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wishful thinking or reality?**

Thude, Bettina Ravnborg; Stenager, Egon; von Plessen, Christian; Hollnagel, Erik

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## Leadership in Health Services

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Bettina Ravnborg Thude, Egon Stenager, Christian von Plessen, Erik Hollnagel,

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# Leadership set-up: wishful thinking or reality?

Leadership  
set-up

Bettina Ravnborg Thude

*Centre for Quality, Region of Southern Denmark, Middelfart,  
Denmark and Department of Regional Health Research,  
University of Southern Denmark, Odense, Denmark*

Egon Stenager

*Department of Neurology, Center Sonderjylland, Hospital of Southern Denmark,  
Aabenraa, Denmark and Department of Regional Health Research,  
University of Southern Denmark, Odense, Denmark, and*

Christian von Plessen and Erik Hollnagel

*Centre for Quality, Region of Southern Denmark, Middelfart,  
Denmark and Department of Regional Health Research,  
University of Southern Denmark, Odense, Denmark*

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## Abstract

**Purpose** – The purpose of the study is to determine whether one leader set-up is better than the others according to interdisciplinary cooperation and leader legitimacy.

**Design/methodology/approach** – The study is a qualitative study based on semi-structured interviews at three Danish hospitals.

**Findings** – The study found that the leadership set-up did not have any clear influence on interdisciplinary cooperation, as all wards had a high degree of interdisciplinary cooperation independent of which leadership set-up they had. Instead, the authors found a relation between leadership set-up and leader legitimacy. In cases where staff only referred to a leader from their own profession, that leader had legitimacy within the staff group. When there were two leaders from different professions, they only had legitimacy within the staff group from their own profession. Furthermore, clinical specialty also could influence legitimacy.

**Originality/value** – The study shows that leadership set-up is not the predominant factor that creates interdisciplinary cooperation; but rather, leader legitimacy also should be considered. Additionally, the study shows that leader legitimacy can be difficult to establish and that it cannot be taken for granted. This is something chief executive officers should bear in mind when they plan and implement new leadership structures. Therefore, it would also be useful to look more closely at how to achieve legitimacy in cases where the leader is from a different profession to the staff.

**Keywords** Health care, Leadership, Legitimacy, Leadership in health care, Interdisciplinary cooperation, Leader set-up

**Paper type** Research paper

## Background

Dual, pooled or multiple leadership is practised in hospitals and other organisations such as newspapers and theatres. However, little is known of how this form of leadership works in practice and if it has a positive effect on an organisation.

Denis *et al.* (2012a, 2012b, 2012c) identified four different streams of research on “leadership in the plural”: sharing leadership for team effectiveness, pooling leadership at



the top to lead others, spreading leadership across levels over time and producing leadership through interactions. This article focusses on pooled leadership at the top to lead others where “a structurally plural group can become a collective source of leadership for people outside it” (Denis *et al.*, 2012a). The leader group can consist of two, three or more leaders (Denis *et al.*, 2012b).

Pooled leadership at the top has been found to be effective in complex pluralistic organisations (Alvarez and Svejenova, 2005; Hodgson *et al.*, 1965; Bhansing *et al.*, 2012; Etzioni, 1965; Denis *et al.*, 2001; Farrell, 2001; O’Toole *et al.*, 2002; Sally, 2002; Fjellv ar, 2010). Hospitals, newspapers, universities and cultural organisations can be characterised as pluralistic organisations because they have to balance multiple objectives, such as economic and non-economic goals (Bhansing *et al.*, 2012). Though more literature is appearing on plural leadership, Denis *et al.* (2012a, 2012b, 2012c) have suggested that more knowledge about the effects, and effective types, of plural leadership is needed.

### **Categorisation of arguments for pooled leadership at the top**

The arguments for pooling leadership at the top fall into two categories. One focusses on outcomes and effectiveness, while the other includes having legitimacy and representing stakeholders. These categories can also be called the “logic of consequentiality” and the “logic of appropriateness” (March and Olsen, 1989; March and Olsen, 2010; March and Olsen, 2011). One logic does not exclude the other; they can exist at the same time, depending on the organisation and the circumstances within it. This article assumes that the two logics exist at the same time, and that both are important for the organisation to fulfil its tasks. However, one logic might be dominant.

### **Dual leadership**

Dual leadership is one type of pooled leadership at the top (Denis *et al.*, 2012b). Dual leadership can be defined as:

[...] a setting where two leaders are mandated without any power difference to have executive roles or duties and are held jointly accountable for the company’s or unit’s results. In this definition a task division has not been specified by the CEO or direct leader (Thude *et al.*, 2017b).

Dual-leader teams can behave in very different ways. Seven categories are important to make dual leadership work. When these categories are fulfilled in varying ways, there is a risk that the leader teams also perform and cooperate in very different ways (Thude *et al.*, 2017a). The seven categories are as follows:

- (1) There should be no difference in leader experience.
- (2) The assignments should be interchangeable.
- (3) The leaders should share offices.
- (4) The leaders must have veto power to all decisions.
- (5) There should be good human material[1] – meaning that the leaders are able to share the power and decision-making and should share the same visions and values for the department.
- (6) The leaders should trust each other and have good communication.
- (7) The leaders should agree on the decision-making process.

One of the leadership set-ups that is addressed here is a dual set-up. The others have some commonalities with dual leadership, but do not fulfil the definition, and we have

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characterised them as pooled leadership at the top. However, it is interesting to analyse how the other set-ups fit in to the seven categories above to determine if these categories can explain any differences in the achievements of the departments.

### **Pooled leadership at the top at Danish hospitals**

We describe and analyse how different leadership set-ups in three hospital departments in Denmark work in practice and relate this to interdisciplinary cooperation within the departments and the legitimacy of the leaders.

According to [Denis \*et al.\* \(2012a, 2012b, 2012c\)](#) “There is more to be learned about when and where dual or multiple leadership groups are likely to be most in demand and more or less effective” ([Denis \*et al.\*, 2012c](#)). We address these aspects and analyse three different leadership set-ups in three different hospital departments – all within the category “pooled leadership at the top” – to determine whether one set-up is better than the others according to:

- interdisciplinary cooperation (logic of consequentiality); and
- leader legitimacy (logic of appropriateness).

Interdisciplinary cooperation is here used as a process goal to provide better care and treatment in the hospital departments. Interdisciplinary cooperation is necessary in the health sector because health care today is too complex for individual groups ([Mitchell and Crittenden, 2000](#)). Furthermore, it has been found that better cooperation between professional groups, specifically nurses and physicians, can create more effective treatment ([Glouberman and Mintzberg, 1996](#)). It is not enough for hospitals to have skilled and dedicated employees; staff must also be able to continuously collaborate and coordinate their work – known as relational coordination ([Gittel, 2012](#)). In this article, we use the term interdisciplinary cooperation as we are analysing cooperation between nurses and physicians.

The interdisciplinary cooperation is analysed through interviews with staff in each department, where the focus has been on the cooperation between professional groups, communication between professional groups and having common goals within the department.

Leader legitimacy characterises staff who accept and recognise their leaders, which means that they voluntarily follow their leaders. Followership is an important aspect to leadership and can be defined in two ways:

- (1) formal hierarchical roles (e.g. followers as subordinates); and
- (2) followership in the context of the leadership in process (e.g. following as a behaviour that helps co-construct leadership) ([Uhl-Bien \*et al.\*, 2014](#)).

We understand to follow and to lead as processes as defined in b). The juxtaposition of leadership and followership naturally points to two issues that require further consideration:

- (1) The first is whether there can be leadership without followership. While in some senses one cannot lead without having followers, there are two forms of this relationship. One form is leadership with voluntary followership, where the leader has both legitimacy and official authority. In this case, people follow the leader both because they want to and because they have to. The other form is compulsory followership, where the leader does not have legitimacy yet is leader by official authority as he or she has been placed in a position and given authority by

superiors. In this case, people only follow their leader because they have no other choice.

- (2) The second issue is whether there can be followership without leadership. This may not seem possible in the context of the organisation of human activities. However, if we consider well-known phenomena such as self-organising groups, the issue is less clear-cut. In 1959, the study of the behaviour of ants led to the introduction of stigmergy as a form of coordination through the environment between agents or actions so that a trace left in the environment by an action stimulates the performance of the next action (Theraulaz and Bonabeau, 1999). More recently, the concept has been extended to other types of activity, including humans in organisations, where stigmergy can be seen as a consensus mechanism of indirect coordination (Borghini, 2017). In such situations, there is no explicit leadership; but rather, what one might call a collective followership.

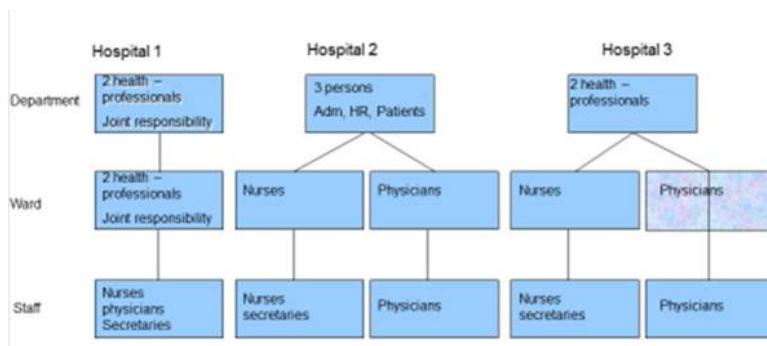
In our case, it is important to focus on voluntary followership as that is what we find gives legitimacy. If the leader has legitimacy, tasks can be performed efficiently, and if the leader only has authority, it will be more difficult to perform tasks and to lead. Leader legitimacy has been analysed through interviews with staff in all three departments, with a focus on how staff perceive and use their leaders. The leadership set-ups are analysed using a framework that was developed for categorising dual leadership (Thude *et al.*, 2017a).

### Three cases

The three cases chosen for this analysis represent different ways to organise the leaders of hospital departments. The different leadership set-ups are shown in the following figure, and each case is explained further in Figure 1.

#### *Hospital 1*

Hospital 1 is a small hospital with around 400 beds. As shown in Figure 1, the hospital has two health professionals as leaders at both the department and ward levels. The two leaders sharing the leadership tasks are mandated without a power difference and are held jointly accountable for the results of the department. This can also be defined as dual leadership (Thude *et al.*, 2017a). All staff at Hospital 1 report to both leaders, so the hospital does not have a separate leader for each profession, and nurses, physicians, secretaries and other staff are led by both leaders at the same time.



**Figure 1.** Forms of leadership at the departmental level of three Danish hospitals

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### *Hospital 2*

Hospital 2 is also a small hospital and has around 300 beds. The departmental leadership consists of three leaders: a chief leader and two deputies. The chief has the final responsibility, and the two deputies each have an area of responsibility. One is responsible for managing all staff and the budget, while the other is responsible for creating better patient pathways.

The leaders at the ward level report to all three departmental leaders, depending on the topic, but mostly to the human resources leader concerning leader development, staff problems, budget issues, etc. The leaders at the ward level are a nurse and a physician. They have shared responsibility for running the ward according to quality, budget and development, among others, but they also lead their own group of staff; nurses and secretaries or physicians.

The organisation of the departmental and ward leaders in Hospital 2 is characterised as dual leadership (Thude *et al.*, 2017a).

### *Hospital 3*

The third hospital is a large teaching hospital with around 1,200 beds. The department at this hospital is larger than at the other two hospitals and has more research and highly specialised functions than the other two departments. The leaders of the department are two health professionals – a nurse and a physician. They share the responsibility for managing the departmental budget, quality and patient satisfaction, among other factors. Furthermore, the nurse is the head of the nurse leaders, and the physician is head of all physicians.

At the ward level, they have a nurse who is in charge of the ward and all staff on the ward, including nurses and other staff. The nurse cooperates with a physician leader who is not in charge of any staff but has responsibility for the quality of treatment and research.

The leaders of the department have a type of dual leadership set-up, even though not all areas of responsibility are interchangeable (Thude *et al.*, 2017a). As there is only one leader of the ward who cooperates with a physician without any staff responsibility, this cannot be defined as a pure form of dual leadership. Still, the leaders share responsibilities for work planning and the development of the ward, which is why the set-up is not only strictly unitary but also has some dual aspects.

We named the leadership teams at the department level Team 1 and those at the ward level Teams 2 and 3. In the following, we focus our analysis on the leader teams at the ward level. The leaders at the ward level are in direct contact with the staff and have a direct influence on interdisciplinary cooperation and should therefore show whether there is a relationship between the leadership set-up and interdisciplinary cooperation. Furthermore, the legitimacy of the ward-level leaders depends on the staff, and by focussing on the ward level, we can assess the connection between the staff and their direct leaders.

## **Methodology**

Together, the wards from the three departments had ten leaders, who were all interviewed to clarify how the leaders at each hospital experienced the leadership set-up and how they were working under this new system. The analysis is based on interviews with the leaders and therefore investigates the leaders' own perceptions of their leadership set-up.

The interviews with the leaders were semi-structured (Kvale and Brinkmann, 2009) and lasted for approximately 1 h each. The interviews focussed on how the leaders cooperated within their team, what they found to be the most important tasks, how they would organise

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meetings and make decisions and if they trusted each other and agreed on decisions. As shown in [Table I](#), the interviews were held individually and lasted for approximately 1 h.

Staff from all three departments were interviewed to obtain their views on interdisciplinary cooperation in their departments and on management. The interviews were semi-structured ([Kvale and Brinkmann, 2009](#)). The respondents at Hospital 2 were interviewed in focus groups of four-seven participants, separated into nurses and physicians. The interviews lasted for 60-90 min. The intention was that all interviews with the staff should be focus group interviews, as we were interested in the group perspective rather than the individual focus. However, this was only possible at Hospital 2, as the other two hospitals could not do without that many staff at one time. Instead, we held individual interviews with the respondents at the other two hospitals; these interviews lasted from 20 min to 1 h, which is also shown in [Table II](#).

The first author of this article conducted all interviews with leaders and staff. All interviews with the leaders were transcribed and coded according to the seven principles found essential for dual leadership ([Thude \*et al.\*, 2017a](#)). Interviews with staff were transcribed and coded according to their perceptions of their leaders and interdisciplinary cooperation. Nvivo was used for coding and analysis. The analysis was performed by the full research team. The first author translated the quotes used in this article from Danish to English, while a colleague back-translated them from English to Danish to ensure accurate translation.

As the interviews were held during working hours, the number of interviews were limited to the number of staff who were assigned by their leaders or were available at the time. Therefore, it was not possible to conduct supplementary interviews. However, after analysing the data, we found that the data in the interviews with the same group of staff from the same ward were very similar.

### Analysis

The analysis was based on the interviews, using the seven categories of dual leadership ([Thude \*et al.\*, 2017a](#)), to categorise the leadership teams. Some of the teams cannot be defined as dual-leader teams, and therefore, not all the categories are relevant here. As we have

**Table I.**  
Interviews with  
leaders at the ward  
level

	Small hospital 1	Interviews with leaders	
		Small hospital 2	Large hospital 3
Who were interviewed	Leaders of ward	Leaders of ward	Leaders of ward
Number of interviews	4	2	4
Duration of interview (min)	60	60	60
Type of interview	Individual	Individual	Individual

**Table II.**  
Interviews with staff

	Small hospital 1	Interviews with staff	
		Small hospital 2	Large hospital 3
Who were interviewed	Staff	Staff	Staff
Number of respondents	9	16	6
Number of interviews		3	
Duration of interview (min)	20-60	60-90	30-60
Type of interview	Individual	Focus group	Individual

limited the research to only focus on the leadership set-up at the ward level, we defined the leadership teams as Teams 2 and 3 to make it clear that the teams at department level – Team 1 in each department – are not analysed in this article.

### Hospital 1

At Hospital 1, all leaders were in a dual set-up, but the leadership teams functioned differently. Team 2, the ward leaders, did not have many common tasks and therefore did not communicate very much. However, they trusted each other, and each leader felt the other was supportive. As they did not have common tasks, we do not know if they would give each other veto power or if they had good human material. In Team 3, the leaders did not trust each other; they would hardly communicate and did not feel that the other leader was supportive. Both leaders found that the other leader was not fulfilling their role as a leader should, and they did not have the same views of leadership.

The differences in the leadership teams at Hospital 1 according to the dual leadership categories (Thude *et al.*, 2017a) are shown in Figure 2, in the Small Hospital 1 column.

### Hospital 2

The leadership team in the ward at Hospital 2 consisted of a nurse and a physician. Both leaders were new in their positions and did not have any leadership experience. They had shared responsibility for the ward, but each had their own areas of responsibility, as the physician was in charge of the physicians and the nurse was in charge of the nurses and secretaries. Because of their shared responsibility, this leadership team is characterised as a dual-leader team. Neither of the leaders had experienced any disagreements yet; both leaders stated that they trusted and respected each other. Even though they had not been working together for long, it seemed that they trusted each other and could discuss different subjects. Most of the leadership assignments were divided beforehand, and therefore, they only had to agree on the shared assignments and challenges.

Because the leaders were new in their positions and had not yet experienced disagreements, we do not know if they would give each other veto power. Furthermore, they had not discussed the decision-making process and had not had any disagreements over it yet. Therefore, we do not know if they would agree on the decision-making process. This is why there are two question marks in Figure 2 in the Small Hospital 2 column, which lists the seven categories the leadership teams at Hospital 2 fulfils.

Leadership teams at ward level at all three hospitals					
	Small hospital 1		Small hospital 2	Large hospital 3	
	Team 2	Team 3	Team 2	Team 2	Team 3
Equal leader experience	No	No	Yes	Yes	Yes
Interchangeable assignments	No	No	No	No	No
One office	Yes	No	No	No	No
Veto power	?	No	?	?	No
Good human material	?	No	Yes	Yes	No
Trust and good communication	Yes	No	Yes	Yes	No
Agreeing on decision process	Yes	No	?	Yes	?

**Notes:** “?” means that we either do not know or it is not possible to answer yes or no to the question

**Figure 2.**  
Leadership teams at  
the ward level at all  
three hospitals

*Hospital 3*

At Hospital 3, Team 2 comprised a nurse leading a ward in cooperation with a physician. The nurse was responsible for the nursing staff on the ward and the ward as a whole and had a full-time leadership position. The physician did not have any staff responsibility but would cooperate with the nurse leader on tasks concerning the ward, such as development and changes in the ward. The physician leader also had clinical work and was only working part-time (or less) on leadership tasks. The two leaders would meet many times during the day and felt they had a good working relationship, helping each other. The leaders had not had any disagreements in their decisions, and as they had divided responsibilities, we do not know if they would give each other veto power in certain situations, which is why there are two question marks in [Figure 2](#) in the Large Hospital 3 column.

The third team was structured in the same way as the second team. This was another kind of ward and the leaders did not meet during the day. They had a planned meeting once every month, where they would discuss ward issues, such as patient satisfaction and physical premises. As a result of the specific work on the ward, many decisions would be made by the departmental leaders – Team 1. The leaders did not have the same confidence in each other, and the nurse leader explained that the physician leaders lacked leadership education and understanding of the organisation. At the same time, the physician leader stated that as physicians, they would do whatever it took not to be led. As the leaders did not make many decisions in common, we do not know if they would agree on the decision-making process, which is why this category is marked with a question mark.

As shown, all leadership teams have different set-ups and work very differently. [Figure 2](#) gives an overview of the leadership teams and if they fulfil the demands for dual leadership, as well as how many of the demands each team fulfils.

As [Figure 2](#) shows, none of the teams fulfil all categories, and each of the teams fulfils different categories. In the next section, we will focus on whether there is interdisciplinary cooperation on the wards and if one leadership set-up achieves better interdisciplinary cooperation than another. Furthermore, we will focus on leader legitimacy to analyse if one leadership set-up results in more legitimacy than another.

**Interdisciplinary cooperation**

To analyse interdisciplinary cooperation, we interviewed nurses and physicians from all three departments concerning the two categories mentioned by [Gittell \(2012\)](#): common goals, knowledge and respect; and good communication, meaning frequent, timely and precise communication.

*Hospital 1*

At Hospital 1, we spoke with staff reporting to Team 2 and staff reporting to Team 3. The physicians on the ward reported to Teams 2 and 3. Staff explained that there was good cooperation between nurses and physicians and all other professional groups. The staff mentioned that they had good communication with others and trusted their colleagues, who all tried to do their best but were under time pressure. As one nurse put it:

[...] we cannot complain about the cooperation with the physicians. We know they are under a lot of pressure and they know we are under a lot of pressure. So there is some kind of implicit agreement that we all are doing our best.

A physician said: “it is an interdisciplinary collaboration. And ahh, I cannot do without information from the nurse, because it contributes to the picture I need to have of the patient.” The nurses reporting to Team 3 were most happy about their interdisciplinary

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cooperation, while the nurses reporting to Team 2 said that they had very good collaborations with the physicians, but it could be difficult because the physicians did not spend much time in the ward.

Our data indicate that there is good interdisciplinary cooperation in the department at Hospital 1, although it appeared to be better in the ward referring to Team 3.

### *Hospital 2*

At Hospital 2, we spoke to staff referring to Team 2. Both nurses and physicians experienced good interdisciplinary cooperation, and they all spoke about good communication and good relations. The physicians also reported good cooperation with the nurses and said that: “[. . .] we use each other a lot [. . .] I wouldn’t know what to do without the nurses.” One physician explained:

[. . .] you will have to work closely together with someone to know what they are capable of. That is what we do [. . .] If you do not work closely together across professions if it is just because you refer to a dietitian then it is not interdisciplinary cooperation. I know the dietitian here and I know her profession and what she can handle. And I can say it would be good if you could see precisely this and this patient [. . .].

Within the ward at Hospital 2, the nurses and physicians, and the other professions, appeared to have good cooperation, respecting each other, maintaining good communication and using the each other’s competencies.

### *Hospital 3*

At Hospital 3, both nurses and physicians explained that they had good interdisciplinary cooperation. One nurse commented that the interdisciplinarity in this specific department was much better than at other departments she had worked in.

The physicians also generally reported good interdisciplinary cooperation, although one physician did not think it was that important to cooperate, as he did not have much use for the nurses – he stated that he could manage tasks himself:

I am not that demanding in my every day or in my cooperation with the nurses. It actually works quite well, we have a good climate in the department and a management who expects that we cooperate [. . .] sometimes you are a bit more independent and can handle the tasks yourself [. . .].

That might be the case, but it is difficult to know if the task could have been managed better in a more cooperative manner with a nurse or other professional person.

Therefore, we obtained a picture of a ward with much interdisciplinary cooperation, but cooperation might not have reached all staff within the department. The ward at Hospital 3 was the only ward where some nurses and physicians talked about the physicians as having autonomy, and it was the only ward where the same physician leader had been in charge for many years. Whether these aspects influenced interdisciplinary cooperation is difficult to tell, but they stand out from the other departments. Hospital 3 is a large university hospital, and we cannot determine if the size of the ward, department and hospital has an influence on interdisciplinary cooperation.

However, we conclude that in the department at Hospital 3, the nurses and physicians had good cooperation and good communication, although this might not be as widespread as in the other two hospitals.

Our data indicate that the departments at all hospitals showed considerable interdisciplinary cooperation. At Hospital 3, the cooperation may be slightly less than that in the two smaller hospitals, but we do not have adequate data to assess this definitively.

### **Legitimacy**

Leader legitimacy was analysed based on interviews with staff from all three departments at the three hospitals.

#### *Hospital 1*

At Hospital 1, we got the impression that nurses and physicians from both wards would only use the leader from their own profession, and they did not have much, if any, contact with the other leader. One physician explained: "I use the physician leader [. . .] I have not thought about contacting the nurse leader [. . .]". Another physician said: "I do not use the nurse leader unless I have a question that professionally concerns the nurses [. . .]". The nurses referring to Teams 2 and 3 did not perceive the physician leader as their leader. One nurse explained that she only had contact with the nurse leader:

[. . .] the physician leader is a physician like all the other physicians. It is not because she [the physician leader] is my leader I do not see her as my leader because she is not my leader.

The nurses referring to Team 3 met the physician leader every day as he was also a physician on the ward. However, they still did not see him as their leader and they did not contact him as a leader.

Team 1 was hardly mentioned by the respondents, and it seemed as though the staff had very little contact with the leaders of their department. However, one physician was frustrated that the physician leader of the department (Team 1) did not have any understanding of the work on the ward as he was trained in another clinical specialty.

At Hospital 1, the data indicate that each leader had legitimacy only from their own profession. Both professions knew they officially had a second leader, but they did not use the second leader and they did not perceive him or her as their leader. At the department level, our data show that clinical specialty can counteract legitimacy so that a physician might not have legitimacy in the group of physicians if he or she is from another clinical specialty.

#### *Hospital 2*

At Hospital 2, the nurses referred to the nurse leader and the physicians to the physician leader. We found there was general frustration among the staff – both nurses and physicians – because the head of the department and one of the deputies in Team 1 was from another clinical specialty, and the staff explained that these leaders did not understand the workflow, culture and priorities of the ward. The physicians said: "[. . .] everything that we need to decide passes through leaders from another clinical specialty [. . .] we work in different ways that they do not have an understanding of [. . .]"

Both the leader of the nurses and the leader of the physicians in Team 2 had been away from the job for long periods because of illness. When the interview with the nurses took place, they still did not have their new nurse leader and they were very frustrated and felt that they needed a leader close by. The physicians were happy to have a new physician leader, even though she was caught up in meetings.

At Hospital 2, it seemed that the leaders of Team 2 had legitimacy while the leaders of Team 1 did not, because they did not have an understanding of the clinical specialty of the ward.

*Hospital 3*

At Hospital 3, the nurses from both wards were very happy with their leaders on the ward and also with the nurse leader of the department. One nurse explained:

[. . .][the nurse leader of the ward] is a model for how we talk together and that we have respectful communication [. . .] she is always available and she is visible [. . .] Practically, she is wearing a uniform like the rest of us and she starts in the morning at the same time as us.

The nurses did not perceive the physician leader of Team 3 as a leader. They said: “she is chief physician, she has a clinical specialty [. . .] that is what she spends all her time doing [. . .] The physicians at this ward are being lead very autonomously [. . .]”.

One physician explained:

[. . .][the physician leader of the department] has one day a week in ambulatory care [. . .] so he still has some clinical work [. . .] and not because it is needed to be respected, but it is often the case that some of the colleagues you hear, that if they do not have clinical work they lose their understanding of clinical practice [. . .].

On the question of whether it was important to work “hands on”, the physician answered:

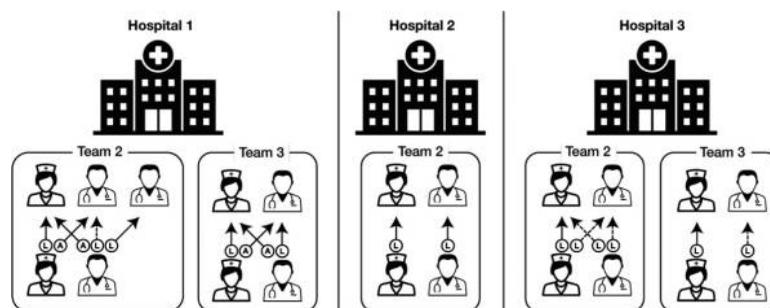
[. . .] at least that is the case in the medical profession that to maintain the respect from colleagues but also to have knowledge of what is going on, you have to have been a part of the clinical work.

According to the interviews, the leaders at Hospital 3 had legitimacy. The nurses might not respect the physician leader as a leader, but as she was not the leader of the nurses, she did not need legitimacy from that group.

We found that leader legitimacy can be divided in two areas: profession and specialty. At Hospital 2, both the nurses and physicians were frustrated that two of their leaders of the department, a nurse and a physician respectively, were from another specialty. This was also mentioned at Hospital 1, even though it did not gain much attention.

At Hospital 1, where the staff formally had two leaders, they only used the leader from their own profession, and they did not see the other leader as their leader. At Hospital 3, it was very important that the physicians were led by a physician and that he was still a part of the clinical work. The nurses expressed the opinion that the nurse leader wore a uniform and worked at the same time as the nurses, which was how she also showed that she was connected to the nurse group.

We found that not all leaders had legitimacy but some were compelled to lead by formal authority. By using these terms, we can map the follower approach from each ward as shown in [Figure 3](#):



**Figure 3.**  
The leader-follower  
approach

As [Figure 3](#) shows, the leaders had legitimacy in their own professional groups. At Hospital 1 and within Team 2, one physician leader did not have as much legitimacy as the others, because a third and more experienced leader was used instead.

When examining leadership across professions, we saw a different picture. At Hospital 1, where the leaders were required to lead across professions, they did not have legitimacy from the staff in the other professional group, which means that that leader would have to lead by authority, based on the role assigned to them by their superiors.

At Hospital 2, we found that the leaders had legitimacy in the staff group within their own professional group. We did not see much contact from nurses to the physician leader or from physicians to the nurse leader. This was, however, expected, as the leaders did not have responsibility for both professions.

At Hospital 3, we found that the leaders of Team 2 had legitimacy. However, the physician leader's legitimacy is shown by a dotted line in [Figure 3](#) as the physicians were supposed to refer to the leader of Team 1, as he had the staff responsibility. Even though they did not have leadership responsibility across both professions, it seemed like there was an acknowledgement of the other leader, which is why this perception is indicated as dotted line for legitimacy. The leaders in this team met many times during the day, and the staff would also meet both of them many times during the day. In that regard, the team leaders and staff seemed very tightly knit. In Team 3, the leaders had legitimacy within their own professional group. Again, a dotted line marks the physician leader's legitimacy as the staff responsibility was placed within Team 1. In this team, there was not much contact between one staff group and the other leader, and the leaders were not expected to lead across staff groups.

The differences in legitimacy accorded by the staff to their leaders show us that legitimacy cannot be taken for granted. A precondition to dual leadership, which is practised at Hospital 1 at all levels and at the departmental level at Hospital 3, is that both leaders have legitimacy from both professional groups. We found that this legitimacy can vary: sometimes, it does not exist, and therefore, dual leadership is not achieved. Our data show that the intention of having dual leadership, where the leaders have a shared responsibility and staff refer to both leaders, does not work when staff do not accord legitimacy to both leaders.

## Discussion

In the literature, pooled leadership at the top is proposed to have a positive influence on outcomes and legitimacy. This article has analysed whether there is any relationship between the leadership set-up and interdisciplinary cooperation and leader legitimacy in the ward.

We found that the leader teams in the three cases we studied were organised differently and also acted and cooperated differently. We did not find a relationship between interdisciplinary cooperation and the leader set-up or the behaviour of the leader team. It appears that interdisciplinary cooperation is driven by other aspects, such as a wish to help patients. We are aware that in more wards, staff explained that in general, interdisciplinary cooperation was very good within that clinical specialty. As we investigated the same specialty in all departments, and all departments showed good interdisciplinary cooperation, it would be interesting to study if the degree of cooperation is related to clinical specialty.

In terms of leader legitimacy, we found differences from hospital to hospital. At Hospital 1, where staff were supposed to report to two leaders – a physician and a nurse – it did not work that way. Staff would only refer to the leader from their own profession. This

may be because the leader set-up was still new and the staff were not used to talking to a leader from another profession, or it might be because it is difficult to gain legitimacy from another profession or perhaps the leaders did not have any intention to lead across professions; we do not know. However, we found that the dual leadership set-up was not working in the way it was supposed to, and that the leaders need to have legitimacy in both groups of staff if dual leadership is to be achieved.

At hospitals where staff were only reporting to one leader from their own profession, the leaders had legitimacy. Furthermore, we found that clinical specialty can influence whether a leader has legitimacy. In one ward, the leaders in Leader Team 1 did not have legitimacy because they were from another specialty. Staff in that ward felt that their leaders had no understanding of the workflow and procedures of the ward. In some cases where the leaders did not have legitimacy, staff would only refer to the other leader, which was accepted by the leaders. However, at Hospital 2, it was not possible to refer to another leader, and the lack of leader legitimacy lead to frustration in the staff group.

We found that legitimacy is an important factor in how leader teams can expand their leadership.

### Limitations of the research

As hospitals are complex organisations, many factors will influence the performance of a department. Here, the focus has only been on the leadership set-up. Other factors such as budget, staff skills and culture are of course important and can influence the achievements of a department.

Furthermore, leader teams are described using a categorisation tool developed to categorise dual leadership set-ups. In this study, not all set-ups can be categorised as pure dual leadership, and therefore, other aspects such as leader education, time available to focus on leadership tasks and relationship to superiors might be important for how the leader teams work.

This study is based on qualitative data from one department at three hospitals. As we only have one department from each hospital, the data are not generalisable to the rest of the hospital. We only have a picture of how the situation is perceived by staff and leaders at the time the interviews were held. It would be interesting to see if the same picture was evident at the other departments in each hospital and if the situations have changed over time and the leadership set-ups work in a different way now compared to at the time of this study.

### Conclusion

In terms of interdisciplinary cooperation, we found that all departments had good cooperation between staff members, and that staff respected each other, communicated well and shared the same goal of helping their patients. We did not find a connection between leader set-up and interdisciplinary cooperation. This study does not support the assumption that leader set-up is a primary tool to achieve interdisciplinary cooperation and therefore cannot recommend one set-up over another. However, it is interesting to consider which other factors may influence interdisciplinary cooperation. As our interviews showed that clinical specialty might influence interdisciplinary cooperation, we propose that future research should examine if clinical specialty has an impact on interdisciplinary cooperation.

We did find a relationship between leader set-up and leader legitimacy, and the data showed that where staff were only reporting to one leader from their own profession, the leader had legitimacy, but where staff were reporting to two leaders from two professions, only the leader from their own profession had legitimacy. This is important knowledge for leaders and chief executive officers (CEOs) in the health-care sector, as it shows that they

cannot take legitimacy for granted. If CEOs want leaders to lead across professions, they will have to focus on developing leader legitimacy across professions.

Furthermore, we found that clinical specialty also can be an important factor in legitimacy, and in the two departments where the physicians were from another specialty, the leader's legitimacy was challenged. Therefore, another recommendation for decisionmakers in the health-care sector is that clinical specialty can influence leader legitimacy, and CEOs therefore should also focus on leader legitimacy when they choose leaders to lead staff from clinical specialties other than their own.

We have found that that legitimacy can be difficult to establish and that it cannot be taken for granted. Therefore, it would also be useful to look more closely at how to achieve legitimacy in cases where the leader is from a different profession or clinical specialty to that of the staff.

#### Note

1. The term "good human material" was originally defined by [Alvarez and Svejenova \(2005\)](#).

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**Corresponding author**

Bettina Ravnborg Thude can be contacted at: [bettina.ravnborg.thude@rsyd.dk](mailto:bettina.ravnborg.thude@rsyd.dk)

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