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

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Abstract

Talk by members of executive hospital boards influences the organizational positioning of nurses. Talk is a relational leadership practice. Using a qualitative-interpretive design we organized focus group meetings wherein members of executive hospital boards (7), nurses (14), physicians (7), and managers (6), from 15 Dutch hospitals, discussed the organizational positioning of nursing during COVID crisis. We found that members of executive hospital boards consider the positioning of nursing in crisis a task of nurses themselves and not as a collective, interdependent, and/or specific board responsibility. Furthermore, members of executive hospital boards talk about the nursing profession as (1) more practical than strategic, (2) ambiguous in positioning, and (3) distinctive from the medical profession. Such talk seemingly contrasts with the notion of interdependence that highlights how actors depend on each other in interaction. Interdependence is central to collaboration in hospital crises. In this paper, therefore, we depart from the members of executive hospital boards as leader and "positioner," and focus on talk—as a discursive leadership practice—to illuminate leadership and governance in hospitals in crisis, as social, interdependent processes.

KEYWORDS

boards, crisis, hospital, interdependence, leadership, nursing, relational, talk

1 | 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., 2016, 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 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).

2 | BACKGROUND

2.1 | 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., 2016). Nursing leadership literature slowly acknowledges this approach as relevant to nursing practice (Kok et al., 2022, 2023; 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., 2016), or discursive practices (Barge, 2012). All are discursive perspectives focused on communication in leadership and organizing as social, performative, and overt behavior (Uhl-Bien & Ospina, 2012; Uhl-Bien, 2006). Oldenhof et al. (2016) state "with the help of words, (…) different relations between managers and care workers are being performed" (2016, 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.

2.2 | 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, 2001). 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).

2.3 | 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?*

3 | METHODS

3.1 | 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.

3.2 | 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 "urba." 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 (see, e.g., De Graaff et al., 2021; Hancock et al., 2021; Wallenburg et al., 2021)

4 | 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.

TABLE 1 Participant data.

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**

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, 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.

5 | 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, 2020, 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).

6 | 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.

6.1 | 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.

6.2 | 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.

6.3 | 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.

6.4 | 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 forefronted 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.

7 | 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.

7.1 | 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., 2016). 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."

7.2 | 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, 2016, 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.

7.3 | 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 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.

7.4 | Strengths and limitations

This study is a valuable addition to the dominant nursing leadership and governance literature. The literature is focussed 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., 2016) 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).

8 | 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.

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflict of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available upon request to the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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