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WHAT DOES IT MEAN LEADERSHIP IN ITALIAN HEALTHCARE: A RESEARCH ACTION

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Abstract

This research is part of a wider project called CompAct (Compassionate Leadership: an Italian model) funded by the Veneto Region (Italy) as part of its strategic initiatives to improve healthcare workforce retention, explores the meaning and practice of leadership within the Italian healthcare system. The present study involved healthcare managers (physicians and nurses) from two public hospitals, focusing on three key departments: Emergency, Internal Medicine, and Primary Care. This phase of the project aimed to investigate how healthcare leaders interpret their roles and responsibilities, particularly in supporting their teams. Through a series of participatory meetings following the Participatory Action Research approach (Kemmis et al., 2014), participants were encouraged to reflect on their leadership experiences, challenges, and strategies. The qualitative data collected revealed a shared understanding of leadership as a relational and supportive function, rather than a purely managerial or directive one. One of the most significant findings was the emphasis placed on the concept of compassion as a central dimension of effective leadership, involving the capability of noticing, understanding, empathizing, helping (Dutton et al., 2006). However, the way the support is enacted varies considerably depending on the department and professional role. In Emergency departments, leadership is often expressed by a close synergy between the two leaders (physician and nurse) supporting each other to manage the whole team. In Internal Medicine, two different approaches between physician and nurse arose: physicians focus more their leadership on clinical supervision, and managing complex patient care pathways; nurse leaders are more oriented to create mutual trust and collaboration, as a family. In Primary Care, leadership takes on a more distributed and delegative form, emphasizing the need to understand situation where they cannot be physically present. Overall, the research underscores the need for healthcare organizations to recognize and invest in leadership development as a key factor in workforce retention. By fostering a culture of support and compassion (West, 2021), healthcare leaders can contribute significantly to psychological well-being, job satisfaction, and retention. These results represent a first step toward understanding and enhancing leadership practices in Italian healthcare, offering insights that can inform future policies and training programs aimed at strengthening the healthcare workforce.

Keywords: *Action-research, physicians and nurses, healthcare leadership, compassionate leadership.*

1. Introduction

The present study is part of the CompAct project (Compassionate Leadership: an Italian model), funded by the Veneto Region (Italy) to support strategic initiatives aimed at improving healthcare workforce retention. Healthcare systems are facing persistent workforce pressures characterised by staff shortages, high turnover, and declining retention. In this context, leadership has gained increasing relevance as a key resource shaping staff wellbeing and professionals' willingness to remain within organisations. The paper explores how leadership is understood and enacted within the Italian public healthcare system, focusing on leaders' interpretations of their roles and responsibilities in relation to supporting professional teams. The empirical focus is on physician and nurse leaders working in Emergency, Internal Medicine, and Primary Care, selected as settings characterised by complexity and professional interdependence.

2. State of the art

Over the past decade, leadership in healthcare is increasingly seen as embedded in everyday organisational practices rather than tied to formal authority, reflecting the relational dynamics of complex healthcare systems (Carroll, Levy, & Richmond, 2008; Denis, Langley, & Sergi, 2012). Within this view, compassionate leadership addresses the human and emotional dimensions of organisational life and responds to the limits of performance-driven, control-oriented models in contexts of high workload, staff shortages, and moral distress (de Zulueta, 2015; West, 2021). Grounded in Compassion at Work (CAW), compassion is conceptualised as a socially embedded, processual phenomenon—recognising suffering, acting to alleviate it, and generating individual and organisational outcomes—distinct from empathy as perspective-taking (Dutton et al., 2006; Dutton et al., 2014; Strauss et al., 2016). Compassionate leadership fosters a climate characterised by listening, empathy, support, and collaboration (Cervai & Blasutig, 2025), which contributes to relational trust, psychological safety, and positive organisational climates with implications for both well-being and effectiveness (Shuck et al., 2019). This processual understanding is particularly relevant in healthcare, where exposure to suffering is structural and often constrained by regulatory and performance pressures. Leadership shapes organisational climates that enable or inhibit compassionate responses, and compassion is increasingly described as a collective capability sustained through practices, structures, and routines (Vogus & McClelland, 2016; West, 2021). Within this framework, West's model identifies four interrelated practices—attending, understanding, empathising, and acting—which are relational, mutually reinforcing, and enacted in everyday work, shifting the focus from individual competence to context-dependent organisational practice (West et al., 2017; West, 2021). Systematic reviews show that healthcare professionals experience compassionate leadership through leaders' presence, psychologically safe communication, individualised consideration, and comprehensive support (Östergård et al., 2023; Ramachandran et al., 2024). At the same time, the literature highlights the emotional demands associated with compassionate leadership and the risk of compassion fatigue when organisational support is insufficient (Papadopoulos et al., 2020). Despite growing international attention, empirical studies within the Italian public healthcare context remain limited, indicating the need for context-sensitive investigation of how compassionate leadership is interpreted and enacted.

3. Aim and objectives

This study seeks to:

1. examine how healthcare leaders make sense of their leadership roles within public healthcare organizations, focusing on the meanings they attribute to leadership in their daily work;
2. investigate how leadership practices are enacted in concrete organizational situations, taking into account relational dynamics, professional interactions, and contextual constraints;
3. identify recurring themes and patterns in leaders' accounts of leadership experiences across different organizational settings (Emergency, Internal Medicine, and Primary Care).

By addressing these objectives, the study aims to develop an empirically grounded understanding of leadership as it is interpreted and practiced by healthcare leaders, contributing to a reflective analysis of leadership in Italian healthcare organizations within the broader framework of the CompAct project.

4. Research design

The study adopts a Participatory Action Research (PAR) design. Drawing on critical participatory traditions (Kemmis et al., 2014; Kemmis, McTaggart & Nixon, 2014), inquiry is framed as a joint process with practitioners aimed at developing context-sensitive understandings of leadership practice.

4.1. Context and participants

The study was conducted within the Italian public healthcare system. In line with a practice-based perspective, the organizational context is treated not as a neutral backdrop, but as a constitutive element shaping how leadership roles and responsibilities are interpreted and enacted in everyday work (Nicolini, 2012). The empirical work took place in two public hospitals located in the Veneto Region. The study does not aim to produce generalizable claims, but to develop context-sensitive insights grounded in the analysis of leadership practices as they unfold in specific healthcare settings. Participants were healthcare professionals holding formal leadership roles within the selected hospitals. The study involved both physicians and nurses with managerial or coordination responsibilities at the unit or service level. Participants varied in age, gender, professional background, and length of professional experience; all

participants were university graduates, employed within the Public Health Service, and held Italian nationality. Their presence was voluntary and based on informed consent. Consistent with the PAR orientation, participants were included because of their direct involvement in leadership practices.

4.2. Organizational settings

The research focused on three organizational settings: Emergency Departments, Internal Medicine units, and Primary Care services. These settings were selected to reflect distinct organizational configurations within the healthcare system while sharing common challenges related to coordination, responsibility, and relational work. Emergency Departments are characterized by time pressure, uncertainty, and rapid decision-making; Internal Medicine units involve longer-term patient management and complex interprofessional coordination; Primary Care services are positioned between hospital-based and community-based systems and operate mainly in domiciliary and territorial contexts. Together, these settings provided differentiated yet comparable contexts for examining how leadership practices are interpreted and enacted across healthcare organizations.

4.3. Participatory action research approach

In this phase, PAR was carried out through two participatory meetings. Each meeting lasted three hours and involved a group of eight participants (Meeting 1: N = 8; Meeting 2: N = 8). Each group belonged to a different hospital and included physician and nurse leaders from Emergency, Internal Medicine, and Primary Care. Participants were invited to discuss concrete situations from their everyday work as leaders. Qualitative data were gathered through an open-ended stimulus question. Data consisted of fieldnotes and observational memos produced by a team of researchers during the participatory meetings: four researchers were primarily observing interactional dynamics, while two researchers facilitated the sessions. More specifically, notes were first drafted and analyzed individually by each researcher involved. Subsequently, interpretations were discussed within the broader research team, which also included additional members not directly involved in the participatory meetings, enabling further critical scrutiny and refinement of emerging patterns. Findings were subsequently examined in depth, with a focus on patterns emerging across hospital departments. This approach supported the co-construction of analytically grounded insights into leadership as a situated and relational practice, which inform the analyses presented in the following section.

5. Leadership as a relational and supportive function: meanings and variations

Across the participatory meetings, given the question "*In your experience, what does it mean to be a leader and in which moments does leadership materialize?*" participants' accounts varied considerably from one another, but one theme emerged as a common denominator: leadership was consistently described as being linked to the relational aspects of their job, grounded in everyday interactions with subordinates, rather than the exercise of formal authority or managerial tasks. Participants emphasized leadership as something enacted continuously throughout their everyday work, through presence, reliability, openness to confrontation and the capability of accompanying professionals through difficult situations. Within this perspective, leadership was primarily framed as a form of support, closely associated with leaders' availability and proximity to their teams. Being a leader for them meant knowing what happens in the unit, understanding the personal and professional struggles of staff members, and acting as a reference in moments of uncertainty. Leadership was thus portrayed less as a positional role and more as a way of inhabiting everyday work relationships. Within this relational understanding, compassion emerged as a key -though largely implicit- dimension of leadership practice. The activities described closely align with the core aspects of Compassionate Leadership, as identified in literature: *noticing*, *understanding*, *empathizing*, and *helping* (Dutton et al., 2006). Noticing took the form of attentiveness to signals of distress, fatigue, or overload among staff, as well as recognition of individual efforts that might otherwise remain invisible. Understanding involved interpreting those signs and identifying discomfort through an attentive listening dialogue, a process that requires connection and empathy, and that can place a considerable emotional strain on leaders themselves. Helping represented the subsequent step, operationalized through concrete actions such as providing support in conflictual situations, mediating between staff and upper management, ensuring a fair workload distribution, exploring new solutions to organizational challenges, or simply by being present and offering assistance in critical moments. Although compassion was rarely named explicitly by participants, it was clearly embedded in the many accounts of what leadership meant to them, not as an abstract value, but more as an orientation that shapes how leaders respond to the needs of their team. This was unsurprising, given that "*caring for the health and well-being of others is intrinsically compassionate behavior"* (West, 2021, p. 5). Across all settings, participants highlighted how they frequently act as intermediaries, translating top-down decisions into practices that are manageable for the staff.

Compassionate leadership therefore involved sustaining this mediating function over time, remaining available and credible even in situations of uncertainty, scarce resources, and reduced autonomy. These dynamics further reinforce the understanding of leadership as a context-related practice.

What emerged as relevant in this study was the way in which supportive and compassionate practices varied across departments and professional roles.

In Emergency departments - contexts shaped by constant time pressure, unpredictability, high patient inflow, and frequent staff turnover - leadership was described as a highly demanding and consuming function. Leadership here was strongly characterized by proximity and by the mutual support between physician and nurse leaders, who emphasized the need to operate as a coordinated and cohesive professional pair. This close synergy was described as a key factor in sustaining the effective functioning of the team, in an environment that requires continuous and reciprocal adaptations. In this setting, support was enacted through the capacity to filter organizational demands and excessive information, absorb external pressures, and provide a form of safeguards, particularly in relation to the legal and medical risks associated with emergency care. Compassionate leadership was expressed through the recognition of high levels of commitment by staff members, provision of concrete legal and bureaucratic support, and the willingness to remain available for confrontation after difficult or unpopular decisions Leaders stressed the latter as a fundamental practice: being present and explaining the rationale behind such decisions helps immensely the staff when it comes to process frustration and resistance. Compassion, in this sense, was closely linked to themes of reassurance and protection, by offering professionals the sense that they were not alone in critical situations and that their burden would be shared.

In Internal Medicine, leadership took on more differentiated forms depending on professional role, while remaining firmly grounded in relational support. Physician leaders tended to emphasize clinical authority and experience as a prerequisite for their legitimacy, framing leadership as the ability to always guide the team through complex clinical cases and care pathways. Maintaining high levels of clinical competence was perceived as essential for preserving trust within their workgroups. In this sense, compassion is manifested by being trustworthy, offering guidance in difficult decisions and sustained commitment to patient care as a priority. Nurse leaders, in contrast, described their leadership styles primarily in relational and emotional terms. For them being a leader was associated with the act of listening to others, being emotionally available and the continuous effort to build a strong and cohesive group. Several participants used familial metaphors to describe their units, going so far, in one instance, to describe their leadership style using maternal metaphors, and highlighting trust, fairness, and mutual support as fundamental resources needed for building resilience in a very unstable workplace. Paying attention to, and confronting their collaborator's problems emerged not only in relation to the professional field, but particular care was put into noticing personal and private situations as a factor of distress. Compassion emerged predominantly in this setting, and was closely associated with the values given to dialogue and active listening, as well as with care to individual needs and situations.

In Primary Care, leadership was shaped by geographical and organizational fragmentation, with professionals operating across wide territories and small service units. Limited opportunities for face-to-face interactions required leadership to assume a distributed and delegative form, with heavy reliance on trust, autonomy and professional responsibility. Leaders emphasized the necessity of identifying reliable reference-figures within teams that can offer guidance to their co-workers, as well as calibrating levels of autonomy according to years of experience and competence. Compassionate leadership involved remaining available despite distance, developing alternative relational strategies -like frequent phone-based communications and recognizing different needs and levels of autonomy and adapting support accordingly. Delegation emerged as a structural necessity, and this requires strong trust and confidence among team members, in a way that reinforces the relational dimension, even in a context marked by the risk of professional isolation.

6. Limits and conclusions

Beyond highlighting leadership as a predominantly relational dimension of everyday organisational practices, this study points to compassion as an implicit, and already present, orientation embedded in how leadership is enacted within healthcare contexts. A core contribution of the study lies in showing how compassion is contextually shaped across different organisational settings, even within the same healthcare organisation. Rather than assuming compassionate leadership as a universal model, future research should examine how it is enacted through specific behaviours and relational strategies aimed at supporting co-workers. Contextual constraints, professional cultures, and institutional logics play a central role in shaping what compassion means and the forms it can realistically take, and, thus, should not be overlooked. Findings suggest that leadership-development initiatives in healthcare should support leaders in reflecting on and adapting compassionate practices in ways that are coherent with their specific settings,

as the CompAct Project aims to investigate in future steps of research. Creating and sustaining structured spaces for shared reflection and peer dialogue may represent a key lever for maintaining a compassionate organisational climate over time.

Limitations to the study include the restricted number of settings, participants and the singular regional context analyzed, which constrain transferability. The participatory and reflective process may have shaped accounts through collective sense-making; this is treated as an intrinsic feature of PAR rather than a methodological flaw. Importantly, this phase does not assess outcomes (e.g., retention or well-being) and does not establish causal relationships. Despite these limits, the study provides a grounded basis for subsequent phases of the project and suggests that leadership initiatives should prioritise structured spaces for collective reflection on practices and their adaptation to local organisational conditions.

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