

# Political Skill Across Health Care Leaders: A Longitudinal Analysis

Journal of Leadership &  
Organizational Studies  
1–15

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DOI: 10.1177/1548051820956651

journals.sagepub.com/home/jlo



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## Abstract

The health care industry is recognizing the importance of political skill among its professionals. To address this need, a longitudinal study investigates how the political skill of health care leaders ( $N = 555$ ) evolves and impacts unit performance. Utilizing cross-lagged panel through a three-wave study, measurement equivalence and analysis of variance, we found political skill to influence performance differently over time, across professions, and at the dimension level. Interestingly, political skill did not just influence next year's political skill levels in health care leaders, but also showed a strong positive influence on the unit's performance. Similar lagged overall effects were found for both clinical and nonclinical leaders with the caveat that political skills dimensions can evolve differently. For instance, networking ability is underdeveloped and likely to decrease over time for clinical leaders. In summary, future theories and applications consider the temporal elements, the dimensionality of political skill, and the differences in leaders' occupational interests. We discuss further implications and future research.

## Keywords

political skill, health care, leaders, time

The ever-changing context of health care requires leaders who are competent in meeting both technical and social demands (Spehar et al., 2012). Albeit these are professionals who are highly trained and skilled in their jobs, it is not uncommon to witness a lack of communication, coordination, and proper provision of patient care (Rau, 2016). Consequently, technical competence is not enough to properly excel in leadership positions in such complex environments, such as health care. It is important for leaders to portray social skills that facilitate interactions of the various professionals, such as political skill which is at the core of these social skills (Lvina et al., 2017). As a whole, the construct of political skill has been often used as a proxy for social competence (e.g., Blickle, Frohlich, et al., 2011), and a precursor for a variety of key work-related outcomes, such as job performance (e.g., Liu et al., 2007) and leadership effectiveness (e.g., Ewen et al., 2013).

Accordingly, political skill is one of the key leadership capabilities that one must develop in any position (Zaccaro et al., 2018). In particular, these health care leaders must be especially politically skilled, and demonstrate “the ability to effectively understand others at work, and to use such knowledge to influence others to act in ways that enhance one's personal and/or organizational objectives” (Ahearn et al., 2004, p. 311). There is growing evidence that these capacities enable necessary influence to achieve critical

organizational goals (Ferris et al., 2002). For instance, powerful leaders that were high in political skill achieved greater follower satisfaction (Blickle et al., 2013). However, to what extent will political skill of leaders influence organizational outcomes?

Considering the context of health care where burnout is a common threat (Kilroy et al., 2017), having leaders that are politically skilled can aid in understanding the needs of other employees as well as the environment of the workplace. Particularly good leadership requires individuals to read situations and adapt their behaviors accordingly (Zaccaro et al., 2018). However, political skill may be differentially useful for managing the complexities of both clinical and nonclinical settings (Stefl & Bontempo, 2008). This comparison between clinical and nonclinical leaders (NCLs), albeit predominant in health care, is currently understudied (e.g., Clay-Williams et al., 2017). With such distinct roles and responsibilities, these leaders are likely

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required to portray different knowledge, skills, and abilities to properly navigate their daily activities. Furthermore, the underlying skills for health care professionals that shape the adjustment of their behaviors can differ due to the demands from each occupation. Some may innately adapt to situational demands and influence followers, while all leaders have potential to foster political skill through intentional development (Shaughnessy et al., 2017). It is important to untangle the stability of political skill across these types of health care leaders to shape more effective interventions, especially longitudinally.

Because recent calls have brought soft skills, such as the combination of social astuteness (SA; i.e., empathy) and adjustment of behavior according to situational demands (i.e., adaptability), to the forefront of health care (e.g., iCIMS, 2017), it is timely that an investigation of the extent to which health care leaders possess and maintain a certain level of political skill at work is conducted. To address these gaps, it is important to hone in on whether leaders' political skill can influence unit performance as well as the extent to which this construct evolves differently across health care leaders over time. Thus, the purpose of this study is three-fold. Specifically, the present study contributes to the literature of occupational and organizational psychology by (a) empirically testing how clinical and NCLs differ in their levels of political skill, (b) assessing the stability of political skill, and (c) understand the political skill-performance relationship across a 3-year timespan.

## **Political Skill in Health Care**

Although the main concern of all employees is to deliver the best service to patients, the decision makers around hospitals can greatly differ in backgrounds, from more administrative to clinical (Mountford & Webb, 2009). In this article, we differentiate them as clinical leaders (CLs) and NCLs. More specifically, CLs may be thought of in their simplest form as "leadership by clinicians of clinicians" (Malby, 1998), but the definition has expanded to include those leaders who retain some clinical role while simultaneously contributing to the health care system's strategic direction and operational resource management, and working collaboratively with their colleagues, health care managers, and other agencies (e.g., social care; Edmonstone, 2009). In contrast, NCLs typically have a macro-view, focused on the entirety of the organization in relation to outcomes. NCLs typically gain power through a competitive selection process, selected to lead based on prior experience and achievements (Edmonstone, 2009).

Albeit these two vocations are under the same category of leadership in health care, their emphasis can widely differ as CLs can be more patient-focused and the NCLs more organizational focused, leading to divergence in political skill nuances. Some may have self-selected into such

occupations due to their preferences, whereas others may have developed such skills along the way. Although there are many differences between CLs and NCLs, they both serve the key function of exerting influence over their followers. While the development of political skill in CLs and NCLs may vary, both professions require social competence to appropriately adapt their behavior across contexts and interpersonal interactions to elicit desired responses from those around them and, subsequently, enhance their unit outcomes.

As briefly mentioned, political skill can be defined as the ability to adapt to changing situations and to shape others' behaviors to align to self or organizational goals, and is composed of four dimensions: interpersonal influence (II), apparent sincerity (AS), networking ability (NA), and SA (Ferris et al., 2005). II refers to one's flexibility (Pfeffer, 1992) or the extent to which individuals can appropriately adapt and calibrate their behavior to elicit particular responses from others (Ferris et al., 2007), whereas AS is related to how such influence is perceived by followers, in terms of demonstrating genuineness and a lack of ulterior motives (Ahearn et al., 2004). These two dimensions are more closely related to the influence and perception of the politically skilled individuals. As for NA, this dimension can be defined as the ability to leverage one's network to influence others and to effectively create ties with influential people to help foster their initiatives (Shi et al., 2013). Relatedly, SA refers to effectively interpreting behaviors of others, perceiving their hidden agendas, across different situations (Ferris et al., 2005). The latter two dimensions can be clustered as those in which individuals properly understand and utilize others to attain individual, subgroup or even overarching organizational goals.

## **Measurement Equivalence/Invariance**

When trying to identify subgroup differences, it is important to first establish measurement equivalence/invariance (ME/I) for the variables of interest in order to ensure these comparisons and conclusions are based on psychometrically sound properties. ME/I refers to how similarity constructs operate across subgroups by establishing that both groups interpret scale items in the same way and have equivalent factor structures (Byrne & Watkins, 2003). Therefore, to compare CLs and NCLs, an important first step is establishing that both groups share a similar frame-of-reference when interpreting political skill. In the event the subgroups differ in their views of the construct—regardless of mean differences—, they should not be compared. This is, in fact, a pre-requisite, although often overlooked, for cross-group comparisons (e.g., van de Vijver & Leung, 2000).

However, one cannot assume different professions in health care, with divergent occupational interests, will see the construct similarly to each other. While both CLs and

NCLs likely require some degree of political skill, the differential factors that influence these separate leaders may pose challenges from a measurement equivalence perspective. For example, ME/I evaluations may examine the stability of a measure over time (Golembiewski et al., 1976) and across different sample populations (e.g., cultures, clinical vs. nonclinical; Riordan & Vandenberg, 1994). However, the different training backgrounds and work environments that CLs and NCLs face may influence not only their development of political skill, but also their view and interpretation of the construct as a whole.

To compare the differences of political skill between leaders in health care, it is critical to first ensure these two subgroups view political skill in a similar light (e.g., configural invariance would indicate they agree with the four-dimensional structure). Political skill has shown evidence of construct validity and reliability, but, most importantly, measurement equivalence across other groups. For instance, Lvina et al. (2012) show how this construct was seen by five different cultural groups (i.e., employees from China, Germany, Russia, Turkey, and the United States) similarly. With the growing evidence that even more distinct subgroups have achieved measurement equivalence with this measure, similar findings should be expected when comparing leaders in the health care industry. Thus, prior to exploring differences in the nuances or levels of political skills across CLs and NCLs, we must first hypothesize:

**Hypothesis 1:** The factor structure of political skill will be viewed similarly across CLs and NCLs in regards to (a) factor structure (i.e., configural invariance); (b) loadings (i.e., metric invariance); and (c) intercepts (i.e., scalar invariance), thereby indicating strong measurement equivalence.

### *Leader Type by Political Skill Dimensions*

As noted previously, political skill is comprised of four sub dimensions: II, AS, NA, and SA. However, CLs and NCLs may excel within differing areas of political skill due to their roles within the hospital. Assuming measurement equivalence across these subgroups, we expect political skill to develop differently for these leaders. For instance, II refers to adapting one's behavior situationally to different targets of influence across various contextual conditions in order to achieve one's goals (Pfeffer, 1992). This type of adaptation is common within health care given the continually changing work and conditions that employees face (e.g., Weaver et al., 2014). These conditions can vary within high workload periods to allow for fast decision making.

While both CLs and NCLs must adapt to these changes, since they are immediately involved in delivering care, CLs more often have to adapt to rapidly changing patient and subordinate needs. Specifically, CLs must quickly change

their schemas to deliver care that may greatly differ in regards to social and technical needs (Schwartz & Pogge, 2000) as well as to appropriately draw from the present varying conditions in ways that still encourage their peers, followers, and patients to follow their direction (Stoller, 2009). While CLs aim to influence others through persuasion and evidence, NCLs influence their peers through more hierarchical means using their status and power (Edmonstone, 2009). Considering CLs operate across a diverse range of settings rather than situations that are similar in nature when influencing others, it is likely CLs are more interpersonally influential than NCLs as they are continually challenged to adapt within their roles.

Similarly, individuals with AS possess high levels of integrity, authenticity, sincerity, and genuineness, inspiring trust and confidence in those around them (Ferris et al., 2005). Establishing such trust is critical for CLs when delivering patient care and spans beyond patient interactions alone to also define how clinicians interact with peers. More specifically, with their primary focus oriented toward patient safety, CLs establish trust within their units by using evidence-based practices to support their views and escalate their influence attempts among others (Edmonstone, 2009). Their AS is not only established by leveraging scientifically backed practices but is also mandated by the Hippocratic Oath where clinicians swear to protect patient safety (Schwartz & Pogge, 2000). Failing to uphold this oath by acting for one's own personal interests could result in loss of lives and the clinician's license, highlighting the need for CLs to possess this skill throughout their career. While the aim of CLs is to protect patient safety and deliver care, NCLs may be more likely to be viewed as having self-interested goals. For example, CLs tend to feel obligated to step into leadership roles to represent the views of their clinical peers. However, those in NCLs may be more likely to compete against one another for leadership roles, coming off as less sincere as they serve their own needs before those of others (Ferris et al., 2007).

On the other hand, individuals possessing a strong *network ability* are seen in central positions within their team's and organization's communication networks, providing them access to a breadth of information and personnel (Shi et al., 2013). NCLs are ideal to serve as boundary spanners between clinical and nonclinical personnel as they often reach outside of their direct unit for their job to facilitate information sharing. Accordingly, to be successful within their role, NCLs must maintain a diverse set of ties and possess a holistic understanding of their network, as many times their work requires input from those outside their group.

Contrastingly, CLs are able to achieve their goals and deliver patient care by working directly with their units and teams. Rather than leveraging a diverse network, these individuals rely heavily on the tight knit group of clinicians within their unit (Zhou et al., 2015). Not only do clinicians

rarely work outside their unit to deliver care, the team familiarity these units create is critical for patient safety. Specifically, patient outcomes are negatively impacted when clinicians work with unfamiliar individuals outside their network to deliver care (Xu et al., 2013). The narrow scope of their network becomes apparent when clinicians step into leadership roles; indeed, qualitative reviews of nurse leaders suggest that nurses stepping into such roles must network to develop a clear corporate view (Cook, 2001). Contrary to CLs, NCLs become leaders with an intact view of the organization network and more training opportunities available to build their networking ties.

Along these lines, *socially astute* individuals are seen as indigenous, even clever in dealing with others (Ferris et al., 2007). This characteristic is apparent in NCLs, as they are likely to be central within the organizational network and therefore interact with many individuals. NCLs must learn to understand opposing views and to anticipate the behaviors of others in order to successfully complete their work and push their objectives forward. As NCLs are uniquely situated to observe both clinical and nonclinical interactions, their SA may be more readily developed through interactions with individuals across a wide range of organizational and social situations.

In contrast, CLs primarily operate within the context of delivering patient care, making many of their social interactions contextually similar in comparison with nonclinical employees. They may not need to interpret other's behaviors/hidden agendas, as they largely work with others who share their goal of delivering excellent patient care to ensure patient safety (Westaby et al., 2014). As CLs may take on leadership positions as a sense of obligation to protect the best interests of the clinical staff (Spehar et al., 2012), SA from an organizational perspective may simply not be as well-developed or as important for CLs when compared with NCLs. Taking these arguments together, we hypothesize:

**Hypothesis 2:** CLs will demonstrate (a) higher levels of II, (b) higher levels of AS, (c) lower levels of NA, and (d) lower levels of SA than NCLs.

### Political Skill Stability

Due to the dispositional-situational nature of political skill, training, practice, and experience all shape its development across individuals (Ferris et al., 2002). This complexity makes understanding the development of political skill within health care challenging, as hospitals and health care systems are comprised of both clinical and nonclinical roles that expose employees to contrastingly different situations and experiences that may shape their political skill development in varying ways. Indeed, while CLs may be coordinating with their medical team to deliver patient care and relay

accurate information to patients and their families, NCLs may be corresponding with one another to create a new strategic organizational plan. These situations likely require different aspects of political skill, resulting in differential development of this characteristic within the health care system.

Considering these differences, it becomes necessary to consider political skill not as one construct, but as the four facets that compose political skill, including II, NA, AS, and SA, to more accurately assess how political skill emerges in this population and identify areas that may be underdeveloped across these different roles. Accordingly, a study done with leaders from various types of organizations identified II and NA as key political skill dimensions for leadership effectiveness (Moss & Barbuto, 2010). When interacting with NCLs, clinicians' primary aim is to ensure that organizational decisions are made in alignment with the medical population's views and needs (Edmonstone, 2009; Spehar et al., 2012). As CLs serve in managerial roles to represent these views, they will likely draw on evidence-based recommendations to persuasively influence NCLs and ensure they reach an informed decision within the hospital (Edmonstone, 2009). Thus, this skill begins to develop when CLs start their journey as a medical resident, and it is continually practiced in their medical environment.

The research on the dimensions of political skill over time remains underdeveloped. Although some have started to find evidence toward the dispositional nature of political skill (Liu et al., 2007), others make strong claims that social and emotional competencies are usually developed on-the-job for administrative leaders in health care (Robbins et al., 2001). In reality, these arguments are not on polar opposites of the spectrum, but the possibility that some of the dimensions have a dispositional-based component that attracts individuals for such roles can be integrated with the fact that the situation will call for further development of some of these dimensions. Taking a step further, we can extrapolate that not only will CLs and NCLs have different levels of political skill but also that these levels will change as they spend more time in their leadership roles. Thus, we ask:

**Research Question 1:** Does political skill have more stable or malleable dimensions across CLs and NCLs?

### Over Time Effect

In addition to understanding how political skill works and evolves in health care professionals, it becomes crucial to understand whether this construct can bring short-term and long-term gains to the organizations. There is a wealth of research showing that politically skilled individuals will perform better (e.g., Andrews et al., 2009; Ferris et al., 2005; Liu et al., 2007), in terms of both contextual and task



performance (Jawahar et al., 2008). It is not surprising that individuals with high levels of understanding of their coworkers and the ability to influence their followers to support organizational objectives will achieve the highest levels of performance in an organization.

However, most of the studies on political skill only show this influence either using some type of archival (e.g., Treadway et al., 2013) or cross-sectional data (e.g., Blickle, Kramer, et al., 2011). An exception includes a longitudinal study of political skill focusing on its role as a moderator of the personality–performance relationship and, albeit collecting over time data, all data were collected within a year (e.g., Hochwarter et al., 2007). Although the effect is likely to weaken over time, having politically skilled leaders should still have an impact on the unit performance for many years to come. Part of the association between political skill and performance is often due to these individuals' ability to better manage others' impressions (Harris et al., 2007). This is a crucial skill to have within health care leadership where simultaneous management of patient, peers, and organizational needs are required and changing. Having the ability to influence multiple layers of the organization and push others toward organizational goals is a strength that should yield results at the individual and unit-level of analysis. Therefore, we hypothesize the following:

**Hypothesis 3:** There is a positive time-lagged effect of political skill on unit performance.

## Method

### Sample and Procedure

We conducted a longitudinal assessment of health care leaders employed at a large health care system in the southeast by administering annual self-report surveys. This study was designed as a three-wave study with a time lag of 1 year, in which participants completed brief online surveys in 2014 (Time 1 [T1]), 2015 (Time 2 [T2]), and 2016 (Time 3[T3]), capturing self-reported political skill in all years as well as unit performance for the latter years. Leaders were classified as either CLs or NCLs based on their formally appointed roles, where CLs worked in clinical areas and oversaw employees directly involved in patient care (e.g., anesthesiologist, nurses, doctors, lab technicians), while NCLs oversaw employees not involved in patient care (e.g., health care administrators, executives, financial services).

Overall, we had 555 leaders who completed at least two time-points of the study. More specifically, at T1, 446 leaders participated (response rate 58%;  $N_{CLs} = 218$ ,  $N_{NCLs} = 228$ ); at T2, 629 leaders participated (response rate 64%;  $N_{CLs} = 311$ ,  $N_{NCLs} = 318$ ), and T3, 627 leaders participated (response rate 63%;  $N_{CLs} = 312$ ,  $N_{NCLs} = 318$ ). Three participants were removed from analyses due to moving from a CL to a NCL

role between years. After removing participants who only completed one time point of the study and that did not include their occupation, the final data sample had 267 participants categorized as CLs and 266 as NCLs. On average, CLs had been in management for 4.59 years and the majority were female (17.80% male), while NCLs had been in management for an average of 5.25 years and 38.14% were male.

Data were matched by the research team using employee ID numbers. To ensure that selective dropout would not bias our results, we compared those that participated in at least two time points with those that did not complete our surveys or only filled out one time point (the details of which can be found in the online Appendix A, all appendices mentioned in this article can be found online as supplemental materials). When comparing the demographic data of all system leaders, there were no significant differences between those that participated at two time points or more in comparison to those who did not in terms of race,  $\chi^2(5) = 1.38$ ,  $p = .927$ ; gender,  $\chi^2(1) = 3.67$ ,  $p = .055$ ; and tenure,  $\chi^2(8) = 10.679$ ,  $p = .221$ , but there was a significant difference in age,  $\chi^2(5) = 22.53$ ,  $p < .05$ . However, there were no significant differences in our primary study variables of political skill and unit performance for those that completed two or more surveys in comparison with those that only completed one survey for any of our measurement occasion. Therefore, we are confident that our results are not due to selective dropout.

### Measures

**Political Skill.** For T1 and T2, we used the 18-item political skill scale (Ferris et al., 2005) that measured the four sub-dimensions of political skill: NA, II, SA, and AS. The Cronbach's  $\alpha$  values were  $\alpha = .89$  and  $\alpha = .90$ , for T1 and T2, respectively, whereas a shortened version of the scale with 12 items was used for T3 ( $\alpha = .84$ ). Participants indicated the extent to which they agreed with each statement on a 7-point Likert-type scale (1 = *strongly disagree* to 7 = *strongly agree*). Cronbach's  $\alpha$  for the overall scale and its dimensions were above the recommended cutoff of .70 across all 3 years, except for AS at T2 ( $\alpha = .635$ ; Nunnally & Bernstein, 1994; see Table 1, for reliabilities).

**Unit Performance.** To assess unit performance, we used an adapted version of Hackman's (1987; Edmondson, 1999) team performance measure. At T2, we used one item from this metric to assess unit performance, "The unit I supervise meets or exceeds expectations," which is a common team performance measure leveraged in health care (Edmondson, 1999). At T3, two items were used to assess team performance, which included both the previous item and the item "The unit I supervise does superb work." At T3, the Cronbach's  $\alpha$  for unit performance was  $\alpha = .86$ .

**Table 1.** Means, Standard Deviations, and Correlations Between Political Skill and Political Skill Dimensions Over Time.

	M	SD	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
<i>Year 1 (N = 446)</i>																			
1. NA T1	5.24	0.87	(.85)																
2. AS T1	6.53	0.46	.33**	(.71)															
3. SA T1	5.35	0.81	.58**	.31**	(.81)														
4. II T1	5.82	0.60	.55**	.39**	.60**	(.75)													
5. PS T1	5.74	0.54	.84**	.57**	.84**	.81**	(.89)												
<i>Year 2 (N = 629)</i>																			
6. NA T2	5.20	0.92	.62**	.25**	.39**	.39**	.56**	(.83)											
7. AS T2	6.46	0.50	.23**	.50**	.20**	.31**	.37**	.34**	(.64)										
8. SA T2	5.37	0.80	.39**	.20**	.65**	.42**	.56**	.61**	.34**	(.81)									
9. II T2	5.78	0.66	.39**	.27**	.40**	.62**	.54**	.56**	.43**	.59**	(.71)								
10. PS T2	5.70	0.57	.56**	.36**	.55**	.56**	.66**	.85**	.60**	.84**	.81**	(.90)							
11. Perf T2	5.78	1.18	.22**	.17**	.11*	.20**	.22**	.21**	.17**	.14**	.20**	.23**	—						
<i>Year 3 (N = 626)</i>																			
12. NA T3	4.92	1.06	.53**	.13*	.24**	.27**	.40**	.61**	.19**	.30**	.32**	.48**	.12*	(.75)					
13. AS T3	6.57	0.56	.17**	.47**	.20**	.26**	.32**	.24**	.47**	.21**	.25**	.34**	.19**	.22**	(.80)				
14. SA T3	5.10	0.95	.42**	.21**	.55**	.41**	.53**	.42**	.18**	.58**	.41**	.53**	.12*	.38**	.26**	(.84)			
15. II T3	5.95	0.71	.38**	.28**	.35**	.57**	.50**	.41**	.39**	.39**	.59**	.56**	.12*	.34**	.41**	.54**	(.84)		
16. PS T3	5.63	0.60	.55**	.31**	.47**	.51**	.59**	.62**	.37**	.54**	.55**	.68**	.18**	.75**	.56**	.79**	.76**	(.84)	
17. Perf T3	6.05	0.93	.16**	.23**	.08	.16**	.19**	.14**	.14**	.07	.13**	.14**	.32**	.15**	.23**	.11**	.15**	.21**	(.86)

Note. The coefficients on the diagonal are the Cronbach's  $\alpha$  of each scale.  $N$  = sample size; NA = Networking Ability; AS = Apparent Sincerity; SA = Social Astuteness; II = Interpersonal Influence; PS = Political Skill; T1 = Time 1; T2 = Time 2; T3 = Time 3.

\* $p < .05$ . \*\* $p < .01$ .

**Control Variables.** No control variables or third variables were included in the analyses. As noted by Taris (2000), within longitudinal designs, control variables, and third variables have minimal impact as these designs allow for participants to act as their own controls.

## Data Analysis

**Confirmatory Factor Analysis.** Before conducting our analyses, we conducted tests of normality assumptions and found only slight nonnormality in our data, as the absolute values for both skewness and kurtosis were less than 1.0 (i.e., political skill skewness range =  $-.34$  to  $-.54$ , political skill kurtosis range =  $.25$  to  $.36$ ; Lei & Lomax, 2005). Although there is slight nonnormality in political skill, simulations indicate that such nonnormality has minimal effects on parameter estimates for maximum likelihood and that sample sizes with over 100 participants, such as ours, produce more precise estimates (Lei & Lomax, 2005). Subsequently, an item-level confirmatory factor analysis using maximum likelihood estimation was conducted on the political skill items for T1, T2, and T3 using EQS 6.3 (see Appendix B for details on its psychometric properties). Using the four-factor model presented by Ferris et al. (2005), the fit indices revealed an increasingly good model fit for T1 (comparative fit index [CFI] =  $.89$ , root mean square of approximation [RMSEA] =  $.079$ , 90% confidence interval [CI]:  $.071$ ,  $.086$ ], normed fit index [NFI] =  $.85$ ), T2 (CFI =  $.91$ , RMSEA =  $.068$  [90% CI:  $.062$ ,  $.075$ ], NFI =  $.89$ ), and even

better for T3 (CFI =  $.98$ , RMSEA =  $.049$  [90% CI:  $.038$ ,  $.049$ ], NFI =  $.96$ ).

**Hypotheses Testing.** To test our hypotheses, we utilized different analysis strategies. First, we employed structural equation modeling techniques to test the ME/I in Hypothesis 1 as well as the cross-lagged panel (CLP) analysis in Hypothesis 3 using LISREL 9.2 statistical program (Jöreskog & Sörbom, 2015). More specifically, we applied the ME/I Mean and Covariance Structure Analysis (MACS) method to examine the ME/I of political skill across CLs and NCLs (i.e., Hypothesis 1) to capture the extent to which participants interpret the construct and its dimensions in a similar conceptual manner. For Hypotheses 3, a CLP analysis was conducted to investigate the extent to which political skill influences unit performance across the 3 years. This hypothesis is estimated and compared with the following structural equation models:

1. A stability model with cross-lagged structural paths (Model  $M_1$ );
2. A model with cross-lagged structural paths and correlation between same-time variables (Model  $M_2$ );
3. A model without same-time and without the reciprocal effect from Unit Performance T2 and Political Skill T3 (Model  $M_3$ );
4. A model rearranging causal order by having same-time unit performance predict political skill as well as Political Skill T1 predicting Unit Performance T3 (Model  $M_4$ );

**Table 2.** Measurement Equivalence/Invariance Results.

ME/I Model	$\chi^2$	df	RMSEA (90% CI)	TLI	CFI	$\Delta$ CFI
<i>Clinical vs. nonclinical leaders (Year 1)</i>						
1. Configural invariance	734.445	258	.091 [.083, .099]	0.936	0.946	
2. Metric invariance	750.185	272	.089 [.081, .096]	0.939	0.946	0.000
3. Scalar invariance	761.890	286	.086 [.079, .094]	0.943	0.946	0.000
<i>Clinical vs. nonclinical leaders (Year 2)</i>						
1. Configural invariance	690.796	258	.073 [.067, .080]	0.957	0.964	
2. Metric invariance	719.867	272	.072 [.066, .079]	0.958	0.963	−0.001
3. Scalar invariance	742.148	286	.071 [.065, .078]	0.959	0.962	−0.001
<i>Leaders' political skill Year 1 vs. Year 2</i>						
1. Configural invariance	998.084	258	.073 [.068, .078]	0.958	0.964	
2. Metric invariance	1007.935	272	.071 [.067, .076]	0.960	0.965	0.001
3. Scalar invariance	1021.354	286	.069 [.065, .074]	0.962	0.965	0.000

Note. RMSEA = root mean square of approximation; CI = confidence interval; TLI = Tucker–Lewis index; CFI = comparative fit index.

- 5a. A model of lagged effects of Political Skill to Unit Performance without Political Skill T3 (Model  $M_{5a}$ );
- 5b. A model with the addition of correlation of same-time variables (Model  $M_{5b}$ );
- 5c. A model with the addition of same-time paths (Model  $M_{5c}$ ).

We followed recommendations to interpret nonoverlapping 90% RMSEA CIs (Cadiz et al., 2009; Wang & Russell, 2005), and a  $\Delta$ CFI larger than .01 (Cheung & Rensvold, 2002) as indicators of nonequivalence and because of recognized concerns about the restrictiveness of the chi-square statistic, as well as its sensitivity to sample size (Jöreskog, 1969; Quintana & Maxwell, 1999), more reliable indices in assessing the reasonableness of proposed model fit were used, such CFI higher than 0.90 and RMSEA lower than 0.07 (e.g., Byrne, 2006; Steiger, 2007). The CLP used a path analytical approach where we tested the causal direction from political skill and unit. For the analyses, the method of estimation of the entire data was maximum likelihood. Additionally, we draw from independent samples  $t$  test as well as repeated measures analysis of variance in SPSS version 22 to test Hypothesis 2 and answer Research Question 1, respectively.

## Results

Descriptive statistics, intercorrelations, and internal consistency coefficients of our study are shown in Table 1. All the study variables correlated positively with each other and a similar pattern of correlations were found CLs and NCLs.

### Measurement Equivalence/Invariance

In Hypothesis 1, we predicted that we would find strong measurement equivalence in political skill measures across

CLs and NCLs. This was an assumption that was deemed necessary to be met prior to any subgroup comparisons. ME/I can be defined as a similarity in the conceptualization of a given construct across two or more groups (Meade et al., 2008; Vandenberg & Lance, 2000). When measurement equivalence is established, it refers to the similarity in the relationships between the observable and concealed variables across the subgroups (Drasgow, 1984).

After ensuring the four-factor structure was appropriate, we assessed ME/I across CLs and NCLs based on Vandenberg and Lance's (2000) recommendations. More specifically, we interpret no overlapping 90% RMSEA CIs (Cadiz et al., 2009; Wang & Russell, 2005), and a change in CFI larger than .01 (Cheung & Rensvold, 2002) as indicators of nonequivalence. As both the factor structure and subgroup comparisons are deemed acceptable, we were able to properly juxtapose mean levels determined whether there were differences in levels of political skills, across each dimension. As Table 2 shows, the political skill construct seems to be viewed similarly across CLs and NCLs in our sample, within a given year, over time when comparing them across the 2 years. Configural, metric, and scalar invariance were found in all comparisons, indicating our subgroup comparisons are meaningful as they see the construct to a similar extent. Thus, Hypothesis 1 is supported.

### Leader Type by Political Skill Dimensions: Across and Within

To test our directional Hypothesis 2, determining which of the political skill dimensions (II, AS, NA, and SA), we utilized one-tailed  $t$  tests. Hypothesis 2a formulated that CLs would have a higher level of II than NCLs. Our results did not show significant differences in this dimension for either one of our samples, Year 1:  $t(444) = .650, p = .10$ ; Year 2:  $t(627) = -.347, p = .37$ , with all personnel possessing high

**Table 3.** Political Skill Dimensions of Health Care Leaders Over Time.

	Clinical leaders (CLs)			Nonclinical leaders (NCLs)		
	Year 1	Year 2	Year 3	Year 1	Year 2	Year 3
II	5.85 <sub>a</sub>	5.82 <sub>a</sub>	5.92 <sub>a</sub>	5.83 <sub>a</sub>	5.71 <sub>b</sub>	6.01 <sub>c</sub>
AS	6.55 <sub>a</sub>	6.57 <sub>a</sub>	6.63 <sub>a</sub>	6.53 <sub>a</sub>	6.46 <sub>a</sub>	6.64 <sub>b</sub>
NA	5.19 <sub>a</sub>	5.18 <sub>a</sub>	4.87 <sub>b</sub>	5.33 <sub>a</sub>	5.32 <sub>a</sub>	5.30 <sub>a</sub>
SA	5.45 <sub>a</sub>	5.45 <sub>a</sub>	5.13 <sub>b</sub>	5.26 <sub>a</sub>	5.29 <sub>a</sub>	5.18 <sub>a</sub>

Note. NA = networking ability; AS = apparent sincerity; SA = social astuteness; II = interpersonal influence.

levels of II  $M_{\text{range}} = 5.80\text{--}6.00$ . However, our results did show support to our Hypothesis 2b. While NCLs were only marginally significantly different to CLs in Year 1,  $t(444) = -1.27, p = .103$ , AS was significantly different across CLs and NCLs in Year 2,  $t(627) = -2.89, p = .002$ , such that CLs ( $M = 6.52, SD = 0.48$ ) had higher AS than NCLs ( $M = 6.40, SD = 0.52$ ).

Furthermore, our results also supported Hypothesis 2c. While NCLs were only marginally significantly different to CLs in Year 1,  $t(444) = 1.44, p = .075$ , NCLs showed a significantly higher level of NA ( $M = 5.28, SD = 0.93$ ) than CLs ( $M = 5.11, SD = 0.91$ ) in Year 2,  $t(627) = 2.309, p = .011$ . On the other hand, NCLs did not have a significantly higher level of SA than CLs, Year 1:  $t(444) = .650, p = .26$ ; Year 2:  $t(627) = .229, p = .41$ . Taking these together, Hypothesis 2 was partially supported, showing that significant differences appeared in regards to two political skill dimensions across the different health care leader types: AS and NA.

Besides having differences across the health care leader types, we investigate the extent to which political skill dimensions change over time to settle the argument regarding the dispositional components of this construct. In answering Research Question 1, a repeated measures analysis of variance with a Greenhouse–Geisser correction determined that mean political skill dimensions differed statistically significantly between time points. Table 3 shows the different means and significant difference within the two types of health care leaders. More specifically, NA in CLs decreased over time,  $F(1.925, 229.021) = 9.540, p < .001$ , as well as their SA,  $F(1.813, 217.581) = 14.284, p < .001$ . Post hoc tests using the Bonferroni correction revealed that although no significant differences were observed from T1 to T2, the levels in NA significantly decreased when comparing T3 with T2 ( $p = .002$ ) and T1 ( $p = .001$ ). Similarly, the levels in SA significantly decreased when comparing T3 with T2 ( $p < .001$ ) and T1 ( $p < .001$ ). Contrary to these results, NCLs experienced an increase in some of the political skill dimensions, particularly II and AS,  $p < .001$ . Therefore, we can conclude that time elicits a statistically significant reduction in NA and SA for CLs and a statistically significant increase of II and AS for NCLs.

### Cross-Lagged Panel Model

In Hypothesis 3, we predicted there would be a time-lagged effect of political skill on unit performance. To look at these specific causal effects and the strengths of these relationships, we tested five overarching models (see Appendix C, for an illustration). Table 4 shows the results of all the tested models. More specifically, Model 3 is the specified path model with the most adequate fit with the entire sample ( $\chi^2 = 182.296$ , degrees of freedom [ $df$ ] = 3, RMSEA = .30, standardized root mean square residual [SRMR] = .08, CFI = .95). Accordingly, this model shows the longitudinal effect from political skill to unit performance at different time points without the same-time effects. Considering the RMSEA and nonnormed fit index are largely based on chi-square, where concerns about the restrictiveness of this statistic as well as its sensitivity to sample size (Jöreskog, 1969; Quintana & Maxwell, 1999), we rely on more reliable indices in assessing the reasonableness of proposed model fit such as CFI and SRMR. Because the model fit improves over and above when the causal order is rearranged, it shows support to our Hypothesis 3.

Furthermore, similar models were tested to compare NCLs and CLs relationships separately. The results show Model 5b was the most adequate when investigating CLs ( $\chi^2 = 4.109$ , degrees of freedom [ $df$ ] = 1, RMSEA = .03, SRMR = .03, CFI = .99) and NCLs ( $\chi^2 = 18.166, df = 1$ , RMSEA = .25, SRMR = .06, CFI = .94). This model indicates the lagged effects exist from political skill and the following year's unit performance, such that Year 1 influences Year 2 and Year 2 influences Year 3, without the same-time path effects, only allowing them to correlate. The differences in path coefficients are illustrated in Figure 1 and model fit indices are summarized in Table 4. Political skill at T1 played a large role in subsequent years political skill, path coefficient of .73, and unit performance T2, path coefficient of .52. Similarly, political skill at T2 influenced political skill and unit performance T3. Surprisingly, unit performance T2 had a very small negative relationship with T3. Looking closer to the two types of leaders, the two subgroups were very similar with the exception of the stronger effect of political skill T3 onto unit performance T3 for CLs in comparison with NCLs. Thus, this continued to strengthen the support of political skill onto unit performance over time for Hypothesis 3.



**Table 4.** Fit Statistics for the Study Models.

	Chi-square	df	RMSEA (90% CI)	NNFI	CFI	SRMR
Entire sample ( <i>N</i> = 647)						
Model 1	156.131	2	.345 [.300, .392]	0.328	0.866	0.076
Model 2	243.256	4	.304 [.272, .337]	0.478	0.791	0.099
Model 3	182.296	3	.304 [.267, .342]	0.479	0.951	0.0795
Model 4	287.113	2	.441 [.360, .532]	—	0.751	0.203
Model 5a	164.466	2	.354 [.310, .401]	0.489	0.83	0.097
Model 5b	78.758	1	.347 [.284, .414]	0.511	0.918	0.067
Model 5c	78.758	0	—	—	0.917	0.067
Clinicians ( <i>N</i> = 261)						
Model 1	51.664	2	.308 [.239, .384]	0.245	0.849	0.073
Model 2	73.211	4	.257 [.208, .386]	0.474	0.79	0.095
Model 3	61.605	3	.274 [.217, .335]	0.406	0.822	0.0765
Model 4	93.921	2	.420 [.350, .494]	—	0.721	0.145
Model 5a	23.185	2	.201 [.133, .279]	0.751	0.917	0.0693
Model 5b	4.109	1	.109 [.016, .227]	0.927	0.988	0.0265
Model 5c	4.109	0	—	—	0.984	0.0265
Nonclinicians ( <i>N</i> = 266)						
Model 1	45.382	2	.286 [.217, .360]	0.287	0.857	0.069
Model 2	73.5	4	.256 [.206, .308]	0.42	0.772	0.091
Model 3	50.769	3	.245 [.188, .306]	0.477	0.843	0.072
Model 4	60.049	2	.330 [.261, .405]	0.046	0.809	0.132
Model 5a	43.384	2	.286 [.217, .360]	0.51	0.837	0.0885
Model 5b	18.166	1	.254 [.160, .362]	0.612	0.935	0.0565
Model 5c	18.166	0	—	—	0.932	0.0565

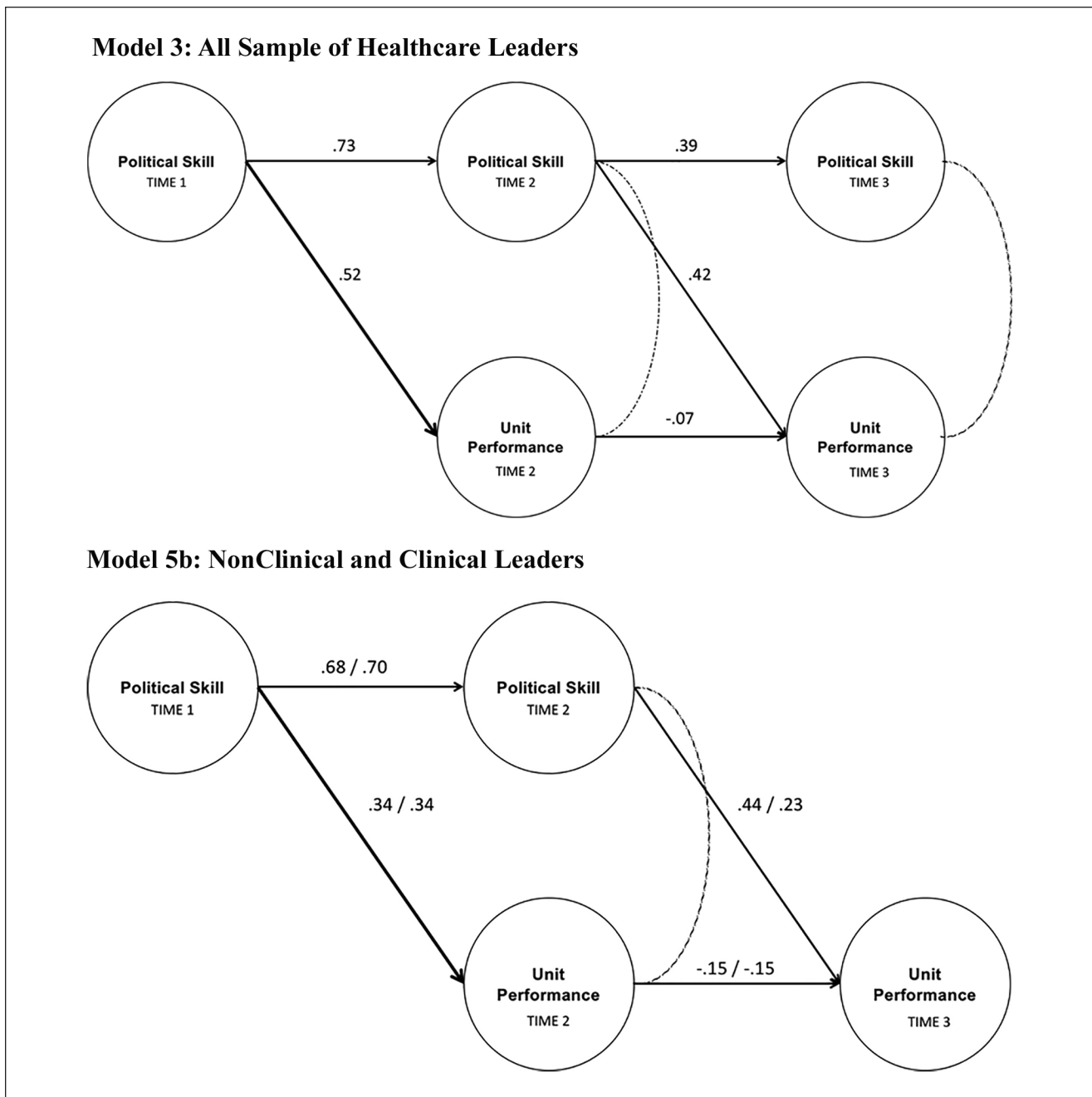
*Note.* Some of the indices are not calculated due to low degree of freedom of some models; Model 1 = a stability model with cross-lagged structural paths; Model 2 = a model with cross-lagged structural paths and correlation between same-time variables; Model 3 = a model without same-time and without the reciprocal effect from Unit Performance T2 and Political Skill T3; Model 4 = a model rearranging causal order by having same-time unit performance predict political skill as well as Political Skill T1 predicting Unit Performance T3; Model 5a = a model of lagged effects of Political Skill to Unit Performance without Political Skill T3; Model 5b = a model with the addition of correlation of same-time variables; Model 5c = a model with the addition of same-time paths; *df* = degrees of freedom; RMSEA = root mean square error of approximation; NNFI = nonnormed fit index; CFI = comparative fit index; SRMR = standardized root mean square residual.

To summarize our findings, political skill showed high psychometric properties including measurement equivalence across the CLs and NCLs as well as over time (Hypothesis 1). This allowed us to move on to within time and across occupation comparisons. In the comparison across the two types of health care leaders, significant differences were found for AS and NA such that CLs had higher levels of AS but lower levels of NA (Hypothesis 2). Furthermore, the way in which political skill evolved for each one of these occupations differed over time. More specifically, some political skill dimensions decreased for the CLs, whereas the exact opposite happened to NCLs in our sample (Research Question 1). Last, a 3-year perspective allowed us to investigate the relationship between political skill and unit performance evolving into a strong relationship over time. Across the entire sample as well as when we considered the CLs separately from NCLs, political skill influenced unit performance within the same year and in subsequent years (Hypothesis 3). Overall, our results shed light to the nuances and importance of investigating politi-

cal skill by considering a number of contingencies: leadership type, dimension-level, and temporal elements.

## Discussion

This study adds to the growing literature that highlights the importance of “soft” skills in health care leaders by showing its nuances through comparing CLs versus NCLs as well as its derail over time from both a dimensional and high-level perspectives across these two subgroups. First, we settle an argument that is often overlooked prior to subgroup comparisons by establishing measurement equivalence of political skill across CLs and NCLs. Indeed, our sample composed of CLs and NCLs showed configural, metric, and scalar invariance regarding political skill not only across the occupations but also across time points. This sets the proper foundation to make meaningful subgroup comparisons (e.g., Feitosa et al., 2017). Furthermore, this conclusion helps in accumulating growing evidence for the psychometric properties of political skill, which was



**Figure 1.** Standardized estimates of the cross-lagged relationship between political skill and performance.

Note. The path coefficients on the left refer to clinical leaders (CLs) and on the right to nonclinical leaders (NCLs) in Model 5b.

already shown across cultures (e.g., Lvina et al., 2012), by providing evidence that political skill is interpreted similarly across health care leaders that possess different professional identities.

Second, our results highlight the differences of political skill dimensions within and across these subgroups. Based on our findings, AS (apparent sincerity) was more prevalent in CLs than NCLs, whereas NA (networking ability) was

more dominant in NCLs rather than CLs. These are very distinct political skill dimensions, as AS refers to being perceived by others as being honest and having integrity, while NA refers to the ability to build meaningful ties within a network and possessing the capacity to leverage those connections to yield desired outcomes. In contrast, both CLs and NCLs had similar, high levels of II (interpersonal influence) as well as SA (social astuteness). Consistent to researchers

that have found that up to 93% of the meaning conveyed when communicating is nonverbal (Gentry & Kuhnert, 2007), there is a lot of information available to a leader in social interactions beyond what is actually said. Thus, it is encouraging to see both types of personnel demonstrating equal levels of skill in this area, which is especially necessary for maintaining the socially adept organizational culture needed within health care. For instance, leaders interact with people across the entire organization, bringing the importance of these skills to the forefront.

Furthermore, the development of political skill can be more targeted and specific depending on who the trainees are, which is absolutely critical in these professions where time is such a limited resource. The issue of divergent AS, for example, has an obvious influence of halo effect in regards to others' competence, and this may stem from the extensive years of training focusing on patient care for CLs but less so to NCLs. Accordingly, it may reflect societal expectation that clinicians will be competent in delivering their skills to their patients as fiduciary professionals (Bhatti & Cummings, 2007). The NA dimension, on the other hand, can provide a lot more opportunities to NCLs as these individuals often understand who knows what across the organization, what the general needs of organization are, and when positions become available. Considering the fact that previous research found NA to be the strongest political skill dimensions when relating it to leadership effectiveness (Moss & Barbuto, 2010), CLs may face an uphill battle when trying to move up the organizational ladder and achieve those organizational goals. While NCLs increased in regards to their II and also AS, perhaps after recognizing such gap in their training; the same was not true for CLs, instead, these leaders actually decreased even further on their NA and SA. Thus, albeit all leaders have potential to foster political skill through intentional development (e.g., Shaughnessy et al., 2017), some occupations may be targeting this skill more than others.

However, we did not just focus on differences across these dimensions, but also the extent to which political skills evolved over time. Although the dimension-level information can be quite informative for developmental purposes, it is often too narrow of a construct to influence broader categories (e.g., unit performance). Drawing on the compatibility principle (Ajzen, 2005; Fishbein & Ajzen, 1974), in which the broadness of the predictor (e.g., political skill) should match the criterion (e.g., unit performance), we investigate this relationship over a 3-year period. The results of this study shed some light regarding political skill as a broader category, influencing more distal outcomes such as unit performance. This approach explicitly shows the benefit of investigating temporal elements as political skill in Year 1 predicting political skill and unit performance in Year 2, which in turn influenced political skill and unit performance in Year 3. More comprehensively, from this

perspective, the present findings suggest that enhanced political skill of leaders actually has an influence on unit-level performance in subsequent years. Although the literature has been hinting at the importance of political skill, this finding of its effect on unit-level performance further reinforces the idea that investing in political skill development for leaders has tremendous benefits for organizations.

### *Implications*

Our results imply that the benefit of investing in political skill development is a worthy initiative when dealing with leaders in health care contexts. Our research suggests that CLs and NCLs have increased potential to respond to political skill development, which in turn can shape unit-level outcomes. In our analyses, we discovered that CLs experience weakening of important political skill dimensions such as NA and SA over time. Given the importance of these skills for leadership (Moss & Barbuto, 2010), and the fact that CL positions do not inherently foster development of these skills (Spehar et al., 2012; Zhou et al., 2015), it would be especially important to target political skill training for CLs toward developing NA and SA skills, especially as CLs advance in their positions and have less chance to practice these skills. Taken together, this further emphasizes the importance to invest on training interventions to increase political skills, especially in CLs, in order to maximize unit outcomes. As a brief summary, this article highlights the complexity of studying political skill across health care leaders and how limited study designs can easily undermine important temporal and dimension-level nuances.

### *Limitations and Future Research*

This study is not without limitations. As most field studies, the internal validity threats cannot all be controlled. There could be differences between these two types of leaders as well as across the 3 years that could have influenced our results beyond the variables of interest. However, the fact we found a strong and positive link between political skill and performance utilizing a 3-year wave study, points to the importance of this relationship. Accordingly, a three-wave study reduces the likelihood of common method bias (Podsakoff et al., 2003). To continue to build on such impact, this calls for more controlled studies to examine the strength of the role of political skill to performance.

This study also opens the door for whether or not such a relationship would evolve similarly in other contexts beyond health care leaders. All health care professionals in both of our samples had negatively skewed results (e.g., most of the scores above average in regards to their political skill). While this may be great news for health care, as research has shown a positive correlation between political skill and coping with workplace stressors (Perrewé et al.,

2000), it can restrict the range of our data, which in turn can mask important relationships. In areas or industries where political skill is more variable, these results may show an even stronger relationship to performance. Thus, this area of research could benefit from investigating across different industries and levels of professionals.

Given the significance of political skills for leaders' performance (Andrews et al., 2009; Ferris et al., 2005; Liu et al., 2007), an important next endeavor in this line of research would be to create or improve on existing political skill development interventions and evaluate their effectiveness. Evaluation of the intervention would determine whether political skill is mostly an inherent trait, one that must be developed through on the job experience, or whether it can truly be developed through training. In developing and evaluating an intervention to develop political skill, we could also uncover whether dispositional or learned political skill is more useful for effective leadership. This could inform hiring practices, in that if dispositional political skill is most influential for effective leadership, employers may wish to hire highly political skillful individuals. However, if it was found that political skill development was more influential in promoting better leadership than dispositional alone, employers could discriminate candidates based on other desirable skills and rely on training to improve political skill.

As future research, political skill should continue to be at the forefront of research in health care, as it has many benefits for the employees, organizations, and, more important, patients. Considering burnout in this industry, the agenda should include knowing *how* to train health care leaders to enhance their political skill as well as distinguishing *what* components are trait-based and/or disposition-based to sort them into either selection batteries or training interventions. With that being said, this study leaves open the exploration of political skill interventions and its incremental impact on performance.

## Conclusion

In conclusion, our study showed the relationship between political skill and unit performance in health care leaders using a panel design over a 3-year study and important nuanced analysis. First, we further established a consistent measure of political skill for health care leaders, serving as an important step toward providing the critical tools and metrics for health care leadership development. This is especially true given the increasing call for nontechnical skill training and development in health care as a vital predictor of patient outcomes (Rosenman et al., 2015). Second, by determining key aspects of political skill for CLs and NCLs, this allows for better intervention planning. More specifically, the development of political skill can be more targeted and specific depending on who the trainees are, which is

absolutely critical in these professions where time is such a limited resource. Organizations need to pay extra attention to current levels of political skill in their employees as well as the influence that this has on subsequent performance. Third, we found the staggered gains in unit performance when leaders—both CLs and NCLs—had high political skill values across multiple years. We suggest that future theories and applications consider the temporal elements, the dimensionality of political skill, and the differences in leaders' occupational interests. Considering the practical implications of this research, the time is ripe to continue to understand the nuances of political skill in organizations.

## Authors' Note

Any opinions, findings, and conclusions or recommendations expressed in this material are those of the author(s) and do not necessarily reflect the views of the National Science Foundation or Greenville Health System.

## Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

## Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This material is based in part on work supported by Greenville Health System and the National Science Foundation (NSF CAREER Award 165054, Marissa L. Shuffler PI).

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## Supplemental Material

Supplemental material for this article is available online.

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