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International Journal of Research and Community Empowerment
e-ISSN: 2985-6175
Vol 04, No 02, 130-140
https://doi.org/10.58706/ijorce
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Organisational Inertia in Healthcare: An Integrative Qualitative Review Using the Dead Horse Theory

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Abstract

Organisational inertia continue to influence the effectiveness of healthcare systems globally, contributing to operational inefficiencies, increased workforce pressures, and concerns regarding the sustainability of optimal patient outcomes despite continued reform efforts. While structural interventions are frequently introduced, many fail to produce meaningful change, instead reinforcing existing dysfunctions. Using the Dead Horse Theory as an interpretive lens, this study examines how organisational inertia, leadership avoidance, and systemic denial interact to sustain ineffective practices in healthcare settings. An integrative qualitative literature review was conducted, drawing on peer-reviewed studies sourced from major academic databases. The analysis focused on how organisational inertia, leadership behaviour, workforce dynamics, ethical accountability, and stakeholder engagement interact as interconnected rather than isolated factors. Through thematic and narrative synthesis, the study identified recurring patterns of symbolic reform, leadership avoidance, workforce disengagement, and weakened organisational responsiveness across healthcare contexts. Findings indicate that organisational inertia stabilises outdated routines and limits adaptability, while leadership avoidance reinforces these patterns through symbolic or procedural actions that fail to address underlying problems. Although such approaches may maintain short-term stability, they contribute to long-term consequences including burnout, reduced motivation, weakened team cohesion, and diminished psychological safety. Ethical accountability and stakeholder engagement emerged as key moderating factors that influence whether systems remain stagnant or shift toward adaptive change. The study develops an integrated conceptual framework linking organisational inertia, leadership avoidance, workforce dynamics, ethical accountability, and stakeholder engagement into a unified explanation of healthcare system performance. The study challenges linear interpretations of healthcare reform and highlights the need for adaptive, ethically grounded, and accountable leadership to disrupt entrenched system failure, supporting Sustainable Development Goal (SDG) 3: Good Health and Well-being and Sustainable Development Goal (SDG) 8: Decent Work and Economic Growth.

Keywords: Organisational Inertia, Leadership Avoidance, Healthcare Systems, Dead Horse Theory, Ethical Accountability
SDGs: Goal 3 (Good Health and Well-Being), Goal 8 (Decent Work and Economic Growth)

Manuscript History
Received: December 28, 2025 Revised: May 3, 2026 Accepted: May 11, 2026

How to cite:
Willie, M.M. and Jikwana, S. (2026). Organisational Inertia in Healthcare: An Integrative Qualitative Review Using the Dead Horse Theory. *International Journal of Research and Community Empowerment*, **4**(2), 130-140. DOI: https://doi.org/10.58706/ijorce.v4n2.p130-140.

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INTRODUCTION

Healthcare systems globally continue to experience persistent inefficiencies, workforce burnout, and declining patient outcomes despite extensive reforms and sustained investment. Burnout among healthcare professionals remains a longstanding and pervasive challenge, driven by rising service demands, workforce shortages, administrative complexity, and emotional strain conditions that predated the COVID-19 pandemic but have since intensified (Sipos et al., 2024). At the same time, projections indicate a global shortfall of at least ten million healthcare workers by 2030, which threatens equitable access to essential services. However, evidence suggests that closing this gap could prevent approximately 189 million years of life lost and generate economic gains of around USD 1.1 trillion, though these benefits are contingent on a fundamental transformation of care delivery models rather than incremental workforce expansion alone (McKinsey Health Institute, 2025).

These challenges extend beyond technical or resource limitations and are better understood as manifestations of deeper organisational and leadership dysfunction. Ineffective processes are often sustained over time, with endurance mistakenly interpreted as resilience. In many healthcare settings, outdated systems are reproduced through symbolic restructuring, repeated committee formations, and blame-shifting, which collectively reinforce inefficiencies and weaken workforce morale (Rosen et al., 2018; Bayat et al., 2023). Powell and Mannion (2024) similarly caution that policy reforms frequently recycle familiar but ineffective solutions, thereby perpetuating rather than resolving systemic problems. In contrast, evidence from high-performing organisations shows that sustainable improvement depends on adaptive workflows, multidisciplinary collaboration, and psychological safety, highlighting that meaningful change requires systemic redesign rather than isolated, individual-level interventions (Singh et al., 2024; Shankar et al., 2025).

Within this context, the Dead Horse Theory provides a useful explanatory lens for understanding organisational inertia in healthcare. The theory highlights the tendency to persist with failing systems rather than to discontinue or redesign them. However, contrary to the simplistic assumption that persistence reflects commitment, empirical studies suggest that continued investment in obsolete structures often compounds inefficiencies, worsens burnout, and declines the quality of care (Sinnott et al., 2020; Paudel, 2025). Although some leaders interpret persistence as organisational resilience, research increasingly shows that genuine resilience is grounded in adaptive problem-solving, distributed leadership, and evidence-informed decision-making. Nevertheless, when change efforts fail to incorporate these principles, they risk reinforcing cycles of dysfunction rather than resolving them (Al Hamad et al., 2018; Alqahtani et al., 2023).

Despite an expanding body of literature on healthcare leadership, organisational inertia, and workforce well-being, these domains continue to be examined in relative isolation. Evidence from healthcare systems consistently points to persistent challenges such as burnout, weak retention, and declining workforce morale, which suggest that the issue extends beyond individual organisational factors to deeper systemic and leadership-related dynamics (Al Hamad et al., 2018; Sipos et al., 2024). At the same time, organisational inertia has been widely documented as a key constraint on meaningful reform, where entrenched routines, risk aversion, and institutional habits reinforce the status quo even in the face of policy pressure for change (Teofilus et al., 2022; Dong, 2023). Within this context, leadership is often positioned as a critical lever for change, yet empirical evidence suggests that symbolic or surface-level leadership practices frequently fall short in disrupting embedded inefficiencies, particularly in complex and resource-constrained health systems (Masike & Mahomed, 2025; Singh et al., 2024).

What remains less clearly understood is how symbolic leadership and institutionalised inertia interact to sustain and normalise persistent organisational dysfunction over time, representing an important conceptual and practical gap in the literature. While existing research has not fully clarified the mechanisms through which these “dead horse” dynamics endure or how adaptive leadership might effectively disrupt them in complex healthcare environments (Musaigwa, 2023; Paudel, 2025), Lakin and Kane (2023) emphasise that meaningful reform also depends on setting realistic expectations of what health systems are designed to achieve, aligning accountability with legitimate system functions and capacities.

Accordingly, this study positions itself within the emerging discourse on systemic healthcare transformation by applying the Dead Horse Theory as an analytical lens to examine how organisational inertia, symbolic leadership, and systemic denial sustain inefficiencies in healthcare systems. In contrast to previous studies that treat leadership behaviour, organisational culture, and workforce outcomes as separate constructs, this study proposes an integrated framework that links these dimensions to explain persistent system failure. The study further seeks to investigate how adaptive leadership practices, stakeholder engagement, and public

service motivation influence team dynamics, decision-making processes, and workforce well-being, with the aim of contributing to sustainable healthcare reform.

METHOD

This study adopted a qualitative, interpretive, literature-based design to explore leadership and organisational dynamics within healthcare systems, recognising that qualitative inquiry provides rich, context-sensitive and meaning-oriented insights into complex phenomena (Lim, 2024). In extending this approach, Goñi (2025) argues that critical interpretive reviews can achieve both depth and methodological rigour when supported by transparent procedures such as clear documentation of search strategies, audit trails, and systematic yet reflexive analytical practices.

Interpretive qualitative approaches are particularly valuable for developing theory that is grounded in existing scholarship while still enabling conceptual innovation. They extend analysis beyond describing "what" is present in the data to explaining "how" and "why" meanings are constructed, thereby strengthening explanatory depth and rigour (Wiesner, 2022). This process also requires reflexivity, as meaning is shaped through interpretation rather than detached observation, making researcher positionality central to analysis (Wiesner, 2022). However, the increasing use of structured reporting checklists introduces a tension: while they improve transparency and consistency, overly rigid application can restrict interpretive depth and theoretical engagement (Ahmed et al., 2025; Wiesner, 2022). In this regard, Braun and Clarke (2025) caution against universal reporting standards in qualitative research, arguing that such tools can create methodological incongruence with core qualitative values such as reflexivity and contextual meaning-making. They instead advocate for values-based guidelines that prioritise flexibility, transparency, and alignment with qualitative epistemology.

To strengthen methodological clarity, the literature search followed a structured, transparent procedure. Relevant studies were identified through academic databases including Scopus, PubMed, Google Scholar, and Web of Science, using keywords such as *healthcare leadership*, *organisational inertia*, *systemic inefficiency*, *adaptive leadership*, and *change management in healthcare*. Inclusion criteria focused on peer-reviewed studies published in English that addressed organisational dynamics, leadership behaviour, and healthcare system performance, while exclusion criteria eliminated non-peer-reviewed sources, opinion pieces, and studies not directly relevant to healthcare organisational contexts. The selection process was iterative, with reference tracking used to identify additional relevant studies.

A purposive and conceptually guided approach was adopted to select relevant literature, with a specific focus on organisational inertia and the Dead Horse Theory. Organisational inertia is understood as the persistent resistance to change, embedded in entrenched structures, routines, and cultural norms that constrain adaptability and organisational performance (Dong, 2023). Although existing studies identify key drivers such as hierarchical decision-making, risk aversion, and regulatory complexity, they largely examine these factors in isolation. However, they do not sufficiently integrate structural, behavioural, and leadership dimensions to explain how inertia is sustained or how it can be systematically addressed through practical, actionable interventions (Dong, 2023).

Similarly, the Dead Horse Theory was used as a complementary lens to explain how organisations continue to invest in failing systems due to denial, institutionalised routines, fear of disruption, or symbolic compliance rather than meaningful transformation (Paudel, 2025). Nevertheless, the literature indicates that leadership avoidance, superficial reform efforts, and continued reliance on outdated processes reinforce inefficiency and negatively affect workforce morale. This underscores the importance of decisive, evidence-informed, and ethically grounded leadership in disrupting persistent system failure (Paudel, 2025).

A critical review of the leadership literature further reveals important conceptual contrasts. On the one hand, transformational and ethical leadership approaches are consistently associated with improved organisational performance, higher employee engagement, and enhanced job satisfaction. On the other hand, alternative leadership models such as dark leadership, instrumental leadership, and hybrid forms remain underexplored in empirical healthcare research, despite their theoretical recognition. This gap limits understanding of how such leadership behaviours may contribute to or mitigate organisational dysfunctions (Hale & Onur, 2025).

Nevertheless, the literature search followed a structured, transparent process. Peer-reviewed journal articles, policy documents, and authoritative sector reports were identified through major academic databases, including PubMed, Scopus, and Google Scholar, using keywords such as "organisational inertia," "healthcare leadership," "Dead Horse Theory," "system failure," "adaptive leadership," and "healthcare workforce

engagement." Studies were included if they focused on organisational behaviour, leadership practices, or healthcare system performance in resource-constrained or complex environments. Exclusion criteria removed non-peer-reviewed sources, opinion pieces without empirical or conceptual grounding, and studies not directly linked to healthcare organisational dynamics.

The study selection process followed a systematic literature review framework, as presented in Figure 1, which transparently illustrates the sequential stages of identification, screening, eligibility assessment, and final inclusion, thereby ensuring methodological rigour and traceability of decisions. An initial search yielded 1,256 records. Of these, 289 were excluded prior to screening due to duplication and clear irrelevance to the study's inclusion criteria. The remaining 991 records proceeded to the screening phase, where 712 were excluded after abstract and title reviews, as they were either not aligned with the study's conceptual focus, only tangentially related, or insufficiently relevant to the research objectives. This process resulted in 279 full-text articles being assessed for eligibility. During this stage, a further 243 studies were excluded on closer examination, primarily because they did not engage substantively with leadership or internal organisational dynamics, were not situated within healthcare contexts, or lacked empirical grounding. A total of 36 studies satisfied all eligibility criteria and were included in the final synthesis, forming the evidentiary basis of the review.

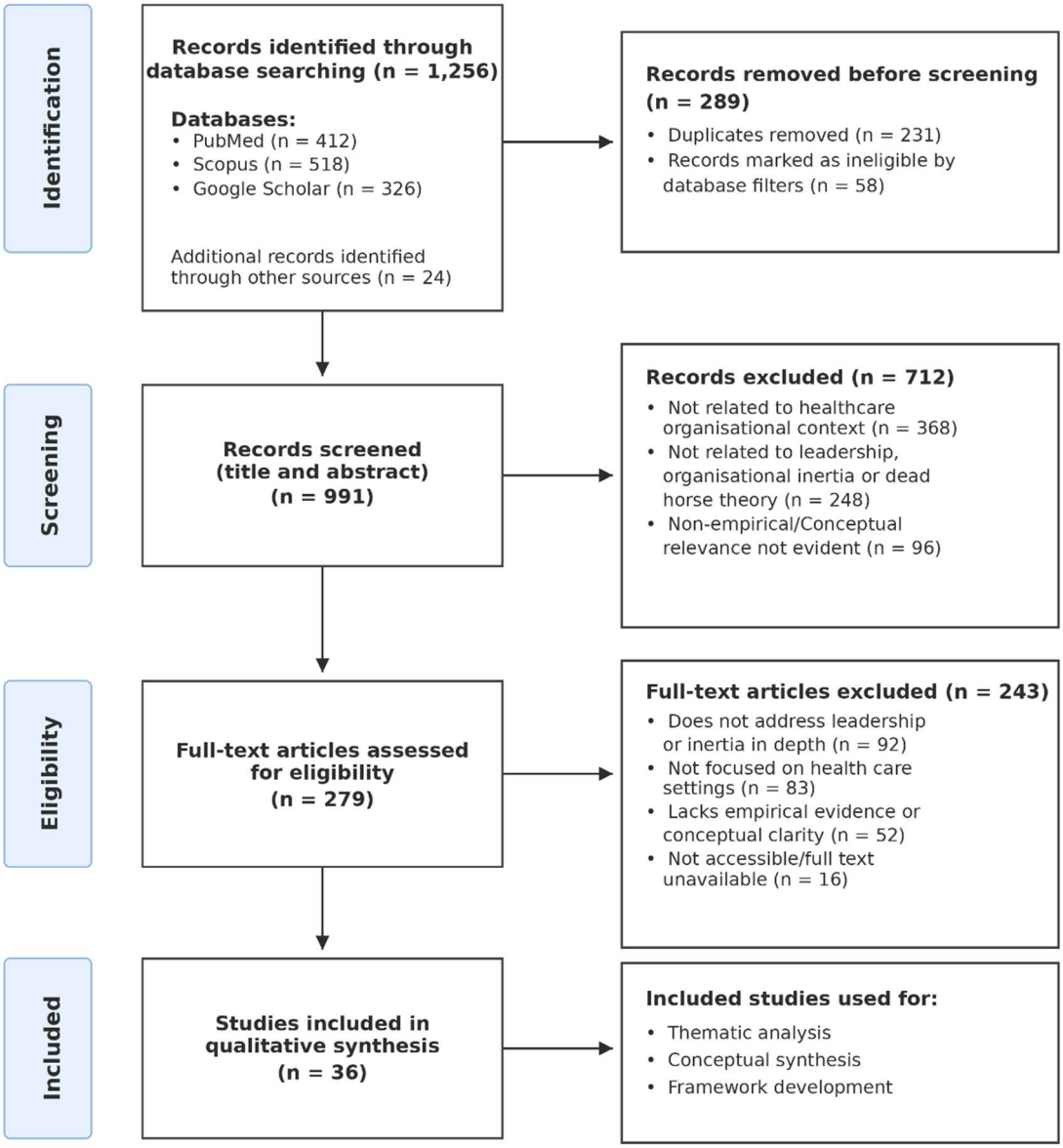


Figure 1. Literature Search and Selection Flow Diagram

Textual narratives, interpretations, and reported experiences from the selected literature formed the primary data for analysis. Patterns indicate that leadership avoidance and symbolic compliance frequently contribute to reform fatigue, intensifying workforce distress and weakening organisational resilience (Musaigwa, 2023; Paudel, 2025). Conversely, examples of transparent and ethically grounded leadership were associated with enhanced staff engagement, adaptive problem-solving, and sustainable organisational change (Koeslag-Kreunen et al., 2018; Alqahtani et al., 2023).

An iterative process of close reading and reflective engagement facilitated the identification of passages related to leadership avoidance, reform fatigue, symbolic compliance, and workforce distress. This approach preserved sensitivity to nuance and context, acknowledging that organisational dynamics are shaped not only by formal structures but also by tacit norms, power relations, and emotional labour, as embedded in the literature (Tosanloo et al., 2019; Zajac et al., 2021). The study therefore foregrounds the human, relational, and socio-cultural dimensions of organisational behaviour, ensuring insights are analytically robust and grounded in lived realities reported in the literature.

Data were analysed using a combination of thematic and narrative synthesis to identify patterns across diverse sources while retaining contextual depth and interpretive richness. This analytical approach aligns with Braun and Clarke's (2022) position that thematic analysis should be understood as a flexible family of methods rather than a rigid procedural technique, thereby requiring methodological reflexivity and coherence throughout the analytical process. Ahmed et al. (2025) further support this perspective by demonstrating that Braun and Clarke's six-phase framework enhances transparency and consistency in coding, theme development, and interpretation. In addition, Barnett-Page and Thomas (2009) highlight that qualitative synthesis is shaped by underlying epistemological positions, particularly realist and constructivist orientations, which influence how evidence is interpreted and integrated. Guided by these principles, the analysis in this study remained iterative, interpretive, and reflexive, ensuring that emerging patterns were continuously compared and refined.

The initial coding process involved line-by-line examination of the literature to identify recurring concepts and relational patterns. For example, statements such as "leaders implement task teams without addressing root causes" were coded as *symbolic reform*, while references to "staff disengagement despite policy reforms" were coded as *workforce demotivation under structural inertia*. Similarly, descriptions of "failure to discontinue ineffective systems despite evidence of poor outcomes" were coded as *institutional persistence of failure*. These initial codes were then clustered into broader categories such as organisational inertia, leadership avoidance, performative reform, and workforce consequences of systemic dysfunction. This process ensured that coding remained grounded in the data while progressively moving toward conceptual abstraction.

Through iterative refinement, these categories were synthesised into higher-order themes using the lens of the Dead Horse Theory, which provided an explanatory framework for understanding how organisations sustain ineffective systems despite clear evidence of failure. For instance, codes related to *symbolic reform* and *avoidance of accountability* were integrated into the broader theme of leadership avoidance sustaining organisational inertia. Similarly, *workforce demotivation* and *psychological strain* were grouped under the theme of human consequences of systemic stagnation. This interpretive layering allowed for a more nuanced understanding of how leadership behaviour and organisational culture interact to reproduce dysfunctional systems over time.

The analytical process was not linear but cyclical, with themes repeatedly revisited to ensure coherence and conceptual alignment with the emerging framework. This reflexive engagement enabled continuous refinement of categories and prevented premature closure of interpretation. Ultimately, the synthesis produced a set of interconnected themes that collectively explain how organisational inertia, leadership avoidance, and workforce responses interact to sustain or disrupt system performance (Alqahtani et al., 2023; Shankar et al., 2025).

This study's trustworthiness and ethical integrity are grounded in qualitative principles emphasising transparency, rigour, and responsible scholarship. Lemon and Hayes (2020) show that software-assisted triangulation (e.g., Leximancer) improves analytical transparency and consistency, strengthening credibility. Stahl and King (2020) argue that trustworthiness is ensured through credibility, transferability, dependability, and confirmability, which support methodological rigour. Ethically, Resnik (2024) highlights honesty, accountability, and respect for persons as core to research integrity. Additionally, Noble and Smith (2025) note that qualitative rigour is best assessed through trustworthiness rather than traditional validity and reliability, ensuring findings are meaningful and credible for practice.

RESULTS AND DISCUSSION

The findings of this integrative qualitative review demonstrate that healthcare inefficiencies are not isolated operational failures but are produced through interconnected organisational and leadership systems. At the core of these systems is organisational inertia, which functions as a stabilising mechanism that entrenches outdated routines, reinforces structural rigidity, and limits adaptability. This is consistent with Dong (2023) and Teofilus et al. (2022), who similarly argue that institutional resistance to change is sustained by deeply embedded organisational norms and routine practices. Within this context, leadership avoidance emerges as a reinforcing mechanism in which leaders respond to systemic challenges through symbolic or procedural actions rather than substantive reform. Such behaviours perpetuate what has been described in the literature as "illusory change," where visible activity masks the absence of meaningful transformation (Musaigwa, 2023; Masike & Mahomed, 2025). As a result, inefficiency becomes structurally normalised rather than episodic.

The study further identifies workforce motivation and team dynamics as critical mediating pathways through which organisational and leadership conditions translate into performance outcomes. Where leadership is adaptive, ethical, and participatory, there is stronger alignment between organisational objectives and employee engagement, resulting in improved collaboration, psychological safety, and service delivery. This aligns with Fernandes et al. (2022) and Rosen et al. (2018), who emphasise the central role of leadership in shaping motivation and team effectiveness. Conversely, when leadership is avoidant or symbolic, workforce disengagement, burnout, and fragmented teamwork become more pronounced, reinforcing operational inefficiencies and weakening organisational resilience (Sipos et al., 2024; Al Hamad et al., 2018). In this way, workforce dynamics are not independent variables but are actively shaped by leadership behaviour and organisational structure.

Ethical accountability and stakeholder engagement emerge as critical moderating mechanisms that influence whether healthcare systems remain trapped in cycles of dysfunction or move toward transformation. When ethical principles such as fairness, transparency, and responsibility are embedded in decision-making, they enhance trust, reduce resistance to change, and strengthen organisational legitimacy (Ilori et al., 2024; Schroeder et al., 2019). Similarly, meaningful stakeholder engagement fosters participatory governance and continuous feedback, which supports adaptive change processes (Shankar et al., 2025; Khaw et al., 2022). However, in contexts where ethical accountability is weak and stakeholder engagement is symbolic, existing inefficiencies are reinforced rather than resolved.

The proposed conceptual framework (Figure 2) integrates eight interrelated constructs organisational inertia, leadership avoidance, workforce motivation, team dynamics, operational inefficiencies, ethical accountability, stakeholder engagement, and change management into a unified explanation of healthcare system performance. At its core, organisational inertia is identified as the foundational mechanism that stabilises entrenched routines, reinforces structural rigidity, and constrains adaptability, consistent with Dong (2023) and Teofilus et al. (2022). Within this context, leadership avoidance reinforces inertia through symbolic or performative responses rather than substantive intervention, thereby sustaining dysfunctional patterns and limiting meaningful reform (Musaigwa, 2023; Masike & Mahomed, 2025). As a result, inefficiency becomes structurally embedded rather than episodic, shaping the overall trajectory of organisational functioning.

Within this system, workforce motivation and team dynamics emerge as downstream effects of the interaction between inertia and leadership behaviour. When leadership fails to challenge entrenched systems, employee engagement weakens and team coordination becomes fragmented, reflecting misalignment between organisational intent and operational reality. This is consistent with Fernandes et al. (2022) and Rosen et al. (2018) emphasize the central role of leadership in shaping motivation, collaboration, and team effectiveness. Consequently, operational inefficiencies are produced not as isolated failures but as system-level outcomes of weakened motivation and disrupted teamwork, reinforcing a cycle of declining performance and reduced organisational responsiveness.

The framework further positions leadership practices as the primary driver of system behaviour, influencing organisational dynamics, stakeholder engagement, and ultimately systemic outcomes. Leadership shapes decision-making approaches, ethical orientation, and responses to system failure, while organisational dynamics reflect the structural and cultural conditions that either enable or constrain reform. Stakeholder engagement, through participatory decision-making and transparent communication, functions as a moderating mechanism that enhances legitimacy and reduces resistance to change (Shankar et al., 2025; Paudel, 2025). Ethical accountability further strengthens this system by aligning leadership actions with fairness, responsibility, and patient-centred care.

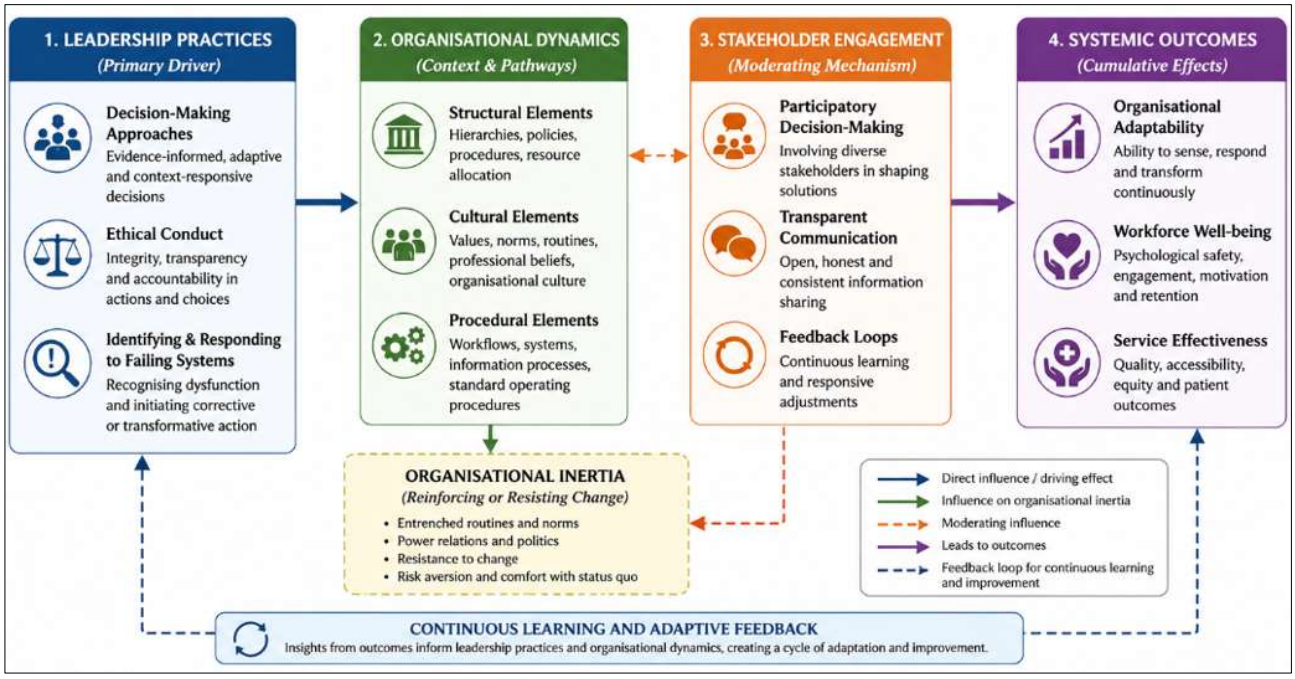


Figure 2. Conceptual Framework (Source: Own Construct)

Practically, the model provides a useful diagnostic and intervention tool for healthcare leaders and policymakers. It helps identify where breakdowns occur whether at the leadership level, within organisational systems, or in stakeholder engagement processes and guides targeted interventions to improve system responsiveness. Moreover, it can be applied to assess the effectiveness of reform initiatives by tracking whether changes in leadership behaviour translate into improved engagement and measurable system-level outcomes.

In terms of contribution, the framework advances existing literature by integrating leadership, organisational inertia, and stakeholder dynamics into a single explanatory model rather than treating them as separate constructs. It also extends the application of the Dead Horse Theory by demonstrating how persistent inefficiencies can be understood and addressed through interconnected system components rather than isolated interventions. Ultimately, the model contributes to both theory and practice by offering a structured way to understand how healthcare systems can shift from entrenched dysfunction toward adaptive, sustainable performance.

This study demonstrates that inefficiencies within healthcare organisations are not merely operational shortcomings but are deeply embedded within structural, cultural, and behavioural systems that reinforce organisational inertia. The persistence of hierarchical decision-making, routine reliance on outdated processes, and the use of symbolic interventions reflects a pattern in which surface-level compliance substitutes for substantive transformation. Rather than improving performance, these practices often reproduce stagnation by shielding underlying dysfunctions from scrutiny. In this sense, the findings extend prior work by positioning inefficiency as an emergent property of institutionalised routines and cultural norms rather than isolated managerial failures (Teofilus et al., 2022; Musaigwa, 2023). This reframing strengthens the argument that organisational change in healthcare cannot be understood through technical optimisation alone, but must be located within the interplay of structure, culture, and leadership practice.

A key theoretical contribution of this study lies in its more explicit articulation of the mechanisms through which organisational transformation is constrained. The analysis shows that leadership avoidance and symbolic action operate as intermediary mechanisms that mediate between structural pressures and organisational outcomes. In practice, avoidance manifests through delayed decision-making, deflection of accountability, and reliance on procedural conformity, which collectively sustain what is conceptualised here as “illusory reform.” This mechanism helps explain why adaptive leadership interventions often fail to produce sustained change, despite being widely advocated in the literature (Koeslag-Kreunen et al., 2018; Masike & Mahomed, 2025). Compared to previous studies that largely describe leadership effectiveness in normative terms, this study advances a more causal interpretation by showing how avoidance behaviours actively

reproduce inefficiency rather than simply reflecting leadership weakness. This contributes to a more process-oriented understanding of organisational stagnation.

The findings also clarify the role of workforce dynamics as a mediating mechanism linking leadership behaviour to organisational performance outcomes. Motivation, professional identity, and team cohesion are shown to function as dynamic pathways through which organisational conditions are translated into behavioural responses. Where leadership is transparent and participatory, these mediating conditions enhance resilience and adaptive capacity; where leadership is fragmented or avoidant, they deteriorate, leading to disengagement and reduced performance (Hussain et al., 2025; Zajac et al., 2021). Importantly, this study moves beyond descriptive accounts of workforce engagement by illustrating how these factors interact causally with leadership practices and organisational culture. However, the analysis also reveals that existing literature has not sufficiently integrated these mediating pathways into a unified explanatory model, resulting in fragmented interpretations of organisational change processes.

Ethical accountability further emerges as a reinforcing mechanism that shapes both leadership legitimacy and organisational responsiveness. While prior studies tend to treat ethical leadership as a normative ideal, this study demonstrates that ethical practice has observable effects on organisational behaviour when embedded in decision-making structures. Transparency, stakeholder engagement, and patient-centred governance are not merely aspirational values but function as mechanisms that reduce resistance and enhance institutional trust (Ilori et al., 2024; Shankar et al., 2025). By linking ethical governance more explicitly to organisational outcomes, the study addresses a limitation in the literature where ethics is often discussed independently of performance dynamics. This strengthens the theoretical contribution by positioning ethical accountability as an enabling condition for transformation rather than a peripheral consideration.

The study advances a more integrated and mechanism-oriented explanation of organisational transformation in healthcare settings. Unlike previous research that tends to separate leadership, culture, workforce behaviour, and ethics into distinct analytical domains, this study demonstrates that these elements operate as interconnected causal pathways within a single system of organisational change. Theoretical contribution is therefore located in identifying how leadership avoidance triggers symbolic action, which in turn weakens workforce motivation and undermines ethical coherence, ultimately sustaining inefficiency. This represents a shift from predominantly normative interpretations of leadership and organisational change toward a more explanatory framework that clarifies how and why transformation is constrained in practice.

This study contributes a conceptual framework for understanding organisational inertia and leadership failure in healthcare, but it is important to recognise its limitations. Because the analysis relies exclusively on secondary literature, the findings remain interpretive and cannot be directly validated through primary data or stakeholder perspectives, meaning the framework reflects existing research rather than real-time observation. Although reflexive engagement and conceptual triangulation were used to reduce subjectivity, the selection and interpretation of sources are still influenced by the researcher's perspective, which may shape thematic emphasis and relationships.

The focus on published literature may underrepresent experiences from resource-constrained or politically complex settings, limiting the breadth of contextual insights. While the Dead Horse Theory offers a useful lens, its application here remains theoretical and requires empirical testing to confirm its relevance across diverse healthcare environments. The framework also emphasises leadership and organisational dynamics, which means broader macro-level factors such as national policy environments, funding constraints, and socio-political determinants are not fully addressed. The study does not distinguish between specific healthcare service areas, and therefore, future research should test and refine the framework across different settings to enhance its applicability and generalisability.

This study has important implications for healthcare leadership, policy, and organisational reform, particularly in resource-constrained settings. The findings show that organisational inertia, combined with symbolic or performative leadership, can sustain inefficiencies and slow meaningful change within healthcare systems. Over time, this weakens organisational responsiveness and contributes to increased pressure on already stretched healthcare workers. The study further highlights the impact on staff well-being, including heightened stress and burnout, which can negatively affect service delivery and continuity of care. It therefore reinforces the need for adaptive, accountable, and ethically grounded leadership that responds effectively to both system demands and workforce needs. Ultimately, strengthening leadership practices is essential for improving organisational resilience, staff welfare, and patient outcomes.

These insights directly support SDG 3 (Good Health and Well-being) by emphasising the importance of functional, accountable health systems that can deliver safe and effective care. Moreover, the focus on

workforce motivation, psychological safety, and operational improvement aligns with SDG 8 (Decent Work and Economic Growth), as it stresses the need for humane working conditions, fair leadership practices, and sustainable organisational performance. The proposed framework, therefore, contributes to achieving both goals by guiding leaders to dismantle failing systems, foster resilient workforces, and implement reforms that are both ethically responsible and operationally effective. Future policy and management strategies can use this framework to strengthen health system responsiveness, reduce burnout, and ensure that reforms are meaningful rather than symbolic.

CONCLUSION

This paper argues that many healthcare organisations continue to "ride dead horses" through symbolic actions, leadership avoidance, and systemic denial. Rather than demonstrating resilience, such behaviour reflects organisational exhaustion with real human and clinical costs. The Dead Horse Theory provides a useful conceptual lens for explaining why healthcare reforms often fail and for reimagining leadership accountability in health systems. However, to strengthen the practical value of the proposed framework, future research should empirically test its applicability across different healthcare settings, including resource-constrained environments and varied service areas such as primary care, hospitals, and emergency services. Further studies should also examine how macro-level factors, such as policy environments, funding constraints, and socio-political dynamics, interact with organisational inertia and leadership behaviour. Ultimately, meaningful healthcare transformation requires leaders to have the courage to dismount, redesign, and move forward, co-creating solutions that prioritise both patient outcomes and workforce well-being.

AUTHOR CONTRIBUTIONS

Michael Mncedisi Willie: Conceptualization, Methodology, Formal Analysis, Investigation, Writing - Original Draft, Writing - Review & Editing, and Supervision; and **Siyabonga Jikwana**: Investigation, Data Curation, Formal Analysis Support, and Writing - Review & Editing. All authors have read and approved the final version of this manuscript.

DATA AVAILABILITY STATEMENT

The data supporting the findings of this study are available from the authors upon reasonable request, subject to ethical approval and institutional regulations.

DECLARATION OF COMPETING INTEREST

The authors declare no known financial conflicts of interest or personal relationships that could have influenced the work reported in this manuscript.

DECLARATION OF ETHICS

The authors declare that the research and writing of this manuscript adhere to ethical standards of research and publication, in accordance with scientific principles, and are free from plagiarism.

DECLARATION OF ASSISTIVE TECHNOLOGIES IN THE WRITING PROCESS

The authors declare that generative artificial intelligence (Gen AI) and other AI-assisted tools were used prudently, not excessively, during the preparation of this manuscript. Specifically, Grammarly and QuillBot were used for language editing, including grammar correction, sentence structuring, and improvement of readability and clarity. ChatGPT was used to assist in visualising the conceptual framework based on the authors' own ideas, and the resulting output was reviewed and validated for accuracy. These tools were not used to generate, conceptualise, or develop the intellectual content, analytical framework, research findings, interpretations, or conclusions of the study. All AI-assisted material was reviewed and edited for accuracy, completeness, and compliance with ethical and scholarly standards. The authors accept full responsibility for the final content of the manuscript.

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