Towards more caring and consultative crisis management: perspectives and experiences from women healthcare workers during the COVID-19 pandemic

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INTRODUCTION

The COVID-19 pandemic has generated a global conversation about gender equality and pandemic leadership. Organisations such as UN Women, Women in Global Health and Global Health 50/50 have advocated for greater representation of women in leadership, noting that despite women making up over 70% of healthcare workers, they made up only 24% of COVID-19 task force members. These conversations have been successful in gaining high-profile recognition of the need for greater gender parity in leadership, with the WHO and Women in Global Health coauthoring a report on Closing the Leadership Gap in global health. These discussions have primarily focused on global and national level leadership, as opposed to the health systems leadership directly involved in crisis management. Here, we add this microlevel perspective to these discussions, exploring how women healthcare workers providing direct care perceived and experienced healthcare leadership and crisis management during the COVID-19 pandemic.

We also aim to move the discussions beyond the focus on representation in terms of the portion of women in pandemic response. As Wenham and Herten-Crabb note, analyses purely focused on representation are limited in that, ‘by exalting women’s executive leadership as the signpost for equality, we inculcate the idea that individual women can independently overcome patriarchal structures (ie, ‘if they only try hard enough’) and obscure the plight of millions of women who do not benefit from such a position’. The broader leadership literature does analyse the positionality of women as leaders and leadership styles associated with femininity, but rarely situates these within broader gendered contexts, particularly health systems.

In the crisis management field, there is discussion of the dominance of masculine norms and traditions, but this tends to focus on male dominated professions, such as firefighters. Ericson notes crisis management literature generally includes gender in analysis of vulnerable populations’ risk perceptions, not in terms of how crisis management is implemented. Here, we aim to bring together conversations around gender and pandemic response, women in leadership and the gendered nature of crisis management to reflect on how dominant forms of management during crises can reflect and reinforce inequities.

In doing so, we draw on interdisciplinary feminist scholarship that explores how gender norms not only affect individual behaviour but are embedded in institutions and forms of leadership. This differs somewhat from liberal approaches that focus on individual traits of masculine and feminist leaders, and constructivist approaches with their focus on power as expressed through meaning. Instead, drawing on critical traditions, we consider how gendered forms of leadership result from the interactions of material experiences (contextual factors), ideas (norms around crisis management) and institutions (health systems). For example, long-standing gender norms shape how care is viewed within the health system in general, were in care-based work (as opposed to clinical work) is feminised and devalued in material terms. Recognising the need, elucidated in critical leadership studies, to not just document power inequities in leadership but also consider possible transformations, we turn to the leadership literature on feminist ethics of care. This literature argues that there is moral significance in the fundamental elements of relationships and dependencies in human life, and that the ‘ethic of care’ most often associated with women should be as valued and esteemed as is the ‘ethic of rights’ most often associated with men.

In addition, while the focus is on women’s experiences, as valuable in their own right (as opposed to only in comparison to other genders), we recognise these experiences occur within a gendered context. In particular, we explore how dominant masculine norms, experiences and institutions shape crisis response, raising questions about expressions of hypermasculinity during crisis. Hypermasculinity is an exaggerated form of masculinity that celebrates ‘typical’ masculine characteristics, such as dominance and aggressiveness, and may include discrimination towards women and under-represented groups. Research on hypermasculinity notes it is often pronounced in hierarchal male dominated institutions and can be a response to a breakdown of hegemonic masculinity, including during crisis. Hypermasculine behaviours may be an individual response to stress and/or reflective of structural factors.

In this perspective piece, we weave feminist scholarship—on leadership, crisis management and care—together with examples from the lived experiences of women healthcare workers, gathered...
 Commentary

through research conducted in British Columbia (BC), Canada during the first year (March 2020–2021) of the COVID-19 pandemic. In doing so, we aim to illustrate how, even within a context of comparatively high gender equity and notable women’s representation in leadership, dominant approaches to crisis management can impose exclusive, hypermasculine and discriminatory forms of leadership on a highly feminised workforce. Experiences from women healthcare workers suggest such leadership approaches may not only cause harm but reduce the effectiveness of crisis response.

BC, Canada provides a unique case study to explore questions of gender and leadership during crisis because of the prominence of women in both the health workforce and in COVID-19 leadership. The sector is feminised, in that over 80% of healthcare workers identify as women. High-level leadership also reflects these workforce dynamics. The Chief Public Health Officer of Canada is a woman, and when the COVID-19 pandemic broke out in 2020, 8 out of 10 Provincial Public Health Officers were women. Prime Minister Justin Trudeau, though a man, frequently refers to himself as a feminist and both the Canadian federal and BC provincial governments have committed to gender-based-analysis plus, a policy approach that incorporates intersectional feminist principles.

Analysis of hospital leadership across Canada indicates gender parity. The makeup and commitments of leaders suggest that the ‘problem’ of gender and leadership has been ‘solved’ in BC and Canada. However, accounts from women directly responding to the COVID-19 pandemic suggest otherwise—as is demonstrated below.

In this perspective, we draw on previously published findings from the Canadian case study of the Gender and COVID-19 research project, which focused on the experiences of women healthcare workers in BC during the first year (March 2020 to 2021) of the pandemic. We conducted focus groups and semi-structured interviews with 105 women healthcare workers in BC, including physicians (27), nurses (13), those working in long-term care (26), community healthcare workers (26) and midwives (13). As in-depth methods and results from this research have been published elsewhere, here, we draw on common themes that we identified across publications, situating them within theoretical discussions on gender, leadership and crisis management.

As our original research was qualitative, exploring the lived experiences and perspectives of a relatively small group of women, we intend the examples presented to be exploratory and illustrative, as opposed to generalisable and conclusive. Such qualitative examples can provide in-depth, meaningful inquiry to health research and policy discussions. Feminist scholarship argues that grounding analysis in lived experience reflects a commitment to generating knowledge based on the experiences of people belonging to those groups most affected by the subject of the research—in this case healthcare workers. The holders of these experiences, as those with intimate knowledge, are recognised as experts, particularly in terms of evaluating the effects of policy implementation, such as crisis response. This approach aims to make visible experiences that are often ignored or obscured in mainstream research.

Crucial to qualitative feminist analysis is reflection on our own positionality as researchers, as well as recognition of our biases. We recognise that as researchers we hold a degree of privilege and power, not only during research interactions, but also in terms of how we analyse and share findings. In order to mitigate this, previous research findings have been shared with respondents for input, and recommendations drawn from these interactions and respondents’ lived experience.

We are aware our analysis is limited by the specific focus on women’s experiences, with women defined as anyone who identifies as such, regardless of sex assigned at birth. As our research only included women, we do not aim to contrast women’s experiences of leadership or as leaders with those of other genders, but to explore how women (as a group worthy of study in its own right) experienced crisis management. Further research is needed to understand the experiences of other genders, particularly people who identify outside the women-man binary, as they are under-represented in health research. We also recognise the need for further intersectional research that considers other social positions, such as race and ethnicity, and how they interact. While we do not mean to confine all women healthcare worker experiences, recognising they differ along multiple and intersecting identity axes, we seek to explore how experiences of crisis management and leadership are shaped by one factor that most healthcare workers have in common—their gender as women.

WOMEN HEALTHCARE WORKERS’ LIVED EXPERIENCE OF CRISIS MANAGEMENT

Branicki writes that the dominant form of crisis management ‘tends to be conceptualised as a rational and linear process which follows discrete stages of signal detection, preparation/prevention, containment, recovery and learning’. Ericson argues these established approaches reflect processes of remasculinisation that foster rationalities such as ‘assertiveness’, ‘quick fixes’ and a general ignorance of the complex relations of existing dependencies and the social context in which safety and crisis preparedness work takes place. In other words, dominant approaches to crisis management reflect a bias that privileges hierarchal decision-making, reflective of leadership styles associated with the masculine, and that have benefits in terms of urgency and control, but also lack consideration of relationships and context.

Women healthcare workers, who participated in the Gender and COVID Project Canada case study, noted that during the early phase of the pandemic such models of top down decision-making prevailed with few opportunities for them to feed into processes. For example, midwives expressed frustration that they were not consulted about changes to labour protocols. Numerous healthcare workers noted that the limitations of top-down leadership were exacerbated by physical distancing requirements, where decision-makers were often not on-site and therefore lacked knowledge of day-to-day realities. Long-term care workers recounted a common experience of managers working from home, directing protocols with little insight into working conditions within facilities. One care aid recounted, ‘The door was closed, the lights were off and [our manager] just never showed up’. Another noted that when she tried to communicate concerns regarding standards of care, she was dismissed by her supervisor who was working from home. She noted, ‘they weren’t on the ground with us working. They didn’t know what was happening. So there’s a disconnect in that’. Other respondents also noted they felt lack of consultation limited the effectiveness of the response, particularly in a context of limited scientific knowledge around a novel pathogen and therefore information gaps. A nurse described the frustration of constantly changing personal protective equipment (PPE) protocols with no prior discussion, ‘I would like to at least be involved. If they’re going to implement a new change or policy, I would love for my opinion to be heard, or my thoughts, just because I think that a lot of the initiatives taken sometimes aren’t taken from the front-line staff’s considerations—like, how much time that
adds to our day. Or how much that small change affects patient care or time management'. She felt knowledge gained by those providing care in the pandemic context should be incorporated into decision-making but was not due to linear management styles.

It was recognised that some leaders were privileged by the urgency of pandemic response. A women physician felt, ‘Male leaders were making decisions, that had to be made quickly but also have a stay-at-home wife or children who were no longer dependent on them’. While the necessity for rapid decision-making was acknowledged, it was also felt that urgency was sometimes used to justify the lack of consultation. Another healthcare worker felt leaders were ‘using COVID-19 to avoid consultation. They seem to just proceed and decide’ and another noted, ‘Men are making more decisions now with less process or consultation, they are more directive and dictatorial. Men are advancing their careers and using a more command and control style’. These comments must be contextualised within the province wide school and childcare closures early in the pandemic, and then frequent interruptions, that forced many parents—most often mothers—to miss work. Even though essential workers in BC technically had access to childcare, this rarely corresponded to shift work schedules. Therefore, almost all the women with young children who participated in the research spoke of notable burdens managing childcare and professional obligations. The inequitable impacts of these dilemmas are now well documented, with women's labour participation and research outputs dropping sharply during the first year of the pandemic. Comments from research participants suggest there were also effects on opportunities to take on leadership roles, which were exacerbated by the fast pace of decision-making.

Crisis management has developed largely from the military sector, and so reflects norms and approaches associated with that male dominated field. As quoted above, women healthcare workers described a ‘command and control’ approach to crisis management, reflective of this military tradition. A long-term care aid described a superior standing with a stopwatch, timing how long aids washed their hands. A nurse in a management position described being told ‘to just follow orders’ when she queried a directive about PPE. Healthcare workers found such top down approaches belittling, discouraging them from sharing their expertise with leaders. While military approaches provide expertise in rapid decision-making and logistics deployment, military culture can also be described as hypermasculine.

Respondents noted a resurgence of hypermasculine behaviours, such as the use of sexist comments and talking down to women. A woman physician noted, ‘The old school, traditional male traits became very prominent during this time. Men in leadership roles become more intolerant and abusive verbally, and overall difficult to deal with’. Another physician reflected that ‘Old school man behaviour was heightened during COVID, the mansplaining, the talking down to women’. Another felt the emergency response was used to excuse such behaviour: [COVID] allowed people to just assume and make statements like that. They felt like this before but now it’s ok to say. It was recognised that discriminatory behaviour did not just affect women, but also younger men and healthcare workers of different races and ethnicities, and could be perpetrated by women in leadership as well as men. A woman physician, explained, ‘It has affected me emotionally that a lot of that abuse was turned towards me, to the extent that I didn’t want to attend meetings with those leaders any longer’. While these findings do not indicate how widespread such behaviours were, research from humanitarian emergencies and similar contexts suggests that during crisis, hypermasculinity is often elevated and more frequently expressed.

Militarised language, often adopted in crisis response, of being at war (eg, against a virus) celebrates destroying and conquering, as opposed to caring and nurturing. Conversely, to care—both physically and emotionally—is rarely considered a desirable attribute in crisis response. This presents a notable tension for health crisis response, as caring is central to health service delivery. Respondents spoke of this contradiction regarding their own appreciation of more caring forms of leadership, and an overall devaluing of caring qualities by formal leadership. A woman physician noted, ‘I had to work from home and the response of my female colleagues in leadership roles was more compassionate and supportive during this time. Women leaders tended to ask more ‘how are you today?’ and ‘how are things at home?’ Another physician noted, ‘A non-physician woman manager sent out an email telling everyone to give themselves a break and take some time off—being reminded of that helped’. Yet, this type of leadership was not appreciated within the dominant crisis management culture. A woman physician also described being told she ‘cared too much’ and ‘to leave her heart at home’. When a hospital manager asked a superior—not onsite—if changes in a policy could be delayed until the following day as her colleagues were already stressed due to multiple rapid changes and conflicting information, she was told ‘if people die it’s your fault’. This signalled incongruity between the type of leadership women healthcare workers value and the expectations of leaders during a crisis.

Women healthcare workers described how lack of consultation and devaluing of care contributed to experiences of moral distress. Respondents felt they were inhibited from acting on their moral agency as decisions were being made quickly in a top-down manner, and this negatively impacted their own well-being. For example, the hospital manager quoted above was recovering from a heart attack at the time of the interview and noted, ‘I’ve never had a heart issue in my life, but the moral distress, the moral distress was so great’. Others spoke of how their ideas of how to improve resident and patient care were ignored, leaving them feeling powerless. ‘When I went off work, I would come home and I’m like people are dying, there’s nothing I can do about it. I became obsessed with death. I couldn’t eat, I couldn’t sleep… I’m like ‘People are dying I’ve got to do something.’ But there’s nothing I can do’. Multiple participants noted that they, as well as colleagues, had to take time off from work, considered quitting, or left their jobs because of moral distress.

TOWARDS MORE CARING AND CONSULTATIVE LEADERSHIP DURING CRISIS

The COVID-19 pandemic provides an opportunity to reflect on lessons learnt and enhance health system leadership during crises. Findings from our research with women healthcare workers suggest dominant forms of crisis management had negative impacts on the well-being of the healthcare workforce, and therefore, the effectiveness and sustainability of the response. Opportunities to incorporate the expertise of those with on-the-ground knowledge were limited, and the potential of women and more caring leaders were not fully realised. The effects of moral distress and burnout continue to be felt within the current context of acute healthcare worker shortages. This is the effect of confluence of factors including masculine norms in crisis management, as well as the material and institutional constraints of the pandemic.
While women and other under-represented groups clearly need to be represented in crisis management (for a variety of reasons laid out by liberal feminist scholarship), we argue here that dominant approaches to crisis leadership also need to change. Experiences and perspectives from women healthcare workers suggest a relationship between representation and forms of leadership; dominant forms of crisis management can discourage women from participating due to hypermasculine norms that tolerate discrimination and fail to value more caring forms of leadership. At the same time, the urgency of the response privileges those who can act immediately, unencumbered by other responsibilities, such as childcare. It is perhaps not surprising that this style of leadership, which developed from masculine-dominated sectors such as the military, privileges masculine experiences and attributes; or that ability to respond rapidly is prioritised during crises. Yet, as is well documented in other areas of leadership studies, masculine norms can change, and rapid response does not have to be exclusive.

The experiences and analysis here add to previous calls for greater valuing of caring forms of leadership. When leaders are told they care too much or that their care is less important than other factors—such as ever-changing guidelines dictated from afar—caring is positioned as the problem. Instead, from a feminist perspective, the lack of support for those who care and the devaluing of care as a form of expertise is the problem. Caring is only a weakness when that leader is unable to act on their compassion, in which case it can lead to moral distress. Feminist scholarship has demonstrated how caring can be empowering, and leadership scholarship has demonstrated value of relationship-based forms of management. Similarly, crisis management research has demonstrated the importance of social support to both effective crisis response and the psychological outcomes of healthcare workers.

More caring forms of leadership might be fostered by replacing, or supplementing, the dominant military traditions and language around crisis response with traditions and language that reflect an ethics of care and caring forms of leadership. This would require commitment from institutions and leaders to incorporate such language into preparedness plans and communication strategies. Concepts, such as Gilligan’s central tenants of the ethics of care (non-violent conflict resolutions, contextual and narrative understandings, the activity of care and networks of relationships and responsibilities) might also be incorporated into crisis management training.

The experiences of women healthcare workers provide several further practical suggestions on how crisis management and leadership might adapt to be more inclusive, empowering and effective. First, pandemic preparedness can include developing systems for consultation that facilitate dynamic communication between front-line providers and decision-makers when crisis occur. Importantly, this requires that the experiences of those at the front-line be valued alongside the expertise of decision-makers. While physical distancing can complicate consultation—as demonstrated during COVID-19 and as is likely in other infectious disease events—the pandemic has also seen a rapid uptake of virtual technologies that can be used to facilitate consultation. Second, addressing the structures that benefit some leaders at the expense of others during a crisis requires action across policy sectors. For example, in BC the lack of childcare that corresponded to shift-work disadvantaged women leaders. Accessible, onsite, 24-hour childcare could help rectify this inequity.

In this perspective, we have aimed to contribute to discussions on crisis management by moving beyond a focus on women in leadership, to how dominant forms of leadership during crisis reflect masculine norms and experiences. Recognising much feminist literature on the subject is theoretical, we have weaved in evidence from empirical research with women healthcare workers. We note this is just a starting point and our findings are drawn from a limited set of experiences in a particular time and place. Not only would other theoretical perspectives likely illuminate further dynamics, perspectives from participants point to the need for further research on specific topics, such as around the perceived increase of hypermasculine behaviours and potential causes for these expressions. There is notable potential for further research on masculinity and crisis response which could focus on how men experience dominant forms of leadership.

Studies focused on the traits of masculine and feminine leaders might also consider more how individual behaviours and preferences interact with crisis response and to what effect. Further intersectional research on leadership during crisis is also urgently needed. Lack of intersectional analysis limits our understanding of the structures of privilege that perpetuate specific forms of crisis management and benefits some women over others. More caring leadership will require deconstructing these nuances.

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