

**AN EXPLORATION OF HOW NURSES CONSTRUCT THEIR  
LEADERSHIP ROLE DURING THE PROVISION OF HEALTH CARE**

Submitted by

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## **STATEMENT OF AUTHORSHIP AND SOURCES**

This thesis contains no material published elsewhere or extracted in whole or in part from a thesis by which I have qualified for or been awarded another degree or diploma.

No other person's work has been used without due acknowledgment in the text of the thesis.

This thesis has not been submitted for the award of any degree or diploma in any other tertiary institution.

All research procedures reported in the thesis received the approval of the relevant Ethics Committee (Appendix 1).

Signed:\_\_\_\_\_ Date:\_\_\_\_\_

Yvonne Therese OSBORNE

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## **ABSTRACT**

This research explores how registered nurses constructed their leadership role during the provision of health care services in acute care, adult hospitals in Brisbane, Queensland, Australia.

As health care organizations change to meet the demands of the twenty first century, nurses in Australia are coming to realize there is a dissonance between what they perceive to be the relevance of their work and the perception of the relevance of nurses' work by others in the health care system. Consequently, nurses' contributions to health care services are not recognized. The literature highlights that one way to address this problem is to articulate the various leadership roles contemporary nurses are asked to undertake. This is the aim of this thesis.

This research seeks to illuminate the role of the nurse within changing health care systems by making clear the nature of their work through the perspectives of leadership. Consequently, the purpose of this study is to explore how nurses have undertaken leadership initiatives in their role as health care providers within contemporary health care organisations. The literature review generated following research questions:

1. How do nurses describe leadership within their health care organisations?
2. How do nurses experience leadership within their health care team?
3. How do nurses construct their leadership role whilst providing health care services?

In order to legitimate its findings this study aimed to provide a clear theoretical framework. In order to gain a clear understanding of the personal experiences and meanings of the participants, the theoretical framework for this study was underpinned by the interpretive philosophies the epistemological framework of constructionism and the theoretical perspective of symbolic interactionism. The methodology of case study enabled an empirical investigation of a contemporary nursing phenomenon, leadership wherein the researcher was able to pose questions to those nurses from whom most could be learned. Data were collected through two

stages. In stage one, the exploratory stage data was collected through three focus group interviews. Stage two aided deeper exploration of the nurses' leadership constructs with data obtained through one-to-one interviews. Analysis of the data enabled the development of a model of nurse leadership.

Participants identified that their leadership was constructed through three perspectives of Self as Leader, Self and Others and Self in Action. The findings contrast the nurses' unique leadership constructs to those of health care organisations, highlight the lack of acknowledgment for nurse leadership within health care teams, and demonstrate how the nurses' leadership constructs influence their decision to act in the provision of patient care. This study concludes that as the nurses come to realise traditional leadership models are incompatible with their goal of achieving patient centred care, they have developed a different style of leadership to achieve their vision of patient centred care.

Finally this study offers recommendations in the areas of nursing practice, nursing education and research.

## **GLOSSARY OF TERMS**

### **Level 1 Nurse**

- The Registered Nurse is appointed to the position of first level nurse who is licensed to practice nursing without supervision and who assumes accountability and responsibility for their own actions and acts to rectify unsafe nursing practice and/or unprofessional conduct. It is essential that the nurse is registered by the Queensland Nursing Council and holds a current practising certificate.
- The degree of expertise will increase as the Registered Nurse advances through this level.
- The Nurse may be a beginning practitioner or a Registered Nurse returning to the field after a period of absence.

### **Level 2 Nurse**

- The Registered Nurse is appointed to the position of Clinical Nurse. The Nurse assumes accountability and responsibility for own actions and acts to rectify unsafe practice and/or unprofessional conduct.
- The Nurse is responsible for a specific client population, and is able to function in more complex situations while providing support and direction to Level 1 Nurses and other non nursing personnel.
- The Nurse identifies, selects, implements and evaluates nursing interventions that have less predictable outcomes.

### **Level 3 Nurse**

- The Registered Nurse is appointed to the position of Clinical Nurse Consultant.
- The Nurse is a proficient practitioner who is accountable for the coordination of standards of care delivered in a specific patient/client area.

- The Nurse collaborates with the Nurse Manager, Nurse Educator and Nurse Researcher to facilitate the provision of cost effective care.
- The Nurse demonstrates advance level skills and leadership qualities and fulfils the function of change agent, role model, patient/client educator and action researcher.
- The Nurse has the authority to coordinate care for one patient/client and assumes accountability and responsibility for own actions and acts to rectify unsafe practice and /or unprofessional conduct.

(Summarised from Queensland Nurses' Union of Employees Federal Award, 2004)

# TABLE OF CONTENTS

STATEMENT OF AUTHORSHIP AND SOURCES	II
ACKNOWLEDGMENTS	III
ABSTRACT	IV
GLOSSARY OF TERMS	VI
TABLE OF CONTENTS	VIII
LIST OF TABLES AND FIGURES	XII
CHAPTER 1: IDENTIFYING THE RESEARCH PROBLEM	1
1.1 INTRODUCTION	1
1.2 THE RESEARCH CONTEXT	1
1.3 THE RESEARCH PROBLEM AND PURPOSE	4
1.4 THE RESEARCH QUESTIONS	5
1.5 SIGNIFICANCE OF THE RESEARCH	6
1.6 THE RESEARCH DESIGN	7
1.7 LIMITATIONS OF THE RESEARCH	9
1.7.1 Delimitations of Study	9
1.8 OUTLINE OF THE THESIS	10
CHAPTER 2: DEFINING THE RESEARCH PROBLEM	13
2.1 INTRODUCTION	13
2.2 NURSES' WORK	14
2.3 HEALTH CARE REFORMS	15
2.4 CONSEQUENCES OF HEALTH CARE REFORMS FOR NURSES	16
2.5 NURSES' RESPONSES TO HEALTH CARE REFORMS	17
2.6 PROBLEM	20
CHAPTER 3: LITERATURE REVIEW	21
3.1 INTRODUCTION	21
3.1.1 Purpose of the Research	21
3.1.2 Conceptual Framework for Literature Review	22
3.1.3 Sequence of the Literature Review	26



<b>3.2</b>	<b>CHANGING WORLD VIEWS</b>	<b>27</b>
3.2.1	Industrial to Post Industrial Views of Organisations	27
3.2.2	Changing Organisational Theories	28
3.2.3	Changing Organisations	30
3.2.4	Nursing in Contemporary Health Care Organisations	31
<b>3.3</b>	<b>TENSIONS AND ORGANISATIONAL CHANGE</b>	<b>33</b>
3.3.1	Organisational versus Personal Values	33
3.3.2	Implications for Organisational Leadership	35
3.3.3	Nurses' Vision, Work, Values and Leadership	36
3.3.4	Development of Informal Leadership and Groups	39
<b>3.4</b>	<b>LEADERSHIP FOR A CHANGING WORLD</b>	<b>41</b>
3.4.1	Evolving Leadership Perspectives	42
3.4.2	Moving Towards a Post Industrial Leadership Paradigm	44
3.4.3	New Leadership	46
3.4.4	Nurse Leadership	48
<b>3.5</b>	<b>CONCEPTUALISATION OF NURSE LEADERSHIP</b>	<b>52</b>
<b>3.6</b>	<b>CONCLUSION</b>	<b>58</b>
<b>CHAPTER 4:</b>	<b>DESIGN OF THE RESEARCH</b>	<b>63</b>
<b>4.1</b>	<b>INTRODUCTION TO DESIGN OF THE RESEARCH</b>	<b>63</b>
<b>4.2</b>	<b>THEORETICAL FRAMEWORK</b>	<b>65</b>
4.2.1	Epistemology: Constructionism	65
4.2.2	Theoretical Perspective: Symbolic Interactionism	68
<b>4.3</b>	<b>RESEARCH METHODOLOGY: CASE STUDY</b>	<b>70</b>
<b>4.4</b>	<b>PARTICIPANTS</b>	<b>73</b>
4.4.1	Selection of Participants	73
4.4.2	Demographic Details	75
4.4.3	Coding for Participants	77
<b>4.5</b>	<b>DATA COLLECTION</b>	<b>78</b>
4.5.1	Interviews	79
4.5.2	Stage 1 Exploration: Focus Group Interviews	80
4.5.3	Stage Two Inspection: One to One, Semi-Structured Interviews	83
4.5.4	Data Collection Sequence	85
<b>4.6</b>	<b>DATA ANALYSIS</b>	<b>86</b>
4.6.1	Organising of Data	87
4.6.2	Analysis of the Data	90
4.6.3	Interpreting the Data	91
<b>4.7</b>	<b>ROLE OF THE RESEARCHER</b>	<b>94</b>
<b>4.8</b>	<b>RIGOUR</b>	<b>95</b>
4.8.1	Credibility	96
4.8.2	Dependability	97
4.8.3	Confirmability	97
4.8.4	Transferability	97
4.8.5	Assessment Framework for Rigour	97
<b>4.9</b>	<b>ETHICAL CONSIDERATIONS</b>	<b>99</b>
<b>4.10</b>	<b>SUMMARY OF RESEARCH DESIGN</b>	<b>100</b>

<b>CHAPTER 5: FINDINGS</b>	<b>103</b>
<b>5.1 INTRODUCTION</b>	<b>103</b>
<b>5.2 RESEARCH QUESTION 1</b>	<b>104</b>
5.2.1 Leadership is Hierarchical	104
5.2.2 Personal Leadership Values versus Organisational Leadership Values	106
5.2.3 Recognising Organisational Barriers to Leadership Initiatives	107
5.2.4 Recognising Leadership Opportunities in Changing Organisations	110
5.2.5 Taking Leadership Initiatives within the Organisation	111
5.2.6 Being Aware of How and When to Act as a Nurse Leader	112
5.2.7 Conceptualisation of Themes from Research Question 1	113
<b>5.3 RESEARCH QUESTION 2</b>	<b>114</b>
5.3.1 Developing a Leadership Mindset	114
5.3.2 Selecting Appropriate Leadership Role Models	115
5.3.3 Knowing when to take Leadership Initiative within the Team	116
5.3.4 Recognising Leadership Responsibility	117
5.3.5 Developing the Health Care Team	118
5.3.6 Creating Working Relationships	120
5.3.7 Leading by Sharing and Stepping Back	123
5.3.8 Leadership Visible to Self, Invisible to Others	124
5.3.9 Influencing Others	126
5.3.10 Conceptualisation of Findings from Research Question 2	127
<b>5.4 RESEARCH QUESTION 3</b>	<b>129</b>
5.4.1 Leadership has no Specific Definition	129
5.4.2 Being Aware of own Leadership Potential	130
5.4.3 Leadership is being Open to Learning Opportunities	132
5.4.4 Acting on Behalf of Others	134
5.4.5 Recognising One's own Leadership Attributes	136
5.4.6 Conceptualisation of Findings from Research Question 3	138
<b>5.5 RECONCEPTUALISATION OF THE DATA</b>	<b>140</b>
5.5.1 Self as Leader	141
5.5.2 Self in Relation to Others	142
5.5.3 Self as Leader in Action	144
<b>5.6 CONCLUSION</b>	<b>145</b>
<b>CHAPTER 6: DISCUSSION OF FINDINGS</b>	<b>146</b>
<b>6.1 INTRODUCTION</b>	<b>146</b>
<b>6.2 SELF AS LEADER</b>	<b>147</b>
6.2.1 Leadership is Recognising One's own Attributes	147
6.2.2 Summary	158
<b>6.3 SELF IN RELATION TO OTHERS</b>	<b>158</b>
6.3.1 Leadership is Influencing Others	158
6.3.2 Summary	170
<b>6.4 SELF AS LEADER IN ACTION</b>	<b>171</b>
6.4.1 Leadership is Knowing when to Act	171
6.4.2 Summary	182
<b>6.5 A MODEL OF NURSE LEADERSHIP</b>	<b>183</b>
<b>6.6 CONCLUSION</b>	<b>185</b>
<b>CHAPTER 7: CONCLUSION AND RECOMMENDATIONS</b>	<b>186</b>

<b>7.1</b>	<b>INTRODUCTION</b>	<b>186</b>
<b>7.2</b>	<b>THE PURPOSE OF THE STUDY</b>	<b>186</b>
<b>7.3</b>	<b>RESEARCH DESIGN</b>	Error! Bookmark not defined.
<b>7.4</b>	<b>RESEARCH QUESTIONS ADDRESSED</b>	<b>188</b>
7.4.1	Research Question 1	188
7.4.2	Research Question 2	189
7.4.3	Research Question 3	191
<b>7.5</b>	<b>CONCLUSIONS OF THE STUDY</b>	<b>192</b>
<b>7.6</b>	<b>RECOMMENDATIONS</b>	<b>198</b>
7.6.1	Nursing Practice	198
7.6.2	Nursing Education	199
7.6.3	Research	199
<b>7.7</b>	<b>PERSONAL POSTSCRIPT</b>	<b>200</b>
	<b>APPENDIX 1</b>	<b>202</b>
	<b>APPENDIX 2</b>	<b>205</b>
	<b>APPENDIX 3</b>	<b>208</b>
	<b>APPENDIX 4</b>	<b>210</b>
	<b>BIBLIOGRAPHY</b>	<b>213</b>

## **LIST OF TABLES**

Table 3.1	Sequence of the Literature Review	26
Table 3.2	Comparison of Leadership Perspectives	41
Table 4.1	Interpretive Research Design	64
Table 4.2	Criteria for Case Selection	74
Table 4.3	Participant Demographics	76
Table 4.4	Data Collection and Analysis Stages	78
Table 4.5	Overcoming Limitations of Focus groups	83
Table 4.6	Data Selection Sequence	85
Table 4.7	List of Emerging Themes and Sub themes from Focus Group Interviews	88
Table 4.8	Initial Framework for Data Write Up Following One to One Interviews	89
Table 4.9	Themes for the Findings Chapter	94
Table 4.10	Summary of Trustworthiness Assessment by Reseachar	98
Table 4.11	Summary of Research Design	101
Table 5.1	Key Themes from Data Analysis	103
Table 5.2	Nurse Leadership	141

## **LIST OF FIGURES**

Figure 3.1	Conceptualisation of the Literature	24
Figure 3.2	Conceptualisation of Nurse Leadership	53
Figure 3.3	Development of Research Questions from the Literature Review	61
Figure 4.1	Overview of Research Design for the Study	65
Figure 4.2	Stages of Data Collection	80
Figure 5.1	Conceptualisation of Themes from Research Question 1	114
Figure 5.2	Conceptualisation of Findings from Research Question 2	129
Figure 5.3	Conceptualisation of Findings from Research Question 3	139
Figure 6.1	A Model for Nurse Leadership:	183

# **CHAPTER 1: IDENTIFYING THE RESEARCH PROBLEM**

This introductory chapter provides a preamble to the thesis by considering several important areas in nursing and leadership within the Australian health care system. Initially, the context within which the study took place is identified, the research problem is defined, the purpose of the research study is presented and the research questions that govern the study are displayed. Furthermore, the significance of this research is explicated and its limitations acknowledged. The research design is then outlined. Finally this section provides a chapter by chapter outline of the whole thesis.

## **1.1 INTRODUCTION**

This thesis concerns nursing and leadership provided by nurses in the Australian health care context. Nursing was established over 150 years ago and currently provides the largest group of employees in the health care sector. Despite its presence in the Australian health care system, nursing is still overlooked in health policy development and workforce calculations. Consequently, the shortages of nurses in all areas of health care services that has been threatening for years has now reached crisis point (Senate Community Affairs Reference Committee, 2002). Therefore, it is proposed that if nurses are to be retained or recruited into the health care workforce their contributions to health care services need to be recognised and valued by those other than nurses.

## **1.2 THE RESEARCH CONTEXT**

The nature of nurses' work is largely determined by the context in which nursing takes place and described in terms of nursing practice (Queensland Nursing Council, 2005). Over last 10-20 years there has been significant work intensification within the Australian health care system. This has been evidenced by decreased length of stay, increased throughput and an increase in the level of patient acuity (Queensland Nurses' Union of Employees, 2005). Consequently, as the role of the nurse expands so too does the scope of nurses' work as nurses rise to meet the challenges of health care in the 21<sup>st</sup> century. Additionally, increasing reliance on technology requires

nurses to remain informed and educated on health care innovations in order to keep the patients safe both physically and ethically.

Within this context, nurses have raised concerns about the quality of health care delivery and increased pressures of work (Corey-Lisle, Tarzian, Cohen, & Trinkhoff, 1999; Oulton, 2000). Yet as the voices of nurses are failing to be heard by those other than nurses, it is not surprising that nurses are leaving the health care system (Queensland Nurses' Union of Employees, 2005). The attrition of nurses at all levels, is attributed to the loss of patience by nurses who are choosing to seek better salaries and working conditions, retire or select another field of work (Senate Community Affairs References Committee, 2002). Additionally the numbers entering nursing schools have decreased, with a quarter of the nursing workforce retiring in this next decade (Queensland Nurses' Union of Employees, 2005). More significantly, people are not choosing nursing as a career option (Oulton, 2000). Overall, these factors contribute to a national and global shortage of nurses (Hegney, Plank, Buikstra, Parker, & Eley, 2005; Oulton, 2000; Prescott, 2000).

In order to raise the profile of nursing and make it an attractive career option there is a need to articulate its value in the health care system by clearly identifying the contributions nurses make. The ability to clearly articulate nurses' contributions presents a problem, as the nature of nurses' work is multi dimensional, inter relational and complex. This complexity makes it difficult to articulate the value of nursing in a language that is clearly understood by all key stakeholders (Senate Community Affairs Reference Committee, 2002). Furthermore, the meaning about who can legitimately hold the title 'nurse' contributes to the confusion of who is a nurse. Unlike other professions who have one entry point, nursing has three entry levels defined by educational merit – Registered Nurse (undergraduate degree level and regulated), Enrolled Nurses (diploma level and regulated), Assistant in Nursing (no formal education and unregulated) (Gleeson, 1998; Queensland Nursing Council, 2005). Each level of nurse has different levels of responsibility, association and scope of practice within the health care system (Queensland Nursing Council).

Along with the multiple entry levels, nursing is further fragmented by variations on scope of practice, narrow specialties defined by medical categories and leaders educated in other disciplines (Cody, 2000; Pratt, 1994). Additionally, the least (and

cheapest) prepared nurses are increasing in numbers. It is from this cohort that the public and media, being unable to discriminate, often form their opinions of nursing (Borbasi, 1999; Christman, 1998). They cannot appreciate what nurses, with tertiary qualifications, do in terms of incredibly demanding, intellectual, physical and emotional hard work that is the reality of today's knowledge based, high technology, rapid throughput, high intensity health care environments (Fralic, 1999, Queensland Nurses' Union of Employees, 2005). Primarily, these nurses seek to care for and improve the health status of communities they serve regardless of the direction of socio-political, economic, and cultural forces that delineate practice (Jackson, 1995).

Nursing brings with it a history of responding to the changing health care needs of society (Hawkins & Bellig, 2000). Over several decades of change, nurses' roles have gradually evolved as nursing developed and refined its practice, education and research (Hawkins & Bellig, Porter-O'Grady, 1999). More recently, observations of nursing practice have highlighted evidence of nurse leadership within interdisciplinary teams in contemporary health care organisations (Scott, Sochalski, & Aiken, 1999).

In order to gain a higher profile and independence in practice so as to achieve their goals of health care, nurses need to look at explicating their leadership practices (Cook, 2001a, Graham, 2003). It has been suggested that by focusing on the nurses' leadership role during health care provision, nursing's contribution to health care can become visible (Graham). Ultimately, articulation of nursing practice through a leadership perspective could create a clearer understanding of the value of nursing within the health care system and influence recruitment and retention of nurses in the workplace (Greenwood, 1999).

If nurses are to survive in a health care system that fails to recognise nursing's contribution, nurses need to communicate clearer, common understandings of their leadership among professional groups. The challenge for the nursing profession is therefore, to produce nurse leaders who can develop people with vision and entrepreneurial capability so that they can improve health care and meet the needs of a rapidly transforming health care system (Fralic, 1999; Velsor-Friedrich & Ferguson, 1999).

In the light of changing health care organisations, new models of care and new models for education are required to promote new leaders in new contexts. It is within this context, that nurses have the opportunity to take a shared leadership position within the interdisciplinary health care teams, (Fralic, 1999). As they take their positions within interdisciplinary teams, nurses leaders need to exhibit leadership qualities that are enduring, success oriented in any situation, and develop aspirations beyond traditional boundaries (Malone, 2000; Oulton, 2000). It is anticipated that these leadership qualities will enhance the visibility of nursing and move the profession creatively through continued change. In support of development of nurses as leaders, recent reviews of nursing education highlight the importance of incorporating nurse leadership within curricula, so as to develop leaders who are competent, successful, persuasive and influential in the integration of health care services (Queensland Nursing Council, 2005).

### **1.3 THE RESEARCH PROBLEM AND PURPOSE**

The initiative for this study arose from personal observations of nurses in their practice settings. Personal observations as a practising nurse, nurse educator and researcher have demonstrated that nurses working at all levels of health care organisations were often excluded from decision making by other health care professionals, health administrators, policy makers and consumers. Given recent developments in nurse education and research initiatives undertaken in response to changing health care systems and consumer expectations, this failure to recognise the nurse as an equal partner in health care decisions is concerning. In order to investigate this phenomenon further, an exploration of recent nursing literature that examined nurses' work was undertaken. Overall, the literature highlighted that despite nurses' actions to undertake leadership initiatives within changing health care organisations, the relevance of nurses' work continued to be unrecognised by others (Chiarella, 2000; Tourangeau, 2003; Wynne, 2003).

Review of the literature relating to the context within which nurses' practised revealed the problem underpinning this study. The problem was identified as a dissonance between what nurses' perceive to be the relevance of their work and the perception of the relevance of nurses' work by others in the health care system (Chiarella, 2000). Consequently, this study suggests that one way of addressing this problem is



to articulate the various leadership roles contemporary nurses undertake within their daily practice.

Therefore the purpose of this study is to explore how nurses have undertaken leadership initiatives in their role as health care providers within contemporary health care organisations. In order to enact the purpose of this study and manage its scope, exploration will focus upon how nurses construct their leadership role during the provision of health care services.

#### **1.4 THE RESEARCH QUESTIONS**

An extensive literature review developed a conceptual framework for the study (see section 3.1.2). The conceptual framework evolved during the dialectical process of synthesising the literature in the light of the research purpose. Synthesis of the literature generated three themes that served as the foundation for examination of nurse leadership within the context of health care services. Each theme was used to explore the nursing perspective and develop research questions that assisted in focussing the conduct of this study. The themes are as follows::

- Changing World Views,
- Tensions and Organisational Change and,
- New Leadership.

Whilst amplifying and revealing the research problem, the literature review also generated three research questions. These research questions are articulated below:

1. How do nurses describe leadership within their health care organisations?

This question provided an opportunity for the nurses to describe leadership within their own organisations. The question acknowledged that the nurses were working within changing health care organisations and provided an opportunity to explore whether the nurses identified whether their leadership initiatives were recognised by the organisation. Furthermore, it enabled them to draw on their perceptions of leadership and how these related to their practice. Consequently, the nurses were encouraged to reflect upon their own role as leaders within the organisation.

2. How do nurses experience leadership within their health care team?

This question considered the way in which the nurses described their role in health care teams. In particular, it focussed on how they experienced leadership when working in health care teams.

3. How do nurses construct their leadership role whilst providing health care services?

This question aimed to elicit the nurses' personal leadership meanings, so as to gain an understanding of what it was that they perceived leadership to be. Overall, the nurses' responses to this question clarified some of the leadership constructs that had developed in their response to other questions. This question enabled a personal meaning of leadership to become obvious.

## **1.5 SIGNIFICANCE OF THE RESEARCH**

This study is important because it intends to extend both practical and theoretical knowledge on nursing leadership. Firstly, insights gained from this study have the potential to contribute to professional knowledge of nurses at all levels of health care services as well as offering new methods for explicating the nature and value of nurses' work through contemporary leadership perspectives. It is intended that the findings of this study influence current job evaluation methodologies that in the past have failed to adequately identify and measure the full range of skills employed by nurses in their work (Queensland Nurses Union of Employees, 2005).

Secondly, the need for this study is determined by the lack of clear theoretical frameworks for previous inquiries about nurses' leadership roles during the provision of health care services. Patterns of inquiry into nurse leadership have been influenced by traditional images of nurses and utilised the mechanisms of traditional managerial leadership theories from the industrial paradigm. Additionally, like other studies of leadership, exploration of nurse leadership has been reported from the etic perspective of the researcher rather than the emic perspective of the participant (Ribbins & Gunther, 2002). Consequently, this research aimed to address this

lacuna in the literature by seeking to understand how the nurses constructed their meanings of leadership during the provision of health care services.

Thirdly, for most of the 20<sup>th</sup> century, leadership had been described in terms that have been meaningful and exclusive to disciplinary and positional specificity rather than to the individual (Rost, 1991; Ribbins & Gunter, 2002; Yukl, 2002). This study intends to challenge the traditional view of leadership through which nursing is viewed and explicate a model of leadership that provides both etic and emic perspectives of leadership.

Finally, this study will add to the growing body of contemporary leadership literature. Reflection on the continually changing focus of leadership studies and consequent theory development has highlighted that the phenomenon of leadership continues to be an evolving and elusive concept (Mello, 1999). As a result "...we do not as yet have any consistent or reliable leadership theories...At best, we have divergent views that may eventually be shaped into theories that are testable" (Onsman, 2002, p. 25). In the light of this statement, the timeliness of this study is supported by changes in contemporary health care organisations where there is evidence of a shift from the solo model of leadership to leadership which is discussed in terms of relationship with others (Popper, 2004; Rost, 1991).

## **1.6 THE RESEARCH DESIGN**

Given the purpose of this study, an interpretive design was adopted to explore how the nurses who were participants of the research had undertaken leadership initiatives in their role as health care providers within contemporary health care organisations. Because of the inter relational nature of nurses' work, the interpretive paradigm enabled the researcher to acknowledge that concepts of reality are constructs of the human mind and could, therefore vary from one person to another and that descriptions of human actions were based on social meanings (Bassey, 1999). In addition, choice of interpretive design, presented the study with its epistemological underpinning of constructionism and theoretical perspective of symbolic interactionism. These were the research orientations that guided this study (Crotty, 1998).

In order to elicit the participants' individual, personal constructions of leadership and gain understanding of their meaning of leadership from their lived experiences, constructionism was used (Peters, 2000). Constructionism enabled understanding of the nurses' reality as "it is internally experienced, socially constructed and interpreted" through them (Sarantakos, 1998, p. 36). Through use of constructionism as an epistemology, the researcher could accept that each of the nurses' way of making sense of the world was seen as valid and worthy of respect as any other (Crotty, 1998). Because constructionism provided an opportunity to gain an understanding of the human drive (the nurses' motivation to act as leader) which actively created and constructed meaning, the researcher was able to give intellectual significance to the nurses' life experiences (Crotty, 1998; D'Andrea, 2000; Holloway, 1999;).

Symbolic interactionism formed the theoretical perspective through which data analysis was conducted because, for the nurses who practised within health care teams, the meaning of nurse leadership was reliant upon social interactions which influenced the way the nurses constructed their leadership meanings (Cossette, 1998). Furthermore, nursing is recognised as a socially interactive process with nurses engaged in thoughtful, self-reflexive behaviour, so that they can interpret the world they are confronted with (Schwandt, 1998). Therefore, symbolic interactionism enabled the researcher to gain a deeper understanding of nurse leadership from the naturally socially interactive situations the nurses described (Longmore, 1998). It was the nurses' subjectively constructed meanings of leadership within interactive situations that were the object of interest of this study (Cossette, 1998).

The methodology of case study enabled empirical investigation of nurse leadership, in contemporary health care settings, wherein the researcher was able to pose questions to those nurses from whom most could be learned (Merriam, 1998; Yin 1994). The case was bounded by research questions that focussed upon the nurses' construction of leadership during their provision of health care services. Furthermore case as a bounded system, guided participant selection of nurses who provided health care services in acute, adult public and private health care settings in Brisbane, Queensland. Data were collected through three focus groups (n=4,6,6) and six one-to-one interviews.

All participants were purposively selected based on criteria established for the case (Table 4.2). Purposive selection allowed the researcher to gain access to nurses who were most likely to be information-rich with respect to the purpose of the study. The nurses were all registered in the state of Queensland and directly provided care. A total of 22 registered nurses were interviewed. The registered nurses cohort exemplified three levels of their organisational structure. This group of nurses comprised the largest percentage of the health care workforce with their educational background and positions affording them opportunities to undertake leadership roles. In addition, this group of nurses has been the most widely studied. Data were collected and analysed contemporaneously from May 2002 to March 2003.

## **1.7 LIMITATIONS OF THE RESEARCH**

This study explored how twenty two nurses undertook leadership initiatives as health care providers within contemporary health care organisations in acute care, adult public and private health care settings in Brisbane, Queensland. It is acknowledged that the qualitative nature of this study means that its findings can only be accepted for the group under study at a point in time. Accordingly, recognition is given to the limitations of case study methodology when it comes to transferability to other groups or contexts (Stake, 1995). However, the purposively selected participants of this study provided sufficient rich, thick descriptions of the phenomena of leadership so that readers will be able determine how closely their situations match the research situation (Merriam, 1998). Therefore each reader will apply their own limitations through a process of engaging with the discussions presented, applying their own understanding and perhaps through a “vicarious experience” (Stake, 1995, p. 87) make generalisations through case to case transfer.

### **1.7.1 Delimitations of Study**

This study employed an interpretive approach to gain an understanding of each nurses’ meaning of leadership as it was constructed by them within the context of their practice. In undertaking this approach, it was accepted that the concepts of reality are constructs of the human mind and can vary from one person to another because descriptions of human actions are based on

social meanings (Bassey,1999). In the light of this constructionism was selected to guide the study's epistemology because

There is no such thing as knowledge uncontaminated by any particular system of human purposes, beliefs, values and activities, the world and values...it is grounded in experiences and practices, in the efficacy of dialogue, negotiation and of action. (Howe & Berv, 2002, p. 33)

The use of case study and the subsequent development of a bounded system required purposive selection of participants from whom most could be learned. Consequently, the research questions guided data collection, which enabled the researcher to be open and sensitive to new ideas and insights as they emerged (Merriam,1998).

## **1.8 OUTLINE OF THE THESIS**

This study offers an exploration of how nurses have undertaken leadership initiatives in their role as health care providers within contemporary health care organisations. This introductory Chapter has briefly established the context for the research and demonstrated how the research has responded to the issues raised in the literature about the relevance of nurses' work.

Chapter 2 provides an account of the clarification and final articulation of the research problem and its purpose. In particular this chapter highlights the problem for the research through discussion about nurses' work, health care reform which influences nursing practice, the consequences of health care reform for nursing practice and nurses' responses to changing contexts. Overall, this chapter demonstrates that within contemporary health care organisations there is no single framework of measurement that captures the significant bed based, relational nursing work which compromises the majority of nurses' work (Malloch & Porter-O'Grady, 1999; Wynne, 2003). Hence nurses' work is not visible to others. Recent studies of nursing practice indicated that nurses were undertaking leadership initiatives in a number of areas, with Cook (2001b) and Graham (2003) both offering a new perspective for explicating the nature of nurses' work through contemporary leadership theories.

Chapter 3 offers synthesis and analysis of the literature pertinent to the purpose of the research. Synthesis of the literature generated three themes: Changing WorldViews, Tensions and Organisational Change and New Leadership. These themes serve as the foundation for the conceptual framework, which was generated to examine nurse leadership within the context of contemporary health care services. The chapter is divided into a number of sections. Section 3.2 of this chapter demonstrates the impact of a paradigm shift from the industrial to post industrial era on changing worldviews of leadership within contemporary organisations. This section also discusses how nurses in health care organisations are responding to the changes that resulted from these shifting paradigms. Section 3.3 reports on the tensions that have emerged from changes to organisational structures. Examination of conflict between personal and organisational values highlighted the emergence of an informal, relational and dynamic leadership. Section 3.4 explores a new leadership that is emerging within contemporary organisations. It highlights the existence of two perspectives of leadership and examines the relevance of these for nursing in the post industrial era. Section 3.5 offers concluding statements, provides the research questions as they have emerged from the literature and offers a model that demonstrates conceptualisation of the research questions from the literature review.

Chapter 4 presents the research design and methodology of the study. Details of the methods and approaches used for the collection and analysis of data are described. This study utilised an interpretive approach which provided constructionism as its epistemological framework and symbolic interaction as the theoretical perspective through which the data was analysed. A case study approach organised the collection of data from a selected group of twenty-two nurses through focus group and one to one interviews. Overall the design enabled the researcher to collect data from those from whom most could be learned and focus on the meanings of leadership that the nurses constructed during the provision of health care services.

Chapter 5 presents the findings that emerged from data analysis of the nurses' responses to the three research questions. A final analysis of the data enabled the researcher to inductively reconceptualise the data and presents the nurses' perceptions and constructions of leadership.

Chapter 6 focuses on discussing the findings with supporting data from the literature (Chapter 3) and presents a model of nurse leadership developed from the ensuing discussion.

Chapter 7 offers a review of the research questions and conclusions of the study. It puts forward recommendations for nursing practice, nursing education and for further research.



## **CHAPTER 2: DEFINING THE RESEARCH PROBLEM**

The purpose of this chapter is to provide an account of the process undertaken to defining the research problem. In particular, this chapter discusses nurses' work, health care reform which influences the context within which nursing is practised, the consequences for nurses practising within this, as well as their responses to the changing context. This chapter concludes by articulating the research problem and purpose for the study.

### **2.1 INTRODUCTION**

The impetus for this study came from personal observations of the limited recognition given to the relevance of nurses' work in a changing health care system. In my role as a practising nurse, nurse educator and researcher I have observed that nurses, in health care organisations were often excluded from decisions regarding health care services by other health care professionals, health administrators, policy makers and consumers. Over time, despite expansion of nursing's knowledge base through tertiary education and a broad spectrum of research, health care decision makers appear to have failed to invite nursing's input into health care decisions at both the macro and micro levels of organisation. This failure to include nurses can contribute to the formation of the impression that the value of nurses' work within health care services was not relevant to others. Personal discussion with nurses in the clinical areas, has highlighted to me that whilst they recognise the value of their own health care contributions to patient outcomes, they have come to accept that others fail to recognise the value of their work. This failure to acknowledge nursing's contribution has become a crucial issue for me as the nursing profession comes under scrutiny of an economically driven health care reform that is shaping health care systems and influences the viability of the health professionals who operate within it.

My concern regarding this issue led me to explore recent nursing literature that examined nurses' work. The literature confirmed that my observations existed in other sites and indicated that nurses, working within changing health care contexts, have undertaken a robust and flexible approach to leadership in health care services (Antrobus & Kitson, 1999; Cook, 2001a; Gordon, 2003). Despite their actions, there is limited indication that the relevance of nurses' work has been recognised by others

with reports that health care decision-makers continue to view nurses as passive participants in health care services operating under the authority of the medical profession (Chiarella, 2000; Tourangeau, 2003).

This problem offered a broad focus with a number of complex, interrelated problems that were difficult to isolate or clearly identify. As a consequence, the first step in this research study was to clarify the research problem. Subsequently, the research problem was clarified by developing a rich picture of nurses' work in a changing health care system.

## **2.2 NURSES' WORK**

Nursing views itself as a practice discipline with the consumers of health care services at its core (Fralic, 1999) and focuses nurses' work on the provision of holistic, quality care to those consumers (Wynne, 2003). In particular, nurses individualise their health care services by responding to the unpredictable and unique ways that individuals and their families react to health and illness (Barker, 2000; Fagin, 2001). They perceive themselves as the only continuing presence across the spectrum of health care services (Biggs, 1999; Cook, 2001a), which in response to consumer needs, takes on and completes the work of other health professionals in a covert rather than overt way (McCloskey & Maas, 1998).

Whilst nurses appeared to be conscious of the relevance of their work, nurses' work is viewed differently by those outside the nursing profession. In short, there appears to be a dissonance between how those outside the nursing profession perceive the relevance of nurses' work and the nursing professions' view and value of nurses' work (Chiarella, 2000; Takase, Kershaw, & Burt, 2001). This is exemplified by society's impression that health care outcomes are uniquely attributed to physician's contributions (Gordon, 1997; Chiarella, 2000). This depiction of physician as solo contributor with its scientific, male instrumental and superordinate orientations of medicine contrasts with the traditional depiction of nursing in terms of the claimed practical, feminine, moral and subsidiary character (Degeling, Maxwell, Kennedy, & Coyle, 2000). Consequently, the traditional handmaiden image of the nurse is perpetuated in society and continues to ignore the reality of nursing practice and the contribution it makes to health care services (Chiarella, 2000; Gordon & Buresh,

2001). This image of nurses ignores nursing as a knowledge based, highly technological, rapid throughput and specialised profession, which is capable of meeting the demanding, intellectual, physical and emotional nature of consumer needs in changing health care contexts (Gleeson, 1998; Fralic, 1999; Porter-O'Grady, 2003).

## **2.3 HEALTH CARE REFORMS**

The relevance of contemporary nurses' work, is further influenced by the escalating costs of health care which drive health care reforms (Tourangeau, 2003; Wynne, 2003). These reforms are aimed at cost containment, with reduced levels of financial support for health services (Rafferty, 2000; Burke & Greenglass, 2001). Cost containment decisions are influenced by an emerging interest group from a wide variety of professional backgrounds known as "corporate rationalisers" (Heslop & Peterson, 2003, p. 161). This group does not necessarily include those who directly deliver or receive health care services (Heslop & Peterson; Wynne, 2003). Consequently, Australian health care organisations are experiencing changes which focus on economic rather than service agendas. These agendas highlight cost cutting in the form of down grading, closure, co-location, amalgamation, or significant organisation restructuring with little input from health care professionals (McCarthy, Pearson, & Hegney, 2000; Smith, Ocskowski, Macklin, & Noble, 2003). Moreover, these developments have resulted in a health care system that has less concern for equity, social cohesion and social policy and greater focus on economic pluralism and primary market forces (Borthwick & Galbally, 2001; Porter-O'Grady, 2003a).

Health care professionals now operate in a health care system that imposes tight fiscal restraints, flat and increasingly flexible, decentralised structures, and a multi-skilled rather than specialist specific workforce (Warr, Gobbi, & Johnson, 1998). Furthermore, fiscal restraints have directed a trend towards employment of unregulated health workers, decreasing lengths of stay for patients, increasing complexity of patient care, rapid technological change and reimbursement constraints (Young, Urden, Wellman, & Stoten, 2004). Consequently, models of health service delivery are also changing as health care decision makers move toward an interdisciplinary team approach because it better contributes to cost containment and optimal patient outcomes (Hansen, Bull, & Gross, 1998). As a

result, health care professionals now operate in a health care system which demonstrates (i) continuous and accelerating change; (ii) customer expectations with greater propensity to challenge and complain and (iii) competition for resources and getting better service for a better price (Hammer & Champy, 1994; Richardson & Cunliffe, 2003). In summary, market forces and the goal of cost effective, quality care influence the delivery of health care services by all health care professionals (Maas, 1998; White & Rice, 2001; Porter-O'Grady, 2003a).

## **2.4 CONSEQUENCES OF HEALTH CARE REFORMS FOR NURSES**

Contemporary nurses believe that they work within health care reforms that are driven by economic ideologies (Rafferty, 2000; White & Rice, 2001; Gordon, 2003). Examination of the effects of the drive for efficiency and economy on nurses' work has resulted in nurses struggling to balance the value of caring relationships with their clients within an economically driven agenda (Fralic, 1999; Parker, 1999; Bamford & Porter-O'Grady, 2000). Nurses now face the difficulty of attempting to demonstrate the relevance of the human nature of their work as a quantifiable, consumable commodity (Lumby, 2000). These developments raise a number of challenges for the nursing profession.

Firstly, job security for registered nurses is under threat as nurses, who represent the largest group of health care professionals, account for a substantial proportion of total health care costs (Borbassi, 1999; Buresh & Gordon, 2000; Schreiber & Nemetz, 2000). In an effort toward cost containment, health care decision makers have assumed that particular patient care activities do not require nursing expertise (Patterson, Del Mar, & Najman, 2000). This view has resulted in the replacement of registered nurses with unregulated health care workers (Warr, et al., 1998). The role of the registered nurse is further threatened as recent reviews of certain sections of the *Queensland Nursing Act 1992*, on recommendation from the *National Competition Policy*, are redefined in order to introduce market forces and fair competition (Samuels, 1999; Queensland Nurses' Union of Employees, 2000).

Secondly, the pressure to reduce spending means that nurses' work is being subjected to intense scrutiny (Warr, et al., 1998). The influence of this scrutiny is evident with reports that nurses are required to move away from their role as

significant care givers to become cost efficient employees, monitoring their work in a statistically calculated manner with cost consciousness and accountability becoming disciplinary mechanisms (Wong, 2004). As a result, nurses experience tension between their disciplinary work values and the requirement of cost effectiveness by health care decision makers (Graham, 2003; Porter-O'Grady, 2003b). This tension increases as nurses attempt to maximise a balance between competing goals by being primarily concerned with the effective use of resources, at the same time attempting to align their fundamental concerns for holistic, quality patient care within changing context (Wynne, 2003).

Finally, nurses find themselves needing to legitimise their services within the health care system by having their practice exposed to economic analysis (Heslop & Peterson, 2003). Nurses are faced with performance indicators designed by other health professionals who require quantitative, evidence based evaluation to demonstrate the effectiveness and efficiency of services (White, et al. 2000; Borthwick & Galbally, 2001; Chiarella, 2000). This poses a challenge for nursing's credibility, as nurses' work has historically been described in terms of qualitative methods of interpretation (Cody, 2000; Hawkins & Bellig, 2000; McCloskey & Maas, 1998; Parker, 1999).

Nurses are faced with the challenge of demonstrating the relevance of their work in a manner whereby health care decision makers, professionals and consumers are able to recognise the value of their contributions to health care reforms (Fralic, 1999; Borthwick & Galbally, 2001). Consequently, the concern for nurses is that performance indicators established for health care reform fails to recognise the legitimacy of nurses' work (Warr, et al., 1998; Wynne, 2003). This lack of recognition of nurses' work and its contribution to health care has been attributed to the difficulty of quantitatively measuring the human nature of nurses' work, as well as the perpetuated stereotypical image the nurses as handmaiden to the physician (Chiarella, 2000).

## **2.5 NURSES' RESPONSES TO HEALTH CARE REFORMS**

Nurses recognise that there are opportunities within current health care reforms to re-examine their roles in order to make the relevance of their work visible to others

within the health care system (Graham, 2003; Wong, 2004; Wynne, 2003). Accordingly, nursing has sought to develop its discipline by integrating discourses between managerialism and holistic care (Wong). The result of these discourses has highlighted that the solo practice model for practice for health care services is changing (Wilson-Barnett, Barribal, Reynolds, Jowett, & Ryrie, 2000). Nurses have come to recognise that the solo model of health care with its disciplinary specific goals and specialised, often fragmented models of health service delivery is being replaced by interdisciplinary models of practice, where all team members contribute to cost containment and assurance of optimal patient outcomes (Hansen, Bull, & Gross, 1998). The drive for delivery of health care services by interdisciplinary teams has provided nurses with opportunities for leadership as they modify their models of practice to embrace the new realities of changing health care systems (Porter-O'Grady, 2003c).

Evidence of modification to nursing practice has been indicated by early trends where nurses, operating within interdisciplinary teams, consciously moved away from using the traditional, hierarchical models to one of shared governance where health care professionals worked together on an equal basis (Sheehy, 1995; Peach, 1999, July). Within these interdisciplinary teams, nurses demonstrated a unique capability of developing complementary rather than subordinate relationships with other health care professionals (Greenwood, 1999). In addition, nurses have been able to demonstrate better financial integrity in the health services they provide when compared to other members of the interdisciplinary team (Campbell & Rudisill, 1999; Malone, 2000).

Despite positive indications of emerging nurse leadership and nursing's contributions to health care services, nurses continue to struggle with their traditional image as they attempt to have their contributions recognised (Chiarella, 2000). Consequently, nurses face the challenge of overcoming the image of handmaiden and adopting suitable measures to ensure the relevance of their work is not lost in the shadows of their health care team members (McCloskey & Maas, 1998; Chiarella, 2000). Past experiences of having their contributions overshadowed by other health professionals have led nurses to express the relevance of their work in an language that embraces managerialist devices and technologies (Arbon, 2004). Therefore, in order to address the lack of quantifiable evidence of their work, nurses have attempted to

adopt evidence based practice to demonstrate outcomes of their work (Thompson, 2004).

However, examination of reports on evidence based practice indicates that it only partially measures some of the contribution that nurses makes to health care services (Lumby, 2000; Seago, 2002; Gordon, 2003). The inability of evidence based practice to fully measure nurses' contributions has been attributed to it being too technical therefore not truly demonstrating the nature of nursing's work (Winch, Creedy, & Chaboyer, 2002). In the light of this, it would appear that there is no single framework of measurement which captures the significant portion of bed based, relational nursing work which comprises the majority of nurses' work (Malloch & Porter-O'Grady, 1999; Wynne, 2003). The continuing discussion on the inability to measure or make visible the relevance of nurses' work, has led some authors to recommended studies which aim to explicate the unique nature of nurses' work more clearly (Lumby, 2000; Chiarella, 2000).

Failure by others to clearly explicate the unique nature of nurses' work has led to a review of recent studies on nursing practice and nursing leadership. Reports from the authors highlighted that nurses were taking leadership initiatives in such areas as: managing different health care professionals (McAllin, 2003); people management (Antrobus & Kitson, 1999); influencing health care team members to continuously improve patient care (Cook, 2001b); providing cost effective services (Malone, 2000); and building collaborative partnerships and coalition within interdisciplinary teams (Sarros, 2002). The findings of these reviews which are well supported by recent, more specific examinations of nurse leadership by Cook (2001b) and Graham (2003) offer a new perspective for explicating the nature of nurses' work by use of contemporary leadership theories. In the light of these recent findings, and at a time when contemporary health care organisations are beginning to recognise the need for leadership from experienced clinicians, such as a nurse (McAllin, 2003), it is proposed that the relevance of nurses' work could be further explored from a leadership perspective.

## **2.6 PROBLEM**

The literature highlighted the lack of recognition of nurses' work in the context of health care reforms. Despite evidence of nurses' efforts to adapt their practice to the requirements of health care reform, other health care professionals, health administrators, policy makers and consumers fail to recognise the relevance of nurses' work and its contribution to health care services (McCloskey & Maas, 1998; Chiarella, 2000; Porter-O'Grady, 2003c).

The problem underpinning this study is the dissonance between what nurses' perceive to be the relevance of their work and the perception of the relevance of nurses' work by others in the health care system. One way to address this problem is to identify the leadership nurses undertake in contemporary health care organisations. This is the aim of this thesis. Consequently, the purpose of this thesis is to explore how nurses undertake leadership initiatives in their role as health care providers within contemporary health care organisations.



## **CHAPTER 3: LITERATURE REVIEW**

The purpose of this chapter is to synthesise and analyse the literature pertinent to the purpose of the research. Themes important to the study are illuminated throughout the literature review. The literature reviewed therefore sought to highlight the place of this study in understanding how nurses in contemporary health care organisations constructed their leadership when providing health care services. Subsequent data analysis and discussion of the findings were informed by the themes identified in the literature review.

### **3.1 INTRODUCTION**

This chapter provides a review of the literature to further amplify the research problem and to generate research questions through which to focus the conduct of this study. Within this process it is important to gain insight from research about nurses and the relevance of their work within contemporary health care systems.

#### **3.1.1 Purpose of the Research**

In the previous chapter, exploration of the relevance of nurses' work in the context of health care reform was presented as a justifiable issue for research. The literature served to amplify the problem for this study. In addition, it demonstrated a dissonance between what nurses' perceive to be the relevance of their work and the relevance of nurses' work as perceived by others in the health care system. This dissonance became obvious when nurses attempted to make overt their values concerning holistic care within health care organisations where health care services were economically restrained (Wynne, 2003). In addition, society's perpetuation of the image of the nurse as physicians' handmaidens denied them acceptance as professionals capable of meeting the intellectual, physical and emotional needs of health care consumers (Gleeson, 1998; Porter-O'Grady, 2003b). One way to address this problem is to articulate the various leadership roles contemporary nurses are asked to undertake. Therefore, this research

provides an opportunity to illuminate the role of the nurse within changing health care systems by making clear the nature of their work through the perspectives of leadership. Consequently, the purpose of this study is to explore how nurses have undertaken leadership initiatives in their roles as health care providers within contemporary health care organisations.

This chapter, therefore, proposes to explore nurses' work through the perspective of leadership. The contexts for this study are the contemporary health organisations within which nurses' work takes place. Accordingly, the literature review intended a broad approach by firstly exploring changes within contemporary organisations which have resulted in challenges to traditional leadership perspectives, concluding with an examination of nurse leadership within health care organisations.

Themes important to the study are highlighted throughout the literature review. The review serves to provide a conceptual framework for exploration of nurse leadership in contemporary health care organisations.

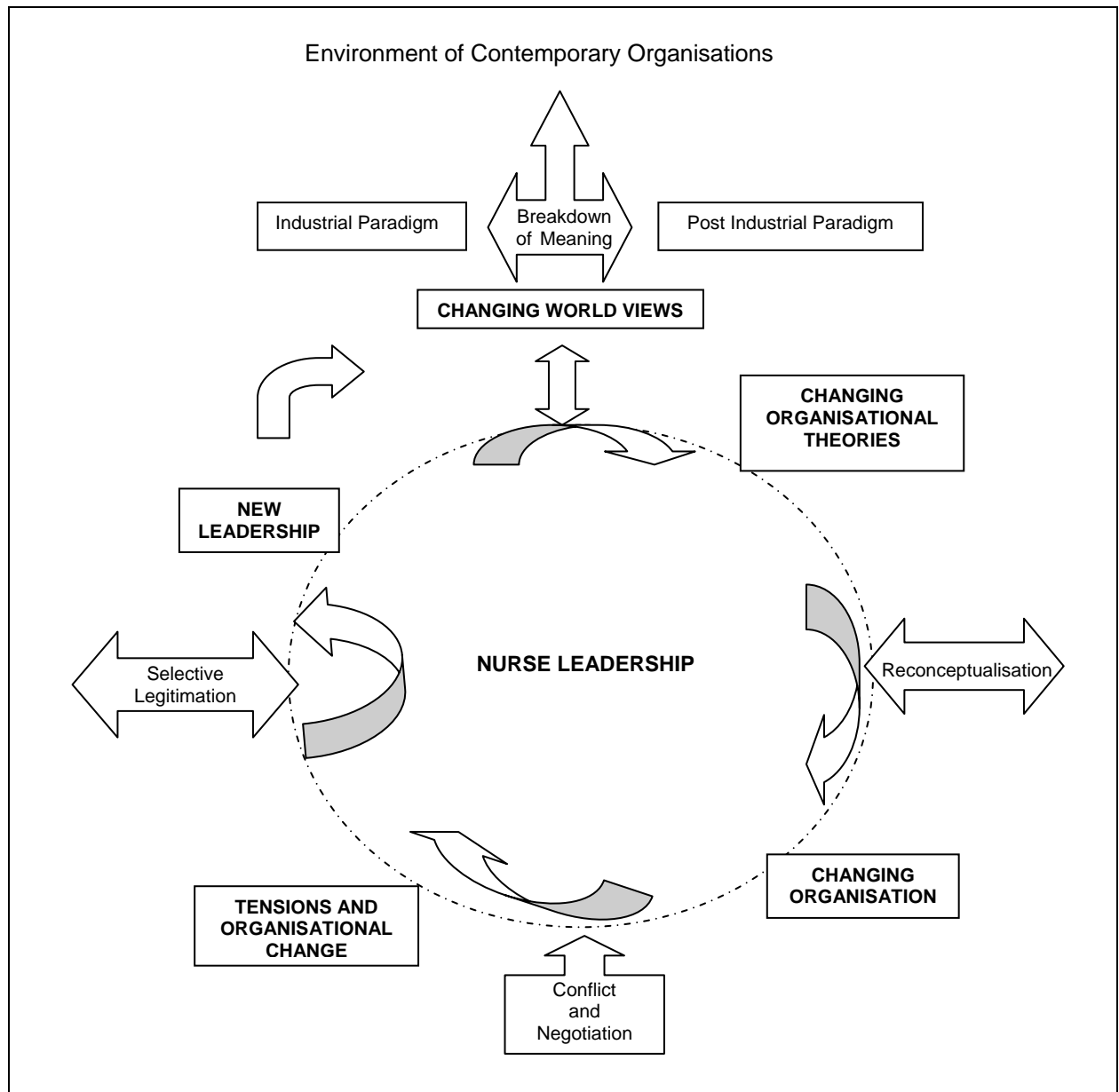
### **3.1.2 Conceptual Framework for Literature Review**

The conceptual framework that underpins this review evolved during synthesis of the literature in the light of the research purpose. The synthesis of the literature generated three themes: Changing World Views, Tensions and Organisational Change and New Leadership. These themes served as the foundation for the conceptual framework which was generated to examine nurse leadership within the context of health care services.

The conceptual framework acted as a heuristic device to highlight the issues implicit within the research questions and moved beyond limited, unsophisticated understandings of contemporary reality, toward deeper understandings of more complex realities and their potentials (Slaughter, 1988). For added clarity, issues that are explicitly identified in the conceptual framework are **bolded**.

This review aims to amplify how contemporary organisations transformed their leadership structures and functions in order to meet the demands of globalisation in the post industrial era. So as to reconceptualise leadership and its relationship to nursing, an adaptation of the transformative cycle developed by Slaughter (1988) as a device for illustrating continuity and change was selected. Slaughter's transformative cycle was particularly suitable for this study because it offered the opportunity to augment a new world view of leadership. Slaughter's work in futures studies focusses upon a changing society and culture which is not merely driven by the past but also responsive to the emerging near future context (Davies & Lynch, 1995). His views of change from a socio-cultural perspective have enabled me to use a dynamic process to reconceptualise the meanings of leadership that emerged within each major theme of this chapter.

**Figure 3.1 Conceptualisation of the Literature Adaptation of Slaughter's Transformative Cycle**



In the initial stage, **breakdown of meaning**, understandings, concepts, values and agreements which are used to support social interaction become problematic where what was once taken for granted begins to dissipate (Slaughter, 1988). This stage explains contemporary organisations' **changing world views** as they respond to demands of globalisation. These organisations undergo transformation as they are exposed to a new set of social and economic realities (Shriberg, Shriberg, & Lloyd, 2002; Skipton Leonard, 2003). Consequently, they find the orderly world of work thrown into disarray because the predominant **industrial paradigm** of leadership was

inadequate to guide contemporary organisations such as health care systems towards the change (Porter-O'Grady, 1998).

As organisations reach the second stage of Slaughter's (1998) cycle, a need for transformation is recognised. At this stage Slaughter suggests that resistance to change could be attributed to the challenges that new ideas impose upon existing structures and the interests embedded within them. This has been evidenced by contemporary organisations demonstrating reluctance to relinquish the industrial world view, even though it has been found to be unresponsive to turbulent environments and inhospitable to human creativity and development (Laiken, 2003).

In order to move forward, **reconceptualisation** of traditional standards and values that guide organisational practices toward **changing organisational theories** are required. At this stage contemporary organisations move to form a new leadership which offers a humanistic approach in order to adapt to the changes required by the **post industrial paradigm** (Lawler, 2001; Shriberg, et al., 2002). Changing organisations undergoing this stage of **reconceptualisation** transform leadership practices in the process of becoming more dynamic and interactive (Smith, et al., 2003; McSherry, 2004).

According to Slaughter it is during the third stage of transformation that **conflict and negotiations** become inevitable. This occurs when an established structure, represented by the legacy of the **industrial paradigm**, perceives a threat to its continued existence and mobilises resources to defend itself and repel the threat (Slaughter, 1988). Subsequently, new resolutions will only emerge from the negotiation stage when those with conflicting interests are prepared to communicate with one another. As the **changing organisations** experience the effects of competing paradigms, closer scrutiny highlights **tension and organisational change** especially when personal values are involved (Graham, 2003).

The proposals that emerged from the negotiation may lead to stage four, **selective legitimisation**. Slaughter (1988) cautions that selective legitimisation

may not necessarily produce effective change, as it directly serves particular interests and validates meaning which work against the majority. For effective change to take place, within the framework of this study, contemporary organisations are required to shift from the traditional, hierachical, mechanical model of leadership which served the **industrial paradigm** toward a **post industrial** era whereby a **new leadership** with shared human processes and meanings emerges (Lawler, 2001).

It is within this transformative cycle that the literature is reviewed and **nurse leadership** is examined. The literature has called for further exploration of nurse leadership utilising the impetus of organisational transformation to enable new thoughts to emerge. Nurses' work may well look different when examined under the light of new leadership, it is anticipated that by utilising the lens of new leadership the relevance of nurses' work will subsequently become recognised.

### 3.1.3 Sequence of the Literature Review

For the sake of clarity, a linear model of how the review of the literature was undertaken is illustrated in Table 3.1.

**Table 3.1 Sequence of the Literature Review**

<b>3.2</b>	<b>Changing World Views</b>
3.2.1	Industrial to post industrial views of organisations
3.2.2	Changing organisational theories
3.2.3	Changing organisations
3.2.4	Nursing in contemporary health care organisations
<b>3.3</b>	<b>Tensions and Organisational Change</b>
3.3.1	Organisational versus personal values
3.3.2	Implications for organisational leadership
3.3.3	Nurses' vision, work, values and leadership
3.3.4	Development of informal leadership groups
<b>3.4</b>	<b>Leadership in a Changing World</b>
3.4.1	Evolving leadership perspectives
3.4.2	Moving towards a post industrial leadership paradigm
3.4.3	The new leadership
3.4.5	Nurse leadership
<b>3.5</b>	<b>Conclusion</b>

## **3.2 CHANGING WORLD VIEWS**

### **3.2.1 Industrial to Post Industrial Views of Organisations**

Contemporary organisations face a new set of social and economic realities that have resulted from changes brought about by globalisation (Shriberg, et al., 2002; Skipton Leonard, 2003). The literature highlights an organisational shift toward a post modern or post industrial era which focuses on societal values of service, information technology and human capital as transforming organisational contexts (Horner, 1997; Senior, 2002, Skipton Leonard, 2003). Therefore, to be useful in this new era, organisations are becoming increasingly reliant upon individuals to contribute their creativity, innovation, energy and foresight (Senior). Moreover, as organisations begin to change and take on the attributes of the post industrial paradigm, the known and orderly world of work has been thrown into disarray and chaos (Porter-O'Grady, 1998; Skipton Leonard, 2003).

The industrial paradigm now offers an incomplete and inadequate explanation of changes that are occurring in organisational contexts (Shriberg, et al., 2002). Skipton Leonard (2003) clearly articulates this criticism

The problem with the industrial paradigm is that it ill fits the needs of a world rapidly being transformed by a massive paradigm shift in societal values. There is more and more evidence to conclude that the industrial paradigm is losing its hold on the culture of Western societies and that some kind of post industrial paradigm will dominate societies in the twenty first century. In this view of paradigmatic change, the 1980s and 1990s are seen as a transition period wherein the dominant values and cultural norms shift from an industrial to post industrial paradigm (p. 7).

Organisational leadership has been traditionally viewed through the lens of the industrial paradigm. In the past, this world view demonstrated how management and leadership held synonymous values such as efficiency, productivity, maintenance of organisational structures, development of processes, and use of reward power to get routine things done (Hughes, Ginnet, & Curphy, 1999). Consequently, literature from the 1980s and 1990s focuses on control and structure of human behaviour and demonstrates a lack

of distinction between the role of leader and manager (Limerick, Cunningham & Crowther 1998, Rost, 1991; Shriberg, et al., 2002).

Examination of the post industrial paradigm, recognises that human capital has become the value of changing organisations (Hughes, et al., 1999; Lawler, 2001). Organisations capitalise on change within this new era, recognising that they need to develop their own “capacity to learn and change, to anticipate and initiate future environmental developments and to deploy resources imaginatively” (Dunphy & Griffiths, 1998, p. 151). In order to enhance organisational capabilities and core competencies, changing organisations depend on the talent of individuals and effective leadership to shift them into the post industrial era (Lawler, 2001). Consequently, post industrial organisations are realising, that if they are to successfully adapt to change, they need to move from a mechanistic model of leadership toward one which uses a more humanistic approach (Kerfoot & Wantz, 2003).

As health care organisations shift toward a post industrial era, nurses recognise the responsibility they hold with the agency’s dependence upon them as human capital. Within the humanistic model of post industrial leadership, nurses recognise that they already possess the “motivation and desire for responsibility” (Skipton Leonard, 2003, p.7). Evidence of the nurses’ responsibility, demonstrates itself in changing practice models that shift away from the industrial paradigm with its hierarchical models of care to nursing models of shared governance where everyone has an equal voice and everyone assumes a position (Sheehy, 1995; Peach, 1999, July). Within interdisciplinary teams, changing models of health care offer nurses an opportunity for recognition through shared decision making and its resultant cost containment and assured optimal patient outcomes (Hansen, et al., 1998; Greenwood, 1999).

### **3.2.2 Changing Organisational Theories**

Since the Industrial Revolution in the nineteenth century, formal organisations have been the primary site for work and leadership studies for most of the



industrial world (Laiken, 2003). Whilst this sounds innocuous, examination of organisational forms revealed the legacy left by the industrial world view through which both work and leadership have been examined (Shriberg, et al., 2002). Laiken (2003) describes organisational theories developed in the 1940's by Taylor (Scientific Management Theory), Weber (Bureaucracy Theory), and Fayol (Administrative Theory) as perpetuating a view of organisations that restrict human creativity and development. Laiken suggested these theories were tenaciously hierarchical and inflexible in practice, unresponsive to turbulent environments and inhospitable to human creativity development. Within this world view, the human being is focussed upon with "instrumental calculativeness" (Popper, 2004, p. 11) through the use of scientific observation within a power regime that is supported by its own matrix of practices (Laiken, 2003; Rost,1991). It is this view that has mostly contributed to the development of contemporary leadership theory.

As industrial organisational bureaucracies transform into post industrial organisations, attempts have been made to understand leadership by exploring the lived experiences of workers within organisations (Laiken, 2003). Within these organisations, a new focus for leadership is emerging whereby the relational and social elements of leadership and their contributions to organisational successes are examined (Shriberg, et al., 2002). However, contemporary organisations maintain an industrial view as they continue to define leadership from the perspective of achievement of greater efficiencies and expansion of bureaucratic rationality through the application of principles which highlight calculability, predictability, control and rationality (Rost,1991, Shriberg, et al., 2002).

Contemporary health care organisations also continue to reflect this view. This view is supported by studies of nurse leadership that are grounded in administrative and management functions and explained through theories from the industrial paradigm (Grossman & Valiga, 2000; Kerfoot & Wantz, 2003; Armstrong, 2004). Subsequently, nurses, when seeking recognition for their work, express the value or worth of nursing in a language that may be heard by others through managerialist devices and technologies (Hewison, 1999; Antrobus, 2003). Moreover, these expressions of leadership could

influence how nurses construct their leadership role and ignore the articulation of leadership from the perspective of nurses' other than those in administrative positions (Antrobus).

### **3.2.3 Changing Organisations**

Organisational practices are moving toward processes and structures that are more flexible, creative, and responsive to changes (Fullan, 2001). Organisations, that have been tightly integrated and bureaucratically controlled hierarchies, are relinquishing bureaucratic practices and mechanistic thinking as they enter the post-industrial era (Johnson, 1998; Limerick, et al., 1998; Yukl, 2002). As organisations transform to meet the needs of this era, they are becoming "kaleidoscopically changing organisations with structures built upon highly transient human relationships" (Skipton Leonard, 2003, p.143). Consequently organisations are required to consider the human element as they "manage their organisational structures, leadership, processes, competencies, and practices" (Limerick, et al., 1998, p.10).

Over the last decade, there has been documented evidence of organisational changes as demonstrated in the "second Australian Workplace Industrial relations survey" which showed that "over half of all Australian workplaces have undergone significant structural change in 1995" (Smith, et al., 2003, p. 2). New management practices, highlighted during the restructuring processes, gave greater levels of responsibility to employees and decentralisation of power from managers to employees (Smith, et al.). Contemporary organisations are no longer considered to be "single entities" as restructuring and new management processes create "dynamic and interactive" organisations where different groups of people, different sections, and different areas interact with each other to determine "what the organisation is" (McSherry, 2004, p. 138).

As contemporary health care organisations also adopt structures that are dynamic and interactive, nurses leadership is becoming more overt (Cook, 2001). Nurses are initiating leadership by interacting with different groups and

disciplines at different levels to develop collaborative relationships, building partnerships and coalitions (Greenwood, 1999; Malone, 2000; Scott, et al., 1999). These initiatives have been viewed as representing the post industrial era whereby leadership principles are based on collaboration rather than competition (Sarros, 2002).

### **3.2.4 Nursing in Contemporary Health Care Organisations**

Despite the views that new forms of leadership are required to move contemporary health care organisations into the twenty first century, evidence suggests that industrial leadership models are perpetuated in organisational structures even though these fail to adequately contribute to organisational change or successful integration of health care services (Skipton Leonard, 2003). Consequently, reluctance to change to new models of leadership is demonstrated by those in health care organisations who fail to recognise the holistic, interactive and collaborative nature of nurses' work (de Jonge & Jackson, 2001). Furthermore, in the past, exploration of nurse leadership utilised traditional leadership theories to focus on the domain of the most senior nurses within the industrial organisation, thereby largely ignoring the nature of informal leadership within health care teams (Cook, 2001a; Allen, 1998). Hence studies on the nature of nurse leadership within the practice context are limited (Cook, 2001b).

Moreover, even though nurses are striving to meet their organisations' goals of productivity, quality and efficiency through leadership initiatives, their contributions fail to be recognised (Degeling, Maxwell, et al., 2003). Failure to recognise "a significant portion of nursing work" because it does not appear to have economical value is further attributed to the perpetuation of the industrial model of leadership within contemporary health care organisations (Malloch & Porter-O'Grady, 1999, p. 300). In addition, because the organisation's acknowledgment of success is linked to leadership at the macro level and the majority of nurses' work is undertaken at the micro level of the organisation, it is argued that the value of nurses' work remains ignored (Cook, 2001b). For example, in the past organisations and studies have focussed on the

leadership of nurses who have been formally appointed to traditional leadership roles within the hierarchy of their organisations and who “lead medical teams, deliver front line care, chair committees and government inquiries, conduct wide ranging research and influence health policy” (Armstrong, 2004, p.18).

Because of its bureaucratic nature and rigid hierarchies, the industrial view of nurses as leaders threatens to maintain the stereotypical images that have played a part in the socialisation of nurses as passive and subordinate to other health professionals (Liaschenko & Peter, 2004). Because the majority of nurses provide health care services at the micro level of their organisations, lack of formal recognition has also influenced the way in which nurses perceive themselves as leaders (Cook, 2001a; Wynne, 2003).

Closer inspection of nursing leadership practices within contemporary health care organisations suggests that nurses have found themselves working in environments that require re-examination of strategy, structure and functional activities (Wynne, 2003). As organisations restructure to obtain greater efficiencies, nurses report increasing reliance on them by health care organisations and teams for achievement of patient outcomes and the establishment of collaborative practices (Maas, 1998; Malloch & Porter-O’Grady, 1999). Consequently, as they attempt to meet the demands of changing organisations, nurses have identified a need to replace old bureaucratic forms of management. They highlight a need for new organisational cultures of “transparency, openness, relationships and partnerships” whereby “ownership of the idea, unit and organisation is shared and all staff are full and participating members in health care services” (Kerfoot & Wantz, 2003, p. 34). In addition, nurses have adopted multiple forms of leadership in order to influence health care services at all levels of the organisation (Grossman & Valiga, 2000). Grossman and Valiga indicate that these multiple forms of leadership create variation that enables nurses to move away from their traditional task focussed activities toward a collaborative form of leadership.

Studies of nursing practice have indicated that nurses are subtly using new leadership actions and values to form health care teams that work together in interdisciplinary, coordinated and integrated ways to achieve mutually, agreed to positive health care outcomes (Graham, 2003; McAllin, 2003; McSherry, 2004). McSherry reported that nurse led initiatives resulted in collaborative, effective and interactive health care teams who use multiprofessional, collaborative, partnerships and effective communication to achieve their goals. Furthermore, examination of nurses' work at the micro level of the organisation has provided nurses with opportunities to voice their multiple perspectives of leadership as they "generated meaning and understanding about themselves and others that appear to be personal and transferable across all fields of practice" (Arbon, 2004, p.152).

As leadership paradigms shift and different meanings of leadership are generated at different levels of the post industrial organisation, there is a lack of unanimity about what people understand by the concept of leadership. Yet one's understanding of leadership determines to a large extent how one perceives leadership behaviour. Consequently, as this research is focussed on exploring how nurses construct their leadership, it is important to pursue how participants describe the concept of leadership within their own organisation. Given these observations the following became the first research question:

**How do nurses describe leadership within their health care organisations?**

### **3.3 TENSIONS AND ORGANISATIONAL CHANGE**

#### **3.3.1 Organisational versus Personal Values**

As the relational elements of post industrial leadership undergo closer scrutiny, tensions between organisational and personal values become more

obvious as organisational change occurs in the face of competing paradigms. Within this environment, individuals are demonstrating that the depth of their work commitment depends upon how closely their own values are aligned to the organisation's values (de Castro, Agnew & Fitzgerald, 2004; Graham, 2003). Dissonance between work and personal values became obvious, when management failed to meet the worker's declared values, such as respect and trust, in times of diversity (Dunoon, 2002). Laiken (2003) noted how "intensification of the pressure to produce work" from their organisation gave individuals the impression that "time spent on specific task completion" was the "only legitimate form of work" (p. 10). Furthermore Laiken reported that to these individuals, management held the view of work as a commodity valued by the organisation rather than giving precedence human values within their workplace. Consequently, the tensions that emerged from conflicting values saw any changes proposed by management towards an organisation with structures and cultures of a more humanistic nature, being met with a degree of resistance and cynicism by individuals at the micro level of the organisation (Limerick, et al., 1998). The individuals' attitudes were attributed to their perceptions of lack of autonomy and lack of importance of role and responsibility within their daily working context (Gordon, 2003). Overall, conflict of values have resulted in a sense of apathy and powerlessness of the workers wherein the organisation responded by designating responsibility for decisions regarding organisational change to middle, senior and executive managers (McSherry, 2004). Therefore, the industrial model of organisational leadership with individuals being dependent upon top down, bureaucratic mechanisms tended to be maintained (Degeling, Maxwell, et al., 2003).

Similarly, nurses have experienced tensions in their work as they strive to maintain a holistic care discourse in an environment where managerialism quantifies health services and outcomes in monetary terms (Chiarella, 2000; McCloskey & Maas, 1998; Porter-O'Grady, 2003a). Particularly, these tensions are manifested in health care organisations where managers in the organisation have the power to control the supply of resources necessary for the provision of health care services (Beil-Hildebrand, 2002). Consequently, nurses may find themselves in situations whereby management decisions have created unpredictable variations in nursing workloads and staffing which

impacted upon them sustaining continuity of care and the ability to provide minimally safe standards of care for all patients (Adams, Bond, & Hale, 1998). At a time when their own role in organisations is in question, nurses appear to be finding it increasingly difficult to provide leadership when there is a dichotomy between the values of caring and the values motivated by finance within their organisations (Ainsworth, 1998). Evidence suggests an increase in staff burnout amongst nurses, with emotional exhaustion being demonstrated in nurses during organisational restructuring and downsizing (Burke & Greenglass, 2001).

### **3.3.2 Implications for Organisational Leadership**

As organisations move from hierarchy to horizontalism, from boundaries to organisations without walls, the nature of the worker in contemporary organisations is changing (Bennis, 2001; Limerick, et al., 1998). In order to be satisfied and productive in their jobs, individuals are expressing a desire for freedom and autonomy in their work so they can give rein to their individual creativity (Hughes, et al., 1999; Laiken, 2003). Yet, at the same time as they desire freedom, they expect leadership (McSherry, 2004). Likewise as nursing emerges from the industrial era, nurses in searching for the boundaries of organisational expectations within which to exercise creative potential, feel lost and chaotic when some form of leadership is not in place (Porter-O'Grady, 1998). Therefore, in order to develop environments whereby teams are motivated to work effectively, "careful nurturing by leadership which is enabling rather than controlling, empowering rather than overpowering, and facilitative rather than coercive" (Laiken, 2003, p. 13) is required. Ultimately, the effectiveness of leadership will be judged not by who the leader is but what leadership is produced in others (Fullan, 2001; Hughes, et al., 1999).

Post industrial organisations expect that a new type of leadership will create a culture of change to move organisations forward and cause a greater capacity within the organisation for better results (Fullan, 2001; Limerick, et al., 1998). Consequently, in response to organisational expectations, individuals who find themselves in leadership roles, have come to realise they cannot achieve

“their personal vision by themselves” (Skipton Leonard, 2003, p. 10). As a result, changing organisational contexts highlight the development of dynamic leadership within a group or team. This type of leadership is one of movement where the individual, moves from being leader to being follower and back to being leader as the projects they are working on change and different individuals who have the knowledge and skills to provide leadership emerge (Lawler, 2001).

### **3.3.3 Nurses’ Vision, Work, Values and Leadership**

As contemporary nurses strive to meet their primary vision that has the patient as the central person in the health care team, they also have come to recognise the benefits of a leadership that is shared among a team in the clinical domain (Arbon, 2004; Kosinka & Niebroj, 2003). Therefore, within this vision, the task of nurse leadership is to “integrate the patient with the health care team who perform caring and therapeutic functions with regard to the given patient, who becomes a true member of the team” (Kosinka & Niebroj, p. 70). Consequently, nurses have shifted their view of leadership from one of indirect, management to one which encompasses all who are involved in the delivery of health care services, including the patient (Cook, 2001a; Armstrong, 2004).

At the same time, it is the vision of nurse leadership that has created tensions at the micro level of contemporary health care organisations as nurses’ work values are challenged by others in the organisation (Porter-O’Grady, 2003b). These tensions can be explained from two perspectives, an external perspective and an internal perspective. Whilst the former focuses on the role of the nurse within the organisation, the latter highlights nurses’ personal responses to their leadership role within groups and the organisation (Cook, 2001a). Both perspectives consider that “that individuals and groups live according to a dynamic, an internal mindset and external lifestyle in which behaviour has its origin” (Tuohy, 1999, p. 29).



From the external perspective, a constant barrier to nurse leadership is presented by the reluctance of organisations to relinquish traditional leadership. The reluctance of contemporary organisations to move toward post industrial leadership models has been identified throughout this chapter. Consequently, tensions emerge as nurses' enactment of their leadership vision continues to be compared against criteria organisational expectations that are underpinned by leadership views from the industrial era (McCloskey & Maas, 1998; Stordeur, D'hoore, & Vandenberghe, 2001). This comparison of nursing practice against the criteria of traditional leadership has resulted in a lack of status and recognition of nurses and their work. For it is within this view, that nurses are determined to be subordinate to organisational structures, professional agendas and the culturally endorsed authoritative knowledge of medicine within sustained organisational hierarchies, (Liaschenko & Peter, 2004). Furthermore, these perceptions reinforce the impression that nurses, who practise at the micro level, are less autonomous and more reliant on the organisation for direction of activities (Kerfoot & Wantz, 2003; Wynne, 2003). Therefore, whilst nurses continue to work at micro levels in complex hierarchies, nurse leadership remains invisible under the mantle of authority held by others within the industrial organisation (McCloskey & Maas, 1998; Porter-O'Grady, 2003b; Wynne, 2003). In addition, there is "disagreement on whether [nurse] leadership exists at present," at the same time organisations are highlighting a need nurse leadership (McKenna, Keeney, & Bradley, 2004, p. 76).

At the same time as a failure to recognise nurses' leadership at the macro level of the organisation is evident, nurse leadership, is further stifled at the micro level. Nurses find themselves working in an environment influenced by competition for resources where efficiency, effective use of resources are rewarded. Within this environment, health care managers are rewarded and the power for decision making is shifted away from health care professionals (Bamford & Porter-O'Grady, 2000; White, et al., 2000). Consequently, a highly competitive workplace is developed at the micro level of the organisation as health care team members vie for resources. Furthermore, nurses find their leadership initiatives further challenged by health care team members who operate out of different disciplinary values, demonstrate reluctance to

relinquish traditional power bases, and refuse participate in organisational changes (Limerick, et al., 1998). Overall, individuals who prefer to operate within a solo model of different work practices, values, authority levels and leadership styles exclude nurses from participating in health care decisions (McSherry, 2004).

It is within this environment that nurses struggle to meet organisational demands and live their professional ideology of holistic care, with the patient at the centre of the team (Barker, Jackson, & Stevenson, 1999; Tonuma & Winbolt, 2000; Wynne, 2003). Consequently, nurses experience tensions that are “characterised by poor morale and increased demands as they attempt to maximise cohesiveness between personal needs to provide quality care and the organisation’s goals” (Wynne, 2003, p.103). As nurses struggle with the eternal factors that limit their vision, identification with self as leader has become diminished, leaving them wondering whether their contributions to health care have any value at all (Skipton Leonard, 2003; Smith & Sutton, 1999).

From the internal perspective, nurses’ as leaders has been viewed from a historical viewpoint. Over time, nursing’s contribution to health services has been masked by the influence of historical socialisation and perpetuation of the nurse’s role as subservient to medicine (McCloskey & Maas, 1998). From this perspective, nurses who practice at the micro level of the organisation failed to see themselves as actively involved in organisational development and restructuring based on the assumption that they do not have a leadership role (Antrobus & Kitson, 2001; Cook, 2001a). Subsequently, when opportunities for leadership arose they were not embraced by all nurses (Kerfoot & Wantz, 2003; Porter-O’Grady, 2003b).

Furthermore, despite reports of nursing working to establish leadership criteria in support of its professional status, there is limited evidence of professional autonomy among nurses. This lack of autonomy among nurses has been attributed to a number of factors such as: socialisation of nurses’ whereby they are unable or reluctant to perceive themselves as leaders (Liaschenko & Peter, 2004; McCloskey & Maas, 1998); personal alignment with the industrial

view of leadership (Wynne, 2003); or the idea that leadership as the sole prerogative of the nurse would be presumptuous (McAllin, 2003).

Over a decade ago, the nurses' personal sense of unworthiness for leadership appeared to be highlighted by actions they undertook to maintain the status quo. Nurses who found themselves with increased responsibility and more involvement in a changing environment tended to hide behind rituals and routines of their practice and developed behaviours of complacency, scepticism and hostility to new ideas and of apathy toward negotiation for change in conditions of their working life (Walker, 1995). More recently, there is evidence that nurses' continue to feel unworthy, doubt their ability to successfully bring about change or to effectively contribute to nursing practice, patient care and changes within the health care system (Porter-O'Grady, 2003b). It would appear therefore, that the traditional subservient roles attributed to nurses continue to influence their reluctance undertake leadership responsibility in contemporary health care organisations (Borthwick & Galbally, 2001).

#### **3.3.4 Development of Informal Leadership and Groups**

Examination of the basic structural units of the organisation have highlighted dispersions of people in groups who share the same values and partake in social action (Fullan; 2001; Hein, 1998, Limerick, et al., 1998). These dispersions form the most influential subcultures within and between organisations (Limerick, et al., 1998). In order fully understand these groups, it has been suggested that, conventional concepts of group cohesiveness, leadership and team work be significantly reframed "if they are to capture the dynamics of such a group" (p. 238).

At the micro level of the organisation, development of informal leadership and groups, became evident during examination of the ongoing tensions between personal and organisational values. Examination of the interactions between organisations and groups highlighted that formation of informal leadership and groups met individual needs in a way the organisations did not (Hein, 1998). It

was the collective responses from informal groups and their leadership that offered “a truer picture of the actual working structure of a formal organisation” (p. 301). Closer inspection of informal leadership within organisations demonstrated that the groups determined the standards for whom they would follow based upon “the values and reputation of the formal or informal leader” (Dubrin & Dalglish, 2003, p. 107).

In order to ease tensions between groups and the organisation, it has been beneficial to clarify values. The clarification of values enabled opportunities for turning around misconceptions which, in turn, developed a context that enhanced individual autonomy and achieved a collective or inclusive relationship for all members of the organisation (Munduate & Bennebroek Gravehorts, 2003; Degeling, Maxwell, et al., 2003). As tensions eased, adaptation to change was undertaken in collective, mutually acceptable and innovative ways (Fullan, 2001; Munduate & Bennebroek Gravehorts). Ultimately, the development of relationships based on mutually acceptable values could ensure that “modernisation becomes part of everybody’s role and responsibility (regardless of how big or small the contribution) through their job description” (McSherry, 2004, p.178).

Even though nurses have experienced tensions that emerged from conflict between their work and organisational values, they have demonstrated leadership initiatives to influence health care decisions through the development of informal teams by engaging other health care workers in participatory governance in order to achieve their vision for nursing (Atsalos & Greenwood, 2001; Spitzer, 1998). Engagement with other health care team members has enabled nurses to use a variety of leadership skills to informally lead health care teams to newer solutions in a post industrial environment that emphasise freedom to act and a sense of involvement for everyone (Axelsson, Kullen-Engstron & Edgren, 2000).

Similarly, health care organisations have come to acknowledge their reliance upon human capital in order to make a successful transition into the post industrial era (Senior, 2002; Skipton Leonard, 2003). Successful transformation into post industrial health care organisations requires

organisations to examine the social and relational elements that drive health care teams and adopt a perspective of leadership that reflects the lived experiences of the workers (Laiken, 2003; Lawler 2001).

Consequently, for the purpose of this study, examination of leadership from the perspective of nurses working in health care teams would enable determination of their leadership effectiveness within the health care organisation (Hughes, et al., 1999; Limerick, et al., 1998). In the light of these observations the second research question has been developed:

### **How do nurses experience leadership within health care teams?**

## **3.4 LEADERSHIP FOR A CHANGING WORLD**

As organisations face the challenges of a new era, they are challenged by the realisation that the industrial perspective of leadership no longer serves its purpose. Consequently, exploration of change within contemporary organisations has demonstrated the emergence of a new face of leadership. Closer examination of these organisations highlighted two competing perspectives of leadership. Table 3.1 summarises comparisons between the perspectives that will be discussed in this section.

**Table 3.2 Comparison of Leadership Perspectives**

<b>Industrial Leadership Perspective</b>	<b>Post Industrial Leadership Perspective</b>
<u>Definition</u> <ul style="list-style-type: none"><li>▪ Disciplinary specific (Ribbins &amp; Gunter, 2002)</li></ul>	<u>Definition</u> <ul style="list-style-type: none"><li>▪ Defined by how a leader serves others and alters their own leadership expression based on the needs of followers in a given situation (Grohar-Murray &amp; DiCroce, 2003)</li></ul>

**Table 3.2 Comparison of Leadership Perspectives (continued)**

<b>Industrial leadership Perspective</b>	<b>Post Industrial Leadership Perspective</b>
<u>Focus</u> <ul style="list-style-type: none"> <li>Control and structure of human behaviour (Limerick et al., 1998; Popper, 2004; Rost, 1991)</li> </ul>	<u>Focus</u> <ul style="list-style-type: none"> <li>Human relationship (Senge, 1998)</li> <li>Influence relationship (Rost, 1991)</li> <li>Shared human process (Drath &amp; Palus, 1994)</li> </ul>
<u>Context</u> <ul style="list-style-type: none"> <li>Formal groups and organisations (Shriberg, et al., 2002)</li> </ul>	<u>Context</u> <ul style="list-style-type: none"> <li>Relationship exists among people in a social situation (Grohar-Murray &amp; DiCroce, 2003)</li> <li>Leadership can spring from anywhere (Shriberg, et al., 2002)</li> <li>Within a community of practice (Drath &amp; Palus, 1994)</li> </ul>
<u>Legitimacy</u> <ul style="list-style-type: none"> <li>Established by management values (Hughes, et al., 1999, Skipton Leonard, 2003)</li> </ul>	<u>Legitimacy</u> <ul style="list-style-type: none"> <li>Effectiveness of leadership judged after the fact reflection in and on action (Rost, 1991)</li> <li>Acknowledges contexts, values and followers as part of the leadership process (Hughes, et al., 1999)</li> <li>Effective leadership is accomplishment of group purpose (Horner, 1997)</li> </ul>
<u>Model of leadership</u> <ul style="list-style-type: none"> <li>Bureaucratic-mechanistic (Grohar-Murray &amp; DiCroce, 2003)</li> <li>Singular, designated, solo model (Yukl, 2002)</li> </ul>	<u>Model of leadership</u> <ul style="list-style-type: none"> <li>Participative, shared and relational in nature (Rost, 1991)</li> <li>Dynamic, interactive and multidimensional (Drath &amp; Palus, 1994)</li> </ul>

### **3.4.1 Evolving Leadership Perspectives**

The literature concluded that there is a lack of clarity concerning any definition of leadership itself, for leadership may be “a universal human phenomenon that many know when they see it... few can clearly define” (Grossman & Valiga, 2000, p. 4). Definitions of leadership are further clouded by leadership researchers defining leadership according to their disciplinary views and aspects of the phenomenon of most interest to them (Grohar-Murray &

DiCroce, 2003; Ribbins & Gunter, 2002). Studies of leadership influences have been numerous, with reports on leadership personality, physical traits, or behaviours of leaders; the relationship between leaders and followers; and how aspects of the situation affect the way leaders act (Hughes, et al., 1999, Mello, 1999). These multifaceted and multifocussed studies whilst highlighting the pluralistic nature of leadership have failed to provide a clear universally acceptable definition of leadership (Leithwood, Jantzi, & Steinbach, 1999; Yukl, 2002).

The current shift from industrial to post industrial era will add further complexity to leadership definitions as most emerged from the industrial paradigm which has failed to address the recent emphasis on the social, emotional, value based, relational aspects of leadership (Popper, 2004; Shriberg, et al., 2002; Yukl, 2002). As Senge (1990) writes:

Our traditional view of leaders - special people who set directions, make key decisions and energise the troops – re-rooted deeply in an individualistic and nonsystemic world view...At its heart the traditional view of leadership that is based on assumption of people's powerlessness, their lack of personal vision and inability to master the forces of change, deficits which can be remedied only by a few great leaders. (p. 340)

In the past, leadership focussed on control and structure of human behaviour, with organisations relying on these views of leadership to quantify human qualities which became highly regarded by them (Limerick, et al., 1998; Popper, 2004; Rost, 1991). Overall, this view has failed to take into account leadership that occurs outside of formal organisational structures. Organisations that reflected the industrial view demonstrated leadership as the property of the individual; considered primarily in the context of formal groups and organisations; [and] equated to management (Shriberg, et al., 2002).

Whilst the industrial leadership perspective provided legitimacy to management values such as efficiency, productivity, maintenance of organisational structures, development of processes and use of reward power to get routine things done in stable times, their irrelevance in an era characterised by rapid change has been well documented (Gibb, 1998; Senge, 1990; Skipton Leonard, 2003). Changing eras require that for

contemporary organisations to be successful, within a world which is information rich and constantly changing, they need to move from a bureaucratic-mechanistic model of leadership toward one that highlights leadership as “a relationship that exists among people in a social situation” (Grohar-Murray & DiCroce, 2003, p. 31). Therefore as health care organisations enter an era of changing leadership opportunities for the exploration of leadership from the nurses’ perspective are emerging.

### **3.4.2 Moving Towards a Post Industrial Leadership Paradigm**

As organisations shift into the post industrial era, recent leadership studies have offered deeper insights into human relationships by identifying that leadership is “grounded in a state of being, not doing” (Senge, 1998, p. 1). Leadership’s relational element has been defined by how the leader serves others and alters their own leadership expression based on the needs of followers in a given situation (Grohar-Murray & DiCroce, 2003). Consequently, this type of leadership relationship is based upon empowerment of “followers instead of using power to dominate them” (Yukl, 2002, p. 404).

In the light of the need for new leadership Shriberg, et al. (2002) reported that in the mid 1970’s leadership views shifted as organisations responded to challenging social and economic times. They reported Greenleaf presenting the case for servant leadership where cooperation and support rather than power and authority were more productive ways of dealing with change, at the same time Burns offered two contrasting approaches of transformational and transactional leadership. Whilst both of Burn’s approaches reflected relational elements, transformational leadership theory demonstrated its strength in the changing world of contemporary organisations and became the genesis for a new paradigm of leadership (Yukl, 2002).

In seeking further clarification of the meaning of leadership and following on from these theorists, Rost (1991) undertook an extensive literature review to gain a clearer understanding of leadership. From this review, he proclaimed a



post industrial paradigm of leadership which clearly distinguished the differences between leadership and management (Shriberg, et al., 2002). For Rost (1991), leadership was an influence relationship among leaders and followers who intended real change that reflected their mutual purposes. He noted that influence was multi-directional, with active collaborators whereby there could be more than one leader. In post industrial paradigm the effectiveness of leadership would be judged after the fact. In summary, Rost's review of leadership highlighted a clear shift in thinking from the rigid leadership models of the industrial era to a leadership that becomes participative, shared and relational in nature, the leader becomes self aware, with leadership effectiveness being defined by the leader's reflection in and on action. In the light of Rost's views of leadership and the needs of contemporary organisations, it is suggested that a new view of leadership is necessary for promoting authentic transformation in organisations.

More recent leadership literature has highlighted other theorists who have drawn on their own experiences in organisations and demonstrated the need for new models of leadership to meet the demands of information rich and complex work environments of the post industrial era (Shriberg, et al, 2002; Spry, 2004). Spry proposed that these scholars reflected the changing values of leadership and demonstrate a growing interest in the relational nature of new leadership. Wheatley (1992) described a new paradigm of leadership that takes into account contemporary understandings of chaos and quantum physics. Bensimon and Neumann (1993) offered a model of collaborative leadership on understanding that information rich and complex environments require more than one mind to understand and solve complex problems. Drath and Palus (1994) suggested that leadership involved meaning making in the context of a community of practice.

Given the changes that are occurring within contemporary health care organisations, it is the relational elements of new leadership that offers the opportunity for exploration of nurse leadership from the nurses' perspective. . Recent studies of nurses working with physicians in contemporary health care organisations have indicated that the hierarchical nature of bureaucracy is changing to structures that are flatter and support a team approach with each

party being recognised as contributing valued skills and experience (Budge, Carryer, & Wood, 2003). These changes, reflected in organisational structure and culture, indicate a shift toward the post industrial era whereby the social, emotional, values based, relational aspects of leadership can be examined (Popper, 2004). For the author, these changes provide the impetus for exploring leadership and nursing practice from a new perspective. Within this paradigm there is an opportunity for nurses to be able to define their unique product in the health producing process through the language of new leadership (Spitzer, 1998).

### **3.4.3 New Leadership**

The decade of the 1990s has seen the emergence of a new post industrial paradigm of leadership (Shriberg, et al., 2002). As has been previously explained, recent leadership studies are moving from the industrial, singular, designated person model to a more participative, “power sharing” model of leadership with the concepts of “reciprocity” and “equity in exchanges” key features (Yukl, 2002, p. 154).

New leadership has shifted thinking away from the solo model of bureaucratic leadership toward the view that “leadership can spring from anywhere, it is not confined to organisational hierarchy, leadership is a political and courageous act to empower followers to become leaders themselves” (Shriberg, et al., 2002, p. 211). Consequently, the basic values of leadership are changing, with leadership viewed as a “shared human process” an activity that people engage in together, “within a community of practice” (Drath & Palus, 1994; p. 4). This notion of community and human relationships is extended by descriptions of leadership taking place within “tangled webs of relationships”, where organisations are “living systems” and each person creates their interpretation of what is real (Wheatley, 1998, pp. 3-6).

Overall, new leadership is “not restricted to the influence exerted by someone in a group” but acknowledges that “contexts, values and followers are part of the leadership process too” (Hughes, et al., 1999, p. 12). Therefore interactive

nature of new leadership encourages consideration of the “impact of social contexts on the dynamics of the leader follower relationships” (Popper, 2004, p. 110). Subsequently, leadership is not separated from the leader, but situates it in patterns of dynamic relationships among leaders within a group, whereby leadership is accomplishment of group purpose (Horner, 1997).

Because of its dynamic nature, the effectiveness of new leadership is determined by a number of variables that “depend partly on the person of the leaders, partly on the situation at hand, and partly on the qualities or maturity of the followers” (Grossman & Valiga, 2000, p. 6). The complexity of new leadership is demonstrated in the following:

Collaborators choose the leaders with whom they wish to affiliate, and they may or may not be the people who hold authority over them. Thus leadership is not confined to those in power in the organisation hierarchy. Leaders and collaborators often change places in the ebb and flow of the leadership process. A number of leadership relationships may be present in any organisation, and leaders in one relationship may be collaborators in another. Leadership is episodic, a stream of activities that occur when people intend a specific and real change for their organisation or group. One is not a leader all the time, but rather occurs when one chooses to exert the most influence on the change process. (Shriberg, et al., 2002, p. 214)

This interchangeable, dynamic and complex leadership has resulted in a plethora of reported observations as researchers attempt consolidate their findings. Overall the studies have emphasised the “relationship development” within a “shared social reality” and the “leader’s success in creating motivated and competent followers” (Skipton Leonard, 2003, p. 10). As a result, Lambert (2002) proposed that leadership now be considered as an interactive, reciprocal, meaning making process rather than a predictable leader authority over follower model.

Within this research effort, Drath and Palus (1994) have situated post industrial leadership within the theoretical perspective of constructivism. This approach has highlighted that leadership is not separated from the leader but situates it in patterns of reciprocal relationships which “enable participants to construct meaning and knowledge together” (Lambert, 2002, p. 41). From this perspective, leadership is understood by the way that participants create

meaning and act on that meaning so that shared purpose and collective action emerges, in short, it is a relational element in which everyone in the organisation is engaged (Horner, 1997; Lambert, 2002). Thus, leadership is a process of providing frameworks by which members of the group or community make sense of what they are doing, why they are doing it, and what they have learned from it:

...meaning-making happens through such processes as identifying vision and mission, framing problems, setting goals, arguing, engaging in dialogue, theory building, testing, story telling and making contracts and agreements... From an individual perspective it's not so much that the person is first a leader and then creates meaning; it is more that, in making meaning a person comes to be called a leader...It is the process of participating in making meaning in a collective sense that makes leaders out of people. (Drath & Palus, 1994, pp. 10-11)

Consequently, the constructivist view of leadership offers this study opportunities to explore leadership as both a process and social construct (Drath & Palus, 1994). Such a view provides the impetus for exploration of nurse leadership from a fresh perspective that can offer conversations “that are broader, with a wider range of possibilities, than ever before” (Lambert, 2002, p. 37). This pioneering work will offer the opportunity to broaden knowledge of leadership in contemporary organisations and contribute to the acceptance of the idea of “new leadership” so that it can be embedded within theory and practice of leadership including, nurse leadership.

#### **3.4.4 Nurse Leadership**

The values and capabilities embedded in the new leadership resonates with contemporary nursing, because at the micro level of health care organisations, one does not *do* nursing, one *lives* nursing in partnership with others. It is within these partnerships that nurses use their unique ability to enact their practice and relate to others in a manner which is associated with personal understandings about who they are and what is important to them (Arbon, 2004). In other words, nurses bring their lived experiences to these partnerships.

When establishing informal partnerships at this level, nurses take into account the social differences within the team that are determined by the team members' values, attitudes and beliefs, (Fagin 2001; Degeling, Hill, Coyle, & Maxwell, 2000). Nurses use their understanding of the lived world of others, to provide them with some of the most fruitful opportunities for nurturing professional relationships and shared leadership (Cortes, Noyes, & Brennan, 2000). By using their understanding of others to form relationships and partnerships, nurses have been able to provide holistic care which is complementary to but different from care available from other care providers (Graham, 2003). In this way, nurses have been able to present their contribution to health care services by customising their services to the unique needs and desires of the client group (Graham). Nurse leadership, in this context, therefore is characterised by reciprocal caring rather than competition or duty (DeMarco, Horowitz & McLeod, 2000). It is a leadership that requires clarification by exploring nurses' thoughts and actions of their work in professional partnerships (Graham, 2003).

Nurse leadership is motivated by its vision that has the patient as the focus in the health care team. The collaborative partnerships formed with other health care team members enable nurses to realise their vision (Kosinka & Niebroj, 2003; McSherry, 2004). It is within these partnerships nurses have adopted the role of interpreter for their patients' needs (Antrobus & Kitson, 1999; Cook, 2001b). Consequently, it is when nurses exert their sphere of influence by practising their nursing knowledge, values and beliefs that leadership becomes visible.

As organisations move into the post industrial era, contemporary nursing literature highlights changes in the way that nurse leadership is examined. Nurse leadership at the micro level of organisations is becoming more widely discussed and explored as it becomes more visible through the lens of new leadership perspectives (Armstrong, 2004). However, there is still a failure to recognise the contributions of nurses' work or give meaning to their leadership whilst health care organisations continue to be measure leadership against the traditional characteristics of organisational status and authority (Stordeur, et al., 2001).

Whilst there is evidence that nurses are demonstrating leadership initiatives in their work, there are limited studies that have closely examined nurses, their leadership and work from the post industrial leadership perspective (Kerfoot & Wantz, 2003). This lack of evidence of post industrial nurse leadership is attributed to the dominance of the industrial leadership perspective which continues with adherence to “leadership models that force compliance and manage by hierarchy and bureaucratic control” (Kerfoot & Wantz, 2003, p. 378). As has been demonstrated in Chapter 2, the industrial model of leadership has influenced and shaped the work of nurses in the past and contributes to restrict full expression of the discipline (Jonsdottir, Litchfield, & Pharris, 2004). Accordingly, nurse leadership is not visible to nor valued by the conventional tests of leadership which relate to a positional power that serves to privilege certain positions above others regardless of their form, structure, utility, or inherent value (Sinclair, 1998; Thorne, Kirkham, & Henderson, 1998).

Failure of contemporary health care organisations to recognise nurse leadership has also been attributed to the variety of individual leadership styles nurses undertake in their practice (Cook, 2001b). Nurses choose from a variety of styles of leadership in order to gain utility rather than status as they act to create harmonious environments so as to achieve successful integration of all health care services (Armstrong, 2004; Graham, 2003). Whilst some styles have been reported by nurses as being more effective and popular than others, their overall, choice of leadership style was influenced by personality, background and circumstances of the context within which they were placed (Armstrong, 2004; Cook, 2001b). However, regardless of their choice of leadership style, nurses have demonstrated a resistance to formal, traditional models of leadership, because they identified the need to be adaptable and “provide multiple strategies, consistency and time” in order to achieve better outcomes for their patients (de Jonge & Jackson, 2001, p. 72).

In order to enact their vision, nurses have used their knowledge to influence other team members so that they could successfully achieve integration of health care services for their patients (Antrobus & Kitson, 1999; Cook, 2001a).

Consequently, nursing practice has become more overt, as nurses operated between the domains of nursing practice and those of other team members. Nurses used this opportunity to interpret issues to the language that was meaningful to all so that “in the translation of their ideology, the values of nursing are not lost” (Antrobus & Kitson, 1999, p. 750). Subsequently, leadership effectiveness has been gauged by the nurses’ ability to access and promote nursing knowledge to make articulate their vision to remind others that the patient remains the primary focus of the clinical domain (Kosinka & Niebroj, 2003).

Furthermore, nurses are influencing health care teams by articulating their practice goals of patient centred care and exercising their leadership to expand their circles of influence (McCarthy, Pearson, & Hegney, 2000; Porter-O’Grady, 2003). Consequently, as nurses become more visible in health care service provision, they are being acknowledged as supporting change within organisations by demonstrating a sense of accountability to financial realism and transparency of actions to self, peers and patients (Degeling, Maxwell, et al., 2003). As nursing’s contributions become more obvious, nurses within their organisations, have proposed an alternative view of leadership so that they can better achieve a collaborative approach toward successful health care outcomes (Porter-O’Grady, 2003). It is therefore anticipated that, as nurses become recognised for their contributions to patients’ well being within their organisations that they will be given the responsibility and authority for leadership for different and independent aspects of health care services (Jonsdottir, et al., 2004; McCloskey & Maas, 1998; Spitzer, 1998).

Recognition of the contribution of nurses’ work by health care organisations will require a shift in thinking about leadership. Because their leadership looks different and, therefore, is difficult to register as traditional leadership, nurse leadership requires a shift in thinking from a model that requires them to be equal and the same as other professions, to one where they can be equal and unique (Armstrong, 2004). As nurses have worked to maintain their vision within changing organisations, they have come to recognise that the industrial model of leadership no longer serves them appropriately as their contributions fail to fit its specific, established criteria (McCloskey & Maas, 1998, Cook,

2001b). In the light of this conclusion, if the nature of nurses' work is to be explicated from a leadership perspective, the concept of nurse leadership, at the micro level of health care organisations needs to be reconceptualised from within a post industrial view. By taking this view, new thoughts on nurse leadership may emerge. It is anticipated that these thoughts will challenge current assumptions of leadership in nursing.

Given the changing contexts and multiple understandings of leadership, it is important to explore how nurses construe their leadership behaviours during the delivery of health care. Consequently the third question is:

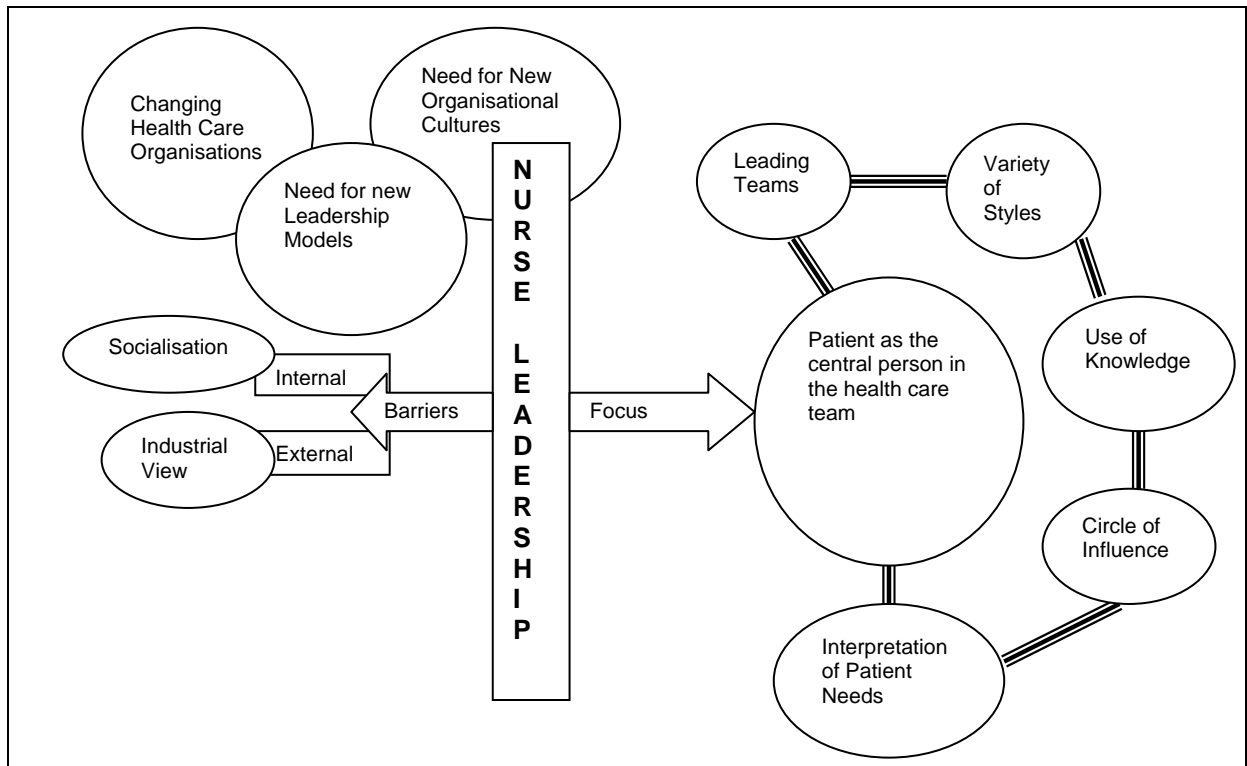
**How do nurses construct their leadership role during the delivery of health care?**

### **3.5 CONCEPTUALISATION OF NURSE LEADERSHIP**

Figure 3.2 illustrates the conceptualisation of nurse leadership. It offers a diagrammatic representation of the major concepts from the literature which underpinned this research. Each concept is embedded in the literature review and related to the review's conceptual framework (Figure 3.1) adapted from Slaughter's Transformative Cycle (1998). Each concept has been **bolded** within the discussion for ease of referral to the figure.



**Figure 3.2 Conceptualisation of Nurse Leadership**



### **Barriers to Nurse Leadership**

As the impact of changing world views becomes more evident within contemporary organisations, there will be organisational shifts that reflect societal values of service, information technology and human capital as transforming organisational contexts (Horner, 1997; Senior, 2002, Skipton Leonard, 2003). Meanings about structures and roles breakdown, people are challenged to create a new way of thinking about leadership (Porter-O'Grady, 2003c). Consequently, as **changing health care organisations** become increasingly reliant upon individuals, they realise that they need to move from a mechanistic model of leadership toward one which uses a more interrelational approach (Kerfoot & Wantz, 2003; Senior, 2002).

The literature has highlighted that whilst contemporary organisations need to reconceptualise leadership there continues to be a reluctance of these organisations to relinquish industrial views of leadership (Laiken, 2003). Resistance to acceptance of **new leadership models** is evident when authority holders continue to define

leadership from the perspective of achievement, greater efficiencies and expansion of bureaucratic rationality (Rost, 1991; Shriberg, et al., 2002).

As organisations fail to shift from their traditional values, dissonance between work and personal values has become obvious (Dunoon, 2002). Conflict and negotiation results as individuals demonstrate that their work commitment depends upon how closely their own values are aligned to the organisation's values (de Castro, et al., 2004; Graham, 2003).

Tensions within changing organisations highlight the need for the development of **new organisational cultures** as the commodification of work holds precedence over human values within the workplace (Laiken, 2003). These tensions have contributed to any proposals for change being met with a degree of resistance and cynicism by individuals at the micro level of the organisation (Limerick, et al., 1998). Overall, conflict of values has created a sense of apathy and powerlessness in the workers as organisation continue to designate responsibility for decisions regarding organisational change to middle, senior and executive managers (McSherry, 2004). Whilst formal leadership models are maintained within the organisation, informal leadership and groups have emerged from the tensions between personal and organisational values. These groups are considered the most influential subcultures within and between organisations because they share the same values and partake in social action (Fullan; 2001; Hein, 1998, Limerick, et al., 1998). In the light of this development, it has been suggested that in order "to capture the dynamics of such a group," conventional concepts of group cohesiveness, leadership and team work be significantly reframed (Limerick, et al., 1998, p. 238). Therefore so as to capture nurse leadership within the context of health care services , insight could be gained from exploration of the nurses' role within the team.

**Socialisation** of nurses in organisations that hold industrial views of leadership, has masked nurse leadership with perpetuation of stereotypical images of nurses as passive and subordinate to other health professionals (Liaschenko & Peter, 2004; McCloskey & Maas, 1998). This in turn, has influenced the way in which nurses perceive themselves as leaders (Cook, 2001b; Wynne, 2003). Nurses, at the micro level of the organisation fail to see their active involvement in organisational

development and restructuring (Antrobus & Kitson, 2001). Consequently, exploration of how nurses construct their leadership may provide an understanding of the impact of socialisation on their personal meanings of leadership.

Despite a demonstrated organisational shift from industrial to post industrial era, it appears that **industrial model** of leadership is being maintained by contemporary organisations even though these fail to adequately contribute to organisational change or successful integration of health care services (Degeling, Maxwell, et al.; Skipton Leonard, 2003). Reluctance to adopt a new view of leadership has contributed to the failure to recognise the holistic, interactive and collaborative nature of nurses' work (de Jonge & Jackson, 2001; Graham, 2003). Consequently, the criteria of traditional leadership against which nurse leadership, at the micro level of the organisation, is judged has resulted in a lack of status and recognition (Liaschenko & Peter, 2004). This is evidenced by studies of nurse leadership that are grounded into administrative and management functions and explained through established theories (Armstrong, 2004; Cook, 2001a; Grossman & Valiga, 2000; Kerfoot & Wantz, 2003; Allen, 1998; Wynne, 2003). Subsequently, nurses, when seeking recognition for their work, have expressed the value or worth of nursing in a language that may be heard by others through managerialist devices and technologies (Antrobus, 2003; Hewison, 1999;). Therefore rather than understand leadership from the traditionalist perspective, there is a requirement to understand how nurses' construct their leadership in their own words. This understanding will, in turn, illuminate the value that leadership holds for nurses.

### **Nurse Leadership**

As nurses provide health care services within **changing health care organisations**, they have demonstrated motivation to change their practice models from the traditional, hierarchical models of care to practices of shared governance where everyone has an equal voice and everyone assumes a position (Peach, 1999, July; Sheehy, 1995). As a result, nurses' work in teams, is becoming selectively legitimised by organisations as their actions contribute to cost containment and assurance of optimal patient outcomes (Hansen, Bull, & Gross, 1998; Greenwood, 1999).

Post industrial organisations expect that a **new type of leadership** will create a culture of change to move organisations forward and cause a greater capacity within the organisation for better results (Fullan, 2001; Limerick, et al., 1998). Nurses who found themselves in a leadership role within this context, have come to realise that they cannot achieve “their personal vision by themselves” (Skipton Leonard, 2003, p. 10). Consequently, nurses have shifted their view of leadership from one of indirect, management to one which encompasses all who are involved in the delivery of health care services, including the patient (Cook, 2001; Armstrong, 2004).

The nurses who encompass this new type of leadership recognise the **need for new organisational cultures**, cultures that replace old bureaucratic forms of management. Nurses describe new organisational cultures as those with “transparency, openness, relationships and partnerships” whereby “ownership of the idea, unit and organisation is shared and all staff are full and participating members in health care services” (Kerfoot & Wantz, 2003, p.34). As nurses strive to maintain a holistic care discourse in an environment where managerialism quantifies health services and outcomes in monetary terms, the tensions experienced by nurses in their work act as a catalyst for their actions toward the development of new organisational cultures (McCloskey & Maas, 1998; Chiarella, 2000; Porter-O’Grady, 2003b). At the same time, nurses find their own role in organisations in question as they try to provide highlight their leadership in a context that demonstrates a dichotomy between the values of caring and the values motivated by finance (Ainsworth, 1998).

Perpetuation of the **industrial model** of leadership within contemporary health care organisations highlighted that “a significant portion of nursing work” does not appear to have economical value (Malloch & Porter-O’Grady, 1999, p. 300). This model has restricted full expression of the discipline of nursing, despite nurses’ actions to meet the organisations’ goals of productivity, quality and efficiency through leadership initiatives, their contributions to holistic patient care fail to be recognised (Degeling, Maxwell, et al., 2003; Jonsdottir et al., 2004; Stordeur et al., 2001). Accordingly, nurse leadership is not visible to, nor valued by, conventional tests of leadership (Sinclair, 1998; Thorne, et al., 1998). However, despite the challenges nurses recognise opportunities for formal inquiry into their leadership through clinical

governance and its influence relationships within health care teams (Armstrong, 2004; Atsalos & Greenwood, 2001).

### **Focus**

**Nurse leadership** focuses its vision on the **patient as the central person in the health care team**. It is this vision that enables nurses to form collaborative partnerships within contemporary health care organisations so that they can meet the patient's health needs and improve health outcomes (Kosinka & Niebroj, 2003; Queensland Nursing Council, 2005).

As contemporary health care organisations adopt structures that are dynamic and interactive, nurses leadership is becoming more overt within health care teams (Cook, 2001a). Nurses are informally **leading teams** and building partnerships and coalitions through interaction with different health care groups and disciplines (Greenwood, 1999; Malone, 2000; Scott, et al., 1999). Examination of these relationships provide an opportunity for examination of nurse led initiatives that have demonstrated leadership principles based on collaboration rather than competition (De Marco, et al.2000; Sarros, 2002).

So far, examination of nurses' informal leadership in health care team members has highlighted that nurses adopt **variety of leadership skills** to (Axelsson, et al., 2000). Variation of leadership has enabled nurses to move away from their traditional task focussed activities toward a collaborative form of leadership that facilitates positive patient outcomes (Grossman & Valiga, 2000). Consequently, for the purpose of this study, examination of leadership from the perspective of nurses working in health care teams would determine the effectiveness of their leadership (Limerick, et al., 1998; Hughes, et al., 1999).

The nurses **use of knowledge** derived from practice combined with their **sphere of influence** over other team members has ensured successful integration of health care services (Antrobus & Kitson, 1999; Cook, 2001a). As they used their knowledge to operate between the domains of nursing practice and **interpretation of patient needs** in a language that was meaningful to others in the health care team, nursing

practice became more visible (Antrobus & Kitson; Wynne, 2003). Visibility of practice became evident when the nurses used knowledge to articulate their vision and remind others that the patient remained the primary focus of the clinical domain (Kosinka & Niebroj, 2003). Consequently, the nurses gauged the effectiveness of their leadership through their unique ability to enact their practice and relate to others (Arbon, 2004). In this way, nurses have been able to present their unique contribution to health care services by customising their services to the unique needs and desires of the client group, (Graham, 2003).

### **Impetus for this Study**

Nurses, operating within the current health care system have identified that the industrial model of leadership no longer serves them appropriately because it fails to recognise their leadership contributions (McCloskey & Maas, 1998, Porter-O'Grady, 2003b). In the light of this revelation, the concept of nurse leadership, at the clinical level of contemporary health care organisations, could therefore be reconceptualised through a post industrial perspective. By taking this view, new thoughts on nurse leadership will be able to emerge. It is anticipated that these thoughts will challenge the basic assumptions about nurses' work established by the industrial paradigm, and promote innovative insights for scholarly dialogue on nurses' contributions to health care services.

### **3.6 CONCLUSION**

The literature concludes that nurses, who operate within contemporary health care organisations, have robustly taken upon themselves leadership initiatives in the conduct of their role as health care providers, yet their colleagues in health care continue to perceive them to be passive participants in the delivery of health care services.

Incomplete understanding of leadership prevails because studies continue to focus on the narrow and often inappropriate traditional theories of the industrial paradigm (Skipton Leonard, 2003). As a result, full appreciation of contemporary leadership is confined by mental models that significantly limit knowledge development of

leadership in a post industrial era is (Limerick, et al., 1998, Shriberg, et al., 2002). Likewise, studies of nurse leadership have been largely undertaken on nurses who hold formal leadership positions within the organisational structure such as nurse administrators and nurse managers rather than at the clinical level where the majority of nurses practice (Cook, 2001a). Therefore in order to explicate the relevance of nurses' work by exploration of their leadership initiatives, it is timely to put aside the grand narratives of leadership which have developed knowledge from the view of the organisation, not the individual (Skipton Leonard, 2003).

New knowledge about leadership can be gained through post industrial thinking, with leadership studied from the perspective of the relationship between leader and follower within a social context, rather than through the exclusive influence of one person (Drath & Palus, 1994; Lambert, 2002; Shriberg et al, 2002). The point of this view is that it encourages scholars to explore the notion that there are many appropriate ways to lead (Limerick, et al. 1998; Skipton Leonard, 2003). Exploration of leadership through this paradigm offers opportunities for contemporary nursing practice to explore nurse leadership, especially as effective nurse leadership has been identified as pivotal to the creation of a work environment that harnesses collective strength, develops membership and shares successes (Creegan & Duffield, 2004).

This study will consider an alternative approach to leadership theory development by considering a process of meaning making referred to by Drath and Palus (1994) as constructionism. In order to advance the study of leadership, Ospina and Schall (2001) considered constructionism to be a valuable resource for understanding leadership, because it suggests that leadership, as a form of human behaviour, is a social construct. Within this research focus, leadership can be observed as something that emerges as people make sense out of their everyday lives and can therefore be understood as a contextualised process that develops over time (Drath & Palus, 1994). This is particularly relevant as nurse leadership has been demonstrated at the clinical level, where nurses take the initiative to develop working relationships, empower individuals and teams in order to achieve more effective and better health care outcomes (Cook, 2001a; Creegan & Duffield, 2004). Therefore this study aims to highlight the role of the nurse within contemporary health care

organisations by making clear the unique nature of their work through the perspective of post industrial leadership.

Whilst amplifying and revealing the research problem, the literature review also generated following research questions (as can be viewed in Figure 3.3). The research questions that focus the conduct of this study are:

1. How do nurses describe leadership within their health care organisations?
2. How do nurses experience leadership within their health care team?
3. How do nurses construct their leadership role whilst providing health care services?



**Figure 3.3 Development of Research Questions from the Literature Review**

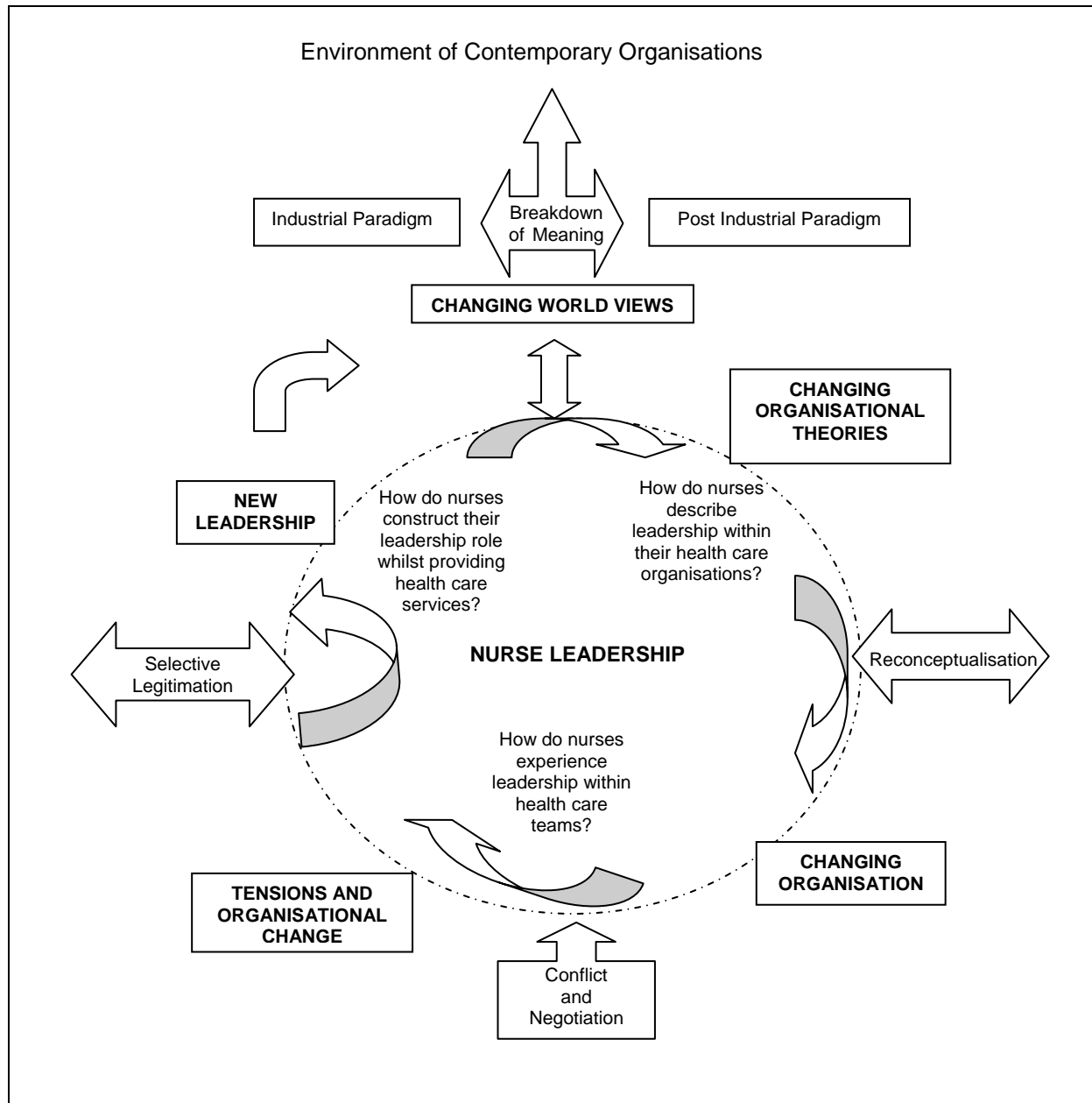


Figure 3.3 utilises the conceptual framework established for the literature review to demonstrate how the questions for this study emerged. It demonstrates how changing paradigms have stimulated organisational change from which new views of leadership and organisational theories have emerged and give rise to the first question. This question will offer the opportunity to come to know how nurses' describe leadership in their organisation.

As organisations responded to change, conflicts and tensions emerged as roles and functions of teams have been challenged by new environments and values of work. Consequently, examination of the nurses' role in teams will illuminate how nurses experienced their role in the health care team.

Finally, as negotiations between organisations and workers legitimate new leadership, nurses have recognised the opportunities for leadership initiatives. This focussed the question on how they construct their leadership role whilst delivering health care services.

The research questions will enable this study to gain a clearer understanding of nurses, their work and leadership. In order to do this the researcher is charged with developing a research design whereby meanings that nurses give to leadership can be theoretically explicated.

## **CHAPTER 4: DESIGN OF THE RESEARCH**

The purpose of this chapter is to explain and justify the research design adopted in the exploration of how nurses have undertaken leadership initiatives in their role as health care providers within contemporary health care organisations.

The research questions that focus the research design are

1. How do nurses describe leadership within their health care organisations?
2. How do nurses experience leadership within their health care team?
3. How do nurses construct their leadership role whilst providing health care services?

### **4.1 INTRODUCTION TO DESIGN OF THE RESEARCH**

Given the purpose of this study, the researcher adopted an interpretive design to explore how the nurses who were participants of the research had undertaken leadership initiatives in their role as health care providers within contemporary health care organisations. In order to elicit the participants' individual, personal constructions of leadership and gain understanding of their meaning of leadership from their lived experiences, the epistemological framework of constructionism was used (Peters, 2000). Because the meaning of nurse leadership was constructed through social interaction, symbolic interactionism formed the theoretical perspective through which data analysis was conducted. Symbolic interactionism enabled the researcher to gain a clearer understanding of how social interactions with the organisation and other health care team members influenced the nurses construction of their leadership (Cossette, 1998). Case study was used as the methodology. This complemented both the study's epistemology and theoretical perspective and enabled a deeper understanding of the wholeness or the unity of the case (the nurses) in its natural setting (Miles & Huberman, 1994). Consequently the contemporary nursing phenomenon, leadership, within a real world setting, could be empirically investigated as the researcher posed questions to those nurses from whom most could be learned (Merriam, 1998; Yin 1994).

The study aims to extend both practical and theoretical knowledge on nursing leadership. Insights gained will have the potential to contribute to professional knowledge of nurses at all levels of health care services.

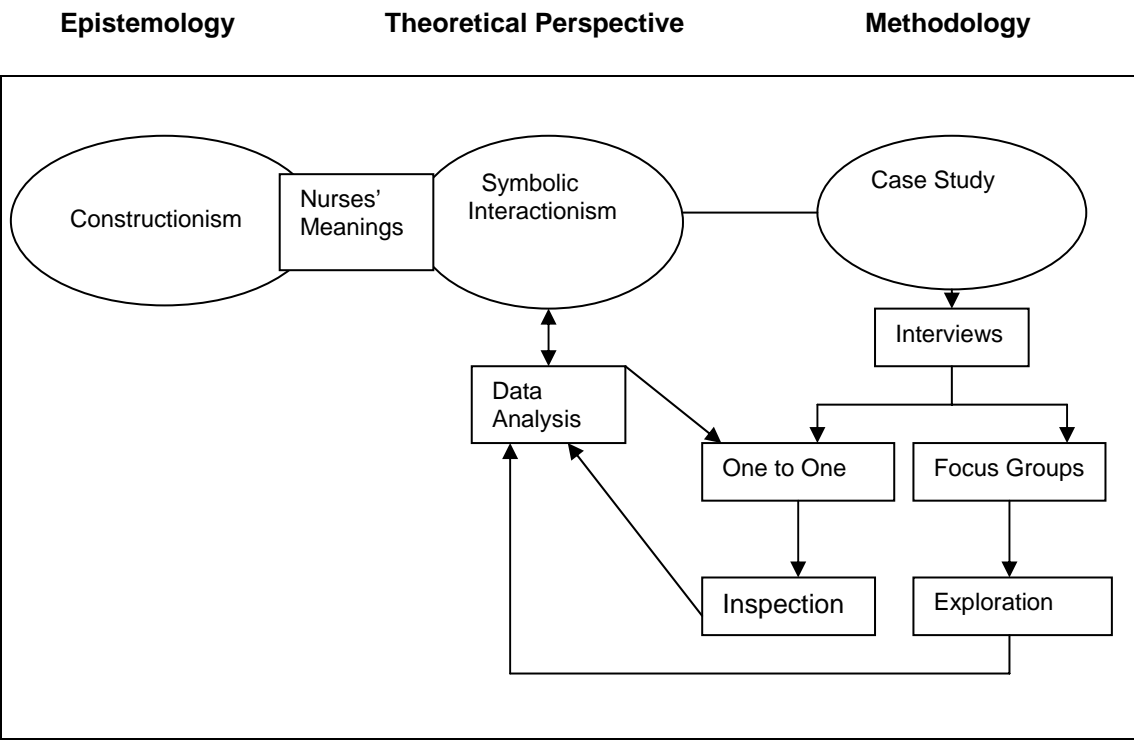
Table 4.1 offers an overview of the four elements of the interpretive research. The subsequent text in the Chapter addresses each element in detail.

**Table 4.1 Four Elements of Interpretive Research**

<b>3.2 Research Paradigm</b>	Interpretive
<b>3.2.1 Epistemology</b>	Constructionism
<b>3.2.2 Theoretical Perspective</b>	Symbolic Interactionism
<b>3.3 Research Methodology</b>	Case Study
<b>3.4 Participants</b>	Purposive Selection
<b>3.5 Data Collection Methods</b>	Interviews: semi-structured and informal Focus group interviews One to one interviews

Figure 4.1 offers a diagrammatic representation of the research design. This will be expanded on in subsequent text.

**Figure 4.1 Overview of Research Design for the Study**



## 4.2 THEORETICAL FRAMEWORK

An interpretive approach has been adopted for this study. The aim of interpretivism is to explore the values, attitudes and beliefs which influence people to act in a particular manner (Punch, 1998). Interpretive researchers accept that concepts of reality are constructs of the human mind and can, therefore vary from one person to another and that descriptions of human actions are based on social meanings (Bassey, 1999). Constructionism and symbolic interactionism are two research orientations embedded in the interpretivist paradigm that guided this study (Crotty, 1998).

### 4.2.1 Epistemology: Constructionism

This study has adopted the epistemological underpinning of constructionism (Crotty, 1998) or social constructivism (Stieb, 2005) to give voice to the meanings of leadership embedded in the language of the nurses as they responded to the research questions. Constructionism acknowledges realism

in a personal and subjective way as human beings engage with the world they are interpreting (Crotty, 1998; Peters, 2000; Watts, 1994).

Epistemologically, constructionism is centred around the view that all knowledge and therefore all “meaningful reality as such, is contingent upon human practice being constructed in and out of interaction between human beings and their world, and developed and transmitted within essentially social contexts” (Crotty, 1998, p. 42). Within this context, the use of constructionism enables understanding of the participants’ reality as “it is internally experienced, socially constructed and interpreted” (Sarantakos, 1998, p. 36). In order to achieve a deeper understanding of how meanings are constructed by the participants, this study acknowledges that each person’s way of making sense of the world is seen as valid and worthy of respect as any other (Crotty, 1998; Holloway, 1999; Phye, 1997). In order to understand each person’s meaning, constructionists emphasise language, narrative, socio-historical, and cultural processes as “primary factors in meaning making and in understanding their own constructions and knowledge base” (Rodwell, 1998, p. 20). Consequently, the multifaceted nature of constructionism is useful for the purpose of this study as nurses’ constructions of leadership within the reality of their practice have been influenced internally by their personal values and beliefs and externally, by their professional values and their practice contexts (Schwandt, 1998)

The appropriateness of constructionism for this study is in its assumption that, in dialogue, the person is engaged in constructing something for others to appreciate and therefore it is concerned with:

- Recognition of reality from within the human mind whereby one has to experience the world to know it (Peters, 2000; Ribbins & Gunther; 2002; Schwandt, 1998).
- The process of constructed meaning which is subjective and active, whereby the participants draw on their personal background and knowledge to make sense of their world (Peters, 2000; Schwandt, 1998).

Because constructionism provided an opportunity to gain an understanding of the human drive which actively creates and constructs meaning, these assumptions were incorporated in the process of data collection and analysis (Crotty, 1998; Fensham, Gunstone, & White, 1997). This enables the researcher to offer intellectual significance to the nurses' life experiences (D'Andrea, 2000; Holloway, 1999).

The complexity of constructionism is demonstrated in the literature whereby it is described as both diverse and moving, being used in differing and changing ways that makes its meaning uncertain (Bredo, 2000). Consequently, constructionism can often polarise internal versus external perspectives, resulting in conflict of interpretation, which raises the question as to whether knowledge or meaning is either individually or socially constructed (Dickins, 2004; Howe & Berv, 2000). There tends to be a lacuna in the literature which fails to clearly differentiate between constructionism (socially constructed meaning) and constructivism (individually constructed). What makes constructionism so challenging "is the issue of judging between competing discourses" (White, 2004, p.10). In the light of these concerns about constructionism, the researcher takes the position that

There is no such thing as knowledge uncontaminated by any particular system of human purposes, beliefs, values and activities, the world and values...it is grounded in experiences and practices, in the efficacy of dialogue, negotiation and of action. (Howe & Berv, 2002, p. 33)

To provide further clarity and develop theoretical knowledge from this study, the researcher acknowledges the influence of Vygotsky's (1978) theory of social constructivism because Vygotsky determined that knowledge and meaning making were not undertaken in isolation but rather through social interaction (Bredo, 2000; Woolfolk, 1998). During the process of this study, Vygotsky's theory (cited in Woolfolk, 1998, p. 279) was used to make the following suppositions about the meanings the nurses' gave to their leadership:

- Knowledge was constructed based on social interactions and experience
- Knowledge reflected the outside world as influenced through culture, language, beliefs, interaction with others, direct teaching and modelling
- Knowledge which drove their constructions emerged from both their internal and external world

#### **4.2.2 Theoretical Perspective: Symbolic Interactionism**

A theoretical perspective is based on a way of looking at the world and constructing an understanding of the world. The theoretical perspective must be congruent with the purpose of the research and justify the selection of particular methodology and methods to fulfil that purpose and to answer the research questions (Crotty, 1998). Symbolic interactionism has been adopted as a lens to inform the theoretical perspective of this study because it is concerned with how people define events or reality and then act accordingly (Horn, 1998; Stake, 1994).

Symbolic interactionism is based on the belief that people react to situations as they perceive them and hold meaning for them (Blumer, 1986). Meanings are created by human beings in interaction with one another, rather than as individual agents (Charon, 2001). Likewise, the world of nursing is recognised as a socially interactive process with nurses engaged in thoughtful, self-reflexive behaviour, so that they can interpret the world they are confronted with (Schwandt, 1998). In order to gain an understanding of that world, symbolic interactionism enabled the researcher to gain a deeper understanding of nurse leadership from the naturally socially interactive situations the nurses described (Cossette, 1998; Longmore, 1998). Symbolic interactionism is focussed not on the perspectives of the researcher, but rather on that of the research participant.

Consequently, symbolic interactionism guided the theoretical development for this study. Symbolic interactionism provided the focus for concept development during data analysis, it acted as a filter through which to highlight the importance of social interaction whereby human conduct was described and meanings created (Blumer, 1969). Concept development was assisted by the use of Blumer's three interactionist assumptions:

- that human beings act toward things on the basis of meanings that those things have for them;
- that the meaning of such things is derived from, and arises out of, the social interaction that one has with one's fellows;



- that these meanings are handled in, and modified through, an interpretive process used by the person in dealing with the things that he encounters. (p.2)

Within symbolic interactionism, individual meanings are constructed through an interpretive process, modified through and dealt with by the use of individually labelled objects called symbols or perspectives (Charon, 2001; Wood, 1992). As a result, the research questions for this study grew out of an understanding of the common sets of symbols and beliefs that emerged from the literature that highlighted nurses' interactions within their practice context from which they drew their meanings. Consequently, much was learned about the symbols the nurses attributed to leadership as the nurses reflectively explored their meanings.

Even though it was not possible to directly observe nurses interacting in their naturally occurring environment, analysis of the nurses' verbal responses to the research questions enabled the researcher to determine each participant's meaning of leadership as she focussed on their symbolic use of language. Symbolic interactionism enabled the researcher to focus on how the participants constructed their realities within the organisation in which they worked, defined their relationships with others and how they acted within their own behaviour. For each individual participant, perceptions were constructed through the lens of socially created symbols which were transformed to create the nurses' reality (Charon, 2001). Consequently, shared meanings could be likened to the norms of the group because language is the most significant shared symbol that describes how individuals clarify possible ways to act (Cossette, 1998; Sarantakos, 1998).

The symbolic interactionist perspective, allowed the researcher to pragmatically focus on the participants' construction of their reality through the purposeful action of language (Charon, 2001; Schwandt, 1998). In doing so, the researcher was able to relate the perceptions and reported experiences of all participants in a way that made sense of the data (Candy, 1989). Each person was recognised as a constructor, creator or copier, continually interacting with the world, adjusting means to an end, and sometimes ends to

means, both influencing and being influenced by structures (Wood, 1992). Therefore, each nurse was acknowledged as taking an active role in the construction of his or her own reality of leadership (Charon, 2001). Hence, this study focussed on the perspectives the nurses used in order to gain a deeper understanding of their leadership constructs by exploring how they confronted their world, how they interpreted their actions and gave meaning to their leadership role.

Through the research process, the researcher recognised that this study could only offer a “snapshot” of the nurses lived leadership experiences in the reality of their social interactions during the delivery of health care services (Wood, 1992). In addition because social interaction has been regarded as a dynamic process with multiple influences, the researcher adopted Blumer’s interactionist assumptions to move beyond her personal understanding of the situation to focus on the meanings that the nurses constructed from their social interactions.

For this study, symbolic interactionism clarified the researcher’s world view and theoretical stance, identified the key points of interest, and highlighted the research design which adequately and accurately constructed meaningful and manageable concepts as representations of the realities sought (Merriam, 1998; Neuman, 1994; Roberts & Taylor, 1998). In addition, symbolic interactionism assisted in achievement of the purpose of this study. This theoretical perspective provided a focus whereby the nurses’ leadership meanings could be clearly explicated so that secure, authentic information could be acquired. Consequently, the use of symbolic interactionism as a theoretical perspective offered an opportunity to gain a deeper understanding of how the nurses constructed their leadership role during provision of health care services (Eisner, 1997; Punch, 1998; Ragin, 1994).

#### **4.3 RESEARCH METHODOLOGY: CASE STUDY**

This research adopts a case study approach to explore how nurses construct leadership during the provision of health care services. Case study empirically

investigates contemporary phenomenon within a real life context by seeking to convey in depth understanding of the interpretations and meanings being explored (Campbell, & Ahrens, 1998; Merriam, 1998). Therefore, as the methodology for this study, it is consistent with both the epistemology of constructionism and theoretical perspective of symbolic interactionism. Additionally, case study is amenable to the present research because it “investigates a contemporary phenomenon within real life context; when the boundaries between the phenomenon and contexts are not clearly defined” (Yin, 1994, p. 13). The holistic focus offered by case study enables the researcher to gain as full an understanding of the case as possible in order to shed light on a particular phenomenon (Campbell, & Ahrens, 1998; Punch, 1998).

By acknowledging the holistic and contextual nature of case study, the essential feature of the case, constructions of the nurses’ meanings of leadership within a real life context, can be concentrated on and consequently, “could uncover the interaction of significant factors characteristic of the phenomenon” (Merriam, 1998, p. 29). Through the use of this strategy the phenomenon (nurse leadership as it occurred within the socially interactive context where nursing takes place) is able to be explored (Bergen & White, 2000). As a result, a thick description of the case as textual data is able to be collected (Campbell & Ahrens, 1998; Merriam, 1998; Stake, 1995).

In order to advance the purpose of this study, active personal involvement with the case was undertaken for two reasons (i) control over case definition needed to follow logically from the nature of the research questions; and (ii) so that the study could be easily replicated or understood by others (Yin, 1994). Therefore, to be able to define the case clearly, specific boundaries were established to form a single case (Merriam, 1998). The case was bounded by the nurses’ constructions of leadership during the provision of health care services.

When preparing to collect data, the researcher identified that case study methodology:

- Enabled data to be effectively presented within a rich, narrative (Maykut & Moorehouse, 1994);

- Allowed the researcher to pursue meanings to a greater depth in real situations by use of a limited group or purposively selected participants; (Black, 1999);
- Confined the phenomenon under examination within a bounded context (Miles & Huberman, 1994).
- Provided authentic explanation of how the nurses constructed their leadership role during the provision of health care services (Black, 1999; Merriam, 1998).

The advantages and disadvantages of case study have been well documented and are acknowledged (Bassey, 1999; Merriam, 1998; Yin, 1994). A critical issue for case study is that of keeping the wholeness, unity and integrity of the case from the perspectives of the participants (Gall, Gall & Borg, 1999). Another criticism of case study highlights its as a familiar yet illusive approach to research that has been described as a generic term for the investigation of an individual, group, or phenomenon that has a range of meanings (Bassey, 1999; Bergen & White, 2000; Gall, et al., 1999; Punch, 1998). The volume of data collected from the case can also lead to large quantum of data which has the potential to overwhelm the researcher (Gall, et al., 1999; Yin, 1994). Case study has also been demonstrated to have many different research interpretations (Stake, 1995, Yin, 1994).

In response to the first criticism, to preserve the wholeness, unity and integrity of the case, the emic perspective of the participants were recorded verbatim (Stake, 1994, Merriam, 1998; Punch, 1998). This action elicited a rich, thick description of the nurses' experiences and created deeper understanding of leadership from their perspective (Merriam, 1998; Gall, et al., 1999). Secondly, in the light of the above reservations, this study has made an effort to demonstrate the characteristics of the known case so that they could serve as a guide for further research (Punch, 1998). The researcher contained the volume of data by maintaining focus on the questions for this study thereby capturing multiple perspectives of the nurses' leadership in the nurses' real world contexts (Campbell & Ahrens, 1998; Punch, 1998).

In summary, the researcher adapted the following characteristics of case study from Merriam (1998) and Punch (1998) in order to obtain a detailed description and deeper understanding of the nurses' meanings of leadership:

- The case is bounded system (see table 4.2)

- The case has been identified as purposively selected group (participants were purposively selected. See section 4.4.1)
- There is evidence of attempts to preserve the wholeness, unity and integrity of the case (See section 4.5)
- Multiple sources of data in natural settings were evident (two stages of data collection were undertaken. See section 4.5).

## **4.4 PARTICIPANTS**

The process of participant selection was guided by the boundaries which established the case of nurses, registered in Queensland, who directly provided health care and worked in acute, adult public and private health care settings in Brisbane, Queensland (Punch, 1998). Purposive selection allowed the researcher to gain access to nurses who were most likely to be information rich with respect to the purpose of the study. This enabled the researcher to “discover, understand and gain insight ... from [those] which most can be learned” (Merriam, 1998, p. 61). Given that the purpose of this study was to discover, understand and gain insight into nurse leadership, all participants were purposively selected based on criteria established for the case.

### **4.4.1 Selection of Participants**

Criteria for selection of desired participants was influenced by the criteria of established for the case as indicated in Table 4.2.

**Table 4.2 Criteria for Participant Selection**

- Nurses must be registered within the state of Queensland and hold a current licence to practice with the Queensland Nursing Council
- Registered nurses must be employees of the adult, public and private health care settings on a full or part time basis
- Registered nurses hold a level 1, 2 or 3 positions in the organisational structure
- Registered nurses must be directly involved in the provision of health care
- Registered nurses work in acute, adult health care settings located within Brisbane, Queensland

The case study was bounded to include only those nurses who were registered within the state of Queensland, because this cohort was the focus of the study. Only those nurses who were employed full or part time were invited to participate, because nurses who hold full or part time employment status have established patterns of practice and continuous exposure to their organisation. These nurses could provide true accounts of interactions that contribute to their leadership constructs within their organisation. The specific organisational level of the nurse was included because nurses who are employed between level 1 to 3 provide direct patient care. This group could best provide a variety of perspectives of leadership that could be examined (Merriam, 1998). The demographic boundaries for the case were defined for ease of access to the participants.

In order to gain access to the participants, the researcher requested that an administrative assistant at her place of work access the data bases of nursing graduates from 1993 to 2000 and randomly select for each year, eight graduates who had undertaken a Bachelor of Nursing degree. Following selection, 64 invitations to participate in the study were mailed out by the administrative assistant. The invitation outlined the purpose of the study, the criteria for participation in the study, an explanation of the research design and data collection methods to be employed, expectations of the study and how findings would be communicated to participants, university and wider

community. Details of the letter to participants have been included as Appendix 2. Participants were advised that ethical clearance had been obtained from the ACU Research Projects Ethics Committee (Appendix 1), and a consent form and demographic questionnaire (Appendix 4) were also included.

From the 15 responses, 10 confirmed they would attend an interview. Subsequently, two focus group (n=6 and n=4) for interview were formed. A third focus group (n=6) was formed from acceptances to an invitation to participate in the study which was posted on the staff notice board at a private hospital in Brisbane, Queensland.

Following the focus group interviews, six participants (n=6) for one to one interviews were selected from a group of nurses who were nominated by key nursing personnel at both public and private health care settings. Consistent with case study methodology, the profiles of the participants of the one to one interviews reflected the criteria established as boundaries for the case. These participants were seen as key informants for this study because they could confirm or not emerging themes from the focus group data and provide additional insights about what was relevant to this study and (Appleton & King, 1997). Consequently, their profiles reflected the profiles of those who had participated in the focus group interviews (Table 4.3).

Invitations to participate in one to one interviews were extended personally by the researcher to these nurses. All accepted the invitation and a mutually convenient time and date was established for each interview.

#### **4.4.2 Demographic Details**

All participants completed a demographic questionnaire prior to the interview (Appendix 4). This enabled the researcher to describe the case under study.

Participant demographics are presented in Table 4.3

**Table 4.3 Participant Demographics**

CHARACTERISTIC	CRITERIA	FOCUS GROUP	ONE TO ONE
(a) Gender:	Male Female	4 12	2 4
(b) Current level of employment	Full time Part time	9 7	5 1
(c) Level of employment	Level 1 Level 2 Level 3	4 6 6	2 2 2
(d) Nursing Unit Medical Surgical	Medical Surgical High dependency Aged care Education Administration	5 2 2 4 2 1	1 4 1 0 0 0
(e) Type of setting	Public Private	8 8	3 3
(f) Length of time in current position	<1 year 1-2 years 3-5 years 6-10 years >10 years	6 5 2 2 1	0 2 1 2 1
(g) Year of registration	1960-1969  1970-1979  1980-1989  1990-1999  2000-	3  2  5  3  1	0  2  1  1  2
(h) Basic level of education	Basic certificate (hospital trained) Diploma Bachelor degree	8 0 8	3 0 3
(i) Other education*	None Professional development inservice Post registration Post basic certificate Post graduate certificate Master's degree	4 10 1 6 1 4	3 6 1 2 1 0
(j) Direct reporting mechanism*	Director of Nursing Assistant Director of Nursing Nurse Unit Manager Medical Director Medical Registrar Medical Resident/Intern Other Health Professionals	6 5 8 1 1 1 1	0 2 4   0 0
(k) Decisions for care delivered are made by:*	Medical staff: Nursing staff: Other health professionals: You: Peers: All of the above Other (please specify)	9 13 6 6 5 11	0 0 0 0 6 0

\* items i, j, and k respondents could indicate more than one response



All participants were registered within the state of Queensland and were licensed to practice nursing by the Queensland Nursing Council. All participants held a tertiary qualification in nursing at undergraduate level. Six of the participants had undertaken post graduate education in nursing related fields. Length of experience in nursing varied with level 1 nurses having less than 1 year experience in their current position. The level 3 nurses demonstrated greater length of experience with 6 to more than 10 years in their position. Direct reporting mechanism was varied in the focus group responses but very specific in the one to one interview cohort where there was evidence of reporting to the next in the chain of command. Decision for care responses were varied the largest number of responses indicating all of the above choices.

#### **4.4.3 Coding for Participants**

In order to identify the data sources the following coding has been applied to the data. Data that most clearly explicated the theme were quoted from either focus group or one to one interview. The following criteria were developed for data identification. Whilst names have been changed, the first initial of the participant's name, level of employment and data sources have been maintained so that data can be traced back to its original source.

##### **Names**

- Nurses have been provided with a pseudonym that denotes their gender.

##### **Focus Groups**

- The focus group number and level of employment (level 1, level 2, and level 3) have been recorded beside the name. For example, Cathy (3/2), denotes the participant's name by gender, focus group number 3 and employment level 2.

##### **One to One Interviews**

- Participants are coded by name to denote gender and employment level. For instance, Rod 2, denotes his gender and employment level 2.

## 4.5 DATA COLLECTION

The procedures for data collection and its contemporaneous analysis were guided by the research design. Overall, data collection was influenced by the theoretical perspective of symbolic interactionism which enabled the researcher to adopt a two stage approach to the research (Blumer, 1969). The first stage of exploration, which was undertaken as focus groups interviews, aimed to sharpen the inquiry so that the direction of the research, the collection of data and the analysis of data “remain grounded in the empirical life under study” (Blumer, 1969, p. 40). The end product of the exploration stage provided detailed description of what is happening and development of further questions for clarification in stage two (Charon, 2001). Questions identified at the completion of the exploratory stage directed stage two, inspection. Inspection sought to uncover meaning from a smaller number of nurses through deeper inspection of fewer categories than stage one. This “intensive focused examination” of the concept of leadership experienced by the nurses was undertaken in one to one interview sessions (Blumer, 1969, p. 43). At this stage, the methods employed to interview the participants were flexible enough to allow a more imaginative and creative response from the participants in terms of their experiences with leadership (Charon, 2001). Table 4.4 exemplifies the stages of data collection and analysis for this study.

**Table 4.4 Data Collection and Analysis Stages**

Data Collection Stage	Activity	Data Collection Methods	Data Analysis Methods
Stage 1 Exploration	Obtaining data from three focus group discussions (n=16) (duration 60-75 minutes)	Source triangulation Guide: Research questions Mode: Semi structured interviews (audiotaped)	Thematic Analysis using QSR NUD*IST 4.
Stage 2 Inspection	Obtaining data from discussion with nurses (duration 60-90 minutes)	Source triangulation Research questions In-depth, one to one semi structured interviews (audiotaped)	Thematic Analysis using QSR NUD*IST 4*.

\* QSR\*NUDIST 4 (Qualitative Solutions Research, 1997).

In addition use of multiple sources enabled application of source triangulation that encouraged collecting data from multiple key informants on the same topic to draw conclusion about what constitutes truth (Polit & Hungler, 1997; Merriam, 1998; Gall, et al., 1999).

Data were collected by audio taping both stages so that the lived experiences of the participants could be reported (Punch, 1998). Focus group data were collected between February 2002 and July 2002. Individual in-depth interviews were conducted between February 2003 and March, 2003. Data collection and data analysis occurred simultaneously during these periods.

#### **4.5.1 Interviews**

The main purpose of an interview is to obtain a special kind of information (Merriam, 1998). Interview is one of the most powerful ways of understanding others, in that, it is a good way of assessing people's perceptions, meanings, definitions of situations and constructions of reality (Punch, 1998).

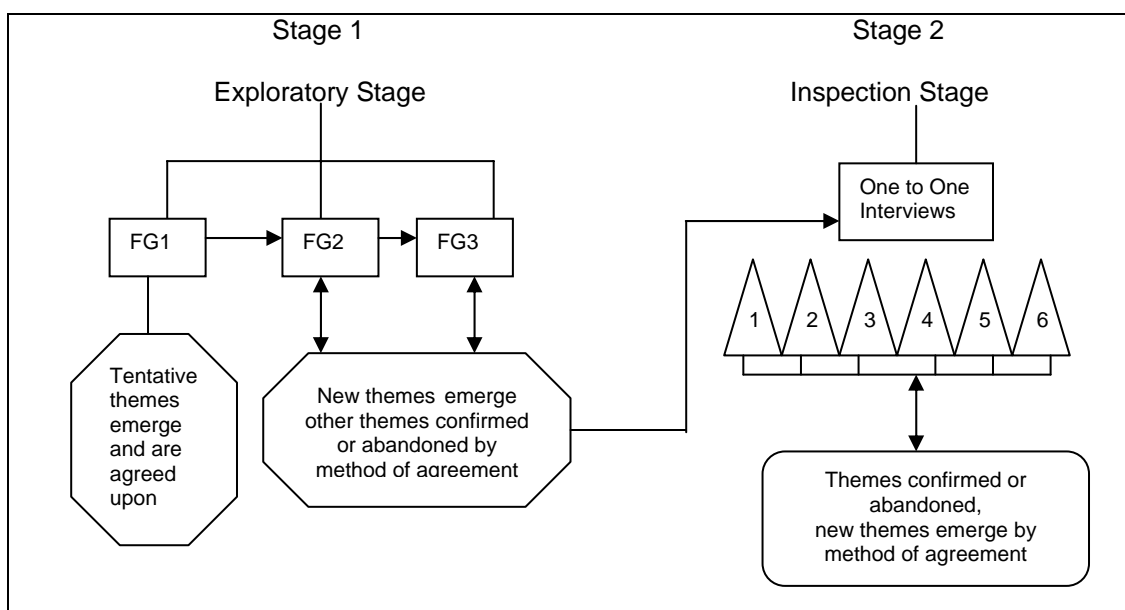
Because of the interpretive, exploratory nature of this study it was decided to conduct semi-unstructured, conversational style interviews which were guided by the questions that were central to this study: Without pre-established interview criteria, responses helped to form related questions as the interviews unfolded (Punch, 1998). Through this process the researcher was able to collect data that were information rich.

In order to maintain standardisation of information, all participants were exposed to similar questions as well as being given the opportunity to provide new insights (Merriam, 1998). Authentic understanding was gained by the researcher maintaining verbal distance from the participants and interjecting only to seek clarification, validation for a point of interest or to keep the participant's focus on the questions of the study (Silverman, 2001). As common meaning or interpretation of themes emerged during the interviews, their relevance was determined by methods of agreement that were established between the researcher and participants (Neuman, 1994).

Agreement on the relevance of themes focussed the “researcher’s attention on common meanings across the case” (Neuman, 1994, p. 413).

All participants were informed of the study and consented in writing prior to the interviews. Because of the interview schedule it was possible to manage and analyse the volume of data that emerged in a timely fashion. For this study, interviews were undertaken in two stages.

**Figure 4.2 Stages of Data Collection**



#### 4.5.2 Stage 1 Exploration: Focus Group Interviews

The use of focus group interviews could best be described as providing a non directive form of data collection that led to an exploration of participants feelings or opinions in a free flowing open ended discussion (Fontana & Frey, 1994; Gall, et al., 1999; Dimmock & O'Donoghue, 1996). The aim of these interviews was to become acquainted with socially constructed meanings of nurse leadership as it occurred in the nurses' practice settings, so that it could be described in detail (Blumer, 1969). As a result, this study gathered volumes of rich, thick data.

Three audio taped, focus group interviews (n=4-5-7) were conducted between February 2002 and July, 2002. Each interview lasted 60-75 minutes. The groups' discussions were guided by the research questions that were

developed for this study. It was during the focus group interviews, that the nurses were stimulated to make explicit their views, motives and reasons as well as bringing to the surface aspects of their leadership role that might otherwise not have been exposed.

During the exploratory stage, focus groups provided early data that aided understanding of what was going on with ideas, concepts and leads that altered as the interview went along. This process also provided sufficient data from which to reframe questions in order to stimulate participants' recall and aided in developing cumulative and elaborative responses. Whilst the researcher was guided by the questions for the study she remained "open and sensitive to new ideas and insights as they emerged" during the interview process (Merriam, 1998, p. 139). In addition, direct interaction between the researcher and the participants provides an opportunity for clarification of responses, for follow up questions and for probing of responses. Below is an example of the process.

**EXAMPLE: Focus Group 1 describing how they see themselves as leaders in the situation of health care delivery.**

(Q) Okay. Can I ask a question then? In your daily practice do you see yourselves as leaders [general "yes" murmurs] or taking leadership positions, maybe not all of the time [general "yes" murmurs] but at a variety of times? [general 'yes']

(W3/1) Well, I think a lot of it is in my face, that I've got this leadership...I quite often think I have to go about this and think how can I bring out the best in the staff at work?

(Q) What about someone who is not in a designated leadership position?

(M2/1) Well....I've chosen not to go into a leadership position...I find the nurses who are coming out of uni are respecting my years of experience...there's two sorts of leadership-some of us have got it through experience and are respected...uni trained nurse has got it through education...so I guess that's where my leadership comes in

The following example highlights how the open response format established for the focus groups provides an opportunity to obtain large and rich amounts of data in the participants' own language.

**EXAMPLE: Focus Group 2 reflecting how they see themselves in their leadership role.**

- (Q) What about you with regard to nursing care? Who do you think actually develops you in the quality of care you provide?
- (S2/2) I, myself. I have a model of praxis that I do. I look at my own leading on an ongoing shift by shift basis. I am usually in charge of the shift...I co-ordinate in a similar way to um...the doctors do ward rounds, the patients' and relative's concerns, complaints...we've changed in our hospital to team nursing which has sort of changed leading the shift...more participating with other nurses, sort of team. And it's less autocratic, it's more, um working together, um style.

Focus group interviews allowed participants to react and build upon responses of the other group members. This synergistic effect of the group setting resulted in responses, similar to the example provided, that may otherwise not have emerged.

**EXAMPLE: Focus Group 3 discussing how the health care agency values nurses taking a leadership role when they have not been formally designated or rewarded for this.**

- (B1/3) I guess we do value them, I mean I used the term taking advantage of them...
- (A1/3) But you'll find the majority are probably happy to provide leadership to other people when it's asked for, but it's not something they're rushing to put their hands up to do all the time...
- So they're able to? The health care The agency supports them in their leadership role as they need them? Would that be right? Or they support the agency with their leadership role as the agency needs them?
- (A1/3) I wouldn't say the agency support them really.
- (B2/3) I think it is a two way thing really. I mean it works both ways.

In order to address criticism for the use of focus groups as a method for data collection, the researcher considered suggestions proposed by Litoselli (2003, p. 21) to develop strategies to address the limitations. These are presented in Table 4.5.

**Table 4.5 Overcoming Limitations of Focus Groups**  
(adapted from Litoselli, 2003,p.21).

Limitation	Strategy
Mismatch between researcher's topic of interest and participants' ability to discuss topic	Use of purposive selection of participants and establishment of boundaries for the case
Bias and manipulation	The researcher's maintained a subjective "distance" during discussion and gauged responses in one to one chats during the interview process
Difficulty in distinguishing between an individual view and a group view	All voices of the group were heard, each participant had was encouraged to contribute to the discussion
False consensus, participants with strong views or personalities may dominate group	Some group members were known to one another, the situations within which they delivered nursing care were different and each was encouraged to discuss their unique situation
Difficulty of analysis and interpretation of results	Researcher maintained focus on research questions and purpose of the study
Difficulty in making generalisations based on focus of group information	Data collected were authentic as demonstrated by spontaneous and personal accounts of leadership and accepted as relevant to person at that time.

#### **4.5.3 Stage Two Inspection: One to One, Semi-Structured Interviews**

One to one, semi structured interviews enabled the researcher to explore, in depth, the questions for this study and the relevant themes that emerged from

the focus group data. This second stage in the interview process is described as inspection (Blumer, 1969). This allowed for closer inspection of themes and involved “isolating the important elements within the situation and describing the situation in relation to those elements” (Blumer, 1969, p. 42). In order to seek further elaboration on the phenomenon being studied, the researcher’s role became more interactive in the interview process as she used open ended questions and effective probing to seek deeper understanding of the nurse’s leadership.

Six ‘one-to-one’ audio taped interviews were conducted between February and March, 2003. Each interview lasted 60-90 minutes. These interviews provided an opportunity for fresh insight into the phenomenon of leadership and allowed the researcher to inspect or interpret the tentative themes that had emerged from analysis of focus group data. The second stage of inspection, enabled the researcher to confirm agreed upon meanings of themes with these nurses, individually, and moved interpretation of themes away from the researcher’s own to mutually constructed understandings of leadership (Silverman, 2001). The example below demonstrates the participant’s own construction of her leadership role and confirmation of that meaning.

**EXAMPLE: One-to-one interview with Sharon, Level 1 Registered Nurse, seeking confirmation of themes that had emerged in data analysis with focus groups.**

Q       ...The other thing that some of the group are saying is their recognition of their role as the co-ordinator of care. They’ll see a doctor coming in, a physio coming in and a social worker coming in. They all come, in like you identified, for a short period of time and they prescribe the care that the patient is to have but it’s the nurse who takes those and delivers it to the patient and makes it unique to the patient. Would you agree to that?

S (1)   I think that’s what I was trying to say before. We get input from everyone else and then it stops with us...and we take it forward or like as the co-ordinator of that particular patient. Yeah. I’d agree with that.



Within the intimacy of one-to-one interviews, the researcher overcame the potential for influence or bias during the interactive interview processes by awareness of self in the discussion, maintaining focus on the research questions, purpose of this study and theoretical framework. In addition, these actions assisted in the collection of relevant data for this study. The interview milieu established by the researcher gained each participant's co-operation and enabled them to articulate their inner thoughts and feelings and freely confirm or reject emerging themes proposed by the researcher. Within this environment, they were willing to be guided back to the research questions by the researcher during discussion, and spontaneously offered new and personal insights into the phenomenon of leadership.

#### 4.5.4 Data Collection Sequence

Table 4.6 presents a summary of the data collection sequence.

**Table 4.6 Data Selection Sequence**

December, 2001	64 Registered Nurses are purposively selected from a university graduate data base by an administrative assistant.  32 graduates from the Bachelor of nursing (pre registration) and 32 registered nurses from the Bachelor of nursing (post registration) and other post graduate nursing courses offered by the university between 1993-2000.
Mid January 2002	64 invitations to participate in focus group interviews are mailed out.
14 February, 2002	Focus group interview 1 takes place (n= 6). Duration 75 minutes (Exploratory Stage)
22 May, 2002:	Focus group interview 2 takes place (n=4). Duration 60 minutes (Exploratory Stage)

**Table 4.6 Data Selection Sequence (continued)**

13 June, 2002	An invitation to participate in focus group interviews is posted on a notice board at an acute care, adult private hospital in Brisbane, Queensland.
29 July, 2002:	Focus group interview 3 takes place. (n=6). Duration 75 minutes. (Exploratory Stage)
January, 2003:	Registered nurses who closely fitted the demographic profiles of the focus groups were put nominated by key health care agency staff. Letters (n=6) of invitation to participate were mailed out and appointments for audio taped interviews were made with 2 level 3 registered nurses, 2 level 2 registered nurses and 2 level 1 registered nurses.
February-March, 2003	In depth interviews of approximately 60-90 minute duration were undertaken. (Inspection Stage)
Ongoing	Transcription and tentative analysis of data

#### **4.6 DATA ANALYSIS**

Data analysis was conducted simultaneously with data collection; all data were maintained within the theoretical framework established for this study. So that the researcher could select data relevant for the purpose of this study, a deeper examination of the participants' lived leadership experiences was made possible by use of the theoretical underpinnings of social interactionism as a filter (Woolfolk, 1998). Within this framework, data analysis could focus on examination of nurse leadership through the reported interactive experience of the participants in their health care setting (Cossette, 1998).

Data were analysed in two stages. The first stage, exploration, was marked by collection of a large volume of rich data from three focus groups who responded to the research questions posed to them. Initial analysis of the data at this stage, led to the development of tentative themes that warranted further inspection. Inspection of these emerging themes was the task of stage two, through one to one interviews (Blumer, 1969).

The large quantities of data collected by way of interview transcripts and data were managed with the assistance of the computer programme QSR NUD\*IST 4 (Qualitative Research Solutions and Research, 1997). Using this computerised tool, thematic analysis was undertaken to identify answers to the questions that were embedded in the data collected (Roberts & Taylor, 1998). The theoretical framework of symbolic interactionism enabled data to be viewed from the personal and interactive experiences of the nurses and led to the emergence of numerous essences, patterns and themes (Table 4.7).

#### **4.6.1 Organising of Data**

##### **Stage 1 Exploration: Focus Group Data**

Initially, data were transcribed from audiotapes. During the transcription stage, data were analysed and numerous themes were highlighted using QSR NUD\*IST 4. This computer package initially, assisted in the development of themes from the large volume of data that emerged from the case. These themes formed a framework for the purpose of this study, further data collection and validation of further findings. Over time, as transcripts were read and re-read, themes were refined and confirmed or discarded when explored during subsequent interviews. As the data became more manageable, themes were recorded and revised manually. The final list of themes that emerged from the exploration stage focus group interviews were presented verbally for inspection to all the nurses who participated in stage two of the study.

**Table 4.7 List of Emerging Themes and Sub themes from Focus Group Interviews (using QSR NUD\*IST 4)**

<b>F1: ROLES</b> <ul style="list-style-type: none"> <li>• F1.1 role performance</li> <li>• F1.2 role outcomes</li> <li>• F1.3 role models</li> <li>• F1.4 role expectations</li> </ul>	<b>F6: VALIDATION</b> <ul style="list-style-type: none"> <li>• Researcher validating statements from the data</li> </ul>	<b>F11: INFLUENCE</b> <ul style="list-style-type: none"> <li>• F11.1 impact of education</li> <li>• F11.2 traits</li> </ul>
<b>F2: COSTS</b> <ul style="list-style-type: none"> <li>• F2.1 making a difference</li> <li>• F2.2 reality of costs</li> <li>• F2.3 impact on role</li> <li>• F2.4 creative costing</li> </ul>	<b>F7: LEADERSHIP ACTION</b> <ul style="list-style-type: none"> <li>• F7.1 co-ordination</li> <li>• F7.2 education</li> <li>• F7.3 responsibility</li> <li>• F7.4 opportunities</li> <li>• F7.5 awareness of self</li> <li>• F7.6 influencing others</li> </ul>	<b>F12: VISION</b> <ul style="list-style-type: none"> <li>• F12.1 influence of past</li> </ul>
<b>F3: EDUCATION</b> <ul style="list-style-type: none"> <li>• F3.1 developing others</li> <li>• F3.2 empowering others</li> <li>• F3.3 strategies used</li> <li>• F3.4 guiding</li> </ul>	<b>F8: PERCEPTIONS</b> <ul style="list-style-type: none"> <li>• F8.1 ignorance of role</li> <li>• F8.2 other's views of role</li> <li>• F8.3 working in teams</li> <li>• F8.4 ordering care</li> <li>• F8.5 integration of care</li> </ul>	<b>F13: RISK TAKING</b> <ul style="list-style-type: none"> <li>• F13.1 level of responsibility</li> <li>• F13.2 cost of risk</li> <li>• F13.3 coming forward</li> </ul>
<b>F4: LEADERSHIP IS</b> <ul style="list-style-type: none"> <li>• F4.1 an experience</li> <li>• F4.2 style</li> <li>• F4.3 developing others</li> <li>• F4.4 human element</li> <li>• F4.5 qualities</li> </ul>	<b>F 9: SETTINGS</b> <ul style="list-style-type: none"> <li>• F9.1 context</li> <li>• F9.2 speciality</li> <li>• F9.3 influences on</li> </ul>	<b>F14: OPPORTUNITIES</b> <ul style="list-style-type: none"> <li>• F14.1 policy making</li> <li>• F14.2 being in the chair</li> <li>• F14.3 change agent</li> <li>• F14.4 peer feedback</li> <li>• F14.5 matter of choice</li> </ul>
<b>F5: SELF REFLECTION</b> <ul style="list-style-type: none"> <li>• F5.1 impression of self</li> <li>• F5.2 thinking in action</li> <li>• F5.3 influence of past</li> <li>• F5.4 influence of context</li> <li>• F5.5 attributes of leaders</li> </ul>	<b>F10: OWNERSHIP OF PATIENT</b> <ul style="list-style-type: none"> <li>• F10.1 competing</li> <li>• F10.2 exclusion from</li> <li>• F10.3 integration of care</li> </ul>	

### **Stage Two Exploration: One to One Interview Data**

Initially, each participant was asked to respond to the research questions, the researcher then sought confirmation of the themes generated from focus group's data analysis if they had not emerged during the discussion with the participant. New themes or ideas that emerged were clarified at the time of interview. Audio tapes were transcribed, with new themes clearly emerging from the data. As data were contemporaneously analysed, themes were modified and rejected or accepted according to their validation or repetition in existing data. At completion of the one to one interviews the researcher sought other leadership literature to provide a tentative framework by which to

articulate the themes. Table 4.7 illustrates the list of emerging themes that, initially, gave voice to the nurses' leadership constructs.

**Table 4.8 Initial Framework for Data Write Up Following One to One Interviews (manual revision)**

SELF	OTHERS	SITUATION
<p>Focus on making a contribution (Sinclair,1998)</p> <ul style="list-style-type: none"> <li>- Emphasis on contribution to health care services</li> <li>- Relish intellectual challenge</li> <li>- Extending oneself beyond comfort zone (H,G&amp;C,1999)*</li> <li>- Outcomes or problem solving emphasis</li> <li>- Building confidence</li> <li>- Learning from others</li> </ul>	<p>Submerging ego (Sinclair,1998)</p> <ul style="list-style-type: none"> <li>- Giving others opportunities to make key decisions</li> <li>- Being prepared for others to look better than oneself to promote desired outcomes</li> <li>- Taking a back seat</li> <li>- Innovative, creative contributions welcome (H,G,&amp;C,1999)</li> <li>- Mutual, reciprocal interaction</li> </ul>	<p>Building a team (Sinclair,1998)</p> <ul style="list-style-type: none"> <li>- helping others to do their best</li> <li>- secure resources to ensure team effectiveness</li> </ul>
<p>Persistence and professionalism (Sinclair, 1998)</p> <ul style="list-style-type: none"> <li>- never being seen to give up</li> <li>- resolute impartiality</li> <li>- assertiveness (H,G &amp;C,1999)*</li> <li>- acting on one's own account</li> </ul>	<p>Being a confidante (Sinclair,1998)</p> <ul style="list-style-type: none"> <li>- being a safe and trusted ally</li> <li>- being mentor, guide and teacher</li> <li>- being a good listener</li> <li>- avoiding rivalry (H,G&amp;C,1999)*</li> <li>- building competence of others</li> <li>- enhancing other's self worth</li> </ul>	

**Table 4.8 Initial Framework for Data Write Up Following One to One Interviews (manual revision continued)**

SELF	OTHERS	SITUATION
Developing balcony mentality (self reflection) (Heifetz & Linsky, 2002) <ul style="list-style-type: none"> <li>- watching self in relation to others and action simultaneously(dance floor metaphor)</li> <li>- action-observation-reflection model (Kolb,1983) (H,G&amp;C,1999)*</li> <li>- creating opportunities for feedback</li> </ul>	Effective communication <ul style="list-style-type: none"> <li>- using departure and distance</li> <li>- high levels of communication (H,G&amp;C,1999)*</li> <li>- engender trust in others</li> <li>- interaction dynamic</li> </ul>	Defined boundaries (.Sinclair,1998) <ul style="list-style-type: none"> <li>- limiting social interactions with subordinates</li> <li>- interactive strategies</li> <li>- participation and shared power</li> <li>- intergation of care</li> <li>- big picture view (H,G,&amp;C,1999)*</li> </ul>
	Persuasion of others/Influence tactics (H,G & C,1999)* <ul style="list-style-type: none"> <li>- rational persuasion</li> <li>- consultation</li> <li>- ingratiation</li> <li>- exchange</li> <li>- coalition exchange</li> <li>- recognising common interest goals</li> </ul> (use of these depended upon desired outcome)	Adapting to change (adaptive change (H,G &C, 1999)* <ul style="list-style-type: none"> <li>- questions and redefines aspects of identity</li> <li>- challenging sense of competence</li> <li>- improvisation (Heifetz &amp; Linsky,2002)</li> <li>- building creative environment (H,G&amp;C,1999)</li> <li>- developing nurturing environment</li> </ul>

(\* denotes Hughes, et al, 1999)

#### 4.6.2 Analysis of the Data

Content of the data were analysed for themes and recurring patterns of meaning in order to gain insight into how the nurses constructed their meaning of leadership. The researcher's interpretation of the data was assisted by the three principals of symbolic interactionism established by Blumer (1969). Data analysis for this study was undertaken in two stages. These stages according to Blumer (1969) ensure rigour for this study in that:

- (1) Exploratory stage(focus groups): enabled the reacher to form a close and comprehensive acquaintance with the phenomenon of leadership as constructed by the nurses. Exploration was seen as a flexible procedure whereby the researcher was able to shift from one line of inquiry, adopted new points of observation as the interviews progressed and move in new directions.

Consequently, the researcher was able to gain a better focus on relevant data as she gained more information and better understanding of the nurses' constructions of leadership.

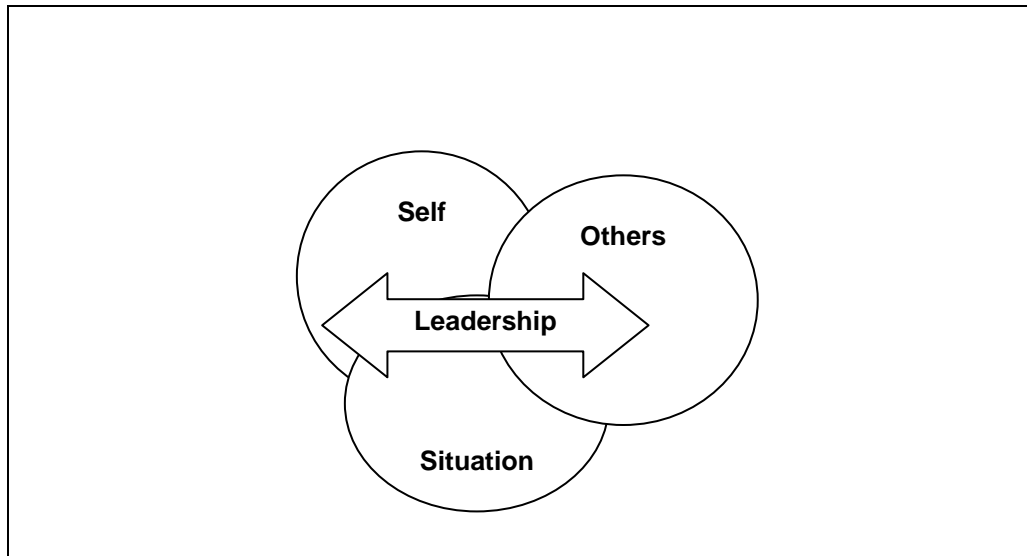
- (2) Inspection stage (one to one interviews): enabled the researcher to meticulously examine or more closely scrutinise the emerging constructs of leadership posed by the registered nurses in one to one interviews. This stage allowed for re examination and comparison of themes that emerged from initial, tentative analysis of data from the focus groups. It also allowed new constructs of the nurses' leadership to emerge. These constructs will be discussed in Chapter 5.

#### **4.6.3 Interpreting the Data**

Interpretation of the findings occurred through the researcher's familiarity with the data and the literature (Appleton & King, 1997). For the researcher, the theoretical perspectives of symbolic interactionism required that reality of leadership for the nurses was discovered and not contained within the analysis of data. This meant maintaining an openness of mind, not prejudging the data and not settling for first or second appearance but repeatedly looking for common themes and testing these (Silverman, 2001). A return to the original data sources during the interview processes, enabled the researcher's intuitive grasp of the meaning of the phenomenon under examination to be confirmed by the method of agreement between the participants and the researcher. Throughout this process, tentative themes were substantiated, abandoned revised and reconfigured (Merriam, 1998; Roberts & Taylor, 1998). Themes were developed using a step by step process whereby transition from the systematic review and analysis of the words to interpretive statements revealed insights, and relative answers to the research questions (Roberts & Taylor, 1998).

The following model (Figure 4.3) and explanation demonstrates the process used by the researcher to generate the final interpretation of the meanings the nurses gave to their leadership. This model is also reflected the research questions and the theoretical framework for the study.

**Figure 4.3 Model for Data Interpretation**



**Self:** related to the nurses' inner experiences of leadership and the meanings (or symbols) they personally attributed to the construction of their leadership role (Wood, 1992). Data analysis took into account that the self related to how "...we see ourselves in relation to the situation (context); we think about ourselves in the situation; we judge ourselves; we identify ourselves" (Charon, 2001, p. 81).

**Others:** described the socially interactive nature of nursing. It related to how influence of others (health care team members) impacted on the way the nurses constructed their leadership role. Data analysis took into account the influence of the transactional nature of social life wherein "schemes of interpretation became established through the use and continued confirmation by defining acts of others" (Wood, 1992, p. 342). The participants could better understand their relationship with others when consideration was given to "human beings acting in relation to the acts of another and taking one another's acts into account when they act" (Charon, 2001, p. 28).

**Situation:** related to how the context (organisation) shaped the language that represented the meaningful constructions of the nurses' leadership role and their descriptions of leadership. Data analysis took into account that language



and the use of meaning ascribed to it depended upon the outside environmental context within which the interactive situation (nursing practice) takes place (Cossette, 1998)

**Leadership:** This concept was considered a process of social construction and not a neutral mechanism but rather a formative one influenced by the interaction of the three concepts during data analysis (Wood, 1992)

This model acknowledged the simultaneous nature of data collection and analysis undertaken in the two stages suggested by Blumer (1969) and supported by Charon (2001). It also assisted in clarifying the process of data analysis and confirmation of themes that occurred throughout the interview process. These are presented in the following chapter.

The labelling of the relevant themes that have emerged in the light of the research questions have come from three sources, the researcher, the participants and other sources outside the study such as the literature. The researcher recognises that by doing this she must ensure the naming of the themes is compatible with the purpose and theoretical framework of the study (Merriam, 1998). Theme congruence was achieved by ensuring that:

- the relevant themes reflected the purpose of the study and the constructs presented by the registered nurses
- the search for themes was exhausted when all data relevant to that theme were placed under that theme
- data was mutually exclusive and attributed to that theme only
- the theme was sensitive to the data attributed to it (Merriam, 1998, p.184)

Following this process the researcher presented the themes that emerged from the three research questions.

**Table 4.9 Themes for the Chapter 5, Findings**

<b>Research Question 1. How do nurses describe leadership within their health care organisation?</b>	<b>Research Question 2. How do nurses experience leadership within their health care teams?</b>	<b>Research Question 3. How do nurses construct their leadership role whilst providing health care?</b>
1.1 Leadership is knowing when to act	2.1 Leadership is recognising own leadership contributions	3.1 Leadership has no clear definition
1.2 Leadership is awareness of potential outcomes of leadership action	2.2 Leadership is recognising and acknowledging contributions from others	3.2 Leadership is learned from others
1.3 Leadership is recognising opportunities for leadership action	2.3 Leadership is influencing others	3.3 Leadership is developed by creating own learning opportunities
1.4 Leadership is overcoming challenges to leadership action	2.4 Leadership is building relationship with others	3.4 Leadership is being aware of leadership attributes in self
	2.5 Leadership is stepping back	

## **4.7 ROLE OF THE RESEARCHER**

The progress of this study was guided through the experiences, interest and knowledge of self as the researcher (Appleton & King., 1997; Crotty, 1998; Merriam, 1998, Punch, 1998). Because of this, use of self as the primary instrument for data collection and analysis enabled immediate process data, clarification and summarisation of anomalous responses as the study evolved (Appleton & King, 1997). Reliance on personal observation, empathy, intuition, judgement and other psychological processes created an environment whereby the participants could best respond to the research questions. Deep and rich data were collected as a result of

the genuine and respectful relationship that was established with the participants (Merriam, 1998).

Because of a personal interest in this study, the potential to influence or bias the responses from the participants to the research questions was acknowledged . To overcome this and ensure data were untainted, active participation in the interviews was minimised to verbal interventions to maintain focus on the questions, clarify a point or seek validation for was perceived to be an emerging theme. Recognition of the fallibility of self as a human instrument when it came to maximising opportunities for collecting and producing meaningful information realised that mistakes could be made, opportunities could be missed when personal biases interfere (Merriam, 1998). To overcome these problems, a focus on the theoretical framework throughout the process of data collection and analysis was maintained. By carefully listening to the nurses' leadership constructs during interviews and by using the lens of symbolic interactionism during data analysis, the symbolic meanings of leadership presented by the nurses from the perspective of their social interactions was able to be documented.

Despite being known to a number of participants through both educational and professional activities that could have affected the richness and honesty of data, close observation for this during interviews indicated a high degree of spontaneity and honesty in the participants' responses. These responses resulted in the collection of data that was rich, deep, and varied, which demonstrated that the participants did not feel intimidated.

#### **4.8 RIGOUR**

In interpretive research, rigour offers an opportunity to demonstrate the trustworthiness of this study by explicating its credibility, confirmability and transferability (Gall, et al., 1999; Roberts & Taylor, 1998). Whilst these criteria may appear quite different from those described to ascertain validity and reliability in quantitative research, it is argued, that these differences are completely admissible, in that the both positivist and interpretive approaches to research have many differences of what constitutes "truth" and the appropriate way of finding it (Merriam,

1998; Polit & Hungler, 1997; Roberts & Taylor, 1998). The researcher for this study is charged with the dual responsibility of demonstrating that the research design demonstrated a theoretical framework that can be understood by others and that the subsequent findings have credibility.

#### **4.8.1 Credibility**

Credibility is described as being similar to the criteria of validity for quantitative research and “refers to confidence and truth in the data” (Polit & Hungler, 1997, p. 304). Credibility, also refers to the extent to which “participants and readers of the research recognise the lived experiences described in the research as being similar to their own” (Roberts & Taylor, 1998, p. 174). In order to achieve credibility for this study, the researcher offered clear descriptions of participant selection and faithful descriptions and interpretations of their meaning of leadership so that readers who have had similar experiences could relate to the meanings. Furthermore, the credibility of the study’s findings have been enhanced by use of the multiple sources from which data was gathered. Consequently, this technique known as source triangulation, permitted conclusions to be made about what constituted truth for these groups of nurses (Gall, et al., 1999; Merriam, 1998; Polit & Hungler, 1997).

During the data collection stage, the schedule of interviews and simultaneous data collection enabled the researcher to systematically search for data that would challenge emerging categorisation of themes. Throughout this process, researcher-participant engagement enabled external member checks. By checking her findings and interpretations of data against the reactions of participant’s during interviews and with other focus groups and individual interviewees, the researcher sought to confirm or disconfirm evidence (Roberts & Taylor, 1998). Therefore a more comprehensive description of the phenomenon of leadership was obtained as conflicting accounts or points of view were provided for (Polit & Hungler, 1997).

#### **4.8.2 Dependability**

Dependability is interrelated with credibility. It refers to the stability of data over time and conditions. Like the reliability-validity relationship in quantitative research, in qualitative research there can be no credibility in the absence of dependability (Polit & Hungler, 1997). Dependability was enhanced for this study because only the researcher influenced selection of participants and collected and analysed data.

#### **4.8.3 Confirmability**

Confirmability refers to the 'neutrality' of the data so that there could be agreement between two or more independent people about the data's relevance or meaning (Roberts & Taylor, 1998). The researcher's position determined to ensure confirmability by explicating the sequence (an audit trail) of this study and the methods and procedures used. An audit trail is visible through descriptions of the theoretical framework that underpinned this study, transcripts with emerging themes and theoretical notes, reports on member checks, records from the NUD\*IST 4 software programme and reports made during the progress of the study.

#### **4.8.4 Transferability**

The researcher acknowledges that the interpretive design limits the findings of this study to the group under study at a point in time (Roberts & Taylor, 1998). In recognition of this limitation, she has taken the responsibility of providing sufficient descriptive data so that the findings can be evaluated and applied in other contexts (Polit & Hungler, 1997). In addition, this study has provided sufficient rich, thick description so that readers will be able determine how closely their situations match the research situation (Merriam, 1998).

#### **4.8.5 Assessment Framework for Rigour**

In summary this interpretive research has utilised several dimensions to enhance the rigour of this study by explicating its credibility, confirmability and

transferability (Roberts & Taylor, 1998; Gall, et al., 1999). The following table presents the strategies employed by the researcher in order to ensure that rigour was achieved for this study. This framework reflected the interpretive nature of the study and its questions.

**Table 4.10 Strategies for Establishing Rigour**

Strategy	Example from Study
Prolonged engagement	3xFocus group interviews (n=16 > 60 –75minutes) 6xOne to one interviews (n=6 >75-90 minutes) provided sufficient time for in-depth understanding
Persistent observation	Sequence of interviews and the research questions enabled researcher to focus on conversation and identify that which was relevant to phenomena being studied.
Triangulation: data source	Use of a variety (level 1, level 2, level 3 registered nurses) and number of (n=22) participants improved the credibility of findings
Member checks	Feedback was provided to participants throughout the interview as relevant issues arose. Researcher was able to clarify her understanding of leadership constructs as she interpreted the participant's meanings and also during one to one interviews. Themes were checked with participants.
Searching for disconfirming evidence	This was achieved through member checks during interviews and review of the literature that is presented in the Discussion Chapter/Chapter 6.
Use of audit trail	An audit trail for this study is evident by its raw data, evidence of data reduction and analysis, process notes which highlights notes from member checks, instrument development information whereby a model for data analysis is presented, data reconstruction evident in the Findings Chapter/Chapter 5.
Presenting a clear theoretical framework	The researcher identified the limitation of the applicability of the findings of this study to one case only, however, because it has developed a clear theoretical framework to guide data collection and analysis, it has the potential to be replicated (but not with same results) and generate further research.

(Adapted from Polit & Hungler, 1997, p.305)

## **4.9 ETHICAL CONSIDERATIONS**

During the course of this study, the primary concern was to safeguard human rights of its participants, the nurses. Prior to selection of participants, ethical approval was sought and gained from the Australian Catholic University Research Projects Ethics Committee. The main ethical considerations for this study were the protection of the participants, informed consent, disclosure and the role of the researcher. Data storage, privacy and confidentiality were also taken into account (see Appendix 1).

All participants had the right to full disclosure and were, individually, provided with a detailed written explanation of the study, its aims and processes and what was expected of their involvement. Each participant was informed they had the right to refuse to participate or to withdraw at any time during the study's process, without penalty of any kind. Prior to commencing and during the interviews, the researcher ensured participants were given opportunity to ask questions, make comments, and voice any concerns they may have had concerning the study (Roberts & Taylor, 1998, p. 237). The researcher's and her supervisor's contact details were clearly evident in the letter of invitation to participate (Appendix 2). Participants were also sent a consent form and a demographic questionnaire (Appendix 3 and 4).

All participants signed a form that indicated they had received sufficient information regarding the study either prior to attending or at the interview venue (Appendix 3). In addition, the researcher clarified that the participants' consent was informed, verbally, prior to commencement of each interview.

Anonymity and confidentiality were assured in the letter of invitation to participants and also verbally assured prior to the interview commencing. The researcher ensured there were no identifying features in the recorded or written data and provided pseudonyms for all participants.

Because the researcher was known to a number of participants, their confidence with regard to anonymity and confidentiality was potentially threatened. However, the participants who were known to the researcher verbalised that her reputation and professional integrity promoted their trust and confidence. Additionally, she was aware that her status as university lecturer and position on professional organisations

could intimidate some participants. This potentially negative aspect was overcome by following the guidelines for interviewing and demonstrating respect for all participant contributions. All participants were aware of the emerging themes from the data they presented during the time of interview when the researcher summarised each potential theme, sought clarification or confirmation by checking the participants' responses at different stages of the interviews.

All the interviews were all conducted in the participant's own time and at venues and times suitable to them. This ensured confidentiality for them as their participation was only known to them and the researcher. One focus group was conducted on the site of the health care agency where they worked, however, the venue was well away from the mainstream and accessed only through a set of offices.

Data currently stored on computer files are accessible only through the researcher's passworded access. Hard copies of notes and data are kept in a safe place in the researcher's home where no access by others is possible without the researcher's consent. All data have been de-identified in such a way that participants and their health care settings cannot be recognised.

#### **4.10 SUMMARY OF RESEARCH DESIGN**

The general approach and rationale for the research design was driven by the purpose of the study. Preceding discussion highlights the application of strategies that reflect the interpretive paradigm of research which incorporated constructionism and social interactionism both of which informed data collection and analysis. Case study was the methodology that complemented the research design in that the researcher was able to collect rich and meaningful data from a defined group of participants from whom most could be learned about leadership, the nurses.

Throughout the research process, three research questions focussed the study.

1. How do nurses describe leadership within their health care organisations?
2. How do nurses experience leadership within their health care team?
3. How do nurses construct their leadership role whilst providing health care services?



**Table 4.11 Summary of Research Design**

Timeline	Interpretive Process	Data Collection	Data Analysis
January-2001- December 2001	<ul style="list-style-type: none"> <li>– Literature Review</li> <li>– Identify relevance, problem and purpose of the study.</li> <li>– Establish a research design.</li> <li>– Develop research questions</li> </ul>		
June 2001	<ul style="list-style-type: none"> <li>– Ethical Approval Application submitted and approved</li> </ul>		
December 2001	<ul style="list-style-type: none"> <li>– Boundaries for the case are established</li> <li>– Purposive selection of participants</li> </ul>	<ul style="list-style-type: none"> <li>– 64 registered nurses are selected from the University graduate data base (1993-2000) by an administrative assistant.</li> </ul>	
January 2002		<ul style="list-style-type: none"> <li>– 64 invitations to participate in focus group interviews are mailed out.</li> </ul>	
February-May 2002	<ul style="list-style-type: none"> <li>– Stage 1 – Exploratory</li> <li>– Validation of themes in light of research questions.</li> </ul>	<ul style="list-style-type: none"> <li>– Focus groups 1 and 2 undertake audio taped interviews. These are conducted and transcribed.</li> </ul>	<ul style="list-style-type: none"> <li>– Contemporaneous data analysis begins and continues. Tentative themes emerge and are confirmed or disconfirmed by participants</li> </ul>
June 2002		<ul style="list-style-type: none"> <li>– An invitation to participate in focus group interviews is posted on a notice board at an acute care, adult private hospital in Brisbane, Queensland.</li> </ul>	
July 2002		<ul style="list-style-type: none"> <li>– Focus group 3 undertakes audio taped interviews. These are transcribed.</li> </ul>	

**Table 4.11 Summary of Research Design (cont.)**

Timeline	Interpretive Process	Data Collection	Data Analysis
January 2003	– Purposive selection of nurses for Stage 2.	– Registered nurses who closely fit the demographic profiles of the focus group participants are nominated by key health care agency staff. Letters of invitation to participate are mailed out and appointments for audio taped interviews set.	
February-March 2003	– Stage 2-Inspection – Validation of themes in light of research questions	– One to one interviews are conducted.	– Contemporaneous data analysis continues. Tentative themes emerge and are confirmed or disconfirmed by participants.
March – July 2003			– Transcription and analysis of data continues. Thematic analysis is conducted with the use of QSR NUD*IST 4.
July 2003-December 2003	- Validation of data. Return to literature for confirmation of themes.		– Data analysis and synthesis
December 2003-January 2004	– Report key themes in Draft Findings Chapters and use key themes and literature reviewed to develop Discussion Chapter		

## CHAPTER 5: FINDINGS

The purpose of this chapter is to present findings that emerged from the exploration of how nurses constructed their leadership role during the delivery of health care services to adults in public and private health care settings in Brisbane, Queensland.

### 5.1 INTRODUCTION

Data were collected using semi structured focus group and one to one interviews of twenty two nurses who were registered within the state of Queensland. The research questions that focussed this study are:

1. How do nurses describe leadership within their health care organisations?
2. How do nurses experience leadership within their health care team?
3. How do nurses construct their leadership role whilst providing health care services?

Table 5.1 presents the key themes that emanated from the data collation for each research question. The themes are presented under the headings of each question and are intended as a guide for the reader through the Chapter. The themes are numbered to correspond with the section within which they are discussed.

**Table 5.1 Key themes from Data Analysis**

<b>Q1: How do nurses describe leadership within their health care organisations?</b>	<b>Q2: How do nurses experience leadership within their health care team?</b>	<b>Q3:How do nurses construct their leadership role whilst providing health care services?</b>
5.2.1 Leadership is hierachical	5.3.1 Developing a leadership mindset	5.4.1 Leadership has no specific definition
5.2.2. Conflict between personal and organisational leadership values	5.3.2 Selecting role models	5.4.2 Awareness of own leadership potential

**Table 5.1 Key themes from Data Analysis (continued)**

<b>Q1: How do nurses describe leadership within their health care organisations?</b>	<b>Q2: How do nurses experience leadership within their health care team?</b>	<b>Q3:How do nurses construct their leadership role whilst providing health care services?</b>
5.2.3 Organisational barriers to nurse leadership evident	5.3.3 Knowing when to take leadership initiative within the team	5.4.3 Being open to learning opportunities
5.2.4 Leadership opportunities exist in changing organisations	5.3.4 Recognising leadership responsibility	5.4.4 Acting on behalf of others
5.2.5 Taking leadership opportunities	5.3.5 Developing the health care team	5.4.5 Recognising one's own leadership attributes
5.2.6 Knowing how and when to act in changing organisations	5.3.6 Creating working relationships	
	5.3.7 Leading by sharing and stepping back	
	5.3.8 Leadership is visible to self, invisible to others	
	5.3.9 Influencing others	

## **5.2 RESEARCH QUESTION 1**

### **How do nurses describe leadership within their health care organisations?**

#### **5.2.1 Leadership is Hierarchical**

The nurses reported that their health care organisational operated out of models of leadership that incorporated hierarchy, management and authority. This was validated by Annette (1) when she described how “hierarchy exists” when her manager demonstrated “ownership” of her formal leadership position

by using an “autocratic style and positional authority”. Sharon’s (1) experience of formal, hierarchical structure of leadership, became evident when she began “initiating things for the ward and the general run of things” she “felt” she was “stepping on the higher level toes” but accepted “that’s how they work.”

When contrasting their personal leadership to that of their organisation’s they indicated that autocratic, hierarchical leadership they experienced was not appropriate to them. They constructed a personal leadership role that was “more about leading others to develop” (Catriona 1/3). Even though they had developed a personal leadership construct, the nurses were aware that the hierarchical levels within their organisations limited recognition of their leadership. Peter (2) highlighted this in his response:

I think barriers, bureaucratic barrier, the fine delineation between doctors and nurses, the level of hierarchy and its perceived importance of authority such as ownership of the patient. It’s a status and authority thing. I’ve worked with consultants who you can’t approach purely from their arrogance and it’s their perceived status within the organisation that makes them that way... There are also environmental barriers where the situation doesn’t allow you to address something at the time. It doesn’t have the same impact if you do it later. Personality is a barrier, some people don’t have the personality with which you can address things easily. They become argumentative and defensive, you can only reason with people who are prepared to be reasonable.

According to the nurses, lack of recognition of their leadership was attributed to the organisation’s emphasis on formal leadership positions. Because of this emphasis, Rod (2) was vigilant of how he acted during the time he was the “leader when the nurse manager was not around.” He was aware of a need “to be seen in the same eyes as she’s seen.” At the same time he saw the opportunity to develop his personal leadership which encouraged him

...to seek feedback yourself but at the same time you need to be given it because you are still learning ...at my level now I’m sort of feeding back to even myself or to peers at the same level and you sort of know there’s things you’re still wanting to know or learn...it’s from within myself or from people in the same or higher position ...you can almost feedback to yourself (Rod, 2).

The nurses’ willingness to undertake leadership initiatives was influenced by how they personally experienced these comparisons. Comparison of Peter’s

(2) leadership role to the organisation's established model provided insight into how his leadership role was perceived:

being a nurse leader is that...you're where the buck stops...you're the pivot for management of the department...you basically round up and move them on and you're therefore the sounding post for everybody...you're there to cop all the complaints....to resolve conflict...make clinical decisions which results for patient welfare...actively communicating with everybody, to keep the peace, to keep morale going, to keep everybody motivated...keep the flow of the department...basically non stop...

Because their leadership values did not align with those of their organisation's some of the nurses had chosen to reject offers of formal leadership positions. However, when it came to situations of need at the local level, such as staff shortages and uneven skill mix, all the nurses indicated they willingly stepped into a leadership role to fill the gap to support others so that appropriate care could be provided. Annette (1) recalled her sudden allocation to a formal leadership position when she was the only permanent staff member on the team:

...I was on with an agency person and someone back on their first day after 5 weeks holiday....I was able to tell them things...I had to assume a lot more responsibility on myself and the other two coming back to me asking questions...took a bit of a leadership role...

### **5.2.2 Personal Leadership Values versus Organisational Leadership Values**

Despite non-alignment with organisational leadership, the nurses acknowledged it was their relationship with the patients that created their leadership obligations. They were there to ensure supportive and caring environments were developed for their patients. Furthermore, they indicated that their actions were evidenced through improved patient care. Caring was a strong motive for leadership action, even though they acknowledged that this concept was often invisible and immeasurable within their organisations. This was identified by Jenny (3):

...caring is probably a little undervalued in the health care service...talking and caring for patients is equally important to the skills and knowledge for me...patients need to be cared for and need to nurtured and helped through these times which are extremely

stressful for them...in health care...we put a lot of focus on throughput and knowledge and skills of staff...but not on the caring and nurturing elements of nursing...equally important to balance these factors for me as a leader...

Furthermore, the nurses' leadership initiatives were challenged by their organisation's focus on cost effectiveness that created a context of limited resources. Within this context, the nurses described their conflict between personal and professional values of providing holistic care and organisational values of cost containment. Caroline (3) explicated her dilemma:

I guess that depends on the leader. You might have hospital policy, you might have outcomes that your hospital wants you to achieve. It depends on your training and your personal goals and visions too. As to those standards being met and what you hope to achieve, we have to make allowances these days because the almighty dollar rules a lot of things such as staffing, skill mix. You have to take into account at the end of the day whether you still want to achieve those standards, you try to get there somehow.

This conflict was further described by Annette (1) when she felt torn between

...considering things we need are at hand and the costs as in how long is the patient on paper supposed to stay here. That can be a bit hard thinking "hold on, day 2, you're supposed to be out of bed" and they don't feel like it. It can be a boundary you have to weigh up. They have to have something legitimately going on. So do we need to look further? It's hard because you've got that pressure, and we're concerned. We're undertaking industrial action, speaking out because we are rushed. One of the main things is we're not delivering the care that the hospital is advertising. I've said that and quite a few of us have said that, the nurses do know that this isn't happening. We're not providing what we should be.

### **5.2.3 Recognising Organisational Barriers to Leadership Initiatives**

The greatest concerns for nurses' in relation to restriction of resources were workload issues and skill mix. These issues created barriers for effective leadership and nurse led initiatives in the achievement of organisational goals and positive health care outcomes. Margaret (2/1) explicated her dilemma when she was expected to perform with "limited resources and being able to give the best possible care and best practice possible under those circumstances." This was further supported by Jenny (3):

As a leader I have to work within the boundaries provided by Queensland Health and they are quite stringent. They talk quality but quality for them is resource allocation, how much throughput is very much number oriented, how much this, how much that. We have expectations to meet Queensland Health expectations and the client expectations when they come to a unit such as SSH because of its expertise, they expect that we're going to meet their needs the majority of times.

Restricted resources also impacted on the nurses' ability to adapt to change as recognised by Cathy (2/3) who highlighted that "nurses are struggling which can create resistance to change because of too much workload. Nurses feel very overworked and undervalued." For beginning practitioner, Bob (1/2) added anxiety was introduced when he realised that "a lot rides on the end result when you try to implement something new."

Whilst they recognised the barriers created to their leadership by the lack of organisational resources, the nurses indicated that having knowledge of these barriers created leadership opportunities. Being aware of the "chaoticness" of the "health care system at the moment and so much change, there is so much culture that needs to be broken into. Sometimes it looks like it's going backwards with prescribed pathways, prescribed roles, prescribed everything" for Sarah (2/2) which enabled her to look for leadership initiatives whereby she could improve patient care. In addition, Jenny (3) indicated she took a leadership position to protect the reputation of the organisation when dealing with patient complaints:

...[the organisation] cancel their operations for lack of ICU beds...patients do have the frustrations consistently...if we didn't defuse it...they would be up in admin or at the health minister...it's the nurse, the doctor's not there...It's the nurse saying 'I'm sorry Mrs Jones this is what we'll do...I'll let you know as soon possible'.

Despite taking what they constructed as taking a leadership position to defend the organisations' reputation, the nurses indicated that they were not identified as key decision makers in health care. However, because of staffing shortages and variable skill mix, the nurses, because of their functional adaptability, often undertook formal leadership positions when it came to making decisions at the ward level. For some, finding themselves in and out of formal roles led to role confusion as described by Bob (1/2) "during the



morning shift I share a workload with other nurses, on the evening shift I am in charge.” Peter (2) highlighted the multifaceted nature of his leadership role:

...you’re protecting the legalities of the unit should something arise. The last thing you need is a vicarious case against the hospital, you’re protecting the patient, you’re protecting the relationship between the nurse and the rest of the allied health. You’re giving her support and confidence, allowing her to edge into the situation, you’re also protecting her from being in a situation which is compromising. The last thing any organisation can afford is putting people in situations ...they think “I’m going to leave.”

The nurses’ indicated that within the formal organisational structure their leadership action was influenced by their awareness of the contributions they could make to improve patient care within their organisations. They acknowledged the difficulty of undertaking leadership initiatives in a context that was resource poor, but indicated that it was the context within which they worked that stimulated them to reflect on their own leadership strengths and weaknesses. It was within this context that they often made decisions regarding who was best able to provide the health care service to the patient.

Knowledge of how to achieve positive health outcomes in a resource poor context was identified as an important leadership requirement. The nurses overcame organisational restrictions by using their knowledge of diverse skills of the human resources available to them within the health care team. Their familiarity with the human resources enabled them to identify the strengths and weaknesses within the team by “...tapping into the appropriate resource” (Cathy 2/3) and “actually pulling together more...bring someone else in” (Susan 3/3). Susan (3/3) indicated she reflected on her ability to be “...aware of what you can do to fill in the gaps and knowing who to tap in to, to fill the other holes.”

The nurses demonstrated leadership initiative in maintaining quality care services by actively seeking assistance. This is exemplified by Angela (2/3) who indicated the need to go “...outside the circle to bring another member...use another expert”. Andrew (2/3) used his knowledge of available resources by “...putting in place the best person for the job” (Andrew 2/3).

When challenged beyond her scope of practice, Sharon (1) identified how she sought input from other health professionals:

If it's information we've got on the ward I feel I can handle it. I do it with them. If not, referrals to different health care professionals such as social worker and community nurses are made. It feels good to be able to refer them and they can come and specifically talk to that patient about their needs.

#### **5.2.4 Recognising Leadership Opportunities in Changing Organisations**

Leadership initiatives were influenced by the nurses' sense of responsibility to achieve the best outcomes of care for their patients. They highlighted awareness of the importance of their leadership roles in patient advocacy and health care interpretation. Annette (1) explained how she became the interpreter between the patient and other health care professionals. She described her experiences after a doctor had visited patients and how the patients saw her as an "intermediary person between other health professionals and themselves". She stated: "Often the doctor will walk out and the patient will say to me 'What's going to happen today?'"

The nurses indicated that their unique relationship with the patients and families, created a reliance upon their knowledge and experiences to provide feedback on the outcomes of all health care services by the organisation and other health care team members. They acknowledged that the responsibility covertly rested "...back on the nurses' shoulders..." (Linda 2/1) with the "knowledge that ...a lot rides on the end results...you are consciously aware of that ...so much depends on the outcomes being positive..." (Bob 1/2)

Being aware of changes in the organisation was viewed as offering opportunities for leadership initiatives. Cathy (2/3) reflected that her organisation had moved from "strict hierarchical structures to a structure where leadership roles were less defined and people looked to clinical nurses for leadership". Experience with organisational change provided the nurses with opportunities to gain confidence in their personal leadership constructs as described by Catriona (3/1):

My first model was autocratic. That was the culture then, of being able to fit in. You move and spread yourself from there. As I got more experienced I realised this is inappropriate, this is not what nursing is about. It's about developing people, patient outcomes, about lateral thinking, being creative, outside the box sort of thinking.

### **5.2.5 Taking Leadership Initiatives within the Organisation**

Having a broader understanding of the organisation allowed the nurses to take leadership initiatives that would benefit the whole organisation. Sarah's (2/2) knowledge of her organisation enabled her to take leadership initiatives that influenced "change based on the needs of the whole hospital population" rather than "an individual ward." A broader perspective for Jenny (3) ensured discussion regarding implementation of a new procedure included "all the types of patients and all of its effects." According to Caroline (3) having a broader understanding of the health care system offered more opportunities for nurse leadership because "the narrow specialised focus of health service delivery would broaden to open up leadership opportunities for others and ultimately improve health care."

The more experienced nurses accepted formal leadership opportunities within the organisation so as to gain a broader understanding of the organisation's structure and function and nursing's place in it. According to Caroline (3) this initiative contributed to her leadership development in that it "...broadened horizons and allowed me to share my knowledge with others". Both Jenny (3) and Caroline (3) felt that by seeking out leadership opportunities within the organisation, they would be offered more challenging leadership opportunities that, in turn, would enable them to gain a broader view of health care whereby, ultimately, they could influence change for improved patient care.

The nurses combined their knowledge of specific patient needs, the human resources available to meet these needs to influence decisions regarding distribution of health care resources. So as to exert influence the nurses ensured they would be heard by placing themselves strategically within committees established by the organisation. This was exemplified by Jenny (3) when she described her role as chair on a resource allocation committee:

...it's a weekly meeting...all allied health and doctors and those...I actually run the meeting...also a monthly budget meeting with surgeons...we talk about costs and things...I having a fair say in the resource stuff...it's been a big change for medical staff...they're quite interested because we have to prove and prove to fight for our survival...it's in their best interest...we do it collaboratively...we decide.

In addition to being heard with regard to improvement of patient care, the nurses used their knowledge of the organisation to act as advocates for improvement of team members working conditions. Jenny (3) demonstrated how she used her knowledge to give voice to issues regarding health care team members' concerns within a committee:

...got to get the basics right like car parking and child care, food...they said "We can't control that" and I said "I think we can" and the DON\* said to me "...write me a report on car parking"....she...devolved the responsibility to me...they believe that Queensland Health has certain directives and we can't change it, but if you challenge...I do get up and say things that I believe in passionately because I think car parking for my is very important from a security, safety, access, all those things....little issues that for me being a leader, being their voice ...

\* Director of Nursing

### **5.2.6 Being Aware of How and When to Act as a Nurse Leader**

The nurses recognised that in order to take up leadership opportunities and influence change in their health care organisation they needed to "be flexible and different in our approaches constantly" (Jenny 3). By taking leadership action during a critical incident, Caroline (3) was able to ensure that "the organisation learned and that there are now stringent policies in place and support services for people in that sort of situation. That will never happen again, there is a process now...we did learn a lot from it."

Within their organisation, opportunities for leadership resulted from the nurses' unique, ongoing relationship with their patients. They acknowledged this relationship provided them with the opportunity to demonstrate the value of their work through provision of continuous care. Because other health care team members "were not always available or could not attend at the same time" Susan (1/3) felt that health care, could become fragmented, "which could

impact negatively on patient outcomes...". Because of continuity with the patients' care, Angela (2/3) was able to "pick things up a lot easier and quicker" than other health care team members who "only had a short view, a small snapshot and we have more global picture." The nurses indicated their continued presence with the patients had "health care team reliant on them to provide a total picture of the patient and their condition" (Belinda 1/2) and to seek their opinion on "how the patient is managing with what they've given to the patient" (Sharon 1).

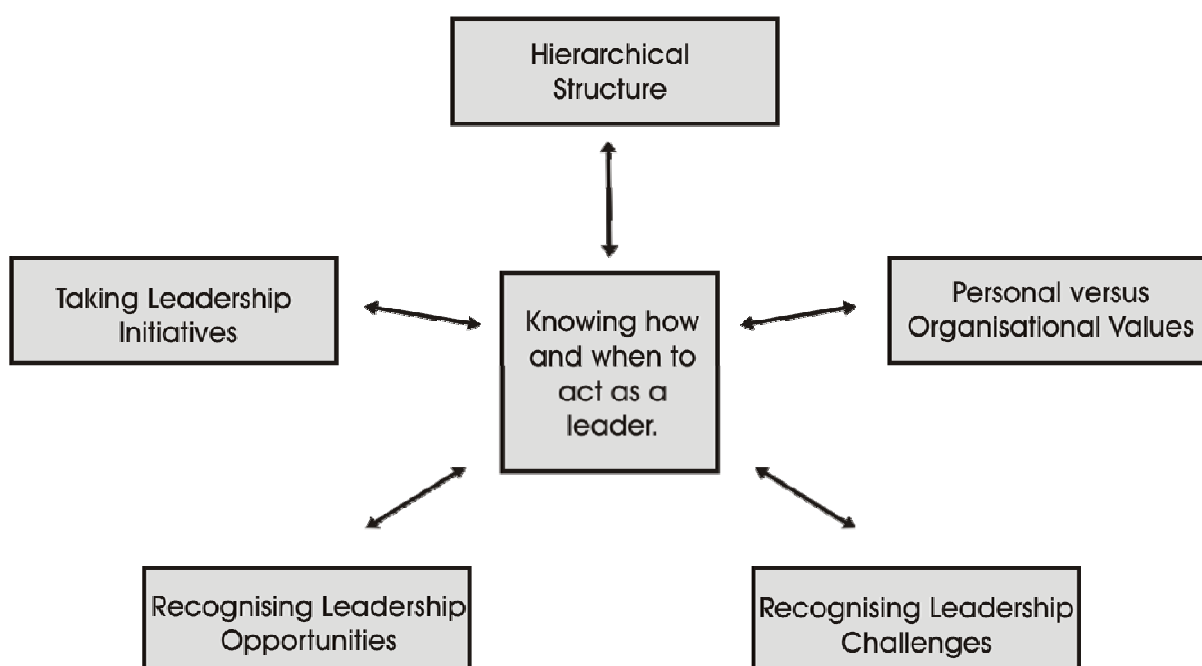
### 5.2.7 Conceptualisation of Themes from Research Question 1

The nurses revealed that for them health care organisations continued to hold traditional, **hierarchical**, authoritative forms of leadership that were not congruent with their own leadership actions. They acknowledged that this context created an environment whereby their **personal values** of health care provision were in conflict with the **organisation's values**. For the nurses, leadership initiatives were stimulated by their obligation to the quality of patient care. Concern for maintaining standards of patient care was a consistent motive for leadership action even though they recognised that caring initiatives were not highly valued by the organisation. They used the relationships they created with their patients and families to develop unique knowledge by which to overcome organisational barriers to their leadership which they used to influence the standards of health care provision from other team members and the organisation. In short, by recognising the **organisational challenges** to their leadership, the nurses were able to identify **leadership opportunities** from which they took their **initiative**.

Overall awareness of the organisation, its structure and values presented leadership opportunities to the nurses. These opportunities highlighted for them **how and when to act** as a nurse leader within their organisation. Figure 5.1 represents the summary and conceptualisation findings from research question 1. The key themes presented in the figure have been bolded throughout the summary of this section.

**Figure 5.1 Conceptualisation of Themes from Research Question 1.**

**How do nurses describe leadership within their health care organisations?**



### **5.3 RESEARCH QUESTION 2**

**How do nurses experience leadership within their health care team?**

#### **5.3.1 Developing a Leadership Mindset**

The nurses created an “ideal leader” mindset from lessons learned when they worked with members of the health care team who had what they perceived to be positive leadership attributes. This mindset guided selection of “...only those that they found really good and aimed to be like them” (Cathy 1/3). It was the personal benchmarks that they developed from their mindset that guided their leadership development. During both sets of interviews, the nurses constantly referred to the attributes of being “assured”, “knowledgeable”, “open to other’s ideas”, “motivated to provide quality care” and “having time to develop others” as leadership strengths they had acquired or aspired to. For some it was also important that leaders “need to be approachable...confident in what you are doing and saying...calm, well

informed...well educated” (Annette 1), “visible and there to make ...leadership flow” (Andrew, 2/3). A clear picture of admired leadership traits was presented by Rod (2) when he described working with a leader he admired:

A leader should be a patient-staff advocate...I've learned from my leader...who's a clinical expert...a resource person for all the staff, other health professionals within a particular unit but also a staff advocate...identify her as a leader and someone...obviously shown to be running the ward and calling the shots, not someone who's there sometimes in the ward and sometimes in the office ...who is approachable for whatever reason from staff...

### **5.3.2 Selecting Appropriate Leadership Role Models**

Whilst the nurses developed their leadership from observing others they recognised there was a “...the stage where further education is necessary” (Sharon 1). At this stage, they described how they were required to leave the safety of self-learning and take a risk with selection of role models who could contribute to their leadership development. For the beginning practice nurses, knowing whom to trust “with your ignorance” was an important aspect in their quest for new knowledge (Brendan 1/3). Even more experienced nurses such as Rod (2) sought out “who you go to and who you feel comfortable approaching.” Learning depended upon the development of a respectful relationship with the selected role model as “...how you're treated will speak volumes of how you grow as a nurse...treat me as a fool, push me out of the way...very damaging to my growth...other people haven't said anything...a pat on the back...watched and said afterwards...helps inestimably.” (Bob 1/2)

For beginning practitioner, Sharon (1), learning by working with experienced team members she considered leaders developed her confidence in that “the senior nurses may have a better way of doing things that I don't know how.” This made her feel “less vulnerable ...then I'll know what would have been better but not at the patient's expense.” Even more experienced nurses such as Linda (2/1) indicated that confidence in her leadership role had been enhanced by people who empowered her “to think for myself and nurtured me.”

Whilst the nurses felt vulnerable when exposing their leadership for feedback from others, they recognised the positive contribution to their leadership development that taking a risk of being open to criticism could contribute. This was highlighted by Sarah (2/2) who benefited from an approach that balanced both negative and positive criticism “if it was all critique...I would have said forget it....if there was just encouragement I wouldn’t have grown.”

### **5.3.3 Knowing when to take Leadership Initiative within the Team**

The nurses’ primary motive for undertaking leadership initiatives within their health care teams was their commitment to patient care. They indicated that other health professionals recognised this commitment and therefore saw them as “the first line of defence” because, metaphorically, they were able to have “their finger on the pulse of the patient for 24 hours a day” (Andrew 2/3). It was this ongoing relationship with the patients that had them best placed to monitor and communicate changes to other team members. Beginning practitioner, Belinda (1/2) illustrated this:

...if you notice anything that needs to be addressed for your patient, make sure you’ve got the right health professional, to obtain what needs to be done for your patient...make sure you get immediate attention that is required...we’re there...we’re the first people to take their general obs...the first people to see the decline...make sure immediate action is taken...

Even though the nurses reported that they acted on other team members’ health care directives, they were able to describe the leadership initiatives undertook within the health care team. They acted by interpreting health care directives, implementing them, and delivering individualised care to the patient by putting “our holistic side of care into it” (Belinda 1/2). They knew that “it was up to the registered nurse to interpret the orders and put it together in a plan of care that’s unique for that patient” (Bob 1/2). When they identified potential patient problems with the health care directives, they consulted with the relevant health care team member:

If it’s information we’ve got on the ward I feel I can handle it. I do it with them. If not, referrals to different health care professionals such as social worker and community nurses are made. It feels good to be able to refer them and they can come and specifically talk to that patient about their needs (Sharon, 1).



Overall, the nurses' indicated it was their continued presence on the ward that contributed to their leadership role of coordinating care. They interacted with "anybody who has anything to do with the ward" (Maureen 3/2) by "pulling everyone together" (Brendan 1/3). Jenny (3) acknowledged "there is no doubt that other health professionals and medical staff nominally know and understand the nurse will be coordinating the care and we know what they're going to need." Within their leadership role, they took the responsibility to ensure they had input from all the health care team so that care could be integrated and coordinated for the best outcomes. They "invited [team members] into the arena..." (Susan 1/3), asked team members to "put forth ideas" (Bob 1/2) and "gave their opinions" (Brendan 1/3). The nurses monitored whether they had met the expectations of patients and team by "...doing surveys of patients to see if we've met their expectations....look to staff to see their satisfaction levels....look at complaints from patients...incidents....doctors..."(Caroline 1).

#### **5.3.4 Recognising Leadership Responsibility**

The nurses identified their leadership responsibility was determined by the reliance of the health care team members on their ability to coordinate care and maintain standards of patient care. It was this responsibility that motivated their leadership initiatives. Caroline (3) explained:

At the end of the day the doctors are really good in their directives and say it's up to the nursing staff and the physios to sort out when the patient's going to be able to go home...they listen.... they're very much guided by that...nurses play an integral role in being chief advocate for the patient from physios, the doctors and from themselves...to achieve the best outcomes.

In addition, this responsibility compelled the nurses to take action when health care team members' decisions or actions could compromise patient care. Caroline (3) stated her responsibility was to "do something in order to bring about a change in practice". Whilst Sharon (1) enacted her responsibility by directly verbalising her concerns:

It may have worked for the time the other health professionals were with them but if it's really not right then I'd probably intervene and let them know as well...like just take a stand..."Well it's not working" or "Can you reassess this?" or something...I do think we have a voice actually...a voice for the patient...

The nurses, at all levels, spontaneously indicated they were willing to challenge practice standards of other team members if they fell below the required standards. "You have to be ready to challenge what another nurse has told you or the procedure they've shown you and look at it and think 'Mmmm, no!'" (Shaune 1/2). This was supported by Annette (1) who stated that she actively intervened where patient care fell below a certain standard "You still have an expectation that it's going to be of a certain sort of level."

### **5.3.5 Developing the Health Care Team**

The level 2 and 3 nurses expressed that an important function of their leadership role was that they consciously developed leadership in the team so that standards of care were upheld and for team members to "accept responsibility for their actions" Margaret (2/1). These nurses encouraged team members to initiate actions, take responsibility for those actions and then "allow them to see exactly what they achieved" (Catriona 3/1). This, Caroline (3) believed, developed "a sense of self worth and confidence in others which could potentially result in leadership actions by others on behalf of the patient."

In order to develop others, the nurses, at all levels, indicated they created environments free from threat. Even at beginning level, they drew upon their own positive and negative learning experiences to influence the development of knowledge, skills and confidence in others:

You use your own experiences and you have a knowledge base of what you should and should not be doing ...so you use that to gently show them the direction they should be taking. A good role model is good at what they do...they have all the attributes...you will go to them before anyone else...you also take note on what they have got (Annette 1)

To achieve the best outcomes of patient care, the nurses ensured the team was well prepared to act in specific situations, that members were “up to date with best practice principles and use knowledge to achieve the best outcomes for the patient” (Caroline 3). In order to ensure optimal care was provided to the patient, the nurses utilised their knowledge of “team members’ competency and provided education as required and made sure they understood the policies and procedures of the organisation” (Susan 2/3).

The nurses collectively, acknowledged that within a team of health care professionals they would use leadership initiatives to identify and utilise each team members’ expertise to contribute to the outcomes for health care and achieve the organisation’s goals. This was especially the case when the team was required to provide specialised health care services. The nurses stated that it was then that they undertook leadership initiative to identify the strengths and weaknesses of team members “so then I can use my strengths to move them in the direction” (Angela 2/3).

When making selecting the team member who was best able to provide care, the nurses utilised a competency framework which they had mentally developed from previous leadership experiences. Andrew (2/3) identified the usefulness of this framework for him, in that it “fills the gaps and guides and ...helps you interpret data that then comes to you to be able to delegate.” The nurses also used this framework to observe and judge the performance of other team members during a shift. Jenny (3) explicated how she utilised her competency framework in order to support staff as required where skill mix was varied:

I talk to them at the start of shift...go through the patients...run through what I expect and what’s happening so I’ll give them a bit of an overview ...then I’ll go and do a few things...I’ll go back a couple of times and tell them to come and speak to me if they have any queries...I tend to allocate them a workload that is not as heavy as the others...I’ll prioritise the patient care according to the skill mix...I will ask them when they come in their background...I’m very prescriptive with people that-...I’ll do some assessment and go through a short period, if I get a sense ...you have intuition... someone with a bit of knowledge will communicate what they know, ...if they have no idea...you get a sense... it’s sort of like intuition in a sense...I wouldn’t give them the complex patients...[or] I would buddy them up with someone...what is best for the patient...

If the expertise required was lacking within the team, the nurses indicated that they used their leadership initiative by “going outside the circle to bring another member in...use another expert...” (Angela 2/3). This initiative provided an opportunity for “actually pulling together more...we start the process, we recognise there is a problem, so use an expert” (Susan 3/3). They knew “that tapping into the appropriate resource...” (Cathy 2/3), they were “putting in place the best person for the job” (Andrew 2/3).

The nurses indicated that, because they were operating within resource poor organisations, skill mix within the team was variable, it was important to lead the way in welcoming new team members. They believed this increased the self worth and confidence of the new team member, which ultimately benefited the quality of team performance and patient outcomes. Annette (1) communicated her acceptance of new team members “in a non threatening way to choose your words carefully.” Caroline (3) highlighted leadership opportunities for new team members in a welcome session on her ward:

...and if people don't see the opportunities I often push things their way so they can facilitate the opportunities. I try to empower staff to make decisions so they can actually develop their own potential. I see that as part of my role as a leader and teacher.

### **5.3.6 Creating Working Relationships**

The level 3 nurses, with designated leadership roles indicated that whilst they tried to develop others, they established professional boundaries for the type of relationships they developed with team members. Caroline (3) explained why she felt this was necessary:

you do have to set yourself aside, not higher, but you do have to set yourself aside because you have a host of issues there...you can't go to the pub and fraternise with everybody and still be their friend on Monday morning where you have to pull them in over something they've done in disciplinary action...you can still be their friend, one of the team but you do have to set yourself aside...you're usually privy to organisation information...they may not need to know.

When it came to devolving responsibility to other team members often contributed to better working relationships, even the level 1 nurses never

“...fully relinquished their leadership” responsibility for patient care (Cathy 1/3).

This was further exemplified by Sharon (1)

Usually I work with another nurse with my patient load, we do a little plan on paper each shift just like each hour to see we both see what is due when. I still like to go around every patient and write what's due for the whole shift, even though the other nurse has gone and done the obs. I'll just go and check that I've seen the patient, I know where they're at, because I've got to tell the next nurse coming on about this patient.

Honest communication and early intervention with performance issues were highlighted by Caroline (3) as leadership responsibilities for creating team relationships that demonstrated trust and mutuality. She highlighted a situation where she had had to deal with a staff issue and other team members: “...certainly are very quick to tell us when somebody has done the wrong thing and they don't really trust them. We have to work with that person and say you really have to reach that trust.’

In order to develop trusting relationships with others, the nurses ensured they were at the forefront in maintaining open communication channels between team members. Helen (1/3) demonstrated this by being available to answer questions “from patients, relatives, other health professionals and nurses to make sure they are well equipped to make sure they do what they should be doing...”

Within their daily interactions, the nurses observed that by being respectful of self and others the best interests of the patients were met. At the same time, they acknowledged that for them respect was not automatically awarded. As Maureen (3/2) observed it had to be “earned from other members of the health care team.” In her ward, she indicated that each person who came onto the ward was naturally awarded respect until they proved otherwise because “we're all here to serve a purpose, to do our part toward patient care” (Maureen 3/2). Peter (2) supported the benefits of respectful relationship for team relationships by stating:

...respect for others and sincere...very motivated, very open, there's no hidden agenda, no bias...everyone is on equal footing regardless...never any favouritism ever shown...see that person and be totally objective .no matter what the situation.

When it came to taking a leadership initiative in dealing with performance issues of team members, the nurses indicated they kept an open mind and were respectful in a non-judgmental manner. Rod (2) described the strategies he used:

It depends if a person has come to me personally and he's asking for assistance...I can take it from that point forward, see what they want and what they're wanting to achieve...someone might mention to you that they're not coping, someone's not doing their best...that person is obviously not prepared to deal with that person...so they bring it to me...a matter of working a bit of a loop...whether I go back to the person and say ..."it's come to my attention that you ...need support"...or I sort of stand back and watch that person...see if I can pick something up...performance issues...I make myself pretty available in the role...hopefully will pick things up before they get directed to me...if they get directed to me then I'm a pretty straight forward person ...pull them aside and have a chat...see how they're going.

Peter (2), also, highlighted the importance of mutually respectful relationships when he focussed on team member's positive attributes:

you just have to walk the diplomatic line and what you try and do is generate a way of putting it across so they believe it's actually their idea ...it doesn't impinge on them...it all depends upon their rapport with you. You start off with the positive attribute and work it through.

In order to maintain standards of practice within a context of cultural and educational diversity, Wendy (3/1) found her relationships with the health care team depended upon "a lot of creativity and persuasion to inspire the team to realise the importance ...". Within this context, she identified that she could best persuade others to accept standards of practice by sharing rationales for all her actions and decisions. Jenny (3) also recognised that professional relationships depended upon the establishment of shared goals for health care services. She described how the implementation of new processes of care relied on working together with "input from the dietician and from physio and people who manage TPN\* within the hospital." Likewise, Annette (1) described how her nursing practice benefited from "sharing ideas and learning other ways to do it". The development of working relationships based on mutuality, enabled Peter (2) to overtly demonstrate his leadership because he felt:

...free to contribute to patient care decisions in this environment highlighted the leadership stand the nurses were able to take because of their insight into the patient and their condition.

\*TPN - Total Parenteral Nutrition

Part of the nurses' leadership initiative in creating working relationships was evident in their public acknowledgment of the whole team's contribution to achievement of health care outcomes or organisational goals. Acknowledgment of the team's achievements was seen as contributing to "the success of the ward" (Jenny 3). Caroline (3) highlighted the importance of developing a culture of gratitude for team members' efforts:

I inspire people that you need to say thank you at the end of a really dreadful day...thank the team, but people to watch them grow...like being a mother...a nurturing process...really get a buzz out of seeing kids being able to make their own decisions and not come to you...become less dependent on you...it's great.

### **5.3.7 Leading by Sharing and Stepping Back**

In situations where the expertise of the health care team member or themselves was lacking, the nurses indicated that sharing leadership with other health care team members achieved better health care outcomes. This was highlighted by Jenny (3):

must be able to share the leadership role...there may be patient who has specific expert requirements...which the nurse who is actually designated to look after that patient may not necessarily have the expertise or feel she has the expertise...I will delegate to a far more expert person for the duration of what is needed for that patient.

All the nurses described shared leadership experiences whereby they consciously stepped back to allow other team members to take the lead in providing health care services. Catriona (3/1) explained the purpose for this action "Don't be a doer, don't issue tasks because there's no learning, no development, there's no extension..." The motive for this deliberate action was to develop leadership skills in others. Carolyn (3) achieved this by stepping back from her formal "in charge" position during a shift and letting "people do my shift and it's always worked out quite well in the end."

When the nurses willingly stepped back from the leadership role in order to allow team members to "work together for the best outcome" (Peter 2), they tended to acknowledge contributions from all members. They held no unique

sense of ownership for their leadership initiatives, as highlighted by Caroline (3):

It's not just my ward it's everybody's ward...everybody has a job to do...if people see a need for change...we'll sit down and have a pow wow about it...we talk about it and it's everybody's problem, I don't take ownership of anything really...it's just a shared environment that everybody feels proud.

The notion of stepping back was demonstrated by the nurses when they described how they chose to take a back seat so that others could develop their leadership competence. From their descriptions, it appeared they were leading from behind as evidenced by Angela (2/3):

I like to give as much autonomy to the nurses working in my unit as they want to take...that doesn't mean I'm not necessarily hanging around watching them, I tend to watch people fairly closely. It may seem laissez faire but at the same time you're letting people develop their own leadership and their own ability to control what they want. I tend not to push people to do things too quickly...if there's a problem or if I can see they missing something I step in, I can share my knowledge and perhaps wisdom...redirect them and get them back on track.

Likewise, Jenny (3) identified a situation where she took a back seat but maintained discrete visibility to act as a safety net for the least skilled nurse in the team to take charge of a patient who

...had a significantly difficult time and his relationship with one of the nurses is that he feels comfortable with her...she feels comfortable in dealing with him...he's chosen the least skilled nurse and he's probably one of the most complex patients ...she says "yes, Jenny I can do it"...have also aligned her with an experienced nurse...she's developing...good skills ...at the beginning of her career...but she has the care and concern that this patient needs.

### **5.3.8 Leadership Visible to Self, Invisible to Others**

The nurse identified that their leadership contributions were lost in the complexity of multidisciplinary health care delivery within their organisations. Despite lack of recognition for their leadership contributions, the nurses utilised their leadership initiatives to influence health care decisions by forming collaborative partnerships within the health care team. Jenny's (3) influence



was evident when she described her actions during a resource planning committee:

It's collaborative...we're finding they're quite supportive of why we're spending certain money on nursing...we can say "we've done x amount of liver resections...therefore nursing expertise is required."...we can state certain patients that have required very high levels of nursing care...so they'll support me...it actually helps because I will say to the executive... The quality of the care...we have needed...really comes from a collaborative perspective...supportive of each other...they'll say 'Yes, we needed that'.

Wendy (3/1) identified that her motivation for influencing the team was not only related to achieving "good health care outcomes." She also used her influence to gain more resources "...if you give extra quality care and you know how to document it you get paid for it...I get nurses to think about how care can be improved."

Whilst the nurses recognised their own contributions to health care and took as many opportunities as were available to them to develop their skills and knowledge their leadership role, they indicated that the worth of this role was unacknowledged by others within the organisation. Jenny (3) provided an example:

...nurses sit on executive divisions equally as the head yet we don't get paid equally. There's enormous inequity in what the medical director gets paid and us. I don't begrudge him from a clinical perspective but I do from a management perspective. I see that as being inequitable because we are equals running clinical units or running executive board. We are equal supposedly, we take equal responsibility, for management of funds, we run millions of dollars worth of budget. In private enterprise if you ran budget that we do and HRM\* and the clinical, they have experts in those areas but we do it all

\*HRM – Human Resource Management

Furthermore, the nurses indicated that exclusion from patient care decisions by other health professionals challenged their leadership. Whilst they highlighted that exclusion from care decisions resulted in a sense of frustration and breakdown of communication channels, they also attempted to provide an explanation for this

Most doctors have a little touch up with the arrogant brush...depends on the situation...if they feel they can't manage certain things then

they'll allow the nurse to cross over the line, to take charge...allow is the operative word, you can underline that one...given other situations where they feel the nurse is overstepping the mark, they'll be tapped back into their box. (Peter 2)

Whilst the nurses provided a number of examples of team members creating barriers to their leadership initiatives, they also demonstrated that the challenges posed created a determination to persist with their actions. Rod (2) observed

Doctors writing their bit, physios\*, OTs\*\* whoever...I think nurses are probably the only professionals that read everybody else's input, not many people read the nurses' input...the doctor...if the treating team has written something and asked for a review there's always 'Thanks for your review'...nurses could write a half page spiel about events on one shift and there wouldn't be one mention from a doctor's round the following day...something does lack...we take time to read their entries, their advice but ...whatever the reason the reverse doesn't happen. It probably stems back from when nurse were first introduced into the health care system. I think there will always be that gap. We've got to respect ourselves for them to respect us.

\*physios – physiotherapists

\*\*OTs – occupational therapists

Linda (2/1) faced the challenges to her leadership by others through “direct, open, honest communication, using nursing' scope of practice as a framework.” In addition, Bob (1/2) sought out those he felt comfortable approaching such as health professionals who were “open to suggestion, they respect your opinion, your ideas...they listen.’ The nurses reported that it was open communication that established a collaborative team, especially when the nurses felt responsible for dealing with issues related to direct care provision at both local and organisational level. As Jenny (3) described her own leadership role as support person for her staff:

We are all the time defusing and dealing with issues...I mean you've got to deal with the issues as ...you've got to be in there and so try to solve the issues...we do it consistently, every day ...defusing their anxiety and stress...and that's my role.

### **5.3.9 Influencing Others**

The nurses consciously used their knowledge of the team and its attributes to employ a number of strategies to influence health care decisions made by the

health care team. Members were challenged to “think about how care could be improved [and how] their care could make a difference” (Wendy 3/1). In order to maintain standards of care, the nurses encouraged other nurses to stand up to those “who may not have good, safe work practice and never be afraid to say something” (Linda 2/1). Leading by example was a strategy employed to persuade others to maintain standards of practice as demonstrated by Sharon (1):

From the example I set from one shift to the next...nurses coming after me...I like to leave the shift as best I can and the way I'd want to be coming onto the shift with the work being done as well as I could....passing on information that's necessary for them in the next shift.

Role modelling was also seen as an important leadership initiative when it came to influencing others to provide quality patient care. Caroline (3) described her willingness to be visible in action, she identified that team leaders “roll up his/her sleeves and get in when the chips were down [as] demonstrating leadership action by taking the responsibility of sharing the workload.”

The nurses observed that the effectiveness of their leadership was demonstrated in the professional development in others. Jenny (3) described this phenomenon:

I know I do have a significant influence and I see it in the way they perform because the things they do remind me very much of me. I don't want to develop clones but there are certain things that have to be done that way and because I have a good rationale for them

### **5.3.10 Conceptualisation of Findings from Research Question 2**

When discussing how they experienced leadership within their health care team, the nurses indicated they had developed a leadership mindset from observing admired leadership attributes in others. This mindset assisted them in selecting appropriate role models. These role models were team members whom they felt they could trust to assist them to develop their leadership. Their leadership mindset also determined criteria by which they judged the clinical performance of other health care team members.

The nurses' primary motive for **undertaking leadership initiatives** within their health care teams was their commitment to patient care. They believed that it was their ongoing relationship with the patients that had them best placed to monitor and communicate changes to other team members. Consequently, their unique relationships with their patients developed their commitment to maintaining standards of practice and continuity of care. It was this commitment that created reliance by other team members on them for the achievement of successful outcomes of care. This reliance by other team members on them motivated their leadership initiatives and reinforced to them that the team covertly acknowledged their contributions. Additionally, this reliance created a sense of **leadership responsibility** for the coordination of care that enabled them to challenge other members' performance standards.

Within the team, the nurses demonstrated a strong sense of leadership responsibility for **developing other health care team members** so that the best outcomes could be achieved for their patients. They identified that good outcomes depended upon bringing out the best in the team and **created working relationships** set by distinct boundaries, open communication channels in an environment of mutual respect and a culture of gratitude.

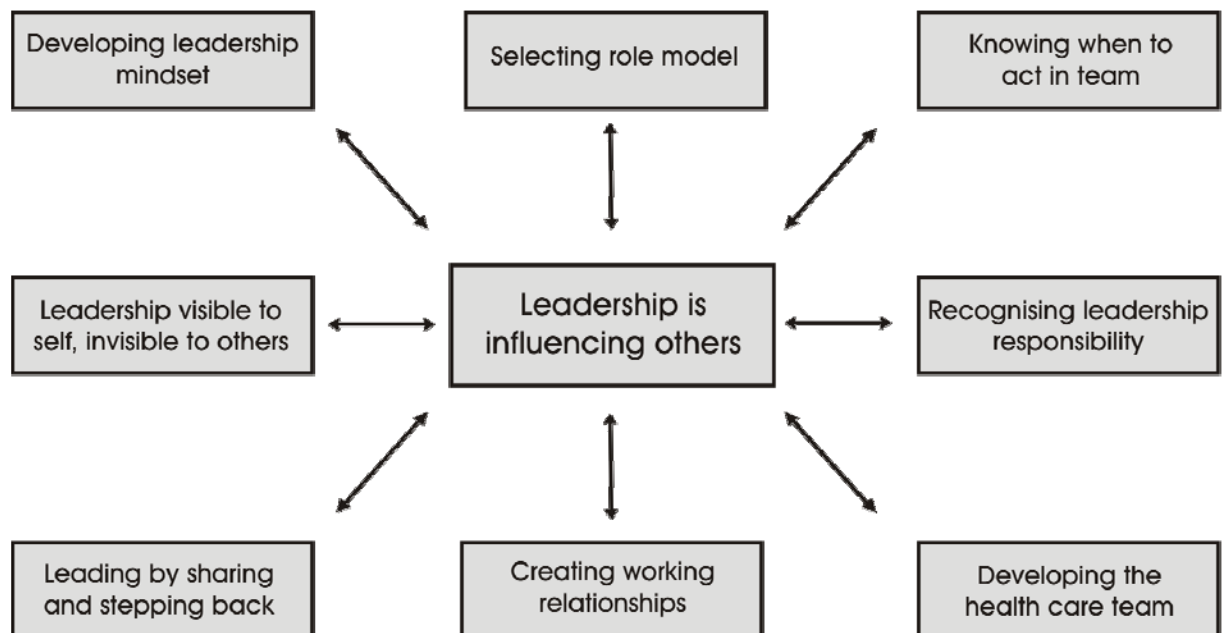
The nurses' relationships with other team members also saw them demonstrate leadership through **sharing** and **stepping back**. The nurses did not possess a unique sense of ownership of their actions and willingly stepped back to share leadership with others. In order to ensure care provision by the most appropriate health professional, the nurses developed a competency framework from past leadership experiences by which to select the most expert team member. The data indicated that whilst they willingly shared or relinquished direct care delivery to others, they never totally relinquished their leadership responsibility.

Even though to the nurses their leadership contributions within the health care team were **visible**, they also acknowledged that their contributions were often **invisible to other** team members. To overcome this they sought out team members who could support them when it came to them taking leadership

initiatives on issues of concern. Overall, the data highlighted that the unique leadership initiatives demonstrated by the nurses as they worked with others in the health care team offered them opportunities to overcome the challenges imposed by team members and use their vision to **influence others'** health care decisions. Figure 5.2 represents the summary and conceptualisation of findings from research question 2. The key themes presented in the figure have been bolded throughout the summary of this section.

**Figure 5.2 Conceptualisation of Findings from Research Question 2.**

**How do nurses experience leadership within their health care team?**



## 5.4 RESEARCH QUESTION 3

**How do nurses construct their leadership role whilst providing health care services?**

### 5.4.1 Leadership has no Specific Definition

The nurses indicated they used no specific definition of leadership to guide their leadership actions. Leadership was something they “found themselves doing for each other...something you put together yourself” (Andrew 2/3). Lack of specificity was further demonstrated by Jenny (3) for whom the meaning of leadership was both individualistic and pluralistic. Leadership was

...a whole range of things, you know, what is leadership? You know I've thought about that a lot. You know it's the ability to lead but what is to lead? Is it to do this or do that? I've thought about leadership and I've read what people have said about leadership to them it is...I don't know if there is any one thing that makes a good leader...there's multiple facets to your world....leadership is something you think about consciously...it's something that for me evolved over many years...I travelled...worked in places and one day someone said “You should be a charge nurse.” It wasn't that I set out to be a leader...I don't think you do that...I just sort of got there and you think ‘Well here I am, now I've got to manage this group’.

The nurses acknowledged that they acted out of their own meanings of leadership. They accepted that their personal constructs of leadership did not fit neatly within organisational role descriptions, nor did they provide a singular, clear definition for others to understand and that these factors contributed to the invisibility of their contributions to health care. Rod (2) felt that the models of leadership adopted by nurses “blurred the distinct boundaries set by traditional models of leadership”. The meaning of leadership for Sharon (1) highlighted its diversity

...someone who is a leader for me can be actively involved still in patient care, as well as running a shift...they take on board the nurses as well...they look out for their fellow nurses, instead of being caught up in paper work...they're at our level...the bedside level, but they're still standing alone as well ...I think leadership can be anybody...don't need a title...different qualities in each different person that would make a good leader as well...different perspectives they have on patient care.

#### **5.4.2 Being Aware of own Leadership Potential**

What was important to all the nurses was that they operated out of models of leadership that provided them with the best opportunity for successful health care outcomes for their patients. Leadership for the nurses was constructed

more in terms of attributes through which the nurses were able to achieve the desired outcomes of health care

...you have to be an organiser, planner, good communicator, you have to be efficient, you have to be able to stay calm, you have to be able to cope with all sorts of situations...that's what I look to a good leader to be. You're inspired and you think that's what you want to be. (Caroline 3)

As the level 2 and 3 nurses began to recognise their distinct leadership role within the health care team and organisation they developed a stronger and more overt sense of self as leader. This recognition of self as leader developed over time and was influenced by factors such as knowledge and ongoing experiences. As Jenny (3) explained:

Overtime you become very aware of yourself as a leader and the responsibility...it's a big role...when you go away people go "I don't know how you do it." ...it's hard to describe, you know when you say what is it. I don't know what it is...it's such a multitude...it's emotions, it's a whole range of things that make you a leader...

Past leadership experiences and the knowledge, experience and confidence gained from being involved in the changing organisation influenced the way these nurses constructed their leadership meanings. This was described by Jenny (3) as she reflected on her leadership evolution:

Health care has changed significantly over the years...we've been through enormous changes...we've changed our practice as clinicians...to adapt to health care changes...we've had to change the way the team approach patient care issues...I've had to change my leadership to encompass and change the direction of the team fairly consistently for the last 10 years. but predominantly more in the last 5 years, if we couldn't adapt to changes I wouldn't be there...we couldn't have moved on...the other significant thing is the way the acuity of the patient, the change in complexity and where patient of medium care levels, we now have large numbers of very high care levels, so we've had to adapt the way we manage patients and develop our knowledge and skills significantly to cope with very intense and high acuity patients.

Reflections on their leadership potential revealed the nurses' values. Linda (2/1) highlighted the importance of her ability to "contribute to patient and staff advocacy" (Linda 2/1). Whilst Margaret (1/2) valued "guiding others to achieve the best outcomes for health services" (Margaret 1/2). Utilising these values to judge their leadership performance was demonstrated by Caroline (3) who questioned herself as an advocate when she "really reflect[ed] on my practice,

was I not a strong enough advocate for the clients or staff?" This reflection of self as leader within a health care team was further exemplified by Rod (2):

I am a motivated person...I do it because I enjoy the role so I make sure when I am in those positions I do it properly...I am a pretty calm person, I don't get stressed to easily, which I guess comes from experience so I don't get flustered in the heat of the moment...or work through things pretty methodically...I'm an approachable person.

A statement by Peter (2) highlighted the dynamic nature of his leadership responsibility and complexity

...you're where the buck stops...you're the pivot for management of the department...you basically round up and move them on and you're therefore the sounding post for everybody...you're there to cop all the complaints....to resolve conflict...make clinical decisions which results for patient welfare...actively communicating with everybody, to keep the peace, to keep morale going, to keep everybody motivated...keep the flow of the department...basically non stop.

#### **5.4.3 Leadership is being Open to Learning Opportunities**

The nurses indicated that their leadership meanings were constructed from the variety of strategies they had employed to open themselves up to leadership development. Their learning was built upon existing levels of confidence, knowledge and experience that were used as baselines on which to build their leadership skills. This was exemplified by Caroline (3) who identified her learning needs "...changed depending on where you developed as a leader as you too climb the scale." For Sharon (1) being open to learning contributed to "a leadership opportunity and also education...I found something on the ward that you could be educated on, I'd come back and be the resource person for the ward...and taking initiatives and risks..."

The nurses indicated how they allowed themselves to be open to challenges from those whose decisions affected them because they were placed in the position where "someone had to make the tough decisions" (Andrew (2/3)). In order to develop his leadership, Peter (2) indicated he had to



...be prepared for feedback that may not be nice to hear and be open with it and be prepared to say "Oh, look I'm sorry, I didn't realise that was the situation and be the first one to go up to people and say "Look I made a mistake....please accept my apology" and knowing when to back off...sometimes best just to shut up and try to think outside the square and remove yourself from the situation...all of us can be reactionary, defensive.

Persistently seeking feedback from other team members enabled the nurses to develop criteria and skills to consciously reflect on their own leadership and develop their skills to feedback to self. Self feedback was commonly used to provide the nurses with a sense of self as leader which enabled them to take responsibility for their own leadership development and undertake self-identified learning opportunities. As Rod (2) explained:

That's how you learn...you go to someone and they don't give you what you need, so you think "Well, I'll go somewhere else" or I'll go to someone else...it's the nature of the job...you've got to keep up with the times, you have to know where you're heading, what's happening

Self questioning was a method used by the nurses to feed back to self and identify areas in need of leadership improvement or development. Bob (1/2) reflected this when he asked "Did I do okay or could I have done better?" This was supported by Sharon (1) who used both self questioning and feedback from others to construct her leadership role when she asked:

If I'm meeting the standard of care as well as the nurse I am working with...if I feel I have got to all the patients adequately through each shift and attended to that standard...I'll come away...much better.....ultimately the responsibility stops with me, I don't need my fellow mates telling you what you did and didn't do. But it's also good to hear how you could have done something better...so, a bit of both...I get most of my feedback from the patient care that I give...I want people to tell me if they come on after me and found something not done...I am really open to that...but I am more reliant on the patient...the patient is what I'm there for.

Overtime and with more exposure to leadership opportunities within their health care organisation, the nurses had developed the ability to identify deficits in their own leadership knowledge and skills. Margaret (2/1) had come to realise she could not "do it all." When the nurses realised personal leadership weaknesses they sought out the best person to guide them, by tapping "into an expert in the right place, at the right time" (Cathy 1/3) using a

“more participative type of leadership, sort of team working together” (Sarah 2/2) to “fill the gaps” (Andrew 2/3).

#### **5.4.4 Acting on Behalf of Others**

Leadership responsibility for the delivery of health care services was motivated by the nurses’ ability to act on behalf of others. They identified with their leadership role as advocate, coordinator and interpreter within the health care teams and also with the “patient and their family [who] relied on you for explanation of directions other health professionals had given” (Belinda 1/3). Because of this they chose to take leadership action even if “...it knocks someone else’s nose out of joint...you’ve got to be prepared...if it’s for the patient” (Sharon 1).

The nurses indicated that for them leadership meant demonstrating persistence and determination to ensure standards of patient care were adhered to. Despite negative consequences to themselves, the nurses were determined to take a leadership position by insisting upon adherence to practice standards by all team members. Linda (2/1) described a situation where her persistence isolated her from other team members “...you’re not always there to be liked...you’ve sort of got your guidelines.” She indicated that to place herself in this position required “a lot of energy” to stand up in the face of opposition, saying to herself “Just keep plucking on.” Even level 1 Annette, demonstrated her persistence, when confronted with a patient issue, regardless of other team members responses to her:

...I do feel as if they’re just going “Oh, just leave me alone” but I’ll keep pestering them until...or I’ll just write in the notes that it was passed onto the charge nurse or I’ll hand it over as an ongoing concern...I’ll keep asking about it.

The primary motivator of patient centred care for leadership action was reflected by Rod (2) who saw “the patient...is our responsibility at the end of the day and they deserve a decent level of care...they can rely on us for that.” The nurse patient relationship was described by Brenda (3/1) as “a humbling experience” which enabled them to enter the patient’s “personal space,

whereas nobody else does.” They perceived that the patients gained confidence in the nurses’ ability to act on their behalf because they were “visible” and “considered to be experts in care delivery” (Shaune 1/1). Linda (2/1) described her experience:

They [patients] feel safe, just from my experience they know they are safe and secure and they know we know what we’re doing. Trying to treat a person as a person without being judgmental, helping them, providing information where they’re going to be empowered.

The nurses’ leadership constructs involved a moral sense of duty to develop other health care team members’ practice so that the patient’s well being would be assured. This sense of duty was demonstrated by Jenny (3):

We have to be leaders, we’re the teachers, we set the trends so really you’re in fine hands because we are the experts... for me as a leader I have to set the trend, I have to be progressive, I have to change practice...collaboratively... as the clinical leader, I see myself as a clinician predominantly.

Assertiveness helped the nurses, at all levels, maintain resolute impartiality in situations where performance issues could compromise patient care. Shaune (1/1) indicated how he took leadership action by identifying that “You have to be ready to challenge what another nurse has told you or the procedure they’ve shown you and look at it and think “Mmm, no!.” Furthermore Shaune (1/1) stood resolutely apart from the group “especially when it came to issues regarding patient dignity.” (Shaune 1/1). However, even though they tended to morally distance themselves from the persuasion or biases of other team members, the nurses continued to provide an integrated team approach to care delivery. Annette (1) recounted her experiences where a patient was ostracised by other health care team members:

...the things they were saying I didn’t think...you really needed to know...I met him and so formed my own basis of what this man was like...you can be swayed by it all but you’ve sort of got to bring yourself back to...you have to be able to... this is my opinion and that’s all there is to it...I’ll have mine and you have yours and that’s the way it is.

The nurses maintained resolute impartiality even when those with authority and experience exerted pressure on the nurses to act in accord with the rest of the group. The nurses believed that their impartiality demonstrated a leadership

role that highlighted individual patient's rights during provision of health care.

The feelings the nurses experienced were best described by Sharon (1):

It's kind of like you're comfortable in a group, but you've still got to do what you think is right, so if that knocks someone else's nose out of joint...you've got to be prepared...if it's for the patient to stick with that...I just have to continue doing what I feel is right and what I feel is benefiting my patients ...maybe jeopardise the comfort zone...

By standing apart from the rest of the team, the nurses indicated that to gain patients' and team member's confidence in their leadership, they needed to demonstrate they were "authentic in what they give and they know themselves" (Brendan 1/3). In order to achieve this confidence of others in their leadership they described a sense of responsibility for ensuring that those who sought them out for advice or guidance were given the best responses available. Jenny (3) highlighted this:

...there is that respect for me in a sense...they seek my advice and support and come to me when they need me...I spend a lot of time on it as well...people management...is for me...the singularly most time consuming thing that I do.

#### **5.4.5 Recognising One's own Leadership Attributes**

It was the nurses' levels of confidence, knowledge and experience that ultimately influenced their decision to act as leader. Awareness of their ability enabled them to predict and reflect upon potential outcomes of their leadership actions. Annette (1) explained that if she felt inadequate to the leadership role she would rather "take a back seat and let others assume leadership." She recognised that "if I didn't have the confidence and knowledge that I would need to provide care in that role...I could not assume the position ...however if it is within my realm I will take control of it." Peter (2) demonstrated how he reflected upon his ability to initiate leadership action:

You have confidence to take charge of given situations...we follow orders, but there's a certain component on which your expertise allows you ...some elements of diagnostics... how do you triage the importance of a patient if you don't have some underlying expertise to formulate some diagnosis of what you think is wrong with that patient ...it's about recall...the picture you formulate...that gives you the insight into what could possibly be wrong with the patient...knowledge breeds confidence.

Whilst the nurses recognised that health care outcomes depended upon the knowledge, experience and confidence of all team members, they were also able to identify the unique leadership contributions they made to health care. This was demonstrated by Rod (2) when he described his leadership role:

...assessment is the first thing...that first contact with the patient is crucial...what their needs are...something we've always focussed on...not just what's happening now, but thinking ahead as well...we're the primary direction provider, the person that feeds the information to them more than anyone...explaining the rationales...actually implementing the care...evaluating it too...with the family too... are the central, most important figure in patient care.

The nurses acknowledged their leadership contribution in maintaining open communication with a diverse group of people who were all involved in health care. The complexity of achieving this was highlighted by Peter (2):

We constantly talk to the medical staff, reception staff, ambulance personnel...communicate hospital admin...we do a lot of communicating with ward staff and getting patient's admitted... ..you have to negotiate ...we look after police headquarters and then both internal and external customers...you're doing it the entire time...it always falls on the nurse in charge...

By vigilantly scrutinising communication between health care team members, the nurses reported they could intervene as necessary in the best interest of patient care. Rod (2) elaborated upon this:

...[if] there is communication breakdown between doctors, and physios,...it's just monitoring them and if it's becoming an ongoing issue then you need to follow it through...they have a very big involvement in the planning and the outcomes of patient's care.

Active listening enabled the nurses to recognise leadership opportunities and gain a broader perspective of the situation prior to deciding whether or not to act. Andrew (2/3) identified this as "listening to what is going on around you and that includes people around you...taking on board the responsibility from what you assess yourself or what others tell you." Caroline (3) described how she found solutions for problems by looking at the big picture of health care services and ensuring complaints were dealt with

You look at complaints from patients but also incidents and doctor's complaints, if they're not happy with the way things are...a multidisciplinary approach...talking about ...what everybody's grievances are and how we all feel we're going and what we've

achieved...they're the big things...complaints, incidents, satisfaction, staff surveys, patient surveys.

The nurses indicated that part of their leadership construct was to seek leadership opportunities within the boundaries placed upon them by the organisation. Andrew (2/3), recognised that:

in the last ten years there's been a lot of development with being more involved. We have a lot more ability to share our thoughts and we get a lot more response from medical and paramedical people

The broader perspective encouraged thoughts of leadership possibility for Angela (2/3) who was able to "...see not only the micro picture which is the patient and their environment but also seeing the macro picture, seeing the hospital and beyond...fitting your role into that...you've got to be on your toes watching and listening and continuously reassessing the situation."

In order to overcome one of the boundaries placed upon their leadership by other health care professionals, their exclusion from health care decisions, the nurses utilised the attributes of assertiveness coupled with self respect to ensure a leadership position. Wendy (3/1) stated that "Leadership is how you respect yourself" when she related how she had introduced case conference in her organisation and another health professional (not a nurse) had started to take over. Despite the ensuing tensions where even the Director of Nursing supported the other health care professional's position, Wendy persisted "I *am* the expert in nursing care here...I had to sort of stick to my guns that nursing care was my expertise...they now know I am the nurse." Wendy believed that as a result of her persistence she made the nursing leadership role visible to others.

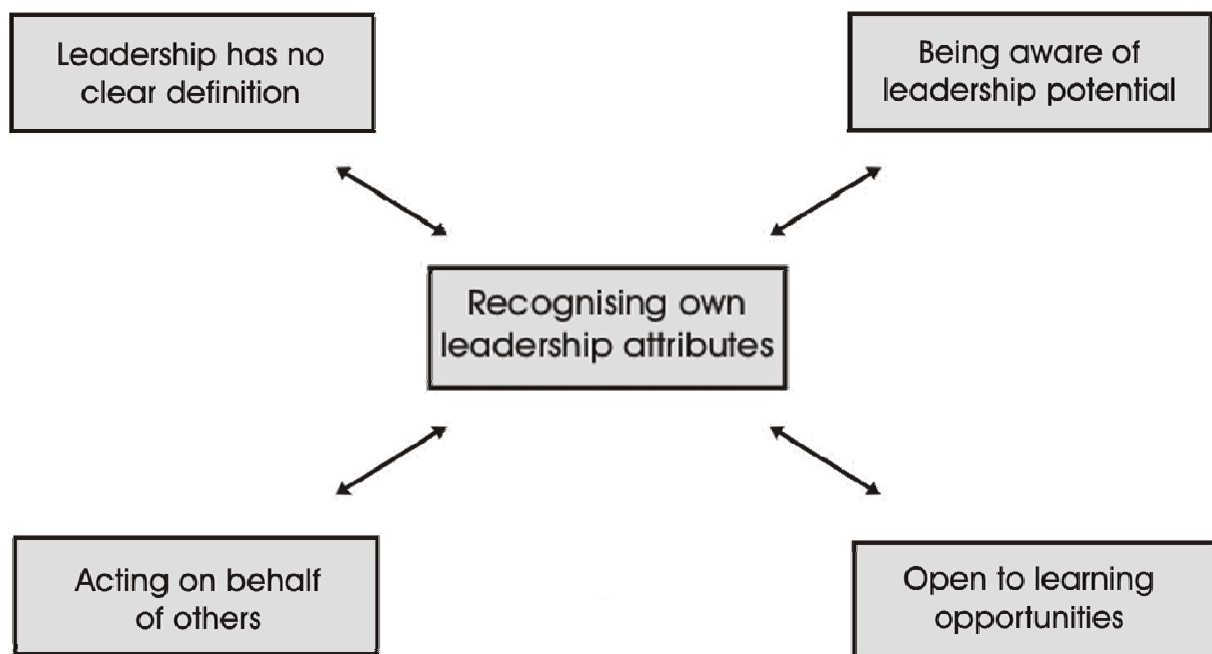
#### **5.4.6 Conceptualisation of Findings from Research Question 3**

The nurses offered **no clear definition** of leadership, instead they gave individual and pluralistic meanings to their leadership construct. They identified that it was confidence, knowledge and experience that made them

aware of their leadership potential and that, by reflecting on the criteria they attributed to leadership, they were able to identify deficits in their personal leadership ability as well as their **leadership potential**. The nurses believed that part of their leadership construct was being **open to learning opportunities** and utilised a number strategies to develop their knowledge, experience and confidence in their leadership. A key construct of the nurses' leadership related to **acting on behalf of others** whereby they demonstrated how moral duty influenced their decision for action. Overall for the nurses their leadership constructs were influenced by their ability to recognise their own **leadership attributes**; which in turn initiated a chain of leadership action. Figure 5.3 represents the summary and conceptualisation of findings from research question 3. The key themes presented in the figure have been bolded throughout the summary of this section

**Figure 5.3 Conceptualisation of Findings from Research Question 3.**

**How do nurses construct their leadership during the delivery of health care services?**



## **5.5 RECONCEPTUALISATION OF THE DATA**

This chapter initially presented the findings of this study under the headings of the three research questions that were developed to guide conceptualisation of the data. A number of major themes emerged from the data (Table 5.1). Further analyses of the data demonstrated that the themes were interactive, with each contributing to one major theme for each section (Figures 5.1, 5.2, 5.3). The responses from the nurses to the research questions reflected the emic perspective of their leadership constructs. Subsequently, whilst the questions provided an initial framework for data analysis, it was the application of the Model for Data Interpretation (Figure 4.3) that advanced the conceptualisation of data. Inspection of the data through this model highlighted that the nurses' leadership was constructed through the perspective of (1) self as leader; (2) self as leader with others in the health care team; and (3) self as leader in action within their practice context or the organisation. For every response to the research questions provided by the nurses, the themes generated by the nurses pivoted from the central concept of the self.

Consequently, final analysis of data revealed that leadership was viewed through three clear perspectives: Self as leader; Self in relation to others; and Self in action. Re-examination of the data also revealed that, through these perspectives, the nurses' unique constructions of leadership were intertwined with threads of confidence, experience and knowledge. These threads influenced their willingness to take leadership action.



Reconceptualisation of the data utilising these perspectives will be explained in this section.

**Table 5.2 Nurse Leadership**

**The nurses' perspectives and constructions of leadership.**

<b>Perspective 1</b>	<b>Perspective 2</b>	<b>Perspective 3</b>
<b>Self as Leader</b>	<b>Self as Leader with Others</b>	<b>Self as Leader in Action</b>
<b>Construct</b> <b>Leadership is recognising one's own attributes</b>	<b>Construct</b> <b>Leadership is influencing others</b>	<b>Construct</b> <b>Leadership is knowing when to act</b>

### **5.5.1 Self as Leader**

#### ***Leadership is recognising one's own attributes***

Data revealed that whilst hierarchical types of leadership existed within the nurses' health care organisations, this model was not appropriate for them. For the nurses the meaning of leadership was multi-faceted. Consequently, they offered no clear definition of leadership. They appeared to create and act out personal meanings of leadership that were both pluralistic and individualistic (5.4.1). It was interesting to note that at no time during the interviews was I asked by any of the participants what I meant by 'leadership.' In response to questions regarding leadership, the nurses spontaneously told their own stories to demonstrate their meanings.

Leadership for the nurses was constructed in terms of the personal attributes they had acquired through which they could achieve better health care outcomes. These attributes became more obvious to the nurses as they were exposed to further experience and consequently, developed a stronger, more overt sense of self as leader (5.4.2).

For the nurses, leadership construction was a dynamic and risk taking phenomenon. They demonstrated persistence and determination in being open to learning a variety of experiences to further develop their leadership. Overall the nurses used numerous strategies to gain further knowledge and experience at both local and organisational levels. In addition, the nurses selected those from whom they could learn most and were willing to step outside their comfort zone by exposing themselves to feedback and criticism of on their leadership (5.4.3).

Overall whilst it was knowledge, experience and confidence that influenced the nurses' willingness to take leadership action, all the nurses, even those at beginning level of practice, acted on behalf of others to ensure best practice standards were achieved for their patients, regardless of the consequences to themselves. Their leadership constructs demonstrated a moral duty for ensuring their patients' well being at all times (5.4.4). Finally, it was recognition of their leadership attributes that enabled the nurses to act on behalf of their patients. It was through their relationship with the patients, that nurses were able to clearly articulate the unique leadership contributions they made to health care services. This relationship produced a chain of leadership action that influenced health care team members and the organisation toward the betterment of health care provision (5.4.5).

## **5.5.2 Self in Relation to Others**

### ***Leadership is influencing others***

It through working with others that the nurses developed their personal leadership constructs. They used their leadership mindset to gauge the potential of self as a leader and determine their ability for leadership action during the provision of patient care. Subsequently, by reflecting on past leadership experiences, knowledge and confidence they were able to determine their leadership potential and act accordingly (5.3.1). They used their personal leadership mindset to determine selection of appropriate role

models that could further contribute to their leadership development. Additionally, their ability to utilise the leadership criteria to select role models enabled them to take a risk with their leadership so that they could develop confidence to act as leader (5.3.2).

When reflecting on the self as leader with others, the nurses indicated the dependence the health care team had on their contributions. They highlighted that it was the health care team members' acknowledgment of their role in the coordination of health care services that provided the impetus for their leadership action and responsibility (5.3.3). The leadership responsibility experienced by the nurses motivated them to ensure standards of patient care were maintained by all. When acting as leader the nurses highlighted that team members relied upon them for the coordination of patient care. This reliance gave strength to their leadership action and also heightened a sense of responsibility for the provision of uncompromised patient care (5.3.4). In order to achieve their goal, the nurses acted to create environments to develop knowledge and confidence in other health care team members so as to ensure the team was successful and well prepared to act (5.3.5).

Accordingly, nurse leadership was about creating environments whereby self as leader could respectfully work with others in a collaborative manner to influence health care decisions. So that the best interests of the patient were met, the nurses created a relationship with team members, which was based on communication that was respectful of self and others. Their leadership initiatives were used to influence others to act competently and professionally and develop working environments where participative or shared leadership had flexible professional boundaries and mutually acceptable practices. The findings suggested that the nurses couched their leadership contributions in terms of team achievements rather than personal achievements. (5.3.6).

Within the collaborative work relationship, part of the nurses' leadership construct was a moral obligation to ensure the patient was provided with the best care available. With this in mind, the nurses indicated that the best health care outcomes could be achieved by sharing the responsibility of leadership with others. The nurses' leadership role varied within their practice

contexts; these influenced their need to be flexible and creative when they led from a variety of positions. At times when health services required, they led from behind, they stepped back to allow experts to fill the gap they were unable to fill. When stepping back they never fully relinquished their leadership obligations as they closely monitored the outcomes of care and acted accordingly (5.3.7).

The nurses' leadership actions were most visible when it came to influencing others, however they identified that because their leadership did not fit the mould of the hierarchical model favoured by their organisations, their contributions often went unrecognised by others. They recognised that their leadership initiatives and contributions were lost in the complexity of multidisciplinary health care delivery. However, despite lack of acknowledgment of their contributions, they personally recognised and valued their leadership during the provision of patient care decisions. They intentionally influenced health care decisions by using their knowledge of the team's attributes and the team's dependence on them to coordinate care. In addition, the nurses identified that their willingness to share successes with other team members and establish a culture of gratitude within their workplace also contributed to invisibility of nurse leadership (5.3.8).

### **5.5.3 Self as Leader in Action**

#### ***Leadership is knowing when to act***

Reflection on the nurses' leadership constructs highlighted that the nurses' leadership initiatives occurred at both local and organisational levels. The nurses' willingness to take leadership action within their organisations was influenced by how they personally experienced the results of their actions and feedback from others in the health care team. They highlighted that their personal leadership construct differed from the organisation's formal, hierarchical structure and therefore their contributions often went unrecognised (5.2.1). Even though there was no formal recognition of their leadership actions, the nurses vision for patient care motivated them to act.

Leadership initiatives were undertaken despite non alignment between their personal values which were driven by their obligations to provide caring environments for their patients and their organisation's values of resource restraint (5.2.2).

Having the ability to overcome the organisation's barriers to their leadership initiatives was a challenge highlighted by the nurses. The nurses indicated that having knowledge of these barriers encouraged them to reflect upon their role and identify leadership opportunities as they arose (5.2.3). It was their ability to recognise the need for patient advocacy and health care interpretation that encouraged leadership actions within their changing organisations (5.2.4). They used their familiarity with the organisation and the health care team to gain a broader understanding of leadership in order to enact their vision of improving care for their patients (5.2.5). It was their relationship with the patients that encouraged them to seek out leadership opportunities and influence health care decisions. Overall, they recognised the need to be flexible and different in their leadership approaches so as to ensure continuity of care in the ever changing contexts within which they undertook their leadership actions (5.2.5).

## **5.6 CONCLUSION**

This chapter has presented the qualitative data obtained through the one-to-one interviews and the focus group discussions with nurses who provided health care services to adults in acute care hospitals, Brisbane, Queensland. Data from the interviews were used to address the three research questions. Whilst data from the one to one interviews were used to confirm the themes that emerged from the focus group discussions, responses that best exemplified the theme were used to provide understanding of the nurses' leadership constructs. These data were validated by all participants during both stages of data collection. Furthermore, the Model of Data Interpretation (figure 4.3) enabled the researcher to reconceptualise the data through the perspectives of Self, Others and Situation. The major themes that emerged in this chapter will be further discussed and analysed in the light of the context and literature review in the next chapter.

## **CHAPTER 6: DISCUSSION OF FINDINGS**

The purpose of this chapter is to discuss the findings that were presented in the previous chapter and critically reflect on these under the light of relevant literature.

### **6.1 INTRODUCTION**

The findings of this study highlighted that the nurses constructed their leadership through three clear perspectives of self as leader, self with others and self in action that emerged from the findings of this study (Table 5.2). During the final stage of data analysis phase these perspectives served as useful guides for the inductive development of themes that emerged from the meanings of leadership provided by the nurses. Each perspective represented the focus the nurses' gave to their leadership meaning or constructions. The relationship between the perspectives and themes is summarised in the following:

- From the perspective of self as leader it was important for the nurses to recognise their leadership attributes prior to undertaking action for the provision of patient care;
- From the perspective of self with others the nurses highlighted the importance of taking leadership action to influence others during the provision of health care services to their patients; and
- From the perspective of self in action it was important for the nurses to know when they could act as a leader to provide patient care.

Three major themes emerged from these perspectives (1) Leadership is recognising one's own attributes; (2) Leadership is influencing others; and (3) Leadership is determined by knowing when to act in the provision of patient care. Woven throughout the perspectives and their related themes were the elements of confidence, experience and knowledge. The nurses' awareness of these elements within themselves further influenced their willingness to undertake leadership action for the provision of patient care. Finally, this chapter presents a model of nurse leadership that represents the synergistic relationship between the findings and the literature.

For each section of this chapter, discussion has been prefaced by key words that provide the reader with a succinct indication of the focus of the content and the leadership constructs that emerged.

## **6.2 SELF AS LEADER**

### **6.2.1 Leadership is Recognising One's own Attributes**

For the nurses in this study, the meaning of leadership provided no clear, singular definition. Examination of the data indicated their meanings were pluralistic and individualistic. The individualistic nature of the nurses' leadership construct has been attributed to their levels of confidence, knowledge and experience. These factors influenced the findings, in that they influenced the nurses' ability to articulate the meaning of their leadership role and willingness to take leadership action. This is consistent with Graham's (2003) study of clinical nurses whereby he identified that the "visibility of self depended upon three things: awareness, experiences and concept. Through these three factors, individuality was appreciated and celebrated" (p.219).

#### **Leadership is pluralistic and individualistic**

On examination of the data, the pluralistic and individual nature of leadership became obvious in the nurses who had a greater depth of experience and knowledge. This was demonstrated by Jenny (3) when she defined leadership as "...something you think about consciously...it's something that for me evolved over many years...I travelled...worked in places and one day someone said 'You should be a charge nurse'." For her, even though the path to her leadership role was not one she consciously followed somehow she "...just got there...."

Despite Jenny's (3) length of experience in nursing practice she still found her leadership role "... hard to describe, you know when you say what is it. I don't know what it is...it's such a multitude...it's emotions, it's a whole range of things." From her responses, it became apparent that her inability to define

leadership was influenced by its diverse nature and lack of clarity. Overall, Jenny did not provide a succinct definition of leadership instead she maintained a broad, general perspective. She appeared to maintain an individual, pluralistic rather than prescribed, limiting definition of leadership. According to Jenny (3) this personal model of leadership “worked” for her. The inability to clearly articulate a personal model of leadership is consistent with Onsmann’s (2002) suggestion that whilst leadership could be acquired through dedication, learning and practice, over time it becomes second nature, so much so that it almost becomes inherently indescribable. Therefore, whilst tacit knowledge of leadership amongst the more experienced nurses created an inherent sense of ownership of the role, it also contributed to an inability to clearly define the meaning of their leadership.

The individual and pluralistic meaning of leadership was not confined to the more experienced nurses. Beginning level nurses such as Sharon (1) and Annette (1) were able to clearly identify the differences between their own leadership role and that imposed by the traditional hierarchical and authoritative models of leadership which they identified as existing in their own organisations. Both Sharon (1) and Annette (1) contrasted their meanings of leadership against the authoritarian and impersonal leadership model they were exposed to in their own workplace. Sharon (1) expanded on the theme of formal leadership by stating “...leadership can be anybody...don’t need a title...different qualities in each different person that would make a good leader as well...different perspectives they have on patient care.” She identified that leadership was not just one formally appointed person but that it depended upon the qualities of the individual in the situation. These beginning level nurses had already constructed their personal leadership definition, one they were comfortable with and which directed them to undertake actions toward successful health care outcomes for the patient within the context of their practice.

Evidence of the plurality of leadership definition from this study is supported by the literature which highlight that despite numerous descriptions and explanations of the same phenomenon by researchers and theorists there has been no consistent definition of leadership (Hughes, et al., 1999; Mello, 1999).



The nurses attempts to define leadership invariably fell into three parts: (1) what the leader did, (2) for whom or with whom the action was taken, and (3) toward what end the actions were taken (Lambert, 2002). This was exemplified by Sharon (level 1) when she explained "...a leader for me can be actively involved still in patient care, as well as running a shift...they take on board the nurses ...they look after their fellow nurses." Accordingly, it is suggested the nurses' definitions of leadership align with the social, emotional, value based aspects of contemporary leadership (Yukl, 2002). Despite their own meanings of leadership, the nurses' descriptions of their organisations' leadership reflected the rigid, bureaucratic model where leadership was the "property of an individual; considered primarily in the context of formal groups or organisations; or equated with concepts of management" (Shriberg, et al., 2002, p. 203). They indicated that this model was not appropriate for their leadership actions toward the provision of patient care.

### **Leadership is a personal construct**

Overall the nurses' responses for leadership definition lacked unanimity with traditional leadership models favoured by organisations. Leadership statements by the nurses were described within the contexts of their practice which highlighted their role and personal attributes. Accordingly, their leadership constructs were closely linked to successful patient care outcomes, which resulted from the actions they had undertaken when providing care. Therefore, leadership from the perspective of the nurses reflects Cook's research (2001a) on clinical leaders, where he identified that nurses who were not deemed to be in conventional leadership positions displayed many attributes of highly effective leaders. Subsequently, this study agrees with Cook (2001b) in that if nurses' contributions are to be recognised and health care organisations effective in all aspects of their services, leadership qualities at all levels of the organisation need to be acknowledged.

Ownership of leadership was demonstrated by personalisation of leadership statements. During explanations of what leadership meant to them, the nurses at level 3 were more likely to personalise their leadership meanings than those at level 1. This personalised meaning of leadership was influenced by the factors of confidence, knowledge and experience. For example,

beginning practice nurse, Sharon (1) identified her leadership role from a third person perspective. Leadership for her appeared to be multidimensional: "...someone who is a leader for me can be actively involved still in patient care, as well as running a shift...they take on board the nurses as well...they look out for their fellow nurses, instead of being caught up in paper work...they're at our level...the bedside level, but they're still standing alone as well." This response also highlighted the dynamic, interactive, and complex nature of the leadership role that she had experienced.

Whilst Jenny (3) was aware of her journey towards leadership, it was her level of knowledge and experience that enabled her to consciously reflect on what leadership role meant personally. The differences in ownership statements of leadership became evident when comparing Jenny's responses "...it's something that evolved for me over many years...it wasn't that I set out to be a leader...I just sort of got there" to those of Sharon (level 1): "...someone who is a leader for me can be actively involved ...they take on board the nurses...they look out for their fellow nurses..."

Consequently, what was of interest to this study was that nurses defined their leadership from either an internal perspective (use of first person) or external perspective (use of third person). These perspectives indicate the personalisation of leadership was demonstrated more strongly by the level 3 nurses. This sense of personalisation could suggest an ownership which could be attributed to the organisational structures that legitimated leadership through its bureaucratic structures. For instance, the level 3 nurses held formal management roles that gave them authority to openly act as leaders, whereas, for the level 1 nurses, leadership was informal and covert. Personalisation of leadership statements was also related to the nurses' level of confidence, knowledge and experience which this study suggests could influence the way the nurses integrated their personal identity with their professional identity.

In explanation of this phenomenon, Ohlen and Segesten (1998) suggested that integration and maturity of professional identity becomes obvious when the nurse's professional identity reflected the subjective part, the person's

feeling and experience about her/himself as a nurse, and other people's image of the nurse, the objective part. They reported that the maturity of the nurses' professional identity was influenced by their socio-historical context and through intersubjective processes of growth, maturity and socialisation where interpersonal relations were important. As with this study, their results indicated that it was through exposure to these influences that nurses gained maturity in their professional identity.

### **Being open to leadership experiences**

The nurses opened themselves up to selected learning experiences so as to create and develop a personal leadership mindset by which to develop their learning and identify leadership attributes of self and others. Closer inspection of the data revealed that the nurses' attempts at leadership definition reflected the leadership attributes they admired and aspired to. Consequently their descriptions provided insight into how, within their practice domains, they informally constructed their leadership role to act and influence others, identified relevant learning opportunities and defined their leadership. These findings are consistent with those of Ospina and Schall (2001) who suggested that all individuals carry around individual mental models of leadership and that by invoking these models it is possible to imagine and list the qualities that make that person a leader.

Examination of the data indicated a list of consistent attributes that were commonly referred to when the meaning of leadership from either the perspective of "self as leader" or "self in relation to others" was presented. Overall, the nurses listed the following as leadership attributes: being assured, knowledgeable, open to other's ideas, motivated to provide quality care and having time to develop others. For Annette (1) it was important that leaders "need to be approachable...confident in what they are doing and saying...calm, well informed...well educated", and for Andrew (2/3) "visible and there to make ...leadership flow."

The leadership constructs created by the nurses from these attributes were individual and informally learned in their specific practice context. Accordingly, the attributes could only be interpreted as unique to each individual because

each meaning was individually constructed because they were internally created whereby the individual's context provided meanings in a manner which was neither uniform nor predetermined (Tuohy, 1999). Overall, this study accepted that whilst each nurses' construct of leadership was unique the nurses presented numerous attributes that created similar constructs.

As they gained experience and confidence with themselves as leaders, the nurses consciously used their leadership attributes as baselines for further leadership development. In addition, they used their observations of self as leader and leadership of others to develop a leadership mindset which set the standards for their leadership. Leadership development for them was personally created and informally learned. Awareness of leadership attributes they aspired to provided some inherent measure of leadership that they used to determine appropriate role models. Use of this inherent measure of leadership was evidenced by Cathy (1/3) who learned from leaders she found to be "really good" or Rod (2) who sought out leaders with "clinical expertness". Overall, the nurses used their leadership mindset to establish a benchmark for which they could determine leadership criteria in others. They used the criteria for self development and to critique the performances of themselves and others in the health care team during the provision of health care services. Unlike the clinical leaders identified by Cook and Leathard (2004) who demonstrated that learning about leadership was undertaken once the nurse had been formally designated as a clinical leader, these nurses were individually motivated to develop their leadership role in order to provide patient care at all levels of the organisation.

### **Learning to lead**

The nurses' leadership mindset was used as a baseline to gain further knowledge, confidence and experience to guide leadership actions for patient care. Learning was a constant for them, but their strategies for learning changed over time. For example, Caroline (3) noted that as her confidence grew, her learning needs "...changed depending on where you developed as a leader as you too climb the scale." Embedded within the desire for further learning, was an altruistic motive. This was unearthed, when both Sharon (1)

and Caroline (3) indicated that a deeper understanding of leadership would allow them to share their leadership knowledge with others.

More overtly, the nurses' openness to learning was motivated by the need to gain an understanding of the effectiveness of their leadership actions. For the nurses, learning was a continuous, self directed and informal process. In order to gain a better understanding of their leadership they implemented a number of strategies to expand their leadership mindset. The nurses had developed persistence in seeking feedback from others and the use of self-questioning to feedback to self. When it came to feedback from others, they carefully selected whom they would go to and like Rod (2) when that "someone" did not "give you what you need," they would persist and go to someone who could. If they found something particularly challenging to them they were inclined ask of self..."Did I do okay or could I have done better?"(Bob 1/2). Sharon (1) used both feedback from others and self-questioning to construct her leadership role. She asked herself "if I'm meeting the standard of care as well as the [other] nurse ...but it's also good to hear how you could have some something better...so, a bit of both." The beginning practice nurses demonstrated a greater need to seek validations for their actions and to identify with the ideology of the profession of nursing. These findings are supported by Clouder (2003) who suggested that "positive feedback reinforces a particular sense of self as a professional person that incorporates desirable behaviour, fitting in with social practices identified by the profession" (p. 219).

Overall, informal learning practices enabled Sharon (1) to take responsibility for her leadership development. This is consistent with Skipton Leonard's view (2003) that Sharon's responses of "motivation and desire for responsibility" (p. 7) represented the more humanistic traits of leadership. This drive for access to knowledge was also identified by Antrobus and Kitson (1999) as essential to nurses' leadership success.

A safe learning environment whereby beginning practice nurses could consciously expose themselves to new knowledge and diverse learning experiences to develop their leadership was important. According to Bob (1/2)

the way he was treated by others spoke “volumes of how you grow as a nurse.” Brendan (1/3) was also more tentative when approaching those whom you trust “with your ignorance.” The creation of safe learning environments depended upon a number of factors that were clearly explicated by the more experienced nurses. Rod (2) identified the need to go to someone “who you feel comfortable approaching,” whilst Linda (2/1) felt empowered by role models who had nurtured her and gave her confidence “to think for myself...” These nurses consciously sought out learning environments that could be described as enabling, empowering and facilitative. This appears consistent with the Laiken (2003) argument that leadership can be nurtured, begun and developed.

### **Stepping out of your comfort zone**

The more experienced nurses recognised the benefits of taking a risk or stepping out of their comfort zone when it came to developing their leadership role. The nurses, who held formal leadership positions, willingly exposed their vulnerability by being open to challenges and criticism from others. Like Andrew (2/3) they recognised they were often at the forefront when “someone had to make the tough decisions.” In order to develop as leaders, they exposed themselves to situations where they were open to challenge and criticism. In the interest of his own leadership development, Peter (2) acknowledged that he had to “be prepared for feedback that may not be nice to hear and be open with it.” Meanwhile, Sarah (2/2) benefited for a balanced approach of both negative and positive criticism: “if it was all critique...I would have said forget it....if there was just encouragement I wouldn’t have grown.” Not only did openness to feedback from others have personal benefits, the nurses, like those in Outhwaite’s (2003) study identified the benefits of self awareness in gaining insight into how to work towards reducing obstacles to change within the team environment. Overall, willingness to question self and seek feedback highlighted a focus on becoming aware of leadership effectiveness and making changes. This willingness for self development was reported by Cook and Leathard (2004) when they observed effective clinical nurse leaders willingness to look for new ways of doing things through constant questioning, a willingness to challenge the status quo and sharing knowledge with others.

## **Being flexible**

The nurses who held formal leadership status within their organisations were aware that their leadership effectiveness would be compared against criteria for leadership established by their organisation. They indicated that the criteria against which their leadership was judged was not appropriate for their actions. Because of this incongruence, they recognised the need to be adaptable and flexible in their leadership role. For example Rod (2) found himself acting in the manner of the nurse manager he replaced in order to be judged "in the same eyes as she's seen." Shriberg, et al., (2002) suggested that this need to be seen through the "same eyes" could be construed as the nurses seeking to maintain the status quo in changing organisations. Alternatively, in explanation, Porter-O'Grady (1998) proposed that nurses acted like all individuals emerging into a new era for organisations, they searched for the boundaries of organisational expectations within which to exercise creative potential. Therefore it is possible, that in order to gain recognition as a leader, the nurses consciously undertook to cloak their leadership within the familiar, rigid, formal models of leadership upheld by their organisations when they were designated formal management roles whilst at the same time exercising their own individual leadership style.

## **Recognising challenges as opportunities for leadership**

Awareness of the uniqueness of their leadership in traditional organisations highlighted the challenges presented to the nurses' leadership role. The nurses counteracted these challenges with a number of strategies. When confronted by an environment that had shifted from hierarchical structures to a structure where leadership roles were less defined, Catriona (3/1) used the challenges she faced as opportunities for leadership development. She tested her leadership skills through creative thinking using "out of the box sort of thinking". Likewise, others developed skills in areas of assertiveness, persistence in putting forward the nursing perspective and self respect to ensure their leadership position. Wiesia (3/1) provided an example of a situation where her leadership role in a nursing situation was encroached upon by management that failed to acknowledge her credibility as a health

care professional and leader. She drew upon her self respect to assertively demonstrate that she was best placed to deal with the situation. In the light of this experience, it would appear that the legitimacy of nurse leadership continues to be challenged, because it does not fit the traditional model of leadership or that its services are not valued within a rigid bureaucratic framework. In accord, Stordeur, et al. (2001) reported that the traditional model of leadership acted as a barrier to nurses' independent actions. Within their study, the authors found that rather than comply with a model of leadership that was not appropriate to them, that in order to enact their own leadership, nurses used a number of strategies to overcome its challenges. The findings of both this study and those of Stodeur et al., suggest that despite the challenges posed to their leadership, nurses create environments whereby they can give rein to their individual creativity in order to provide patient centred care (Hughes, et al., 1999).

The nurses used creativity to develop and improve the practice of team members who provided patient care. Their creative potential was developed through awareness of their leadership attributes. When Jenny (3) observed the way in which team members' actions were similar to her own, she acknowledged the "significant influence" she had on encouraging others to develop and maintain standards of practice that were similar to her own. Whilst she utilised her own leadership attributes to role model practice, Jenny (3) did not "want to develop clones but there are certain things that have to be done that way and because I have a good rationale for them." Overall, Jenny (3) was confident in her own knowledge, experience and thus the effectiveness of her leadership actions. Consequently, awareness of their own attributes enabled the nurses to re-examine their strategies and functional activities in order to openly review the efficiency and effectiveness of their leadership role. According to Graham (2003), Kerfoot and Wantz (2003) these actions indicated a move to transparency, openness toward relationships and partnerships. Cook and Leathard (2004) also identified the benefits of a transparent self as leader with others in that clinical nurse leaders overtly established partnerships and used their influence to help others to see and understand the situations from various aspects.



Being aware of exclusion by other health care team members from the decision making process encouraged the nurses to maintain open communication channels between the health care team members. They recognised communication with team members as an opportunity to highlight the interactive nature of their leadership role as exemplified by Peter (2) “we constantly talk to the medical staff, reception staff, ambulance personnel...communicate hospital admin...we do a lot of communicating with ward staff and getting patient’s admitted...you have to negotiate ...we look after police headquarters and then both internal and external customers...you’re doing it the entire time...it always falls on the nurse in charge.” Peter’s (2) description demonstrated the interactive nature of the nurses’ leadership role within an ever changing context, the multiplicity of the communication channels they utilise and the relationships and partnerships with the health care team (Kerfoot & Wantz, 2003).

Because two way communication between team members benefited patient care, the nurses indicated they persistently scrutinised communication on their wards and intervened as necessary when situations changed. The importance was highlighted by Rod (2) who indicated that “communication breakdown between health care team members could impact on the delivery of patient care.” Creating favourable environments through effective communication is supported by Stordeur, et al., (2002) who found that within changing organisations, nurse leaders who encouraged greater participation in decision making generated a favourable climate among the team, characterised by less interpersonal conflict and hostility and fewer non-cooperative relationships. Overall, the nurses of this study demonstrated a distinct responsibility for using communication to develop interactive teams that could respond in changing contexts.

The significance of communication in an environment where coordination of care relied on good communication between health care team members was highlighted by Peter’s (2) reflection on the complexity of his leadership actions. He described his responsibility as “where the buck stops...the pivot for management of the department...you... round up and move them on...the sounding post for everybody...you...cop all the complaints....to resolve

conflict...make clinical decisions which results for patient welfare...actively communicating with everybody, to keep the peace, to keep morale going, to keep everybody motivated...keep the flow of the department...basically non stop.” This dynamic representation is supported by Degeling, et al. (2003) who observed that nurses, more than any other health professionals, were committed to team performance within changing organisations.

### **6.2.2 Summary**

The leadership mindset developed by the nurses shaped their leadership constructs and determined the attributes by which they judged their ability and the ability of others to undertake leadership action. This mindset was developed from what the nurses determined to be admirable leadership attributes in others and their professional ideology of patient centred care (Antrobus & Kitson, 1999; Graham, 2003). Awareness of leadership attributes and professional ideology motivated them to open themselves up to informal learning opportunities to develop their leadership toward improvement of patient care. This desire to learn independently demonstrated a shift from the influence of control and structure of human behaviour by the organisation toward an emancipatory model of self directed learning (Rost, 1991). The nurses’ responses highlighted their “own capacity to learn and change” within the new era of organisations (Dunphy & Griffiths, 1998, p. 151). The findings suggested that rather than waiting for their organisations to learn and change, these nurses acted to acquire the attributes to prepare themselves for the journey of leadership development and action in changing contexts.

## **6.3 SELF IN RELATION TO OTHERS**

### **6.3.1 Leadership is Influencing Others**

Two major factors influenced how the nurses’ developed their leadership construct of influencing others. Firstly, their relationship with the health care team and how this affected their leadership contribution to patient care and secondly how their relationship with the patient affected their leadership

actions within the team. For the nurses, the notion of team was implicit within their leadership constructs. Their concepts of shared leadership within teams could be attributed to two realisations. Firstly, that they could neither provide health care services alone and secondly, that they did not know it all. Overall, the Rod's (2) response supported the nurses' dependence upon effective team relationships to achieve successful outcomes for patient care ""Doctors writing their bit, physios, OTs, whoever...". Consequently, they recognised the value of human capital in ensuring successful health care outcomes, especially in contexts that were resource poor (Hughes, et al., 1999; Lawler III, 2001).

### **Being resourceful**

For the nurses, human capital, was described in terms of the members of the health care team whom they could access as resources to provide appropriate health care for their patients when they did not have the skills or knowledge to do so. Martin and Christopher (2005) highlighted the importance of leaders forming relationships whereby they could use the skills of others in changing organisations in order to "build a proficiency to move faster with greater collaboration and shared commitment" (p. 91).

Overall, the benefits of a supportive environment for the nurses of this study demonstrated that they conserved their energy for dealing with issues related to patient care by recognising their own strengths and weaknesses and acting to develop partnerships with health care providers when other resources were required. Likewise, Graham (2003) highlighted that a supportive environment was important to nurses as they used a considerable amount of personal resources when caring for their patients within changing organisations.

### **Recognising the potential of others**

The nurses, knowledge, confidence and experience with the patient care situation, influenced their decisions on whether or not to take leadership action or whether to delegate responsibilities to other team members. Susan (3/3)

demonstrated this “tap into” other health care member’s expertise for patient care when she acknowledged her own limitations. Likewise, Andrew (2/3) would seek outside his own discipline to ensure “the best person for the job...”was in place”. Overall, these nurses used their leadership skills to create therapeutic environments for their patients. These findings are consistent with Graham (2003) who noted that a scholarly leadership style helped to interpret information in order to realise care and develop a coherent team whereby all members responded to the patients’ needs.

### **Leadership is participative and shared**

In order to ensure that the best patient care was provided the nurses utilised a participative style of leadership when seeking the expertise of others. The nurses tended to move away from the solo model of leadership toward a leadership that is discussed in terms of others when they realised their inability to undertake individual leadership action. This style of leadership has been described as collaborative and shared among all members of the team (Popper, 2004; Rost, 1991). Additionally, Graham (2003) demonstrated the outcomes of what he termed the notion of shared leadership when he described how he developed a partnership role and offered personal support alongside nurses’ professional development and learning that enabled them to achieve effective and creative patient centred care. Overall, the benefits of participative leadership for this study were consistent with those documented by Christian and Norman (1998). These authors reported that clinical leaders who developed environments wherein staff felt a sense of ownership of their practice noted increasing contribution of new ideas, a sense of involvement in changing practice as well as responsibility for professional development.

### **Sharing successes**

Whilst the nurses identified with their own unique type of leadership, they also recognised that their style of leadership within a traditional, hierarchical setting, blurred professional boundaries which according to Rod (2) “made our leadership contribution invisible.” This observation is widely supported by nursing literature whereby lack of recognition of nurses’ contributions to health

care services within interdisciplinary teams is well documented (McCloskey & Maas, 1998; McKenna, et al., 2004; Porter-O'Grady, 2003b; Wynne, 2003). Furthermore, data indicated that the nurses' reflections on their leadership actions tended to acknowledge team achievements rather than their personal contributions. Whilst Linda (2/1), Margaret (1/2) and Caroline (3) acknowledged their leadership actions toward patient and staff advocacy, they chiefly focussed on the actions they undertook to guide others team members to deliver best health care outcomes. These nurses developed a culture of gratitude that acknowledged team achievements within their practice contexts. These actions reflect those of Graham (2003) who demonstrated the outcomes of what he termed the notion of shared leadership when he described how he developed a partnership role and offered personal support alongside nurses' professional development and learning that enabled them to achieve effective and creative patient centred care.

Furthermore personal accolades were dismissed by Jenny (3) who chose to acknowledge the "success of the ward" whereas Caroline (3) wanted to "...thank people and watch them grow." This inclusivity provided insight into the way the nurses expressed their leadership which could be described as a way to serve others (Grohar-Murray & DiCroce, 2003).

In addition, for the nurses, the development of relationships with other team members' has an intentional component. The forming of intentional relationships by nurses with others is consistent with the views of Munduate et al., (2003) who identified nurses developing mutually dependent relationships with team members in order to influence health care decisions. In order to achieve their vision of patient centred care, the nurses for this study have used a complex web of social and power relationships to develop relationships with health care team members (Yukl, 2002).

Within the complexity of these relationships, it was very difficult to identify the unique contributions of the nurses' leadership actions toward patient care. As McCloskey and Maas (1998) suggested the nurses' actions got lost in the multidisciplinary maze.

Overall, the relationships that the nurses developed with team members appeared to have an intentional component that was not about individual accolades but rather about development of a team that worked toward mutually determined health care goals for their patients. Within these actions, the nurses' leadership was clearly visible as they acted to develop the teams and demonstrated that a culture of gratitude within their contexts enhanced team performance. Carolyn (3) the benefits for team relationships in an environment where a culture of gratitude was evident. She felt it created a sense of shared purpose for patient care and emphasised "it's everybody's ward...I don't take ownership of anything...it's a shared environment that everybody feels proud" and "I inspire people that you need to say thank you at the end of a really dreadful day...thank the team, but people to watch them grow...like being a mother...a nurturing process..."

### **Recognising one's own contributions**

The nurses identified that the health care team was dependent on them for the coordination of health care services. Even though they acknowledged a lack of recognition for their leadership by others, the indicated that because of their proximity to the patients, other team members acknowledged them as being best placed to monitor and communicate patients' health service needs. This recognition supported their self-determined leadership role of coordinating health care services within the health care team. Within this construct, Belinda (1/2) recognised her responsibility "...we're the first people to see the decline...make sure immediate action is taken."

The nurses used the art of persuasion to influence team members to achieve successful health care outcomes. The strategies they used to persuade team members to think about how care could be improved depended upon their level of confidence, experience and knowledge. Inexperienced Sharon (1) chose to lead by example when she found herself needing to persuade others to maintain standards of practice. Whereas experienced Jenny (3) could assertively articulate her influence at higher levels "...I will say to the executive... The quality of the care...we have needed [resources]...really comes from a collaborative perspective...supportive of each other...they'll say

“Yes, we needed that.” In order to achieve their vision or goals they enacted the art of persuasion at all levels of the organisation. Weisia (3/1) used creative persuasion at all levels of the organisation to achieve health care goals. She indicated that making goal achievement visible ensured the organisation would recognise her leadership credibility. This credibility gave her greater influence with regard to gaining more human resources and improved standards of care. Overall, the nurses reflections on the importance of influencing health care team members toward successful patient outcomes is supported in the literature (Graham, 2003; McAllin, 2003).

The nurses highlighted how other health professionals paid little attention to the leadership actions they undertook to ensure successful health care outcomes were mutually achieved. This was exemplified by Linda (2/1) who reported other health care team members’ failure to pay attention to nursing documentation that communicated patients progress to others. In support of this data, Rod (2) indicated that “...nurses are the only professionals that read everybody else’s input...we have to take time to read their entries, their advice...whatever the reason the reverse does not happen.” From these examples, it was evident that whilst nurses recognise the value of their own leadership role and contribution to health care services other fail to acknowledge it. Awareness of the nurses’ own contributions to health care and lack of recognition by others is well documented (Armstrong, 2004; Cook, 2001a; Porter-O’Grady, 2003b). The nurses’ reports also continue to support the image others hold of nurses as compliant and subservient, shaping their roles to meet the demands of the organisation and others (McCloskey & Maas, 1998). Likewise, Daiki (2004) suggested that though nurses thought their work was important, nursing lacked recognition because medicine’s continuing dominance made it difficult to define their professional boundaries. Consequently, these nurses sensed that others exploited their selfless dedication and sense of duty.

### **Acknowledging responsibilities**

As they came to realise their responsibility for leadership action within the team, the nurses ensured that all health care team members maintained

standards of patient care. They utilised their leadership attributes and professional ideology to develop a mental competency model to influence team performance. Their mental competency model provided a voice for their leadership. Both Caroline (3) and Sharon (1) had no hesitation in assertively communicating to individuals that their standards of practice could result in negative consequences for the patient. Sharon (1) indicated she felt the values she held gave nurses' "...a voice actually...a voice for the patient". By giving voice to their action, nurses have been able to turn around misconceptions and enhance individual autonomy (Degeling, Maxwell, et al., 2003; Munduate, et al., 2003). Furthermore, Arbon (2004) suggested that when nurses articulated their practice values and standards they generated meanings and understanding about their leadership role to themselves and others. The findings demonstrated that the nurses had found their voice for leadership actions, especially in the area of patient and staff advocacy.

The nurses used understanding of their leadership role to creatively develop situations whereby they shared leadership responsibility with team members. Accordingly, their actions enabled them to meet their professional obligations and maintain their scope of practice. Jenny (3) highlighted how she shared her leadership with other team members according to needs of "the patient who has specific expert requirements." She reflected that better team relationships were developed as a result of devolving responsibility to others.

When devolving patient care actions to others, the nurses never fully relinquished their leadership responsibility for the outcomes of care. They indicated a preference for shared leadership, whereby they maintained their responsibility through a watching brief as exemplified by Jenny (3) who delegated to a "far more expert person for the duration of what is needed for that patient". The nurses' descriptions of shared leadership holds some of the characteristics of shared leadership by Lawler (2001). Within this model, leadership Lawler indicated a shift from leadership to followership and back to allow those who have knowledge and skills to provide leadership in given situations. She demonstrated a relinquishment of responsibility to those who took over the role, in this case the nurses did not.



For the nurses of this study, leadership responsibility was continuous and never relinquished, even when they had delegated to others. This hold on leadership responsibility was not related to lack of trust in others, but rather to their relationship with and commitment to the patient for whom they felt total responsibility. The nurses created a leadership that was described by Drath and Palus (1994) as a “shared human process” (p. 6) situating its patterns within the dynamic group relationships they had established (Drath & Palus; Horner, 1997; Lambert, 2002).

### **Supporting others**

The nurses also used their voice to maintain open, honest communication especially in early intervention with performance issues. These leadership actions were undertaken to maintain performance standards and ensure successful outcomes for their patients. Assessment of team member’s abilities enabled Jenny (3) to utilise supporting skills such as mentoring, being available for questions and keeping a watching brief on team members’ performance and development. She acknowledged she would intervene “...if they have no idea...I wouldn’t give them complex patients...I would buddy them up with someone...what is best for the patient.” Jenny’s (3) actions were consistent with the attributes awarded to effective clinical nurse leaders by Cook and Leathard (2004) who “recognised that supporting others through various situations enhanced their ownership of the problem and enhanced effective learning“(p. 439). However, the leadership from behind demonstrated by Jenny (3) for development of others, has been found to mask nurses’ leadership actions to others (McCloskey & Maas, 1998; Lambert 2002). Consequently, despite the benefits of Jenny’s (3) actions to the patients and other team members, this leadership style could be classified as covert thereby maintaining the invisibility of the nurses’ leadership effectiveness to other team members or the organisation as a whole.

The nurses highlighted the inclusive nature of their leadership constructs when they described that part of the nurses’ leadership actions were to develop autonomy and leadership in team members, as well as to uphold nursing’s vision for patient care. Catriona (3/1) and Caroline (3) described how they

acted to develop a sense of confidence and self worth in others so that they could come to appreciate the nurses' vision for patient care and undertake leadership actions on behalf of the patient. Linda (2/1) acted to encourage assertiveness in others so they could challenge those who did not have safe work practices. On reflection, these nurses primarily acted to develop leadership in others to ensure quality of patient care. This is consistent with the new order of leadership whereby individuals are encouraged to express a desire for freedom and autonomy in their work so they can give rein to individual creativity, in order to be satisfied and productive in their jobs (Hughes, et al., 1999; Laiken, 2003).

### **Stepping back**

Stepping back from the leadership role was described as an important attribute when it came to developing leadership skills in others. Catriona (3/1) gave insight into the purpose of this action "don't be a doer, don't issue tasks because there's no learning, no development, there's no extension." Whilst the action of stepping back appeared to indicate the nurses were relinquishing their leadership role, further examination of this data demonstrated the nurses kept a close watching brief over others, leading from behind as the need arose. They acted as a metaphoric safety net for others "...to give as much autonomy to the nurses working in my unit as they want to take...that doesn't mean I'm not necessarily hanging around watching them, I tend to watch people fairly closely." (Angela 2/3)

To ensure successful patient outcomes, the nurses demonstrated leadership action through visible role modelling to influence team members' health care provision. Caroline (3) highlighted the benefits of rolling up her sleeves "when the chips were down, demonstrating leadership action by taking the responsibility of sharing the workload." This action according to Caroline (3), developed non threatening influential relationships with team members. Likewise, Annette (1) indicated she made her leadership visible by her willingness to "be a good role model." The personal actions taken by both Caroline (3) and Annette (1) are consistent with Limerick et al., (1998) observations that direct leadership initiatives rather than the organisation's

adapt their structures [and roles] to develop human relationships (Limerick, et al., 1998). In accord, Cook and Leathard (2004) suggest that effective clinical leaders acting as role models have been found to have well developed perceptual ability and therefore are able to respect signals from individuals and the wider organisation when it comes to knowing how to act. In addition, the initiative of assisting others and role modelling and could also enhance clinical credibility for nurse leadership. According to Christian and Norma (1998) hands on clinical work has been seen by clinical leaders as a way of achieving respect and support of others and maintaining good personal relationships with them. Therefore, the nurses' leadership actions of role modelling has a wider purpose than just demonstrating a skill or overtly acting in a role, it also enhances development of relationships with others in the health care team resulting in the potential for clinical credibility.

### **Maintaining your vision for leadership action**

Overall, the nurses' leadership actions were influenced by the value they placed on the unique relationship they had with their patients. It was the regard they held for their patients and their health care needs that motivated them to influence other team members' health care actions or decisions. The action of intentionally influencing others was clearly explicated by the nurses as part of their leadership construct. With this in mind, according to Yukl (2002) the primary motivation the type of relationship the nurses formed with health care team members was based upon the successful outcomes of health care rather than emphasised as some form of rational, cognitive process whereby leaders influence followers. Consequently, the nurses utilised their vision of achieving a humanistic relational model of care with the patient to drive their leadership actions.

### **Being respectful of self and others**

The relationships established by the nurses within their health care team members were created in a mutually respectful environment. Respect was initially, naturally awarded to all by the nurses. When approaching other team members Peter (2), an experienced nurse, demonstrated he was

“...sincere...very motivated and open, there’s no hidden agenda, no bias...everyone on equal footing regardless.” The nurses indicated they looked for the best in all people, unless they were presented with situations that proved otherwise. When it came to dealing with performance issues, the nurses utilised communication strategies that were objective, direct, open and honest. In addition, Rod (2) provided a humanistic dimension to the support he gave “I sort of stand back and watch that person...see if I can pick something up...I make myself pretty available in the role....hopefully will pick things up before they get directed to me...if they get directed to me then I’m a pretty straight forward person...”

Despite initial unconditional respect for other team members, the nurses acknowledged that respect for their contributions was the team or organisation was not automatically awarded. Maureen (3/2), with many years of experience in a speciality setting, indicated she even “had to earn respect” from new health care team members. Even within their contemporary health care organisations the lack of respect felt by the nurses for their contributions was attributed to the team’s or organisation’s inability to view the nurses as health care professionals working in equal partnership. This supports the finding that the visibility of nurses’ contributions to health care outcomes within a health care team remains clouded by the past. In the past groups were made up of single entities and were disciplinary specific, today interdisciplinary groups of individuals interact to achieve common goals of practice (McSherry, 2004). Moreover, Daiksi (2003) also identified that nurses remained largely excluded from decision making because they felt they received less respect from physicians and nurse managers. Therefore if nurses continue to work in complex hierarchies where organisational structures and the culturally endorsed authoritative knowledge of medicine [or a specific discipline] are reinforced, their leadership actions toward patient care will remain unacknowledged (Liaschenko & Peter, 2004)

The nurses indicated that it was important for them to have respect from patients and other team members in order to successfully achieve patient care goals. They felt that lack of respect from others, could compromise their actions. Brendan (1/3), early in his career as a leader, realised that in order to

gain respect from others he needed to demonstrate he was authentic in all aspects of the care he provided. Respect from others was achieved by Jenny (3) consciously making time for those who needed support and advice "...I spend a lot of time on it as well...people management...is for me...the singularly most time consuming thing that I do." In addition to respect, nurses' careful, nurturing leadership actions also had the potential to develop an environment which was enabling, empowering and facilitative for others. This environment, according to Laiken (2003), contributed to effective teams. Whilst these nurses indicated that they were struggling for recognition and respect, the nursing literature reports that overall, nurses are well respected as successful people managers and therefore readily acceptable as leaders within teams to directly influence and continuously improve clinical care (Antobus & Kitson, 2001; Cook, 2001b; Davidson, Elliot, & Daffurn, 2004). It would appear that nurses are aware of the benefits of a respectful environment and have demonstrated their ability to influence patient care, yet are still largely ignored when it comes to health care decision making and acknowledgment of their contributions.

The nurses acknowledged that their continued focus on standards of care could result in negative attitudes from other health care team members, despite this, they persistence in monitoring the performances of others. When Linda (2/1) persisted in focussing on standards of health care services she experienced social isolation from the team. Likewise, Annette (1) experienced negative consequences of her persistence "...I do feel as if they're just going "Oh, just leave me alone" but I'll keep pestering them until...or I'll just write in the notes that it was passed onto in charge nurse or I'll hand it over and an ongoing concern...I'll keep asking about it." Furthermore, when it came to poor standards of practice by others, the nurses resolutely stood apart. They morally distanced themselves from the actions of others, whilst at the same time continuing to work toward the team goals for successful outcomes and safe patient care. Shaune (1/1) and Annette (1) both demonstrated how they stood apart in situations where their team members' biases and stereotyping had impacted negatively on patient care. Resolute impartiality was also demonstrated by Sharon (1) who, in the face of authority and the more experienced, felt she maintained a leadership position by highlighting the

patient's rights even though she felt her "comfort zone jeopardised". Though these less experienced nurses were prepared to stand alone, they also felt they were taking the opportunity for leadership action by role modelling their assertiveness skills for others.

### **Having a voice**

The nurses used open, direct, honest communication to overcome barriers to their leadership role. They also used their professional ideology to articulate and legitimate their leadership role during the delivery of health care services. In order to gain support when it came to meeting their patients' needs, the nurses sought to establish collaborative relationships with team members who were open to suggestion and respected their contributions. These findings are consistent with the views of Daiski who (2004) reported nurses in inter and intra-disciplinary relationships valued collaboration and acceptance by those outside of nursing, with increased emphasis on interdisciplinary teamwork being mentioned as one of the positive outcomes of restructuring. Accordingly, these relationships enhanced understanding of each other's roles and developed closer collaboration and improved continuity of patient care (Daiski).

#### **6.3.2 Summary**

The nurses' utilised their personal vision of patient centred care as the motivator to influence relationships with other health care team members. It was their leadership attributes and levels of knowledge, experience and confidence that created their circle of influence toward taking action on behalf of their patients. Data demonstrated that the nurses' actions to influence their teams' standards of practice and health care decisions required them to utilise a model of leadership that was flexible and adaptable. This model of leadership was described by the actions the nurses undertook such as participation, sharing, stepping back, guiding and supporting. Whilst their leadership actions required they be prepared to use other team members' expertise to maintain continuity of care, they never relinquished the

responsibility of their own involvement, choosing to keep a watching brief and acting on behalf of the patient if the need arose. Overall, the nurses' leadership actions were enmeshed within their health care teams' performances and outcomes. Consequently, their leadership contributions went unrecognised by the team and the organisation. Even though they realised that their performances as leaders was judged against the standards of traditional leadership models, the nurses chose their own leadership styles because it worked for them and more importantly, they were able to acknowledge the successes of their actions through their team's performance.

## **6.4 SELF AS LEADER IN ACTION**

### **6.4.1 Leadership is Knowing when to Act**

It was the nurses' knowledge of their attributes, skills in developing influential relationships with others and confidence in self as leader that determined when they would undertake leadership actions. They acknowledged that it took confidence to take charge of a situation and that knowledge and experience guided them to appropriate leadership action whether that was undertaken personally or delegated to another.

#### **Being confident in your ability**

The nurses' demonstrated a variation in the attributes that created awareness and confidence in their own leadership ability and consequently, determined their willingness to act. For Bob (1/2) knowledge of professional standards made him "consciously aware..." of actions "because it reflects back on you as a leader." Sharon's (1) leadership responsibility was upheld by confidence in her ability to maintain practice standards even if it meant not being liked by the team. She chose to act even if "...it knocks someone else's nose out of joint...you've got to be prepared...it's for the patient." By the same token, Rod (2) defended his leadership position as a patient advocate. He believed that "nurses are the central, most important figure in patient care." Furthermore, he explained that nurses were best placed to make sophisticated judgements based on their ability to assess the patients' and their families' needs,

preparing a plan of action and communicating between the patient, their family and other health care team members. This supports Arbon's (2004) suggestion that nurses seemed to have characteristics required to coordinate patient care (as recognised by these nurses) that made a difference to the quality of their interaction with others. In addition, exposure to clinical experiences for the nurses in Arbon's study played a role in how they understood themselves and others in the lived world of work. Like the nurses in this study, experience and knowledge enabled them to bring "practice understandings about people and situations that they utilise to their work" (p.153).

### **Aligning with one's values**

The nurses indicated they were best placed to take leadership action because they were familiar with their patients' needs and the skills of health care team members. Awareness of their patients' needs enabled them to tap into appropriate human resources, whilst, the sense of responsibility they experienced for patient care gave them a voice to influence management decisions regarding distribution of health care resources. Accordingly the literature also recognises that within the clinical domain, it is the vision for nurse leadership with the patient as the central person in the health care team that provided the impetus for physical or verbal action (Arbon, 2004; Kosinka & Niebroj, 2003).

The extent of physical and verbal action undertaken by the nurses was determined by their levels of experience, knowledge and confidence. Awareness of their need to develop leadership attributes the nurses opened themselves up to the challenges of learning. Overall the nurses indicated they were not willing to compromise patient care at any stage, but personally were willing to take risks to develop by being open to challenge and criticism of their leadership from others. This was exemplified by Sharon (1) who found herself in a patient care situation where she was required to weigh the risk to the patient and an opportunity for leadership learning. She used her professional judgement to weight the differences between personal learning needs against risk of her actions to the patient and found herself at "...the stage where



further education is necessary". Sharon's (1) decided not to act in this situation. Her decision indicated she was active, internally directed and motivated to maintain safe care for her patient. This event reflects that the individual leadership attributes depicted by Sharon (1) are in direct opposition to those of the traditional, mechanistic model of leadership whereby members of a group are identified as inactive, externally directed and unmotivated (Skipton Leonard, 2003). Overall for this study, the beginning practice nurses demonstrated an innate sense of responsibility that was clearly driven by their motivation to maintain a safe environment for patients. Whilst the motivator was the same for the more experienced nurses, articulation of their actions to achieve goals for patient care were more covertly enmeshed in their discussion on patient care.

Because the nurses spent more time with their patients than other health care team members, they had developed a unique knowledge of their patient needs. They used this knowledge to direct their leadership actions and influence health care decisions to ensure their patients were placed in a supportive and caring environment. The relationship between their unique knowledge of the patient and their leadership responsibilities created a dissonance between their personal values of care and the organisation's values of care. Particularly for Jenny (3) who found her ability to meet her patients' needs restricted by the resource constrained context established by her organisation. She reflected that "...caring is probably a little undervalued in the health care service...caring for patients is equally important...to throughput and knowledge and skills ...equally important to balance these factors for me as a leader." These tensions between personal and organisational values as a result of the nurses' leadership actions have been reported by Limerick, et al., (1998) and McSherry (2004) and could offer a reason as to why nurses leave the profession.

Part of the tensions that were described by the nurses was the lack of recognition of the legitimacy of their leadership actions by others in their organisations. This has been identified in the areas of discussion under respect, lack of involvement in decision making and resources. The nurses' reports are consistent with findings in the literature where it would seem the

power of designated, formal authority continued to hold the greatest influence on decisions with regard to resources for health care services (Bamford & Porter-O'Grady, 2000; Parker, 1999; White, et al., 2000). Accordingly, this study reflected failure to recognise the legitimacy of nurse leadership by others, even though the nurses were well aware of the acceptance of their organisations' leadership requirements. The nurses were not awarded formal power or authority to undertake leadership actions which indicated their contributions continue to be largely ignored. According to Antrobus and Kitson (1999) this observation reflects the bi cultural nature of nurse leadership whereby "leaders hold the values of nursing, whilst recognising and influencing the values of the contextual ideology" (p. 750).

### **Overcoming tensions between personal and organisational values**

Even though their leadership went unrecognised by their organisations, the nurses indicated they were conscious that the responsibility of the quality of health care services was often placed on their shoulders. They perceived that this informally, self designated responsibility gave them an opportunity to demonstrate leadership and contribute to health care services. Consequently, responsibility for achieving their organisations' unspoken expectations heightened their need to ensure their leadership actions resulted in positive outcomes that were recognised and acknowledged by others in the health care organisation. Because their organisations tended to review leadership performance through formal, authoritative models they acknowledged that measurable outcomes of their style of leadership were a challenge. The continued focus on positive outcomes measured in the light of organisational goals has been identified by Laiken (2003) as intensifying the pressure of work and intimidating the inexperienced. This was exemplified by Annette (1) who experienced the tension between she felt in providing care in an environment with scarce resources, high organisational expectations and patient needs.. Overall, this according to Skipton Leonard (2003) is not an environment within which leadership is developed.

Despite the tensions that existed between personal and organisational expectations, the nurses described situations where they acted to protect the

reputation of their organisation. They provided examples of situations where they were required to diffuse conflict between patient and organisational inefficiencies, as well as attempting to allay the patient's fears and anxieties when their expectations were not met. Jenny (3) explained the nurses were exposed to this leadership responsibility because they were at the interface of patient issues and complaints that were associated with constantly changing situations within health care. When dealing with patient complaints, the nurses identified the tensions that emerged for them when discrepancies between organisational rhetoric and patients expectations were unrealistic in terms of the outcomes they could achieve. Annette (1) indicated how she felt torn between consideration of cost and patient needs when she discussed her leadership dilemma about early discharge programmes for patients within her organisation. Within this context, she experienced a sense of powerlessness as felt her voice was not heard. This sense of powerlessness could be attributed to tension emerging from conflicting values that had the potential to erode Annette's (1) perception of the importance of her leadership role and consequently, over time, see her shift leadership responsibility to others (Gordon, 2003; McSherry, 2004). These observations are supported in literature which identified that organisations undergoing change neglect or fail to meet the needs and actions of individuals (Limerick, et al., 1998; Popper, 2004; Yukl, 2002).

Whilst the nurses identified that their organisations had neglected or failed to deliver its promises, they chose to describe these situations as opportunities for leadership action and acknowledged that it took confidence, knowledge and experience to deal effectively with these issues. The more knowledgeable and experienced Caroline (3) also recognised that dealing with these issues was individual and "very much depended upon the leader and what they hoped to achieve at the end of the day...." Furthermore, Caroline (3) desired to act out her leadership in a broader manner so that individual needs of others could be met, consequently releasing the tensions of conflicting values and overcoming deficits in the organisation. These characteristics are reported to be representative of informal leadership within formal organisations, whereby the informal leader sets the standards for others to follow (Dubrin & Dalglish, 2003; Hein, 1998).

It was the organisation's formal leadership structures, the dissonance between personal and organisational values and the expectations of the patients that caused a number of the nurses to reject offers of formal leadership from the organisation. The nurses believed that the organisations leadership structure did not reflect their own leadership styles and they would have difficulty achieving the organisation's goals. They saw the formal leadership structures in their organisations as "...barriers...the fine delineation between doctors and nurses...a status and authority thing..."(Peter,2). However, discussion on leadership with these nurses revealed a distinct separation between responsibility for the patient and responsibility for the organisation. This was clearly exemplified in situations of resource restraint where staff shortages occurred and there was inadequate skill mix for the patients' care requirements. During situations when the quality of patient care could be compromised, the nurses used their knowledge, experience and confidence enabled to step forward and take informal leadership actions to support and guide other team members to the desired outcomes of patient care. They recognised the dilemma of performing with "limited resources and being able to give the best care possible..." (Margaret 2/1). During these times, the nurses utilised their leadership attributes and meanings which enabled the emergence of shared purpose and collective action (Horner, 1997; Lambert, 2002). Furthermore, had the nurses constructions of leadership been bounded by formal, traditional leadership, Armstrong (2004) suggests they would not have undertaken leadership action. According to Cook (2001a) the impetus for their actions resulted because they constructed their own meaning of leadership within the circumstances in which they found themselves.

### **Being visible to self and others**

It was the nurses' unique relationship with the patient that provided the nurses with opportunities to make visible their leadership through the actions they undertook within the health care team. They believed their leadership was made visible by their ability to maintain continuity of care, be a voice for the patient and present a total picture of the patient to the health care team they needed to demonstrate a leadership to suit all situations. Jenny (3) indicated

“there is no doubt that other health professionals and medical staff nominally know and understand the nurse will be coordinating the care and we know what [information] they’re going to need.” However, Jenny reflected that the team’s expectation was an unspoken assumption rather than an overt acknowledgment of her leadership. Jenny’s realisation reflected the observations of McCloskey and Maas (1998) who noted that that members of the team regarded the nurses’ actions as being dependent upon a the team member’s decisions rather than initiated by nurses.

In order to fulfil their leadership responsibilities the nurses reported they were required to be flexible and different in their actions constantly. They indicated because of the diverse situations in which they found themselves, they could not be distinguished as following one specific model of leadership. Lack of adherence to a clear, singular model of leadership could contribute to the nurses’ contributions going unrecognised by other health team members and the organisation. Consequently, the failure to attribute a clear leadership model to nursing in a complex hierarchy has maintained the traditional, dependent role of the nurse by identified by others that is highlighted in the literature (Liaschenko & Peter, 2004; McCloskey & Maas, 1998, Porter-O’Grady, 2003c). Accordingly, McAllin (2003) suggests nurses’ contributions within interdisciplinary teams is little understood and thus, further explanation of how they integrate interdisciplinary roles and responsibilities thereby adding value to the team, is required. Furthermore, failure to acknowledge the contribution of nurse leadership, also highlights the reluctance of other team member’s to release their traditional power bases, accept organisational change or acknowledge different models of leadership (Limerick, et al., 1998; Parker, 1999).

### **Harnessing adaptability and flexibility**

Adaptation of the nurses’ leadership role to certain situations was attributed to the complexity and chaotic nature of the changing organisations within which they functioned. The nurses purposively did not operate out of a single model of leadership, because they were required to adapt their leadership to suit the context and patient needs. Jenny (3) indicated that if she had not adapted her

leadership style over her years of practice she would no longer “be here”. Overall the nurses’ awareness of the need for adaptation and flexibility in their leadership roles is supported by Parker (1999) and Wynne (2003) who suggest the need to re-examine roles and practice in the light of a move toward a new era for organisations. Whilst the data suggested that adaptability and flexibility of the nurses’ leadership role has contributed to lack of recognition of the nurses’ contribution to health care services, it also revealed that the nurses intentionally choose their style of leadership within the changing health care organisations so they can contribute effectively to patient care.

The nurses’ leadership action for patient care was challenged by organisational decisions that had created resource poor contexts within which they had to deliver patient care. Subsequently, the nurses’ described how increased workloads and organisational expectations challenged their professional standards and leadership credibility. As a result, Cathy (2/3) reported that “nurses felt overworked and undervalued.” Working within a context of limited resources offered the nurses a mixture of leadership opportunities within the organisational structure. For some, leadership selection was ad hoc and situational, this led to role confusion and anxiety. Peter (2) highlighted the complexities he faced during a shift during which he held temporary, formal leadership responsibility. He identified the need to protect the organisation as well as ensuring a safe environment for the patient, whilst at the same time supporting and guiding inexperienced team members. The nurses’ concerns regarding their ad hoc and situational leadership positions reflect Porter-O’Grady’s (1998) observations of individuals emerging from an industrial paradigm. Porter-O’Grady noted that when individuals were faced with situations out of their control, they searched for the expectations of the organisation within which to exercise their creative potential without this they often felt lost and chaotic. However, whilst the nurses experienced a sense of chaos, they tended to take control and use their own leadership attributes to overcome their sense of being governed by an external locus of control and deliver quality patient care. This attitude according to Reiger and Keleher (2004) reflects the need to be resourceful in changing organisations as well as providing opportunities for leadership. These authors demonstrated

how resourcefulness provided the impetus for nurse coordinators to provide innovative services as well as gaining visibility across their specific field of practice (Reiger & Keleher). Overall, it would appear that rather than be intimidated by the challenges posed to their leadership, the nurses in this study identified the need to be resourceful in changing environments.

Because they “were seen to be at the frontline” (Bob 1/2), the nurses expressed their concern that unsatisfactory health care outcomes resulting from issues beyond their control could impact on how their leadership was perceived by other team members. They felt they had limited control over situations when they were still left out of the decision making loop at all levels of the organisation. Peter (2) identified even though he developed a unique relationship with his patients, the status and authority awarded to other health professionals, especially medical officers, appeared to give them a strong sense of ownership of the patient. He felt it was this sense of ownership and status awarded by the organisation that resulted in these health care team members excluding him from the decision making process. He felt that this situation left him “powerless” but “not inactive” as he determined to “work around it.” Shaune (1/1) also observed that despite the nurses on his ward actively seeking participation in the decision making process with other health care team members, they were often excluded. This exclusion resulted in feelings of frustration, “being left out” which Shaune (1/1) believed had directly impacted “negatively on patient care.” Regardless, both Peter (2) and Shaune (1/1) demonstrated a willingness to participate in effective leadership within this environment. Both Peter’s (2) and Shaune’s (1/1) experiences highlight a need for a new organisational culture whereby ownership is shared and “all team members are full and participating members in health care services” (Kerfoot & Wantz, 2003, p. 34). From these observations, it appears that their organisations had failed to identify the need for a shift toward post industrial leadership whereby recognition is given to the contribution of individuals (Horner, 1997; Senior, 2002). By maintaining traditional structures, according to Shriberg, et al., (2002) and Laiken (2003) the tenacious adherence to strict hierarchies with associated role status within these organisations maintains the status quo of the industrial paradigm of leadership, stifles the creativity of leadership that depends upon relationships between members for their

success (Shriberg, et al., 2002; Laiken, 2003;). Within this culture, where the main source of power is position in the hierarchy, the role or job description is more important than the person who fills it (Brazier, 2005). The data suggest that failure to develop new organisational structures for patient care continues to be a major barrier to recognition of the nurses' leadership contributions.

### **Creativity in overcoming barriers**

Despite the restraints placed on them as leaders, the findings suggested that the nurses continued to undertake leadership action. Whilst differences between personal and organisational values were evident in the data, these did not appear to affect the depth of the nurses' work commitments as suggested by Graham (2003) and de Castro et al., (2004). Instead the nurses continued to use their leadership attributes to give impetus to their leadership actions for maintaining standards of care for their patients.

Whilst the nurses identified that their leadership benefited from flexible, professional boundaries they described the working contexts of their organisations as rigid hierarchical structures. In order to undertake leadership action within their practice contexts, the nurses created their own work environments by developing informal structures whereby all could participate in health care decisions. Where possible they used their formal, designated level to influence change. For example, Jenny (3) used her formal leadership position to influence her own practice context and develop flexible, informal boundaries that resulted in mutual problem solving and development of acceptable, achievable goals for health care services within the team. She indicated that for her informal structures were beneficial for "happy working relationships..." Annette (1) and Peter (2) used their informal leadership influence to create mutuality in their work environments by ensuring learning and ideas were shared among team members. All felt that mutuality gave a voice to nurse leadership within their health care team. The development of informal groups and leadership within formal organisations is consistent with Hein's (1998) observations that the creation of informal work groups that meet individual needs are often developed in organisations where there are tensions between formal organisations and groups needs. According to Hein,



these informal groups are said to be a collective response to deficits within a formal organisation. It would appear therefore, that despite the formal structures that continued to exist within their health care organisations, the nurses utilised strategies to develop informal structures and groups whereby they could carry out their leadership actions.

The data demonstrated that the nurses clearly recognised the barriers that had the potential to restrict and stifle their leadership. Identification of these barriers provided them with the motivation to make creative decisions on how to overcome the challenges that emerged and develop their leadership role. Andrew (2/3) identified how he had observed that nurses had become a lot more involved in health care issues over the last ten years because they actively listened and looked for leadership opportunities. He, personally, believed that being “on my toes, constantly monitoring the situation and acting when needed” gave him a broader understanding of the health care system that in turn had developed his nurse leadership role.

Additionally, understanding of the big picture [the organisation and its structures] enabled Caroline (3) to overcome barriers set by team members to her leadership. By gaining a broader perspective of health care Jenny (3) was able to deal with changes and give her the voice to advocate for team members within her organisation. She identified that whilst the organisation set certain directives which “could not be changed” she was “willing to challenge” these because she had confidence in her knowledge and experience in the organisation. Sarah (2/2) and Jenny (3) both encouraged other nurses to take broader perspectives when it came to issues related to change, this they felt would open up leadership opportunities for others. Taking a broader perspective by which to come to understand an organisation is a recommendation proposed by Hewison and Griffiths (2004) who indicated that nurse managers must find a way to keep focused on the big picture in order to be able to work with their team to develop overall performance goals and achieve satisfactory health care outcomes. Overall, the findings for this study suggested that the experienced nurses utilised a broader perspective of the organisation to develop creative strategies that would enhance their

leadership within the team and consequently undertake, guide and support actions for patient care

#### **6.4.2 Summary**

The nurses' awareness of their leadership attributes, levels of knowledge, ability in developing influential relationships with others and confidence in self as leader determined their leadership actions. It was their awareness of self as leader that enabled them to consciously choose how and when to act in the provision of health care services. Even though, they were able to acknowledge their own leadership contributions to health services within their organisations, the nurses demonstrated that creativity in an environment that presented challenges to their leadership styles was a virtue. Rather than succumbing to the tensions placed on them by dissonance between personal and organisational values and the resultant lack of recognition of their services by both team members and their organisations, the nurses actively developed strategies for being seen and heard when it came to acting as leaders to serve their patient's best interests. Creativity in practice has enabled the nurses to take leadership action to develop environments where open communication, shared values and goals, decentralised decision making, participative leadership, risk taking and overcoming limited resources became the norm within their setting. This type of environment ultimately encourages creativity in practice, and new ideas for the betterment of patient care (Brazier, 2005).

## 6.5 A MODEL OF NURSE LEADERSHIP

Figure 6.1 A Model for Nurse Leadership: Synthesis of the nurses' view of nurse leadership.



### Self as Leader

Nurse leadership was constructed by the nurses in a way that was both individualistic and pluralistic. Leadership held personal meaning for each of the nurses. As the nurses gained more knowledge, experience and confidence they were able to recognise and acknowledge the self as leader. Their developing leadership awareness enabled them to more clearly recognise their leadership attributes and

determined the type of leadership actions they would take during patient care provision. In addition, reflection on leadership effectiveness highlighted the strengths and weaknesses of their attributes and provided the impetus for seeking out further learning. Consequently, this model reveals a circle of learning encompassed within leadership action and reflection of self as leader in and on action.

### **Self with Others**

Nurse leadership was constructed by the nurses as they reflected upon their relationship with other health care team members and their patients. Within this construct, they held strong their vision of patient centred care in all types of situations. The nurses acknowledge that the health care team and their organisations covertly relied upon them to enact their vision and take leadership actions that would ensure all patients' needs were met in a resourceful manner. Within this context, they established a leadership responsibility for coordination of patient care and acted to develop intentional, collaborative relationships with team members. The nurses used their leadership action to seek out appropriate resources and influence health care decisions toward better patient care. They demonstrated their knowledge of the health care team and the organisation enabled them to develop strategies by which to creatively enact their leadership. Their knowledge, experience and confidence determined the type of leadership action they chose to form influencing relationships with others.

### **Self in Action**

Nurse leadership was constructed during observation of self in action within the health care context. The nurses recognised the benefits of identifying the challenges and opportunities for leadership within the organisation and tapped into their creative ability to overcome barriers. Their knowledge, experience and confidence influenced their ability to be adaptable and flexible with their leadership actions. Reflection on their leadership attributes in given situations, provided them with the knowledge of knowing when and how to take leadership effective action during the provision of patient care.

## **6.6 CONCLUSION**

In conclusion, nurse leadership as constructed by the nurses does not fit into the rigid models of traditional leadership theory. Instead it offers a model of leadership that reflects contemporary leadership theory, whereby nurse leadership is shared, participative, and relational. Because of its personal nature, the nurses reported that their own model of leadership worked best for them. At the same time they demonstrated that their model of leadership offered minimal opportunity for recognition of the value their work in organisations that adhered to traditional models of leadership. This study proposes that whilst these organisations maintain tight bureaucratic models, the nurses will be denied the opportunity to present a model of service that is tangible and develops deeply personal and profoundly significant professional, recipient relationships which involves dimensions of caring and comforting in times of intense personal need (Parker,1999; Barker,2000).

In order to achieve their vision of patient centred care, the nurses for this study maintained a model of leadership that focused on interdisciplinary action. Their leadership relied on principles of shared governance and included partnership, equity, accountability and ownership. Within this model, nurses expressed leadership through team management and coordination by developing integrated health care team approaches which according to Fralic (1999) and Peach (1999 ) enable a range of health care experts to work together and whereby team members can have an equal voice and position. Ultimately, as the nurses work to develop collaborative, interdisciplinary relationships their leadership has the potential to create an environment that enables all members in a team to demonstrate leadership qualities as they are called upon.

## **CHAPTER 7: CONCLUSION AND RECOMMENDATIONS**

The purpose of this chapter is to present a synthesis of the findings from this study, draw conclusions and put forward recommendations for further action.

### **7.1 INTRODUCTION**

The participants for this study were nurses who were registered in the state of Queensland, Australia and held practising licences with the Queensland Nursing Council. The nurses represented three levels of nurse on the career structure and all worked in acute care, adult hospitals in both the private and public sector of health care in the city of Brisbane, Queensland.

This chapter will, firstly reflect upon the study's purpose and research design. Following this, a summary of the findings framed by the research questions will be presented. The summary will lead to the conclusions and recommendations section where proposals for further research are highlighted. Finally, the thesis is completed with some concluding remarks.

### **7.2 THE PURPOSE OF THE STUDY**

The literature highlighted that despite nurses' efforts to adapt their practice to requirements of health care reform, other health care professionals, health administrators, policy makers and consumers still failed to recognise the relevance of nurses' work and its contribution to health care services (Chiarella, 2000; McCloskey & Maas, 1998; Porter-O'Grady, 2003a). This study's findings have supported the literature by demonstrating that the nurses identified the lack of recognition of their work and its contribution to health care services by others in contemporary health care organisations.

The problem that underpinned this study was the dissonance between what nurses' perceive to be the relevance of their work and the perception of the relevance of nurses' work by others in the health care system. In order to address this problem,

the study chose to illuminate the value of nurses' work through the leadership constructs presented by the nurses. Therefore, the study explored how nurses undertook leadership initiatives as health care providers in contemporary health care organisations. In order to enact the purpose of this study and manage its scope, exploration focused upon how nurses constructed their leadership role during the provision of health care services.

### **7.3 RESEARCH DESIGN**

Given the purpose of this study, an interpretive design was adopted to explore how the nurses had undertaken leadership initiatives within their own health care organisations. The leadership constructs presented by the participating nurses were accepted with the realisation that the constructs could vary from person to person as leadership actions were influenced by context and social interactions (Bassey, 1999). The epistemological framework of constructionism, from the interpretive paradigm, was selected to gain an understanding of the nurses' leadership constructs as they were internally experienced, socially constructed and interpreted by them (Sarantakos, 1998).

Furthermore, symbolic interactionism offered a theoretical perspective through which data were filtered. In order to gain a deeper understanding of the lived experiences of the nurses data were analysed in two stages. The first stage, exploration collected data from three focus groups and offered tentative themes which warranted further inspection which was the task of stage two. Inspection offered the opportunity to validate or reject themes as they were presented to participants in one to one interviews. This perspective strengthened the study's findings by offering a deeper understanding of nurse leadership from the natural, socially interactive situations the nurses described (Longmore, 1998). Subsequently, symbolic interactionism as the theoretical lens for data analysis provided the opportunity for the object of interest of this study to be clearly illustrated as the nurses' subjectively constructed meanings of their leadership within interactive situations (Cossette, 1998).

Empirical investigation of nurse leadership was enhanced by the use of case study as the methodology. This study selected a case of nurses who were registered in Queensland and held practising licences with the Queensland Nursing Council. The

nurses represented three levels of nurse on the career structure, all worked in acute care, adult hospitals in both the private and public sector of health care in Brisbane, Queensland. By having the opportunity to engage with participants from whom most could be learned about leadership during the provision of patient care, this study was able to focus on maintaining the wholeness of the case through the participants' responses to the research questions.

Overall, this study contributes to literature that reflects upon the nature of nurses' work, the value of nurses' work and nurse leadership. This study adds its own particular value to the discussion on leadership and its relationship to nurses by answering the study's three research questions. These were:

1. How do nurses describe leadership within their health care organisations?
2. How do nurses experience leadership within their health care team?
3. How do nurses construct their leadership role whilst providing health care services?

The study's conclusions are drawn with the understanding that the nurses' meanings of leadership within their organisations were not fixed, but subject to constant change as a result of the complex interactions that occurred within their contexts of practice. Therefore the responses provided by the nurses were meaningful at the time they were recorded.

## **7.4 RESEARCH QUESTIONS ADDRESSED**

This section presents a summary of the findings of the three research questions.

### **7.4.1 Research Question 1**

The first research question sought to discover participants' personal understanding and experience of leadership within health care organisations. It aimed to explore how nurses described leadership within their organisation. The question asked:

#### **How do nurses describe leadership within their health care organisations?**

The nurses revealed that they functioned within organisations that operated out of traditional, hierachical and authoritative forms of leadership. They



recognised that the traditional models of leadership evident within their own organisations did not work for them. Consequently, they operated out of a model of leadership that was seen to be individualistic and pluralistic. Even though, they acknowledged that their leadership actions did not fit the criteria by which the organisation judged leadership, they determined that their personal leadership style more appropriate for them in the provision of patient care. They overcame organisational barriers to achieve their vision of patient centred care by undertaking informal leadership actions to achieve their goals. It was the awareness of their leadership attributes that determined for them how and when they would act to overcome barriers that restricted their nursing practice.

The strength of their commitment to their professional ideology of patient centred care was highlighted by the nurses' persistent use of personal leadership constructs in organisations that subscribed to traditional models of leadership. This persistent use of a personal model of leadership within their organisations' traditional structure was acknowledged as contributing to the lack of acknowledgement of their contributions to health care services. It was through the descriptions of their leadership actions undertaken during the provision of patient care, that the nurses could clearly articulate their contributions. With their vision of patient centred care as their leadership goal, they took every opportunity to take what they described as leadership action despite the organisational barriers and challenges to their vision.

#### **7.4.2 Research Question 2**

The second research question sought to discover participants' personal understanding and experience of leadership within health care teams. It aimed to explore how nurses experienced leadership within their health care team. The question asked:

## **How do nurses experience leadership within their health care teams?**

The nurses used their vision of patient centred care to influence relationships within their health care team. Their circle of influence was determined by the level of knowledge, experience or confidence to directly provide health care services to their patients they had acquired prior to acting. The levels of knowledge, experience and confidence also enabled them to clearly articulate their leadership attributes.

The nurses realised they could not provide all health care services alone therefore they utilised leadership models that were intentionally flexible and adaptable to informally form relationships with other health care team members. These relationships were formed through a variety of leadership actions which were described as stepping back, participative, sharing, guiding and supporting. The leadership actions the nurses undertook were intentional, and aimed at forming relationships with other health care team members in order to influence care decisions and standards. Additionally, the nurses relied upon the health care team to fill the gaps in services they could not provide, at the same time, they were also cognisant that the health care team covertly depended upon them for the coordination of care. Knowledge of the dependency the team had upon them for the coordination of care attributed to the nurses' sense of leadership responsibility.

The nurses also relied on health care team members for their leadership development. Learning leadership was an informal process whereby their leadership was developed through observation of selected role models who demonstrated leadership attributes they admired. Through their observations of others they developed a leadership mindset that acted as a baseline for their leadership development as well as a competency model for judgement of practice standards of others.

Even when they delegated patient care to others, the nurses never relinquished their leadership responsibility. Using their developed standards of practice, they maintained a watching brief over the practice of the health care team member they had selected to deliver care. In this situation, their

leadership was unobtrusive. As a result their contributions within teams often went unnoticed and unacknowledged. Moreover, they recognised that their leadership actions had become enmeshed within the health care team's performance and outcomes. This lack of recognition of their work and its contributions by both their team and the organisation rendered the nurses' work unacknowledged by others. Overall whilst the nurses acknowledged the importance of developing successful relationships with other health care team members, they also accepted that the relational, participative and shared nature of their leadership rendered nursing's contribution ignored by others.

### **7.4.3 Research Question 3**

The third research question sought to discover participants' personal meanings of leadership. It aimed to explore how the nurses constructed their leadership when providing health care services within their organisation. The question asked:

**How do nurses describe leadership within their health care organisations?**

The nurses developed leadership mindsets which were developed by observing those whom they would most admired as leaders within the context of their practice. The leadership mindsets contributed to their constructions of leadership in self and others. Levels of knowledge, experience and confidence influenced the different personal perspectives through which they expressed their leadership. Underpinning their leadership constructs was their vision for patient centred care. Consequently, leadership actions revealed a moral obligation to act on behalf of others by serving as advocate, coordinator and interpreter for their patients, their families and within the health care teams. Overall, leadership was internally motivated by both personal and professional values, with ownership influenced by the nurses' knowledge, experience and confidence. As a result, the nurses' personal constructs of leadership enabled them to take leadership action in a form and manner that was unique to them.

Potentiality for leadership development motivated the nurses to seek both formal and informal learning experiences. Leadership knowledge was gained through exposure to a variety of informal learning opportunities and personally selected sources. Being open to learning opportunities was a leadership construct that highlighted the nurses' motivation to life long learning. The nurses devised numerous learning strategies to consciously built upon their leadership attributes so as to develop and gain confidence. Overall, awareness of their leadership attributes heightened their leadership potentiality. They used the knowledge of their personal leadership attributes to gauge the effectiveness of their leadership actions and seek feedback from others so as to develop further.

In summary, the nurses demonstrated constructs of leadership that were individualistic and pluralistic. Their personal meanings of leadership were explicated by the leadership attributes they held and demonstrated. It was awareness of these attributes that guided them to seek out further learning in order to develop their leadership and initiate actions for patient care. By using their own model of leadership to provide health care services the nurses were able to satisfy themselves that patient centred care was achieved despite their health care team's and organisation's lack of acknowledgment of their contributions.

## **7.5 CONCLUSIONS OF THE STUDY**

The following conclusions represent an attempt to better understand nurse leadership from the perspective of nurses who provide health care services in contemporary health care organisations. The findings for this study have been drawn from the exploration of group of nurses and their constructs of leadership within their health care organisations.

Following reports in the literature that new perspectives on leadership are becoming more widely discussed and explored, but lack theoretical substance, this study took formally examined nurse leadership at the micro level of contemporary health care

organisations (Armstrong, 2004). The findings confirm that despite evidence of nurses adopting new leadership models, there is still a failure to recognise the contributions of nurses' work or give meaning to their leadership (Stordeur, et al., 2001). Evidence suggests that full expression of the nursing profession will be restricted whilst leadership continues to be measured against the traditional characteristics of organisational status, achievement of greater efficiencies and expansion of bureaucratic rationality (Jonsdottir, et al., 2004; Rost, 1991, Shriberg, et al., 2002;). Accordingly, nurse leadership presented in different forms, has not become visible nor valued by the conventional tests of organisational leadership which relate to positional power that serves to privilege certain positions above others regardless of their form, structure, utility, or inherent value (Sinclair, 1998; Thorne, et al., 1998).

### **The invisibility of nurses' work**

Contemporary health care professionals operate in a health care system that imposes tight fiscal restraints, flat and increasingly flexible, decentralised structures, and a multi-skilled rather than specialist specific workforce (Warr, Gobbi & Johnson, 1998). Within this context the nurses demonstrated models of leadership which created interdisciplinary relationships that contributed to optimal patient outcomes in resource restrained environments (Hansen, Bull & Gross, 1998). As the nurses recounted their lived experiences of leadership, a new focus for leadership became evident. This new leadership contained relational and social elements that enabled the nurses to individually demonstrate leadership and their contributions to organisational successes (Laiken, 2003; Shriberg, et al., 2002). However, because the majority of nurses' work was undertaken at the micro level of the organisation and the organisations' acknowledgment of success was closely linked to leadership at the macro level the value of the nurses work failed to be acknowledged (Cook, 2001b). Lack of acknowledgment was evident even when the nurses were striving to meet their organisations' goals through leadership initiatives. Therefore, if the value of nurses' work through its holistic, interactive and collaborative nature is to be recognised, health care organisations will need to broaden their views of leadership, otherwise a large part of nurses' work will continue unacknowledged (de Jonge & Jackson, 2001).

Within their organisations, nurse leadership at the micro level of the organisation lacked status and recognition. Within the traditional view of organisational leadership, nurses continued to be determined as subordinate to organisational structures, professional agendas and the culturally endorsed authoritative knowledge of medicine within sustained organisational hierarchies, (Liaschenko & Peter, 2004). Furthermore, these perceptions reinforced the impression that nurses, who practised at the micro level, were less autonomous and more reliant on others for direction of activities (Kerfoot & Wantz, 2003; Wynne, 2003).

From the external perspective, there has been a demonstrated reluctance of organisations and health care team members to relinquish traditional leadership and power bases. This reluctance to relinquish power continued to present a barrier to the recognition of nurse leadership and the value of nurses' work and was evidenced by exclusion of the nurses from health care decisions (Limerick, et al., 1998; McSherry, 2004).

### **Overcoming the barriers**

Internally, despite awareness of nursing's historical socialisation and perpetuation of the nurse's role as subservient to medicine, the nurses consciously chose to enact their leadership and overcome the barriers of status and socialisation. They utilised a form of subversive professionalism to overcome the barriers by actively but unobtrusively involving themselves in health care services. Even though their leadership fell outside the traditional models, they enacted a form of leadership, that through others gave voice to nursing's interest and concerns about the quality of health care delivery and increased pressures of work (Corey-Lisle, et al., 1999; Oulton, 2000).

Despite the differences in leadership philosophies, the nurses assumed that they *did* have a leadership role, a role that was unique to them, a role in which they embraced opportunities for leadership in patient care, organisational development and restructuring. Overall the nurses chose to ignore the established wisdom of their organisations and used their leadership to seek to improve the health status of the

people they served regardless of the direction of socio-political, economic, and cultural forces that delineated their practice (Jackson, 1995). Their form of leadership worked for them.

### **Making nursing visible**

It was through and within their health care teams that the nurses chose to enact their leadership's vision of patient centred care. The nurses developed complementary rather than subordinate relationships with other health care professionals. Consequently their leadership actions became enmeshed within their health care team's successes and achievements obscuring the unique contributions of nursing (Greenwood, 1999). The nurses' contributions were discretely linked to the outcomes of patient care with their successes measured by their leadership effectiveness against a personal gauge or mindset. This suggests that examination of nursing practice through a leadership perspective will provide a clearer understanding of the value of nursing within the health care system (Greenwood, 1999).

Nurses are waiting for contemporary health care organisations to adopt structures that are dynamic and interactive so their leadership will become more overt (Cook, 2001b). In the mean time nurses operate between the domains of nursing practice and the practice domains of other team members they have attempted to interpret issues to the language that translated the ideology and values of patient centred care (Antrobus & Kitson, 1999). Subsequently, leadership effectiveness could also be gauged by the ability to access and promote nursing knowledge, to make clear nursing's vision and remind others that the patient remained the primary focus of the clinical domain (Kosinka & Niebroj, 2003).

### **Nurses' Work**

Whilst nurses appeared to be conscious of the value of their work, nurses' felt their contributions continued to be viewed differently by those outside the nursing profession. In short, there continues to be a dissonance between how those outside

the nursing profession perceive the relevance of nurses' work and the nurses' view and value of their work (Chiarella, 2000; Takase, Kershaw, & Burt, 2001).

Leadership for the nurses related to overcoming the effects of the drive for efficiency and economy and developing strategies to balance the value of caring relationships with their clients within an economically driven agenda (Bamford & Porter-O'Grady, 2000; Fralic, 1999; Parker, 2000;). Their challenge was to demonstrate the relevance of the human nature of their work in organisations that focussed on outcomes of care as a quantifiable, consumable commodity (Lumby, 2000). In order to overcome the formal the power of status and authority accorded to some members of the health care team by their organisations, nurses have subtly enacted new leadership actions and values to influence different disciplinary groups to achieve mutually, agreed to positive health care outcomes (Graham, 2003; McAllin, 2003). These nurse led initiatives resulted in the maintenance of a holistic care discourse in an environment where managerialism quantifies health services and outcomes in monetary terms (McCloskey & Maas, 1998; Chiarella, 2000; Porter-O'Grady, 2003).

Overall, despite their leadership initiatives, nurses found it increasingly difficult to realise their vision when there was a dichotomy between the values of caring and the values motivated by finance within their organisations (Ainsworth, 1998). However, by keeping their vision to the forefront of their actions, the nurses overcame conflict of values and demonstrated leadership responsibility for decisions regarding patient care. In order to enact their vision, nurses used knowledge of their leadership attributes to develop a circle of influence with other team members so that they could successfully achieve integration of health care services for their patients (Antrobus & Kitson, 1999; Cook, 2001a).

### **Nurse leadership**

In order to maintain a circle of influence nurses sought out those who supported them in their actions. Consequently, nurse leadership emerged in informal groups amongst team members who shared the same values and participated in social action (Fullan; 2001; Hein, 1998, Limerick, et al., 1998). As nurses informally created *intentional* relationships with team members in a socially interactive manner, they



appeared to be subliminally aware that these dispersions formed the most influential subcultures within and between organisations (Limerick, et al., 1998). Overt recognition was given to their lack of power within the organisation and that it was through informally created teams that their leadership aspirations of patient centred care could be realised. Engagement with supportive health care team members enabled nurses to creatively use a variety of leadership skills to informally lead health care teams to newer solutions that emphasised freedom to act and a sense of involvement for everyone (Axelsson, et al., 2000).

Overall, this study of nurse leadership has highlighted the pluralistic nature of leadership and, like other studies, has failed to provide a clear universally acceptable definition of leadership for nurses (Leithwood, et al., 1999; Yukl, 2002). It is proposed that the truth of leadership will remain elusive whilst nurses continue to work in health care organisations that experience shifts from the industrial to post industrial era. New forms of leadership will emerge as organisations come to value the social, emotional, value based, relational aspects of leadership (Popper, 2004; Shriberg, et al., 2002; Yukl, 2002;).

Overall this study contributes to the limited literature on nurse leadership and work by reporting that nurses are demonstrating leadership actions in their work that reflect the post industrial era (Kerfoot & Wantz, 2003). The theoretical framework for this study was motivated by a need to explicate the value of nurses' work in contemporary health care organisations and the lack of formal evidence of nurse leadership in the post industrial era. The combination of nurses' work and nurse leadership motivated an exploration of nurses' work from a leadership perspective. The findings of this study are well supported by recent, more specific examinations of nurse leadership (Cook, 2001a, Cook & Leathard, 2004; Graham, 2003). In the light of these findings, and at a time when contemporary health care organisations are beginning to recognise the need for leadership from experienced clinicians, such as nurses, this study has explicated the relevance of nurses' work from a leadership perspective and offers a model of nurse leadership (Figure 6.1) for further examination.

This study offers a view of leadership that is explained in terms of participation, sharing and relationships wherein the leader became self aware, with leadership

effectiveness being defined by the leader's reflection in and on action (Armstrong, 2004; Grossman & Valiga, 2000; Kerfoot & Wantz, 2003; Rost, 1991; Wynne, 2003;). Leadership has been understood from the perspectives of the participants and the meanings they have created. This study has enabled the emergence of leadership that demonstrates shared purpose and collective action (Horner, 1997; Lambert, 2002).

As contemporary health care organisations change to meet the demands of today's society, nurse leadership requires a shift in thinking from a model that requires them to be equal and the same as other professions, to one where they can be equal and unique (Armstrong, 2004). It is expected that through the development of the nurse leadership model described in this study, nurses will be able to create a culture of change to move organisations forward and cause a greater capacity within the organisation for better results in patient care (Fullan, 2001; Limerick, et al., 1998). In order to create a shift in thinking the following recommendations are put forward.

## **7.6 RECOMMENDATIONS**

### **7.6.1 Nursing Practice**

In order to raise the profile of nursing and therefore make it an attractive career option there is a need to articulate its value in the health care system by clearly identifying the contributions nurses make. The ability to clearly articulate nurses' contributions is possible through the perspective of nurse leadership whereby the nature of nurses' work can be articulated in a language that is clearly understood by all key stakeholders. Therefore it is recommended that the nursing profession through its political, educational and research activities influence health care organisations' structures at the macro level and the nurses' job descriptions at the micro level. It is only when the role statements of nurses at the micro level reflect the unique nature of nurse leadership that the value of nurses' work will become obvious to others and the value of nurses' work will be reflected in organisational structures.

### **7.6.2 Nursing Education**

The challenge for nursing education is to produce nurse leaders who can develop people with vision in a rapidly transforming health care system. In the light of changing health care organisations, new models of care and new models for education are required to promote new leaders in new contexts.

As they take their positions within interdisciplinary teams, nurses leaders will need to exhibit leadership qualities that are enduring, success oriented in any situation, and develop aspirations beyond traditional boundaries (Malone, 2000; Oulton, 2000). This study highlighted how nurses accessed informal learning opportunities by personally selecting role models for their leadership development. It also demonstrated how the nurses' knowledge, experience and confidence influenced expression of ownership for leadership. These observations coupled with the statements that indicated a traditional model of leadership was not appropriate for their practice indicate a need to rethink education of leadership to nurses at both undergraduate and post graduate levels. Therefore, it is recommended that nursing education develop curricula that reflects the relational and interactive elements of leadership. This thinking requires a move from traditional leadership theory to a new leadership for changing organisations so as to develop leaders who are competent, successful, persuasive and influential in the integration of health care services (Queensland Nursing Council, 2005).

### **7.6.3 Research**

Organisational transformation requires that leadership studies focus upon the social and relational elements that drive successful health care teams and adopt a post industrial perspective of leadership that reflects the lived experiences of the workers. Therefore it is recommended that studies on nurse leadership utilise new leadership models through which to explore nursing.

Furthermore like all research this study has raised more questions than answers and offers possibilities for further work:

- That the model of nurse leadership (Figure 6.1) developed from this study be tested and further developed within nursing and across other disciplines.
- That the research design be applied to another group of nurses who provide health care services in similar or different health care settings.
- That the research design be applied to groups from education and business disciplines.
- That the study expands its focus and explores how nurses learn their leadership
- That findings from this study be utilised guide data collection tool for the evaluation of the relevance of current leadership education to nurses at the micro level of health care organisations
- That the findings of this study are written up and distributed in such a way that they contribute to dialogue amongst nurses in order to contribute to change and articulate nurses' work.
- That the findings from this study contribute the evaluation of current career structures and position descriptions for nurses in the light of new leadership perspectives.

## **7.7 PERSONAL POSTSCRIPT**

The decision to explore nurse's work through the perspective of leadership has enabled me to realise a life long ambition of demonstrating the worth of nursing within the health care system. My past experience with nurses was that they had been socialised to believe their work held no great value within the health care system and therefore they subsumed their contributions under the guise of 'only a nurse.'

By researching the work of nurses through the perspective of nurse leadership I have discovered that nurses believe their work is pivotal in the delivery of patient care services. The value of their leadership in the coordination of health care services in contemporary health care organisations became evident during the interview

processes. These nurses enacted a personal leadership as a means of overcoming challenges to achieving their professional ideology of patient centred care. They personally knew the value of their work and it was this value that motivated them to take up the responsibility of ensuring standards of patient care were maintained by all. For them leadership was not about personal accolades, instead accolades were collective as they moved the health care team towards successful patient outcomes. The meaning the nurses gave to their leadership is encapsulated by the following quotation that, for me, reflected the nurses' philosophy of leadership:

A leader is best

When people barely know that  
he exists,

Not so good when people obey and  
acclaim him,

Worst when they despise him.

"Fail to honor people,

they fail to honor you;"

But of a good leader, who talks little,

When his work is done,

his aim fulfilled,

They will say

"We did this ourselves."

(Lao Tzu in Hughes, et al., 1999, p.25)

## **APPENDIX 1**



**AUSTRALIAN CATHOLIC UNIVERSITY**  
Research Services

Human Research Ethics Committee  
**Ethics Clearance for a Research Project - Modification of a Research Project**

Supervisor/s (if staff):	1) Dr Gayle Spry	Campus:	McAuley
Researcher/s (if student):	1) Ms Yvonne Osborne	Campus:	McAuley

Ethics clearance has been modified for the following project:

*An exploration of how registered nurses construct their leadership role in the delivery of health care services in two Public Hospitals in Brisbane*

for the period: 19 October 2001 to 31 December 2002

Human Research Ethics Committee Register Number: Q2000/01-16

subject to the following conditions as stipulated in the National Health and Medical Research Council (NHMRC) Statement on Human Experimentation and Supplementary Notes 1992:

- (i) that principal investigators provide reports annually on the form supplied by the Institutional Ethics Committee, on matters including:
  - security of records;
  - compliance with approved consent procedures and documentation;
  - compliance with special conditions, and
- (ii) as a condition of approval of the research protocol, require that investigators report immediately anything which might affect ethical acceptance of the protocol, including:
  - adverse effects on participants;
  - proposed changes in the protocol, and/or
  - unforeseen events that might affect continued ethical acceptability of the project.

and subject to clarification of the following to the Human Research Ethics Committee:

A Final Report Form will need to be completed and submitted to the UHREC within one month of completion of the project.  
OR

An Annual Progress Report Form will need to be completed and submitted to the UHREC within one month of the anniversary date of approval.

Please sign, date and return this form (with any additional information or material, if requested by the Committee) to the Administrative Officer (Research) to whom you submitted your application, for approval to be confirmed.

Signed: .....

Administrative Officer (Research)

Date: .....

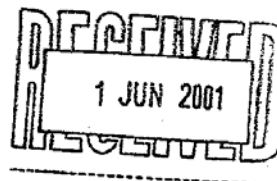
19/10/01

**Australian Catholic University Ethical Clearance for a research Project-  
Approval Form**

Approved by .....

Date of Approval .....

*[Signature]*  
5/06/2001



## AUSTRALIAN CATHOLIC UNIVERSITY

Research Services

### University Human Research Ethics Committee Ethics Clearance for a Research Project - Approval Form

Supervisor(s)

1) Dr Gayle Spry

Campus: McAuley

Researcher(s) (if student/s)

1) Ms Yvonne Osborne

Campus: McAuley

Ethics clearance has been provisionally approved for the following project:

*An exploration of how registered nurses understand their leadership role in the delivery of health care services*

for the period: 1 July 2001 to 1 July 2002

University Human Research Ethics Committee Register Number: Q2000/01-16

subject to the following conditions as stipulated in the National Health and Medical Research Council (NHMRC) Statement on Human Experimentation and Supplementary Notes 1992:

- (i) that principal investigators provide reports annually on the form supplied by the Institutional Ethics Committee, on matters including:
  - security of records;
  - compliance with approved consent procedures and documentation;
  - compliance with special conditions, and
- (ii) as a condition of approval of the research protocol, require that investigators report immediately anything which might affect ethical acceptance of the protocol, including:
  - adverse effects on participants;
  - proposed changes in the protocol, and/or
  - unforeseen events that might affect continued ethical acceptability of the project.

and subject to clarification of the following to the University Human Research Ethics Committee:

1. Research Procedures

- ✓ Participant Details Section 3.1 - Please provide reasonable estimates of total numbers (perhaps expected minimum and maximum).
  - ✓ Participant Details Section 3.1 - Please provide reasonable estimates of expected age range.
  - ✓ Description of Procedures Section 4.1 - This Section is quite confusing, however the procedures are clearly presented on Pages 14 through 18 of the Application.
2. Information Letter to Participants
- Please amend the contact details for the Supervisor - School of 'Education'.
  - Please rephrase Paragraph 3, on Page 21 to read - 'In the event you have any complaint about the way you have been treated during the study, or a query that the Researcher or the Supervisor have not been able to satisfy, you may write care of the nearest branch of Research Services'.
3. Consent Form
- Please note that a 'signature block' is not required for the Supervisor.
  - Please remove the statement in parenthesis 'or stipulate the deadline by when the participant may withdraw'.



## **APPENDIX 2**

### **Letter of Invitation to Participants**

School of Nursing  
McAuley Campus  
Australian Catholic University  
PO Box 247, EVERTON PARK, QLD., 4053

xxx  
xxxxx  
xxxxx QLD. 4503

7 January, 2002

Dear xxx

I am writing to ask you to contribute to nursing research in 2002. Currently, I am undertaking a Doctorate of Education (Leadership) at the Australian Catholic University. The title of my research project is "Understanding how registered nurses construct their leadership role in the delivery of health care services."

I am writing to invite you to participate in a forty five minute audiotaped focus group interview which will explore the topic of my study. I intend to offer four different times for the interviews and will be offering appropriate refreshments for each one. If you wish to bring along a friend or colleague who is a Registered Nurse, please feel free to do so. Prior to the commencement of the interviews I will be seeking written consent and providing assurance of anonymity and confidentiality (see attached).

I do hope you will consider assisting me in my studies and can look on this as an opportunity to catch up with other graduates and network in an informal atmosphere.

Please do not hesitate to contact me on (07) 3855 7210 or email [y.osborne@mcauley.acu.edu.au](mailto:y.osborne@mcauley.acu.edu.au) if you have any questions what so ever.

Yours sincerely

YVONNE OSBORNE

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✂✂✂✂✂✂✂✂✂ PLEASE DETACH AND RETURN IN STAMPED ADDRESSED ENVELOPE

Yes, I would like to participate in the focus group interviews. The time and day that suits me best is:

- Thursday 7 February, 2002 from 10.00am – 11.00am (morning tea provided) ☐
- Thursday 7 February 2002 from 4.00pm – 5.00pm (afternoon tea provided) ☐
- Thursday 14 February, 2002 from 10.00am – 11.00am (morning tea provided) ☐
- Thursday 14 February 2002 from 5.30pm – 6.30pm (wine and cheese provided) ☐

Please meet me outside the library. Parking on campus should not be a problem at those times.

THANK YOU FOR CONSIDERING THIS IMPORTANT PROJECT

School of Nursing  
McAuley at Banyo Campus  
Australian Catholic University  
PO Box 456  
VIRGINIA QLD 4014

14 February, 2003

Dear

I am writing to ask whether you would like to contribute to a study I am undertaking. The title of the study is "Understanding how registered nurses construct their leadership role in the delivery of health care services." This is part of my thesis for the Doctorate of Education (Leadership) which I hope to complete this year.

I am hoping you would be able to participate in a forty five minute audiotaped interview which will explore the topic of my study. The venue, time and date for the interview can be determined by both of us. Prior to the commencement of the interview, I will be seeking written consent and providing assurance of anonymity and confidentiality (see attached).

If you are willing to be part of my study, please contact me at home on (07) 3511 6009 or my mobile number is 0416 10 9764 as I am on leave from the University. Hoping that you can assist me in this study.

Yours sincerely

YVONNE OSBORNE

## **APPENDIX 3**

### **Consent Form for Participation in Study**



## Australian Catholic University

TITLE OF RESEARCH PROJECT: AN EXPLORATION OF HOW REGISTERED  
NURSES CONSTRUCT THEIR LEADERSHIP ROLE IN THE DELIVERY OF  
HEALTH CARE SERVICES

NAME OF RESEARCHER: MS YVONNE OSBORNE

NAME OF SUPERVISOR : DR GAYLE SPRY

*I ..... (the participant) have read (or, where appropriate,  
have had read to me) and understood the information provided in the Letter to the  
Participants and any questions I have asked have been answered to my satisfaction.  
I agree to participate in this activity, realizing that  
I can withdraw at any time.*

*I agree that research data collected for the study may be published or provided to  
other researchers  
in a form that does not identify me in any way.*

NAME OF PARTICIPANT .....  
(block letters)

SIGNATURE .....  
DATE .....

NAME OF RESEARCHER: MS YVONNE OSBORNE

SIGNATURE .....  
DATE .....

## **APPENDIX 4**

### **Demographic Questionnaire**

## DEMOGRAPHIC QUESTIONNAIRE

In order to demonstrate the characteristics of the participants of this study, I am asking you to complete this demographic questionnaire

- a. Gender  
(1) female ☐  
(2) male ☐
- b. Is your position:  
(1) full – time ☐  
(2) part – time ☐
- c. Your current level of employment is:  
(1) Level 3 Registered Nurse ☐  
(2) Level 2 Registered Nurse ☐  
(3) Level 1 Registered Nurse ☐  
(4) Other: (please state): \_\_\_\_\_
- d. Nursing Unit:  
(1) medical ☐  
(2) surgical ☐  
(3) emergency ☐  
(4) intensive/coronary care ☐  
(5) continuing care/geriatrics ☐  
(6) mental health ☐  
(7) other (please specify): \_\_\_\_\_
- e. How long have you been in your current position:  
(1) less than 1 year ☐  
(2) 1-2 years ☐  
(3) 3-5 years ☐  
(4) 6-10 years ☐  
(5) more than 10 years ☐
- f. What year did you become registered?  
\_\_\_\_\_
- g. What level is the basic level of your nursing education?  
(1) basic certificate ☐  
(2) diploma ☐  
(3) bachelor degree ☐  
(4) other (please specify) \_\_\_\_\_
- h. What other education have you undertaken?  
(1) none ☐  
(2) post basic certificate ☐  
(3) post graduate certificate ☐  
(4) post graduate diploma ☐  
(5) masters degree ☐  
(6) doctoral degree ☐

Please provide description of additional educational programmes (e.g. post basic certificate in coronary care)

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i. To whom do you directly report ( tick all that apply):

- |     |                               |                          |
|-----|-------------------------------|--------------------------|
| (1) | Director of Nursing           | <input type="checkbox"/> |
| (2) | Assistant Director of Nursing | <input type="checkbox"/> |
| (3) | NPC/CNC                       | <input type="checkbox"/> |
| (4) | Medical Director              | <input type="checkbox"/> |
| (5) | Medical Registrar             | <input type="checkbox"/> |
| (6) | Medical Intern                | <input type="checkbox"/> |
| (7) | Other health professionals    | <input type="checkbox"/> |

i. In your unit are decisions for care you deliver are usually made by (tick all that apply):

- |     |                                 |                          |
|-----|---------------------------------|--------------------------|
| (1) | medical staff                   | <input type="checkbox"/> |
| (2) | nursing staff                   | <input type="checkbox"/> |
| (3) | other health care professionals | <input type="checkbox"/> |
| (4) | you                             | <input type="checkbox"/> |
| (5) | peers                           | <input type="checkbox"/> |
| (6) | other (please specify):         | <input type="checkbox"/> |

Thank you. Your time and contribution to this research activity are sincerely appreciated.



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