Knowing, relating and the absence of conflict: relational leadership processes between hospital boards and chairs of nurse councils

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Abstract

Purpose – 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

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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

Paper type Research paper

Introduction

Leadership is said to be a key differentiator of the organizational performance of hospitals (West *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 *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 and Foldy, 2010; Raelin, 2016). The leader-, skills- and competency-focused literature in contemporary nursing research has not been able to tackle these mundane (Alvesson and Sveningsson, 2003), 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 and McGrath, 2016) through, for example, NCs (Porter O'Grady and 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" (2020).

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." (2021) 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 and 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); 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). 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 (Uhl-Bien, 2006; McCauley and Palus, 2020) and the debate on connectivity (Noordegraaf, 2020), complexity (Uhl-Bien and 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; Glouberman and Mintzberg, 2001; Gilmartin and D' Aunno, 2007).

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 (Raelin, 2016; Kok *et al.*, 2022) 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, 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" (Uhl-Bien and Ospina, 2012; Schwartz-Shea and Yanow, 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 and 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.

Table 1.
Research overview

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 and website	110	71	50	Financial	CFO
2	Academic	Leadership document NC, org. chart, website and annual report	89	85	78	Medical	CMO
3	General	Website, annual report and org. chart	103	69	79	Managerial	CEO
4	General	Vision on nursing, website and annual report	94	77	78	Managerial	BM
5	General	Website, org. chart and evaluation report positioning of nursing	98	73	55	Medical	CEO
6	General	Annual report, position paper NC and org. chart	105	65	94	Managerial	CEO
7	General	Website, strategy paper on nursing and annual report	84	48	86	Managerial	CEO
Total		>250 pages	683	488	520		
# Pages of transcript				167	204		

Notes: *All CNC are registered nurses (RNs) and conducted work for the NC while also being active as a staff nurse on the wards during the data collection. **One BM also has a degree in nursing but is not active as a nurse; CFO = Chief Financial Officer; CMO = Chief Medical Officer; CEO = Chief Executive Officer

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. 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 and Yanow, 2012).

Interviews

We conducted interviews from an interpretive stance (Langley and 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 and 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 and 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 and Tavory, 2012) process of broad coding, "memoing" and confrontation (Deterding and Waters, 2018). In practice, this meant that analysis started during data collection (Nicolini and 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 and Clarke, 2006). When we identified the "cross-patterns of themes" (Ospina and 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 and Waters, 2018) to make this thought process transparent. This adds to the rigor of the analysis (Deterding and Waters, 2018; Schwartz-Shea and 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 workfloor. [. . .] 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 workfloor 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 do respect for management, team leads and boards of directors, they are not at the workfloor. 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 forefronting 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 corrects. 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, hospital 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 and Sveningsson, 2003) 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 and Eriksen, 2011)

for all collaboration. Knowing and relating are intertwined (Clark *et al.*, 2014) but are often approached as conscious acts of agency (Alvesson and Sveningsson, 2003). 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. Forefronting the collaborative relationship as an interaction instead of as a static, taken for granted entity can enable BM and CNCs to collaborate more effectively (Fulop and Mark, 2013; Erkutlu and Chafra, 2019). 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 *et al.*, 2017).

Position and hierarchy over process and expertise

The nursing PG literature (Sundean and McGrath, 2016; Porter O'Grady, 2019; Kanninen *et al.*, 2021) is focused on relational skill and leadership style as enablers for nursing governance 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 (Oc, 2018; Nicolini *et al.*, 2014). 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 and 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 and 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 and 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 and 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). Conflicting can then be a helpful source for collaborating across organizational (Ernst, 2020; Farchi *et al.*, 2022) and professional boundaries (Noordegraaf, 2020; Langley *et al.*, 2019), and can even be part of dialogically working together (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 *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.

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