



Global Leadership Without a Passport: Hospital Chaplains and the Micro- Construction of Organizational Culture

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Abstract

Background: Global leadership scholarship has treated the national border as a proxy for cultural complexity, which confines the field to leaders who travel. Research on organizational culture, for its part, tends to assume that culture is made by executives or by established occupational subcultures. Neither literature has a place for the practitioner who works across several cultural worlds within a single institution while holding no formal rank and belonging to no occupational community. **Objectives:** This article introduces the concept of non-positional cultural leadership to account for how such practitioners take part in the micro-construction of organizational culture. **Methods/Approach:** Board-certified hospital chaplains serve as an extreme case. The article draws on five theoretical traditions in sequence (cultural intelligence, boundary spanning, leadership-as-practice, relational leadership, and micro-constructionism) to explain how influence can arise from the margins of an organization. **Results:** The explanation rests on a mechanism the article calls witnessed repetition: relational encounters, repeated in view of colleagues over long periods, gradually change what a unit assumes a clinical encounter should contain. Four testable propositions follow, concerning how these practitioners work within institutional hierarchies and why standard measures of cultural intelligence may perform poorly when the stakes are existential rather than commercial. **Conclusions:** Moving the unit of analysis from the executive suite to the bedside shows cultural leadership to be widespread and largely unrecorded. The article closes by marking the limits of third-person theory and calling for phenomenological research into how practitioners themselves experience this work.

Keywords: global leadership; non-positional cultural leadership; cultural intelligence; hospital chaplaincy; organizational culture; boundary-spanning leadership

Paper type: Research article

Introduction

Hospitals are among the most culturally complex institutions in modern society. They bring together scientific precision, ethical uncertainty, and human vulnerability, often in the same room and within the same hour of the same day. While clinical guidelines and technical skills determine the care patients receive, the informal rules governing how doctors, nurses, and other caregivers treat each other and their patients are equally vital. Culture is more than a byproduct of hospital operations. It shapes whether frontline workers speak up when they see something go wrong (Edmondson, 1999, 2018), whether patients with different cultural and religious backgrounds experience competent and respectful care (Kleinman & Benson, 2006), and whether moral responsibility for clinical decisions is shared or borne individually (Epstein & Hamric, 2009).

Two mature scholarly fields should be well equipped to account for how these cultures arise and change. Global leadership theory has studied the actions of leaders within culturally complex environments for 40 years (House et al., 2004; Mendenhall et al., 2017; Reiche et al., 2017). Organizational culture scholarship has documented how cultures work, especially in healthcare settings (Cameron & Quinn, 2011; Mannion & Davies, 2018; Schein & Schein, 2017). Both fields, however, share the same blind spots. Global leadership theory has historically treated cultural complexity as a matter of geography, assuming that leadership becomes global only when a leader crosses a national border (Mendenhall & Bird, 2013; Mendenhall et al., 2012). Organizational culture theory presents a different challenge. Schein (1990) treats founders and senior executives as the primary architects of culture, and that perspective remains the field's most cited, despite its founder-centric bias. While an interpretive stream has located culture-making in the meanings members construct, it typically theorizes this work as a collective output, a product of subcultures, occupational communities, or coalitions (Bechky, 2003; Kellogg, 2009; Martin, 2002).

Neither literature accounts for a particular kind of practitioner. This practitioner holds no rank, belongs to no occupational community within the organization, and works through relationships that cross every such community without settling in any of them. Such work contributes to the culture in which care happens, yet the practitioner has no collective through which to make it. This article introduces non-positional cultural leadership as a theoretical construct to describe this practitioner. The practitioner in question shapes culture from a position the organization chart treats as insignificant, and board-certified hospital chaplains serve here as the primary test case.

Chaplains were chosen for this inquiry because their conditions are extreme. An extreme case is selected for what it reveals rather than for how well it represents a population, and it earns its place when the mechanism under study runs at unusual intensity there (Flyvbjerg, 2006; Seawright & Gerring, 2008). Chaplains hold no positional power, yet they work at the juncture where a hospital's unspoken norms come briefly open to renegotiation. If cultural leadership without rank exists anywhere, it should be visible here.

The article makes three arguments. First, it extends global leadership theory downward into domestic healthcare microsystems via the nested competency argument. Cultural complexity is present in these systems in concentrated, high-stakes forms, and the competencies identified in global leadership are thus pertinent to

domestic practitioners who will never cross a border. Second, it provides a micro-constructionist correction to organizational culture theory, shifting the site of cultural production from the executive suite to the mundane, relational interaction. Third, it sequences five established theories, not previously brought into relation with one another, into a model of non-positional leadership, identifying witnessed repetition as the primary mechanism through which influence crosses from the interpersonal to the unit level.

This article defines non-positional cultural leadership as an informal, relationally mediated practice of meaning-making, boundary-spanning, and ethical reflection. The construct describes how practitioners contribute to the micro-construction of culture through repeated, witnessed interaction rather than through any formal authority. While the construct is bounded to board-certified chaplains in U.S. hospitals to ensure testability, the implications extend to a wider class of non-positional boundary-spanners, such as interpreters, patient advocates, and ethics consultants, who operate in the margins of complex organizations. Attending to these practitioners rather than to the executive suite shows that the field has overlooked a group of cultural producers already at work in its institutions. Studying them brings global leadership research closer to its stated subject, which is leadership under conditions of cultural complexity wherever those conditions occur.

Global Leadership Recast

Whether global leadership theory applies to a hospital chaplain at all has to be established before anything can be built on it. The argument of this section is that the competency demands of the chaplain's terrain are the ones the field already measures. Cultural intelligence is treated as the individual threshold, and the analysis is placed at the level of the hospital microsystem rather than the enterprise.

The Nested Competency Argument

Reading U.S. hospital chaplains through global leadership scholarship needs explaining. The incongruity is real: the theory was developed for executives in multinational corporations, and chaplains are not executives. The justification is the competency demands of the terrain on which chaplains operate. U.S. hospitals serving diverse urban and suburban populations are sites of perpetual cross-cultural encounters among patients and families from plural national, religious, and ethnic backgrounds; among staff formed in distinct occupational subcultures; and among institutional value systems that are simultaneously biomedical, administrative, spiritual, and communal. The complexity global leadership theory was built to analyze is present here in concentrated form, even though the geographic scope is entirely local.

This extension follows the field's own trajectory. The earliest cross-cultural leadership literature arose from necessity, as U.S. multinational corporations expanding abroad in the 1970s and 1980s confronted the practical problem of selecting and training expatriate managers (Mendenhall et al., 2017). The literature treated culture as a feature of place, encountered through movement, and interpreted leadership as an individual's ability to get along in a foreign country. The layering of occupational, generational, ethnic, and institutional cultures present in any diverse workplace went unobserved.

The shift began in the 1990s and gained momentum with the GLOBE study (House et al., 2004). By examining leadership values across 62 societies, GLOBE demonstrated wide cross-cultural variation in endorsed leader behaviors alongside the near-universal valuation of certain attributes. What counts as good leadership, the study established, depends on cultural expectations, an insight that has since informed the field's most influential definitions. Reiche et al. (2017) define global leadership as “the processes and actions through which an individual influences a range of internal and external constituents from multiple national cultures and jurisdictions in a context characterized by significant levels of task and relationship complexity” (p. 556). They note that the definition goes beyond formal positions or job titles. Little in that definition requires a passport to enter. Its operative terms, a range of constituents, multiple national cultures, significant task and relationship complexity, describe the daily condition of a major urban hospital nearly as well as they describe a multinational corporation.

Calling domestic hospital chaplaincy “global leadership” only holds if one can say clearly what makes leadership global. The field has already answered this question, and the answer is not geography. Mendenhall et al. (2012) broke the construct into three dimensions. Complexity is contextual, produced by the interaction of multiplicity, interdependence, ambiguity, and flux. Flow is relational and refers to the richness and volume of information a role must move across boundaries. Presence is spatial-temporal and refers to how far a role requires someone to move physically across geographic and national boundaries, rather than communicate across them. Global, on this account, is a matter of degree along three axes. No role is simply global or not.

Scored this way, the hospital chaplain is a specific and instructive case. Complexity is high on all four drivers (Mendenhall et al., 2012). A single bedside can hold attending physicians, nursing staff, social workers, an ethics committee, an interpreter, and a family spanning three generations and two languages. Each party carries different stakes, and none can act alone (Currie et al., 2012). The same clinical facts support incompatible readings, and the disagreement is frequently about what the facts mean rather than what they are (Kleinman & Benson, 2006). The situation reorganizes itself hour by hour. A chaplain standing at one bedside may have to work across the positivist logic of Western biomedicine, the efficiency logic of hospital administration (Reay & Hinings, 2009), and a family's sacred, cosmological, or ancestral account of what is happening to them. Such accounts may be Abrahamic, Dharmic, indigenous, or secular humanist. Adjusting one's communication style does not meet this demand. The work is closer to translation between worlds that do not share a description of reality. Flow runs high as well, since boundary spanning is constitutive of chaplaincy, a claim developed at length below.

Presence is the exception. On that dimension the chaplain scores nothing, because the chaplain never leaves the building. The extension proposed here stops at that limit, and the limit should be stated plainly. The article does not claim that chaplaincy is global leadership in every dimension the construct names. The claim is that chaplaincy sits high on the two dimensions that carry the competency demands and low on the one the field has used as its admission criterion. Mendenhall and Bird (2013) argue that development should be targeted by where a role actually falls on complexity and boundary spanning, rather than by an assumption about who counts as global in the first place. Applied consistently, that reasoning extends to the chaplain. The same

reasoning excludes many workplaces. Where differences are demographic rather than ontological, stakeholders are few, conditions are stable, and practitioners span no boundaries, a workplace scores low on complexity and flow and falls outside this account, whatever its diversity profile.

A second shift ran alongside it: from traits to competencies that can be learned. Earlier trait models looked at stable qualities such as openness to experience and tolerance for ambiguity (Caligiuri & Tarique, 2012). This implied that a person either had the makings of a global leader or did not. Ng et al. (2009) reframed the question. They described cultural intelligence as a meta-level capability that a person builds by drawing developmental value from unfamiliar cultural encounters. If this is correct, the relevant question about practitioners is one of training: what has their formation actually equipped them to do?

Global mindset scholars locate the capacity for global leadership in managerial cognition, cosmopolitanism, and cognitive complexity; mobility does not figure in it. Levy et al. (2007) show that the construct has been theorized largely without reference to where a manager is standing. If what makes a leader global is a way of holding difference in mind, then nothing in the construct is doing the work the border has been asked to do.

Cultural Intelligence: The Individual Threshold

Of these paradigms, cultural intelligence (CQ) has the strongest empirical record, and its limits are also the easiest to specify.

Earley and Ang (2003) proposed the construct, and Ang et al. (2007) provided the form most researchers now use. Borrowing the multiple-loci model of intelligence (Sternberg & Detterman, 1986), Ang et al. argued that functioning well across cultures draws on four separate capacities rather than a single general capacity. Metacognitive CQ is the ability to catch one's own cultural assumptions in motion and revise one's reading of a situation. Cognitive CQ is knowledge of value systems, religious traditions, and how cultures organize themselves. Motivational CQ is the willingness to stay in an interaction once it becomes effortful instead of pulling back from it. Behavioral CQ is what a person does with voice, face, and body in a particular encounter. The four predict different outcomes. Metacognitive and cognitive CQ predict cultural judgment and decision-making; motivational and behavioral CQ predict cultural adaptation; and metacognitive and behavioral CQ predict task performance (Ang et al., 2007). The fact that different dimensions predict different outcomes supports the claim that the four measure distinct capacities.

That CQ adds predictive power beyond general and emotional intelligence is one of the better-replicated findings in the literature. Rockstuhl et al. (2011) studied 126 Swiss military officers who led both at home and across borders. Emotional intelligence was the stronger predictor of domestic effectiveness; cultural intelligence was the stronger predictor of cross-border effectiveness. Groves and Feyerherm (2011) found that leader CQ predicted leader and team performance on culturally diverse teams beyond what leader emotional intelligence and other competencies explained. General intelligence and warmth, in other words, do not by themselves make cultural difference legible. The implication for the caring professions is considerable. A practitioner who is emotionally attuned but culturally uninformed can misread the cultural content of an

emotionally charged moment and end up interpreting the patient's suffering through a personal frame rather than the patient's.

None of these findings transfers to healthcare without qualification. CQ was developed and validated almost entirely in corporate and military settings, where a cross-cultural encounter is a performance problem and the costs of failure are economic or operational. Hospital work occurs under other conditions: suffering, dying, grief, and moral crisis. What is at stake is how a patient understands their last weeks, or whether a bereaved family can grieve in a way that makes sense to them. Whether the model's dynamics hold when the stakes are existential is a question the literature has not addressed.

Critics have also charged the model with a universalist and quietly essentialist ontology, one that treats cultures as bounded and knowable enough to be measured on standardized scales, and reviews of the field have questioned current measurement approaches and proposed alternatives (Leung et al., 2014). The assumption is strained in clinical settings. People's relationships with their own religious and cultural identities are frequently unsettled, ambivalent, or mid-change. Immigration, illness, disagreement between generations, and the disorienting experience of a biomedical institution carrying its own cultural assumptions all press on those identities.

Identities under that kind of pressure are also identities under someone's authority, and about authority CQ research has had very little to say. The model describes what an individual practitioner can do inside a cross-cultural encounter. It says nothing about how hierarchy, structural inequality, and the routine dismissal of non-biomedical knowledge shape what is available to be done in the first place. No published finding contradicts CQ on this point. The gap is one of omission: the reviews describe what the construct measures, and power does not appear. Some practitioners sit low in the medical hierarchy and belong to minority religious, cultural, or racial groups inside institutions that are predominantly secular and White. For those practitioners the omission matters a great deal.

These criticisms do not disqualify CQ. They mark its boundaries. The construct maps the architecture of cross-cultural competency and has little to say about existential stakes, cultural fluidity, or power.

The article relies on CQ's empirical record while predicting, below, that the CQ instrument will underperform in the setting studied here. The two positions are compatible because they concern different things. The record establishes that cross-cultural capability is differentiated rather than unitary, and that its dimensions predict different outcomes; that is a claim about the structure of the construct. The later prediction concerns the calibration of a scale developed for managers and military officers when it is carried into rooms where someone is dying. What this argument borrows from CQ is the four-factor architecture of capability, not the effect sizes. Carried into this setting, the instrument should keep its four-factor structure and lose much of its predictive power.

Proposition 1. The CQ instrument will lose predictive power in this setting while retaining its four-factor architecture, and the loss will be uneven. Rockstuhl et al. (2011) supply the benchmark: the strength with which CQ predicted cross-border effectiveness among officers who led both at home and abroad. Metacognitive and

cognitive CQ should hold near that benchmark. Motivational and behavioral CQ should fall well below it, because existential stakes change what those two capabilities consist of. The unevenness matters because of a competing explanation. Board certification already selects on the capacities CQ measures, and any population selected in that way will show weaker correlations simply because the range of scores is restricted. Range restriction, however, predicts that every factor attenuates by roughly the same amount, whereas the argument here predicts a specific pattern. Uniform attenuation would count against the argument and the predicted pattern would count for it. A weak result of either kind would bear on the transportability of the instrument rather than on the construct itself.

Nesting Global Leadership in the Hospital Microsystem

An obvious objection remains. These theories were built for executives with formal cross-border mandates, and nothing in a chaplain's job description resembles one. The nested competency argument answers it by shifting attention from the mandate to the terrain, and recent work questions the executive-and-border framing from another angle.

Chua et al. (2023) argue that cultural diversity inside the workforce has grown complex enough to require new organizational approaches from leadership, and they treat that complexity as a general condition of organizational life rather than a feature of a company's international operations. Cross-cultural skill, on that reading, is as relevant to people working in multicultural environments at home as to those who travel (Caligiuri & Tarique, 2012). In healthcare, workforce diversity is itself a leadership problem: learning to connect with patients who do not share a language or a theory of illness, and building a team people want to belong to (Figueroa et al., 2019; Pelasoja et al., 2026). Chen et al.'s (2020) synthesis of the multicultural aged-care workforce found cultural skill already present among staff and team cohesion widely wanted, alongside something less comfortable: experiences of racism largely kept quiet, rarely reported upward, and met with inaction from management when they were.

The parallels are real, but two differences need to be acknowledged, because passing over them would make the argument look easier than it is. One is stakes. The gap between a bad quarter and preventable deaths, unnecessary suffering, or families left feeling disrespected is vast. The other is articulability. Much of what cross-border executives need to know is available in codified form: legal codes, published cultural briefings, documented business practices. Much of what the hospital practitioner needs to know is not codified at all: the different ways a family approaches end-of-life care, their understanding of pain, the way institutionally held beliefs about the boundary between faith and biomedicine operate in practice. Much of that knowledge lives in practices its holders have never fully articulated. The cultural terrain on which hospital practitioners work is therefore less charted and less directly accessible than the terrain executives face.

The nested competency argument comes down to a single claim. Skills that global leaders use successfully in cross-cultural interactions are reflected in the day-to-day activities of practitioners operating in multicultural microsystems, closely enough that the two can be read in tandem, from either direction. Global leadership scholarship helps explain key elements of their practice, and their practice shows the limits of global leadership scholarship's language.

The Chaplain as Organizational Actor

Reading the chaplain as a leader presupposes a description of the role. The following sections describe how chaplains are formed and credentialed and then ask what the evidence shows about whether their work reaches beyond the bedside into the organization.

Formation and Certification

Healthcare chaplaincy is conceptually rich and empirically under-researched compared to other clinical professions (Fitchett, 2017; Pesut et al., 2016). Its history of professionalization also differs in ways that bear on the cultural leadership argument. Parish pastors first provided hospital chaplaincy services. Much of the early American hospital infrastructure was founded by religious communities, and they sent clergy to provide sacramental ministry to fellow believers (Cadge, 2012). These clergy received ecclesiastical rather than medical education and were marginal to the emerging healthcare team. The distance between that arrangement and current board-certified chaplaincy helps explain why chaplains' cultural contributions are possible today when their predecessors' were not.

Anton Boisen led the change. Boisen was a minister who spent time in an involuntary psychiatric commitment and came to believe there were lessons to be learned from those who suffered and broke down. In 1925 he founded a training program at Worcester State Hospital focused on learning from what he called living human documents rather than relying on doctrinal texts alone. His program led to what eventually became clinical pastoral education (CPE) (Boisen, 1936; Cadge, 2012). Today a board certification candidate must complete a graduate-level theological degree, four units of clinical pastoral education, a period of supervised professional experience, and a certification review based on published competencies, and must hold current endorsement from a recognized spiritual or faith community (Association of Professional Chaplains, 2017; Cadge, 2012). The endorsement requirement bears on the argument that follows: the chaplain is credentialed by a community outside the hospital and is a delegate of none within it.

What CPE does to the person who completes it has begun to be measured. A pilot study of seven chaplains in NHS England found that CPE participation sharpened self-awareness, made practice more deliberate, and raised measured emotional intelligence (Szilagyi et al., 2024). The sample is small and the setting is not American, so the finding should be generalized with caution. It does suggest that formation changes the practitioner in ways that patient-level outcome measures were not designed to detect.

Details in the profession's competency standards bear directly on this argument. The *Common Qualifications and Competencies for Professional Chaplains* organizes competencies into four domains: integration of theory and practice, professional identity and conduct, professional practice skills, and organizational leadership (Association of Professional Chaplains, 2017). The final domain is not a marginal addition, and two of its five competencies name the institution directly. OL1 requires the candidate to "promote the integration of spiritual care into the life and service of the institution in which one functions" (Association of Professional Chaplains, 2017, Section IV, OL1). OL3 requires the candidate to "understand and function within the

institutional culture and systems, including utilizing business principles and practices appropriate to one's role in the organization" (Association of Professional Chaplains, 2017, Section IV, OL3).

Read closely, these competencies establish more than the chaplain's status as an organizational actor. They require the candidate to understand institutional culture and to operate within it, but they go no further. The standard does not ask what happens to that culture when a practitioner formed in this way works within it for a decade. Culture appears in the credentials as terrain to be worked in, not as something the profession's members help to produce. The present article takes up that omission from the side of theory.

The formation may also be less even than the standard implies. Cadge et al. (2019) report that theological educators, clinical educators, professional chaplains, and the organizations that employ them are not working from a common understanding of what makes a healthcare chaplain effective. The formal standards, then, appear more ambitious in their organizational dimensions than the formation processes preparing practitioners to meet them. Whatever chaplains are credentialed to contribute may be unevenly distributed across the profession, and that heterogeneity shapes how the argument should be tested.

From Clinical to Organizational

Since the mid-2000s the literature on chaplains' clinical contributions has grown substantially, as the evidence-based medicine movement pressed all clinical services to demonstrate measurable outcomes (Fitchett, 2011; Handzo & Koenig, 2004). Validated instruments such as the FICA Spiritual History Tool (Puchalski & Romer, 2000) and the HOPE questions (Anandarajah & Hight, 2001) have moved spiritual assessment from a courtesy extended to religious patients to a standard dimension of clinical evaluation. Patients whose spiritual needs are attended to report higher satisfaction and less anxiety, and they engage more with advance care planning that matches their beliefs (Pearce et al., 2012; Steinhäuser et al., 2000, 2017; Williams et al., 2011). All of these outcomes are patient-reported. That is the strength of this literature and also the limit of what it can show.

In palliative and end-of-life care, attention to dying patients' spiritual needs is associated with greater peace, less psychological distress, and less non-beneficial aggressive treatment at the end of life (Balboni et al., 2007, 2010; Phelps et al., 2009). National guidelines now list spiritual, religious, and existential care as one of the eight core domains of quality palliative care (National Consensus Project for Quality Palliative Care, 2018). The conversation has shifted from whether chaplains belong on the team to how their work is best used.

Within interprofessional teams, chaplains work across patient experience, clinical decision-making, and institutional practice in a way no single clinical discipline does (Cadge, 2012). Without biomedical expertise, chaplains contribute to ethics consultations by attending to the value-laden aspects that principle-based ethics do not fully address (Cadge, 2012; Fox et al., 2007). Each consultation builds the chaplain's institutional standing through relationships rather than position, consistent with boundary-spanning theory (Ernst & Chrobot-Mason, 2011).

Boundary-spanning theory also anticipates resistance to the full inclusion of chaplains. The literature reports exactly that. Department directors' understanding of what chaplains do varies widely (Flannelly et al., 2005), and spiritual care is still treated as optional rather than expected. The structural evidence is blunter. Between 1980 and 2003 the share of U.S. hospitals with chaplaincy services held between 54% and 64% with no upward trend, and over the last decade of that span church-operated hospitals were more likely to drop the service than to add it (Cadge et al., 2008). These findings show how organizational culture conditions the extent to which chaplains can affect it, a reciprocal relationship taken up again under Proposition 2.

Almost no evidence exists for chaplains' effects on organizations beyond their clinical work, a gap U.S. chaplains have named as a priority for the field's research agenda (Damen et al., 2018). Szilagyi et al. (2022) convened an international expert panel of chaplaincy leaders and researchers during the COVID-19 pandemic. The panel described six themes of chaplaincy leadership: professional confidence, trust-building with executives, decision-making, innovation and creativity, trusting connections with colleagues, and the promotion of cultural competence. All six name organizational effects rather than patient-level ones. A panel of this kind, however, documents expert perceptions of effect rather than the effect itself. The distinction matters here because little other evidence supports the organizational side of the argument.

Professional confidence meant being comfortable asking questions about spirituality and meaning when they would not otherwise arise, usually in formal decision-making meetings. Trust-building refers to the social capital that accrues from a dependable presence. Snowden's (2021) survey of 1,657 chaplains in 36 countries found that chaplains supported staff, took up unfamiliar technology, and improvised where guidelines were lacking.

Judged by the vocabulary of positional leadership, these activities did not count as leadership, and Snowden (2021) concluded that chaplains in general lack leadership skills. An alternative reading is that the practice was present and the vocabulary for recognizing it was not. Supplying that vocabulary is part of what this article attempts.

The Dutch evidence cuts the other way. Den Toom et al. (2023) compared chaplaincy surveys taken 20 years apart and found professionalization concentrated in what chaplains know and what they believe rather than in where they stand. Their expertise had broadened and their worldviews had pluralized to include non-religious and non-affiliated positions, but their organizational embedding had not changed, and structural participation in multidisciplinary consultation had fallen. If organizational standing followed from professionalization, the Netherlands should show it, and it does not. The Dutch setting lacks the board-certification structure that anchors the U.S. profession, which may be part of the explanation. The finding still stands as a caution against assuming that a more professional chaplaincy is a better-positioned one.

Jeuland et al. (2017) described how palliative care chaplains routinely support healthcare personnel in addition to patients. More recently, interviews with a German neuropalliative home-care team described the chaplain as shaping team culture and what the authors call workplace spirituality (Bublitz et al., 2025). The country and setting differ from the U.S. hospital, and the team was small enough that a single person could plausibly account for the whole effect. If a chaplain sits with a nursing team after a spate of patient deaths, or stands with them through institutional turmoil,

the effect may extend beyond those directly involved: their actions may shape team norms about emotion, self-care, and what it means to care for people in this institution. That inference goes beyond what the studies show. Jeuland et al. and Bublitz et al. document chaplains supporting staff, but neither traces an effect beyond the people in the room. The step from supporting a team to shaping its norms is the step this article asks the reader to consider, and the research agenda below is designed to test it.

Working cross-culturally raises a harder question. Bang et al. (2024) interviewed 14 chaplains and found high comfort working across cultural difference, which the chaplains attributed to training in cultural sensitivity and humility. The same study named gaps in that training as a separate theme. Confidence and preparation are different things, and a profession can have a good deal of the first while lacking the second. The gap is a reason for caution before describing chaplains as cultural brokers, and it points to the Western, Abrahamic center of gravity that still shapes chaplaincy training.

Taken together, the formation, clinical evidence, and organizational data describe board-certified chaplains as participants in institutional culture rather than bystanders. None of this literature explains how that participation works. An explanation requires two further accounts: how influence travels in the absence of rank, and how that influence comes to register as culture. The next two sections take these up in turn.

Leadership Without Position

Cultural intelligence, as argued above, is the individual threshold. Three further traditions carry influence from the individual outward. Boundary spanning explains structural access, leadership-as-practice makes the work recognizable as leadership, and relational leadership supplies its ethical register. Where that influence registers, and through what mechanism, is the subject of the section after this one. The traditions are not separate pillars. Each depends on the one before it, and together they form a sequence of requirements.

Boundary Spanning: Structural Mechanisms of Access

Cultural intelligence describes what a practitioner brings into the room but not how that influence travels beyond it. Boundary spanning addresses that question. The concept receives little attention in the general leadership literature, yet global leadership research identifies it as one of the most frequently cited components of effectiveness (Mendenhall & Bird, 2013). For that reason the concept is introduced here from global leadership research, where it is central, rather than from a neighboring field in which it is peripheral.

Building on Aldrich and Herker's (1977) account of boundary roles, Ernst and Chrobot-Mason (2011) developed a more active concept of boundary work. Boundary spanners do more than transmit information between groups; they shape what moves across boundaries and which alliances become possible. They identified six practices: buffering, reflecting, connecting, mobilizing, weaving, and transforming. The concept fits healthcare well because the institutional setting is marked by proliferating specialties and by repeated encounters among clinical, administrative, and patient communities (Currie et al., 2012; Reay & Hinings, 2009). Healthcare has tested the idea at close range, and the results are mixed. Gibeau et al. (2020) followed 20 co-

leadership dyads and found that bridging competing logics, where it happened at all, often came about through one side absorbing the other rather than through balanced integration. Recent fieldwork also identifies trust-building as a mechanism for involving groups not represented in formal structures (Bianchi et al., 2025).

Chaplains are close to a textbook example of a boundary-spanning position. They are not clinicians, administrators, or family members, yet they have legitimate access to all three groups, and they enter at moments when institutional assumptions become visible and open to negotiation. Ernst and Chrobot-Mason's practices align broadly with the chaplain's role: buffering, by protecting a patient's spiritual needs from operational pressures; reflecting, by naming implicit assumptions within the team; connecting, by maintaining long-standing relationships with clinical staff. Research has shown that chaplains help orient newcomers to the institution, support cultural bridge-building, and contribute to ethically charged decisions no single member of a professional subgroup can make alone (Cadge, 2012).

Antoine et al. (2021) interviewed healthcare executives about how they decide to fund spiritual care. The executives named the chaplain's work with staff, in tragic situations and through organizational change, before they named patient satisfaction, and that work figured in their resource decisions. Chaplains therefore register at the level where budgets are set, through a channel that lies outside the patient encounter altogether.

What studies have shown but not yet theorized is how costly boundary spanning can be for an individual. Those who span boundaries risk injuring their identity when they move between groups that do not fully accept them as members (Kane & Levina, 2017). Needham et al. (2017) separate boundary spanning that is written into a job from boundary spanning that merely emerges in one, and argue the emotional labor lands differently in the two cases. The chaplain's boundary spanning is of the second kind, and no job description accounts for it. For a chaplain who spans boundaries throughout every working day, the costs accompany the benefits. The concept may also romanticize spanning across groups, as if this were possible outside existing structures of power. In organizations, boundary spanners must work across vertical hierarchies as well as horizontal ones (Yip et al., 2016), and those hierarchies tend to discount or suppress voices from outside dominant professional subgroups (Langley et al., 2019).

Leadership-as-Practice: Relocating the Unit of Analysis

A practitioner may span every boundary in the building without doing anything that conventional theory would recognize as leadership. Leadership-as-practice (LAP) addresses that problem. Where conventional research locates leadership in the decisions and traits of those with formal authority, LAP argues that leadership is a feature of particular interactions. It is distributed among members, emerges from everyday activity, and is not held by any single person (Crevani et al., 2010; Denis et al., 2012; Raelin, 2016). LAP shifts the unit of analysis from the leader to the practice.

Healthcare has provided fertile ground for LAP. Clinical work requires expertise distributed across teams, constant coordination, and a high cognitive and emotional load (Denis et al., 2012; Spanos et al., 2024). The benefits of collective leadership include improved teamwork, greater psychological safety, and better patient safety (De Brún et al., 2020). Research on distributed leadership is increasingly common in the

field (Sfantou et al., 2017; Spanos et al., 2024). Many articles report the experiences of practitioners who lead without holding formal positions (Leclerc et al., 2021; MacPhail et al., 2015). What this means is unsettled, and LAP raises the question directly. Conventional leadership research cannot ask what effect chaplains have on culture through their day-to-day interactions, because such actions would not qualify as leadership. If leadership emerges from practice rather than position, and culture emerges from collective practice, then in LAP any member's daily practice is potentially a form of cultural leadership. A chaplain leading a family meeting where team and family hold different expectations, or sitting with a nurse working through a difficult moral decision, is engaging in leadership in this sense. During the pandemic Snowden's (2021) survey found chaplains improvising in precisely these ways. Snowden interpreted the improvisation in positional terms and concluded that chaplains were deficient in leadership skills. Klitzman et al. (2023) add that institutions shape how much room there is for creative improvisation in the first place.

Strong versions of LAP hold that collective practice constitutes leadership, rendering individuals analytically invisible. That position is too restrictive for cases where practitioners' formation, long tenure, and relational skills make a difference. As a secular theory, LAP also has no language for the vocational and theological concerns practitioners value. Positioned at the organizational level, LAP addresses the first objection. Relational leadership theory addresses the second.

Relational Leadership: The Ethical Register

Relational leadership treats leadership as something made in the relation between people rather than held by one of them (Uhl-Bien, 2006; Uhl-Bien & Ospina, 2012). Relational skills remain underdeveloped in primary care teams despite their importance (Cleary et al., 2018; Maritsa et al., 2022) and the evidence linking them to reduced burnout and greater work satisfaction (Cummings et al., 2018; Wei et al., 2020).

Its alignment with chaplaincy education is what makes this theory especially relevant. Non-anxious presence, a term that reaches chaplaincy from Friedman's (1985) work on family systems, is developed through CPE and through contemplative practice across traditions. It is the capacity to stay in the room, and stay quiet, when the situation is unbearable. Cultural humility, as taught in chaplaincy training, parallels the medical field (Tervalon & Murray-García, 1998) in emphasizing lifelong self-examination, attention to power between caregiver and care receiver, and learning from those receiving care. Whether chaplains actually practice relationally remains an open empirical question. Two observations are possible: chaplains are trained for the roles this theory describes, and documented examples show chaplains supporting teams facing ethical challenges (Jeuland et al., 2017; Kwak et al., 2022).

The theory is also largely prescriptive. It describes what relational leadership looks like when it works, but it has less to say about why practitioners who endorse it may still be unable to act relationally under time pressure, power dynamics, and organizational norms. A second limitation matters most in multicultural contexts. The account of selfhood underneath this theory belongs to a particular culture. Cunliffe and Eriksen (2011) build relational leadership on a dialogic reading of the self, and the stream draws its ethics more broadly from Levinas (1961/1969), for whom the encounter with the Other grounds moral obligation. Alterity in that sense assumes a bounded,

individuated self meeting another distinct moral subject. It cannot be assumed to transfer smoothly to practitioners and patients socialized elsewhere. Interdependent conceptions of the self, such as those in Confucian relational ethics, Ubuntu, and many Indigenous traditions, treat the self as constituted through relationships and therefore derive moral obligation from a different source. Behaviors these theorists describe as authentic, such as direct verbal acknowledgment, may not match what other traditions take to express integrity, where discretion, deference, and mutual silence carry the same weight. The theory does not exclude such actions. It has simply not theorized them yet. For practitioners whose daily work involves exactly this kind of cross-cultural engagement, the limitation is also an opening, since practice can inform theory and the theory can be refined.

From Interaction to Culture: Schein and Micro-Construction

The three traditions above explain how a chaplain's influence travels outward but not where it takes effect. That account is developed here in two steps. The first examines Schein's architecture of culture and its bias toward founders and executives. The second turns to the micro-construction literature, which shows how culture is also made and remade in ordinary interaction.

Schein's Architecture and Its Founder-Centric Bias

Organizational culture is among the most consequential and least well-specified variables in healthcare systems research (Braithwaite et al., 2017; Mannion & Davies, 2018). It affects how staff talk to each other, whether they report or hide mistakes, how they treat patients from non-dominant cultures, and how they implement institutional policy (Betancourt et al., 2003; Institute of Medicine, 2000; Mannion & Davies, 2018; Reason, 2000). Making claims about non-positional practitioners' capacity to shape culture requires a clear account of what culture is and how it changes.

Edgar Schein gave the best-known account, arguing that culture operates at three levels: artifacts, espoused values, and basic underlying assumptions. The deepest of these remains hidden and shapes how organizations function without being stated (Schein, 1990). The model locates the practitioner's role at each level. Artifacts are the visible and felt dimensions of care: handoffs, rounds, and the rituals that mark milestones, including memorial services and ethics consultations. Chaplains are actively involved in several of these, and their absence from others indicates where spiritual care sits in the institution's structure.

Patient-centered care, clinical excellence, cultural responsiveness, and staff wellbeing sit at the espoused level. Among the most reliable sources of cultural tension in healthcare is the gap between what an organization says it values and what it rewards (Braithwaite et al., 2017). Chaplains work inside that gap: in ethics committees where stated values collide with operational realities, and in the support they provide to staff after adverse events. The basic underlying assumptions are rarely stated and almost never contested. They govern daily clinical decisions and patients' experiences of the institution: what counts as legitimate knowledge, which professional categories merit deference, and what defines a good death.

One weakness in the model bears directly on this argument. It says a great deal about what culture is and very little about how culture is created and negotiated through daily action. For Schein it is mainly founders and senior executives who create culture, with most employees receiving culture rather than producing it (Schein, 1990). The fifth edition devotes more space to negotiation (Schein & Schein, 2017). A clear distinction still remains between actors who produce culture and those who consume it, with the practitioner without rank left on the consumption side. Chaplains are not founders or senior leaders, yet their relational work seems to touch the deepest levels of culture in ways the founder-based model does not anticipate.

Denison's model of culture as involvement, consistency, adaptability, and mission (Denison & Mishra, 1995) has the same limitation from the other side. It measures culture from the outside, through aggregated survey scores, and does not address how cultural dynamics arise and are negotiated by professionals inside the organization. Mission is precisely the dimension where practitioners shaped by questions of purpose and value would be expected to be most strongly engaged.

Smircich (1983) drew the distinction that exposes this limitation, and Martin (2002) built a three-perspective framework around the claim that the integration perspective mistakes an executive's account of culture for culture itself. The differentiation perspective replaces the executive with the subculture, and the chaplain has no subculture in the hospital. The chaplain belongs to neither the nursing culture alongside which the work happens, nor medicine, nor administration, and the interfaith character of chaplaincy formation rules out acting as a delegate of a religious community either. Interfaith spiritual care is by now its own literature, and what a review of it shows is a practice defined by working across traditions rather than from inside one (Liefbroer et al., 2017). Any correction that accounts for this practitioner must therefore be located below the level of the group.

Micro-Construction: Culture Made in Interaction

Berger and Luckmann (1966) characterized the social construction of reality as a three-part dialectic. In externalization, humans produce cultural artifacts and ways of relating to them. In objectivation, these products begin to seem detached from the people who created them, as simply the way things are. In internalization, newcomers absorb these features as their own unquestioned assumptions. The dialectic assigns no role to leadership in driving it forward. All it requires is regular interaction among members, accumulating over time.

The process unfolds over time, and Weick (1995) explains how. After events occur, people make sense of them and form plausible accounts by acting on those accounts. Culture develops from such accounts over time.

Giddens (1984) gives the fullest account. Rules, resources, and taken-for-granted ways of acting are social structures that practitioners use in practice. Through action they reproduce or alter the structures available for subsequent action. Over a long tenure, such variations accumulate into structural change.

Barley (1986) showed what this looks like inside a hospital. Two radiology departments installed the same CT scanner in the same year and within months had settled into different working orders, with a different balance of authority between radiologists and

technologists in each. Barley attributed the difference to what the people around the machine did during the uncertain early weeks, such as who asked whom for help, who admitted to not knowing, and who stayed in the room, rather than to the technology itself, which was identical in both departments. The structures that formed around it were not. The analogy has limits, but a chaplain's arrival on a unit is likewise an occasion for structuring in Barley's sense, and what the unit becomes depends on what its members do with the chaplain over years of encounters.

Applied to the chaplaincy case, the three perspectives align. Nearly everything a chaplain does involves relational interaction at organizationally significant moments: after a death, during an ethically charged decision, in a conflict between the care team and the family. Chaplains are positioned within all three moments of Berger and Luckmann's dialectic, at the points where Weickian retrospective sensemaking is most active. Structuration explains what their presence does.

The literature has not asked which rules chaplains work with. They use interpretive schemes concerning relevance, that is, what counts as a consideration a clinical team is expected to weigh. They also work within norms about who may raise which subject in rounds or family meetings. Their resources are limited. They control no budget and can order nothing. What they have is access, granted by invitation, and the standing their certification and conduct in the room have earned.

They work with little, but one thing they can influence is the interpretive scheme itself. When a chaplain names the patient's fear of dying alone and the attending then takes that concern into account, the scheme for distinguishing clinical from non-clinical significance has been varied. When the same remark is received as kindness and set aside, the existing scheme has been reproduced and reinforced, because it survived the test. To alter the meaning conveyed by the decision, a chaplain need not persuade the attending to change the decision. Chaplains can influence culture simply by doing their job. Whether that influence is desirable is a separate question, and this article does not take it up.

Proposition 2. Chaplains' organizational influence lies at Schein's deepest level. A unit with a long-standing chaplaincy presence will differ from comparable units in basic assumptions about meaning, mortality, and legitimate knowledge, while remaining largely the same in espoused values and artifacts, meaning the things it would list if asked what it stands for.

The proposition faces a selection problem that should be acknowledged at the outset. The units that keep chaplains are oncology, intensive care, palliative care, and the neonatal unit. Their assumptions about mortality and meaning were already different before any chaplain arrived, which is part of why a chaplain was invited, so the causal arrow can run the other way as easily as the way proposed here. This is the reciprocal relationship noted earlier: culture conditions access, and access, if the argument is right, then conditions culture. A cross-sectional comparison of units cannot separate the two. Two designs can. The first follows a single unit across a change in chaplaincy presence, a program started, expanded, or lost to a budget cut, and asks whether basic assumptions move after the change rather than before it. The second compares matched units inside one service line, two oncology floors in the same hospital, one with a chaplain embedded in rounds and one without. Without one of these designs,

any support for the proposition would be correlational and open to the reverse explanation.

Proposition 3. Influence rests in interaction and accumulates with length of stay. A chaplain's tenure in a single unit will predict cultural influence better than seniority, credentials, or committee affiliation.

The Core Mechanism

Up to this point the argument has identified a candidate leader, a route by which that influence travels, and a level at which culture gets made. What it has not done is say how these connect. The mechanism that does the connecting is the subject of this section, along with the question of how its effects could be detected and, at the end, why culture is worth influencing in the first place.

Witnessed Repetition

The central mechanism proposed in this article is witnessed repetition. It is offered as an answer to a question that theorists of organizational culture have asked for a long time without settling: how does something that happens in one hospital room, between two or three people, become a norm for an entire unit, or for a system?

The answer starts from a term in institutional theory and then leaves it behind. Isomorphism describes how organizations come to resemble one another by imitating practices that appear to work (DiMaggio & Powell, 1983). The process described here operates on a much smaller scale and is different in kind. It takes place within a single unit and among individuals rather than organizations, and what builds up over time is a changed expectation about what belongs in a clinical encounter, not a copy of anything the chaplain did. In the terms Kozlowski and Klein (2000) use, this is compilation rather than composition, because the unit-level property emerges from encounters that differ from one another and from the whole. Witnessed repetition is the name given here to the process through which that compilation takes place.

The closest rival account is Zucker's (1977). In a series of experiments, Zucker showed that an act handed on as simply the way things are done here persists across generations of members with no one enforcing it, and that it persists more faithfully the more institutionalized the setting is. Witnessed repetition accepts Zucker's premise that culture travels through interaction rather than decree. The parting point is the question of who changes. Zucker's mechanism acts on newcomers, who accept an act as objective fact because it reaches them with no identifiable author attached. The mechanism proposed here acts on people who are already there. A nurse who has spent eleven years on the unit is not learning a new fact when watching the chaplain work. What shifts is the nurse's expectation of what a clinical encounter ought to contain, and it shifts slowly, mostly unnoticed, because the same kind of thing has happened often enough that it no longer registers as unusual. Zucker's account explains why a culture holds steady. The account offered here is concerned with how a culture changes even though its membership does not.

Consider a chaplain who pauses during a clinical handover and lets its pace slow to match the tempo of a family's existential concerns. The clinical staff who are present see this happen. When it happens month after month, and then year after year, it

gradually ceases to read as a chaplaincy intervention and comes to read as something the unit simply expects. This is how the mechanism connects the individual level to the organizational one. The claim is not merely that the chaplain is helpful. The chaplain's practice changes what the unit assumes a clinical encounter should include. Staff do not copy what the chaplain does. At first they make room for it. Later they come to defer to it, and in time some of them begin asking for it. Over a period of years the unit's basic assumptions about death, grief, and patient autonomy change, and they change without anyone having written a policy, because the repeated encounters have made this response the one that requires the least effort.

To name the mechanism is one thing; to specify it is another. Multilevel theorizing requires an account of how phenomena at one level connect with those at another, and so far the argument has asserted a relationship between levels without saying exactly how it runs. Two matters have to be settled before the mechanism can be considered specified. The first is what has to be true for a practitioner's cultural intelligence to be realized in relational practice at all. The second is what kind of level-crossing takes place in between.

The answer to the first is visibility. So long as a chaplain's cultural intelligence stays inside a dyad behind a drawn curtain, it does nothing whatever to the culture of the unit. It begins to matter when a third party watches it work. Berger and Luckmann would call this objectivation: a practice becomes the way things are done here only after it is visible to people who had no part in its origin. What allows cultural intelligence to register at the level of the unit, then, is an audience. Additional skill on the chaplain's part adds nothing if no one is there to see it.

Visibility bears on the second matter as well. Kozlowski and Klein (2000) distinguish two routes by which a lower-level property can become a higher-level one. Under composition, the unit's property is assumed to be the sum or the average of what its members hold; the content is the same at both levels and can be recovered by survey. Compilation makes no such assumption. It permits the higher-level property to arise from contributions that differ from one another and from the whole, and this is the compilation introduced above. Basic assumptions do not behave in the way composition requires. Schein's whole point about them is that they are taken for granted, and a nurse cannot report an assumption held without knowing it. The unit-level property must arise instead from a configuration of encounters that are not alike, accumulated over years and spread across staff, most of whom did not witness one another's encounters. Repetition is what aggregates them, and it does so unevenly. Nothing changes at the level of the unit until enough people have seen enough instances that a new expectation has become the default and no longer draws comment.

It follows that influence should track how visible a chaplain's encounters are rather than how many there are. Two chaplains of equal skill will leave quite different marks on a unit if one works mostly at the bedside and the other mostly in rounds and family meetings. Because a compiled property is a configuration and not a total, the same unit-level assumption can arise from quite different histories, and studies that treat chaplaincy exposure as a single dosage variable should find weaker effects than they predict (Morgeson & Hofmann, 1999). Both points refine Proposition 3. Tenure predicts influence, but only through the visibility of what accumulates over that tenure.

Why Culture Is Worth Influencing: The Outcome Evidence

Culture is among the strongest predictors of the outcomes that hospitals exist to achieve. Among the safety-related constructs, psychological safety has one of the most developed evidence bases. Edmondson (1999) defined it as a team's shared sense that it is safe to take interpersonal risks. Newman et al. (2017) distinguish it from trust: trust is what one person makes of another, whereas psychological safety is what a group takes to be its norm. Their review also finds that its antecedents are spread out. Leader behavior matters, but peer relationships and the unit's own habits matter as well, and it is this that makes the construct relevant to someone who supervises no one.

Units that foster open conversation and treat improvement as routine work report better quality metrics (Braithwaite et al., 2017). Relational nursing leadership increases patient satisfaction and reduces adverse events (Wong et al., 2013). A unit's relational norms correlate about as strongly with burnout, moral distress, and turnover as workload does (Laschinger & Leiter, 2006; Shanafelt & Noseworthy, 2017; West et al., 2018). Shanafelt et al. (2021) conclude that whether work remains meaningful in the face of suffering depends on institutional context and not on individual strength alone. The practices this literature identifies as protective, which involve finding meaning, reflecting ethically, and accompanying others through suffering, are practices that chaplains spend years developing and are trained to bring to others.

Culture grants voice to some while denying it to others. Hierarchical culture determines who speaks up and silences non-physician voices, even when the information they hold bears on outcomes (Mannion & Davies, 2018). Moral climate shapes retention and moral capacity (Fumis et al., 2017; Pauly et al., 2009). Chaplains fit uneasily within these hierarchies. Their role lets them see across the silos that keep an organization from seeing itself whole, and it leaves them belonging to none of those silos, a trade consistent with Williams's (2002) account of boundary-spanning competence as relational work done from outside the hierarchy. When chaplains persist in raising perspectives that hierarchical norms suppress, the effect goes beyond advocacy. Repeated year after year, the practice gradually weakens the assumption that the hierarchy is inevitable. This literature also suggests that leaders' emphasis on vision, hope, and altruistic love affects practitioners' experience of meaning, which in turn influences burnout and commitment (Ashmos & Duchon, 2000; Duchon & Plowman, 2005; Fry, 2003; Fry & Cohen, 2009; Gotsis & Grimani, 2017; Hunsaker, 2019; Steger et al., 2012).

Spiritual leadership theory is not integrated into this article. The omission reflects a principle rather than a judgment about the value of the tradition. It is also why Schein (1990) is included even though his structure is founder-centric, and why Cunliffe and Eriksen (2011) are included even though their cases are managers. A tradition is included when its mechanism continues to function in the absence of formal position and set aside when the mechanism depends on that position. Cultural intelligence, boundary spanning, practice, and responsiveness to others all continue to work when no one has rank, so their mechanisms are integrated. Spiritual leadership claims a causal relationship grounded in the leader's formal role, and that relationship disappears once the role is removed. The same standard applies to what this article can claim. Both Fry's and Shanafelt's effects are tested in people who stand in a supervisory relationship to those affected. That relationship may account for the effect.

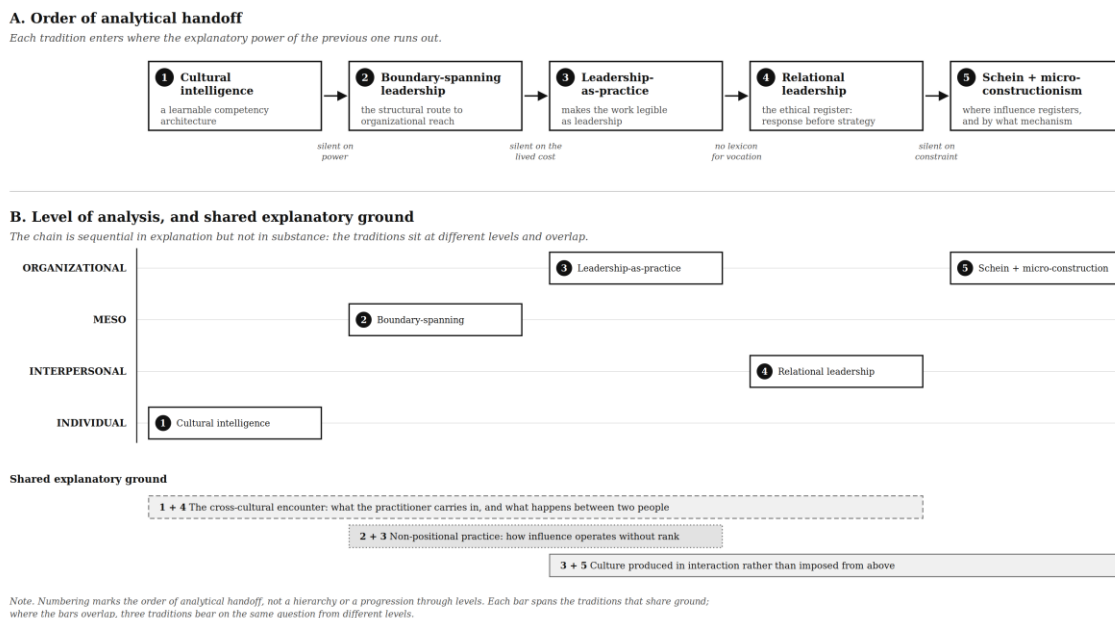
This article asks whether making meaning yields the same outcomes when the person doing it lacks authority.

Holding the Tensions

Some of the tensions among these traditions are better left open than resolved prematurely. Individual agency and structure pull against each other. In LAP's strong version, the individual disappears. Relational leadership focuses on the interaction between individuals but can neglect the organizational constraints that determine which interactions are possible at all. Keeping the theories at different levels of analysis, as Figure 1 shows, is what allows them to complement rather than duplicate one another.

Figure 1

The Five-Tradition Chain: Order of Analytical Handoff and Levels of Analysis



Source: Author's illustration (2026)

Idealized accounts of relational and boundary-spanning practice also sit awkwardly beside the settings where the practice happens. Gibeau et al. (2020) state the problem most sharply: collective leadership may be most needed exactly where it is hardest to achieve, and when it looks smoothest it may not be doing its work at all. Koonce and Hyrkäs (2023) interviewed nurses about moral distress and concluded that chaplains should be used strategically to help with it. Whether anyone helps the chaplain is a separate question, and the available evidence is not encouraging. Fantus et al. (2025) argue that institutions marginalize practitioners trained for ethical advocacy, producing cumulative distress and moral injury that are difficult to measure from outside (see also Guthrie, 2014).

A further strain runs through all five traditions, and it is methodological. Each works from the outside in, reconstructing the actor's meaning from what an observer can see rather than asking the actor. When a chaplain attends to one cue and lets another pass, or chooses not to speak for a reason colleagues cannot guess, an outside-in

theory must decide whether this is noise or evidence that the frame does not fit. Without access to the actor's account, that decision is inevitably speculative. Interpretations from outside the practice, however confident, can dismiss as random variation what was, from the inside, the most important thing the practitioner did.

What the chain describes is a distinct form of leadership: a continual relational practice of ethically responsive, culturally intelligent, boundary-spanning influence at the deepest levels of culture, achieved through accumulation rather than command. Servant and spiritual leadership both begin with a formal leader developing followers. This one does not, because its unit of analysis is practice rather than office. Generic models of informal influence assert that such influence exists; the chain specifies what it consists of.

What the Construct Is Not

Six established constructs describe adjacent territories closely enough to need separating. Meyerson and Scully (1995) named the tempered radical as the committed insider who works across conflicting value systems without positional power and sustains ambivalence rather than resolving it. Star and Strauss (1999), drawing on Strauss's studies of hospital work, traced the ecology of invisible work, the relational labor that keeps an organization running without appearing in anyone's account of it. Dutton and Ashford (1993) specified issue selling as the mechanism by which someone without authority places a concern on a senior agenda. Kellogg (2009) showed that low-power actors can produce durable institutional change in surgical services. Feldman and Pentland (2003) split the organizational routine into an ostensive aspect, the routine in principle, and a performative one, the routine as carried out on a given day, and located change in the gap between them. Bandura (1977) explained how people acquire behavior by watching others perform it.

Each of these touches something non-positional cultural leadership also touches, but none accounts for what it names. The tempered radical acts against a dominant culture on behalf of a personally held commitment; the chaplain more often has no position to advance and works instead to keep competing accounts open. Invisible work describes labor that goes unrecognized, while the claim here concerns labor that registers in a unit's assumptions whether or not anyone recognizes it, which is why witnessed repetition rather than recognition is the mechanism. Issue selling moves a discrete issue upward through a hierarchy and ends when the issue is taken up, whereas witnessed repetition works laterally, accumulates over time, and is addressed to no one in particular. Kellogg's reformers act as a mobilized cohort with shared identity and common grievances. The chaplain has none of these. The routines literature comes closest. What a unit expects a clinical encounter to contain is the ostensive aspect of a routine in Feldman and Pentland's sense, and change through repeated performance is their mechanism as much as this one. The difference is in who performs. Their performers are the routine's own participants, varying a script they are all party to. The chaplain is not a party to the clinical script. The chaplain performs alongside it, and the routine changes without any of its owners having varied it. Bandura's observers, for their part, reproduce what they have seen, whereas staff do not replicate the chaplain's act but change what they expect to happen around it. What remains, and what this construct names, is culture-making by a practitioner who works alone in structural terms, without rank, without a cohort, and without an audience that can be required to attend.

Bringing these five traditions together crosses an epistemological threshold. Cultural intelligence originated in the positivist tradition. It hands a practitioner a questionnaire and reports a score on the assumption that cross-cultural ability is a measurable individual capability (Ang & Van Dyne, 2008). LAP and relational leadership reject that, holding that leadership is co-constructed and present only while it is being done (Carroll et al., 2008; Uhl-Bien, 2006). The tension can be put to use. Cultural intelligence is what a chaplain brings into the room before knowing what to do with it, and the other two describe what becomes of it once the chaplain is in the room with someone looking back. On this reading cultural intelligence is renegotiated in each situation rather than carried as a fixed score.

Critical Frames

The mechanism proposed here has a blind spot, and identifying it alters the argument.

Standing is not distributed evenly. Crenshaw (1989) showed that disadvantage compounds where categories intersect, so that a person can be poorly served by any account treating race and gender one at a time. Yancy (2017) describes what it is to be looked at rather than seen, and what a body carries into a room before it has said anything. Ahmed (2006) makes the point in spatial terms. Institutions are oriented; some bodies arrive already aligned with what a space expects while others arrive at an angle to it, and the difference is experienced as ease or friction rather than recorded as policy. None of these authors writes about chaplains, but all three describe the conditions under which being witnessed confers standing on one person and nothing on another.

For chaplains the issue is concrete. White et al. (2021) found gendered patterns in U.S. chaplaincy board certification, where the patriarchal structures of both religious and healthcare institutions surface inside the profession's own credentialing system. Chaplains are largely formed in predominantly Christian institutions (Cadge, 2012). The chaplain is not a culturally neutral figure and does not work from a blank slate. A framework that celebrates the chaplain as a boundary-spanning cultural leader without asking who sets the terms of that leadership, and whose cultural perspective the institution actually values, misdescribes the terrain it claims to map. The chaplain's own perspective is part of that question, and it may be minoritized by race, religion, or gender.

The critical frames therefore do more than counsel caution. They identify a condition within the mechanism itself. If cultural influence accumulates through witnessed repetition, it accumulates only where what is witnessed is granted standing, and standing is distributed by the same hierarchies this literature describes. Power is thus internal to the argument, and it enters as a moderator.

Proposition 4. Institutional recognition moderates the mechanism. The influence predicted in Propositions 2 and 3 will be weaker where the chaplain's own cultural, racial, religious, or gender position is minoritized relative to a unit's dominant norms, because witnessed repetition accumulates only where what is witnessed is granted standing. Two chaplains of equal tenure and comparable practice will leave different marks on otherwise similar units, and the difference should be predictable in advance from whose cultural perspective the institution already treats as credible.

Skeptical Voices

These cautionary voices strengthen the argument by imposing discipline on it. A theory shows its value through the predictions it supports. This one predicts its own mechanism operating differently in different settings, with different histories of formation, and to varying degrees depending on whether a given unit's culture is open to change. Cadge's (2012) detailed descriptions of how chaplaincy looks in various settings are exactly what a structuration-based account would expect: the structures practitioners draw on vary from institution to institution, and so what their practice reinforces or changes varies as well. Skeptics are most useful in identifying what evidence is missing. What is missing is not more outcome studies; the phenomenon has to be described before its effects can be measured.

One counter-reading would reverse the argument outright. A critical account could hold that chaplains do not erode the hierarchy but preserve it. By absorbing moral distress that would otherwise accumulate into open conflict, the practice may relieve the very pressure that produces structural change and leave the arrangements generating that distress intact. On this reading the chaplain is a safety valve, and the deeper the chaplain's cultural influence, the more efficiently the institution is stabilized. Currie et al. (2012) describe this kind of institutional work, in which an activity that looks like accommodation turns out to maintain professional power. Nothing in the argument as stated excludes this reading.

The two readings make different predictions, and the difference is observable. If witnessed repetition works as claimed, units with long chaplaincy presence should over time show more open disagreement across professional lines, not less, because what accumulates is the standing of perspectives that hierarchical norms would otherwise suppress. The co-optation reading predicts the opposite: distress is absorbed, the surface quiets, and upward challenge decreases. Durable chaplaincy presence alongside falling rates of cross-professional challenge would falsify the account advanced here and support the co-optation reading. Cultural construction from below is seldom a quiet process. By introducing alternative value systems into the clinical decision-making space, the practitioner complicates the life of the hierarchy rather than easing it, and an institution that grows more comfortable with ambiguity, dissent, and existential friction over time is showing evidence of genuine cultural construction.

The Residual Gap and a Research Agenda

It remains to take stock. This section states what the argument contributes to global leadership theory and to the study of organizational culture, identifies the gap that remains once the five traditions have said what they can, and proposes two research programs to address it.

Theoretical Contribution

Global leadership theory comes out of this argument with a wider scope. The literature has used the national border as a proxy for cultural complexity, with the result that leadership becomes global only when someone crosses a frontier. If the proxy is replaced by the condition it stood in for, the field's competency apparatus becomes applicable wherever cultural complexity is dense, including an intensive care unit

staffed by people who will never work abroad. The border began as a convenient sampling criterion and hardened into a definition.

Organizational culture theory needs a correction of a different kind. Schein's architecture is persuasive about the layers of culture and less so about who produces them. Reading those layers through Berger and Luckmann, Weick, and Giddens moves cultural agency from position to interaction. This shift is what allows a practitioner with no rank to be understood as a producer of culture as well as a recipient of it.

The third contribution is the construct itself. Non-positional cultural leadership names a practice that neither literature has been able to see. It specifies the mechanism through which the practice operates, witnessed repetition, and in doing so makes audience rather than skill the condition of any unit-level effect. It also yields four propositions that can be tested and falsified if the mechanism is wrong.

What the five traditions cannot do is another matter. Even assembled and corrected, they share a limitation: each does genuine analytical work, and none reaches first-person experience. Each has its particular limit, such as the secular gap in leadership-as-practice or the inattention to power in cultural intelligence, and together those limits mark a single boundary between third-person theory and the lived experience of the practitioner.

This absence is neither a defect in the argument nor a finding in its own right. It marks a boundary. No one has yet written what it is like, in Nagel's (1974) sense, to be a practitioner with cultural influence at the margins of a multicultural healthcare organization. The silence follows from the nature of the traditions themselves, which between them exhaust what third-person theory can say. Beyond that point, phenomenological description has to take over.

A Research Agenda

This diagnosis calls for two research programs running in parallel, of which first-person description is the more urgent.

Descriptive phenomenology in the Husserlian sense is the appropriate method here. It asks the researcher to bracket all personal preconceptions and to treat experience itself as the primary text (Moustakas, 1994), and that discipline is needed for a phenomenon whose most important expressions, such as the cue attended to and the silence held, cannot be seen by outcome-based assessment at all.

In such descriptions the five traditions should serve as sensitizing concepts in Blumer's (1954) sense. They are ways of noticing what might turn out to matter in a practitioner's account, and they should not be turned into coding categories into which those accounts are sorted. The critical frames work in the same way. They direct attention to how practitioners handle cultural difference and to the uneven recognition an institution gives to different cultural perspectives, the practitioner's own among them.

Some of what such descriptions would need to capture can be specified now, before any interview is conducted, and doing so keeps the method honest, since the targets are named before the inquiry begins rather than after. Four of them stand out. The first

is the moment when a practitioner decides not to speak, together with what that practitioner weighs in reaching the decision. The second is the cue attended to when the room presents several at once. A third is the cost of holding a position that no one else in the room shares. The last, and perhaps the hardest to get at, is how the practitioner knows, if at all, that anything done carried beyond the doorway. All four are drawn from the literature and not from observation, and they should be understood as targets for the method rather than as evidence that the phenomenon exists.

At least one such description now exists. Tyohemba (2026) conducted a descriptive phenomenological study with twelve board-certified chaplains working in U.S. hospitals, asking how they had experienced influencing organizational culture in multicultural settings. Leadership and culture theories served as sensitizing concepts, much as proposed above. The chaplains who took part described an authority that came from encounter rather than from position, and a trust that had built up over years until the unit came to treat it as a resource it could draw on. One study settles very little, and that study was not designed to test the propositions set out here. What it does establish is that the phenomenon can be described in practitioners' own words, and it supplies a first set of accounts against which the four targets above can be checked.

Measurement Framework

The propositions call for a second program of work, and here the difficulty is practical. The instruments needed to test them have not been built. A tally of chaplain visits, which is what most departments already keep, will not capture anything described in this article, since what produces the effect is an encounter that somebody else saw, and a visit log records only that a service was delivered. What follows are three measures that might serve as a beginning. Their status should be stated plainly. None has been validated. Each is a candidate indicator that a research team would need to refine, pilot, and probably revise before it could bear any weight. Still, each connects to a specific proposition. The Silence-Fill Threshold and the Inquiry Pivot look for behavioral evidence of the change in basic assumptions that Proposition 2 predicts, and if the argument is right, both should grow stronger as a chaplain's visible tenure lengthens (Proposition 3) and grow weaker on units where the chaplain's standing has been minoritized (Proposition 4). Existential Lexicon Density asks a different question: whether the change has spread to staff who were never in the room when the originating encounters took place. Compilation predicts that it should.

The Silence-Fill Threshold

Anyone who has sat in a family meeting knows what happens when a patient asks whether dying will hurt, or whether a life amounted to anything. There is a pause, and someone fills it. On a unit where a chaplain is new, the person who fills it is usually a clinician, and the filling is nearly reflexive: a reassurance, a change of subject, a return to the care plan. On a unit where a chaplain has been present and visible for years, the pattern reverses. Clinicians let the pause stand. They have learned that the silence is doing something, and they wait for the chaplain to indicate when the conversation can move on. The point at which this reversal occurs is what the measure would try to locate.

The Inquiry Pivot

The second indicator concerns who initiates. Early on, if an existential perspective enters a clinical conversation at all, it enters because the chaplain put it there. Later, and this is the pivot, the attending or the charge nurse turns to the chaplain and asks. The question may be as brief as "Anything from your side?" but it signals that the clinical lead now expects the perspective to be present and has taken responsibility for calling for it. When insertion has given way to solicitation, a new assumption about what the encounter should contain has, in all likelihood, taken hold.

Existential Lexicon Density

The third indicator is the least direct and, for that reason, perhaps the most telling. It tracks how often words such as hope, legacy, narrative, and dignity appear in the ordinary speech of staff during routine rounds, in conversations where no chaplain is present. Nurses and residents who were never in the room for any of the originating encounters may nonetheless begin to use this vocabulary, and when they do, something has traveled. A visit count would show nothing here. A rising frequency of these terms among people who did not witness the encounters would be the closest thing to a direct observation of compilation that the argument allows.

Conclusion

The oversight this article has tried to correct is an old one, and it is easy to see why it has persisted. Organizational studies has looked for cultural leadership where organizations say it resides, in the offices of those with authority to set direction, and a practitioner who holds no such office, belongs to no clinical profession, and moves among competing cultural worlds within a single building was never going to appear in that field of view. The argument here has taken five bodies of theory in turn, cultural intelligence, boundary spanning, leadership-as-practice, relational leadership, and micro-constructionism, and used them to build a model in which cultural influence emerges from relational practice that is kept up over long periods and carried out where colleagues can see it. Hospital chaplains were the case, but they need not be the only one. Any organization that distributes its work across professional boundaries has someone in the non-positional boundary-spanning role, and that person's importance is poorly represented by the organization chart. Studying such roles means studying leadership in complex systems as it is actually distributed rather than as it is formally assigned. A theory of leadership that confines itself to formal positions will go on overlooking the people who negotiate an institution's underlying assumptions every day. Critical scholarship, for its part, would find more of interest if it looked past official agendas to the patterns of practice that take shape in the spaces between roles.

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