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Research Article

Leadership-Followership Relationship through the Pandemic for our First Lines of Defense: Healthcare Workers and Military Personnel

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Abstract

The scientific community internationally was compelled to find answers and therapies to control SARSCoV-2. In 2020, the World Health Organization (WHO) [1] affirmed a Public Health Emergency (PHE) of international concern, the highest level of alarm under international law (2020). The Centers for Disease Control and Prevention (CDC) warned that SARS-CoV-2, the virus that causes coronavirus disease 2019 (COVID-19), seemingly transmitted most by person-to-person contact (CDC, 2020) [2] so nationwide public health orders were exhorted. Amid an infectious pandemic, vaccines are a public health strategy implemented to prevent the spread of disease. The CDC continues to collaborate partnerships to fight new variants and lineages, maintaining global efforts to combat the largest viral genomic sequencing effort thus far. Nevertheless, the PHE for COVID-19, declared under Section 319 of the Public Health Service (PHS) Act, expired May 11, 2023. As we continue our fight with new variants of SARS-CoV-2, the virus that causes COVID-19, it is suggested that we learn from the past three years to understand and reference previous experiences, successes, and failures, to make better decisions in the present into the future. Not only is there an opportunity to strengthen the leadership-followership relationship by building trust through transparency, but now is the time to reimagine healthcare to create true interoperable visibility and consider how the first lines of defense can be better protected to serve others. This article reviews the timeline of the COVID-19 pandemic, the vaccine mandate, the effects on the first lines of defense, and the toxic triangle that created an onset of confusion, controversy, and fear throughout the country..

Keywords: Leadership-followership relationship; Pandemic; Public Health Emergency; Toxic Triangle of Leadership

COVID-19 Pandemic ~ Follow the Leader or Not?

We are taught early in life to be effective followers to our leaders and a question worth examining is what constitutes an effective follower? Does merely complying with authority or leaders make a follower effective or does questioning authority when uncertain equate to learning followers? The question that could be argued in times of crises, is it viable and trustworthy to blindly follow leadership-without questioning?

This paradoxical mystery of whether to follow the leaders leaves more questions than answers. Unequivocally, we live in a society where the notion of freedom is echoed. Freedom of what, exactly? If we discuss freedom of thought, then it is worth pondering the influence of our thoughts. Thoughts can be manipulated, persuaded, controlled, motivated, pressured, directed, swayed, or even inspired. During times of instability or disorder, people often seek decisive actions to restore order. This order can create a willing population to comply with rules, regulations, and stability. In the event of the recent pandemic, the virus can be viewed as the threat and a sense of 'being under attack' as we watched

people from around the globe display hardship, bewilderment, uncertainty, and suffering. As a result, fear deployed, and this extremely powerful human emotion prompted a willingness to comply with guidance heard from authority. Whether a threat is real is irrelevant to perception. Thousands of individuals lose their lives to drugs, crime, cancer, and the flu; nevertheless, the numbers of COVID-19 related deaths were plastered on the news regularly and prominently. The counter-terrorism budget compared to the war on drugs/crime within our nation hardly compares. Naivete can be a beautiful simplicity in life; however, if we are naïve with a curious insatiability and willingness to blindly follow, we must accept the consequences – good or bad.

In context of the pandemic, possibly the toxic triangle of factors created a vicious cycle of consequences that undermined the effectiveness of the nation and people within. The toxic triangle becomes poisonous when all three components are active participants: ineffective leadership, susceptible followers, and conducive environments (pandemic) and mixed the perfect storm for disaster. It is questionable whether those broken-hearted and confused questioned authority regarding the superfluous and often contradictory guidance on the virus, the vaccination mandate, and the quarantine guidelines. Self-preservation was highlighted by those who lived through the pandemic; however, what about those individuals who did not survive the virus – even when complying with the authorities?

An abundance of videos streamed throughout the internet provoked ridicule, thought, and empathy as healthcare workers to Soldiers were left without work for not complying with the vaccine mandates. It makes me wonder if we should be questioning guidance that forces out two of our strongest front-line lines of defense during the recent crisis or other crises. Don't we rely on these lines of defense to care for us in times of need? If we can force them out of their position for non-compliance, are we simply not opening the possibility of following toxic leadership as susceptible followers?

With the COVID-19 vaccination mandate lifted, where do these individuals remain? Whether moral beliefs against the mandate, other personal/religious values, or the freedom to question authority caused the force out, those forced may not feel the very freedom preached in our nation.

First Lines of Defense

Healthcare Workers and Military Personnel

There were twenty-two million workers in the health care industry, one of the largest and fastest-growing sectors in the United States accounting for 14% of all U.S. workers, according to the Census Bureau's 2019 American Community Survey (ACS) [3]. Within a year of the pandemic onset, Healthcare Workers (HCWs) began quitting in droves with nearly 1 in 5 leaving the industry [4].

Healthcare workers (HCWs) have historically experienced challenging working conditions with vulnerable populations, stressful deadlines, emotional situations, role ambiguity and conflict, exposure to infectious diseases and other challenges prior to the pandemic. The COVID-19 pandemic exacerbated these conditions through increased workloads, shortages in staffing, and limited personal protective equipment. With these unique conditions, the amount of anxiety, strain, stress, fatigue, and grief intensified. As HCWs placed others' care as a top priority, often their well-being (along with their families) suffered. As a result, HCWs experienced burnout. Stress and burnout were recognized internationally as work hazards for nurses before the pandemic. The pandemic has exposed nurses and other healthcare workers to conditions that threaten their health, well-being, and ability to work. One could argue the lack of accountability, pressure to care for patients, exhausting work schedules, and mismanagement could lead to disgruntled HCWs. Rightfully so when working beyond your scheduled hours with extreme challenges. Money alone will not fix the problem. Putting a price on mental health and work/life balance is not working. The same concern is echoed by HCWs: worker shortages lead to a lack of accountability from workers that are disengaged or working at a minimum. The result is more work for those other workers, which may create distrust in management.

At the management level there is a conundrum in determining whether having a worker with minimal productivity is better than having no worker. HCWs care for people. If a worker ends his or her scheduled shift but no one is available to pass off to the next shift, the patient must still be cared for. Leaders must assess the situation and know the capabilities and availability of workers who can assume duties in that area concerning the needs of the patient. When considering staff assignments and delegation of duties, leaders must also consider factors such as worker schedules, fatigue, level of knowledge or experience, and abilities to provide safe care. Abandonment of patients can occur in common behaviors from stressed workers such as leaving without reporting to the on-coming shift or licensed supervision, sleeping on duty, improperly or failing to report abuse or neglect, providing incompetent care, or many other behaviors. Leaders have the ethical and social responsibility to decipher when these behaviors breach basic responsibilities or ethical imperatives and become patient abandonment versus employment issues.

A survey of frontline HCWs from 2020 found that 93% faced stress, 86% reported anxiety, 77% experienced frustration, 76% described exhaustion and burnout, 75% were overwhelmed, 67% suffered sadness, 60% felt unappreciated, 56% noted anger, 55% conveyed fear, and 55% claimed feelings of loneliness [5]. Side effects of stress from the pandemic were reported in the following ways: Emotional exhaustion (82%), sleeping problems (70%), exhaustion (68%), work-related dread (63%), appetite

changes (57%), physical symptoms (56%), and questioning career path (55%), compassion fatigue (52%), and heightened awareness/worry/attention to exposure (52%) [6].

Even before the COVID-19 pandemic, HCWs were experiencing alarming levels of burnout-broadly defined as a state of emotional exhaustion, depersonalization, and low sense of personal accomplishment at work. Burnout can also be associated with mental health challenges such as anxiety and depression. In 2019, the National Academies of Medicine (NAM) reported burnout had reached "crisis" levels with up to 54% of nurses and physicians, and up to 60% of medical students and residents, suffering from burnout. The pandemic has since affected the mental health of health workers nationwide, with more than 50% of public health workers reporting symptoms of at least one mental health condition, such as anxiety, depression, and increased levels of Post-Traumatic Stress Disorder (PTSD) [7].

A comparable analysis of healthcare workers is the U.S. military service members regarding challenging working conditions. In 2021, there were 1.33 million active-duty U.S. Department of Defense members, including officers and enlisted personnel. There were over 1.3 million active-duty military members in 2022, according to the state of the union. Specifically, there were a total of 1.195 million active-duty military personnel within the five-armed services and more than 778,000 reserve forces according to September 2021 data from the Department of Defense [8]. The five-armed service members include Army (426,624), Navy (306,272), Marine Corps (147,846), Air Force/Space Force (275,298), and Coast Guard (39,029).

Service members, along with first responders, must prepare for and work through frequent potential life- threatening crises. For that reason, occupational stress has also been shown to be significant in this field. Both HCWs and military personnel are required to adjust and adapt to emerging threats, including disease outbreaks such as Coronavirus-19. These front lines of defense face direct morbidity and mortality effects of such disease outbreaks and must implement novel health and safety practices, adjust to new insight and up-to-date information, and grapple with managing related stressors. To support the public health goals, these lines of defense are confronted with following interventions and mitigation measures to maximize disease prevention and spread. A year into the pandemic over half (55%) of Army participants experienced stress to possible exposure to COVID-19, more than half (56%) were moderately to extremely worried about the ability of the health system to care for COVID-19 patients, and most participants (61%) were moderately or extremely worried about the government's ability to manage the pandemic [9].

Interventions such as resilience training, stress inoculation with biofeedback, mindfulness, psychological first aid, front-line mental health centers, two- to seven-day restoration programs, debriefing (including critical incident stress debriefing), third-location decompression, post-deployment mental health screening, reintegration programs, family-centered programs, acceptance-based skills training, attention bias modification training, group psychotherapy, eye movement desensitization, decompression, psychological resource strengthening, etc. have been prompted to combat stress and mental health issues within military personnel. Although interventions had positive effects on return to duty, absenteeism, and distress, minimal evidence was found for improving symptoms of psychological disorders such as PTSD, depression, and anxiety [10,11]. Studies have shown resilience-training programs to be beneficial for psychobiological stress response and recovery with one study that found resilience training helpful in real-life high-stress situations [12].

Healthcare Workers (HCWs) and Military Personnel Self Sacrifice

Both HCWs and service members were more worried about the threat of the pandemic to loved ones than themselves. Although this aligns with the self-sacrifice values historically embedded in caregivers and the military culture, the leadership ability to prioritize the greater good or others' well-being is noteworthy under normal circumstances and heightened during crises. With such a self-less value, it can be questioned whether a worrisome degree of mistrust in the government and leadership was increased. The lack of transparency could heighten the mistrust and shorten the confidence in the country's leadership. This potential mistrust within our two lines of defense during crises can have potentially grave consequences compared to the other populations or industries. A 2021 poll found that the public trusted healthcare workers more than the nation's public health institutions and agencies according to the Robert Wood Johnson Foundation and the Harvard T.H. Chan School of Public Health [13]. Not only did members of society question authority, but the military personnel did also. A vast majority of service members felt that the government lacked transparency with the public about COVID for political reasons diminishing confidence in leadership to provide accurate information [9]. In 2022, a CNBC poll reported that low trust in the federal government as a reason for unvaccinated Americans. "Census Bureau data from December show that lack of trust in the vaccine and lack of trust in the government are among the top reasons chosen by the unvaccinated to explain their vaccine decision-making" [14]. By 2023, UNICEF warned the confluence of factors suggested the threat of vaccine hesitancy might be increasing with an uncertainty about the pandemic response, emerging access to misleading information, diminishing trust in expertise, and political polarization. "Alarmingly, the decline in confidence comes amid the largest sustained backslide in childhood immunisation in 30 years, fuelled by the COVID-19 pandemic" [15]. In effect, 52 out of 55 countries reported a decline in the public perception of the importance of vaccines for children [15].

COVID-19 Pandemic Crisis

n 2020, the World Health Organization (WHO) affirmed a public health emergency of international concern, the highest level of alarm under international law (2020). Correspondingly, the Centers for Disease Control and Prevention (CDC) warned that SARS-CoV-2, the virus that causes coronavirus disease 2019 (COVID-19), was thought to be transmitted most by person-to-person contact [16]. As a result, the execution of nationwide public health orders to regulate person-to-person interaction and employment of personal protective practices were coordinated to slow transmission of the virus. Personal protective practice strategies were noted as stay-at-home orders, business closures, bans against mass gatherings, usage of cloth face coverings, and physical distance between persons [17]. What began as a public concern quickly turned into a pandemonium of confusion with continuing variants emerging. Currently, a total of 102,171,644 COVID-19 cases have been reported, a total of 1,103,615 COVID-19 deaths have been counted, and 668.8 million vaccine doses have been administered in the United States (as of January 25, 2023) [18]. Nevertheless, as of February 2023, "based on current COVID-19 trends, the Department of Health and Human Services (HHS) [19] is planning for the federal Public Health Emergency (PHE) for COVID-19, declared under Section 319 of the Public Health Service (PHS) Act, to expire at the end of the day on May 11, 2023" (para. 1).

Vaccine Mandate

The mandate proved to be controversial from the onset of discussions. However, vaccine mandates have historically been issued in both healthcare and the military (e.g., smallpox, anthrax, measles, mumps, hepatitis, rubella, influenza, etc.). Individuals may request a medical (e.g., pre-existing condition) or administrative exemption to the vaccination requirement [20]; however, it has been shown that minimal exemptions are approved according to the Associated Press (2022) [21].

In August 2021, the Food and Drug Administration (FDA) approved the licensing application for the Pfizer-BioNTech COVID-19 or Comirnaty vaccine (to be used on individuals aged 16 or older) [22]. President Biden ordered mandatory vaccinations for all 1.3 million active service members of the U.S. armed forces, for all U.S. businesses with 100 or more employees, and health care facilities participating in Medicare and Medicaid programs in November 2021. Because of the mandate and deadlines for compliance, employees from all industries were discharged or released from duty-including military service members and healthcare workers-for not complying with the ordered mandate.

The overarching adversity faced by those who lost their careers over a now-rescinded mandate are bemused and suffering by the devastation upon whom the mandate affected (e.g., titles stripped away, lost wages, health benefits, education, etc.). Thousands of healthcare workers were dismissed for not receiving the vaccine or quit since the onset of COVID and others have left the industry altogether. As of July 2022, over 60,000 unvaccinated Guard and Reserve Soldiers were released from their military duties, including military benefits [23]. During a current recruiting crisis [24], the Defense Department may continually struggle to fill the ranks with an abundance of Soldiers forced out of the military. Similarly, the healthcare industry may continually battle to fill staffing shortages.

The confusion blanketed the population as often changing public health information and recommendations surfaced. According to top scientists and nine experts from Harvard, Johns Hopkins, and others claimed booster mandates were unethical based on the questionable efficacy and disconcerting safety issues (e.g., serious adverse effects) of the COVID-19 vaccines [25].

The mandate controversy continues to wreak havoc in the public eye with differences of opinion. Nevertheless, the bill passed the House in December 2022 to rescind the COVID-19 vaccine mandate for the U.S. military and provide approximately $858 billion for national defense.

President Biden and the Department of Defense honoured the legal commitment of directing the Pentagon to rescind the COVID vaccine mandate; nevertheless, has our society corrected the wrongs felt by those suffering from mortality, illness, unemployment, financial hardships, etc.?

Status within the First Lines of Defense: Great Resignation and Disengagement

According to the State of the Global Workplace report, 85% of employees are not engaged or are actively disengaged at work. This sign of global mismanagement results in struggling organizations and frustrated employees prompting a hostile culture to grow exponentially. The "Great Resignation" or "Great Disengagement" is evident in healthcare. In May of 2022 during mental health awareness month, the new surgeon general advisory sounded alarm on health worker burnout and resignation according to the U.S. Department of Health and Human Services. An increased shortage of HCWs intensifies burnout. This linked cycle can be detrimental to facilities and staff as these devastating effects can further because turnover rates to increase. The problem is healthcare worker burnout harms individual workers and patients which can threaten the public health infrastructure. Longer working hours and even more challenging conditions cause an already susceptible staff to reach breaking points. Among the highest turnover positions within the healthcare industry, higher than most professions in other industries, include those staff directly caring for patients: Certified Nursing Assistants (CNA), Registered Nurses (RN), and Patient Care Technicians [26]. The

U.S. healthcare industry is forecasting a shortage of 3.2 million workers by 2026. The International Council of Nurses (ICN) (2021) [27] projected a global shortfall of more than 10 million nurses by 2030, which did not consider the pandemic effect - increasing the numbers of nurses reaching burnout, absenteeism, or leaving the profession – which could push that shortage to 14 million nurses.

With demographic shifts, educational challenges, and heightened turnover rates recruitment efforts to combat the healthcare shortages, include increasing educators to increase programs, enrolment, and training opportunities [31]. Based on the COVID-19 pandemic, about 1/3 of nurses are likely to leave the healthcare profession, roughly 94% of nurses reported a severe or moderate shortage of nurses in their area and approximately 89% of registered nurses (RNs) claimed the shortage is worse than five years ago [32,33]. Strategies for increasing enrolment through financial incentives (e.g., tuition assistance, scholarships, etc.) for accelerated, online, and shorter programs allow more flexibility for learners [34].

Every branch of the U.S. military is also struggling to meet recruiting goals and narrated as a "crisis plaguing our nation's best line of defense" [28]. The Army is particularly struggling with the lowest recruitment numbers. The shortage will continually reduce total force strength by thousands each fiscal year. By the end of fiscal year 2023, our services could be all but 30,000 Soldiers short of its 476,000-troop target [29]. As a volunteer service, military personnel must volunteer and with the diminished trust in the Biden administration, the recruits have minimized [29]. The battle to recruit new troops was projected into 2024 or longer without lowering admissions standards [30]. To optimize the recruiting shortages occurring in the military, strategies for 2023 and beyond include bonuses of up to 50 thousand dollars, promotions for referral signups, new recruiting ribbon, and the opportunity to choose service location as additional incentives [28,30].

Pandemic with Epidemic: Occupational Stress

Occupational stress has risen to be one of the most serious health issues globally. The World Health Organization (WHO) recognizes workplace stress as a global occupational phenomenon and epidemic because of the negative economic, health, and social outcomes. Occupational stress has been linked to adverse individual health outcomes at the psychological (poor emotional and mental health) and physiological levels (poor physical health). Occupational stress also leads to organizational symptoms and costs, causing employee turnover and absenteeism, loss of productivity, absenteeism, increased health care costs, and jeopardizing the safety of other employees and patients [35].

The National Institute for Occupational Safety and Health (NIOSH) defines occupational stress as "the harmful physical and emotional responses that occur when the requirements of the job do not match the capabilities, resources, or needs of the worker." Stress caused by a working environment, is a mental and physical condition that produces negative organizational and individual outcomes.

Stress arises due to physical or psychological demands (stressors causing strain), and the accumulation of the strain can result in long-term problematic emotional, psychological, physiological, and behavioural outcomes when an individual's adaptive capabilities are overextended. Stressors (e.g., environmental factors such as work demands or chronic work stress) directly influence perceptions of stress (e.g., appraisals or the degree of stress endured), which then follows several potential strains (e.g., emotional, behavioral, physical, and psychological reaction outcomes)-negative consequences of the stressors causing strain and stress [35].

Occupational stress has been a long-standing concern of the health care industry and military personnel. Workers providing health services or protecting our country have always faced challenges-or stress-as part of their jobs. Because of stressful occupations, both health workers and military personnel are more likely to experience mental health problems because of the working conditions.

Prior to the pandemic, studies indicated that health care workers had higher rates of substance abuse and suicide than other professions and elevated rates of depression and anxiety linked to job stress [36]. In addition to psychological distress, other outcomes of job stress include burnout, absenteeism, employee intent to leave, reduced patient satisfaction, and diagnosis and treatment errors. Treatment rationing was a main problem that faced among healthcare professionals. On April 11, 2020, the American Medical Association (AMA) released guidelines, a code of medical ethics for healthcare professionals during the pandemic. The urgency of medical need, anticipated benefits, and change in quality-of-life following treatments were among the guidance provided criteria for limited resources.

Combat and operational stress reactions (COSRs) are defined as "physical, emotional, cognitive, or behavioral reactions, adverse consequences, or psychological injuries of service members who have been exposed to stressful or traumatic events in combat or military operations," according to DOD Instruction 6490.05.

Military personnel are prone to exposure of potentially traumatic events that can threaten occupational functionality based on psychological distress and mental health issues. Previous research has repeatedly shown that work stress or occupational stress was prevalent in military personnel, with higher rates of depression than the general population [37] and even considered an occupational health hazard [38]. Enlisted military service members

were highlighted as having the "most stressful job in the world" [39]. The most noted mental health challenges among Veterans and service members include Post-Traumatic Stress Disorder (PTSD) and depression [40]. Although the stigma of mental illness has decreased in our society and culture over the decades, many Soldiers are still struggling to receive mental health assistance [41]. An aggravated problem is that military families - spouses and children, in particular – also may experience emotional and behavioral problems as a result.

Stress Disorder and Burnout

Experiencing or witnessing life threatening or traumatic events affects everyone differently. In some circumstances, the distress can be managed successfully to reduce associated negative health and behavioral outcomes. In other cases, people may experience clinically significant distress or impairment, such as acute stress disorder, Post-Traumatic Stress Disorder (PTSD), or secondary traumatic stress (also known as vicarious traumatization). Acute stress disorder can develop following a person's exposure to one or more traumatic events according to the American Institute of Stress. Posttraumatic Stress Disorder (PTSD) is defined by the Association for Behavioral and Cognitive Therapies as a stress-related disorder that develops after a traumatic experience, involving a combination of emotional, physical, and behavioral symptoms because of experiencing the traumatic event and that significantly affects the daily well-being of a person. The Vicarious Trauma Institute defined vicarious trauma as an indirect exposure to trauma through a first-hand account or narrative of a traumatic event. Since the start of the pandemic, the International Council of Nurses (ICN) reported mass trauma experienced by the global nursing workforce and has been calling for protection of the health workforce.

Since the start of the pandemic, the International Council of Nurses (ICN) reported mass trauma experienced by the global nursing workforce and has been calling for protection of the health workforce. Compassion fatigue and burnout may also result from chronic workplace stress and exposure to traumatic events during the pandemic. Research estimates that burnout cost the health care system about $4.6 billion a year before the spread of COVID-19, and that number has risen exponentially since. Burnout has reached crisis levels since the pandemic [42]. The World Health Organization (WHO) declared burnout an occupational phenomenon-rather than a medical condition. Characterized by feelings of exhaustion, disengagement from one's job along with increased mental distance with feelings of negativism or cynicism related to one's job, and a sense of diminished professional fulfilment or efficacy-burnout is considered the result of chronic work stress that the individual is not able to manage [43].

Leadership Role of Communication

Planning is key in any national crisis and especially in a pandemic that affects every element in society. During a pandemic with an expeditious nature of transmission and vast effects, effective assessment, coordination, and collaboration is essential for initiating a response. Accurate monitoring and assessment are crucial for enabling an effective response. Although this crisis influenced transparency between national and international public health agencies, there was still a misleading epidemiological picture of the situation. Effective communication with transparency allows leaders to clearly identify, assess, and activate solutions based on best strategy approaches. Ineffective communication can be an obstacle to not only activating solutions but may also fail to be integrated into the communities - causing additional confusion or misrepresentation of the situation exacerbating the situation even more. Given the immense uncertainty of the pandemic and its effects, complete transparency and clear communication was necessary at the government level down to the communities-to understand both real and potential risks, outcomes, and assistance. In January of 2022, the lack of regular communication from the CDC prompted criticism of the agency for confusing isolation and quarantine guidance from public health experts.

According to Dr. Tom Frieden, CDC director during the Obama administration now known to lead Resolve to Save Lives, an initiative to help governments and outside groups prevent epidemics, claimed that the CDC should uphold the principles: "Be first, be right, be credible, be empathetic and give people practical, proven things to do to protect themselves, their families and their communities" [44].

The public relies on professional health experts, government, and agencies to communicate during crises-especially when a pandemic virus is circling the globe and drastic actions are being taken. Nevertheless, during the pandemic, the variants of the virus and contagiousness of transmission were not clearly communicated with the public. There was debate on the transmission, the effects, and guidance for the public ranging from mask mandates to vaccinations-to name a few.

This lack of clear communication is complicated when viewed through both the lens of the agencies and the public. To save face or prevent misinformation, often information is withheld. This tactic can be beneficial when a lack of understanding is involved. However, this tactic can also cause mass confusion and limited guidance to the public that is unable to make an informed decision about the safety of themselves and/or families.

The leaders set the tone of the culture. Employees leave people, not organizations. Although the pandemic has drastically

changed the world of work, worker needs remain constant. Workers still need to feel valued, recognized, and heard. Meaningful relationships built on trust and transparency where employees feel heard, listened to, and understood build retention and strengthen culture. People leave when environments do not foster connection, collaboration, and engagement.

A Gallup analysis from March 2021 found that 48% of America's working population was actively job searching or watching for opportunities [45]. As this percentage grows, the time to act is now by reverse the tide. Managers and leaders must lead by example and foster cultures that empower purpose, inspiration, and motivation in workers to stay.

Conclusions: To Follow or not to Follow

Is leadership solely to blame or are the followers equally at fault throughout this pandemic? Leadership may not communicate as openly and frequently as desired by the public, messages that were communicated may have been contradictory and confusing in nature, and followers may not have followed guidance provided. Was there a complete breakdown in communication or policymaking transparency?

The pandemic created a flux of hysteria as some individuals yielded minimal to no symptoms, others drastic and long-lasting symptoms, still others suffered mortality. It is common to receive passive compliance from the mass public, especially when it came to wearing masks, using proper hand-washing techniques, and properly quarantining according to authorities. Therefore, even those blindly following may have been in contact with those non-compliant followers which fed the transmission rates. Others could have unintentionally transmitted the virus – unaware of housing the hosted virus to be spread. Moreover, the virus could have also been transmitted while seeking medical assistance or those treating the medical conditions. There are too many factors in this global crisis with too many variables to confidently point the finger in any one direction. For that reason, the truly valuable lesson is how effective are we-as individuals-during times of crises?

Toxic Triangle of Ineffective Leadership

The toxic triangle in ineffective leadership results from a confluence of components - when dysfunctional or ineffective leaders act together with susceptible followers in encouraging environments [46,47]. The toxic triangle requires three components working individually and collectively towards destruction, each contributing to flawed leadership situations: an ineffective leader; followers, who are either willing to submit to the leader or actively join the leader; and the conducive environment, including the contexts, circumstances, and conditions where leader-follower relationships occur [46,47].

The first component of the toxic triangle is an ineffective leader. The theory of follower compliance posits that followers comply with the directions of an ineffective leader through a system of influence triggers from a perceived need for compliance based on three prevailing variables: (a) the leader's perceived base of power, (b) the follower's source of motivation, and (c) the follower's resistance level [48]. Within the theory, five personal characteristics of ineffective leaders were identified: (a) charisma, (b) arbitrary use of power, (c) narcissism, (d) negativism, and (e) a hateful ideology (Padilla, 2013; Padilla et al., 2007). Flawed or ineffective leaders use their authority to further a personal agenda, by using control and coercion to execute their goals and resist opposing viewpoints rather than considering the benefit of the organization [49].

The second component of the toxic triangle is followers as a contributing factor of ineffective leadership [46]. Two types of susceptible followers were identified: conformers and colluders. Whereas the conformer complies with a flawed leader out of fear of punishment, the colluder willingly participates with the wishes of the flawed leader [46-48].

Finally, the third component of the toxic triangle is the conducive environment - the context in which the interactions between the flawed leader and their followers occur [46]. The climate of the organization can make ineffective leadership practices more or less averse based on acceptable cultural norms. In an environment where dysfunctional behavior is accepted, negative behaviors prevail, and victims develop coping skills [50]. The following four environmental factors play a role in flawed or ineffective leadership: uncertainty or instability, perceived threat, cultural values, and a deficiency of checks and balances [51]. Empirical evidence indicated that instability in an environment presents an opportunity for leaders to seize more power, thereby playing a role in effective leadership. Perceived threats also present a leader with an opportunity to gain more control over followers based on a willingness to submit during threatening situations. Furthermore, cultural values in an environment can be reinforced by a leader to promote an abstention of uncertainty, collectivism, and a high-power distance. Finally, the absence of a system of checks and balances creates an environment where a leader is free from constraints to collect and abuse power [51].

Final Thoughts

The pandemic raised varied ethical medical dilemmas and found areas for improvement in our leaders. Not only do our armed forces and healthcare organizations have a duty to prepare for and plan for crises, but our leaders must communicate an established plan well before it occurs to the people it serves [52-55]. Leaders must communicate with transparency, be decisive and take

immediate action, and allocate resources. We should be critical thinkers who are adaptable and knowledgeable to be effective, informed decision makers. We must understand that effectiveness and ineffectiveness are both contagious and what we do as individuals can have a real effect on others [56-61]. So, before we place blame on any one leader, agency, or authority figure, take the time to reflect on how our own actions and behaviors may have contributed to the present-day crisis and future crises we face as one humanity-all-inclusive and undivided. This crisis taught us the true lesson of areas we all could improve in regarding the importance of the leadership-followership relationship.

Clarine M. Jacobs, PhD-DBA, leads by example and strives to inspire others through her service work as a university educator and administrator. Her fascination in leadership and followership research began during her academic endeavours and continues to evolve with the emerging trends in the field.

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