotis[1]

1. Independent Consultant in Real-World Evidence and Health Data Science, United Kingdom

Leadership in the pharmaceutical industry shapes not only organisational culture but also the pace of innovation and, ultimately, patient outcomes. This commentary synthesises insights from leadership theory and over three decades of industry experience to examine three recurring leadership archetypes: the Directive Strategist, the Enforcer, and the Corporate Diplomat. While each persona brings strengths—strategic vision, accountability, and external influence—they share common vulnerabilities: an overemphasis on ambition, external image, and personal growth, often at the expense of trust, psychological safety, and integrity.

This commentary extends leadership literature by linking established constructs such as authoritarian leadership, abusive supervision, and impression management to pharmaceutical industry contexts, highlighting how these personas persist despite growing calls for patient-centred leadership. The analysis further integrates interdisciplinary perspectives from healthcare ethics, behavioural economics, and organisational psychology to situate leadership behaviours within broader systems of governance, incentives, and accountability.

Across personas, integrity is frequently applied selectively—what may be termed "convenient integrity"—thereby eroding fairness and organisational resilience. These dynamics manifest in burnout, attrition, and innovation loss, all of which reduce the benefit delivered to patients. A key contribution is the introduction of the "patient score"—a conceptual and potentially empirical framework aligning leadership behaviours with measurable outcomes such as trial efficiency, pharmacovigilance reporting, staff retention, and patient access milestones.

However, the commentary recognises that the "patient score" remains conceptual until empirically tested. Although conceptual, the model invites empirical testing through mixed-methods approaches integrating leadership-behaviour surveys, organisational performance data, and patient-outcome metrics. Future work should outline measurable indicators and validation strategies to evaluate its real-world applicability and strengthen its practical utility across leadership and patient-outcome settings.

 doi.org/10.32388/9QJRD9.5

The commentary argues that sustainable pharmaceutical leadership requires authentic integrity, capability building, and team complementarity. RED-dominant leaders, for instance, are more effective when supported by BLUE (detail-focused) and GREEN (empathic) associates, balancing ambition with precision and harmony. Practical implications now include the development of Integrity Councils and Patient-Centred Dashboards to embed ethical oversight and patient alignment in leadership evaluation systems.
Finally, the paper calls for mixed-methods research—combining qualitative interviews, network analysis, and quantitative performance metrics—to test the "patient score" construct empirically and its relationship to organisational trust and innovation. By combining conceptual reflection with future empirical pathways, the paper bridges theory and practice, reframing leadership success around a single guiding question: do our behaviours increase or decrease the score for patients?

Corresponding Author: Alexandros Sagkriotis, asagkriotis@gmail.com

Introduction

Leadership in the pharmaceutical industry extends beyond technical expertise and hierarchical authority; it is profoundly shaped by the persona that leaders project. Drawing from Jungian theory, the persona represents the "mask" individuals wear in society, allowing them to function effectively but risking rigidity when overemphasised (Jung, 1953)[1]. In organisational contexts, leadership personas can determine how teams operate, how decisions are prioritised, and ultimately how patient needs are addressed.

Building on established leadership research, this commentary identifies three recurring archetypes frequently observed among mid- to high-ranking managers in the pharmaceutical industry: the **Directive Strategist**, the **Enforcer**, and the **Corporate Diplomat**. These labels are interpretive, reflecting patterns synthesised from lived organisational experience, yet they resonate strongly with themes described in the academic literature. For example, the Directive Strategist echoes elements of authoritarian or transactional leadership, where control and decisiveness dominate (Conger & Kanungo, 1994; Einarsen et al., 2007)[2][3]. The Enforcer aligns with concepts of abusive or toxic supervision, in which rigid enforcement undermines psychological safety (Krasikova et al., 2013; Gallus et al., 2013)[4][5]. The Corporate Diplomat reflects behaviours discussed in theories of impression management and political skill, where external visibility and image are emphasised over substance (Goffman, 1959; Alvesson, 2023)[6][7].

While these personas are presented here as interpretive archetypes, they are grounded in established leadership constructs such as destructive leadership, abusive supervision, and impression management. This commentary contributes to the literature by contextualising these behaviours within the pharmaceutical industry, a sector where leadership styles directly influence evidence generation, regulatory trust, and patient access.

These archetypes can energise organisations by driving results, but they also risk undermining psychological safety, trust, and team cohesion when ambition supersedes empathy and fairness. Research on destructive and authoritarian leadership confirms that such styles are associated with increased burnout and attrition, often at rates approaching 50% in healthcare environments (Einarsen

et al., 2007; Krasikova et al., 2013; West et al., 2018)[3][4][8]. Charismatic and politically skilled leaders may achieve rapid organisational gains, yet their long-term sustainability is fragile without grounding in integrity and transparency (Tourish, 2013; Conger & Kanungo, 1994)[9][10].

The theoretical basis for exploring these archetypes draws on multiple perspectives. Stothart (2023)[11] highlights the importance of aligning intrinsic motivation with team purpose, while Ford (2008)[12] warns against neglecting the "shadow self," where ambition unchecked by integrity can distort ethical decision-making. Riemann (2009)[13] links anxiety-driven leadership with defensive behaviours, while Brassey and colleagues (2022)[14] advocate for deliberate calm and authentic confidence to sustain leadership under volatility. Sinek (2009; 2019)[15][16] distinguishes between finite, ego-driven approaches and infinite mindsets that prioritise long-term, purpose-driven impact. Together, these perspectives emphasise that leadership must balance ambition with empathy, and personal visibility with authentic service.

One consistent feature across many ambitious leadership personas in the industry is the cultivation of an **external image**. Leaders frequently project polished professional profiles on platforms such as LinkedIn, maintain carefully curated photographs, and participate in external interviews, panel discussions, or thought-leadership initiatives. These outward-facing signals serve multiple purposes: strengthening individual credibility, enhancing the company's brand, and demonstrating authority to external stakeholders. However, as noted in organisational studies, image-driven leadership risks prioritising appearances over substance, leading to internal cultures where psychological safety and trust are weakened (Goffman, 1959; Alvesson, 2023)[6][7].

Ultimately, ambition must be balanced with compassion, as leadership that prioritises the self over the collective erodes trust and sustainability. This commentary therefore addresses three key questions: (1) Can leadership archetypes dominated by ambition operate within a patient-oriented mindset? (2) Which associate personas complement such leaders, enabling more effective collaboration? and (3) To what extent does overreliance on these archetypes risk prioritising personal growth over patient benefit?

By posing these questions, the manuscript contributes to ongoing debates in leadership theory and organisational behaviour, while situating them in the specific context of pharmaceutical leadership.

Although the analysis is interpretive, this commentary explicitly invites empirical investigation. Mixed-method designs—combining interviews, survey instruments, and longitudinal performance data—could help translate these archetypes from reflective theory into testable organisational models. Such work would allow validation of the "patient score" construct, connecting leadership personas with measurable organisational and patient-oriented outcomes. This commentary employs a reflective-synthesis methodology grounded in analytic autoethnography, combining three decades of lived professional experience with systematic triangulation against peer-reviewed leadership constructs. While not empirical in the quantitative sense, this reflexive framework enhances transparency, mitigates hindsight bias, and enables reproducibility of interpretation.

Persona 1: The Directive Strategist

The **Directive Strategist** is a leadership persona frequently observed among mid- to senior-level managers in the pharmaceutical industry. Characterised by decisiveness, clarity of vision, and a strong external orientation, this archetype seeks to project control and authority. It often presents itself as fairness-signalling and strategic, with a compelling narrative of organisational progress and ambition.

One of the defining features of the Directive Strategist is the repeated emphasis on **ambition**. This archetype frequently conveys that personal ambition is both desirable and necessary for professional advancement. While ambition can serve as a motivational driver, its unbalanced expression risks undermining collaboration. Research in leadership studies demonstrates that ambition, when pursued as an individual trait rather than as part of a shared vision, can erode team trust and cohesion (Stothart, 2023; Ford, 2008)[11][12]. It is therefore critical to distinguish between fostering **ambitious plans**—which align collective energy toward organisational or patient-centred goals—and fostering **ambitious individuals**, which may foster competition, rivalry, and destabilisation within teams.

This distinction is not trivial. Teams thrive when leaders channel ambition into plans that all members can align behind. By contrast, when leaders hire or promote associates primarily for their individual ambition, the result may be a fracturing of coherence. Competing personal trajectories risk overshadowing collective purpose, leading to the marginalisation of those who prioritise collaboration over self-promotion. Riemann (2009)[13] observed that such dynamics often create defensive organisational climates, where trust is replaced by guardedness and efficiency declines.

Behavioural frameworks such as Insights Discovery place the Directive Strategist firmly within the **RED profile**—assertive, competitive, and outcome-driven. When such a leader surrounds themselves with equally RED, individually ambitious associates, the likelihood of conflict intensifies. Instead of complementarity, the team becomes characterised by rivalry, selective empowerment, and internal contest. Studies on authoritarian and high-control leadership suggest that this dynamic fosters high turnover, with talent attrition representing not only a human cost but also a strategic loss for organisations focused on patient value (West et al., 2018)[8]. These observations mirror findings in destructive leadership research, where outcomes such as burnout, disengagement, and silencing are strongly correlated with high-control, ambition-driven environments (Einarsen et al., 2007; Krasikova et al., 2013)[3][4]

Externally, the Directive Strategist often manages image effectively, cultivating a polished professional presence through conference appearances, publications, and curated social media profiles. This external projection can enhance credibility with stakeholders, but—as Goffman (1959)[6] and Alvesson (2023)[7] caution—it may conceal backstage realities where team culture is fragile. The literature on political skill suggests that such impression management can be advantageous in the short term but unsustainable when not grounded in authentic trust (Ferris et al., 2005)[17]. The risk is that organisational narratives of ambition and progress are maintained outwardly, while internally, associates experience an erosion of psychological safety and a weakening of team bonds.

In theoretical terms, the Directive Strategist maps closely to authoritarian and transactional leadership styles, both of which prioritise control and results but struggle to integrate empathy and flexibility. This mapping strengthens the conceptual link between observed pharmaceutical personas and established leadership frameworks, addressing the reviewer's call for more analytical grounding.

From a **patient-oriented perspective**, the central concern with this persona lies in the potential misalignment between personal ambition and collective service. Ambition directed at personal growth may appear to drive organisational results in the short term, but when it undermines team stability, it threatens the sustainability of outcomes. By contrast, when leaders orient ambition toward plans, not people, they create conditions in which collaboration flourishes and patient-centred goals can be credibly advanced. Future research should examine this dynamic empirically by assessing how leadership ambition correlates with proxies such as employee turnover, timelines for regulatory submissions, and rates of safety reporting—indicators that directly affect patient outcomes. Further empirical validation could correlate this persona's behavioural traits with measurable outcomes—including innovation cycle time, attrition rates, and pharmacovigilance completeness—to clarify its causal influence on patient-centred results.

Persona 2: The Enforcer

The **Enforcer** is a leadership persona marked by authority, control, and rigid enforcement of rules. Commonly observed in managers who transition from clinical or bureaucratic systems into pharmaceutical leadership, the Enforcer prioritises compliance, efficiency, and adherence to established procedures. Such leaders often stress accountability and order, positioning themselves as guardians of quality and discipline. Conceptually, this archetype aligns with theories of abusive supervision and toxic leadership, where strict control is exercised at the expense of trust and collaboration (Krasikova et al., 2013; Gallus et al., 2013)[4][5].

The Enforcer's defining trait is **micromanagement**. While intended to secure performance, close oversight often reflects an underlying anxiety about control and a lack of trust in subordinates. This dynamic, frequently observed in healthcare settings, is associated with disengagement and reduced intrinsic motivation. Research demonstrates that abusive supervision is consistently linked to negative employee outcomes, including reduced job satisfaction, diminished well-being, and higher turnover intentions (Zhang & Liao, 2015)[18]. The gap between leaders' intentions (to demand accountability) and subordinates' perceptions (to experience intimidation) is critical in understanding the Enforcer persona.

Another recurring feature is **abusive behaviour patterns**—not always overt aggression, but subtle acts of exclusion, preferential treatment, and dismissive feedback. In organisational psychology, abusive supervision and toxic leadership have been shown to erode psychological safety and trust. Gallus et al. (2013) [5] found that toxic leadership in military settings negatively affected both unit cohesion and individual well-being, illustrating how rigid, fear-based leadership diminishes collective performance. Schmidt (2008)[19] further operationalised these traits through the Toxic Leadership Scale, confirming that behaviours such

as authoritarianism, narcissism, and unpredictability are measurable and strongly correlated with poor organisational outcomes.

The Enforcer also struggles with **feedback avoidance and authority conflicts**. Research shows that fear of dissent or loss of authority creates organisational climates of silence, where associates withhold concerns—leading to errors, misaligned priorities, and reduced adaptability (Morrison & Milliken, 2000)[20]. Detert and Burris (2007)[21] further highlight how authoritarian leadership behaviour discourages "employee voice," reinforcing a cycle of silence. Leaders who avoid constructive feedback inadvertently allow problems to accumulate, creating "silent teams" that perform below their potential.

Externally, the Enforcer may still project credibility through structured presentations, policy contributions, or participation in external forums. Yet, as with the Directive Strategist, this cultivated image can mask internal realities. Goffman's (1959)[6] impression management theory suggests that the "front stage" of authority often obscures the backstage strain experienced by teams.

From a **patient-centred perspective**, the Enforcer poses risks where enforcement of order eclipses empathy. While discipline and procedural integrity are essential for regulated industries, rigid enforcement without psychological safety undermines innovation and collaborative problem-solving. Evidence from healthcare shows that bullying and intimidation reduce speaking-up behaviours, leading to poorer patient safety outcomes (West et al., 2018; Detert & Burris, 2007)[8][21]. Translating this to pharmaceutical development, a culture of fear may delay critical decision-making, reduce scientific creativity, and ultimately limit the flow of innovative therapies to patients.

Theoretically, the Enforcer can be situated at the intersection of authoritarian and abusive leadership frameworks, both of which are known to compromise trust and employee voice. This mapping highlights the contribution of this commentary by contextualising these patterns in the pharmaceutical sector, where procedural discipline is necessary but insufficient without empathy and adaptability.

Future research should explore how the Enforcer persona affects measurable outcomes such as trial discontinuation rates, staff retention, and error reporting in pharmacovigilance systems. Such indicators would provide empirical grounding for the claim that rigid, fear-based leadership ultimately lowers the "patient score." Longitudinal or mixed-methods studies could test these associations and determine whether the Enforcer's control-based culture mediates the relationship between leadership style and patient-outcome metrics.

Persona 3: The Corporate Diplomat

The **Corporate Diplomat** is a persona characterised by charisma, political skill, and strong external visibility. In the pharmaceutical industry, this archetype is frequently observed among senior executives who excel at building networks, positioning themselves in external forums, and projecting organisational influence. The Corporate Diplomat often appears polished, persuasive, and inclusive in public, reinforcing credibility with external stakeholders such as regulators, clinicians, and the media.

A defining feature of this persona is **impression management**. Much like Goffman's (1959)[6] concept of the "presentation of self," the Corporate Diplomat invests heavily in crafting a favourable image—through interviews, conference

appearances, or thought-leadership contributions. While such visibility can enhance organisational profile, it risks creating a gap between external narratives and internal realities. Alvesson (2023)[7] warns that image-building cultures may prioritise appearance over substance, leading to disillusionment within teams. Research on political skill confirms that such behaviours often provide short-term influence and access to resources, but when unaccompanied by authentic integrity, they contribute to long-term fragility in organisational trust (Ferris et al., 2005)[17].

Internally, the Corporate Diplomat may cultivate an appearance of inclusivity ("we are all equal") yet simultaneously exercise **selective empowerment**. Associates often experience uneven treatment, with some granted privileged access and others sidelined. Such dynamics align with organisational behaviour research on **favouritism** and **exclusion**, which are shown to correlate with higher turnover and reduced trust (Mayer et al., 2007; Wolf, 2025; Hoel & Einarsen, 2003) [22][23][24].

The Corporate Diplomat's political acumen can yield **short-term organisational benefits**—securing resources, enhancing reputation, or advancing strategic partnerships. However, the darker side of charisma is well documented. Tourish (2013)[9] highlights that charismatic leaders may manipulate narratives to serve personal ambition, while Conger and Kanungo (1994)[2] show that political skill without ethical grounding risks undermining sustainable leadership. The "shadow side" described by Ford (2008)[12] becomes particularly relevant here: when personal growth or visibility outweighs collective purpose, patient orientation is compromised.

Another recurrent issue with this persona is the **destabilisation of teams**. While the Corporate Diplomat may attract admiration externally, internally, teams may experience competition for recognition, a lack of transparency, and eroded trust. Studies confirm that environments where psychological safety is low and alignment is fragile lead to disengagement, attrition, and reduced performance (Gallus et al., 2013)[5]. In regulated industries such as pharmaceuticals, these outcomes can delay evidence generation, stall innovation, and hinder the delivery of therapies to patients. In theoretical terms, this persona aligns with models of impression management and charismatic leadership, both of which highlight the tension between external legitimacy and internal fragility. By situating this archetype in the pharmaceutical industry, this commentary adds to the literature by showing how external legitimacy can paradoxically reduce patient-centred outcomes when internal trust collapses.

From a **patient-centred perspective**, the key concern is whether the Corporate Diplomat's external focus aligns with authentic internal integrity. A persona that invests more energy in cultivating personal visibility than in fostering team trust risks prioritising individual growth over patient value. By contrast, when complemented by associates with **BLUE (detail-focused)** or **GREEN (harmonising)** traits, the Corporate Diplomat can balance ambition with substance, ensuring that external reputation is matched by internal cohesion.

Future research could investigate this balance by assessing whether leaders with strong political skill but weak internal integrity have measurable impacts on outcomes such as innovation cycle time, trial recruitment efficiency, or staff retention rates. Triangulating qualitative case studies with quantitative data would allow for the validation of causal pathways, ensuring that proposed links between charisma, trust, and patient impact are empirically testable.

Cross-Persona Reflections

Beyond psychological and behavioural dimensions, these archetypes also intersect with broader organisational systems—such as regulatory oversight, incentive frameworks, and market forces—that define how leadership operates in the pharmaceutical sector. While grounded in lived experience, this analysis recognises that shareholder expectations, regulatory constraints, and economic pressures co-shape leadership behaviour. These systemic factors are treated as boundary conditions influencing, rather than being omitted from, the interpretation. Exploring these macro-system linkages would situate pharmaceutical leadership within its full ecosystem and clarify how governance, compliance, and economic pressures amplify or mitigate persona effects. This extension helps bridge micro-level leadership behaviour with industry-wide accountability and policy realities.

1. Cultivation of External Image

All three personas invest heavily in external visibility, often through a professional social media presence, polished photographs, and participation in industry interviews or panel discussions. Such practices align with Goffman's (1959)[6] notion of impression management, where the "front stage" presentation of authority may conceal a "backstage" reality that is less stable. Alvesson (2023) [7] similarly warns against the rise of "empty image-building" cultures that prioritise appearances over authentic organisational substance. This commentary contributes by demonstrating how such dynamics are not only reputational but also directly linked to team trust, attrition, and patient-centred outcomes in the pharmaceutical sector, an area where literature remains scarce.

2. Ambition as a Double-Edged Sword

Ambition appears as a common denominator across the personas, yet it manifests differently. For the Directive Strategist, ambition is a mantra; for the Enforcer, it is operationalised through control; for the Corporate Diplomat, it is expressed through external visibility. Ford (2008)[12] notes that ambition unbalanced by integrity activates the leader's "shadow," distorting ethical decision-making. When ambition is oriented towards personal growth, it risks eroding team trust. When channelled into ambitious plans, however, it can unite teams and strengthen patient-oriented goals (Stothart, 2023)[11]. The novelty here lies in reframing ambition not as a binary good or bad trait but as a contextual variable: "ambitious individuals" often fragment collaboration, while "ambitious plans" foster coherence. This distinction, though present implicitly in leadership research, has not been explicitly applied to pharmaceutical contexts before.

3. Integrity Gaps and Preferential Treatment

A recurring concern across the three personas is the potential for integrity erosion. Whether through selective empowerment (Corporate Diplomat), abusive supervision (Enforcer), or ambition-driven marginalisation (Directive Strategist), the gap between "convenient integrity" and authentic ethical leadership is evident. Research confirms that bullying, favouritism, and intimidation diminish innovation, reduce psychological safety, and increase attrition in both healthcare and pharmaceutical contexts (Gallus et al., 2013; Schmidt, 2008; Wolf, 2025; Lambert et al., 2024)[5][19][23][24]. By drawing these threads together, this

commentary advances theory by showing that “convenient integrity” functions as a cross-persona mechanism through which patient-centred outcomes are undermined.

4. Consequences for Teams: Burnout and Attrition

Despite differences in style, all three personas are linked to environments where psychological safety is compromised. Associates exposed to high-control, high-image, or high-politics leadership often experience burnout, disengagement, or forced exits. West et al. (2018)[8] demonstrated that burnout correlates with attrition and reduced quality of care. Organisational research further shows that without trust, respect, and coherence, high-performing teams cannot be sustained (Lencioni, 2016)[25]. This section extends those findings by linking attrition directly to patient impact: when associates exit prematurely due to toxic climates, expertise is lost, trial timelines are delayed, and innovation pipelines are disrupted. Attrition, therefore, is not only an HR issue but also a patient issue.

5. Complementary Personas as Moderators

Finally, the analysis suggests that these archetypes can only succeed sustainably when complemented by associates with contrasting behavioural profiles. RED-dominant leaders may clash with similarly RED associates, creating rivalry and fragmentation. By contrast, associates with BLUE (detail-oriented) or GREEN (harmonising, relational) traits can temper ambition with precision and empathy, enabling more balanced leadership dynamics (Stothart, 2023)[11]. This highlights an underexplored area in leadership research: the moderating role of associate personas in shaping leader impact. Future research could empirically test these dynamics through mixed-method studies that combine personality assessments, organisational outcomes, and patient-centred metrics.

In sum, this section strengthens the theoretical contribution of the commentary by moving beyond anecdotal reflection. It shows how ambition, integrity gaps, and impression management function as cross-persona mechanisms that compromise trust and sustainability. The commentary advances leadership theory by situating these dynamics within the pharmaceutical industry and introduces future research pathways to empirically validate the concept of the “patient score” as a measure of leadership alignment with patient outcomes.

Integrity and the Code

Integrity is a cornerstone of pharmaceutical leadership, enshrined in industry codes of practice and compliance frameworks. Yet, as the analysis of the three personas demonstrates, integrity is often interpreted through the lens of persona-driven ambition. The distinction between **authentic integrity** and **convenient integrity** is crucial. Authentic integrity places patients at the centre, ensuring decisions are consistent with ethical principles even when inconvenient. Convenient integrity, by contrast, involves selective adherence to codes—applied when reputationally or strategically beneficial but overlooked when ambition dictates otherwise.

Across the three personas, patterns of integrity erosion are visible. The Directive Strategist risks prioritising personal ambition over fairness in team structures; the Enforcer enforces compliance but undermines psychological safety through control; and the Corporate Diplomat proclaims inclusivity while practising selective empowerment. These dynamics illustrate how codes can be

superficially upheld while their deeper intent—serving patients through trust and transparency—is compromised.

Research on workplace behaviour supports this distinction. Ford (2008) [12] highlights how the "shadow" of ambition may lead good people to unethical actions when unchecked by self-awareness. Lencioni (2016)[25] shows that team dysfunction often begins with an absence of trust, which is aggravated by leaders who avoid vulnerability in the pursuit of authority. Grenny and colleagues (2022)[26] argue that difficult conversations, when avoided, create conditions where hidden conflicts fester, eroding integrity and undermining collaboration. More recent research links integrity-driven leadership with reductions in bullying, burnout, and turnover, reinforcing that ethical climates are not only moral imperatives but also strategic assets (Lambert et al., 2024)[24].

Industry analyses further emphasise these risks. Convenient integrity manifests through double standards, selective empowerment, or silencing of dissent. Studies confirm that such behaviours reduce speaking-up behaviours, diminish innovation, and increase attrition (Gallus et al., 2013; Schmidt, 2008; Lambert et al., 2024)[5][19][24]. These integrity gaps are therefore not merely interpersonal but systemic, with direct consequences for patient trust and access to therapies.

Future interdisciplinary integration—drawing from organisational psychology, behavioural economics, healthcare ethics, data science, and sociology—could provide stronger theoretical scaffolding for this argument. Such perspectives would clarify how incentive systems, ethical frameworks, and public-trust mechanisms jointly shape integrity in pharmaceutical leadership.

This commentary contributes by conceptualising "convenient integrity" as a cross-persona mechanism: while each archetype expresses it differently, the outcome is the same—erosion of trust and patient-centred value. By framing integrity not as adherence to external codes but as alignment between values, words, and behaviours, the paper offers a novel lens through which to evaluate pharmaceutical leadership.

To enhance practical relevance, the commentary expands on how "Integrity Councils" and "Patient-Centred Dashboards" could be operationalised. Integrity Councils may include senior leaders, compliance officers, patient advocates, and external ethicists, meeting quarterly to review ethical dilemmas and publish anonymised summaries of decisions. Success could be tracked through fairness surveys, resolution rates, and patient-trust indices. Dashboards could visualise metrics such as trial-timeline adherence, pharmacovigilance completeness, staff-retention trends, and patient-access milestones—integrated via existing analytics platforms with quarterly executive review. Pilot testing these mechanisms within one therapeutic area would generate data for empirical validation and demonstrate feasibility within regulatory and operational constraints. Implementation should follow standard change-management steps —executive sponsorship, stakeholder engagement, pilot evaluation, cost–benefit analysis, and independent ethics auditing—to ensure operational feasibility and sustainability.

Addressing these risks requires shifting focus from ambitious individuals to capable systems. Capability building, rather than overreliance on persona-driven ambition, ensures sustainable patient-centred leadership. Gundu and Mateti (2021)[27] emphasise that organisations must invest in deliberate skill-building, psychological safety, and leadership development that balances ambition with empathy. This aligns with Brassey et al. (2022)[14], who call for deliberate calm

and authentic confidence as antidotes to volatile, ambition-driven leadership. Practical strategies might include the creation of integrity councils and patient-centred dashboards as formal accountability tools within leadership evaluation frameworks, ensuring that ethical intent is continuously measured, not assumed.

Future research should explore how integrity climates can be operationalised as measurable constructs. Proxies might include frequency of whistleblowing, rates of employee voice behaviours, or transparency in safety reporting. Quantitative correlation of these proxies with organisational outcomes (e.g., turnover, regulatory timelines, safety-signal reporting) could empirically validate integrity as a determinant of patient outcomes. By testing these measures across leadership contexts, scholars could validate the claim that integrity is not only a code-based expectation but a determinant of patient outcomes.

Integrity, then, is not simply about adhering to external codes, but about cultivating leadership cultures where ambition is channelled into collective plans, capability is distributed, and patient outcomes are prioritised above personal visibility. Without this deeper alignment, codes risk becoming symbolic, while patients—ostensibly the ultimate beneficiaries—receive diminished attention. By embedding empirical evaluation, interdisciplinary theory, and actionable tools into this framework, pharmaceutical organisations can transform integrity from a compliance obligation into a measurable driver of trust, innovation, and patient value.

The Patient "Score" Metaphor

Ultimately, the effectiveness of any leadership persona in the pharmaceutical industry must be judged by a single criterion: its impact on patients. While leadership styles vary in ambition, authority, and external visibility, their collective value can be expressed through what may be called the **"patient score"**—a **conceptual metaphor** for the extent to which leadership behaviours advance or undermine patient benefit.

The three personas analysed in this commentary illustrate how unbalanced ambition diminishes this score. The Directive Strategist reduces it when personal advancement overshadows collective planning. The Enforcer subtracts from it when rigid enforcement suppresses psychological safety, stifling innovation, silencing dissent, and driving valued associates to disengage or leave. The Corporate Diplomat lowers it when energy is invested disproportionately in external image rather than authentic internal engagement. In each case, the result is not only fractured teams and weakened trust but also premature exits of associates, disruption of knowledge continuity, and delayed delivery of therapies —clear downstream effects for patients.

To strengthen its empirical grounding, the "patient score" could be assessed through quantitative correlations between leadership-behaviour surveys and operational metrics such as trial timeliness, pharmacovigilance completeness, or staff-retention rates. Qualitative case studies and ethnographic observations could complement these data, examining how leadership culture influences innovation and patient access. Benchmarking organisations with strong integrity climates against those with high attrition could test whether a higher "patient score" predicts improved patient outcomes. Such triangulated approaches would help move the metaphor from conceptual to measurable.

This commentary contributes to the literature by introducing the patient score as a conceptual framework for evaluating leadership impact in regulated industries. Unlike traditional measures of leadership (profitability, visibility, compliance), the patient score is explicitly oriented toward whether leadership behaviours add to or subtract from patient value. It reframes success away from personal recognition and organisational prestige toward outcomes that matter most in healthcare.

This distinction echoes the argument that what organisations need are **not ambitious individuals, but ambitious plans**. Plans unify teams behind shared objectives, enabling collaboration, coherence, and resilience. By contrast, ambition centred on individuals creates fragmentation and rivalry. West et al. (2018)[8] demonstrated that burnout in healthcare environments directly correlates with poorer outcomes, a finding equally applicable to pharmaceutical research and development. Leadership cultures that elevate ambition over patient purpose therefore risk subtracting from the patient score rather than adding to it.

Conversely, the patient score rises when leaders channel ambition into **purpose-driven, patient-centred goals**. Sinek (2019)[16] highlights that infinite-minded leaders—those who define success as advancing a cause beyond themselves—create more enduring impact. Brassey and colleagues (2022)[14] similarly argue that authentic confidence and deliberate calm allow leaders to balance volatility with stability, sustaining environments where teams can innovate effectively. By operationalising these measures and testing them empirically, the "patient score" can evolve from metaphor to applied framework, guiding ethical and performance evaluation in pharmaceutical leadership. Future empirical work could include the development of a validated psychometric instrument, factor-analytic testing of construct coherence, and cross-functional pilots across R&D, manufacturing, and medical affairs to assess generalisability.

The originality of the patient score lies in its potential to be operationalised through measurable proxies, such as trial timelines, pharmacovigilance reporting rates, staff retention, and patient access milestones. By tying leadership behaviours to concrete indicators, the metaphor can evolve into a framework for empirical validation.

Future research should test the patient score empirically, using mixed methods to correlate leadership personas with measurable outputs (e.g., turnover rates, innovation cycle times, safety reporting, regulatory delays). Longitudinal studies could further establish whether leadership cultures oriented toward collective plans, rather than individual ambition, consistently achieve higher patient scores.

In practical terms, pilot implementation of the "patient score" could begin within leadership-development or compliance programmes, linking performance reviews to patient-impact metrics. Insights from these pilots would offer both academic and operational validation of the model, helping organisations quantify how leadership integrity translates into real-world patient benefit.

The patient score metaphor underscores the urgency of **recalibrating leadership development in the pharmaceutical industry**. Leaders should be assessed not merely on metrics of visibility, ambition, or compliance, but on whether their behaviours increase or decrease the score for patients. Ambition, when paired with integrity and balanced by complementary associates, can indeed drive

positive outcomes. But when personal growth becomes more important than the patients served, the score inevitably falls.

Discussion and Conclusion

This commentary has explored three common leadership personas in the pharmaceutical industry: the Directive Strategist, the Enforcer, and the Corporate Diplomat. Each brings distinctive strengths—strategic vision, accountability, and external influence—but also significant risks when ambition supersedes empathy, integrity, and patient focus. What unites these archetypes is a tendency to overinvest in external image and personal growth, while underinvesting in the internal conditions that foster sustainable innovation and trust.

The analysis highlights that ambition is not inherently negative. Ambitious plans can mobilise collective energy, generate coherence, and accelerate progress. The challenge arises when ambition is personalised—when leaders emphasise being ambitious individuals rather than cultivating ambitious goals for teams and patients. In such cases, ambition fragments collaboration, fosters rivalry, and diminishes what this paper has termed the *patient score*.

A consistent thread across the three personas is the risk of **convenient integrity**. Codes of conduct and compliance frameworks provide a formal structure, yet their value is undermined when selectively applied. Integrity that shifts with ambition or reputation erodes trust and weakens organisational resilience. Authentic integrity, by contrast, is grounded in consistency between values and actions—ensuring fairness, respect, and accountability even when inconvenient. This paper's contribution is to conceptualise "convenient integrity" as a cross-persona mechanism through which patient value is eroded, thereby offering a theoretical bridge between destructive leadership research and the specific dynamics of pharmaceutical organisations.

The commentary also introduces the **"patient score"** as a novel evaluative framework, moving beyond traditional performance metrics (e.g., financial outcomes, compliance audits) to emphasise whether leadership behaviours increase or decrease patient-centred value. This reframing contributes theoretically by integrating leadership theory, organisational behaviour, and healthcare ethics. Practically, it suggests that organisations could track proxies such as trial timelines, pharmacovigilance reporting, employee retention, and patient access milestones as part of leadership performance dashboards. In practical application, these dashboards could be piloted in specific departments to evaluate leadership impact on measurable patient outcomes, integrating human resources data with clinical-development timelines to form an evidence-based "patient scorecard." Such initiatives would enable early empirical testing of the framework in real-world pharmaceutical settings.

The cross-persona reflections also demonstrate that sustainability requires **complementarity**. RED-dominant leaders, characterised by drive and competitiveness, rarely thrive when paired with equally RED associates. Instead, teams achieve greater balance when leaders are supported by associates with BLUE (precision, detail) and GREEN (empathy, harmony) profiles. This reinforces Stothart's (2023)[11] point that motivation must align with team purpose, not merely individual ambition. This opens a future research agenda on how associate personas moderate leadership outcomes—a dimension underexplored in both leadership and organisational behaviour literature.

From a **patient-centred perspective**, the findings are sobering. Leadership archetypes that elevate ambition, visibility, or enforcement above empathy and coherence risk lowering the patient score. Burnout, attrition, and loss of psychological safety are not abstract organisational problems; they directly translate into delays in evidence generation, reduced innovation, and ultimately slower delivery of therapies to patients (West et al., 2018)[8]. By contrast, when leaders orient ambition toward collective goals, supported by integrity and complementary personas, the patient score rises—delivering measurable benefit. Moreover, connecting these leadership effects to regulatory compliance, organisational trust, and patient access would help quantify the societal value of ethical leadership. Such alignment between leadership quality and patient outcomes could inform both internal evaluation systems and external policy frameworks promoting patient-centred accountability.

Limitations of this commentary must be acknowledged. The analysis is primarily reflective, based on professional experience and synthesis of existing theory, rather than empirical testing. While this allows for novel conceptual framing, it requires empirical follow-up to validate the archetypes and test the patient score framework. Future research should employ qualitative methods (e.g., interviews, ethnographic case studies) to capture lived experiences of these personas, as well as quantitative methods (e.g., surveys, performance metrics) to test their impact on measurable outcomes such as turnover, innovation cycle times, and patient safety reporting. By articulating these archetypes within a transparent reflective framework and explicitly acknowledging potential confirmation and hindsight biases, the commentary positions itself as a catalyst for empirical exploration rather than as definitive causal proof. Additionally, integrating behavioural-economic, organisational-psychology, and public-policy perspectives could clarify how incentive structures, governance models, and regulatory expectations either reinforce or dilute patient-centred leadership. Explicit linkages to societal impact—such as public trust in pharmaceutical innovation and health-system credibility—would expand the relevance of this work beyond the organisational domain.

In conclusion, the Directive Strategist, the Enforcer, and the Corporate Diplomat are archetypes that illuminate both the strengths and shadow sides of pharmaceutical leadership. Their lessons converge on a single insight: when personal growth is prioritised above patients, the score falls; when ambition is channelled into patient-oriented plans, supported by integrity and balance, the score rises. This distinction advances leadership theory by integrating ambition, integrity, and patient outcomes into a unified evaluative lens. It also challenges organisations to adopt patient-centred metrics for leadership development. By advancing clear pathways for empirical validation, interdisciplinary linkage, and practical implementation, this commentary responds to recent scholarly critiques and moves the “patient score” from a conceptual metaphor toward a testable framework for ethical, sustainable, and patient-centred pharmaceutical leadership. Recognising and addressing these dynamics is not only an organisational imperative—it is an ethical obligation to the patients whom the industry ultimately serves.

Statements and Declarations

Funding

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

Potential Competing Interests

No potential competing interests to declare.

Data Availability

Data sharing is not applicable to this article as no new data were created or analysed in this study.

Author Contributions

AS is the sole author of this commentary and is responsible for conceptualisation, drafting, and final approval of the manuscript.

Acknowledgements

The author acknowledges his daughter for her encouragement and inspiration, which have been a constant reminder of the importance of striving for a better, evidence-informed future in healthcare. This manuscript draws on the author's personal work, professional reflections, and thematic explorations previously shared in public forums such as LinkedIn, now reframed in an academic context. Portions of the manuscript, including language refinement and structural suggestions, were supported using OpenAI's ChatGPT-4 model. The author critically reviewed, edited, and validated all content to ensure accuracy, originality, and alignment with scholarly standards.

Having held senior leadership roles across several global pharmaceutical companies over a 30-year career, with a focus on clinical development, real-world evidence, and medical affairs, the author offers this commentary not only as a synthesis of accumulated knowledge and reflective insights, but also as a wake-up call for the industry to consider whether it is cultivating and rewarding the right leadership personas—those who place patient benefit above personal ambition.

The author also extends sincere thanks to the anonymous reviewers and editors of *Qeios*, whose constructive critiques and thoughtful suggestions substantially improved the clarity, balance, and practical applicability of this manuscript.

References

1. ^*Jung CG (1953). Two Essays on Analytical Psychology. London: Routledge. ISBN 9780710016379.*
2. a, b*Conger JA, Kanungo RN (1994). "Charismatic Leadership in Organizations: Perceived Behavioral Attributes and Their Measurement." J Organ Behav. **15**(5):43952. doi:10.1002/job.4030150508.*
3. a, b, c*Einarsen S, Aasland MS, Skogstad A (2007). "Destructive Leadership Behaviour: A Definition and Conceptual Model." Leadersh Q. **18**(3):20716. doi:10.1016/j.leaqua.2007.03.002.*

4. ^ a b c d *Krasikova DV, Green SG, LeBreton JM (2013). "Destructive Leadership: A Theoretical Review, Integration, and Future Research Agenda." J Manage. **39**(5):1308 38. doi:10.1177/0149206312471388.*
5. ^ a b c d e f *Gallus JA, Walsh BM, van Driel M, Gouge M, Antolic E (2013). "Intolerable Cruelty: A Multilevel Examination of the Impact of Toxic Leadership on US Military Units and Service Members." Mil Psychol. **25**(6):588601. doi:10.1037/mil0000 022.*
6. ^ a b c d e f *Goffman E (1959). The Presentation of Self in Everyday Life. Garden City, NY: Doubleday. ISBN 9780385094023.*
7. ^ a b c d e *Alvesson M (2022). The Triumph of Emptiness: Consumption, Higher Education, and Work Organization. 2nd ed. Oxford: Oxford University Press. ISBN 97 80192865274.*
8. ^ a b c d e f *West CP, Dyrbye LN, Shanafelt TD (2018). "Physician Burnout: Contributors, Consequences and Solutions." J Intern Med. **283**(6):51629. doi:10.1111/joim.127 52.*
9. ^ a b *Tourish D (2013). The Dark Side of Transformational Leadership: A Critical Perspective. London: Routledge. doi:10.4324/9780203558119.*
10. ^ *Conger JA, Kanungo RN (1994). "Charismatic Leadership in Organizations: Perceived Behavioral Attributes and Their Measurement." J Organ Behav. **15**(5):43952. doi:10.1002/job.4030150508.*
11. ^ a b c d e *Stothart C (2022). Motivation: The Ultimate Guide to Leading Your Team. London: Routledge. doi:10.4324/9781003286646.*
12. ^ a b c d e *Ford D (2008). Why Good People Do Bad Things: How to Stop Being Your Own Worst Enemy. New York: HarperOne. ISBN 9780060897376.*
13. ^ a b *Riemann F (2009). Anxiety. London: Continuum. ISBN 9783497020430.*
14. ^ a b c *Brassey J, De Smet A, Kruyt M (2022). Deliberate Calm: How to Learn and Lead in a Volatile World. New York: Harper Business. ISBN 9780063208988.*
15. ^ *Sinek S (2009). Start with Why: How Great Leaders Inspire Everyone to Take Action. London: Portfolio Penguin. ISBN 9781591842804.*
16. ^ a b *Sinek S (2019). The Infinite Game. London: Portfolio Penguin. ISBN 978073521 3500.*
17. ^ a b *Ferris GR, Treadway DC, Perrew PL, Brouer RL, Douglas C, Lux S (2005). "Development and Validation of the Political Skill Inventory." J Manage. **31**(1):12652. doi:10.1177/0149206304271386.*
18. ^ *Zhang Y, Liao H (2015). "Consequences of Abusive Supervision: A Meta-Analytic Review." Asia Pac J Manag. **32**(4):95987. doi:10.1007/s10490-015-9425-0.*
19. ^ a b c *Schmidt AA (2008). "Development and Validation of the Toxic Leadership Scale." University of Maryland. http://hdl.handle.net/1903/8176.*
20. ^ *Morrison EW, Milliken FJ (2000). "Organizational Silence: A Barrier to Change and Development in a Pluralistic World." Acad Manage Rev. **25**(4):70625. doi:10.54 65/amr.2000.3707697.*
21. ^ a b *Detert JR, Burris ER (2007). "Leadership Behavior and Employee Voice: Is the Door Really Open?" Acad Manage J. **50**(4):86984. doi:10.5465/amj.2007.26279183.*
22. ^ *Mayer DM, Nishii LH, Schneider B, Goldstein HW (2007). "The Precursors and Products of Justice Climates: Group Leader Antecedents and Employee Attitudinal Consequences." Pers Psychol. **60**(4):92963. doi:10.1111/j.1744-6570.2007.00096.x.*
23. ^ a b *Wolf M (2025). The Psychology of Workplace Dynamics: Unlocking the Secrets to Thriving Teams and Empowered Leadership. London: Routledge. ISBN 979831 5475170.*

24. ^a, ^b, ^c, ^d*Lambert JR, Brown LW, Lambert TA, Torres Nava C (2024). "The Effect of Ethical Leadership on Nurse Bullying, Burnout, and Turnover Intentions." J Nurs Manag.* ***2024****:3397854. doi:10.1155/2024/3397854.*
25. ^a, ^b*Lencioni P (2016). The Ideal Team Player: How to Recognize and Cultivate the Three Essential Virtues. San Francisco: Jossey-Bass. ISBN 9781119209591.*
26. ^*Grenny J, Patterson K, McMillan R, Switzler A, Gregory E (2022). Crucial Conversations: Tools for Talking When Stakes are High. 3rd ed. New York: McGraw-Hill. ISBN 9781260474183.*
27. ^*Gundu J, Mateti S (2021). "Capability Building is New Normal in Pharmaceutical Industry." Presented at: PHUSE US Connect; 2021 Mar 15. https://www.lexjansen.com/phuse/2022/th/PAPTH02.pdf.*

Declarations

Funding: This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors. The work was independently conceived and written by the author without external financial support.
Potential competing interests: The author declares no financial, personal, or professional conflicts of interest related to the content of this manuscript. The reflections presented are based on publicly available leadership literature, personal professional experience, and academic interpretation. The author has previously held senior leadership roles in the pharmaceutical industry; however, these affiliations had no role in the conception, drafting, or preparation of this work.