



Collective leadership in collaborative practice: a qualitative secondary analysis of how plural leadership is enacted in practice

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ABSTRACT

Research on interprofessional collaboration often includes the assumption that leadership is enacted individually. However, collaboration involves a form of leadership, sometimes known as *plural leadership*, that occurs from the combined influence of individuals. We examined plural leadership in practice for the purpose of informing strategies to support leadership specifically, and interprofessional collaboration more generally. We conducted a secondary analysis of 13 semi-structured interviews collected as part of a larger study on interprofessional collaboration in long-term care. First, we categorized data using concepts theorized from research on plural leadership. Next, we identified themes within each of the categories that represented how plural leadership is enacted according to the concepts. We then combined these themes to arrive at three actionable ways that plural leadership is enacted in long-term care: familiarity to create leaders; sharing and empathy to foster leadership; and structuring leadership. We use these to offer some practical approaches based on evidence and theory to support plural leadership in practice. Strategies include supporting staff continuity, providing space to share knowledge, and equipping team members with tools for navigating organizational structures. Our work contributes theoretical ideas about how to study and support leadership in collaboration.

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Introduction

Interprofessional collaboration (IPC) involves different professions working together with patients¹ to achieve optimal health outcomes (Reeves et al., 2017; World Health Organization, 2010). An IPC approach improves patient outcomes (e.g., length of stay), provider outcomes (e.g., job satisfaction), and organizational outcomes (e.g., staffing) (Wei et al., 2022). Improving healthcare quality and outcomes are priorities in long-term care (LTC) (Cranley et al., 2020). Leadership that fosters healthy relationships is critical for IPC in LTC (Cranley et al., 2022; Doornebosch et al., 2022). Thus, LTC is a valuable setting to study leadership and IPC. Understanding how leadership supports IPC is important for clinicians and decision-makers.

Conceptually, IPC is often depicted as consisting of individual competencies. For example, The Canadian Interprofessional Health Collaborative (CIHC) (2010) identifies six competencies outlining the knowledge, skills, and behaviors necessary for collaboration. Further, the Interprofessional Education Collaborative (2016) includes four core-competencies and various related sub-competencies—all related to individuals. Notably, an updated draft now explicitly identifies *shared leadership* (Interprofessional Education Collaborative, 2023). Leadership is consistently present within other existing frameworks; however, it is rarely conceptualized beyond individual competencies and researchers have, thus, adopted an individualistic approach to studying leadership and IPC (Brewer et al., 2016; McLaney et al., 2022). Collaboration is dynamic, shared, and contextual

(Folkman et al., 2019), thus prompting calls for a more collective view of the competencies required for IPC (McLaney et al., 2022).

Denis et al. (2012) introduced *plurality of leadership*. Plurality of leadership refers to “a collective phenomenon that is distributed or shared among different people, potentially fluid, and constructed in interaction” (Denis et al., 2012, p. 212). This definition aligns with IPC practice. Given a reliance on individual leadership in IPC literature, and research suggesting that leadership is key to IPC, we undertook a qualitative study to answer the following question: How is plural leadership enacted in IPC? Our aim was to examine plural leadership for the purpose of informing strategies to support IPC in LTC settings.

Background

Collaboration requires effective leadership (Brewer et al., 2016; Iachini et al., 2019; McLaney et al., 2022). However, little research exists on what effective leadership is within IPC (Brewer et al., 2016). Equivocal findings stem from how leadership is a broad and diverse area of scholarship containing much debate (Kort, 2008). Historically, leadership was ascribed to individual characteristics or skills—akin to displaying strong communication, dominance, or heroism (Sergi et al., 2021; Van Wart, 2013). A criticism of this approach is that it positions leadership as an individual responsibility (Orchard et al., 2017) and overlooks complexities.

Contemporary views of leadership in healthcare acknowledge that leaders are situated within, and influence, broader contexts, and that these contexts are complex and unpredictable (Alilyyani et al., 2018; Benmira & Agboola, 2021). Given the newness of these relational perspectives on leadership, research on IPC is also beginning to encompass a less individualistic and more collective view of leadership (Brewer et al., 2016; Varpio & Teunissen, 2021).

Collective leadership is based on an assumption that leadership is shared and, therefore, may come from individuals at different times and in different ways (Brewer et al., 2016; Iachini et al., 2019; Sergi et al., 2021; Silva et al., 2022). Given the fit with principles of IPC, researchers are beginning to examine this form of leadership in the context of IPC. For example, Iachini et al. (2019) found that embedding a model of collaborative leadership within an interprofessional education course led students to view leadership as being less about individual attributes, and more about collective responsibilities. Varpio and Teunissen (2021) extended these findings to argue how, in IPC, different professions experience equally powerful leadership and followership responsibilities that co-produce outcomes. They termed this *knotworking* to depict how there is no organizing center (i.e., individual leader) and how leadership responsibilities are dynamic given the situation (Varpio & Teunissen, 2021). Previously, MacNaughton et al. (2013) reported that autonomy can influence IPC and highlighted how leadership can foster collaboration among autonomous clinicians by empowering clinicians to be both autonomous and collaborative depending on the context. Similarly, Orchard et al. (2017) and MacNaughton et al. (2013) have both argued that hierarchy can influence leadership in IPC. For example, Orchard et al. noted that hierarchical culture focused on autocratic approaches to care can create challenges for leaders working to foster IPC. Moreover, MacNaughton et al. found that, while leadership can foster IPC, positional hierarchy within healthcare teams can be either a positive or negative influence on realizing IPC.

Researchers agree that a collective perspective offers a useful conceptualization of leadership, especially in an IPC context (McLaney et al., 2022). To that end, we adopted a *plural leadership* (Denis et al., 2012) approach to inform our research.

Conceptual framework: plurality of leadership

Plural leadership has been described for decades across multiple disciplines using terms such as collective, relational, and shared leadership (Denis et al., 2012; Flocco et al., 2021). Generally, *plurality* refers to the actions of a group (Kort, 2008) and emphasizes that leadership is not the responsibility of one individual (Sergi et al., 2021). Denis et al. (2012) conducted a highly cited literature review on plural leadership and presented four distinct streams of research: sharing, pooling, spreading, and producing leadership. According to Denis et al., sharing leadership is aimed at mutually leading individuals in groups to achieve goals and is focused on achieving team effectiveness or performance. Pooling leadership is about leaders combining to lead others located outside of the combined

group. It involves individuals working together as co-leaders and, as such, being evaluated by other leaders. Spreading leadership refers to multiple leaders coming together from across and within levels of an organization over time. It is hierarchical and involves leaders spanning boundaries. Finally, producing leadership pertains to a form of leadership that is created from relationships between people in an organization (Denis et al., 2012). These four streams are epistemologically and methodologically different and, therefore, focus on different phenomena related to plural leadership.

Plural leadership differs from other forms of collective or shared leadership due to its conceptual precision (highlighted above) and, therefore, empirical strength. As Denis et al. (2012) suggested, there is risk in romanticizing leadership as a “naive democratic ideal in which leadership is an organizational quality shared by all” (p. 274). Terminology such as *collective leadership* or *shared leadership* both depict leadership as involving multiple individuals; however, they lack the clear conceptualizations of how leadership occurs plurally. It is because of this conceptual precision—specifically sharing, pooling, spreading, and producing leadership—that plural leadership differs from other lesser developed notions of collective leadership. So, while different terminology is often used synonymously to describe forms of leadership that are not individually focused, from an empirical perspective, plural leadership offers the most developed lens for examining a non-individualistic view of leadership.

Plurality of leadership has informed previous research. For example, Flocco et al. (2021) used a case-study approach guided by Denis et al. (2012) to explore how formal and informal leaders interacted to achieve innovation. They found that leadership in innovation was shared among multiple individuals—both formal and informally (Flocco et al., 2021). Researchers have also reported that individuals can influence plural leadership. For example, White et al. (2014) suggested that individuals influence the environments for realizing plural leadership. This finding was supported by a systematic review examining leader behavior and health team performance, with the authors reporting that leaders were capable of redistributing power and influence across teams thereby leveraging expertise within the group (O'Donovan et al., 2021).

While literature offers insights on plural leadership and how it aligns with IPC, it does not explicitly identify how plural leadership occurs in IPC. Without this understanding, it is difficult to create strategies to support effective leadership (Silva et al., 2022). Because research has shown that leadership supports IPC in LTC (Cranley et al., 2022; Doornebosch et al., 2022), LTC provides a unique setting to examine plural leadership.

Study aim

Our aim was to examine plural leadership for the purpose of informing strategies to support leadership specifically, and IPC more generally.

Methods

Research design and question

We conducted a secondary analysis of qualitative data from a larger study on IPC in LTC (Thompson et al., 2021). Qualitative secondary analysis permits reexamining of data collected as part of a previous study while maximizing data utility (Ruggiano & Perry, 2019; Tate & Happ, 2018). Our overarching design was qualitative descriptive. Qualitative descriptive research is aimed at providing “close-to-data” descriptions of an event or phenomenon that can incorporate a theoretical orientation to that phenomenon (Sandelowski, 2010). To reexamine the original data, we applied a plural leadership perspective by Denis et al. (2012) to the analysis. Our research question was: How is plural leadership enacted in IPC?

Research setting

The original study was conducted within two publicly funded LTC homes in a medium-sized city in Ontario, Canada. Combined, the facilities totaled approximately 700 beds and consisted of 21 units.

Participants and sampling

Personal support workers (PSWs), Registered/Licensed Practical Nurses (R/LPNs), and Registered Nurses (RNs) who worked full- or part-time for at least a year in long-term care were eligible to participate in the original study. Participants were invited to participate using information sessions, posters, and e-mail. Participants were offered a \$15 gift card to coffee shop. The original study enrolled 13 participants and identified redundancy in responses during interviews (Thompson et al., 2021), suggesting an adequate sample size (Polit & Beck, 2017). The research reported here included the entire sample from the original study. Due to dynamic staffing models in LTC at the time of this research, it is difficult to estimate the number of nursing staff working at the facilities; therefore, it is unknown how many refused to participate in the original study. No participants withdrew after participating in interviews.

Data collection

Data collection began in 2018 and ended in 2020 due to COVID-19 restrictions. Data was collected using semi-structured open-ended individual interviews with participants. The interview protocol was developed using the Canadian Interprofessional Health Collaborative (2010) Framework.

The CIHC framework represents the beliefs, knowledge, and skills required for a variety of professions to operationalize collaboration across multiple settings (Karam & Brault, 2025). Thus, the framework was chosen to guide our work because it offered a perspective on IPC that captured both action and thinking of clinicians. We asked general questions about IPC, and specific questions related to the following IPC competencies outlined in the CIHC Framework: role clarification, client-centered care, team functioning, collaborative leadership, communication, and conflict resolution. Questions were adapted to reflect the profession of the interviewee. The interview guide was not pilot tested and is available from the first author. Interviews were conducted by a PhD trained researcher or assistant trained in qualitative interviewing. Interviewers were male, nurses, and knowledgeable in IPC. The interviewers had not worked at either facility. The participants and researchers did not have a relationship prior to data collection. Further, the participants were informed that the researchers were Registered Nurses, employed at the local university (which is not affiliated with the LTC settings), and interested in exploring how IPC occurs in LTC. Importantly, participants were made aware that their involvement or non-involvement in the study would not affect their employment and that their employer would not be aware of who participated or not. Field notes or journal entries related to data collection or researcher bias were not created. Interviews lasted 45–60 min and were audio-recorded. A professional transcribed the recordings and anonymized the data.

Analysis

We used a combination of deductive and inductive analysis guided by Fereday and Muir-Cochrane (2006) to ensure our findings remained close-to-the-data as is recommended (Sandelowski, 2010). The categorization/deductive approach involved all four authors and the inductive/thematic analysis involved two authors. To begin, we all read the transcripts several times and categorized data according to the four types of plural leadership (Denis et al., 2012)—while being open to additional categories as recommended (Crabtree & Miller, 1999; Fereday & Muir-Cochrane, 2006) (see Table 1). Once data was categorized, two authors reviewed the data and identified themes within the categories. This process was iterative as themes and patterns were identified within and across different categories of data. The final step of analysis involved the same two authors who then clustered the themes to arrive at the final set of three overarching themes (Crabtree & Miller, 1999; Fereday & Muir-Cochrane, 2006). We discussed categorizations and themes throughout both the deductive and

Table 1. Description and focus of plural leadership concepts.

	Producing Leadership	Spreading Leadership	Shared Leadership	Pooling Leadership
How we described the concepts of plural leadership.	Leadership is relational and emerges from interaction.	Leadership is distributed across levels within an organization and over time.	Leadership is mutually shared amongst individuals to achieve outcomes.	Leadership at the top of group/team is jointly shared to lead others.
The focus of our deductive analysis.	Emergence of leadership from interactions.	Spread of leadership across boundaries.	Sharing of leadership for outcomes.	Jointly sharing leadership at the top.

inductive analysis. While the entire analysis included some interpretive processes (e.g., interpreting concepts of plural leadership and participant responses), we attempted to keep our analysis close-to-the-data as is recommended for descriptive approaches (Sandelowski, 2010).

Trustworthiness

We used three methods to establish trustworthiness. First, a researcher trained in qualitative data collection and analysis, as well as IPC research, led both the original study and secondary analysis. Second, we used analyst-triangulation (Patton, 1999). Specifically, several authors independently coded the data and then discussed the interpretations and results. Further, we met several times during the analysis to clarify, discuss, and consider the consistency of categories and themes. Third, we maintained detailed records of data collection, theory interpretation, and data analysis decisions across both studies (Polit & Beck, 2017).

Ethical considerations

Institutional Research Ethics Board approval was obtained from the university (#156 17–18) and participating sites (#2018004) for the original study. The university research ethics board reviewed the secondary analysis plan and exempted the research from further review due to the use of anonymized data.

Findings

Participant demographics can be found in Table 2. Data aligned with the four types of plural leadership (see Online Supplement), thus, lending support for Denis et al. (2012) plural leadership framework. From the four categories, we initially identified 10 themes related to plural leadership in collaboration. *Producing leadership* contained *morale boosters* and *insightful knowledge*; *spreading leadership* contained *building rapport* and *shifting structures*; *shared leadership* contained *understanding roles*, *space and time to share*, and *empathy toward other roles*; and *pooling leadership* contained *license/regulation designations*, *organizational structure*, and *culture of disrespect* (see Table 3). From these 10 themes, we subsequently identified three overarching themes: *familiarity to create leaders*; *sharing*

and empathy to foster leadership; and *structuring leadership* (see Figure 1). In the following section, we present the three overarching themes. Of note, 2 of the 10 initial themes did not fit within the final set of three themes. These included *morale boosters* and *culture of disrespect*. We mention them above and include them in Figure 1 to demonstrate support in our data for aspects of plural leadership theory in general, despite them not aligning with our final themes.

Familiarity to create leaders

Familiarity to create leaders originated from two concepts in Denis et al. (2012) plural leadership theory: spreading leadership and producing leadership. Specifically, spreading leadership contained the theme of building rapport, and producing leadership contained the theme of insightful knowledge (see Figure 1). Conceptually, attributes such as rapport and knowledge are foundational for healthcare workers to develop familiarity with colleagues, clients, and environments (e.g., regulations).

Participants in our study spoke about how they would build rapport with coworkers and become familiar with clients to provide better care and take on leadership roles. A PSW commented:

Because you have to communicate – usually what we would do is say, I'll talk – because it will confuse them [clients] if everybody starts talking or not talking to them. And that's a big part of dealing with any of the dementia patients. One would just be quiet and – unless maybe the resident started getting agitated with that person, then they take over and see if that works. (A11PSW)

Here, the PSW described how familiarity with a client, and their changing conditions and behaviors, can influence who and when someone lead care. Familiarity with clients and how it influenced PSWs taking on leadership was echoed by an R/LPN:

So right away the PSW came to me and said: I know her [the client]. And this is a new unit I'm on. She's [the client] not right. There's just something about her. I don't know what it is. So, then I went to the registered nurse and then the nurse practitioner, and we all talked about it. We talked about her blood pressure medications. I took her blood pressure. It was low. I held her medications. (J13R/LPN)

The preceding quote illustrates how familiarity with a client's usual behavior triggered a PSW to take on a leadership role and initiate an assessment and change in care. From an IPC perspective, that change involved input from multiple professions. Further, although vital sign assessment and medication administration are beyond the scope of PSWs, the cascading effect of the PSW's leadership led to these actions. The same R/LPN commented: "their [PSW] hands-on care is so critical to what I do because I need to know. They're my eyes and they're

Table 2. Participant demographics.

Discipline	Sample Size (%)	Years of Experience
Personal Support Worker	6 (46%)	4–17
Registered/Licensed Practical Nurse	4 (31%)	1–23
Registered Nurse	3 (23%)	3–37

Table 3. Themes identified within data categorizations.

Producing Leadership	Spreading Leadership	Shared Leadership	Pooling Leadership
(1) Morale boosters	(1) Building rapport	(1) Understanding roles	(1) License/regulation designations
(2) Insightful knowledge	(2) Shifting structures	(2) Space and time to share	(2) Organizational structure
		(3) Empathy toward other roles	(3) Culture of disrespect

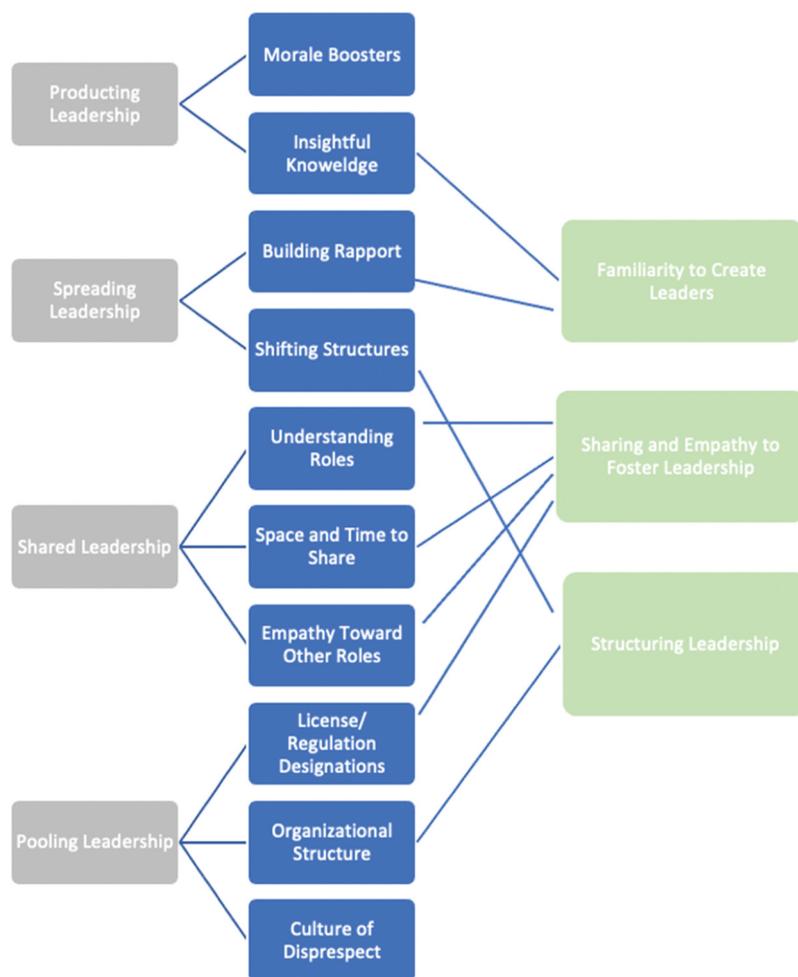


Figure 1. Categories and themes.

my ears” (J13R/LPN). This quote illustrates how the R/LPN was aware of how complementary scopes of practice and roles combine to support IPC.

Another PSW described how familiarity with clients’ preferences can produce leadership when providing care to clients:

Another PSW that’s had better luck with a resident – they’ve just said certain phrases that seemed to calm them down. Or certain spots on them, like, I notice when you touch this resident’s hands, they really get upset. So, they pass it on or when we’re doing their care . . . then they kind of lead. R/LPNs are pretty good. (D20PSW)

In the above quote, the PSW described how they used their familiarity of a client’s preferences (and dislikes) to lead R/LPNs when providing care. In this quote, the familiarity of client behaviors created space for a leadership role. Further, the mention of transferring information to others speaks to the importance of professions to have an overarching understanding of how their roles and scopes combine to provide care.

Familiarity to create leaders also refers to insightful knowledge of organizational aspects. For example, knowledge of broader organizational and professional policies positioned some professions to take on a leadership role within IPC. An RN commented:

It’s not just experience in general nursing care. It’s the experience of knowing policies, knowing the long-term care act. Knowing how the College of Nurses works. How the College of Physicians works. How everything else works and, people have great ideas, but they don’t understand you are legislated. (M10RN)

In this quote, the RN described how they lead by balancing people’s ideas with what can be accomplished within broader policies. The same RN acknowledged the importance of cultivating an environment where workers from other professions felt safe to provide input:

In our profession of nursing, it’s very disheartening to think that you’re not going to listen to a PSW who takes care of that person day in and day out. They know what’s changed from yesterday. They’ve seen them naked. When they’re bathing them, are they going to feel comfortable coming to me and saying, “I was washing and I felt a lump here” or “he’s got a rash” or “this is nothing new”?(M10RN)

In the above quote, the RN described the importance of cultivating a culture of openness and respect where all professions feel comfortable sharing information. Familiarity with workers, clients, and environments created opportunities for different professions to take on leadership roles and contribute to plural leadership in IPC.

Sharing and empathy to foster leadership

Sharing and empathy to foster leadership originated from two, albeit different, concepts in Denis et al. (2012) plural leadership theory: shared leadership and pooling leadership. Shared leadership contained the themes of understanding roles, space and time to share, and empathy toward other roles. Pooling leadership contained the theme of license/regulation designations (see Figure 1).

Data within the sharing and empathy to foster leadership theme related to understanding roles, understanding regulation designations, empathy toward roles, and how those roles contributed to an interprofessional team. An RN spoke about how R/LPNs would contact the RN for advice as opposed to other R/LPNs when encountering a new situation: “New R/LPNs that are new to the floor or agency R/LPNs because we have agencies that come in and, they’ll just ask the RN. If there’s questions that they don’t know, instead of talking to other R/LPNs across the way, they call the RNs” (A15RN). In this quote, the RN implied that in some scenarios, the R/LPNs could consult with other R/LPNs rather than the RNs. However, the RN understood their role as a leader in these situations due to their professional designation. Also, within this quote, the RN highlighted how, despite other workers (i.e., R/LPNs) being closer in proximity (“across the way”), they call the RN. The sharing of information, specifically across licensure designations and spaces, creates, or even forces, plural leadership. Another RN spoke of a similar scenario: “I can’t follow 14 people around to make sure they do their job. If you come to me and say, I don’t feel comfortable doing this. Then it’s my job to catch you up” (M10RN). In this scenario, the RN highlights the challenges associated with how sharing information can foster leadership but can also create tension due to time pressures. The same RN highlights how time and regulation requirements can cause tension: “You’re not always on top of that, you can’t supervise, you can’t overlook every person” (M10RN).

The aspects of space and time, specifically how they can foster leadership through sharing, were also mentioned by R/LPNs: “We, as an R/LPN, have a leadership role all the time on the unit because the RN has two units.” (J13R/LPN). In this quote, the R/LPN acknowledged how they must lead on their unit because the RNs share regulatory responsibilities across units and are not always present. In combination with the preceding quotes by RNs related to sharing, the complexity of plural leadership across spaces, times, roles, regulations, and designations is apparent.

Despite the complexities and challenges, empathy toward other roles and regulatory designations was appreciated and fostered leadership. A PSW commented:

I think everybody kind of knows their roles. R/LPNs, you know, if it’s not their care to wash someone up, that’s not technically their care, but they will do. Or same with us PSWs, if we see a mess on the floor, we’re not housekeeping, we do that too.” (D20PSW)

In this quote, the PSW referred to workers completing tasks outside their regulatory scope of practice or role—which can be a form of plural leadership. When asked about healthy relationships within the workplace, another PSW noted:

I don’t feel threatened that my R/LPN can come to me and say, “can you do this for me?” And I know that she’s not telling to do that because she feels that I’m lower on the pole than her. She’s asking me because she sees me as an equal and that she’s doing something else. (J19PSW)

Appreciating other responsibilities, and ultimately demonstrating empathy, and leadership was identified by multiple professions. An R/LPN described an RN assisting with a task:

I’ve seen RNs bend over backwards because we don’t do a lot of IVs. So, it’s hard because we don’t do the skill very often. It scares people. We have a couple RNs that are good at it and they’re happy to come, show you, walk you through it. I think, it is really good collaboration.”(S14R/LPN)

Sharing knowledge and responsibilities outside one’s scope of practice was interpreted as a way of demonstrating empathy and showing respect—and ultimately fostering IPC and shared leadership.

Structuring leadership

Structuring leadership is from two concepts in Denis et al. (2012) plural leadership theory: spreading leadership and pooling leadership. Spreading leadership contained the theme of shifting structures, and pooling leadership contained the theme of organizational structures (see Figure 1). While these two themes are similar, they differ as shifting structures related to changes in micro elements such as staffing, whereas organizational structures pertained to macro elements such as hierarchy. Collectively, both micro and macro structures influence leadership.

Staffing ratios contributed to structuring leadership related to interprofessional communication. A PSW remarked:

Every day was a learning experience about different techniques . . . the R/LPN and the RN might come up and share something with us . . . The R/LPNs were there all the time. The RNs, because they were spread so thin, sometimes they were there and then we could talk to them, but they weren’t as accessible because they were responsible for different floors . . . I guess there’s a shortage of them too throughout the building . . . after a while, it probably became more R/LPN.” (A11PSW)

In the above quote the PSW referenced how changing staffing ratios influenced IPC. An RN also spoke about how the structure of RN and R/LPN work differed and, thus, influenced how interprofessional communication occurred:

When the doctors come in and do their rounds, they just speak to the R/LPNs because the R/LPNs know everything . . . they’re not spread thin like the RNs are. If the R/LPNs put stuff in their doctor’s book and then we go and round with the doctors, they’ll [MDs] will be like: What’s this? [I respond]: I don’t know, It’s not on my list. So, I have to ask in rounds and then I’ll have to get back to them” (A15RN)

The same RN also remarked about how the staffing challenges extended to allied health and how it has changed interprofessional communication in other areas:

I had to bring in the social workers . . . I know the social worker is spread very thin as well. So, lots of times we just correspond through email and then once in a while they shoot me an email back saying: What’s going on? it’s not often that we get to meet face-to-face and have a discussion.” (A15RN)

Staffing resulted in restructuring how professions communicate which can necessitate a need to structure leadership in different ways within healthcare teams. For example, working to support other professions when teams are short or inexperienced was common. An R/LPN commented:

We could have different, PSWs that don't have the experience in the unit and it really is giving them a boost to help and delegate and if there are other team members that have add on things to do, but you have to at least help within the context of what you can do, and just to help out. (M13RPPN)

Structuring leadership to assist with staff experience levels was also noted by PSWs. A PSW reported: "I work with a lot of new staff coming in. Because of the shortage, they would bring in agency workers and just explaining to them the differences on the residents making sure that they're comfortable" (A11PSW).

According to participants, organizational structures also contributed to the need to structure leadership within interprofessional collaboration. Several participants spoke about the organizational communication structures that can influence communication. A PSW reported:

We have to go through a chain of command. We have to basically go to our R/LPNs, who are supposed to go to the RNs who are supposed to then maybe go to the doctors. But a lot of times, you tell an R/LPN, maybe that R/LPN is busy or something. Maybe it just gets bypassed. (J19PSW)

Another PSW stated: "I was told it is not my job to talk to an RN because I'm a PSW. It is my job to talk to the R/LPN and the R/LPNs job to talk to the RN" (J20PSW). An RN elaborated about this communication structure: "They [PSW] get to the habit of bypassing the R/LPN, leading directly to the RN. So, then what I do is try and redirect them back to the R/LPN" (A15RN). Structuring leadership relates communication decisions. As illustrated, these decisions are influenced by organizational leadership. A PSW spoke about deciding to seek assistance: "If I noticed something with a resident, I could talk to the R/LPN, we could even go to the RN, we're all very good that way where you can talk to anybody" (A15PSW). An RN reported: "They [PSW] deal with the physical care and if there's any issues or problems, they bring those forward." (A15RN). In these instances, leadership was required within the scope of each profession's practice to decide to initiate collaboration to "deal with an issue."

Discussion

Leadership in IPC is often conceptualized as individual attributes that can be learned, developed, and implemented (McLaney et al., 2022). Collective approaches to defining and studying leadership in IPC are needed (Interprofessional Education Collaborative, 2023; McLaney et al., 2022). To that end, we used Denis and colleagues' plural leadership model (Denis et al., 2012) to study how leadership occurs in IPC practice. The findings suggest that plural leadership is enacted and supported via familiarity, sharing and empathy, and various structures within the workplace.

Our results align with existing research findings, highlighting the influence of changing context and sharing on collective

leadership. For example, our results suggest that leadership shifts across individuals depending on familiarity with situations and organizational structures. Varpio and Teunissen (2021) reported that leadership responsibilities are dynamic and based on the situation—with leadership shifting depending on expertise. Further, MacNaughton found that leadership can foster collaboration by empowering clinicians to be both autonomous and collaborative depending on the context (MacNaughton et al., 2013)—a finding that is reflected in how structures and familiarity influence collaboration. Finally, the theme of sharing and empathy is aligned with Orchard et al.'s (2017) work—specifically that spaces to share information collaboratively are important for effective teamwork. Our findings also support the work of others who have used Denis et al.'s (2012) plural leadership model to show that context is both a key ingredient to leadership and how it can influence how leadership shifts (White et al., 2014).

Our work extends existing research in that our themes represent the ways in which leadership, when viewed using a plurality lens, is achieved. Therefore, from these themes, we offer some actionable approaches to creating and supporting plural leadership. In the remainder of the discussion, we expand on ways to leverage plural leadership.

Familiarity to create leaders emphasizes the importance of continuity of care, the client-provider therapeutic relationship, and the need for rapport building within the healthcare team. These three concepts are well supported in the IPC literature and their benefits to client care well documented across multiple professions (English et al., 2022; Jaensch et al., 2019; Ladds & Greenhalgh, 2023). Familiarity to create leaders involves workers having knowledge of clients' needs, and rapport with worker clients—both of which result over time to create a sense of familiarity. The data in our study indicates that producing leadership results when workers are familiar with the minutiae of client care, lending details and guidance to other coworkers in the collaborative context—which, as was shown in the data, is dynamic based on context. Leadership via familiarity is also borne from rapport building within the workplace, leading to instances of spreading leadership as workers feel competent and supported by those around them over time. Collectively, to support familiarity and foster plural leadership in IPC, the importance of stable staffing is key; especially within the fragmented workforce facing multiple settings (Figueroa et al., 2019).

Sharing and empathy to foster leadership embodies the concept of shared leadership resulting in collaborative decision-making and improved quality of care. Empathy and understanding others' situations contribute to the culture of respect where members operate outside of their responsibilities, but not outside of their professional scope. Our findings suggest that sharing and empathy promote shared leadership, rejecting the hierarchical nature that often defines leadership (MacNaughton et al., 2013). This allows clinicians to navigate hierarchical structures and appreciate contributions to overall care (Emich, 2018). Further, knowing one's role including scope, licensing, and role on their team allows individuals to lead themselves and their profession. This is an important antecedent of IPC as knowing the roles and skills of the healthcare team allows for the most qualified members to aid

in challenges (Emich, 2018). Finally, shared leadership encompasses sharing expertise transferred in structured space and time. Findings from this study show that shared leadership is yielded when during structured spaces, team members learn and pass on knowledge of what care is required. Thus, the importance of creating space and time to share and convey empathy may act as a foundation to supporting plural leadership.

Structuring leadership can be supported by attending to organizational structures that substantiate hierarchy. By structuring leadership to support plurality, there may be improvements in clinician and client outcomes as leadership changes based on dynamic contexts (Leach et al., 2021). Furthermore, Leach et al. (2021) suggest that structuring leadership may also promote sharing, empathy, and familiarity—attributes also supported by our findings. For example, Leach et al. (2021) suggested that discussions are often focused on the “type of person who can fill” the leadership role (p. 354). Our data suggests that sharing and empathy across professions (e.g., aspects related to roles, regulations, and time) are important parts of plural leadership. Therefore, rather than considering the *type of person* when considering leadership, more appropriate questions may relate to the *type of professions* and the *mix of professions*. Considering these questions could facilitate plural leadership that extends across organizational hierarchies.

Each of these themes has different practical implications for facilitating leadership in interprofessional settings—at staff, unit, and organizational levels. Interventions supporting familiarity may be targeted to the individual employee level and focus on staff retention and employee wellness, as well as workplace safety and staff satisfaction to retain staff and promote familiarity and collegiality. Sharing and empathy relate to interventions at the unit or team level. Feasible interventions may include regularly scheduled meetings for facilitated collaboration and knowledge exchange, or team building activities that contribute to mutual understanding and empathy between coworkers. Finally, interventions at the organizational level may be implemented, providing organizational structure and mitigating inherent barriers and creating a shift in organizational structure or staffing. This may result in hierarchy and changes to the way leadership is taken on among staff.

This secondary analysis has highlighted the importance of plural leadership related to IPC in LTC and the need to work toward promoting this form of collective leadership, in conjunction with the traditional individual approach. However, given the dearth of literature specific to leadership in the plural as it relates to IPC, and actionable implications for advancing such leadership, there is a need for more studies in this area. Studies may report more findings regarding leadership in the plural and also help to push efforts forward to promote this important aspect of healthcare innovation.

Limitations

This research has several limitations. First, it was a secondary analysis and, thus, the data was collected for a purpose different from the current research objective. As such, we could not adjust data collection approaches based on our preliminary

findings. Second, we interpreted plural leadership concepts to categorize data. Our interpretations may have differed from Denis et al. (2012). Third, we analyzed data collected from PSWs, R/LPNs, and RNs in LTC; thus, our findings are limited to this context. It is possible that plural leadership may be enacted differently from other settings and professions, and, thus, generalizing our findings is limited. Finally, the sample sizes from each of the professions, when considered separately, are small. This limits generalizability of our findings.

Conclusion

Leadership in IPC has traditionally been viewed from an individualistic perspective. Plural leadership moves beyond individuals and captures how leadership can occur collectively. In this study, we used an existing framework to understand how plural leadership is enacted in IPC. We found that plural leadership occurs through familiarity, sharing and empathy, and structures. We offered some practical approaches to support these processes—but we stop short of suggesting such approaches are simple as they most definitely are not. However, we argue that efforts aimed at supporting leadership that is collective, and individual, may prove useful for those charged with supporting IPC.

Note

1. Including clients, families, and communities.

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