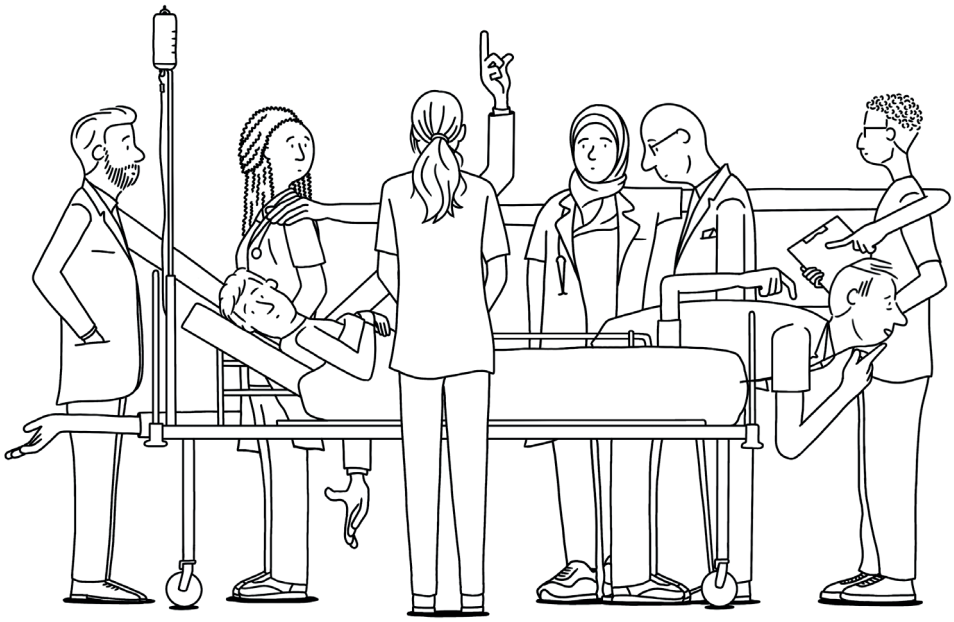
MUNDANE MATTERS

ON THE RELATIONAL REALITIES OF LEADERSHIP AND GOVERNANCE IN HOSPITALS



ARJAN VERHOEVEN

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Mundane Matters

On the Relational Realities of Leadership and Governance in Hospitals

Arjan Verhoeven

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Arjan Verhoeven

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Mundane Matters

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Arjan Verhoeven

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Prologue

Op mijn theevelden heb ik altijd een paar kerststerren laten planten, ook wel wonderbomen of wolfsmelk genoemd.

Om de driehonderd voet wat rood blad tussen het groen voorkomt blindheid bij de pluksters. Wanneer je lange tijd maar één kleur ziet, krijg je een waas voor ogen, alsof je te lang in de zon gekeken hebt. Één blik op de tegenkleur herstelt het contrast.

Zo'n eenzame rode plant heeft een opvallend effect op haar omgeving. Al wat groent trekt naar elkaar toe. (…) De rode plant zelf daarentegen vlamt tussen het groen vuriger dan tussen haar gelijken.

In de akker die ik voor de kerststerrenkweek altijd speciaal heb laten aanleggen, viel ze nauwelijks op tussen de andere exemplaren. Die kerstster was niet rood tot ik haar in haar nieuwe omgeving liet zetten. Kleur heb je nooit zelf, kleur krijg je door anderen.

De zwarte met het witte hart,
Arthur Japin (1997)

On every tea field I had, I always planted some poinsettias, also called flame-leaf or euphorbia.

A touch of scarlet amid the green every hundred yards or so prevents blindness among the pickers. Seeing the same colour for hours on end causes the vision to blur, like staring into the sun. A single flash of a different hue restores the contrast.

Such a lone red plant has a remarkable effect on its surroundings. Everything that is green draws together. (…) Conversely, the red plant itself burns a brighter red when set off by the green than when it grows among its peers.

In the bed I always reserved for poinsettia seedlings, there was little to distinguish one plant from its neighbours. My poinsettia did not turn scarlet until I planted it out in new surroundings. Colour is not something one has, colour is bestowed on one by others.

The Two Hearts of Kwasi Boachi,
Arthur Japin (2000)

A journey of relational leadership

Leadership in complex healthcare environments is often depicted as technical, structured, and competency driven. However, working in roles as a manager, consultant, researcher, and observer in Dutch hospitals—has revealed a different reality to me. Leadership is not a static skillset or a predefined set of traits. It is an evolving relational process—a collaborative act shaped by human connections, shared histories, conflicts, and moments of creative adaptation.

Writing this dissertation has been as much a process of discovery as the research itself. Like the messy realities of leadership, my PhD-trajectory has been filled with moments of doubt, reflection, and reorientation. Inspired by the work of Ann Cunliffe (2010, 2016), Karen Locke (2008) and Karen Golden-Biddle's (2020) insights into reflexivity, doubt, and abductive reasoning, I have come to accept doubt and messiness as generative forces in research and practice. Such forces allow us to question our assumptions and navigate the constant tension between involvement and distance. A tension that was central in my working life and research and therefore in this dissertation.

Looking back

My explorations began long before my doctoral research. As an intern and teacher at an Indonesian university and later as an anthropological master's student in Belize, at The Amandala, a local newspaper, rooted in the Civil Rights movement, in a postcolonial society, I grappled with the richness and complexities of immersing myself in these cultures vastly different from my own. Later, as a consultant trainee at Berenschot, these experiences helped me navigate, make sense of, and collaborate in contexts I knew little about. Furthermore, at Berenschot I learned to balance structure, analytical thinking, and a business mind with a critical, reflexive stance. This combination of practice and theory taught me to see myself as an instrument in my work—a principle rooted in anthropology and further honed during my time at Berenschot, Radboudumc and different Dutch hospitals.

A reflexive stance

Working across different hospital departments, in different professional roles and by visiting hospitals abroad, I tried to navigate and understand the interplay

of collaboration and conflict among healthcare professionals, managers, and executives, and learned about the influence of time, task and territory (space).

As part of my role as a business manager in the Otorhinolaryngology (ENT) department at Radboudumc, Henri Marres—professor, head of the department, and head and neck surgeon—offered me the opportunity to pursue a PhD on relational leadership. For me, this represented the fulfillment of a long-held ambition to specialize in a specific aspect of organizational life, while also providing the chance to reconnect with my anthropological training. Together with Henri, I began exploring the relational dimensions of leadership and identifying methodologies to investigate this subject. Erik van de Loo, professor of organizational behavior at INSEAD and TIAS, later joined the team, contributing a behavioral and psychodynamic perspective. Shortly thereafter, Pieterbas Lalleman, a nurse and professor of nursing leadership, brought additional expertise in relationality and qualitative research in healthcare. Together, we formed a multidisciplinary team that, in many ways, mirrored the dynamics of my research itself: an interplay of diverse professional perspectives, interdependencies, professional boundaries, and the ongoing negotiation of these factors.

Supported by my supervisors, I wanted to understand leadership as it unfolds in the daily practice of professionals in the complex setting of hospitals. My often dual role as both participant and observer allowed me to navigate between involvement and reflection—a (research) practice I found both illuminating and challenging. While being part of the system, I sought to maintain a researcher's perspective, grappling with the difficulty of remaining reflexive (Cunliffe, 2016) regarding my own stance. This duality—working as a project- and business manager while conducting research—became an intrinsic part of my experiences as a PhD student. It enabled me to see and experience leadership as deeply relational: as *'webs of significance'* (Geertz, 1973, p. 5) where people navigate complexity, manage crises, and co-create meaning. I realized that the essence of leadership is not confined to formal meetings, hierarchy, or organizational charts. It emerges in the informal, everyday interactions where people interact, built trust, conflict, pursue shared goals, and construct meaning (Hosking, 1988; Smircich & Morgan, 1982).

A relational lens on leadership

When I completed my first data collection on the interactions between hospital board members and nurse advisory councils, the COVID-19 pandemic struck. It

was both a curse and a blessing for my research. The pandemic accelerated my work, providing a profound lens into the experiences of relational leadership for professionals under extreme pressure, and opened up the opportunity to conduct an at-home ethnography (Alvesson, 2003, 2009) with some of my colleagues. Furthermore, and to my surprise, professionals across Dutch hospitals opened their doors, offering insights into their leadership struggles and triumphs. The interviews we held often served as reflective spaces for them to contemplate their own leadership practices amidst the uncertainty of an ongoing crisis. This added even more depth to our research. Invited by and in collaboration with Pieterbas Lalleman and Janet Bloemhof (nurse scientist and PhD candidate), I had the opportunity to expand my research to all 72 hospitals across the Netherlands amid the first wave of COVID. This exploration deepened my understanding of relational leadership in multiple contexts in a time of crisis. Technical decision-making, I found, often emerged from relational practices, where people came together to create solutions in ways that defied rigid structures or logic.

This dissertation examines relational leadership as a practice that unfolds in the interplay of perspectives, roles, and power dynamics. Influence, I have found, is not an individual trait or skill but the outcome of collective, relational processes. Leadership is about creating spaces for collaboration, attribution of power, fostering connections, and engaging with differences—not resolving them, but making them generative.

Creating access to the findings

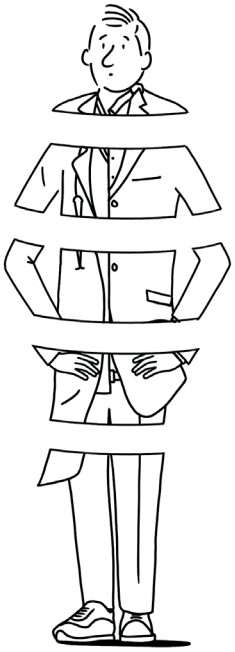
Accessibility of our findings for leaders in health care has been a guiding principle in shaping this dissertation. Language plays a vital role in this. In complex environments, like hospitals, language can either clarify or obscure meaning. By offering Dutch translations of papers and contributing to conferences, workshops, and festivals, we aimed to make this work more accessible to those who might otherwise find academic discourse out of reach due to time constraints, language barriers, or unfamiliarity with scholarly discourse. Creating access is a fundamental step toward democratizing knowledge. This stems from my belief that relational leadership is about fostering collaboration, inviting those with expertise—especially those with less access—to contribute to the conversation. Furthermore, this approach recognizes that positions of power come with the responsibility to create space for others to participate. For this reason, too, each chapter begins with an illustration by artist Arjan Jager, whose work captures the nuances and

diversity of leadership in ways that words alone cannot. These drawings were born out of generative discussions between him and me and aim to offer an immediate, visual representation of each chapter's essence. Through these illustrations, the complexities of researching relational leadership are made accessible in an entirely different way—one that invites reflection and connection.

Deliberately simple, this dissertation is presented in black and white. Because leadership and healthcare practice are anything but simple. They are rich with color, shades, and nuances. As Arthur Japin reminds us in the opening quote, colour is not ours, it is bestowed on us by others. This dissertation seeks to contribute to that relational understanding, offering insights to make the complex practical and the nuanced more visible.

ONE

INTRODUCTION



Relational leadership in healthcare

Leadership in healthcare, particularly in hospital settings, plays a pivotal role in navigating the complexities of modern healthcare systems (Fund, 2014). The dominant leadership paradigms in healthcare have traditionally centered on individual competencies, emphasizing hierarchical decision-making and the discrete capabilities of leaders (Cummings et al., 2021). However, this focus has been increasingly criticized for failing to address the relational and processual dynamics (Cunliffe & Eriksen, 2011; Hosking & Haslam, 1997; Ospina et al., 2020; Uhl-Bien, 2006) inherent in healthcare collaboration.

Relational leadership (Uhl-Bien, 2006) offers an alternative framework, positing leadership as a socially constructed process emerging through interactions and relationships rather than as an inherent trait or individualistic endeavor (Ospina et al., 2020; Uhl-Bien, 2006). In healthcare contexts, this theory highlights the interdependence of professional groups—such as physicians, nurses, managers and hospital board members—and underscores the importance of collective agency in achieving organizational objectives (Denis et al., 2012; Kislov et al., 2024).

This theoretical approach explores the evolution of leadership models in healthcare, focusing on relational leadership as a response to the challenges posed by pluralistic organizational structures (Denis et al., 2023) and crises such as the COVID-19 pandemic. It examines key concepts, including interdependence, role attribution, and collaborative processes, to contextualize their significance in hospital management.

The limitations of traditional leadership models

Traditional (healthcare) leadership research predominantly focuses on individual skills and hierarchical structures, viewing leadership as a static attribute possessed by individuals (O'Donovan et al., 2021). Studies have emphasized transformational leadership, which champions charisma, vision, and inspiration as key attributes of successful leaders (Cummings et al., 2018). However, this approach often overlooks the relational and contextual factors that shape leadership effectiveness in complex environments like hospitals (Jalilvand et al., 2024; Kislov et al., 2024; Kok et al., 2023; Lalleman et al., 2015; Martini et al., 2024). For example, the concept of *'heroic leadership'*, frequently cited in traditional models, tends to relegate collaborative dynamics to secondary importance, thereby underrepresenting the roles of relational practices (Uhl-Bien & Ospina, 2012). Furthermore, the traditional

models also tend to neglect the influence of power dynamics, informal networks, and shared histories (Martini et al., 2023) in shaping effective leadership practices during crises (Langley et al., 2019; Mackay et al., 2022).

Relational leadership and interdependence in healthcare

Relational leadership theory shifts the focus from individual competencies to the relational processes through which leadership emerges. This approach recognizes leadership as an iterative and dynamic process shaped by interactions among individuals, groups, and organizational systems (Ospina et al., 2020; Uhl-Bien, 2006).

Interdependence, a core tenet of relational leadership, is particularly relevant in hospitals, where professionals from diverse disciplines must collaborate to ensure quality care (De Graaff et al., 2021; Kuijper et al., 2022). Interdependence is defined as the mutual reliance among professionals, which manifests through shared decision-making, goal alignment, and the negotiation of power and roles (Van Lange & Balliet, 2015). It underscores the relational dynamics that facilitate or hinder effective collaboration in hospital settings.

During the COVID-19 pandemic, interdependence became starkly evident (Barton et al., 2020; Greenhalgh et al., 2023). Nurses, physicians, managers, and board members were required to operate with shared responsibilities while addressing resource shortages, rapid decision-making demands, and organizational pressures (Wallenburg et al., 2021). Studies have shown that fostering interdependence through relational leadership practices—such as open communication, mutual respect, and shared accountability—can significantly enhance organizational resilience (Chreim et al., 2013; Kahane, 2023; Mayo, 2022; Raveendran et al., 2020; Sklaveniti, 2020; Sluss et al., 2011) and responsiveness during crises (Barton et al., 2020; Langi Sasongko et al., 2024; Sansolo et al., 2022; Soela et al., 2024; Spyridonidis et al., 2022). However, as we will show in this dissertation this is not without tension.

Role attribution and power dynamics

Role attribution is a central concept in relational leadership, highlighting how roles are assigned and negotiated within organizations (Sluss et al., 2011). Unlike traditional views that frame roles as static or pre-defined, relational leadership

emphasizes their fluidity and dependence on ongoing interactions (Hosking, 1988, 2011b) and collective meaning-making (Smircich & Morgan, 1982). This perspective is especially relevant in hospitals, where crises often blur traditional role boundaries (Langley et al., 2019; Oldenhof et al., 2016a), requiring adaptive and collaborative practices (Tarakci et al., 2023).

Power dynamics further complicate role attribution (Looman et al., 2021), as they influence who is seen as a leader and how leadership is enacted. In hierarchical hospital settings, power disparities can create barriers to collaboration, marginalizing the voices of certain groups—such as nurses—while privileging others (Bartmess et al., 2021; Kee et al., 2021; Looman et al., 2021), like physicians or board members (Barton et al., 2020; Boivie et al., 2021; Langley et al., 2019; Lopez-Deflory et al., 2023a). Although relational leadership aims to democratize these dynamics by fostering inclusive practices that empower all professionals to contribute to organizational decision-making (Denis et al., 2012; Uhl-Bien, 2006), we demonstrate that this process is not without its struggles and conflicts.

Relational leadership in crisis settings

Healthcare crises act as stress tests for leadership models, exposing the limitations of traditional hierarchical approaches while highlighting the potential of relational leadership (Petriglieri, 2020). Crises demand rapid decision-making, cross-disciplinary collaboration, and the ability to adapt to constantly changing circumstances (Kvist et al., 2022; Petriglieri, 2020; Wallenburg et al., 2021). Relational leadership, with its emphasis on collective processes and interdependence (Cunliffe & Eriksen, 2011; Uhl-Bien, 2006), provides a framework for navigating such challenges. During the COVID-19 pandemic, relational leadership practices were critical in fostering effective crisis management (De Graaff et al., 2021; Lloyd-Smith, 2020). Research revealed that knowing colleagues well, having a shared professional history, and maintaining open communication were pivotal for successful collaboration (Kvist et al., 2022; Porter-O'Grady & Pappas, 2022). Despite formal hierarchies, much of leadership during the pandemic emerged through informal networks and adaptive practices, underscoring the relational nature of leadership (Hawley & Wall, 2024; Wallenburg et al., 2021).

In sum, relational leadership represents a paradigm shift in healthcare leadership research and practice, moving away from solely individualistic and hierarchical models toward collective, processual, and context-sensitive approaches (Denis et al., 2023; Uhl-Bien & Ospina, 2012). By emphasizing interdependence, role attribution,

and collaborative dynamics, a relational leadership perspective provides valuable insights into how healthcare organizations can navigate complexity and crises.

Aim and research questions

The central aim of our study is to explore how leadership is experienced and understood in the daily work of board members, managers, nurses, and physicians in Dutch hospitals. This research seeks to contribute to the growing body of literature on relational leadership, particularly within the complex and dynamic context of healthcare organizations. By adopting a qualitative - interpretative approach, this study aims to uncover the nuanced ways in which leadership emerges from relationships and interactions in hospital settings.

Main research question

How is leadership experienced and understood in the daily work of professionals in Dutch hospitals?

This question resulted in five separate studies described in the following chapters:

- **Chapter TWO -** How can the collaboration between board members and chairs of nurse councils be understood as a relational leadership process?

Answering this question enables us to better understand this process of collaborating and adds to the practice of relational leadership and collaboration in complex settings such as hospitals.

- **Chapter THREE -** How does talk by executive hospital board members influence the positioning and voicing of nurses in crisis management?

With this we contribute to the call from the scientific (nursing) community to all in the health care system to understand how to better involve nurses in strategic (crisis) decision making.

- **Chapter FOUR -** How do nurses perceive their positioning in crisis management, from a relational leadership perspective?

Essential in strategic crisis management is how nurses themselves enact their (relational) leadership, work with interdependence, and believe in the importance of their voice and positioning.

- **Chapter FIVE -** How do business managers in academic medical centers perceive their roles and leadership during crisis?

The crisis prompted unprecedented efforts to coordinate patient referrals and manage hospital capacities, fostering new relationships and leadership practices.

- **Chapter SIX -** How do professionals within the academic medical center (AMC) perceive and construct their work during the crisis, and how do they interpret leadership in this context?

The role of physicians in crisis management in an AMC was highlighted and explored through interviews and a relational leadership lens, with the help of role attribution theory.

- **Chapter SEVEN** - Critical reflections, implications, and recommendations.

Based on five empirical studies, we critically examine leadership in hospitals, focusing on structural constraints, the illusion of harmony, and the performative effects of leadership. Additionally, we reflect on the methodological choices made, their implications for leadership research, and provide practical recommendations for strengthening leadership education and fostering collaborative hospital cultures.

1

TWO

KNOWING, RELATING AND THE ABSENCE OF CONFLICT: RELATIONAL LEADERSHIP PROCESSES BETWEEN HOSPITAL BOARDS AND CHAIRS OF NURSE COUNCILS.

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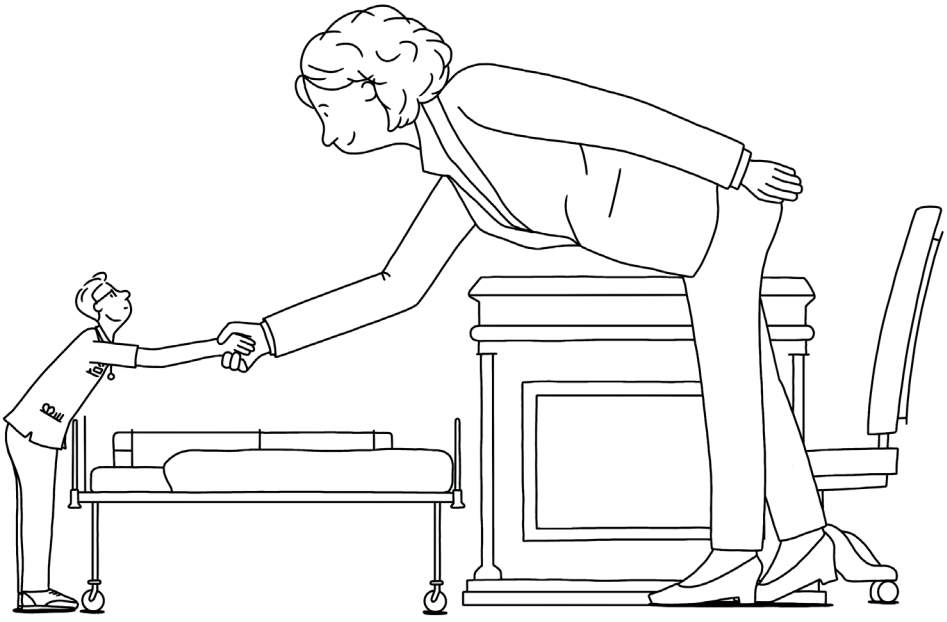

Abstract

Purpos: This study aims to enhance understanding of the collaboration between chairs of nurse councils (CNCs) and members of executive hospital boards (BM) from a relational leadership perspective.

Design/methodology/approach: The authors used a qualitative and interpretive methodology. The authors study the daily interactions of BM and CNCs of seven Dutch hospitals through a relational leadership lens. The authors used a combination of observations, interviews, and document analysis. The author's qualitative analysis was used to grasp the process of collaborating between BM and CNCs.

Findings: Knowing each other, relating with, and relating to are distinct but intertwined processes that influence the collaboration between BM and CNC. The absence of conflict is also regarded as a finding in this paper. Combined together, they show the importance of a relational process perspective to understand the complexity of collaboration in hospitals.

Originality/value: Collaboration between professional groups in hospitals is becoming more important due to increasing interdependence. This is a consequence of the complexity in organizing qualitative care. Nevertheless, research on the process of collaborating between nurse councils (NCs) and executive hospital boards is scarce. Furthermore, the understanding of the workings of boards, in general, is limited. The relational process perspective and the combination of observations, interviewing and document analysis proved valuable in this study and is underrepresented in leadership research. This process perspective is a valuable addition to skills-and competencies-focused leadership literature.

Keywords

Nursing, Conflict, Leadership, Hospital, Executives, Process, Boundary work, Nurse, Boards, Council, Relational, Professional governance

Introduction

Leadership is said to be a key differentiator of the organizational performance of hospitals (West, Eckert, et al., 2014). Although empirical evidence for this is scarce (Clarke, 2018), it has led to the dominance of skills and competencies of individuals in contemporary health care leadership research, development, and practice (Cummings et al., 2021; West, Lyubovnikova, et al., 2014). This dominance contrasts with collectivistic approaches to leadership. Such approaches see the collective (Denis et al., 2012) instead of the individual as the locus of leadership (Hernandez et al., 2011) and privilege leadership as a relational process over leadership as an individual attribute (Crevani et al., 2010). Furthermore, in this literature, collaborative practices and agency are stipulated as key leadership processes (Ospina & Foldy, 2010; Raelin, 2016c). The leader-, skills- and competency-focused literature in contemporary nursing research has not been able to tackle these mundane (Alvesson & Sveningsson, 2003a), processual and relational issues that characterize boardroom dynamics and board practices in hospitals. Therefore, in this paper, we use relational leadership (Uhl-Bien, 2006) as a collective leadership lens (Ospina et al., 2020) to enhance our understanding of the strategic collaborating and professional governance (PG) of boards and nurse councils (NCs) in the daily practice of hospitals.

Background

In a vast majority of the nursing leadership and PG literature, emphasis is placed on structure and position (Sundean & McGrath, 2016) through, for example, NCs (Porter O'Grady & Clavelle, 2021). This is in contrast with the increasing attention for relational and collective aspects of leadership processes (Ospina et al., 2020). According to Porter-O'Grady and Clavelle (2020), NCs are *'the vehicle within which practice, quality, competence, and the generation of new knowledge and innovation thrive and grow'* (p. 182). Although the structure and individual competencies are important, their overrepresentation in leadership literature and practice cloaks the relational aspects of collaborating in the complex setting of a hospital. Hence, in line with our emphasis on relational and processual approaches to leadership in hospitals, Kanninen et al. (2021) recently showed in a review on PG that *'relational skills and the ability to work collaboratively in a supportive environment.'* (p. 2) are keys in making PG work. In other words, structure is only part of what people do together in organizing their collaborative relationship. Furthermore, in the PG literature, the responsibility of other (nonnursing) organizational agents [i.e. members of

executive hospital boards (BM)] in the positioning of nursing is underrepresented. Conversely, a relational process approach emphasizes this interdependence between agents in collaboration. Thus, in line with the relational leadership literature (Cunliffe & Eriksen, 2011), hospital boards and nurse representatives [e.g. chairs of nurse councils (CNCs)] should be more attentive to the processual aspects of collaborating in their daily leadership practices. Furthermore, hospitals have long been acknowledged to be *pluralistic organizations* where multiple objectives, a complex stakeholder arena and fluid and ambiguous power structures complicate collaboration This coincides, first, with the increasing concern of whether hospital boards have *'the necessary experience, knowledge and skills for effective governance of quality'* (Jones et al., 2017, p. 978), and second, with (health care), professionals experiencing the tension of collaborating with *'others and outsiders and remain 'knowledgeable', 'autonomous', and 'authoritative' at the same time'* (Noordegraaf, 2020, p. 205). According to Carroll et al. (2008), these are potentially reinforcing developments that cannot be managed solely by developing individual skills and competencies. Nevertheless, while in other scholarly fields the relational turn (McCauley & Palus, 2021; Uhl-Bien, 2006) and the debate on connectivity (Noordegraaf, 2020), complexity (Uhl-Bien & Arena, 2017) and boundary work (Langley et al., 2019) is well on its way, in health care leadership research and practice, hierarchy and competency thinking appear to have remained dominant (Cummings et al., 2021; Engelsberger et al., 2021; Gilmartin & D'Aunno, 2007; Glouberman & Mintzberg, 2001a).

Collective and relational leadership as process

Relational leadership is a collective leadership form (Ospina et al., 2020), as are distributive, collaborative (Fairhurst et al., 2020) and leadership-as-practice (Kok et al., 2022; Raelin, 2016c) approaches. These leadership forms all encompass how different agents look at, act in, and speak about their interaction, collaboration, and relationality and how they construct reality together. From such a socioconstructionist approach (Denis et al., 2012), individuals do not have or exhibit leadership, but leadership emerges in interaction. Leadership is seen as *'processes in which influential 'acts of organizing' contribute to the structuring of interactions and relationships.'*. Ospina et al. (2020) call this a *'lens'* approach to leadership and state that herein the focus is *'on identifying and understanding the* consequences *of actual conversations and other relational processes.'* (2020, p. 451, our emphasis). In this approach, relations and processes are, thus, central in defining leadership and forefront *'issues of process, context and relational interacts, in ways that have been*

overlooked in the cognitive and behavioral approaches that have predominated in leadership theory' (Schwartz-Shea & Yanow, 2012; Uhl-Bien & Ospina, 2012). Such a relational processual approach contrasts with an *'entity'* approach, which assumes *'individual agency - that organizational life is viewed as the result of individual action'* (Hosking et al., 1995, p. 10; Uhl-Bien, 2006). Thus, relational leadership offers the opportunity to see collaborating and PG in practice through a process lens. Interactions, not the attributions of individuals, are centralized.

Kanninen et al. (2021) already acknowledged collaborating as an essential leadership process in PG. However, in the PG literature, this is approached as an individual skill and this downplays the essential social-contextual factors (Oc, 2018) that influence collaboration (i.e. networks, relations, and culture). We, therefore, studied the daily interactions between BM and CNCs of seven Dutch hospitals through a relational leadership lens and ask: how can the collaboration between BM and CNCs be understood as a relational leadership process? Answering this question enables us to better understand this process of collaborating and adds to the practice of relational leadership and collaboration in complex settings such as hospitals.

Method

Design

We conducted a qualitative-interpretive (Schwartz-Shea & Yanow, 2012) research project in seven Dutch hospitals. We used an abductive (Locke et al., 2008) approach based on observations, interviews, and documents to grasp the collaborative relationship of BM and CNC as a relational leadership process.

Settings and participants

As per hospital, we interviewed a BM and the CNC. The interviews took place before and after observing an organizational meeting. Interviews took place in meeting rooms and offices of the participants. An overview is visualized in Table 1.

Data collection

Eleven hospitals responded to our social media call addressed to members of Dutch NCs (N = 72). We selected hospitals based on size (No. of employees) and geographical location (nationwide coverage). Four hospitals decided not to participate because of the time investment and access needed for the researcher.

Table 1.

Hospital	Academic/ general	Document review	Observations (#min.)	Interviews BM (#min.)	Interviews CNC* (#min.)	Background BM**	Role BM in board
1	Academic	Yearbook NC, annual report, position paper NC, website	110	71	50	Financial	CFO
2	Academic	Leadership document NC, org. chart, website, annual report				Medical	CMO
3	General	Website, annual report, org. chart				Managerial	CEO
4	General	Vision on nursing, website, annual report				Managerial	BM
5	General	Website, annual report, org. chart, evaluation report positioning of nursing				Medical	CEO
6	General	Annual report, position paper NC, org. chart				Managerial	CEO
7	General	Website, strategy paper on nursing, annual report				Managerial	CEO
Total		>250 pages	683	488	520		
#Pages of transcript				167	204		

* All CNC are registered nurses (RNs) and conducted work for the NC while also being active as a staff nurse on the wards during data collection

** One BM also has a degree in nursing but is not active as a nurse

Data was collected through observations, interviews, and document analysis, from January 2019 until February 2020.

Observations

Observations were done during regular meetings. The BM and CNC decided together which meeting would be observed. In all meetings other members of NC, physicians, and managers, besides the BM and CNC, participated. We informed all participants of our presence and of the objective of the observation. We chose a position in the room with a good overview of the participants, and which would cause minimal interference. In the interviews with BM and CNC after the observation, the influence of the researcher's presence was discussed to validate whether the observed meeting was representative for *'normal'* interaction between BM and CNCs. The observations focused on the interactions between the BM and the CNC. During the observations, we made so-called jotted notes (Bryman, 2012; i.e. keywords, quotes, short sentences), which were structured into fieldnote reports afterwards. The fieldnotes from the observations were treated as data, consistent with qualitative-interpretive methodology (Geertz, 1973; Schwartz-Shea & Yanow, 2012).

Interviews

We conducted interviews from an interpretive stance (Langley & Meziani, 2020) before and after the observations. The first interviews focused on the topics of (social) order, collaboration, goal setting, organizational structure, leadership, and governance. Based on the first interview, we constructed a so-called observation guide (Roller & Lavrakas, 2015) per hospital. The interviews after the observations focused on clarifying information from the first interview and to increase understanding and/or validating our observations (Schwartz-Shea & Yanow, 2012). All interviews were audio recorded and transcribed.

Documents

Prior to the initial interviews, an internet search was conducted on the specifics of the participating hospital and relevant documents were retrieved from the hospital websites. In addition, documents were provided by the participants prior to and after the initial interviews. Based on the documents, we made a topic guide (Bryman, 2012) for the interviews.

We used the three methods to understand both *'sayings'* and *'doings'* (Schatzki, 2016). In this way, we were able to understand the interviewees' perception of

key items in collaboration and grasp the collaborative relationship between the interviewees in their daily interaction.

Data analysis

We followed an abductive (Timmermans & Tavory, 2012) process of broad coding, *'memoing'* and confrontation (Deterding & Waters, 2018). In practice, this meant that analysis started during data collection (Nicolini & Korica, 2021). We learned throughout the process of collecting and analyzing this for the use in the next hospital. This was a somewhat messy process of switching between sources and between cases (hospitals). Nevertheless, this enabled us to increase understanding while collecting data. Furthermore, we used Atlas.ti to manage this messiness by connecting codes from the fieldnotes to our interview transcripts and information from the organizational documents. This iterative process led to the identification of themes (e.g. agenda setting) and recurrent patterns (e.g. meeting informally; Braun & Clarke, 2006). When we identified the *'cross-patterns of themes'* (Ospina & Foldy, 2010) between knowing and relating, we then revisited the data for quotes and descriptions. During analysis, this iterative process of switching between data and findings was discussed extensively between first and last author. In line with our qualitative-interpretive approach, we used *'memoing'* (Deterding & Waters, 2018) to make this thought process transparent. This adds to the rigor of the analysis (Deterding & Waters, 2018; Schwartz-Shea & Yanow, 2012).

Findings

In our study, participants found collaborating a normal work practice and stressed the importance of it for hospital performance. Nevertheless, in our interviews positioning, hierarchy and power differences were brought forward as influential elements of collaboration, and conversely, in the observed meetings, the task at hand was dominant. In other words, the explicit discussions from the interviews on role clarity, processual goals, or expectations toward each other were scarcely seen during observations. Collaborating seemed assumed in practice by BM and CNC and little attention was given to the collaborative relationship itself and the context in which the meeting played out.

We learned that knowing each other and relating are important processes for BM and CNC to collaborate. We also observed that relating is complex and not always *'a two-way street.'*. For instance, we found CNC leveling up to BM, whereas the BM was more focused on task execution and hierarchical positioning. Therefore,

we differentiate below between *'relating with'* when we present the process of interacting in achieving shared goals, and *'relating to'* when one of the participants attunes to the frame of the other, and this is not acknowledged by the other.

We present our findings as three distinct and intertwined relational processes; knowing each other, relating with, and relating to. Furthermore, our fourth finding is not so much finding as an *'absentee.'*. From a reflexive stance (Cunliffe, 2016), we found that the absence of conflict in the observed interactions stood out. Although, in the interviews, tensions (e.g. not feeling heard and different expectations) were emphasized by participants we did not observe in the meetings. Below, we elaborate on these four findings and in the discussion section, we reflect on our findings in the light of relational leadership theory.

Knowing each other

In our study, collaboration was fueled by understanding others and their context. This was done for the good of the relationship, emphasizing of shared goals and sometimes for personal goals, such as positioning. In the interviews, we learned that the relation itself, personal connections, and the view on the positioning of self and others are important and is a continuous process for participants in collaborating. The next fragment illustrates this:

> *Well, I know a lot of people. On the level of team lead, but even on the work floor. (…) And this is helpful. Certainly, for us as board of directors, it is good to know people in the organization. You know the people; you know the context. And for the people on the work floor it is nice to feel that, well, that you even know the member of the board, they are accessible, approachable.*(Interview BM, hospital 1)

Being there, in context, adds to the relationship and helps the collaboration is what the BM brought forward in this interview. The CNC in the same hospital was attentive to what the BM knew and highlighted that where nursing was concerned. She said:

> *(…) of course, we all have this one goal of delivering the best patient care. But, with all due respect for management, team leads and boards of directors, they are not at the work floor. So, my job is also to inform them on how things are actually working out.*(Interview CNC, hospital 1)

Processes of knowing are highly contextual and temporal, as we learn from this interview fragment of a CNC. Furthermore, this fragment shows that there is a difference between knowing each other (i.e. name and position) and knowing what is going on. We heard about and observed many instances in which participants made an effort in this knowing each other and each other's context to collaborate.

Relating with

Relating with is about connecting with the other and understanding where they come from. We found examples of practices by CNCs putting forward information which they assessed was necessary to make a decision or to be informed. What is referred to as *'to inform'* in the quote above is an example of this, based in knowing each other. This is a process of relating. This interview fragment of a CNC is an example of this:

> *On the work floor we often talk like what did 'they' come up with this time, how can 'they' do this. But 'they' who thought of it, are 'they' who I need (…). If I want them to consider nurses, I also need to consider them.*(Interview CNC, hospital 1)

The interdependence, the development over time and the shifting social order between the professional groups come forward in this quote. These determine possibilities for influencing and organizing. Also from this quote, we can see that relating with needs bridging the differences, considering the needs of the other. This is not for the CNC alone. In an interview with a BM, we heard:

> *Well, I coach them in their role as NC in that for instance they can take a bit more space. (…) it is not formally my role as BM to coach participation bodies, but in this case, it fits, and I feel like they appreciate it, and I see growth.*(Interview BM, hospital 4)

We learn that the BM stretches the relationship - in her opinion - to better work together. Furthermore, BM and CNC in the interviews both pointed to the importance of language use for relating. As one CNC put it:

> *It is in her jargon, well she [BM] speaks differently than I do, uses different words (…). If she would talk to me as she does with her colleagues on the board, then well, we would probably speak two different languages.*(Interview CNC, hospital 3)

Adjusting of language is a form of relating with each other when it aligns with informing each other timely and fore fronting the shared task.

Relating to

In the interviews, we often heard that participants relied on their own interpretations of context and tasks in collaborating with the other. In the complexity of collaboration, worldviews, logics, and knowledge can align or collide. We observed instances where thinking for each other or not realizing what the impact of using a particular framework in collaboration might be occurred. An example of this comes from a "patch" from the fieldnotes and interviews regarding an observed meeting:

> *(…) the board member starts to 'lecture' on how this process works. He does not actively invite questions. Midway of his talk, he says 'millions', where he means 'thousands'. No one interrupts or correct. When I [researcher] later reflect on this with the CNC, she confirms that not all people present understood the process - and related jargon - that the BM presented. She states, 'We all know him and how he likes to impress people. So mostly we let it be.'*('patch' hospital 5)

In the meeting, the workings of budget cycles were put on the agenda to learn and better understand together. Nevertheless, we witnessed a misalignment whereof the BM seemed unaware, and the other participants actively chose to *'let it be'*. This reaction has an impact on the collaborative relationship just as not inviting to ask questions as a mean to know if everybody is attuned. We observed often how BM and CNCs deal with differences due to context and/or to specific professional perspectives in their interactions. We found that BM used clarity of expectations as a way of relating to the CNC:

> *Certainly, yeah, these sort of councils (…) are to us as BM, sources of information. Working with them provides insight - not necessary per se - but is helpful in understanding how things play out of what we [boards] decide. I therefore expect them to timely inform me about what's going on and what we [boards] should worry about.*(Interview BM, hospita! 2)

This fragment shows that BM sees the added value of a NC more as a mean for informing, testing, and validating during the decision-making process of the BM. Furthermore, we observed that the meetings were mostly led by the BM. Here, another use of language (i.e. ordering) and positioning (i.e. chairing the meeting)

was seen. This aligned with the BM emphasizing the organizational hierarchy more often in the interviews and with more emphasis than CNC did. Conversely, the expectations of the NC toward the BM remained unclear in the interviews and observations. The CNC talked about collaborating with the BM as a task of, or even a privilege for, the NC. The CNC regularly referred to BM as being 'higher' or "more." They talked about "levelling up" and relating to the situation and to the collaboration as a primary goal for the CNC. Furthermore, references, we expected, such as the opportunity to influence decision-making, contributing with nursing-specific knowledge to organizing of care or positioning of nursing within the organization, were absent. We observed herein a tension between interdependence and the importance of balancing personal and shared goals. In our observations we saw dealing with this tension leading to misalignments. In some of our observations, this reinforced an unequal power dynamic with more importance given to organizational hierarchy than to the collaborative relationship in interaction.

In sum, knowing each other is an implicit but invaluable relational process for the collaboration of BM and CNC. Obtaining information, helping people, learning together, and achieving goals are overlapping reasons for the relevance of knowing people and knowing the context in which you collaborate with them. Part of this is relating. Relating is done by creating relational space where BM and CNC work on shared and personal goals. We found that for BM and CNC relating is the process of connecting on shared goals and understanding each other's context. We named these processes "relating with." We also heard of and observed instances of unequal power structures constructed by both BM and CNC through language use (i.e. jargon) and social order construction (i.e. levelling). We named this process "relating to." Although relating seemed needed to cross the differences between contexts we found that this is difficult for BM and CNC together, in part because expectations on role and task are not made explicit, continuously, in interaction.

Absence of conflict

Manifestations of tensions fitting with collaborative leadership relationships in a professional and complex setting were absent in the observations. Interestingly, we found "conflict remarks" throughout the interview data but these were hardly seen in the meetings observed.

In the interviews with BM, it became clear that most BM view themselves as coaches and leaders of the NC. In these interviews, BM stress that their aim is to position the NC firmly because this adds to the quality of care and even to the quality of

the decision-making process. Strangely, they also refer to the CNC as "the coachee and follower" and therewith reinforce the asymmetric relationship. Although this is consistent with our observations of how CNCs presented themselves in meetings, it is in contrast with an interdependent collaborative relationship between two professional groups. The CNC were firm and clear on what the goal and structure of the relationship with the BM was or needed to be in the interviews. These were often qualified as being "good" or "bad" for nursing, and "helping" or "hindering" in positioning the CNC or the NC. However, in the meetings that we observed, no direct references were made to this. Tensions seemed ignored or downplayed by the CNC, and we did not observe any instance of open conflict, nor did we see BM make an effort to light a discussion on what the CNC or NC needed from the BM to get into position, for example. Something which could be expected when viewing oneself as a coach or leader of health care professionals. The CNC (nor NC) challenged the BM openly on their leadership role in positioning the CNC, the NC or nursing. Neither was the firmness in expectations from BM in the interviews toward the CNC observed in the interactions. Participants worked on their tasks, together, without expressing tensions.

Discussion

This paper contributes empirically to the health care and leadership literature by showing how collaborating in hospitals between BM and CNCs can be understood as enabling leadership process. We studied the collaborative relationship between BM and CNCs interpretively with the use of relational leadership as a theoretical lens. First, we found that processes such as knowing and relating are influential but also taken for granted in daily practice. Second, we showed that CNCs and BM privilege position and hierarchy over expertise in a time of increasing complexity. Last, we found that BM and CNCs talk about tensions but do not portray them in their daily interactions. We will discuss the findings and reflect on the consequences of collaborating in hospital settings.

Collaborating taken for granted

In line with previous research, we found that knowing and relating as mundane processes (Alvesson & Sveningsson, 2003a) influence the collaboration between boards and CNCs. Although processes such as knowing have been deemed important before (Nicolini et al., 2014), they mostly refer to knowledge and not so much to knowing each other. Nevertheless, the processes of knowing and relating to each other are essential (Cunliffe & Eriksen, 2011) for all collaboration. Knowing

and relating are intertwined (Clark et al., 2014) but are often approached as conscious acts of agency (Alvesson & Sveningsson, 2003a). However, in our study, BM and CNCs talk about the power of these processes but fall short of valuing and using them in their interactions. Fore fronting the collaborative relationship as an interaction instead of as a statie, taken for granted entity can enable BM and CNCs to collaborate more effectively (Erkutlu & Chafra, 2019; Fulop & Mark, 2013). We, therefore, find there is a need to develop an understanding of how these taken for granted processes (Kee et al., 2021) shape and are shaped through the leadership processes of collaborating, in addition to the development of skills and competencies. Literature suggests that (peer-to-peer) shadowing can help surface these taken for granted and tacit interactions (Lalleman, Bouma, et al., 2017).

Position and hierarchy over process and expertise

The nursing PG literature (Kanninen et al., 2021; Porter O'Grady, 2019; Sundean & McGrath, 2016) is focused on relational skill and leadership style as enablers for nursing govemance structure. Nevertheless, our findings show that these alone are not enough for CNC to influence a change in positioning of nursing. Knowing and relating are too contextual and temporal dependent for this (Nicolini et al., 2014; Oc, 2018). Moreover, depending on skill and style makes PG a task of nurses alone and diminishes the role of context and the responsibility of other (nonnursing) agents. The importance of relating (Uhl-Bien et al., 2020), understanding and using the influence of context (Oc, 2018; Stoker et al., 2019) and effectively influencing social order (Hosking, 1988; Uhl-Bien, 2006) is essential for leadership in health care (MacCarrick et al., 2014) and should be part of the repertoire of BM (Sundean & McGrath, 2016) and CNCs in their interaction. In relating to, we found CNC "othering" (Abdallah-Pretceille, 2006) boards by talking about BM as "higher" and giving the lead to BM even when their nursing expertise was needed. Othering is often a process of magnifying differences and fortifying power asymmetries (Ybema et al., 2012) to construct and protect one's own identity (Sutherland, 2016). CNC, as well as BM, can benefit from what Ybema et al. (2012) all "othering the self." Herein, the process is reversed, and the differences and power distance are purposefully diminished. Nevertheless, this can not only be a task for the CNC. BM seem to approach interdependency with other agents by placing themselves outside of the relationship even when required expertise is available (Forbes & Milliken, 1999). For instance, in their relationship with the CNC, we saw BM position themselves as coaches and directors, emphasizing hierarchy and distance, not explicitly aligning interests, and ignoring needed (nursing) expertise. "Interrelating" is deemed important for the functioning of boards (Forbes & Milliken, 1999), but this is mostly approached as a dynamic within boards or as an interaction with other

agents regarding boards' direct tasks (Carroll et al., 2017; Kane et al., 2009), such as decision-making. How BM relate and how they manage the interdependency with agents outside of the board remains scarce in research (Boivie et al., 2021) but can be a valuable avenue regarding the previously mentioned pressures of board accountability and the development of professionalism (Noordegraaf, 2020; Raftery et al., 2022).

Conflict as a resource for collaboration

Conflict is an element of collaboration (Follett, [1926] 1942; Godwyn, 2022) and of collective leadership processes (Denis et al., 2012). While conflict is mostly seen as a destructive process (Edmondson & Smith McLain, 2006), it can also be a potential force for collaborating (Streeton et al., 2021) and structuring. Although, in the interviews, participants were explicit on their judgement of the acts of the other in the observed interactions, these judgements remained unsaid (Engbers, 2020). Viewed from the literature that sees value in constructive conflict (Follett, [1926] 1942) this is a potential loss for complex organizations such as hospitals. This literature sees conflict as a *'(…) natural process that begins when agents in a system begin to ideate around novel solutions in the face of complexity pressures.'* (Uhl-Bien et al., 2020, p. 111). Conflicting can then be a helpful source for collaborating across organizational (Ernst, 2020; Farchi et al., 2022) and professional boundaries (Langley et al., 2019; Noordegraaf, 2020), and can even be part of dialogically working together (Den Uijl, 2022).

Strengths and limitations

This study is compliant with the consolidated criteria for reporting qualitative research standards (Tong et al., 2018) for qualitative research. Furthermore, the combination of observations, interviews and document analysis led to insights that could not have been reached otherwise. The insights from the interviews fueled the observations and vice versa. Nevertheless, the study also has its limitations of space, definition, and process (Fairhurst et al., 2020). First, although the ambiguity of the collective leadership space has received ample attention, the participants most likely also interpreted leadership meaning, process and outcome from the skills and competencies paradigm. Methods such as group interviews or vignette experiments to test and discuss the findings could have led to the bridging of paradigms and, in that way, enriched the process and added to the transferability of the findings. Second, we used relational leadership as a lens (Ospina et al., 2020) and followed Hosking (1988) in defining leadership as an influential process of

organizing. This enabled us to highlight the emergence of influential acts regardless of formal organizational positions (Ospina et al., 2020). However, this also entails the risk that everything becomes leadership (Alvesson, 2020). A group discussion with boards and CNC as an observational intervention could have added to the definition of leadership from the participants' perspective. Last, by following the experience of boards and CNC over time in seven different hospitals, we embraced the process. Nevertheless, the study could have been more process oriented by generating data in between interviews through shadowing (Lalleman, Bouma, et al., 2017), for example.

Conclusion

Collaborating is a key leadership process in the complexity of hospitals. We showed that CNCs and boards know how to collaborate, that it takes knowing and relating and that perspectives can differ between professional groups. Nevertheless, we found that they take their collaboration and relationship for granted, focus on tasks, and position and avoid conflict. Understanding the processes of collaborating is important for health care professionals and boards alike but using this understanding for collaborating is imperative. Collaborating *is* a relational leadership process.

THREE

BOARD TALK: HOW MEMBERS OF EXECUTIVE HOSPITAL BOARDS INFLUENCE THE POSITIONING OF NURSING IN CRISIS THROUGH TALK.

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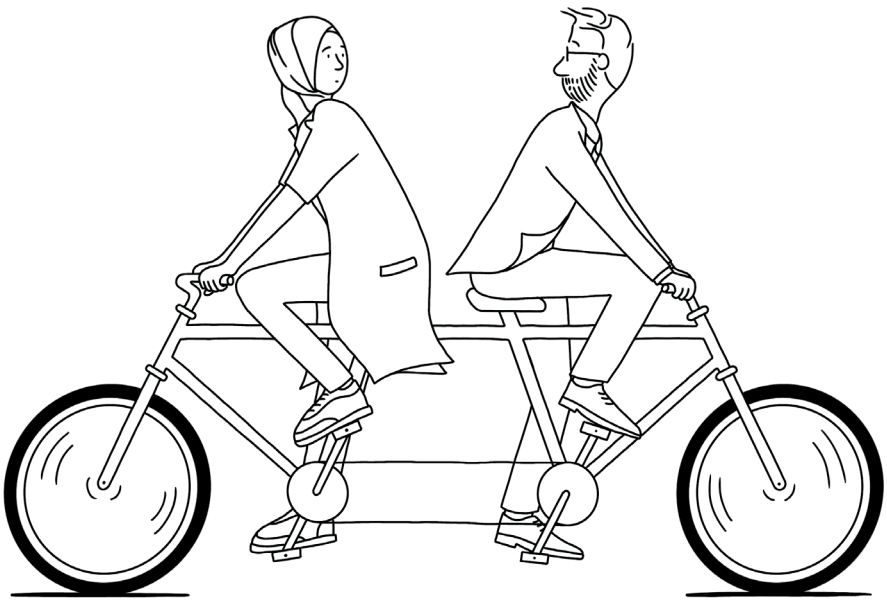

Introduction

In hospital crises, professional groups are highly dependent on each other for expertise, decision-making, and guarding the quality of care (De Graaff et al., 2021). Such processes of interdependence (Bender, 2018) are inherently social, relational, and contextual (Kee et al., 2021; Ladkin, 2020). Nevertheless, the nursing leadership literature is predominantly focused on individual skills and competencies (Cummings et al., 2021). And, as such this literature cloaks aspects of interdependence and relationality (MacDonald, 2002) between nursing and nonnursing agents.

Furthermore, this individualistic focus on nursing leadership (Porter-O'Grady, 2023) contrasts with the relational turn in leadership literature (McCauley & Palus, 2021; Uhl-Bien & Ospina, 2012). More collectivistic and relational leadership approaches, such as shared, distributed, or leadership-as-practice (Ospina et al., 2020) centralize social interactions in, by, and between individuals and organizational groups (Denis et al., 2012). In these interactions who is leading and who is following is constantly (re)constructed (Alvesson & Sveningsson, 2012).

The notion of "talk" is an essential component of this constant reconstruction (Dahlke & Hunter, 2020) and *'not only concerns itself with sentences, but also embodies action, frames attitudes, and has certain performative effects'* (Oldenhof et al., 2016b, p. 52). Furthermore, talk is especially relevant for processes of organizational positioning because talk *'allows us to focus on the dance of positions, how leaders position others through their talk, as well as how leaders are positioned by others'* (Barge, 2012, Para. 4.4).

In this paper, we, therefore, zoom in on how members of executive hospital boards (hereafter: board member(s)) and nurses use talk as a relational dance of positions in times of crisis. Although the importance of talk has been acknowledged for frontline nursing work (Barcelona et al., 2023; Dahlke & Hunter, 2020; Lopez-Deflory et al., 2023b; Marey-Sarwan et al., 2022) it seems overlooked in the nursing leadership and governance literature (see Cummings et al., 2021; Kanninen et al., 2021). However, Verhoeven, Loo, et al. (2023) showed that such a discursive leadership perspective can be supportive for comprehending the relational processes and interdependencies between board members and nurses. Therefore, in our study, we focus on such discursive, relational leadership practices (Barge, 2012; Uhl-Bien, 2006) and aim to uncover how these influence the positioning and voicing of nurses, in times of crisis, when interdependency is high (De Graaff et al., 2021).

Background

Relational leadership, talk, and interdependence

A processual relational leadership approach (Uhl-Bien, 2006) focuses on social order and organizational interaction (Cunliffe & Eriksen, 2011; Hosking, 1988) and forefronts communication as a process of ongoing construction (Oldenhof et al., 2016b). Nursing leadership literature slowly acknowledges this approach as relevant to nursing practice (Kok et al., 2023; Kok et al., 2022; Martini et al., 2023). Nevertheless, this approach remains in contrast with the dominant leadership literature in which (heroic) individuality (McCauley & Palus, 2021; Uhl-Bien & Ospina, 2012) and *'primacy of the mind and rationality'* (Ladkin, 2020, p. 56) are central.

Furthermore, processes of talk are in relational leadership literature referred to as language (Clegg, 1987), professional talk (Oldenhof et al., 2016b), or discursive practices (Barge, 2012). All are discursive perspectives focused on communication in leadership and organizing as social, performative, and overt behavior (Uhl-Bien, 2006; Uhl-Bien & Ospina, 2012). Oldenhof et al. (2016b) state *'with the help of words, (…) different relations between managers and care workers are being performed'* (2016b, p. 66). And, according to Barge (2012), this is *'local (…), fluid and dynamic as shifts in language create fresh understandings for leadership as well as new patterns of social arrangements'* (2012, Para. 4.1). In other words, talk structures social order and influences positioning.

Therefore, a relational (leadership) approach highlights the interdependency between organizational actors. Interdependence is the process *'by which interacting people influence one another's experiences'* (Van Lange & Balliet, 2015, p. 65). Interdependence is inherent to working in health care (Porter-O'Grady, 2015), and to the nursing profession (D'Antonio et al., 2014). Nevertheless, attention to interdependence in health care research is surprisingly scarce (Mayo et al., 2021) and traditionally approached as task-related (e.g., what people do together) (Raveendran et al., 2020). However, Raveendran et al. (2020) state that shifting workflows and increasing interrelatedness in work leads to interdependence not only on tasks but also on goals and knowledge of different groups, such as nurses and board members.

The workings of executive hospital boards

Executive boards in general, focus on strategic decision-making, quality management, and governing strategy execution (see, e.g., Boivie et al., 2021; Jones et al., 2017). Nevertheless, the functioning of boards in practice is unclear

and coined as a "black box" (Francoeur et al., 2018). Some have argued that this is due to the overreliance on explicit academic theories in governance research and a lack of empirical grounding (Boivie et al., 2021). Carroll et al. (2017) showed that board members are mainly driven in their activities and talk by discourses on conformance, deliberation, and enterprise and that these *'inevitably shape how they exercise governance'* (2017, p. 615). Moreover, the importance of board work is increasing (Boivie et al., 2021). And, intersecting pressures of accountability and connection with professionals (Jones et al., 2017) force boards to balance distance and proximity toward the organizations they work in (Glouberman & Mintzberg, 2001b). Board members balance these tensions by simultaneously behaving as "interested outsiders" (Stoopendaal, 2009, p. 192) and as involved team members (Stoopendaal, 2015).

Furthermore, according to Erwin et al. (2019), high-performing hospital boards connect with professionals (especially nurses) for relevant and accurate information (2019, pp. 158, 159). And, others show that the voice of nurses at the board level creates conditions that enhance organizational performance (Sundean & Gatiba, 2022), especially in crisis (Sansolo et al., 2022). All these studies resonate that nursing expertise at the board level is needed for managing the complexity of hospitals. Conversely, nurses are underrepresented as board members (Prybil et al., 2019; Sundean et al., 2018).

Positioning of nursing in times of crisis

Positioning of nursing in hospitals has historically been complicated (D'Antonio, 2006) because of the one-sided historical frame of nursing as a relatively powerless profession (D'Antonio et al., 2010; Lopez-Deflory et al., 2023a). This frame aligns with the frame of nurses as *'heroes at the bedside'*, resurfacing during the pandemic (Boulton et al., 2022). After all, both frame nursing as a caring profession and disregard the invisible (Allen, 2014), organizing (Noordegraaf, 2011), and *'heads-on' caring work'* (Lalleman, Smid, et al., 2017, p. 9) as an essential part of nursing in hospital crises settings (Irwin, 2017; Sansolo et al., 2022). This disregard is due to *'the limitations in language to articulate the nature of (…) [the] distinctive [nursing] professional discipline'* (Thorne, 2015).

Conversely, there are numerous examples of *'other histories'* wherein nurses have been organizers, leaders, and contributors to complex decision-making in crisis (see Keeling & Wall, 2015; Marey-Sarwan et al., 2022; Sadurni-Bassols et al., 2023). Nevertheless, the frame of *'heroes at the bedside'* remains dominant (Boulton et al., 2022). And, the acknowledgment of nurses as professional contributors

to organizational work, well beyond patient care, is lacking in the positioning of nurses in crisis management.

Furthermore, crisis management is the central coordinating management function for unanticipated and ambiguous events that are threatening and permit only a short decision time (Kornberger et al., 2018). Furthermore, in the nursing leadership and governance literature structure and position are centralized (Sundean & McGrath, 2016). Nursing professional governance is *'nursing's control and ownership over decisions and actions related to nursing practice, quality, competence, and knowledge management. (…) [And] can be an invaluable mechanism for nursing engagement in the midst of managing a crisis'* (Porter-O'Grady & Pappas, 2022, p. 217). Nevertheless, although, nurses are recognized as competent and accountable professionals (Kanninen et al., 2019) in crises their nursing professional governance structures seem to be abandoned or ignored (Hancock et al., 2021; Porter-O'Grady & Pappas, 2022; Porter-O'Grady et al., 2022).

With this paper, we contribute to the call from the scientific (nursing) community to all in the health care system (The Lancet, 2023) to understand how to better involve nurses in strategic (crisis) decision-making (Thorne, 2021). We guided our analysis with the question: how does talk by executive hospital board members influence the positioning and voicing of nurses in crisis management?

Methods

Study design

We conducted a qualitative-interpretive study (Schwartz-Shea & Yanow, 2012; Thorne et al., 2004) using online focus groups with 34 participants from 15 Dutch hospitals. Focus groups were aimed at understanding the positioning and voice of nurses in crisis management in Dutch hospitals during the onset of the COVID pandemic.

Research context and participants

The hospitals our participants worked for ranged from 400 to 1125 clinical beds. Half of these hospitals can be seen as "rural" and half as "urban" Of our participants, 74% were female. Furthermore, six of the seven board members were women. Of the seven board members, three were CEOs at the time of data collection. The others were members of boards and were concerned with business and financial topics. Of the board members, three had a background in nursing. None of them were practicing as nurses at the time of data collection.

Managers were middle managers concerned with the business of hospital departments. Of the six managers, two were women. All had a background in nursing. One was still practicing as a nurse at the time of data collection. The representatives of the nurse councils were all registered nurses—besides their council work—and were active as nurses on the wards.

Furthermore, during COVID (March 2020 to May 2021) there was a relevant media discourse about the collaboration, interdependency, and leadership of (health care) professionals in hospitals and the role of board members (De Graaff et al., 2021; Hancock et al., 2021; Wallenburg et al., 2021).

Data collection

We invited chairs of nurse councils of all 72 Dutch hospitals via email to participate in focus group meetings on the positioning of nurses during COVID. We asked them to invite a manager, board member, and physician from their hospital to participate. We received 15 responses (21%) from nurses. These nurses involved colleagues (i.e., board members, managers, physicians) from their hospitals to participate. Nurses gave us the email addresses of their colleagues through which we invited the other participants. Informed consent was retrieved before the focus groups. Table 1 summarizes the collected data.

We conducted four consecutive focus groups in the last week of June 2021. The main topics were collaboration, decision-making, learning, structure and governance, and positioning of nursing and councils. The focus groups focused on the positioning of nurses and nursing expertise in crises and encompassed the experienced collaboration between and positioning of professional groups (i.e., boards, managers, nurses, physicians) in Dutch hospitals between March 2020 and June 2021, and transcended the topic of positioning of nurses alone.

Furthermore, because of the relational nature of topics, we composed each focus group with a diverse professional (i.e., board member, nurse, manager, physician) and organizational perspective (i.e., no more than two participants from the same organization in one focus group). This elicited (Barton, 2015) a discussion between perspectives that enabled us to learn about how participants talked about working with differences (Cunliffe & Locke, 2019) and the differences in positioning and voicing of nurses in crisis management structures.

All focus groups took place via ZOOM (https://zoom.us/). The first and last author chaired (A.V.) and observed (P.L.) the meetings. The chair guided the focus group,

Table 1.

Focus group	# Different participating hospitals	# Participants	Board member	Manager	Nurse	Physician	Duration (# min)	# Pages transcript
1	7	7	1	1	4	1	100	24
2	8	9	2	2	3	2	94	22
3	7	10	2	1	4	3	105	24
4	**8**	**8**	***2***	***2***	***3***	***1***	***99***	***22***
Total	**15**	**34**	**7**	**6**	**14**	**7**	**398**	**92**

and the observer observed the interactions between participants, and between participants and the chair. For each focus group, notes were jotted (Bryman, 2012) and discussed afterward by the chair and observer. Insights were used in the following focus groups for structuring, prioritizing, and deepening topics. In this way, the data collection developed from the first to the fourth focus group (Nicolini & Korica, 2021). All focus groups were video recorded and transcribed afterward. The recordings, transcripts, and notes were used for analysis.

Data analysis

We used interpretive description (Thorne, 2013) and abductively analyzed the data (Timmermans & Tavory, 2012) by making multiple rounds of iterations between the data perspectives and the theoretical concepts of relationality (Ladkin, 2020; Sklaveniti, 2020) and interdependence (Van Lange & Balliet, 2015) to understand what we found.

The findings were discussed with the research team, which led to further deepening of the analysis to get beyond the initial themes (Thorne, 2020). The influence of talk by board members was derived from this analysis. "Talk" itself was not an explicit topic during the focus groups.

Furthermore, we used Atlas.ti software for structuring the data, memoing (Deterding & Waters, 2018) our reflexive (Lazard & McAvoy, 2017, p. 160) thought process, and facilitating the coding process. We coded the transcripts looking for themes and patterns (Ospina & Foldy, 2010) and plotted the transcripts by interview topic and by perspective (i.e., board member, nurse, manager, physician).

Findings

We found that most board members, through their talk, positioned nursing as (1) more practical than strategic, (2) ambiguous in positioning, and (3) distinctive from medical expertise, in crisis. Furthermore, board members consider the positioning of nursing in crisis management as a task of nurses and not as a collective, interdependent, or board responsibility.

Interdependency between nursing and board work

Most board members were able to reflect on their experiences and connect these with the societal discourse on what happened in the hospitals during the pandemic, and what this could mean for future crises. An example of this was the reflection on

the unprecedented workload for health care professionals and its impact on staff shortages in the near future. Nevertheless, what stood out was that a majority of the board members talked as if they were not influential actors in the voicing and positioning of nurses in crisis. Other participants in the focus groups talked more in terms of action, about what they themselves would do differently, or the same, in the next crisis. We found that board members talked *'from a distance'*.

Furthermore, participants talked about differences between professional groups and how these differences justified task separation. However, there was little reflection by board members on how they framed these differences in crisis management. In most hospitals, board members had a leading role in the crisis management structure and were able to position agents accordingly. One board member framed this lack of reflection in a broader perspective by stating;

> *(…)On the one hand there is a large amount of appreciation for nurses, but on the other hand this is a classic example of the long road we [boards] must travel to bridge the existing gap between work floor and board room.* (Board member 7)

Below we use talk by board members to highlight the influence of their discursive leadership practices on the positioning of nurses in crisis.

More practical than strategic

Board members stressed the practical attribution nurses made to crisis management, and that nurses prefer working with practical matters over strategic topics such as decision-making. Utterances such as "they feel more at ease in our preparation teams' and 'the practical matters align better with the nature of nursing" are exemplary quotes of board members in the focus groups. These underpin that board members see nurses as "doers" and front-line workers and that this contrasts with strategic thinking and organizing. However, we found no negative judgment in these sayings. Nursing expertise was talked about with much respect by board members and was considered essential for delivering care and managing crises by all participants. One board member stated:

> *Nurses evidently played a key role in our hospital in this crisis. We are slowly learning the value of this. Nurses mostly did the preparatory work of crisis decision making. The advantage was that they with the other departments—such as management, cleaning, microbiology, and communications—jointly prepared policy.* (Board member 4)

In this quote, the key role of nurses is explicitly highlighted and simultaneously nurses are equated with support staff disciplines, during an unprecedented health care crisis. This shows the visibility of nurses during crisis management, but also the outlook of the board members on where nurses were adding value to the task at hand; *'preparatory work of crisis decision making'*. Also, when this added value was related to the complex decision-making process that board members were in during this crisis, the position of nurses was related to front-line work.

> *(…) it is very important to hear back from nurses how certain measures work out in practice. This can be very different from what we think of in our offices, behind a desk or the sketch board. I have experienced this myself firsthand and this is why it is so important to have nurses with direct bed-side experience to participate in the decision-making process.* (Board member 5)

The choice of words by the board member in this quote positions nurses as bearers of first-line knowledge for the board member. This fortifies the boundary between care work and organizing work. Furthermore, the board member positions nurses as different than the people in "the offices." In these offices, decisions are made that impact the place of care where nurses work. Although validating such decisions is seen as an essential task, with this talk the board member positions the nurse as reactive instead of proactive to the decision. However, we also learned in the focus groups that nurses themselves—in the heat of crisis—chose to privilege front-line work over more strategic work, such as helping strategic decision-making from the council, as a nursing expert, for instance.

According to several participants in the focus group (including nurses) nurses chose to be in preparation teams. One board member said;

> *(…) nurses wanted to be in the preparation teams. Policy was prepared by these teams for decision-making in the crisis management team [consisting of board members, managers, and physicians]. This was a logical development in our hospital after the evaluation of the first wave [COVID-19].* (Board member 5)

Although this quote portrays well that crisis management is a team effort it also shows that nurses are positioned in the preparation phase of crisis decision-making while the other essential perspectives are represented in the team where the decisions are made. This positioning has much to do with the perspective on who

can add what value in which part of the process and how access to these positions is given. According to several board members nurses in general are (not yet) suited for the work needed at the strategic level. The board talk in the following quote positions nurses as such.

> *(…) role clarity and role firmness are important here. There is a development needed, and I have said this often to our nurse councils, the moment you arrive at the strategic level you accept a certain responsibility.* (Board member 1)

In sum, in most hospitals nurses and councils were positioned at a practical level, and for most nurses, this was acceptable in crisis. Furthermore, for most board members this was the outcome of how nurses themselves preferred to contribute to crisis management and in line with a lack of experience of working at a strategic level. However, we did not find reflections by board members on their own influence on the frame of nursing as a more practical than strategic profession, nor how they balanced this frame to what was needed of nursing expertise in strategic crisis management.

Ambiguous in positioning

According to most board members, nursing expertise was in most hospitals ambiguously positioned because three groups claimed this expertise: frontline nurses on the wards, managers with a background in nursing (often no longer practicing as a nurse), and the council. The latter had an ambivalent position between expertise in nursing and that of a participation body (i.e., representing a group of professional employees, such as registered and auxiliary nurses). Board members talked about all three for different solutions, thereby adding to the ambiguity who they saw as expert in nursing and as helpful for crisis management.

(…) certainly when it concerned face masks, it is very helpful that the council could validate with their followers [nurses on the wards] how a specific decision will be valued. Then we can decide whether we go through with it or better alter the decision. (Board member 1)

This quote exemplifies that board members, in relation to the crisis of impending shortages of face masks, positioned the council as part of the decision-making process. Nevertheless, not in every hospital and/or situation it was clear what the role of nurses was. Furthermore, we learned from nurses in the focus groups that the nurse workforces in hospitals were, as a whole, unable to claim a clear role in strategic crisis management.

Furthermore, board members extensively discussed the importance of focusing on the task and role clarity for positioning in crisis management. In contrast, board members also talked about the importance of managers and participation bodies as information channels for boards in crisis management, as shown in the following quote.

> *(…) these councils have an important informal task to bring signals up to the board room. This to me is an important role of participation bodies.* (Board member 2)

Although this can be seen as regular organizational practice it also contributes to the ambiguity of roles and tasks within the organizational arena. Such performative talk by the board members brings informality into a formal setting. This practice of board members was rationalized by talking about managing crises as regular board work. Herewith, board members made board work sound exceptional, and distinguishable from the work of managers and participation bodies. However, it is—according to most board members—not only this responsibility that distinguishes board work from other work, board work also demands specific skills and attitude.

> *If you want to be part of board level than you have to play according to those rules; no 9 to 5 attitude and take a professional stand.* (Board member 3)

This highlighting of differences sparked the discussion in the focus groups about whether these skills were specific for board work or whether they were also exemplary for other complex work in hospital crisis management.

> *(…) playing the game at board level requires knowing the rules and this is not something nurses do naturally. This is a needed development. Same goes for me. If I want to work with you as a nurse, I also have to understand how your work needs to be done and what is asked of me.* (Board member 1)

Role clarity and task clarity are needed—according to the board members—to be able to contribute to crisis management from the width of nursing expertise. In our analysis, we found that board members are also contributors to this ambiguity through their talk and how they position nursing representatives as information channels for board work.

Distinctive from medical

Board members extensively used the comparison between nurses and physicians to explicate how they viewed the needed development of nurses.

> *Nurses from the wards should be in the crisis teams but first they need to be trained for it and positioned in a management function, just as physicians are.* (Board member 3)

This quote exemplifies that board members see skills and a management position as needed for nurses to contribute to crisis management. In the focus groups, it became clear that according to board members, firm organizational positioning in a management function helps in crisis management due to the internal network and relevant relations that these render. According to the board members in our focus groups, this is in most hospitals the case for physicians but not for nurses.

> *(…) you want nurses from the wards or from a management function to be in crisis management. Then you get nursing expertise at the table. But this requires a specific skill set which is now absent in our hospitals. You want nurses to be just as well positioned as the physicians. Physicians are well rooted in our line organization and firmly positioned. They too were not at board level from day one. This takes practice and development.* (Board member 1)

This quote parallels the broader talk of some board members where the nursing and medical professions were in talk seen as equal and in need of the same development. However, physicians were seen, by board members, as being ahead of nurses. Board members, in our focus groups, did not talk about their own role in this perceived difference. Furthermore, the development that the board member refers to in the quote above brings forward a paradox; you will get experience by being well-rooted and firmly positioned, and you need experience to participate and to be firmly positioned. Furthermore, board members were not consistent in their talk on this. On the one hand board members talked about the necessity of organizational skills and positioning, as mentioned above. And, on the other hand, they fore fronted the need for substantive knowledge for effective crisis management. Knowledge of infectious disease, for example. This inconsistency is portrayed in the following quote.

> *(…) councils are here for participation. They signal and test but are not primarily in the line of the organization and therefore they were not part*

> *of crisis management at strategic level. At that level we do of course have several medical specialists from their specific expertise, relevant to the crisis.* (Board member 2)

Such highlighting of the necessity of medical expertise, as in the quote above, downplays the importance of nursing expertise. Moreover, this shows that nurses are dependent on (among others) board members for their positioning and voicing.

Discussion

Our paper contributes to the relational, nursing leadership, and governance literature by elaborating on the role of talk and interdependency in hospitals in crises. We explored how the talk of board members can be understood as a discursive leadership practice in positioning nurses in crisis. We found that board members are appreciative of the practical contribution nurses have. However, they are not actively working as "strategic positioners" for nursing in crisis management structures. Furthermore, in contrast with theories on interdependence, board members reflect on and pose the positioning of nursing foremost as a task of nurses themselves, and as a profession that is practical, ambiguous, and distinctive from the medical profession. We discuss our findings and reflect on the power of talk in hospital crises.

Influence of talk on positioning

Our findings show that what board members say about nurses influences the positioning of nursing in strategic crisis management. This aligns with extant literature on talk and its influence on positioning (Greenhalgh et al., 2023; Oldenhof et al., 2016b). However, this literature states that the influence of talk is dependent on hierarchical positioning (Essex et al., 2023). However, this is too limited as organizational interaction is more complex than just organizational hierarchy. In other words, agents have certain role expectations (Anglin et al., 2022) of themselves and others and this is materialized in influence and talk (Lopez-Deflory et al., 2023b). Kee et al. (2021) highlight that an excessive focus on hierarchy can diminish the value of expertise, adversely affecting organizational performance. Within our focus groups, it became evident that board members often positioned themselves as detached from the nursing crisis positioning process. They frequently asked questions and offered suggestions to assist nurses, reflecting what Porter-O'Grady (2023) terms "parentalism" in nursing—a stark contrast to nursing's professional aspirations. This gap between perception and practice is perpetuated by the

language, infrastructure, and overall dynamics within boards, management, and also within nursing. Moreover, our focus group discussions revealed a consensus among nurses that they excel in preparatory tasks rather than strategic roles during crises. And, therefore, as Lopez-Deflory et al. (2023a) state dominant approaches toward nursing agency deny the interdependency with and responsibility of other agents, for the positioning of nurses. Thus, board members and nurses need each other to reach a more effective interdependent collaboration based on expertise instead of hierarchy or "parentalism."

Positioning and interdependence

In our focus groups, board members referred mostly to the structures and processes for decision-making during the crisis and less to relational work and interdependencies between them and nurses. This aligns with extant board literature (Carroll et al., 2017; Kane et al., 2009) where the relational work of boards focuses on internal board dynamics and interactions with others concerning the board's direct tasks. However, Bogue and Joseph (2019) recently showed that an interdependent stance of board members leads to nursing empowerment and strategic alignment, performance improvement, and retention of nurses. The latter are priorities for boards in this time of unprecedented labor shortages, according to our participants. Moreover, recent literature on effective teamwork in health care shows a clear task for management and clinicians to collaborate effectively and embrace interdependence (see, e.g., Mayo, 2022; Mayo et al., 2023). And, all this aligns with the recent statement in The Lancet (2023) that adequate positioning of nursing strengthens global health systems. Positioning is, therefore, an interdependent process (Barge, 2012) based on co-construction and relying on access given and access taken by different agents, such as board members (Nembhard & Edmondson, 2006). Having a certain skill or competence alone is not enough to realize positioning in the complexity of social organizational interaction between board members and nurses.

Ethnographic and practice research approaches in leadership studies (Kok et al., 2023; Martini et al., 2023; Raelin, 2016a, 2019) can help unravel these processes of positioning, interaction, and interdependence and enhance collaboration between nursing and non-nursing agents in complex settings such as crisis management in hospitals.

Interdependent and distant

In contrast with other participants in the focus groups, board members reasoned more *'from a distance'* (Stoopendaal, 2015). Highlighting this as part of the influence

on the positioning of nurses in crisis management unintendedly fuels a limiting narrative of a disadvantaged nurse and/or a detached board member. These limiting narratives are not helping in bettering the positioning of nursing (see, e.g., D'Antonio, 2006; Lopez-Deflory et al., 2023a). However, from a relational leadership approach, the discursive practices (Barge, 2012) are complex and social interactions (Greenhalgh et al., 2023; Hosking, 1988; Hosking & Haslam, 1997). From that rationale, nurses also influence how board members talk. Nevertheless, we cannot deny the asymmetric power relations (Aspinall et al., 2022; Kee et al., 2021) and the gendered images (Essex et al., 2023; Langley et al., 2019) that exist of and between board members and nurses in crises. As Lopez-Deflory et al. (2023a) recently stated; *'Nurses play an active role not, only in the reproduction of the institutional status quo which maintains their subordination, but also in the challenge of the complex network of power that constitutes its subordination (…). Nurses should not be considered as the only ones responsible for this'* (2023a, p. 6). Our findings are, therefore, better seen as a contribution to understanding the reasoning, world, and logic of board members in crisis management toward nursing through an analysis of their talk. Then, the stewardship and agency of both the board members and the nurses are taken into account and the focus is on the dynamic process of interaction (Langley et al., 2019; Verhoeven, Loo, et al., 2023).

Furthermore, literature on interdependence and collaboration clearly leaves no room for board members to position themselves solely as distant and observing leader (see, e.g., Mayo, 2022). Especially, in the dynamics of crises, board members should actively participate in, and position expertise directed at managing the crisis. More empirically grounded knowledge can help to better understand collaboration in crisis and consequently help in highlighting the importance of interdependence as a tenet for collaboration in health care crisis management.

Strengths and limitations

This study is a valuable addition to the dominant nursing leadership and governance literature. The literature is focused on individual skill and trait. Our study, however, shows the relevance of a relational perspective on leadership. It advances relational leadership theory by using it as a research "lens" (Ospina et al., 2020) to show how talk can be understood as leadership practice (Uhl-Bien & Ospina, 2012) between collaborating agents in crisis. Furthermore, the video recordings enabled us to frequently observe the talk and interactions of participants.

Nevertheless, this study also has limitations. First, our findings focus on the performativity of talk in practice (Oldenhof et al., 2016b) and, although the focus groups functioned as a multilogue (Uhl-Bien, 2006), what people say is not necessarily what they do in practice (Schatzki, 2016). More practice-oriented methods such as shadowing (Lalleman, Bouma, et al., 2017; McDonald, 2005) and detailed analysis of organizational talk in situ (Fairhurst & Uhl-Bien, 2012) can make the influence of talk on positioning in practice and the agency of the nurses in crises settings (Lopez-Deflory et al., 2023a) even more tangible. Second, due to the temporal constraints of an ongoing pandemic, we did not member-check our findings. Ideally, we would have repeated the focus groups with the same groups to substantiate the findings and make them more transferrable to other settings (Schwartz-Shea & Yanow, 2012).

Conclusion

Taking talk seriously as a discursive leadership practice is imperative to the positioning of collaborating professionals in crisis settings. The role of board members is crucial in crisis positioning due to their central, oversight, and hierarchical position. However, board members enact a "parentalistic" (Porter-O'Grady, 2023) distance to the process of the positioning of nursing in crisis. In their talk, board members seem to disregard the interdependency they too have on nurses, and nurses let them. Nevertheless, working in crisis is inherently interdependent and, therefore, to position and to be positioned is a matter of involving all actors in the health care system. Focus on talk is crucial for all working in health care and especially for collaborating in future health care crises.

FOUR

NURSES' RELATIONAL LEADERSHIP STRUGGLES ON POSITIONING IN STRATEGIC HOSPITAL CRISIS MANAGEMENT: A QUALITATIVE-INTERPRETIVE STUDY.

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Abstract

Aim(s): To understand how nurses experience their positioning amidst hospital crises.

Background: Nursing leadership literature is predominantly focused on the skills and competencies of nurses and less on the relations in practice with nurses. Nurses are often valued for bedside care but are overlooked in strategic decision-making during crises. Foundational research emphasizes the need for nurses' equal participation in interprofessional healthcare practices and governance.

Methods: We conducted a qualitative-interpretive interview and focus group study, amidst the COVID-19 crisis. We interviewed 64 chairs of nurse councils and deepened our understanding of our initial findings in four focus groups with 34 participants.

Results: Nurses differ widely on (a) what is important to them in crisis management, (b) how they can contribute to crisis management, and (c) how they value their involvement or lack of it. Furthermore, we uncovered three relational leadership struggles for nurses concerning (1) navigating, (2) positioning, and (3) collaborating, in crisis management structures.

Conclusion: The ailing positioning and representation of nurses in crisis management result from their limited participation in strategic decision-making, and the lack of intervention on this by board members, physicians, and managers.

Implications for Nursing Management: This study highlights the need for agents such as board members, managers, physicians, and nurses themselves to create clear frameworks and policies that define nurses' roles in crisis situations, emphasizing the importance of addressing power dynamics and enhancing communication and collaboration in hospital settings. Effective crisis management requires involving nurses from the start, providing regular training, and promoting a more equal approach to teamwork. Understanding relational leadership and its impact during crises can empower nurses and improve overall hospital crisis response.

Introduction

Nursing leadership plays a crucial role in ensuring and providing quality care during hospital crises (Ahlqvist et al., 2023; Kvist et al., 2022). According to Kim (2021), nursing leadership in crisis is *'clear, fast, and frank communication and a high degree of collaboration; sharing of information; decision-making and fair prioritization; building trust; and competency'* (p. 4). However, recent research indicates that professional nursing governance structures, which empower nursing leadership, are often overlooked in strategic decision-making during such crises (Porter-O'Grady & Pappas, 2022). Most nursing leadership literature focuses on individual attributes such as style, traits, and skills (Cummings et al., 2018; Jordal et al., 2022; Porter-O'Grady, 2023), which contrasts with the growing emphasis on leadership as a collective, relational, and ongoing process (Ospina et al., 2020).

Healthcare crises act as a *stress test* for relational and collective leadership within hospitals (Petriglieri, 2020) because these situations demand collective awareness (Porter-O'Grady & Pappas, 2022), collaborative efforts (Wallenburg et al., 2021), rapid decision-making (Kvist et al., 2022), and cooperation across organizational and professional boundaries (Langley et al., 2019). As Martini et al. (2023) highlighted, nurses need to navigate relationships, influence social structures, and gain the trust and respect of key stakeholders, such as board members, managers, and physicians, who dominate strategic organizing during crises.

Positioning in the strategic management of hospital crises is a highly interdependent and relational leadership task (Cardiff et al., 2023; Uhl-Bien, 2006). Despite this, clinical nursing leadership remains primarily focused on bedside care (Cummings et al., 2021; Porter-O'Grady, 2023), which suppresses broader professional nursing organizing work(Allen, 2018; Kuijper et al., 2024). This narrow focus hinders the necessary relational work for collective strategic positioning in crisis management (Sansolo et al., 2022).

Therefore, there is a need for a practical and relational approach to nursing leadership (Ahlqvist et al., 2023; Kee & de Jong, 2022). This approach should complement the existing literature and practices, particularly regarding the relevance of relational nursing leadership during crises. This study, therefore, used a qualitative-interpretive methodology to explore nurses' experiences during the COVID-19 crisis, focusing on relational leadership and crisis management. Findings revealed significant differences in nurses' perspectives on crisis management and highlighted key leadership struggles in navigating, positioning, and collaborating.

The study's findings can help agents in hospitals to be better prepared for the positioning of nurses and collaboration between professionals. According to Kvist et al. (2022), such collaboration leads to better decision-making and empowerment of all agents involved.

Background

Relational leadership processes in crises

In the nursing leadership literature, there has been an overreliance on the transformational model of leadership (Hutchinson & Jackson, 2013) and the "focal leader" (O'Donovan et al., 2021). This focus has emphasized skills and traits (Cummings et al., 2021), portraying nursing leadership mainly as "effective leadership" (Martini et al., 2023). However, following the practice (Carroll et al., 2008) and relational (Uhl-Bien & Ospina, 2012) turn, relationships have received increased attention in nursing leadership and governance research (Cardiff et al., 2023; Cummings, 2012). Despite this shift, the literature still primarily focuses on interpersonal relationships (Cardiff et al., 2023), relational skills (Kanninen et al., 2021), and leadership styles (Cummings et al., 2018). According to Uhl-Bien (2006), such approaches to relations are entitative, focus on individual agency, and consider agents involved as *'independent, discrete entities'* (Uhl-Bien, 2006, p. 655). A relational, processual approach departs from *"processes and not persons, and views persons, leadership and other relational realities as* made *in processes"* (Hosking (2006) in Uhl-Bien, 2006, p. 655, emphasis in original). Relational leadership is then a plural and collective form of leadership (Uhl-Bien, 2006), as are distributive, shared and leadership-as-practice (Ospina et al., 2020). From this perspective, leadership is seen as an *'iterative and messy social process that is shaped by interactions with others'* (Sayles (1964) in Uhl-Bien, 2006, p. 664). This fits with the understanding processes of positioning by nurses, and other agents, in crisis settings (Verhoeven, Marres, et al., 2023).

Positioning of nurses in crises

The frames of nursing as a powerless (Lopez-Deflory et al., 2023a) and exceptional profession (D'Antonio et al., 2010) are paradoxical and have historically led to *'circumstances of marginalization, invisibility, and gender biases'* (D'Antonio et al., 2010, p. 207). Furthermore, the acknowledgment of nurses as professionals has not led to a change in the (organizational) positioning of the nursing profession (Kanninen et al., 2021). Consequently, the positioning of nurses in the recent pandemic was poor and is reviewed critically (Porter-O'Grady et al., 2022).

According to Porter-O'Grady (2023), nurses have widely received appreciation for their bedside work but have been neglected as professional experts in strategic decision-making during this crisis.

The work of, among others, Porter O'Grady and Finnigan (1984) laid the foundation for research on such strategic, shared, and professional positioning and governance of nurses. This work created a structure for positioning of *'(…) professional nurses as an equitable partner in translating clinical principles into interprofessional practices and relationships across the healthcare continuum.'* (Porter-O'Grady et al., 2022, p. 249). According to Porter-O'Grady and Pappas (2022), professional governance encompasses *'(…) decisions about practice, quality, competence, and knowledge. (…) (and these) are the substance of the work of a profession and, by both regulation and disciplinary mandate, are drivers of the life of the professions in the world.'* (p. 218). However, these governance structures affect not only the positioning of nurses alone but also the positioning of other agents (i.e., board members, managers, and physicians) in hospitals. This interdependence seems to be overlooked in the professional governance literature and practice. Moreover, this neglect of interdependence of nurses and others hinders the involvement of nurses in strategic decision-making (Promes & Barnason, 2021), and this is not the responsibility of nurses alone (Kvist et al., 2022; Lopez-Deflory et al., 2023a). However, how nurses themselves enact their (relational) leadership, work with interdependence, and belief in the importance of their voice and positioning are essential in strategic crisis management (Kiger, 2021; Kvist et al., 2022). Our study was, therefore, led by the question of how do nurses perceive their positioning in crisis management, from a relational leadership perspective?

Methods

Study design

We used a qualitative-interpretive approach (Schwartz-Shea & Yanow, 2012) and used individual and focus group interviews to capture "the meaning of lived experience" (Langley & Meziani, 2020, p. 9). This approach and these methods fit with the aim of our study to enhance the understanding of how nurses in Dutch hospitals, amidst COVID-19 pandemic, perceived their positioning in crisis management.

Context of crisis in the Netherlands in early 2020

On the 11th of March, the World Health Organization (WHO) declared the COVID-19 outbreak a pandemic (Freysteinson et al., 2021). Late March, the crisis reached a peak in the Netherlands due to the shortage of personal protection equipment (e.g., high-quality face masks and gloves), (specialized) nurses, intensive care unit (ICU) beds, and ventilators (Wallenburg et al., 2021). The pressure, however, was not evenly spread over all 72 Dutch hospitals as mainly the hospitals in the South of the Netherlands were overrun by very sick and dying patients. At this time, the Dutch society, as most of the world, was in a state of crisis. Internationally, the general opinion was that nurses played a crucial role in keeping the healthcare infrastructure afloat (Wallenburg et al., 2021).

Data collection

The research was conducted between April 2020 and December 2021. In April 2020, interviews (N = 46) and email exchanges (N = 18) with nurses took place. In addition, based on the interview data, four-member check focus groups (Birt et al., 2016), with 34 participants, were conducted in June 2021. Figure 1 visualizes this research process.

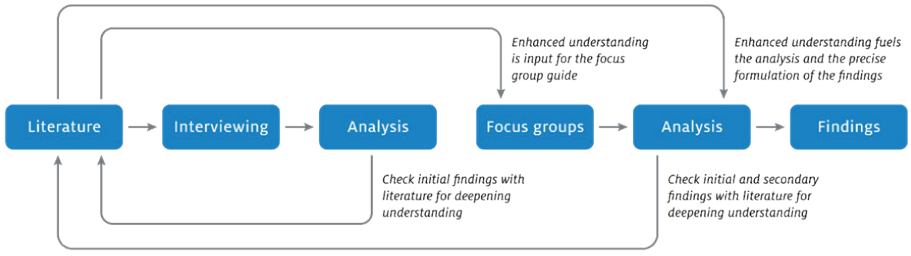


Figure 1. Visualization of the research process

Interviews with nurses (April 2020)

Via a database from the Dutch Nurses Association (i.e., V&VN), we emailed the chairs of the nurse councils of all 72 Dutch hospitals. These chairs were registered nurses (RNs), and worked, besides their chairing work, on the wards, during data collection. Therefore, in this paper, we refer to them as nurses.

We made an interview topic guide based on nurses' first-hand experiences in crisis management and emailed the interview questions (see Appendix A) prior to the interviews. We interviewed 46 nurses via (video)calls, in a 13-day timeframe. The other 18 nurses answered our questions by responding to our email because they were unable to be available for our interview.

The interviews were conducted by the first author and last author, and eight other interviewers. All interviewers are knowledgeable about the work of nurses and specificities of (Dutch) hospital governance. The interviews were guided by eleven open-ended questions regarding the role, involvement in hospital crisis management, voice and leadership, relationality with other organizational actors, and foreseeable involvement of nurses in the postcrisis organization of care processes. All participants were asked to score their involvement in strategic crisis management on a scale from 1 (no position) to 10 (excellent position) and to elaborate on their score. This was done to elicit (Barton, 2015) a discussion on what nurses experience as positioning (e.g., "Why do you score a six? What would have made it a seven?").

In four of the 46 interviews (9%), no score was given, or was, in hindsight, ill substantiated. In addition, in four of the emails (22%), the explanation of the score was insufficient. Therefore, 56 useable scores were included as data.

All interviews were audio-recorded (> 21 h) and transcribed (466 pages). The average interview duration was 28 min. Per interview, a summary was made directly after the interview and sent to the interviewee for a check. Informed consent was initially audio-recorded and afterward retrieved via emails. Table 1 gives an overview of the interview data per type of hospital.

Focus groups with nurses and various agents (June 2021)

After the initial analysis of the interviews, we found that the interdependence between nurses, managers, physicians, and board members, in crisis management, stood out. We therefore emailed all our interviewees in January 2021 and asked them to participate in a focus group interview and to invite representatives of these groups for focus group discussions on the positioning of nursing in crisis from different perspectives. We received more response than anticipated. We, therefore, added a fourth focus group. In total, 34 participants from 12 general hospitals and three academic medical centers participated in the focus groups, in June 2021. Topics were based on the analysis of the interviews: collaboration, decision-making, learning, structure and governance, and positioning (see Appendix B). Because of the relational nature of these topics and to elicit (Barton, 2015) a dialog between various involved agents, we composed each group with a mix of board members, managers, nurses, and physicians from different organizations. The aim was to make the groups as diverse as possible.

All focus groups took place via ZOOM© and were chaired and observed by the first author (A.V.) and last author (P.L.). The observations were discussed directly after each focus group and led to brief reports, which were used in the following focus group meetings. All focus groups were video- and audio-recorded and transcribed. The recordings, transcripts, and discussion reports (10 pages) were used for analysis. All participants gave informed consent prior to the focus groups. This study is compliant with the COREQ-standard (Tong et al., 2018). Table 2 shows the data collected with the focus groups.

Data analysis

We familiarized ourselves with the audio and video recordings, the transcripts, and the observation reports. We used Atlas.ti© software for the coding process. Research memos and timestamps logged the process of the researchers during familiarization and coding for reflexivity and rigor. This is consistent with the interpretive description methodology (Ocean et al., 2022) and led to insights into how crisis management was structured in different hospitals.

Furthermore, with the use of Microsoft Excel©, we plotted the process of involvement in crisis management and the different scores that the interviewees gave to their involvement. We ran different analyses in Excel to see the relations between the type of hospital, the moment of involvement, and the given valuing score for involvement. We read the transcripts to filter on understanding the value of the scores given. In eight interviews and emails, the scores were missing or ill substantiated. We eliminated these from the data. Understanding the background of the scores given led to plotting the scores on a three-part scale in low (1–5), medium (6–8), and high (9-10) scores. This leads to a better representation of the scores given and the explanation thereof given by the participants. An overview is enclosed in Appendix C.

Furthermore, iterative rounds through the data using Atlas.ti© and discussions on our findings enabled us to deepen the analysis and reach beyond initial themes (Thorne, 2020). Moreover, the influence of the talk by the board members on positioning and voicing stood out in the analysis of the focus groups. We, therefore, ran a separate, additional analysis on this part of the data and reported on this in a separate paper. This paper focused on the perspective of board members (Verhoeven, Marres, et al., 2023).

Table 1. Participants and data interviews.

Type of hospital	# Participating hospitals	# Interviews included	# Emails included	Duration (# min)	# Pages transcript	# Usable scores
AMC*	8	8	0	252	85	6
General	29	19	10	457	167	26
Top clinical**	27	19	8	603	214	24
Total	***64***	***46***	***18***	***1312***	***466***	***56***

* Due to a merger, there are seven academic medical centres (AMC) in The Netherlands since 2018. Nevertheless, the nurse councils were not merged at the time of the interviews and both were interviewed for our study. Hence, the 8th AMC-entry in our data set.

** Besides academic and general there are also so-called top clinical hospitals (26) in The Netherlands. These hospitals have a more specialized infrastructure for complex care than general hospitals. (See https://www.stz.nl/over-ons/stz-ziekenhuizen/, visited on 5th of February 2023). Antoni van Leeuwenhoek and Princes Maxima Centre for (child) oncology are specialized hospitals and are in this study labeled 'Top clinical' to warrant anonymity.

Table 2. Participants and data focus groups.

Focus group	# Different participating hospitals	# Participants	Board member	Manager	Nurse	Physician	Duration (# min)	# Pages transcript
1	7	7	1	1	4	1	100	24
2	8	9	2	2	3	2	94	22
3	7	10	2	1	4	3	105	24
4	8	8	2	2	3	1	99	22
Total	**15**	**34**	**7**	**6**	**14**	**7**	**398**	**92**

From the analysis of the interviews and focus groups emerged three relational leadership struggles specifically for nurses. In this paper, we report on these struggles.

Findings

We present our findings, first, by unpacking the organization of crisis management in the hospitals. Second, we show the data on how nurses perceived their involvement in crisis management, and third, we present three relational leadership struggles for nurses that emerged as such from our abductive analysis of the interviews and focus groups.

Organizing crisis management

In the interviews and focus groups, much was said about how the crisis management was structured in different hospitals. In general, the crisis management structures consisted of operational teams and a strategic crisis management team. The operational teams were structured around topics such as safety, deployment of personnel, and collaboration with other institutions. They prepared policy and advised the strategic crisis management team on decisions to take. The strategic crisis management team was leading and took decisions that were executed by the operational teams and/or other organizational units.

We learned that this formal structure developed over time. In the focus groups, participants stated that at the start of the crisis (March 2020), there was a strict "command structure" with rules and hierarchy determining decision-making. From July 2020 onwards, this developed into what a participant called a "deliberation structure." This was often referred to as a diffuse situation because there was a crisis management structure, but there was no crisis anymore in the sense that COVID no longer had the characteristics of a crisis (unanticipated, ambiguous event that is a significant threat). The crisis management structure, however, held priority over the daily (hierarchical) organizational management structure. In the focus group discussion, this role's ambiguity was referred to as hindering clear positioning of groups, such as nurses.

Perceived involvement of nurses in crisis management

Interviewees differed widely on how they perceived and valued the involvement of nurses in crisis management.

In only four hospitals, nurses were directly involved in crisis management from the early start. In these cases, the nurse council (hereafter council) was invited to participate by an executive hospital board member (hereafter board member) in the strategic crisis management team.

Twenty interviewees reported that they were involved in crisis management after they themselves requested to be structurally involved. These requests were all done via a board member. In most cases, these nurses were referred by the board member to the chair of the strategic crisis management team for their request to participate.

No less than forty interviewees reported that they were not involved in crisis management in their hospitals. Of these, in 14 hospitals, a request by the nurses for the involvement toward the chair of the strategic crisis management team or directly to the board was either declined or ignored. On two occasions, the reason for declining participation was the hospital's crisis management policy that participation bodies (such as the council) were not seen as necessary to bring in specific expertise because other frontline professionals were given the task of providing nursing expertise. Councils regarded this a valid and acceptable decline because nursing expertise was believed to be secured in the crisis management structure by either frontline nurses or nurse managers with adequate expertise.

Furthermore, 13 nurses reported that no or little involvement was acceptable to them if timely and adequate information was given or when nursing expertise was guaranteed.

Three interviewed nurses stated that nursing expertise was absent in crisis management and their request for involvement in crisis management was declined. In these cases, either a management representative involved was considered to be sufficient by those responsible for crisis management or nurses were not seen as essential in crisis management. Both reasons were not acceptable according to the interviewees. The former—commitment of a management representative as sufficient to bring in the nursing expertise—was to the interviewees striking. One of the interviewees stated on this:

> *So, it is a manager that represents nurses in crisis management. (…) I had a discussion on this topic with a physician. He told me "What are you whining about? Lisa is at that table representing you, right!?" And then I said, "Well, she is not working as a nurse, now, is she?". On which*

he replied, "Well, she was once, wasn't she?" And then I asked him if this would hold for the medical manager (who is not practicing medicine for some time)? And he replied, "No, of course not, but this is different for nurses, is it not?" It is these beliefs that are persistent and to me really disappointing. And he (doctor) is not the exception. (Interview nurse, hospital 33)

Scoring of satisfaction on involvement in crisis management

In our interviews, nurses scored and elaborated on their involvement in crisis management. Of the 56 scores, there were three "high" scores. Thirty-one nurses gave their involvement a "medium" score, and 22 valued this as "low." The distribution of scores across academic, general, and top clinical hospitals is shown in Figure 2.

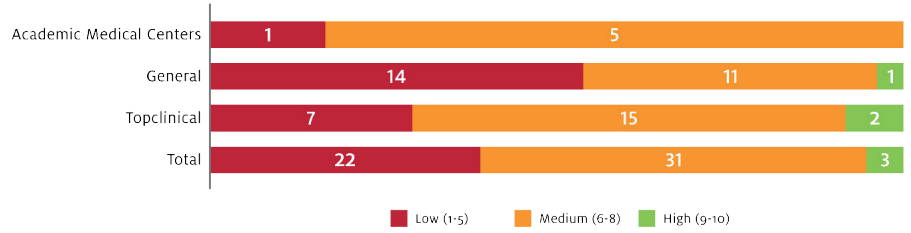


Figure 2. Scoring of satisfaction on involvement in crisis management

Access to information, being informed, level of participation in crisis management, and being heard by the board were the most influential factors for the scores (e.g., valuable information led to a higher score, and no access to the board led to a lower score).

We learned that the score of the involvement in crisis management and the actual involvement differed. What stood out, for instance, was that the interviewees of academic medical centers mostly scored their involvement as "medium," but none were involved in the strategic crisis management team. Their score was substantiated with arguments referring to how they were informed on crisis management, how other involvement of nursing expertise was organized in their hospitals, and when appropriate the nurse council was consulted as a participation body. One of the interviewees stated on this:

No, we as council are not involvement in crisis management. When we realized this, we checked with the nurse managers—who have been well organized for the last two years—whether they were involved, and

> *when we found out that they were we let it be. (…) For us as council it is most important that wards are prepared for COVID and non-COVID, adequately, and with the right staff. (…) We are regularly informed by the board and at times consulted on council topics. This is sufficient, for now.* (Interview nurse, hospital 6)

Therefore, being informed stood out as why a lack of direct involvement of our participant was acceptable, at that moment in the crisis. Three paths of information were distinguished by our interviewees: first, direct information from the board, second, information via members of the council who also worked as nurse managers and participated in crisis management in their management role, and third, information reaching the council informally from co-workers who were in diverse ways involved in or informed about crisis management. On some occasions, the informal information also came from a board member.

From the interviewees we learn that in some cases, the absence of nursing representation in (initial) crisis management is due to "simple" facts such as that nurses were missing on the lists of people or bodies that need to be informed, consulted, or involved in the case of emergency or crisis in mandatory and standardized organizational emergency plans. In contrast, according to the interviewees, management and medical representatives are always mentioned in these plans.

In other cases, not involving councils or securing nursing expertise at strategic crisis management level in other ways was a deliberate choice by crisis management or boards. This was mostly because nurses were seen as being of more added value in an operational team. There were also cases wherein councils themselves decided that strategic crisis management was for others to manage and that nurses needed to be on the front line of care, as we learn from the quote below:

> *Well, when we are asked last week which strategy, we as council had chosen for our involvement my first thought was; 'Did we do the right thing?'. But you know, at that moment when the corona crisis broke out in full force and that it, uhm, that the whole hospital was turned upside down and became a, uhm, corona hospital. Well then, we went with the flow. We rolled up our sleeves and went to work. We did not reflect on our position or strategy. We just went in.* (Interview nurse, hospital 70)

Relational leadership struggles of voicing and positioning in crisis

In our analysis of the interviews and focus groups, we found three distinct relational leadership struggles for nurses: navigating, positioning, and collaborating in times of crisis. We coin our findings as struggles to stress the perceived complexity by nurses of relational leadership in crisis. We elaborate on each of these three struggles and highlight these with quotes.

Navigating

The struggle of navigating was part of the crisis but was, for the interviewees, intensified because of decisions made at the start of the crisis and the limited possibilities given by other agents to restore this ambiguity on tasks, roles, and positioning.

For all working in a crisis management structure, this was new, and there was no guideline on who was supposed to do what in this situation. This led to insecurity and ambiguity. Furthermore, the scale of the crisis and the call to nurses to contribute to the frontline of care made navigating in what was wise to do complex. In addition, as one of the interviewees stated, "there was no manual."

Part of this struggle was the complex decisions that some nurses felt forced to make between organizing work and direct, frontline nursing work. Overtaken by the crisis and in hast, most decided to contribute to direct care. This led in numerous hospitals to unmanned councils and was seen as a "surprising move," by board members and managers in our focus groups. However, we learned that they took no action on this "surprise." One of the nurses said

> *So, no, we were not clear in why we wanted to be in a operational team, or that we should be in the strategic crisis management team. (…) No, we did not make that clear, and honestly, I don't think we were able to live up to that either. (…) But in hindsight, I wish we had been more persistent. It would have been a lot of work but it would have helped us (nurses) enormously in staying in tune with the (crisis) organization. Now that we are not in we can't keep up and are not informed well enough to do our council tasks.* (Interview nurse, hospital 20)

In this quote, the struggle for navigating expectations becomes apparent. Furthermore, it highlights the interdependencies between agents on information and expectations.

However, time to consider the task at hand and the role of the council in crisis was absent, according to the interviewees. According to one of the nurses, this led to complications in the role and task navigation later in the crisis. He stated:

> *Well, my personal experience is, that when we went to the chair of the board earlier this week to pass on signals we received—negative signals—on flexpool and other topics, well, then, he sighs, so to speak. So, well, of course it is not nice to receive these negative signals from your nurses, but I do feel this is our task here. (…) And, this is important; be clear on the task you take up, so you don't run too fast for others to understand what you are doing.* (Interview nurse, hospital 20)

It becomes clear that relating and attuning was important for nurses to navigate the channels of information and tasks in crisis and that such processes come with responsibilities for other agents, such as the chair of the board in the quote above.

Positioning

Positioning highlights the interdependencies between agents and is therefore part of relational leadership work. Positioning also affects how, for instance, nurses are informed and are able to contribute to organizing work in crisis.

The struggle for positioning unfolds between how the council presents itself and how the council is perceived and positioned by other agents (i.e., board members, managers, and physicians) and the nurses on the wards of the hospital. From one of the emails, we received in response to our request for an interview, we learned

> *I find it hard to determine how satisfied we are with involvement. I would score it a 5 because we are not involved. Then again there is medical and nursing expertise represented in crisis management. When we proposed to the board member that we would participate in crisis management she replied that this is not a job for participation bodies such as the council because there is a need for direct care expertise and therefore front line professionals.* (Email nurse, hospital 45)

Although all interviewed nurses were also working as nurses on the wards, the quote highlights that the positioning of the council and the possible contribution to crisis management are unclear to the board member, and this leads to a certain positioning on which the nurse has little influence.

In contrast with nurses, we learned that formal management roles of physicians led, automatically, to positioning in (strategic) crisis management structures. However, although some of our nurse interviewees also had such "double roles" (i.e., being a member of the council and being a nurse manager), our interviewees expressed concerns for how the crisis management structure depended on the general quality of nursing expertise from managers. One interviewee informed us as follows:

> *The managers are not nurses, anymore, if you ask me. But they participate in the crisis management structure as nurse representative, and of course they have some knowledge, but in this way nursing expertise is missing, in my opinion.* (Interview nurse, hospital 33)

The interaction between nurses at the wards and managers of nurses was also linked to exchanging information as part of positioning. One of the interviewees stated that contribution was central to the goal of positioning:

> *We are well connected to the work floor; a representative of each ward is represented in our council. So, this makes it easy to discuss and check 'are things taken care of, or are we missing anything', positive or negative. Also, positive things can be informative to encourage to stay on a certain track.* (Interview nurse, hospital 13)

This quote shows not only the goal of contribution but also how positioning opens channels of information. These channels can lead to collaboration, but to an extent, these also constitute the information dependency of nurses on other agents. Our interviewees informed us that they were mostly okay with not being part of the (full) crisis management structure but that they experienced unwanted information dependency. This conflicted with the tenet of the council to be informed and able to advise or mobilize based on an informed status.

Collaborating

Collaborating was seen as a process influenced by expectations and the interaction between organizational and crisis management structures. The ambiguity of the context (i.e., crisis and confusing structures) influenced processes of collaborating and had a backlash on the possibilities for nurses to position themselves because it was unclear who had what position.

Furthermore, in the interviews and in the focus groups, it became apparent that the meaning of collaborating is influenced by the perspective (e.g., nurse, physician,

manager, and board member), context (e.g., crisis and noncrisis), and hierarchy (e.g., subordinates versus "superordinates"). While managers and board members (i.e., "superordinates") often named the constructive and pleasant collaboration with nurses, nurses highlighted the struggle to find balance between their professional standards and autonomy and what they were ordered to do in the crisis setting by those higher in the hierarchy.

Furthermore, in the focus groups, we learned that at the beginning of the crisis, there was no room for discussions on positioning and the ideal organization. There was a strict hierarchy, focused on what participants called "military-like, command and control." The focus was on survival, and the limited space for other kinds of communication appeared to be difficult for nurses.

Furthermore, we learned that attuning between agents is essential for collaborating in crisis, and nurses found themselves as not seen. As a nurse told us

> *But honestly, the board nor the involved managers ever asked us to share our knowledge. Not at all. And we keep telling them 'Hello, here we are, we want to help, and it also concerns nurses and not only physicians, to know how things are going, what decisions are made, and which effects this resort'.* (Interview nurse, hospital 25)

Furthermore, examples were given by our participants on certain assignments from the top of the crisis management hierarchy that were in contrast with ethics and good practice in nursing such as the limiting of visiting hours for family. This led to tensions that fueled the importance of hierarchical positioning and therewith complicated collaborating.

Discussion

This paper contributes to the nursing leadership literature by examining how nurses struggle with their positioning in strategic crisis management during crises. Our study reveals that nurses are often positioned in practical roles rather than strategic ones, partly due to their own choices that limit their involvement in decision-making. Additionally, our findings indicate that interdependencies among various stakeholders—such as nurses, board members, managers, and physicians—are often neglected in practice, which undermines effective collaboration during crises. Board members and managers typically see nurses as primarily useful for

practical crisis preparation, without recognizing the importance of addressing these interdependencies (Verhoeven, Marres, et al., 2023). Furthermore, our study shows that positioning during crises is intertwined with hierarchical power dynamics and the ability to express one's voice. While hierarchy and enabling nurse positioning can coexist, most nurses reported their involvement in crisis management as "medium" (55%) or "low" (39%).

Below, we will first discuss the practical positioning of nurses during crises, then examine the neglect of interdependencies, and finally reflect on the tension between hierarchical structures and the positioning and voicing of nurses.

Positioning of nurses as practical

The importance of involving nurses in strategic decision-making has been well researched (Fischer et al., 2018) and is seen as crucial for the post pandemic future of healthcare (Feistritzer et al., 2022). In our study, nurses and other agents viewed informing and being informed as acts of involvement. However, being informed is not the same as being positioned to influence strategic decision-making, which can result in poor positioning of nurses in crisis management.

In recent work, Porter-O'Grady (2023) states that, "much of the structure, systemic relationships, leadership approaches, and organizational infrastructures relate to nurses predominantly as a blue-collar employee-dependent work group." (p. 201). This indicates that the inadequate positioning of nurses during crises is not incidental but systemic. Therefore, all agents, including nurses, must work to change the narrative and agency of nurses to ensure their effective positioning in crisis management (Lopez-Deflory et al., 2023a).

Neglecting interdependencies

The relational struggles, central in this paper, were portrayed as struggles of nurses in the interviews and focus groups. However, such struggles are not of nurses but are systemic, relational, and social (Porter-O'Grady, 2023) and highlight interdependence between agents. Seen as such, these struggle are of board members, managers, and physicians as well (Verhoeven, Marres, et al., 2023). Furthermore, although interdependence between professionals is inherent to healthcare and nursing (D'Antonio et al., 2014), the literature on interdependence in healthcare is scarce (Mayo et al., 2021). Moreover, the dominant focus in the interdependence literature is on task interdependence (e.g., what is done) and not on agent interdependence (e.g., who does what) (Raveendran et al., 2020). Agent interdependence encompasses goal setting and expertise between agents and is,

therefore, relational. The little attention to agent interdependence is, according to Raveendran et al. (2020), the consequence of ignoring the shifting complexity of work. For nursing, this involves a lack of acknowledgment of the profession's breadth (Allen, 2018; Khoury et al., 2011; van Wijk et al., 2022). Recognizing the full scope of nursing by others is essential for effective and interdependent collaboration. In other words, if an agent does not recognize another agent as relevant to their task, goal, or knowledge, they cannot begin to cooperate from an interdependent perspective. For example, Verhoeven, Marres, et al. (2023) demonstrated that when the board members acknowledge and consistently position the organizing expertise of nurses, they can work more effectively on quality and safety goals (goal interdependence) and innovate work processes to address staff shortages (knowledge interdependence). These interactions are relational and not typically outlined in job descriptions (Cardiff et al., 2023).

Hierarchy and voice

In our study, we found that positioning during crises is relational and intertwined with hierarchical power and influences the ability to use one's voice. Furthermore, although all agents expressed a willingness to collaborate, those with hierarchical power—such as board members and managers—often seemed unaware of their power and its effects on the voicing of others (Verhoeven, Marres, et al., 2023). Voicing is essential for unlocking the knowledge of all occupational groups, which is key to organizational performance (Kee & de Jong, 2022). However, agents with hierarchical power sometimes limit the voicing and agency of nurses (Kee et al., 2021; Lopez-Deflory et al., 2023a). In the interviews, we found that especially in crises, the influence is blurred and limited due to high stakes and time constraints. In line with this, Martini et al. (2023) stated that for empowerment, agents need to get "wired in" (p. 8). Therefore, agents need to navigate relations in the complexity of practice. This can function as a counterbalance to hierarchical power. Navigating is then dependent not only on skills, competence, or hierarchy but even more on how social structures work and how access to the relevant "tables" is organized in strategic crisis management and decision-making (Freysteinson et al., 2021).

Our study shows that hierarchy and the enabling of positioning should go together. They do not exclude each other. A relevant future avenue for research is, therefore, to study how power structures, from a relational leadership perspective, shift across organizational boundaries (Langley et al., 2019) and how these interact with the positioning and voicing of interdependent agents, such as nurses and board members. It is, therefore, important that nursing leadership research finally embraces relational leadership (Cummings, 2012) as an addition to the dominant

perspective of individual skill and trait. Understanding relationships better in practice is crucial for nurses—and board members and managers—to better position nurses as organizing professionals (Braam et al., 2023; Cummings et al., 2023).

Implications

This study contributes to nursing management by emphasizing the need for clear frameworks that define roles and expectations for nurses in crisis situations. We underscore the importance of addressing power dynamics, role positioning, and representation within organizational structures, particularly in crisis settings. Organizational behavior and power dynamic theories should consider these aspects that ensure nurses have a defined and respected role during crises.

Furthermore, hospital management should prioritize policies that ensure nurses are actively included in crisis management teams from the outset. Developing effective communication strategies is essential to ensure that nurses receive timely and accurate information, which includes establishing direct lines of communication among all team members involved in crisis response. Regular crisis management training programs are also crucial. These programs should equip all team members, including nurses, with the necessary skills and knowledge to perform their roles effectively during a crisis. Training should also address how to manage and reduce hierarchical tensions that may hinder collaboration and should promote a more egalitarian approach to teamwork.

Moreover, it is important to explore the impact of hierarchical structures on collaboration and develop models that facilitate better interprofessional teamwork, particularly under crisis conditions. Understanding how relational leadership operates during crises and recognizing the interdependencies between different agents, including nurses, are vital for effective crisis management in hospital settings. By implementing these strategies, hospital management can foster an environment where nurses are empowered and can contribute fully to crisis response efforts.

Conclusions

The context of crisis entails uncertainty and ambiguity, and this has a backlash on the positioning of nurses in hospitals. Our study shows that positioning of nurses is mostly approached from the frontline work of nurses and disregards their invisible, strategic organizing work in times of crisis. This was, in part, due to how nurses themselves, in the tense crisis context, took position and prioritized caring work over strategic organizing work. However, other agents in the crisis management structures turned a blind eye to the lacking strategic involvement of nurses too. Nurses felt, therefore, at best, engaged, and at worst, not involved. Therefore, the workings in strategic crisis management did not allow for the full blending of professional nursing work and strategic crisis management, and this hindered the interdependent strategic decision-making in crisis. Nurses experience such exclusion as problematic, and this fuels the imperfect positioning of nursing in crisis management.

Limitations and future research

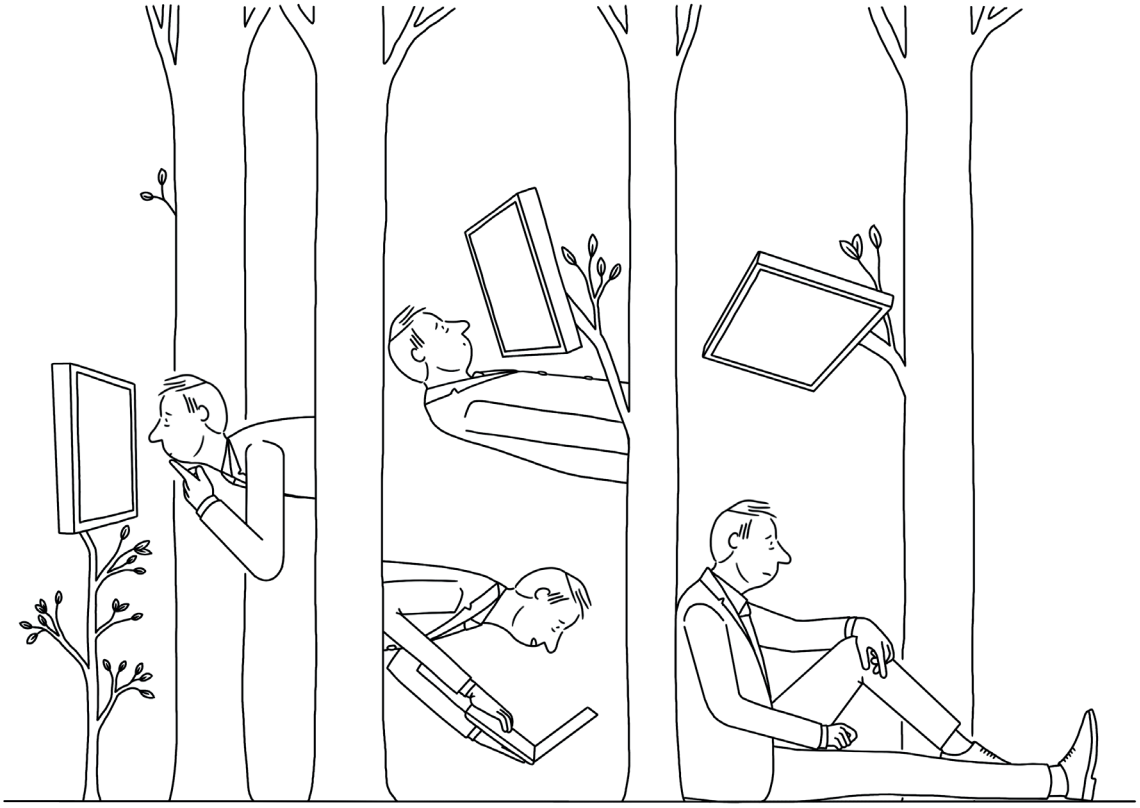
In this study, we used interviews and focus group meetings to discuss the processes of voicing and positioning. Although we validated our findings through member checking (Birt et al., 2016) and adhered to quality measures for qualitative-interpretative research (Schwartz-Shea & Yanow, 2012), we did not observe these processes in situ. Practice-oriented and ethnographic methods can provide insights into these real-time processes (Martini et al., 2023).

Additionally, we collected data over a 13-day period during an unprecedented crisis. With 10 interviewers, we used telephone, video calls, and emails to conduct the interviews. This combination may have introduced unwanted variation in data collection, impacting the study's rigor as we could not return to the field. While our study focused on intraorganizational leadership processes in hospitals during crises, further research is needed on the external factors influencing strategic choices by managers and board members (Kiger, 2021). Understanding how they translate policies and political decisions into their collaborative work with nurses will benefit all agents involved in strategic care organization.

FIVE

RELATIONAL LEADERSHIP IN CRISIS: HOW BUSINESS MANAGERS IN HOSPITALS NAVIGATE ROLE ATTRIBUTION AND ORGANIZATIONAL CHALLENGES

Under review at Leadership: Verhoeven, A., Loo, E. v. d., Marres, H., & Lalleman, P.. *Relational leadership in crisis: How business managers in hospitals navigate role attribution and organizational challenges.*



Abstract

Purpose: The aim of this paper is to enhance understanding of what business managers in an academic medical center in crisis see as their work and role, and how they perceive their leadership practices.

Design/methodology/approach: Our study is a qualitative-interpretative study into the leadership practices of business managers in a Dutch university hospital. We used a combination of at-home ethnography, in-depth interviewing, elicitation techniques, and member check focus groups.

Findings: We found that when managers in our study describe leadership during crises, they emphasize skills and competencies. However, when discussing their own leadership practices during crises, they forefront relational practices and how other organizational members attribute leadership to them. They emphasize three key aspects: 1) crises magnify both the strengths and weaknesses in organizational processes, 2) listening, shielding, and providing support to their teams are essential practices, and 3) decision-making and connecting internal networks are intertwined.

Originality/value: Our findings show that everyday managerial activities—such as listening, supporting, making decisions, protecting, and connecting—become vital forms of leadership for business managers during crises. Participants view these actions as relational practices, emphasizing that their significance stems from the role, power, and influence granted by colleagues and senior management.

Keyword

relational leadership process, middle manager, role attribution, hospital, crisis

Introduction

Middle managers possess a dual understanding of both their organization's strategies and its social structure (Kempster & Gregory, 2015). This knowledge allows them to stay connected with ongoing operations and safeguard employee well-being, especially during times of change, such as crises (Mackay et al., 2022; Mintzberg, 1989). Gjerde and Alvesson (2019) recently coined the term 'middle-levelness' to describe the balancing act these managers perform between senior management ambitions and workplace expectations. Despite the acknowledged importance of this role, leadership research often overlooks its complexity, treating middle managers as isolated entities (Harding et al., 2014; Hartviksen et al., 2019; Tengblad & Vie, 2012).

Most leadership literature focuses on individual skills and competencies (Carroll et al., 2008; Garretsen et al., 2022; Mackay et al., 2022), neglecting the relational dynamics that are essential for middle managers (Espedal et al., 2023; Korica et al., 2017; Roth, 2022). As Sluss et al. (2011) state, *'a role is not lived or maintained 'solo' but relies on the relational incumbents to give it meaning and substance'* (p. 508). Thus, role attribution is highly relational for middle managers (Meschitti, 2018). However, these processes are rarely discussed in relational leadership literature (Crevani, 2015; Uhl-Bien, 2006).

While role attribution theory (Anglin et al., 2022) and relational leadership theory (Uhl-Bien, 2006) emphasize roles and relationships, they differ significantly; the former is often individual and cognitive, while the latter focuses on social interactions. By combining these approaches, we aim to understand how middle managers perceive their roles and leadership practices during crises. Our study aligns with collective and processual leadership approaches (Ospina et al., 2020; Raelin, 2016b), emphasizing process and interaction over individual actions (Cunliffe & Eriksen, 2011). Furthermore, this paper challenges traditional, individualistic views of leadership by interrogating the power dynamics and social contexts that shape leadership practices. With this paper we respond to calls within leadership literature to highlight relational processes as integral to understanding leadership (Ladkin, 2020; McCauley & Palus, 2021; Uhl-Bien & Ospina, 2012).

Background

Relational leadership

Relational leadership (Uhl-Bien, 2006) focusses on social interactions and meaning making in interactions and collaboration. However, there is a distinction in the relational leadership literature between a post-positivist approach and a social constructionist approach (Fairhurst & Connaughton, 2014; Fulop & Mark, 2013). The former emphasizes individual agency and treats agents involved as *'independent, discrete entities'* (Uhl-Bien, 2006, p. 655). In contrast, a relational, processual approach, as advocated by Uhl-Bien (2006) departs from the concept of *'processes, not persons'* (p. 655) Therewith, viewing individuals, leadership, and other relational realities as dynamically linked through processes (Uhl-Bien, 2006, p. 655). Relational leadership, conceptualized as a plural and collective form of leadership (Denis et al., 2012; Fulop & Mark, 2013; Uhl-Bien, 2006), aligns with other leadership forms such as distributive, shared, and leadership-as-practice (Kempster & Gregory, 2015; Ospina et al., 2020; Raelin, 2016b). The processual relational leadership approach shifts the focus to how individuals collectively act, and create change and order, shaping context and action (Cunliffe & Eriksen, 2011; Hosking, 1988; Spyridonidis et al., 2022). Leadership, in this perspective, is perceived as an *'iterative and messy social process shaped by interactions with others'* (Sayles, 1964, cited in Uhl-Bien, 2006, p. 664). This approach fits with the aim to comprehend how middle managers give meaning to leadership, as a significant determining factor of how they take up their leader role responding to crisis, and what is attributed to them in their role as leaders (Smircich & Morgan, 1982).

Positioning and role attribution of business managers

Middle management in hospitals is complex (Oldenhof et al., 2016a), with positioning being crucial for these managers (Gjerde & Alvesson, 2019). Positioning theory, which explores how individuals position themselves and others in social interactions, provides a nuanced understanding of leadership as a collective process involving multiple actors (Meschitti, 2018). This theory highlights how positioning impacts the effectiveness of middle managers, especially in the dynamic environment of hospital management. Understanding middle management practices and their consequences is vital (Tengblad, 2006; Tengblad & Vie, 2012).

Traditional views emphasize planning, organizing, leading, and controlling, while recent perspectives underscore the dynamic nature of managerial work (Azambuja et al., 2022). Role attribution further illustrates how organizational and societal expectations influence individual behavior and self-perception (Anglin et al.,

2022). Biddle (1986) explains that roles are shaped by both others' expectations and individual self-perception. Sluss et al. (2011) expand on this by showing that organizational roles are co-constructed through ongoing interactions, making them fluid and context dependent. They argue that roles create a framework where structured interdependencies organize tasks and responsibilities (Sluss et al., 2011).

However, in crisis settings, such role attribution becomes even more critical and complex. Tarakci et al. (2023) note that middle managers often face shifting roles based on organizational needs. Gjerde and Alvesson (2019) emphasize the necessity for middle managers to navigate various organizational layers while managing evolving expectations. This fluidity requires quick adaptation and balancing hierarchical directives with collaborative engagement (van Schothorst-van Roekel et al., 2020). Understanding this context is essential for grasping how roles and leadership are perceived by middle managers, particularly during crises (Mabey & Morrell, 2011). The interpretations of managerial work by both managers and others shape the positioning and roles of all actors involved (Western & McDonnell, 2022). Therefore, Korica et al. (2017) advocate for a practice-based approach that considers the situated, relational, and socio-material aspects of managerial work (Mintzberg, 1994). We argue that this is especially relevant in crisis settings.

COVID-pandemic in the Netherlands

In early 2020, the Netherlands faced the COVID-19 pandemic, an exogenous shock with significant impacts on society, organizations, and individuals (Garretsen et al., 2022). The first case was officially reported on February 27, 2020, by a Dutch hospital (Rijksoverheid, 2020). Shortly after, the World Health Organization (WHO) declared it a global pandemic on March 11, 2020 (WHO, 2020). As March progressed, the crisis intensified, driven by shortages of essential resources like face masks, gloves, specialized nurses, ICU beds, and ventilators (Wallenburg et al., 2021). This strain was not evenly distributed across the 72 Dutch hospitals; those in southern regions faced overwhelming numbers of critically ill patients. The escalating pressure raised concerns about life-and-death decisions for healthcare professionals, leading to what was termed 'Code Black'.

The crisis prompted unprecedented efforts to coordinate patient referrals and manage hospital capacities (Wallenburg et al., 2021), fostering new relationships and leadership practices. This study examines how business managers in academic medical centers perceived their roles and leadership during this crisis.

Methods

Design

This paper is based on a qualitative - interpretive study (Schwartz-Shea & Yanow, 2012) into the work of business managers in a Dutch academic medical center (AMC) during COVID pandemic. We used at-home ethnography (Alvesson, 2003, 2009), in-depth interviewing (Langley & Meziani, 2020), elicitation techniques (Barton, 2015) and member check focus groups (Birt et al., 2016), in 2020 and 2023, to understand how business managers in an AMC construct their work in times of crisis and what leadership means to them in that context of crisis.

Research context and participants

The AMC in our study is one of seven AMCs in the Netherlands, with over 1,100 clinical beds, nearly 12,000 employees, and a 1.2-billion-euro turnover in 2020.

AMCs play a vital role in Dutch healthcare, combining complex patient care, biomedical research, and professional training (Cardinaal et al., 2022). These AMCs also serve regional and national functions, particularly during COVID-19, when they coordinated care efforts due to their advanced infrastructure in imaging, care facilities, and laboratories.

The eight business managers in our study had five to twelve years of management experience. They had diverse backgrounds in finance, law, and business management, and ranged in age from mid-thirties to mid-fifties. Four of the managers were men. These managers oversaw non-medical affairs in medical departments, including budget management, process optimization, and clinic supervision. Department budgets ranged between 15 and 70 million euros.

Medical departments were organized by specialty (e.g., ENT, Cardiology) and headed by professors who reported directly to the executive board. The business managers acted as the 'right hand' to these department heads.

The first author's role as a business manager during the COVID pandemic provided firsthand access to data collection, despite the limitations of pandemic research methods (Kuijper et al., 2022). We addressed the challenges of 'at-home ethnography' and potential bias (Alvesson, 2009; Cunliffe & Karunanayake, 2013) by integrating ethnography with interviews and focus groups.

Data collection

Data were collected using a subjective approach (Cunliffe, 2010) in three steps, beginning in March 2020 at the onset of the pandemic. The first two steps involved at-home ethnographic accounts and semi-structured group interviews (Langley & Meziani, 2020) aimed at capturing the experiences of business managers as their work changed due to the crisis. These methods interacted and informed each other throughout data collection (Nicolini & Korica, 2021). The third step, a member-check focus group (Birt et al., 2016), took place in 2023 to reflect on the initial findings from a reflexive distance (Cunliffe, 2016). Table 1 summarizes the collected data.

At-home ethnography

Ethnography is defined as *'a way of writing about and analysing social life'* (Watson, 2011, p. 202). For this study, we employed what Alvesson (2009) describes as *'at-home ethnography'* to explore the practices of business managers in an AMC and the significance of relational leadership (Uhl-Bien, 2006) from a firsthand perspective. The first author, a business manager at the AMC during the COVID-19 pandemic, also pursued a PhD on relational leadership. This unique combination allowed him to conduct an ethnographic study while actively working, positioning him as an *'observing participant'* (Moeran, 2009).

This approach mitigated common challenges of ethnographic research, such as access and time constraints (Alvesson, 2003), but also increased the risk of *'going native'* (Gioia & Chittipeddi, 1991, p. 435). Unlike autoethnography, which emphasizes deep personal experiences (Greenhalgh, 2017), at-home ethnography focuses on interpreting actions and communications from a reflective distance (Alvesson, 2009, p. 162). The first author maintained a diary to document changes in work tasks and evolving relationships with colleagues, because in ethnography *'one may be less able to liberate oneself from some taken-for-granted ideas or view things in an open-minded way'* (Alvesson, 2009, p. 166). This diary facilitated reflexive memoing (Deterding & Waters, 2018) and included observations from crisis management meetings, which were compiled into field notes (Bryman, 2012).

Diary keeping, field notes and time-use analysis

At the onset of COVID-19, the first author asked seven business manager colleagues to keep a diary as part of a study on relational leadership. Participants were selected based on gender, department size, and involvement in COVID care. All provided formal consent. An Excel file was created for diary entries, and a WhatsApp group was set up to encourage participation and facilitate discussions. The first author also checked in with participants twice weekly.

Table 1.

Step	Data collection method	#Participants	Time	Type of content	# Minutes	# Pages
1	At-home ethnographic diary	1	February - June 2020	86 Diary entries in Microsoft Excel		13
	Email and Whatsapp conversations	8	March - September 2020	Email and Whatsapp messager		8
	Fieldnotes	1	February - December 2020	Jotted notes / reports		12
	Time-use analysis	1	August 2020	Microsoft Outlook weekschedules		5
2	*Interpretive* interviews 2020	7	September 2020	Transcripts	416	118
	Interventionist interviews 2020	7	October 2020	Transcripts	369	98
	Member check focusgroup 2020	7	November 2020	Transcripts	100	30
3	Member check focusgroup 2023	5	September 2023	Transcripts	137	52
	Interventionist interviews 2023	2	December 2023	Transcripts	102	42
	Total				1124	378

After two weeks, it became clear that maintaining diaries was too burdensome due to increased work pressures. Data collection methods were then adapted, focusing on reflective discussions in the WhatsApp group, observations of online meetings, and email reflections from March to May 2020.

We collected the first author's 15-page ethnographic diary (Alvesson, 2009), 15 diary entries from participants, 8 pages of WhatsApp and email discussions with three participants, 12 pages of fieldnotes from work meetings, and a 5-page time-use analysis from the first author's Outlook schedule. Time-use analysis, which reveals how time is allocated and its significance (Feldman et al., 2020), was used to compare business managers' activities pre-COVID and during the pandemic.

Interviewing

After May 2020 the initial wave of COVID had passed and the collected data were analyzed. This, firstly, led to an *interpretive* interview (Langley & Meziani, 2020) with

each of the seven business managers. The aim of this interview was to uncover and identify leadership experiences and meaning given to these experiences by the business managers in their practice before and during COVID. Secondly, the first author interviewed all business managers a second time from an *interventionist* perspective (Langley & Meziani, 2020). This second interview round was focused on reflexively going through daily practices of the business managers. In these interviews quotes from relational leadership literature were used to help and elicit (Barton, 2015) reflexivity of the interviewee on her/ his experience from a relational leadership perspective. See appendix A for topic guides of both types of interviews. All fourteen interviews were audio recorded and transcribed verbatim.

Focus group interviews

Following the analysis of the fourteen interviews and the at-home ethnographic accounts, a focus group was held in November 2020 to validate the findings (Birt et al., 2016) and explore key topics further. These included the importance of relationships, decision-making during crises, organizational structure, and the social positioning of business managers in crises. An independent chair led the session, while the first author observed and took notes (Bryman, 2012), which were later discussed with the chair. The session was recorded, transcribed, and analyzed.

In October 2023, we conducted a second focus group to examine whether perspectives on the managers' roles during crises had evolved since 2020. Due to scheduling conflicts, five participants joined the focus group, and the remaining two were interviewed separately. The same topics from the 2020 focus group were revisited, with the addition of 'the influence of hierarchy' and 'the relevance of power distance' on the business managers' work. These topics had emerged from the initial analysis.

Both the 2020 and 2023 discussions helped clarify the evolving dynamics of relational leadership during crises. The topic guides for the focus group meetings are provided in Appendix B for reference.

Data analysis

The data collection and data analysis were intertwined throughout the study (Gjerde & Alvesson, 2019; Nicolini & Korica, 2021), consistent with our qualitative – interpretive methodological stance (Schwartz-Shea & Yanow, 2012). Our choice of methods such as diary keeping, observational – participation (Moeran, 2009), interviewing (Langley & Meziani, 2020), and at-home ethnography (Alvesson, 2009) asked for continuous analysis of the meaning of the data in the 'local and situated'

in relation to the aim of the study. Our analysis is therefore what Locke et al. (2015) call *'an open-ended, forward-looking, trial-and-error'* (p. 372) process between systematic analysis and iterative discovery.

To deepen the empirical analysis, we analyzed the data abductively (Timmermans & Tavory, 2012) by making multiple rounds of iterations between the at-home ethnographic accounts and the interview and focus group data. Part of this process was discussing the findings with the research team. Through this circular process we were able to focus on what stood out in the whole of the data (Gjerde & Alvesson, 2019; Locke et al., 2022; Locke et al., 2015; Locke et al., 2008). By means of reflexive thematic analysis (Braun & Clarke, 2020, 2022) and live coding (Locke et al., 2015) we structured our analysis while capitalizing on the firsthand knowledge of the context by the first author.

We used Atlas.ti to structure our coding and identify themes and patterns (Ospina & Foldy, 2010). We used memos and time stamps in Atlas.ti to code the diary, email, and WhatsApp conversations, as well as the interview and focus group transcripts. Furthermore, in the Summer of 2024 we member checked the findings with the participants prior to writing the final version of the manuscript. This approach adds to the rigor of the analysis process (Deterding & Waters, 2018; Lazard & McAvoy, 2017) and is consistent with at-home ethnographic methodology (Alvesson, 2003, 2009). Furthermore, this process fueled the discussion in the research team on positionality and reflexivity of the first author (Nicolini & Korica, 2024).

Findings

In our study, business managers initially described leadership using terms from general leadership literature, emphasizing skills and competencies. They referenced visionary leadership and cited figures like Nelson Mandela while viewing management tasks, such as budget decisions, as aspects of leadership. However, later interviews and focus groups shifted their focus to relational and processual leadership. They highlighted the importance of being present, making protective decisions for their teams, and maintaining connections during crises, prompting us to explore their perceived roles in these situations.

The experiences of business managers during crises varied significantly based on role expectations, contextual factors, and their relationships with colleagues. Our ethnographic data revealed that while COVID-19 amplified the ambiguity of the

business manager's role, this ambiguity was not new. Their roles are inherently fluid, requiring flexibility that provides informational advantages in negotiations, such as managing employee demands and contracting suppliers. This adaptability allows them to be decisive and supportive.

The COVID-19 crisis intensified relational dynamics without fundamentally changing the nature of their work. It highlighted the intertwined nature of management and leadership, particularly the significance of role attribution from colleagues for effective leadership.

We present our findings organized into three themes: first, the crisis magnifies existing dynamics, revealing strengths and weaknesses within the organization; second, the importance of listening, shielding, and providing support; and third, the necessity of swift decision-making and connecting internal networks. Each theme is supported by ethnographic accounts and relevant quotes from our data sources.

Crisis magnifies

During the crisis, everything was amplified, as noted by business managers in the 2020 focus group meeting. All meetings were held online, and new meetings were scheduled to share information or discuss developments concerning crisis management. The online format was initially challenging and required adaptation, making the workday feel more intense, according to our participants. This added to the general stress that business managers also experienced in their private lives due to the pandemic, that obviously impacted beyond organizational boundaries. They stated that the crisis consumed all aspects of work, magnifying both successes and failures. Especially the disconnect and missing 'lines of communication' of were highlighted by the managers.

Manager 5 *'I think that the crisis has magnified everything. So, I believe that where we previously had minor disconnections, such a crisis makes it painfully obvious that connections are missing.'*

Manager 6 *'Yes, I think you must be very conscious of it because the entire playing field has changed. All the normal lines of communication suddenly disappeared, and you must actively organize new ones.'*

Patch from focus group meeting 2020

Managers observed that work and organizing *'became fluid'* (Manager 4, diary excerpt), with increased speed and hyper-focus, particularly during the initial wave of COVID-19, in March 2020. Access to information was central to the managers' leadership during the crisis. Although information was often scarce, unclear, and volatile, managers stated that they remained perceived by their teams as the ones who knew what to do. Furthermore, according to our managers, this perception sometimes allowed other agents to avoid certain tasks and the related responsibility.

As the crisis progressed in June and July, the internal crisis organization became more explicit about what was possible, expected, and demanded from the regular line organization. This also had a *'magnifying'* effect. One of the managers stated that:

> *(…) in the onset of crisis, a lot of 'business as usual' things disappeared for months. Suddenly they were not important at all, no longer a priority. And when the new crisis team came, it came back in full force. And then you're just sitting there again... well, I found that quite a difficult experience... uh, period. Because you were still half in the crisis with all kinds of things. And then you must get to work on everything that was left behind.* Manager 2, interview 1

In the interviews and focus group meetings, managers highlighted differences between the initial crisis management structure, which focused on command and control, and the subsequent phases of crisis management. According to the managers, the later phases were less in touch with the organization's needs. The focus quickly shifted to resuming patient care, research, and education, while part of the organization remained in crisis mode and most of the organization was still processing the impact of COVID-19. According to our participants, this shift made it difficult to prioritize attention for their team members, as room for such efforts was limited. This discrepancy not only complicated their work but also highlighted pre-existing issues within the organization. Managers noted that the crisis acted like a magnifying glass, revealing flaws in information flows, (un)clarity of role expectations, command structures, and decision-making procedures.

First author reflections based on the at-home ethnographic accounts

In general, the dynamics described by managers are consistent with my ethnographic accounts. However, an analysis of my agenda showed that appointments from January and February 2020 (pre-COVID) were not significantly different from those in March and April 2020. The main difference was that all meetings were held online,

and new meetings were added to focus on executing crisis management orders at the organizational and department level. These new meetings centered on sharing information and discussing the implementation of policy changes announced by the crisis management team. The *'all-consuming'* nature of the crisis, that managers described, is also evident in my agenda, which included crisis meetings on Saturdays and Sundays. However, although I remember it as if these weekend meetings lasted for months, my own minutes from these meetings reveal that such meetings only took place during three weekends. After that, department crisis meetings were only held during the regular work week, Monday to Friday.

This intense experience of the crisis, as reflected in my diary and agenda, revealed nuanced insights which contrast with certain memories of that period. The diary showed reflections on the personal impact of the crisis, noting certain 'positive effects' by the end of March. For example, one diary entry stated,

> *'Tomorrow is my first visit to the hospital in two weeks. I feel I should be more present but at the same time find this remote working effective and beneficial to my family.'* This highlights the complexity and width of the crisis experience, blending intense work demands with unexpected, personal benefits.

Listening, shielding, and providing support

In the initial interviews conducted in September 2020, the focus was on what managers experienced as their leadership during the early 2020 crisis. Initially, most interviews began with discussions about charismatic and high-level activities. However, as the conversations delved deeper into how managers constructed their work during that time, more mundane, and practical tasks emerged. The following interview excerpt neatly illustrates this development:

> *Because I was also just... Of course, I couldn't do anything at the bedside or in the helicopter... That was of no use to them. But I was always there, so also, I tried to be here, so that if one came back exhausted, at least I was there, and the door was open, and they could briefly tell me what it had been like. (…) that is a very important part, I think, of my position. By the way, my door is always open, but it was to an extreme extent. You know, just dropping all… business as usual, when attention was needed. Of course, you try to do that anyway, but in this case, it was just to an extreme extent, and I felt, yes, sometimes a little powerless. Hey, like: gee, what can I do to help? And if you are present in such a crisis meeting, it*

> *is of course very marginal what you can really add. And I found that very difficult, yes.* Manager 4, interview 1

This quote shows that managers struggled to define their added value when their typical, rational tasks such as budgeting and managing long-term projects were replaced by the urgent demands of crisis management. Dealing with fearful team members, reluctant colleagues, and uncertain prospects suddenly became a crucial part of their daily responsibilities. Although the initial policy during the crisis mandated non-essential personnel to work from home and avoid the hospital, many managers chose to be as much present as possible, navigating permissions from their families. One manager referred to this as *'professional disobedience'*, considering it a privilege of his role to exercise such indiscretion.

Furthermore, during the interviews, managers also reflected on their own position within the organization. They acknowledged being employees themselves and discussed whether their supervisors inquired about their well-being, mirroring their own role in supporting their team members. They noted that such inquiries were not extended to them, nor did they expect them to do so They expressed that managing both their rational work and personal resilience was inherent to their role and seniority level. Despite this expectation, managers shared doubts about their perceived value during the crisis, citing numerous examples of introspection and uncertainty in their leadership roles. This reflection had practical implications for managers as we can see in the following quote:

> *But of course, something really happens to us, right? We pretend that we have not had any problems at all as a person or manager, or that we just carry on. (…) both of my departments, were completely turned upside down. And I was really just an observer, because from the* [new crisis management team]*, new assignments came every minute, and left, right doesn't matter. Okay, you know, it took a while before I found my place, like: What can I still contribute to this organization? It really took a while. And then I thought, OK, I'm a bystander, and what can I do? Yes, my people, who were all a bit frantic, like: Where should we go? And: who can we be with? Okay, I thought, that's my role now. But that was strange because it felt like scaling down. Because you are letting things go.* Manager 2, interview 2

In the focus group meetings that we organized in 2023, managers reflected on their experiences during the COVID-19 pandemic and the differences with the period

after the pandemic. They noted that during the initial interviews in September 2020 and the focus group meeting in November 2020, most of them were still operating in a crisis mode. Although COVID-19 resurged several times after November 2020, it never reached the same level of intensity as in March and April 2020. However, it continued to significantly affect their teams and their work. In the focus group meetings in 2023, managers emphasized the value of mundane activities, such as listening and being present, as crucial components of their role, regardless of whether they were in a crisis or not. They recognized that these seemingly simple actions were essential in maintaining team cohesion and support, but also the relevance of this to the rational management tasks of budgeting and project management. They described these processes as intertwined. This highlights the importance of relational leadership processes in both routine and extraordinary circumstances.

Furthermore, in the focus group meetings (2020 and 2023), business managers shared examples demonstrating the value of their role within the organizational setting. This awareness helped them support their team members more effectively. One business manager provided the following example:

> *'And he just can't get through some things. But if I send an email: 'kind regards, [name], manager', then it will be arranged tomorrow. And I think that's crazy. I mean… So apparently if one person asks, who doesn't have that job, and then the other person asks again, you can get it done. So, hierarchy is indeed there. And well, what I just said, it is also about being taken seriously. So, someone who has that [managers'] position is more likely to be taken seriously than the other…'* Manager 3, interview 1

This example highlights not only the hierarchy but also the significance of the business manager's role. It also reveals the manager's surprise that the same question can receive different answers depending on who asks it. Interviews with the business managers indicate that this shifting social order within the organization became more intense during the crisis, demanding substantial time and effort from them. Managers discussed their responsibilities in influencing, assisting, and shielding their team members from the impacts of these organizational processes. One manager articulated it as follows:

> *(…) we all try to keep unclear messages away from our people, as much as possible. Choices that are made now, whether it is the nurse from orthopedics, or something else that must come to us, it certainly has a lot*

> *of consequences. And then I think, as a department manager, you monitor that communication. Because it may also come from a different source, but we decided that it can only come via me, and that is how it should be. And I then ask those people: "This is what we are going to do! What's it like there* [on the ward]*? Do you understand the meaning of what we need to do? How can I help?"* Manager 8, focus group meeting 2020

Mundane activities such as being present, listening, helping, and prioritizing were not only seen by business managers as their tasks but were also attributed to them by their team members and other organizational members based on the role of business manager. The business managers in our study observed that the crisis setting intensified the need for these activities, highlighted their value, and stated that such activities are intertwined with the more rational tasks of their jobs.

First author reflections based on the at-home ethnographic accounts

The positioning of business managers and the impact of their roles and actions were evident from the analysis of my own ethnographic diary and WhatsApp conversations with other business managers during that period. While mundane activities were noted, the more significant finding was the role assigned to me by others. In my team and department, a local crisis management team was established to implement organizational crisis management policies. We prioritized medical, nursing, administrative, and planning expertise over traditional hierarchy. In this context, I assumed a more supportive role, different from my usual leadership position. This shift was both supported and expected by team members in the department. Reading back through my diary, I see that I had to adjust to this new role, but I found that providing support by taking minutes and connecting with other departments was the most valuable contribution to the team at that time. An excerpt from my diary illustrates this:

> '*This morning, we have decided to close outpatient clinics and scale down OR programs. The department works like a well-oiled machine, the team leaders take the lead. I don't really have to do much. What is my added value? I created a Whatsapp group for the crisis-* [department name] *team and scheduled daily online meetings. We will inform each other every day and set out actions.* [name of head of department] *is the chair. I am asked to make to-do lists and make a lot of phone calls to hear if everyone is okay and can proceed. In particular,* [team leader A]*, takes a leading role with* [doctor A] *and* [doctor B]*; They organize the entire clinic and OR. Terrific!* Diary excerpt, 12th of March 2020

Making decisions swiftly and connecting internal networks

Although decision-making is a regular part of business managers' work, in both interviews and focus group meetings managers revealed that the crisis introduced heightened stress into these processes for them. The nature of the situation meant that even routine matters required decisions. For example, due to remote working, managers had to determine who was entitled to desks, chairs, and laptops at home, and how these items would be distributed. While central policies existed, local (departmental) business managers were responsible for implementation. Furthermore, employees and representatives from other departments expected certain decisions to be made. For instance, decisions were needed on the allocation of medical support to COVID-19 wards or on downsizing the planning for the operating rooms. This led to a different positioning and role for business managers, adapting to the unique demands of the situation. One business manager summarized this experience as follows:

> *(…) in a crisis management attitude, you feel even more decisive, you feel that a more decisive appeal is being made to you or something. And at the same time, you must remain connected, be extra transparent. And those are some of the words that come to mind, like: that is the appeal that I really feel that people are making and the call for clarity, transparency, choices. (…) That is the appeal that I feel very strongly.* Manager 7, interview 2

According to the managers in our study, decision-making and the acceptance of these decisions were based on trust, which is the manager's job to cultivate. In the second round of interviews, managers elaborated individually on how they created connections with team members, colleagues, supervisors, and board members to establish a baseline for decision-making. One manager explained the value of this process as follows:

> *(…) from building trust in the relationship that you have with each other. That trust is created toward you as a leader so that you carefully consider the decisions you make and then you will experience that if a decision comes up that conflict with what is good for the employee, he or she will accept it much more easily. Because he knows that you have integrity, transparency, organizational interests, that you also weigh the employee side and say: "Okay, I have thought about everything carefully, but we will go straight ahead."* Manager 5, interview 2

Although initially creating trust as a baseline for decision-making seemed functional and instrumental, discussions in the focus group meetings revealed a deeper understanding. The managers emphasized that building trust and relationships is relational and part of continuous collaborating. The following excerpt from the focus groups highlights this and underscores the importance of networking for business managers during a crisis:

Manager 6 *I think that our work mainly consists of making connections, making,creating, I think that is very much a part of our work. You worktogether based on connection, even in the position we are in, it isimportant to connect with parts of the organization that you do not yetknow or that you do not know the employees.*

Chair *And which organizational units are you not yet familiar with? What do you mean?*

Manager 6 *Well, I can imagine that we are the ones who should know a little about all the layers and all parts of the organization, or at least know that if you don't have the answer, you can go somewhere for an answer, to fetch the right information. And I notice that this is also very important for employees, for example, that you function as a kind of source of information to take people to other parts of the organization.*

Manager 5 *And I also think that knowing the organization, we can always sense undercurrents, et cetera, and you only get that if you are connected to each other and if you are let in.*

Patch from focus group meeting 2020

First author reflections based on the at-home ethnographic accounts

From the agenda analysis and diary entries, my own experiences did not indicate that decision-making was more intense for me. Despite managing two other large projects outside the department during the crisis, the diary entries reveal my struggle to stay in tune with the department's needs and ensure timely information delivery. I worked closely with the department chair, who had strong connections with other department heads. My role as a connector between my department and

others was evident in my diary entries, where I frequently mentioned coordinating with other business managers to address various issues.

Most of these connections were established before the crisis, though some were disrupted as roles and power structures shifted. The usual points of contact for certain information were no longer the same due to the new crisis management structure. Typically, business managers were the first to be informed about major organizational changes, but this shifted towards front-line professionals during the crisis. While many saw this as a positive change, it also caused frustration due to disrupted information flows. This disruption was visible in the breakdown of some connections.

One WhatsApp message I received from a floor manager during that time illustrates this new connector role:

> *'Information is lacking. Other departments are also running into this. Can you please check with your colleagues if they have the same problem? If so, we will need to organize something to be better informed.'*
> WhatsApp message to business manager

By early May, my diary notes that the uncertainty lasted only a few weeks before everyone knew the new points of contact and information flows were restored. These information flows were mostly informal. Although the crisis management team and the board of directors made significant efforts to keep the organization informed through webinars, newsletters, and intranet messages, the work in large part relied on informal networks. The interviews with business managers corroborate this, emphasizing that effective policy execution often depended on connecting people through these informal networks.

Discussion

In this study, managers frequently described their roles during the crisis using general management and leadership terminology. They noted that the crisis intensified existing organizational processes. When discussing relational and collective leadership, they emphasized their efforts to listen, make decisions, protect their teams, and connect with colleagues. These actions were vital to them in their functional management work.

All managers identified their role in bridging gaps across organizational layers and addressing information asymmetries. Some were tasked with leading crisis management efforts for their departments or the entire AMC. Role attribution varied based on available opportunities and recent task divisions. Managers acknowledged the confidence and influence bestowed upon them by colleagues and senior management, which often stemmed from their past crisis experience or strong (organizational) relationships.

Although managers felt their hierarchical positions mattered less during the crisis, these positions allowed them to effectively influence outcomes. Their access to the board and critical information enabled decisive actions. They found that the crisis revealed both strengths and weaknesses within the organization, supporting Weick (1988) assertion that crises expose underlying dynamics. Their ability to make quick decisions and leverage internal networks demonstrated how relational leadership practices—like listening and supporting—are deeply intertwined with their managerial roles.

In the following discussion, we will reflect on these findings and the connection between role theory and relational leadership in hospital management.

Leadership as vernacular

The expanding field of leadership studies has made the concept of leadership a common part of workplace vocabulary, a phenomenon that Smircich and Morgan (1982) refer to as "vernacular." Alvesson and Sveningsson (2003a) note that leadership often arises from daily interactions and discussions among organizational members with specific roles. These actions are recognized as leadership based on the individual's status rather than the intrinsic value of the activities themselves (Alvesson & Sveningsson, 2003b). Researchers highlight the importance of middle management's everyday activities, such as conversations (Shotter & Cunliffe, 2003) and task deviations (Azambuja & Islam, 2023). Additionally, Larsson and Lundholm (2010) suggest that we should view leadership as *'embedded in management rather than distinct from it'* (p. 160). However, like *'manager-centrism'*, there is a risk of *'leaderism'* (Bresnen et al., 2015), which interprets all activities as leadership and thus reinforces a narrow focus on individual leaders (Alvesson, 2017). This perspective, often criticized for *'blackboxing'* leadership (Larsson & Alvehus, 2022), overlooks the co-constructed nature of leadership practices.

In this context, relational leadership practices align with Kars-Unluoglu et al. (2022) concept of *'unleading'*, referring to *'leaderly actions'* that often go unnoticed. For

leadership to become part of the vernacular, however, it is essential for all involved parties to recognize and understand these practices. Fairhurst et al. (2020) stress the importance of understanding how leadership becomes relevant in a collective setting to fully grasp how it is enacted in practice. Our study supports this view, showing that relational leadership practices (Uhl-Bien, 2006) derive meaning from daily interactions and the attributions made by others. Leadership emerges through its enactment and the discussions surrounding it, which aligns with Carroll et al. (2008) call to move beyond the *'competency paradigm'*. Therefore, future research should investigate how meaning is attributed to leadership from a relational perspective.

Beyond manager-centrism

Traditional views of leadership and management often emphasize individual managerial actions, focusing on the behaviors, traits, or decisions of leaders. However, our study highlights that understanding the complexities of organizational life requires attention to context, processes, and relational interactions (Cunliffe & Eriksen, 2011; Ybema et al., 2009). This perspective aligns with recent critiques of *'manager-centrism'*, which argue that focusing solely on managers obscures the dynamic and interactive nature of leadership in practice (Larsson & Alvehus, 2022). Our findings show that managers' everyday activities—such as listening, supporting, and decision-making—are essential to relational leadership (Fulop & Mark, 2013; Larsson & Lundholm, 2010), particularly during crises (Wilson, 2020). Interestingly, managers initially did not recognize these actions as leadership; instead, others attributed leadership to these practices, rendering the managers' contributions largely invisible. This phenomenon is not the *'extra-ordinarization'* of mundane activities that Alvesson and Sveningsson (2003b) warn against, as the managers did not assign special meaning to their actions; rather, that attribution originated from others.

In contrast, our findings align with interactional perspectives on leadership, emphasizing that leadership emerges through social interactions and is co-constructed by multiple actors (Clifton et al., 2020). Business managers in our study did not consistently label their work as leadership; instead, others recognized them as leaders through their interactions and roles. This emphasizes the importance of relational processes, where leadership is continuously shaped and negotiated within the social context. Managers meet these expectations by connecting, protecting, and making decisions, which are then perceived as leadership practices.

The concept of leadership as an interactional process, as discussed by Clifton et al. (2020), is particularly relevant in crisis situations, where quick decision-making and relational engagement are crucial. Our research demonstrates that during crises, the need for these activities becomes more pronounced, illustrating that effective leadership in healthcare settings involves ongoing relational engagement, especially under pressure. This shift from a manager-centric view to a relational and process-oriented understanding of leadership reflects the complexities of organizational life and the multifaceted nature of leadership as it is practiced and perceived in real time.

Social order through role and position

The roles and positions of business managers help establish a social order that maintains organizational structure and supports decision-making, even during crises (DiBenigno, 2019; Oldenhof et al., 2016a). With their ability to establish order through their roles, managers provide a framework for organizational processes. This emphasizes the importance of relational leadership in maintaining stability within organizations. Our study found that during the crisis period, relational processes intensified, showing that managers must continuously adapt and negotiate their roles (Sluss et al., 2011). Traditional role theory, however, often overlooks these relational aspects (Anglin et al., 2022).

Our findings reveal that role attribution is not just an individual or cognitive process but also relational, shaped by interactions and shared responsibilities between managers and their teams (Sluss et al., 2011). These interactions create a mutual understanding of roles, enabling managers to execute their duties, take on influential positions, and manage communication flows, particularly during crises. This underscores the importance of relational leadership practices, which are deeply embedded in managerial work (Korica et al., 2017; Larsson & Lundholm, 2010).

Therefore, our findings highlight the crucial role of relational leadership, the interaction between roles and relationships, and the centrality of leadership within managerial work. These insights contribute to a better understanding of leadership and role attribution in organizations, especially during crises. They show how hospital business managers can improve crisis response by fostering strong relationships and maintaining flexibility in their roles. Future research should continue to examine these relational dynamics and their effect on organizational resilience and effectiveness in healthcare settings.

Strengths and limitations

This study provides an in-depth exploration of relational leadership practices among hospital business managers during a crisis, leveraging interviews, at-home ethnography (Alvesson, 2009), and document analysis. The combination of these methods allowed for a nuanced and humanized (Cunliffe, 2022) examination of role attribution and relational leadership, with abductive reasoning highlighting key relational dynamics. While Korica et al. (2017) point out the limited scope and potential biases of such methodologies, they also emphasize the depth of insight they provide.

However, the first author's position within the hospital introduced potential bias, as participants may have felt pressure to align with the researcher's role or withheld certain information due to ongoing collaborations. To mitigate these biases, we triangulated the ethnographic data with interviews (Langley & Meziani, 2020), employed an external supervisor during focus groups, and incorporated reflexive memoing (Deterding & Waters, 2018) to enhance rigor and reflexivity.

Furthermore, our findings stress the relational nature of role attribution (Anglin et al., 2022; Sluss et al., 2011). Future research would, therefore, benefit from the use of more practice-oriented methods, such as shadowing (Lalleman, Bouma, et al., 2017; Nicolini & Korica, 2024), to further explore the relational nature of role attribution in situ.

Conclusion

Our study showed that, initially, managers described their leadership using terms from general leadership literature, emphasizing skills and competencies. However, reflecting on the nature of their work in crisis they highlighted relational and processual aspects of leadership, and named practices such as being present, making decisions, protecting teams, and maintaining connections. As such, they underscore the importance of relational leadership, particularly in crisis situations where the need for adaptive and supportive roles becomes paramount and show that leadership is embedded in managerial work.

We found that the crisis amplified existing organizational dynamics and exposed the natural fluidity of the business manager's role. Managers had to bridge gaps between organizational layers, address information asymmetries, and balance

crisis and non-crisis tasks. Their leadership involved both rational processes and relational processes. Furthermore, despite feeling that their hierarchical position was less relevant during the crisis, this very position enabled them to access crucial information and make impactful decisions.

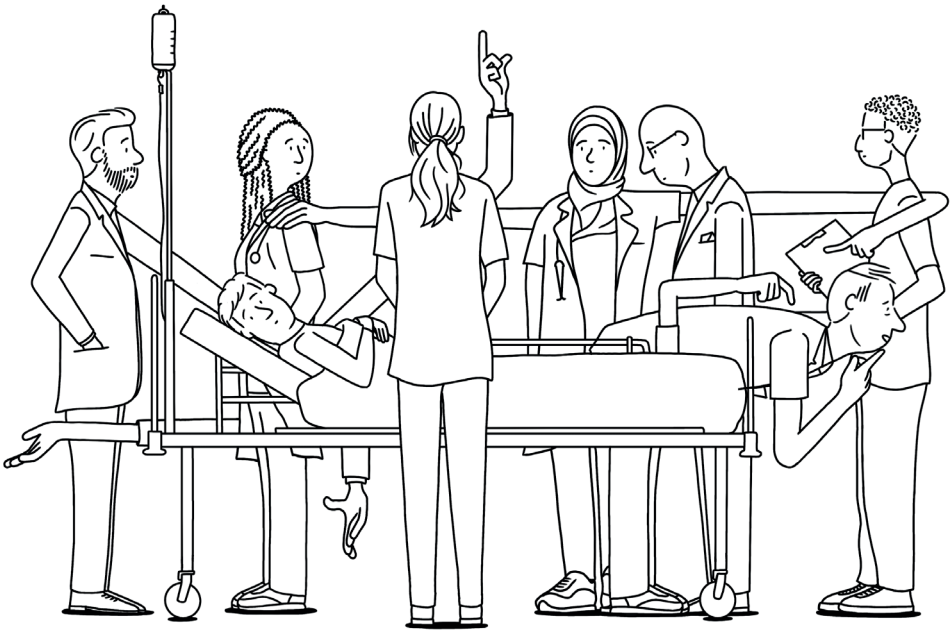
Ultimately, the COVID-19 crisis did not fundamentally change the core of the work of business managers but intensified relational role processes due to the pressure and rapid unfolding of events. Hospital leaders should recognize the value of relational leadership in both routine and extraordinary circumstances, providing insights into the adaptive and supportive roles that are crucial for effective crisis management in hospital settings.

5

SIX

WORKING APART TOGETHER: RELATIONAL LEADERSHIP OF PHYSICIANS IN CRISIS MANAGEMENT DURING THE COVID-19 PANDEMIC.

Under review at BMJ Leader: Verhoeven, A., Lalleman, P., Loo, E. v. d., & Marres, H.. *Working apart together: relational leadership of physicians in crisis management during the COVID-19 pandemic.*



Abstract

Objectives: This study examined how relational leadership and role attribution were perceived by key players in the crisis management teams of one academic medical center. Furthermore, we explored the role of hierarchy and power dynamics when crisis management takes over responsibility.

Design: The research design was qualitative – interpretive with use of Relational Leadership Theory. We followed an abductive and iterative research approach with observations, document analysis and semi-structured interviews as main methods.

Results: Physicians occupied all key leadership roles in the crisis management structure, with their suitability for these positions unquestioned. However, they actively fostered a collaborative environment during meetings, ensuring all voices were heard and working closely with other professionals, managers, and the board.

Within the physicians' group, perceptions of each other's leadership abilities varied, with specific crisis competencies linked to individual traits. Despite the hierarchical, command-and-control presentation, much of the work occurred through emergent deliberative processes and informal networks. Knowing colleagues well and having a shared history and collective memory were seen as critical to effective crisis management.

Conclusions: Effective crisis management in healthcare depends on relational leadership, power dynamics, and adaptive practices. Emphasizing collective efforts, shared experiences, and flexible leadership approaches can strengthen healthcare organizations' resilience and responsiveness in navigating crises beyond formal training and established hierarchies.

WHAT IS ALREADY KNOWN ON THIS TOPIC

- Crisis management in healthcare often relies on hierarchical structures and individual leadership skills and competences.
- Relational Leadership Theory posits that leadership emerges through social processes and interactions.
- COVID-19 has challenged traditional healthcare leadership models.

WHAT THIS STUDY ADDS

- Insights into how relational leadership manifests in crisis management within an academic medical center.
- Evidence of the dynamic interplay between formal hierarchies and emergent, informal networks during a crisis.
- Understanding of how physicians' roles are attributed and negotiated in crisis leadership.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

- Encourages healthcare organizations to further develop flexible, relationship-based leadership approaches for crisis management.
- Advices to incorporate relational leadership insights into crisis management training.
- Highlights the importance of integrating emergent practices from crisis periods into long-term organizational structures and leadership development programs.

Introduction

The COVID-19 pandemic has presented unprecedented challenges to healthcare organizations worldwide, necessitating rapid adaptations in leadership and crisis management structures (Hawley & Wall, 2024; Langi Sasongko et al., 2024). Much existing leadership literature, however, focuses on individual competencies and leadership traits (Carroll et al., 2008), overlooking the significance of relationships (Cunliffe & Eriksen, 2011), processes (Uhl-Bien, 2006), and practices (Raelin, 2016b) essential to understanding leadership in complex healthcare environments (AlKnawy, 2019; Basterrechea et al., 2024; Langi Sasongko et al., 2024).

The intersection of relational leadership and crisis management in healthcare, particularly in the context of COVID-19, presents a compelling area for research. While studies have examined crisis management practices during the pandemic, there is a gap in understanding how relational aspects of leadership influence the effectiveness of crisis management teams in healthcare settings (Cleary et al., 2018; Soela et al., 2024). This study addresses this gap by examining how leadership roles were attributed (Anglin et al., 2022; Sluss et al., 2011) to physicians within the crisis management structure, how physicians perceived their leading role, and how power dynamics (Looman et al., 2021; Saxena et al., 2019) influenced decision-making and collaboration in a hospital environment, during crisis (Verhoeven, Marres, et al., 2023).

Our research is, therefore, grounded in Relational Leadership Theory (RLT) (Uhl-Bien, 2006), which posits that leadership emerges through social processes and interactions rather than residing solely within individuals (Cunliffe & Eriksen, 2011; Hawley & Wall, 2024). This perspective is particularly relevant for healthcare crises, when traditional hierarchies are challenged, and new forms of collaboration emerge within and across boundaries of medical professionals, administrators, board members and support staff (Hawley & Wall, 2024; Langley et al., 2019). Furthermore, Hawley and Wall (2024) showed how the COVID-19 crisis altered power relationships in a hospital setting, shifting organizational structure and culture. In the adaptive spaces created (Langi Sasongko et al., 2024; Uhl-Bien & Arena, 2018) by the crisis, healthcare professionals with different levels of formal authority worked together, navigating existing relationships (Martini et al., 2023; Verhoeven et al., 2024) and finding ways to bridge differences to create solutions that directly impacted patient care and organizational effectiveness.

Our study challenges the traditional view of crisis leadership as a top-down process led by a single authoritative figure, such as a CEO or director (AlKnawy, 2019; Reitz & Higgins, 2021; Soela et al., 2024; Uhl-Bien, 2021). Instead, we argue that the distributed and relational approach to leadership allowed for more flexibility and responsiveness in addressing rapidly changing healthcare needs, during the COVID-19 crisis.

Theoretical concepts

RLT focuses on social interactions and collaborative processes in shaping leadership (Uhl-Bien, 2006). This approach views leadership as a dynamic, collective process rather than an individual trait, aligning with distributive and shared leadership models (Raelin, 2016b). Smircich and Morgan (1982) emphasized that leadership emerges from shared meaning-making between leaders and followers. Such a process concerns also role attribution because this is the process in organizations that involves assigning roles based on societal expectations and individual self-perception (Anglin et al., 2022). Roles are shaped relationally through ongoing interactions, making them fluid and context dependent (Sluss et al., 2011). In crisis situations, role attribution becomes more complex and relational, as individuals often assume roles through collaboration and interaction with others and are under high pressure. Foldy and Ospina (2022) state that since *'all leadership emerges from shared meaning-making, all leadership is collective.'*(p. 4). As such this inherently means that power dynamics are in play. These dynamics are shaped by relationships, knowledge, and goals, and their effects can be constructive or unconstructive depending on context (Looman et al., 2021). Furthermore, power dynamics play a key role in organizational resilience (Langi Sasongko et al., 2024). As such this relational perspective on leadership, power dynamics, and role attribution is particularly relevant in understanding how leaders respond to crises in healthcare settings.

This research contributes to both relational leadership and crisis management literature in healthcare by examining their intersection in the context of a global pandemic. Our aim is to extend our understanding of how relational leadership operates in extreme circumstances within healthcare organizations, potentially challenging or refining existing models of hospital management. Therefore, our goal was to understand how professionals within the academic medical center (AMC) perceived and constructed their work during the crisis, and how they interpreted leadership in this context.

Practically, the insights gained can help healthcare organizations design more resilient and flexible crisis management structures(see for example Barton et al., 2020) that leverage the power of relational leadership. By fostering a culture that values collaborative decision-making and adaptive leadership, hospitals and healthcare systems can be better prepared to face future crises while maintaining high standards of patient care and organizational efficiency.

Setting the scene

The AMC in our study is one of seven such institutions in The Netherlands. In 2020, this AMC comprised over 1,100 clinical beds, employed nearly 12,000 staff members, and had an annual turnover exceeding €1.2 billion. AMCs play a vital role within the Dutch healthcare system, combining three essential functions: the provision of complex patient care, conducting (biomedical) research, and the training of students and healthcare professionals (Cardinaal et al., 2022). Additionally, AMCs in the Netherlands have a specific role, particularly due to their advanced infrastructure, which includes state-of-the-art imaging, care, and research facilities.

Crisis management organization

At our AMC, a structured crisis organization was established at the onset of the COVID-19 pandemic. This organization consisted of various operational teams, including the infection outbreak team, the care team, internal and regional ICU coordination, and personnel allocation. These teams were coordinated by a crisis policy team (CBT), responsible for decision-making regarding personnel, resources, and communication (see Table 1 for an overview). Physicians played a central role in leading the CBT and the operational teams and adhering to the established protocols.

Figure 1 illustrates the development of the crisis management structure alongside the progression of the number of COVID-19 patients.

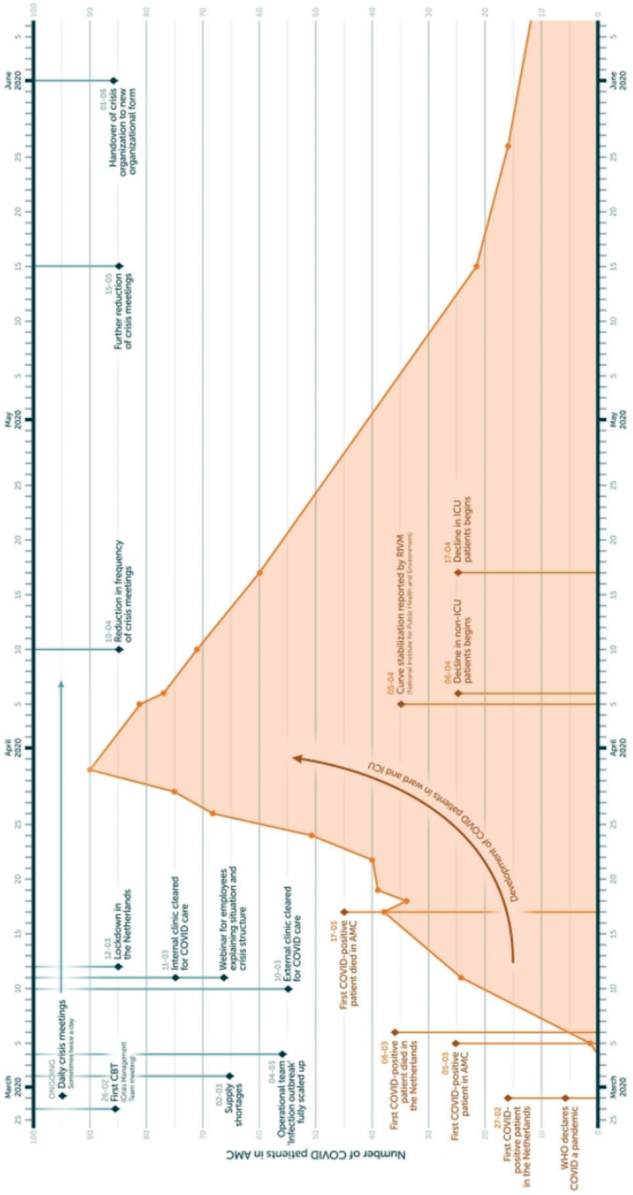


Figure 1 – Development of crisis

Figure 1. Development of crisis

Table 1. Overview of focus of the CBT

Focus	Explanation
Epidemiological and care coordination	Daily updates on the epidemiological situation were crucial. Physicians reported infections and emphasized preventive measures like hygiene and team cohorting. Collaboration with regional hospitals ensured effective care coordination.
ICU capacity and coordination	ICU capacity was expanded due to increased demand. Physicians monitored and managed ICU patient distribution across the region, ensuring optimal care and resource allocation.
Personnel allocation	Redistribution of personnel became essential as pressure increased. Physicians helped prioritize surgeries and set up dedicated wards for COVID-19 patients. A flexible workforce pool allowed physicians with relevant expertise to volunteer for redeployment beyond their usual roles, enabling the healthcare system to adapt to the evolving crisis.

Methodology

This paper presents a qualitative-interpretive study (Schwartz-Shea & Yanow, 2012) on crisis management in a Dutch AMC. We conducted in-depth interviews with 37 participants across the AMC, and document analysis (see Table 2).

Data collection

At the start of the pandemic, we attempted to observe the daily crisis meetings. However, the researcher (AV) was unable to attend in person due to COVID-19 restrictions. Digital participation was also not allowed due to concerns over confidentiality and the desire to ensure open discussions within the crisis management team. This decision was influenced by the first author's dual role as a business manager at the AMC and a PhD candidate researching relational leadership in complex organizations at the time of the onset of COVID-19.

We, therefore, collected audio recordings and meeting minutes of CBT meetings between February 26, 2020, and May 22, 2020. Additionally, we gathered relevant organizational documents, such as intranet communications, webinars, and evaluations of the crisis management structure. Furthermore, we interviewed 37 key individuals involved in crisis management, including all (3) chairs of the CBT and 2 (out of 3) members of the executive hospital board (See table 2 for an overview). Interviews took place between November 2020 and January 2021. Due to ongoing contact restrictions, 23 of these interviews were conducted online, while the remaining 15 were held in person at the AMC. The following key themes were central in the interviews: coordination and decision-making, personal involvement and role, structure and collaboration, crisis management versus regular organization, boundaries between organizational units and between professionals.

The background of these topics are the theories of relational leadership (Uhl-Bien, 2006), leadership-as-practice (LAP) (Raelin, 2016b) and boundary work (Langley et al., 2019). See appendices D and E for topic guides of interviews and focus groups.

The first author's (AV) position as a business manager andthe focus groups and the last author's (HM) position as head of a medical department during the COVID-19 pandemic provided a unique opportunity to collect real-time data when many researchers were limited to online methods due to national crisis management measures. Furthermore, these dual roles enabled us to enrich the interviews with first hand experiences and to have reflexive discussions on the collected data afterwards (Cunliffe, 2018).

Data analysis

Data collection and analysis were closely intertwined throughout the study, following the approach outlined by Nicolini and Korica (2021) and in line with our qualitative-interpretive methodology (Schwartz-Shea & Yanow, 2012). We conducted an abductive analysis (Timmermans & Tavory, 2012), iterating between different data sources multiple times. This process included regular discussions with the research team, allowing us to focus on key findings emerging from the data, as a whole (Locke et al., 2022).

Table 2. Overview of collected data

Data collection	Profession	# Participants	# Minutes	# Pages
In-depth interviews	Director	3	155	41
	Manager	6	354	101
	Member of the Executive Hospital Board	2	94	26
	Nurse manager	3	148	38
	Physician	15	697	195
	Support staff	8	457	127
Minutes crisis management team meetings				226
Observations and audio recordings of crisis management team meetings			491	
Organizational documents on strategic crisis management				85
Total		37	2396	839

We applied reflexive thematic analysis (Braun & Clarke, 2022), which enabled us to structure our analysis while leveraging the first author's knowledge of the context. To organize our coding and identify themes and patterns, we used Atlas.ti, which contributed to the rigor of the analytical process. This structured approach also facilitated discussions within the research team regarding the first and last author's positionality and reflexivity (Cunliffe, 2018), further strengthening the analysis.

Results

Role attribution towards physicians in crisis

Our findings reveal a complex interplay of role attribution and leadership dynamics among physicians and between physicians and other agents, during the hospital crisis. Physicians were assigned and assumed leadership roles. We identified the factors influencing these attributions, and the challenges they faced in balancing their medical expertise with broader crisis management responsibilities.

Physicians were often automatically placed in leadership positions, both formally and informally, due to their expertise and status within the hospital and outside of it (table 3).

This attribution occurred even when they were not always 'crisis competent', as indicated in multiple interviews. The decisions made by physicians had a significant impact on crisis management. However, not all physicians felt equally comfortable with this role, and some found it challenging to step back from their medical expertise to make broader decisions that, for example, had to with logistics.

The crisis competence of physicians was frequently discussed in relation to daily work in acute care settings, such as the emergency department or intensive care unit (table 3). Although, physicians with experience in acute situations were seen as having an advantage in crisis management, this did not apply to all physicians. Furthermore, there was not an active discussion in the crisis management team, prior to COVID-19, about how expertise and experience outside of crisis times influence the leadership roles that physicians assume during a crisis.

Table 3. Subthemes and illustrative quotes on role attribution towards physicians

Subtheme	Illustrative quotes	Participant
Placement in leadership positions	*Well, I think (physicianX) is a leading scientist in his field who has achieved a lot and has great influence on a global scale. Yes, if he has an opinion on infection prevention and knows how it plays a role in the WHO, as he is at the table there himself, it carries more weight.*	Interview support staff member4
Crisis competence of physicians	*And that is why it's so important to have people in a crisis organization who are used to working in the acute domain in their daily lives. They know how it is and that you must make decisions, because the worst thing you can do as an organization is to delay or postpone something. In surgery, we say 'make a decision, make an incision.' That applies here too.*	Interview physician8
Attribution	*Well, I think we all look up to them* [physicians]. *We see it too, they are... I often think I'm just* [support staff], *if I collapse tomorrow, the hospital will go on. If those doctors collapse tomorrow, there won't be any hospital care anymore.*	Interview support staff member3
Connection to the line organization	*I thought it was good that there were two doctors involved because, in the end, we needed information from the medical domain to pass on to the department heads to get them on board with: when can we start up or not?*	Interview physician12

The dynamic nature of role attribution in crisis leadership was evident in our findings. Physicians took leading positions within the crisis organization structure. They were given responsibility for communication and decision-making. This dynamic role attribution illustrates how leadership is relationally constructed in crisis situations.

Interestingly, our data suggest that role attribution in crisis is not solely based on formal positions or expertise. There is also an element of expectation and perception involved. While physicians actively sought connection and alignment in the meetings, others looked to them for leadership and decision-making. There was a prevailing assumption that all physicians are *'trained for decision-making in crisis'* (Interview board member2) which influenced how others perceived and attributed leadership roles to them.

The concept of crisis competence emerged as a characteristic often attributed to physicians, but our findings indicate that this is also a relational construct. The fact that physicians were listened to and consulted demonstrates the

relational nature of their leadership during the crisis. Another relational aspect of this was the connection that physicians could make with the line organization (table 3). Participants indicated that the positioning of physicians as leaders in the crisis management structure helped in making the connection with the organizational hierarchy.

The role of hierarchy and power dynamics in crisis

Our findings reveal complex hierarchical structures and power dynamics that significantly influenced leadership and decision-making processes. Traditional hierarchies were both reinforced and challenged, and power was distributed and negotiated among various stakeholders, during the hospital crisis.

The crisis led to a temporary adjustment of hierarchical structures, as noted in several interviews. While physicians often held formal leadership positions, there was an increased emphasis on relational competencies. For example, in managing stakeholders in a specific way. This managing is relational while also being decisive. Leading physicians stated in our interviews with them that they actively listened to diverse perspectives and tried to create space for input from various team members. However, according to other interviewees, the inherent status of physicians sometimes remained a barrier to less hierarchical decision-making, creating tensions between doctors and other professionals such as nurses. Tensions may arise, for example, when the doctor, acting as the chair of a meeting, contributes to decisions or discussions on topics that fall more squarely within nursing expertise. This dynamic can create friction regarding who holds decision-making authority versus who possesses the relevant expertise. This dynamic reflects the ongoing struggle between traditional (medical) hierarchies and the need for more collaborative approaches in crisis management.

The CBT was legitimated to create overarching policies, but often acknowledged that departments had the final say in decision-making. This was evident in discussions about closing outpatient clinics, where departments made their own decisions. The tension between standardizing policies and maintaining the autonomy of medical specialties was a recurring theme, illustrating the constant negotiation of power and influence between different actors. This balancing act was also present in the minutes of the crisis meetings (table 3).

Table 4. Subthemes and illustrative quotes on hierarchy and power dynamics

Managing stakeholders	*Look, in an academic hospital, there are big egos, and they must be managed. And as a chair you can't always have the final word. But if you think: something is really at stake, and that is often in a crisis, you need to decide. But people also need to accept that you take that responsibility and say: "No, we're going to do it this way". And then you need also to give people a good feeling about it.*	Interview Director2
Balancing standardization and autonomy of medical departments	*Can we motivate department leadership to look at the outpatient clinics and convert appointments to phone calls? Create a plan for approaching patients and ensuring proper administration.*	Minutes March 10, 2020
Layered structures	*So, in the first wave, there was also a bit of ignorance, but just the way it was organized and how responsibilities were assigned was very fragmented. I also think department heads benefit from that remaining the case because then they maintain control over their own department. And the more you give up, the more impact it has on your own department, which you can no longer manage yourself.*	Interview support staff member7
Loose consultation structures outside the CBT	*Actually, a lot was searched for outside the CBT: okay, and also consultation with external parties, the federation of medical specialists, with the ROAZ, name it. A lot was achieved, collaborated, and discussed outside the CBT. Then often a direction was already given in broad outlines, and of course, it could be that suddenly someone in the CBT had a different insight or brought something to the table that had not been discussed before. And then it was either done again, the round, then outside the CBT, or it could be because, for example, that infectiologist, that chair of the OT, but also that new party, all three being present at the CBT, it could then be closed in the CBT.*	Interview support staff member 3
Informal contacts and pre-existing trust	*I already had certain phone numbers of people in my mobile because you've worked with them before. So, you do have a certain bond of trust with each other or a work relationship, so that makes it easier to just make that call or to say: 'Well, you know, I'll take care of that.' Because at that moment, you do know, yes, let's act quickly, that person knows me already, I'll take care of it, jump right in, rather than letting the nurse from the department make that call.*	Interview nurse manager 1
Informal networks and formal hierarchies	There was so much work to be done that I think everyone realized it was unavoidable. Anything you could do quickly, you arranged quickly, or in a two-way call with 'I'll call that one.' Yes, that was no secret, and it was not backroom politics, not unwillingness, but just: we are in a crisis, water at our lips, and something needs to be arranged by tomorrow. And yes, let's try to make the best of it. Then, very quickly, and certainly at the beginning and towards the end as well, yes, the structure is no longer leading. Then the end-goal justifies the means, and yes, it's like, okay...	Interview support staff member 3

The need to 'motivate' indicates interdependence and awareness of a relational challenge. Furthermore, communication and decision-making occurred in layered structures, with information shared at different levels. Chairs of the CBT were given responsibility for communication and decision-making and at the same time considered the position of the departments to make their own decisions. This layered perspective highlights how the crisis management structure both reinforced and challenged existing hierarchies.

While some interviewees noted a decrease in 'political' games during the crisis, invisible dynamics still played a role. Decision-making occurred also outside official meetings through informal networks and ad-hoc agreements. This underscores the relationship between formal power structures and informal influence, revealing how leadership emerged through interactions and mutual influence.

The crisis also led to the emergence of new organizational structures and informal networks.

Our findings highlight the dynamic nature of organizational structures and networks during the hospital crisis, illustrating how relational leadership takes shape in practice. We observed the emergence of new consultation structures and the critical role of informal networks in crisis management. The crisis prompted the development of 'loose' consultation structures outside the formal CBT (table 3).

These emergent structures reveal the need for flexibility and rapid responses during crises, often bypassing formal hierarchies. The crisis management approach evolved as the organization adapted its structures to meet changing demands, showcasing the adaptive nature of relational leadership. Informal contacts and pre-existing trust, built through previous experiences, were crucial for decision-making and information-sharing. These informal networks often complemented or even replaced formal hierarchies.

The formation of new teams, such as additional operational teams and so-called *'future-ops teams'*, focused on post-crisis challenges, illustrates how the organization adapted its structures to address emerging needs. Furthermore, as the acute crisis phase subsided in late April, the organizational structure shifted significantly, with preparations made to transition the crisis organization to a new form that would address post-crisis challenges. This further demonstrates the adaptability of leadership in response to evolving conditions beyond the initial crisis phase.

Discussion

This study provides valuable insights into the dynamics of relational leadership, power structures, and role attribution during the COVID-19 crisis in a Dutch academic medical centre. Our findings contribute to the understanding of crisis management in healthcare settings and have important implications for leadership practices in complex medical environments.

Relational leadership in crisis

Our research demonstrates that leadership during the COVID-19 crisis emerged through social processes and interactions (Langi Sasongko et al., 2024; Uhl-Bien). The formation of alternative, informal and loose consultation structures and the evolution of crisis management approaches highlight the adaptive nature of leadership in response to rapidly changing environments (Hawley & Wall, 2024; M. et al., 2024). This supports the view that leadership in healthcare crises is not solely dependent on individual traits or formal positions, but rather on the collective ability to navigate complex situations through relationships and emergent practices (Ahlqvist et al., 2023; Verhoeven et al., 2024).

The constant shift between traditional hierarchical structures and more collaborative approaches during the crisis illustrates the potential for relational leadership to foster flexibility and responsiveness in healthcare organizations (Uhl-Bien, 2021). However, this transition was not without challenges, as evidenced by the tensions between centralized crisis management and departmental autonomy, in our findings. These findings suggest that healthcare leaders need to balance the benefits of hierarchical structures with the adaptability offered by relational leadership approaches, particularly in crisis situations (Uhl-Bien, 2021). Future research could focus more on such relational practices in situ (Martini et al., 2023; Raelin, 2019).

Power dynamics and decision-making

Our study reveals the complex interplay between formal power structures and informal influence in crisis management. While physicians often held formal leadership positions, the crisis demanded a constant negotiation with the normal hierarchical structures as well as at times deviating from them. This emphasized relational competencies of leaders in the crisis management structure. Such demand highlights the importance of collaborative decision-making and the need for leaders to create space for diverse perspectives (Barton et al., 2020; Hawley & Wall, 2024). Furthermore, it also lays bare the illusion of command and control that

when the crisis management structure is activated all existing formal and informal hierarchies are dissolved (Cunliffe & Eriksen, 2011).

Moreover, the persistence of traditional (medical) hierarchies and relational practices (Verhoeven, Loo, et al., 2023; Verhoeven, Marres, et al., 2023) sometimes has created barriers to truly collaborative approaches (Cleary et al., 2018; Witman et al., 2010). The tension between standardizing policies and maintaining the autonomy of medical specialties reflected ongoing power negotiations in the AMC. These findings underscore the need for healthcare leaders to be aware of and actively manage power dynamics (Looman et al., 2021), fostering an environment where expertise from various professional groups can contribute to effective crisis management.

Role attribution and physician leadership

The placement of physicians in leadership positions during the crisis raises important questions about role attribution and crisis competence. While medical expertise was often equated with crisis management skills, our findings suggest that this assumption may not always hold true. The concept of crisis competence emerged as a relational construct, influenced by perceptions and expectations of physicians' capabilities. Such 'automatic' role attribution presents both opportunities and challenges (Anglin et al., 2022; Sluss et al., 2011). On one hand, it leverages the expertise and status of physicians in guiding crisis response. On the other hand, it may overlook valuable contributions from other healthcare professionals (Verhoeven et al., 2024; Verhoeven, Marres, et al., 2023) and potentially place physicians in roles for which they are not adequately prepared.

Emergent structures and informal networks

The emergence of alternative organizational structures and informal networks during the crisis demonstrates the adaptive capacity of healthcare organizations. These emergent structures facilitated rapid decision-making and information sharing, often complementing, or bypassing formal (crisis) hierarchies. This finding aligns with the concept of 'adaptive spaces' (Uhl-Bien & Arena, 2018) in complex adaptive systems theory, where new forms of collaboration emerge to address novel challenges (Langi Sasongko et al., 2024).

However, the transition from acute crisis management to a 'new normal' revealed challenges in maintaining these adaptive structures. The observation of a 'shadow board of directors' emerging in the post-acute phase suggests that there was a struggle to integrate emergent practices and learnings into formal structures. This

highlights the need for healthcare leaders to consider how to maintain the benefits of adaptive, relational leadership approaches when learned in crisis while ensuring clear governance and accountability in the long term.

Implications for practice

Our findings have several important implications for healthcare leadership practice. Healthcare organizations should prioritize the development of relational leadership practices, fostering the ability to build and leverage relationships in crisis situations. Leaders can learn how to strike a delicate balance between maintaining necessary hierarchical structures and creating flexibility in decision-making processes. This enables them to become adept to navigating and managing power dynamics, ensuring that all relevant expertise is utilized in crisis response.

Furthermore, organizations should also expand crisis management leadership training beyond physicians to, for example nurses. In this way hospitals create a more diverse pool of crisis-competent leaders.

By implementing these strategies, healthcare organizations can enhance their resilience and responsiveness to future crises, creating a more adaptive and effective leadership culture.

Limitations and future research

This study focused on a single AMC in the Netherlands, which affects the transferability of our findings. Additionally, while the personal relationships of the first and last authors with most of the key players in crisis management facilitated data collection in a challenging context and period, these relationships may have influenced the information provided by interviewees. Future research could explore these dynamics across diverse cultural contexts to assess the transferability of our findings.

Moreover, our study highlights the need to differentiate between levels of risk and the degree of deviation from traditional leadership practices. Some crisis situations may fall within a *'bandwidth'* where leaders instinctively feel the flexibility to adjust their approach within accepted norms, while other, higher-risk scenarios may compel leaders to step beyond conventional practices, facing greater uncertainty

and challenge. Future studies could further investigate these varying categories of decision-making and leadership adaptation.

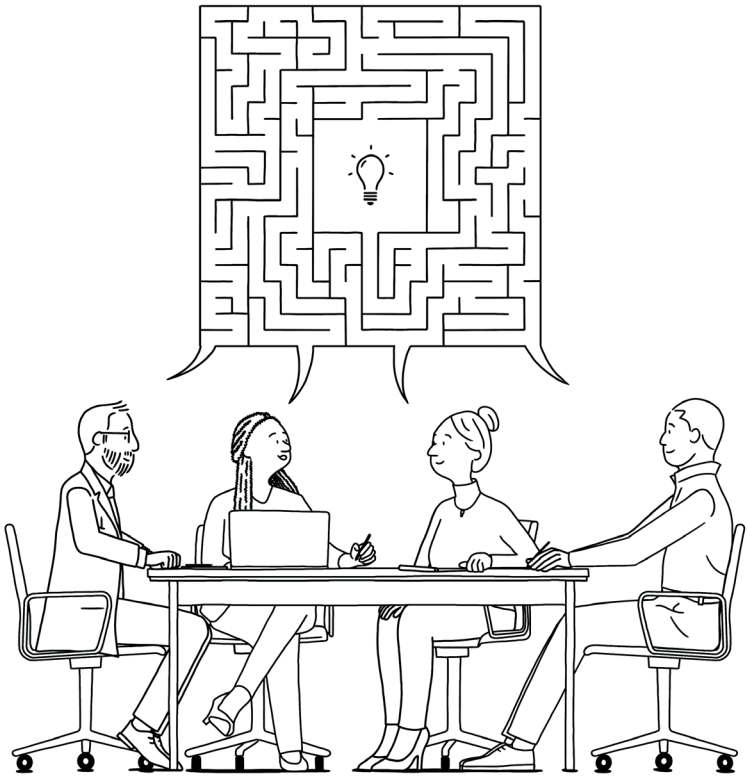
Conclusion

Our study demonstrates that effective crisis management in healthcare settings relies not only on formal training and structure but also on a complex interplay of relational leadership, power dynamics, and role attribution. The COVID-19 pandemic has highlighted the need for healthcare organizations to foster adaptive leadership approaches that can navigate the tensions between established hierarchies and emergent practices. By acknowledging the importance of relational leadership practices and power dynamics effectively healthcare organizations can enhance their resilience and responsiveness to future crises.

Healthcare leaders must recognize that crisis management is not solely about individual competencies or formal positions. Instead, it is a collective endeavour that emerges through relationships, shared experiences, and adaptive practices. By embracing this relational perspective, healthcare organizations can build more robust and responsive systems capable of meeting the challenges of crises.

SEVEN

CRITICAL REFLECTIONS, IMPLICATIONS, AND RECOMMENDATIONS



This dissertation examines relational leadership in hospitals, focusing on its fluid, situated, and emergent nature, particularly during crises. Through five qualitative-interpretive studies (Schwartz-Shea & Yanow, 2012), we explored how leadership processes emerge through collaboration, adaptability, and sensemaking among professionals, including board members, nurses, managers, and physicians, in the complex settings of hospitals. By taking this approach, the research provides a much-needed counterbalance to the dominant individual-centric leadership literature (Denis et al., 2023; Denis et al., 2012; McCauley & Palus, 2021) and addresses the call for leadership studies grounded in daily practices (Cunliffe & Eriksen, 2011; Fairhurst et al., 2020; Raelin, 2019).

Our findings align with relational perspectives on leadership, which define it as an emergent and collective process rather than a static individual trait (Hosking, 1988; Ospina et al., 2020; Uhl-Bien, 2006). This research builds on the framework of relational processual leadership (Hosking, 1988; Uhl-Bien, 2006), emphasizing leadership as a dynamic process shaped through interactions and relationships rather than individual characteristics. For example, chapter two examines how board members and nurse councils collaboratively shaped leadership processes but frequently avoided constructive conflict, limiting opportunities for transformative change. Chapter three explores how board members' discourse shaped nurses' roles and positional authority during crises, highlighting the power of language in reinforcing professional boundaries. In chapter four, nurses demonstrated boundary-spanning leadership practices, navigating organizational hierarchies to foster collaboration and influence. These first four chapters illustrate the interdependence of leadership practices and the role of contextual negotiation in shaping leadership dynamics. Furthermore, in chapter five and six, crisis management served as a relevant lens for understanding relational leadership dynamics in this research. Leadership during crises requires balancing formal hierarchies with informal networks to coordinate actions and adapt to rapidly changing circumstances. In chapter five, managers integrating formal structures with informal relational practices during the COVID-19 crisis, revealed a tension between hierarchical control and the need for flexibility. Similarly, chapter six demonstrates that both individual and collective leadership efforts are crucial during crises, advocating for a balanced approach that integrates individual agency with collective dynamics.

This dissertation advances an understanding of leadership as a relational phenomenon, emphasizing the importance of collaboration, adaptability, constructive conflict (Moerkerken, 2021), and reflexivity (Cunliffe, 2018; Cunliffe & Eriksen, 2011; Follett,

[1926] 1942; Uhl-Bien & Ospina, 2012). Examining a broad and loosely defined concept like relational leadership requires methodological reflexivity, where researchers critically evaluate how their positionality, methods, and interpretations shape their findings (Alvesson & Sandberg, 2023; Cunliffe, 2016). Instead of offering rigid definitions, this research focuses on deepening insights into how leadership unfolds in practice, while identifying pathways for further exploration and refinement. Our findings underscore that relational leadership cannot be reduced to a universal solution for complex organizational challenges. Instead, it must be understood as an ongoing, context-dependent practice that requires constant reflexivity and negotiation.

Below, I critically reflect on the concept and practice of relational leadership, the methodological choices we made in this research and their implications. Finally, I conclude with practical recommendations aimed at strengthening leadership education, fostering collaborative cultures, and addressing systemic barriers to (relational) leadership in hospitals.

Relational leadership: A critical reflection

Relational leadership, as conceptualized by Uhl-Bien (2006) and further developed by Cunliffe and Eriksen (2011), Denis et al. (2012), and Ferry et al. (2024), marks a significant paradigm shift in leadership studies (McCauley & Palus, 2021; Uhl-Bien & Ospina, 2012). It moves away from traditional individual-centric models, instead framing leadership as an emergent property of relational processes characterized by collaboration, adaptability, and shared sensemaking (Ospina et al., 2020). However, despite these advancements, our findings show that relational leadership literature, on various moments, reproduces some of the same conceptual ambiguities and oversimplifications it aims to critique. Three key aspects of relational leadership that emerged from our empirical work and highlight areas that require deeper conceptual reflection are: the structural and contextual challenges embedded in organizational practices, the illusion of harmony, and lastly, the performative effects of leadership practices. With these three specific reflections we aim to contribute to a more nuanced and critical understanding of relational leadership, particularly within the complex, hierarchical context of hospital organizations.

Structural and contextual challenges embedded in organizational practices

The traditional nursing and medical leadership theories often focus on individual leaders, emphasizing personal attributes, styles, and behaviors as key drivers of

effective leadership (Barrow et al., 2011; Berghout et al., 2017; Cummings et al., 2021). While theories such as transformational, resonant, and authentic leadership (Bass & Avolio, 1994; Northouse, 2004) have been linked to positive outcomes for nurses (Cummings et al., 2021; Cummings et al., 2023), physicians (Berghout et al., 2017; Swensen et al., 2016), and healthcare management (Giordano, 2010), they often fail to fully address the structural and contextual characteristics that shape leadership practices (see for further explanation Drath et al., 2008; Felder et al., 2024; Martini et al., 2025). A similar gap exists in the literature on workplace environments (Maassen et al., 2021; van Kraaij et al., 2025) and professional governance (Porter-O'Grady et al., 2022) in healthcare. This dissertation examines relational leadership in hospital settings, focusing on the interplay between relationships *and* the structural and contextual conditions that shape them. However, while relational leadership is appreciated for its emphasis on collaboration, shared sensemaking, and adaptability (Cunliffe & Eriksen, 2011; Denis et al., 2012; Uhl-Bien, 2006), its literature frequently overlooks the structural and organizational factors that influence leadership dynamics. By adopting a qualitative – interpretive and practice approach, this study highlights the need to critically engage with the broader realities, both relational and structural, that define leadership practices in complex healthcare organizations.

Relational leadership theory often frames leadership as a solution to organizational challenges (Uhl-Bien, 2006). However, as Alvesson (2017, 2020) critiques, relational approaches are conceptually vague and tend to ignore the contradictions, complexities, and structural barriers inherent in real-world leadership practices. Similarly, Cunliffe (2016) questions whether relational leadership adequately addresses the contextual limitations embedded in organizational life. Following Hosking's (2011a) perspective, which conceptualizes leadership as creating scripts and schemas that allow for acceptable influence and maintain a flexible social order, we acknowledge that relational leadership processes unfold in practice and that they are shaped by structural constraints. As Drath et al. (2008) emphasize, relationships and individuals are mutually constitutive, underscoring the need to address both relational processes and the structural frameworks in which they are embedded. In our study, the structural tensions of relational leadership were particularly evident in the interactions between nurse councils and hospital boards. Although nurses were encouraged to adopt collaborative leadership practices, they were often constrained by hierarchical power structures, unclear roles and responsibilities, fragmented communication channels, and limited access to essential information. These barriers hindered nurse councils from effectively positioning themselves within the organizational structure. Chapters three and four

illustrate how nurse councils operated primarily in advisory capacities, limiting their ability to exert strategic influence and leadership despite their relational efforts.

Moreover, the impact of relational leadership across diverse contexts is frequently overstated in the literature (Bass & Avolio, 1994; Yukl, 2006). Relational leadership alone cannot overcome the structural and hierarchical dynamics that often determine access to decision-making spaces. For example, during the early stages of the COVID-19 crisis, nurses were excluded from key crisis management meetings because they were not explicitly included in formal hospital crisis plans. This exclusion sidelined their expertise, delayed decision-making processes, and created communication and operational gaps in a for patients' crucial phase of the pandemic.

These processes of inclusion and exclusion of nurses align with Jasanoff and Kim's (2015) concept of sociotechnical imaginaries—collective mental models that shape expectations about how organizations and their members should function. These imaginaries are inherently relational and become enacted, stabilized, and reinforced through organizational practices and cultural norms. However, as Jasanoff and Kim (2015) argue, when such imaginaries remain implicit and unexamined—such as was the case with nurse leadership during the pandemic—they can perpetuate exclusionary practices and reinforce hierarchical barriers. In line with this perspective, addressing relational leadership solely in the present is insufficient. It also requires examining the socialization processes, historically evolved hierarchies, and institutional practices and routines that have shaped and continue to shape leadership dynamics today.

The idea of sociotechnical imaginaries resonates with the call of Drath et al. (2008) for an alternative ontology of leadership that is centered on the outcomes of direction, alignment, and commitment, rather than traditional frameworks of leaders, followers, and shared goals. Direction involves achieving collective agreement on goals and mission, alignment focuses on coordinating collective work, and commitment emphasizes prioritizing collective interests over individual ones. By following Uhl-Bien (2006) in reframing leadership as a relational and processual phenomenon embedded in collective dynamics, Drath et al. (2008) highlight the need to interrogate the structural frameworks within which relationships operate and function as meaning-making processes (Smircich & Morgan, 1982). However, structural barriers to relational leadership are not incidental but are deeply rooted in institutional routines, ingrained beliefs, and cultural socialization processes (Berger & Luckmann, 1966; Roth, 2022). Leaders must recognize the entrenched

nature of structural routines while leveraging relational processes to challenge and reframe them in practice. This requires actively creating discursive spaces where alternative perspectives can emerge and imaginaries flourish, fostering opportunities for change (Cunliffe, 2018). Relational approaches alone—or even the acknowledgment of imaginaries and alternative leadership ontologies—are insufficient to address the structural and contextual challenges in practice.

In sum, leadership thinking, development, and practice in hospitals must not only move beyond traits and competencies but should as well be aware of theoretical idealism to become a dynamic, context-sensitive practice capable of addressing both relational dynamics and deeply embedded structural constraints. Only through an integrated approach can relational leadership contribute to a more resilient and effective leadership practice in complex healthcare organizations.

The illusion of harmony in (relational) leadership

Leadership literature often portrays an overly harmonious image of leadership processes, emphasizing shared goals and vision, collective sensemaking, joints efforts and collaboration (Cunliffe & Eriksen, 2011; Denis et al., 2012; Uhl-Bien, 2006). However, as shown above, leadership is not solely about building and maintaining harmonious relationships—it is, as mentioned above, deeply embedded in historically grown, organizational systems, hierarchies, and cultural imaginaries which can be quite chaotic, foul, or at least complex. Or as Ybema et al. (2009) state, organizational life is inherently messy, characterized by contradictions and ambiguities that cannot be neatly resolved through relational processes alone. Similarly, Jasanoff and Kim (2015) highlight how collective visions of how organizational life ought to function— i.e. sociotechnical imaginaries—both describe possibilities and encode normative expectations (e.g. formal roles, responsibilities, hierarchy) about leadership enactment.

Nevertheless, relational leadership literature often assumes that collaboration naturally leads to positive outcomes, overlooking the contested and power-laden realities of leadership practices. This assumption creates an idealized image of harmony, glossing over the frictions and conflicts that drive change and are integral to organizational life. In our research, this illusion of harmony was most apparent in the positioning of board members as *'coaches'* to nurse councils. On the surface, this framing suggested partnership, mentorship, and mutual respect. However, underlying power asymmetries often remained unaddressed. Strategic conversations were frequently dominated by board members, while nurses hesitated to assert their position or demonstrate their expertise. A dynamic

that has been central in the body of literature on negotiated order (Allen, 1997; Nugus, 2019; Strauss et al., 1963; Svensson, 1996). A literature that views social order as the product of continuous negotiations among individuals in everyday interactions. Rather than being strictly dictated by formal rules and structures, this negotiation process involves an emergent, dynamic exchange—shaped by institutional contexts yet allowing for adaptability in roles, responsibilities, and boundary-setting (Allen, 1997; Langley et al., 2019). In our one-on-one interviews, participants acknowledged these negotiated dynamics, expressing frustration about their limited roles and autonomy, and/ or the behavior of other agents. Yet, in group settings, they often maintained a façade of agreement and collaboration.

This practice of a different representation in public than in a research setting aligns with Alvesson's (2020) critique that leadership theories often reproduce rather than disrupt existing hierarchies. Goffman's (1956) dramaturgical framework provides a useful lens to understand this dynamic. He distinguishes between frontstage and backstage behavior, where individuals present polished public personas (frontstage) while reserving unfiltered interactions for private spaces (backstage). Our findings suggest that relational leadership practices frequently operate on this frontstage level, with participants performing harmony and shared purpose while concealing underlying tensions and frustrations backstage. This façade of harmony in both literature and practice (see for example Lunkka et al., 2021) raises a critical question: Is collective agreement in public spaces a strategic necessity or an example of what Brunsson (1993) describes as *'necessary hypocrisy'*? Brunsson defines the necessary hypocrisy as the intentional gap between what is said and what is done—a gap that allows organizations to function despite internal contradictions. From this perspective, the appearance of harmony does not reflect a failure of relational leadership but could instead be a deliberate strategy to preserve connections and prevent destabilizing fragile collaborations. However, the avoidance of openly addressing tensions and conflicts often leads actors to prioritize superficial consensus over substantive engagement with contentious issues.

Conflict, when managed constructively, can play a transformative role in organizations. As early as Mary Parker Follett ([1926] 1942) scholars argued that conflict, if approached constructively, can stimulate organizational growth and innovation. Likewise, among others, Moerkerken (2021) and Den Uijl (2022) emphasize that productive conflict enhances collective sensemaking, fosters practical wisdom in governance, and improves organizational decision-making. Despite this potential, our research revealed that conflict was often avoided or kept *'under the radar'* (Kok et al., 2023) in the name of preserving superficial relational

harmony (see chapter two). This avoidance fostered passive compliance rather than meaningful collaboration, ultimately undermining the transformative potential of relational leadership.

Instead of accepting compliance or framing it as *'necessary hypocrisy'*, as Brunsson (1993) suggests, organizations should adopt approaches proposed by authors such as Mary Parker Follett ([1926] 1942), Moerkerken (2021) and Den Uijl (2022). These approaches advocate for embracing constructive conflict to strengthen relational leadership and promote meaningful collaboration. While hierarchical pressures may persist, leaders can create spaces for relational engagement where disagreement and conflict are not feared but seen as opportunities for growth. These spaces must acknowledge the inherent complexities and contradictions of organizational life, ensuring that the pursuit of collaboration does not obscure its messiness. To achieve this, leaders must cultivate reflexive capacity, which Cunliffe (2016) defines as the ability to critically examine their assumptions, behaviors, and interactions in real time and in dialogue with others. Reflexive leaders can discern between harmony and genuinely productive collaboration. This requires leaders to embrace discomfort, balance interactions rooted in professional logics and hierarchy, and encourage others to engage reflexively. By fostering an environment where constructive conflict is normalized, leaders can ensure that relational leadership effectively addresses organizational challenges, navigating the tensions between shared goals and individual agency.

In sum, relational leadership often idealizes harmony, overlooking organizational messiness and power dynamics. Constructive conflict drives growth and better decision-making. Leaders must, therefore, embrace reflexivity and discomfort, keep addressing tensions, and foster spaces for meaningful engagement, ensuring relational leadership effectively navigates complexities and supports collaboration.

Performative effects of leadership

Relational leadership is not neutral or value-free—it is inherently performative (Hultin & Mähring, 2016; Oldenhof et al., 2016b). Performativity means that some words or actions don't just describe something — they make it happen. For example, at a wedding, when the officiant says, *'I now pronounce you husband and wife'*, those words create the marriage. In organizations this means that actions, statements, and policies do more than describe an existing reality; they actively shape and transform it (Gond et al., 2015). Annemarie Mol's *The Body Multiple: Ontology in Medical Practice* (2002) illustrates how medical practices produce multiple realities of the body. In a hospital, a condition such as a diseased

leg is understood differently by various professionals: a physician may focus on anatomical issues, a nurse on mobility challenges, and a lab technician on biochemical markers. These perspectives coexist and interact, creating a *'multiple'* body that emerges through the practices and tools of each discipline. Mol argues that this multiplicity, as performative process, is not problematic but productive, as it enables collaboration and tailored care within the healthcare system. Reality, in this view, therefore, is not static but is continually enacted through actions, tools, techniques, and interactions. Similarly, in relational leadership, actions, language (Barge, 2012), and decisions actively construct organizational realities, often in subtle and unnoticed ways.

Furthermore, leadership itself, as Smircich and Morgan (1982) observe, has become *'vernacular',* seamlessly integrated into workplace vocabulary and practices. This embeddedness makes leadership as a concept performative, as its enactment reproduces the interpretations and expectations associated with it. Gherardi (2017) underscores this idea, showing how leadership practices, much like her experimental performative writing (see Gherardi, 2017), simultaneously reflect and construct social and organizational dynamics. These performative effects of leadership were evident in our research, particularly in how language, positioning, and relational dynamics significantly shaped leadership practices and outcomes. However, these effects often appeared unintended by participants, as they seemed (partly) unaware of the implications of their actions. For example, during budget discussions, board members often used technical jargon, which—whether intentional or not—effectively excluded nurses from meaningful participation. Another instance, as discussed in chapter four, involved nurse councils dissolving at the onset of the COVID-19 pandemic. Members of the councils, being nurses, shifted their focus to bedside care, *'rolling up their sleeves'*, and prioritizing patient needs over their strategic roles. This shift meant that, in some hospitals, nurses were not strategically involved in critical crisis management decisions.

In contrast, some performative effects were recognized by managers, as described in chapter five. For instance, business managers observed that their job titles carried significant influence, enabling them to secure decisions that other employees, without similar titles, struggled to achieve. This awareness highlighted how organizational hierarchies and role designations can subtly shape decision-making dynamics and outcomes.

Performative effects are reinforced by historical and contextual factors (Martini et al., 2025; Martini et al., 2024; Schalkwijk et al., 2024). Leadership in hospitals

extends beyond formal decisions and strategic plans to include everyday relational interactions. For example, during a crisis, a nurse strategically positioned herself near the boardroom corridor to leverage informal access and ensure her concerns were heard by decision-makers. Knowing where to be, in space and time has performative effects. Furthermore, this example also highlights how leadership often unfolds through apparently mundane micro-interactions (see for example Alvesson & Sveningsson, 2003b; Larsson & Lundholm, 2010, 2013; Shotter & Cunliffe, 2003; Sklaveniti, 2020; Sutherland, 2016) that traditional leadership discourses overlook. Similarly, as discussed in chapter six, physicians' efforts to foster collaboration stemmed from their hierarchical positioning, where their expertise made them default leaders in crisis settings. Furthermore, the performative nature of leadership was also evident in symbolic acts. For instance, a vignette from our study describes a nurse council chair changing out of her nurse uniform into formal attire before meeting a board member, believing this would make her appear more representative. However, the board member told us afterwards that she saw the meeting as an informal reflection with a nurse representative rather than a strategic governance meeting. Such disconnect highlights the tension between perceived expectations and actual intentions in leadership interactions, illustrating how performative behaviors shape and are shaped by relational dynamics.

Attention is another critical dimension of leadership's performative effects. Nicolini and Korica (2021) and Nicolini and Mengis (2024) argue that attention is not solely an individual cognitive act but is shaped by socio-material arrangements, tools, and organizational practices. However, in our study, we observed little evidence of deliberate attention to the relational aspects of the interactions. For example, board-level agendas often (unintentionally) sidelined the concerns of nurse councils, highlighting how organizational focus can exclude key perspectives. Reflective questions such as *"to what and how am I paying attention?"* (Nicolini & Korica, 2021, p. 24) can help leaders uncover neglected relational tensions and marginalized voices in their decision-making processes. According to Nicolini and Korica (2021) this demands consciously working with a *'attentional infrastructure'*. This infrastructure, established and maintained through routine practices (e.g. agenda setting, inviting the 'right' people to the table), allows leaders to remain attentively engaged, manage fragmentation, and mitigate risks of oversight. This aligns with what is called reflexivity (Cunliffe, 2018; Hosking & Pluut, 2014; Medico & Santiago-Delefosse, 2014). Reflexivity, as described by Cunliffe (2016), involves an ongoing critical examination of one's assumptions, positionality, and practices. In our research, reflexivity proved valuable for identifying gaps between relational leadership ideals and their enactment but was to us largely absent in the practices

we studied. Reflexivity offers a pathway for leaders to critically engage with their performative effects, fostering doubt and interrogating the organizational systems within which they operate. Although doubt is often viewed as disruptive in leadership practices, it can also be generative. Locke et al. (2008) describe doubt as a force that disrupts established routines, encouraging critical questioning and innovation. Similarly, Weick (2003) emphasizes doubt as central to sensemaking, describing how it animates leadership practices through improvisation, lightness, and interdependence. Leadership, according to Weick, involves embracing uncertainty and using doubt as a tool for collective problem-solving. Leaders must create environments where doubt is acknowledged, attention is key, reflexivity is supported and incorporated into decision-making processes to mitigate the inherent performative effects of leadership in hospitals.

In sum, relational leadership must be understood as an emergent, collective phenomenon shaped by the interplay of relational dynamics, structural positioning, and the performative consequences of leadership actions. As Weick (2001) aptly states: *'Action generates outcomes that ultimately provide the raw material for seeing something'* (p. 53). This encapsulates leadership as an ongoing, situated, and reflexive process. Leadership in hospitals, therefore, is not something that just happens. Leadership requires action, to navigate uncertainty with intentionality, lightness, attention, and openness, recognizing that every action, word, and relational exchange contributes to shaping the organizational landscape.

Reflection on methodology

This dissertation employs a qualitative-interpretive approach (Schwartz-Shea & Yanow, 2012) to examine relational leadership in hospital settings. Grounded in a constructionist epistemology (Cunliffe, 2010) and closely aligned with practice theory (Nicolini, 2012; Raelin, 2019), the methodology emphasizes the contextual, emergent, and processual nature of leadership. While this approach provided rich insights into the lived experiences of hospital professionals, it also presented methodological and practical challenges that merit critical reflection. This section examines the role of reflexivity and doubt, reflective space, practice theory and embodiment, and the value of abductive reasoning in this research.

Reflexivity and the role of doubt in leadership research

Reflexivity was a foundational element of this research, acknowledging both the co-constructed nature of relational leadership and the influence of the researcher's

positionality (Cunliffe, 2010, 2016). Alvesson's (2003, 2009) concept of at-home ethnography was especially pertinent, as my dual role as both manager and researcher granted me privileged access to the everyday practices and dynamics of hospital leadership. This insider perspective allowed me to observe nuanced, revealing moments—hallway conversations, informal exchanges over coffee, and interactions during meetings. However, this dual role demanded ongoing reflexivity to counteract the risks of over-familiarity and bias.

My positionality as a business manager with an anthropology background and an external PhD candidate influenced not only my access to respondents but also the framing of questions and interpretation of data. For instance, justifying the value of qualitative-interpretive research in a field dominated by positivist and quantitative methodologies posed a recurring challenge, even though nurses and medical professionals often rely on observation, interpretation, and abductive reasoning in their clinical practices (Karlsen et al., 2021; Stanley & Nyrup, 2020). This negotiation of roles and perspectives of and between participants and researcher underscored the relational nature of the research process, which depended on trust, dialogue, and shared vulnerability.

Furthermore, doubt, as emphasized by Locke et al. (2008), also played a critical role in shaping reflexivity in our research. At times, doubt was implicit—such as when I briefly considered conducting a systematic review on relational leadership to validate the research's academic contribution. My supervisor, Pieterbas Lalleman, highlighted that this inclination stemmed from personal insecurities and showed confirmation to a, in his opinion, academic and especially positivist norm, rather than methodological necessity. Doubt also arose explicitly during team discussions, such as debates over the validity of diary entries as data sources, or the robustness of interpretations drawn from at-home ethnographic accounts. Far from hindering the research, these moments of doubt and epistemological negotiations and boundary work proved productive, challenging assumptions, and fostering an iterative, collaborative approach to data collection and analysis. Therefore, researchers (and leaders) should be encouraged to embrace doubt and uncertainty as strengths for fostering innovation and reflective growth in complex situations.

The research as a reflective space

This study employed multiple qualitative methods, including in-depth interviews, focus groups, ethnography, document analysis, and observant participation (Moeran, 2009). COVID-19 restrictions significantly constrained opportunities for shadowing (Lalleman, Bouma, et al., 2017; Nicolini & Korica, 2024) and extended

ethnographic observation (see chapters 1, 2, 4 and 6 in Ybema et al., 2009) which are common in practice theory related ethnographies. While interviews and focus groups partially compensated for these limitations, they could not fully replicate the immediacy of observing relational leadership practices in action (see for examples De Graaff et al., 2021; Kuijper et al., 2024; Lalleman et al., 2015; Mol, 2002).

Interviews provided valuable insights into participants' reflections on leadership experiences (Langley & Meziani, 2020). However, as Schatzki (2016) argues, interviews often privilege *'sayings'* over *'doings'*, potentially neglecting the practical enactment of leadership. To address this gap, interview data were triangulated with meeting minutes, audio recordings, ethnographic accounts, and policy documents. This combination enriched the analysis by contextualizing participants' narratives within their organizational settings. Furthermore, my role as an observing participant provided opportunities to witness real-time leadership dynamics, capturing informal negotiations and power dynamics during crisis meetings.

Interestingly, participants frequently noted that interviews and focus groups provided valuable spaces for reflection and shared learning. Many emphasized the benefits of stepping back from their daily routines to critically examine their practices. The research served as a reflective space by offering participants opportunities to engage with findings, analysis and learning of diverse perspectives. This resonates with Weick's (2003) concept of sensemaking, captured in his statement: *'How can we know what we think until we see what we say?'* (p. 108). Meaning that, according to Weick, our understanding of a situation often emerges through the process of articulating and expressing our thoughts (see also Kuiken, 2024 for further elaboration). As such, these reflective spaces not only enriched the research findings but also underscored the significance of collaborative sensemaking in relational leadership. Although we did not systematically trace how participants' reflections and/or participation to these *'spaces'* influenced their subsequent practices, the process itself highlights the iterative and relational nature of leadership dynamics.

Practice theory and embodiment

The integration of practice theory (Nicolini, 2012; Raelin, 2019) and abductive reasoning (Golden-Biddle, 2020; Timmermans & Tavory, 2012) was fundamental to this research. Practice theory provided a framework to understand leadership as a dynamic, collective, and context-dependent phenomenon, emphasizing the interplay of historical, material, and social factors. Nicolini (2012) positions practice as dynamic, relational, and central to social and organizational life, showing how

everyday actions enact, reproduce, and transform organizational realities. Nicolini (2012) builds on the work of influential thinkers such as Bourdieu (habitus and practical logic), Giddens (structuration theory), Foucault (power and discourse), and Schatzki (practice ontology) to develop a practice-based approach to studying organizations. Bourdieu's (1990) concept of habitus, understood as embodied dispositions, illustrates how ingrained patterns of thought and behavior both shape and are shaped by social structures.

Marcoulatos (2001) and Melancon (2014) explore the intersection of Merleau-Ponty's phenomenology and Bourdieu's social theory, emphasizing the embodied and relational dimensions of leadership practice (Küpers, 2013). They argue that individuals and their social context exist in a dynamic, reciprocal relationship of mutual influence, as thinking itself is an embodied, social, and political activity. Consequently, leadership researchers, as Küpers (2013) suggests, are inherently embedded in the very practices they study, deepening their understanding of leadership's relational, reciprocal, and embodied nature.

Our research embodies an embedded approach, with the team leveraging our personal and lived experiences within complex hospital environments to enrich the research design, data collection, and data analysis. These experiences were made productive by, for example, accessing research settings (i.e. board rooms, crisis management meetings) through personal networks, personal connection (e.g. rapport), and employing at-home ethnography. This embodied embeddedness allowed the study to illuminate the perceptual, emotional, and systemic dimensions of leadership practices. As Den Uijl (2022) highlights, drawing also on Merleau-Ponty, meaning arises not solely in the mind but through lived, sensory experiences situated in material and social contexts.

Leadership—and its study—is not merely a cognitive process but an embodied, iterative engagement with the complexities of organizational life. The processual perspective on relational leadership, central to this dissertation, highlights the dynamic and co-constructed nature of leadership as it emerges through continuous interactions between leaders and followers (Ladkin, 2020). A key concept in this perspective is Merleau-Ponty's notion of 'flesh,' which aligns with what Bradbury and Lichtenstein (2000) describe as the 'space between'—a relational and embodied dimension of leadership. From this perspective, leadership is not solely an individual act but an interdependent phenomenon that transcends isolated agency (Den Uijl, 2022). This relational interdependence was particularly evident in our studies on the positioning of nurses (see chapters two and three), where

participants described feeling excluded or not taken seriously—experiences that were often sensed in the body before they were consciously articulated. These embodied sensations shaped their understanding of leadership and their role in organizational decision-making.

This perspective underscores the idea that just as one perceives, one is also perceived, reinforcing leadership as an embodied and relational practice (Ladkin, 2013). It aligns with broader interpretations of intersubjectivity, in which leaders and researchers are embedded in relationally responsive encounters (Cunliffe, 2010). Recognizing leadership as an embodied phenomenon offers a more nuanced understanding of how meaning, alignment, and influence emerge through bodily perception and interaction. In this view, leaders and their interactions serve as meaning-making instruments, requiring intentional and reflexive engagement.

Building on this, Küpers (2013) argues that leadership practices are interrelated and continuously evolving, requiring leaders and researchers to engage in 'inter-practices'—an ongoing negotiation of materiality, subjectivities, and institutional norms. Den Uijl (2022) further asserts that this process demands practical wisdom that extends beyond cognitive approaches, integrating being, feeling, knowing, and doing. He describes leadership as an iterative process of 'wayfinding' or 'muddling through,' rather than a structured and predictable course—a concept explored in chapters two and five that applies equally to researchers, reinforcing the interconnected nature of leadership as practice and the study of it.

By focusing on leadership as a processual and embodied accomplishment embedded in cultural and societal contexts (Crevani et al., 2010; Uhl-Bien, 2006), practice theory moves beyond static notions of leadership roles to explore how leadership is actively constructed, negotiated, and experienced in everyday interactions. This practice vantage point as a relational, embodied and *'collective knowledgeable doing'* (Gherardi, 2017, p. 347) fueled our abductive approach.

The value of abductive reasoning

Abductive reasoning allowed for an iterative interplay between theoretical insights and empirical observations, enabling our research to adapt dynamically to the data and evolving research questions. This process is often referred to as methodological bricolage (Pratt et al., 2020). Bricolage involves making do with the situation encountered and the tools available (Blijleven & van Hulst, 2021). In qualitative research, this means actively choosing methods from a wide array of options to fit the unique demands of the study (Pratt et al., 2020). For instance,

ethnographers often use their methods flexibly and pragmatically to deepen their understanding of the field. In our study, research questions and analytical focus evolved dynamically, informed by ongoing discussions between my supervisors and myself and reflections from participants. The sequential structure of the four focus groups in chapter three exemplifies this abductive approach. After each session, we critically reflected on the process and outcomes, refining subsequent focus groups to address emerging themes and tensions more effectively (van Hulst & Visser, 2024). This iterative approach, enabled our research to remain flexible and responsive, fostering a deeper engagement with the complexities of relational leadership in hospitals. For example, in 2023, based on the analysis of interviews, focus groups, and the at-home ethnographic accounts from the study on business managers, we identified a need to explore how the findings related to crisis management resonated in the managers' everyday practices after the crisis. In response, we organized an additional focus group session, framed by a refined analysis, and conducted within a different timeframe, to examine this aspect in greater depth. Furthermore, our iterative process implied that analysis started with data collection (Nicolini & Korica, 2021), producing a richer and more dynamic understanding of relational leadership. As Locke et al. (2022) notes, *'iterativity advances the mundane everyday work entailed in developing explanations'* (p. 277).

Capturing the fluid and emergent nature of relational leadership, however, remains a challenge. Among others, Yanow (2014) and Thorne (2013) caution that qualitative-interpretive methodologies require a careful balance between depth and breadth, particularly when studying context-dependent phenomena like leadership. The reliance on interviews and document analysis during pandemic restrictions limited opportunities to fully observe leadership practices in action. Nevertheless, the methodological flexibility afforded by practice theory enabled creative adaptations, such as incorporating informal observational data and leveraging participants' reflective accounts.

In sum, this dissertation highlights the relational and iterative nature of leadership research. By integrating abductive reasoning, reflexivity, and practice theory, it underscores the value of qualitative-interpretive approaches and bricolage in capturing the complexity of relational leadership in hospitals. As such this combination can help leaders in practice as well to become more aware of their positionality, the performative effects of actions and how to deal with them in complexity.

Furthermore, the methodological adaptability demonstrated in this research offers a nuanced understanding of the contextual, emergent, embodied, and processual aspects of leadership, enriching both theory and practice. These contributions hopefully help pave the way for further exploration of how relational leadership unfolds in dynamic, organizational contexts.

Recommendations

Leadership practices are deeply influenced by diverse contexts, professional roles, and interpersonal interactions, each demanding tailored approaches and ongoing reflexive engagement. This diversity within relational leadership dynamics creates opportunities for more adaptive, inclusive, and context-sensitive leadership. Based on our research and reflections, we offer the following recommendations for practitioners in complex organizations:

1. Recommendations for leadership education and development programs

Emphasize relational leadership: Develop programs that conceptualize leadership as a relational process rooted in collaboration, networks, and shared practices, complementing individual skill training.

Interprofessional training: Facilitate sessions where physicians, nurses, business managers, and executives collaboratively explore shared responsibilities, interdependence, and performative positionality in relation to shared organizational goals.

Embrace doubt and conflict as a strength: Encourage leaders to appreciate uncertainty, conflict, and doubt as opportunities for innovation and reflective practice in complex situations.

Practice-Oriented learning: Incorporate experiential learning, such as real-world hospital (crisis) scenarios, peer reflection, (peer to peer) shadowing, and mentoring, to highlight informal networks, relationality, and emergent leadership practices.

2. Recommendations for nurses

Strengthen strategic positioning: Equip nurses with skills to amplify their voices and relational practices in governance structures, leveraging sponsors (e.g., board members, managers) for support.

Develop relational leadership senses: Train nurses to sense relational dynamics, navigate power dynamics and foster collaboration within and beyond their teams and profession.

Leverage informal networks: Encourage nurses to actively utilize informal networks to enhance their influence and effectiveness across professional and organizational boundaries.

3. Recommendations for physicians

Recognize shared responsibilities: Support physicians in developing interprofessional leadership by fostering shared goals and mutual understanding with healthcare teams.

Engage in relational leadership: Train physicians to actively create spaces for diverse perspectives and to organize collective attention within teams.

Adapt in crisis management: Ensure physicians can adapt to and promote flexible collaboration during crises to effectively influence outcomes.

4. Recommendations for business managers

Strengthen the bridging role: Equip them with advanced training in relational leadership, systems thinking, and reflexivity to actively address structural tensions, foster cross-departmental/ professional collaboration, and align strategic goals with team dynamics.

Relational decision-making: Encourage managers to approach decisions through relational and social processes, not solely structural frameworks such as formal hierarchy.

Enhance tools and processes: Train managers to design and implement tools and routines that foster attention and collaboration within teams.

5. Recommendations for hospital boards

Promote inclusivity in governance: Revise governance structures to include nurses and other healthcare professionals in strategic decision-making processes.

Support informal networks: Cultivate a culture that values and supports informal collaboration, particularly in crisis scenarios.

Foster relational leadership at the board level: Make relational leadership a core principle in board practices, emphasizing interdependence and shared goals with the agents in the organization.

Leadership development: Invest in leadership programs that blend relational, processual, and formal, individual leadership skills, focusing on crisis management, daily practice, and long-term strategies, with an emphasis on practical application.

Implement interprofessional reflexive practices: Introduce joint governance structures and reflexive practices to bridge the gap between formal hierarchies and relational dynamics, fostering collective ownership.

6. Recommendations for researchers

Emphasize reflexivity in research: Incorporate researcher reflexivity in studies of leadership, acknowledging how the positionality, background, and engagement (skin-in-the-game) of the researcher shape data collection, analysis, and interpretation. Using at-home ethnography, participant observation, and relational research approaches can enhance context-sensitive and practice-oriented insights.

Develop methodologies that capture leadership in situ: Move beyond heroic retrospective accounts and static leadership assessments by designing methodologies that capture leadership-in-practice. Recognize the past. Use longitudinal studies, real-time ethnographic observations, and participatory methods such as shadowing to trace how leadership emerges, shifts, and adapts over time.

Bridge theory and practice: Strengthen the connection between diverse leadership research ontologies and organizational practice by engaging in co-creative research with nurses, doctors, managers, and board members. Develop practice-informed theoretical insights that directly contribute to leadership education, governance strategies, and hospital decision-making processes.

These recommendations aim to integrate relational leadership principles into everyday practices, empowering agents across professional and organizational boundaries to collaboratively address the complexities of organizational life.

Concluding remarks

Leadership in hospitals is not confined to formal hierarchies, predefined roles, or structured processes. Instead, it emerges as a relational, adaptive, and context-dependent practice shaped by daily interactions, shared histories, and collaborative sensemaking. Moreover, agents are not always consciously aware of the nature and meaning of these emerging processes. This dissertation demonstrates that leadership is not simply about decision-making authority or individual competencies but is deeply intertwined with how professionals—nurses, physicians, managers, and board members—navigate complex organizational landscapes together.

Drawing on insights from five qualitative-interpretive studies, it becomes clear that leadership in hospitals is experienced and shaped through moments of negotiation, alignment, and tension. Professionals engage in leadership not only in meeting rooms or strategic plans but also in the informal spaces of hospital life—hallways, team discussions, and spontaneous interactions. These micro-level interactions reveal how power, trust, and shared responsibility are co-constructed over time and influence organizational outcomes.

Leadership in hospitals cannot rely on pre-designed plans or rigid structures alone; it thrives in the ability to respond flexibly and reflexively to emerging situations, to recognize the expertise of others, and to create spaces for embodied, shared reflection and collective action. However, this dissertation also highlights the structural constraints and power imbalances that often hinder relational leadership practices. Formal hierarchies, cultural norms, and institutional policies frequently limit the potential for inclusive collaboration. Yet, even within these constraints, moments of relational leadership arise—often in surprising and informal ways—as professionals adapt, negotiate, and collectively make sense of their realities.

In conclusion, leadership in hospitals is not a static or individualistic attribute but an ongoing, dynamic process. It emerges from embodied, relational practices and is performed in spaces where professionals come together to make sense of complexity. To navigate these complexities effectively, professionals and leaders alike must remain reflexive, embrace uncertainty, and recognize the relational and performative nature of their leadership actions.

This dissertation invites both scholars and practitioners to rethink leadership as a collective and situated practice—one that, in the words of Karl Weick (2001) (noted at the back cover of this book), is less about commanding waves and more about learning to surf them together.

SUMMARY

Introduction

Leadership within hospitals is traditionally viewed through a structural or competency-based lens. However, this dissertation challenges that perspective by exploring relational leadership as a dynamic and interactive process. The study positions leadership as a socially constructed phenomenon emerging through interdependent relationships rather than being a static, individual skill. Using a qualitative-interpretative methodology, the research delves into leadership practices within Dutch hospitals, emphasizing interdependence, role attribution, and organizational positioning.

Chapter TWO – Knowing, relating, and the absence of conflict: Relational leadership processes between hospital boards and chairs of nurse councils

This chapter investigates the relationship between hospital boards and nurse councils, highlighting three intertwined relational processes: knowing each other, relating with, and relating to. Findings indicate that while collaboration between these entities is taken for granted, an implicit power imbalance exists. Nurse councils strive for influence, but their positioning is frequently subordinated to the authority of hospital boards. Furthermore, the study notes a surprising absence of conflict in observed interactions, despite interviewees mentioning tensions in private conversations. This paradox suggests that leadership relationships in hospitals may prioritize harmony over productive confrontation.

Chapter THREE – Board Talk: How members of executive hospital boards influence the positioning of nursing in crisis through talk

This chapter examines how executive board members influence the strategic positioning of nurses in crisis situations through discourse. Findings highlight that talk functions as a performative act shaping professional identities and power relations. Board members predominantly frame nursing as a practical rather than strategic profession, reinforcing a historical narrative that limits nurses' participation in high-level decision-making. The study also identifies ambiguity in nursing representation, with three different groups—frontline nurses, nurse managers, and nurse councils—claiming to represent nursing expertise, leading to confusion and inefficiency. By shedding light on these dynamics, the study argues that linguistic framing is a crucial mechanism in determining which professionals gain influence in crisis settings.

Chapter FOUR – Nurses' relational leadership struggles on positioning in strategic hospital crisis management: A qualitative-interpretive study

Building on the previous chapter, this section investigates how nurses experience and enact leadership during hospital crises. The study found that despite their critical role in patient care and crisis response, nurses struggle with organizational positioning. Their preference for frontline work over strategic engagement often reinforces their exclusion from high-level crisis management. This chapter underscores the need for structural changes that enable nurses to participate more actively in decision-making processes beyond bedside care.

Chapter FIVE – Relational leadership in crisis: How business managers in hospitals navigate role attribution and organizational challenges

This chapter explores how business managers navigate leadership responsibilities during crises. Business managers often act as intermediaries between hospital boards, physicians, and nurses, requiring them to balance multiple perspectives. The study finds that role attribution is fluid, with managers frequently assuming different leadership approaches depending on the situation. Some adopt a directive approach, while others embrace a facilitative role that fosters collaboration. These findings suggest that relational leadership is not merely a concept but a practice that emerges dynamically through everyday organizational interactions.

Chapter SIX – Working apart together: Relational leadership of physicians in crisis management during the COVID-19 pandemic

This chapter examines the role of physicians in crisis leadership, focusing on the COVID-19 pandemic. Physicians traditionally occupy a high-status position in hospital hierarchies, but the pandemic disrupted conventional leadership norms, necessitating greater collaboration. The study reveals that while some physicians adapted to relational leadership models, engaging in team-based decision-making and cross-disciplinary cooperation, others maintained a more traditional, hierarchical approach. The findings indicate that leadership during crises is not solely about authority but also about the ability to engage with uncertainty and leverage collective expertise.

Chapter SEVEN – Critical reflections, implications, and recommendations

This concluding chapter synthesizes key insights from the dissertation and offers reflections on relational leadership literature. Three main issues are highlighted. First,

the illusion of harmony, where the absence of visible conflict in leadership interactions may indicate an avoidance of difficult but necessary discussions. Productive conflict could serve as a resource for innovation and improved collaboration. Second, structural constraints on relational leadership, as relational leadership practices exist in hospitals but are often constrained by rigid structures privileging certain professional groups. Overcoming these barriers requires institutional support for cross-disciplinary leadership models. Third, the performative nature of leadership, as leadership is enacted through talk, interactions, and positioning rather than formal titles alone. Recognizing this performativity allows leaders to rethink how leadership is cultivated across all professional groups.

Methodological reflections

The dissertation employs a qualitative-interpretative research design, using interviews, observations, at-home ethnography, and document analysis to explore leadership as a relational process. A reflexive stance acknowledges the researcher's dual role as both participant and observer. The study embraces abductive reasoning, which allows for iterative interpretation of data while recognizing the challenges in maintaining objectivity. It also integrates embodiment and practice theory, demonstrating that leadership is enacted through bodily presence and habitual practices rather than just discourse. These reflections underscore the importance of transparency, reflexivity, and continuous self-examination in qualitative leadership research.

Conclusion

This dissertation contributes to leadership theory by demonstrating that relational leadership processes are a key aspect of hospital governance, particularly in times of crisis. The study emphasizes leadership as a social and discursive process rather than a fixed competency. Key contributions include advocating a shift from traditional, top-down leadership models toward a more inclusive, relational, and processual approach and providing practical insights for hospital executives, policymakers, researchers, and healthcare professionals seeking to improve collaborative leadership in complex organizations. Through qualitative-interpretative methods, this dissertation not only advances theoretical understanding but also offers actionable recommendations for enhancing relational leadership in hospital settings.

SAMENVATTING

Inleiding

Leiderschap binnen ziekenhuizen wordt traditioneel gezien door een structuur of competentiegerichte lens. Deze dissertatie daagt dat perspectief echter uit door relationeel leiderschap te verkennen als een dynamisch en interactief proces. De studie positioneert leiderschap als een sociaal geconstrueerd fenomeen dat voortkomt uit wederzijdse afhankelijkheid in relaties, in plaats van als een statische, individuele vaardigheid. Door gebruik te maken van een kwalitatief-interpretatieve methodologie, onderzochten wij leiderschapspraktijken binnen Nederlandse ziekenhuizen, met nadruk op wederzijdse afhankelijkheid, de toekenning van rollen en organisatorische positionering.

Chapter TWO – Knowing, relating, and the absence of conflict: Relational leadership processes between hospital boards and chairs of nurse councils

Dit hoofdstuk onderzoekt de relatie tussen ziekenhuisbesturen en verpleegkundige adviesraden, waarbij drie onderling verbonden relationele processen worden belicht: elkaar kennen, met elkaar relateren en tot elkaar relateren. De bevindingen geven aan dat hoewel samenwerking tussen deze groepen als vanzelfsprekend wordt beschouwd, er vaak een impliciete machtsongelijkheid bestaat. Verpleegkundige adviesraden streven naar invloed, maar hun positionering wordt vaak ondergeschikt gemaakt aan de autoriteit van bestuurders. Bovendien constateerden we een onverwachte afwezigheid van conflict in de door ons geobserveerde interacties, ondanks dat geïnterviewden spanningen noemden in privégesprekken met ons. Deze paradox suggereert dat leiderschapsrelaties in ziekenhuizen harmonie prioriteren boven productieve confrontatie.

Chapter THREE – Board Talk: How members of executive hospital boards influence the positioning of nursing in crisis through talk

Dit hoofdstuk onderzoekt hoe bestuurders van ziekenhuizen de strategische positionering van verpleegkundigen in crisissituaties beïnvloeden via taal. De bevindingen benadrukken dat taal functioneert als een *performatieve* handeling die professionele identiteiten en machtsverhoudingen vormgeeft. Bestuursleden positioneren verpleegkundigen grotendeels als een praktische in plaats van een strategische professie, wat een historisch narratief versterkt dat de deelname van verpleegkundigen aan besluitvorming op strategisch niveau beperkt. De studie identificeert ook een ambiguïteit in de vertegenwoordiging van verpleegkundigen, waarbij drie verschillende groepen—verpleegkundigen aan het bed, verpleegkundig managers en verpleegkundige adviesraden—claimen

de verpleegkundige expertise te vertegenwoordigen, wat leidt tot verwarring en inefficiëntie. Door deze dynamiek te belichten, stelden wij dat positionering via taal een cruciaal mechanisme is in de bepaling van welke professionals invloed krijgen in crisissituaties.

Chapter FOUR – Nurses' relational leadership struggles on positioning in strategic hospital crisis management: A qualitative-interpretive study

Voortbouwend op het vorige hoofdstuk onderzoekt dit hoofdstuk hoe verpleegkundigen leiderschap ervaren en uitoefenen tijdens ziekenhuiscrises. De studie constateert dat verpleegkundigen, ondanks hun cruciale rol in patiëntenzorg en crisisrespons, worstelen met hun organisatorische positionering. Hun voorkeur voor zorgwerk boven strategische betrokkenheid versterkt vaak hun uitsluiting van crisismanagement op strategisch niveau. Dit hoofdstuk onderstreept de noodzaak van structurele veranderingen die verpleegkundigen in staat stellen om actiever deel te nemen aan besluitvormingsprocessen buiten de directe patiëntenzorg.

Chapter FIVE – Relational leadership in crisis: How business managers in hospitals navigate role attribution and organizational challenges

Dit hoofdstuk onderzoekt hoe managers bedrijfsvoering omgaan met leiderschaps-verantwoordelijkheden tijdens crises. Onze managers bedrijfsvoering fungeren vaak als intermediairs tussen ziekenhuisbesturen, artsen en verpleegkundigen, wat vereist dat zij meerdere perspectieven balanceren. De studie toont aan dat roltoekenning fluïde is, waarbij managers afhankelijk van de situatie verschillende leiderschapsbenaderingen aannemen. Sommigen hanteren een directieve aanpak, terwijl anderen een faciliterende rol omarmen die samenwerking bevordert. Deze bevindingen suggereren dat relationeel leiderschap niet louter een concept is, maar een praktijk die zich dynamisch manifesteert in dagelijkse organisatorische interacties.

Chapter SIX – Working apart together: Relational leadership of physicians in crisis management during the COVID-19 pandemic

Dit hoofdstuk onderzoekt de leiderschapsrol van artsen in crisis, met specifieke aandacht voor de COVID-19-pandemie. Artsen hebben traditioneel een hoge status binnen ziekenhuisstructuren, maar de pandemie verstoorde conventionele leiderschapsnormen en vereiste meer samenwerking. Onze studie laat zien dat terwijl sommige artsen zich aanpasten en een relationele leiderschapsrol aannamen, door deel te nemen aan teambesluitvorming en interdisciplinaire samenwerking, anderen een meer traditionele, hiërarchische aanpak behielden.

De bevindingen suggereren dat leiderschap tijdens crises niet uitsluitend draait om autoriteit, maar ook om het vermogen om met onzekerheid om te gaan en collectieve expertise te benutten.

Chapter SEVEN – Critical reflections, implications, and recommendations

Dit afsluitende hoofdstuk brengt de kerninzichten uit deze dissertatie samen en biedt reflecties op de literatuur over relationeel leiderschap. Drie hoofdthema's worden belicht. Ten eerste, de illusie van harmonie, waarbij de afwezigheid van zichtbaar conflict in leiderschapsinteracties kan wijzen op het vermijden van moeilijke maar noodzakelijke discussies. Productief conflict kan dienen als een bron voor innovatie en verbeterde samenwerking. Ten tweede, structurele beperkingen op relationeel leiderschap, aangezien relationele leiderschapspraktijken bestaan in ziekenhuizen, maar vaak worden beperkt door rigide structuren die bepaalde beroepsgroepen bevoordelen. Het overwinnen van deze barrières vereist institutionele steun voor interdisciplinaire leiderschapsmodellen. Ten derde, de performatieve aard van leiderschap, aangezien leiderschap wordt uitgevoerd via taal, interacties en positionering in plaats van alleen via formele titels. Het erkennen van deze performativiteit stelt leiders in staat om opnieuw na te denken over hoe leiderschap betekenis krijgt binnen verschillende beroepsgroepen.

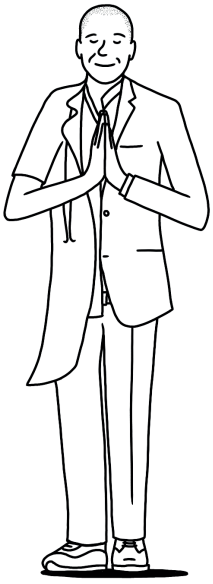
Methodologische reflecties

De dissertatie hanteert een kwalitatief-interpretatief onderzoeksontwerp, waarbij interviews, observaties, 'at-home-etnografie' en documentanalyse worden gebruikt om leiderschap als een relationeel proces te verkennen. Een reflexieve houding erkent de dubbele rol van de onderzoeker als zowel deelnemer als waarnemer. De studie maakt gebruik van abductief redeneren, wat iteratieve interpretatie van gegevens mogelijk maakt, maar tegelijkertijd de uitdagingen erkent van objectiviteit behouden binnen een organisatorische omgeving. Ook worden belichaming en praktijktheorie geïntegreerd, waarbij leiderschap wordt beschouwd als iets dat niet alleen discursief wordt geformuleerd, maar ook wordt uitgevoerd door lichamelijke aanwezigheid en ingesleten praktijken. Deze reflecties onderstrepen het belang van transparantie, reflexiviteit en voortdurende zelfevaluatie in kwalitatief leiderschapsonderzoek.

Conclusie

Deze dissertatie draagt bij aan leiderschapstheorie door aan te tonen dat relationele leiderschapsprocessen een cruciaal aspect vormen van ziekenhuizen, met name in crisistijden. De studie benadrukt leiderschap als een sociaal en discursief proces in plaats van een vaste competentie. De belangrijkste bijdragen zijn een pleidooi voor een verschuiving van traditionele, top-down leiderschapsmodellen naar een meer inclusieve, relationele en procesgerichte benadering, evenals het bieden van praktische inzichten voor ziekenhuisbestuurders, beleidsmakers, onderzoekers en zorgprofessionals die streven naar verbeterde samenwerking binnen complexe organisaties. Door middel van kwalitatief-interpretatieve methoden draagt deze dissertatie niet alleen bij aan theoretisch begrip, maar biedt ze ook toepasbare aanbevelingen voor het versterken van relationeel leiderschap binnen ziekenhuizen.

WORDS OF GRATITUDE



Deze dissertatie is meer dan een academische studie; het is ook een weerspiegeling van mijn persoonlijke reis. Dit was een gedeelde, relationele praktijk—een werkelijkheid die ik heb onderzocht én geleefd. Ik ben iedereen dankbaar die aan dit onderzoek heeft bijgedragen en mij onderweg heeft gesteund en begeleid. Toch wil ik in dit waarschijnlijk meest gelezen hoofdstuk van het proefschrift een aantal mensen speciaal bedanken—omdat het me de kans geeft woorden te geven aan relaties die ik in het dagelijks leven vaak voor lief neem.

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Beste Erik, Henri en Pieterbas,
'een KNO-arts, een verpleegkundig socioloog en een psychoanalyticus zaten eens met hun promovendus in een Utrechtse pinchos bar'…..Aan alles komt een eind. Ik had ook kunnen promoveren op de botsende én elkaar versterkende

wereldbeelden die jullie vertegenwoordigen en belichamen. En het is ook precies die rijkheid die dankzij jullie in dit boek is terechtgekomen. We werkten veel op afstand, maar ik voelde me altijd verbonden. Dank voor dit. Werken met jullie is een cadeau.

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Mas – Makasih. Voor de lange gesprekken en voor het vlottrekken van mijn denken met je geweldige talent. Jouw tekeningen maken dit proefschrift af.

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LaBrada – Hoe mooi is wat wij met z'n achten hebben!? Ezels, wijn, pizza, blaffende honden en snelle fietsen. Geweldig. En doorrrr.

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Claire, Aiden en Evan – Het boek is af. Had ik niet gekund zonder jullie. Tijd voor nieuwe avonturen. #alles4en

Lieve Evan, lieve dromer, jouw eeuwige vrolijkheid, creativiteit en lach zijn aanstekelijk. Ik kijk ernaar uit nog veel van je te leren.

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Claire, Liefde. We hebben het hier vaak over gehad—en nu is het écht. We hebben het samen geflikt. Op naar de volgende. Ik houd je. Mucho & tudo. #samennietsdoen

En voor wie ik ben vergeten. Jij ook bedankt. #mand

RESEARCH DATA MANAGEMENT PLAN

Ethical approval

This thesis is based on the results of research involving human participants (or existing data from published papers), which were conducted in accordance with relevant national and international legislation and regulations, guidelines, codes of conduct and Radboudumc policy. The study was not subject to the Dutch Medical Research Involving Human Subjects Act (WMO).The COREQ framework (Tong et al., 2018) was used as a quality measure for this study.

Privacy of participants

The privacy of participants was ensured through pseudonymization. The pseudonymization key was securely stored on a restricted network drive, accessible only to project members who required access due to their role. The key was stored separately from the research data to maintain confidentiality.

Informed consent and data availability

All participants provided informed consent to collect and process their data for this research project. Consent was not obtained for sharing the (pseudonymized) data after research.

Data collection and storage

Data were collected with interviews, observations, at-home ethnography, and document analysis. Data were stored and analyzed in the Azure DRE environment. These secure storage options ensure the availability, integrity, and confidentiality of the data.

Data sharing according to the FAIR principles

While no consent was obtained for sharing the pseudonymous data, the data are archived and published under 'closed access' conditions in a Data Acquisition Collection (DAC) in the Radboud Data Repository; the persistent identifier (DOI) is **10.34973/33js-nf64**.

CURRICULUM VITAE

Ik ben Arjan Verhoeven (1980) – zelfstandig adviseur, interim-manager en onderzoeker. Mijn leerweg liep van de mavo via mbo en hbo naar de universiteit en postacademisch onderwijs. Tijdens mijn studie woonde ik in Indonesië en deed ik mijn masteronderzoek in Belize, en later reisde ik langdurig door Latijns-Amerika en Europa. Die ervaringen hebben mijn perspectief verbreed, mijn denken verdiept en mijn nieuwsgierigheid naar mensen, systemen en verschillen blijvend gevormd.

Tussen 2006 en 2011 werkte ik als organisatieadviseur bij Berenschot. Daar begeleidde ik maatschappelijke organisaties bij vraagstukken rond strategie, cultuur en verandering. Van 2011 tot 2021 was ik werkzaam binnen het Radboudumc in diverse rollen – onder meer als business manager, projectleider en adviseur van de Raad van Bestuur. Ik werkte er aan de ontwikkeling van nieuwe organisatievormen, leiderschapstrajecten en veranderopgaven binnen de academische zorg.

Sinds 2022 werk ik zelfstandig in het publieke en maatschappelijke domein, met opdrachten op het snijvlak van bedrijfsvoering, leiderschap en samenwerking. Daarbij zoek ik steeds naar de verbinding tussen systeem en praktijk.

Als promovendus aan de Radboud Universiteit deed ik onderzoek naar relationeel leiderschap in ziekenhuizen – niet als model of functie, maar als iets dat ontstaat in de alledaagse interactie tussen mensen. Ook na afronding van mijn promotietraject blijf ik onderzoek doen naar leiderschap, verandering en organiseren in de context van maatschappelijke organisaties. In mijn werk en onderzoek verbind ik de logica van organisaties met de logica van mensen. Juist in die spanning – tussen structuur en betekenis – ligt voor mij de sleutel tot duurzame verandering.

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APPENDICES

Appendix A – Interview questions

1. Are you as nurse and/or NC involved in corona crisis management? Please elaborate.
2. On what levels of the organization are you, as NC, involved? Operational, strategic, different.
3. How are you/ the NC attributing to the crisis management?
4. In what way, and by whom, is the NC asked to contribute to crisis management? Please elaborate on the actions of the NC itself to contribute.
5. How content are you – on a scale from 1 to 10 – with the involvement of the NC in crisis management? Please elaborate.
6. What are the tasks of nurses and NC in crisis management, and can you elaborate on to what extent nurses and members of the NC are equipped to execute these tasks?
7. What are your learning experiences this far on working in crisis management?
8. How do other agents (managers, physicians, board members, nurses) in the hospital perceive and value the contribution of nurses/NC to the crisis management?
9. How did working in crisis influence the involvement and/or positioning of the NC in the hospital? Please elaborate.
10. What was observed as 'nurse leadership' during crisis? Please share your observations.
11. How are nurses/ NC involved in the transition from crisis management back to post-crisis organization of care processes?

Appendix B – Topic guide focus groups

Topic guide focus group meetings – collaboration in times of crisis				
Central question: How do nurses, management, physicians, and members of executive hospital boards (BM) perceive their collaboration in crisis (March 2020 – June 2021)?				
#	**Theme**	**Intro**	**Question/ statement**	**Subquestion/ subtheme**
0	Opening	Showing video of news item – BM states nurse is directly involved in crisis management and directly after a nurse reports that she is not involved.	What do you see in this news clip and how can you relate this to your own practice?	What does it mean that people perceive a situation (or involvement) differently? How is this for managers, and for physicians (how are not in the clip)?
1	Collaboration	In crisis collaboration is crucial. This is also about trust, knowing each other and relating. Different interests, connection and power.	How do you look back at the the collaboration in crisis between nurses, physicians, managers and BM?	What were successes and what is there to improve? What does this mean for the coming period? How do perspectives of management and work floor align or conflict? What were troublesome topics?
2	Decision	A crisis demands swift decision-making. However, sometimes it is better to be thorough than swift.	How is decision-making in crisis organized in your hospital and how are relevant perspectives involved?	How is the proces of decision-making perceived? Who is responsible for this process? What is different in crisis?
3	Position	In our interviews in May 2020 on the positioning of nurses and nurse councils (as representatives of nurses) we learned positioning and involvement was poor.	How are nurses positioned in crisis in your hospital? What was the role of other organizational groups in this positioning? How do you reflect on this positioning?	How did positioning of nurses develop in time? What changed? If any, what caused the change?
4	Developing/ learning	We are now (June 2021) in a somewhat quite phase. What does the recent experience mean for collaboration and care in the coming times?	What are the learnings from recent experiences concerning collaboration in crisis? Working with different perspectives.	
5	Structure	Structure is seen as a symbol of collaboration. In our interviews in 2020 the crisis structure was portrayed as such. Structure as a vehicle of collaboration, network, knowing and relating.	How is de crisis management structure used in your hospital, and is it seen as supportive or hindering for collaboration?	How did organizational structure and crisis structure work together? What was the role of the informal structure? How was highest in command in crisis management?

Appendix C – Overview of involvement score and start according to (C)NC, per type of hospital and data collection method

		Start of involvement*				
Hospital	**(C)NC involvement score****	**Start**	**On request (C)NC**	**None**	**Type of hospital *** / ********	**Type of response**
3	No score				Academic	Interview
6	No score				Academic	Interview
7	8				Academic	Interview
1	7,5				Academic	Interview
8	7,5				Academic	Interview
4	6				Academic	Interview
5	6				Academic	Interview
2	4,5				Academic	Interview
31	No score				General	No response
43	No score				General	No response
15	Insufficient information				General	Email
35	Insufficient information				General	Email
45	Insufficient information				General	Email
48	Insufficient information				General	Email
49	Insufficient information				General	Email
53	Insufficient information				General	Email
55	Insufficient information				General	Email
22	9				General	Interview
11	8				General	Interview
34	8				General	Interview
50	8				General	Interview
57	8				General	Email
64	8				General	Email
23	7				General	Email
29	7				General	Interview
41	7				General	Interview

Appendix. Continued

		Start of involvement*				
Hospital	**(C)NC involvement score****	**Start**	**On request (C)NC**	**None**	**Type of hospital *** / ********	**Type of response**
51	7				General	Interview
66	7				General	Email
70	6				General	Interview
16	5,5				General	Interview
9	5				General	Interview
26	5				General	Interview
30	5				General	Email
60	5				General	Email
63	5				General	Interview
67	5				General	Interview
14	4				General	Interview
20	4				General	Interview
62	4				General	Email
65	3				General	Interview
71	3				General	Interview
68	2				General	Interview
58	1				General	Interview
18	No score				Top clinical	No response
21	No score				Top clinical	No response
25	No score				Top clinical	Interview
40	No score				Top clinical	Interview
27	Insufficient information				Top clinical	Email
37	9				Top clinical	Email
46	9				Top clinical	Interview
10	8				Top clinical	Email
47	8				Top clinical	Interview
56	8				Top clinical	Interview
59	8				Top clinical	Interview
61	8				Top clinical	Interview
19	7,5				Top clinical	Interview
17	7				Top clinical	Interview
24	7				Top clinical	Email

Appendix. Continued

		Start of involvement*				
Hospital	**(C)NC involvement score****	**Start**	**On request (C)NC**	**None**	**Type of hospital *** / ********	**Type of response**
32	7				Top clinical	Email
33	7				Top clinical	Interview
44	7				Top clinical	Interview
12	6				Top clinical	Interview
39	6				Top clinical	Interview
54	6				Top clinical	Interview
69	6				Top clinical	Interview
13	5				Top clinical	Interview
28	5				Top clinical	Interview
38	5				Top clinical	Email
72	5				Top clinical	Email
36	4				Top clinical	Email
42	1				Top clinical	Interview
52	1				Top clinical	Interview

* We asked CNC to pinpoint when their involvement in the crisis management structure of their hospital materialized - from the start of the crisis, on their own request, or not at all.

** We asked CNC to score their involvement in the crisis management structure of their hospital on a scale from 1 to 10 (low to high).

*** Due to a merger there are seven academic hospitals in The Netherlands since 2018. Nevertheless, the NC's were not merged at the time of the interviews and both were interviewed for our study. Hence the 8th academic entry in our data set.

*** Besides academic and general there are also so-called top clinical hospitals (26) in The Netherlands. These hospitals have a more specialized infrastructure for complex care than general hospitals. (see https://www.stz.nl/over-ons/stz-ziekenhuizen/, visited on 5th of February 2023). Antoni van Leeuwenhoek and Princes Maxima Centre for (child) oncology are specialized hospitals and are labeled 'Top clinical' in this overview to warrant anonymity.

Appendix D – Interview guide – second round of interviews – October 2020

Study 'Leadership in hospitals'

The study of leadership, properly conceived, is the study of the processes in which flexible social order is negotiated and practised so as to protect and promote the values and interests in which it is grounded.(Hosking, 1988, p. 164)

In fact, (…) as I have made the claim that leadership is not what leaders do but what leaders and collaborators do together—the interaction that goes on among them as they propose significant changes that reflect their mutual purposes. Understanding leadership as a relationship among leaders and collaborators makes the ethics of leadership much more difficult to conceptualize and practice than if leadership is understood as the behaviors of a single or a few leaders. (Rost, 1995, p. 132)

The definition is this: Leadership is an influence relationship among leaders and collaborators who intend real changes that reflect the purposes mutually held by both leaders and collaborators (…). (Rost, 1995, p. 133)

In leadership research to date, a plethora of studies have been conducted on the leader, but in comparison there has been a dearth of studies in the other two areas. Clearly, more research is needed on followers and the leadership relationship. By explicitly acknowledging the importance of these other 'components to the leadership process, we hope to encourage more attention to learning as much as we can about all three domains of leadership and how they work together. (Graen & Uhl-Bien, 1995, p. 222)

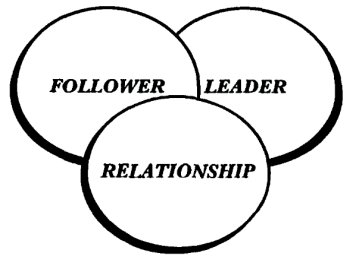

Figure 1. The Domains of Leadership

Applied to leadership, a relational perspective changes the focus from the individual to the collective dynamic (e.g., to combinations of interacting relations and contexts). It sees an appointed leader as one voice among many in a larger coordinated social process (Hosking, in press). "Within a relational perspective appointed leaders share responsibility with others for the construction of a particular

understanding of relationships and their enactment…leaders and those with whom they interact are responsible for the kinds of relationships they construct together" (Dachler and Hosking, 1995, p. 15) (Uhl-Bien, 2006, p. 662)

Adaptive responses resist the pull to order and capitalize on the collective intelligence of groups and networks. Organizations that enable an adaptive response do not turn to a top-down approach. Instead they engage networks and emergence. Emergence is the creation of new order that happens when agents (e.g., people, technology, information, resources) in a networked system combine together in an environment poised for change to generate the emergence of something that did not exist previously. (Uhl-Bien & Arena, 2017, p. 10)

One of the biggest challenges facing leaders today is the need to position and enable organizations and people for adaptability in the face of increasingly dynamic and demanding environments. (…) [Leadership] involves enabling the adaptive process by creating space for ideas advanced by entrepreneurial leaders to engage in tension with the operational system and generate innovations that scale into the system to meet the adaptive needs of the organization and its environment. (Uhl-Bien & Arena, 2018, p. 89)

Because too much formalization can be harmful, leaders must delicately balance formal (e.g., formal structures and systems) and informal (e.g., social networks, both internal and external) sources of ideation. They should also "bound" ideation conditions, meaning stimulating ideas by engaging appropriate limitations and boundaries. (…) Leaders must establish the right incentives, combined with supportive systems, processes and roles, to help generate a multitude of ideation approaches, across both individual and collective processes.(Uhl-Bien & Arena, 2018, p. 93)

The original research question they set out to answer was "what is the process by which ideas emerge and flow n the organization?". The spark for the image of the answer, as Arena notes, that in 1989 sociologist Ray Oldenburg 'pioneered the concept of a 'third place", a 'free trade zone' that provides a sense of connectivity that facilitates and fosters more creative interactions. This is the basis of 'adaptive space', which enables three key activities: opening connections for people, ideas and information; fostering environments where organizations can be positively disruptive before others; and creating bridges between fragmented pockets of entrepreneurialism dotted throughout

organization and connecting them to the more formal operational system. (https://www.ideasforleaders.com/book-review/adaptive-space, visited on 6th of September 2020)

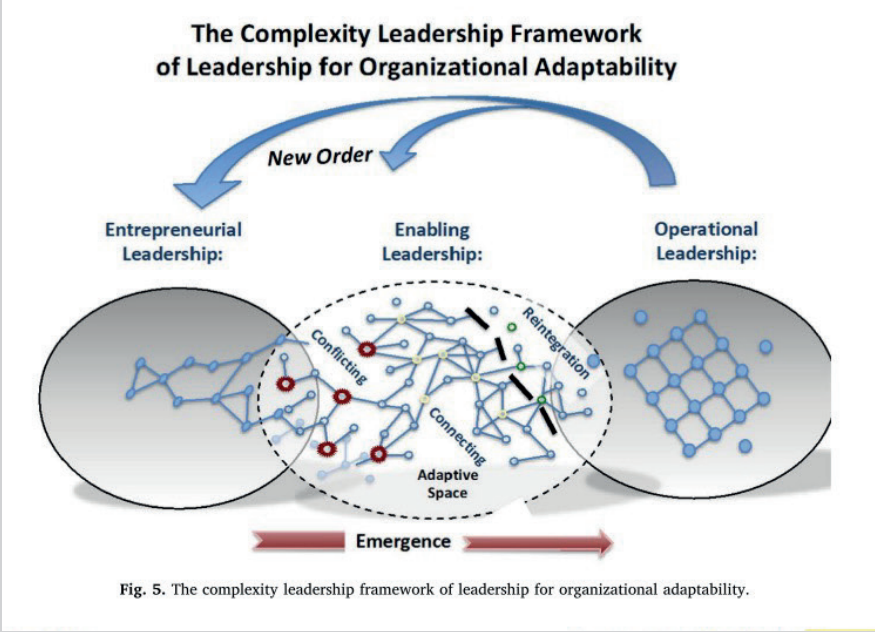

Fig. 5. The complexity leadership framework of leadership for organizational adaptability.

Appendix E – topic guide focus groups 2020 and 2023

Focus Group - Leadership experiences of business managers during the 1st wave of COVID

Monday 30th of November 2020 – 16h30 – 18h15, [location]

Participants: [names of participants]

Chair: [name]
Observer: first author

Central question: How do you work as a business manager between connection and decision-making in times of crisis?

No.	Topic	Introduction	Question / Statement	Sub-question / Sub-themes
1	Connection	Connection between the work floor and business leader. Knowing people and knowing the company play an important role in daily work. Business leaders indicate that they are playing on many boards and making many connections.	What does this mean in practice, what are the experiences with this (when good and when not), and how important is the connection with the work floor in times of crisis compared to non-crisis?	How important is making connections as a task of a business leader? How do you make connections? What are experiences in coming into this central and connecting role? How is this important for influencing decisions and results?
2	Connection	There is tension in the work and position of a business leader between business-oriented work and people-oriented work.	Is there tension between connective work and business-oriented work? If yes, how did this tension between being responsible for 'the company' and the dynamics of the crisis manifest in the daily practice of business leaders?	How do these business leaders decide when the task is to perform work (by themselves) and when it is the task to help/facilitate/ direct others in performing work? And what is different in this during crisis time and outside of it?
3	Decision-making	Reaching decisions and making and recording decisions are two different matters. These intertwine when we talk about leadership. Much of leadership seems to come down to forming decisions and making decisions. This also seems to be specifically connected to a (hierarchical) function.	How do these business leaders form decisions and how do they make decisions? In what way is this connected to the hierarchical function?	What is the role of hierarchy in this? And how do the connection aspects play a role in this? Is there a difference between forming decisions and making decisions?

No.	Topic	Introduction	Question / Statement	Sub-question / Sub-themes
4	Structure	Everyone talks interchangeably about performing work and ensuring that work gets done.	How decisive is structure (organizational structure, work agreements, mandates) in achieving results? And is this different in the crisis than outside of it?	Relationship between crisis organization and line responsibility? Difficulty in the second part of the crisis (intro CTOZ and CTD) and the line organization?
5	Social order	The order of organizing and relationships between people and officials. Who has the say in the departments; doctors or department management?	What are the strategies of these business leaders in dealing with the order, and how important is it?	What did this tension mean in crisis time? And what were the differences between the primary 'crisis departments' and the departments outside? And how do business leaders deal with this tension?
6	Hierarchy	How does the hierarchical structure in your organization influence the way connections are formed between different levels of leadership?	In what ways does the existing hierarchy impact collaborative efforts across departments or teams?	How do leaders at different levels of the organization contribute to building and maintaining relationships with their teams and peers? // Have you observed any changes in hierarchical dynamics when leaders focus more on relational aspects of their role?
7	Power distance	Power distance refers to the degree to which less powerful members of a group or organization accept and expect that power is distributed unequally.	How does the concept of power distance manifest in day-to-day interactions between leaders and team members in your organization?	How do leaders in your organization balance maintaining authority while also fostering close working relationships with their teams?

PORTFOLIO

PhD portfolio of Arjan Verhoeven

Department: **Otorhinolaryngology, Head and Neck Surgery**
PhD period: **01/12/2019 – 02/04/2025**
PhD Supervisor(s): **Prof. dr. H.A.M. Marres, Prof. dr. E.L.H.M. Van de Loo (INSEAD)**
PhD Co-supervisor(s): **Dr. P.C.B. Lalleman (Fontys)**

Training activities	Hours
Courses	
• Kwalitatief interviewen (2018)	16.80
• Qualitative Research Methods in Health Care (2019) University of Antwerp	84.00
• Radboudumc - Scientific integrity (2020)	20.00
• RIHS - Introduction course for PhD candidates (2020)	15.00
• RIHS PhD introduction course (2020)	21.00
Conferences	
• Exponential Medicine 2018 (2018) Singularity University (visit)	28.00
• Research Colloquium on Board and Executive Leadership Development - may (2019) Vrije Universiteit (oral)	5.60
• EPIC Conference 2019 - AGENCY (2019) EPIC People (visit)	21.00
• Research Colloquium on Board and Executive Leadership Development - december (2019) Vrije Universiteit (oral)	5.60
• Boards research: An international conference INSIDE THE BLACK BOX OF BOARDS' DECISION MAKING (2020) VU Center for Boards and Executive Leadership Development (oral)	14.00
• Het digitale MMV-congres Voorop in vernieuwing op woensdag 9 december 2020 (2020) Federatie Medisch Specialisten (visit)	7.00
• EGOS 2021 (2021) Dancing with the boards: relational leadership as process for understanding daily collaboration between nurses and executives of Dutch hospitals to 17: Boards Interaction and Decision-making: Inside the Black Box of Board Performance at the virtual 37th EGOS Colloquium (hosted by VU Amsterdam), July 8–10, 2021. (oral)	20.00
• Future Proof Nursing (2022) European Nursing Congress (oral)	28.00
• Kennisfestival BRUIS (2023) RN2BLEND en NVZ (oral)	28.00
Teaching activities	
Lecturing	
• Minor Medisch Leiderschap - BA3 - GNK (2018) Radboud Universiteit	14.00
• Minor Medisch Leiderschap - BA3 - GNK (2019) Radboud Universiteit	28.00
• Minor Medisch Leiderschap - BA# - GNK (2020) Radboud Universiteit	14.00
• MINK BA GNK (2021)	14.00
• MINK BA GNK (2022)	28.00
• Opinieleiderschap (2023) NU91'en Fontys Hogeschool	28.00
• MINK BA GNK (2023) GNK	28.00
Supervision of internships / other	
• Janique Kraan - Masterthesis Beleid, Communicatie en Organisatie - 01/19 - 07/19 (2019) Vrije Universiteit	56.00
• Lisanne van 't Hull - Masterthesis Cultuur, Organisatie en Management - 01/20 - 07/20 (2020) Vrije Universiteit	56.00
• Rebecca van Egmond - Masterthesis Cultuur, Organisatie en Management - 01/20 - 07/20 (2020) Vrije Universiteit	56.00
Total	**636.00**

‘Be willing to leap before you look. If you look before you leap, you may not see anything. Action generates outcomes that ultimately provide the raw material for seeing something. (…) People who surf do not command the waves to appear, or to have a particular spacing, or to be of a special height. Instead, surfers do their best with what they get. They can control inputs to the process, but they can’t control outcomes. To ride a wave as if one were in control is to act and have faith.’ (Weick, 2001)

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