LEADERSHIP IN NURSING ADMINISTRATION:
THE PERSPECTIVES OF SENIOR NURSE ADMINISTRATORS

BY

KATHRYN JEAN HYNDMAN

A Thesis

Submitted to the Faculty of Graduate Studies

in Partial Fulfilment of the Requirements

for the Degree of

MASTER OF NURSING

Faculty of Nursing

The University of Manitoba

Winnipeg, Manitoba

ISBN 0-315-81717-8

LEADERSHIP IN NURSING ADMINISTRATION:

THE PERSPECTIVES OF SENIOR NURSE ADMINISTRATORS

BY

KATHRYN JEAN HYNDMAN

A Thesis submitted to the Faculty of Graduate Studies of the University of Manitoba in partial fulfillment of the requirements for the degree of

MASTER OF NURSING

ACKNOWLEDGMENTS

The support and guidance of several individuals during this thesis is acknowledged here:

The Research Participants

Dr. Barbara Paterson

Dr. Ina Bramadat

Dr. Roger Hall

Mr. David Ford

Miss Sheena Aimée Hyndman Ford

Mr. Harold and Mrs. Sophia Hyndman

Mr. Charles Ford

ABSTRACT

This exploratory and descriptive qualitative research study was designed in order to identify the cognitive maps of leadership for the purpose of theory development in nursing administration. Symbolic interaction theory guided the exploration of the meaning of leadership for six senior nurse administrators (SNAs) who worked in urban, acute care tertiary or community hospitals in one Canadian province. The research methods selected were designed to explore the contextual reality of leadership from the participants' perspective. The research methods included interviewing, concept mapping, and document analysis. Each SNA's leadership concept map was constructed. Four major categories of leadership, reflecting the SNAs' perspectives, were identified by means of the constant comparative method of qualitative data analysis: attaining and maintaining competency, information sharing, decision making, and team building. One category of contextual variables which mediated the SNA's leadership perspective was also identified. The research findings were analyzed in relation to theories of leadership and in the context of the domains of nursing proposed by Benner (1984). No one theory encapsulated the entirety of their experience. The findings revealed that the SNAs considered building interpersonal relationships the basis for leadership. The researcher proposes that SNAs lead out of their practice as nurses.

SNAs in this study who have learned to care as nurses have incorporated caring as an epistemological system in nursing leadership. The implications for nursing practice, research and education are discussed in this research report.

TABLE OF CONTENTS

Chapter One

INTRODUCTION

Nursing administrators occupy a pivotal position in Canada's health care system (Rodger, 1988; Styles, 1988). Nursing administrators manage a major portion of Canada's health care budget by directing the provision of nursing care (Evans, 1988; Thomlinson, 1991). Since over half of Canadian nurses work in hospitals (Statistics Canada, 1991), the senior nurse administrator (SNA) fulfils an important leadership role in the delivery of nursing care in Canada. Understanding SNA leadership is important to illuminate and extend leadership knowledge in nursing administration.

The Canadian Nurses Association (CNA) and other professional bodies have recognized the importance of and have emphasized various aspects in nursing administration. The study of nursing administration has been a priority with CNA in the past decade (Evans, 1988). Leatt (1981) identified a lack of appropriate educational opportunities for nurses who wished to pursue a career in administration. This shortcoming was identified as one of the weakest links in the health care delivery system (Danielsen, 1978; Fine, 1983; Thomlinson, 1991).

In 1983, CNA's first Position Paper on the Role of the Nurse Administrator and Standards for Nursing Administration(1983a) was published. Methods for implementing this position paper were outlined in the

National Plan for Nursing Administration in 1985. Enhancing leadership in nursing administration was an explicit goal in this plan.

CNA published The Role of the Nurse Administrator and Standards for Nursing Administration in 1988. This paper demonstrated the nursing profession's commitment to implement a set of standards which would create an environment for the provision of quality nursing care. Standard Six in this document outlined explicit criteria in order to provide expert nursing leadership.

Much of the literature about nursing administration in Canada and the United States has focused on the roles, responsibilities, and educational experiences deemed essential for effective practice in nursing administration (AARN/AHA, 1984; CNA, 1983a, 1985; 1988; Gooding & MacKenzie, 1988; Leatt, 1981; Scalzi & Anderson, 1989; Thomlinson, 1991). Hospital studies in the area of nursing leadership focused most often on nursing productivity, quality assurance, and risk management (Henry, O'Donnell, Pendergast, Moody, & Hutchinson, 1988). However, few studies of SNAs were documented.

Wagner, Henry, Giovinco, and Blanks (1988) identified the lack of research regarding the epistemology of knowledge for nursing administration. Arndt, Di Vicenti, and Marriner-Tomey (1989) challenged researchers to "identify the cognitive maps of nursing and management for the purpose

of theory-finding for nursing administration"(p.155). Meleis (1985) stressed the importance of understanding the nature of knowledge, and how it evolves, for continuing development of any discipline.

Leadership research in nursing administration has focused on the head nurse. Several studies examined head nurse leadership style and staff nurse job satisfaction (Anderson, 1964a, 1964b; Blankenship, Wilhoit, & Blankenship, 1989; Campbell, 1986; Cronin-Stubbs, 1977; Duxbury, Henly, & Armstrong, 1982; Duxbury, Armstrong, Drew, & Henly, 1984; Everly II & Falcione, 1976; Zurlinden, Bongard, & Magafas, 1990). There was a paucity of research on leadership in hospital-based SNAs. This exploratory and descriptive qualitative research study was designed to identify the cognitive maps of leadership for the purpose of theory development in nursing administration.

Problem Statement

To accomplish the purpose of this study, the perspectives of six senior hospital-based nursing administrators were sought regarding the nature and experience of leadership. The following research questions directed the study:

1. What are the elements that constitute a SNA's perspective on leadership?

2. What assumptions about leadership guide a SNA in decision making?

3. What internal and external contextual variables influence a SNA's perspective on leadership?

Significance of the Study

It is important to study senior nurse administrators because SNA leadership influences the present and can shape the future of Canadian health care delivery. Benner (1984) studied practising nurses to determine how skills are acquired and developed. Benner (1983) related how nurses' stories revealed both the nature of nursing practice and the knowledge embedded in practice. Diekelmann (1991) related how stories of teaching revealed teaching expertise and practical knowledge. The narratives of SNA leadership revealed these nurses' expertise and practical knowledge.

This study has contributed to a more complex understanding of the nature of leadership in the context of their worklives. Understanding how the SNAs' leadership knowledge is structured has illuminated relevant concepts for nursing administration. This study has contributed to the knowledge base of leadership in nursing administration by probing the knowledge structures of SNAs, grounded in their lived experiences, and has provided a basis for further research and curriculum improvements.

Definition of Terms

The following concepts are defined as follows:

Corporate: "refers to the nurse administrator's participation in the organization's administrative team for the purpose of determining policies, priorities, allocation of resources, and general management issues"(CNA, 1983a, p.3).

Leadership: "the use of interpersonal influence to mobilize people toward the attainment of a specified goal or goals. Outcomes are contingent upon leader, task, group, and situation variables"(CNA, 1988, p.17).

Nursing Administration: "a process through which nurse administrators work to establish, attain, and evaluate goals. The goals of nursing administration are to provide for effective and efficient delivery of organized nursing services and for the professional practice of its nursing personnel"(CNA, 1988, p.18).

Perspective: the way in which an individual consistently defines a succession of similar situations (Shibutani, 1967). Perspective is the matrix through which one perceives the environment; individual actions depend on this perspective.

Professional: refers to activities "in which an administrator demonstrates knowledge and expertise with respect to professional nursing, exerts leadership in relation to the discipline, and acts as an advisor on

nursing matters"(CNA, 1988, p.17).

Senior Nurse Administrator (SNA): "a nurse who has overall responsibility for the delivery of nursing services within a health care facility"(CNA, 1983a, p.10).

Assumptions

This study was based on several assumptions about behaviour and the SNA position. The first assumption was that humans were complex individuals whose ability for self-interaction was the basis for forming meaning (Chenitz & Swanson, 1986). The second assumption was leadership is a major role of a SNA's practice. The third assumption was SNAs make decisions in their practice based on their perspective of leadership. The fourth assumption was the narratives of SNAs will reveal the elements of their practice.

Conceptual Framework

Symbolic interaction theory provided the framework for this study. Symbolic interaction is a theory about human behaviour and an approach to the study of human conduct (Chenitz & Swanson, 1986). Symbolic interaction is concerned with how people define events or reality and how they act and interact in relation to elements in their environment. In symbolic interaction, meaning guides behaviour.

The concepts central to George Herbert Mead's perspective on human society have been elaborated by Blumer (1966): the self, the act, social interaction, objects, joint action. A brief description of each concept is provided. An explanation of how symbolic interaction theory relates to this study is presented.

Mead believed it was in social interaction that the individual achieved a sense of self which is central to symbolic interaction theory. The ability to hold a concept of self, and the ability for self-interaction, was the basis for forming meaning in the world (Chenitz & Swanson, 1986). Individuals interpreted what confronted them and organized their action on the basis of this interpretation (Blumer, 1966). In this study, SNAs - possessing selves - actively shaped their worlds. Their interpretation of events, and the meaning given to leadership, guided their actions.

Human action is formed through a process of self-interaction (Blumer, 1966). Blumer explained the elements of an act included the individual's wants, feelings, goals, expectations of others, group rules, the situation, memories, and anticipated outcomes. SNAs who engaged in the leadership act took into account matters of self-concern, others, nursing, and the situation.

Participants in social interaction construct their own acts by interpreting and defining others' actions. Participants reinterpret and redefine other's acts as new

information or new behaviour emerges. This dual process makes social interaction a developmental process (Blumer, 1966). Leadership, as one form of group action, emerged as individuals (the SNAs) aligned their actions to the actions of others by determining their intentions (Blumer, 1967).

Mead considered an object as anything that could be referred to (Blumer, 1966). Blumer (1969) classified objects into three categories: physical (e.g., chairs, trees), social (e.g., students, friends), and abstract (e.g., moral principles, philosophical doctrines, ideas). The object itself had no meaning but meaning arose from how a person acted toward the object. People acted toward objects based on the meaning the objects had for them (Blumer, 1969).

To understand SNA leadership, it was necessary to identify their world of objects. This identification had to be in terms of the meanings which these objects had for SNAs. In the SNA's world, goals were included as objects. The SNA's leadership actions reflected the meaning of the goal for both SNA and nursing staff.

Blumer (1966) used the term "joint action" for Mead's term "social act"(p.540). Joint action refers to the fitting together of individual acts. Joint action can range from simple collaboration between two people to complex alignment of the acts of large organizations (Blumer, 1969). SNA leadership as joint action, involved the fitting

together of acts of both the SNA as leader and nursing personnel as followers, toward mutually shared goals.

Blumer (1969) described three basic theoretical premises of symbolic interaction. The first was that "human beings act toward things on the basis of the meanings that the things have for them"(p.2). A SNA who believed leadership was primarily task-oriented would act in a task-oriented manner toward followers. Another SNA who espoused a humanistic approach to leadership would demonstrate different behaviour focused on interaction. The second premise was "that the meaning of such things is derived from, or arises out of, the social action one has with one's fellows"(p.2). If a SNA valued the needs of nurses, then leadership was perceived as an important way of satisfying mutually held needs.

The third premise was "meanings are handled in, and modified through, an interpretative process used by the person in dealing with the things he encounters" (Blumer, 1969, p.2). Symbolic interactionism emphasized the meaning of the situation to the person. Interaction between the SNA and nursing staff is affected by the symbolic meaning that actions, objects, or events have acquired for these people both individually and together. SNA leadership in a situation may be perceived one way by nurses who will then behave accordingly. As the staff nurse or SNA roles changed, or as needs or motivation changed, the behaviour of

both the SNA and the nursing staff changed.

Organization of the Thesis

In Chapter One the scope of the problem and the need for the study have been discussed. In Chapter Two a review of the relevant literature in leadership in nursing administration, and leadership in related fields, is presented. The research design, including the setting, sample, research methodology, and ethical considerations, is described in Chapter Three. A description of the SNAs' perspective concerning leadership and their concept maps is contained in Chapter Four. In Chapter Five the findings, including implications for nursing practice, education, and future research are discussed. The summary and conclusion of the research report is provided in Chapter Six.

Chapter Two

REVIEW OF THE LITERATURE

The literature review provides a context for the concepts and practices associated with SNA leadership. This review is compiled from the following sources: a computer search of the Cumulative Index to Nursing and Allied Health Literature from January 1983 to December 1991, a manual search of the Dissertation Abstracts International from July 1979 to February 1992, and tracking of citations from articles and books on leadership.

The literature on leadership is voluminous. Larsen (1983) stated the "phenomenon of leadership is probably the most extensively researched social process in all the behavioral sciences"(p.430). The literature reviewed in this report was a selective examination of leadership in nursing, generally in the area of nursing administration and specifically pertaining to SNAs. Selected literature from management, psychology, and sociology was also reviewed. The criteria for inclusion in this review were as follows:

a) nursing research-based published reports or unpublished Master's theses and Doctoral dissertations dealing with SNA leadership;

b) research-based reports that provided sufficient information to reveal a conceptual framework, research design, method of data collection, and sample (Merriam & Simpson, 1984);

c) anecdotal reports in the nursing literature related to senior nursing administration;

d) issues in nursing administration leadership which were defined as problems, concerns, and/or questions with the potential to affect SNA leadership;

e) literature which pertained to SNA leadership in Canada and the United States.

This review is organized according to the three main premises of symbolic interaction theory. Each major section was critically evaluated and limitations of the research were discussed. The chapter concludes with a summary of the reviewed literature.

Conceptualization of Leadership

Concepts and Practices

Blumer's (1969) third premise, that meanings change and are modified through an interpretive process by the person in varying situations, served as an introduction to the conceptualization of SNA leadership. SNA leadership reflected the individual's unique hospital perspective. Their world of objects, persons they met and worked with, were influenced by their organizational position, role responsibilities, and personal philosophies or values.

The first section of this chapter examines the concepts and practices identified in the literature relevant to SNA leadership. It provides an analysis of SNA leadership based

on themes from the literature review. The chapter concludes with a discussion on the differences between leadership and management.

Communication.

Communication emerged as the major theme in the literature. Wolf (1986) described effective communications as the "bricks in the road to corporate excellence"(p.26). Kramer and Schmalenberg's (1988b) purpose was to ascertain to what extent the "magnet" hospitals possessed characteristics similar to Peters and Waterman's "best-run" companies. Kramer and Schmalenberg explained that magnet hospitals were very successful in attracting and retaining professional nurses. These authors analyzed 16 hospitals in the United States using the eight characteristics identified by Peters and Waterman (1982) in their book In Search of Excellence. They found informal communication to be an integral characteristic of magnet hospitals in their study.

Kramer and Schmalenberg (1988b) characterized communication as a continuous exchange of information on an informal basis between the SNA and directors, head nurses, and nursing staff. Several meetings and much communication preceded planned department-wide changes. According to Kramer and Schmalenberg, the end result of this investment in staff was improved productivity. One must question the validity of using a business model to compare a patient care environment.

Dunham and Fisher (1990) reported that communication contributed to excellent nursing leadership. These researchers used the key informant technique to identify excellent nurse executives in senior administrative positions. In this qualitative study, 85 hospital chief nurse executives (CNEs) were interviewed. In Dunham and Fisher's analysis, CNE leadership involved "constant communication"(p.3), both written and verbal. CNEs were viewed as being committed to direct communication, to listening, and knowing when to ask the right questions. Dunham's (1989) theoretical article provided further support for communication as an element of nursing leadership. This author argued a successful nurse administrator is an effective communicator. Dunham believed communication could be used effectively to manage conflict, conduct business, and make decisions.

Successful leadership was based on the ability to communicate in a wide array of work situations (Brueckner, 1978; Edwards & Lenz, 1990; Miller, 1989). Edwards and Lenz pointed out how effective communicators resisted interruptions. According to these authors, all nursing administrators must strive to develop assertive verbal and nonverbal communication patterns to enhance their leadership effectiveness. Brueckner conceptualized communication as a three-way process: "up, down, and across"(p.13). Success, according to Brueckner, depended on effective communication

with nursing and medical colleagues and hospital administrators. A strong internal communication network which included peers, superiors, and subordinates was reported to enhance SNA leadership (Dunham, 1989; Jacobsen-Webb, 1985).

Lawrence and Lawrence (1984) examined nursing leadership in light of changing organizational structures. They based their argument on changing societal forces described by Toffler (1970). In this new "ad-hocracy" (p.130), power and authority are decentralized with more people sharing temporary decision making (Toffler, 1970). Lawrence and Lawrence called for expert leaders in communication to work in this new adhocracy, to share in decision making, and to coordinate health care services.

Work climate.

Work climate was the next major leadership theme to emerge in the literature. Jenkins (1991) proclaimed that, as nursing leaders, SNAs have the responsibility to create a climate where employees have a say in their work. She stated nursing administrators have not communicated a clear vision of nursing to other groups, nor have they allowed for practice partnerships to develop. Jenkins proposed a professional governance model designed to enhance the work climate in hospitals. She suggested this strategy will enable nurses to achieve organizational goals and to cope effectively with rapid technological and environmental

changes. Sovie (1987) agreed professional nurses expect to participate in decisions affecting their practice. According to Sovie, SNAs who promoted participative management could expect enhanced productivity through a "culture of shared ownership"(p.17).

Climate setting activities included being an "image setter and spokesperson"(Simms, Price, & Pfoutz, 1985, p.241). SNA activities in this regard have been identified as publicizing the benefits of nursing, developing leadership potential in others, acting as a role model, teacher, facilitator, and change agent. These leadership behaviours are perceived to be important to staff satisfaction and retention (Adams, 1990; Kramer & Schmalenberg, 1988a, 1988b; Powers, 1986; Ripple, 1988).

Other authors agreed SNAs had a unique responsibility to influence the practice environment (Dunham & Fisher, 1990; Miller, 1989). Facilitating nursing practice meant being an advocate for nurses whose concerns the nurse executive represented. Dunham and Fisher asserted SNAs who consistently modeled values such as quality of nursing care, innovation, respect, caring, nurse autonomy, and excellence could expect staff to emulate these values when caring for patients.

Empowerment.

Inherent in a work climate of shared values was the notion of empowerment (Dunham & Klafehn, 1990; Ehrat, 1990).

This was the third major leadership theme in the literature review. SNAs empowered staff by recognizing their value as colleagues or by ensuring they had the right to make decisions and make mistakes (Ripple, 1988; Sovie, 1987). Empowerment occurred when the vision and direction of the senior nursing executive were clear. Relinquishing control and decentralizing departments was an integral part of empowerment (Dunham & Fisher, 1990). SNAs who recognized the energy which could be released with empowerment could function to support, coach, and develop their staff (Sovie, 1987).

Buffering.

One form of supporting staff in their work involved buffering. Smith and Mitry (1984) visualized the buffering leader as one who supported staff by reducing barriers to the completion of their work. Buffering was an attempt to "absorb"(p.45) disruptive environmental influences. These authors provided a conceptual model of the nursing leadership buffering process, where a leader protected subordinates from various pressures in the health care environment to permit them to achieve organizational goals. Smith and Mitry compared a buffering SNA to a "semi-permeable boundary"(p.45) who filtered external pressures. Gilmore (1990) described this boundary role of leaders as an "uncertainty absorbing function"(p.141). Subordinates were often unaware of this function because the

leader performed buffering activities as unobtrusively as possible.

Balance.

As a buffering leader, the SNA is also expected to maintain balance. Stivers (1991) spoke with four nurse administrators while she was preparing her opinion-based article regarding nursing leadership. The nurse administrators, with whom Stivers spoke, reflected on the "balancing act"(p.50) of their role performance. Balance to these respondents meant managing the tension between the need for assertive, authoritative, and politically astute behaviour, and the need to advocate to others what care meant. They all agreed understanding "the big picture" and being "as global as possible"(p.50) was important. Stivers did not report the participants' level in their employing organization or their educational preparation in her article.

Another example of balance involved the balancing of values in terms of potential harms and benefits (Fry, 1986). Fry questioned how nurse executives learned to balance values in general management decisions. She noted there was little known about how nurse executives make value-based decisions concerning allocation of nursing services or quality of care decisions.

Dunham (1989) explained that leadership meant keeping a balance in the structure of organizations. She referred to

an unbalanced bureaucratic structure where few people had autonomy and many managers exercised control. She believed this unbalanced structure exists today in many health care organizations. Dunham cited Kramer and Schmalenberg's (1988b) magnet hospital study as support for establishing more adhocratic structures in hospitals. Again the validity of applying a business model to the structures of a patient care environment is questioned.

Successful executive leadership in Miller's (1989) opinion reflected a balance between economic productivity and quality of patient care services. Dunham and Fisher (1990) agreed. Excellence among nurse executives included a balance of educational and business skill, clinical expertise, and leadership principles. Ehrat (1990) offered these descriptions of leadership behaviours in the 1990s: "gentle control, general direction, and flexible support" (p.6).

Integration.

Part of maintaining balance was the concept of integration. Both McClure's (1989) opinion article and Dunham and Fisher's (1990) study emphasized this aspect of nursing leadership. They conceptualized the excellent nurse executive as a team player who skilfully wove nursing into the total organizational effort. With a clinical background and knowledge of the contribution of non-clinical departments to patient care, the SNA made a unique

contribution to the senior executive team in supporting delivery of total patient care.

Vision.

Visionary nursing leadership emerged as an attribute among SNAs in Dunham and Fisher's (1990) study. Nursing administrators were expected to be knowledgeable about social, economic and political factors influencing health care (Dunham, 1989; Simms, 1991). They were "idea people" whose perspective was more global than that of their staff. Top nursing leaders were expected to be proactive (Kirk, 1987), to be forerunners of the hospital (Ripple, 1988),and to use political skills in operating a hospital nursing department (Simms, 1991). Not only must SNAs have vision but they must be able to describe their vision with enthusiasm, vividness, and energy so that it inspires other nurses to work collaboratively in order to make the vision a reality (Dunham & Fisher, 1990; Dunham & Klafehn, 1990; Ehrat, 1991; Sovie, 1987).

Change.

Comfort with change was an additional theme in the literature review. SNAs were expected to welcome change, to be proactive, and to show a willingness to examine situations from other points of view (Kirk, 1987; Ripple, 1988). Gilmore (1990) believed the health care environment of the past was comprised of short periods of turbulence and longer calm periods. He referred to the calm periods as

"slack"(p.137), where one had the opportunity to stop and collect one's thoughts. Today's environment is characterized as increasingly turbulent; continuous and rapid change is the norm. Leaders must simultaneously plan and implement their decisions with little or no slack time.

Conflict.

Leadership involves constant interaction with people and, whenever people interact, conflict is likely to occur. SNAs regularly dealt with conflicts of many kinds. One particular set of conflicts arose from nursing's historical tradition as a caring and humanistic discipline (Dunham, 1989; Dunham & Fisher, 1990; Kramer & Schmalenberg, 1988b; Miller, 1989). The conflict centred around the sometimes disparate goals of optimal nursing care and economy and efficiency (Brueckner, 1978). SNAs were challenged to preserve what is caring and human in nursing practice and yet respond effectively to the demands of the business world (Miller, 1989).

Decision making and problem solving.

Decision making and problem solving emerged as important concepts. Johnson's (1990) theoretical article illustrated a nurse executive's effectiveness is related to the effectiveness of decision making. The author proposed the set of assumptions held by the nurse executive about the problem, the role, and the decision making process have the most important influence on effective decision making.

Decision making was an important part of problem solving. Problem solving and decision making were integral to SNA leadership (Dunham & Klafehn, 1990; Sovie, 1987).

Professional responsibilities.

Several concepts and practices emerged which can be grouped under the SNA corporate and professional responsibilities. Simms et al. (1985) used the constant comparative method of data analysis developed by Glaser and Strauss (1967) as an inductive approach to define the role of the nurse executive. A convenience sample (n=30) of nurse administrators was selected, where 10 of the SNAs represented the most senior nursing administrative position in the hospital. The results indicated in all settings (acute, long term, and home care), SNAs had a major responsibility for the quality of patient care.

The Simms et al. (1985) study revealed the SNA's important leadership role in research, particularly in the acute-care setting. Stevens' (1978) and Sovie's (1987) opinion articles addressed the SNA's leadership role in the advancement of nursing through research. All concurred the SNA must be capable of assessing clinical research and must develop nursing systems to apply the results of selective clinical research.

SNAs and head nurses shared the accountability for a nursing unit's productivity; that is, the relationship between resources and output (Sheafor, 1991). Sheafor

asserted the SNA who used a deliberate and problem-solving approach to head nurse concerns facilitated a supportive and stress-free relationship. The expected outcome was increased productivity in the head nurse's unit.

Corporate responsibilities.

Corporate responsibilities involving long- and short-range planning, financial management, and policy making emerged in studies by Dunham and Fisher (1990), Simms et al. (1985) and in several opinion articles (Kirk, 1987; Ripple, 1988; Sovie, 1987). Business expertise kept the SNA "on top" of the situation and able to respond to changes within the organization and in the broader marketplace (Kirk, 1987; Sovie, 1987).

Continuous learning.

The concepts of continuous learning and educating were evident in the nursing administration literature. Excellent leadership in Dunham and Fisher's (1990) study and Dunham's (1989) opinion article portrayed the SNA as role model, mentor, and facilitator. According to these researchers, SNAs perceived themselves as able to constantly grow and learn. Education-related activities for SNAs included self-development, and staff and community education (Simms, 1991; Simms et al., 1985). Self-development included self-assigned homework, participation in professional organizations, formal and continuing education, public speaking, or consulting. Simms noted the role of nurse

executives as teachers was largely unrecognized.

Personal attributes.

Several personal attributes of the SNA such as creativity, high energy, optimism, a positive outlook, and enthusiasm were evident in several articles (Kirk, 1987; Kramer & Schmalenberg, 1988b; Simms et al., 1985). Traits of responsibility, commitment, and trustworthiness were valued in SNAs by nursing staff (Dunham & Klafehn, 1990; Jacobsen-Webb, 1985; Miller, 1989). Self-acceptance and positive self-esteem were valued among nurse administrators (Dunham, 1989; Jacobsen-Webb, 1985; Miller, 1989). McClure (1989) noted the quality of selflessness, or the ability to put the good of the group above the good of self, was being overlooked in SNA research.

Dunham and Fisher's (1990) study revealed some of the strengths and the weaknesses in traditional SNA leadership. Some strengths included total commitment, high energy, physical appearance and dress, and a sense of humour. There were many commonalities in the identified weaknesses: a dislike of detail and a tendency to procrastinate; a dislike of paperwork; being impatient with those who appear incompetent; and an inability to say "NO!", leading to overextension.

Related Concepts

Cohen (1989) and Scalzi (1988, 1990) agreed the SNA must make decisions in an increasingly turbulent and complex

health care environment. Both authors noted that stress at the SNA level is receiving little current study. In 1970, Arndt and Laeger studied 47 directors of nursing service from 50 randomly selected hospitals in California to identify the sources and consequences of stress. These researchers found the Director of Nursing Service occupied a boundary position between several departments and was expected to maintain a complex balance of relationships among several groups of people. Their study identified the major stressors of these directors as conflicts within the work role, and tension between role demands and personal needs. Arndt and Laeger attributed high stress levels to a lack of trust and respect in the workplace and to ineffective coping strategies.

Scalzi's (1988) study described the major factors related to SNAs' role stress and coping strategies used by them. Stage I of the study was a survey of 124 SNAs in all general hospitals in Los Angeles County, California. The three instruments used were a demographic questionnaire, an instrument to measure role conflict and ambiguity, and an instrument to measure depression. Stage II consisted of in-depth taped interviews with 30 SNAs randomly selected from the 75 respondents to the Stage I survey. Four major factors in role stress were identified from the study: overload, quality of care concerns, role conflict, and role ambiguity. The study highlighted the importance of

understanding how stressors were inherent in the SNAs' role. Scalzi identified 10 coping strategies from her analysis of the taped interviews that could assist nurse executives to cope with stress constructively.

Tracy's (1991) survey research described the relationship of organizational structure measured by reporting arrangement and scope of responsibility to role conflict and role ambiguity of SNAs (n=151) in acute care hospitals (bed size 300 and over) in nine southeast states in the United States. The findings demonstrated role conflict and role ambiguity were significantly lower (alpha=0.05) where nurse administrators reported to the Chief Executive Officer (CEO) than other senior officers. There was no difference in role ambiguity and role conflict for SNAs who had only responsibility for nursing or responsibility for nursing and other areas. Both role conflict and role ambiguity scores lessened with increased age of SNA, as total number of years in the role as SNA increased, and as total number of hospital beds increased (with the exception of 600-700 bed size).

Leadership and Management

One of the difficulties with the concept of leadership is that it is often used interchangeably with the concept of management. "Leadership is the process of influencing people to accomplish goals, whereas management is moving an organization toward achievement of its goals. Leadership is

not management, but it is hoped, indeed necessary, that managers are leaders"(McCloskey & Molen, 1987, p.178). Similar discussions are noted by Gilmore (1990) and Brown (1988). Examples from two recent nursing articles illustrate this point:

Example #1: "nurses are instructed in leadership techniques to be utilized for acquiring compliance with their orders; that is, they learn how to control subordinates to better achieve departmental efficiency and effective care"(Smith & Mitry, 1984, p.44);

Example #2: "women who use a participative management style not only solicit information from others, but also give their employees information"(Davidhizar, 1991, p.9).

Zaleznik (1977) wrote of the difference between leaders and managers. He pointed out differences in "motivation, personal history, and in how they think and act"(p.8). According to Zaleznik, managers tend to adopt impersonal attitudes towards goals; whereas leaders were active in shaping ideas. Managers tried to shift balances of power towards acceptable solutions as a compromise among conflicting values; leaders turned ideas into images that created excitement in work. Managers preferred to work with others and tended to keep a low level of involvement; leaders maintained a sense of separateness and participated actively in risk-taking behaviour. Bennis and Nanus (1985) also noted the difference between management and leadership.

"Managers are people who do things right and leaders are people who do the right thing"(p.21).

Summary and critique.

This part of the literature review described several major concepts associated with SNA leadership. Leadership was comprised of an inventory of traits, behaviours, practices, and role expectations. However, few of the studies reviewed allowed for an exploration of the leadership phenomenon, that is, how leaders think about their practice as leaders.

Many of the citations were opinion-based or theoretical discussions. The often-cited magnet hospital study was based on the premise of using business-model criteria as a framework to evaluate patient-care organizations. Several articles did not define the organizational level at which the nurse administrators worked (i.e., is the nursing leader a head nurse, supervisor, Director of Nursing, or Vice-President of Nursing?). It was difficult to say if the effect of hospital size was considered in their analyses.

Theoretical Frameworks of Leadership

Blumer's (1969) first premise, that meaning guides behaviour, serves to frame this section on theoretical frameworks of leadership used in nursing. SNA leadership actions were guided by the meaning given to leadership. Theories were one factor which influenced a SNA's perception

of leadership. Leadership theories found in the literature are numerous; those most often utilized in the reviewed literature are presented.

Ohio State Leadership Studies

Prior to the mid-1940s, the trait theory provided the basis for most leadership research (Marriner, 1978). The trait theories tried to identify traits or personal characteristics common to successful leaders. Marriner pointed out that although trait theory expanded our knowledge of leadership, several flaws were evident: few traits were identified in all the research, traits were not mutually exclusive and there was considerable overlap among them, and it was not clear which traits were most important. Trait theory did not view personality as a whole and avoided situational and environmental influences.

Behavioral theories attempted to identify what leaders did when they functioned in leadership roles (Bonaquist, 1986). These theories became prominent around the mid-1940s. The Ohio State Leadership Studies (OSLS) were examples of the behavioral approach to studying leadership. The OSLS studies marked a significant shift away from trait theories.

The OSLS studies attempted to identify leader behaviours which affected work performance. Two questionnaires were developed to measure the leadership style of an individual. The Leadership Opinion

Questionnaire (LOQ) measured self-perceived leadership style. The Leader Behaviour Description Questionnaire (LBDQ) measured leadership as perceived by subordinates. Bryman (1986) explained the main impact of the OSLS studies was the development of precise operational definitions of leadership performance.

After testing the LBDQ with members of air crews, the OSLS researchers' analyses revealed four key factors in leadership behaviour: Consideration, Initiating Structure, Production Emphasis, and Sensitivity / Social Awareness (Halpin & Winer, 1957). Consideration denoted camaraderie, mutual trust, liking, and respect, in the relationship between aircraft commanders and their crew. Initiating Structure denoted those who organized work tightly, whose structured work content provided clear definitions of role responsibility, and who played an active part in getting the work scheduled. Production Emphasis is regarded as "motivating the crew to greater activity by emphasizing the mission or job to be done"(p.43). Sensitivity appeared to suggest the "aircraft commander's sensitivity to, and awareness of, social interrelationships and pressures existing both inside and outside the crew"(pp.43-44). Bryman (1986) noted the emphasis in later leadership writings was on Consideration and Initiating Structure.

Fleishman and Harris (1962) investigated the relationships between the leader behaviour of industrial

supervisors and the behaviour of their group members at the International Harvester Company. This study confirmed the usefulness of the constructs of Consideration and Initiating Structure for describing leader behaviour in industry. Fleishman and Harris explained both are independent dimensions. A person could score high on both, low on both, or high on one and low on the other. Their definitions are used often in the nursing literature:

> Consideration includes behavior indicating mutual trust, respect, and a certain warmth and rapport between the supervisor and his group. This does not mean that this dimension reflects a superficial "pat-on-the-back", "first name calling" kind of human relations behavior. This dimension appears to emphasize a deeper concern for group members' needs and includes such behavior as allowing subordinates more participation in decision making and encouraging more two-way communication. Structure includes behavior in which the supervisor organizes and defines group activities and his relation to the group. Thus, he defines the role he expects each member to assume, assigns tasks, plans ahead, establishes ways of getting things done, and pushes for production. This dimension seems to emphasize overt attempts to achieve organizational goals.(p.43)

Limitations.

Fleishman and Harris (1962) noted limitations of their research. Firstly, they pointed out cause and effect inferences should be made with caution. They noted the descriptions of foremen behaviour came from their workers. Although their study examined relationships between labour grievances and employee turnover, it may not hold for other indices like group productivity.

Although the Ohio researchers contributed significantly

to knowledge on leadership, their studies are criticized. Korman (1966) questioned whether leadership - the way the Ohio Studies measured it - was an important predictor of various outcome measures like job satisfaction, group effectiveness, and morale. Bryman (1986) noted the underlying assumption in leadership research was that leadership style, as an independent variable, affected various outcomes, the dependent variables.

Korman (1966) observed that it may be incorrect to deduce a cause-effect relationship from the correlation of two variables. In 1974, Kerr and Schriesheim reported that Korman's observation regarding the use of OSLS instruments was no longer valid. Kerr and Schriesheim attributed this improvement to the increased efforts of researchers to conceptualize and measure situational variables related to leadership behaviour.

Korman (1966) criticized the OSLS because situational variables (e.g., organizational size, organizational climate) which could moderate the relationship between leader behaviour and various outcomes were not considered in many of their analyses. Kerr and Schriesheim's (1974) review of the leadership literature revealed several other supervisor, subordinate, and situational variables which could influence individual or group performance (e.g., job knowledge and expertise of subordinates, degree of time urgency, presence of stress related to the task). Bryman

(1986) asked why so little attention was paid to informal leadership in organizations. He asserted its existence may be another moderator variable influencing various group outcomes.

Bryman (1986) observed the OSLS measurement tools averaged subordinate's accounts of leaders. Variations within the group may be lost with grouped data. Bryman noted the difficulty with group-directed questions. He believed these kind of questions forced respondents to focus their response from the group rather than the individual perspective. Bryman pointed out the OSLS instruments purported to measure leader behaviour when, in fact, they really measured subordinates' perceptions of leader behaviour (LBDQ) or leaders' beliefs about what they do or should do (LOQ).

Fisher (1987) noted the effects of Initiating Structure and Consideration on leader effectiveness yielded mixed results. Fisher conducted a meta-analysis of 80 studies (530 correlations) which investigated relationships between these two leader behaviours and effectiveness criteria (e.g., job performance, subordinate satisfaction, and organizational stress). His research indicated both Initiating Structure and Consideration positively correlated with leadership effectiveness, particularly Consideration with subordinate satisfaction. Situational variables continued to influence leadership effectiveness.

Empirical support in nursing administration literature.

Despite the criticisms, there were empirical studies using the OSLS theoretical constructs in the nursing administration literature. Many of the studies focused on the head nurse role. Anderson's (1964a) study examined the relationship between the head nurse's activity preference and leader behaviour as seen by subordinates. A convenience sample of head/charge nurses (n=25) and nursing staff (n=79), composed of registered and practical nurses and nursing aides, was selected from a 475-bed general hospital. The response rate was 96 percent. The primary finding was that head nurses who exhibited a strong preference for nursing care activities were rated as better leaders by their staff than head nurses who preferred personnel- or coordinating-activities.

Anderson's (1964b) second study explored whether or not superiors and subordinates of head nurses associated different qualities with leader behaviour. Anderson surveyed the same head nurses' two immediate superiors using a modified LBDQ. Their rating was averaged and correlated with subordinate scores from the earlier study. In contrast to the subordinate view, superiors rated head nurses who preferred coordinating and personnel activities best. Anderson attributed this difference to the organizational climate of the hospital where the "bureaucratic" head nurse is rewarded, although these activities are not seen as being

a good leader by subordinates. Convenience sampling, use of a mixed group of head/charge nurses and subordinates, and a 32 percent attrition rate of head nurses prior to the second study limited the generalizability of Anderson's findings.

Pryer and Distefano's (1971) study of nurses, attendants, and aides of a large mental hospital reported the leadership dimension of Consideration was positively related to job satisfaction at all levels. Initiating Structure was related to job satisfaction with supervision only where non-professional staff rated professional-level supervisors. Randomized stratified sampling (n=99) of the personnel in this large psychiatric hospital strengthened the study. The cross-sectional analysis, although internally valid, suffered from the weakness of the cross-sectional glimpse of leadership behaviour that Korman (1966) described. Its setting also limited generalizability of findings. Nealy and Blood (1968) found the leader behaviour of Initiating Structure to be negatively related to job satisfaction for a group of professional nurses rating their nurse supervisors.

Duxbury, Armstrong, Drew and Henly (1984) studied neonatal intensive care units (NICU) to determine if a relationship existed between staff nurse perceptions of leadership style and staff nurse satisfaction and burnout. Three instruments measured staff nurse (n=283) satisfaction, burnout, and leader opinion. Head nurse Consideration was

found to be related to staff nurse satisfaction and to a lesser extent to burnout. Initiating Structure, by itself, was not related to satisfaction or burnout. In the NICU setting, high head nurse Consideration was found to protect against burnout and job satisfaction associated with Structure.

Duxbury's research team respected the basic assumptions inherent in correlational survey design. However, the study may be limited in the following areas. Firstly, the incomplete description of sampling procedures left the randomness and representativeness of the sample in question. This had an impact on the statistical analysis and later on inferences drawn. Secondly, variable measurement at the interval level was in question. Theoretically, interval or ratio level data is appropriate for the parametric statistical procedures used in this study. Thirdly, the number of journals referenced but not cited may be an oversight in editing; it may, however, have influenced the authors' conceptualization of the study.

Two unpublished doctoral dissertations measured SNA leadership using the theoretical constructs of Consideration and Initiating Structure. Peterson's (1985) research questions focused on the identification of ideal leadership behaviour and differences in perceptions among SNAs and graduate nursing students. The LOQ was used with graduate students (n=179) from 10 accredited universities and SNAs

(n=87) from accredited hospitals with a bed capacity between 400 and 500. There were no identified differences in the perceptions of students and administrators in their profile of ideal SNA leadership behaviour.

McCarty (1985) stated the primary purpose of her research was to determine relationships between several variables and SNA self-perceived leadership behaviours of Consideration and Initiating Structure. Using data from 148 SNAs (68% response rate) who returned the LBDQ-Form XII, several analyses were conducted. Statistical analysis revealed no significant relationships between institution size, age, education or experience of the SNA, and leadership behaviours of Consideration or Initiating Structure.

Situational Leadership

Life cycle theory / situational leadership theory.

Marriner (1978) explained that situational theories became popular in the 1950s. While the behavioral theories were criticized for not considering situational variables, situational theories considered multiple variables to determine how a leader should behave in a given situation. In this approach, leadership effectiveness depended on the contextual demands of the situation.

Hersey and Blanchard, who are leadership theorists, developed and published their Life Cycle Theory of Leadership in 1969. At this time, both men worked in the

Department of Management and Organizational Behaviour at Ohio State University. Their theory has been refined and further developed and is commonly referred to as Situational Leadership Theory (SLT). According to these authors, no one leadership style was effective in every situation. The leader, the group members, and the situation determined which leadership style a leader used. The degree to which leader behaviour was appropriate in a situation (style adaptability) was critical in determining a leader's effectiveness. They stated "when the leader's style is appropriate to a given environment measured by results, it is termed effective; when his style is inappropriate to a given environment, it is termed ineffective"(p.28).

Hersey and Blanchard (1988) defined task behaviour as production-oriented and relationship behaviour as people-orientated. The right leadership style was the appropriate combination of task (Initiating Structure) and relationship (Consideration) behaviour according to the readiness level of the group. Readiness was the ability of the followers to be responsible for directing their own behaviour. These variables were considered in relation to a specific task and indicated whether the leader should use a telling, selling, delegating, or participative style.

Critique of SLT.

Hersey and Blanchard (1988) stated their assumptions were based on behaviour within organizations. The authors

ensured congruency among several assumptions. Acceptance of these assumptions may limit its applicability to only those organizations whose values are toward growth, change, and productivity. Overall, the theory was logically congruent and internally consistent. Some overlap is noted in the definition of concepts. This may be because some concepts are operationally defined for research (Hersey & Duldt, 1989). Their theory was generally unparsimonious. Walker and Avant (1988) noted this is common for theories dealing with complex human phenomena.

Blake and Mouton (1982) criticized the development of concepts in SLT. They claimed the underlying attitudes reflecting concept development are contradictory. They stated SLT is paternalistic because it suggests the leader can tell a follower what, how, and when to do things, without giving the follower alternative behaviour options.

Vecchio (1987) studied teachers and high school principals to explore SLT in organizations. The purpose was to test SLT accuracy in predicting leader effectiveness. Vecchio concluded that SLT predictions are relevant for newly-hired employees. He suggested that skilled and motivated subordinates may do well in the absence of any leader behaviours. Vecchio did not report operational definitions. It was not possible to say with accuracy whether these definitions reflected the theoretical concepts. In three other similar studies (Hambleton &

Gumpert, 1982; Hersey, Angelini & Carakushansky, 1982; McMurray & Bentley, 1989) none reported operational definitions and no assessment of SLT operational adequacy could be made.

Hambleton and Gumpert's (1982) study provided some support for SLT effectiveness. The authors reported when managers use the theory correctly, they are rated higher and seen as more flexible by both subordinates and superiors. Hambleton and Gumpert noted the data were nearly all based on self-reports. They could not claim their sample of managers was representative. These factors limited the generalizability of results.

In conclusion, SLT's greatest contribution was the emphasis on leadership flexibility and the importance of situational factors (Bryman, 1986). Reported empirical testing has been limited (Vecchio, 1987; Zurlinden, Bongard, & Magafas, 1990).

SLT and nursing administration.

SLT appeared in the nursing literature in 1976 with two tools to help nurse supervisors measure their leadership behaviour. The LEAD-Self measured three aspects of a leader's behaviour: style, style range, and style adaptability. The LEAD-Other measured subordinates and superior's perceptions of nurse supervisor leadership (Hersey, Blanchard, & LaMonica, 1976a, 1976b).

Many of the SLT articles which appeared in the nursing

literature were anecdotal (Bonaquist, 1986; Kison, 1989; Larson, 1986; Marriner, 1978; Wilson, 1980), or theoretical (Hersey, Blanchard, & LaMonica, 1976a, 1976b; Hersey & Duldt, 1989; Zurlinden, Bongard, & Magafas, 1990). Empirical studies using SLT in nursing administration occurred at the head nurse and senior executive level.

The following two studies are guided by Hersey and Blanchard's SLT. All used the LEAD-Self and LEAD-Other instruments. Maguire's (1986) descriptive correlational study compared staff nurses' perceptions (n=70) of head nurses leadership style on primary and non-primary care nursing units. Head nurses on primary care units showed a higher relationship behaviour than those head nurses on non-primary care units. This study is limited due to convenience sampling and a 35 percent response rate by staff nurses.

In a rare longitudinal evaluation study, Johnson and D'Argenio (1991) measured the effectiveness of a management training program on the leadership behaviour and effectiveness of a group of nurse managers (head nurse level). The author's conclusions showed it was possible to obtain short term changes in leadership behaviour through involvement in a leadership training program. Johnson and D'Argenio recognized these limitations: non-experimental design with convenience sampling of nurse managers (n=11) and three to five of their respective staff nurses, a small

sample decreasing the chance of obtaining statistically significant findings, and attrition of nurse managers and staff over the 12-month period. The authors reported the culture of the Nursing department may also influence leadership styles used.

Adams (1990) research, framed by SLT, focused on the leadership style and effectiveness of CNEs to determine if they used leadership behaviour that promoted staff retention. Fifty-seven (86% response rate) acute care CNEs responded to a mail survey. The LEAD-Self instrument measured style and effectiveness. The dominant leadership styles were selling (54%) and participating (30%). The analyses of variance and LEAD-Self effectiveness scores that were statistically significant included: years of experience in the CNE role, educational level, bed size, and hospital ownership. Adams suggested CNEs must begin to use a delegating style with mature subordinates to both retain them and develop their administrative skills. Experience in the CNE role was related to effectiveness as opposed to experience in nursing administration. The primary limitation of this study was the nursing department setting of which 94 percent were decentralized. No explanation as to what constituted decentralization was included in the discussion.

Davis (1989) examined the relationship between organizational culture and leader effectiveness of the nurse

executive. Leadership was measured with the LEAD-Self instrument. Two hundred nurse executives in acute care hospitals were surveyed with a final sample of 88 SNAs. No significant relationships were found among any study variables. The authors concluded the lack of significant relationships may reflect the nurse executive's autonomous position in the hospital. They suggested the greatest influence on a SNA is the profession of nursing and not the setting.

Transforming and Transactional Leadership

Burns (1978), a political scientist who studied world leaders, has written about leadership. Burns proposed two kinds of leadership. The first was what he called transactional. This kind of leadership involved exchanges: jobs exchanged for votes, favours exchanged for hard work. The purposes of the leader and follower were related, but the leader gave no thought to the follower's needs or goals. Burns acknowledged that transactional leadership was not the kind "that binds leader and follower together in a mutual and continuing pursuit of a higher purpose"(p.20).

In contrast to transactional leadership, "transforming" leadership occurred when the leader and follower engaged more fully with each other. The leader considered follower's needs and goals and the outcome of transformational leadership was positive for both. Burns (1978) explained that transforming leadership ultimately

became "moral in that it raises the level of human conduct and ethical aspiration of both leader and led, thus it has a transforming effect on both"(p.20).

Burns' (1978) writings are cited in the 1980s nursing literature. Larsen (1983) called for the development of transformational leadership if nursing was to develop excellence in clinical practice, to meet the expectations of the nursing profession, or to participate in shaping Canada's health care system. Schlotfeldt (1985) asserted transforming leadership would be effective in transforming nursing into a "fully autonomous profession"(p.251). Burns' transforming leadership appeared in several anecdotal articles related to SNA leadership (Cottingham, 1988; McClure, 1989; Miller, 1989; Sovie, 1987; Trofino & Strickland, 1990; Wolf, 1986). Effective nurse executive leadership included qualities of both transformational and transactional skill (Dunham & Klafehn, 1990).

Bass (1985) expanded on Burns' theory of both transformational and transactional leadership. Bass operationalized Burns' theory with the development of the Multifactor Leadership Questionnaire (MLQ) to measure leadership style. The MLQ had two versions: one for the leader (the Self MLQ) and one for staff (the Staff MLQ). These instruments yielded data on Bass's "transformational factors of charismatic leadership, individualized consideration, and intellectual stimulation, and the

transactional factors of contingent reward and management-by-exception"(p.230). Bass pointed out that Zaleznik's (1977) leaders displayed transformational leadership and his managers transactional leadership.

Critique of transformational / transactional leadership theory.

Yukl (1989) provided a conceptual critique of transformational/transactional leadership theory. He acknowledged the distinction between the two kinds of leadership was useful to shift the attention of researchers to neglected leadership processes. Yukl believed this distinction was becoming a "two-factor theory of leadership processes"(p.212) which he believed oversimplified a complex phenomenon. Yukl noted the distinction among the two kinds of leadership was unclear. He called for empirical research to reveal the nature of these differences. Yukl explained there are slight differences between Burns and Bass regarding their conceptualization of the two kinds of leadership.

Curphy's (1991) thesis was an empirical evaluation of the construct validity of Bass's (1985) theory. Research subjects were United States Air Force officers (n=160) and cadets (n=12,000). This report provided little support that transformational and transactional leadership are separate factors. Curphy suggested Bass's theory should be reworked to include a single leadership dimension "not the multiple

dimensions hypothesized by Bass"(p.186). Curphy concluded that leadership positively affected organizational performance and climate.

Transformational leadership theory and SNAs.

Yukl (1989) criticized the choice of questionnaire research when knowledge of transformational behaviour was so "primitive"(p.224). He questioned whether questionnaire research would provide useful insight into the nature of transformational leadership. Yukl suggested using descriptive research using interviews and observation to discover what leaders actually do to transform their followers.

Dunham and Klafehn's (1990) exploratory and descriptive study identified transformational leadership characteristics of nurse executives. The key informant technique was used to contact nurse executives perceived as "excellent"(p.30) by their peers. Eighty nurse executives completed the Self MLQ and 213 staff who reported directly to the nurse executive completed the Staff MLQ. Transformational and transactional scores were determined for each executive. The results showed that all executives were predominantly transformational leaders but also possessed transactional leadership skills.

Gottlieb's (1990) research described self-reported leadership styles of Chief Nurse Supervisors (CNS) and Associated Chief Nurse Supervisors (ACNS) and the

perceptions of their leadership by their immediate subordinates. A descriptive correlational survey was conducted nationally in the Department of Veterans' Affairs Medical Centers in the United States. Leadership styles were measured using Bass's (1985) MLQ. The findings revealed differences in self-reported leadership styles of both the CNS and ACNS as well as differences in perceptions of these senior nurses by their respective subordinates. For both the ACNS and their subordinates, charismatic leadership correlated positively with job satisfaction and effectiveness. The dimension of inspiration explained most of the variance for subordinate's extra effort. Both CNS and ACNS displayed transformational and transactional leadership behaviours, although the CNS did more frequently than the ACNS. Gottlieb questioned whether the leadership style of the ACNS changed to become more transformational when their role changed.

Interactive Leadership

Krysl (1990) described how the Interactive Leadership model provided a humanistic view of group and leader actions. The dominant features of this model are the notions of sharing, shifting of power among leader and members, consensus, and shared ownership. The roles of leader and follower are complementary and valued equally.

This model focuses on empowerment as a means to growth and problem solving. Empowerment occurs through the

processes of decision making, relating, influencing and facilitating. These four components were conceptualized by Yura, Ozimek, and Walsh (1981) as the basis for the nursing leadership process and served as a founding framework for Interactive Leadership. Krysl (1990) related how leadership concepts from Mintzberg (1973) and Bennis and Nanus (1985) provided additional concepts for this model. Rosener (1990) and Davidhizar (1991) have conceptualized Interactive Leadership similarly. These authors argued that this model reflected characteristics of how women lead. No nursing research was located which examined leadership from this interactive perspective.

Summary and critique.

The discussion of theoretical frameworks used in nursing revealed several points. Firstly, there was limited research at the SNA level using any of the theories. The prevailing quantitative paradigm and measurement tools did not allow for the exploration of what or how SNAs viewed their practice. The theories have been borrowed from disciplines other than nursing. Further study is required to determine whether leadership is discipline-specific. These theories have been developed and the instruments tested primarily on male subjects in the military, business, or industry. With so little replication in nursing the question of whether they have been adequately evaluated and adapted to nursing is raised. Vanance (1989) noted in her

review of leadership theories that no one theory can be viewed as complete or as capturing the essence of leadership in nursing.

Leadership Effectiveness

Blumer's (1969) second premise, that meaning arises out of social interaction, serves to frame this section on leadership effectiveness. In leadership, one form of social interaction, participants construct their own acts by interpreting each other's actions instead of merely reacting to each other's actions. Participants' response is based on the meaning with which they attach to such actions (Blumer, 1967). Blumer (1967) explained that anything of which a person is conscious is something the person is capable of indicating to himself. "Self-indication is a moving communicative process in which the individual notes things, assesses them, gives them meaning, and decides to act on the basis of meaning"(p.141). Blumer (1967) explained the formation of human action by the person through the process of self-indication (e.g., leadership) always occurred in a social context. Thus, as Blumer (1967) noted, behaviour is not the result of factors like environmental pressures, motives, and attitudes but arises from how the individual interprets and handles these factors in situations with which the individual is confronted.

From Blumer's (1967) analysis, and based on the

literature review, one can conclude there are several potential factors which could influence leadership effectiveness. Much of the research already reported in this chapter conceptualized and measured leadership effectiveness as a consequence or result on the work group: job satisfaction, morale, productivity, and burnout. Some authors preferred not to define effectiveness (Freund, 1985; Moore, Biordi, Holm, & McElmurry, 1988). As Larsen (1984) noted, the concise conceptualization of leadership effectiveness remains elusive.

In this section of the report, leadership effectiveness refers to when a leader's style is appropriate to a given environment measured by the results (Hersey & Blanchard, 1969). A style is a pattern of consistent behaviour perceived by others (Hersey & Duldt, 1989). Leadership style is a consistent pattern of behaviour exhibited by the leader when attempting to influence the actions of others (Hersey & Blanchard, 1988; Hersey, Blanchard, & La Monica, 1976b). In the constraints of this thesis, it is not possible to discuss all the factors contributing to SNA leadership effectiveness. Three factors which were prominent in the literature review are presented briefly in this section: leadership styles, crisis in nursing leadership, and gender and nursing leadership.

Leadership Styles

One approach to studying nursing leadership

effectiveness was to examine leadership styles. Hersey, Blanchard, and LaMonica (1976b) described style as a product of one's personality, socialization, and life experiences. Style usually remains fairly constant and is considered important because the style exhibited lends predictability to a leader's behaviour (McGee, 1984). McGee pointed out leaders are not usually constrained to one style but often exhibit alternate styles depending on the situation.

To summarize the literature reviewed in this report, several conceptualizations of style predominate. Many studies focused on the two dimensional styles of Initiating Structure or task behaviour and Consideration or interpersonal relationship behaviour. Several studies in the situational approach classified leadership styles as a set of four communication patterns: telling, selling, participating, and delegating. A SNA is expected to have both a transformational leadership style, yet maintain transactional leadership skills.

One taxonomy of leadership styles not yet mentioned in this report refers to the autocratic, democratic, and laissez-faire leadership styles. These titles were originally given to three variations of social climate used in studies by White and Lippit in the 1940s (White & Lippit, 1953). These researchers experimentally varied the leadership climate to examine the effects upon individual and group behaviour of groups of children. Current

definitions of these terms have changed little from White and Lippit's descriptions. The autocratic leader favours one-way downward communication and tells subordinates what to do. The democratic leader encourages group members to determine their own policies, make decisions, and evaluates them objectively (Kison, 1989). Kison described the laissez-faire leader as one who avoids attempting to influence subordinates, one who leaves authority and decision making up to the subordinates.

Yura, Ozimek, and Walsh (1981) did not believe a categorization of styles was necessary or appropriate. "The style emerges as the leader operationalizes the selection and combination of behaviors inherent in the use of the nursing leadership process with followers, in a particular setting, and appropriate to the goals to be achieved"(p.101). According to Yura et al., leadership will be "effective or ineffective according to the success with which goals are achieved"(p.101). Based on the reports in this literature review, one can conclude that no one leadership style is appropriate for every situation.

Crisis in Nursing Leadership

The nursing leadership crisis theme permeated the nursing administration literature. In this section of the report nursing leadership crisis refers to a decisive or crucial situation whose outcome determines whether possible bad consequences will follow. Both Leininger (1974) and

Larsen (1983) provided analyses of causes of nursing leadership crises. Each discussion was summarized to demonstrate factors that are relevant to a SNA's practice.

Leininger (1974) talked of the critical shortage of nurse administrators who were strong, competent, and politically astute in a crisis. Leininger believed this crisis related to changes in the expectations between the earlier "establishment-maintenance style" and the present "confrontation-negotiation"(p.29) style of leadership. Nursing leaders in the establishment-maintenance era had more time, less organizational structure, and more potential resources in which to function. The environment was less complex and less competitive. In contrast, nursing leaders in the 1970s were in a highly competitive and complex health care environment. Significant issues arose quickly and the successful nurse administrator was expected to take action quickly, to assess the problem, confront the persons involved, and negotiate solutions. Leininger believed some female leaders were reluctant to use this style because of their "traditional role perceptions of female leadership behaviours or because they lack the skill to use the approach"(p.29).

Leininger (1974) discussed in depth several factors which influenced nursing leadership which are relevant to a SNA's practice. These factors included the following: "large scale and complex organizations, political regimes,

professional competition, anti-leadership societal attitudes, interdisciplinary pressures, limited finances and space and the need for major changes in health care"(p.34). Several of these factors were evident in the earlier review of how leadership is currently conceptualized in a SNA's practice.

Larsen (1983) provided a Canadian opinion on causes of the nursing leadership crisis. Larsen believed the crucial situation involved the impact of opportunity structure, power, and education on the leadership behaviour of nurses. She described opportunity structure in nursing jobs as the "expectations and future prospects" built into the design. This included nurses' location in the organization in terms of career advancement. She described the nurse as a generalist who may be exchanged for another nurse from another unit. Larsen described the outcome among nurses: a low level of nursing expertise, and unhappy nurses with low self-esteem who have little opportunity for growth and advancement.

Larsen (1983) asserted nursing leaders need organizational power to support nursing demands and decisions. She explained this power is derived through status, membership in informal "inner circles" and "influence in the upper reaches of the organization"(p.434). Nursing leaders who lacked organizational power promoted powerless behaviour in nursing staff.

Larsen (1983) related the structure of nursing education created additional problems. Larsen believed this factor and the multiple levels of education for the same qualification were more important in denying nurses autonomy than was gender. She believed the scarcity of leaders was not surprising when so few (10-15%) had access to even baccalaureate-level nursing education.

The CNA recognized, prior to and again in the early 1980s, there was a crucial situation in educational preparation of nursing administrators which could be considered a nursing leadership crisis. Adequate education and innovative leadership was considered necessary for nurses in order to function as nurse administrators in the increasingly turbulent and technological health care environment. Several strategies were implemented to address this crisis and have been summarized in Chapter One of this report. The crisis in educational preparation was particularly relevant when considering SNA leadership effectiveness. In 1989, of the 18 percent of Canadian nurse administrators who held baccalaureate or higher degrees, only one in 10 held a master's degree or higher (Stinson, 1989).

Gender and Nursing Leadership

The topic of gender and leadership emerged in both discussions by Leininger (1974) and Larsen (1983). According to symbolic interaction theory, gender can be

considered a factor of which an individual is conscious; it may influence the meaning an individual gives to leadership and consequent actions. Rice, Instone, and Adams (1984) explained not until the early- to mid-1970s was there much concern for leadership research concerning females. They reported by the 1980s several studies were available which considered whether gender influenced leadership effectiveness.

Vanance (1989) reviewed the literature on gender and leadership. She concluded "studies focusing on leadership differences based on gender are inconclusive and neither refute or support the premise that differences exist between male leaders and female leaders"(p.42-43). Dobbins and Platz (1986) provided a meta-analysis of the research examining sex differences in leadership from 1970 to 1983. Their review included studies (n=17) involving laboratory experiments, laboratory simulations, and field studies which used Initiating Structure and Consideration as a comparative framework for male and female leaders. They concluded that male and female leaders exhibited equal amounts of Initiating Structure and Consideration and had equally satisfied subordinates. Only in laboratory settings were male leaders rated more effective than female leaders. Despite the research efforts to understand sex differences in leadership, no consistently clear pattern of differences can be discerned between male and female leaders (Bartol,

1978; Brown, 1979; Chapman, 1975; Day & Stogdill, 1972; Dobbins & Platz, 1986; Larsen, 1983; Rice, Instone, & Adams, 1984).

In a report of a world-wide research survey of female and male leaders, Rosener (1990) concluded there were unexpected similarities between men and women leaders related to money and children. According to Rosener their leadership styles differed. The men were more likely than women to describe themselves as transactional, whereas women described themselves as more transformational. Rosener then interviewed these women who described themselves as transformational and called their leadership style "interactive leadership"(p.120). Rosener concluded that women encouraged participation, shared power and information, enhanced others' self-worth, and got others excited about their work. She attributed their interactive leadership style to their socialization and career paths. Although the models of Interactive Leadership arise from both the nursing and management literature, there are striking similarities in regard to sharing power and information and participation. No research was located which utilized Rosener's proposed model.

Summary and Conclusions

An overview of the literature pertaining to leadership in senior nursing administration has been presented in this

chapter. It has provided a brief discussion of several factors which may influence how leadership is conceptualized and practised. Leadership is comprised of traits, behaviours, practices, and role expectations. Few of the studies reviewed allowed for an exploration of the leadership phenomenon.

Research activity was evident although studies relating precisely to SNA leadership are scarce. The theoretical underpinnings for the majority of studies are based on theories from other disciplines and adhere largely to the quantitative paradigm. Results regarding leadership effectiveness were varied, inconclusive and sometimes contradictory.

Much of the literature in nursing administration was opinion-based or theoretical. The vast majority of research studies were conducted in the United States. No Canadian studies published of a qualitative nature that explored leadership from the SNA's perspective were found in the literature review. Canadian studies are required to provide a perspective of SNA leadership in the Canadian health care system.

The significance of this study is supported by the literature. The use of alternative research strategies was encouraged in the literature. Given the influence of SNA leadership on nursing practice, research, and education, it was important to investigate this concept through the

research process. Considering the paucity of relevant research in the area, and the descriptive nature of the research questions, a qualitative methodology was the most appropriate approach to study the perspectives of senior nursing administrators.

Chapter Three

THE RESEARCH DESIGN

The goal of qualitative research is to document and interpret the totality of whatever is being studied from the participant's perspective (Leininger, 1985). Consistent with the goals of qualitative research, methods selected for this research study permitted participants to describe and explore leadership from their unique perspectives. Symbolic interaction guided the development of the research questions and directed the methods of data gathering and analysis procedures in this study (Appendix A).

This chapter describes the research design. The respective roles of the researcher and participants are discussed. Ethical considerations and those particular to qualitative research are explored. Strengths and limitations in the research design are discussed. Steps to enhance the rigour of this study are described.

Sample and Setting

Sampling techniques that ensure the quality of a quantitative study should not be used for qualitative research (Morse, 1989). Morse explained how an unbiased, random sample violates the qualitative principles of obtaining information from those who have knowledge of the topic and sample size adequacy. In purposeful or theoretical sampling, the researcher selects a sample

according to the participants' knowledge of the research topic. Qualities of good informants include the following characteristics: knowledgeable about the topic, currently experiencing the phenomenon under investigation, able to provide information and willing to share their experience with the researcher (Burns & Grove, 1987; Morse, 1989; Sandelowski, 1986).

Samples in qualitative research must be appropriate and adequate (Morse, 1989). Morse defined sample appropriateness as the degree to which the methods used and the sample obtained facilitate understanding of the research problem. Morse referred to adequacy as informational adequacy. In qualitative research informational adequacy is "ensured by the completeness and the amount of information" (p.123). To ensure sample appropriateness and adequacy the investigator must control who is selected or interviewed.

Settings are important because events or factors within the setting can influence interaction and thus affect behaviour (Blumer, 1969). The nursing administrators in the study were employed in urban, acute care tertiary or community hospitals. They had the responsibility for the delivery of nursing services within their facilities. All participants resided within one Canadian province.

Sample sizes in qualitative research are often small because of the large volume of verbal data that must be analyzed and because of the intensive and prolonged contacts

with participants (Sandelowski, 1986). Paterson (1991) described the perspectives of clinical teaching of six clinical teachers in three schools of nursing. Tochon (1990) presented the perspectives of planning of five experienced teachers of French to 12-15 year old school children. The sample size in this study consisted of six SNAs.

Morse (1989) acknowledged the valid criticism of bias in purposeful samples. She explained the intent of this sampling procedure was to include informants with certain knowledge. Strategies to ensure all sides of SNA leadership were represented included the following: carefully and fully describing their perspectives of leadership, constructing concept maps (i.e., using diagrams) and confirming the findings with the participants.

Roles of the Researcher and Participants

"Assumptions regarding the boundaries of relationships between researcher and subject differ in the qualitative and quantitative approaches"(Haase & Myers, 1988, p.133). Haase and Myers described the assumption of objective distance between the researcher and participant in the quantitative approach; while at the same time, interaction among participant and researcher in the qualitative approach is assumed. This interaction influenced the entire research process and is accepted as part of the design (Haase &

Myers, 1988; Leininger, 1990; Ramos, 1989; Yonge & Stewin, 1988). In this study, the researcher and research participants were considered partners in the research. Participants validated information and provided feedback to the researcher throughout the study.

Robinson and Thorne (1988) described a researcher in a qualitative study as the "instrument of inquiry"(p.68). They believed knowledge of a researcher was an asset to the research process because the context of the relationship that was the basis for data gathering was known. The researcher's experience in nursing administration spanned five years at a mid-line management level. She had recently completed the Administration in Nursing course (49:710) at the University of Manitoba. These experiences plus the literature review provided the researcher with a beginning understanding of the world of a SNA.

The researcher completed a one-day study of a senior nursing manager in 1991 under the direction of the external member on the researcher's thesis committee. Leininger (1990) called this a mini-study. Although the method, non-participant and structured observation differed from the strategies in this study, the mini-study introduced the researcher to issues such as gaining entry to the field, informed consent, reactivity, and exiting the field.

The researcher was part of a research team conducting a qualitative inquiry entitled The Informed Integration of

Computer Technology in Nursing Education. The primary research strategy was focus group interviewing. This research provided further experience with issues of consent, confidentiality, and data analysis procedures. Some examples included the transcription of audio-taped interviews, coding the data, collapsing categories, and comparing and contrasting categories of data.

Insider versus Outsider Role

In this study nursing administration is considered a subculture of nursing. The researcher's role contained aspects of both insider and outsider status in relation to the nursing administration subculture. The researcher's administrative experience, familiarity with the organizational context and language of a SNA, were considered as membership in the culture of nursing administration: the insider role. The researcher was not, however, a part of a functioning nursing administration "social system"(Stephenson & Greer, 1981, p.130). She had not experienced a senior role in a nursing services department, nor did she have any kinship ties or share social contacts with the participants: the outsider role.

Stephenson and Greer (1981) reflected on their roles as insiders. They are both social scientists who have conducted ethnographies of entire communities in the United States. They discussed several advantages of the insider role: less time is required in the field, saves from asking

superfluous questions, able to understand cultural meanings which can prevent erroneous misinterpretation, increases researcher's confidence which encourages exploration. Stephenson and Greer and other researchers (Lipson, 1984; Morse, 1989) explained how prior knowledge may make the job of entering the field, problem solving, and developing rapport in the field easier. Paterson (1991) described the benefits of being an "insider"(p.65) in nursing education because she spoke the language of those in the field. Paterson discussed one situation where her insider status proved to be a disadvantage. In that situation, she monitored herself in order to prevent "imposing"(p.65) her own terms and expressions on her informants.

Stephenson and Greer (1981) discussed several risks of the insider role: familiarity with the situation may blind a person to patterns in daily events, the "ordinariness" (p.130) of observations in a familiar culture may be overlooked or not recorded, the problem of bias in selection of informants with entry to the field and establishment of rapport, and the problem of relationships to the participants when disengaging from the field. Stephenson and Greer, and Lipson (1984) discussed the balance between involvement and detachment which is needed in studying a familiar area. Strategies to overcome bias in this study, as suggested by Stephenson and Greer, and Morse (1989) included the following: being aware of the risks and

advantages of insider research, practising a naive approach, regularly recording what appears to be ordinary (e.g., physical surroundings), forcing myself to ask obvious questions which may open new avenues of understanding, using thesis committee members to help identify biases, self-monitoring and monitoring by thesis advisor in data collection and analysis phases.

Data Collection

Interviewing

From the symbolic interaction perspective, Wilson (1985) explains how fieldwork "commits the researcher to learning to define the world from the perspective of those being studied and requires that he or she gain as intimate an understanding as possible about their way of life"(p.421). The primary method of data collection in this study was interviewing. In the context of symbolic interactionism, interviewing is dramaturgical in nature (Paterson, 1991). Here the researcher and participants encountered each other in the context of interactionary performance.

Interviews in this study were face-to-face interactions and formal in that they were prearranged with the participants for the purpose of detailed conversations (Morse, 1989). Interviews were one-on-one encounters in a setting comfortable to the participants; the SNA's office.

An appropriate setting, which was comfortable and free from interruptions enhanced the quality of the data (Morse, 1989). In this study, one pre-interview, two interviews, and a debriefing session occurred with each SNA. These interviews began following facility approval for access for data collection (Appendix B).

The researcher telephoned each SNA and made a one hour pre-interview appointment via their respective secretaries. SNA001 received the Invitation to Participate Letter (Appendix C), a short description of the study, and a copy of the Ethics Committee Approval Form (Appendix H) at the beginning of the pre-interview. The researcher mailed these forms to the other SNAs prior to the pre-interview in order to inform them more fully about the study.

The purpose of the pre-interview was to introduce the researcher to the participant. The researcher made a short verbal presentation to the prospective participants and invited them to become involved in the research. Written consent was obtained at the end of the pre-interview (Appendix E). Dates and a two-hour appointment for Interview One were scheduled at the end of the pre-interview.

The pre-interviews ranged from twenty-five to forty minutes. Two SNAs had never been audiotaped and examined the equipment to be used in Interview One. All SNAs were shown the recording equipment. The SNAs asked several kinds

of questions: regarding the researcher's clinical and educational background, interests, and family. Questions regarding the process of ethical approval and the methodology were raised. Three SNAs asked what preparation was required of them prior to the interviews and what time commitment was expected. Three participants asked about the differences between leadership and management. Two SNAs began to volunteer information regarding leadership. The researcher reminded them to make these comments again during Interview One.

Prior to the start of the study, an interview guide was developed. The guide was field tested with a Director of Nursing known to the researcher but who was not part of the study (Appendix D). Minor changes to improve the clarity of the wording of the questions were made. The number of questions were deemed sufficient for one interview. A copy of the interview guide used in the study is included (Appendix F).

Interview One was partially structured. In this format the researcher began with an outline of topics to cover (Appendix F), but both the researcher and participant deviated from the interview guide somewhat and introduced thoughts relevant to their personal perspectives (Wilson, 1985). Wilson described how partially structured interviews offer the researcher some latitude to move from one area to another and to follow up on cues from the participant. The

interview guide was helpful as it was a way to keep the interview directed when occasionally it wandered. Generally, the SNAs started at Question One and worked their way through the guide. Some SNAs started and ended with different questions.

All the first interviews were conducted in the SNAs' offices. They ranged from one hour thirty minutes to one hour forty-five minutes. The researcher encouraged the participants to talk freely and resisted interrupting. Only one interview was interrupted for an urgent telephone call.

The researcher wore a tie-clip microphone attached to a battery operated tape recorder. The researcher had originally planned to clip the microphone on the participants, however, they moved about in their chairs and in their offices during the interview. Therefore, the decision was made not to restrict their movement with the recording equipment.

On two occasions the battery operated tape recorder jammed and could not be fixed quickly. In these interviews the tape from the "back-up" electric tape recorder was used for transcription. In one interview, the electric plug in the SNA's office did not work and the tape from the battery operated tape deck was utilized. Each audiotaped interview was transcribed verbatim. Written transcripts were mailed to each participant for validation.

Upon receipt of the participant's validated transcript,

the researcher made the corrections and drafted each SNA's leadership concept map. A telephone appointment was made with each SNA for Interview Two. Each lasted approximately one hour.

The second interview was generally unstructured and held in the SNA's office. The purpose of this interview was to have each participant validate their concept map, which was constructed initially by the researcher from their validated transcript. The advantage in this kind of interview was greater freedom to explore all parts of the concept map, and to add, clarify, and validate the map.

The debriefing session served to provide closure in the research project. In all the interviews, time and energy was invested by both the researcher and the participant. These debriefing sessions were important to signal the termination of the participant-researcher relationship (Morse, 1989; Ramos, 1989). Five interviews were held in the SNAs' offices and one was conducted by telephone.

These debriefings were intended to fulfil commitments made in order to gain access and interviews with the participants (Wilson, 1985). Each participant saw their own concept map and received a summary of the findings prior to the formal report in the researcher's thesis defense. The participants stated they valued participating in nursing research and learning more about leadership. Most commented they appreciated the opportunity to reflect on their own

leadership.

Wilson (1985) described feelings which may emerge when leaving the field. Researchers may be so attached they may find ways of staying longer and may experience feelings of "alienation, guilt, and melancholy when relationships are ended"(Wilson, 1985, p.431). Participants may feel enthusiastic or they may be worried about some aspect of the report. The researcher anticipated these possible concerns and feelings prior to the debriefing session and was prepared to cope with unanticipated emotions or concerns (Morse, 1989).

Advantages and disadvantages of interviewing.

Wilson (1985) discussed several advantages of interviewing: improved response rate compared to a mailed questionnaire; increased efficiency in data collection because barriers to open communication have been reduced; enhanced effectiveness in getting at people's complex perceptions; and provision of a forum to clarify and probe participants' responses, to reword and rephrase questions so the participant can understand them. Wilson described the disadvantages in this technique: time consuming for participants both during the interaction, for the researcher transcribing the interviews, and the participants in validating the transcripts; participants may expect some sort of direct help as a result of participating in the interview; participants may be self-conscious about being

recorded on tape and may not respond as freely as they would to a mailed questionnaire; and interviewers must be skilled in using clear language and active listening skills.

This process was time consuming for both participants and researcher. In addition to the four interviews, participants used from one to three hours of their time in validating their transcripts. The researcher utilized from eleven and one-half to twelve and three-quarters hours transcribing each audiotaped interview. Data collection from pre-interview to Interview Two entailed a three and one-half month period from late May to the end of August 1992.

The advantages of interviewing in this format yielded rich transcripts, up to thirty pages with each participant. There was sufficient time in each interview for the participants to speak freely and candidly. One SNA commented on the opportunity of being able to reflect on leadership, and this gave the SNA much enjoyment.

Morse (1989) described a major threat to qualitative research: the systematic bias through investigator control of data collection. Robinson and Thorne (1988) referred to this issue of influence and stated that it required examination in every research study. While quantitative studies attempt to control for possible influences on the data, qualitative researchers accept the premise "there is no way to study a thing without changing it"(Sandelowski,

1986, p.34). Robinson and Thorne cautioned that during the interview the researcher must be careful to adhere to the perspective inherent in the research design. The interviewer must not selectively attend to certain aspects of the participant's experience and not to others.

Strategies to minimize bias in interviewing are presented. Audio-taping the first interview enhanced auditability of data collection (Morse, 1989). The researcher encouraged participants to "talk out loud" about their experience, avoided interrupting, and attended psychologically and physically throughout the entire interview. Paying close attention to the participant's language helped to prevent misinterpretation of the interview question or the participant's response (Becker & Geer, 1969). Throughout the interviews the researcher strove to maintain the same amount of consistency and flexibility with each participant (Morse, 1989). Using open-ended interview questions (Appendix F), field testing the interview guide, and submitting anonymous transcripts to thesis committee members for critical review reduced subtle topic control through the use of language (Morse, 1989).

Field Journal

Robinson and Thorne (1988) suggested that nurses who engage in qualitative research "have an obligation to account for the influence of their professional perspective upon the process and outcome of their research"(p.69).

Maintaining a field journal was one such strategy to fulfil this obligation. The field journal was used as another source of data (Drew, 1989; Lincoln & Guba, 1985). Following Lincoln and Guba's suggestions, this researcher's field journal consisted of three sections. The first section was a log of day-to-day activities, appointments with participants and committee members. The second section was a personal log. Entries here included reflections on the research process, hunches, a "commentary on the perceived influence of one own biases"(p.281), and a "cathartic section"(p.281) where the researcher documented frustrations and anxieties. The third section was the methodology section. Decisions which related to the design or procedures in the study and interview summaries were recorded here.

Drew (1989) utilized a diary during an earlier investigation of hospitalized patients' experiences with caregivers. She reported several benefits. The first benefit was as a tension-relieving strategy. She wrote because she was emotionally stressed by some of the interviews. For Drew, the diary served as a means to purge her thoughts of inadequacy as an interviewer. Drew believed the awareness of her emotional reaction to some of the subjects resulted in the emergence of two new categories for data analysis. The benefits of a field journal to this researcher was primarily to record the process of the study

and, secondarily, as a tension reducing strategy.

Triangulation

Triangulation can be defined as "the combination of multiple sources of data, investigators, or several different methods"(Yonge & Stewin, 1988, p.63). Differences exist among researchers as to what methods are or are not appropriate. Goodwin and Goodwin (1984) advocated the advantages of using both quantitative and qualitative methods of data collection in the same study. Leininger (1990) argued researchers should not mix methods. She believed it was contrary to the purposes of each paradigm.

Triangulation of data is extremely important in qualitative studies (Lincoln & Guba, 1985). As pieces of information emerge in the study, the information should be validated against at least one other source. Examples of these sources can be a second interview or a second method, such as observation, in addition to an interview. In this study, triangulation to achieve comprehensiveness in the data set was handled within the qualitative paradigm. Procedures describing triangulation in this study which include investigator and data source triangulation are discussed under the Enhancing Rigour section.

Data Analysis

Two major techniques for processing and analyzing interview transcript data were utilized in the study. The

first technique, concept mapping, demonstrated by Tochon (1990) was modified slightly for use in this study. A description of the technique of concept mapping, its use in research, and an explanation of the strategies used in this study is presented. The second technique, constant comparative analysis, developed by Glaser & Strauss (1967) is described and discussed in relation to the study.

Definition of a Concept Map

Novak and Gowin (1984) defined a concept map as a "schematic device for representing a set of concept meanings"(p.15). These authors believed concepts, and propositions composed of concepts, formed the "central elements in the structure of knowledge and the construction of meaning"(p.7). They believed knowledge is constructed.

In concept mapping, an individual's cognitive structures, or knowledge of a phenomenon, can be abstracted to form a visual schematic drawing. Novak and Gowin (1984) stated concept maps do not reflect a "complete representation of the relevant concepts and propositions" but are a "workable representation"(p.40) of an individual's knowledge. By externalizing the concepts and propositions a SNA maintains about leadership, knowledge structures of leadership were illuminated.

In a concept map, "the concepts are organized with the broadest concepts on top of the map and more specific ones subsumed under larger ones"(Smith, 1992, p.17). Smith

explained how linking words joined concepts and identified relationships. She said the more links between concepts, the more "interconnected the concepts are in one's knowledge structure"(p.18).

Concept Mapping and Research

Concept maps have been demonstrated as an effective technique in research dealing with student learning and comprehension (Novak & Gowin, 1984; Rauch & Fillenworth, 1980; Stensvold & Wilson, 1992). In recent nursing research, Smith (1992) found that baccalaureate nursing students who used concept maps rather than traditional modes for learning were significantly better able to identify scientific principles and describe why specific steps of a nursing skill were done.

Tochon (1990) explained that concept mapping has been used since the late 1970s as a "heuristic schematization" (p.183) in student and teacher thinking. Elbaz, Hoz, Tomer, Chayot, Mahler, and Yeheskel (1986) used concept mapping to study the way teacher thinking developed during their initial training. Tochon explained that concept mapping offers a means of identifying and representing changes in the knowledge structures of teachers and students.

Novak and Musonda (1991) demonstrated how concept maps could be constructed from interview transcripts. They gained experience in this technique during their 12-year longitudinal study of science concept learning. They

described the robustness of transforming clinical interviews into concept maps and offered a scoring procedure which, in their view, represented construct validity.

Concept Mapping in this Study

Tochon (1990) has effectively demonstrated how concept maps can be used to analyze and process interview data in research. Several authors have described the time it takes for participants to construct their own concept maps (Rauch & Fillenworth, 1980; Smith, 1992). Teaching SNAs to construct their own concept maps was not deemed feasible because of anticipated SNA time constraints. This researcher utilized Tochon's strategy and constructed initial concept maps from transcribed interview data. Therefore the strategy demonstrated by Tochon was modified slightly in this study. The steps of this process were as follows:

a) keywords or concepts were identified and corroborated through reading and interpretation by the researcher's advisor or thesis committee members;

b) a second reading of the data permitted the grouping of concepts into certain epistemic fields. Links among the concepts were indicated by arrows or intermediate steps. Tochon used hand sketches to illustrate explicit metaphorical networks of five teachers' conceptualizations of planning. This researcher utilized a computer program, "C-MAP" (Hunter & Stahl, 1984) provided by Dr. Joseph Novak

(Appendix G), to draw the initial concept maps;

c) the concepts maps were validated and refined in a second interview with each participant;

d) Tochon's third stage of analysis did not involve the participants. He performed an analysis of the keyword relationships. He reported how teachers' conceptions were articulated through opposing terms. For example, planning, the concept under study, was viewed as "providing a sense of security, gives confidence, allows one to anticipate"; while in practice it was conceptualized as "perplexing, but impossible to put into practice, but even then never works, but also brings guilt, but is a source of dissatisfaction" (p.191). This third stage of analysis was applied to the participants' interview data. Factors perceived as restricting or altering the SNAs' leadership are reported in the category entitled constraints.

Using heuristics can themselves be sources of bias. Tochon (1990) described how biases could occur in selecting of keywords, during initial construction and refinement of concept maps, and during keyword analysis of individual maps. Strategies to reduce this bias included the following:

a) awareness of this potential;

b) repeated readings by the researcher and validation by thesis committee members;

c) participant checking and validation of transcripts and

concept maps.

Constant Comparative Analysis

Constant comparative analysis (Glaser & Strauss, 1967) was used concurrently with concept mapping to code and analyze the data. The following chart summarizes the steps taken in applying both techniques to the interview data. The initial step in each technique is similar, then the techniques diverge.

Concept Mapping:	Constant Comparative Analysis:
1. Identify key words or categories;	1. Note concepts or themes;
2. Group concepts into epistemic fields, links among fields indicated with arrows or intermediate steps (relationship among categories, how do they relate to one another);	2. Note contrasts and similarities within interview, reconcile contrasts with participants;
3. Draft concept map;	3. Compare incidents applicable to each category;
4. Validate concept map with participant;	4. Bring together (integrate) categories which can be enveloped under broad categories (delimiting by using broader concepts and

	fewer categories);
5. Analyze relationships.	5. Include noteworthy quotes in transcript;
	6. Writing the theory (findings);
	7. Discuss findings in relation to relevant literature.

All interview data from the first interview with each participant were transcribed in total. Interview data were organized using the computer software program Ethnograph (Seidel, Kjolseth, & Seymour, 1988). During transcription, the researcher took the following steps to render the transcripts anonymous. A code number was substituted for each participants' name. Information that could possibly link the transcript to the participant was either deleted or disguised. Typed transcripts were mailed to each participant, who was asked to review, edit, add, or delete information. These revisions were incorporated into the transcripts. With the validated transcripts, the researcher completed a significant part of the analysis prior to the third interview with each participant.

Key words or concepts were underlined in the data during the first reading. In subsequent readings, the researcher concisely summarized and wrote the major concepts or themes on the right-hand side of the transcript. The researcher avoided interpretation of the data at this time.

Contrasts or similarities within each interview were noted with the letter D (differences) or S (similarities). Noteworthy quotes were starred with an asterisk (*). Colourful metaphors were marked with the letter M (metaphors).

After several readings of the transcripts, concepts were grouped into epistemic fields or clusters. Participant concept maps were drawn with the assistance of the computer program C-MAP. The researcher was careful to use as many of the participant's actual words or phrases in the map construction in order to represent the participant's perspective as closely as possible.

During the third interview, each participant validated their own concept map. This involved the researcher reviewing each cluster of concepts out loud. The participants validated the concept map by adding, deleting, or changing phrases or wording to their satisfaction. The researcher informed each participant that the shape of their final map may look somewhat different as future revisions were made, but that the intent of what they had validated would remain the same. Any differences or contrasts within the interview that were noted by the researcher were discussed with, and clarified by, the participant. The participants' concept maps are displayed in Appendices I, J, K, L, M, and N.

This third interview was interesting in that many of

the participants reflected on their concept map and cited other examples in their leadership to support a certain cluster of concepts. All participants were able to point out words or phrases that did not fit with their perspective. Two participants, SNA001 and SNA002, received a second draft of their concept map. There were two reasons for this additional step with two participants. Firstly, these two maps were the researcher's first concept maps. After input from thesis committee members, the shape of these two maps changed significantly; the other four concept maps did not change as significantly. Secondly, SNA001 and the researcher had agreed to review the map again as SNA001 had suggested several changes. The revised maps were mailed to both SNA001 and SNA002 along with a copy of the first map, so the SNA could clearly see how the researcher had regrouped the concepts.

Tochon suggested an analysis of relationships, that is, drawing links among the epistemic fields with arrows or intermediate steps. This was meant to show how they related to one another. As the maps stand now, the participants have validated the concept clusters but have not assigned an order of importance. One question that may have produced a relationship context to each map was to have asked "How do you prioritize in a day?" which may have revealed the more or less important clusters. Or the researcher could have requested the participants to order the concept clusters

during the validation of the maps in Interview Three. Including these strategies may have more fully tested Tochon's analysis techniques.

Initially, the researcher constructed the concept maps, cluster by cluster, with pieces of coloured paper on a large space on the floor in the researcher's home office. This technique was suggested by Novak and Gowin (1984) as helpful to a novice concept mapper. The map was copied onto a large sheet of paper and entered into the computer. Because some of the concept names and phrases were so long, the researcher was unable to place them on the computer page exactly as they had been initially placed on the floor. This may be a limitation of the study in that the placement of the concepts may not accurately represent SNA knowledge structures' spatial placement on leadership thinking.

The researcher attempted to follow Novak and Gowin's (1984) procedures whereby the broader concepts were placed above the smaller concepts/phrases comprising the broad concept. It should be noted that many of the concepts and phrases validated by the participants were complex. The C-MAP computer program was very helpful in drawing these maps. The ease of changing concept clusters' placement, editing, and time saving via the computer were positive benefits.

After the third interview with each participant, the researcher continued the analysis utilizing the constant comparative method described by Glaser and Strauss (1967).

The transcripts were read again. Each of the participants concept clusters were compared to determine similarities or differences. Similar incidents were grouped under broader concepts called categories. Four categories emerged from this analysis: attaining and maintaining competency, information sharing, decision making, and team building. A fifty category, entitled constraints, referred to those factors which restricted or altered SNA leadership. These findings are presented in Chapter Four. A discussion of the findings in relation to the relevant literature is presented in Chapter Five.

Enhancing Rigour

Sandelowski (1986) related how qualitative methods were viewed as "failing to make explicit rules for achieving reliability, validity and objectivity - criteria of adequacy for scientific research"(p.29). Several authors argued that evaluating qualitative research with quantitative indices was inappropriate and problematic (Leininger, 1990; Lincoln & Guba, 1985; Sandelowski, 1986; Yonge & Stewin, 1988). The reasons given for this argument included the following: different historical origins, different interpretation of the words "meaning" and "truth", and different emphasis on data collection (Yonge & Stewin, 1988, p.62); reality is viewed differently, boundaries of relationships between researcher and participant differ, the nature of truth

differs in each paradigm (Haase & Myers, 1988).

Lincoln and Guba (1985) offered four criteria to establish rigour which strengthened the trustworthiness of qualitative research: truth value, applicability, consistency, and neutrality. Lincoln and Guba noted within the quantitative paradigm the equivalent criteria were internal validity, external validity, reliability, and objectivity. Each of these trustworthiness criteria are discussed and steps to operationalize these criteria in this study are presented.

Truth Value

Truth value in qualitative studies is concerned with establishing confidence in the findings which reflect the participants' perceptions and experiences (Lincoln and Guba, 1985; Sandelowski, 1986). Lincoln and Guba stated in order to demonstrate truth value, the researcher must show the findings and interpretations are credible to the participants or the "constructors"(p.26) of the findings. Sandelowski noted credibility was the criterion against which the truth value of qualitative research should be evaluated.

In this study, credibility was enhanced in the following ways. The first strategy was "prolonged engagement"(Lincoln & Guba, 1985, p.301) with the participants during data collection. A pre-interview, two interviews, and a debriefing session occurred. This allowed

for building of trust and an appreciation of the culture of the work environment of a SNA. A potential threat in this strategy was the closeness of the participant-researcher relationship which has been described as becoming so "enmeshed"(Sandelowski, 1986, p.30) that researchers had difficulty separating their own experiences from the participants. Strategies to offset this threat included the following:

a) researcher awareness this was a potential threat;

b) maintaining a field journal to document feelings so that they could be analyzed separately;

c) having the researcher's advisor monitor the process of data collection and analysis.

In building trust, the researcher followed the strategies suggested by Lincoln and Guba (1985): to constantly demonstrate to the participants that their information will not be used against them, to maintain anonymity, to keep no secrets or hidden agendas from the participants, to expect and respect input from the participants.

A second strategy to enhance credibility was triangulation of investigators and of data sources. The following procedures described triangulation in this study:

a) the transcripts from the first audio-taped interview were verified for accuracy by each participant;

b) initial drafts of each participant's concept map were

validated by the participant. Further input was sought from each participant in the confirmation of the final concept map. Lincoln and Guba (1985) called these first two strategies "member checking"(p.314). Lincoln and Guba claimed member checking was the most crucial technique for establishing credibility;

c) advisors on the researcher's thesis committee independently identified the key concepts from participants' verified transcripts: investigator triangulation (Morse, 1989). Analyses were compared and potential differences reconciled through mutual agreement;

d) data from other documents, such as the nursing organizational chart and hospital's mission statement, were reviewed to more fully understand the context of each participant's work environment. Smith (1988) noted the "context in which nursing takes place has a significant impact on the way nursing is practiced"(p.293). "Document analysis may confirm, extend or contradict other findings"(Morse, 1989, p.295);

e) purposeful sampling of the participants and their respective work settings was an attempt to provide an analysis of several "social systems"(Stephenson & Greer, 1981, p.130), a kind of contextual validation;

f) maintaining a field journal served as another data source for triangulation during data collection and analysis;

g) Lincoln and Guba (1985) suggested peer debriefing. This

technique involved two analytic sessions with a disinterested peer (Master of Nursing student) who asked meaningful questions, discussed ideas with the researcher, and provided an opportunity for catharsis.

Applicability

Applicability means the extent to which findings of one study are applicable with other subjects or in other contexts (Guba & Lincoln, 1989; Lincoln & Guba, 1985). In this study the degree of transferability was threatened by small sample size, and subjects who may be considered the "most articulate, accessible or high-status members of their groups"(Sandelowski, 1986, p.32). Strategies to enhance this trustworthiness criterion included the following:

a) the literature was reviewed to support the importance of the research study and to describe the work environment of a SNA;

b) the findings were grounded in the lived experiences of the participants and reflected six diverse individuals;

c) the researcher described the context of the interviews carefully in order to "facilitate transferability judgements on the part of others who may wish to apply the study to their own situations"(Guba & Lincoln, 1989, p.242).

Consistency

Consistency is the determination of whether the findings of an inquiry would be repeated with similar subjects in similar settings (Lincoln & Guba, 1985).

Establishing consistency helps to decrease the criticism that qualitative studies are not replicable (Kidd, 1989). Guba and Lincoln (1989) described the dependability audit: one technique to examine the logic and decision making in the study. Thesis committee members were asked to review the data to determine to what extent the process was possible to track and was documented (Guba & Lincoln, 1989). Sandelowski (1986) described a study and its findings as auditable when another researcher can clearly follow the "decision trail"(p.33) used by the investigator in the study.

Neutrality

Sandelowski (1986) described neutrality as the "freedom from bias in the research process and product"(p.33). Lincoln and Guba (1985) suggested confirmability be the criterion of neutrality in a qualitative study. Sandelowski noted "confirmability is achieved when auditability, truth value and applicability are established"(p.33). To establish the fact that the findings of the study were free from researcher bias, several strategies were employed:

a) the researcher maintained a field journal and documented regularly and honestly any observations, comments, or biases that were recognized in both the personal and methodological sections;

b) during the entire process, the researcher refrained from imposing her values on the participants;

c) the researcher asked her thesis committee members to monitor the data for potential bias unrecognized by the researcher;

d) a thorough description of the study with accompanying rationale provided a decision trail. Essentially this was the research report;

e) triangulation of data sources, investigators, and member checking of all the documents and concept maps provided for a concurrent check of potential researcher bias.

Reactivity

Reactivity is often defined as the participant's awareness of the observer's presence (Polit & Hungler, 1987). Reactivity is a source of bias. Complete control of reactivity is not always possible in qualitative research (Davis, 1986). This section indicated potential sources of reactivity and described strategies to minimize reactive effects in this study.

Paterson (1992) defined reactivity "as the response of the researcher and the research participants to the presence and behaviour of the other during the research process"(p.1, used with permission of the author). Paterson argued that defining reactivity only in terms of the effect on research participants denies the interactional nature of qualitative research. Drew (1989) pointed out how the researcher's own feelings and responses to the participants may influence the

study's outcome. Sources of reactivity in qualitative research included the following:

a) becoming so "enmeshed"(Sandelowski, 1986, p.30) with participants the researcher has difficulty separating their experience from the participants;

b) the presence of the researcher (Glaser & Strauss, 1967);

c) the friendliness of the researcher (Polit & Hungler, 1987);

d) the manner in which the researcher poses questions may influence participants' responses (Becker & Geer, 1969);

e) the researcher's own feelings and responses to the participants may be a source of influence (Drew, 1989);

f) the insider and outsider roles of the researcher may contribute to reactivity (Glazer, 1982). The researcher as an insider and familiar with nursing administration may overlook or not record ordinary events which may be significant (Stephenson & Greer, 1981). As an outsider, the researcher may experience difficulty gaining the trust and rapport of the participants (Glazer, 1982).

Strategies to minimize reactivity included the following:

a) awareness of this potential source of bias;

b) maintaining a field journal and completing field notes immediately following the interviews;

c) arriving at interviews dressed appropriately for interviews to match the participants' dress;

d) encouraging participants to speak out loud with minimal probing and few interruptions from the researcher;
e) planning and scheduling interviews to allow sufficient time in between to complete documentation and rest prior to next interview to prevent interviewer fatigue (Davis, 1986);
f) continuous monitoring of the data for reactivity effects by the researcher.

Ethical Considerations

The Ethical Guidelines for Nursing Research Involving Human Subjects (CNA, 1983b) were respected in this study. Some additional ethical considerations in qualitative research as proposed by Munhall (1988) and Oskamp (1984) were respected. This discussion follows the outline provided in the CNA document.

Firstly, the research proposal received ethical approval from the Ethics Committee of the Faculty of Nursing, University of Manitoba (Appendix H). Following ethical approval and facilities access approval, informed consent from the participants was obtained.

Informed Consent

To ensure the participants consented freely, several strategies were followed. The researcher provided the participants with information concerning the nature and purpose of the study, their role, what information and records were required, and an estimation of their time

commitment. They were guaranteed anonymity. Their names were not used on any of the transcripts, concept maps, or written reports of this study. Identification was made by numbers where the code was known only to the researcher. Interview transcripts and audio-tapes were kept in a locked filing cabinet in the researcher's home. The coding list which linked the participant to the data was stored in a sealed envelope in the researcher's safety deposit box. All data will be kept for ten years. Audio tapes will be erased and the coding list destroyed in 2002.

As qualitative research is an ongoing process, informed consent should be an ongoing process (Munhall, 1988). Munhall believed consent needed to be renegotiated as unexpected events or consequences arose. She believed "both informed and process consent should carefully delineate the data to be included in the study"(p.157). In this study informed consent was documented during the first interview (Appendix E). Process consent was negotiated at every subsequent interview. Participants were made aware their participation was voluntary and they were free to withdraw at any time.

Participants were made aware at the outset they would be debriefed as soon as the study was completed (Oskamp, 1984). Participants needed to know at the outset the researcher planned to try and publish the findings (Armiger, 1977). Planned publication of findings implies invasion of

privacy. As participants in the research study they had the right to have input into the dissemination of the findings (Munhall, 1988). This occurred prior to the thesis defense. A summary of the findings was made available to participants at the debriefing session.

Research Setting

The researcher had the obligation to make the research-related requests to specific agencies (CNA, 1983b). The researcher addressed this access issue in the first letter to the facilities and in the pre-interview with participants. The researcher cooperated with agency requirements as requested. Two SNAs required the completion of their facility's research access policy forms and procedures. Four SNAs gave their verbal approval for the research project. All approvals were completed prior to the first audiotaped interview with each participant.

Research Ethics

The researcher was obligated to adhere to the preceding ethical considerations through the entire process. The most important ethical obligation, according to Munhall (1988), was to describe and report in the "most authentic manner possible the experience that unfolds even if contrary to your aims"(p.153). Slight psychological risk may have occurred for those participants who may have felt their knowledge of leadership was being evaluated; some may have experienced anxiety, others may have felt challenged. The

researcher acknowledged the SNAs' risk in participating in the study. The benefit of participating in research and knowledge development about leadership was that it was one way to advance the discipline of nursing (Hagerty & Early, 1992).

Summary

The nature and size of the sample may be considered a limitation. However, this may be offset by findings that Sandelowski (1986) described "fit" with the experience of SNAs in other acute care tertiary and community hospitals. One strength of the study was the participation by SNAs whose findings were grounded in their lived experience.

The research design has been described in this chapter. Data collection, coding, and categorizing of the data were guided by the research questions and theoretical framework of the study: symbolic interactionism. The study findings and concept maps are described in Chapter Four.

Chapter Four

FINDINGS

The perspectives of six SNAs regarding leadership were identified by means of four interviews with each participant, their concept map of leadership (Appendices I, J, K, L, M, and N), and an examination of the context of their leadership from selected documents. The participant's perspectives are discussed according to five categories which emerged from the qualitative analysis. Four of these categories represented the perceptions of the participants regarding their leadership role: attaining and maintaining competency, information sharing, decision making, and team building. One category, constraints, related to those factors perceived as restricting or altering their role. The participants engaged in minor discussion about other mediating variables which influenced their perspective on leadership. These will be reported briefly.

Attaining and Maintaining Competency

Participants stated they had a responsibility to attain and maintain competency in all aspects of their role. This included having a vision and being proactive. All the participants agreed that educating themselves and others was an integral aspect of their leadership and an important way to attain and maintain competency. The experience of attaining and maintaining competency is discussed in this

section according to the two broad dimensions of the concept as identified by the SNAs: "vision" and "being proactive".

Vision

The participants agreed it was essential that SNAs possess a vision of what the Nursing department could become in a health care agency. They stated they were expected by their staff to provide guidance or direction for Nursing. Being a visionary was viewed by the participants as a responsibility associated with their leadership.

> I think I have to have more ideas, and bear more responsibility, and am more accountable, because the scope is broader than anyone who works for me. (SNA005)

According to the participants, vision was the ability to assume a futuristic outlook that was frequently not visible at first to a SNA's employees. Examples of visions given by the participants included introducing concepts such as self-governance, total quality management and collaborative university education to the Nursing department. Vision was constructed from a variety of sources including personal expertise, reading nursing and related literature, continuing education programs, and discussions with staff and colleagues.

> Where does this vision come from? For one thing, it's almost as if you don't have an appreciation for the knowledge you have yourself... When you are in this position like I am, an overview position, you have access to all kinds of information. Everything from the Board. What comes from the Ministry of Health in terms of direction the government is going... so you have more information from the overview... with regard to your nursing information, I chose six nursing journals that I get. I read these journals on a

> regular basis and I don't miss... I meet with the Directors who report to me once a month... I read all that stuff [Budget Variance Analysis and monthly reports] because I have to know what is happening in all of the departments... so I know about the issues in their department and that helps me when I am reading. People send me stuff, articles, to read. Then there is who you are as a nurse in the first place. I believe in the professional role of the nurse. I believe the family is part of a system... to assist and facilitate this individual to the optimum of health, whatever that means for them, and nurture their independence. So that never leaves you. (SNA005)

In addition to these sources of vision, two participants related that keeping an open perspective toward learning influenced vision.

> If you're going to be in a leadership job you have to be open to learning. You have to be open to seeing something at a distance and seeing what you would like to see happening. (SNA002)

Vision was also identified by three of the participants as a necessary response to changes in health care which cause the SNA to revise the role and functioning of the Nursing department.

> Health care is changing very rapidly; we have to figure out how our facility fits into the community. We may decide that we need a link, a very formal link with the community, in that we would provide certain services and the community would provide other services. But we will link with each other. Our strategy is to provide that linkage. The structure that we use to provide that service then falls out of it. In other words, I may say that I need a DON that is called "DON Community Services". I never had that position before. All of a sudden I have a new branch in my organizational chart, in the structure. It's because there is a new vision out there. (SNA004)

The participants stated that generally visions need more definition than they have at their birth. Administrative retreats, meetings with staff and colleagues, reading, and

the monitoring of health care statistics and trends were identified as means of clearly defining the nature of the vision. Specifying the nature of the vision was believed by the participants to require time, particularly time for self-reflection.

> I think I'm trying to spend more time in sorting out what things have to be done now, and where do we want to go. So, on my walks, that is what I think about. It's sorting that out and trying to figure out the right direction. I do a lot more of that, I think; more than I used to. (SNA004)

Vision, according the participants, was often a lonely process in which the SNA "pilots" the staff in the Nursing department to recognize and achieve the envisioned goal. An additional challenge was that the SNA's vision usually entailed strategies, policies, and procedures which were not yet developed.

> We were very strategic in retrospect, but no one showed us the way. We had to do what we thought was going to work because there was no one out there that we could copy. (SNA002)

Being Proactive

The participants agreed it was necessary to be proactive. Being proactive was defined by the SNAs as having a global perspective of hospital functioning and using vision, which meant actively involving themselves in creating and shaping change. All participants stated they utilized the strategy of teaching others in order to effect change.

The participants spoke of a global perspective

primarily in relation to the overall functioning of their facilities. This broad knowledge was reported to be helpful in making patient care decisions or in justifying staffing patterns to nurses. The participants noted that a global perspective also included considering other hospitals in the health care system. Reported benefits of continuing interorganizational liaisons were as sources of support, and for learning.

> I don't think we can work in isolation. My philosophy is "If you have something that you think is working, share it. And if somebody else has something, go and see it. Don't reinvent the wheel." We have no time for that; we are too busy to start everything from scratch. You know we are working in one health care system and that is something to always keep in mind. (SNA003)

The participants agreed that implementing vision was an important aspect of being proactive. The following examples were provided which demonstrated the SNAs' commitment to their vision and their involvement in the change process. Reported benefits of implementing vision included improving nursing practice and improving patient care.

> I said to the Director of Nursing at the time, "We have to introduce this model [nursing] into practice"... I stayed involved through the whole thing. I still am. We meet every two months... I think I have been able to produce a better population of nurses because these nurses have been taught to really look at patients through the eyes of a nurse instead of the eyes of a doctor. (SNA002)

> I had watched trends over a year... What I saw is that we had a 12-bed unit for geriatric patients but consistently...had at least 32... We had 32 patients that had been here for a minimum of 8 months... I started making comments to medical staff, to the nursing administration, to other key groups saying

> "Look at this trend..." and through quality assurance saying "We are not providing adequate care for these other 20 patients". ...If you watch...the geriatric patient got very little nursing time compared to an acute surgical case. The surgical patients would come and go and this geriatric patient would sit there for 8 months. The programming was nil... so first of all the leadership role comes by making everybody aware this is happening... Then you start to look at how you are going to administer this whole program... Then you have to move your system very systematically so that people do not lose their jobs... And nursing has to take the lead role in geriatric nursing. Nursing cannot be left out because they are the ones in charge of the assessments of these patients... The nurse is the key person who sets up family conferences, does all the assessments, really is responsible for those patients. (SNA003)

The SNAs related that implementing change also entailed systematic evaluation. The participants reported it was important to anticipate feedback and to be ready to respond to evaluative comments.

> It was a laborious, incredible experience... Then we audited. Well, of course what we found out in the audit was the greatest disappointment... Nurses were still documenting the same old way they documented in the old days. We had to then change our documentation. We set up a new committee... (SNA002)

> You have to be proactive...and when you make changes you better have a lot of evaluation following these changes... People are going to resist the change. There are only a few that are able to change very quickly. You'd better be very ready to respond to some of the evaluations... If it doesn't work, it doesn't work! Sometimes you have to try another alternative. (SNA003)

Educating

In addition to keeping an open perspective toward learning, the participants reported several self-directed learning activities. These activities were considered important in attaining and maintaining their own competency.

The SNAs considered these learning activities sources of vision and they included the following: reading, continuing education programs, experience, learning from positive and negative role models, networking, and support groups.

> So, a lot of it you had to learn on your own, take your own initiative and your own experience, but do an awful lot of reading. And to kind of have support groups. In this specific area we have an interest group or support group. We don't have formal agendas, but we all experience the same difficulties, or share the same concerns. Those kind of things are helpful. (SNA003)

Equally important, according to the participants, was their belief in ongoing education and teaching activities. Several benefits of teaching others were reported: maintenance of professional practice standards, improved nursing practice and patient care, improved staff morale, and a means to effect change. The SNAs reported several teaching strategies: role modelling a keen interest in keeping current in your area of expertise, facilitating decision making, coaching, encouraging review and reflection, and creating learning opportunities such as conferences. In all of these strategies, the participants stressed the importance of clear, timely communications.

Personal beliefs about the scope of education influenced the kind of learning activities that were created.

> Continuing education could also mean...being involved as one of the participants on a core group where you had to develop a seminar or conference. You learnt an awful lot behind the scenes. That is education to me. It was simple for me to arrange a conference, but when I had these ten people who had never done it before...

> But the leadership role comes from deciding that maybe these ten people would like that experience, and they come out quite different after arranging the conference... Being a leader means giving people that kind of experience. (SNA003)

Three SNAs described a supportive or nurturing aspect in their teaching.

> You can't do it all at once. And that's part of leading: to support your people in growing to the point where they can take the ball and run with it. There are those that run with it from Day 1 and others you need to coax along to that point and show them the way, and that is what leadership is all about. (SNA002)

> There is a lot of emphasis that the patient is part of a family system, part of a community. All those things are important in them getting well and adapting to their illness... Well, it's the same for the people who work for you. If you want to inspire healthy leaders with a future, you have to recognize that they are a whole person as well. (SNA005)

Information Sharing

All the participants agreed that information sharing, consisting of written and verbal communication, was both an important and time-consuming activity.

> What I find most of my day is spent doing is trying to keep that In-pile Out; talking with angry families on the telephone; talking with the angry person who comes to the door. It's not on the schedule but you have got to fit them in... because it impacts on patient care. (SNA001)

Information sharing was viewed by the participants as a responsibility associated with their leadership.

> All I have in my role that other nurses don't have is overview. Everybody reports to me so I basically have more information or should have more information if I'm reading reports and meeting with people and going to meetings and listening and taking notes and thinking about things. I have more information, so it's my

> responsibility to take that information to other people. (SNA005)

The participants reported that information sharing was utilized in all aspects of their leadership role: attaining and maintaining competency, decision making, and team building. SNAs received and transmitted information by means of informal and formal mechanisms within and outside the facility. The SNAs transmitted information in their role as a nursing spokesperson and in networking. The experience of information sharing is discussed in this section according to the three broad dimensions of the concept as identified by the participants: informal and formal structures, nursing spokesperson, and networking.

Informal Structures

All participants described various informal and formal mechanisms whereby information was shared. Informal activities included the following strategies: visiting the nursing units, talking with nurses, using simple language, having an open-door policy (i.e., encouraging individuals to telephone or stop by their office), being open to meetings called by staff at short notice, and encouraging and giving feedback to others regarding their performance.

> Trying to go up to the units, even if I'm just walking through, trying to talk to people. Every opportunity up to now I've had to talk to a group, I tell them where my office is located. Don't be afraid to come in! A lot of time has been focused on trying to develop communication and some understanding on who I am... and they're getting better [nurses in MNU]. Now they'll freely come by the door, and if I'm available they'll try and squeeze themselves in, or they'll make

appointments. (SNA001)

> Yesterday I got a call from Unit X's Head Nurse. She said "I have to meet with you. There is a crisis!" ...This was yesterday afternoon. My day was filled for today. I said I had time between 8:30 am and 9:00 am... my gut told me "You'd better meet with them. You better get something started!" ...I did not want to let them sit and stew... Leadership, to me, is to be visible and to find out where you have got the problems, and to get in there and to do something about them. (SNA004)

One SNA described how the physical layout and proximity of administrative offices influenced informal communication patterns. Some of the effects of this layout were later offset with a change in the senior administrator whose communication patterns differed from the previous CEO.

> Sometimes your location makes a difference. When I first assumed this role [as SNA], my office was right next door to the CEO's, so I was aware of everything that went on because I was right in the 'hub' of things. [Then the hospital's structure was changed and the Nursing office was physically located away from the other administrative offices.] I like this area [the Nursing office] because it brought me closer to nursing. But I became more distant to the rest of the management team and I wasn't always as aware as I used to be of everything that was happening. I found there were a lot of assumptions that I knew certain things were happening, when there was no way I would know... the location, with the change of administrators, has not been a problem because he is very conscientious about making sure I know what's going on. I really appreciate that; I sometimes don't like what's going on, but I know what's going on. (SNA006)

Formal Structures

The participants stated that information sharing via more formal mechanisms was required to communicate effectively with large numbers of staff. Reported formal activities included establishing and maintaining the

following structures: open forums or fireside chats with staff, administrative retreats, organizational charts, publishing reports, formal meetings, steering committees, and standing committees with formal rules for disseminating information.

> I'm trying to get more grass-roots participation in decision making. In the past two years we've worked on refining what's called the Nursing Practice Committee, and that's the nursing executive... This is where all our nursing subcommittees report... And how do we now communicate? How do we communicate all this stuff to the masses? Now, we've got it so that we have a rep from every area sitting on the committee... We post the minutes in every unit so the communication piece is starting to happen and some of the reps... take this very seriously and they meet with groups of people after the meeting and inform them about what's happening... To me this is leadership. Creating that kind of 'milieu' and setting up structures whereby there is input. I'm saying that is my style of leadership; it's my strategy of leadership to involve people, to get at grass-roots people... (SNA002)

Two SNAs reported the benefits of administrative retreats as they were an organized and effective way to set goals and objectives in concert with the hospital's mission and philosophy.

> Our idea of a retreat is we book one of the conference rooms and bring in [food]... We look at and review what we have done over the course of the year. We talk about some of the problems we have encountered. We get our standing committees to give reports, and look at what has been accomplished... At the end of the day we set goals for the coming year. By the end of the day we have articulated our goals and we have mutually agreed to them. (SNA002)

Information Flow

Influenced by the SNAs' overview role and position in the hospital's organizational chart, information sharing

flowed in several directions. Firstly, it went upwards to those to whom the SNAs reported: the Chief Executive Officer, the hospital's Board, and the Ministry of Health. Information was also shared across the chart to colleagues in senior management positions within the hospital. These included individuals in departments other than nursing and nursing colleagues in similar positions in other health care facilities. Information was also shared downwards (in relation to the hospitals's nursing organization chart) to Directors of Nursing (DONs), Head Nurses, and nursing staff. The reported rationale for information sharing was to assist staff to make their best informed decisions and to assist them in problem solving.

> What I'm trying to do is develop relationships in this organization... That includes all kinds of things, like opening up the organization, sharing information 'down the pike', making sure that people have important information. If there is information that they need to have, that could impact on their action, I want to make sure that they have it. (SNA001)

Personal beliefs also influenced SNAs' information sharing activities.

> What I do in those cases are I always arrange meetings where I personally go up on the units and say "This is the way". So I have to deal with direct hostility; I have to deal with challenges to my decision; I have to take it, sort of, first-hand and deal with it. I don't shy away from that responsibility, but it is difficult going up. I don't have to; I can always send somebody, but I take it and I go directly. (SNA003)

Two SNAs identified they used humour in their communications. Being able to laugh at your own mistakes and then go back and correct them was valued. SNA002

explained that humour was used to create a social milieu, which enhanced the spirit of cooperation. In-house jokes were valued for the same reason. In the example provided of the 1991 Nurses' Strike, SNA002 noted that laughter and food were sustaining forces which helped nurses cope more positively during an extremely difficult month.

> We have an in-joke here, our nursing admin group. We have the reputation for eating a lot... We don't 'eat on the company'; we are always bringing food... "If you are eating together you can't argue, you can't hate someone when you're eating with someone." That sustained us through the strike... Those were the things that sustained us: the laughter, the eating, and the carrying-on. And we continued that social milieu in spite of our fatigue. (SNA002)

This section of the report has detailed the SNAs' perspective of information sharing via informal and formal structures. Several strategies and personal beliefs were described that affected receiving and transmitting information. The following sections describe the SNAs' perspective regarding the transmitting of information in their nursing spokesperson and networking roles.

Nursing Spokesperson

Five SNAs reported that being a nursing spokesperson was one aspect of information sharing which comprised part of their leadership role. Being a spokesperson involved representing nursing within their facility as well as in the community. The participants agreed that sharing nursing's vision was facilitated by the spokesperson role.

> One of the key pieces is auditing the [narcotic] system regularly. [Nursing Directors] were suggesting to me

> that one of the... pharmacists would do a random audit. My point was that I don't think we will have pharmacists randomly auditing Nursing performance. I think we will have nurses randomly auditing Nursing performance... if it's someone to randomly audit whether or not nurses are following the system, and whether they are adhering to the practice guidelines, it should be Nursing and not the pharmacists. (SNA005)

> If we're talking [nursing team], I'm not there as ME alone. Usually I'm there representing a whole group of people [within facility]... I tend to be the voice if there is a voice needed: I see that as my role... But Nursing is seen. You do have to represent the profession. (SNA001)

In all examples given, the participants believed it was important to represent the nursing profession in a positive and assertive way.

> That's an experience, an education. There's all the cameras, the media and you were chairing the whole formal program. But I would never refuse an opportunity to do that because I don't do it for myself personally. It is always pulling up Nursing one more notch... Some things I lose a lot of sleep over... I have to do my part. (SNA003)

> ...senior nursing administrators, they have to convey that Nursing is a very important part of the hospital and that you are a very intelligent group of people... to try and make people realize that Nursing sees themselves as peers to Medical people; not subordinates or 'handmaidens', as used to be the case... It's important for senior nursing people to somehow convey that isn't the case but in a way that it becomes acceptable... (SNA006)

Networking

The description of information flow in the preceding section regarding Informal and Formal structures described the sharing "across" of information which was both intrafacility and interorganization. The SNAs referred to this activity as "networking". It was reported by all the

participants as an integral part of their leadership role. Setting up a network, as well as actually networking, was deemed by the participants as an inherent part of their worklife.

> As a leader, and as an administrator, it is very wise to network a lot with others because you also learn from their experiences. But when you first start you don't have a network. So it takes you a little while to get that established. (SNA003)

Networking was defined by one participant (SNA001) as a combination of the available resources and the networks open to a SNA. SNA networks included individuals from other businesses whose interests were similar.

> A good friend of mine is a partner in [an accounting firm], and when we talk about strategies and leadership, we are saying the same thing... He shared written materials with me and I've shared written materials with him. It's the same stuff. (SNA002)

The groups or teams in the SNAs' networks were as follows: the SNA's own team of nursing managers such as DONs, Head Nurses, and Nurse Supervisors; the corporate team, including other senior managers and the CEO; other departments within the facility; the community group including Continuing Care and Public Health; and other SNAs in other health care facilities.

Within an organization, the whole question of networking was deemed important and viewed by the participants as part of working together as a team. Involving the stakeholders at the outset, was reported to ensure the success of an intended program or program change.

The perception of partnership in this team was viewed by the participants as integral to its success.

> A lot of negotiation all the time... We try working together for the best possible decision. Nobody likes to go away thinking they had to give today; certainly that is what is going on. We are working very hard with concepts. There is a lot of talk about continuous quality improvement. We are working very hard to influence the culture of the institution in the direction of "We are all on the same team here, and we are all working toward the same goals. This is the best decision today." (SNA005)

In addition to the information sharing dimension of networking, the participants reported that networks were utilized for support, help in problem solving, for education, and for assistance in vision setting.

Decision Making

Decision making was the third category of the SNAs' perceptions of leadership. The participants agreed decision making was an essential aspect of their role. It underpinned and was utilized by the SNAs in all the categories comprising leadership: attaining and maintaining competency, information sharing, and team building. According to the participants, a large portion of their time each day was devoted to making decisions. Decision making enabled the SNAs to enact their leadership role and to carry out managerial functions of their role. The experience of decision making is reported in this section according to the three broad dimensions described by the SNAs: independent and collaborative decisions, and maintaining balance.

Factors influencing decision making, and decisions that were particularly difficult for the SNAs to make, are reported at the conclusion of this section.

Collaborative Decision Making

All the participants agreed that collaborative decision making was their preferred style. According to the SNAs, collaboration involved several groups of colleagues: other senior hospital managers/physicians, and groups of staff who reported to the SNA (e.g., DONs). Collaborative decision making was described as complex and time consuming. Examples of collaborative decisions which were provided related to the hospital budget and nursing practice directions. A drawback to collaborative decision making was cited as the time involved.

> You can't collect information for 17 months when you have a six week time limit [set] by the people you are reporting to. (SNA005)

However, the benefits of collaboration were reported to be worth the effort. Collaboration was perceived as promoting a sense of team, often ensuring the success of an intended program. It frequently was the only way to guide a group in the making of difficult decisions.

> In May I went on a site visit to two places with [two physicians and a nurse manager]. And that was actually the inception... When you go on a site visit, part of being the leader is saying "Okay, is this good or not? Is it possible? Should we even start thinking about it?" Just some very basic questions. Everybody liked it, thought it was possible, we went through a lot of discussion for two hours, and when we came back we were almost on the same wave length. It was definitely

> feasible for [our hospital], so that's how it starts. (SNA003)

Another example of collaboration centred around decisions related to the budget.

> What I've tried to do so far with budgeting, and we've had a very close working relationship this year with budget because of all the deficit problems we are having, is to have all Directors very familiar with the budget. They have had many opportunities to take it away, bring it back, worst-case, best case, what I could do with, what could I do without... They put in their "best-case" scenarios, you work with them, revise it, modify it. (SNA001)

Although the process of decision making relating to budget was collaborative, the SNA was expected to make the final decision in relation to budget.

> But I ultimately know what the pot is. And I have to ultimately make the decision... But in the end, there still isn't enough to go around in the pot. So, in the end, somebody has to say "Here it is". So decisions are made on a best-case scenario. (SNA001)

One example provided by SNA005 described clearly the processes utilized in collaborative decision making regarding budget reductions that would affect members of the group.

> So how I'm going to [make a difficult decision] is by taking it to the people who are going to be impacted, gathering all of the information in every shape or form, especially for the difficult decisions, you can never have too much information... But to get the appropriate players there, and listen to what they have to say... and if they suggest so-and-so, another piece of information that we can gather here... follow up on those leads to bring the information to the table. By now my original idea has been reformed or shaped or has another piece to it so I bring the fresh idea back to the group for interaction, consultation, and reworking of the notion. It means accepting the fact that they may not agree with it. They may not want to do it; accepting that and keeping the group focused on moving

> toward the decision that has to be made. Then going away and bringing it back perhaps another time where it sort of jelled, and lay it out - the final decision or the consensus the group has come to - for one more kick at it in case there are other thoughts people may have. (SNA005)

In addition to being complex and time consuming, collaborative decision making involved strategic planning. The length of time it took to complete a decision at times required several months to years.

> Four years ago our Board put an ad hoc [Committee] together, of which I was a member, along with Medical staff and Board members... Task forces were set up, we had a lot of reviews, we made presentations to the Manitoba Health Services Commission... You go broad; you look geographically, you look at your trends, what your service has been, and then you start... From start to finish - for the implementation - was one year. (SNA003)

Independent Decision Making

The participants agreed that at times they were required to be decisive and to take independent action. Independent decision making and making the final decision was reported to occur often when difficult or "tough" decisions had to be formulated (e.g., budget decisions, staff deletions). According to the SNAs, they accepted the responsibility for making difficult decisions. It was an expectation associated with their leadership role. They stated that along with making independent decisions came the responsibility to implement the decision and the accountability to communicate their choice to the individuals involved. Although all the SNAs reported their preferred style was to collaborate with others in decision

making, they shared their belief that when the situation required independent action to be taken, they would intervene.

> I do want [the nursing team] to be able to think and make decisions, and cooperatively, collaboratively, work together. But I also want them to recognize that there are times when you must take action... There are times when hard decisions have to be made, and if people don't expect that in you it's really hard to do that as well... But there are times when decisions have to be made, and you do have to step in and make those decisions independently of consultation with "They" as a group... I have expectations that there will be [Quality Assurance] programs. There will be quality care in an area. If there are problems, I expect that people will deal with those issues, identify them, maybe talk to me about them, take steps to change them. If they don't, they're not doing their job. I hope they believe that I will step in, because I believe that's part of my responsibility. (SNA001)

> I finally reached a point where I had to make a decision. It was either have that discussion and make her aware I didn't feel that things were right and couldn't continue in that way [i.e., employee not meeting performance expectations] or continue to be miserable the way things were going. So I had the discussion and she did retire, hopefully not with too many ill feelings. She's very happy now... I'm sure she was unhappy with me at first. (SNA006)

Four of the SNAs reported they encouraged independent decision making by their staff in all levels in the organization.

> I would try to encourage the majority of decisions to be made at an appropriate level... Directors don't need to come here for a blessing. They should be able to make decisions and implement change. If they want my input, that's fine too. I think I'm here as a resource, but I would encourage decision making outside this office. (SNA001)

> [Leadership] is getting the right people in the right places doing the right things. You've got to give people responsibility, but you can't do that without giving them authority. It's a chain reaction thing...

> this whole style of decentralization, delegation, giving people responsibility along with authority, getting feedback... I truly have decentralized probably 90% now. I still am looking at the 10%. At the same time I have decentralized, I have tried to bring more of the Japanese model into place where I'm trying to get more grass roots participation in decision making. (SNA002)

One SNA explained it was important to respect a DON's responsibilities and decision making authority, even in their absence. In this example, the Head Nurse and staff were experiencing several problems while their DON was on vacation.

> I said "I will meet with you next week. The DON still won't be back but we will try and categorize the issues and get some of the solutions set up before the DON gets back, like explaining some things, to you that you don't understand or don't know. I can fill in the gaps, but I will not intervene for the Director. I will not do what functions are rightfully hers." (SNA004)

Another SNA described how following others' decisions was necessary at times.

> Most of the time, at this level, I prefer - and I like I think - supporting individuals to make their best decisions. And then I follow their direction. When I am comfortable that they have got all of the information, and I have given it due concern, and they can justify the decision they are making, I go with it. (SNA005)

Maintaining Balance

The participants frequently referred to trying to create a balance in their administrative practice. According to the SNAs, this desire to maintain a balance was viewed as both responsible and fair leadership.

> Management, very simply put, to me would be seeing that the business plan is prepared... is fair, in other

> words something that our personnel can work under... It's an accountability, or being in line with the business plan. I think leadership comes in how well you do that job... if...I was to tell you that I know nothing about the business plan, and I do not look at the bottom line, I would say you weren't a leader, a responsible leader. I mean, the nursing profession, a caregiving profession, has to have the knowledge and an accountability and a responsibility for the business side as well. (SNA005)

Responsibilities associated with their role reflected both a financial and caregiving side. In the current economic milieu of cost constraints, decisions related to budget control were a frequently cited item.

> Today, if you are going to do a project, there has to be an element of cost-effectiveness in it before it can fly. You can no longer do something just for quality, or just for professionalism. You have to look at what are the savings. (SNA002)

According to the participants, creating a balance in decision making meant weighing the pros and cons, showing a willingness to hear all sides, and being fair. Examples of balance given by the participants included decisions related to balancing cost-effectiveness and quality patient care, weighting nursing and hospital committees to ensure a balanced representation of personnel, and delegating responsibility and authority for decision making while retaining some independent decision control. The significant factors reported to influence their decisions were economic and resource constraints in their worklife and their self-expectation of being fair.

> That Committee had existed for a long time, but for the past two years that I have refined it, we now have probably more representation of people from the direct

> "hands on" as we do from nursing administrators. I had balanced that piece so that now there is a real mix of true "practice people" there as well as managers who can put the brakes on. (SNA002)

Integrating head nurses into the global picture of hospital functioning was mentioned by four SNAs. This change was accomplished by changing organizational committee structures to include head nurses, educating head nurses regarding entire hospital functioning rather than just their nursing unit, and expecting them to think more broadly. The SNAs reported it was important for head nurses to realize that nursing was a significant stakeholder in improving patient care. The SNAs reported it was important to support Head Nurse decisions and provide balanced responses if asked for assistance.

> I have to respect what the Director has told [the nurses]... I had to play a fine balance here, answer their questions as best I could, and say "This is what we are going to do" but not overstep my bounds. The DON would be responsible for instituting the major solutions. (SNA004)

The need to create balance extended into several other aspects of the SNAs' worklives. One SNA reported that maintaining balance meant knowing your own strengths and recognizing your limitations. This SNA described the job at times as "walking a tight rope" where trust had to be established among the nursing staff. A colleague of SNA006 bestowed the phrase "iron hand in a velvet glove" upon SNA006 as she felt it appropriately reflected SNA006's approach to leadership.

> I feel... nursing has to exert some assertiveness. I feel it's important for senior nursing administrators to do this. On the other hand... you don't want to create the wrong impression, you don't want to be bossy and miserable... I think as far as the relationship with people who are responsible to you, I think the same goes for this too. You have to encourage a certain amount of assertiveness, but there has to be a certain amount of control too. I like to be firm and I also like to be kind. I don't like to be cruel, but I also don't like to be wishy-washy and I don't like people to be wishy-washy; I find it a little irritating sometimes when people sometimes just can't make up their minds. I know we all find certain decisions difficult to make, but they have to be made eventually. (SNA006)

The SNAs also reported the need to balance hospital services and community programs.

> I want to get involved in a more collaborative way with the community, and see how we could bridge the gap better and facilitate the provision of health care... You have to be careful with that...; you can't step on people's toes. (SNA004)

Factors Influencing Decision Making

The participants described several factors that influenced their decision making. These factors were grouped and will be reported according to internal (personal and historical) and external contextual variables.

Internal contextual variables.

Internal contextual variables were those variables that intervened or were related indirectly to the SNA's decision making. The participants shared examples of several decisions they had made that were influenced by their past experiences with leadership, their personality characteristics, and their values, morals, and beliefs. Two SNAs spoke of past experiences with leadership which

influenced how they now led. SNA002 reported an "imprinting" experience where exposure to another SNA imprinted several values and influenced SNA002's leadership style.

> I had the imprinting experience with [Nurse X], I mentioned earlier. I copied a lot of her style because it worked for me. It fit me as a human being. So I started off with a lot of those values built in about leadership. The need to delegate. The need to give responsibility and authority together, instead of giving responsibility and no authority. How to get people making decisions based on their knowledge. I adopted those principles early on when I was a supervisor, and did it with my Head Nurses... When I...became a supervisor the first thing I said to Head Nurses when they gave me a problem "How are you going to solve it? What are you going to do? What do you think needs to be done?"... because I wanted those nurses to start figuring out for themselves how they were going to work this out, then, How could I facilitate it? (SNA002)

The combination of working with individuals who provided "no guidance" and past experiences where individuals who could have provided answers were never consulted, were additional factors that influenced SNA002's current decision making style.

Personality characteristics were described by one SNA as influencing decision making and leadership.

> You can be a slave driver and you can work your people half to death, which I tend to do. I'm too much of an "A" personality. I take on a lot of work and then I give it out... There were times I had to play hardball. The Directors saw this as an insurmountable task. There was no way this was going to happen and they argued with me and a couple of them brooded over this and I would just relentlessly keep on them... I really piloted it through. (SNA002)

Only one SNA reported that some decisions were based on

"intuition".

> I am also very sensitive to [the Directors] when they are overwhelmed. I'm pretty intuitive about that, so I can tell when people have just had it. So my job becomes "Why don't you take a break?"... My gut told me "You'd better meet with them. You better get something started." So I went in there this morning. (SNA004)

The participants' belief in the professional practice of nursing was reported to influence their decision making. The SNAs agreed their staff had the ability to make their own decisions and solve problems. They viewed their role as one of resource, supporter and facilitator. The strategies described under collaborative and independent decision making such as decentralization of decision making, encouraging and supporting their staff to make decisions at an appropriate level, and respecting staff decisions, demonstrated the SNAs' value placed on professional nursing practice. Two SNAs described how professional practice standards influenced their decision making.

> You have to protect the patient. And ultimately we want to help the nurse as well. Our Act identifies our responsibility... Within our own Act we have two responsibilities which indicate that we, as an employer or as a nurse, if you are aware of, you are as guilty as the individual...if you don't take some action... If the employer takes the action, then we have the accountability to make known that we have taken action for those reasons, or we too can be accountable. ...Our own professional responsibilities require us to do something... I think ultimately the decision I encouraged was based on our practice standards. We are a profession and we must live up to our standards. (SNA001)

Personal ethics such as honesty (SNA006) and right versus wrong (SNA001) also influenced SNA decision making.

> But it again boiled down to wanting to protect this comrade, even though in my mind there is a definite very major wrong occurring here. ...I basically there had to say "In my mind what I believe has to be done, and if you won't do it I will do it". (SNA001)

External contextual variables.

Several external contextual or environmental variables in a SNA's worklife were reported to affect their decision making. These variables were as follows: time, statistical data, milieu of the hospital environment, hospital size and organizational structure, and responsibilities associated with their role.

Decisions in a SNA's worklife were influenced by the urgency of time. Compared to an educational milieu, the service orientation of Nursing characterized by the immediacy of patient care decisions, was reported to take priority over other aspects.

> When I came [to Nursing Administration] somebody would be at my door saying "What do we do right now? You have to make a decision!" For example, if you are overloaded you have to cancel surgery because you can't bring any more patients in. You have to make some decisions on the spot with nursing administration... You still have to have your finger on the pulse daily because you are service oriented. (SNA003)

In addition to the urgency of time, one SNA explained the hospital's milieu was one of rapid change and uncertainty. All the participants reported that their decision making was influenced by having access to accurate, factual information (i.e., statistical "hard" data). Occasionally their decisions would be delayed until statistical information was available.

> I recognized we made the decision late; if we could have done it earlier we would have, but we didn't have the statistics. (SNA004)

> You also can influence your group to some extent, but you can't influence if you don't know your facts, or don't know what repercussions or implications this decision has. (SNA003)

Hospital size and the organizational structure of the Nursing department was reported by one SNA to affect decision making.

> [Researcher:] It seems like decisions are a pretty big part of your role.
> [SNA:] Yes they are and it's because we are a small place. So I maybe don't make decisions that "affect the world" but there are a lot of internal decisions that I have to make and probably have a fair bit of bearing on other people... I probably get involved more, in the day-to-day workings of my hospital, than other people in my position do... I probably make more decisions relating to patients than other people in my job do. (SNA006)

In addition to the variables which influenced their decisions, the SNAs reported how remaining flexible, showing a willingness to "give and take", and having good negotiation skills were helpful skills in their worklives.

> I spend a fair bit of time in this job "negotiating". Not from the formal contract sense. A particular director will come up with a situation and something they want to try, and something that seems good, but it impacts on the whole hospital... I have to be able to convince the [senior management team]. Often they're not convinced on the first go-around. And so you have to be able to give, take, resell, re-advertise, bring in supports at all levels... You then have to be able to sell them on rethinking. (SNA001)

> In leadership, the trick is to probably change your hat a hundred times a day;... You have to be flexible, you can't say "Nursing won't budge. Nursing will never do this." If you concede today, in some small aspect, tomorrow you may get a larger piece of the pie. It's

> negotiations; it's being that kind of a leader in negotiations... A leader requires a lot of different kinds of skills, and you switch. Being flexible, being able to understand where each other is coming from, being approachable... I guess I see [leadership] as a large portion of your day. (SNA003)

Making Difficult Decisions

All the participants agreed the most difficult decisions they had to make were in regard to deleting people, positions, programs, or services.

> Most of the most difficult ones, the ones that cause you to be the best leader, are very confidential kinds of things. I'll try and describe some without crossing that line... We are looking at streamlining non-union management positions. That means "bottom line", deleting positions and people. (SNA005)

> I'm probably sitting on the precipice of making one of the most difficult decisions and that is I see the need to reorganize the Nursing Admin group once again... which means maybe demoting a couple of them. Which could be maybe the most difficult thing that I ever had to do. Because I have said that I am a people person. I get very involved with people... I find the most difficult things I've had to [do is] to let people go. I've had to fire people or encourage them to resign and that's been very difficult. Coming to the place where I realize they have to go because they are doing more harm to the organization than good. That I find very difficult. (SNA002)

These decisions were made after considerable input, study, and time.

> I had a lot of input into that decision before the final map was drawn... It impacts on people's lives. You try to accommodate [people's careers and expertise] into your organization, as well as something that will be suitable for years to come. It's taken a while. (SNA001)

> So I said "Let's get some stats"... I went over, in my head, all the demographics... From back to 1985 we had all the statistics... The stats were very convincing, so the Board passed it. (SNA004)

> Task forces were set up, we had a lot of reviews, we made presentations to MHSC... You go broad: you look geographically, you look at your trends, what your service has been, and then you start... After review, and a literature search, and everything else, then we look at what we can do. (SNA003)

Three SNAs reported that, along with the effort put into decisions, they often worried whether the decision was the right decision.

> I have to admit there are times when I have agonized over the decisions I've made, and hoped they were going to work out, and lost sleep over them. I think that's a human quality. Because some decisions have not been easy, and you think "Maybe I should have considered something else". (SNA006)

The participants reported that what was so difficult was the impact the decision had on people's lives, careers, and the indirect influence on their families.

> Only one person "walked out of the door" out of [all] those ... moves. I think that is responsible leadership, but it is never easy... I am not naive: I know people have families, have difficulties, have kids. A lot of them are single income families. (SNA003)

> The hard part was saying to her that she was no longer doing her job. It's sometimes easy to do if it's a person who makes no bones about the fact that they don't give a darn... I think she believed and thought she was doing a good job, and I was telling her she was not, and I was going to hurt her as a result. (SNA006)

Other difficult decisions shared by the participants involved making professional practice decisions (SNA001) and handling patient complaints (SNA003).

> It's something you have to do. You have to protect the patient... So I took action and suspended that nurse. Others thought that it would not go on her record and I said "I think this is a go-on-your record. Somebody's life was threatened." There was a breach of policy... misinformation on the chart... These are major

> practice issues. We are a profession and have to be accountable. (SNA001)

SNA003 noted that handling patient complaints were often difficult because "they catch you off guard". Because patients could phone the SNA at any time, these kind of decisions were difficult because of having to make decisions "on the spot" without much preparation.

Team Building

Team Building was the fourth category of the SNAs' perceptions of leadership. All previously described components of leadership (i.e., attaining and maintaining competency, information sharing, and decision making) were integrally linked to, and utilized by, the SNAs in team building. The participants agreed that team building activities were an essential aspect of their leadership. According to them, team building meant getting to know people professionally and establishing and maintaining interpersonal relationships. The SNAs reported team building was important in order for the nursing department to function effectively as a team, to accomplish mutually agreed-to goals, and to implement change. The experience of team building is discussed in this section according to the three broad dimensions described by the SNAs: building relationships, being there for staff, and inspiring confidence.

Building Relationships

The participants reported that the basis of a "team" was building interpersonal relationships among members of a group the SNA was leading. This group included the nursing team: DONs and head nurses. The participants' beliefs and activities regarding building interpersonal relationships were extended to members of the corporate team within the facility: other senior managers of hospital departments, and the CEO. Building relationships included having an awareness of their own strengths and limitations, as well as acknowledging the attributes and deficiencies of others. The SNAs shared their belief that reciprocal trust and mutual respect formed the foundation for a team.

> People have to get to know one another's limits and be able to interact with one another. I think trust is quite important. If you don't have trust I don't think you will develop the team. It's not only one-on-one; it's the whole group working together. (SNA001)

One SNA described how honesty and openness promote a solid relationship.

> I really feel you are a very poor leader if you are not truthful with people. It also undermines your position because people lose respect for you. I have caught people in lies, and I have never trusted them again. I think it's extremely important to be honest with people, even if sometimes that honesty isn't easy for them to accept. But I do think that honesty and openness are extremely important. (SNA006)

Participants reported their belief that getting to know other SNAs and nursing staff professionally was important in building interpersonal relationships. This activity required an investment of time and energy to know who

nursing staff were as individuals and for them to know the SNA as a leader. Benefits of getting to know each other were articulated as follows:

(1) knowing clearly what the expectations were of each other promoted trust:

> I think the relationship with the group you work with is paramount. Trust must be developed if they are to take any ideas that you may come forward with or in them bringing forward the ideas... As they get to know you, I think it gives them the freedom to take risks and to try new things as well. To be more open about what their concerns are. (SNA001)

(2) according to SNA005, having a relationship served as a beginning point for individuals to establish credibility with each other:

> When we hire someone now who comes to work for me, [establishing the relationship is] the first thing. You get to know them; I meet with them. I meet with people regularly so that people can count on the fact that they have an uninterrupted hour with me once a month... There are those kind of things and people do them differently, that you do to establish a trust, a credibility... so you have to have a relationship with people; it has to be based on trust; you have to be credible with each other. So that is what promotes leadership and what inhibits it is the absence of those things. (SNA005)

(3) one SNA reported that knowing an individual on a first-hand basis rather than relying on second-hand information changes your perspective. It allowed a SNA to make reasonable expectations according to an individual assessment of staff's abilities:

> You have to figure out the strengths and weaknesses of the people who work with you or for you, on a first-hand basis. If you looked at their performance appraisals that someone else wrote, or you look at the result of some situation they worked through, it isn't

> going to be good enough. It would be sort of like building your foundation on quicksand, so it takes an investment of time and energy and intellect to figure it all out. You have to know who the people are. Then once you know that you will have a totally different view of those 14 individuals... As a leader, I think you have to buy into that, quite seriously, that people have strengths and weaknesses. You'll free up and avoid a lot of grief in expecting that this individual, who has this capacity and is going to function well there, is never going to function up here. (SNA005)

Being There for Staff

In addition to building interpersonal relationships based on trust, honesty, reciprocal respect and openness, the SNAs described other aspects of team building that promoted a sense of belonging and maintained interpersonal relationships among the team. These beliefs and activities were subsumed in a category entitled "being there for staff". Role modelling the importance of relationships, sharing, and being a team player were given by the SNAs as examples of this category.

Two SNAs reported that role modelling the importance of relationships was important in developing and maintaining credibility among the SNA and the team.

> It's again part of your responsibility. It's a role model situation once again, to show that relationships are important; working relationships, expectations, trust. If you can demonstrate that's important to the group, hopefully then that group will eventually be able to develop that in others as well. (SNA001)

Three SNAs reported "being there" meant being available to staff when staff needed them and actively supporting them in times of their need.

Leadership is establishing a relationship with people

> you are attempting to lead, knowing about them, being available to them. Not when you have an issue, but when they have an issue; establishing credibility with them in that. When you don't know you say "I don't know, but I'll see if I can find out" and you do find out and come back. (SNA005)

> Yesterday I got a call from the Emergency Room Head Nurse. She said "I have to meet with you. There is a crisis."... This was yesterday afternoon. My day was filled for today. My 'gut' told me "You'd better meet with them. You better get something started."... I did not want to let them sit and stew. (SNA004)

According to these participants, to be effective in supporting staff SNAs had to have a self-awareness of their own strengths and limitations (i.e., personal insight) in order to promote empathy for the people who work for them.

> I consider when a nurse is on [maternity] leave, there is six months they are away and the next six months of coming back is almost like a re-entry phase... I wanted her to know that I knew that, and that I supported her 100%. Well, that child is 3 or 4 years old now. She's one of the best head nurses I've got. In fact, all I did was invest another six months of knowing where she was at and supporting her through that. (SNA005)

Buffering.

One SNA viewed supporting staff from a unique perspective. Part of being there for this SNA involved "buffering" activities. This SNA described buffering as the use of self to defend or protect followers and to absorb obstacles to their progress. This SNA's belief in the importance of trust between a leader and follower was described as the basis for buffering activities.

> The biggest thing to me as an example of enacting my style of leadership is to defend [staff] in good times as well as bad. And that's important because today there are a lot of bad times... The main thing is the

> people who are following the leader have to trust the leader. And the biggest thing in trust is that they have got to know that you are going to stand behind them... I've had a lot of bosses, the ones that I would walk over broken glass for are the ones I trusted totally; that I knew wouldn't pull rank on me. I know that if I fumbled they would not hang me out on the flagpole, but they would take some of the heat as well. I will follow if I trust my leader, which is very important. (SNA002)

One examplar which was given to illustrate buffering was in relation to the Manitoba Nursing Strike of January 1991. This SNA acted as a buffer, absorbing emotional stress in the examplar. Buffering was interpreted in the exemplar as trying to take the "heat" off the staff.

> What happened is that [the Strike] almost killed me because I took the brunt of the stress. I protected them from the Union meetings and interactions... The fighting that was taking place at a different level... I handled all the calls in for essential service... made rounds with the Union and I met with the Union every day. I did all of those things so that I took the heat off all the staff. All they had to worry about was their patients and getting their work done. (SNA002)

Sharing.

Four SNAs reported that sharing was a strategy they used to promote among the nursing staff a sense of belonging to the nursing team and to the organization. These participants believed sharing was important in developing the individual staff member as well as being helpful in achieving individual and organizational goals.

SNA002 referred to the concept of sharing in the interviews: sharing written materials with colleagues, sharing decision making, sharing stories of staff's

accomplishments, sharing the prestige and the money among staff who worked on various projects.

> I try to make the people who are doing the work take the credit, the 'doers'. At conferences they are the ones that I have presenting, and they are the ones that are in the limelight... I sent nine people. I didn't go. They cost-shared, stayed in residence, things like that. Made sure we spread the money around... (SNA002)

SNA002 also reported that sharing stories, food, and a social milieu were sustaining to a group in times of crisis.

> We assigned [a room] as our 'disaster headquarters' for Nursing... and we had food being 'trucked in'. And everybody came for their breaks and they came in there and put their feet up. And they ate and we laughed and joked and told stories and laughed about things people shared... Those were the things that sustained us: the laughter, the eating, the carrying-on. And we continued that in spite of our fatigue. (SNA002)

One SNA's perspective on sharing the leadership role was unique. During the 1991 Manitoba Nursing Strike, this SNA described how important it was to be on the ward involved in patient care and actively supporting the staff and management nurses. In this scenario, the SNA acted as a team player, relying on corporate colleagues' judgements and decisions.

> It was a strange type of leadership. I guess it was an "example leadership", I tried to do the "meeting bit" as well. I gave up the "meeting bit" after a period of time because it interfered with my ward work. I knew it was essential to be involved in some of those discussions [with the Union], but I felt there was an Executive-Director, a non-nurse, and another admin person and a Medical director who could attend these meetings, discuss things with the Union, who could bring things to me if they needed my opinion... I really felt that I had to be there, to do it myself and felt that that was the kind of leadership they needed at that time. (SNA006)

Inspiring Confidence

In addition to building interpersonal relationships and being there for staff, the participants agreed that the SNA had to inspire confidence in their followers and colleagues. Inspiring confidence was viewed by the participants as a responsibility associated with their leadership. According to the participants, there were some additional strategies which were utilized to promote trust and confidence in the SNA as a leader. Examples of inspiring confidence included demonstrating ability, being visible, demonstrating a commitment to a vision, having energy and enthusiasm, and providing a positive, charismatic outlook.

Demonstrating ability.

The participants described several different ways of demonstrating their ability to their corporate colleagues, their nursing team and the nursing staff. Reported benefits of demonstrating their ability included establishing and maintaining credibility, earning respect which enhanced team functioning in order to achieve organizational goals.

> You have to be able to demonstrate to [corporate colleagues] that you've looked very carefully at a scenario... or that you've looked at the benefits for the whole institution... I think you also have to be a leader within that group or demonstrate some ability within that group as well.. (SNA001)

Being visible.

The participants agreed that being visible to staff was a means of supporting them, enhancing communication, and inspiring their confidence. According to the SNAs, being

visible and keeping up their involvement in nursing activities helped them maintain their credibility and earn respect from their staff. Examples of being visible within their organization included walking tours to the nursing units, explaining where the SNA's office was, holding open forums or "fireside chats", and meeting personally with staff when difficult decisions were made. One participant explained it was important for staff "to know a little bit about you" so they could determine for themselves if they believed in the SNA's ability to lead.

> There is a need for leaders to be visible and to be out there so people feel they know a bit about you... Does that person represent their personal philosophy? or what they want to believe in?... People have to believe in the leader. (SNA004)

According to SNA004, keeping visible was necessary for the SNA to recognize and identify salient issues.

> This visibility is important; I need to feel the staff out there. I need to get a sense of what goes on in their heads and what bothers them... Otherwise, my only context is the DON. Not saying that they are not excellent, but I need more than that. (SNA004)

In addition to the in-hospital component of visibility, two SNAs described a component external to their organizations. They shared the expectation that the SNA ought to become knowledgeable of community resources and ought to demonstrate leadership in the larger health care community.

> I think with health care moving in new directions, there is a great need on my part to become very visible in that community and to get to know what's out there. (SNA001)

> It really takes hard work to position yourself in providing leadership outside of your normal everyday work... I think there is an internal component of visibility and an external. I haven't done very much of the external and I'd like to do more. I'm involved in MARN but not enough... I want to get involved in a more collaborative way with the community, and see where we could bridge the gap better and facilitate the provision of health care. (SNA004)

Energy and charisma.

Three of the participants stated that their energy and enthusiasm inspired confidence. They reported these attributes were required to fulfil their leadership role and to demonstrate their commitment to the hospital, patient care, and their vision for the future.

> The minute you quit working toward improving your system; you can't today; you have to stay very current. We are fast moving here. It takes a lot of energy, and enthusiasm, but a lot of current thinking. You always have to keep putting more in. (SNA003)

> A leader has to be positive... You have to be open and say "I'm available to you. Let's talk about it. We will figure out the solution together." There has to be a real positive charismatic force. Many times you don't feel "charismatic", but I think if you are not that way, then the group feels let down... If the person in charge is not providing that positive force and positive outlook and saying "We can solve this problem. We are good at it. We've got the skills to do it. Let's do it." If you're not able to do that, people get so bogged down and their morale gets so low, that they can't get the job done. (SNA004)

Constraints

Each participant reflected on their practice and described factors that restricted or inhibited their leadership. These inhibitors comprised the category entitled constraints. Reported constraining factors varied

from one to seven per participant. The SNAs deemed this category important because it influenced and directed several aspects of their leadership. SNA004 and SNA006 requested the researcher to order their constraint variables in order of influence from the most to the least restricting (Appendices L and N). Other reported constraining variables have been validated by the SNAs but not ordered (Appendices I, J, K, and M). The category of constraints is discussed according to the major contextual variables reported by the SNAs: lack of time, cost constraints, making difficult decisions, union-management relationships, follower effectiveness, and staff turnover. Lack of support, gender, and poor physical/mental health are reported at the conclusion of this section.

Contextual Variables

Lack of time.

Four of the six participants described lack of time as a constraining variable. Three SNAs reported there was simply not enough time for developmental or creative kinds of activities.

> Time. I would say time is one of the greatest inhibitors. The days are definitely too short and the weeks aren't long enough... I have very little time other than my time - the evening time, the weekends - to look at those kind of issues. (SNA001)

Two SNAs agreed that what was really lacking was "think time" or longer periods of time for developmental issues.

> It's incredible what kind of time you don't have. In the period of a day, or even a few hours, you are

> dealing with many issues. Very infrequent, so far, has been my experience that there is a time where I can block and focus on an issue. Say, block three hours in an afternoon out, where I can take that afternoon and work. You know, go to the library and read, gather information and documents. The "think time" is what I would call that. (SNA001)

> I find time a limiting factor, and I feel there is a limit to what you can take home with you too... There are days when I don't want to take things home and I have to take things home. If you really want to work on something you need to have blocks of time when you can actually think and organize... You do need "think time". (SNA006)

Three SNAs reported that lack of control of time was constraining. They described certain factors in their worklife beyond their control as constraints to their leadership. The nursing organizational structure in one facility and the context of their worklives were given as examples.

> More time would help me. We have a very flat structure... I find it very difficult to work on developmental things because of the day-to-day things taking up so much of my time... (SNA006)

> A lot of the issues that I deal with on a daily basis; they are not things I have spent many hours preparing for... They are quick notes, information brought by somebody or myself, they are issues that need quick responses. So you find yourself constantly going from issue to issue to issue... The crisis meeting that is called because of the budget. As well as scheduled meetings, where your presence is required and expected. (SNA001)

Cost constraints.

Three SNAs acknowledged cost/resource constraints as inhibiting their leadership. Imposed financial decisions such as the Health Services Commission not picking up hospital deficits and expecting hospitals to reduce $18

million from health care in the province were given as examples. Two viewed the worry about costs as a constraint to creativity, however one SNA suggested cost constraints required a SNA to be more creative when money was in short supply.

> [Budget constraints] affects your leadership because you can only be as innovative as far as ways in which money can be saved. It's extremely difficult to do any special projects, because no matter what you do...there are usually costs attached... You have to be very ingenious to find monies to do things differently... I find it's rather restricting to have to worry about dollars. (SNA006)

> It's too late in this economic time to even consider going into a nursing model. It takes an incredible amount of time. An incredible amount of planning and time is money. (SNA002)

SNA002 reported that imposed financial decisions with government cutbacks not only had a direct impact on nursing practice but also on the future direction for nursing education. The uncertain future of collaborative programs to prepare nurses for entry into nursing practice was of particular concern for this SNA.

Making difficult decisions.

Three SNAs described making certain difficult decisions as restricting their leadership. SNA002 reported that having to make decisions which may be perceived as uncaring were particularly worrisome. One example that was provided was recognizing the need to reorganize Nursing administration again, perhaps under fewer directors, which would mean demoting some individuals.

SNA003 described how making unpopular decisions was constraining. SNA003 explained that the consequences of program and organizational changes affected people's lives, careers, and families. In these situations, SNA003 coped by arranging meetings, informing people personally, and directly confronting challenges or hostility toward the decision.

SNA006 reported it was constraining to have to make decisions that nursing staff may perceive as a lack of understanding. SNA006 believed it was important to try and explain the rationale for making certain decisions, but noted these explanations were overlooked by nursing staff in times of their own need.

> It might sound okay when you are explaining it to them [nursing staff], but a month later when you say to them you can't provide, simple example, an additional float nurse for the Emergency Department, because there just aren't budget dollars and the whole hospital is busy. They don't see beyond their immediate need... Maybe that's true with people in admin positions too. We are often not too sympathetic with our colleagues in other places because we feel our problems are greater than theirs. (SNA006)

Union-management relationships.

Although all SNAs mentioned union-management relationships, two SNAs described working with the nursing union as a constraint to their leadership. These participants described the frustrations on both sides.

> [Head Nurses] "I find this very difficult to accept. I am a member of the Union, yet I'm treated as an enemy... " As far as we in Administration were concerned, there were things we wanted to share and do

> with the Head Nurses; we felt we couldn't, as Union members. (SNA006)

One SNA noted that differing goals with the Union was a significant leadership inhibitor.

> The goals of the Union are different than my goals... The Union grieved and wouldn't allow us to do it that way. They said "You have a position; you have to fill it." But we said "We are going to have some empty spots down the road." They said "That's not according to contract. We have a signed agreement and you will follow the agreement." So they are more watchdogs, gatekeepers of the Collective Agreement, which doesn't allow for the individual situation. So, we had to go that route, and we had to then lay off people which broke my heart... I find those things inhibit my leadership, which is very personalized. I worry about individuals. So that to me has been a significant inhibitor. It has cramped my style of leadership very much. (SNA002)

In contrast, one SNA described working with the nursing union as one part of leadership that required fostering and ongoing collaboration.

> I have met with the Union... It's important that we work together. I don't believe in a We-They, and they are getting better. Now they will freely come by the door, and if I'm available they'll try and squeeze themselves in, or they'll make appointments. They'll phone and find out I'm busy but... People have to get to know one another's limits and be able to interact with one another. (SNA001)

Follower effectiveness / staff turnover.

Two SNAs agreed that leadership effectiveness is influenced heavily by follower's effectiveness.

> I would like to say that a leader is only as effective as the individuals working for them. I can't imagine having an effective leader and ineffective group. (SNA005)

SNA005 attributed leadership effectiveness to healthy team functioning. According to SNA005, previously described team

building activities were required to enhance follower effectiveness and thus SNA leadership effectiveness. This SNA believed an effective team was built on trust and established credibility, not on rigid rules and the expectation people would follow them.

SNA003 reported it was difficult at times to promote change within the organization. According to SNA003, nurses were reluctant to embrace the notion that they could initiate new changes or manage proposed changes. SNA003 attributed some of this resistance to change and the more traditional beliefs regarding the role of the nurse to nursing's long history of subservience.

SNA002 identified staff turnover as a constraint to leadership. The example cited was in regard to turnover in a Project Coordinator's position. The responsibility of the individual in this position was to publish a report of the project's implementation. Over the period of five years, four Project Coordinators occupied this position. Because of the high turnover rate, the individuals were unable to take the lead and publish a report regarding this innovative nursing project. According to SNA002, nurses did not received as much credit as was possible and the experience of nurses in this facility was not shared as widely as would have been possible with a publication.

Lack of support.

Three SNAs denoted lack of support as a leadership

constraint.

> When am I in difficulty as a leader, and when are things really tough for me is when there is no support; there is something the matter with my support system. Or I am out of sync. (SNA005)

> It [lack of support] does impair your thinking because you've got to be very clear thinking. And I have to be very cognizant when I am reaching the end. (SNA004)

Lack of support was identified as feelings of isolation, uncertainty or even competition from executive colleagues.

> This is a very political environment... I do not get a lot of support from my colleagues. Suffice it to say there is some competition from some people, even though I don't prefer to have that competition... If I'm looking for support I would probably talk to the DONs. (SNA004)

Support was important to these SNAs in their respective facilities.

> Someone said to me at one time "When you get promoted or move into a position where you are one of a kind, some people mistakenly think that they have to be by themselves or alone now that they are up here. And they have no one to share with." I don't know anybody that works well for, because you become insular, isolated, out of touch, unrealistic with the demands you make on other people. (SNA005)

All the SNAs reported different sources of support. These included friendship from individuals at work, Directors of Nursing at work, individuals in their personal life, and networking with SNAs in other facilities. SNA004 did not find perceive CEO support while SNA006 found the CEO very supportive.

> I work very closely with my [CEO]. He uses me as a 'sounding board'. I appreciate that because I feel very well informed about what his plans are and what

the hospital is facing. (SNA006)

Poor physical / mental health.

Three SNAs described how poor physical and mental health were constraining variables to their leadership.

> And this is my fear, sometimes when you are so tired and you are not 'with it' enough, you get overwhelmed. (SNA004)

> I have to look after myself... In order to be able to carry out that load [workload] I have to be physically well, well rested. I have to keep up with my reading, I have to find outlets for my frustration. (SNA005)

Identified coping strategies included regular weekly walking and keeping up with reading.

> I always know when I'm starting to deplete. I will definitely pick up on my reading... I take on a different kind of challenge and I will seek out courses. (SNA003)

Gender.

Two SNAs described gender as a mediating variable in their perspectives. Although neither of the SNAs could confirm whether gender was an inhibitor or promoter in leadership, it nonetheless influenced their perspective. In the context of job interviews, SNA004 reported several gender-related comments from males about females but noted that females seemed to refrain from making comments about males.

> The male/female ratio is a factor...that you can't avoid. You just have to be conscious of it. It will probably never go away. (SNA004)

SNA003 explained the influence of gender as stemming from the history of nursing subserviency.

> It doesn't mean that [gender] is a detriment, but I've certainly/probably had to work harder than some of my ... counterparts; for example, Finance or Medicine. Those portfolios come with some unwritten credibility... (SNA003)

Summary

In this chapter, the individual perspectives of the research participants regarding leadership have been described. The elements of their perspective (e.g., team building, attaining and maintaining competency) were identified by means of concept maps, and compared and contrasted in the qualitative analysis. The research findings proposed that SNAs lead in their practice as nurses. The assumptions underlying the practice of nursing guided the SNAs in their leadership role and decision making. Several internal and external contextual or environment variables which influenced the SNAs' enactment of leadership were described.

Chapter Five

DISCUSSION OF THE FINDINGS

Chapter Five is an analysis of the research findings presented in Chapter Four. The analysis occurred within the framework of symbolic interaction, focusing on the meaning of the leadership experience shared by the SNAs. The first part of the analysis included a comparison of the findings with current theoretical frameworks of nursing leadership. A summary comparison is included in Appendix O. The second part of the analysis is a discussion of the SNAs who lead out of their practice as nurses. The discussion entailed a comparison of the research findings with the domains of nursing as detailed by Benner (1984). A summary is included in Appendix P. Chapter Five ends with the implications of the research findings for nursing practice, education, and research.

Comparison of Findings with Theories of Leadership

Attaining and Maintaining Competency

A number of theories of leadership have addressed leadership effectiveness. However, only some aspects of the SNAs' experience are reflected in the current theories of nursing leadership. The categories of the research findings are subsumed by several elements in various leadership theories. No one theory encapsulated the entirety of the SNA experience. Vanance (1989) concluded, in her review of

leadership theories, that no one leadership theory captured the essence of leadership in nursing.

Vision.

Vision was part of charisma, the most important characteristic of transformational leadership theory (Bass, 1985). According to Bass, charismatic leaders had high self-confidence, a strong need to influence others, superior communication skills, were visionary, had an action orientation, and behaved in a manner which aroused the motives and emotions in their followers relevant for mission accomplishment. Thus, charisma was based on both the behaviour and qualities of the leader, as well as on the needs, values, and attitudes of the followers (Bass, 1990).

Leaders who used visionary skills created pictures of the future and shared their vision with others to create a new reality for both the leader and followers (Tichy & Ulrich, 1984). The SNAs described how they were expected by their staff to have this futuristic outlook. All the SNAs utilized every opportunity to share their vision of what the Nursing department could become in the hospital. They recognized the need to keep their vision current, and they utilized their networking and spokesperson roles to communicate their vision. The findings reflected that envisioning was a lonely process which is not represented in any current theory of nursing leadership.

Being proactive.

Being proactive was part of transformational leadership theory and was also included in the Interactive Leadership model. "Transformational leaders display anticipatory, visionary, value congruence, empowerment and self-understanding skills"(Byrd, 1987). Anticipatory skills and planning ahead are used by leaders who believe the world is constantly changing. Anticipatory skills included information seeking, establishing trust and confidence, and projecting consequences and risks to the organization (Bass, 1985; Bennis & Nanus, 1985; Byrd, 1987). The research findings demonstrated the SNAs' anticipatory skills. They read journals, monitored societal trends, and networked with colleagues to get the most current information. They described the importance of accepting change as a constant and of managing change. They planned ahead for the introduction of new concepts like total quality management, self-governance, or collaborative baccalaureate nursing education. All the participants engaged in self-directed learning activities and networking to keep current or to address a learning need. The SNAs believed that being open to learning positively influenced their ability to envision the future for nursing in their hospital.

In every major decision the risks and benefits to the organization were considered. SNA decisions were influenced by their value of responsible and fair leadership. Other

values such as trust, respect for individual nurses, teamwork, and commitment to quality patient care were espoused and reflected in their decision making.

Educating.

The developmental orientation of transformational leadership was evident in the educating cluster of concepts which reflected the individualized consideration and intellectual stimulation dimensions. A wide range of teaching strategies were utilized, including coaching staff who needed help. Some of the SNAs utilized the strategy of encouraging review and reflection to stimulate their DONs. They challenged their DONs to think about problems in new ways. They sought their feedback or ideas for improvements to the organization. The leader as teacher was also reflected in the Interactive Leadership model and to a lesser extent in Situational Leadership Theory.

In a non-strike situation, SLT, as proposed by Hersey and Blanchard (1988) and Hersey and Duldt (1989), reflected some of the SNAs' leadership experience. In SLT, the leader considers the task to be accomplished and the readiness of the followers. The SNAs discussed having to change their approach from support of practice to coaching for individuals who required increased direction.

Bennis and Nanus (1985) described the transformational leader with self-understanding skills as one who is able to understand their own strengths and limitations. Self-

understanding reflected the desire to know yourself and the openness for performance feedback. The findings demonstrated these transformational beliefs in both the team building and attaining and maintaining competency categories. Part of building interpersonal relationships entailed maintaining an open and honest rapport with staff and colleagues. Expecting and encouraging feedback regarding performance was promoted. Lack of feedback about work performance was cited as a constraint to leadership.

The research participants said more about leadership effectiveness. To them, a leader was only as effective as the employees believed them to be competent and credible. Building an interpersonal relationship and demonstrating ability to establish credibility was reported by the SNAs. Valuing the complementary role of leader and follower is reflected in the Interactive Leadership model. However, it does not account for the SNAs' report of their need to demonstrate credibility among colleagues and with staff.

Information Sharing

The importance of communication as essential between SNA and staff in this study was not surprising. This finding was an important concept in all the leadership theories and anecdotal articles reviewed in this report. It is of significance that all SNAs perceived the importance of communicating. They valued and shared several similar communication strategies (e.g., networking).

Formal structures.

The SNAs encouraged two-way communication as proposed by Fleishman and Harris (1962). They expected this of colleagues and their staff. They set up several mechanisms in order to effect two-way communication such as forums, fireside chats, and formal meetings. A review of each SNA's nursing organizational chart revealed formalized reporting channels. These formal structures for information sharing which are reflected in Initiating Structure as theorized by Fleishman and Harris made information flow more manageable. SNAs dealt with a large volume of written information and discussed battling with the in-basket. The participants valued their time with people more than their time with paper. Therefore, these structures were not seen as bureaucratic hurdles but as helpful and necessary systems.

Informal structures.

The informal structures utilized by the SNAs for information sharing are partially addressed by the leadership theories. Activities such as maintaining visibility by walking around the nursing units, having an open-door policy, encouraging nurses to stop by their office and initiating informal interactions, were perceived as ways to find out information about their performance and a gauge of how they were doing. Learning from others, particularly through their networks of contacts with SNAs in other institutions, was perceived as invaluable. The participants

valued the narratives of colleagues as information to assist them in making similar decisions or to resolve problems. Kramer and Schmalenberg (1988b) found informal communication to be an integral characteristic of magnet hospitals in their study.

SNAs particularly required informal and temporary mechanisms for communicating effectively in times of crisis. During the Nursing Strike of 1991, the more consultative approach to leadership for two SNAs changed. One assumed an in-charge responsibility and viewed the hospital as though it were one unit. A "disaster headquarters" was established. Tasks were assigned by the SNA to the available personnel. Planning ahead, organizing and attempting to "take the heat off all the staff" were emphasized.

Another SNA's role during the strike was slightly different. This SNA expected other senior non-nursing management staff to meet with the Union and consult as needed. The belief in "example leadership" led this SNA to the patient's bedside. From the bedside this SNA could plan and support management nurses and other nursing personnel in patient care activities. In the two situations described above, the theoretical constructs of Initiating Structure and Consideration partially explain the SNA's leadership experience.

During the January 1991 Nursing strike, the SNAs were

faced with multiple variables: reduction in the number of nurses to provide patient care, management nurses with less current clinical expertise, support personnel with no direct patient care experience, increased numbers of meetings with the Union, the Essential Services agreement, and changing relationships with management colleagues. The nurses provided for in the Essential Services agreement were unused to working with reduced numbers of nurses and with the variety of personnel provided for their units. As well, this new staff was inexperienced working together as a group and differences in expectations emerged. In this crisis, SLT proposed by Hersey and Blanchard (1988) most closely reflected these SNAs' leadership experience as they adapted to the changes required of them in the nursing strike. Their behaviour was highly task-oriented, and yet they maintained relationships with their staff. The sharing of food and narratives related to the strike experience was perceived as necessary to maintain an effective working climate.

The Directors of Nursing in Anderson's (1992) study demonstrated a similar change in leadership during the initial phases of the 1991 Nursing Strike. They reported their previous participative leadership style was inefficient in this situation and adopted a more autocratic leadership style. Anderson likens their directive approach which resulted in effective hospital management to the

"intelligence, command, control, and communication structures"(p.140) of a military organization.

Information flow.

Information flow is partially explained by Initiating Structure (Fleishman & Harris, 1962). Structuring activities, such as establishing ways of getting things done and assigning tasks, were utilized by all participants when they were required to communicate effectively with large numbers of staff. Formalized rules for receiving and disseminating information were useful channels for the SNAs to direct information flow within the organization.

Information flowed in several directions: up to senior management, down to staff, and across to colleagues both inside and outside the organization. In this "nerve center"(p.72) role, the SNAs could be compared to Mintzberg's (1973) managers. The participants in this study established their own formal and informal communication networks within and outside the hospital. These networks were seen as valuable sources of information to do their job.

Nursing spokesperson.

Articulating vision through the spokesperson role is accounted for in transformational leadership. Here the SNAs demonstrated visionary, charismatic leadership where they took every opportunity to represent the facility or the nursing profession. The SNAs consistently described how

important their networking role was in representing nursing in the hospital, to corporate colleagues, and to the public. Although some of the SNAs described feelings of uneasiness with cameras and the media, they stated they would never miss an opportunity to speak on behalf of nursing.

The SNAs reported how in all their communications and in sharing their vision, they believed they had to remain positive, even when they did not feel that way. They felt they had to keep up the appearance of being rested and enthusiastic because the confidence of staff depended on them looking optimistic and cheerful. Transformational leadership theory addresses the motivational aspect of charisma and the Interactive Leadership model emphasizes a positive outlook. No theory of leadership discussed the SNAs' sense of responsibility for staff morale in the same way.

Decision Making

Collaborative.

The SNAs expanded Fleishman and Harris' (1962) proposal in regard to Consideration. According to the Fleishman and Harris theory, the leader allows staff input into decision making. In this study, the participants promoted and expected independent decision making among their staff. They set up systems whereby information would be directed to them to help in their decision making. They were available for support or as a facilitator to assist their staff in

making their own decisions. Once the staff members' decisions were made, the SNAs respected them. The charismatic component of transformational leadership, the participative component of SLT, and the participative approach to decision making in the theoretical model of Interactive Leadership accounted for the SNAs' collaborative approach to decision making.

Independent.

Initiating Structure partially reflected the SNAs' experience in making independent decisions, however the action orientation of charisma in transformational leadership theory accounted more fully for the SNAs' experience. At times the participants made tough decisions on their own without staff involvement. They perceived that staff did not want involvement in these decisions and expected the SNA to be able to deal with the decision alone. The participants explained they were expected by their staff to make difficult decisions, to keep visible, and to take independent action to solve certain problems.

According to SLT, leadership effectiveness depends on the demands of the situation. The SNAs stated they preferred a collaborative or participative approach in making decisions. SLT described this as a participative or delegating style. The participants explained that at times when decisions were difficult, such as making program and staffing changes, they took independent action which

reflects a more "telling" approach. In the previously described Strike situation, the SNAs changed their leadership style; they perceived their followers to require direction rather than consultation.

Davis (1989) has said that a limitation of SLT in nursing was that the greatest influence on a nurse leader's decision making is the profession, not the setting. The research findings suggest that when the SNA was required to make a decision about a problem which had jeopardized patient safety or welfare, the usual leadership style was altered to be authoritative and, at times, punitive. This reflects the leader's professional practice values and standards, rather than merely the nature of the situation itself.

Maintaining balance.

Portions of several theories reflected the SNAs' balancing experience. The theoretical constructs of Initiating Structure, Consideration, Sensitivity, and Social Awareness reflected the balancing between individual needs and institutional goals. SLT reflected the consideration given to follower readiness in goal setting and performance expectations. Transformational leadership theory in both the charismatic and individualized consideration constructs reflected the SNAs' experience where they balanced firmness and kindness, assertiveness and diplomacy, and encouraged independence while maintaining some control.

None of the theories addressed balancing quality patient care versus cost effectiveness. This may be explained in part by the dilemma faced by the SNAs where, on one hand as a nurse, they are committed to excellence in nursing practice and quality patient care. On the other hand as a manager, they deal on a daily basis with shrinking human and financial resources, rapid changes in technology, and changing demographics in their nursing staff.

Factors influencing decision making.

Several internal and external contextual variables were reported which mediated the SNAs' leadership experience. Transformational leadership theory addresses that both leader and followers needs are significant. The Interactive model (Rosener, 1990) suggested that women lead differently from men. This has been transposed to the nursing profession. The participants in this study were selected on the basis of their role. If gender were to be considered as a factor in decision making, a larger group of participants or a different methodology would be necessary in order to make conclusions about the influence of gender on decision making in leadership.

The LBDQ measurement tool and transactional theories noted the leader's time as an element to be planned and managed. The SNAs referred to time more as a constraint to their practice. Because of their belief that they should be available to staff and their acknowledgement of the benefits

of an open-door policy, the SNAs may have been unable to effectively manage their time. Consequently, time for reflection and planning was limited.

Making difficult decisions.

Situational leadership theory discussed the impact of a situation as a variable which affected how decisions were made. SNAs reported that decisions related to the good of the institution which would result in a decrease in positions or services were very difficult. They feared the staff would view these unpopular decisions as not caring and that their explanations for the decision would be misunderstood. No theory of leadership discusses the conflict experienced by the SNAs when required to make decisions which might be perceived as uncaring.

SNAs reported they were frequently uncertain about whether they had made a correct decision. Some actively sought feedback from their staff as to the staff's perceptions of the appropriateness of the decision. This feedback was one way of determining their leadership effectiveness.

Team Building

All the participants participated in team building activities. They referred often to their people-orientation, to their need to get to know people professionally, and to the need to establish and maintain interpersonal relationships. Using interpersonal skills and

interpersonal influence was utilized to help people make their own decisions, to help staff develop their own abilities and skills, and to manage change.

Building relationships.

All the participants engaged in considerate behaviour as proposed by Fleishman and Harris (1962). However, the participants acknowledged that they did much more than merely consider their employees. The SNAs emphasized a deep concern and caring about group members' needs. They believed their relationships with each other and with staff had to be founded upon mutual trust, respect, and reciprocal appreciation. According to Bass (1985), charismatic leaders had the ability to understand the necessity of building on the needs, values, and hopes of the followers. The SNAs' actions in establishing this interpersonal relationship and using interpersonal influence with their followers can be described as charismatic behaviours of transformational leadership as proposed by Bass.

These interactive processes, of relating and influencing, also occurred in the Interactive Leadership model. This interdependence was seen as necessary for commitment to goals and team functioning. The participants discussed the importance of being open intellectually with followers for new ideas, and with themselves regarding their strengths and limitations. These self-understanding skills were a component of transformational leadership.

Being there for staff.

Role modelling the importance of team, relationships, buffering, and sharing activities are reflected in the Interactive Leadership model and implied in the charismatic component of transformational leadership. The research findings confirm several examples of these activities.

Inspiring confidence.

Keeping visible, having vision, demonstrating confidence, and a positive outlook were part of the charismatic component of transformational leadership and the Interactive Leadership model. The participants explained how being available to their staff, offering support, and maintaining a positive outlook were perceived as important actions and attitudes which the SNAs believed inspired confidence among their staff.

The participants discussed the importance of keeping physically and mentally healthy in order in have to the energy to make competent decisions and to inspire confidence in their staff. Humour was used as both a cathartic and a team building strategy. In jokes, laughing at oneself, and sharing funny stories were perceived as cementing the nursing team. The leadership theories do not address the importance of humour in the SNAs' experience.

Constraints

House, Spangler, and Woycke (1991) suggested the conditions under which transformational leadership would be

more appropriate. Situations of crisis, of turbulence or change, where a combination of highly involved and interactive leadership, emotional commitment, and an extraordinary effort by both leader and follower are situations where charismatic/transformational leaders could make their greatest contribution. In the rapidly changing milieu of the hospital environment, it was appropriate for the SNAs to demonstrate transformational leadership attributes.

SLT looked at variables in the environment but it was not specific enough in nursing to address the constraints identified by the SNAs. SNAs identified lack of time, cost constraints, and having to make decisions which had an impact on the welfare of others, union-management relationships, and follower effectiveness / staff turnover as constraints. Lack of support in the organization was also identified as a constraint to leadership. Larsen (1983) alluded to lack of support in her call for organizational power for nurse leaders to support nursing demands and decisions in hospitals.

Summary

There are some significant omissions in the current theories of leadership, specifically in regard to the conflicts which arise in nursing leadership that relate to issues of professional practice and patient welfare. Many

of the research findings are captured under the charisma element of the transformational theory. The transactional activities of leadership were mentioned infrequently (i.e., dealing with incidents of professional malpractice, and rewarding the efforts of administrative team during a retreat).

The interdependence of leader and follower has only recently been recognized in the theoretical model of Interactive Leadership. However, the model was insufficient in explaining all of the SNAs' perspectives regarding leadership. This may be explained as a limitation of this model.

It may also be proposed that because nursing leaders work with many male hospital administrators, they may adapt their perspective regarding leadership to reflect a patriarchal approach. Therefore, any theory of leadership which suggests that SNAs lead as women may be inaccurate. Yet another explanation is suggested in the following section of this report: nursing administrators lead as nurses. Therefore, any theory of nursing leadership which does not capture the elements of nursing practice will be inadequate in explaining this phenomenon.

The participants suggested that reciprocity is an essential characteristic of interactions between themselves and their staff. Reciprocity is demonstrated by expectations for mutual respect of each other's competency

and credibility, as well as for openness and honesty. The leader and the staff were expected to learn from one another. No theory of leadership addresses this. It is frequently implied in the theories that leadership is something that is "done to" the staff, rather than as a mutually beneficial process.

Domains of Nursing Leadership

The theories of leadership have failed to capture that which was reported by the research participants as the elements of nursing leadership. However, the findings can be appropriated within the domains of the nursing profession, as identified by Benner (1984). The match of the domains of nursing with those identified by the SNAs are discussed in this section of the report. The significance of this comparison is discussed.

The Helping Role

The goal of nursing is to assist the patient to realize their goals for health. According to Benner (1984), nurses created a climate for health by providing comfort measures, being with the patient, empowering the patient in their self-care decisions, and providing relevant information, emotional support and guidance through times of change. SNAs created a climate for a "healthy" working relationship. They did so by valuing and respecting their employees, by being a visible and credible presence, and by encouraging

the staff to collaborate in organizational decisions. Other helping behaviours of SNAs included "taking the heat off" staff by making difficult and painful decisions independently and emulating a positive, optimistic outlook.

The Teaching-Coaching Function

According to Benner (1984), nurses have learned to communicate with and teach patients who are in unfamiliar environments and who are ill. The nurses in Benner's study explained their teaching and coaching occurred in the context of daily patient care activities and was timed to respond to patients' readiness to learn. They shared, through their exemplars, how they assisted patients to integrate their current illness into the context of recovery by being open to their patients' perspectives regarding their illness, and by providing contextual explanations for new experiences.

The SNAs valued and created a teaching-learning environment in their hospitals. Educating others was accomplished by creating and providing learning opportunities for nursing staff. They stressed the importance of clear, timely communications, sharing information informally, and encouraging collaborative decision making. Where nurses in Benner's (1984) study spoke of integrating the implications of illness and recovery into their patients' lifestyles, the SNAs described how they planned the integration of their Head Nurses into

the global picture of hospital functioning.

Based on established interpersonal relationships with staff (e.g., DONs, Head Nurses), the SNAs' coaching role emerged. They coached by role modelling, encouraging review and reflection, and guiding DONs and Head Nurses who needed help while delegating authority and responsibility to others who were ready for it. Being open to staff and being there for them resulted in the SNAs' self-learning.

The Diagnostic and Monitoring Function

According to Benner (1984), nurses underestimated their diagnostic and patient monitoring functions. With the rapidly changing technologies in nursing practice, Benner described how the nurses "careful monitoring and early detection of problems are the patient's first line of defense"(p.95). In this domain, Benner's nurses engaged in "future think"(p.102), where they anticipated the future course of a patient, what problems might occur and what their response would be. The expert nurses were careful to make their observations grounded in the meaning the patient had and tried to act as a positive, patient advocate.

In the context of the SNAs' worklives, their diagnostic and monitoring functions were applied to their immediate nursing staff, the patients as a whole and the hospital. The participants had established intricate internal and external systems whereby information relating to changes in the hospital or the Canadian health care system would be

detected. They were proactive and continually envisioned what future concepts, technologies, or resources would have an impact on nursing staff and patient change. The SNAs' observations were grounded in the meaning their staff had based on their interpersonal relationships with them (e.g., DONs, Head Nurses). They took every opportunity to promote staff participation in decision making, and to promote or share the positive accomplishments of nursing staff.

Effective Management of Rapidly Changing Situations

Through the exemplars in this domain, Benner (1984) described the importance of the nurses' ability to coordinate the roles of the health care team members in emergency situations. These nurses were able to rapidly grasp the patient's problems and were able to match the patients' needs to available resources. Benner acknowledged that "the nurse walks a fine line"(p.116) and balances safe practice within the domain of nursing and aspects of medical life-supporting practices in emergency situations.

Hospitals in today's health care system can be characterized by the following descriptors: constantly changing, rapidly changing technologies; increased amount and flow of information; and shrinking human and financial resources. SNAs by virtue of their role are expected to effectively manage the turbulence until new equilibriums can be attained. The SNAs in this study utilized several strategies to manage these changes in their environment.

They inspired confidence by having vision, remaining optimistic, and demonstrating their ability by being knowledgeable of actual and potential changes and the impact on the nursing staff and patient care. They took action by making difficult decisions. They utilized themselves as a buffer to defend or protect their staff from disruptive influences. They constantly balanced the available resources and patient care needs. While physician assistance eventually became available to the nurses in Benner's (1984) study, assistance in relation to helping the SNAs cope with these situations came in the guise of support from other SNAs in other facilities, their nursing team, self-learning activities, previous experience, and inconsistently from their CEOs and senior management colleagues.

Administering and Monitoring Therapeutic Interventions and Regimens

Benner (1984) asserted that nurses underestimate the knowledge and practical expertise embedded in administering complex therapeutic interventions. According to Benner, nurses have inherited these responsibilities in an ad hoc way, either from physician delegated practices or from having to implement a new concept or therapy in practice without advance planning. The exemplars in Benner's study demonstrated the nurses skilled performance, positive attitude, and caring manner in preventing hazards of

immobility.

Although the context of the SNAs practice differed from the nurses in Benner's (1984) study, their approach to implementing change and monitoring the effects of planned changes was similar. The SNAs described how they kept current with new concepts and procedures. They often planned years ahead for implementation of these concepts or procedures in the Nursing department. They were visionary, proactive, and constantly encouraged professional growth and development among their staff. The SNAs preferred to implement changes in a collaborative way: a team approach. They created formal and informal structures for feedback and monitored the effects of planned changes. Their caring was evident in their desire to "be there" for staff, their openness and willingness to correct, modify, or withdraw a planned intervention if it did not work.

Monitoring and Ensuring the Quality of Health Care Practices

Benner (1984) described how nurses were in the best position to safeguard and coordinate the patient's total plan of care. In this domain, nurses used their skilled clinical judgement to determine when changes or omissions to the patient's plan of care could occur. The exemplars in this domain reflected the frustration and problems they encountered in getting appropriate, timely responses from physicians. Benner concluded that the patient would benefit from improved communication and collaboration among nurses

and physicians.

Although the SNAs had infrequent direct contact with patients they continued to monitor the quality of health care practices in their hospitals. They utilized several strategies to attain this goal: educating staff, encouraging collaborative decision making in decisions affecting patient care, being proactive, and introducing new concepts and technologies to the Nursing department. In decisions relating to patient care, the SNAs tried to maintain a balance between quality of patient care and cost-effectiveness. The SNAs made difficult decisions such as temporarily suspending a nurse from practice when patient safety was jeopardized.

The SNAs monitored quality health care practices from a broad perspective, encompassing both nursing and medical practice. Formal and informal communication structures within the hospital were conduits of patient information. Monitoring of these systems enabled the SNAs to spot potential problems before they occurred or to take direct action to improve patient care. One example of direct action was to implement a multidisciplinary committee to improve the care provided to geriatric patients in acute care. They utilized their spokesperson roles and informal networks to communicate their concerns to stakeholders as well as plans for improvement.

Organizational and Work Role Competencies

Benner (1984) related how the competencies in this domain reflected the demanding and complex role of nurses in a hospital setting. The nurses in Benner's study managed with multiple patient needs and requests by organizing and planning ahead and by continually resetting their priorities. The nurses recognized the need to work together as a team to maximize effective patient care and to maintain morale among the team. They coped with staff shortages and high turnover rates by maintaining their caring attitude, by remaining flexible to constant changes in their environment, and working toward maintaining team spirit.

The context of the hospital environment affected the SNAs in a similar way. The SNAs were required to set priorities among multiple requests from their DONs, Head Nurses, and management colleagues. They utilized both independent and collaborative ways in decision making and spoke often of the need to make balanced, fair decisions. The SNAs, like the expert nurses, recognized that team building activities were essential to their own effectiveness and a means to boost morale in their nursing team.

The SNAs utilized similar coping strategies used by Benner's expert nurses. They maintained a caring attitude toward staff and patients, and were open and flexible in order to respond to frequently changing demands placed on

them. Additional coping strategies included networking, using humour, and keeping mentally and physically fit.

Significance of the Comparison

If SNAs lead out of their practice as nurses, nursing leadership cannot be studied or explained out of the context of nursing. Consequently, generic theories of leadership are irrelevant to the reality of the SNA experience. While the disciplines of management and psychology may be utilized to inform the practices of leadership in nursing, they can not account for the many unique elements which are context driven (i.e., unique to leadership within the nursing profession). The domains of nursing as identified by Benner provided a helpful structure for communicating the uniqueness of leadership in nursing administration to nursing students and staff. These domains may be used to structure leadership course curricula and to identify areas for further research.

Caring.

SNAs who have learned to care as nurses have incorporated caring as an epistemological system in nursing leadership in this study. Caring was modelled and enacted in all aspects of their leadership role. Educating individuals to be nursing leaders and evaluating the performance of SNAs require that nursing be acknowledged as the basis of leadership within the profession. If SNAs care for staff, grounded in their practice as nurses, some of the

same issues which must be addressed in how nurses care for patients are applicable in the study of caring in nursing leadership.

The issue of establishing boundaries of care is significant for nurse leaders. SNAs must be critically aware of the assumptions they hold regarding caring for staff which may serve to eradicate the boundaries necessary to preserve the privacy and identity of the cared-for and the care-giver. SNAs who believe it is selfish to demand time for themselves, and that they have no right to refuse a staff member their time and energy, are apt to unconsciously contribute to staff dependency and their own burnout. As well, SNAs who ignore their own needs for space and rest may communicate to staff that such self-destructive behaviour is the ideal of nursing.

The SNAs who took part in this study revealed through their beliefs and values that caring was an inherent part of their leadership. It was not possible for the researcher to isolate caring as one distinct variable; rather, it influenced all aspects of their practice. Decisions such as staff layoffs and program deletions were identified as constraints to their leadership. It may be proposed that because those decisions were in conflict with caring, they caused considerable agony to the SNA.

SNAs' caring was grounded in a relationship based on mutual respect, trust, and reciprocal appreciation. They

believed they had to be open emotionally and intellectually with their staff and shared many strategies of "being there for staff". Building interpersonal relationships with their staff was an inherent part of their caring leadership.

SNAs' caring was demonstrated in many ways. They used their power in a transformational way to empower their staff by educating, encouraging collaborative decision making, inspiring confidence, and praising efforts of their staff in a spokesperson role. They took the position of staff advocate and at times acted as a buffer to "take the heat off" staff. They make difficult decisions and suspended nurses from practice when patient safety was threatened. They envisioned changes and actively involved themselves in implementing the vision and facilitating change.

Their creative problem solving and visioning was evident when they envisioned new policies and procedures well before they were introduced into the Nursing department. Decisions were balanced among quality care for patients, care for nurses involved, and care for the "bottom line" or hospitals' budget. Through the narratives of the SNAs in this research and in the context of their practice, the participants demonstrated similar patterns of caring that nurses in Benner's (1984) study demonstrated.

Implications for Future Research

The following recommendations and research imperatives

incorporated the domains of nursing leadership in the research findings. They related to proposed changes and improvement in nursing practice, research, and education. The supposition that SNAs lead from their practice as nurses requires further testing. Research which replicates the design of this study but investigates the perspectives of SNAs in different types of health care institutions (e.g., rural hospitals, community hospitals, personal care homes, community health clinics) would be helpful. A survey of SNAs across Canada which explored their agreement with the findings of this study would also be useful.

The Helping Role

Because much of the leadership role in nursing is learned by trial and error and because there appears to be little direction about decision making which SNAs could implement to lead effectively, it is not surprising that the SNAs expressed some degree of uncertainty as to whether they had made correct decisions. A need for SNAs to be prepared for their role by studying theories of leadership which are applicable to nursing is evident.

Diekelman (1990, 1991) referred to the necessity of developing "communities of care" among nursing faculty in order to promote dialogue about what and how to teach. The participants stated that they learned much about leading from networking with one another. It would appear from the findings of this research that health care agencies should

encourage and provide the means for SNAs to engage in such discourse about their leadership. Provision of technologies such as personal computers with the capacity to send electronic mail messages would be one way of enhancing such discourse.

SNAs should be encouraged and supported in their professional development at a national level by their respective hospitals and the CNA. CEOs can assist the SNA by facilitating and publicly recognizing the SNA's commitment to their role, nursing staff, and patients. SNAs themselves can recognize and take ownership of their helping role and the contributions they make to patient care.

The Teaching-Coaching Role

Practice implications.

SNAs can and should take ownership of this teaching-coaching function and explain to others that it is part of their role. Hospitals must provide the financial and human resources to assist SNAs in promoting continued knowledge utilization and professional development among their nursing personnel. CEOs who recognize the SNA's need for continuous learning can provide for career development through seminars and workshops. CEOs should recognize and reward SNAs appropriate to their responsibility, knowledge, and skill. This kind of activity may contribute to retaining these nurses in their role.

Research and education.

The SNAs' commitment to self-learning and educating others formed a major portion of their conceptualization of leadership. These findings are in contrast to Simms' (1991) conclusions that these concepts were noticeably absent in the role of the nurse executive. Descriptive ethnographies, as suggested by Benner (1984), of effective and ineffective coaching strategies in the context of the SNA role would add knowledge and improve the skill of the SNA as coach. This knowledge would also be helpful to educators in curriculum planning.

The Diagnostic and Monitoring Function

The SNAs in this study coped with a massive amount of information on a daily basis. SNAs need to acknowledge the importance of this function. Time management strategies on a daily basis may free up time and allow for the energy required in the envisioning process in which the SNAs engaged. Descriptive research which examined what information systems were utilized by other SNAs in similar contexts would be helpful. Educators could address this aspect to assist SNAs to be psychologically prepared for their role and to teach them time management strategies.

Rapidly Changing Situations

Benner (1984) asserted that nurses must be able to manage as well as prevent crises. SNAs should acknowledge and celebrate their ability to manage daily crises in the

context of the unsettled hospital milieu. The amount of energy invested in this function is considerable. SNAs need to plan time to keep mentally and physically fit. CEOs must recognize and assist SNAs in this work and support the SNAs in these stressful times. Formal recognition by the CEO and senior management of the complexity of SNA decision making may legitimize this aspect of their role. Benner (1984) asserted that formal sanction "reduces role strain and confusion associated with unacknowledged responsibility" (p.183).

Descriptive research examining the changes in leadership style required of SNAs in both short-lived and longer periods of crises or change would be useful to practicing SNAs. For example, Anderson (1992) has noted there is a paucity of research available about the role of a SNA in a strike situation. Studies which examined SNA decision making practices in these situations could be used to improve the SNAs' performance and coping abilities. A replication of Scalzi's study in the Canadian context may reveal more fully the effective coping strategies utilized by Canadian SNAs.

By studying how experienced SNAs cope with stress and changes we can learn new ways to teach nursing students about leadership. Educators can acknowledge the contextual variables in environments when teaching crises intervention, critical thinking, and creative problem solving. In this

study, SNAs perceived they were expected by their staff to have these abilities or be able to creatively manage crises.

Therapeutic Interventions and Regimens

Benner (1984) related knowledge in this domain was hidden in procedures which did not account for thoughtful adaptations made by nurses when implementing new regimens. The SNAs in this study utilized their networks and site visits when they were implementing new concepts, programs, or technologies. Descriptive accounts of SNAs' experience in a case study format which focused on practical knowledge in implementing various strategies and evaluation of their effectiveness would be helpful to SNAs and to educators. It may be helpful for SNAs to acknowledge and communicate this aspect of their role to others. They may find that information shared in this regard may enhance their creative problem solving and decision making that go into implementing new regimens.

Monitoring Quality Health Care

Similar to the nurses in Benner's (1984) study, SNAs found this aspect of their role stressful. They agonized over whether decisions were right, and lost sleep when their decisions affected staff or program deletions. Of concern was that some of the SNAs felt unsupported in their role and at times overt competition from other senior management colleagues. It is important for the CEO to work cooperatively and collaboratively with the SNAs in making

these decisions. The CEO could also support the SNA with policy initiatives that promoted a team approach among senior managers. As well, CEOs and other senior managers could recognize and reward SNAs' very complex role.

Research which examined the narratives of SNAs and how they coped with balancing quality patient care and cost-effectiveness would also be helpful. Benner (1984) concluded that monitoring and ensuring quality of care delivered by health care members made up the "invisible glue"(p.169) that kept the system going. Studies that describe the SNA in similar and varied organizational contexts would legitimize this aspect of their role.

Work-Role Competencies

Benner (1984) concluded that nurses in her study needed "exquisite organizational and work role skills"(p.161). SNAs require the same skill set to provide the leadership required in their role. SNAs new to their role will require time to be socialized into their organizational milieu. Novice SNAs may benefit from a relationship with a mentor, an experienced SNA who has studied nursing leadership theory and research, and who would offer guidance and direction to the inexperienced SNA. An experienced and skilled DON could act as a preceptor and could contribute practical knowledge when orienting a new SNA to their workplace. Benner claimed this may help lessen "reality shock"(p.194) which a new SNA may be experiencing.

Descriptive research which examines the SNAs' experience in these new roles may reveal what strategies were effective in coping with this role transition. A narrative approach would allow for description of content and meaning associated with an event as well as processes involved (Benner, 1984). Descriptions of actual SNA nursing practice can provide a basis for planning curriculum in graduate nursing administration courses. The findings support the continued liberal arts emphasis in undergraduate nursing curricula as well as the focus on critical thinking, problem solving, leadership, and decision making. The principles of learning how to learn cannot be overemphasized.

Summary

The findings imply that leadership may have an era-specific nature. This study has captured the current era concept maps of leadership influenced by the turbulent economic times and recent developments in the role of the SNA and nursing profession. For example, leadership theories of past era such as Fleishman and Harris (1962) theorized allowed for subordinate input into decision making. The research participants in this study encouraged independent decision making among their staff.

Economic turbulence in health care is likely to continue into the near future with the present economy and

planned reform to the Canadian health care system. Transformational leadership will likely continue to be utilized by SNAs in the next decade. Concepts which appeared in the participants' concept maps (e.g., vision, being proactive, inspiring confidence, empowerment) are likely to be present in the next era.

As baccalaureate education becomes the entry level for the practice of nursing, SNAs will be working with more highly educated nurses. Rapid technological change and access to a wider array of information will continue. Leadership concept maps of the next era may contain concepts described by these participants. Newer concepts which reflect changing organizational structures such as shared governance and decentralized work teams may be added. The emphasis on managing change and educating with concepts like mentoring, coaching and precepting is likely to continue.

This chapter has included an analysis of the findings of the research study in Chapter Four. The first part of the discussion included a comparison of the findings with current theoretical frameworks of nursing leadership. The second and third parts of the analysis were organized in relation to the domains of nursing identified by Benner (1984). This was a helpful structure for communicating the uniqueness of leadership in nursing administration to practicing nurses and students of nursing. The discussion of the research findings included recommendations for

further action and study. Although Larsen (1983) called for transformational leadership to meet the expectations of the nursing profession, the findings in this study support a theory of leadership within the context of nursing. Questions have been raised which must be answered in order to more fully understand the entirety of SNA leadership.

Chapter Six

SUMMARY AND CONCLUSION

The research presented in this report was a qualitative investigation of the leadership experience of six senior nursing administrators in urban acute care community or tertiary hospitals. The study focused on the meaning of leadership grounded in descriptions of their lived experience. This entailed the research methods of interviewing, concept mapping, and document analysis. Four interviews were conducted with each participant. Concept mapping and constant comparative analysis of the data revealed each participant's leadership concept map and four main categories of leadership: attaining and maintaining competency, information sharing, decision making, and team building. A fifth category, entitled constraints, related to factors which the SNAs perceived to restrict or alter their role. The summary of the SNAs' leadership experience is presented in the context of symbolic interaction theory: SNAs' leadership perspective, variables influencing perspective, relationships, and role identification.

SNAs' Leadership Perspective

The first premise of symbolic interactionism is that meaning guides behaviour. The meaning of leadership to the SNAs encompassed their knowledge, values, and beliefs about leadership. Their world was described as one of constant change, where the SNA interacted with several individuals,

personal and contextual variables.

The comparison of the findings with the leadership theories revealed that SNAs utilized aspects from several theories in their practice. No one theory encapsulated the entirety of their experience. The elements of transformational leadership, primarily charisma - and to a lesser extent, individualized consideration and intellectual consideration - dominated their perspectives. There was considerable evidence of visionary, anticipatory, self-understanding, value congruence, and empowerment skills. Transactional skills of contingent reward and management by exception were minimally evident in this research.

Concepts and practices emanating from the Interactive Leadership model were also evident. The sharing and shifting of power between leaders and followers and the focus on problem solving, empowerment, and growth were evident in the SNAs' perspectives. To a lesser extent, the findings revealed evidence of the utilization of the theoretical constructs of Consideration and Initiating Structure and SLT in their perspectives.

Variables.

Both internal and external contextual variables which mediated their leadership were identified and described in this report. Caring emerged as being interwoven in their perspectives. The lack of time and the lack of control of their time were also significant variables and mentioned

often by the SNAs. As individuals in a busy society, the SNAs were not immune to the constraints of time.

One variable that created considerable agony for the SNAs was described as making difficult decisions. All SNAs concluded it constrained their leadership. This may be a reflection of the dilemma that arises in their role as leader/manager which was in conflict with tenets of caring and nurturing, tenets of nursing.

Relationships

The second premise of symbolic interaction is that meaning arises out of social action one has with one's fellows (Blumer, 1969). The research findings revealed that the SNAs considered building interpersonal relationship as the basis for leadership. These relationships were based on mutual trust and respect, honesty, and reciprocal appreciation. Relationship building was the most important thing to establish. Through relationships, leadership actions could occur. The participants' perspectives revealed the importance of both leader and follower and the shifting of these roles in their relationships with their teams of nurses. Relationships were a way to use interpersonal influence to effect goals; they were also utilized as sources of support by the SNAs. The research findings revealed variables which are included in the CNA definition of leadership and lend support to the CNA's use of the term "interpersonal influence" in leadership.

Role Identification

The research findings also proposed that SNAs lead out of their practice as nurses. The domains of nursing leadership proposed in the discussion are strikingly similar to the domains of nursing proposed by Benner (1984). Central to and interwoven in their role as SNAs is caring. The SNAs learned about their leadership role largely from their past experience, beliefs, and values about leadership and nursing, by trial and error, by reading, self-directed learning activities, self-reflection, and communication among their networks. Sharing of their leadership role was identified as one way of empowering their staff.

The research findings revealed that the SNAs changed their leadership style in response to the meaning of the situation to them. This kind of activity is consistent with Blumer's (1969) third premise that meanings change and are modified by an interpretive process by the person in varying situations. This was evident in the SNAs' perspectives where in one crisis situation they assumed a "command and control" kind of leadership while in another situation they became a follower and supported the decisions of their team of nurses.

Conclusion

The findings and analysis of this qualitative investigation of the experience of leadership in senior

nursing administration have been detailed in this report. The implications of the research findings were analyzed in the context of the domains of nursing proposed by Benner (1984). A number of practical suggestions for improvements in SNAs' practice in relation to specific aspects of their role were suggested. Several areas for future research in regard to leadership in senior nursing administration were identified. The implications for nursing educational programs were discussed.

The research has contributed to a more complex understanding of the nature of leadership in the context of the SNAs' worklives. The findings of the study may be utilized to identify what constitutes effective leadership in senior nursing administration. Many constraints to the SNAs' leadership have also been identified in this research. The proposition that SNAs lead out of their practice as nurses needs further testing.

The proposition that there is caring in SNA leadership warrants further study. Consistent with Benner's (1984) assertion, the design of this study did take into consideration the personal and contextual meanings associated with leadership. An unexpected contribution of this research is that caring was interwoven in the SNAs' leadership experience.

If the above propositions hold true, there are several implications. The recognition and valuing that SNAs lead as

nurses, who care about their staff and patients, may help to lessen the negative societal bias about administrative roles that Stevens (1978) and Leininger (1974) identified. The recognition by well qualified nurses in other areas of nursing that nurse administrators do lead as nurses may make the role of the SNA more attractive and a consideration for career advancement. Nurses who may be considering a career move may find comfort in knowing that in this new role, they would still be nursing and that their caring would not be eroded by such a move. Is it not time to recognize and celebrate the complexity, responsibility, and inherent worth in the leadership provided by senior nursing administrators? Nurses, by extending a community of care to include SNAs, can empower nursing more so by utilizing their power and caring to contribute to excellence in nursing leadership.

REFERENCES

Adams, C. (1990). Leadership behavior of chief nurse executives. Nursing Management, 21(8), 36-39.

Alberta Association of Registered Nurses / Alberta Hospital Association Joint Committee - Nursing Manpower Issues (1984, January). Roles, responsibilities, and educational preparation of senior nurse managers. Edmonton, AB: Author.

Anderson, R. M. (1964a). Activity preferences and leadership behavior of head nurses: Part 1. Nursing Research, 13(3), 239-243.

Anderson, R. M. (1964b). Activity preferences and leadership behavior of head nurses: Part 2. Nursing Research, 13(4), 333-337.

Armiger, B. (1977). Ethics of nursing research: Profile, principles, perspective. Nursing Research, 26(5), 330-336.

Arndt, C., & Laeger, E. (1970). Role strain in a diversified role set - The director of nursing service: Part II sources of stress. Nursing Research, 19(6), 495-501.

Arndt, H. B., Di Vincenti, M., & Marriner-Tomey, A. (Eds.). (1989). Dimensions of nursing administration: Theory, research, education, practice. Boston, MA: Blackwell Scientific Publications.

Bartol, K. M. (1978). The sex structuring of organizations: A search for possible causes. Academy of Management Review, Oct, 805-815.

Bass, B. M. (1985). Leadership and performance beyond expectations. New York, NY: The Free Press.

Bass, B. M. (1990). From transactional to transformational leadership: Learning to share the vision. Organizational Dynamics, 18(3), 19-31.

Becker, H. S., & Geer, B. (1969). Participant observation and interviewing: A comparison. In G. J. McCall & J. L. Simmons (Eds.), Issues in participant observation: A text and reader (pp.322-331). Reading, MA: Addison-Wesley.

Benner, P. (1983). Uncovering the knowledge embedded in clinical practice. Image: Journal of Nursing Scholarship, 15(2), 36-41.

Benner, P. (1984). From novice to expert: Excellence and power in clinical nursing. Menlo Park, CA: Addison-Wesley.

Bennis, W., & Nanus, B. (1985). Leaders: Strategies for taking charge. New York, NY: Harper & Row.

Blake, R. R., & Mouton, J. S. (1982). Grid principles versus situationalism: A final note. Journal of Applied Psychology, 7(2), 211-215.

Blankenship, M., Wilhoit, K., & Blankenship, C. (1989). Leadership: Do it with style. Nursing Management, 20(2), 81-82.

Blumer, H. (1966). Sociological implications of the thought of George Herbert Mead. American Journal of Sociology, 71, 534-544.

Blumer, H. (1967). Society as symbolic interaction. In J. G. Manis & B. N. Meltzer (Eds.), Symbolic interaction: A reader in social psychology (pp.139-170). Boston, MA: Allyn and Bacon.

Blumer, H. (1969). Symbolic interactionism: Perspective and method. Englewood Cliffs, NJ: Prentice-Hall.

Bonaquist, P. A. (1986). What is leadership? Nursing Success Today, 3(1), 9-13.

Brown, K. C. (1988). Can you be a manager and a leader? AAOHN Journal, 36(3), 123-124.

Brown, S. M. (1979). Male versus female leaders: A comparison of empirical studies. Sex Roles, 5(5), 595-611.

Brueckner, S. J. (1978). The evolving field of nursing administration. In C. H. Slater (Ed.), The education and roles of nursing service administrators (pp.9-20). Battle Creek, MI: W. K. Kellogg Foundation.

Bryman, A. (1986). Leadership in organizations. London: Routledge & Kegan Paul.

Burns, J. M. (1978). Leadership. New York: Harper & Row.

Burns, N., & Grove, S. K. (1987). The practice of nursing research: Conduct, critique and utilization. Philadelphia, PA: W. B. Saunders.

Byrd, R. E. (1987). Corporate leadership skills: A new synthesis. Organizational Dynamics, 16(1), 34-43.

Campbell, R. P. (1986). Does management style affect burnout? Nursing Management, 17(3), 38A-38D, 38F, 38H.

Canadian Nurses Association (1983a). Position paper on the role of the Nurse administrator and standards for nursing administration. Ottawa, ON: Author.

Canadian Nurses Association (1983b). Ethical guidelines for nursing research involving human subjects. Ottawa, ON: Author.

Canadian Nurses Association (1985). A national plan for nursing administration in Canada. Ottawa, ON: Author.

Canadian Nurses Association (1988). The role of the nurse administrator and standards for nursing administration. Ottawa, ON: Author.

Chapman, J. B. (1975). Comparison of male and female leadership styles. Academy of Management Journal, 18(3), 645-650.

Chenitz, W. C., & Swanson, J. M. (1986). From practice to grounded theory: Qualitative research in nursing. Menlo Park, CA: Addison-Wesley.

Cohen, J. S. (1989). Occupational stress among nurse executives. Nursing Administration Quarterly, 13(3), 41-46.

Cottingham, C. (1988). Transformational leadership: A strategy for nursing. Today's O.R. Nurse, 10(6), 24-27.

Cronin-Stubbs, D. (1977). Job satisfaction and dissatisfaction among new graduate staff nurses. Journal of Nursing Administration, 7(10), 44-49.

Curphy, G. J. (1991). An empirical evaluation of Bass' (1985) theory of transformational and transactional leadership (Doctoral dissertation, University of Minnesota, 1991). Dissertation Abstracts ,52(5), 2804-B.

Danielsen, S. L. (1978). Independent study program in patient care administration: University of Minnesota. In C. H. Slater (Ed.), The education and roles of nursing service administration (pp.78-86). Battle Creek, MI: W. K. Kellogg Foundation.

Davidhizar, R. (1991). When women lead. Today's O.R. Nurse, 13(9), 8-12, 30-31.

Davis, M. Z. (1986). Observation in natural settings. In W. C. Chenitz & J. M. Swanson (Eds.), From practice to grounded theory: Qualitative research in nursing (pp.48-65). Menlo Park, CA: Addison-Wesley.

Davis, N. K. (1989). Relationship of organizational culture and leader effectiveness of the nurse executive (Doctoral dissertation, Columbia University Teacher's College, 1989). Dissertation Abstracts International, 50(4), 1323-B.

Day, D. R., & Stogdill, R. M. (1972). Leader behavior of male and female supervisors: A comparative study. Personnel Psychology, 25, 353-360.

Diekelman, N. (1990). Nursing education: Caring, dialogue, and practice. Journal of Nursing Education, 29(7), 300-305.

Diekelman, N. (1991). The emancipatory power of the narrative. In NLN, Curriculum revolution: Community building and activism (pp.41-62). New York, NY: NLN.

Dobbins, G. H., & Platz, S. J. (1986). Sex differences in leadership: How real are they? Academy of Management Review, 11(1), 118-127.

Drew, N. (1989). The interviewer's experience as data in phenomenological research. Western Journal of Nursing Research, 11(4), 431-439.

Dunham, J. (1989). The art of humanistic nursing administration: Expanding the horizons. Nursing Administration Quarterly, 13(3), 55-66.

Dunham, J., & Fisher, E. (1990). Nurse executive profile of excellent nursing leadership. Nursing Administration Quarterly, 15(1), 1-8.

Dunham, J., & Klafehn, K. A. (1990). Transformational leadership and the nurse executive. JONA, 20(4), 28-34.

Duxbury, M. L., Henly, G. A., & Armstrong, G. D. (1982). Measurement of the nurse organizational climate of neonatal intensive care units. Nursing Research, 31(2), 83-88.

Duxbury, M. L., Armstrong, G. D., Drew, D. J., & Henly, S. J. (1984). Head nurse leadership style with staff nurse burnout and job satisfaction in neonatal intensive care units. Nursing Research, 33(2), 97-101.

Edwards, J. B., & Lenz, C. L. (1990). The influence of gender on communication for nurse leaders. Nursing Administration Quarterly, 15(1), 49-55.

Ehrat, K. S. (1990). Leadership in transition. Journal of Nursing Administration, 20(10), 6-7.

Elbaz, F., Hoz, R., Tomer, Y., Chayot, R., Mahler, S., & Yeheskel, N. (1986). The use of concept mapping in the study of teachers' knowledge structures. In M. Ben-Peretz, R. Bromme, & R. Halkes (Eds.), Advances of research on teacher thinking (pp.45-54). Netherlands, Le Tilburg: International Study Association for Teacher Thinking.

Evans, H. (1988). Message from the president of the Canadian nurses association. Canadian Journal of Nursing Administration, 1(1), 6-7.

Everly II, G. S., & Falcione, R. L. (1976). Perceived dimensions of job satisfaction for staff registered nurses. Nursing Research, 25(2), 346-348.

Fine, R. B. (1983). The supply and demand of nursing administrators. Nursing and Health Care, 4, 10-15.

Fisher, B. M. (1987). Consideration, initiating structure, and leader effectiveness: A meta-analysis (Doctoral dissertation, School of Advanced Studies of Illinois Institute of Technology, 1987). Dissertation Abstracts International, 49(4), 1089B.

Fleishman, E. A., & Harris, E. F. (1962). Patterns of leadership behavior related to employee grievances and turnover. Personnel Psychology, 15(1), 43-56.

Freund, C. M. (1985). Director of nursing effectiveness: DON and CEO perspectives and implications for education. The Journal of Nursing Administration, 15(6), 25-30.

Fry, S. T. (1986). Moral values and ethical decisions in a constrained economic environment. Nursing Economics, 4(4), 160-164.

Gilmore, T. N. (1990). Effective leadership during organizational transitions. Nursing Economics, 8(3), 135-141.

Glaser, B. G., & Strauss, A. L. (1967). The discovery of grounded theory: Strategies for qualitative research. Chicago, IL: Aldine Publishing.

Glazer, M. (1982). The threat of the stranger: Vulnerability, reciprocity, and fieldwork. In J. E. Sieber (Ed.), The ethics of social research: Fieldwork, regulation, and publication (pp.49-70). New York, NY: Springer-Verlag.

Gooding, B. A., & MacKenzie, F. (1988). Education for nurse administrator roles. In L. Besel & R. G. Stock (Eds.), Benchmarks I: A source book for Canadian nursing management (pp.166-176). Toronto, ON: Carswell.

Goodwin, L. D., & Goodwin, W. L. (1984). Qualitative vs quantitative research or qualitative and quantitative research. Nursing Research, 33(6), 378-380.

Gottlieb, T. W. (1990). Transactional and transformational styles of chief and associate chief nurses in Department of Veterans' Affairs Medical Centers: A descriptive study (Doctoral dissertation, Columbia University Teachers College, 1990). Dissertation Abstracts International, 51(7), 3322-B.

Guba, E. G., & Lincoln, Y. S. (1989). Fourth generation evaluation. Newbury Park: SAGE.

Haase, J. E., & Myers, S. T. (1988). Reconciling paradigm assumptions of qualitative and quantitative research. Western Journal of Nursing Research, 10(2), 128-137.

Hagerty, B. M. K., & Early, S. L. (1992). The influence of liberal education on professional nursing practice: A proposed model. Advances in Nursing Science, 14(3), 29-38.

Halpin, A. W., & Winer, B. J. (1957). A factorial study of leader behavior descriptions. In R. M. Stogdill & A. E. Coons (Eds.), Leader behavior: Its description and measurement (pp.39-51). Columbus, OH: Ohio State University.

Hambleton, R. K., & Gumpert, R. (1982). The validity of Hersey and Blanchard's theory of leader effectiveness. Group and Organizational Studies, 7(2), 225-242.

Henry, B., O'Donnell, J. F., Pendergast, J. F., Moody, L. E., & Hutchinson, S. A. (1988). Nursing administration research in hospitals and schools of nursing. JONA, 18(2), 28-31.

Hersey, P., Angelini, A. L., & Carakushansky, S. (1982). The impact of situational leadership and classroom instruction on learning effectiveness. Group and Organizational Studies, 7(2), 216-224.

Hersey, P., & Blanchard, K. H. (1969). Life cycle theory of leadership. Training and Development Journal, May, 26-34.

Hersey, P., & Blanchard, K. H. (1988). Management of organizational behavior: Utilizing human resources (5th ed.). Englewood Cliffs, NJ: Prentice-Hall.

Hersey, P., Blanchard, K. H., & LaMonica, E. L. (1976a). A situational approach to supervision: Leadership theory and the supervising nurse. Supervisor Nurse, 7(5), 17-22.

Hersey, P., Blanchard, K. H., & LaMonica, E. L. (1976b). A look at your supervisory style. Supervisor Nurse, 7(6), 27-40.

Hersey, P., & Duldt, B. W. (1989). Situational leadership in nursing. Norwalk, CT: Appleton & Lange.

House, R.J., Spangler, W. D., & Woycke, J. (1991). Personality and charisma in the U.S. presidency: A psychological theory of leader effectiveness. Administrative Science Quarterly, 36, 364-396.

Hunter, S. & Stahl, H. (1984). C-MAP 1.0 [Computer Program]. Ithaca, NY: Cornell University.

Jacobsen-Webb, M. L. (1985). Team building: Key to executive success. The Journal of Nursing Administration, 15(2), 16-20.

Jenkins, J. E. (1991). Professional governance: The missing link. Nursing Management, 22(8), 26-30.

Johnson, L. J. (1990). The influence of assumptions on effective decision-making. JONA, 20(4), 35-39.

Johnson, K. R., & D'Argenio, C. (1991). Management training effects on nurse manager leadership behavior. Nursing Economics, 9(4), 249-254.

Kerr, S., & Schriesheim, C. (1974). Consideration, initiating structure, and organizational criteria - An update of Korman's 1966 review. Personnel Psychology, 27, 555-568.

Kidd, C. (1989). Determinants of job satisfaction in critical care nursing: Development of a process theory. Unpublished master's thesis, University of Manitoba, Winnipeg.

Kirk, J. (1987). Being a proactive leader. JONA, 17(2), 6-8.

Kison, C. (1989). Leadership: How, who and what? Nursing Management, 20(11), 72-74.

Korman, A. K. (1966). "Consideration", "initiating structure" and organizational criteria - a review. Personnel Psychology, 19(4), 349-361.

Kramer, M., & Schmalenberg, C. (1988a). Magnet hospitals: Part I, Institutions of excellence. JONA, 18(1), 13-24.

Kramer, M., & Schmalenberg, C. (1988b). Magnet hospitals: Part II, Institutions of excellence. JONA, 18(2), 11-19.

Krysl, M. (1990). An interactive model of leadership. Nursing Administration Quarterly, 15(1), 36-43.

Larsen, J. (1983). Leadership, nurses, and the 1980s. Journal of Advanced Nursing, 8, 429-435.

Larsen, J. (1984). The importance of leadership in nursing organizations. The Canadian Nurse, 81(8), 35-38.

Larson, L. (1986). Choosing leadership. Journal of Emergency Nursing, 12(2), 65-66.

Lawrence, S. A., & Lawrence, R. M. (1984). Leadership: What it is and how to teach it. Journal of Nursing Education, 23(4), 173-176.

Leatt, P. (1981). Education for nursing administration in Canada: A discussion paper. Ottawa, ON: Canadian Nurses Association.

Leininger, M. (1974). The leadership crisis in nursing: A critical problem and challenge. Journal of Nursing Administration, 4(2), 28-34.

Leininger, M. M. (Ed.). (1985). Qualitative research methods in nursing. Orlando, FL: Grune & Stratton.

Leininger, M. M. (1990). Ethnomethods: The philosophic and epistemic bases to explicate transcultural nursing knowledge. Journal of Transcultural Nursing, 1(2), 40-51.

Lincoln, Y. S., & Guba, E. G. (1985). Naturalistic inquiry. Beverly Hills, CA: SAGE.

Lipson, J. J. (1984). Combining researcher, clinical and personal roles: Enrichment or confusion? Human Organization, 43(4), 348-352.

Maguire, P. (1986). Staff nurses' perceptions of head nurses' leadership styles. Nursing Administration Quarterly, 11(1), 34-38.

Marriner, A. (1978). Theories of leadership. Nursing Leadership, 1(3), 13-17.

McCarty, J. A. (1985). A study of the relationship between leadership behavior of hospital nurse administrators and selected demographic variables - A north central study (Doctoral dissertation, Ball State University, 1985). Dissertation Abstracts International, 46(9), 3007-B.

McCloskey, J. C., & Molen, M. T. (1987). Leadership in nursing. In J. J. Fitzpatrick & R. L. Taunton (Eds.), Annual review of nursing research (Volume 5)(pp.177-202). New York, NY: Springer Publishing.

McClure, M. L. (1989). The nurse executive role: A leadership opportunity. Nursing Administration Quarterly, 13(3), 1-8.

McGee, R. F. (1984). Leadership styles: A survey. Nursing Success Today, 1(2), 26-32.

McMurray, A. R., & Bentley, E. L. (1989). Situational leadership in education: Realistic data for reform decisions through action research. November. (ERIC Document Reproduction Service No. ED 277 099).

Meleis, A. I. (1985). Theoretical nursing: Development and progress. Philadelphia, PA: J. B. Lippincott.

Merriam, S., & Simpson, E. (1984). A guide to research for educators and trainers of adults. Malabar, FL: Robert E. Krieger.

Miller, K. L. (1989). Nurse executive leadership: A corporate perspective. Nursing Administration Quarterly, 13(2), 12-18.

Mintzberg, H. (1973). The nature of managerial work. Englewood Cliffs, NJ: Prentice-Hall.

Moore, K., Biordi, D., Holm, K., & McElmurry, B. (1988). Nurse executive effectiveness. JONA, 18(12), 23-27.

Morse, J. M. (Ed.). (1989). Qualitative nursing research: A contemporary dialogue. Rockville, MD: Aspen Publishers.

Munhall, P. L. (1988). Ethical considerations in qualitative research. Western Journal of Nursing Research, 10(2), 150-162.

Nealy, S. M., & Blood, M. R. (1968). Leadership performance of nursing supervisors at two organizational levels. Journal of Applied Psychology, 52(5), 414-422.

Novak, J. D., & Gowin, D. B. (1984). Learning how to learn. Cambridge, NY: Cambridge University Press.

Novak, J. D., & Musonda, D. (1991). A twelve-year Longitudinal study of science concept mapping. American Educational Research Journal, 28(1), 117-153.

Oskamp, S. (1984). Applied social psychology. Englewood Cliffs, NJ: Prentice-Hall.

Paterson, B. L. (1991). The juggling act: An ethnographic analysis of clinical teaching in nursing education. Unpublished doctoral dissertation, University of Manitoba, Winnipeg.

Paterson, B. L. (1992). Reactivity in qualitative research. Manuscript submitted for publication.

Peters, T. J., & Waterman, R. H. (1982). In search of excellence: Lessons from America's best-run companies. New York, NY: Warner Books.

Peterson, M. R. (1985). Leadership behavior of nursing service administrators as perceived by graduate nursing students and nursing service administrators (Doctoral dissertation, Miami University, 1985). Dissertation Abstracts International, 46(6), 1872B.

Polit, D. F., & Hungler, B. P. (1987). Nursing research: Principles and methods (3rd ed.). Philadelphia, PA: J. B. Lippincott.

Powers, D. M. (1986). A new style of nursing leadership. The Canadian Nurse, 82(10), 18-19.

Pryer, M. W., & Distefano, M. K. (1971). Perceptions of leadership behavior, job satisfaction, and internal-external control across three nursing levels. Nursing Research, 20(6), 534-537.

Ramos, M. C. (1989). Some ethical implications of qualitative research. Research in Nursing & Health, 12, 57-63.

Rauch, M., & Fillenworth, C. (1980, November). Cognitive mapping: Understanding, organizing, and remembering written discourse. Paper presented at the Annual convention of the Minnesota reading Association, Mankato, MN.

Rice, R. W., Instone, D., & Adams, J. (1984). Leader sex, leader success, and leadership process: Two field studies. Journal of Applied Psychology, 69(1), 12-31.

Ripple, H. (1988). Capitalizing on the new economics: Nurse executives as catalysts for action. Nursing Economics, 6(2), 67-70.

Robinson, C. A., & Thorne, S. E. (1988). Dilemmas of ethics and validity in qualitative nursing research. The Canadian Journal of Nursing Research, 20(1), 65-76.

Rodger, G. (1988). "O Canada". American Journal of Nursing, 88(11), 1486.

Rosener, J. B. (1990, November-December). Ways women lead. Harvard Business Review, 119-125.

Sandelowski, M. (1986). The problem of rigor in qualitative research. Advances in Nursing Science, 8(3), 27-37.

Scalzi, C. C. (1988). Role stress and coping strategies of nurse executives. JONA, 18(3), 34-38.

Scalzi, C. C. & Anderson, R. A. (1989). Dual degree: Future preparation for nurse executives? JONA, 19(6), 25-29.

Scalzi, C. C. (1990). Role stress in top-level nurse executives. Western Journal of Nursing Research, 12(1), 85-94.

Schlotfeldt, R. M. (1985). A brave new nursing world: Exercising options for the future. Journal of Professional Nursing, 1(1), 244-251.

Seidel, J. V., Kjolseth, R., & Seymour, E. (1988, March). The Ethnograph: A user's guide (Version 3.0) [Computer Program]. Littleton, CO: Qualis Research.

Sheafor, M. (1991). Productive work groups in complex hospital units: Proposed contributions of the nurse executive. JONA, 21(5), 25-30.

Shibutani, T. (1967). Reference groups as perspectives. In J. Manis & B. Meltzer (Eds.), Symbolic interaction: A reader in social psychology (pp.159-170). Boston, MA: Allyn & Bacon.

Simms, L. M., Price, S. A., & Pfoutz, S. K. (1985). Nurse executives: Functions and priorities. Nursing Economics, 3(4), 238-244.

Simms, L. M. (1991). The professional practice of nursing administration: Integrated nursing practice. JONA, 21(5), 37-46.

Smith, B. E. (1992). Linking theory and practice in teaching basic nursing skills. Journal of Nursing Education, 31(1), 16-23.

Smith, D. L. (1988). Administering nursing workplaces. In A. J. Baumgart & J. Larsen (Eds.), Canadian nursing faces the future (pp.191-209). St. Louis, MO: C. V. Mosby.

Smith, H. L., & Mitry, N. W. (1984). Nursing leadership: A buffering perspective. Nursing Administration Quarterly, 8(3), 43-52.

Sovie, M. D. (1987). Exceptional executive nursing leadership shapes nursing's future. Nursing Economics, 5(1), 13-20, 31.

Statistics Canada (1991). Nursing in Canada 1990. Health Reports (Supplement No.22, Volume 3, No.2). Ottawa, ON: Author.

Stensvold, M., & Wilson, J. T. (1992). Using concept maps as a tool to applying chemistry concepts to laboratory activities. Journal of Chemical Education, 69(3), 230-232.

Stephenson, J. B., & Greer, L. S. (1981). Ethnographers in their own cultures: Two Appalachian cases. Human Organization, 40(2), 123-130.

Stevens, B. J. (1978). Education in nursing administration: Where we are and where should we be? In C. H. Slater (Ed.), The education and roles of nursing service administrators (pp.21-38). Battle Creek, MI: W. K. Kellogg Foundation.

Stinson, S. M. (1989). Education for nurse administrators in Canada: Implications for practice, theory, and research in nursing administration. In B. Henry, R. Heyden, & B. Richardson (Eds.), International administration of nursing services (pp.112-125). Philadelphia, PA: The Charles Press.

Stivers, C. (1991). Why can't a woman be more like a man: Women's leadership dilemma. JONA, 21(5), 47-51.

Styles, M. M. (1988). Realities and paradoxes of the nurse administrator's role. Canadian Journal of Nursing Administration, 1(4), 15-20.

Thomlinson, E. (1991). What educational requirements for a nurse executive? Canadian Journal of Nursing Administration, 4(4), 14-19.

Tichy, N. M., & Ulrich, D. O. (1984, Fall). The leadership challenge - A call for the transformational leader. Sloan Management Review, 26(1), 59-68.

Tochon, F. V. (1990). Heuristic schemata as tools for epistemic analysis of teacher thinking. Teaching and Teacher Education, 6(2), 183-196.

Toffler, A. (1970). Future shock. New York, NY: Random House.

Tracy, M. L. (1991). The relationship of organizational structure to role conflict and role ambiguity of top level nurse administrators (Doctoral dissertation, The University of Alabama, 1991). Dissertation Abstracts International, 52(6), 2998-B.

Trofino, J., & Strickland, R. (1990). Transformational leadership. JONA, 20(4), 3,4,17.

Vanance, D. (1989). Leadership in nursing: A modified grounded theory approach. Unpublished master's thesis, University of Manitoba, Winnipeg.

Vecchio, R. P. (1987). Situational leadership: An examination of a prescriptive theory. Journal of Applied Psychology, 72(3), 444-451.

Wagner, L., Henry, B., Giovinco, G., & Blanks, C. (1988). Suggestions for graduate education in nursing service administration. Journal of Nursing Education, 27(5), 210-218.

Walker, L. O., & Avant, K. C. (1988). Strategies for theory construction in nursing (2nd ed.). Norwalk, CT: Appleton & Lange.

White, R., & Lippit, R. (1953). Leadership behavior and member reaction in three "social climates". In D. Cartwright & A. Zander (Eds.), Group dynamics: Research and theory (pp.585-611). Evanston, IL: Row, Peterson and Company.

Wilson, H. S. (1985). Research in nursing. Don Mills, ON: Addison-Wesley.

Wilson, J. S. (1980). Leadership: A review of the literature and theoretical framework for nursing courses. Nursing Leadership, 3(2), 32-38.

Wolf, G. A. (1986). Communication: Key contributor to effectiveness - A nurse executive responds. JONA, 16(9), 26-28.

Yonge, O., & Stewin, L. (1988). Reliability and validity: Misnomers for qualitative research. The Canadian Journal of Nursing Research, 20(2), 61-67.

Yukl, G. A. (1989). Leadership in organizations (2nd Ed.). Englewood Cliffs, NJ: Prentice-Hall.

Yura, H., Ozimek, D., & Walsh, M. B. (1981). Nursing leadership: Theory and process (2nd ed.). New York, NY: Appleton-Century-Crofts.

Zaleznik, A. (1977). Managers and leaders: Are they different? Harvard Business Review, 55(3), 67-78.

Zurlinden, J., Bongard, B. & Magafas, M. (1990). Situational leadership: A management system to increase staff satisfaction. Orthopedic Nursing, 9(2), 47-52.

Appendix A

Data Collection

Research Questions	Dimension of Perspectives	Dimension of Symbolic Interaction	Major Data Gathering Techniques
1. Elements of perspective	Ideas about leadership	Definition of setting	Interviews. Concept mapping
2. Assumptions	Ideas, actions judgments	Process by which definitions develop and change. Relationship between perspective and behaviour.	Interviews. Concept mapping
3. Internal and external variables which influence the perspective	Ideas, actions judgments	Process by which definitions develop and change. Relationship between perspective and behaviour.	Interviews. Concept mapping

Appendix B

Request for Access to Facilities for Data Collection

Dear _____:

I am a graduate student in the Faculty of Nursing, University of Manitoba. I will be conducting a research project to fulfil the thesis requirements of the Master of Nursing program. I am requesting access to collect information for part of my study at (the setting).

The proposed title of my thesis is Leadership in Nursing Administration: The Perspectives of Senior Nurse Administrators. Leadership in Nursing Administration: The Perspectives of Senior Nurse Administrators. This study will involve two interviews, each being one to two hours in length, with the senior nurse administrator in your facility. This study involves only the senior nurse administrator of (the setting) - access to patients, other staff, or departments is not being sought.

The members of my thesis committee are as follows:

Dr. Barbara Paterson, Chair, Faculty of Nursing (bus. tel. 474-8240)

Dr. Ina Bramadat, member, Faculty of Nursing

Dr. Roger Hall, member, Faculty of Management

Ethical and scientific approval to conduct this study has been granted from the University of Manitoba Faculty of Nursing Ethics Committee on 20 May 1992. I will begin the study as soon as access to (the setting) is received.

If you require additional information I would be pleased to provide it (1-728-9732). You may also contact Barbara Paterson, my Thesis Advisor, at the University of Manitoba.

Thank you for your consideration.

Sincerely,

_____

Kathryn J. Hyndman, RN

Appendix C

Invitation to Participate Letter

Dear _____:

You are invited to participate in a study of leadership of senior nurse administrators of tertiary and community hospitals in Manitoba. This project has been approved by the Ethics Committee of the Faculty of Nursing, University of Manitoba on May 20, 1992. Completion of this study will fulfil thesis requirements for the Master of Nursing program.

Data collection in this study will involve interviews with several senior nurse administrators in Manitoba. If you agree to participate in this study, it will involve two interviews, each one to two hours long, and a debriefing session, approximately one hour or less with the researcher, at a convenient time and location in your facility. I plan to begin interviewing in May 1992.

Your decision to participate is entirely your own. You have the right to withdraw from the study at any time. The information will be used in my thesis. Your name will not be discussed or reported in the thesis, future publications, or presentations.

A summary of the purpose of this study and a copy of the Approval Form from the Ethical Review Committee is appended. I will be pleased to provide further details during our pre-interview_____.

Please do not hesitate to contact me by telephone (1-728-9732). My Thesis Advisor, Dr. Barbara Paterson, may be reached by telephone at the University of Manitoba (474-8240). Thank you for your consideration.

Sincerely,

_____

Kathryn J. Hyndman, RN
4138 Centennial Boulevard
Brandon, Manitoba R7B 3K7

Appendix D

Field Test Consent Form

With my signature, I, _____,
agree to participate in a field test of the interview guide to be used in a research project by Kathryn Hyndman, a Master's student in the Faculty of Nursing, University of Manitoba. I was asked to participate because of my role as the senior nurse administrator in this facility.

I realize that participating in this study will involve one interview, one to two hours in length, and a closing interview, approximately one hour or less, with the researcher. I realize the potential benefits of this field test in that it may reveal meaningful information about the interview guide to be used in the final study.

I understand the decision to participate is entirely voluntary. I am free to withdraw at any time by simply telling the researcher. I understand the first interview will be audio-taped and then transcribed. I acknowledge an anticipated time commitment of 2 to 3 hours for interviewing and for validating my transcript. Although my identity will be known to the researcher through face-to-face interviews, my name will not be used in the transcriptions of the tape. Any data that would link my

identity to the information I will provide will be deleted by the researcher before it is shared with the researcher's thesis committee.

If I have any questions at any time about the study I am free to contact the nurse researcher (1-728-9732) or her Thesis Advisor, Dr. Barbara Paterson (474-8240).

_____	_____
Signature of Nurse Researcher	Signature of Participant
_____	_____
Date	Date

Appendix E

Consent Form

With my signature, I, _____,
agree to participate in the study of leadership of senior nurse administrators by Kathryn Hyndman, a Master's student in the Faculty of Nursing, University of Manitoba. I was selected for participation in this study because of my role as the senior nurse administrator in the facility.

I realize that participating in this study will involve two interviews, each, one to two hours in length, and a debriefing session, approximately one hour or less, with the researcher. I realize the potential benefits of this study in that it may reveal meaningful information about leadership in my role. I recognize that the potential risks of exploring a person's knowledge of a concept may at times cause the person some anxiety. I accept that sharing my experience may help to advance leadership knowledge development in nursing administration.

I understand the decision to participate is entirely voluntary. I am free to withdraw at any time by simply telling the researcher. I understand the first interview will be audio-taped and then transcribed. I acknowledge an anticipated time commitment of 5 to 6 hours for

interviewing and for validating my transcripts. Although my identity will be known to the researcher through face-to-face interviews, my name will not be used in the transcriptions of the tape or in the written or verbal reports of the study. Any data that would link my identity to the information I will provide will be deleted by the researcher before it is shared with the researcher's thesis committee.

I understand I have the opportunity for input into the research project during the interviews and will validate the information to insure it has been accurately interpreted. I understand I will receive a copy of my own concept map of leadership and a summary of the study findings at a debriefing session prior to the researcher's thesis defense.

If I have any questions at any time about the study I am free to contact the nurse researcher (1-728-9732) or her Thesis Advisor, Dr. Barbara Paterson (474-8240).

Signature of Nurse Researcher	Signature of Participant
Date	Date

Appendix F

Interview Guide

1. What does leadership in senior nursing administration mean to you?
2. What is different for you about leadership in senior nursing administration as compared to leadership in business or education?
3. Give me some examples of how you enact leadership in your practice.
4. What promotes or inhibits your leadership?
5. What kind of decisions do you make in your role as leader?
6. Could you give me some examples of decisions you've made recently in your practice?
7. Could you talk out loud about how you arrived at these decisions?
8. How does your style of leadership today differ from the way you assumed the role when you first became an administrator?
9. What influenced these changes?
10. Could you give me an example of a decision that was very difficult to make and how you made the decision?
11. Are there other comments you'd like to make about leadership?

Appendix G

Instructions to Users of C-MAP 1.0

(c) Scott Hunter and Howard Stahl*

This program operates on a Macintosh with 1 Meg of memory running System 4.1 or later. The C-MAP disk includes a system folder, which makes it self-booting when the disk is inserted into a Macintosh computer.

Begin by pulling down menus and reviewing menu options. Use the hand tool to enter new concepts and to move concepts.

Add new concepts by double clicking the mouse. A box will appear for adding concepts names. Use tab to obtain two or three lines for your concept label. Concepts are printed in 12 point type but different fonts and styles (bold, italics, etc.) are available. Click OK or hit Return to Return to map.

Add linking words by using the linker tool. Click linker arrow on concept from which arrow is to be drawn (box turns dark) and then to concept to be connected. Type in linking word(s) in box, then click OK or hit Return. No arrows are added for links running down the page, but arrowheads can be added, on every link, if you wish.

Use eraser tool to remove a concept and/or linking words. Double click eraser on concept or link to be removed. Choosing Undo Erase from the Edit menu will restore erased item.

Save work regularly!!! Save also allows you to give a title to your map. Use new names (e.g., C-MAP 1.1, C-MAP 1.2, C-MAP 1.3) to avoid losing maps.

Link tracer allows you to put in various shapes of linking lines. Double click link tracer arrow on linking word of line to be moved. A full-page screen will appear with selected line flashing. Pick up the line with top of link tracer and move one or more times to desired position. Click OK to return to the map.

Lasso tool allows any number of concepts to be moved together as a group. Print your map when ready.

*Learning How to Learn (Ithaca, NY: Cornell University Press, 1984), or contact Professor Joseph D. Novak, Department of Education, 412 Kennedy Hall, Cornell University, Ithaca, NY, 14853, USA.

Appendix H

FACULTY OF NURSING
ETHICAL REVIEW COMMITTEE

APPROVAL FORM

Proposal Number N#92/12

Proposal Title: "Leadership in Nursing Administration: The Perspectives of Senior Nurse Administrators."

Name and Title of Researcher(s): Kathryn J. Hyndman, R.N., B.S.N.
Master of Nursing Graduate Student
Faculty of Nursing, University of Manitoba.

Date of Review: MAY 04, 1992.

APPROVED BY THE COMMITTEE: MAY 04, 1992.

Comments:

Date: May 20 '92

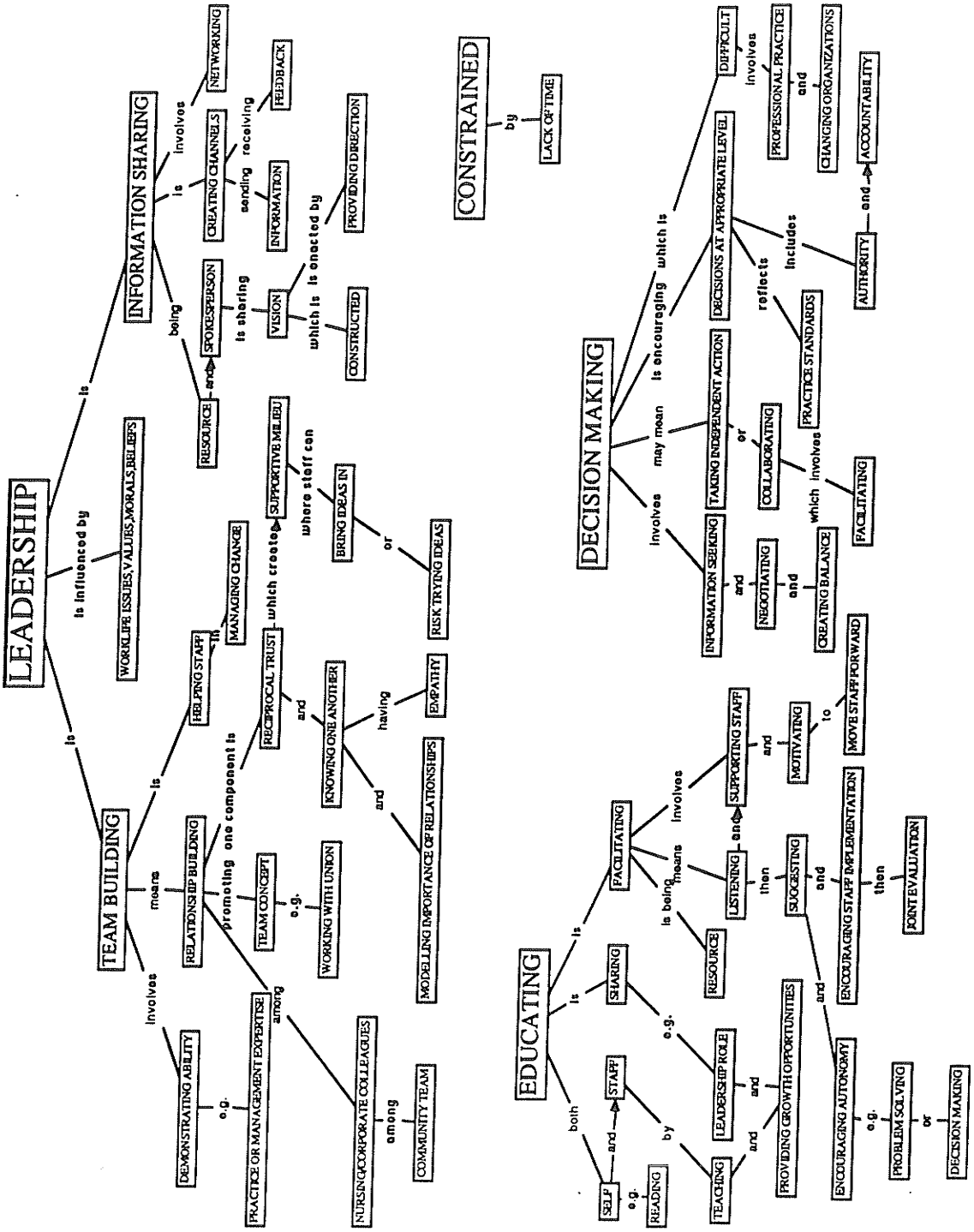
Linda J. Kristjanson, PhD, RN — Chairperson
Associate Professor
University of Manitoba Faculty of Nursing

Position

NOTE:
Any significant changes in the proposal should be reported to the Chairperson for the Ethical Review Committee's consideration, in advance of implementation of such changes.

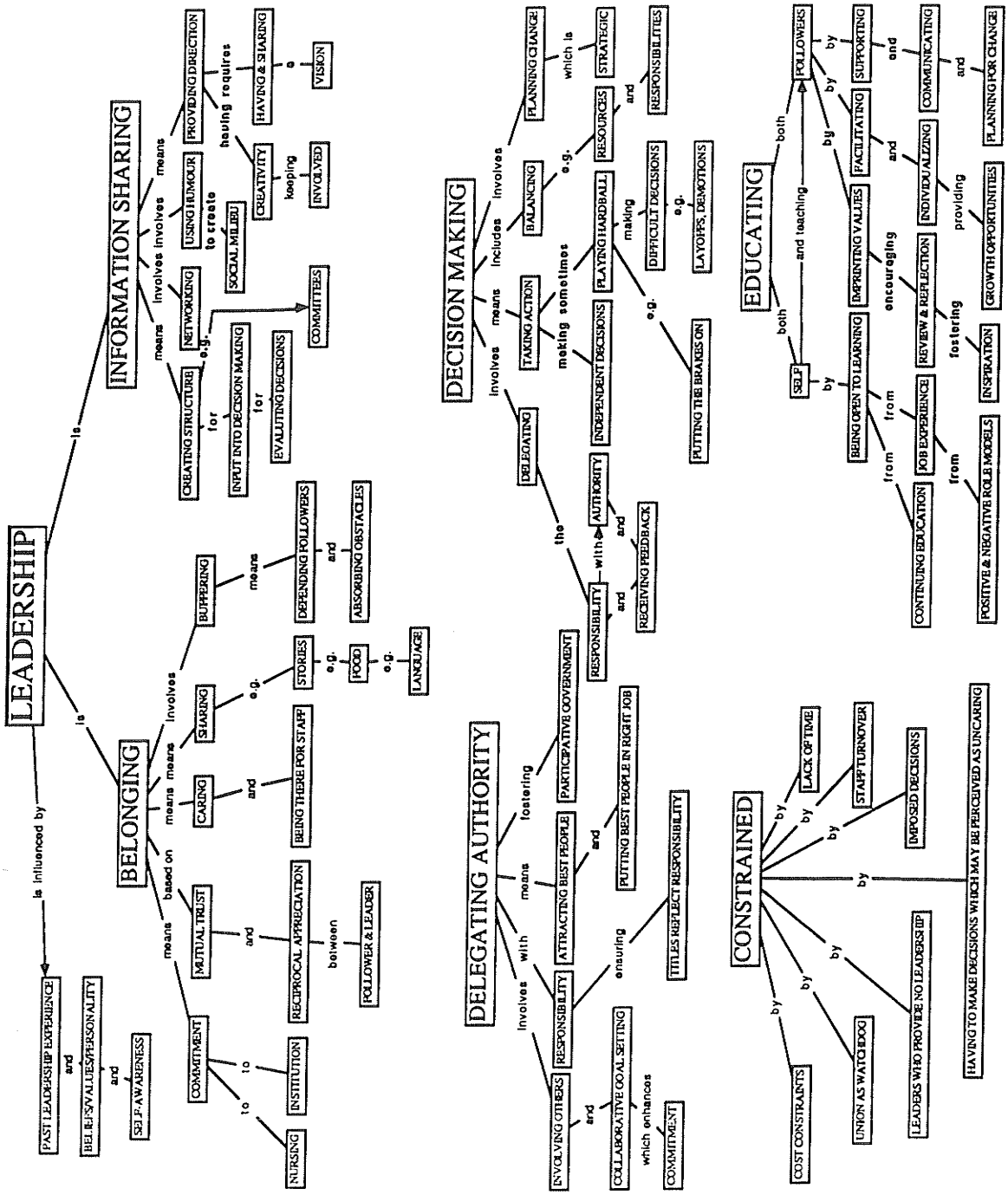
Appendix I

SNA001 Leadership Concept Map



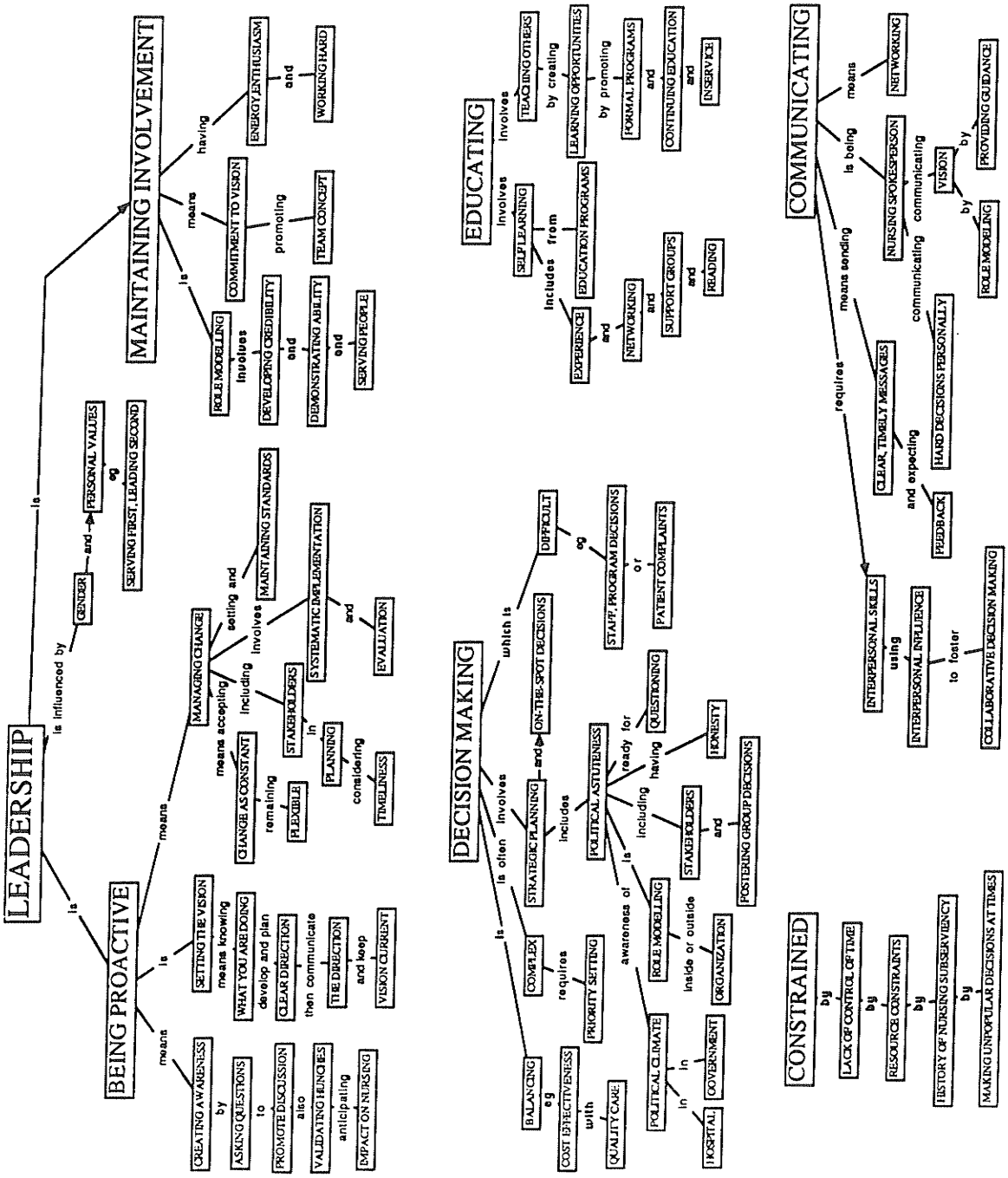
Appendix J

SNA002 Leadership Concept Map



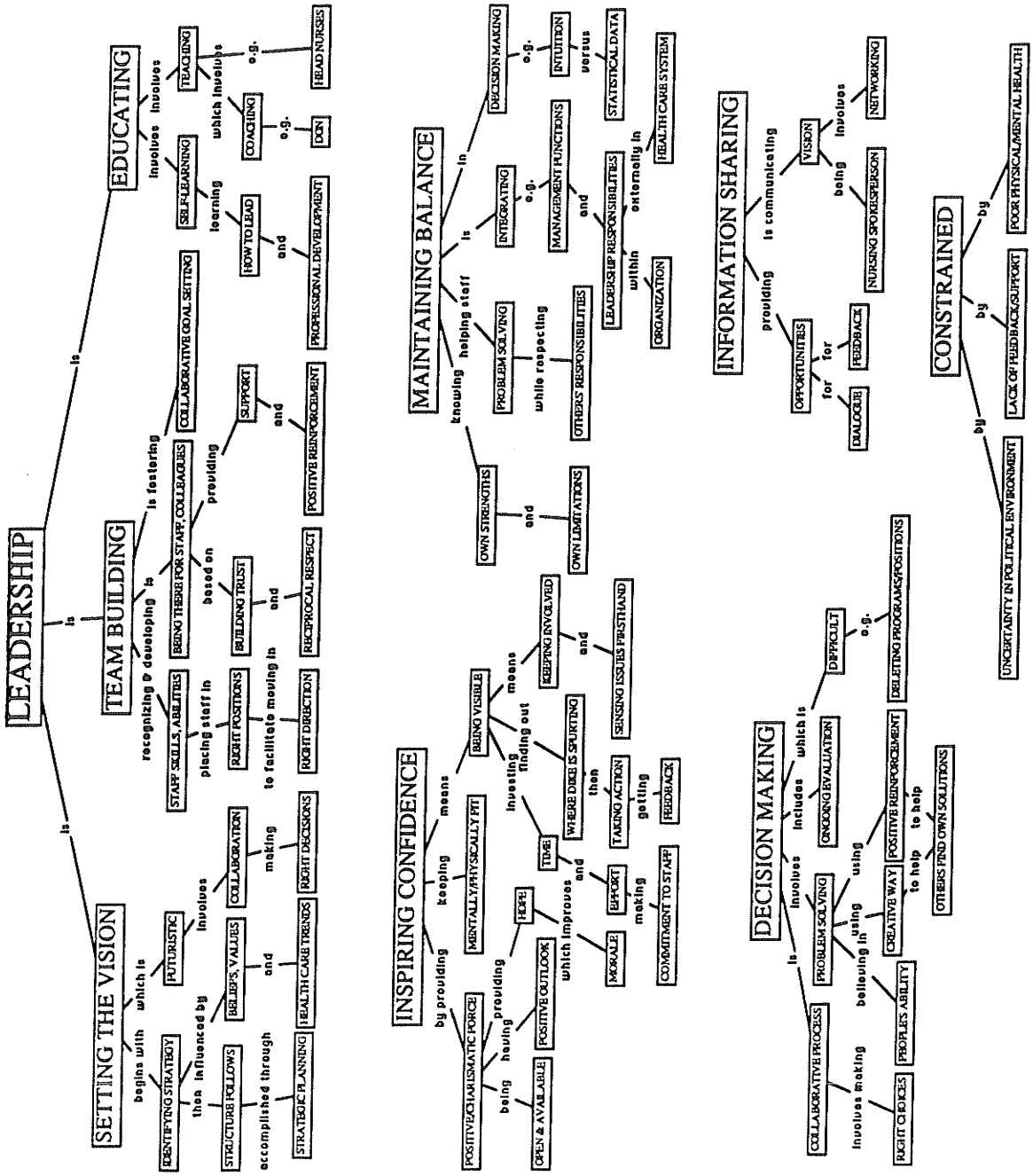
Appendix K

SNA003 Leadership Concept Map



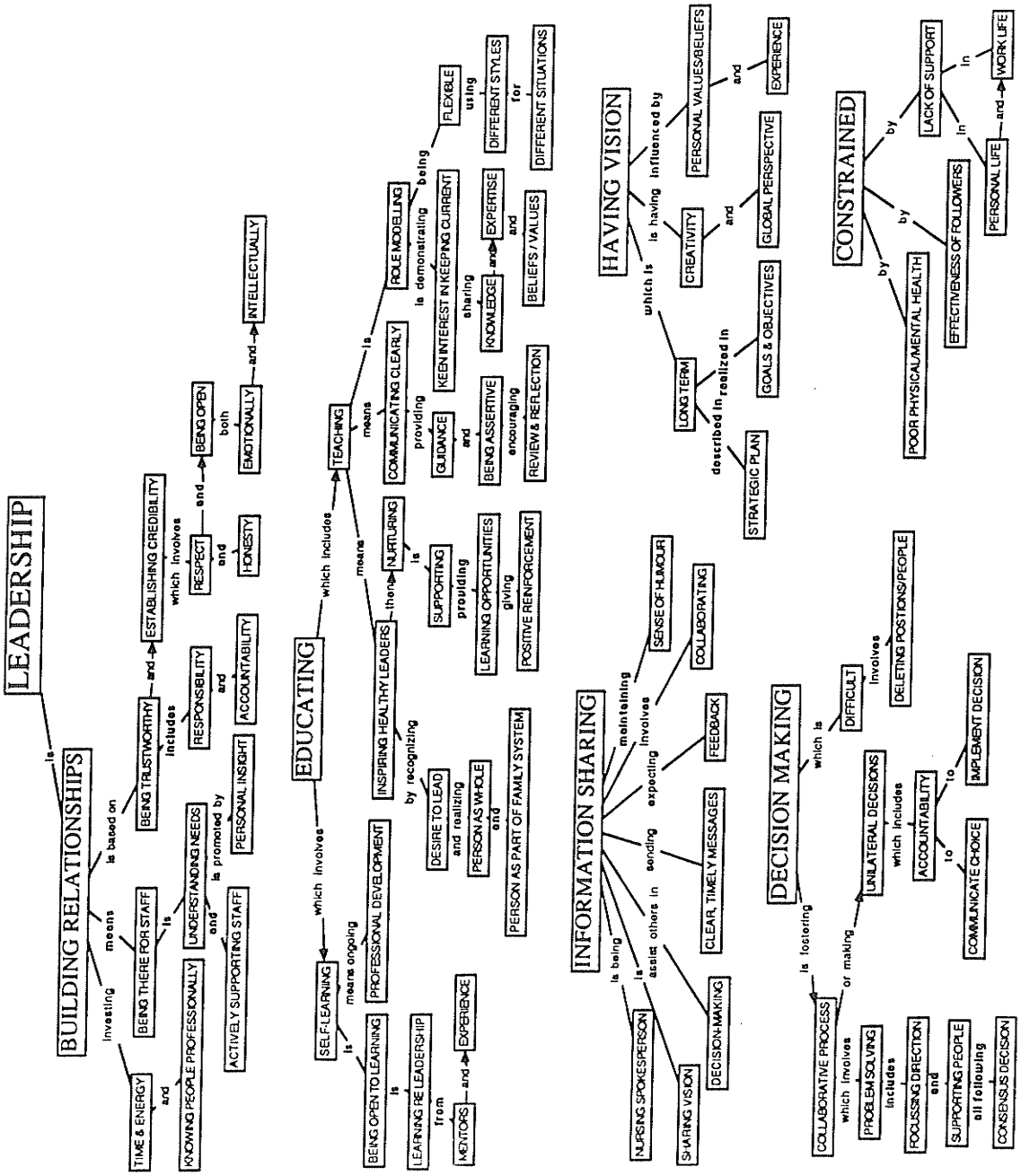
Appendix L

SNA004 Leadership Concept Map



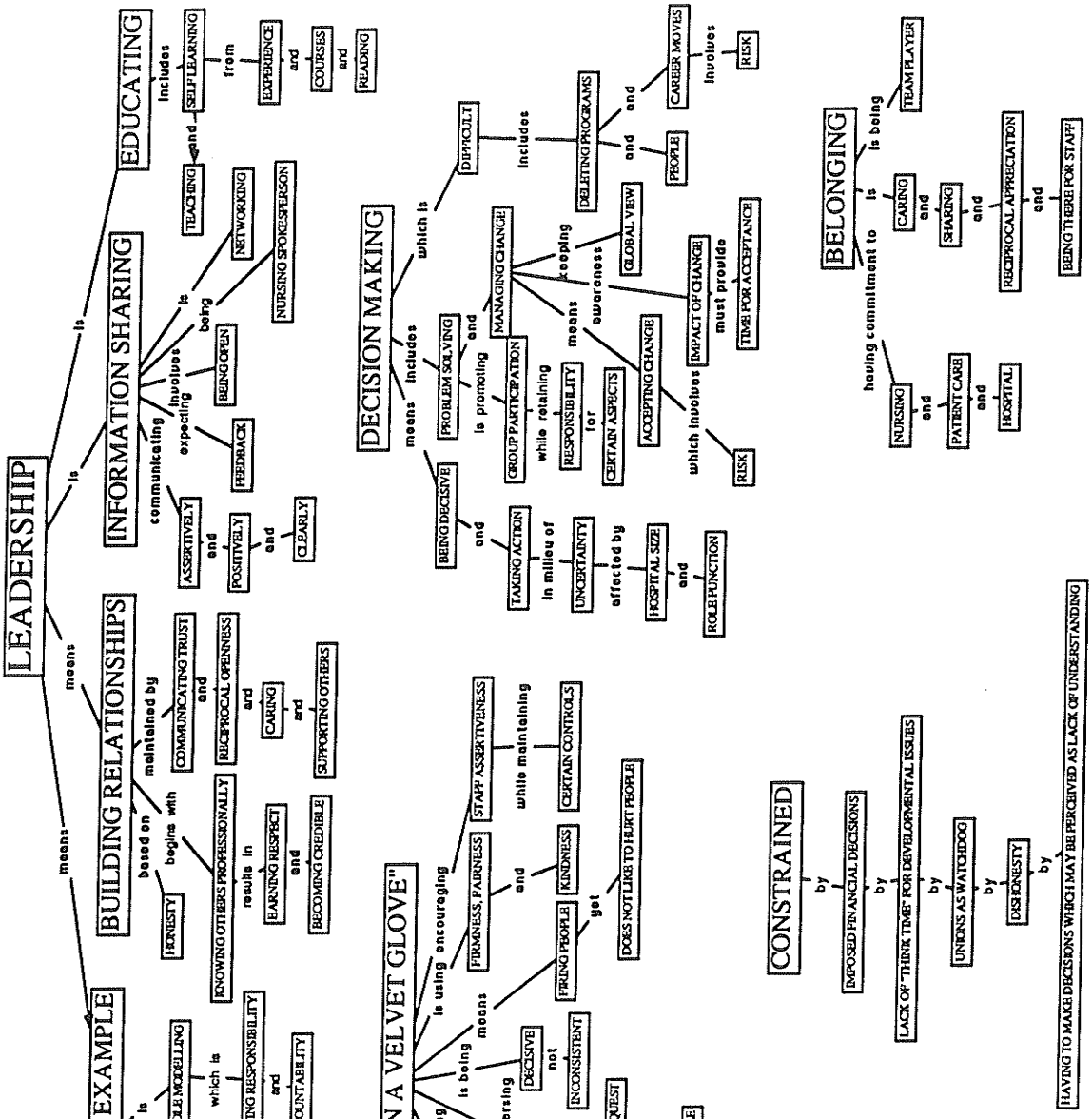
Appendix M

SNA005 Leadership Concept Map



Appendix N

SNA006 Leadership Concept Map



Appendix O

Findings - Leadership Theories Comparison

Theories of Leadership	Similarities in Findings
Behavioural: Ohio State Leadership Studies 1. Consideration 2. Initiating Structure 3. Production Emphasis 4. Sensitivity/Social Awareness	Mutual trust and respect, comraderie, team building; formal communication structures; goal setting; creating a climate for working to accomplish goals; active involvement
Situational: Situational Leadership Theory Leadership effectiveness depends on contextual demands of the situation; style adaptability	Spokesperson; networking; collaboration and independent decision making; balance, personal attributes, buffering, sharing, team building, managing change, leader as teacher, communicating, delegating authority and responsibility.
Transformational/Transactional: Leader and follower engage fully with each other, the outcome is transforming for both.	
1. Charisma	Building and maintaining interpersonal relationships, need to influence others, people orientation, SNA self-expectation they would make tough decisions, take independent action, staying visible, visionary, constant communicating
2. Individualized consideration	Coaching staff who needed help
3. Intellectual stimulation	Educating staff, self-learning

Transformational skills:	
a. visionary	Vision for nursing, communicate vision via networking and spokesperson role
b. anticipatory	Seeking information, establishing trust and confidence, projecting risks and consequences to organization managing change, planning ahead for introduction of new concepts
c. value congruence	Trust, respect, responsibility, fairness, balanced decisions, teamwork.
d. empowerment	Belief in staff's ability; sharing leadership role, involving staff in planning and decision making.
e. self-understanding	Maintaining openness and honesty in relationships; SNA self-directed learning Belief in staff's ability; sharing leadership role, involving staff in planning and decision making.
Transactional factors:	
1. Contingent reward	Administrative retreat and inservice in recognition of goal achievement.
2. Management by exception	Suspending nurses for unprofessional practice

Interactive Model: Dominant features are sharing and shifting of power between leaders and members; model's focus is on empowerment for problem solving and growth. Strategies include the following: encourage participation by inclusion; share power and information; enhance self-worth of others, energize others. Interactive processes are deciding, relating, influencing, facilitating.	Collaborative decision making, create mechanisms to encourage participation, time viewed as leadership constraint, leadership style adaptability, information sharing, delegating responsibility and authority, educating, SNA as teacher-facilitator, sharing and giving credit to others, energy and enthusiasm, being proactive, having a positive outlook, valuing the role of leader and follower, building relationships, using interpersonal influence.

Appendix P

Findings - Domains of Nursing Comparison

Domains of Nursing (Benner, 1984)	Subcategories of Findings
The Helping Role	
The Healing Relationship: Creating a Climate for and Establishing a Commitment to Healing	Information sharing through formal and informal structures; using humour; clear timely communications; educating staff
Providing Comfort Measures and Preserving Personhood in the Face of Pain and Extreme Breakdown	Building relationships based on mutual trust, reciprocal respect; supporting staff/ colleagues
Presencing: Being with a Patient	Being there for staff
Maximizing the Patient's Participation and Control in His or Her Own Recovery	Collaborative decision making; delegating responsibility and authority
Interpreting Kinds of Pain and Selecting Appropriate Strategies for Pain Management and Control	Making difficult decisions
Providing Comfort and Communication Through Touch	Being there for staff; inspiring confidence and keeping visible
Providing Emotional and Informational Support to Patients' Families	Information sharing through formal and informal structures, networking, nursing spokesperson
Guiding a Patient Through Emotional and Developmental Change: Providing New Options, Closing Off Old Ones; Channelling, Teaching, Mediating -acting as a psychological and cultural mediator -using goals therapeutically; working to build and maintain a therapeutic community	Decision making by collaboration, promoting staff independence in decision making; having and implementing vision; managing change; being proactive; sharing; building relationships; inspiring confidence; being there for staff

The Teaching-Coaching Function	
Timing: Capturing a Patient's Readiness to Learn	Educating; clear timely communication
Assisting Patients to Integrate the Implications of Illness and Recovery into Their Lifestyles	Being proactive; integrating head nurses into global picture of hospital; maintaining balance
Eliciting and Understanding the Patient's Interpretation of His or Her Illness	Being there for staff; building relationships
Providing an Interpretation of the Patient's Condition and Giving a Rationale for Procedures	Information sharing via informal structures; collaborative decision making
The Coaching Function: Making Culturally Avoided Aspects of an Illness Approachable and Understandable	Educating by coaching, role modelling, encouraging review and reflection; being there for staff
The Diagnostic and Monitoring Function	
Detection and Documentation of Significant Changes in a Patient's Condition	Information sharing: formal and informal structures, networking to receive and disseminate information
Providing an Early Warning Signal: Anticipating Breakdown and Deterioration Prior to Explicit Confirming Diagnostic Signs	Having vision, being proactive; collaborative decision making involves strategic planning; networking
Anticipating Problems: Future Think	Having vision, being proactive
Understanding the Particular Demands and Experiences of an Illness: Anticipating Patient Care Needs	Building relationships; being there for staff; buffering; educating-coaching

Assessing the Patient's Potential for Wellness and for Responding to Various Treatment Strategies	Building relationships, being there for staff; using collaborative or independent decision making; informal structures
<u>Effective Management of Rapidly Changing Situations</u>	
Skilled Performance in Extreme Life Threatening Emergencies: Rapid Grasp of a Problem	Inspiring confidence by demonstrating ability; independent decision making; having vision
Contingency Management: Rapid Matching of Demands and Resources in Emergency Situations	Independent decision making; being proactive; using vision, strategic planning; flexibility in leadership styles; maintaining balance
Identifying and Managing a Patient Crisis Until Physician Assistance is Available	Independent decision making; maintaining balance; buffering; nursing spokesperson
<u>Administering and Monitoring Therapeutic Interventions and Regimens</u>	
Starting and Maintaining Intravenous Therapy with Minimal Risks and Complications	Building relationships based on mutual trust, reciprocal appreciation
Administering Medications Accurately and Safely: Monitoring Untoward Effects, Reactions, Therapeutic Responses, Toxicities, and Incompatibilities	Being proactive involves implementing change, systematic evaluation and feedback; educating self and others; information flow
Combating the Hazards of Immobility: Preventing and Intervening with Skin Breakdown, Ambulating and Exercising Patients to Maximize Mobility and Rehabilitation, Preventing Respiratory Complications	Having and implementing vision; being proactive; educating; nursing spokesperson; inspiring confidence
Creating a Wound Management Strategy that Fosters Healing, Comfort, and Appropriate Drainage	Creating a team approach by building relationships; being there for staff; buffering; sharing; using

	humour; informal structures; sharing information
Monitoring and Ensuring the Quality of Health Care Practices	
Providing a Backup System to Ensure Safe Medical and Nursing Care	Decision making: independent, collaborative; maintaining balance; being proactive which involves strategic planning; educating
Assessing What Can Be Safely Omitted from or Added to Medical Orders	Making difficult decisions; maintaining balance
Getting Appropriate and Timely Responses from Physicians	Information sharing via informal and formal structures, networking, nursing spokesperson roles; inspiring confidence
Organizational and Work-Role Competencies	
Coordinating, Ordering, and Meeting Multiple Patient Needs and Requests: Setting Priorities	Decision making; maintaining balance; independent and collaborative
Building and Maintaining a Therapeutic Team to Provide Optimum Therapy	Building relationships, being there for staff, buffering, sharing; inspiring confidence
Coping with Staff Shortages and High Turnover:	
-Contingency planning	-Collaborative decision making, being proactive which involves strategic planning, using vision, keeping physically and mentally well
-Anticipating and preventing periods of extreme work overload within a shift	
-Using and maintaining team spirit; gaining social support from other nurses	-Building relationships, being there for staff, buffering, sharing, inspiring confidence, using humour, networking
-Maintaining a caring attitude toward patients even in absence of close and frequent contact	-Caring as an epistemological system in nursing leadership

-Maintaining a flexible stance toward patients, technology, and bureaucracy	-Being there for staff; using independent or collaborative decision making; informal structures; maintaining balance