infinitum LEADERSHIP

Two Lobes, One Centre

The Ad Infinitum Loop: a team effectiveness assessment for executive teams, with the evidence from health care leadership

Jonathan Evans, MA, PCC, MCS
Executive and Leadership Coach
Infinitum Leadership

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The Ad Infinitum Loop and the Ad Infinitum Loop Team Assessment are instruments of Infinitum Leadership, delivered through the Choose Becoming platform. This paper publishes the model's evidence base in full, including its comprehensive bibliography.

About the author. Jonathan Evans is an executive and leadership coach — MA; PCC (Professional Certified Coach, International Coaching Federation); MCS (Mentor Coach Specialization) — and the founder of Infinitum Leadership. His practice works with executive and leadership teams, with a concentration in Canadian health care, and he serves as President of the ICF British Columbia chapter. The Ad Infinitum Loop and its assessment are instruments of that practice, delivered through the Choose Becoming platform. This paper documents the evidence base of one of those instruments and is written to be read alongside the Ad Infinitum Loop Team Assessment it describes.

Executive summary

Teams rarely fail in an event. They lose their edge quietly — a meeting where the hard thing goes unsaid, a decision that unravels in the corridor, a standard everyone assumes someone else is holding — while the conditions that produced the behaviour sit untouched around the room. Leaders asked to fix such a team usually reach for behaviour: harder conversations, another offsite, a fresh round of team building. The research record says the leverage sits in two places at once, and that design — the conditions a leader sets before asking anything of behaviour — in the research program's senior-team study, the six design conditions predicted more than half of the variation in team effectiveness (Wageman et al., 2008).

The **Ad Infinitum Loop** is Infinitum Leadership's model of that joint system, drawn as the Infinitum mark: two lobes turning through one centre. **Dynamics** names the behaviours inside the room — the 4 Ups: Open up for Trust, Speak up for Candour, Stand up for Commitment, Step up for Accountability. **Design** names the conditions around the room — the 5 Ms: Membership, Mastery, Mechanics, Means, and Mentoring. The lobes meet in **The Drive**, where Direction and Delivery convert conditions and behaviours into collective results. The **Ad Infinitum Loop Team Assessment** reads the whole loop — 33 original items, every member rating the team, eleven scales, anonymous by design — and **Tending** is the leader's discipline of acting on the reading: diagnostics, tuning, and repair, repeated in rounds across the team's life.

This paper does the evidence work element by element. Each element of the model receives its own section, and each section synthesizes three bodies of material: the peer-reviewed research programs the model descends from; the current journal literature through 2026; and the author's own *Healthcare Executive Bibliography* — a curated, annotated library of more than seventy works assembled for coaching senior leaders in complex, publicly funded health systems, aligned with the LEADS in a Caring Environment framework that governs health leadership development in Canada (Dickson and Tholl, 2020). The healthcare lens is deliberate. Health care is the sector where the teamwork evidence runs deepest, where the price of silence is measured in patient outcomes, and where many of the model's clients lead. Where the evidence speaks to leadership teams generally, the paper says so; where it speaks to health care specifically, the paper draws the implication out. The paper's lead case is the health care executive team — the sector where the evidence, the author's practice, and the model's first deployments concentrate — and its claims are stated for senior leadership teams generally, with health care as the proving ground.

The paper also keeps the discipline of its first version. The Loop is a synthesis, labelled as one. Practitioner works supply vocabulary, sequencing intuitions, and teaching craft; peer-reviewed findings carry the claims. The model's debts — Lencioni's vocabulary for Dynamics, Hackman and Wageman's conditions research for Design — are named in the text. The methodology is justified decision by decision, and the limitations are stated plainly at the end, alongside the answers the model gives a curious and skeptical reader. Appendix A carries the model's comprehensive bibliography — 57 works — openly, as the author directed.

For the skeptical reader. This paper is built to be checked. Its method is set out in Section 15, its limitations at full strength in Section 17, and its answers to the strongest objections in Section 18 — including the objections it concedes. Readers who want the challenges before the argument can start there; the paper's claims are written to survive the trip back.

1. The problem: teams lose their edge quietly

Team development research has known for sixty years that a team is a moving system. Tuckman (1965) traced the developmental sequence groups travel; Gersick (1988) showed that teams change in bursts, often at their temporal midpoint, rather than by steady accumulation. Performance therefore decays and recovers across a whole working life, through conditions and habits, and a leader watching only results sees the lagging indicator. What leaders lack is a single readable picture of the system producing those results — the behaviours inside the room and the conditions around it, in one frame, measured in a way a team can act on without injuring itself in the measuring.

Health care raises the stakes of that missing picture. A regional health authority is led by an executive team whose members run deep specialty silos — acute care, community health, capital infrastructure, professional practice — inside one publicly funded system serving a population in the millions. The author's healthcare bibliography opens from exactly this operating reality: fragmented services, diverse specialties, continuous operational demand, and high-stakes clinical environments where the quality of the executive team's working relationships reaches patients (Evans, 2026a). In that setting, guarded conversation at the top becomes unreported risk at the front line, and a divided executive team becomes fragmented service delivery. The evidence sections that follow return to this setting repeatedly, because the literature does.

The Ad Infinitum Loop is built to be that picture, and its assessment to be that measurement.

2. The model: two lobes, one centre

Dynamics — what happens inside the room. *Open up* (Trust): members admit mistakes and ask for help without penalty. *Speak up* (Candour): hard issues are debated openly until they are resolved. *Stand up* (Commitment): decisions end clear, and members stand behind them outside the room. *Step up* (Accountability): members hold each other to the team's standards directly, peer to peer, rather than routing every standard through the leader.

Design — the conditions a leader sets around the room before asking anything of the team's behaviour. *Membership* (a Real Team): bounded, stable membership, and work that genuinely

requires each other. *Mastery* (the Right People): members bring the knowledge, skill, and experience the work requires. *Mechanics* (Structure): right size, whole tasks, and norms that help the work. *Means* (Context): rewards, information, and resources pointing the same way as the team's mandate. *Mentoring* (Coaching): the team reviews and improves its own process, and skilled help is available and used.

The Drive — the centre where the lobes meet, drawn as a gear. *Direction* is the team's shared answer to what it exists to achieve and why it matters. *Delivery* is the discipline of turning purpose into collective results, measured on a shared scoreboard rather than on individual reputations.

Diagnostics — the assessment reads all eleven scales: Direction, Results, and the nine Dynamics and Design scales. **Tending** — the leader's discipline of keeping the loop turning, in the model's workshop language: diagnostics reads the engine, tuning makes the small and precise adjustments, and repair does the deeper work when a condition is missing or a pattern is entrenched.

The model's load-bearing claims are six. Performance depends jointly on behaviours and conditions; neither lobe suffices alone. Design accounts for such a large share of performance variation that many behaviour problems are design problems in disguise. Three elements are launch essentials — a Real Team, Direction, and the Right People — and when they are missing, coaching behaviour compensates for design, rarely successfully. Members of the same team can be experiencing different teams, and that spread is itself diagnostic. Teams change across their whole life, so the loop is read in rounds. And a diagnostic earns its keep in the conversation it starts: measurement is followed by a facilitated debrief, tuning, and where needed, repair.

The model at a glance. Each scale below is defined in the model's own language, with the source that anchors it and the response an Address reading triggers under the model's condition-first logic — behaviour is worked through the condition that most directly enables it, and the three essentials are flagged before any behaviour work begins.

Scale	What it reads	Anchor source	An Address reading triggers
Trust (Open up)	Members admit mistakes and ask for help without penalty	Edmondson (1999)	Work through Mentoring: structured review with skilled help
Candour (Speak up)	Hard issues are debated openly until they are resolved	Edmondson and Lei (2014); Morrison (2011)	Work through Mechanics: how meetings are structured
Commitment (Stand up)	Decisions end clear, and members stand behind them outside the room	Lencioni (2002), as vocabulary; Kotter (1996)	Work through Direction: settle the purpose decisions serve
Accountability (Step up)	Members hold each other to the team's standards directly	Edmondson (2018); Rosen et al. (2018)	Work through Mastery: the right people in the right roles
Real Team (Membership)		Wageman et al. (2008)	

Scale	What it reads	Anchor source	An Address reading triggers
	Bounded, stable membership, and work that genuinely requires each other		Essentials flag: repair the condition before coaching behaviour
Right People (Mastery)	The knowledge, skill, and experience the work requires are in the room	Wageman et al. (2008); Hackman (1990)	Essentials flag
Structure (Mechanics)	Right size, whole tasks, and norms that help the work	Hackman (2002); Salas, Sims and Burke (2005)	Redesign the task, the size, or the norms
Context (Means)	Rewards, information, and resources point the same way as the mandate	Hackman (2002); West (2021)	The second look in every condition-first pairing
Coaching (Mentoring)	The team reviews and improves its own process; skilled help is available and used	Hackman and Wageman (2005)	Build the review rhythm; secure skilled help
Direction (The Drive)	Every member can state what the team exists to achieve, and why it matters	Wageman et al. (2008); Ryan and Deci (2000)	Essentials flag
Results (The Drive)	Collective results, read on a shared scoreboard	Collins (2001); Csikszentmihalyi (1990)	Rebuild the scoreboard and the review held around it

3. Foundations: the systems ground the model stands on

The Loop is drawn as a loop because its intellectual foundations treat a team as a living system embedded in a larger one. Four works from the healthcare bibliography carry that ground.

Senge (1990) supplies the first premise: organizations learn or fail to learn as systems, through feedback loops and underlying structures that generate recurring events. His discipline of team learning — a team aligning and developing its capacity to produce results its members genuinely want — is the intellectual root of treating a team as a loop to be read and tended, and his warning travels with it: well-intentioned interventions produce unintended consequences when leaders respond to events while leaving the generating structures untouched. The Loop's insistence on reading conditions alongside behaviour is that warning operationalized.

Wheatley (1992) supplies the second premise. Drawing on the natural sciences, she argues that organizations behave as living systems, and that order inside them emerges from the quality of relationships and the free flow of information. The author's bibliography records her central line: real power and energy are generated through relationships. For the Loop, this grounds the Dynamics lobe in something older and deeper than technique — a team is a web of relationships before it is a chart of roles — and it grounds the model's scepticism toward purely mechanical fixes for relational problems.

Schein (2017) supplies the third premise, and the methodological one. Culture operates at three levels: visible artifacts, espoused values, and the shared underlying assumptions that actually

govern behaviour. Surface change programs fail when the assumptions beneath clinical and administrative cultures stay unexamined. A diagnostic built on this view reads below the artifact level: the Loop's assessment asks members how the team actually behaves and what its conditions actually are, because espoused values are the one reading a team can produce without effort. Schein's companion conclusion — that culture and leadership are two sides of the same coin — is the model's warrant for addressing its readings to the leader.

Oshry (2007) adds the structural caution. His work on systemic power dynamics shows that people become "systems blind," reacting to their structural position — top, middle, bottom — while attributing the friction to personalities. In health care, his frame explains why tension between executives, middle managers, and frontline clinicians recurs regardless of who holds the roles. The Loop absorbs this directly: several of its conditions (Membership, Mechanics, Means) exist to make positional friction visible as design data.

Two further foundations locate the model in its home system. Dickson and Tholl (2020) set out LEADS in a Caring Environment, the capabilities framework — Lead Self, Engage Others, Achieve Results, Develop Coalitions, Systems Transformation — that anchors leadership development across Canadian health care. The author's bibliography treats LEADS as the benchmark that bridges individual growth and whole-system transformation, and as a diagnostic and evaluative reference for coaching engagements. The Loop sits inside that context for its health care clients: an instrument for the team level of a system whose individual leaders are developed and assessed against LEADS. Edmondson (2012) completes the ground from the team side: teaming as a verb, a set of learnable behaviours practised across shifting membership and boundaries, illustrated in part through health care cases including Intermountain Healthcare. The model's Dynamics lobe takes up that behavioural register directly.

Readers trained in team science will recognize the field's organizing grammar underneath the model's own vocabulary. In the input–mediator–outcome–input (IMOI) framing that organizes the modern team effectiveness literature (Mathieu et al., 2008), Design corresponds to inputs, Dynamics to the processes and emergent states through which inputs become outcomes, and the Drive to outcomes that feed back as the next cycle's inputs — which is why the model is drawn as a loop and read in rounds. The Loop keeps its own vocabulary deliberately: its terms are the ones a leader uses in the room. The mapping is stated here so that the choice reads as a choice.

4. Open up — Trust

Trust in the Loop is a behaviour with a price mechanism, and the pricing research is Edmondson's. Psychological safety — the shared belief that the team is safe for interpersonal risk-taking — predicts team learning behaviour: asking for help, admitting errors, seeking feedback (Edmondson, 1999). The field's recent stocktake confirms the pattern across five decades of work while naming what remains unsettled about how safety is created (Edmondson and Bransby, 2023). The Trust scale's items are plain-language operationalizations of those learning behaviours: on this team, saying "I got that wrong" costs nothing; help is asked for early; not knowing something carries no loss of standing.

The healthcare bibliography deepens the account of how such trust is built, and its sources converge on relationship depth. Schein and Schein (2018) distinguish transactional, role-bound

relationships from Level 2 relationships — personalized, trusting connections that generate genuine collaboration and discretionary effort across functional boundaries — and argue that sustainable performance depends on the second kind. Schein (2016) had already drawn the consulting consequence: real help arises inside relationships of mutual trust and candour, and the helper's willingness to set aside expert performance is part of what makes help possible. Greenleaf (1977), the bibliography's oldest entry, supplies the authority claim underneath both: leadership authority is earned through consistent commitment to the growth and wellbeing of the people being led, which is why trust in a leader's team accumulates from service behaviour observed over time. Brown (2018) contributes the practice layer — vulnerability treated as a set of observable, teachable behaviours — and the paper cites her as practitioner synthesis, with the evidential weight resting on the Edmondson program.

One construct decision should be stated plainly, because a scholarly reader will look for it. The team literature distinguishes trust — a willingness to accept vulnerability based on positive expectations of another's intentions and behaviour — from psychological safety, the shared belief that interpersonal risk-taking will not be punished or held against the person who takes it. The constructs are related, and they are not interchangeable: a meta-analysis of the trust literature across 112 studies and 7,763 teams found trust associated with team performance ($\rho = .30$), with the relationship running in both directions (de Jong, Dirks and Gillespie, 2016). The Loop's Trust scale measures the behavioural surface where the two constructs meet in a team's daily life. Admitting error, asking for help, and seeking feedback are at once safety behaviours and the observable evidence from which trust between members is built and read. The model therefore states its equation openly: in this instrument, Trust names safety-based learning behaviour, chosen because it is what members can observe and report; the deeper disposition the trust literature measures is inferred from that behaviour rather than claimed as measured. A future validation round may separate the two constructs; the pilot reports the scale as defined here.

The quantitative record now sits beneath the programmatic one. A meta-analytic review of psychological safety across 136 samples confirmed the construct's associations with learning behaviour, information sharing, and performance, and modelled its antecedents and outcomes together (Frazier et al., 2017); the field's standard systematic review maps the antecedents a leader can actually act on (Newman, Donohue and Eva, 2017). The Dynamics claims in this paper rest on that combined record — programmatic depth from Edmondson's research, quantitative breadth from the meta-analyses — rather than on any single research group.

Health care gives Trust its sharpest edge. Edmondson's foundational safety work is a standing citation in the patient safety literature because clinical teams price admission of error in outcomes: a nurse who cannot say "I may have made a mistake" converts a recoverable event into a harmed patient (Edmondson, 1999; Rosen et al., 2018). In health care teams specifically, leader inclusiveness — explicitly inviting input and appreciating contributions — predicts psychological safety and engagement in improvement work, with professional status cutting the other way (Nembhard and Edmondson, 2006). The executive version of that finding is direct: a team's most senior voices set the price of speech for everyone else. Weick and Sutcliffe (2007), in the high-reliability research carried in the author's reading list, add the organizational form of the same behaviour: deference to expertise, in which authority migrates toward the person who knows most about the problem at hand, regardless of rank. An executive team that opens up — that admits error

early, asks for help without penalty, and defers to expertise across its own hierarchy — is practising at the top the behaviour its safety culture asks of the front line.

5. Speak up — Candour

Candour is Trust made audible, and the model measures it separately for a practical reason: a debrief needs to distinguish a team that feels safe and still stays silent from a team whose silence is priced by fear. The safety literature carries the first distinction — safety predicts speaking up, discussing errors, and surfacing problems (Edmondson, 1999; Edmondson and Lei, 2014) — and current experimental work adds a behavioural microscope: in 150 teams, speaking patterns evidencing collective attention predicted the team's collective intelligence, with the productive pattern varying by team composition (Woolley et al., 2023). The employee voice literature — the peer-reviewed home of the speaking-up construct — adds the leader-side mechanism: across more than 3,000 employees, managerial openness was the leadership behaviour most consistently related to voice, working through psychological safety (Detert and Burris, 2007), and the field's integrative review distinguishes the discretionary, improvement-oriented voice the Loop measures from the formal voice mechanisms it does not (Morrison, 2011). Who speaks, and who is heard, is performance data.

The healthcare bibliography supplies the skill literature and the healthcare diagnosis. Schein and Schein (2021) frame the foundational habit as humble inquiry — asking instead of telling, out of genuine curiosity — and the author's annotation states its stakes plainly: in high-stakes environments, asking instead of telling is a patient safety and organizational learning discipline, because junior staff who cannot surface concerns to senior leaders leave safety information unspoken. Patterson et al. (2002) provide the dialogue mechanics: a pool of shared meaning, maintained by watching for the twin derailers of silence and violence, and their skills are taught in hospitals precisely because speaking up across hierarchy is a safety behaviour. Scott (2017) names the failure mode the model's health care clients will recognize first: ruinous empathy, caring without challenging, in which leaders withhold direct feedback to protect feelings and pay for the kindness in degraded standards and uninformed decisions. Scott (2002) adds the relational premise — the conversation is the relationship — and the discipline of confronting reality inside it. Rosenberg (2015), cited as practitioner literature, contributes the needs-based reading of conflict that debriefs use when candour has curdled into blame.

One peer-reviewed source in the bibliography explains why candour fails structurally even in well-intentioned executive teams. Thomas-Hunt, Wageman, Mannix and Neale (2005) collect the research on status and groups: status hierarchies distort information sharing, isolate minority perspectives, and produce sub-optimal consensus in boardrooms. The implication for the model is direct. Candour problems at executive level are frequently status problems wearing conversational clothes, which is why the assessment measures Candour alongside Membership and Mechanics, and why its anonymity architecture (Section 15) treats protection as a measurement condition.

6. Stand up — Commitment

Commitment in the Loop means decisions end clear and members stand behind them outside the room, including members who argued for another option. Lencioni (2002) supplies the vocabulary and the mechanism: commitment fails upstream, when debate was never genuine, and it requires clarity and buy-in rather than consensus. Lencioni (2012) adds the leadership discipline that sustains it — clarity created and repeated until it cascades — which is why Commitment's condition-first pairing in the model is Direction: teams commit more readily to decisions that serve a settled purpose.

The healthcare bibliography contributes two further warrants, one from practice at scale and one from operations. Kotter (1996) locates commitment inside change that lasts: a guiding coalition genuinely enlisted, a vision communicated until it is shared property, and short-term wins that convert sceptics. Read against the Loop, Kotter's sequence explains why Stand up is measured as a team property renewed across rounds — commitment decays when wins stop being generated and consolidated. Marquet (2013) supplies the operating picture. His intent-based leadership, developed commanding a nuclear submarine, replaces permission-seeking with stated intent: members declare what they intend to do, and the team carries direction collectively. The author's annotation draws the healthcare application explicitly — a blueprint for distributed leadership across broad regional sites, in which mid-level health program directors state clear intentions and speed-to-care rises because decisions travel at the speed of competence. Commitment, in Marquet's demonstration, is visible behaviour: people say what the team has decided, in their own voice, and act on it as theirs.

7. Step up — Accountability

Accountability completes the Dynamics lobe, and the model's placement of it — inside the same lobe as Trust — is an evidence claim. Edmondson (2018) pairs safety with high standards as joint conditions of learning behaviour: teams flourish where it is safe to admit a mistake and expected that mistakes get raised. The Accountability scale's exemplar item states Lencioni's fourth dysfunction positively: if my work slipped, a teammate would raise it with me before our leader would. Peer accountability arriving before leader accountability is the behaviour; the leader's role is designing the conditions that make it normal.

The healthcare sources sharpen both the standard and the setting. Rosen et al. (2018), reviewing the evidence for clinical teams directly, include shared accountability for outcomes among the properties effective health care teams require — in clinical work, peer accountability is a patient-safety behaviour, because the colleague who notices drift is a safety system. Scott (2017) contributes the communication axis: challenging directly, joined to caring personally, with ruinous empathy as the named alternative that health care cultures drift toward. Willink and Babin (2015) state the ownership extreme — leaders accepting accountability for every outcome in their sphere, without blame-shifting — and the paper cites them as practitioner literature drawn from military command, useful in debriefs as a standard of ownership language and weighted accordingly. Katzenbach and Smith (1993) supply the structural root from Section 8: mutual accountability for

shared outcomes is the property that separates a real team from a working group, so Step up reads, in part, whether the team's Membership condition is real.

8. Membership — a Real Team

Membership is the first of the model's three essentials, and it rests on the strongest empirical base in the paper. Wageman, Nunes, Burruss and Hackman (2008), studying more than 120 senior leadership teams, name the real team — bounded membership, stability over time, and genuine interdependence — as the first essential, prior to every enabler. Hackman (2002) states the same condition as the first of his five, with the rule of thumb that design and launch outweigh in-the-moment leadership. The Real Team scale reproduces the construct directly: it is never in doubt who is on this team; membership is stable enough for working relationships to form; the shared work requires members to depend on one another. Katzenbach and Smith (1993) drew the distinction the scale's Address narrative uses in sense: a working group in team clothing, sharing information and a manager while holding only individual accountability.

The author's bibliography adds the senior-team failure anatomy. Wageman and colleagues identify the derailers his annotation records — poorly bounded membership and insufficient leadership engagement among them — and his reading list draws the healthcare consequence: health authority executive teams frequently operate in deep specialty silos, and the conditions research serves as an operational blueprint for aligning such a team under a single overarching mandate, so that regional service delivery is unified rather than fragmented (Evans, 2026b). A team whose members attend as ambassadors for their portfolios has a Membership problem before it has any behaviour problem, and the essentials flag exists to say so before a debrief spends itself on Dynamics.

9. Mastery — the Right People

Mastery is the second essential: the capabilities the mandate requires are present in the room. Wageman et al. (2008) treat the right people as a launch condition — teams fail at the mandate when the knowledge, skill, and experience the work requires are absent, however good their process feels. Collins (2001), cited as a research-based practitioner synthesis, sequences the same point as "first who, then what": disciplined people precede disciplined direction in his account of sustained performance. Hackman (1990) supplies the case evidence underneath the conditions approach — flight crews, surgical teams, string quartets — including how composition separated the effective teams from the ineffective ones across very different kinds of work.

The healthcare bibliography extends Mastery in two directions the conditions literature leaves thin: finding capability that is already present and overlooked, and multiplying the capability already in the room. Grant (2023), writing as an organizational psychologist synthesizing research for practitioners, argues that organizations systematically miss their own human capital — potential is unevenly recognized, and scaffolding systems, mentorship structures, and succession design determine whose capability becomes visible. The author's annotation ties this to health care's succession pipelines and equity commitments: a health authority's Right People problem is frequently a recognition problem distributed across a very large workforce. Wiseman (2010) names

the complementary failure from the leader's side: Diminishers, who drain capability by needing to be the smartest person in the room, and Multipliers, who amplify the intelligence around them. His annotation applies it to academic medicine, where leaders default to over-directing; coaching leaders toward Multiplier habits — calibrated questions, genuine debate — unlocks capacity in existing staff without additional headcount. The scale itself stays with the conditions question — is the expertise the mandate requires in the room, does the team's experience cover its hardest problems, do members' strengths match their responsibilities — while these sources shape what a debrief does with a low reading: verify recognition and leadership behaviour before concluding that recruitment is the answer.

10. Mechanics — Structure

Mechanics covers the team's enabling structure: right size, whole tasks, and norms that help the work. Hackman (2002) names enabling structure as the third condition — a well-designed task, the right number and mix of people, and norms supporting the work. Salas, Sims and Burke (2005) provide the independent scholarly synthesis: five core components of teamwork (team leadership, mutual performance monitoring, backup behaviour, adaptability, team orientation) coordinated by three mechanisms (shared mental models, closed-loop communication, mutual trust). Coordination, in their account, is designed through mechanisms. Wageman et al. (2008) confirm the pattern for the model's primary population: enabling structure is one of the three enablers separating great senior teams from ordinary ones. The Structure scale's items are this condition in plain language — norms make good work easier, the team is the right size for its work, every significant task has a clear owner — and Structure is Candour's condition-first pairing, because guarded debate very often reflects how meetings are set up: who is in them, what they are for, and what happens to a raised problem.

Health care adds two structural lenses. Manser (2009), reviewing teamwork in dynamic clinical domains, links team structure and coordination to patient outcomes in acute care — structure is a clinical variable there. Weick and Sutcliffe (2007) contribute the high-reliability organizing disciplines, of which sensitivity to operations — leadership's maintained grasp of the actual front-line state — is the most structural: a team whose mechanics never carry front-line reality into the room will govern a fiction. Oshry (2007) completes the section's logic from the bibliography: much of what presents as interpersonal friction in executive teams is the predictable output of structural positions, and Mechanics is where the model sends the leader to look first.

11. Means — Context

Means is the supportive context: rewards, information, and resources that point the same way as the team's mandate. Hackman (2002) specifies the systems — reward systems, information systems, and an education system that reinforces the team's work — and the Context scale tracks them closely: how people are recognized here supports the team's goals; the team gets the information it needs in time to act; resources match the size of the mandate. Context is the second look in every condition-first pairing, because a mandate contradicted by its own resourcing produces behaviour problems that coaching cannot reach.

The healthcare bibliography gives Means its fullest treatment of any element, and the evidence runs in one direction: the designed relational and motivational climate shows up in outcomes the organization already measures. West (2021), synthesizing NHS and health system research, defines compassionate leadership through attending, understanding, empathizing, and helping, and ties that climate to reduced staff burnout, improved patient safety, and sustained performance under pressure — his central claim being that compassion and high standards reinforce each other in the conditions health care actually faces. Trzeciak and Mazzarelli (2019) synthesize over a thousand studies into the operational version of the same finding: the relational climate leaders design registers in patient outcomes, staff wellbeing, and system cost, with measurable effects from brief compassionate interactions. Rosen et al. (2018) anchor the point for clinical teams generally: organizational support for teamwork is a safety variable. Ryan and Deci (2017) supply the motivational mechanism underneath all three — environments that support autonomy, competence, and relatedness nourish motivation, while need-thwarting environments actively produce distress, alienation, and disengagement, so a context audit is a motivation audit. Goleman, Boyatzis and McKee (2002), cited as practitioner synthesis grounded in the emotional intelligence research program, add the leader's transmission role: a leader's emotional state cascades into organizational climate, driving resonance or dissonance, which is one reason the Loop addresses context design to the leader personally.

For a health authority, the Means reading is therefore a board-level reading. A team scored low on Context is reporting that the system around it contradicts its mandate — and its members' burnout, turnover, and safety indicators will usually corroborate the report.

12. Mentoring — Coaching

Mentoring holds a double position in the model: it is a Design condition (the team has access to skilled help on how it works, and uses it) and the doorway to Tending (Section 16). The theoretical warrant is Hackman and Wageman (2005): team coaching interventions serve motivational, consultative, and educational functions, they land at the beginning, midpoint, and end of a team's performance cycle, and they help only when the team is adequately designed — coaching cannot substitute for missing conditions. That conditional is the theoretical root of the model's condition-first rule. Hackman (2002) completes the condition statement: expert coaching, available and used well, is the fifth enabling condition. The Coaching scale asks whether the team regularly pauses to examine how it works and adjusts, whether skilled help is available when needed, and whether reviews produce actual changes. A recent meta-analysis of team reflexivity — teams jointly reflecting on and adapting their objectives, strategies, and processes — finds reflexivity facilitates team performance, with psychological safety as a critical enabling condition (Leblanc, Harvey and Rousseau, 2024): current, quantitative support for the scale's review-and-adjust items, and for the assessment round itself as an institutionalized act of reflexivity.

The healthcare bibliography carries the discipline's practice architecture. Hawkins (2011) founded team coaching as a discipline oriented to the team as a whole system; Hawkins (2012) scales it into organizational design, arguing that coaching delivers value when it is built into strategy, systems, and stakeholder relationships as a culture — his Relational Value Chain links the quality of internal relationships to the patient and stakeholder experience, and his case material includes NHS

organizations, which is why the author's annotation recommends the work for publicly funded health systems directly. Leary-Joyce and Lines (2018) operationalize the systemic approach through Hawkins's Five Disciplines — Commissioning, Clarifying, Co-creating, Connecting, Core Learning — and a team diagnostic tradition of their own; their term "We Q," the collaborative intelligence of collective leadership, names what Mentoring builds. Clutterbuck (2020) organizes twenty years of team coaching research around purpose, stakeholders, relationships, process, learning, and leadership, placing the Loop's concerns inside the discipline's mainstream.

The craft layer beneath the discipline is also in the bibliography, and the paper labels it practitioner literature: Whitmore (2017) on awareness and responsibility as the coach's levers; Rogers (2016) on deep listening and restraint from premature problem-solving as the core disciplines; Bungay Stanier (2016) on the "advice monster" — the leader's impulse to jump to solutions — and the habit of staying curious longer, which his annotation commends to time-pressed healthcare executives specifically; Kimsey-House et al. (2018) on the co-active stance, whose practical effect the annotation names well — leaders stepping out of expert-fixer mode, the standing bottleneck when clinicians transition into executive roles; Drake (2018) on narrative approaches to the stories a team tells about itself; and Schein (2016) on humble consulting as the relational posture that makes expert help usable. A first randomized controlled trial now supports the whole element: Passmore, Tee and Gold (2025) found team coaching produced greater gains in psychological safety and team cohesion than a credible facilitation comparison — one trial, perception outcomes, cited at that weight in Section 16.

13. The Drive — Direction and Delivery

Direction sits at the centre of the Loop because two literatures meet there. The conditions research treats compelling direction as an enabler and, in the model's reading, an essential: Wageman et al. (2008) found great senior teams hold a purpose that is clear, challenging, and consequential, stated by the team itself. Motivation science explains the mechanism. Self-determination theory's evidence — founded in Deci and Ryan (1985), summarized in Ryan and Deci (2000), and consolidated in Ryan and Deci (2017) — is that internalized motivation, goals a team has genuinely made its own through integrated regulation, sustains effort and quality in ways imposed targets do not; a direction recited is weaker than a direction owned. Pink (2009) carried that research to executives as autonomy, mastery, and purpose, and the paper cites him as the synthesis layer over the peer-reviewed base. The Direction scale therefore asks every member — all of them — whether they could state, in one sentence, what the team exists to achieve this year: shared direction is a property of the team's understanding, and a leader's report that the purpose was communicated is a different measurement.

The bibliography adds the disciplines that keep direction alive across a long transformation. Kotter (1996) supplies the sequence — urgency, coalition, communicated vision, short-term wins, consolidation — by which direction stays joined to delivery over years. Sinek (2009), cited as accessible practitioner articulation, states purpose plainly enough for a team to steer by. Hyatt (2018), in the bibliography's goal-setting entry, contributes the annual architecture of believable possibility, completed-past review, and specific, emotionally anchored goals; the author's companion white paper on the Quarterly Snapshot and Becoming Plan treats that planning layer in

full, and this paper claims only the team-level point — direction benefits from a written, reviewed, emotionally owned statement. Scharmer (2007), cited as a framework from the systems tradition, names the leader's inner contribution: sensing emerging possibility through deep listening, the stance the author's annotation summarizes as the quality of results depending on the inner state from which the leader acts.

Delivery is the centre's test, and its scale is Results: collective results, read on a shared scoreboard, reviewed together. Collins (2001) supplies the compounding logic — the flywheel, in which sustained, disciplined effort in a consistent direction accumulates into momentum — which is Delivery read across rounds. Csikszentmihalyi (1990), the bibliography's flow research, specifies two properties a good scoreboard has: goals clear enough to steer by and feedback immediate enough to correct by, the conditions under which challenge matched to skill produces full engagement. Marquet (2013) shows delivery distributed: intent stated at every level, execution owned locally, results still collective. Weick and Sutcliffe (2007) give delivery its high-reliability form — resilient performance maintained under volatility through preoccupation with failure and commitment to resilience — which is the version of Delivery a health care executive team is actually being asked for. A team can report warm dynamics and sound conditions and still fail to deliver; the Drive exists so the model cannot.

14. Diagnostics: reading the whole loop

The Ad Infinitum Loop Team Assessment reads the model as designed. Every member rates the team — team-referent items, about the team as it actually is — on 33 original items, three per scale across the eleven scales, on a five-point scale from Strongly disagree to Strongly agree, with "Mixed" as its honest midpoint. Scale scores are means of members' totals, banded Strong (13–15), Watch (10–12), and Address (3–9) on unrounded values, and rolled into three element readings: Drive, Dynamics, Design.

The architecture has a lineage, stated openly. Whole-team, member-rated assessment of a team's essentials and enablers, reported back to the team for development, is the design of the Team Diagnostic Survey tradition beneath Wageman et al. (2008) and of Edmondson's team-level safety measurement, where scores aggregate to the team because the construct lives at team level. The model's source texts include the Team Diagnostic Survey development paper (Wageman, Hackman and Lehman, 2005), which reports the instrument's psychometrics on 2,474 members of 321 teams; under its copyright guardrails, the Loop uses the constructs and writes every item itself. Hackman and Wageman (2005) supply the diagnostic order: the first question is always about design — whether the conditions are in place — before it is about process, which the report enacts through its essentials flag and condition-first pairings. The healthcare bibliography contributes two further diagnostic lenses. Dickson and Tholl (2020) position LEADS as a diagnostic and evaluative reference for Canadian health leadership — the system-level benchmark against which the Loop's team-level reading complements, for health care clients, the individual capability picture. Schein (2017) sets the depth standard: a reading that stays at the level of artifacts and espoused values describes the team's presentation; the assessment aims at experienced behaviour and conditions, the closest a perception instrument gets to the assumption level.

The comparison a buyer will make deserves a direct answer. The Team Diagnostic Survey and its 6 Conditions framework are a validated, commercially licensed instrument, supported by two decades of accumulated team data and a network of certified practitioners; for an organization that wants an established instrument and a licensed delivery network, they are the proven choice. The Loop differs in four stated ways. Its items are original, and its reading is organized around the leader's own tending rhythm across repeated rounds rather than a single diagnostic event. Its report sequences the work, through the essentials flag and the condition-first pairings, instead of describing a state and leaving the sequence to the debrief. It is embedded in a coaching practice and a platform rather than licensed to third-party practitioners. And its synthesis is built for Canadian health care leadership, inside the LEADS context its health care clients already inhabit. Those are differences of purpose and delivery model. On measurement maturity, the licensed instrument is ahead, and Section 17 states what the Loop's pilot must do to close the gap.

Three diagnostic devices carry the model's claims into the report. A **Divided view** flag marks any scale where members' scores span six points or more — the same team being experienced as different teams, surfaced rather than averaged away. An **essentials flag** raises Real Team, Direction, or Right People whenever one lands in Address, because the model holds that coaching behaviour cannot compensate for missing essentials. And the **condition-first pairings** sequence the response when behaviour and condition are low together: Trust through Mentoring, Candour through Mechanics, Commitment through Direction, Accountability through Mastery, with Means as the second look for all four. Item averages appear in an appendix to the leader's report, as means only. Rounds repeat, and the report's most useful comparisons are a team's against its own earlier rounds — Tuckman (1965) and Gersick (1988) ground the rhythm, since a single reading is a snapshot of a moving system. Two current sources discipline the interpretation: Woolley et al. (2023) support treating conversation patterns as performance-relevant behaviour, and Rowe, Hattie and Munro (2024), finding a two-factor structure where a single collective intelligence factor was expected, caution the whole field — this model included — against tidy single-factor stories about team capability.

Anonymity is designed as a measurement decision before it is an ethical one: candour data collected under exposure is unreliable data. Individual answers are never shown to anyone, in any form; the leader sees counts of invited and responded, and never per-member response status — the leader's own included. Two thresholds govern what a report may contain, set by the arithmetic of small teams. Scale and element scores release once at least three members have responded. Item averages — the level at which a single answer can move a mean — release only when at least five members have responded, and are suppressed below that threshold, because in a three- or four-respondent team a leader who is also a respondent could otherwise work backwards from a published mean to a colleague's answers. Section 15 states what these rules mean for the promise the instrument makes to small teams.

15. Method: how the assessment is built, and why

Each design commitment follows from the evidence or is disclosed as judgement.

Original items, written to guardrails. Items are original, single-idea, positively stated, and team-referent, written within established team-diagnostic design constraints. Members answer one

continuous list with no scale names shown, so they rate behaviour they recognize rather than constructs they are guessing at; the report then names every scale and shows item averages, which answers the transparency trade-off. The "Mixed" midpoint is retained deliberately: forced choice on genuinely mixed experience manufactures false signal, and the banding handles the cost — a team answering "Mixed" throughout lands in Address on most scales, which is the correct reading of that pattern.

The whole team rates the team. The constructs — safety, candour, shared direction, supportive context — are properties of a collective as experienced by its members. A leader-only rating would measure the leader's perception; a sampled rating would miss the phenomenon the Divided view flag exists to catch. The census structure makes the leader one voice among the membership, with no special weight. That is the only arrangement under which a Divided view can appear at all, and it matches the instrument's object, which is the team's shared reading of itself.

Aggregation, stated as a composition model. Team scores are means of member ratings, and the step from individual perceptions to a team property needs its warrant stated rather than assumed. The items are referent-shift items — the referent is the team, not the self — so the instrument's composition model is the referent-shift consensus model in Chan's (1998) typology of composition models, the standard apparatus for constructs of this kind (Klein and Kozlowski, 2000). Under that model, a team mean carries meaning to the degree that members agree, which makes within-team agreement a reporting quantity rather than an assumption. The Divided view flag is the report's plain-language dispersion device; the pilot's validation summary will additionally report agreement indices (rWG and ICC) for every scale, interpreted against the standards set out in LeBreton and Senter (2008), so that a scale whose members do not agree is identified as such in the evidence record and not only in the debrief.

Bands, not rankings. Cut points are judgement-based and disclosed: they were chosen so a team answering "Mixed" throughout cannot present as healthy, and so Strong requires consistent agreement. The report's three reading levels — element numbers, scale scores, item averages — are each means of the level below, so every number is auditable against the level beneath it. The element numbers are composites of formative indices — sums of readings, not measurements of a single underlying trait — and they are offered as navigation aids for the debrief, with the scale-level readings carrying the interpretive weight. In the pilot period a team is compared with its own previous rounds — the one comparison already meaningful — until a population of assessed teams supports norms.

Disagreement is data. Averaging a divided team into a single contented mean is the standard failure of team diagnostics; the Divided view flag, the essentials flag, and the condition-first pairings exist so the report sequences a response instead of merely describing a state. The pairings are the model's practice heuristic, derived from the conditions logic and from patterning across debriefs, and Section 17 labels them accordingly.

Anonymity as a measurement condition. The instrument's most valuable data — low Trust, low Candour, a divided team — is exactly the data members withhold when answers can be attributed. Edmondson's work is the standing demonstration that speaking up is priced by expected interpersonal cost; an assessment that raised that cost would corrupt its own input. The release rules in Section 14 are the operational form of the promise: scale scores at three responses, item

averages only at five. For teams below that second threshold, the promise is stated to members and to the leader in its accurate form before launch — responses are confidential and reported in aggregate — because a team of four receives a thinner protection than a team of ten, and the instrument says so rather than letting the word "anonymous" do more work than the arithmetic can carry. In member-facing materials the design goal keeps its name, anonymity, and the thresholds are what make the name honest where it is used.

The debrief is part of the instrument. A facilitated debrief, tuning commitments, and a scheduled next round ship with the assessment, reflecting the field's consistent finding — now with its first randomized support (Section 16) — that diagnostics change teams through the work done with them, and the older caution from the feedback literature, carried in Infinitum's Snapshot and Plan paper, that feedback mishandled can harm. The debrief's specific form — structured, facilitated, developmental, and drawing on multiple information sources — follows the after-action review meta-analyses, which identify exactly those features as the ones that make structured review an effective performance intervention (Tannenbaum and Cerasoli, 2013; Keiser and Arthur, 2021, 2022). Band narratives are written to the leader and operationalize the model inside the report: every Dynamics Address narrative directs attention to Design first. A restricted preview for non-client accounts shows scale names and band words only — no numbers, no graphic, no appendix. That boundary is commercial, disclosed here as one; the methodology underneath it is identical.

Permitted use. The assessment is a developmental instrument. Its readings exist for the team's development conversations and the leader's design and coaching decisions, and for nothing else: Loop results must not be used in selection, promotion, performance management, compensation, or restructuring decisions, and must not be attached to any individual's employment record. The guardrail is stated in the engagement terms and repeated on the report itself, because a diagnostic that can be used against individuals will stop receiving honest data — the measurement argument and the ethical one point the same way.

Data governance. Anonymity of reporting is a measurement property; it is a separate question from privacy compliance, and this paragraph covers that question. Infinitum Leadership is the controller of assessment response data, and the Choose Becoming platform is its processor. Deployments for Canadian clients are contracted so that response data is stored and accessed only in Canada: for British Columbia public bodies, the Freedom of Information and Protection of Privacy Act (FIPPA) restricts the storage of, and access to, personal information in a public body's custody or control to Canada, and Loop engagements in that sector are contracted on that basis, with the deployment's hosting particulars confirmed in writing at contracting. Individual response records are retained only while an engagement's rounds require them and are then deleted; the team-level readings in a report belong to the sponsoring team and are reported only to it.

Sponsor briefing and unionized settings. Every engagement begins with a sponsor briefing at which the permitted-use guardrail, the release thresholds, and the reporting lines are agreed before any member is invited. In unionized settings — much of Canadian health care — that briefing is also where the employer's consultation expectations are settled, and the standing rules are restated operationally: results describe the team, are reported at team level only, and are never attached to individuals. The predictable failure mode of team diagnostics in these settings is staff suspicion that team-functioning data will become individual performance data; the briefing exists to close that suspicion down before the first round opens.

The pilot, on the record. The pilot opened inside the Choose Becoming platform in November 2026, with Leadership and Executive stream teams as its first population. Its first validation summary — item performance, scale structure, band behaviour, and the agreement indices committed to above — will be published when the assessed-team population is large enough for the statistics to mean anything, and this paper will be revised against it. Until that summary exists, every claim in this paper about the instrument itself should be read at the strength Section 17 assigns it.

16. Tending: the leader's discipline

Hackman and Wageman (2005) located coaching's leverage at a team's beginnings, midpoint, and ends — the moments Gersick's (1988) punctuated pattern predicts a team is most open to change. Tending generalizes that rhythm into a discipline: read the loop, tune what is close, repair what is missing, and read again. The claim now has early controlled support. Passmore, Tee and Gold (2025) report the first randomized controlled trial of team coaching, finding greater gains in psychological safety and team cohesion than a credible comparison activity; this paper cites it as a beginning — one trial, perception-based outcomes, one coaching method — and the Tending claims here are written to survive its effects shrinking on replication. The wider coaching literature supplies the frame around that single trial: a 2023 meta-analysis of workplace coaching found a moderate positive effect on organizational outcomes, concluding from three meta-analyses together that coaching is an effective workplace intervention (Cannon-Bowers et al., 2023). One source is the meta-analytic frame; the other is the team-specific trial; the paper leans on each for what it is.

The review rituals inside Tending — the debrief that follows each Diagnostics round, the tuning commitments it produces, the repair work it commissions — also carry a direct evidence base of their own, from the after-action review literature. Debriefs improve effectiveness by roughly 20–25% over control conditions (d = .67 across 46 samples; Tannenbaum and Cerasoli, 2013). A larger meta-analysis found d = 0.79 across 61 studies, with alignment to the individual or team and the use of objective performance information among the contributors (Keiser and Arthur, 2021). An extension across 83 studies reports d = 0.92 overall — a bare-bones, uncorrected estimate, quoted as such — with the largest effects in high-complexity, high-ambiguity task environments: project and decision-making work (Keiser and Arthur, 2022). The Diagnostics cycle is deliberately built to the features that literature identifies as effective: the debrief is structured rather than open-ended, facilitated rather than left to the room, developmental rather than evaluative in purpose, and worked from the assessment's recorded information — objective readings of the team's own scales — rather than from recollection and advocacy.

The healthcare bibliography explains why tending is necessary and why it stalls. Senge et al. (1999) document the balancing loops that defeat change efforts after initial success — fear, internal politics, and legacy resistance restoring the old equilibrium — which is the systems account of why a single good debrief decays without a rhythm behind it. Kegan and Lahey (2009), developmental psychologists writing from Harvard's Graduate School of Education, supply the repair-level lens: their immunity-to-change account reads stagnation as produced by competing commitments and big assumptions that protect the person from vulnerability while quietly defeating their stated

goals. The paper cites that account at its graded weight — a theoretically grounded coaching method, grounded in Kegan's constructive-developmental scholarship and supported by case material from its authors' practice; no controlled outcome study of the immunity-to-change protocol exists, and the model borrows the lens as method, not as validated diagnosis. The author's annotation applies it to health system restructuring, where plans fail when adaptive challenges receive technical fixes; inside the Loop, an entrenched pattern that survives honest tuning is a candidate for immunity mapping before further structural work. The systemic coaching literature (Hawkins, 2012; Leary-Joyce and Lines, 2018) sets tending's reach: a team's conditions are partly set outside the team, by sponsors and stakeholders, so tending includes the commissioning conversation and the stakeholder system, with the Context scale as its instrument. The leader's own stance completes the discipline. Grant (2021) treats rethinking as a practised habit, and Edmondson (2023) supplies its failure-facing form: intelligent failure and honest reporting are the raw material of tuning, and a leader who punishes the data soon stops receiving it. Lencioni (2020), cited as practitioner literature, names the occupational hazard plainly — tending is repetitive, undramatic maintenance, and leaders skip it for work that feels more like leadership — which is why the model builds tending into a system of rounds and scheduled debriefs rather than relying on intention.

One boundary note belongs here. The author's bibliography includes clinical literature on the human cost of sustained self-sacrifice in health care cultures (Maté, 2003; Maté and Maté, 2022). The Loop makes no clinical claims; the relevance is narrower — a tending rhythm that ignores the leader's own sustainability will eventually lose the leader, and West (2021) documents the organizational version of that cost in burnout and turnover. Tending the loop includes tending its tender, at the level of workload and recovery design.

17. What this model does not yet claim

The configuration is untested: every element carries scholarly support, while the Loop as an arrangement — two lobes, this centre, these eleven scales — has never been tested as a whole, and component validity is not model validity. The instrument has no psychometric record yet: the 33 items are original and unvalidated, with no published reliability coefficients, no factor analysis confirming the scales as designed, and no test–retest data; three items per scale trades measurement depth for the brevity that whole-team completion requires, and the scales are best described as structured readings for development conversations. The bands, the Divided view threshold, and the condition-first pairings are disclosed judgements with stated rationales; the pairings have not been experimentally tested as pairings. The assessment measures members' perceptions, and no evidence yet shows that Loop scores predict team outcomes or that score improvements cause outcome improvements. Whole-team self-report is common-method data, vulnerable to mood, politics, and a bad quarter; anonymity, team-referent items, and repeated rounds mitigate that partially, and a bad quarter then shows up as a delta rather than a verdict.

The evidence base is unevenly distributed. The scholarly weight concentrates in Dynamics (psychological safety) and Design (the conditions research). The Drive leans on motivation science translated from the individual to the team — a translation the sources themselves do not all make. Tending leans on theory and practice literature more than on outcome studies, though the after-

action review meta-analyses (Tannenbaum and Cerasoli, 2013; Keiser and Arthur, 2021, 2022) and Passmore, Tee and Gold (2025) begin to close that gap. The samples behind this evidence base lean toward senior leadership teams, health care, and knowledge work in Western settings; generalization to frontline, highly distributed, or non-Western teams is an assumption. The design figure used in this paper — the six conditions predicting more than half of the variation in team effectiveness — comes from Wageman and colleagues' senior-team study as reported in their book and by the research program since (Wageman et al., 2008), on that program's samples and measures. It is one program's estimate, attributed to its source wherever it appears. It should not be confused with the same program's better-known 60–30–10 rule, which apportions a leader's leverage among design, launch, and coaching as a heuristic; that is a different claim, about where effort pays rather than about variance explained. Salas et al. (2005) support the figure's direction without producing the same number.

A word about this paper's own sources. The healthcare bibliography synthesized here is a curated practice library: its annotations are expert curation by the author, several of its entries are practitioner works, and the paper has weighted them accordingly throughout — practitioner sources named as vocabulary, synthesis, and craft; peer-reviewed findings carrying the claims. One rule governs the author's own bibliography throughout: his annotations record how a source is used in his practice and are cited as provenance — where a reading came from — never as evidence for a claim. Wherever an annotation draws a healthcare implication, the claim itself rests on the published source the annotation is about. Some bibliography entries address individual development and personal productivity and were read without being carried into a team-level paper; the selection followed the claims, and the full library stands behind Appendix A as part of the model's scholarly record. The pilot now running inside the Choose Becoming platform is the model's own evidence program — item performance, scale structure, band behaviour, and round-over-round movement across many teams — and this paper will be revised as that record accrues. The promises stop where the data stops.

18. Answers to a skeptical reader

"This is Lencioni plus Hackman and Wageman with new labels." Substantially, yes — and the paper says so. The Loop is presented as a synthesis; its report footer credit names Lencioni (2002) and Wageman et al. (2008) as the particular debts, and its full bibliography is carried openly in Appendix A. The claim is integration and usability: one picture a leader can hold, one instrument that reads all of it, and two rules — essentials, condition-first — that sequence the work. Synthesis is a legitimate contribution when labelled as one.

"Lencioni is a business fable. It is not evidence." Agreed, and the paper does not use it as evidence. Lencioni supplies the vocabulary of the Dynamics lobe and a sequencing intuition. Wherever a Dynamics claim needs evidence, the citation is Edmondson's peer-reviewed program, its 2023 stocktake (Edmondson and Bransby, 2023), and the field's meta-analyses (Frazier et al., 2017; Newman, Donohue and Eva, 2017). Section 4 and Section 5 make that division of labour explicit in the text.

"Your health care sources are a coach's reading list, not a systematic review." Correct, and disclosed in Section 17. The bibliography is the author's curated library, assembled for coaching

practice inside Canadian health care and aligned to LEADS. This paper synthesizes it as expert curation — a record of what a serious practitioner reads and applies — while the load-bearing claims rest on the peer-reviewed programs cited alongside it. The synthesis is the contribution; the curation is labelled as curation.

"Eleven scales, three items each, no factor analysis — why should I believe the scales exist?" At present, on the strength of their construct definitions and their lineage in validated traditions. The scales are formative indices for development conversations. The pilot exists to test whether the item groupings behave as designed; until those results exist, the paper makes no measurement claim stronger than a structured reading. Even the mature collective intelligence literature is still arguing about its factor structure (Rowe, Hattie and Munro, 2024); the Loop holds itself to the same standard it cites.

"Your cut scores are arbitrary, and you have no norms." The cut scores are judgement-based and disclosed as such in Section 15; they were chosen so a team answering "Mixed" across the board cannot present as healthy, and so Strong requires consistent agreement. Norms require a population of assessed teams that does not yet exist; in the meantime, the report compares a team with its own previous rounds.

"The condition-first pairings look invented. Why does Trust pair with Coaching?" The pairings are the model's practice heuristic, derived from the conditions logic — a behaviour is worked through the condition that most directly enables it — and from patterning across debriefs. They have not been experimentally tested as pairings, and the paper labels them a heuristic with a rationale.

"Your RCT measured perceptions, used one coaching method, and compared against facilitation. That is thin." It is one trial, cited as a beginning: first controlled evidence that team coaching moves psychological safety and cohesion perceptions more than a credible comparison activity. The Tending claims are written to survive its effects shrinking on replication.

"Anonymity in a team of four is arithmetic fiction." Substantially fair, and the design now concedes it in its rules rather than only in this answer: scale scores release at three responses, but item averages — the level at which a leader who is also a respondent could subtract their own answers from a published mean — are suppressed below five responses, and teams under that threshold are promised confidentiality in aggregate, in those words, before launch. A team of three or four still receives a thinner protection than a team of ten; Sections 14 and 15 state the position in the instrument's own terms rather than letting the word "anonymous" do more work than it can.

Working with the Loop: the engagement and the next step

A Loop engagement runs in rounds. A sponsor briefing settles the guardrails — permitted use, release thresholds, reporting lines — before any member is invited. The whole team then completes the assessment inside the Choose Becoming platform. The leader receives the report: element readings, scale scores, the Divided view and essentials flags, and, at five or more respondents, the item appendix. A facilitated debrief converts the reading into tuning commitments and, where a condition is missing, commissioned repair work. Rounds repeat on the team's own rhythm, and each new report is read against the team's earlier rounds.

The instrument is in its pilot period, and the pilot is the invitation this paper can honestly make: a limited number of executive and leadership teams — health care teams first — are being onboarded as pilot teams, receiving the full assessment, report, and debrief cycle while contributing their aggregate, unattributed data to the validation record described in Section 17. The validation program is a practice's program, run by Infinitum Leadership rather than by an institutional laboratory, and its scale is stated here so that no reader mistakes it for something larger.

The next step is a conversation: a discovery call to establish whether the Loop fits the team you lead, booked through infinitumleadership.com. For public-sector engagements, this paper and the assessment's member-facing materials are provided in English and French, in accessible formats.

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Rogers, J. (2016) *Coaching skills: The definitive guide to being a coach*. 4th edn. Maidenhead: Open University Press.

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Whitmore, J. (2017) *Coaching for performance: The principles and practice of coaching and leadership*. 5th edn. London: Nicholas Brealey.

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Wiseman, L. (2010) *Multipliers: How the best leaders make everyone smarter*. New York: HarperBusiness.

Woolley, A.W., Chow, R.M., Mayo, A.T., Riedl, C. and Chang, J.W. (2023) 'Collective attention and collective intelligence: The role of hierarchy and team gender composition', *Organization Science*, 34(3), pp. 1315–1331.

Sources and synthesis note. The healthcare synthesis in this paper draws on the author's *Healthcare Executive Bibliography* (original edition: 80 table rows, 76 populated entries across four sections; V2 edition: condensed prose treatments of three entries) and his *Health Care Executive Leadership Reading List* (five core texts with LEADS-domain alignments), read in full from his Drive library on November 3, 2026; the synthesis of those sources into this paper's element sections was completed on November 7, 2026. Every entry carrying a team-level claim was mapped to the Loop element or elements it informs; entries addressing individual development, personal productivity, or clinical practice were read and deliberately held out of a team-level argument, as Section 17 records. A local extract with the full mapping is retained in the paper's working files. The third related document located in the same library, *Executive Leadership & Coaching Bibliography — Vancouver Coastal Health*, was not read for this version and remains available for a future sector supplement.

Appendix A — Comprehensive bibliography

The model's full bibliography — the 57 works the synthesis stands on — follows, organized by the model's elements, exactly as maintained in Infinitum's scholarly record. Works cited in the text above appear in the selected references; the appendix is the complete foundation, carried openly by the author's direction.

Foundations

The research base the whole model rests on: how teams develop, learn, and behave as systems.

- Tuckman, B.W. (1965) 'Developmental sequence in small groups', *Psychological Bulletin*, 63(6), pp. 384–399. The original forming, storming, norming, performing sequence; it grounds the Loop's claim that a team is tended across its whole life, not fixed once.
- Gersick, C.J.G. (1988) 'Time and transition in work teams: Toward a new model of group development', *Academy of Management Journal*, 31(1), pp. 9–41. Shows teams change in bursts at their temporal midpoint, which is why the Loop builds review and tuning into the middle of a team's cycle, not only at launch.
- Katzenbach, J.R. and Smith, D.K. (1993) *The Wisdom of Teams: Creating the High-Performance Organization*. Harvard Business School Press. **Healthcare bibliography.** Draws the line between a working group and a real team with mutual accountability, the distinction behind the Real Team scale.
- Senge, P.M. (1990) *The Fifth Discipline: The Art and Practice of the Learning Organization*. Doubleday. **Healthcare bibliography.** Team learning and systems thinking; the intellectual root of treating a team as a loop of feedback rather than a chart of boxes.

- Wheatley, M.J. (1992) *Leadership and the New Science: Discovering Order in a Chaotic World*. Berrett-Koehler. **Healthcare bibliography.** Argues that order in organizations emerges from relationships, a useful counterweight when leaders want to engineer a team like a machine.
- Schein, E.H. (2017) *Organizational Culture and Leadership*. 5th edn. Hoboken, NJ: Wiley. **Healthcare bibliography.** Culture sits beneath behaviour at the level of shared assumptions, which is why the Loop measures conditions and not only conduct.
- Edmondson, A.C. (2012) *Teaming: How Organizations Learn, Innovate, and Compete in the Knowledge Economy*. Jossey-Bass. **Healthcare note:** its case studies include Intermountain Healthcare and two children's hospitals. Treats teaming as a verb, a set of learnable behaviours, which the Dynamics lobe takes up directly.
- Rozovsky, J. (2015) 'The five keys to a successful Google team', *re:Work*. Google. Reports Project Aristotle's finding that how a team works together matters more than who is on it, contemporary large-sample support for the Loop's two-lobe design.
- Mathieu, J.E., Maynard, M.T., Rapp, T. and Gilson, L.L. (2008) 'Team effectiveness 1997–2007: A review of recent advancements and a glimpse into the future', *Journal of Management*, 34(3), pp. 410–476. The IMOI review of the team effectiveness literature; Section 3 states the Loop's mapping onto that framing openly.

Dynamics

Trust, Candour, Commitment, and Accountability: the behaviours inside the room, and the safety that makes them possible.

- Lencioni, P. (2002) *The Five Dysfunctions of a Team: A Leadership Fable*. Jossey-Bass. **In library. Healthcare bibliography.** The Dynamics lobe's direct ancestor: absence of trust, fear of conflict, lack of commitment, avoidance of accountability, and inattention to results, stated positively in the model as the 4 Ups.
- Lencioni, P. (2004) *Death by Meeting: A Leadership Fable about Solving the Most Painful Problem in Business*. Jossey-Bass. **In library.** Meetings are where Candour either happens or dies; this is the practical companion for teams whose conflict has gone underground.
- Lencioni, P. (2016) *The Ideal Team Player: How to Recognize and Cultivate the Three Essential Virtues*. Jossey-Bass. **In library.** Humble, hungry, and smart as the individual virtues underneath team behaviours; useful when a Dynamics problem traces back to one member's pattern.
- Edmondson, A.C. (1999) 'Psychological safety and learning behavior in work teams', *Administrative Science Quarterly*, 44(2), pp. 350–383. **Healthcare note:** the foundational citation in the patient safety literature on speaking up. Defines psychological safety and shows it predicts team learning behaviour, the mechanism underneath Trust and Candour.
- Edmondson, A.C. (2018) *The Fearless Organization: Creating Psychological Safety in the Workplace for Learning, Innovation, and Growth*. Wiley. **Healthcare bibliography.** The full-length treatment, with the crucial rider that safety pairs with high standards, which keeps Trust and Accountability in the same lobe.

- Edmondson, A.C. and Lei, Z. (2014) 'Psychological safety: The history, renaissance, and future of an interpersonal construct', *Annual Review of Organizational Psychology and Organizational Behavior*, 1, pp. 23–43. The scholarly synthesis of the safety literature, for readers who want the evidence base behind the Dynamics scales.
- Patterson, K., Grenny, J., McMillan, R. and Switzler, A. (2002) *Crucial Conversations: Tools for Talking When Stakes Are High*. McGraw-Hill. (3rd edn, 2022.) **In library. Healthcare bibliography. Healthcare note:** its dialogue skills are taught in hospitals precisely because speaking up across hierarchy is a safety behaviour. The skills manual for Speak up.
- Stone, D., Patton, B. and Heen, S. (1999) *Difficult Conversations: How to Discuss What Matters Most*. Viking. **In library.** Separates the what-happened, feelings, and identity conversations inside every hard discussion, a debrief tool for Candour work.
- Scott, K. (2017) *Radical Candor: Be a Kick-Ass Boss Without Losing Your Humanity*. St. Martin's Press. **Healthcare bibliography. Healthcare note:** its warning about ruinous empathy, caring without challenging, names a pattern endemic in health care cultures. Maps caring personally and challenging directly onto Candour and Accountability.
- Brown, B. (2018) *Dare to Lead: Brave Work, Tough Conversations, Whole Hearts*. Random House. Vulnerability treated as a measurable leadership behaviour rather than a trait; the teaching companion for Open up.
- de Jong, B.A., Dirks, K.T. and Gillespie, N. (2016) 'Trust and team performance: A meta-analysis of main effects, moderators, and covariates', *Journal of Applied Psychology*, 101(8), pp. 1134–1150. The trust literature's meta-analysis — 112 studies, 7,763 teams — against which Section 4 states the model's Trust equation.
- Frazier, M.L., Fainshmidt, S., Klinger, R.L., Pezeshkan, A. and Vracheva, V. (2017) 'Psychological safety: A meta-analytic review and extension', *Personnel Psychology*, 70(1), pp. 113–165. The safety meta-analysis (136 samples) beneath the programmatic stocktake.
- Newman, A., Donohue, R. and Eva, N. (2017) 'Psychological safety: A systematic review of the literature', *Human Resource Management Review*, 27(3), pp. 521–535. The antecedents map for the safety literature.
- Nembhard, I.M. and Edmondson, A.C. (2006) 'Making it safe: The effects of leader inclusiveness and professional status on psychological safety and improvement efforts in health care teams', *Journal of Organizational Behavior*, 27(7), pp. 941–966. **Healthcare note:** leader inclusiveness and professional status in health care teams — the bridge between the Trust section and the healthcare argument.
- Detert, J.R. and Burris, E.R. (2007) 'Leadership behavior and employee voice: Is the door really open?', *Academy of Management Journal*, 50(4), pp. 869–884. Managerial openness as the leadership behaviour most consistently related to voice.
- Morrison, E.W. (2011) 'Employee voice behavior: Integration and directions for future research', *Academy of Management Annals*, 5(1), pp. 373–412. The voice literature's integrative review, distinguishing discretionary voice from formal mechanisms.

Design

Real Team, Right People, Structure, Supportive Context, and Competent Coaching: the conditions a leader sets before asking anything of the team's behaviour.

- Hackman, J.R. (2002) *Leading Teams: Setting the Stage for Great Performances*. Harvard Business School Press. **Healthcare bibliography.** The source text for the conditions approach: a real team, compelling direction, enabling structure, supportive context, and expert coaching, with his rule of thumb that design and launch outweigh in-the-moment leadership.
- Wageman, R., Nunes, D.A., Burruss, J.A. and Hackman, J.R. (2008) *Senior Leadership Teams: What It Takes to Make Them Great*. Harvard Business School Press. **Healthcare bibliography.** The Design lobe's direct ancestor, drawn from more than 120 senior teams; its essentials and enablers map onto the 5 Ms, and in the senior-team study the book reports, the six conditions predicted more than half of the variation in team effectiveness.
- Hackman, J.R. (ed.) (1990) *Groups That Work (and Those That Don't): Creating Conditions for Effective Teamwork*. Jossey-Bass. The case evidence underneath the conditions: flight crews, surgical teams, string quartets, and what separated the effective from the ineffective.
- Salas, E., Sims, D.E. and Burke, C.S. (2005) 'Is there a "big five" in teamwork?', *Small Group Research*, 36(5), pp. 555–599. Distils the teamwork literature into five core components and three coordinating mechanisms; independent scholarly support for the Structure and Context scales.
- Rosen, M.A., DiazGranados, D., Dietz, A.S., Benishek, L.E., Thompson, D., Pronovost, P.J. and Weaver, S.J. (2018) 'Teamwork in healthcare: Key discoveries enabling safer, high-quality care', *American Psychologist*, 73(4), pp. 433–450. **Healthcare note:** written for health care directly, it reviews what the evidence says teams in clinical settings actually need, and it anchors the Design lobe for health authority clients.
- Manser, T. (2009) 'Teamwork and patient safety in dynamic domains of healthcare: A review of the literature', *Acta Anaesthesiologica Scandinavica*, 53(2), pp. 143–151. **Healthcare note:** a clinical-journal review linking team structure and coordination to patient outcomes in acute care.
- West, M.A. (2021) *Compassionate Leadership: Sustaining Wisdom, Humanity and Presence in Health and Social Care*. Swirling Leaf Press. **Healthcare bibliography. Healthcare note:** built on NHS and health system research, it shows a supportive, compassionate context sustains performance under pressure rather than softening it.
- Trzeciak, S. and Mazzarelli, A. (2019) *Compassionomics: The Revolutionary Scientific Evidence That Caring Makes a Difference*. Studer Group. **Healthcare bibliography. Healthcare note:** the evidence, drawn from over a thousand studies, that the relational climate a leader designs shows up in patient outcomes, staff burnout, and cost.
- Dickson, G. and Tholl, B. (2020) *Bringing Leadership to Life in Health: LEADS in a Caring Environment*. 2nd edn. Cham: Springer. **Healthcare bibliography. Healthcare note:** the Canadian health leadership capabilities framework; it situates the Loop inside the system context his health authority clients are assessed against.

- Wageman, R., Hackman, J.R. and Lehman, E. (2005) 'Team Diagnostic Survey: Development of an instrument', *Journal of Applied Behavioral Science*, 41(4), pp. 373–398. The TDS development paper, reporting psychometrics on 2,474 members of 321 teams — one of the model's two source texts, cited by name in Section 14.

The Drive

Direction and Delivery: shared purpose at the crossing, and the motivation science that keeps a team moving toward it.

- Pink, D.H. (2009) *Drive: The Surprising Truth About What Motivates Us*. Riverhead Books. The model's namesake element rests here: autonomy, mastery, and purpose as the durable motivators, translated in the Loop from the individual to the team.
- Pink, D.H. (2018) *When: The Scientific Secrets of Perfect Timing*. Riverhead Books. Beginnings, midpoints, and endings as performance variables; it informs how tending rounds and assessment cycles are paced.
- Deci, E.L. and Ryan, R.M. (1985) *Intrinsic Motivation and Self-Determination in Human Behavior*. Plenum Press. The founding statement of self-determination theory, the motivation science underneath Direction that a team has genuinely internalized.
- Ryan, R.M. and Deci, E.L. (2000) 'Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being', *American Psychologist*, 55(1), pp. 68–78. The concise scholarly version; useful when a sponsor asks why imposed targets underperform shared purpose.
- Collins, J. (2001) *Good to Great: Why Some Companies Make the Leap and Others Don't*. HarperBusiness. **Healthcare bibliography.** First who, then what, and the flywheel: direction as disciplined, compounded effort rather than announcement, which is Delivery in the Loop's sense.
- Sinek, S. (2009) *Start with Why: How Great Leaders Inspire Everyone to Take Action*. Portfolio. **In library.** The accessible articulation of Direction: a purpose stated clearly enough that a team can steer by it.
- Marquet, L.D. (2013) *Turn the Ship Around! A True Story of Turning Followers into Leaders*. Portfolio. **Healthcare bibliography.** Intent-based leadership on a nuclear submarine; direction carried by the whole team instead of issued by one voice, and a standing example in debriefs.
- Kotter, J.P. (1996) *Leading Change*. Harvard Business School Press. **In library. Healthcare bibliography.** Urgency, a guiding coalition, and short-term wins: the change sequence that keeps Direction and Delivery joined over a long transformation.
- Lencioni, P. (2012) *The Advantage: Why Organizational Health Trumps Everything Else in Business*. Jossey-Bass. **In library.** Clarity repeated until it cascades; the sponsor-facing case that Direction is a leadership discipline, not a communications event.

Tending and team coaching

Diagnostics, tuning, and repair: the coaching literature behind the practice of keeping the loop turning.

- Hackman, J.R. and Wageman, R. (2005) 'A theory of team coaching', *Academy of Management Review*, 30(2), pp. 269–287. **Healthcare bibliography.** Coaching lands at the beginning, midpoint, and end of a team's performance cycle, and only on a well-designed team; this is the theoretical warrant for the diagnostics, tuning, repair rhythm.
- Hawkins, P. (2011) *Leadership Team Coaching: Developing Collective Transformational Leadership*. Kogan Page. (3rd edn, 2021.) The foundational text of team coaching as a discipline, and the source of the five disciplines taken up in the systemic works below.
- Hawkins, P. (2012) *Creating a Coaching Culture: Developing a Coaching Strategy for Your Organization*. Open University Press. **Healthcare bibliography. Healthcare note:** draws on NHS case material, and it treats coaching as part of the designed context, the Mentoring condition built at organizational scale.
- Leary-Joyce, J. and Lines, H. (2018) *Systemic Team Coaching*. AoEC Press. **In library. Healthcare bibliography.** Coaches the team in connection with its stakeholders rather than in isolation; its commissioning and clarifying disciplines shape how a Loop engagement is contracted.
- Clutterbuck, D. (2020) *Coaching the Team at Work: The Definitive Guide to Team Coaching*. 2nd edn. London: Nicholas Brealey. (1st edn, 2007.) Twenty years of team coaching research organized around purpose, stakeholders, relationships, process, learning, and leadership; the practice reference for repair-level engagements.
- Whitmore, J. (2017) *Coaching for Performance: The Principles and Practice of Coaching and Leadership*. 5th edn. London: Nicholas Brealey. **Healthcare bibliography.** Awareness and responsibility as the coach's levers; the individual-level craft that a team coach brings into the room.
- Britton, J.J. (2010) *Effective Group Coaching: Tried and Tested Tools and Resources for Optimum Coaching Results*. Wiley. **In library.** Design and facilitation of group and team coaching engagements, useful for structuring multi-team tending work.
- Grant, A. (2021) *Think Again: The Power of Knowing What You Don't Know*. Viking. **In library.** Rethinking as a practised habit; the leader's own stance while tending, since a diagnostic only helps a team willing to update.
- Tannenbaum, S.I. and Cerasoli, C.P. (2013) 'Do team and individual debriefs enhance performance? A meta-analysis', *Human Factors*, 55(1), pp. 231–245. Debriefs improve effectiveness by roughly 20–25% over control conditions, and structured, facilitated, developmental debriefs drawing on multiple information sources work best — the direct evidence base for the debrief inside Tending.
- Keiser, N.L. and Arthur, W. Jr. (2021) 'A meta-analysis of the effectiveness of the after-action review (or debrief) and factors that influence its effectiveness', *Journal of Applied Psychology*, 106(7), pp. 1007–1032. AARs improve outcomes at d = 0.79 across 61 studies; alignment to the individual or team and objective performance information contribute.

- Keiser, N.L. and Arthur, W. Jr. (2022) 'A meta-analysis of task and training characteristics that contribute to or attenuate the effectiveness of the after-action review (or debrief)', *Journal of Business and Psychology*, 37(5), pp. 953–976. Across 83 studies the AAR effect is d = 0.92 overall (a bare-bones, uncorrected estimate) and largest for complex, ambiguous tasks — project and decision-making work.
- Cannon-Bowers, J.A., Bowers, C.A., Carlson, C.E., Doherty, S.L., Evans, J. and Hall, J. (2023) 'Workplace coaching: A meta-analysis and recommendations for advancing the science of coaching', *Frontiers in Psychology*, 14, 1204166. Workplace coaching yields a moderate positive effect on organizational outcomes — the meta-analytic frame cited alongside the Passmore, Tee and Gold (2025) team-coaching trial..
- Lencioni, P. (2020) *The Motive: Why So Many Leaders Abdicate Their Most Important Responsibilities*. Wiley. **In library.** Responsibility-centred leadership versus reward-centred leadership; tending is unglamorous work, and this names why leaders skip it.

Sources and access notes

- Jonathan's *Healthcare Executive Bibliography* (Google Doc) and its V2 edition were located in Google Drive and read on Nov 3, 2026; entries drawn from it are marked above. A third related document, *Executive Leadership & Coaching Bibliography, Vancouver Coastal Health*, was located but not read for this bibliography.
- The NotebookLM research library digest (catalogued 2026–09–27, 190 notebooks) is the basis for every **In library** marker. The digest records titles and topic clusters, so a marker means the work is catalogued in his library, not that a specific edition was verified.
- The model's two source texts supplied by Jonathan on Nov 3, 2026 (*Senior Leadership Teams* and the Team Diagnostic Survey development paper) sit underneath the Design lobe; per the design paper's copyright guardrails, the model uses their constructs only, with all assessment items written originally.

Infinitum Leadership — Executive and leadership coaching. This white paper accompanies the Ad Infinitum Loop and the Ad Infinitum Loop Team Assessment, and is updated as the assessment's validation record develops.

infinitum LEADERSHIP

Put the evidence to work

The Ad Infinitum Loop Team Assessment is in its pilot period. A limited number of executive and leadership teams — health care teams first — are being onboarded as pilot teams, receiving the full assessment, report, and facilitated debrief cycle.

Start with a conversation

Book a discovery call to discuss the pilot, team coaching, or an assessment program for your team. infinitumleadership.com

Read more of the evidence

Infinitum's white papers and research summaries are collected on the Evidence page. infinitumleadership.com/evidence

Jonathan Evans, MA, PCC, MCS
Executive and Leadership Coach, Infinitum Leadership
jonathan@infinitumleadership.com