

Peer Review

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

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The article offers a new conceptual framework for pharma leadership judgment, with the "patient score" metaphor for quantifying leadership contribution to patient outcomes. This is a useful contribution, since it shifts the focus away from traditional measures of profitability and conformance to patient value.

The commentary also synthesizes leadership theory with pharma-specific learning, offering a unique perspective on how ambition, integrity, and psychological safety all intersect in pharma leadership.

However, the paper is not empirically validated and relies extensively on reflective analysis and theoretical integration versus data-grounded evidence. While the patient score introduction is novel, its utility in practice is questionable until empirical testing. The commentary admits the weakness but does not provide concrete suggestions for operationalizing the patient score or empirical testing of the archetypes in the field. This gap weakens the publication case as a stand-alone scholarly work, as the model remains conceptual and not action-oriented.

In addition, the article clearly demonstrates sound awareness of relevant leadership theories, referencing foundational works by Jung (1953), Goffman (1959), and Sinek (2019), along with recent studies of toxic leadership, abusive supervision, and impression management. It effectively integrates these theories into the drug context, which is an area not yet thoroughly investigated within leadership research. The commentary also references an extensive range of literature sources, including empirical studies of burnout, attrition, and psychological safety, in support of its argument. Nonetheless, the paper does not respond well enough to gaps in existing literature or to challenge assumptions. For example, while it critiques ambition leadership, it does not account for counterarguments that well-managed ambition can

drive innovation and organizational growth. In addition, the commentary can be enhanced by exploring in more detail how archetypes of leadership intersect with more universal organizational systems, such as regulatory systems or market forces, which are of greatest importance in the pharmaceutical industry. Major work appears to be correctly referenced, but the paper may broaden its scope by referencing more interdisciplinary research, such as research on ethical leadership, organizational resilience, and patient advocacy. This would strengthen its theory base and provide a broader view of the challenges and opportunities in pharmaceutical leadership.

While the paper offers a fresh framework and incorporates pertinent literature well, its reliance on introspective analysis and lack of empirical evidence limit its impact.

The commentary is thoughtful and offers informative observations, but it falls short of being sufficient to offer actionable recommendations or compelling evidence to justify publication as a valuable scholarly work. Future developments should place increasing priority on empirical validation of the patient score and archetypes and more balanced treatment of opposing opinions within the literature.

Methodology:

The argument of the paper is well-grounded in theory, using established leadership theories like Jungian archetypes, authoritarian leadership, abusive supervision, and impression management. The paper situates these theories well within the pharmaceutical industry, a specialized and so far under-examined field. The development of applying the metaphor of the "patient score" is particularly well-matched to the paper's focus on patient-focused leadership.

However, the study is largely reflective and interpretive on the basis of the author's experience and synthesis of existing literature rather than an empirical study or systematic intellectual activity.

Although this method allows conceptual freedom, it is weaker than empirical proof or systematic data collection.

Lack of qualitative and quantitative methods for testing the archetypes introduced and the patient score system takes away from the validity of the paper as a research contribution. The commentary acknowledges this deficiency but does not provide a clear set of parameters for future empirical testing that would be necessary to substantiate its claims. Furthermore, the paper fails to apply any formal research design, i.e., case studies, surveys, interviews, to support its arguments. This limits its ability to provide actionable recommendations or concrete evidence to support the ideas proposed. The employment of anecdotal introspection and thematic analysis, although beneficial in presenting ideas, is missing the methodological depth typically required in academic papers. Critique and Critical

Assessment: Results The paper does not provide results per se, because it is a commentary and not an empirical work. Instead, it provides a synthesis of theory and industry observation that leads to the discussion of the patient score framework. While the analysis is well-written and provocative, it is not as lucid and rigorous in its findings as those of an empirical study.

The conclusions tie together the components of the paper well, emphasizing the risks of ambition-based leadership and the importance of integrity, psychological safety, and team complementarity.

The commentary also identifies the potential impact of types of leadership on patient outcomes, an important addition to the literature.

While the findings are expressed briefly in the context of synthesized insights and conceptual frameworks, they are yet to be analyzed or validated through empirical means.

The results appropriately bring together the parts of the paper but are speculative due to the lack of evidence. Empirical validation of the concepts in subsequent research is needed to cement the paper's method and evidence base.

Critique and Critical Assessment: Implications for Research, Practice, and Society

Implications for Research The paper proposes a variety of topics for future research, such as empirically testing the "patient score" and leadership archetypes model suggested. It proposes that mixed methods, including quantitative and qualitative case studies and tools, be employed to cross-validate the impact of leadership personas on innovation outcomes, team performance, and patient benefit. These suggestions are to be taken into consideration and are consistent with the mission of the paper to advance leadership theory in the pharmaceutical industry.

Implications for Practice

The article gives practical suggestions for pharma leadership, demanding real integrity, psychological safety, and team complementarity. The article offers actionable concepts such as "integrity councils" and "patient-centered dashboards" to monitor leadership behaviors and patient outcomes. These suggestions can influence leadership development programs and corporate practices in the pharma industry. However, the paper does not connect theory to practice effectively. While the proposed tools and frameworks are theoretically useful, they are not couched in overt implementation strategies or provide clear examples of how these could be implemented into existing organizational systems. For instance, the writing does not indicate how integrity councils would function in practice, how patient-focused dashboards would be designed, or how they would be balanced with regulatory and operating realities in the pharmaceutical sector. The inability to offer pragmatic details limits the immediate applicability of the paper.

Implications for Society

The focus of the paper on patient-centered leadership has clear social relevance, since it highlights the ethical imperative of pharmaceutical leaders to prioritize patient success over individual self-promotion. Through linking leadership behavior to measurable surrogates such as trial quality, reporting of adverse drug reactions, and patient access to medicines, the paper confirms the broader social impact of pharmaceutical leadership. If implemented, the suggested frameworks can enhance the well-being of patients through innovation, minimization of delays in therapy provision, and improvement in the pharmaceutical industry's credibility. The impact on society is still speculative since the document does not present empirical data to support the idea that its suggestions would result in concrete benefits for patients. In addition, the commentary does not address how its findings could influence public policy or regulatory frameworks, which are crucial system levers to modify in the pharmaceutical industry. The absence of consideration for how the proposed concepts could influence public opinion or industry standards further limits the paper's contribution to society.

Economic and Commercial Impact

The article makes a fleeting reference to the economic and commercial costs of leadership, such as the cost of burnout, attrition, and innovation loss. By highlighting the value of sustainable leadership practices, the commentary indirectly implies the potential for economic benefits, such as improved retention of employees, accelerated innovation cycles, and increased organizational resilience. But these economic effects are not fully explored. The paper does not place a number on the potential cost savings or business gains to be achieved by adopting patient-centered leadership styles, nor does it present case studies or examples to illustrate such gains. This lack undermines the paper's argument for the commercial viability of its proposals.

Use in Teaching and Public Policy The paper is educational, particularly in organizational behavior classes and leadership development modules in highly regulated industries. The patient score system and archetypes can serve as a discussion topic for the ethical and pragmatic dimensions of leadership. Its potential as teaching material is diminished by the lack of empirical findings and practical examples.

The essay fails to articulate a clear implication for public policy, and this is an opportunity lost. With the linkage of patient outcomes to leadership behavior, the commentary could have provided policymakers with recommendations on how leadership practices with a patient orientation can be encouraged using regulations, industry practices, or finance.

Conclusion The essay posits significant implications for practice, research, and society, but such implications are not well explained and evidenced.

Although the commentary proposes innovative concepts like the patient score and councils of integrity, it

does not detail how such concepts could be implemented, measured, or scaled up.

The economic and social consequences are compelling but remain hypothetical since they are not supported by empirical evidence.

To best have an impact, the paper should make stronger recommendations for bridging the practice-theory gap, as well as a clearer explanation of how it can influence public policy, pedagogy, and social outcomes.

Consistency of Implications with Findings and Conclusions

The suggestions in the paper are generally consistent with its findings and conclusion. The commentary spotlights the risks of ambition-driven leadership personas and the necessity of patient-driven leadership, and this is consistent with the models suggested, such as the "patient score" and integrity councils. The appeal in the paper for sustainable leadership practice supported by complementary team dynamics also translates into actionable suggestions for organizational tools and initiatives.

But there are gaps in connecting the implications with findings.

Though the commentary chastises the bad influence of leadership personas on psychological safety, teamwork cohesion, and patient outcomes, it is not able to present sufficiently how the proposed solutions (e.g., integrity councils, patient-centered dashboards) address these issues directly. The lack of empirical evidence or case studies to back up such recommendations explains the gap between the results and the implications in real life. Further, the commentary does not fully address how its theoretical findings would translate into wider societal or policy-level changes, and this limits the implications to the scope. Quality of Communication

Clarity of Expression

The author's writing is superb and demonstrates excellent technical competence, with effective use of leadership theory and pharmaceutical industry terminology. The language applied to reading is appropriate for an academic who has some knowledge of organizational behavior and research on leadership and does not become excessively jargonized or full of acronyms that make it hard to read. The "convenient integrity" and "patient score" are defined clearly and properly so that they become understandable to readers.

However, the article sometimes deviates towards wordiness with lengthy sentences and lengthy paragraphs that may challenge readability for a few readers. For example, the theoretical accounts of ambition and honesty may be succinctly reduced for improved clarification and focus. Even though the commentary is full of specifics, the lack of pithy summaries or graphical depictions (e.g., diagrams,

tables) to indicate significant points may make it harder for the reader to comprehend the major arguments swiftly.

Use of Technical Language The technical terminology is well applied, particularly in relation to prevailing leadership theories such as authoritarian leadership, abusive supervision, and impression management.

Invocations of classic theories (e.g., Jungian archetypes, Goffman's impression management) are well integrated and are an indication of the familiarity of the author with his field. Commentary does take high levels of pre-existing knowledge on the part of its readership for granted, and this can limit accessibility to less specialist audiences, such as policymakers or practitioners outside the pharmaceutical sector.

Attention to Readability Even though the paper is generally readable, sections are overly dense with sentence structure and organization and would be better divided into more digestible subsections.

Additionally, the commentary has no practical examples or case studies in place to lend credence to its ideas, something that would make it easier to read as well as make the arguments more accessible to the reader as a whole.

Jargon and Acronyms

The essay shuns jargon and acronyms to excess, which is to be commended. Technical acronyms, when they are inserted (e.g., "RED-dominant leaders," "BLUE and GREEN profiles"), are defined in sufficient detail to enable readers to follow the arguments without confusion. The commentary could use rather clearer language when discussing conceptual abstractions like "convenient integrity" or "shadow self," as these will probably not be at once obvious to all readers.

Increasing Practical Utility Information on Integrity Councils and Patient-Centered Dashboards

Integrity Councils

To render integrity councils more practically relevant, the authors can:

Define Structure and Composition: Identify who would make up these councils (e.g., senior leaders, patient advocates, compliance officers, and external ethical professionals) and what their responsibilities and duties would be. For example, the council could oversee ethical decision-making, conflict management, and goal alignment with patient-centered goals.

Operational Framework: Provide a step-by-step guide to operationalize these councils, including where they would sit in existing organizational structures. This could include meeting frequency, decision-making, and reporting structures.

Metrics for Success: Suggest measurable metrics to determine the success of integrity councils, for example, the number of ethical dilemmas solved, employee scores on fairness, and patient outcome improvement.

Case Studies: Include examples of similar initiatives in other industries (e.g., ethics committees in medicine or compliance boards in finance) to demonstrate feasibility and provide actionable lessons.

Training Programs: Recommend training programs for council members in ethical leadership, conflict resolution, and patient-centered decision-making to equip them to carry out their functions.

Patient-Centered Dashboards

The implementation of patient-centered dashboards can be improved through the consideration by the authors of the following:

Define Key Metrics: Identify precise metrics that should be measured, such as trial timelines, pharmacovigilance reporting rates, patient access milestones, and employee retention rates. These metrics should have a direct link between leadership behaviors and patient outcomes.

Technology Integration: Provide guidance on how dashboards can be developed using existing data analytics tools or platforms. For example, dashboards could integrate clinical trial management system data, HR software, and pharmacovigilance database data.

Visualization Techniques: Recommend simple visualization techniques (e.g., heat maps, trend lines, graphs) to make the data visible and actionable for leaders and stakeholders.

Feedback Loops: Suggest processes for using dashboard insights to inform leadership decisions, e.g., through regular review in executive meetings or integration into performance management.

Pilot Programs: Suggest piloting dashboards in specific departments or initiatives to test their utility before scaling them across the organization.

Specific Interdisciplinary Research to Strengthen the Theory Base

To strengthen the theoretical foundations of the paper, the authors could tap into the following interdisciplinary fields:

Organizational Psychology

Explore studies on teamwork, psychological safety, and burnout to strengthen the explanation of the effects of leadership personas on employee performance and well-being. Studies on trust-building and conflict resolution could provide concrete guidance on how to foster more positive organizational cultures.

Behavioral Economics

Discuss how incentives and decision-making structures influence leadership behaviors. Behavioral economics can perhaps shed light on how leaders can prioritize patient-centered goals above personal ambition and external reputation.

Healthcare Ethics

Incorporate research on ethical decision-making in healthcare, particularly in regulated industries. This would augment the "authentic integrity" vs. "convenient integrity" section and provide frameworks for ethical leadership.

Data Science and Analytics

Offer data-driven decision-making and dashboard design scholarship to support the practical implementation of patient-centered dashboards. Data science findings can operationalize the "patient score" and identify valid proxies for leadership impact measurement.

Sociology

Explain the public significance of pharmaceutical leadership, including public trust in the industry and the impact of leadership on patient access to therapy. Sociological research can provide a broader context for the paper's findings.

Public Policy

Explain how leadership practice influences regulatory compliance and public policy. Research on policy frameworks that incentivize patient-centered leadership can increase the public impact of the paper.

Leadership Studies

Apply contemporary leadership theories, such as servant leadership and transformational leadership, to introduce additional models that are more consistent with patient-centered goals. This would offer a counterpoint to the personalities in the paper.

Through the incorporation of these interdisciplinary perspectives, the authors could provide a more robust theoretical underpinning and specific recommendations, which would enhance both the scholarly and practitioner applicability of the paper.

Providing More Specific Guidance on How to Establish 'Integrity Councils' and 'Patient-Centered Dashboards'

Integrity Councils

To give more particular guidance, the authors could:

Define Structure and Membership: Define the integrity council structure, for example, to have representatives from leadership, compliance, patient advocacy, and external ethics specialists. Define their duties, for example, to monitor ethical decision-making, resolve conflicts, and enforce conformity to patient-centered goals.

Operational Model: Establish a specific process to create and integrate such councils into organizational frameworks. Practical steps such as charter delineation, allocating meeting time, and establishing reporting mechanisms must be included to facilitate accountability.

Decision-Making Processes: Provide some illustrations of how the integrity councils can handle certain issues, e.g., ethical dilemmas of clinical trials or conflicts of being in line with regulatory rules and patient access. This would render the concept more tangible and comprehensible.

Success Indicators: Suggest measurable indicators to determine the success of integrity councils, such as the number of ethical dilemmas resolved, employee attitudes regarding fairness, and improvements in patient outcomes.

Training Courses: Suggest training council members in ethical leadership, conflict resolution, and patient-centered decision-making to equip them to work effectively in their positions.

Case Studies: Use examples of similar programs in other industries (such as ethics committees for the healthcare industry or compliance boards for the finance sector) to demonstrate viability and present actionable information.

Patient-Centered Dashboards

The authors may enhance application to practice through:

Define Key Metrics: Identify the key metrics that need to be measured, i.e., trial timelines, pharmacovigilance reporting rates, patient access milestones, and employee retention rates. These should be directly associated with the leadership behaviors and indirectly with the patient outcomes.

Technology Integration: Detail how dashboards would be constructed on current data analytics tools or platforms. For instance, dashboards could bring together data from clinical trial management systems, HR software, and pharmacovigilance databases.

Visualization Tools: Recommend basic visualization tools (e.g., graphs, heat maps, trend lines) to make the data understandable and actionable to leaders and stakeholders.

Feedback Loops: Recommend procedures for using dashboard findings as a basis for leadership decisions, e.g., regular review at executive meetings or incorporation into performance reviews.

Pilot Programs: Recommend piloting dashboards in specific departments or projects to prove their

impact before deploying them company-wide.

Stakeholder Engagement: Highlight the importance of involving patient representatives and frontline staff in dashboard design and review to ensure that they will pick up on real-world priorities and issues.

Discussing Particular Interdisciplinary Research to Strengthen the Theoretical Basis

To further strengthen the theoretical basis of the paper, the authors may look into the following interdisciplinary fields:

Organizational Psychology

Examine psychological safety, team building, and burnout research to better understand how the leadership personas affect employee well-being and job performance. Trust-building and conflict resolution studies could provide actionable strategies to assist in building healthier organizational cultures.

Behavioral Economics

Investigate how incentives and decision-making frameworks influence leadership behaviors. Behavioral economics could provide insight into how leaders prioritize patient-centered goals over personal promotion and reputation external to the organization.

Healthcare Ethics

Integrate evidence on ethical decision-making in healthcare, particularly regulated healthcare. This could enhance the argument of "authentic integrity" vs. "convenient integrity" and provide roadmaps for ethical leadership.

Data Science and Analytics

Address evidence on data-driven decision-making and dashboard design to guide the practical implementation of patient-centered dashboards. Data science findings could operationalize the "patient score" and recommend suitable proxies for measuring leadership impact.

Sociology

Look at the societal aspects of pharmaceutical leadership, including public trust in the industry and the impact of leadership on patients' access to drugs. Sociological studies can put the findings of the paper into a broader perspective.

Public Policy

Examine how leadership behaviors influence regulatory compliance and public policy. Policy studies on models promoting patient-centered leadership can enhance the paper's impact on society.

Leadership Studies

Resort to contemporary theories of leadership, such as servant leadership and transformational leadership, to introduce alternate models conducive to patient-centered goals. This could serve as a comparison to the personas in the paper.

By incorporating these cross-disciplinary perspectives and introducing nitty-gritty implementation strategies, authors could include theoretical heft as well as pragmatism into their discussion.

Specific Examples or Methods for Empirically Testing the 'Patient Score'

To empirically test the 'patient score' concept, one or more of the following methods could be used:

Quantitative Studies

Correlational Analysis: Examine the correlation between leadership behaviors and measurable patient-centered results, such as trial timeliness, pharmacovigilance reporting rates, patient access milestones, and staff retention rates. Compare organizations with high staff turnover to their ability to meet regulatory submission deadlines or maintain safety reporting standards, for example.

Longitudinal Studies: Track leadership individuals and their associated behaviors over time to quantify their impact on patient outcomes.

Metrics could be times through the innovation cycle, the success of trial recruitment, and therapy delivery rates.

Survey-Based Research: Conduct employee and patient surveys to assess measures of leadership integrity, psychological safety, and patient orientation. Compare these measures with organizational performance metrics.

Benchmarking: Measure patient-centered leadership practice organizations against non-practice organizations, using industry benchmarks such as trial success rates, compliance with regulations, and patient satisfaction scores.

Qualitative Studies

Case Studies: Create in-depth case studies of pharmaceutical companies that have implemented patient-centered leadership programs. Analyze the effects of leadership behaviors on team functioning, creativity, and patient outcomes.

Ethnographic Research: Watch actual leader behavior in action to record what behaviors add to or detract

from patient-centered goals. This could include following leaders during decision-making moments or collaboration with teams.

Interviews and Focus Groups: Gather data from employees, patients, and stakeholders on leadership influence on organizational culture and patient outcomes. Use thematic analysis to identify patterns that recur.

Mixed-Methods Research

Weave quantitative data (e.g., trial timelines, safety reporting rates) together with qualitative data (e.g., worker interviews) to create a rich understanding of how leadership personas influence the patient score.

Practical Steps or Examples for Implementing 'Integrity Councils' and 'Patient-Centered Dashboards'

Integrity Councils

Establish Clear Goals: Define the scope of the council, such as ensuring ethical decision-making, conflict resolution, and linking leadership behavior with patient-focused goals.

Composition: Invite varied stakeholders such as senior leaders, compliance officers, patient advocates, and external ethics professionals. For example, a council could include representatives from clinical development, regulatory affairs, and patient advocacy groups.

Operational Framework:

Charter: Develop a formal charter defining the roles, responsibilities, and decision-making authority of the council.

Meeting Schedule: Hold periodic meetings (e.g., quarterly) to discuss ethical issues, leadership practices, and patient-centered initiatives.

Reporting Mechanisms: Set up a system to report council decisions to senior management and employees.

Training Programs: Provide council members with training in ethical leadership, conflict resolution, and patient-centered decision-making.

Case Example: An institute might use its integrity council to review decisions regarding participation of patients in clinical trials, balancing fairness and transparency and upholding patient safety.

Patient-Centered Dashboards

Define Metrics: Establish key metrics to track, including:

Trial Timelines: Capture delay or efficiency in clinical trial stages.

Pharmacovigilance Reporting: Monitor the quality and quantity of safety reports.

Employee Retention: Capture turnover rates and associate them with leadership practices.

Patient Access: Capture the time it takes for therapies to reach the patient after regulatory approval.

Technology Integration: Utilize current data analytics platforms to consolidate and visualize data. Dashboards, for example, can link data from clinical trial management systems, HR software, and pharmacovigilance databases.

Visualization Techniques: Develop dashboards using easily consumable visuals such as graphs, heat maps, and trend lines to make data accessible to leaders and stakeholders.

Feedback Loops: Implement procedures to use dashboard insights in informing leaders' decisions. For example, executive sessions can review dashboards to identify areas for improvement.

Pilot Programs: Pilot dashboards in specific departments or projects to refine metrics and visualization techniques prior to rolling them out throughout the company.

Case Example: A patient-centric dashboard can be used by a pharmaceutical company to monitor trial recruitment efficiency, identify areas of delay, and take remedial action to provide therapies in a timely manner.

By combining empirical testing practices for the 'patient score' with actionable suggestions for implementing integrity councils and dashboards, the authors can present an efficient model for enhancing patient-centric leadership in the pharmaceutical enterprise.

Declarations

Potential competing interests: No potential competing interests to declare.