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ORIGINAL RESEARCH

Enlightened Change Agents or Nuisance Power? A Qualitative Interview Study Exploring How Hospital Board Members Deal with Dissenting Opinions

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Background: Transformative learning in health professions education aims to develop health professionals as "enlightened change agents", who critically question routines and contribute to health system improvement. In hospital governance contexts, dissent from professionals acting as enlightened change agents may be framed as nuisance.

Objective: To explore how executive hospital board members interpret and respond to dissent from health professionals acting as enlightened change agents, and how they involve these professionals in governance and decision-making.

Methods: We conducted a qualitative phenomenological interview study with six experienced hospital board members from academic and non-academic hospitals. Semi-structured interviews were thematically analyzed using an iterative inductive–deductive approach until data saturation was reached.

Results: Board members portrayed themselves as translators of societal and technological trends into organizational policy who seek broad support while retaining final authority. They operated under ongoing financial and continuity pressures, which constrained room for innovative ideas that fell outside immediate priorities. Board members described dissent as welcome when it was perceived as constructive and actionable within current priorities. When dissent was perceived to delay decision-making or challenge strategic agendas, it was more likely to be reframed as "nuisance power". Three response pathways to dissent were identified: acceptance, tolerance and intervention. Interventions included appealing to majority rule, ignoring dissenters, using hierarchical authority, facilitating exit, or even involving external regulators.

Conclusion: In this hospital governance context, change agency by professionals may be reframed as "nuisance power" when it is perceived to impede board priorities, highlighting how governance conditions shape whether dissent is engaged or marginalized.

Implications: Hospital boards may reduce informal marginalization by explicitly organizing how dissent is heard and fed back within governance processes. Educational programs should better prepare future change agents to work strategically within governance processes through framing, alliance-building, and negotiation.

Keywords: transformative learning, enlightened change agent, hospital governance, organizational dissent, healthcare leadership, dissent

Introduction

Healthcare systems face rising costs, inequities and rapid technological and societal change. Calls for transformative learning in health-professional education aim to develop the leadership attributes health professionals need to act as "enlightened change agents", professionals who are not only experts in their field, but who can critically question

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routines and have the agency and ability to contribute to health system improvement.[1–4] It is therefore important to research what enables such professionals to thrive in hospital practice.

Transformative learning is commonly described as learning that changes how adults make sense of practice: learners critically examine assumptions and may revise the perspectives that guide their judgments and actions.[2,3,5–8] In the workplace, this kind of learning is likely to surface as speaking up, questioning routines and expressing dissent when current practices or priorities seem misaligned with patient care or system improvement.[1,9–12]

Hospitals often function as hierarchical organizations in which speaking up can be difficult, and dissent may be interpreted as disruptive rather than constructive.[9,10,12–15] Within change management and team research, speaking up in psychologically safe environments has been identified as important for effective team functioning.[9,14–16] Research on team roles further highlights the importance of incorporating diverse perspectives within effective teams.[17] When organizations prioritize cohesion over constructive dissent, they may develop structures that implicitly limit members' ability to challenge dominant assumptions and propose alternatives.[11,18] This can hinder the contribution of change agents, and risks creating organizations where dissent is subtly discouraged or redirected, weakening systemic critique and the capacity for reform.[11,12,15,18]

Research on voice, psychological safety, and dissent has largely focused on teams and day-to-day clinical practice,[11,19–21] while we know less about how hospital boards interpret and respond to dissent, determine what counts as legitimate input and how this shapes professionals' involvement in governance decision-making.

Building on this literature, we extend the analysis to the governance level by examining how executive hospital boards interpret and act upon dissent from health professionals positioned as "enlightened change agents". We therefore ask:

1. How do executive hospital boards involve health professionals in governance and decision-making?
2. How do executive hospital boards deal with health professionals who, in their role as "enlightened change agents", express dissenting opinions?

Materials and Methods

Study Design & Data Collection

In this qualitative interview study, we used a phenomenological approach to explore how hospital board members experience and make sense of dissent and decision-making in their governance role.[22,23] Phenomenology was chosen because it centers on participants' lived experience and meaning-making.[22,23] By centering on participants' own perspectives, phenomenology allows us to capture the nuanced meanings they assign to organizational tensions and nuisance power. The participants' experiences, perceptions, thoughts and feelings were elicited in face-to-face in-depth semi-structured interviews, and the responses were analyzed using thematic analysis.[24–26]

Participants and Recruitment

The study evaluated the experiences of board members of different hospitals in the Netherlands. We recruited key informants with expert knowledge of hospital governance who were willing to share experiences and insights.[23,27] Potential participants were initially identified through the research team's professional networks and subsequently recruited via snowball sampling, initiated by a participant with experience across multiple hospital boards. Potential participants were contacted by the researcher by e-mail. Informed consent to participate in the study was obtained from all participants. There was no power relationship nor any conflict of interest between the researcher and the participants. All participants were asked for agreement that results would be shared after publication.

Inclusion criteria were: current or recent membership of a hospital executive board (Raad van Bestuur), at least four years of governance experience, and willingness to discuss concrete cases of dissent. We aimed for variation in hospital type (academic and non-academic), board role (chair vs. member), gender, and professional background.

Given the relatively homogeneous and highly expert nature of the participant group and the focused research questions, the sample size was considered sufficient when no substantively new themes emerged. Recruitment continued until saturation was achieved and we judged that the research questions could be sufficiently answered.

Data Collection

The participants' experiences were collected through semi-structured in-depth interviews. With an interview guide the interviewer focused on the following questions:

- How did the participant involve employees in decision-making, and how did the participant create space within the organization for people with a different opinion?
- What happened when ideas and opinions within the organization were conflicting?
- How did the participant test the soundness of their own opinion or vision?

At the beginning of the interview, participants were asked to focus on past or present situations and to name a specific case in which they experienced dissent. Participants were asked how they handled this situation. Because participants occupied senior executive positions, interview interactions may have been influenced by social desirability or strategic self-presentation. To mitigate this, interviewers emphasized confidentiality, adopted a neutral and non-judgmental stance, and used concrete case prompts and follow-up questions to elicit detailed, experience-based accounts. All interviews were audio-recorded and professionally transcribed.

Analytical Approach

The analytic framework used in this study was based on thematic analysis, to identify major themes in textual data. Preliminary analysis of the interview transcripts involved becoming familiar with the transcripts to recognize first ideas for themes.

One researcher conducted the initial open coding and iterative inductive and deductive refinement of the coding framework using Atlas.ti version 22.1.0. Atlas.ti was used to manage transcripts, codes, and to document axial coding decisions and choices for themes, supporting analytic transparency (audit trail). Emerging codes, axial codes and themes were regularly discussed within the author team during analytic meetings. Differences in interpretation were discussed and resolved through team discussion until agreement was reached, while remaining attentive to alternative interpretations in the data.

When data saturation became evident and no new relevant data relating to our research questions emerged from the interviews, we made the final deductive step.[23]

Reflexivity

The team of authors discussed potential bias based on background, interests, values, and life experiences. At different moments during our research, we reflected on how this research shaped our perspective and we discussed preconceptions. To avoid influencing the answers to fit a researcher's own point of view or perceptions, all interviews were done by two researchers.

The team of authors consisted of professionals with diverse backgrounds in healthcare, governance and educational research. The first author and main researcher is a medical doctor and educational consultant. The second author worked as a pediatrician, has a master's degree in change management and is currently a social entrepreneur. The third author has extensive experience in various boards of healthcare organizations. The fourth author is a professor of transdisciplinary science, and the fifth author is a gynecologist, faculty dean and a professor in Health Systems Innovation and Education, as well as an expert in change management and qualitative research.

Given these diverse professional backgrounds, the team remained attentive to how our experiences and assumptions regarding governance, dissent, and change agency might shape data interpretation.

Results

Six board members were asked to participate in the study. One board member did not reply to our emails, however, we found another through the snowball sampling. The age of the six participants varied between 40 and 66 years. All

participants had more than 4 years of experience on a hospital board. One board member worked in an academic hospital, and five board members worked in non-academic hospitals. Four participants were chairs. Five board members had a background as a healthcare professional (medical doctor or nurse). Five participants were female.

All interviews were conducted in Dutch, the native language of all participants. Interview length ranged from 60–90 minutes. One interview was conducted online via videoconferencing and five interviews were conducted in person. After five interviews, no substantively new themes relevant to the research questions emerged. The sixth interview was used to confirm saturation.

Participants shared their perspective on decision-making and on how dissent from health professionals was perceived and addressed within hospital governance. In addition, the participants revealed the conflicting stakes of the hospital board. These topics are presented below.

Board Decision-Making Lens and Constraints

This subsection addresses board members' accounts of decision-making and how professional input is incorporated (Research question 1).

Board members reported that they needed to make decisions that are widely supported in the organization. To know what is going on in the organization and to broaden their own perspectives, they had to solicit ideas from the organization. They often did so actively by visiting departments, organizing meetings or offering online opportunities for health professionals to voice their opinions. In this way, board members often heard about issues in the organization that require improvement. The board members used this information to take into account the opinions of different stakeholders in the hospital and, where needed, adjust their perspectives accordingly.

Most board members said that their perspectives are not only based on events within the hospital, as they also have to take into account the interests of various external stakeholders and respond to societal changes. The desire is to create as much support as possible, but board members believe that they are the best judges of where the organization should go.

P4: We as board members are much more connected to the outside, follow societal trends and what the future holds. Sometimes, healthcare professionals lag behind that development, or they have not seen that development.

P1: We are in the lead and we are quite convinced of the direction we have to go, because those are the developments in technology and also the requirements of quality, but also the developments in society.

Board members reported that a significant part of their work involves steering organizational change and translating changes in medicine (which are often led by changes in technology and in society) into policy within the organization.

P3: A healthcare organization is organized from the outside in. So as board members, we are always looking at what is coming, what is happening in that outside world.

Board members indicated that they often found it difficult to accommodate and give as much weight to the point of view of someone with a dissenting opinion as to a point of view that corresponds to the ideas of themselves and the board. Board members acknowledged struggling to listen without bias to different perspectives.

P4: It requires some effort on our part to listen without prejudice. One always has one's own ideas and then someone tells you something that's right up your alley and you think, ah, that's a good idea.

The participants agreed that the culture within the organization can prevent professionals from voicing dissenting opinions, and not all perspectives are being heard. To counteract this, board members described deliberately seeking broader input and creating opportunities for dialogue. Board members then consider it is important to gain as much support as possible from all different stakeholders and to reach a decision together.

P3: Create a shared sense of urgency, then define possible solutions and approaches, share those possible solutions, look, and explore them together with the organization.

Conflicting Stakes and Prioritization

Board members recognized that they are limited within their position, for example in terms of finances, to implement major societal changes and at the same time ensure the continuity of the organization. Several participants suggested that,

under these financial and continuity pressures, there is limited room for dissent or proposals that do not align with the board's immediate priorities and agenda.

P2: Just dictate to me that the building has to be sustainable within fifteen years and probably then we will have to close the hospital because I cannot afford to renew everything. The consequences of such a choice are so far-reaching that nobody is going to dictate that to me and that's just the power play.

One of the board members mentioned a specific example of a person with an opinion that did not directly differ from the opinions of the board members and that also was in line with societal changes, but not in line with the board's priorities and agenda.

P2: You may well ask, is the pace towards sustainability fast enough in this hospital of yours. And if I'm very honest, my answer is no, I do try my best, but it's not my priority. The top priority' was COVID and getting rid of OR backlogs. I have another priority. [.] I can say that sustainability is also something that really needs to be done, but if I have to choose as a board member between continuity and paying salaries or sustainability, I choose continuity, paying salaries and patient care because that is what I was hired for.

From Dissent to "Nuisance Power": Appraisal and Board Responses

This subsection addresses how the interviewed board members interpreted dissent and when it became labelled as "nuisance power" (Research question 2).

The participants stated that they are open to dissenting and critical opinions and that they seek different views within the organization and engage with health professionals. In practice, however, participants indicated that they prefer to work with people who think alike and are on the same page. Participants indicated that they believe diversity based on viewpoints to be not too great for effective governance. Participants indicated that dissent was perceived as a nuisance when it was seen to hamper decision-making.

P1: It becomes a problem when the dissent takes a form and size that makes me feel I can no longer do my job.

Board members reported being particularly troubled when individuals with dissenting opinions formed coalitions. One participant described this escalation in terms of a "dark side".

P1: A counterforce becomes a nuisance force the moment the dark side of a person increases exponentially because people come together who have the same dark side.

Some participants also mentioned that dissent may be perceived as a nuisance when it is seen as driven by individual self-interest rather than organizational concerns.

P6: A person is never more important than an organization.

These individuals' opinions can hinder the board to such an extent that they are perceived as toxic personalities. There is little room for such individuals within organizations, and 2 board members indicated that such individuals are better off leaving the organization.

P2: Countervailing power is heartening if you want to run an organization together, but if you really need change, then it has its pros and cons. If you really need a change, then countervailing power is really terrible because then nothing changes, that's just the big disadvantage.

Board members frequently described countervailing power, both from healthcare professionals within the hospital and from stakeholders outside the hospital, as originating from what they viewed as a unidimensional perspective, and that people with a different opinion often miss the total overview of what is entailed in decision-making.

P5: The disadvantage of professionals is that they reason too much from (the perspective of) their own area of expertise.

P3: Very often, of course, those dissenting views are dissenting views from one aspect, from one approach, because all those external stakeholders can never oversee the total context.

Board members expressed ambivalent attitudes in how they value the perspective of professionals and how they weigh their own perspective and knowledge.

P3: You can also say, you've developed a certain set of glasses, a certain perspective shaped by, well, everything that you then already bring along in terms of knowledge, experience, training, development. And the other person has a different context, different experiences.

Board members indicated that they find it important that people are willing to come to a shared solution when there is a disagreement, and that they find it important to recognize in time when someone with a dissenting opinion is right. They also added that it became difficult when individuals with dissenting opinions are not willing to adjust their opinions based on new information.

P1: There is zero use for people who come into a meeting and never leave the meeting with a different opinion. You have to enter a meeting with a willingness to change your opinion, otherwise you're better off staying away.

An important factor in accepting dissent is also to what extent someone is likeable.

P2: I get along with that person and can tolerate dissent from them. If such a person says that I am wrong, I can tolerate it. Still, it may be that because of that mechanism, you are unable to allow dissent too much, because it also has emotional sides.

The participants mentioned several ways to deal with individuals or groups with dissenting opinions. Across interviews, we identified three main response pathways described by board members: acceptance, tolerance, and intervention, each reflecting how boards appraised dissent and shaped professionals' involvement (see Table 1).

Appealing to Majority Rule

The participants indicated that it is not uncommon to encounter situations where individuals may disagree with a decision that has been made. Despite their differing opinions, the dynamics of decision-making often necessitate adherence to the majority's choice, and acceptance of the decision becomes imperative. While being in the minority can be challenging, it is important to recognize the principles of decision-making for a board. Once a decision has been reached, it's generally expected that all members of the group will respect and abide by it, regardless of whether they personally agree with it or not.

P1: You do have to have the practical attitude that in the end you have to come to a decision and yet as a minority you accept the 80% or 60% decision.[.] One has to accept a majority decision. Which does not mean that one has to propagate it with enthusiasm.

Table 1 Response Pathways to Dissent and Implied Involvement

Typical Board Response	Appraisal of Dissent	Implication for Involvement
Acceptance Dissent is engaged with and can be incorporated into decision-making processes	Constructive and aligned with board priorities	High involvement in decision-making
Tolerance Dissent is tolerated and monitored while decision processes continue	Valued but not fully aligned with board priorities (sometimes moderated by interpersonal fit or "likeability")	Conditional or limited involvement
Intervention Dissent is actively countered through escalatory responses (e.g., majority rule, ignoring, hierarchical intervention, facilitating exit or appeal to external authorities)	Perceived as hindering decision-making, coalition-forming, or self-interested ("nuisance power")	Reduced or excluded involvement

Notes: Conditions under which dissent was accepted, tolerated, or escalated, and the associated implications for professional involvement.

Ignore

Another approach suggested by board members was to redirect the focus towards productive conversations with those who share similar views, thus fostering a more positive and supportive environment for their own views. Ignoring dissenting opinions could be a conscious strategy made after careful consideration of the situation and of the potential consequences of paying attention to those with dissenting opinions.

P1: You can ignore them. You certainly shouldn't pay too much attention, because everything you pay attention to grows.

Use Hierarchical Authority

Some participants acknowledged that solving an issue democratically by finding a majority is not always successful. At times, there may even be an entire department that is against a decision of the Board. One of the participants indicated that in that case, the issue can be put to rest or withdrawn.

P2: Sometimes we just have to withdraw [a proposal], but because of that, things in a hospital are very slow compared with, for example, companies where I used to work. There we really couldn't afford this kind of sluggishness.

On the other hand, if the board believed that the decision served the greater good, participants said they would use their hierarchical position and force a decision.

P2: Sometimes you just have to force a department to accept something they are not happy with, because it serves the greater good.

Facilitating Exit

When a decision is finally made and the majority within the organization feels that this is the right choice, board members generally feel that people who experience distress of conscience can always choose to leave the organization.

P3: There are doctors who go along in a kind of passive resistance to change. Then I think: no one is chained. [.] But for this organization, for the patients of this organization and the future patients, this was the only way.
P1: If you disagree, it may be that you are in distress of conscience and think 'I just do not want this', then you should probably just leave, not participate.

Also, if health professionals with their dissenting opinions block policymaking and implementation, these health professionals, who were referred to by some board members as having "toxic personalities" or "dark sides", can best leave the organization.

P1: If a person with his opinion degenerates into a toxic personality and thus makes the flow of business impossible, yes, he should just leave.

Appeal to External Authorities

If the use of the Board members' hierarchical position is not sufficient to force a decision, some participants reported that they might appeal to external authorities in order to break down internal resistance.

P2: I sometimes use the inspection as a means to break too much countervailing power. So, then I ask the inspection 'supervisory board of the government': write me a letter, because we have quite a lot of countervailing power in the hospital.

Discussion

Reflection on Research Questions and Roles of Enlightened Change Agents

Hospital board members consistently positioned themselves as visionary translators and strategic sponsors of change, scanning societal and technological trends and converting them into policy (Board decision-making lens and constraints). This aligns with the role of senior leaders in shaping organizational frames and rallying support for large-scale transformation.[28,29] Front-line health professionals, by contrast, took on the mantle of local champions and reflective

practitioners, surfacing operational issues, voicing dissent, and leading or piloting incremental improvements in their own departments.[11,30,31]

Boards work at a high level: they set broad goals and operate within tight timelines, whereas professionals focus on patient care and local feasibility. This divergence can breed frustration, as each agent may perceive the other as insufficiently "big picture" or overly narrow.[29,32] Power asymmetry further shapes these dynamics. Even when professionals adopt enlightened change roles, the ultimate right to make decisions remains with the board. As our findings show, dissent may be tolerated only when it does not impede board priorities and may otherwise be framed as "nuisance power" (Conflicting stakes and prioritization). Prior work shows that dissenters may be variably labeled by decision-makers, with consequences for how their voice is received.[33] Our findings extend this work by demonstrating how boards actively differentiate between dissent that remains discussable and dissent that becomes treated as disruptive, with direct consequences for who stays involved in decision-making.[34–36]

An even sharper clash occurs when only one party embodies enlightened change agency. In board-only scenarios, top-down mandates may trigger passive or covert resistance.[35,36] Conversely, when professionals act as change agents without alignment with board priorities, their dissent may be framed as nuisance or narrow self-interest, which can constrain broader adoption (Conflicting stakes and prioritization).

These findings suggest that enlightened change agency emerges most productively at the intersection of strategic vision and operational insight. When boards and clinicians co-construct change, they combine the board's broad perspective with the practitioner's grounded expertise. However, this shared change agency depends on ongoing negotiation and remains shaped by hierarchical power relations that can reassert themselves when board priorities, timelines, and financial constraints come under pressure.

Our findings confirm that healthcare professionals who voice dissent often encounter organizational contexts that are unreceptive, or even hostile to critical perspectives, placing "enlightened change agents" at risk of marginalization. Although transformative learning aims to develop these agents of change,[1–3,5–8] our data suggest that hierarchical hospital structures often leave limited room for change agents whose dissenting views are seen as misaligned with board priorities.

The Value and Challenge of Dissent

Dissent is widely recognized as a driver of organizational learning and innovation, because it stimulates divergent thinking and can help prevent groupthink[11,19–21,37] The capacity to question existing paradigms is likewise central to transformative learning.[5–7] However, our study shows that board members may reframe dissent as "nuisance power" once it is perceived to complicate or delay decision-making (see Table 1). When professionals' views conflict with organizational priorities, they may be ignored, suppressed, or met with suggestions to leave the organization. These findings highlight a persistent tension between valuing critical input and maintaining timely decision-making in healthcare governance.

Conceptually, the notion of "nuisance power" may extend existing theories of organizational dissent by specifying a governance-level mechanism through which voiced dissent becomes delegitimized and progressively excluded from decision-making processes. Whereas prior work has primarily examined whether employees speak up or remain silent[35] and how dissenters are perceptually labeled,[33] our findings show how dissent that is initially voiced can be actively reclassified as obstructive when it is perceived to threaten strategic momentum, coalition-building dynamics, or board priorities (Conflicting stakes and prioritization).[34,36]

This reframing marks a critical threshold in the dissent trajectory: once labelled as "nuisance power", responses shift from engagement or tolerance toward containment and escalation, thereby reducing professionals' involvement in decision-making.

While healthcare policy increasingly emphasizes speaking up and transformative learning,[1–3,6,7,13–16] boards remain bound by financial constraints, time pressures, and the need to safeguard organizational continuity.[5,12,38] As a result, dissenting voices may be formally acknowledged yet informally sidelined.[10,15,17]

Taken together, these findings have important implications both for hospital governance practices and for the preparation of future enlightened change agents. We address these implications separately below.

Implications for Hospital Governance

Both the literature and our findings indicate the need to better support professionals who voice dissent.[9,16] However, participants noted how governance realities, including external pressures and formal decision-making structures, limit the space available for dissent in practice. As a result, expecting broad cultural change alone is unlikely to be sufficient. Our findings suggest that hospital boards may benefit from more explicitly designing governance processes that enable constructive challenge while keeping decision-making moving.[9,16] This highlights the potential value of clarifying the process by which dissent is heard, weighed, and fed back into decisions, as well as creating protected moments for critical dialogue across hierarchical lines.[14,15,39] Our findings further point to the importance of governance reflexivity, particularly in making explicit how dissent is appraised and managed under conditions of time pressure and competing priorities.

Capabilities for Change Agents in Hierarchical Governance Contexts

Our findings indicate that enlightened change agents require more than a visionary mindset grounded in transformative and systems-oriented thinking,[5–8] they also need well-developed practical and relational skills to navigate environments that may devalue dissent.[12,16] Negotiation and conflict-resolution skills are particularly important, as they help frame dissent in ways that reduce defensiveness and align proposals with strategic priorities.[40,41]

Equally important are networking and alliance-building skills, as coalitions can provide both influence and psychological safety for minority viewpoints.[15,28] Our findings also point to the role of interpersonal dynamics. Dissent may be more readily tolerated when delivered by actors perceived as likeable, and the strategic use of humor can help defuse tension.[33,40–46] Finally, effective change agents must remain culturally sensitive and reflexive regarding organizational norms and power structures.[18,47,48]

Implications for Education

The urgency for healthcare transformation,[1,7] suggests educational programs need to move beyond teaching purely clinical or managerial competencies. Training change agents solely as visionary leaders may be insufficient, without also preparing them for the political, social, and interpersonal realities of healthcare organizations.

Importantly, these educational implications are distinct from governance reforms: even in improved organizational climates, professionals will still need the skills to navigate power asymmetries and change processes marked by tension. It is therefore essential to redesign curricula so that they integrate not only skills needed to act as a medical professional with a transformational mindset, but also the skills required to navigate resistance and power imbalances within hierarchical organizational structures. Drawing on established negotiation models,[49,50] we can equip students with techniques that enable constructive engagement with both peers and superiors, while incorporating key principles of influence[51] into the curriculum. This helps future change agents to frame dissent in ways that promote collaboration rather than confrontation.

Furthermore, curricula must provide ample opportunities for developing critical reflection and mediation skills.[20,39,52] Encouraging students to critically examine their own assumptions and those of others, prepares them to handle inevitable pushback in rigid organizational structures. Practical exercises such as simulations and role-playing, along with structured mentorship and peer support,[9,10,12,17,28] can effectively build these capabilities.

Finally, close collaboration between educational institutions and healthcare organizations is crucial to ensure that new curricular approaches align with real-world challenges. Initiatives such as joint workshops, internships, and collaborative projects[1,7,53] provide students with direct exposure to the complexities of organizational governance, thereby cultivating adaptive leadership skills[28] that are often absent in traditional training. In this way, educational programs can move beyond idealistic or purely theoretical transformative leadership models and instead prepare graduates with the practical toolkits necessary to challenge, negotiate, and ultimately thrive in environments where dissent is undervalued.

Limitations and Future Research

A limitation of our study is the small sample size and the fact that it was conducted in the Netherlands, which may not make the findings fully generalizable to other cultural contexts.[10,47,48] Additionally, self-reported attitudes and behaviors toward dissent can differ from observed practices. While snowball sampling enabled access to a hard-to-reach elite population, it may have introduced network bias and may under-represent less-connected or more dissenting perspectives. This limitation is considered when interpreting the transferability of the findings.

Future ethnographic studies could offer deeper insights into how board members respond to dissent in real time and whether the strategies they describe align with their actual behavior.[23] Future research could further operationalize and examine "nuisance power," for example by tracing when and how dissent becomes reclassified during governance decision-making, and by comparing whether similar escalation patterns and consequences for involvement occur in different hospitals governance contexts. In addition, research might investigate how formal training in negotiation, mediation, and other interpersonal skills affects the success and well-being of change agents who enter rigid healthcare systems. Longitudinal studies could examine whether equipping new professionals with these skills leads to an effective fulfilment of the role of enlightened change agent, even if an immediate, sweeping culture change remains elusive.

Conclusion

Training health professionals as enlightened change agents for the future of healthcare is important but, based on our findings, may not be sufficient for effective change in hospital governance contexts. These findings point to the need for both adapted training and more structured and constructive engagement with dissenting voices of healthcare professionals in hospitals.

For hospital boards, these findings suggest the importance of making appraisal criteria for dissent explicit and designing governance processes that enable constructive engagement with critical professional input.

For leadership development and medical education, the findings highlight the need to strengthen skills in navigating dissent, perspective-taking, and constructive dialogue across professional boundaries.

Future research is needed to further examine how different governance designs shape the boundary between constructive dissent and perceived "nuisance power."

Data Sharing Statement

Data is not publicly available, though the data may be made available on request by the corresponding author (Efraim Joel Hart).

Ethics Approval and Informed Consent

All subjects gave their informed consent for inclusion before they participated in the study. The study was conducted in accordance with the Declaration of Helsinki, and the protocol was approved by the Institutional Review Board of OLVG Hospital (ACWO 21u.1/MJ/WO 21.149).

Informed Consent Statement

Informed consent was obtained from all subjects involved in the study, with consent to publish statements.

Author Contributions

All authors made a significant contribution to the work reported, whether that is in the conception, study design, execution, acquisition of data, analysis and interpretation, or in all these areas; took part in drafting, revising or critically reviewing the article; gave final approval of the version to be published; have agreed on the journal to which the article has been submitted; and agree to be accountable for all aspects of the work.

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