Meeting with Care: The transformations of meeting practices in post COVID-19 hospital management in Belgium.

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Abstract

Meetings as a phenomenon go by unnoticed, yet in hospitals, as in most organisation, they are an omnipresent organisational practice. Therefore, meetings provide an opportunity to observe the presence of a care ethics approach in hospital environments. Particularly, since hospitals have had to adapt their meeting practices to respond to the exceptional circumstances of the COVID-19 crisis. As a result, this study aims to explore how hospital actors perceive meetings and their transformations to explore the presence of a care ethics approach and how this is situated within the care allocation dilemma. To do so, semi-structured interviews with hospital actors, in managerial and non-managerial roles from different hospitals were analysed. The findings indicate that in-person meetings had evolved due to hospital environment changing to become more structured, but that this is positively met by hospital actors. Nevertheless, the transformation of meeting practices since the COVID-19 crisis, in particular the adoption of online meetings, exposes a tension between time allocated for work and time allocated for care. The COVID-19 crisis required efficient use of the scarce resource that is time, and the sustained adoption of online meetings has allowed hospital actors to be more efficient with time. However, this simultaneously diminishes the social and emotional elements that are present in in-person meetings. Indicating that care necessitates not only time but also presence.

Keywords: Meetings, ethics of care, COVID-19 crisis, change, hospitals, management.

Introduction

In today's organisations, meetings are ubiquitous, and this holds true for hospital environments. Across all hospital levels the number of meetings has increased as a result of organisational and managerial changes (Allen & Lehmann-Willenbrock, 2022; Scott et al., 2015). More recently, meetings have had to adapt to the particular sanitary circumstances brought on by the COVID-19 crisis. During this period, the sanitary measures taken to control the spread of the virus (e.g., social distancing, remote working, etc.) made the habitual in-person meetings impossible, provoking an intensified use of digital communication tools for meetings, such as MS Teams or Zoom (Crosby et al., 2021; Mehta et al., 2020). Online meetings were a means to communicate and coordinate as well as 'stay together' in times when this was physically impossible (Mannion et al., 2020). Having meetings online has since established itself in hospital meeting practices and recent studies have shown that online meetings are perceived by medical hospital actors to perform better than in-person meetings (Bonanno et al., 2023; Rajasekaran et al., 2021; Sidpra et al., 2020). However, online meetings also exhibit

perceived difficulties with, for instance teamworking, communication and engagement (Mohamedbhai et al., 2021).

In Belgium, the adoption online meetings takes place in a hospital context that is troubled by a shortage of hospital staff in various disciplines (Zorgnet-Icuro vzw, 2022). It is estimated that 4690 full-time positions were not filled in general hospitals (Belfius, 2022). Additionally, the hospital sector has seen an increase in problems related to staff well-being, such as burn-outs and a loss of meaning in their work (Bruyneel & Sermeus, 2022; L.Del., 2022). Nonetheless, the COVID-19 crisis has accentuated the value of robust care services (Chatzidakis et al., 2020) and put the importance of healthcare workers for a functioning health system on the global agenda (Valiotis et al., 2022; World Health Organisation, 2020). From this perspective, a call for an ethic of care in hospital management is being put forth (Haliday, 2018). Care ethics presupposes that in the different facets of life, all beings are inherently interdependent on each other, we exist and depend on care relationships from our earliest days to our last as both receivers and givers of care (Tronto, 1995). As a result, an ethic of care (EoC) approach asserts a need for an attention to strengthening relationships and fulfilling responsibilities to others as a means to attain human flourishing and sustainability.

Providing care is the core activity of healthcare environments, however, 'providing care' does not automatically equate 'taking care' from an EoC perspective. Studies with a focus on care ethics in hospitals or in healthcare management have illustrated the discrepancy between the ethical approaches of the organisation and the healthcare professionals. Emphasising the difficulty for healthcare workers to balance, often opposing, approaches (Haahr et al., 2020; MacLellan, 2014; Salminen-Karlsson & Golay, 2022; Waterfield & Barnason, 2022).
The promotion of care in organisations has been put forth by scholars such as (Colbert et al., 2016) and (Gittell & Douglass, 2012), however empirical research on care ethics in organisations remains limited (Elley-Brown & Pringle, 2019; Fotaki et al., 2019). Following these authors, this study is established on the premise that in order to improve the work environment for healthcare workers it is the organisation that needs to be changed, and more specifically that management needs to be revisited. That a managerial care ethic could be a manner of bettering the quality of life of health professionals and counteract the negatives effects of work intensification. Indeed, it would reintroduce the 'human' in healthcare and management as well as give meaning to their work (Haliday, 2018).

Meetings[1] are spaces that bring actors together to confer on the operational as well as strategic aspects within an organisation. Indeed, meetings are unavoidable for people working in teams, cross-functional and/or multi-site settings. However, meetings can turn into stressors when they are perceived ineffective (Scott et al., 2015), highlighting the need to think about how to care for meetings and how meetings can be places of care. This need has been underestimated by scientific research where meetings have been overlooked as a phenomenon in their own right (Schwartzman, 1987; Scott & Allen, 2022). "Meetings have traditionally been assumed to reflect but not constitute the organisations and the group and team interactions that comprise them (Scott et al., 2015)". The primary objectives of meetings, such as sharing information, solving problems and making decisions, developing

[1] Within this study, meetings are understood as planned gatherings of three or more people with an organisational or group purpose (Boden, 1994, 1995; Schwartzman, 1989).

and implementing organizational strategy and debriefing a team after a performance episode (Mroz et al., 2018) overshadow the informal aspects of meetings, such as creating meaning at work, socialisation, a sense of belonging and professional value (Scott et al., 2015).

Meetings, as a pervasive organisational practice, provide a means to explore the ethical approach in hospital management. This paper explores the presence of a care ethic and the manifestation of the related care dilemma in the hospital context by looking at meetings. Questioning, in particular, the recent shift from in-person meetings to online meetings in hospitals. Focusing on whether and how a care discourse emerges in the perception and opinion of the transformation of meetings in the hospital actors' discourses since the COVID-19 crisis. To do so, qualitative semi-structured interviews with hospital actors across the Brussels Capital region and the Walloon region of Belgium are analysed.
Taking a care ethics approach to examine meetings allows the overlooked aspects of meetings, such as socialising and care taking, to be considered. This paper will contribute to the discussion of 'the future of care' by exploring whether and how care appears in the discourses of hospital actors. As such, this study aims to further our understanding of the manifestations and the impasses that a care ethics approach finds in hospital management.

Ethics of care

In traditional organisational and managerial theories, such as the bureaucracy model (Weber, 1947) or the scientific organisation (Taylor, 1919), the focus is put on optimising productivity in organisations to maximise its profits and ensure its survival. Employees are seen as a resource with little emotional or social needs that are motivated by monetary incentives. Furthermore, objectives that do not initially fall within the scope of enhancing profitability or meeting performance targets, such as improving working conditions, are considered only when they advance the business performance (Adler et al., 2007). From an instrumentalist perspective of management, action is evaluated as a means to an end, resulting in the questions surrounding the value of those ends being marginalised. The value of social and emotional needs in the workplace exists as an instrumental tool for the organisation's wellbeing.
Nowadays, there is a call for a more human approach to management. Putting the focus on a form of management that is vested in relationships and increases the importance of the people in the organisation, recognising their social and emotional needs as an important aspect. However, the progress towards a more 'humane' form of management is still stifled by a reluctance to give up the controls associated with classical management theory (Weymes, 2004). The attention assigned to answering individual needs is grasped as a means to enhance productivity, and technology is a medium often used to do so (Taskin et al., 2023).

Following the appeal for a more human management, scholars have proposed the introduction of care ethics to managerial and organisational theory (Fotaki et al., 2019; Lawrence & Maitlis, 2012; Rynes et al., 2012). Care ethicists advocate for a transition towards a politics of interdependence, placing attention to actors their need as a central tenet (Chatzidakis et al., 2020). Care is defined *"as species activity that includes everything that we do to maintain, continue, and repair our "world" so that we can live in it as well as possible* (Fisher & Tronto, 1990). It is a relational practice which focusses on the concern of addressing and meeting the needs of one another. (Fotaki et al., 2019) put forth three central elements to understanding what care is. First, care exists within a relationship, it can only be

administered through a relationship to one another or others. Care is not merely a disposition, but it is a practice. It requires conscious action towards care which requires competence, which can be learned and improved. Finally, it centres around addressing the needs of the other. This is not an unproblematic endeavour, as there is no universal standard regarding needs. Needs change according to the context and thus care is also context-specific endeavour (Fisher & Tronto, 1990; Tronto, 1993).

In organisations, care needs to be actively sought after and should not be taken for granted. However, literature on care ethics in a hospital context underlines the difficulty employees, in particular healthcare professionals, have with the organisational and managerial approaches to their work as care giver. For instance, (Mandavy, 2022) demonstrates how organisations trivialise the reality of care work and the work conditions, ignoring existing vulnerabilities and creating tensions. According to (Tronto, 2010), there are three elements to assess whether an organisation is 'caring', namely politics, plurality and purpose. Care is inherently political, and therefore organisations need to be aware of the power relations on every level of the structure to be able to provide care. Second, as explained above there is no universal standard regarding needs. Therefore, care should understand human activities within a framework that allows it to be context-driven and plural. Finally, there should be an "*awareness and discussion of the ends and purposes of care (Tronto, 2010)".*

The work done to care is a type of work that does not get recognition or is much valued (Held, 2006; Sevenhuijsen, 1998). This can be seen in work organisations undervaluing caring for co-workers (Antoni et al., 2020), which is legitimised by market and economic constraints (Fotaki & Hyde, 2015). Care is a practice that demands resources from staff, such as time, but these are resources that are not infinite (Held, 2006; Tronto, 1993). As a result, a dilemma arises in which the allocation of care for work and care for colleagues enters a competitional space. The dilemma of care allocation is pervasive in work organisations, but neglecting its prominence as well as significance reinforces a logic of organising under the instrumental prism of applying care ethics to better the organisation (Antoni et al., 2020).

Considering meetings

In Western culture, the meeting is defined by the instrumental or strategic functions it performs, most often in the world of business (Schwartzman, 1989; Jarzabkowski and Seidl, 2008). It is therefore considered as an objective and rational means of achieving an explicit goal that is known and linked to the functioning of an organisation or the achievement of a collective action. In this context, the objectives most often assigned to a meeting are to communicate information, decision-making and the resolution of problems or conflict resolution (Allen et al., 2014, 2015).

In general, employees remain disillusioned by meetings in practice (Rogelberg, 2010). Firstly, they are increasingly numerous, in particular in multi-site organisations as a result of participative management. Also, their importance in terms of working time increases with hierarchical progression (Kriesberg and Guetzkow, 1950; Kello, 2015). Furthermore, meetings can be long, chaotic and inefficient. Often, the aims of the meetings are not achieved: decisions are not taken, solutions are not found, conflicts are not resolved, and other meetings are organised (Kello, 2015).

When meetings are experienced as unproductive they can turn into stressors, since they interrupt the workflow and consume precious work time (Rogelberg et al., 2006). As a result, meeting practices tend to favour focusing on organisational elements that might not be the core of the participants' work, as can happen in hospitals. However, meetings also hold a social and emotional role which is often brushed to the side (Scott et al., 2015) and not given importance. What is more, the recent change to more online meetings as a result of the COVID-19 crisis leads to two major results, an increase in efficiency whilst simultaneously increasing fatigue (Luebstorf et al., 2023). As a ubiquitous organisational practice in hospitals, meetings provide a way to study the manifestation of a care ethic approach in the perception and enactment of meetings in hospitals, in particular since the COVID-19 crisis.

Methodology

For this paper, qualitative semi-structured interviews with a diverse panel of hospital managers and staff in hospitals across the Brussels Capital region and the Walloon region of Belgium was analysed. The data was collected by Master students enrolled in a research immersion course, as part of their master's degree in public health, between September - December 2022. The course was developed with the aim of reflecting on the place of care ethics in management in contemporary health organisations. To do so, the focus was placed specifically on how meetings, as an organisational practice, are or could be used in the development of a care ethic in a hospital management.

Data collection instructions

For this course, the students were obliged to shadow a manager in a healthcare facility for an entire week. During their immersion, the students had to observe a minimum of two meetings, of which at least one was organised by the manager shadowed, and conduct interviews with participants after the observed meetings. The students were authorised to work in pairs or to work individually. As illustrated in table 1 below, student working individually were asked to conduct five interviews in total whereas students working in pairs had to conduct nine interviews. The structure for the data collection was the following, interview the shadowed manager prior to the meeting they organised and interview the participants after the meeting had taken place. The structure was given as a guideline to follow, nevertheless it was recalled to students that it was accepted that their data collection process did not follow the guideline due to the constraints of the participants.

	Individual	In pair
Prior to meeting	1x Manager	1x Manager
Meeting 1	2x Participants	4x Participants
Meeting 2	2x Participants	4x Participants

Table 1. Interview instructions.

The students were instructed to observe meetings that had an organizational component, however, there was no preference communicated nor were they obliged to observe the same type meetings during their research immersion. This decision was made considering the current hospital context and to limit difficulties finding a manager to shadow. Furthermore, meetings were allowed to be 'observed' if they were held online. As a result, one meeting had been observed via a digital communication platform (e.g., Teams) and five observed meetings were held in a hybrid mode (e.g., combining in-person and online presence).

To obtain the desired interview data, two interview guides were developed for the students. One guide for the interview with the manager and another guide for the interviews with the participants interviewed post-meeting. It was highly recommended that the interviews be done face-to-face, however this was not compulsory. Consequently, the database includes 5 interviews that were held via an online communication medium. Also, due to time constraints five participants could not participate in an interview and completed the interview guide as if it were a questionnaire. The interviews were recorded, if consent was given by the participants, and fully transcribed.

Creation of the database

A total of 38 student reports was received, of which 24 reports were retained and 153 interviews collected were kept for analysis. The following selection criteria were adopted in the creation of the database, 1) data must be collected in a general hospital, a university hospital or a hospital with a university character, 2) only fully transcribed interviews were kept (note-based interviews were deleted) and 3) the quality of the interviews was evaluated by the researchers to remove interviews that did not meet the expectations.

The diversity of the database combination of different hospital (e.g., type, location), interviewee characteristics (e.g., professional background, job function) and type of meetings (e.g., routine meetings, meetings to identify problems and propose solutions) are seen as a strength to the outcome of the research. Hospitals are heterogenous organisations and therefore the mobilisation of a wide-ranging dataset is believed to put forth a more accurate and comprehensive depiction of transformations to meetings and the place of care ethics within them. An overview of the database characteristics is presented in the sections below, however for detailed information see appendix 1.

Hospital demographic

Of the 24 student reports conserved, a total of 13 hospitals could be identified. Of the 13 hospitals mentioned, seven are general hospitals, four are general hospitals with a university character and two are university hospitals. The majority of the hospitals were private (8)[2]. Furthermore, most of the hospitals in this study are located in Wallonia (8) and the remaining hospitals are located in the Brussels Capital Region (5). Two hospitals were anonymised and were presented as a general public hospital and a public hospital.

Participant sample

There are two types of participants, 1) the managers shadowed and 2) the meeting participants. The managers shadowed each held a managerial and/or coordination role within the hospital and were interviewed regarding the organisation of meetings, meeting practices and their opinion and perception of meetings. Of the 24 managers shadowed, the majority have a nursing background, however, they hold a variety of job functions (e.g., head nurse, director of nursing).

The meeting participants were interviewed to obtain their experience, perception, and opinion of meetings. They were not obliged to hold a managerial or coordination role, but they had to have participated in a meeting that the shadowed manager had organised. The

[2] Public hospitals are managed by a public authority and private hospitals are organized as not for profit organisations. However, the hospital act applies equally to both, and public funding of hospitals is identical. The distinction between public and private hospitals in Belgium is mostly a historical remnant, since in recent years a large number of mergers have created a blended public and private hospital landscape (Federal Public Service, 2020).

sample of meeting participants is diverse in terms of professional background as well as and job functions. For instance, the sample includes doctors, nurses and paramedical staff (e.g., psychologists, physiotherapists) and administrative and logistical staff (e.g., medical secretaries, buyer at the purchasing department).

Meeting purpose

An overview of the purpose of the different meetings observed is presented in table 2 below, using the taxonomy proposed by (Allen et al., 2014). The taxonomy focuses on the content of the meetings, to illustrate what meetings in organisations tend to be about. Overall, the taxonomy has 16 categories of meeting purposes, divided into two meta-taxonomic categories namely, content and instrumental. Content categories focus on meetings as locations to discuss different topics, whereas instrumental categories capture meetings as a place to accomplish one or multiple tasks.

Of the 36 meetings observed in the database, eight categories were not represented, and two meetings did not fit into any of the categories proposed. This could be the result of the specific hospital-based medical context or the focus on solely internal meetings. Consequently, the meetings falling outside of the taxonomy were added as singular meeting types in the category 'other'. The categories not represented in the sample were removed from the table 2. Furthermore, it is understood that meetings can have several purposes, however for this study the meetings are categorized based on what appears to be the focal purpose of the meeting.

Meta-taxonomy	Meeting purpose category	Amount	Example
Content	To discuss new products or services being introduced.	1	Meeting of the Medical Equipment Investment Committee
	To routinely discuss the state of the business	25	Meeting of the Head Nurses; Site Committee Meeting
	To discuss an ongoing project	2	Patient Flows Project Meeting
	To discuss quality, policy, and compliance	6	Quality Project Meeting (Post-Accreditation)
	To discuss a change in process	1	Team Meeting regarding the merger with another service
Instrumental	To educate or train associates	3	Meeting to establish a training program for the nursing staff to better meet the needs of inpatients
	To identify problems and propose solutions	4	Meeting regarding the Security Reform and the necessary arrangements to make
	To brainstorm for ideas or solutions	2	Meeting to discuss 'What we would have done' with two practical cases
Other	a. To meet new boss and discuss expectations	1	Meeting with the newly appointed manager
	b. Psychological intervention	1	Team meeting following the sudden death of a patient

Table 2. Meeting purpose.

Data Analysis

The objective of the paper is to explore whether and how an ethics of care approach emerges in hospital management by examining hospital actors' perception and opinion of the transformation of meetings. To do so, an inductive analysis approach was adopted, where the

study is grounded in the empirical base to develop an understanding of how it applies itself to the EoC theory (Thomas, 2006)

The data analysis focused primarily two themes of the interview guide, namely 'the perception of meetings' and 'the evolution of meetings'. Both interview guides had the same questions. The data extracted from the interviews was analysed using a thematic analysis. This is a method to identify, analyse, organise, describe, and report themes found within a data set (Braun & Clarke, 2006). Following the different phases presented by (Nowell et al., 2017) to conduct a robust thematic analysis.

Findings

The analysis of the interviews with the hospital actors shows that meetings are acknowledged by the hospital actors as a necessary tool for the good functioning of the organisation. Meetings are understood to be a means to transfer information, to communicate, and to build group cohesion. Having meetings is indispensable for the organisation, for the teams and for individuals, nevertheless, the participants are often unsatisfied with meeting practices. Dissatisfaction is voiced regarding the style of meetings, that it is more about information transfer than interaction, and the number of meetings being too high thus taking up a considerable amount of time.

Nevertheless, meetings have been progressively evolving with participants indicating a changed organisational context, a more structured approach to meetings, perceptions of changed styles for meetings and an increase in the number of meetings especially higher up the hierarchical ladder. More recently, during the COVID-19 crisis meetings were adapted to the extraordinary situation. This translated in a decrease of meetings for hospital staff in non-managerial health-providing functions and an increase for managerial or coordination positions as well as the effects that the sanitary measures had on meetings (e.g., social distancing). It is also during the COVID-19 crisis that the use of online meetings became more common practice and altered the mainly in-person meeting habit existent in hospitals. Participants acknowledge the benefits of this transformations by emphasising the enhanced efficiency and productivity online meetings permit, whereas other participants deplore the removal of human presence in meetings. The findings are structured in three sections, (1) discussing the perceptions and changes to in-person meetings over the course of the respondents' career and following this up with a focus on the transformations that occurred (2) during the COVID-19 crisis and (3) after the height of the COVID-19 crisis.

1. *Perceptions and Changes to in-person meetings*

First, participants mentioned that hospitals, as organisations, have evolved. There are stricter rules and a management that is more present, exercising more pressure.

"The hospital environment is much stricter now. There are a lot more rules and management is watching us. We get the impression that we are not allowed to make mistakes, there's a lot of pressure from superiors. I think that, in general, it's all these things that have made meetings evolve and change (Cardiac Surgery Nurse)."

Second, the organisation of meetings focuses predominantly on structuring, by making meetings more systematic (e.g., scheduled in advance) or recording meetings through written reports. Structure has been implemented with the use of digital tools, e.g., shared agendas,

and such tools have also formalised meetings by practices such as sending an invitation, having a meeting agenda, having a PowerPoint presentation and writing a report at the end.

“Regarding the Thursday meeting, this one has mainly become more regular and more structured (Head of the Risk Pregnancy Unit).”

“Yes, there has been a lot of change in the sense that digitalized agendas are much more formal. Now, (...) there's always someone taking notes, we've got minutes, (...) Yes, I think there's been a big positive evolution in the sense that it's more structured (Nurse Head of Psychiatry Service).”

“There's also been a big change in terms of technology. I've been with the company for 25 years, and we used to sit during meetings and the boss would stand up and talk, after we moved to using the big board where everyone could write on during the meeting, and now we have PowerPoint and Doodle to do polls on possible dates for meetings. There has been a huge evolution in the way meetings are organised and presented (Nurse operating room)”.

In general, participants have a positive outlook on having more structured meetings. Structure and the formality that it brings seem to imply that there is an effort made, a care taken to the time made and spent in meetings.

Third, the style of meetings has evolved, however, there is no alignment on the genuineness of this evolution. On the one hand, participants mention that they have become more participative or inclusive. That there is more space to express themselves, to voice their opinions or that there is some form of inclusion.

"We ask all the professionals for their opinion regarding their subject, (…) and I find that beneficial (Medical Secretary).”

However, on the other hand participants believe this to be a false impression. That superiors might say they want a more participative style, and that they allow for this in meetings, but that in effect the subordinates are still not heard. That it doesn’t matter whether meetings are participative, since decisions will have already been made prior to the meeting.

"I don't have the impression that I'm being asked for my opinion more. I think that's a false impression. I think they're trying to show us that they're interested in us, but I'm not sure that many decisions take them in account. (...) And that's also the overall feeling of the other heads when I talk to them (Head Nurse of Pneumology Consultations and the Sleep Unit).

This evolution also happened through the arrival of new personnel in managerial positions with new approaches to meetings which generates positive and negative feedback from participants.

“The previous manager used to have team meetings about everything and nothing, because he didn't listen to our needs nor our comments. In the end, nobody came or listened. The current manager works differently; he brings the whole team together, or as many as possible when it's really important, he listens to us and sees certain problems even if they're not formulated (Nurse).”

Finally, the increase in the number of meetings is frequently stated by participants that have moved up the hierarchical ladder or that hold a managerial or coordination position. It is a

source of dissatisfaction, yet, simultaneously, it is accepted as a normal progression. The more the person has a position of responsibility the more there are meetings. The increase in the number of meetings is also observed, to a lesser extent, by participants in non-managerial positions or without mentioning a change in their position.

"I started my career as a midwife, then I became head of a unit and for the last 4-5 years I've been in charge of a department. So, of course, I've seen an increase in meetings, but that was because of the roles I've (Head of the Mother-Child Department)".

The different transformations indicate a plurality of needs of hospital actors as they relate to meeting practices. Interestingly, caring for meetings happens mainly through better structuring and organisation of meetings, which follows the evolution of the hospital context. Structuring meetings more could be understood as "caring", since it protects from potential mismanagement of time, an important yet lacking resource in hospital contexts.
In addition, whilst the participation or inclusion of the multitude of voices in meetings has acquired momentum, its purpose remains mistrusted. To participants it is a façade, it conceals the unchanged existent relations of power and undermines the purpose of participation. Care is thus seemingly reduced to care giving without much attention to the full process that it entails.

2. Meetings in hospitals during the COVID-19 crisis

The COVID-19 crisis was an exceptional situation for hospitals where an unknown virus led to uncertain and unstable circumstances. It created a situation of urgency, where the focus was solely on the COVID-19 and the work related hereto was done under immense time pressure. The particular sanitary context meant that the occurrence, and the form of meetings changed for hospital staff.

2.1. The occurrence of meetings

The primary effect was the occurrence of meetings and how this was impacted during the crisis. During the COVID-19 crisis, everything revolved around the COVID-19 crisis. All elements that were deemed 'non-essential' were cancelled or postponed, 'put in the fridge'. Therefore, all the meetings that happened revolved around the COVID-19 crisis.
For hospital staff working in the care unit, such as nurses providing care to patients, the number of meetings decreased significantly. An absence of time for meetings was the primary reason for the decrease. The focus was on the immediate demand of providing care to the increased number of patients with higher care needs than in 'regular' times. This line of reasoning was expressed by the hospital staff that worked in the care units as well as by managers and supervisors. Interestingly, there are expressions of regret by managers of not having the hospital staff directly impacted by the COVID-19 included in the meetings or not having been able to organise meetings with the team. According to one manager, team meetings that were cancelled would've been beneficial to the team, but that there was a lack of time to do so.

"The only regret I have, with regard to these meetings (management of the COVID-19 crisis), is that the units directly concerned were not included (Head of the Department of Acute Medicine)."

"During the COVID period I wasn't able to and didn't have the opportunity to hold any meetings. The workload was enormous, and I didn't have the time to take the time to organise a meeting. Even though

I think it would have been very interesting and beneficial for everyone to be able to express themselves during this period. There was a lot to say (Head of Cardiology Surgery Unit)."

However, the number of meetings for managers and leaders was increased. The role the manager was to relay information and of receiving the latest information regarding the situation from the managers and administrators (e.g., the hospital staff that were not in the care units). What is more, once crisis measures were lifted hospital staff deplores the lack of meetings to not only inform the staff of the changes and the happenings since the start of the crisis, but equally to get feedback from the hospital staff. By doing so, the participation of hospital staff has in a sense been put to the side.

"Our team was split in two and I went over to the COVID side. I have no idea what happened. I think we should've had a meeting when we were 'reunited', to explain the changes that had taken place during the COVID phase (Operating Room Nurse)."

"After COVID we had nothing, zero meetings. We weren't asked for our opinion during the COVID period, we weren't asked for anything. There could have been more meetings (Care assistant)".

Yet, there is one case where a new type of meeting had been initiated during the COVID-19 crisis. This meeting gathered all the relevant parties to be able to align themselves more easily. This meeting has been maintained since it was considered beneficial to all members.

"The 'Plan-It' meeting was born during the COVID-19 crisis! Before that, no-one was talking to each other, everyone was doing their own thing, but during the crisis we all had to sit down around a table to decide who was or wasn't essential for surgery. We worked like this for months and it's stayed that way ever since (Administrator of the Operating Area)."

2.2. The effect of sanitary measures on meetings

The sanitary measures put in place to limit the spread of the virus obliged personnel to adapt their meeting practices. These measures required meetings to be held in larger and ventilated spaces to apply the social distancing rules, also wearing a protective mask was compulsory. Nevertheless, the participants that are medical professionals were required to be physically present in the hospital. Therefore, some participants mention the continuation of in-person. However, having meetings in-person became more complicated, but when they were held it also created a physical distance between the actors.

"We're one of those organisations where people were 'in the field' no matter what, so we continued with in-person meetings (Nurse)."

"During the crisis, there was an evolution because there was a huge distance. So before (the crisis) we would reserve a room for 20, since we are 20 and now to put 20, we would reserve a room for 60 (Head Nurse of Liver transplant service and Paediatric Digestive Surgery Service)".

The arrival of online meetings is frequently mentioned as a tool to overcome the difficulty of having not having in-person meetings. The arrival of online meetings was positive, because it allowed to continue with work, and it was a means to be in touch with colleagues.

"I have to admit that it (online meetings) made life a lot easier, because we've been able to carry on working and keep in touch with our colleagues (Director of Operations for Patient Care)."

In general, the rush and demands of the COVID-19 crisis meant that a lot of the meetings of actors working 'in the field' were cancelled due to their necessary presence 'in the field'. Their time administrating 'care' was needed more than their presence and time spent participating in meetings. In addition, the work done by the hospital staff 'in the field' was in itself time-consuming (physically, mentally and emotionally) and adding more 'worktime' seemed impossible. However, the difficulty of the situation also led to a reflection on the necessity to create a space for staff to express themselves. Meetings were restricted to actors in positions of organisational responsibility creating a distance between the different hospital employees, between those doing the care work and those in more managerial and coordinating positions. Furthermore, the in-person meetings with sanitary measures and the use of online meetings created physical distances between the actors. These adaptations meant distance develops between the different actors prohibiting a caring and relational approach.

3. Meetings since the COVID-19 crisis

Meetings since the COVID-19 crisis in hospitals are particularly marked by a new understanding of how to be efficient and the integration of online meetings facilitates this[3]. For the majority of hospitals represented in the sample this practice was non-existent or unusual prior to the crisis and it appears to be a practice that might not have happened so quickly without the COVID-19 crisis. However, the use of online meetings is also criticked, because it does not allow the social and emotional elements of meetings to take place.

3.1. New approach to efficiency

The conditions of COVID-19 crisis in hospitals pushed forward a new understanding of how to best use valuable time. Being in constant urgency and lacking time, it necessitated a more efficient use of time which resulted in being more structured and more rational. Also, it made prioritising useful meetings and discarding the others more straightforward.

"I think that we've really rationalised our time, everyone's realised that we need to make the most of the time dedicated to a meeting in order to manage. Really get to the essential points right away, and really be in an action-reaction mode. (...) Things have changed, at least I feel that in the way I manage things, we're more rational and more structured (Middle manager)."

Online meetings enable this new approach to efficiency and participants see the benefits of online meetings for their work as professionals in the hospital sector. Overall, the arguments emphasising the positives of online meetings seem to be related to 'gaining time' or 'not wasting time' in or with meetings. For instance, with online meetings the logistical aspects of organising a meeting aren't necessary such as finding a meeting room or commuting to the meeting.

"The time it takes to change clothes, go to the cloakroom, go to the car park, drive to the other site, find a spot to park, you can easily lose 20-30 minutes, and it also depends on the day and the traffic. We save a lot of time with videoconferencing (Head Nurse)."

[3] There are participants (7) that mention that there hasn't been (much) change and others (8) that mention that 'things have gone back to normal' since the end of the crisis. That it was as if for the duration of the COVID-19 crisis the hospital had been put on 'pause'.

In addition, participants have mentioned that online meetings are more to the point. The discussions are less likely to dwell from the subject or the objective of the meeting, because there is no space for informal discussions. Furthermore, the amount of time scheduled for the meeting is often not extendible, because participants have online meetings scheduled back-to-back. Therefore, the objectives need to be met in the allotted time, favouring discussion that are to the point.

"*The arrival of online meetings has made us more efficient. And it saves time, there's no time for chit-chat. We get straight down to business (Head Nurse in Cardiology).*"

"Yes, covid has meant that we have fewer and fewer in-person meetings and more and more meetings via videoconference teams. Which is extremely positive. I find that during online meetings you only talk about the subject of the meeting. Whereas when you're face-to-face, you sometimes go off on other subjects, which means that the meetings last longer than they need to. We get to the heart of the matter during online meetings (...) When it's over, it's 'thank you and goodbye', since online meetings follow each other in the diaries and we're more obliged to respect time, but it's positive (Head of the care and nursing records management unit)."

Furthermore, hospital staff can participate more easily. For instance, medical staff are often occupied with patients during regular work hours, but meetings online are easily held 'outside office hours'. Online meetings allow for a certain comfort of being able to go home and participate in a meeting from home and not having to wait in the workplace. Consequently, it becomes possible to do more work and have a better work-life balance.

"Yes, on one point I'd say. People who are not working on the day of the meeting can attend online. (...) I think that's good. It's not always easy to come all the way to the hospital just for a 2-hour meeting when you're working nights or have to look after the children. It allows more members of the team to attend (Nurse)".

"Yes, things will never be the same again and that's a good thing to be honest. I like it, it suits me from time to time to not to have to stay at the hospital after my day's work because I have a meeting at 6pm. I leave and if I can do it at home on my PC it suits me (Assistant Director of Care)".

In sum, removing the constraints of physicality means that the logistical aspects surrounding the meeting are simplified and thus it becomes easier to 'have meetings' more quickly and with more people. Additionally, the meetings are more efficient, because there is less dwelling from the objective.

4.2. Loss of social and emotional elements

Yet, the disadvantages of the new efficient approach are equally mentioned and are generally about the loss of social and emotional elements with online meetings. Participants stress that being physically present for meetings is necessary for socialisation amongst the hospital actors, which is an essential activity. Furthermore, in-person meetings allow for a more comprehensive view of the state of the different individuals present through their non-verbal communication. Moreover, in-person meetings allow informal discussions to occur, which is seen as an important way to obtain additional information.

"It's easier to have people seated around a table. Clearly because sometimes there's a person's non-verbal speech which can make you say to yourself, 'Wow, maybe there's something going on' (...) which is more difficult to perceive through a screen (Site Manager)."

"So, videoconferencing has its advantages and disadvantages, but it's true that it will never replace in-person meetings. It's really essential for socialization and above all for the informal discussions that we have on the side, which are sometimes more important than the subject itself. Sometimes you learn crucial information by talking to the person next to you in a meeting (Head of Visceral Surgery and surgical manager of the operating theatre)."

What is more, there are participants that express a preference for in-person meetings, because they are considered 'more friendly'.

"It's clear that face-to-face is better than videoconferencing. I prefer face-to-face, you understand, you can interact. So, I think it's much more human, much more friendly (Assistant Manager for the Emergency Department)."

In addition, there are participants that state that the COVID-19 crisis has removed the 'little social extras' that used to be part of in-person meetings. For instance, having a cup of coffee or bringing breakfast to meetings have not always been reinstated. Participants highlight the loss of these 'social extras', because it was a moment for bonding that was appreciated.

"Before covid, every meeting included a breakfast. We used to take turns bringing breakfast, it was a convivial thing we did between us. It was intended as a bonding moment, but it had to be stopped. It's a pity because it was a convivial thing to do. (...) It was a little extra that we don't have any more (Nurse coordinating oncology care)".

The COVID-19 crisis has influenced the opportunities available for the social and emotional elements of meetings to exist. The adoption of online meetings creates and facilitates a physical distance between people, diminishing moments of socialisation and complexifying the ability to understand or 'see' one another and to react or pick up on unsaid needs. Furthermore, in-person meetings have also seen the 'social extras', meant to boost the bonding processes between the hospital actors, be regretfully abandoned.

4.3. Disadvantages of online meetings

Participants also mentioned other disadvantages such as the lack of attention in online meetings especially when the meetings are long, technological issues, expressing oneself in an online meeting can be challenging and when there are too many people in an online meeting it can be problematic (e.g., muting, and unmuting microphones, too many people speaking at once). Finally, it is very tiring to have online meetings, because you need to be constantly very attentive.

"If you're alone behind your PC in front of an assembly, it's sometimes very complicated to follow the meeting. (...) If you don't have one person after the other speaking, it's just complicated to follow the discussion (Quality Coordinator)."

"There are always problems with technology, either it interferes, or we make people repeat themselves 15 times because we can't hear (Head of Technical Services).

Moreover, online meetings make it easier for people not to come to a meeting, because of the ease with which people can ask for or organise an online meeting. Online meetings remove the effort necessary to be present physically when it doesn't suit the person.

"The other downside is that being a multi-site hospital, I've noticed that most employees don't really need to travel any more, and it's very easy to use the videoconferencing card when someone finds it a bit cumbersome to travel from one site to another (Director of Patient Operations).

4.4. When to use of online meetings

Participants have mentioned that online meetings should be used only for certain types of meetings. For instance, in-person meetings were preferred for important meetings where big decisions need to be made, for meetings where people needed to be convinced, when it's with people that had never met before, when the subject of the meeting was sensitive or when the meeting was going to last a while. It's more about the objective of the meeting and whether the element of presence is or becomes an added value. The underlying argument being that online meetings should not become the norm just because it simplifies having and doing meetings.

"Videoconferencing is good for some meetings and not for others. You shouldn't think that videoconferencing is good for everything (...) For example, when you're discussing a project with people you've never met, and you need to convince them. It's impossible to convince people through a videoconference. (…) Or, for example, passing on new ideas the first time by videoconference is pointless (Assistant Medical Director)."

The situation of urgency induced by the COVID-19 crisis appears to have left a capacity to be more efficient with their time. A competence which online meetings favour, since the practices around online meetings allow to be more efficient almost immediately. However, this comes with a loss of relational elements, as online meetings don't allow to continue connecting and building a collective cohesion. Where this collective cohesion is hidden in the small informal aspects of being physically present, but perhaps more importantly having and making time to be in each other's presence. This presence allows to diverge from the scripted points of the meeting, to add little personal touches and to take time to 'care'.

Discussion

The COVID-19 crisis has made the importance of healthcare workers for a proper operating healthcare system perceptible. However, the hospital sector affected by insufficient human resources is contributing to worries about patient outcomes, but equally expose increased issues of staff wellbeing, such as burnouts (Gribben & Semple, 2021; Propper et al., 2020). Leading into suggestions of adapting healthcare organisations into organisations that organise a manage from a care ethic approach (Haliday, 2018).

Organisational research contributing to a care ethic approach in hospital management has seldom questioned how the presence of a care ethic situates itself in the roles of meetings. Nonetheless, meetings are omnipresent, intricate, and multi-layered spaces, which can turn into stressors for participants when they do not align with their expectations. In this study the objective is to interrogate how a care ethic emerges in the perception and enactment of hospital actors toward the roles of meetings, focusing specifically on the transformations brought on by the COVID-19 crisis and the manifestation of the related care dilemma in the hospital context.

We found that meetings are important spaces for relational practices of care and that caring exists in and through presence and time taken. However, the COVID-19 crisis detached physical presence from meeting spaces by not having meetings with all the actors during the crisis and more notably by the arrival of online meetings. What is more, the arrival of online meetings comes with an enhanced efficiency by allowing informal and relational practices to be reduced or even removed. The transformation illustrates how care allocation is torn between 'time for work' and 'time for colleagues'. On the one hand, working more efficiently is appreciated as it supports meeting underlying organisational or personal ambitions. In this sense, the discourse of care is instrumentalised to suit the organisation. However, this discourse is equally being deplored for removing an important aspect of work, namely the human and the informal. Politics, plurality and purpose, the elements found in caring organisations as described by (Tronto, 2010), have difficulty emerging as entities in their own right. Care appears to rest within dispositions as opposed to a practice that needs to be actively sought after. Below, we discuss some of the implications of these findings to organisational and managerial research and practice.

From invisible to tangible

The COVID-19 crisis has allowed to highlight the invisibility and the unequal burden of care work in society (Leichsenring et al., 2022; Power, 2020). By its extraordinary sanitary circumstances, the COVID-19 crisis forced multiple adaptations to meeting practices in hospitals which evoke apprehension for the decrease in relational proximity. The exclusion of hospital actors in caring functions to meetings and the sustained and pervasive use of online meetings in the hospital sector being the two primary examples. In both cases, the transformation was abrupt, but (unintentionally) allowed the meetings elements considered secondary and often taken for granted to be 'seen' by hospital actors.
The secondary elements were either seen as elements that could be done without or it made hospital actors recognise that there is fundamental value attributed to and in relational practices (Antoni et al., 2020) seemingly forging an awareness of the first element of care; attentiveness (Tronto, 2013).

It should, nevertheless, not be forgotten that during the COVID-19 crisis online meetings were for numerous hospital actors a means of being together whilst being apart. It filled the need for relationality with the only option available. However, when necessity subsides relationality through online meetings can be perceived as an enactment rather than an embodiment thereof. Which in turn accentuates the need to better understand how online meetings affects employees and how such spaces are being rehumanised (Taskin et al., 2023).
What is more, the COVID-19 crisis was a challenge for hospital management, however it also indicates that there is a possibility to think differently about crisis management, to reflect upon those practices from EoC perspective to avoid emphasising pre-existing structural disadvantages (Branicki, 2020).

Making time for care

In the current hospital context, the scarcity of resources (human, financial and material) puts pressure on the amount of time available for hospital actors to do their job. Furthermore, the quantifiable performance indicators, such as can be found in accreditation systems, reinforce the burden of achieving certain figures (or more) within in a certain amount of time. As a

result, there is an underlying need to be efficient which has translated into meeting practices. Nevertheless, since the COVID-19 crisis and with the arrival of online meetings, efficiency is placed between 'time for work' and 'time for colleagues'.
Online meetings optimise time by being more efficient with the time available (e.g., direct to the point, no possibility of extending meetings, etc.). The optimisation of time can be seen as benefit since it becomes possible to do more and to do it more quickly. In addition, it adds an element of personal comfort and increases the time available for the individual. However, there is a concern about the challenges that online meetings pose to the care that is detached by the removal of human presence from the work environment. For example, not being able to see the hidden subtleties in the body language of co-workers.

Taking care and building relations by making time to be present and allowing time for informal moments in a meeting is not automatically considered a valuable way to spend such a scarce resource. Online meetings reduce the space and the openings for relationality during meetings and push the human element further into the side-lines. What is more, the time gained by the increased efficiency is reintroduced into time for work. Thus, the time that has been gained, is time taken away from care. Time for care does not receive the same level of significance and by doing so the hospital work environment is evermore instrumentalised to maximise efficiency.
In addition, suggestions for best practices for online meetings and the situations of appropriate use of online meetings have not only been raised by the hospital actors but have equally started to emerge in literature (Kerawala et al., 2020; Oeppen et al., 2020). In-person meetings are understood as necessary to build or maintain relations and human presence is still seen as the preferred method to deal with sensitive situations. While such categorisations places importance on human presence, it equally further removes mundane 'care' within meetings as it makes physical attendance necessary when it is considered most effective.

Conclusion

The role of a meeting is multifaceted perception and evokes tensions amongst hospital staff. However, the transformation of meetings in general and more specifically since the COVID-19 crisis with the arrival of online meetings exposes a tension between instrumental caring and caring as a relational practice. The crisis has allowed hospital actors to see the relational practices that were embedded in meetings and shown how care does not fully happen through digital tools. That there is a part of care that exists and needs to happen through presence. Nevertheless, with the arrival of online meetings, time, a scarce resource for hospital staff, for meetings can be further instrumentalised to perform for purposes of the hospital. Meetings as spaces of care require that time is made to be physically present for it to exist.

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