An antidote to what's ailing healthcare workers: a new (old) way of relational leadership

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Abstract

Purpose – The purpose of the study's mixed-methods evaluation was to examine the ways in which a relational leadership development intervention enhanced participants' abilities to apply relationship-oriented skills on their teams.

Design/methodology/approach – The authors evaluated five program cohorts from 2018–2021, involving 127 interprofessional participants. The study's convergent mixed-method approach analyzed post-course surveys for descriptive statistics and interpreted six-month post-course interviews using qualitative conventional content analysis.

Findings – All intervention features were rated as at least moderately impactful by at least 83% of participants. The sense of community, as well as psychological safety and trust created, were rated as impactful features of the course by at least 94% of participants. At six months post-intervention, participants identified benefits of greater self-awareness, deeper understanding of others and increased confidence in supporting others, building relationships and making positive changes on their teams.

Originality/value – Relational leadership interventions may support participant skills for building connections, supporting others and optimizing teamwork. The high rate of skill application at six months post-course suggests that relational leadership development can be effective and sustainable in healthcare. As the COVID-19 pandemic and systemic crises continue to impact the psychological well-being of healthcare colleagues, relational leadership holds promise to address employee burnout, turnover and isolation on interprofessional care teams.

Keywords Health leadership initiatives, Leadership, Organizational culture, Organizational performance, Program evaluation, Transformational leadership

Paper type Research paper

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Introduction

Healthcare workers are facing intersecting and compounding crises affecting their professional and personal lives: ongoing effects of the COVID-19 pandemic, increasing feelings of isolation, uncertainty about workload sustainability and social inequities laid even more bare. The epidemic of burnout that pre-dated COVID-19 has become more widespread (Chor *et al.*, 2021). Current crises will not be solved by replicating leadership practices that have led us to where we are today. Early in the COVID-19 era, healthcare providers and administrators commented on how the pandemic's epidemiologic tail was likely to be characterized by disengagement and burnout, with significant risk of being exacerbated by a lack of attention to collaborative decision-making, psychological safety and power differentials on the healthcare team (Park *et al.*, 2020). Across multiple fields, evidence exists that leadership behaviors strongly influence many aspects of organizational culture and the well-being of teams (Shanafelt *et al.*, 2021; Inceoglu *et al.*, 2018). Furthermore, current evidence supports that predominant leadership approaches in healthcare have often reinforced rigid and hierarchical models that worsen communication, team performance and patient safety (Kearns *et al.*, 2021). In COVID-19's wake, there have been increased calls to examine whether workplace relationships can be improved to address dissatisfaction, disengagement and burnout among healthcare workers (Pal *et al.*, 2022).

In this paper, we describe a relational leadership (RL) development intervention and its observed outcomes to date. The concept and theory of RL has been developed within a number of different disciplines since at least the 1970s. Mary Uhl-Bien's (2006) definition of RL as a social influence process that emergently and intentionally produces change, and that can be practiced regardless of one's formal leadership role, is critical for our use of the term. Another key feature of RL, identified in literature reviews, is its emphasis on "system phenomenon," rather than individual leader traits (Maritsa, Goula, Psychogios and Pierrakos, 2022). Within healthcare, RL has received less attention than more widely researched theories, such as transformational leadership and leader–member exchange (LMX). Transformational leadership, although it includes a construct of "individual consideration" for others, is not predominantly focused on relational skills (Arnold, 2017). LMX has been categorized as an RL style in reviews of the literature (Inceoglu *et al.*, 2018), particularly for its definition of leadership as existing in the quality of relationships themselves rather than in leader characteristics. LMX theory, however, gives a central role to efficiency in relationships, which is of less importance in most conceptions of RL, which increasingly focus on complexity and adaptability as key concepts for study (Hazy and Uhl-Bien, 2015).

Across different theoretical approaches, the empirical evidence base generally supports what many healthcare professionals have observed, particularly over the past two years: leadership that enhances relationships and cultivates trust and respect for all is especially important in times of crisis (Moss *et al.*, 2020; Maritsa *et al.*, 2022). Less relational, more hierarchical healthcare teams are associated with decreased communication, lower team effectiveness and worse patient safety (Kearns *et al.*, 2021), while conversely, "zero burnout" healthcare teams (where no providers reported burnout) have been found in one large national study to have a foundational culture of leadership that is attentive to the interpersonal, relational aspects of work (Edwards *et al.*, 2021).

Far from being new insights into leadership, these are old ones. Many (traditional and contemporary) indigenous concepts of leadership center relationships and the distributed exercise of power (Wilson, 2008; Pieratos *et al.*, 2021), as do feminist (Watson, 2016) and other critiques of systems-control or mechanistic-technocratic approaches to leadership (Park *et al.*, 2020). Although healthcare and health services research has been long concerned

with optimizing the benefits of strong patient–provider relationships, this relational focus has less commonly been theorized for enhancing relationships between and among care team members. This study's novel offering is an evaluation of the impact of centering relational practices (the "old") in leadership development within the *healthcare* field (the "new"). Healthcare has long understood that every leader is necessarily involved in managing relationships and optimizing engagement (Beach and Inui, 2006), yet not all trainings offered to healthcare professionals practice skills to engage in relational behaviors that create and embody leadership as they are practiced. For example, although a recent systematic review of interventions to promote psychological safety among healthcare workers highlighted the need for leaders to actively support such work (O'Donovan and McAuliffe, 2020), many existing leadership training programs do not explicitly focus on this concept or teach the skills that enable leaders to create safe teams.

The skills of RL include fostering team spaces where team members can better bring forth their authentic selves; feel a sense of belonging within that team; adopt a growth mindset (e.g. mistakes are re-framed as learning opportunities); and work interdependently, with a clearer sense of how their work interacts with others (Intend Health Strategies, 2022). Early research on RL practices within interprofessional healthcare teams demonstrated associations with improved quality of care (Gittell *et al.*, 2000), provider satisfaction (Gittell, 2008) and patient satisfaction with care (Azar *et al.*, 2017). Few RL interventions in healthcare settings have been described in the literature. Cleary and colleagues (2018) found that an RL development effort resulted in increased trust and team cohesion at multiple levels across a district health system, but also faced constraints imposed by more hierarchical management practices. A recent single site leadership development initiative that was characterized as relational (and drew on multiple leadership theories) found improvements in meaningful recognition of staff and reduced turnover among the program participants (Leclerc *et al.*, 2022). Published evaluations of RL development interventions with outcomes remain rare, however.

The Relational Leadership Institute (RLI) launched in 2017 at an academic health center in Portland, Oregon, to build skills in relationship-based leadership models firsthand (RELATE Lab, 2022) and to address a perceived gap in leadership development within healthcare. RLI engages participants from a range of healthcare fields (e.g. medicine, nursing, social work, public health) across the career spectrum, from student to senior leader. Course features are intentionally designed to accomplish several things:

- initiate conversations on the impacts power differentials may have on psychological safety;
- flatten power differentials through the modeling of authenticity by program trainers/facilitators;
- generate connection and trust through community-building activities; and
- facilitate participants applying new skills in real time to navigate team dynamics in their small groups.

Sessions intentionally attempt to create psychologically safer spaces for participants, so they may experience this safety and be emboldened to recreate the behaviors cultivating that same feeling within their own work teams. In this paper, we evaluate participants' experiences, skill application and professional impact in five cohorts of this leadership course. We then discuss the implications of these findings for re-imagining leadership and teams within the healthcare field.

Methods

Study setting

RLI launched as a collaboration between the non-profit Intend Health Strategies (Intend Health Strategies, 2022) and Oregon Health and Science University's (OHSU) Department of Family Medicine. The initial two cohorts were piloted in 2017 and led to refinements of the curriculum and evaluation. The subsequent five cohorts, conducted between October 2018 and May 2021, provided the data used in this analysis. Participants applied and were accepted into the cohorts, after paying registration fees on a sliding scale (from US$200–US $800/participant). The OHSU Institutional Review Board approved this project as an exempt protocol (Study #19017).

Course description

The RLI curriculum (Table 1) includes ten modules delivered in full-day weekend and 3-h weeknight sessions (approximately 20–25 h, over a period of two to three months). RLI combines large group didactics, small group activities, one-on-one skill practice and self-reflection.

Small groups (6–8 participants) are facilitated by two prior RLI participants. Trainers (content experts) and facilitators actively model RL skills to engender trust, psychological safety and connection. For example, trainers model authenticity and vulnerability through sharing their own personal leadership stories at the beginning of sessions, regularly admit when they are uncertain and seek feedback from others. Each small group facilitator and

Module	Description
Introduction to RLI	Overview of RL framework and principles
Narrative leadership	Sharing one's unique lived experiences in story form, to communicate values and also identify shared values with others
One-to-one meetings	A face-to-face interaction that shifts from outcomes-driven discussions toward integrating values-based ones, including understanding what motivates others, surfacing shared values, cultivating trust
Introduction to 5 Dynamics*	Understanding diverse work and learning preferences, to both create alignment on teams and highlight the need for interdependent teamwork
Managing stages of teaming	Strategies for managing the common developmental stages of teams
Meeting management/collaborative decision-making	Skills for fostering more inclusive meetings by shifting from leader-driven decision-making to building consensus
Coaching	Supporting others using a strengths-based mindset, to build on existing attributes to get an individual to their unique goals
Conflict transformation	Normalizing the inevitability of conflict, and fostering skills for addressing conflict in intentional ways that transform the underlying relationship
Advocacy	Accelerating systems change through building core teams, understanding the values of decisionmakers and combining data with stories to shift people's positions/decisions
Closure	Highlighting the importance of implementing practices for team and project closure; reflection on personal contributions to teams

Table 1.
RLI curriculum

Notes: (*) Simpli5 powered by 5 Dynamics – an online self-administered assessment of work and learning preferences. Available at www.simpli5.com/ Accessed June 23, 2022
Source: Authors' own work

several trainers are alumni of the program; this trajectory from program participant to small group facilitator to trainer is an intentional component of the course. Facilitators receive training on relational facilitation skills to better foster a sense of community. One of the authors (BP) helped develop RLI; the other co-authors are academic researchers with backgrounds in medicine and social science who designed and implemented the program evaluation.

Study measures

The initial post-course survey, administered immediately following the course, assessed participant perception of logistics, program features and overall quality. The follow-up post-course survey, administered six months post-course, assessed RL skill application at a point distant from the course (i.e. the longer-term application of learned skills).

We invited 17 intervention participants (RLI 3 = 5, RLI 4 = 5, RLI 5 = 7) to a 1-h semi-structured interview conducted six month post-course, in which they were asked to reflect on their experiences in RLI, impacts the course has made on their professional lives and longer-term applications of learned skills. Purposive sampling was used to select this subset from all attendees to maximize diversity with regard to race, training status, professional role and how they rated reported course benefits (e.g. sense of community). Interviews for RLI 3 and 4 were conducted in-person (October 2019 to February 2020) and interviews for RLI 5 were conducted virtually (August to November 2020). All interviews were audio recorded and transcribed verbatim.

Data analysis

We analyzed quantitative results using descriptive statistics. Interview transcriptions were transferred to Atlas.ti 8.4.4 for analysis (Atlas.ti Scientific Software Development GmbH, Berlin, Germany). Consistent with methods used in qualitative conventional content analysis (Hsieh and Shannon, 2005), we coded interview data using categories created from *a priori* concepts that structured the interview guide (e.g. application of skills). Within these categories, we sub-coded responses to group the appearance of RLI course elements (e.g. narrative leadership) in participants' comments. One coder then identified patterns within and across categories using an inductive approach. Our analysis took participants' own emphasis on the ways the course had impacted them as a starting point from which findings were developed. Investigators met regularly by video conference to discuss and interpret emerging quantitative and qualitative findings. A preliminary analysis was developed after each cohort, but as part of an iterative approach, when new patterns emerged in later cohorts, data from prior cohorts were revisited for comparative purposes.

Results

A total of 127 individuals participated in the five cohorts (2018–2021). The gender, race, profession and training status of these participants in RLI 3–7 are shown in Table 2. Participants predominantly identified as women (87%), white (74%) and the majority (71%) were working in their profession, and approximately one-third were students or residents. The most common professions of the participants were: 31% physicians, 15% nurse practitioners, 9% public health workers and 7% social workers.

Course experience

Survey questions assessed the impact of the course features that were specifically designed to create an environment for participants to experience and practice RL (Table 3). All

Demographics	RLI 3 $n = 22$	RLI 4 $n = 33$	RLI 5 $n = 27$	RLI 6 $n = 20$	RLI 7 $n = 25$	Totals % $n = 127$
Gender						
Female	19	31	23	17	21	111 (87)
Male	2	2	4	3	2	13 (10)
Nonbinary	1	0	0	0	1	2 (2)
Race						
African American or Black	1	1	0	0	0	2 (2)
American Indian or Alaska Native	0	0	0	1	0	1 (0.8)
Asian or Asian American	2	3	1	2	5	13 (10
Middle Eastern	1	1	0	1	0	3 (2)
Latin(x) or Hispanic	0	0	2	1	2	5 (4)
Bi or multiracial	1	3	1	1	0	6 (5)
White	16	25	23	13	17	94 (74)
Prefer not to answer	1	0	0	2	1	4 (3)
Profession						
Medicine	11	9	6	8	5	39 (31)
Nurse practitioner	4	5	4	2	4	19 (15)
Physician assistant	0	1	0	0	0	1 (1)
Nursing	2	1	1	0	2	6 (5)
Public health	0	6	1	2	3	12 (9)
Social work	2	2	3	2	0	9 (7)
Pharmacy	1	0	1	0	0	2 (2)
Other*	2	9	11	6	11	39 (31)
Stage of training						
Student/resident	13	8	5	6	5	37 (29)
Working in profession	9	25	22	14	20	90 (71)

Table 2.
RLI Demographics across five cohorts (2018–2021)

Notes: (*) Educator, program coordinator, quality improvement analyst, psychologist, clinical administration, practice facilitator, medical physicist, mental health supervisor, health administration, research, health policy
Source: Authors' own work

features were rated as at least moderately impactful by a high percentage of participants in both in-person and virtual course formats. The most impactful features (based on mean percentage of all participants rating them as having "quite a bit" or a "tremendous amount" of impact) include: trainers and facilitators modeling vulnerability and program skills (91%) and the opportunity for individual and group reflection (90%). The cross-generational nature of the program was the least impactful feature in all cohorts.

Psychological safety and sense of community. In both the in-person and virtual formats, the sense of community in small groups and the psychological safety and trust created were rated as having quite a bit or tremendous amount of impact by a high percentage of participants (mean = 88% and 87%, respectively). At the conclusion of RLI, most participants reported that they "feel a part of an inter-professional learning community that will continue beyond the RLI program," either "quite a bit" or to a "tremendous extent" (range 61%–94% across all cohorts).

In post-course interviews, interviewers asked participants to provide their own definitions of psychological safety – which reflected concepts including vulnerability, non-judgment, respect, trust and "feeling heard" – before being asked about their course experience. Most participants indicated that they did experience psychological safety during

Table 3.
Program features (immediate post-course)

What impact have the following program features had on your overall impression of RLI? Results = % choosing the rating	Response rates RLI 3 n = 17/22* RLI 4 n = 30/33 RLI 5 n = 18/27 RLI 6 n = 14/20 RLI 7 n = 17/25	No or very little impact	Moderate impact	Quite a bit or tremendous amount of impact
Cross-generational nature of the program	RLI 3	12	29	58
	RLI 4	7	27	67
	RLI 5	11	39	50
	RLI 6	14	21	64
	RLI 7	6	25	69
	RLI 3–7 mean	10	28	62
Interprofessional nature of the program	RLI 3	18	6	77
	RLI 4	3	7	90
	RLI 5	11	22	67
	RLI 6	0	7	93
	RLI 7	0	6	94
	RLI 3–7 mean	6	10	84
Trainers and facilitators modeled vulnerability and program skills	RLI 3	6	0	94
	RLI 4	3	3	93
	RLI 5	6	22	72
	RLI 6	0	0	100
	RLI 7	0	6	94
	RLI 3–7 mean	3	6	91
Opportunity for individual and group reflection	RLI 3	0	12	89
	RLI 4	3	10	87
	RLI 5	6	17	78
	RLI 6	0	0	100
	RLI 7	0	6	94
	RLI 3–7 mean	2	9	90

(*continued*)

Table 3.

What impact have the following program features had on your overall impression of RLI? Results = % choosing the rating	Response rates RLI 3 n = 17/22* RLI 4 n = 30/33 RLI 5 n = 18/27 RLI 6 n = 14/20 RLI 7 n = 17/25	No or very little impact	Moderate impact	Quite a bit or tremendous amount of impact
Opportunity for skill practice	RLI 3	6	6	89
	RLI 4	0	13	87
	RLI 5	11	11	78
	RLI 6	0	14	86
	RLI 7	0	6	94
	RLI 3–7 mean	3	10	87
Psychological safety and trust created	RLI 3	6	6	89
	RLI 4	3	10	86
	RLI 5	6	22	72
	RLI 6	0	0	100
	RLI 7	0	12	88
	RLI 3–7 mean	3	10	87
Sense of community created in small groups	RLI 3	0	6	94
	RLI 4	0	13	87
	RLI 5	6	22	72
	RLI 6	0	14	86
	RLI 7	0	0	100
	RLI 3–7 mean	1	11	88

Notes: (*) Rating categories in RLI 3 survey: No or minimal impact: Some impact; moderate or very high impact
Source: Authors' own work

the course and often attributed this feeling to facilitators and trainers honoring participants' experiences, while modeling vulnerability and honesty:

> Leading management in terms of building trust, building psychological safety with my colleagues has been huge, and taking the time to do that is, like, the most important thing that I learned in RLI. It takes – you actually have to go out of your way to do it, and it's a great investment in both a team, or a project or an activity or something that you're working on (Public health professional).

> People who were the facilitators told us their stories very early on, so the expression of vulnerability at a leadership level invites everyone else to show equal vulnerability, which allows for psychological safety (Physician).

The course methods for cultivating safety through shared vulnerability were not uniformly impactful, however:

> I had a really hard time with the narrative leadership [module] personally, and I think it was because it really challenged me and it could have been because it was the first thing we did. It really took me outside of my comfort zone. I really don't like talking about myself, and so having to broadcast about myself and then also [I was] [. . .] really confused about how personal it needed to be (Health administration professional).

Interview questions assessing whether RLI became a community that participants felt connected to yielded the analytic insight that connection was not necessarily about spending time with their training cohort; rather, it was often about feeling part of a group with a shared language and understanding:

> It's like coming together with people who have the same language and the same values around how they want to relate with people, and I really appreciated those and the larger community that RLI has started to build (Psychologist).

Many mentioned that maintaining community was hard, given the COVID-19 pandemic restrictions.

> I have not really been engaging with the RLI community, I would say. With COVID and the pandemic hitting, that kind of changed, a lot of those dynamics. The stress of what's going on with everything related to the – yeah. Basically, the year 2020. It's like I kind of displaced, I guess, some of my priorities (Nurse practitioner).

Skill application

The degree of skill application at six months post-course varied across cohorts and modules (Table 4). A majority of participants reported applying skills taught in all modules "at least sometimes." In both course formats, participants reported applying skills learned in the *one-to-ones* and *coaching* modules more often. These modules cover content to identify shared values, cultivate trust and support others using a strengths-based mindset. Advocacy skills were used at lower rates in all cohorts.

In interviews, there was variability in the different RL skills participants found helpful and the application of skills. For example, many described establishing better lines of communication with colleagues or students; others used their skills to provide trainings for other co-workers. For some participants, RLI validated processes they had already used in the past, and made them more aware of their importance. A resident noted that medical training rarely teaches the types of skills learned in RLI:

> The whole concept of Narrative Leadership and One-to-Ones was powerful, and I have to say that I keep seeing this over and over in a lot of other work that I do. We all know story matters, but,

How often are you using the following skills taught in the RLI course?	In-person RLI 3, 4, 5 combined *Response rates*: RLI 3 n = 12/22; RLI 4 n = 17/33; RLI 5 n = 14/27	
Skills	% using skill often or almost all the time	% using skill at least sometimes*
One-to-one meetings	42	82
Coaching	37	79
Meeting management	30	70
Intro to 5 dynamics	30	60
Narrative leadership	28	63
Conflict resolution/conflict transformation	26	68
Managing stages of teaming	26	59
Advocacy	21	51
	Virtual RLI 6 and 7 combined *Response rates*: RLI 6 n = 10/20; RLI 7 n = 14/25	
One-to-one meetings	50	92
Coaching	46	92
Managing stages of teaming	46	79
Meeting management	42	96
Intro to 5 dynamics	38	67
Conflict resolution/conflict transformation	37	66
Narrative leadership	37	62
Advocacy	29	62

Note: *Combines the percentages for the three categories: Sometimes, often and almost all the time
Source: Authors' own work

Table 4.
Ranking of skills used at six months post-course (based on % using skill often or almost all the time)

> you know, for reporters and everybody else, it does. It just really heightened how important it is and how, in the best possible sense, it's a good hook to get people interested in things, that people will be much more engaged with a story than with statistics and it makes sense, but it – it just brought that home, yet again. And it was – was well done (Physician).

Behavioral health professionals that were interviewed found that the RL training did not teach them much more than they already knew by virtue of their professional training:

> I think that as a mental-health professional, you come in with a lot of skills around some of the things we were learning, and so there might be an opportunity to have a 2.0 or RLI for mental-health professionals, where you're doing a much [. . .] deeper dive or you spend more time in application and less time in learning (Psychologist).

Professional impact

In interviews, participants highlighted several benefits to their professional work: greater self-awareness, deeper understanding of others and having RL skills in their "toolkits" added to their confidence to support others, build relationships and positively influence their teams.

Participants described understanding their own roles and strengths, and better managing their emotions in the workplace. Enhanced understanding of others helped participants manage conflict more effectively and be more efficient and productive on their teams. Some participants, especially earlier career individuals, noted that when RL skills and relationship building are intentionally brought into the workplace, it can create a safer space for more team members, particularly those that may view themselves as being positioned lower in an organizational hierarchy, to share their experiences.

> It gave me the tools to not get so emotionally invested to some of these meetings we were having. And it helped me kind of regain the control that I needed. I don't have any control over how everybody else comes to this space. But I do have control over how I come to this space, and how I react, and navigate through it. So, I think RLI kind of gave me my voice back (Public health student).

> I think an appreciation for differences runs through RLI. An example of that is an employee who is more challenging. We're really different. She's very analytic and a little more structured and less flexible and that's a little bit harder for me to appreciate. So even, like the 5 Dynamics [a leadership and self-awareness tool administered in RLI] and looking at how that can impact a team and appreciating her, I think, our relationship has grown exponentially in the past year (Social worker).

> I think I – and I've alluded to there – there's quite a bit of hierarchy, and people don't feel accepted, or like their opinion matters, and so I've really, along with other colleagues, pushed to make some changes in our organization. And I would say RLI has given me confidence to do that – to actually push through and do that (Public health professional).

Further illustrative quotes supporting the qualitative findings are included in supplemental materials.

Discussion

This mixed-methods assessment of five cohorts (2018–2021) assessed the impact of RLI on a diverse and interprofessional group of professionals including trainees. We found that RLI represents an effective program supporting the development of RL practices among an interprofessional group, across a wide variety of training and experience levels. The selected course features performed well in both in-person and virtual formats, with a majority of participants applying skills six months after completion.

Activities to generate connection, psychological safety and a sense of community were especially impactful features of the course, confirming the importance of these attributes for the healthcare workplace. Creating psychologically safe environments and elevating those with less traditional power is a critical element for interprofessional teams, especially during crises, as has become clear during the COVID-19 pandemic (Kerrissey and Singer, 2020). Our findings suggest that the intervention's pedagogic emphasis on facilitators and trainers modeling ways to build trust and safety was effective in helping participants experience RL in real time and learning how to promote it for others in their own workplaces. Some participants, however, were uncomfortable with the high level of personal sharing in professional spaces. Future research should explore if this was due to people occupying different positions within existing intersectional power dynamics. Other research has documented that power dynamics related to professional roles and scope of work can impact team performance (Okpala, 2021); explicit attention to team power dynamics thus may offer learners unique tools for addressing these tensions in their teams. The curriculum overlapped in places with training that many behavioral health professionals experience; additional course development could better complement the existing skills of behavioral health colleagues and bring the communication practices of different health professions into greater alignment.

The cross-generational nature of the program was the least impactful feature in all cohorts, despite the intentional inclusion of participants spanning the usual hierarchies in healthcare. Given that the course was situated at a large academic health center, many of the participants may have been quite accustomed to having trainees included alongside practitioners. Most participants identified as women, a group that has been under-represented in leadership positions in healthcare (Carr *et al.*, 2018). Further exploration of the influence of race and gender on course experience and impacts are planned for future research.

Based on quantitative results, skills related to building trusting relationships, developing shared connections and fostering a strengths-based approach to teamwork (*one-to-one meetings* and *coaching* modules) were most often applied at six months. Our qualitative findings reinforced that using RL skills enhanced communication and helped participants better understand their own strengths, manage emotions and conflicts and gain confidence in supporting others and making positive changes on their teams. These findings align with calls for enhanced conflict management skills and an approach to leadership that is oriented to relational skills on interprofessional healthcare teams (Bickel, 2012; Hofmann and Vermunt, 2021; McCray *et al.*, 2021).

Reasons for participants using advocacy skills less frequently are likely multifactorial. The course's advocacy module sequences a series of RL skills for *systems change*, making it a longer skill to apply. Additionally, though most RLI participants identify being on a team (and thus able to apply the other skills in that context), not everyone may have the time, opportunity and social capital to embark on systemswide transformation efforts.

Compared to other leadership courses, which tend to group participants homogenously by profession and training level (Blumenthal *et al.*, 2012), the intervention's interprofessional and cross-generational small groups provided participants with experiential learning for fostering psychological safety and effective collaboration. These experiences in turn may generate confidence in re-applying these skills in their work teams. Interprofessional RL development may provide a vehicle for supporting more effective interprofessional collaboration – a critical ingredient for high-performing healthcare systems (CFAR *et al.*, 2015) – by strengthening connections across different specialties, expertise and levels of experience. Additionally, many leadership courses predominantly use faculty or outside consultants as instructors (Sultan *et al.*, 2019), whereas this intervention intentionally invites previous participants to fill the role of facilitator and trainer in subsequent cohorts, to contextualize how these newfound skills might be successfully applied to existing work contexts. Similarly, for prior participants who step into a facilitator and/or trainer role, this "participant to facilitator" pathway represents a built-in mechanism for participants to apply and teach newly learned skills in a supportive learning environment.

The RL development intervention described in this paper departs from many healthcare organization leadership programs in a number of intentional ways, which could uniquely position it to address some key issues facing healthcare currently. First, many leadership programs, consistent with prominent theories like transformational leadership, focus predominantly on advancing the status of individual participants (Lucas *et al.*, 2018). Our findings suggest that relationally focused interventions may not only help individuals to increase self-awareness, but could also generate interpersonal- and systems-level changes through better understanding others' values, cultivating a sense of community and enhancing interprofessional collaboration. This may be especially valuable at present, when the sense of community has been severely disrupted by remote work practices and other challenges of the pandemic. Second, whereas some leadership models may perpetuate notions that exceptional individuals are the instigators of systems change, RL operates on the basis of a collaborative, collectivist change model that may be better-suited for improving healthcare's complex problems. Developing leadership in groups rather than leaders as individuals and having shared leadership is needed in healthcare (Edmonstone, 2011), though as noted previously, distributed leadership models face challenges (Cleary *et al.*, 2018). This is subsequently a critical area for future study, if the potential benefits of RL are to be realized. Studies demonstrate that fostering a sense of belonging is dependent not on individual behavior changes, but interpersonal and cultural shifts, with increased belonging being associated with improvements in care quality, reductions in burnout and reductions in staff turnover at

institutions who intentionally work to build a sense of community (Smith *et al.*, 2018). An emerging body of evidence supports the importance of building community as a leadership skill, particularly in fostering engagement, trust and resilience on teams (Lyng *et al.*, 2022; Hazy and Uhl-Bien, 2015). Both the National Academy of Medicine and the US Surgeon General have recently emphasized community-building as key components of healthcare well-being recommendations for leaders and organizations to implement (National Academy of Medicine, 2022; Office of the Surgeon General, 2022). Finally, leadership development programs in healthcare may overly emphasize the technical and executive skills of leadership (e.g. strategic visioning, budgeting, understanding institutions). As others have also noted (Cleary *et al.*, 2018), RL does not replace or oppose these needed skills but can provide a valuable complement to increase the likelihood they can be deployed effectively to reduce employee burnout, enhance workforce satisfaction, decrease costs of care and improve patient health outcomes (Bolton *et al.*, 2021; Edwards *et al.*, 2021; Baker *et al.*, 2016).

Strengths of this study include a convergent mixed-methods design to better understand the intervention's impact, the longitudinal nature of this evaluation across five cohorts and high response rates for quantitative surveys. Limitations include its small sample size and its limited generalizability, as we report findings from a single institution. Despite the limited sample size, multiple professions were represented, with a mix of trainees and those working in their profession. Another limitation is our use of self-report surveys to assess skill application. Further research of intervention impact, and the RL development interventions more generally, will be enriched by assessments of participant skills from the perspective of peers or direct reports.

Conclusion

Leadership models that emphasize the relational aspects of collaborative work – aspects like fostering trust and psychological safety, identifying shared values, implementing a strengths-based approach to teamwork – have long been understood as being foundational to leading effectively, yet may be overlooked and underutilized within settings like academic healthcare. As the COVID-19 pandemic continues to impact the emotional and psychological well-being of healthcare colleagues, RL may represent a timely approach to addressing the persistent issues of increasing burnout, turnover and isolation within interprofessional care teams, all of which impede better patient care. Our findings suggest that leadership development interventions focused on relational practices may help interprofessional participants gain and sustain skills supporting more effective teamwork, relationship-building and ability to support others. Designers of leadership programs for healthcare professionals should consider greater emphasis on relationship-based practices. Future research is needed to better understand how RL influences larger interprofessional groups in other healthcare settings, who it benefits most and how this type of leadership impacts well-being in healthcare professionals, overall quality of care and organizational or systemic change.

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