LEADERSHIP IN NURSING: A MODIFIED GROUNDED THEORY APPROACH

by

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ABSTRACT

The purpose of this pilot study was to explore the nature of leadership in nursing. A non-experimental, descriptive design was used. A modified grounded theory approach was used. The random sample included four nursing administrators with master's degrees. The data collection was done in four phases and each participant was interviewed three times and observed for a one week period. Tape recordings and field notes were transcribed and coded and together with an ongoing review of the literature provided direction for the next phases of data collection.

The results of the study focused on the development of nursing leaders, key concepts of the leadership process and factors affecting leadership in nursing. Certain experiences were found to contribute to the development of the nursing leaders in this study. Significant experiences identified included experiences in the family, in education, in clinical nursing and in previous leadership roles. Role models were found to be important in their leadership development.

Key concepts in leadership identified from the data were characteristics, values, skills and duties. Nursing leaders were characterized by the following descriptors: creative, knowledgeable, flexible, intuitive, persuasive, empathetic, confident, risktakers, visionary, agents of change and committment. Values identified included patient care, the status/image of the nurse, collegiality and a balance between personal and professional life. Skills for nursing leaders were identified as communication, interpersonal, information gathering, strategizing, decision making, collaboration, problem solving and management. Duties included defining the boundaries of nursing, role modelling, teambuilding, developing others and ongoing self-development.

Nursing leadership was found to be affected by the followers, the organization and society. The follower as a person and the follower's previous education and nursing experience was found to be significant. Unionism, history and structure were the factors within the organization that were identified as affecting nursing leadership. Societal factors included the needs/demands of society, health care funding and the status of women. The results of this study have implications for nurses aspiring to a leadership role or presently in a role in nursing administration.

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CHAPTER I

STATEMENT OF THE PROBLEM

NURSING ADMINISTRATION IN CANADA

The strengthening of nursing administration has been identified as a priority in today's health care environment. There are several issues that have forced the issue of nursing administration to the forefront. In Canada, cost containment within the health care arena has become a major issue. This containment effort should ideally be achieved without jeopardizing the high quality of care demanded by consumers. Because the nursing portfolio accounts for the largest portion of the budget within health care, nursing administrators bear a significant responsibility for achieving this mandate. Increased specialization within the nursing profession; expanded career options for women; fewer medical resident positions and a rise of other disciplines and professions eager to have a role in the health care system have pressured the nursing profession to focus on the role of the nursing administrator (Snider, 1987).

Nursing administration has been identified as a priority for the profession in the 1980's by the Canadian Nurses Association. The Association's goal is to "improve the status of nursing administration and strengthen nursing leadership" (Evans, 1988, p. 7). The Association has identified three key areas as imperative in the achievement of their goal: the educational preparation of nursing administrators, a definition of the role of nursing administrators and the establishment of standards

for the nursing administrator. In 1981 the Canadian Nurses Association published a discussion paper written by Peggy Leatt entitled Education for Nursing Administration in Canada that focused on the academic preparation of nurses presently employed in an administrative capacity in Canada. The paper stressed that advanced preparation, above the nursing diploma level, at the baccalaureate level was needed for all nurses working in a first line management position or supervisory position. Graduate preparation was identified as a prerequisite to assuming roles at a Director of Nursing level or above. The association's most recent publication on administration, in February 1988, reviewed The Role of the Nurse Administrator and Standards for Nursing Administration. The paper addressed the managerial functions of the administrator and organizational structure for nursing administration. There can be no doubt that the Canadian Nurses Association views nursing administrators as key players within the nursing profession today and in the future.

ADMINISTRATIVE RESEARCH IN NURSING

In the United States, the study of nursing administrators has been ranked by an expert panel of nursing and health care educators and practitioners as one of ten themes needing study. In a national study of hospital research in the United States, however, no studies focusing on nurse executives were reported. Few studies were identified that related to the first line or middle manager. In direct contrast, schools of nursing reported that the nurse administrator was the major focus of

research (Henry, O'Donnell, Pendergast, Moody & Hutchinson, 1988). The findings of the expert panel again emphasizes that nursing administration and research related to nursing administrators is and must be a priority within the profession.

Research in nursing administration is concerned with establishing costs of nursing care, with examining the relationships between nursing services and quality patient care, and with viewing problems of nursing service delivery within the broader context of policy analysis and delivery of health services (Henry, O'Donnell, Pendergast, Moody & Hutchinson, 1987, p.309).

Nursing administrators are seen as the leaders in the design of policy; the controlling of costs and the delivery and quality of patient care.

NURSING LEADERSHIP AND ADMINISTRATION

The Canadian Nurses Association recognizes that expert leadership is a requirement for the nursing administrative role (Canadian Nurses Association, 1988). Leininger (1979) stresses that the need for "strong, dynamic and well-prepared leaders" in hospitals, community agencies, schools of nursing and government agencies has never been greater. She believes there is a leadership crisis in nursing. This leadership crisis has developed for a variety of reasons. Nursing leaders in administrative roles may have inadequate educational or experiential preparation for their role; may not be politically astute; may have few organizational supports and often work in an

environment of continual change. Leininger (1974) addressed why leadership roles in administration are not attractive to nurses. She believes the confrontational-negotiational style expected of nursing leaders is in conflict with the collegiality and caring perspective of the profession. Coupled with the fact that society has just begun to accept women into leadership roles and the historical conflict between medicine and nursing, the leadership role of a nursing administrator would appear to be both stressful and unrewarding. The literature suggests that caring and gender may contribute to the uniqueness of leadership in nursing.

NURSING LEADERSHIP AND CARING

The nursing profession is built on a foundation of caring. This caring perspective has followed the profession throughout its evolution (Watson, 1987). Human caring in nursing "is the moral ideal of nursing whereby the end is protection, enhancement, and preservation of human dignity" (Watson, 1985, pg. 29). Caring adds a dimension to leadership that has not previously been addressed by researchers. Nurses enter the profession as caregivers first and leadership roles within administration usually come later in one's career. The assumption made is that nurses continue in the caregiver role throughout their career including those careers in administration. Nurses may have unique behaviors which result in a special approach to leadership in a variety of situations.

NURSING LEADERSHIP AND GENDER

Nursing is female-dominated profession. 97.1% of all registered nurses in Canada are female (Venkatesh, 1988). Throughout the evolution of the nursing profession, nursing has long been considered woman's work. Early writings of the 1900's state "women are peculiarly fitted for the onerous task of patiently and skillfully caring for the patient in faithful obedience to the physician's orders. Ability to care for the helpless is women's distinct nature. Nursing is mothering" (Gamarnikow, 1978, p. 48). The early socialization process that has established a woman's status as wife and mother has directed many women to seek occupational roles, such as nursing that are congruent with traits identified as innately female such as selflessness and caring (Grimm, 1978). Colwill (1982) identified that women have traditionally been rewarded for nurturance, dependence, and servitude while men were rewarded for strength and aggression. Trait theories identify strength and aggression as personality characteristics associated with leadership effectiveness (Bass, 1982). This suggests that socialization may be a factor in the leadership development of women. While a multitude of studies using trait and other theories have been completed to determine if differences exist between male and female leaders, the results have been inconclusive.

A report published by the Registered Nurses Association of Ontario (1982) identified that the socialization of women in society and within the discipline of nursing is not conducive to the development of

leadership qualities. The shortage of effective role models has contributed to ineffective leadership within the profession. In addition, women may have multiple, combined roles (nurse, wife and mother) which create additional stressors for the would-be leader. Conflict between work and family obligations are inevitable as women have been socialized to give the priority to family obligations (Grimm, 1978). Several studies have identified an inverse relationship between a woman's level of education, earnings and occupational committment; and rates of marriage or high rates of divorce (Moore & Sawhill, 1978). The avoidance of leadership roles or ineffectiveness in the role may be a result of incongruency between family, social and professional roles and responsibilities. The price of success may be too high.

LEADERSHIP RESEARCH

Studies on leadership include descriptive theories that focus on individual traits and characteristics; behavioral theories that focus on the behaviors of both leaders and followers and situational theories that assess a variety of variables as determinants for leader behaviors. These theories have emerged from research compiled primarily on male leaders. While no theory has been judged perfect, many have been utilized as frameworks to guide individuals in leadership roles.

Research on leadership in nursing is limited and relies on the use of theories mostly derived from research on male executives in private and public corporations. Coupled with the fact that the actual amount

of research in the area of nursing leadership is sparse and quantitative in design; the need for a fresh approach to leadership in nursing is evident.

BENEFITS OF LEADERSHIP RESEARCH IN NURSING

The study of nursing leadership has benefits for nursing practice. Nurses providing direct patient care have long looked to others for leadership. All nurses must begin to see themselves as professionals and act as leaders in all aspects of nursing care (Hein & Nicholson, 1986). To enable this transformation to take place, nurses must have a framework of leadership that is credible and applicable to the profession.

Leadership by administrators has been linked to a variety of outcomes for employees in organizations. Leadership can affect job satisfaction, motivation, enthusiasm, productivity and the quality of work of employees (Yukl, 1981). An understanding of important aspects of leadership unique to nursing, will assist administrators in leading employees - nurses - more effectively and could directly improve the quality of work life and indirectly improve patient care.

Prior nursing leadership studies have used instruments developed from the study of male business leaders. The validity of these instruments in the study of female nursing leaders has not been established. A lack of factor isolating research in the area of nursing leadership is evident.

Given that nursing leadership has implications for administration, clinical practice, nursing education and future nursing research, critical factors affecting and involved in nursing leadership must be identified. The purpose of this study is to explore the nature of leadership in nursing.

THE RESEARCH QUESTIONS

1. What factors contribute to the development of nursing leaders as identified by nursing leaders?

2. What are the key concepts associated with nursing leadership as identified by nursing leaders?

3. What factors affect nursing leadership as identified by nursing leaders?

DEFINITION OF TERMS

For the purpose of this study, the following terms have the definitions listed below:

Nursing: one or more expert persons caring directly or indirectly for the physical and emotional well being of an individual (Walker, 1986).

Leadership: a role practiced by nurse administrators. Leadership is an active process; is purposeful; is affected by various personal, interpersonal and structural variables and has impact on other individuals.

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" (Canadian Nurses Association, 1988, p.18). For the purposes of this study, only nurses in middle administrative positions or higher, involved in the administrative process, shall be considered.

ASSUMPTIONS

The first assumption of this study is that nursing administrators do act as leaders and have some knowledge of and experience in leadership. The second assumption is that theory development, beginning with factor isolating research is important to nursing science. The third assumption is that theory development in the area of nursing leadership is valuable to the nursing profession.

LIMITATIONS

This study is limited to female registered nurses in administrative positions with, at minimum, a master's degree. The nurses must have worked in an administrative capacity for a minimum of three years and be employed in a health care institution, a school of nursing or a community health agency within the boundaries of Winnipeg. This study is also limited by the small sample size and the financial and time constraints of the author. The results of the study are generalizable

only to the specific population from which the sample was obtained.

METHODOLOGY

A modified grounded theory approach was used in this descriptive study. Grounded theory is " an approach to collecting and analyzing qualitative data with the aim of developing theories and theoretical propositions grounded in real world observations" (Polit & Hungler, 1983). This study served to isolate significant factors, as an initial step in the theory development process.

This approach does not depend on prior theories or research as a basis for the study. Rather, the subject or area of interest is probed methodically and analytically without bias or expectations. The area of nursing leadership has depended too long on borrowed theory from other disciplines and on quantitative methodology, so this approach is both timely and appropriate.

The study had four phases. After the subjects have been selected by the process of random selection, they were interviewed a total of three times. The researcher acted as a non-participant observer for approximately one week and observed the administrators in their professional capacity. One subject could not be observed due to a change in employment. The researcher used a tape recorder and field notes in the data collection process. Analysis took place concurrently to data gathering and ongoing review of the literature. Analysis

consisted of reviewing transcribed notes of interviews and observations to identify categories and organizing key concepts into a framework. Analysis was reviewed by two researchers and the thesis committee to reduce the possibility of researcher bias.

ORGANIZATION OF THE THESIS

This thesis consists of five chapters. Chapter One introduces the statement of the problem, Chapter Two reviews the literature relevant to the study and Chapter Three describes the research methodology. Chapter Four focuses on the study's results and the final chapter discusses the results and overall implications of study.

CHAPTER II

REVIEW OF THE LITERATURE

In this chapter, the major leadership theories shall be summarized. Leadership literature that focuses on differences between male and female leaders shall be presented. Findings from research focusing on nursing leaders shall be reviewed.

LEADERSHIP THEORY

A theory is systematic abstraction of reality that serves to describe, explain, predict or control an aspect of reality (Chinn & Jacobs, 1983, p. 3-4). The various theories to be presented serve to describe, explain and predict but not to control. Theory development in leadership has not reached the stage of control (Bernard & Walsh, 1981, p. 61). Theories of control or situation producing theories are concerned with specifying the goal, providing direction for all activities and considering all variables (Dickoff, James & Wiedenbach, p. 433). A number of researchers have tried to identify the critical variables in leadership; however, at present, there is little consensus.

A summary of the major theories of leadership will now be attempted. The theories are categorized as descriptive theories, behavioral theories and situational theories.

DESCRIPTIVE THEORIES

Descriptive theorists believe that individuals have certain traits or characteristics that contribute to their role as effective leaders.

Trait Theories of Leadership:

Proponents of this theory believe that leaders have certain traits that result in effective leadership. House (1988) reviewed the studies on leadership traits and concluded "(1) traits can, and often do, have main effects with respect to nontrivial criterion variables such as measures of performance, effectiveness, emergence, and succession rate; and (2) many traits likely interact with situational variables to produce effects on such criterion variables" (p. 249). Rather than viewing trait theory as standing alone, it must instead be reframed with other variables such as situational factors and relationships with and characteristics of followers. The initial task becomes identifying the key traits associated with leadership effectiveness.

Barrow (1977) reviewed the leadership literature to identify significant variables in leadership and develop a leadership effectiveness framework. Several leader characteristic factors were identified. Favorable characteristics included the leader's ability to work with subordinates in a collegial and facilitative manner using such traits as openness, fairness, flexibility, tolerance, supportiveness and friendliness. Expertise, a positive self concept and confidence were

other favorable traits identified.

Bass (1982) also completed a comprehensive review of leadership research and identified that leadership effectiveness is associated with the following traits: intelligence, decisiveness, persistence, adaptability, alertness, creativity, integrity, confidence, emotional stability and non-conformity. Key abilities included the ability to gain cooperation and be cooperative with others, knowledge of the task, interpersonal skill, communication skill, diplomacy and persuasiveness.

Other research has discovered further leadership traits. Bennis and Nanus (1985) observed and interviewed 90 male business leaders and found that leaders had four competencies: attention through vision, meaning through communication, trust through positioning and deployment of self. Attention through vision incorporated six dimensions of vision: foresight, hindsight, a world view, depth perception, peripheral vision and revision. Foresight focused on a futuristic vision on how the organization might develop; hindsight focused on knowledge of organizational culture and traditions; a world view emphasized the impact of new trends and developments; depth perception included attention to appropriate details to ensure a global perspective and revision emphasized changes to the vision to meet environmental and organizational changes. Meaning through communication refers to the leader's ability to synthesize information, determine what the message will be and effectively communicating that message verbally and nonverbally to others in a way that is readily

understandable. Trust through positioning focuses on the reliability or constancy of the leader. Deployment of self refers to self knowledge of personal skills and the effective use of those skills. Mistakes are not seen as failures but part of the learning process. The focus, however, is always on success.

Peppers and Ryan (1986) studied 79 leaders and 110 nonleaders and found that leaders perceived themselves as more talkative, aggressive, likable, affectionate, intelligent, friendly, committed and ambitious than did nonleaders. Leaders were more likely than nonleaders to aspire to the following characteristics: greater sensitivity to others and more democratic behaviors, fairness, intelligence, committment, imagination, confidence, self-assurance and critical thinking.

BEHAVIORAL THEORIES:

Supporters of behavioral theories assert that how a leader and followers behave determines effectiveness. Based on this general premise, a variety of specific theories have emerged.

Theory X and Theory Y:

McGregor (1960) developed both theories and viewed each theory as unique, rather than directly opposite. Each theory is based on the assumption that an individual's opinions about their followers and themselves directly affects the leadership style used. A theory X leader

would use an authoritarian style because they believe that followers dislike and avoid work. Leaders make all decisions, supervise closely and closely direct followers (Bergeron, 1987). A theory Y leader believes that followers have an affinity to work, are creative and will direct themselves to the achievement of goals. A democratic style of leadership is most affective in this situation and leaders coach, support advise and include followers in decision making (Bergeron). McGregor (1976) believes that a more open approach to the resources available in employees and an ability to adapt to the needs of employees is critical for organizational innovation.

Ohio State Leadership Studies:

A multitude of studies were completed by a multidisciplinary team at Ohio State University. On the basis of research results, a Leader Behaviour Description Questionnaire was developed that tested eight aspects of leadership behaviour. After testing, the researchers found that consideration, initiating structure, production emphasis and sensitivity were the key factors in leadership behaviour. Production emphasis and sensitivity each accounted for less than ten percent of the variance, so these factors are generally neglected in reviews about the Ohio State Studies (Bryman, 1986).

Initiating structure reflects the extent to which leaders structure their role and the role of followers towards achievement of goals. Consideration reflects the extent to which a leader will have work

relationships with employees characterized by mutual trust, respect and concern (Fleishman & Peters, 1962). Initiating structure and consideration are viewed on a two dimensional continuum ranging from low to high on each factor.

The Ohio State two factor approach to leadership was long viewed as over-simplistic because situational variables have been ignored (Korman, 1966). Recent studies, however, have begun to address specific situational variables and their effect on the behaviour of leaders. Kerr and Schriesheim (1974) reviewed several hundred research studies and found the following additional variables were included:

> Subordinate considerations. Expertise, experience, competence, job knowledge, hierarchical level of occupied position, expectations, concerning leader behaviour, perceived organizational independence, and various psychological aspects. Supervisor considerations. Similarity of attitudes and behaviour to those of higher management, and upward influence. Task considerations. Degree of time urgency, amount of physical danger, permissable error rate, presence of external stress, degree of autonomy, importance and meaningfulness of work, and degree of ambiguity (p. 558).

The two factor approach to leadership has also been questioned because it did not establish a relationship between leadership behaviour and outcomes for the employees (Gibson, Ivancevich & Donnely, 1985).

University of Michigan Studies:

Researchers at the University of Michigan asked leaders to describe the tasks of leadership. From the results, two behaviors were

identified: job-centred and employee-centred behaviours (Sullivan & Decker, 1985). Job-centred behaviors focus on goal achievement as the priority, without concern for followers. Leaders pressure employees for improved performance and output and closely supervise work (Bergeron, 1987). Employee-centred behaviours focus on delegating decisions to employees and providing a supportive environment (Bonaquist, 1986). This approach is criticized because it does not identify when one approach is more effective than the other (Gibson et al., 1985).

Leadership Continuum Theory:

Tannenbaum and Schmidt (1973) developed a continuum that defined several patterns of leadership for managers to choose in relating to subordinates. The continuum ranges from boss-centred leadership, which is based on the use of managerial authority, to subordinate-centred leadership, which promotes maximal freedom for subordinates within limits defined by the superior. Seven types of decision making or leadership behaviours were identified: "the manager makes decision and announces it; manager sells decision; manager presents decision and invites questions; manager presents decision tentative subject to change; manager presents problem, gets suggestions, makes decision; manager defines limits, asks group to make decision; and manager permits subordinates to function within limits defined by superior" (Tannenbaum & Schmidt, p. 164).

In reviewing their original work of 1958, Tannenbaum and

Schmidt (1973b) noted that changing trends in management have focused on an open systems theory which emphasizes subsystem interdependency and the relationship between the organization and the environment. In keeping with changing trends, the original continuum model has been adapted. While managerial power was the primary factor in the original model, changing trends such as unionism and group action and the recognition of the impact of subordinate resistance has resulted in a model that recognizes the power of both managers and subordinates. Subordinates are now called nonmanagers and managerial behaviors are constantly redefined by interactions between managers and nonmanagers and environmental changes. Both managers and nonmanagers are viewed as capable of changing the external boundaries of their own organization and society.

Managerial Grid:

Blake and Mouton's grid approach to leadership is similar to the Ohio State studies which focused on consideration and initiating structure and the Michigan State studies which focused on job-centred and employee-centred behaviors. The grid has two continuums that are numbered 1-9. Concern for people and concern for production are the two continuums or variables from which five styles of leadership have emerged. The 5,5 leader maintains output and employee morale at a satisfactory level. The 1,9 leader has extreme concern for people, while the 9,1 leader has extreme concern for tasks. The 1,1 leader has minimal concern for production and people in contrast to the 9,9 leader

who has extreme concern for both (Luthans, 1981).

A study conducted by Blake and Mouton (1982) determined that the 9,9 style was most often chosen as the superior method of dealing with a variety of situations regardless of employee maturity.

SITUATIONAL THEORIES:

Mockler (1971) describes situational theory as the unifying thread in a jungle of theories. He accuses past theorists of developing oversimplified general theories that are incongruent with reality. In situational theory, multiple variables are considered in determining how a leader should behave in a given situation.

Contingency Theory:

Contingency theory is based on the premise that group performance is dependent on the motivational system of the leader and the degree to which the leader has control and influence in a given situation (situational favorableness). The theory views leadership as an arena where the leader tries to achieve personal as well as organizational goals (Fiedler & Chemers, 1974).

The two key factors are leadership style and situational favorability. Leadership style is determined by the Least Preferred Co-worker Scale, which asks leaders to describe a person they worked with

least well. On the basis of results, the individual is identified as either a relations-oriented leader who is concerned with people or a task-orientated leader who is concerned with getting the job done (Fiedler, 1972).

Situational favorability focuses interpersonal factors, task structure and position power which may make it more or less difficult for leaders to control and influence subordinates. The leadership style is dependent on all three factors or situational favorability (Adams & Yoder, 1985).

Vecchio (1977) and Hill (1969) both conducted studies to determine the validity of Feidler's theory. The results of both studies show that the generalizability or predictability of the model in determining leadership effectiveness has not been empirically proven. Kabanoff (1981) reviewed studies using Fiedler's model and noted that leadership style affects productivity when structural and situational variables are controlled for. The major problem is that appropriate criteria for measuring leadership effectiveness has not been developed.

Path-Goal Model:

Robert House (1971) used expectancy theory to develop the path goal theory. According to expectancy theory, individuals behave in a certain way because they expect that their behaviour will produce satisfactory results. Subordinates consider their abilities, barriers to and

support for goal attainment and the degree to which goal attainment will be recognized and rewarded. The leader facilitates goal achievement of followers and provides rewards for results. The role of the leader is to clarify for subordinates what behaviour will lead to the accomplishment of goals and reduce uncertainties related to the subordinates environment.

In the Path-Goal Model, there are four styles of leadership behaviour: directive, supportive, participative and achievement orientated. Leadership behaviour is viewed as flexible. The leader considers personal characteristics of subordinates, organizational pressures and demands impacting on subordinates and subordinate's perceptions and motivation to determine what style is appropriate (Gibson et al., 1985).

Gibson et al. (1985) identified the following weaknesses of the model: the predictability of the model has not been firmly established and subordinate performance or behaviour may change leadership behaviour rather than the reverse.

Life Cycle Theory\The Situational Leadership Model:

According to the Life Cycle Theory, there are four leadership styles based on different combinations of directive and supportive leader behaviour. Directive behaviour refers to the extent to which the leader tells followers what to do; where, when and how to do it and

closely supervises. Supportive behaviour refers to the extent to which a leader provides support and encouragement and allows followers to be involved in the decision making process. The four leadership styles are: high supportive-low directive, high supportive-high directive, low supportive-low directive and low supportive-high directive. The style used is determined by an assessment of job maturity and psychological maturity of subordinates. Job maturity refers to the ability of the individual to perform the job and is affected by prior education and experience. Psychological maturity reflects the individual's motivation to complete the task (Hershey & Blanchard, 1982; Blanchard, 1983; & Hershey, 1984).

Hambleton and Gumbert (1982) studied managers and subordinates to determine the usefulness and validity of the situational leadership approach. They found that high performing managers had more knowledge of the theory; were more flexible in leadership style selection; were rated by themselves and subordinates as effective and were more likely to rate their follower's performance higher in comparison to managers not applying the theory correctly.

Vecchio (1987) studied high school principals and teachers to test and explore the situational leadership theory in an organization. The theory was most appropriate for subordinates who lack knowledge related to the task and committment. On the results of the findings the researcher suggested that subordinates who are skillful and motivated may in fact do well in the absence of any leadership behaviors.

Transformational and Transactional Leadership

Burns (1978) identified two types of leadership: transformational and transactional. Bass (1985a) noted that in organizations

> the lower order of improvement - changes in degree or marginal improvement - can be seen as a result of leadership that is an exchange process: a transaction in which followers' needs are met if their performance measures up to their explicit or implicit contracts with their leader. But higher-order improvements calls for transformational leadership.

Bass (1985b) completed a pilot study on 70 male senior executives to develop a scale that measured transformational and transactional leadership. Senior managers were asked to describe transactional leaders. Transactional leaders were described as: treating others as equals; providing a model of integrity; being fair; setting clear and high standards of performance; being willing to share knowledge and expertise; being helpful, supportive and a good listener; and providing recognition. A comprehensive literature review identified additional characteristics. Contingent reward and management by exception were found to be the key factors in transactional leadership (Bass, 1985b). Contingent reward denotes telling followers what to do in order for followers to achieve a desired reward. Management by exception refers to a style of non-interference and directions are only given if standards are not met (Bass, 1988). Further studies supported the initial findings.

Bass (1985b) discovered that charisma, individualized consideration and intellectual stimulation were the key factors in transformational

leadership. Avolio and Bass (1988) noted that the leader with charisma encourages others to have pride and self-respect, can readily identify the important issues and has a sense of vision that is effectively communicated to others. Individualized consideration refers to responding to the needs of followers on an individual basis and providing experiences that lead to the development of followers. Intellectual stimulation focuses on the reframing of thinking, enabling followers to analyze and solve problems.

The review of the major descriptive, behavioral and situational leadership theories shows that no one theory can be viewed as either complete or perfect and further research is required.

LEADERSHIP AND GENDER

Are male leaders and female leaders different? This question is not easily answered as the findings in the literature are so variable. As nursing is a female dominated profession, the effects of gender on leadership do have implications for nursing leadership.

FEMALE SOCIALIZATION AND CAREER PATHS:

The traditional socialization process of women is distinctly different from that of men. Little girls are rewarded for behaving in a manner that is considered feminine and emulates the traditional behaviors of mothers. Girls who are aggressive, logical, analytical and

rational are considered unfeminine. Girls are discouraged from pursuing male designated activities. Girls are not encouraged to be independent, but instead are protected and a passive orientation results (Grissum & Spengler, 1976).

Ireson and Gill (1988) identified that there are a number of variables that impact on a female's occupational choice. They include: parental influence; social structure variables such as class, race and place of residence; school influences; peer influences; media influences and individual characteristics such as values, abilities, knowledge and personality.

The traditional model of female socialization may be incongruent with the actual socialization of future female leaders. A study of successful managerial women completed by Hennig and Jardim (1977) identified that the subjects' mothers fit the traditional female model. The subjects' fathers confirmed their right to seek non-traditional roles. The subjects developed masculine qualities yet identified themselves as female. Hennig and Jardim noted "innate masculine traits, might be better understood if they were seen as based on knowledge, skill and competence which boys develop by virtue of the kinds of activities and relationships in which they engage, the ways of thinking to which they are exposed and the rewards they win for mastery of any of these things" (p. 93).

Kanter (1977) completed an observational study of leaders of all

female professional groups in service organizations. She discovered that structure or the situation was the key determinant of behaviour rather than gender. Behaviors of female leaders could not be differentiated from behaviors of male leaders.

GENDER AND LEADERSHIP TRAITS:

Brown (1979) completed a comprehensive review of studies on women in leadership roles. He noted that results comparing male and female leaders are inconclusive; however, sex-stereotyping was evident from the results. In the actual work situation, the belief that women are ineffective leaders does not seem to hold true.

Keown and Keown (1982) studied 21 women who had achieved corporate success. The women in the study noted that: important people were willing to listen to them; promotions were based on competence; relations with superiors were quite good; and education, having a mentor and luck were important in achieving success. They perceived themselves as above average in positive attitude, self-knowledge, intellectual ability and assertiveness. Female executives tended to use the selling style of leadership and participative style as the second choice. Delegating and telling styles were used least. The women relied on their expertise more than their positional power or ability to provide rewards to subordinates.

Moore, Schaffer, Goodsell and Baringoldz (1983) studied

undergraduate students to determine if there was gender-related language differences in the leadership context. When the follower was male, female and male leaders focused on quantities and quotas and were frequently disapproving; however, when the follower was female the focus was instruction. In this study, no gender-related language differences in leaders were identified.

Donnel and Hall (1980) studied 2,000 managers to determine if there were sex-based differences between the two groups. Female managers were found to be more concerned with opportunities for growth, challenge and autonomy and did not exhibit a greater need to belong than their male counterparts. Women managers tended to be more mature and motivated towards high achievement. They were less willing to share information with subordinates.

Bartol (1974) identified that prior research has shown that a high need for dominance is related to leadership. She found that female leaders' high need for dominance did not affect follower satisfaction. Male followers were found to be less satisfied when led by a low need for dominance female. Bartol (1985) completed a further study to determine the effects of male versus female leaders on follower performance and satisfaction. No major differences were identified.

Jacobson and Effertz (1974) completed a study to determine if sex role stereotypes affect perceptions of performance in a leadership situation. Women in leadership positions were perceived by others and

themselves as doing a better job than male leaders despite performance being equal. Males and females were found to enjoy the leadership role equally well.

Van Der Merwe (1978) conducted a descriptive study of 100 women managers in Canada. The results were as follows: the majority of women managers were over 30, unmarried and had no children; only half of the respondents had university degrees or diplomas; the women were most often employed in personnel departments; half of the respondents believe men dislike working for a female; the majority of women were promoted from within the organization; women managers usually worked more than 40 hours per week; their success was attributed to determination, competence, intelligence, interpersonal skill, effort, aggressiveness and luck; and women identified discrimination, management attitudes and low ambition and low self-esteem of women as barriers to advancement.

In a comparative study to determine differences in performance and behaviour patterns of male and female leaders, no differences were noted in regard to human relation skills or administrative technical skill. Female leaders were found to agree more, release more tension and ask for more suggestions than male leaders (Wexley & Hunt, 1974). The findings of this study differ from the results of a study done by Forsyth, Schlenker, Leary and McCown (1985) to determine gender differences in leadership. Female leaders' self-description focused on their openness with others, social attractiveness and willingness to get

along with others. Male leaders described themselves as powerful, influential, skillful and dominant. Both groups, however, viewed task ability as more important than interpersonal skill. The results indicate a conformity to traditional gender roles in society.

The variability of results indicates that there is no consensus on trait differences between male and female leaders. Sex role stereotyping, however, is a significant factor in gender focused leadership research.

GENDER AND BEHAVIORAL THEORIES:

Brown (1979) reviewed 13 studies that used behavioral theories to determine behaviour differences between male and female leaders. Only 3 of the 13 studies noted any significant differences between male and female leaders and these differences existed in studies conducted with student participants rather than individuals in the workplace setting. The following were the differences identified: women scored higher on consideration in one study; women were more task oriented in another study and male leaders were found to be more domineering in the final study.

Donnel and Hall (1980) studied male and female managers to determine their assumptions about subordinate intent and competence based on McGregor's Theory X and Theory Y. No significant difference was found between male and female managers. Donnel and Hall also

studied managers and subordinates using the Styles of Management Inventory based Blake and Mouton's managerial grid model. No differences were found in style preference of male and female managers. Subordinates' perceptions of style preference of male and female managers showed similar results.

Kushel and Newton (1986) completed a study to determine the effects of gender and leadership style on employee satisfaction. No style differences were identified between male and female leaders. Female subordinates were more satisfied with a democratic style of leadership. A study of male and female undergraduate students completed by Linomon, Barron and Falbo (1984) examined gender differences in perceptions of leadership. Women who rated their leadership ability as high usually described themselves as authoritarian leaders in comparison to men who described themselves as democratic leaders. A relationship between self-esteem and females self-rating as authoritarian leaders and males self-rating as democratic leaders was identified. Males were found to value an authoritarian style for others but not themselves. Women valued an authoritarian style in themselves and others. Women's task performance was equal to their male counterpart.

Petty and Miles (1976) conducted a study to investigate sex-role stereotyping in female-dominated organizations where both men and women hold leadership positions. They found that: consideration behaviour of female leaders is positively correlated with employee

satisfaction and negatively correlated with employees' propensity to leave; initiating structure, for male leaders, was positively correlated to employees' satisfaction with the supervisor and work motivation; and female employees perceive initiating structure behaviors of male leaders more positively than those of female leaders. Some support was found for the belief that sex-role stereotypes exist for the leadership role and are common to both male and female employees.

GENDER AND SITUATIONAL THEORIES:

Bullard and Cook (1975) used Fiedler's task-orientated and relationship-orientated framework to determine whether: task-orientated leaders were more productive; followers with a leader of the same sex were more productive and the most productive individuals would rate their teams as the most pleasant. 168 female undergraduates and 168 male undergraduates were divided into groups on the basis of results from the Least Preferred Co-worker Scale. Task-orientated leaders and groups with leaders of the same gender were not found to be more productive. There was some support for the hypothesis that productive groups rate their teams as more pleasant.

The purpose of a study completed by Chapman (1975) was to determine and compare the leadership styles of females and males and to identify relationships between situational and biographical data and leadership styles of both groups. All male and female respondents were in leadership positions and had similar responsibilities and formal

authority. The two groups were studied individually. Fiedler's Least Preferred Co-worker Scale and information about job and biographical data were included in the questionnaire. There was no differences identified between the leadership style of males and females. The researcher found that as the number of males in a female leader's group increased, a task orientated style was often the result. No other relationships were identified. Gender of followers may be more significant than the gender of the leader.

Powell, Butterfield and Mainiero (1981) completed a study of male and female undergraduate students. The purpose of the study was to determine if sex-role identity and sex were predictors of leadership style. The Least Preferred Co-worker scale was used to measure leadership style and The Bem Sex-role Inventory was used to measure masculinity and femininity self-concepts. No difference was identified between leadership styles of women and men. An association was found between masculinity and task orientation and masculinity and structuring behaviors. The researchers suggest that further study in the area of sex-role identity and leadership is warranted.

On the basis of previous research, no conclusions can be drawn that either support or refute that there are differences between male leaders and female leaders.

LEADERSHIP AND NURSING

Leadership in nursing may be viewed as somewhat unique because of the caring that is a part of the nursing role. The relationship between leadership and caring is not well documented in the literature. A variety of studies have been completed that focus on leadership in nursing.

NURSING AND CARING:

Watson (1979) describes nursing as the science of caring. "All human caring is related to intersubjective human responses to health and illness; a knowledge of health and illness,environmental-personal interactions; a knowledge of the nurse caring process; self-knowledge, knowledge of one's power and transaction limitations" (Watson, 1985, p.29). Caring is viewed as an essential component of nursing. Watson identified ten factors of caring: the development of a system of values; the sharing of faith and hope; the development of a sensitivity to others and oneself; the formation of a helping trusting relationship; the promotion and acceptance of the expression of positive and negative feelings; the use of effective problem solving in decision making; the promotion of interpersonal teaching-learning; the provision of a therapeutic environment; assistance with human need gratification and attention to the uniqueness of the individual (p. 9-10). These factors were identified to provide a framework for the study and understanding of caring.

Gilligan (1979) reviewed the literature and studied women contemplating abortion to construct a feminine perspective of reality. Gilligan's research identified that caring is a significant factor in women's development and caring for others is generally a higher priority than caring for one's self.

Knowlden (1988) used a grounded theory design to study nurse caring as constructed knowledge that is derived from experiences in nursing practice and education. Interpersonal communication - content and relationships - was found to be the critical factor. Content related to the teaching, assessment and physical care provided to patients; while relationships were demonstrated by concern, progress and hope, listening, building self-esteem, touching and humour.

Horner (1988) developed a caring model based on intersubject co-presence. Intersubjective co-presence refers to sharing the realities of another. Propositions of the model are: "(1) intersubjective co-presence will enhance the perception of caring; (2) clarifying a client's perception, through caring, may increase the attainment of humanistic goals: (3) clarifying the perceptions, of nurses and clients, may increase the instances of experiencing intersubjective co-presence in nursing" (p. 173). Sharing is a precursor to caring and is based on successful interactions between individuals.

Hernandez (1988) used a phenomenological design to study caring from the perspective of professional nurses. She found that professional

nurse's caring is wholistic in perspective, is intrinsically satisfying, is given without expectation of reward, and is developed through nursing experience and formal\informal learning. Availability of the professional nurse was a critical component to caring.

Benner (1984) found that nurses tend to devalue or hide their expert caring and that caring is not readily captured in a description of nursing. Society, in general, is not comfortable with and does not value caring because it denotes relying on others (Benner; Reverby, 1987). Benner identified that recovery from illness relies on treatment but cure ultimately is reliant on a context of care.

On the basis of research, the characteristic of caring is congruent with females, in general, and the profession of nursing. In the nursing profession, caring is an essential and critical variable.

NURSING LEADERSHIP AND GRADUATE EDUCATION:

Larsen (1984) used open ended interviews and a questionnaire to study the career development of ten nurses with doctoral preparation. Larsen found that the subjects' career was of primary importance and the majority of a subjects' adult life focused on work and ongoing education. Only 6 subjects identified having a mentor, however, the ongoing support of female friends and colleagues was found to be significant. Marriage or male relationships, children and family relationships were other major components of the subjects' lives.

Nurses in masters' programs in nursing who are interested in managerial roles tend to exhibit different personal attributes than graduate students not so inclined. Hanson and Chater (1983) found that graduate students who were interested in management were more practical minded, sociable, conforming, dominant, expressive and showed greater interest in their occupation. Hanson and Chater's study failed to identify whether clinical interests or specialization was controlled for in their research. A study by Gilbert (1975), however, found there was no appreciable difference in leadership potential between medical-surgical graduate nursing students and psychiatric graduate nursing students.

DESCRIPTIVE THEORIES:

Moore and Rickel (1980) studied women in traditional and non-traditional managerial roles to determine if they differed in personal characteristics. The traditional group was comprised of nurses in managerial roles. The non-traditional group included managers in business and industrial positions. Both groups saw their career as important. The nursing group, however, had more children, considered the domestic role more important, were less achievement orientated and less production orientated. The non-traditionalist group and women in higher level positions in both groups viewed themselves "as being more objective, decisive, logical, consistent, having leadership ability, being firm, assertive and skilled in business matters" (p. 328).

Vance (1977) studied nurse influentials or leaders in America. 95% of the subjects had either a doctoral or master's degree and 65% were educators. The following were identified as sources of influence: the ability to mobilize groups, academic credentials, collegial support, communication skills, creativity, credibility within the profession, economic resources, expertise in an area in the profession, innovativeness, intellectual ability, interpersonal skills, personality and charisma, political access, involvement in activities of the professional association, holding a position of power and prestige, research abilities, visibility, courage and a willingness to take risks. Vance (1979) found that the majority of the subjects had mentors and believed that they had acted as mentors to others. Married participants identified that their spouses were very supportive. 50% of the sample, however, were single, divorced or separated and only 33% had children.

Kinsey (1986) replicated the study of nurse influentials originally done by Connie Vance. A total of 42 nursing leaders were surveyed. The results were as follows: 58% of the group held positions in education while only 12% held clinical positions; 62% of the group worked in an urban setting; the median of hours worked per week was 60; on average, nurse influentials travel 30-40 days per year; 86% of the group reported having a mentor; 74% of the group were involved in research and authorship of books; 95% have had articles published and 88% of the group were involved in political activity. The group generally considered communication skills, creativity, a willingness to

take risks, interpersonal skills and professional credibility as key sources of influence. The results of Vance's study (1977) and Kinsey's were similar. This is not unexpected as 62% of the subjects participated in both studies.

Read (1987) compared the achievement orientation of male managers and head nurses. No major differences between the two groups were identified. One minor difference noted was that male managers scored higher on the competitiveness scale.

BEHAVIORAL THEORIES:

White (1971) surveyed 43 nurses in managerial positions in a general hospital. The subjects were each asked to identify the most and least effective supervisor and describe their behaviours on an established questionnaire. Effective managers were found to display characteristics associated with a participative leadership style while ineffective managers were found to display characteristics associated with an autocratic style of leadership. The most effective style of leadership was characterized by: being sensitive to and supportive of subordinates, showing trust and confidence in subordinates, sharing information, utilizing the ideas and expertise of subordinates and focusing on staff development and rewards rather than discipline. The findings of this study are congruent with the results of a study by Pryer and Distefano (1971) which focused on the subordinate perceptions of leadership behaviour, job satisfaction and locus of

control. The sample included nursing assistants and registered nurses. Consideration was positively related to job satisfaction for all groups. Initiating structure was found to be related to job satisfaction for nursing aids supervised by registered nurses. Locus of control was not found to be related to leadership behaviours for the registered nurse group.

Gruenfeld and Kassum (1973) conducted a study to determine the relationship between supervisory style of nurses and perceived organizational effectiveness. Organizational effectiveness was measured on three dimensions: satisfaction with supervision, patient care and organizational coordination. Quality patient care and satisfaction with supervision were associated with high initiating structure and high consideration. Organizational coordination was associated with initiating structure but not consideration.

A study was completed by Duxbury, Armstrong, Drew and Henly (1984) to determine if a relationship existed between staff nurse perceptions of leadership style and staff nurse satisfaction and burnout generally and in a neonatal intensive care unit. The sample consisted of 283 registered nurses from 14 neonatal intensive care units. Three separate instruments were used to measure satisfaction, burnout and leadership opinion. Head nurse consideration was found to be related to staff nurse satisfaction and to a lesser degree, burnout. No relationship was identified between initiating structure and satisfaction or burnout. In the clinical setting high consideration was found to protect against

burnout and job dissatisfaction related to high structure.

Lucas (1986) investigated the relationship between leadership behaviors of deans of nursing and organizational variables. 240 deans of accredited degree nursing programs were randomly selected. A relationship was identified between consideration and faculty expertise. Deans of faculties having a large number of staff prepared at a doctoral level were found to have higher consideration scores. A relationship was also identified between high initiating structure scores and faculty expertise, nursing educational tasks, institutional control, institutional task and institutional size.

SITUATIONAL THEORIES:

Goldenberg (1980) studied 35 heads of nursing diploma programs to determine if their leadership styles were consistent with Hershey and Blanchard's situational leadership theory. The dominant style used was low task/high relationship. The supporting style was found to be high task/high relationship. Style was found to be determined by follower maturity. The key finding was the supportive behaviour exhibited by the nursing leaders. Wakefield - Fisher (1986) reported similar findings. Wakefield - Fisher studied doctoral faculty to determine the relationship between professionalization of nursing faculty, leadership styles of deans and faculty productivity. The Blanchard and Hershey situational leadership model was used. The researcher found that low task/high relationship and high task/high relationship styles occurred

most frequently by nursing deans.

Maguire (1986) compared staff nurses' perceptions of head nurses' leadership style on primary nursing units and nonprimary nursing units. Hershey and Blanchard's situational model provided the framework for the study. Head nurses on primary nursing units were found to focus on higher relationship directed behaviour than their counterparts in nonprimary nursing units.

Yura, Ozimek and Walsh (1981) developed a system's theory of leadership after reviewing the leadership literature and testing their findings. Leadership was found to be influenced by the leader's knowledge and values. Four components of the leadership process were identified: deciding, relating, influencing and facilitating. Communication was a critical component in all categories and goal achievement was the end result. Power and flexibility are inherent in the leadership process. Leadership is affected by the organization, family, follower personality, character and needs and the needs and goals of individuals or groups in society.

SUMMARY

A review of the major theories in leadership has identified that no one theory has captured the essence of leadership. 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. The relationship between caring and nursing leadership has yet to be addressed by nurse researchers. A review of the leadership literature in nursing readily identifies a lack of research that focuses on leadership in nursing. Research that has been completed has generally utilized tools derived from the study of male leaders in the business setting. The review of the literature supports the premise that more research is needed in nursing leadership, particularly qualitative research, that identifies the nursing factor in nursing leadership. The nursing factor would include effects of caring and femaleness which are entwined in the profession.

The next chapter will describe the research methodology. Reliability and validity issues will be addressed. Ethical considerations will be outlined.

CHAPTER III

METHODOLOGY

This chapter includes an indepth description of the research design. Strengths and weaknesses of the methodology, sampling methods, subject recruitment and methods of data collection and analysis will be included. Reliability and validity of the findings and ethical considerations will be addressed.

DESIGN

A non-experimental descriptive design was selected. Polit and Hungler (1983) identify that the purpose of descriptive studies "is to observe, describe, and document aspects of a situation. Because the intent of such research is not to explain or to understand the underlying causes of the variables of interest, experimental designs are not required" (p. 142). As the purpose of this study was to describe leadership in nursing, a non-experimental approach was appropriate. Campbell (1977) suggests that knowledge in the area of leadership will be severely limited unless we go beyond the use of questionnaires in quantitative studies. To gain a more complete understanding of the concept, naturalistic observations and descriptive studies are needed. Lofland (cited in Patton, 1980) identified four key elements for the collection of qualitative data: close proximity to the person\situation being studied, a clear goal to capturing what is seen or heard, the art of description as a primary tool, and documenting the spoken words of

individuals. The major reason for using qualitative methods being that information gathered has greater depth and detail in comparison to information derived from quantitative studies (Patton).

A modified grounded theory approach was the qualitative method of choice for this pilot study. Grounded theory is a rigorous method of collecting and analyzing data. Hinds (1984) identifies six steps to the grounded theory approach that are performed simultaneously rather than individually. The steps are: open-ended data collection, content analysis and coding of data to identify recurring themes or categories, reviewing the literature, structured data collection based on identified themes, hypothesis formulation and review of the entire process. The process continues until no new categories are identified. The researcher has modified this approach. Due to time and financial restraints and a limited sample size, all potential categories were not identified. Multiple methods of data collection (interviews, observation and literature review) were used to increase the likelihood of total saturation of each category.

An initial review of the literature preceded the data collection process. Chenitz & Swanson (1986) recognize that academic requirements stipulate that a review of the literature be done before data collection. The authors suggest that the initial review be used to provide direction and purpose and to delineate the range and scope of the study. The ongoing review of the literature should be done as a form of data collection, focused and guided by findings from the entire data

collection and analysis procedure.

There are several reasons why a grounded theory approach was an appropriate choice for the study of nursing leadership. Chenitz and Swanson (1986) identified that grounded theory is an appropriate choice when prior research has not been done at a descriptive level and when theory does exist but may need refining. Both are the case in the study of leadership in nursing. In addition, grounded theory does not rely on one unit of measurement, so triangulation is possible. Interviews and field observations augment the ongoing review of the literature. Using multiple approaches rather than one single method is recommended by Yukl (1981) to reduce the limitations of any one single method.

STRENGTHS AND WEAKNESSES OF THE METHODOLOGY

Several strengths and weaknesses of grounded theory methodology have been identified. The most significant strength is that grounded theory studies contribute to theory development. Secondly, as categories are saturated, the researcher's confidence in the findings and credibility are increased. Interviewing and observations take place in the natural setting, rather than controlled environments, so an individual's behaviour can be assessed in light of the specific context of the situation and interactions with others. This provides both background and meaning to the behaviour (Emerson & Davis, cited in Chenitz & Swanson, 1986). Stern (1985) further identified that validity is increased as the researcher is not removed from the scene.

There are several weaknesses associated with grounded theory. First and foremost, grounded theory research is a long and painstaking process for both the researcher and the subjects. Subjects must be seen several times in the data gathering and verifying process. For this reason, subjects must be told at the onset the approximate amount of time required of them. Secondly, grounded theory studies cannot be replicated because each interview and observation is unique (Stern, 1985). Thirdly, results are generalizable to only the group from which the data was obtained.

SAMPLING

In grounded theory a strategy called theoretical sampling is utilized. Initially, the sample is selected because the phenomena of interest is known to exist within that group. On the basis of findings, the sample may be changed or increased to achieve the depth and breadth required for each category as it emerges. This process continues until all categories are saturated (Chenitz & Swanson, 1986). This approach was modified. Theoretical sampling was not used in this pilot study. The target population included all nurse administrators in Winnipeg, Manitoba, Canada. According to Polit and Hungler "the target population is the entire specified aggregate of cases about which the researcher would like to make generalizations" (p. 411). Due to time and financial constraints, it was not feasible to study such a large group. Instead a selection of four nurses, employed in an administrative position in Winnipeg, comprised the sample. The

following criteria were specified for the inclusion of nursing administrators in the sample:

1. The individual must be female.

2. The individual must have, at minimum, educational preparation at the masters level or above.

3. The individual must presently be employed in an administrative role and have, at minimum, three years of administrative experience.

4. The individual must be directly responsible for a specific area of nursing practice, research or education and be employed in a health care institution, a school of nursing or a community health agency within the boundaries of the City of Winnipeg.

5. The individual must be in a middle management position (supervisor or coordinator) or above.

SUBJECT RECRUITMENT

The subjects were sought from the roster at the Manitoba Association of Registered Nurses (MARN). Following approval by the Ethical Review Committee at the University of Manitoba, two copies of the research proposal were sent to the MARN for their approval (Appendix A). Permission for access was obtained from the research committee of the Manitoba Association of Registered Nurses. The MARN provided a list of names meeting the criteria. Through a process of random sampling, using a table of random numbers, ten individuals were selected. The potential participants were contacted by

individuals were selected. The potential participants were contacted by telephone to provide a brief explanation of the study and solicit their involvement (Appendix B). The researcher outlined the purpose of the study, the length of contact expected and assured potential participants that steps would be taken to ensure anonymity and confidentiality. Prospective participants were mailed a written explanation. The written explanation provided participants with a brief description of the study and reiterated the time involved in participating in the study and that anonymity and confidentiality were assured. The researcher provided potential respondents with a telephone number so they could ask further questions (Appendix C).

During the initial interview, the consent form, which had been approved by the Ethical Review Committee at the University of Manitoba was signed (Appendix D).

DATA COLLECTION & DATA ANALYSIS

Data were collected through face to face interviews and field observations. All interviews were tape recorded. All observations were documented in written form. Upon completion of each interview each tape was transcribed and with the assistance of a the software program, Ethnograph (Seidel, Kloslth & Seymour, 1988) the researcher coded the data. The same procedure was followed for field notes. Through the analysis process, a large number of categories were identified. Categories that were similar were grouped together as

patterns. The patterns that were identified related to the research questions of this study which were called themes.

A review of the literature followed each phase of the research process. The research process included four phases.

Phase one consisted of semi-structured face to face interviews, approximately one hour to one and a half hours in length, with each nursing administrator. Lofland (cited in Chenitz & Swanson) states "qualitative interviewing is to construct records of action-in-process from a variety of people who have likely performed these actions time and time again" (p. 67). All respondents were asked questions pertaining to demographic data. These questions were followed by the interview schedule (Appendix E). The interview was deliberately general. The questions focused on factors associated with and affecting nursing leadership and prerequisites to the leadership role. Responses from the participants guided the interview.

Phase two consisted of semi-structured face to face interviews, approximately one hour in length. The purpose of second interview was to expand upon the findings from the initial interviews with all subjects and include questions that emerged from the review of the literature. The second interview schedule was developed following analysis of the initial interviews and a review of the literature. Clarification and verification of findings and analysis were also included. Respondents were given the opportunity to recount anything further that has

occurred to them since the last meeting.

Immediately following the second interview, the third phase of the study was implemented. Phase three consisted of non-participant observation of three of the subjects at work for approximately five working days. The fourth subject could not be observed due to an employment change. The researcher confined interactions with the subjects to seeking clarification of behaviors and meaning. Thorough field notes of observations and interactions with the interviewer were kept.

Phase four was the final stage of the study. The four nursing leaders were interviewed individually for one half hour to one hour. The purpose of the final interview was to verify the final analysis which had identified specific themes, patterns and categories with the subjects. Subjects were provided with the opportunity to identify other categories which they believed to be significant.

RELIABILITY AND VALIDITY OF FINDINGS

In any scientific study, researchers must be concerned with the validity and reliability of their findings. In qualitative studies, the establishment of validity and reliability of findings is called trustworthiness. Lincoln and Guba (1985) have identified four criteria for judging the trustworthiness of the results of qualitative research: truth value, applicability, consistency and neutrality.

Truth Value: Truth value refers to credibility (Lincoln & Guba, 1985). Credibility was addressed through: (1) Prolonged engagement with the subjects; (2) Several meetings with the same subjects to confirm the findings; (3) Ongoing confirmation of findings during the period of non-participant observation; (4) Multiple methods of data collection-interviews, non-participant observation and literature review - to permit triangulation.

Applicability: In qualitative studies, applicability is addressed through transferability. Lincoln and Guba (1985) identify that transferability is the problem of the individual attempting to apply the data to another situation. The responsibility of the researcher is to provide enough descriptive data so similar analysis or judgments can be made by others. Applicability has been addressed through indepth presentation of data so that analysis can be confirmed by others.

Consistency: In conventional studies consistency is established by replication. Qualitative studies are not considered replicable so the researcher must instead rely on the dependability. Dependability of the findings was established through the audit process (Lincoln & Guba, 1985). Two transcribed and coded interviews were reviewed independently by two nurse researchers and the members of the researcher's thesis committee to ensure consistency in analysis and interpretations of the data.

Neutrality: According to Lincoln and Guba (1985) neutrality is

accomplished by ensuring objectivity. Objectivity was addressed in several ways. The coded interviews were reviewed by two nurse researchers and the thesis committee. One nurse researcher had no administrative experience while the other was experienced in nursing administration. The auditor without experience served to reduce the possibility of research bias, while the other auditor provided expert opinion. There was general agreement on the analysis of the data. Triangulation and confirmation of analysis by subjects contributed to researcher objectivity.

ETHICAL CONSIDERATIONS

Prior to the implementation of the study, approval was sought from the Ethical Review Committee at the University of Manitoba. Approval to allow the researcher to utilize the MARN roster to sample the population was obtained from the Research Committee at the Manitoba Association of Registered Nurses.

The rights of the respondents were respected. Respondents were provided with a verbal explanation via telephone and a written explanation. A consent form was signed by all applicants. Subjects were informed that:

1. Approximately three and one half hours of interview time and five days of non-participant observation would be required.

2. They may choose not to answer any questions and could withdraw from the study at any time without explanation.

field notes would be identifiable by a code number only. Only the researcher would know the identity of the respondents. Code numbers and names would be kept in separate locked drawers.

4.   All tapes would be erased and all field notes destroyed after transcription.

5. Upon request, an abstract and\or copy of the entire study would be provided to participants.

The researcher ensured that all interviews took place in a comfortable environment. No risks were anticipated as a result of the study. Should any difficulties have occurred, as a result of participation in the study, the researcher, with the consent of the respondent, would have assisted in procuring appropriate assistance. While there were no direct benefits to any of the respondents; some respondents may appreciate the indirect benefits. New knowledge was generated in the area of nursing leadership that may guide further research: for example, an evaluation of previous nursing research findings or an assessment of present nursing leadership education. Through a better understanding of the concept of nursing leadership, nursing administration and leadership roles may become more attractive career alternatives for nurses.

SUMMARY

This chapter has outlined the methods used to conduct a descriptive research study of nursing leadership using grounded theory methodology. Validity and reliability issues were addressed and the data collection and analysis procedures were described. Measures to protect the ethical rights of subjects were identified. The next chapter will present the results of the study.

CHAPTER IV

RESULTS

This chapter will include a description of the subjects as well as a comprehensive description of the data. The identified themes are synonymous with the research questions. Patterns were developed after reviewing emerging categories. Data supporting the categories will be presented.

Description of Subjects

Four subjects were randomly selected. The subjects ranged in age from 34 to 58, with a mean age of 44. Three subjects were currently married and one subject was widowed. Three of the subjects had children. Three of the subjects received their initial education at diploma schools of nursing. One subject received her initial nursing education at a university. Two subjects had undergraduate degrees in nursing. One subject had a Bachelor of Arts degree. One subject had a Bachelor of Science Degree and a Degree in Health Services Administration. Two subjects had Master of Nursing degrees, while the other two had either a Master of Health Services degree or a Master of Business Administration degree respectively. Two of the participants had completed certificate programs. One had completed a program in clinical specialization and three management related programs. The other subject had completed two management programs.

All subjects had worked as general duty nurses. The length of experience in general duty nursing ranged from 1 to 5 years with a mean of 2.75 years. Three of the subjects had been employed as educators for a period ranging from 1 to 5 years. Three of the subjects had completed formal research studies. The subjects had been employed in administrative positions for a period ranging from 5 to 15 years, with a mean of 9 years. While the administrative titles varied, all individuals were presently employed as the senior nursing officer or second in the organization's nursing hierarchy. Two of the subjects identified that they were active in the Manitoba Association of Registered Nurses and none reported being active in the Canadian Nurses Association. All reported that they were active or affiliated with other professional groups. Only one subject reported that she had published 4 articles. All subjects had given presentations at nursing conferences. All subjects subscribed to professional journals. The number of professional journals subscribed to ranged from 2 to 8, with a mean of 4.

FINDINGS OF THE STUDY

Three themes emerged from the analysis of the data. The themes identified were congruent with the research questions that were developed to describe the nature of leadership in nursing. The three themes are Prerequisites to Leadership, Key Concepts of Leadership and Factors Affecting Nursing Leadership. All themes were found to have distinct patterns. Various categories were included under related

categories (Table 1). The ongoing review of the literature added further clarity to the themes, patterns and categories. The verification and clarification process that was ongoing with each of the subjects ensured confidence in the developed themes, patterns and categories.

The data will be presented by identified themes. Each theme shall be further separated into patterns and categories. Themes, patterns and categories shall be defined, as necessary, to ensure understanding. Each category shall be supported with excerpts from the data. In each category only one response from each participants will be provided as examples to support analysis. To protect participants' confidentiality, participant comments shall be identified by the title "subject". Observations made by the researcher will be identified by the title "researcher".

TABLE 1

THE NATURE OF LEADERSHIP IN NURSING

THEME: LEADERSHIP DEVELOPMENT

Pattern: Prior Experience

> Categories:

>> Family
>> Education
>> Clinical Nursing Background
>> Role Models
>> Previous Leadership Roles

THEME: KEY CONCEPTS OF LEADERSHIP

Pattern: Characteristics

> Categories:

>> Creative
>> Knowledgeable
>> Flexible
>> Intuitive
>> Persuasive
>> Empathetic
>> Confident
>> Risktakers
>> Visionary
>> Agents of Change
>> Commitment

Pattern: Values

> Categories:

>> Patient Care
>> Status/Image of Nursing
>> Collegiality
>> Balance Between Personal & Professional Life

Pattern: Skills

    Categories:

        Communication
        Interpersonal
        Information Gathering
        Strategizing
        Decisionmaking
        Collaboration
        Problem Solving
        Management

Pattern: Duties

    Categories:

        Defining the Boundaries of Nursing
        Role Modelling
        Teambuilding
        Developing Others
        Ongoing Self-development

THEME: FACTORS AFFECTING NURSING LEADERSHIP

Pattern: Followers

    Categories:

        The Person
        Experience

Pattern: Organization

    Categories:

        Unionism
        History
        Structure

Pattern: Society

    Categories:

        Needs/Demands
        Health Care Funding
        Status of Women

Theme 1: Leadership Development

Evidence from the data supports the concept that leadership in nursing is the result of a personal and professional developmental process that takes place through childhood experiences, educational experiences and professional socialization. One pattern was identified from the data under the theme Leadership Development: Prior Experience.

Pattern 1: Prior Experience

Prior experiences both in the family of origin and within the profession were identified as important to the development of leadership capabilities. All subjects referred back to prior experiences as either assisting them in their development as leaders or providing support in their overall development. The comments that were made provide strong evidence that past experience is a significant element in nursing leadership.

1. Subject: My experiences over the years have helped me to become more fluent in my thinking and more smooth in my operation because I have built up a lot of confidence and knowledge over the years. I've learned from my experiences, my experiential learning and from my theoretical knowledge. All has improved over the years. So those things have contributed to different behaviors.

2. Subject: Personal experiences, the community that I was in during my youth, family, school, yes, definitely university, both degrees.

3. Subject: I had a strong clinical base, a wide variety of experiences. I've worked with a wide variety of people both in the international scene and that requires a lot of learning. Some very painful experiences, but it has taught me a lot about myself.

The experiences identified by the subjects have been divided into five categories: Family, Education, Clinical Nursing Background, Role Models and Previous Leadership Roles.

Category 1: Family

All subjects related that family experiences had some impact on their development as future nursing leaders. All subjects were encouraged or challenged by family members or youthful experiences to develop as individuals in the way of their choosing.

> 1. Subject: I think that growing up on a farm, as one of three girls, no man around, during the war... I didn't grow up with any male role model that set my mind to any preconceived notion about what men should do and what women should do. For my time, I was considered something of a rebel. I was a rebel and a rabble rouser because I never accepted the stereotypical view of what women could or should do. I learned very early to rely on me. Not that I don't accept help from anybody, I do, but I don't go out asking for it. I think maybe my upbringing had a lot to do with that. I'm English and there is a strong independent streak in English people and it was well developed in me.

> 2. Subject: I had the fortune of coming from a very loving, caring family, who supported you no matter what you did, and always supported you in what you wanted to do, and making what you were doing at the time a very important activity and tried to find out where you were in terms of what is going on in your life.

> 3. Subject: The family history was basically to do whatever you were going to do, to do it well and put a hundred percent effort into anything you choose to do. It really didn't matter what you wanted to do... I think that did encourage me not to be happy with the status quo but to always look at new frontiers and to be willing to risk and we were certainly encouraged to risk. The safety of the home was where you came back to but you needed to risk. That was an expectation, that one wasn't necessarily happy with the status quo and kept moving ahead.

4. Subject: I had a close relationship with my father and I bounced things off him and he was very accommodating and he gave me a lot of encouragement.He saw me as someone who could get people to do things.

Category 2: Education

As all the subjects had educational preparation at a Master's level, the identification of education as a critical factor in their development is hardly surprising. All subjects saw value in their education for a variety of reasons; however, all view education as important to their development. One subject acknowledged that education is a basis for respect from others while another viewed education as a method of reaffirming the correctness of past actions. Education was also recognized as a vehicle for attaining self-knowledge and learning critical thinking skills.

1. Subject: Educational preparation affects leadership because it keeps you on top of things, makes you aware of up and coming trends. It makes you be able to give more of yourself. It gives you more respect because if you have knowledge you are able to impart knowledge to others. People respect you for that, they need you and you're giving them something that they can use.

2. Subject: I studied organizational psychology. I studied a lot of psychology courses. I studied a lot of statistical courses as well. Many of the psychology courses were zeroing in on leadership, organizational leadership types. Many times when I was reading these things, the theories, the behaviors, and so on, I was reading what I had done almost by instinct and then I realized, this is what I should have been doing. So it was reinforced through education...
I learned in the Masters of Business Administration program that the very first step in problem solving is to identify the problem.

3. Subject: The Master's program, in particular, I think was a good founding ground for the kinds of activities that you go through, in engaging in an administrative role. I found that in

doing a research project for instance in my Master's program, it gave you the ability to learn that everything doesn't work out necessarily the first time around, but it doesn't hurt to go back and do things over again and to rethink things and to learn when you are rethinking things through.

4. Subject: In the Master's program or at the baccalaureate, all those courses. The one that keeps haunting me, is the one in the baccalaureate program where it was basically a group process for an entire year. I remember I was horrified that we were moving into a class where there was absolutely no curriculum and there was this horrible experience of sitting in this group, night after night, and the professor saying nothing and telling us nothing until we finally got through all those stages of anger and frustration. Until the group themselves developed that process of what it is that they wanted to learn and so on and so forth. There was just an awful lot of self-knowledge that occurred in that process and to me it was one of the most significant learning processes, very painful but very worthwhile.

Category 3: Clinical Nursing Background

All subjects in the study had previous clinical nursing experience. This experience has not been forgotten but rather is integral to the leadership role in nursing. Clearly, clinical experience is valued by the subjects and provides a base of understanding for the practice of nursing and awareness of the concerns of practicing nurses.

1. Subject: I don't believe in an individual without nursing experience coming in and being in charge of nurses because they do not know, they do not have a concept of what is taught to these nurses. They have never had any hands on care to know the type of care to deliver. How can they measure the quality of care when they don't know what quality is?

2. Subject: I think it was very important for me to work as a bedside nurse and I'll tell you why. It was important to have at least that one year of practice on the unit, to get the feeling that a staff nurse has, in working in a predominantly female profession, in a very structured setting and dealing with the problems that nurses deal with on units. I mean I have been the one registered nurse on nights with an aid that didn't speak

English, trying to take care of 60 patients on a unit. I mean I know the stresses of shortages of staff. I know what it is like to be stretched to the limit, so I have an appreciation for the types of issues, the types of concerns our staff have on units.

3. Subject: I had five years of, I would say, fairly direct patient care and I think a lot of people would say yes but it was so scattered that it was in so many different areas and I fully agree with that. But the learning was principal based, it was physiologically based, it was not procedurally based. I never learned that way. I am not terrified of being thrown into a clinical situation I have never dealt with because I feel very strongly about my knowledge base. I could probably relate to almost all of the clinical issues that people are facing. I have either experienced them myself either first hand or second hand.

4. Subject: Well it didn't matter that you were a student nurse, you were the nurse. It was you and one other student nurse being the only people in charge of a ward. We met many challenges. Yes, there was a supervisor but it may be a half an hour after you paged her before she got there. You either handled it or called a panic stat before she got there. In the end you handled many of these crises.

Category 4: Role Models

A role model is "a person whose behavior in a particular role is imitated by others" (Webster's, 1985, p. 1021). Having had role models, was identified as an important element in each subject's development. Role models identified were within the family of origin and/or within the realm of professional experience. Three subjects identified family members as role models.

1. Subject: My father was my role model. He was a strong person and being a lawyer, as well, you saw him in very different lights. When my daddy said something people had to listen.

2. Subject: In terms of my family, I had role model in my mother. My mother is a nurse and she was always on some committee, was a careerist, and wasn't working because she had to work. But her career was important to her and she always aspired to leadership positions, not just in her career, but in her life.

3. Subject: My husband, while he lived. He was a university graduate and before I went I back to university...He liked university and he was a university professor before the war, and maybe he had some influence. He kept saying why don't you go back to university, why don't you pick up a course or two. You'd really enjoy it.

Role models within the profession were also significant; however, not all role models were identified as being positive.

1. Subject: Some negative role models, that I thought, my God! If that person can do it and do such a ghastly job, I could go in there and do a lot better.

2. Subject: My personal perspective is that I can't ask anyone in the agency to do something unless I can give them some guidance on it. I've worked with supervisors who sent me off on a trail to do something and when I needed someone to bounce ideas off or whatever. I could never get it because there was the paucity of knowledge in the area. I didn't expect my supervisors to know all, but certainly to have enough knowledge to give you some guidance.

3. Subject: There is little doubt about it. I looked at the people in leadership roles within the institutions or the educational institutions and again looked at what I liked and what I didn't like. I think I evaluated people in their role and I certainly identified what I supported or what I did not support. Those kinds of experiences helped me to decide what I would do or not do within a leadership role.

Two of the subjects identified having positive nursing role models while they were completing their nursing education.

1. Subject: The one significant person that comes to mind is professor X from university. There were times, I'm sure everybody has, when they are going through their university years that they question what they are doing. I remember specifically an instance where I thought this was not going to be my chosen field and she sat down with me and we went over the reasons why I went into nursing and why I was thinking that perhaps it wasn't for me. I guess it was because of her that I stayed with it. She was just, she had the foresight that a nursing leader needed, that as students made our lives much easier. And

she was someone that you could look to and feel proud to be associated with. As a professional, she's an important person to me.

2. Subject: I can think about various people, people in all of the learning experiences like in the diploma program, and in the baccalaureate program and in the master's program. All of those areas, very definitely, who I would consider leaders in nursing that had a great impact on me. I know that especially in the diploma program, I modeled my behaviour as a new grad on what I had seen with a couple of my teachers. I recognize that. I think what I saw in them was a professionalism that I that I copied. I would say I had a mentor right in the diploma program. It ended when the diploma program ended. I mean you didn't continue. I think I was always afraid to request the continuation of the mentorship relationship so if I might have requested it might have continued but I didn't request it. I think there is always the dilemma of the student teacher thing and when the class course is over you kind of give up that relationship especially at that point in a diploma program. And I had the same kind of experience in the baccalaureate program. Again I saw an individual who I felt was truly a leader and there were various things she did in the clinical area that really impressed me. The way that she practiced her profession was very significant and I mimicked some of that and some of it went because it just didn't fit with me but it certainly helped me to identify what I felt was significant in leadership in nursing. I experienced the same thing in the master's level again with one of the professors that I was very impressed with. I must admit by that point, I looked at everybody with a little bit more jaded eyes than I did in the other two programs.

Positive role modelling was important to the development of all subjects and was experienced in educational settings and family setting. Experience with negative role models had occurred in the practice setting.

Category 5: Prior Leadership Roles

Two subjects identified that prior leadership roles had contributed to their development as nursing leaders. Neither of these experiences were in nursing groups.

1. Subject: Every time I joined a group, guess who was chairman? It would be me. So people saw me as a leader. When I started to say something people would take notice of what I was saying. Sometimes in the group I would sit back and I would be absorbing whatever they would be saying and then I would just draw a conclusion from that, what they were saying and then make my own personal contribution. I thought I was listened to and sometimes that was scary because many of the other people had good information as well and I thought people were inclined to go with what I was saying.

2. Subject: I think the role in the volunteer group, the X certainly had a very significant role in both consolidating some of my learning and experience and also giving me the forum to try out some skills related to leadership. Facilitating groups, bringing warring factions together and providing a conciliatory role in that but also providing a vision for what could be and assisting a group of people and I would consider marginal people, in this case women, to explore frontiers that they would normally might not have explored and so I think having had that experience... it was seven years in that organization and the last two years as president that it really it gave me an opportunity to learn a whole lot about myself but also what I was capable of as a leader. That was a very significant, there is no doubt about that.

Leadership experience, either intentional or unintentional, was important for two subjects. Through the experience, subjects were able to identify leadership potential, developskills and increase self-knowledge.

Theme: Key Concepts of Leadership

The second theme, Key Concepts of Leadership, is a broad theme that includes three separate patterns: Characteristics, Values, Skills and Duties.

Pattern 1: Characteristics

A characteristic is "a distinguishing trait" (Webster's, 1985, p. 227). Nursing leaders identified several personal characteristics that were significant. Related categories include: Creative, Knowledgeable, Flexible, Intuitive, Persuasive, Empathetic, Confident, Visionary, Risktakers, Agents of Change and Commitment.

Category 1: Creative

Creativity is defined as the ability to produce through imaginative skill (Webster's, 1985, p. 304). Being creative or creativity was generally related to change or improvement in patient services or nursing. Nursing leaders believe creativity is an important characteristic.

1. Subject: Right now, in the health care system, we are looking at community orientated programs; getting people out of hospital earlier. We are looking at day hospitals and so on and so on. And I feel as a health care giver in middle management you should be right in there and come up with ideas.

2. Researcher: In a meeting with her boss the subject related what had occurred during a meeting with consultants who were employed by the institution. The subject recounted some of the suggestions and alternatives she had provided them with that was cost effective, yet still provided support for the unit nurses.

3. Subject: I changed the configuration of the room. I changed the method of presentation, broke it down into smaller groups, changed the configuration of the room, used different methods for the flip-boards and different kinds of things. I told them not to bring any kind of pens or pads because we have great copiers and writers and scribes but to sort of sit there and do some responding. That can be quite difficult in terms of it's a new activity. I knew from myself that to try to use that large group

to get to the point that I wanted to was not going to work for me. That was not a strong way of doing it for me. There was another way that I was going to get what I wanted.

4. Researcher: The subject had created a new method of scheduling staff that was efficient but still flexible enough to meet the personal needs of staff.

Category 2: Knowledgeable

Knowledgeable is defined as "having or exhibiting knowledge and intelligence" (Webster's, 1985, p. 666). Knowledge refers to knowing something through experience or association (Webster's, p. 665). Self-knowledge was identified as a personal strength. Subjects note that knowing oneself will enhance and improve your leadership and confidence and assist in identifying areas for personal improvement.

1. Subject: You have to recognize your strengths and you have to recognize your weaknesses. You have to have the capability to do something about it.

2. Subject: I think you have to know who you are before you can lead or coordinate or manage a number of people.

3. Subject: If you know you're good at certain skills and that's one thing that I find even with the staff around me, not only is it a self awareness but awareness of the ability of people around you. In terms of self-awareness, if you find that you can work well within one type of, say method of delivery, method of instituting change, then you should frame your processes in that format.

4. Subject: The experience taught me a lot about myself and the integration of that learning in practice areas and then the continued learning in the educational areas really made me believe that I did have the ability and now the self knowledge to know what I needed to do to facilitate growth in other people.

Knowledge of the organization was identified as being an important to nursing leadership. Organizational knowledge is general, rather than specifically related to details about the organization.

1. Subject: You have to know about the organization that you work in.

2. Subject: You have to have knowledge of the process of the function of the unit that you are managing, or the organization, the overall function. I don't think you have to be the expert in all levels of procedure and process within in your organization. I think you need to certainly know the basic principles.

3. Subject: A nursing leader should have a feeling for the agency and what's going on, and a feeling for their department.

4. Subject: If you are an individual who is knowledgeable about all those other ares, it is pretty easy for that individual to move into an organization and quickly case the joint and know what's going on, know where the power sits etc. and recognize what they can or cannot do within an organization.

Nursing leaders noted that keeping informed or being knowledgeable about issues in the nursing profession was important. Issues identified by the leaders included nursing education and nursing shortages. The image/status of the nurse was also identified but will be reviewed under the theme Values.

1. Subject: From the professional perspective, there is a lot of emphasis being placed on education right now for us as professional, you want to keep studying.

2. Subject: We have so much quandary over the entry to practice issue. It impinges on us here in this agency on a day to day basis because there is such a split in nursing, in general, around the issue.

3. Subject: I make it a point to watch the staffing because there are nursing shortages happening all over. We haven't felt it here to any great extent.

<u>Category 3: Flexibility</u>

Flexibility refers to "a ready capability to adapt to new, different, or changing requirements" (Webster's, 1985, p. 472).

1. Subject: I do not believe that somebody should have tunnel vision and say this is the only way. If you have tried something this way or if you have been doing it like I said before, if you have been doing this a long time, there is no reason that you cannot look at another way of doing things.

2. Subject: There is a lot of grey. And if you are smart you will listen to the people who are promoting something perhaps I believe that I don't want, or I don't agree with, but you should listen anyway because it could change, refocus your perspective or change even a small part of it by some information that you'll glean from their observation.

3. Subject: I think that you'd be pretty foolish if you thought that at some point in time that you didn't need other people to, or you closed your mind so much to think that you knew it all, and that there wasn't anybody else who could provide you with a different perspective on it, because you lose so much if you don't.

One subject did not view flexibility as a distinct characteristic but rather as a component of creativity.

1. Subject: I see flexibility as part of creativity and I think that is what is important for a leader.

<u>Category 4: Intuitive</u>

Intuition is "the power or faculty of attaining to direct knowledge or cognition without evident rational thought and inference" (Webster's, 1985, p. 635). Intuitiveness was identified as a significant characteristic by all the nursing leaders. Intuition, however, generally

was not viewed as the sole consideration in decision making or problem identification.

1. Subject: Gut reaction, it has to be there. Of course, sometimes you just have a hunch about something and that hunch is going around in your head. On paper this looks pretty good, but I have a hunch. My intuition is telling me that it's not so right.

2. Subject: I think intuition has a place in any leadership, to a certain extent. I don't think you can do everything based on intuition. But I think your intuition comes, is it intuition or the skill of listening.

3. Subject: Intuitiveness. I think that it has a role in balancing some decisions. You have a rating scale, you have an interview panel, but I still rely on intuition and in terms of some, that's not 100 percent what anybody's decision is placed on but I listen to those little messages and that is one example where intuitiveness is important.

4. Subject: I don't know where intuition comes from other than I know that when I sit down with people or when I, in any relationship with people I can quickly get to the heart of the issue.

Category 5: Persuasive

Persuasive comes from the root persuade which means "to advise, urge" (Webster's, 1985, p. 878). While persuasiveness was identified as a significant characteristic by three of the nursing leaders, this characteristic appears to be one that is used with consideration.

1. Subject: I felt that I could persuade people because of my persuasive attitude, persuade people in the right direction.

2. Subject: I had quite a lobbying job to do. We talked about it at length, I gave them the procedures, let them read it, write their comments out, give them back to me, called another meeting. I had a meeting that I required their attendance at. One hundred percent attendance was required. If they were off-duty they got paid for the time, to give them a chance to ventilate and ask questions and to think about it. When we did initiate it last

Monday, a week ago Tuesday rather, again it has gone very, very smoothly.

3. Subject: If you know how to work with people and if you feel strong enough about it, you can try your techniques of persuasion. If it is not an issue that is going to make or break you and you don't have to win every conflict every time, let it go and don't worry about it.

Category 6: Empathetic

Empathetic is the act of understanding and being sensitive to the feelings of others (Webster's, 1985, p. 407). Three subjects believed that they could be described as empathetic and this was important in their leadership role. When the last subject was asked the to verify whether this was true for her, the response was an emphatic no.

1. Subject: I think that perhaps I am a very caring person, and in everything that I do, even in looking after students that come to the hospital. I have never forgotten my days as a student. I remember how I was treated and the care and the nurturing that I needed. And I always look back at that and I always remind staff, now remember that you were a student, so give them the opportunity to learn. And so, in that respect I feel that, I am caring and that I like people to explore, I like people to get ahead.

2. Researcher: Subject spoke with assistant on how a nurse who was having difficulties was doing. In looking at nurses hours the needs of individual nurses in terms of family priorities were considered in addition to providing good client service. Assignments were kept quite flexible.

3. Subject: If a mother has two children at home and doesn't have time to participate in whatever, or the department because they have a different set of priorities. You have to understand that. You can't sort of say , well that person doesn't care.

Category 7: Confident

Confidence is defined as "faith in oneself and one's powers" (Webster's, 1985, p. 275). Confidence was viewed as an end result of experience.

1. Subject: My experiences over the years have helped me become more fluid in my thinking and more smooth in my operation because I have built up a lot of confidence and knowledge.

2. Subject: I think that as long as one isn't frightened by that and knows basically what needs to do be done in any clinical situation one finds themselves in. I think staff feel confident, begin to feel more confident in your own ability. I know as a educator that was something that came across loud and clear. I tended not to give students easy assignments because I felt confident that in handling any of the patient loads and I wanted students to feel confident. I was there to support them and we could work the problems together but I didn't give them easy loads and that basically forced them to move through very quickly and to find a way of handling situations. But that was because of my own confidence in the clinical area.

3. Subject: You can miss a good opportunity just because you don't really believe in yourself and you don't feel confident that you can do a good job, so you fail to take the opportunity.

Category 8: Risktaker

A risktaker is an individual who is willing to expose themself to to danger, hazard or loss (Webster's, 1985, p. 1018). Risktaking is believed to be an important characteristic of nursing leaders. The results of risktaking are not always positive and two subjects noted that you must weigh your decision to take the risk very carefully. An interesting point raised by some subjects was that losing or failing did not always deter the subjects. Weighing the possibilities of success was significant to some subjects.

1. Subject: What I mentioned, risktaking. If you believe in something, you have a strong sense of conviction about something, then you have covered your bases...one, two, three, four and so on. Then if your conviction is that strong, then you should be able to sell your product, bring it forward and say okay, we may fail or we may run with it. This is what I meant by risk taking.

2. Subject: I think you are always, you're always taking risks. Some big, some small.

3. Subject: Risk taking. Yes, particularly on the projects that we worked on. Sometimes risks haven't always paid out, panned out, but sometimes they've paid back in a great fashion.

4. Subject: Risktaking. Well I think that it relates to being willing to try new things, move outside the status-quo, reframing situations, all of those kinds of dimensions. I think being prepared to deal with responses, because you choose to work in a different way. That's what risk-taking is for me. It's a willingness to move outside of the normative frame of reference, the normative way for doing things. I think that you need to be smart about doing that. I think that you need to be careful about it, and you need to constantly evaluate whether you're willing to take it at this time and so sometimes I choose not to because, the fall-out will be too great, and so you need to wait sometimes for a while.

Two subjects suggested that risktaking should not be viewed as only a characteristic of nursing leaders but as an important characteristic to be developed in all nurses. Two subjects identified that part of the role of a leader was to facilitate risktaking in nurses.

1. Subject: I think nurses particularly need to be assisted to move outside of the procedural and to move into the professional and I think the safest way to do that and the way to facilitate that on the part of the leader is to encourage risk taking, to be supportive as they do that, to encourage self evaluation and encourage self-motivation, to encourage self-directedness. Now I know that may be unrealistic for a lot of people but I still believe that is possible. I just think that it'll take longer for some people but that's basically my philosophical bent.

2. Subject: I've taken an awful lot of risks throughout my life. I have been one that's been very fortunate in type of career moves and things that have come my way. But I've also given up a lot at different times and taken the risk, and I do it all the time. There are people that I've gone to school with, there are people

that I look back upon and they haven't changed. They haven't moved anywhere in their career because they've decided to take the steady-Eddy kind of pathway and not done anything different. I think we have to that in nursing, in general, in order to make changes and to broaden our sphere.

Risktaking is not always supported by others and can create difficulties for nursing leaders.

1. Subject: And that risk taking that we end up doing at times because we've become too cautious... it is an incredible disservice and I think that's why I've seen nursing leaders who I consider real leaders eventually just moving out. I think it leads to burn out and I'm very distressed about that. I keep hoping that I can handle that, those restriction, that restrictiveness so that I don't lose the risk taking, the willingness to take risks. After a while you say well what is the point of constantly putting yourself into the breach when in fact you know what you'll end up doing is perhaps marking time there for an extended period of time. And as soon as you start marking time you waste an incredible amount of energy and I think that leads to classic burn out.

2. Subject: After my research I started exploring and found out that there were programs available, and I found out that there was a centre for specialized care, and then I did feasibility studies to see just how this would fit into our structure and sure enough it worked with a lot of resentment from the allied professionals. The doctors for example. They didn't like it initially.

Category 9: Visionary

Webster's (1985) defines vision as "unusual discernment or foresight" (p. 1318). Three subjects identified that they had a vision for nursing. The vision of all the subjects related to the professionalization and improved status of nursing.

1. Subject: I guess my vision for nursing is that it will become a profession, that that the body of knowledge will be discrete and distinct and and our practice area will be very clear.

2. Subject: I would like to see nursing as a profession or, if you like, people who make up the profession of nursing become more self confident in the clinical setting, more convinced that they have something to offer as a nurse.

3. Subject: The vision that I have is to bring the nursing department to a point where it is again perceived as an equal partner in the health care team, as the coordinating and facilitating discipline in the hospital.

One subject clarified the difference between vision and goals. In defining the difference, the subject noted that the work situation is not conducive to exploring the vision.

1. Subject: The vision is more nebulous, the goals. I have a vision but I'm not sure what the goals are to attain that vision, so I see the goals as steps towards attaining the vision. Right now the vision is further away; it's some sense as to what might be. It is still not clear as to how one might go, might attain that vision, so I guess that's why you might spend a great deal of time. There are occasions when we are working that you see a light and you say, ah hah, that's a significant component but you don't have the luxury then of moving yourself out of the work situation to go and explore that and all the dimensions of that, and concertize that and explain it in a way that is transferable knowledge. I think we do have those occasions, but I think the vision cannot be truly identified until we see more dimensions of it. So, I have the vision but the goals are perhaps steps to attaining it. But the goals are more short-term and they're based on experience moment by moment, or they have a time-frame, whereas the vision is still something further away and it's not always possible to know what the steps are that we need to climb to get to that point. It's an evolutionary stage I guess, and I see goals as one way of attempting to move towards that. I think that's what I see as the difference between vision and goals.

Knowledge, based on educational learnings and experience was linked to the development of a vision.

1. Subject: I think in order to be visionary, I think that they need to be fairly knowledgeable about a broad spectrum of other knowledge whether it has to do with social sciences or humanitarian philosophy.I think that they need a good base in that. I think that they need to be very much a current individual and someone who has a lot of world knowledge, world experience.

I think all of those are very significant. So I guess it's all the general knowledge as well as all the professional knowledge. If you're going to be a leader I think you need to know an awful lot about interactive components and I guess those are related to social sciences, or maybe more into the humanitarian sciences. I think they need all of those.

Sharing and developing the vision in others was significant to one subject.

1. Subject: I also think that with relationship to the vision, I think I foster that in people. I certainly have been told that sometimes when I give my little speeches on professionalism, I get people excited and that's important.

Category 10: Agents of Change

An agent is an individual "who acts or exerts power" (Webster's, 1985, p. 64). All nursing leaders viewed themselves as agents of change. In a society where health care services must respond to the changing needs, the ability to accept and implement change is critical.

1. Subject: What I meant was that in any organization nothing is static. If you're not going forward, in response to outside forces and factors and influences and inside ones, then you're going backwards. You're not standing still and then if you are functioning in a leadership role, you have to be ready to promote and implement change as required, not stand with your feet nailed to the floor saying I can't do it or it can't be done.

2. Subject: I like to explore things. I'll give you an example in this area. Years ago nursing care was given quite differently and I thought there has to be better way of doing things. So I went out and did research...I found out there were programs available and sure enough it worked.

Two subjects selected a leadership role in nursing administration

so that they could implement changes within nursing.

> 1. Subject: Being a nurse who's a strong professional, when this position came open, I decided that this would be a good area that I could observe some change, facilitate change in nursing. The way that I saw it was initially to bring the role of nursing from a very traditional medical model type of nursing to one where nursing could stand alone and be an equal partner in the team.

> 2. Subject: I felt that I could probably compute the whole concept of leadership in an administrative role better than I could in the educational role that I had found myself in. And I think it was on that basis where I decided to make the move. I felt that I couldn't particularly effect change to the level that I wanted to as long as I stayed in education and although research really fascinated me and I'd love to spend all of my time doing research I think I was very cognizant of the fact if I really wanted to be satisfied. I needed to have an opportunity where I could make changes. And to me a leader is someone who can facilitate those changes.

One nursing leader had been hired to by an organization to make changes.

> 1. Researcher: The subject stated that she had been told when she was hired that she was hired to make changes and changes were expected.

One of the subjects discussed how changes must be supported by nurses in the organization to be successful.

> 1. Subject: Change has to be brought in and facilitated in a fashion that people can buy into it, that they have ownership on it. If you don't do that, then your change will not last. It will not be sustained and it will be actively undone, be undone behind the scenes, and many of the projects that we've had to work on in the nursing administration have taken us far longer in many respects than maybe it would take in another service setting because we've had to develop the individuals along with the budgets. So, when we talk about a leader and being a facilitator at change, that goes hand in hand with leadership, and if you can't do it I don't think you can be an effectual leader.

Category 11: Commitment

Three of the subjects felt that commitment was a significant characteristic of nursing leaders. Commitment is "the the state of being obliged or emotionally impelled" (Webster's, 1985, p. 265). The commitment may be related to goals, beliefs or the nursing profession. One subject noted that if you stand by your beliefs you will find that there will always be others who disagree with what you believe.

1. Subject: I have a strong sense of conviction. I think, in what I believe in. If it can work I go at it, and if it doesn't work in one perspective, I look at it in another perspective.

2. Subject: If you are someone who can stand by what they believe in then you're only going to be satisfying a portion of the population at any given time. I'm satisfied with my leadership style because I set out clear goals, clear performance standards.

3. Subject: I don't think the leaders that I see in nursing have necessarily set out to become leaders. I think they have evolved because they have such a strong professional commitment.

Pattern 2: Values

Values are defined as areas believed to be of importance to the nursing leader. The values identified by nursing leaders are related to the nursing profession, individuals within the profession and their own personal lives.

1. Subject: I believe very much in the ability of every nurse to come to a point where they understand what would be their ultimate goal. I think they are goal driven. I feel very strongly that people bring, everybody brings skills and abilities...I believe that the individual is driven by a gold ribbon.

2. Subject: We in leadership are trying to build into this

profession the morals, the spirit that people need to feel good about. Nursing is held in such low regard and I don't like being associated with a discipline that is held in low regard. I hold it in high regard so we have to be change agents. So those negative kinds of things just give me, make me all the more determined to change things.

3. Subject: I get the work done I want to do. I find it important to do in as humane a way as I can do it because I remember that it is people I'm working with, not numbers, not bodies, not just blocks that I am moving around. They have personal lives and they have feelings and they have needs.

For the pattern values, the categories identified were: Patient Care, Status/Image of Nursing, Collegiality and A Balance Between Personal and Professional Life.

Category 1: Patient Care

All subjects identified that patient care is a major focus in their role as nursing leaders.

1. Subject: I can make sure that the patients get the best care that they deserve. For example, we do not have to do things for 25 or 30 years and just do the same things. We should be able to go in there and perhaps be able to do some research and make contributions in that area, so that we do not stagnate. We can move on and do, keep abreast of things. And that in the long run offers better patient care.

2. Researcher: The subject was called on the telephone because a patient had a special request. The subject completed the necessary paperwork and called the appropriate individuals who could facilitate the request immediately. Feedback was provided to the client by phone.

3. Subject: The nursing care given in this agency is second to none. That's the one thing that I can't take credit for, wholly, but at least I can take credit for maintaining it, and that is making sure that the patients are being taken care of now. We have not lost the art of caring and taking care of people. We've had patients from other hospitals who come in here with

conditions that are deplorable. I know why. It is because nurses are so busy with technology, they don't take care of their skin, nails, the very basic things that we're taught in nursing. We do that here because that's a core component for taking care of the type of people we take care of. We are experts at taking care of this type of patient.

4. Subject: If I can facilitate changes in nursing, I truly believe that I can feel confident that the kind of care that is given by the nurses will also provide a greater sense of control for the patient. A greater sense of involvement in self-care, but where I fit... I know that I am too many levels removed from the patient, but I truly believe that if I can get nurses to a level of feeling responsible and autonomous and a good sense of who they are as individuals, especially who they are in their profession, the follow-up will be a different kind of interaction between patient and nurse. I think that the changes that will occur will be a greater sense of responsibility for the patient for their own care, a greater sense of involvement for their own care. And that doesn't mean that it's at arm's length care, but it simply means that the nurse begins to support what is there and encourages the individual to perhaps reframe, if I can use that word, reframe their experience of illness and and use their own strengths to to deal with it. So, although it's not direct, it certainly is an indirect goal. I know I talk very much about changes in nursing and that's because I truly believe that's the only way we're going to begin to recognize the patient as an individual who can handle most of the endless components that they're facing.

All subjects view patient care as being directly or indirectly under their control and the focus is on improving or maintaining the quality of patient care.

Category 2: The Status/Image of Nursing

Three subjects related that the negative status or image of the nursing profession was of great concern to them as they value the nursing profession.

1. Subject: I'm annoyed by some of the things that I see in the mass media and I think that we need to speak out to those. It's

not that I don't recognize the power of the printed page or the television or films or that kind of thing, and I think we just need to constantly need to let people know that it's inappropriate. I'm personally not going to spend all my time trying to be reactive. I'd rather be on the side of the proactive and I guess that's the other thing that I've learned, that I can't do both things and I really support the people who keep a constant watch on what's happening in our mass media or in looking at the image. I think that's a very significant role. I'd like to support that, but I can't do both things so I will probably spend more of my time being proactive and just keep moving it ahead as much as I can, the image of the nurse at the bedside, where I know that hopefully the patients will see the role of the nurses as being significant and in opposition of what they see on television or wherever.

2. Subject: I would like to see nursing as a profession, or if you like, people who make up the profession of nursing, become more self confident in the clinical setting, more convinced that they have something special to offer as a nurse and perhaps a little more assertive in stating this without going in there with a chip on their shoulder. We are a colleague in health care in a hospital. We're not the doormat; we're not the gopher; we're not the one who happens to supply a pair of hands and just follows orders. We do think and we have something to offer. I think that nurses, in general, should became more convinced that they have something very special to offer to health care... the medical community for instance. The younger doctors, I must say I think have a much, most of them anyway, have a better appreciation of what nurses do then some of the older ones do. That we're not just the handmaids to the doctors.

3. Subject: What I saw was a department that had stagnated, was not very progressive, was looked at as a secondary component of a multidisciplinary team. The fetchers and goers of a multi-disciplinary team, and I didn't feel very comfortable with that association as a professional and felt that with some direction and with some input we could move this department to being at least an equal partner in the health-care team again. It disappointed me to see nursing that way. It's going to take a long time to change it and I don't think that it's a perspective, that I would say, is unique to the service setting. I think that if you went to other hospitals they may be at different stages in that realm but I wanted to see nursing on an equal footing with the other disciplines in the hospital setting that I was working in.

Subjects identified that the altering the image/status of nursing was an important aspect in their role.

Category 3: Collegiality

Webster's (1985) defines collegial as the "power and authority vested equally in each of a number of colleagues" (p. 260). Collegiality between members of the nursing profession was identified by all subjects as a positive aspect of their leadership role. Collegiality was generally exhibited as peer support between nurses on a similar level in the hierarchy and was two directional. At times the support was given and at times the support was received.

> 1. Subject: And we tell each other, "we'll be going in and you just give me a good stare if you hear me saying something that I shouldn't be saying" and we work like that. I guess we have to depend on one another really. We're the only ones that we have.

> 2. Subject: In terms of my colleagues, here in nursing administration, they are my saviors for the most-part. I say that because we can very openly talk about out frustrations. We all have a working relationship where we feel pretty-well able to say what we feel and what we don't about things.

> 3. Researcher: The subject attended a luncheon held at a restaurant to welcome a nurse who had been recently hired and was assuming a position in the organization at the same level as the subject.

Supportive collegial relationships were evident between the subjects and their followers.

> 1. Subject: The nurses were more or less wanting to go along with me, because they found that they spent a lot of time running backwards and forwards. It wasn't fulfilling for them.

Collegial support, however, was not confined to relationships within the nursing department.

1. Researcher: After the meeting, an informal meeting was held with medical service chiefs. Issues and problems were discussed honestly. Subject provided some possible solutions to their problems. There was some humour and laughter in the discussion. Later, the subject stated that there was many things that nursing can assist medicine with to help them with some of their problems.

The collegiality was also exhibited as peer influence between nurses in similar positions.

1. Subject: Again, it's a trusting relaxed feeling, we're able to communicate with each other. We act as mentors for each other.

2. Subject: I think if you talk about people who influence you, even the colleagues that I work with in this agency, that, the (directors of nursing service) for instance, I find aspects of their practice that I think are
important and I think very much influence my practice, so that there's more than just a supervisor/whatever role. There's a collegial role, a sharing and everyone has their strengths and weaknesses, and if you can look to people for some of their strengths as well and be able to associate with them.

3. Subject: The colleagues, I think I think probably they are still have the greatest influence on me with relationship to in the concept of role modeling. Even my superior, I don't think is the one I model behaviours after but I think colleagues... I think there is still some modelling going on there. I think I still analyze the way they interact. If it seems to be a good fit and I may model that. Again, I don't think they affect my leadership style a great deal anymore but I think they did when I first started into a leadership position. I think I was influenced but I think they influence me less and less.

Nursing leaders were influenced by followers who are colleagues within the profession.

1. Subject: A senior head nurse arrived for a meeting with the subject. The subject and head nurse shared information freely. The behaviour was that of colleagues rather than superior-subordinate. The head nurse, an active union member, discussed union issues and the subject presented her perspective on the issues. The head nurses opinion was asked often.

2. Subject: If you cannot use their suggestions at this time, you're saying I'll store that. I may come back and use it. People feel a part of the group.

Collegiality as peer support and peer influence from and to nurses at a similar level, followers and counterparts in medicine is valued by nursing leaders.

Category 4: A Balance Between Personal & Professional Life.

Nursing leaders can be viewed as career women but the value placed on their personal lives is of equal importance to them as individuals.

1. Subject: My family is still important to me now. My husband is important to me. I've never been one who, and I don't think I ever will... I'm not going to totally devote myself, mind and body, 100% of the time to my profession. My family life is equally as important and I need both parts and if one overshadows the other I can tell. In terms of the fact that there is far too much, you can see the stress on the personal life. My personal life starts to impinge on the professional life. You can see that as well, so a good coming to a good solid, loving family assisted me personally, feeling that I could move and do whatever I put my mind to.

2. Subject: I think that unless the individual, and personal and professional... I see it as three dimensions. The personal, the professional, and then the work environment, and I feel strongly that the personal needs, all three of them need to be in balance. Your own personal agendas whatever that is, you need to protect it because it's probably the only thing that will be there. If, for example, the work situation doesn't work out, the personal needs to be there. So, I think that's sacred territory. Equally I feel as an individual, as a professional I have an obligation to be involved in the professional field in whatever way. I don't think it necessarily means that you need to be on a committee every year but I do think you need to be contributing something either in research or in writing or committee work and I'm very selective because I know the time commitments and then obviously the work situation is significant. But I think it's a three-pronged balancing act.

3. Subject: For my leadership role. Definitely I think that it is important for me because the problems at work, if I go home, then I have a supportive relationship there. If I didn't have that at home when I go home then I'll be back here the next day and I'll be twice as worse, but when you have support and its very good.

A balance between professional and personal life appears to be extremely important as personal relationships provide ongoing support and a lacking in one area would likely infringe upon the other.

Pattern 3: Skills

Nursing leaders have identified that they have a variety of skills that are important in their role. A skill is broadly defined as the ability to do something well. The categories are Communication, Interpersonal, Information Gathering, Strategy, Decision making, Collaboration, Problem Solving and Management.

Category 1: Communication

Effective communication was identified by all nursing leaders as a significant skill. Communication is the vehicle for sharing information. One subject noted that at times her communication methods were questioned, but believes her individual style helps break down barriers.

> 1. Subject: Now I have been criticized for being too abrupt, or something like that and being too shocking or too abrupt as well. I have been criticized for that. Perhaps it's because I want to stress my point, I have a point and I feel that it is valid and of course, I'm sure that it happens with you too. If you want to bear a cross then people will just try to close shop and you're knocking and you want to get in, and you try all angles and sometimes you come out a little bit too strong, and people feel that you are being overpotting. So, but that I do feel that communication is a strong trait for me.

Another subject introduced that respect for the individual was an important message in any verbal or non-verbal communication and what messages are conveyed will be returned in kind.

1. Subject: I consider the sanctity of the other individual. I believe that they are adult human beings and I would refuse to accept anything else. I know that there are people probably who are less adult or mature and have less self knowledge than what I think I do about myself but on the other hand I truly believe that what you give to the other individual, what you are saying whether it be overtly or covertly, verbal or non-verbal, I think that's what you get in return and so to me that's one of the most significant factors.

Communication processes of nursing leaders may be in verbal or written form and are often formal. This is understandable as each subject was employed in the upper echelons of the nursing organization.

1. Subject: Keeping people informed, keeping it clear so that everybody knows, not just the person that you talked to today. Which is why this memo came out. Now I'm sure I could say that X and Y know but am I sure that X and Y are going to talk to the other eighteen people and make sure that they know? I can't. I shouldn't even expect them to do that. That used to be the habit of communication in the department.

2. Subject: I had a supervision meeting with each of the Directors of Nursing (DON) every two weeks. The purpose of that meeting was to, in the privacy of my own office was to share with the DON any concerns that they might have or any of the staff that I directly supervise. Secondly to find out where they are at with their projects, whether its patient classification or whatever, find out where they are and provide direction for them. The same set of supervisory meetings are set up with each of the DONs and each of the head nurses.

3. Researcher: At a head nurse meeting the subject provided information to the head nurses about upcoming changes within the institution.

One nursing leader identified that writing is a significant method of communication for nursing leaders.

1. Subject: I think you either need to be able to speak or you need to be able to write. I think that those are, in order to get your ideas across, I think one or the other or both are probably useful. I enjoy writing because I think that's sharing the vision.

Category 2: Interpersonal

Interpersonal skill refers to the building and maintenance of relationships. Interpersonal skill was identified by three of the subjects as important to their leadership role. Relationships, were built over time, with heavy reliance on these skills. Communication is a integral component of interpersonal skill.

1. Subject: It is the people skills that I have developed a lot over the years that make people want to come to me as a leader, that want to get ideas from me.

2. Subject: They have all called me by my first name , they have from day one. It was, what do you want us to call you? I said call me whatever you are comfortable with. If you are a person who prefers to be formal then you are not going to be comfortable calling me by my first name. If because I say you have to call me Mrs. you are going to be forever uncomfortable then for heaven's sakes call me by my first name.

3. Subject: I have pretty good people skills as well. I think you need that particularly if you are working in an agency where you are not...If I was a researcher or if I was in a type of position where your exchanges with people is minimal you wouldn't have to be as good at negotiating skills. You do have to in a position like this.

One subject believes that while interpersonal skill are important for managers, this is not necessarily true for leaders.

> 1. Subject: I would say that's important if you are, for a manager, to be a good manager you need good interpersonal skills, but as a leader, you can, no I don't think that you need that. In fact I think some of them are totally obnoxious. I mean, when I think about some of our leaders in nursing, I find them quite difficult (laugh), and yet I see them as leaders within their profession.

Interpersonal skill is viewed by two subjects as a method to heal dissention but it is also a time intensive process.

> 1. Subject: I try to improve relations between lab and us, between nursing and transport. There was a lot of locking of heads and horns between X and the staff for quite a long while after I came because they both had adopted the position that's my job and I'm not doing any more and there was just no moving them. But through talking to X and to talking to the staff themselves and winning them over, because I'm quite friendly to them all, and then taking their concerns to my staff and saying wait a minute, this is how you see but this is how transport sees it. Think about how you would feel if you were transport.

> 2. Subject: I took over this area there was great dissention, great, great dissention. People were just wanting to kill each other, and it was a long and arduous task for me to get everyone working together but I did it. And when I say that it was long and arduous, it's because I had to do it not by group process, but on a one-to-one basis. I brought in each staff member one at a time, and related to this person, got some feed-back from them how they were thinking and put it all together and then went to the entire group and said, "This is what I found, how are we going to correct all of these things?" It was a lot of hard work.

One subject noted that a part of interpersonal skill is recognizing and facilitating social processes with others.

1. Subject: There's a social aspect to working with groups and working with people that I didn't realize the importance of until maybe the last two years. I was, when I began as a manager, I was a very type "A" straight-forward, get the task done, and in many ways had blinkers on. It is only having stumbled through a few things and having gone through the school of hard knocks that I've learned some of these other things. I purposely schedule lunches with the staff that I supervise, with the whole staff up here occasionally. We'll order lunch or whatever, just to touch ground, and I have found that invaluable, because you might have some of the clerks for instance here, and I'm not even talking about the nursing staff that work in isolation, they're working fine. If you don't touch base with them every once in a while you're going to have staff turnover, if you're not checking out to make sure that things are going well with them.

Facilitating social activities of nursing groups was also noted to be important. Interpersonal skill, in this case, includes supportive behaviors.

1. Subject: I find that there's a real social element to the working unit on the units. They have their own Christmas parties, they have their own socialization activities which are important and which you support. You don't try and tell them that no, you can't do this on worktime or whatever. When they decide to have a get-together and they want to have some assistance from other units, as much as possible we try to do those kinds of things so that to me there is a social element.

Category 3: Information Gathering

All nursing leaders related that considerable time was spent in gathering information. A wide variety of methods and sources of information were identified. This skill would appear to be related to the characteristic knowledge. One valued source of information was literature in the form of books, journals and research reports.

1. Subject: I was talking to a very nice person on a higher level last week and she gave me the name of a book to read and it is all about power and I thought, that should be quite interesting, to read that. I've never read that book before. But I read a lot.

2. Subject: I mean you don't have to reinvent the wheel. You use the best knowledge that you have from outside sources and from the literature and from research.

3. Subject: I do a lot of reading. I basically try to get over to the library every couple of months and literally go through the titles of all the journals and pick out all of the things that I think are significant for whatever.

People were identified as a major source of information. The people may be peers, superiors or followers. All sources were viewed as valuable and information was used in the self-development process or the decision making process.

1. Subject: I learned a lot from subordinates as well. Up and down, you have to be able to use people effectively and that sounds terrible but I use people. Be able to appreciate what other people are offering unintentionally. They may be just delivering a talk and you have, she has ideas or he has ideas, then you can zero in on that and talk to the person about it more. I like your idea and so, tell me more about it.

2. Subject: I use my boss as a resource. I think I should because she is a forward thinking person, because she has been here a long time and knows a lot more about the history of this organization that what I do. And I think I would be very foolish not to use her as a resource.

3. Subject: I'm talking about senior administration now and we sit on the hospital management committee. I've learned a lot from all of them, not only practical information but also techniques on how to deal with other people.

4. Subject: A leader will probably use a whole host of people and experiences, and well a variety of sources to make those decisions. But I think the most significant one is the use of the wisdom of other people.

Direct research of patients and families was identified by two subjects as an alternate mode of information gathering.

1. Subject: We did a survey, we did a family satisfaction, patient satisfaction, we did a statistical analysis, we got all our hard data related to the application. We invited administration to nursing conference and we presented that information, and then we presented that facts.

2. Subject: I researched 50 patients in the institution and found out from them: what would you like when you come to the hospital? What would you like to see?

Category 4: Strategizing

Strategizing is defined as skillful planning. All nursing leaders were skilled planners and the process is slow and methodical. Strategizing is related to information gathering. Goal setting was noted to be the forerunner of strategizing.

1. Subject: I'm careful. Careful, I mean in gathering my data before I go forward, so I'm not one to jump in before covering the steps. Okay, I try step one...where we've been. Okay, step two, I'm careful that way.

2. Subject: Well, you have to consider where you wanted to go. You have to know what your goal is. I don't think you can lead if you don't have a plan. I don't think you can accomplish a given objective if you haven't worked out some staged approach, no matter what the objective is.

3. Subject: That is another goal for us here in nursing. We sometimes get frustrated with the fact that we had set a six month time frame to get through and it is a year later. And I'm a firm believer of the fact that the best laid plans will work out better for everybody in the end and that there is no sense of trying to put a quick fix on something because in the long due it will undo just as quick, as fast as you fixed it up.

4. Researcher: The subject described the meetings she attends with service chiefs in medicine. She identified that she takes a

maximum of two issues for nursing to every meeting. She stated that she selected those issues very carefully.

Category 5: Decision Making

All subjects identified decision making as an important skill for nursing leadership. Decision making was linked to the category Management.

> 1. Subject: If I had to summarize my philosophy of management, I would have to say that if you are a person who shrinks from decision making, who would rather avoid unpleasant decisions than make them and carry them out, if you are a person who has difficulty confronting an issue when it is there, and some people do, then you had better not get into management.

Three different types of decision making were described: independent, collaborative and delegated. All subjects made independent decisions in some circumstances. Two of the subjects pointed out that independent decision making is not autocratic. The two subjects who identified some of their decisions as independent, noted that other people did have involvement in the decision.

> 1. Subject: I know when there are times when, and I do not think of this as autocratic, but it can be seen as autocratic that at times when a decision has to be made and there is no other way that it can go, you have to come in and say, okay, this is where we're going, we have to go this direction, there's no right or left, we have to go straight ahead. This is the decision. But you have to be able, you should be able to say, okay, we have to make the decision, what are the pros and cons, how are we going to deal with what, this decision is going to channel off into a different direction. But that's the only time I feel that some autocratic decision should be made.

2. Subject: When I think about decision making I'm thinking again probably more long-range as to a focus or goal that I might have and I often make that one independently but I do a lot of data collecting so I, I'm not sure, but its not necessarily going to be a democratic decision, because basically its what I'm going to try to do in the next period months or whatever. You said participative autocratic, I don't know if that's autocratic or not, its certainly independent decision-making, but autocratic, I involve other people, it may be in an indirect way.

3. Subject: If it is day to day decisions... those kinds of decisions I make but I keep my boss informed.

4. Subject: I've always said to said to my nursing group, there are times that I'm going to make decisions unilaterally, and I'll let you know when those times are. And there is no negotiation.

All of the subjects delegated decision making to others;, however, the subjects were kept informed. As the nursing leaders must be responsible for these decisions this communication is necessary. Delegating responsibility indicates trust in the abilities/judgement of followers. One subject identified that allowing other individuals to make decisions enriches their job.

1. Subject: Sometimes they make the decisions on my behalf when I'm not here. Some I'm pleased with and some I'm not.

2. Subject: I'm working with people who are equally as prepared as I am, who look to me for leadership and who develop projects. I have to be able to assist with those projects, and do it in a way that doesn't make them feel that they're inadequate or don't know what they're doing. I always approach that with the fact that we are colleagues, and my comments to you are strictly comments, and if you as a person feels strongly, you are the one that knows your area, and you know your people, and if my comments are not of use, then you don't have to integrate them.

3. Researcher: The subject's assistant (nurse) had taken action on a problem related to a patient. The assistant made many day to day decisions on her own but kept the subject informed.

4. Subject: I think the job, the more decisions they are able to make at whatever level they are working at, the more interesting the job.

Collaborative decision making was used by all the subjects. Collaborative decision making was related to team effort and problem solving.

1. Subject: I really believe in participative management because I like the team effort.

2. Researcher: At a staff meeting clinical problems were raised by staff. Solutions were offered by staff and a decision was made.

3. Subject: You have to know your players when you're , if you want to institute change. I used to think, in my naivety, I could just develop a project and because it was so tight theoretically and was meeting a need, everybody would just grab onto it. That is not the way to go. People have to partake in the decision.

4. Subject: Participative kinds of decisions making to me, probably I would use that mode when there was a direct problem I was trying to deal with, so in that way it becomes more like problem solving.

Category 6: Collaboration

Collaboration refers to the process of working with others (Webster's, 1985, p. 259). Collaboration was not confined to decision making. Nursing leaders collaborate with nurses in program development and through committees. Collaboration was also identified as a method of learning. Collaboration occurs between disciplines and is encouraged.

1. Subject: Take it a step at a time and get people involved. That is one of my philosophies. When developing a program try to get people involved so at the end it is our program and not your program.

2. Subject: Many times I have said this is what I want to do. This is where I want to get and this is how I thought I might approach it to my assistant. And we sit and talk about it for half an hour and nearly always there is something that will have changed in my

approach after I have talked to her because she is the clinical expert. She will see something in what I'm proposing that will make it difficult to do because of the clinical requirements.

3. Subject: Committee involvement is another thing that I've introduced. Prior to this there were no staff on committees. We now have staff on almost all of our departmental committees, policy and procedure, quality assurance etc. We let the head nurses know that there are positions available. Staff are able to submit their names for participation on the committee. They're given back time for their work that they do on these committees. I remember when I first started, one of the nurses said " you never get to have any input on anything". Within 6 months she was on a committee and she said to me "I really didn't think that a change could be put into place that quickly". So yes, that's another type of thing that we wanted the nurses to feel that, yes, your saying things count.

4. Subject: I question the status quo with relationship with respect to expectations of the roles of people, the roles of the nurse for example. I guess a lot of the interactions to between disciplines. I certainly encourage that, not only do I do it, but I really encourage that and I support that in all of the meetings, the settings that I'm involved in.

Category 7: Problem Solving

All nursing leaders identified that they solved problems. Problem identification, actively dealing with the problems and using collaborative problem solving were identified as important. One subject noted that credibility is related to problem solving.

1. Subject: We deal with problems on a day to day basis and in a leadership role but I couldn't say that , that has significantly altered my behaviour because this is an accepted fact that we do have problems and we have to deal with problems.

2. Subject: And I have a way of in a meeting or whatever, listening and focusing attention on the underlying problem. A lot of time is wasted at meetings going around and around in circles in what I call spinning the wheels and they never do get to discussing the problem. They just sit there and spin the wheels and discuss the results of the problem, but they don't go

backwards far enough to say, the problem is this, why are we talking about this? What can we do about that? Quite a few people in management, who have trouble with that approach. And yet, that's about the only way you're going to get the problem solved is when, you can't get the problem solved that you can't identify.

3. Subject: I know from a head nurse point of view that they seem to be very positive and there is a real sense of loss every time there is a change and I think that is because the relationship that has developed is collegial in getting problems solved together.

4. Subject: I think the whole problem solving ability was never there before, when I was new. We came in as a nursing team and am pleased to say at least the nursing administration structure is acknowledged by the remainder of nursing.

Category 8: Management

There was not general agreement regarding the relationship between leadership and management skills. Management and leadership are seen as distinct entities or as an inseparable duo. Webster's (1985) defines management as the act of carrying on business affairs (p. 722).

1. Subject: There's not even a corollary between skilled managers and leaders. I don't see a corollary there at all. I think that you can be a skilled manager and not be a leader at all and most organizations are requiring that you be a skilled manager, that's primary, and the leadership role is an insignificant role for most organizations. So what they're saying in that statement is that you have a leader who also has to be a skilled manager.
I would say for any credibility in an organization in administrative roles, you'd have to be a skilled manager. If you happened to be a leader, that would be nice, but for most organizations that is not a requirement. And in fact, if anything, as I've said, that in fact if anyone's got any sense of leadership is constantly checking that leadership component doesn't take precedent. And so I can't even, if it doesn't fit in my frame of reference at all because I think organizationally what they're looking for is a skilled manager. If you happen to be a leader as well in your profession, that's nice, but please don't show it too often, or only in controlled situations. Like that's the message I

get in organizations. So, I guess in some ways your statement is correct because, but it doesn't, I don't think that they're even looking for leaders personally. Most organizations are not looking for leaders. What they are looking for is skilled managers. And I think if anything a lot of them would say I'll do without any leadership thing, I'd rather just have a skilled manager. Because the leader, the leader tends to turn the basket upside down and perhaps create a certain amount of distress or that kind of thing. So I think a leader who happens to be a skilled manager and therefore working in the organization needs to be very careful, very cautious, and it can create a lot of tension. (laugh)

2. Subject: How can you lead if you do not know how to manage problems . You cannot be a leader if...You have to know some material in order to be able to lead because you have to have an appreciation for where people are coming from.

3. Subject: Leadership is a skill that a manager must have.

Pattern 4: Duties

Duties are defined as actions that are required in a certain role. The five categories related to duties identified were: Defining the Boundaries of Nursing, Role Modelling, Teambuilding, Developing Others and Ongoing Self-Development.

Category 1: Defining the Boundaries of Nursing

Nursing leaders define what the role and responsibilities of nursing are and what they are not. Evidence of this activity was more evident in field observation than from the interviews. Upon questioning all three of the participants who were observed agreed that they did in fact define the boundaries of nursing.

1. Researcher: Subject attended a meeting with other administrators and individuals that the subject liases with in the organization. The subject clarified nursing's position on staff

allocation and what nurses role and activities were in the organization. Other individuals began to define their position of what the nurses' role should be and what nursings' hours should be but the subject would not allow that.

2. Researcher: Subject attended a quality assurance meeting with a Director of Nursing and the head of Central Surgical Supply (CSR). The head of CSR identified a problem in his department. The subject noted that the problem was not related to nursing so the subject should take the problem up with the appropriate group.

3. Researcher: Subject's assistant brought a plan for general duty nurses to check temperatures in medication refrigerators. The subject stated that nurses are already forced to do far too many non-nursing activities and that the plan was unacceptable and action was warranted in a future meeting where the plan would be discussed. The subject noted that nursing time should be spent on nursing duties not others unrelated to patient care.

Two subjects noted that one of the problems is that the practice of nursing is poorly defined.

1. Subject: I think that there are many times we sit down as a group in nursing and we try to name what it is that we do and we become distressed and that's because it's something that is difficult. I think that we need more people that can help us articulate what that is. Maybe that's what academia needs to do for us, become for us, that are so much in the trenches, keep seeing the light every once in a while, but don't have time to truly explore that in order to, in order to concertize it. I think that's what becomes difficult for us in nursing. But, I truly believe that we will reach that point where we can carve it out and say this is what nursing is and I think that we're beginning to see it every once in a while. We talked about some examples just last week with the head-nurse group and at one point they were explaining what one individual was doing who was not a nurse, and they all realized, rather surprisingly that the individual was acting as a nurse at that point because of the kinds of dimensions. It's a constellation of activities that I think that nursing is all about. So I guess my vision for nursing is that it will become a profession, that the body of knowledge will be discrete and distinct and our practice area will be very clear.

2. Subject: I think that one of the most significant issues for nursing is to identify what it is that nurses do and where our professional boundary is. And as the power shifts within an

organization it becomes more imperative that we identify what our professional boundaries are.

Nursing leaders also protect the boundaries of nursing. This includes ensuring nurses are being directed by nurses and the needs of nursing staff are met.

1. Researcher: The subject stated that when she started in the organization nursing followed the orders of others and they defined what we did. We stopped that.

2. Subject: The subject attended a multidisciplinary meeting. The other disciplines were questioning the space needs of nursing staff and offered space in a poor location. The subject insisted that the space was necessary and there must be space in an appropriate place for nursing staff to do their work.

Category 2: Role Modelling

Three nursing leaders believe that acting as positive role models is significant in the development of staff nurses. The findings relate well with the prior experiences of the nursing leaders. Several subjects had reported that experience with various role models both within and outside the profession had impact on their own development as nursing leaders.

1. Subject: And setting a good example for people. Being a good role model so that people have some base to work from which to work.

2. Subject: The bottom line on that reorganization was in fact to bring some role models, bring some nursing expertise into the department. That has been done and a new level of administration, directors of nursing, were brought in to enhance and support the head nurses.

3. Subject: I felt very strongly that role modelling is the way to go. I think as an administrator at this point and hopefully a leader within nursing, I model an awful lot of behaviours and I ask that of that of the people who report to me of the head nurses. If you want changes within your staff in the way they interact with a patient I say model it. You can talk all you want but unless you model it unless you show me how to do it or unless you show me that it can be done my talk is nothing so I think it is that way.

Category 3: Teambuilding

All nursing believe that teambuilding is part of their role. A team is "a number of persons associated together in work or an activity" (Webster's, 1985, p. 1210). Trust was identified by all of the subjects as a key component of team building.

1. Subject: First of all you have to build trust in nurses. You have to build trust. You have to work with people and let them know what your goals are. Let your goals and objectives be theirs as well. They have to agree with your philosophies because if they do not agree then they won't be with you. That is how you build your team. You work together.

2. Subject: And I did develop, I feel, a great amount of trust amongst the grassroots staff when I was in both places.

3. Subject: When I think the trust has been, is strong, I think that people begin to interact with each other on a peer level.

4. Subject: You build the team again by looking at your tasks at hand, but also being open with your staff. I don't profess to know all the answers and I'm always up front about that.

Availability was identified as significant in the teambuilding process.

1. Subject: Perhaps I should say that I'm only working eight

hours and that is it, but I don't work like that. I think that the moment that I start closing my door and I'm not available, I shut my staff off.

2. Subject: We try to have an open door policy. The former group, the former administration was never, maybe didn't perceive their role as being accessible for staff as an important one, and staff never came to administration. I've been talking about head nurses or any of the staff, they seemed to have to go to personnel for instance. Personnel was always swarmed by nursing. So there's been a lot of change that's been implemented over the past two years that I want to attribute to the kind of climate that we in nursing administration had encouraged and that is that we are available.

3. Subject: In the subject's office, a head nurse was waiting to inform the subject about a meeting that was held with a variety of individuals about a mechanical difficulty on the unit. The head nurse stated that there had been lots of powerful people at the meeting. The subject told the head nurse that"you are powerful". Another head nurse arrived to state that there was a problem in that forms documenting patient falls were not filled out. Listened to the problem but left the head nurse to solve the problem.

Category 5: Developing Others

All subjects believed that the development of nursing staff was a critical part of their role. Educational opportunities for nurses are seen as a priority only second to patient care.

1. Subject: Nursing administration here completely supports continuing education for nursing staff as long as I know that there is coverage and that the conferences are applicable. For instance, any number of the nursing staff can avail themselves to something community orientated or within the hospital educational inservice and if time permits and the availability is there, they are very much encouraged to go.

2. Subject: Assisting people to help themselves. I am always one for that, learning, inservice education programs. They must take priority in my area and that has been like that all the time, and I believe that I am able to contribute in those areas.

3. Subject: I encourage them to do reading when they have a slack time in their professional magazines. I encourage them to go

to workshops. I support them financially. I just sent two people down to Florida to a conference. Those two people are now required to give an inservice to the rest, and I make sure that they all get there.

4. Subject: First of all I just basically provide nurses opportunities, whether it has to do with conferences, either in attendance or presentation in conferences on a more global scale with relationship to our professional organization provincially and nationally. I truly believe that the staff nurse is at the interface and so whatever I can do to give credence to that role, I will do so.

The subjects also believe that they are have some responsible for

the ongoing development of nurses within their departments and

actively participate in the process.

1. Subject: I have staff members that come in and say, "Well I want to pursue this course. Now you know me, do you think that I will be able to do it?" We'll sit down and we'll discuss it. I won't make a decision for her but she'll go out and make her own decision because I've given her that amount of time. I can feed to her what I think her potentials are, her strong points and that I think that she should develop it and so on.

2. Researcher: The subject met with her assistant in the nursing department. The assistant noted that one of the staff nurses was having difficulties working with a specialized piece of equipment and was not confident about working alone. The subject noted that the staff nurse should given additional training and that they must remember that the needs of individuals will be different and must be accommodated. Subject offered solutions to reorganizing staffing so the staff nurse could receive more training.

3. Subject: When you're working with people, the majority of whom are not advance prepared, and try to explain to them why a review of the literature is important, it's like you're not only trying to move a project through, but you're also trying to teach them as you're going along. And I have to explain that to both my assistants, because they're very self-directed and goal-orientated, and what I have to bring them back to often is that many of the people that they're dealing with have not even taken a university course, so, when you're trying to conceptualize a project, do a review of the literature, talk about experience, bring the whole problem solving process to an endpoint. They have to also realize that the people who they are working with, have to learn the process as they're going along.

4. Subject: There are times when I'm the leader depending on what the issue is. There are times when somebody else in that team may be the leader on that particular issue. But I feel okay about that. I don't think that I'm giving up my responsibility but I am permitting the others to exercise that leadership for a period of time for a particular issue. So, I think the sense of trust and therefore encouraging other leaders to evolve and I feel very strongly that if I leave this job and I don't have someone else that I could recommend to take my job, I have missed the boat. I feel strongly that we as nurses need to develop other people so I would consider it a loss if I had made sure that everybody had stayed in their place. I'd rather see them develop and move ahead if that's what they wish.

The development of nurses can be done directly by the subjects themselves or indirectly through followers. In both situations, however, the subjects do take an active role in the process.

Category 6: Ongoing Personal Development

Ongoing personal development was identified as important by all subjects.

1. Subject: My belief is that one of my beliefs is that you should put forth, one should have and always strive to, in order to do well. Put forth your entire potential. Don't have the potentials and sit on them. Be able to explore and to learn things. I feel like I keep repeating myself, but I think this is an area in which I feel very strongly that we should always be striving and looking ahead, keeping abreast of things.

2. Subject: I think many skills were developed as I learned, probably through experiences when perhaps I had avoided making a decision for a little while and then by realizing if I'd done it a bit sooner it would it wouldn't have been a major problem. I think we all make mistakes and we all learn through them hopefully. And if you've learned through a mistake then the mistake hasn't been in vain. It hasn't all been a cost. Some of it has been a benefit.

3. Subject: I think that when you realize that you can learn a vast amount from other people and that you keep an open mind when you're working with colleagues, you are able to go much further. And that working with my colleagues, in terms of, I'm talking about senior administration now and we people sit on the hospital management committee, I've learned a lot from all of them, not only for very practical information but also techniques in how to deal with other people.

4. Subject: I think academic studies is a luxury. I think it's wonderful to be able to do that, and I think most of us could spend our entire lives pursuing a variety of options in academia, but that's not always going to be possible so you need to keep increasing your knowledge in a variety of ways, and you may be able to do that in the work setting. I don't think it's as easy. In fact, I think that it's very difficult but I do think that you need to keep pursuing it.

The majority of learning identified by the subjects takes place in the context of the work environment rather than the formal setting.

<div align="center">Theme: Factors Affecting Nursing Leadership</div>

Nursing leadership does not exist within a vacuum. Rather there are three factors that affect nursing leadership. These were identified as: Followers, the Organization and Society.

Pattern 1: Followers

Leadership cannot occur without the presence of followers. A follower is one who follows the teachings or opinions of another (Webster's, 1985, p. 479). The followers of nursing leaders are nurses. The pattern Followers was found to have two categories: The Person and Experience.

Category 1: The Person

Person is defined as "the individual personality of a human being" (Webster's, 1985, p.877). Nursing leaders have identified that followers must be recognized as persons with feelings and aspirations and part of leadership is recognizing and respecting the human factor.

1. Subject: I try not to forget that they are people with feelings, they have personal lives, they have personal requirements that if we can adjust around, we have happier staff.

2. Subject: In leading you, I have to think of where we're at, at the present time what are your goals and aspirations.

3. Subject: I consider the sanctity of the other individual. I believe that they are human beings and I refuse to accept anything else.

4. Subject: That is another perspective that I've had to change because I had a different set of values. I do have a different set of beliefs than some of the things that they feel are important to them.

Category 2: Experience

The experience of staff, both from formal educational and from clinical practice, did affect nursing leadership. In nursing, the two are linked rather than separate entities.

1. Subject: I've also learned that experience from the workplace, played a vital role, extremely vital, and one set apart is not good enough. The educational qualifications without the practice or the practice without the education, I think that they both fit together well. I mean education doesn't necessarily always have to be through the formal fashion. Some people can self-educate themselves to a point where they come in with that theoretical as well as practical experience. I don't mean that you always have to go to formal network. I'm just saying that you need both pieces to close up.

Three nursing leaders noted that both nursing experience and education impacted on their leadership role.

1. Subject: I have people who are reporting to me who are very new in the role, a head nurse for example. I need to spend a whole lot more time with them to get them to the point where I feel that they feel comfortable in the role and that I feel comfortable in the decisions that they make, the way that they solve a problem. I know for a fact that I am going to have to do a lot more work with them if they don't come with a certain level of preparation, academic preparation.

2. Subject: If I have a licenced practical nurse I'm going to allow her to make decisions that she is capable of making in her jurisdiction. So you see you allow them and give them credit for the level of planning and organization that they are capable of doing. The diploma and the B.N. trained personnel... sometimes you find that they, the B.N. trained personnel will be able to talk on a higher level to you, to relate in terms of her planning and organization because she has absorbed a little bit more that the other ones. But, in the same token, sometimes you find the diploma trained nurse who's highly skilled as well. If she's got a lot of initiative and drive, and although she's not gone through the degree program, she's made sure that she's learned. So in answering your question, does the education have a bearing? It does to some extent, given the circumstances surrounding it.

3. Subject: I think that clinical practice is important, but I also think that the other preparation that come along with a degree for instance, gives you that other ability that you need to manage as a nursing graduate or a head nurse in this day and age. Many of the staff that I have had to work with have been here for years, head nurses and many of them haven't taken any courses. They do now. They take them as certificates on different courses like the nursing administration certificate, that would give them some of that preparation that I'm eluding to. I made the mistake as I said, of thinking that people were functioning at a level, where I made my own perception, and it wasn't until I had worked on a few projects that I realized that at that level, that what I was expecting had to be redefined. And once I did that I was better able to work with the staff.

One subject saw experience or the skill that comes from experience, alone, as the factor affecting her role as a leader.

1. Subject: But I think that if, I guess the perception of how the nursing department is running and functioning relies to a large extent on the skill of the nurses. I think that it is very important, and that they identify an area where they are not comfortable or need some extra help. My assistant and I are both ready to provide the time and the equipment for more orientation or more practice.

Pattern 2: The Organization

Nursing leadership is practiced within the confines of the organization. Organizations are complex and, as such, a variety of organizational factors were found to affect nursing leadership. These factors or categories are: Unionism, History and Structure.

Category 1: Unionism

All nursing leaders worked in unionized environments. Three of the subjects identified that working within a unionized environment did affect their leadership role by making the role somewhat more structured. One subject noted that maintaining the separate roles of leader and negotiator was a different experience.

1. Researcher: The subject stated that the union contract tended to make her role more structured as the contract rules must be met.

2. Subject: Some things in relationship to unions, I guess I'd have to be fairly autocratic and make the decision myself, but then you have to live within the contract.

3. Subject: My head nurses are in a union. They are in the same union the staff are in. We also perceive them as being the mid-managerial level of nursing. There's a real conflict there, when you're the head nurses on a unit and you're trying to evoke

change from the management end of things with people who are in the same association with you. You really have to strategize, in terms of how you're going to implement change. Out of twenty-two people, I'd say that's thirteen head nurses. I'd say six of them are on the executive of the union and I really had to converse with them for a long time. I had to know where I could move in and move out of in terms of different issues. I have been through labour negotiations, outside of the contract, negotiating across the table from my own head nurses. I mean you have to be able to... to me that was a whole new experience. I mean the next day I would be at a meeting with them, and you had to be able to detach yourself from the arguments and negotiations at the table on one hand and still hold their respect as a leader on the other hand.

Category 2: History

Organizational history refers practices or traditions that have been accepted and maintained in an institution. Two nursing leaders identified that organizational history had impact on their leadership role. Individuals, who have over time become influential or have been allowed special privileges can create difficulties for nursing leaders. One subject described two instances where history has affected her nursing leadership.

1. Subject: Sometimes, tradition within the organization. There's one of the managers here for instance, who has worked in this institution for 25 years plus, ran her department well, according to what I am told and by what I see. It's a big department and was the strongest and the most management-oriented manager apparently in the organization for many years and because of this became the authority. Almost for all departments, because the managers in the other areas wouldn't tangle. If that area wanted it they got it. Then I was hired and I had a bit of a different focus. For instance, my surprise came after I was working here three or four months. I went down and saw somebody doing something that was totally opposite to what I had just indicated about a week previously, as the route a certain procedure should follow. I forget what it was all about, but anyway they hadn't been doing it the way I had just simply laid it out. That this is

the way that it is easier for us to monitor it and to follow through and it works best. Do it this way, and I went down there and they were doing it absolutely opposite. And I think they were doing it the way that they used to do it. I asked why, and they said well, the other department came down and said this is what we have to do. I said sorry, I'm you're boss, you do it the way I told you. I said no other department changes our routes or our procedures or our whatever, unless they go through me.

2. Researcher: The subject stated that a physician runs a medical clinic using nursing staff. The physician used to be medical director so the clinic has been allowed to continue. History was noted to have impact.

Another nursing leader noted that the history of organizations had an impact on the change process, in that the process had to occur very carefully.

1. Researcher: The new director of patient information systems arrived. The subject told the individual that the history or culture of the organization affected policy or lack of policy in the organization. The subject described how departments interface in the organization and how things worked. The subject stated that while she supported change in the institution, the changes must be made with care to decrease the resistance.

Category 3: Structure

Structure is defined as "features of an organization that serve to control" (Gibson et al., 1985, p. 417). Organizational structure includes organizational philosophy, policies and goals. Three of the nursing leaders identified that organizational philosophies, policies and goals have a negative impact on nursing leadership.

1. Subject: You have to work within the parameters of these organizational philosophies, so there are a lot of barriers.

2. Subject: Philosophies, policies. I think those all, and what it does is, it basically holds leadership in check, in constant check and tension all the time and that is why I think it is very difficult.

Goals, philosophies and policies of the organization are often developed without input from the nursing leaders by powerful others or are poorly communicated. Nursing leaders must adapt and conform. The situation can be frustrating and stressful.

1. Subject: Sometimes the hierarchy can affect your leadership role especially in middle management. You have ideas and you have reasons for wanting to do things but again your hands are tied because you have to report to somebody who does not like your ideas and whose priorities are in a different area that you cannot get headway. Sometimes if you're not informed, for example, for us as middle managers... if we do not know what the objectives of senior management are, what their goals are for this institution we may be down here in the middle planning and doing our own thing, and later to find out that it's to no avail because we cannot make a headway. So if senior management does not communicate effectively to us and let us in on what is going on then it desperately affects our leadership role, because it causes a lot of frustration.

2. Subject: The need to change was there. What the change was going to be was a result of many meetings, and many people's ideas and that compiling these into what the end result has been is this written questionnaire which are still being reviewed and monitored and evaluated and will be changed again. When it's changed again I can't respond as the leader by saying I don't like your questionnaire so I'm not going to use it, I'm going to use the old one, because this is a national decision, it's not a local decision. And I think that you have to be able to adapt to this need for change as a leader.

3. Subject: It is all of the things. Whether it is policies, procedures, interaction with people that are holding back on changes that one might want to make. And they are so distantly involved and one would think we should just be able to tell them this is what we want to do as nursing or whatever and we can't do it. And I think the thing that concerns me most about it is that you constantly lose the cutting edge on it and I think if one looked at all the stuff that's been written about good companies, excellent companies, is an attempt at reducing the amount of red

tape of bureaucracy that exists within an institutions so that we are now constantly stifling creativity. And that risk taking that we end up not doing at times because we've become too cautious, its an incredible disservice. I think that's why we sometimes I've seen nursing leaders who I consider real leaders eventually just moving out. I think it leads to burn out and I'm very distressed about that. I keep hoping that I can handle that, those restriction, that restrictiveness so that I don't lose the risk taking, the willingness to take risks. After a while you say, what is the point of constantly putting yourself into the breach when in fact you know what you'll end up doing is perhaps marking time there for an extended period of time. And as soon as you start making time you waste an incredible amount of energy and I think that leads to classic burn out.

While the power of others significantly impacts on nursing leaders, nursing leaders do have power. They have power by virtue of their role.

1. Subject: I would say that I'm not vying for power in any other department other than my own. But this is my department and I'm running it.

2. Subject: I've seen a number of leaders or managers who backed off from using the power of the position. They were almost apologetic because it was there. It is there whether you use it or not or whether you know you're using it or not. I don't like to see it used needlessly. But at the same time I don't like seeing people backing off and making the decision when the buck stops here and you have to make a decision. And be accountable for the results. I'm not explaining it very well but you also have the power of discipline, assignment, I mean there's power, there's power there whether you want to admit its there or not. There is a power.

3. Subject: I think it's power. You do have to have the ability to institute change because if you don't, you can find yourself in a position of not being able to implement that which you wish, and if you can't do that, then you're only grinding the wheels. For instance, if we didn't have, in the nursing administration have the ability to set policy, if we didn't or if I didn't have the ability to make some decisions regarding finances etc. in an autonomous fashion, the frustration I suppose, and the lack of change, would permeate the system. You wouldn't be a change agent, you wouldn't be able to implement any of the ideas of the staff, you wouldn't be able to make any of the changes, you wouldn't be

able to move forward because you have to have that power and ability to make decisions.

One subject disagreed.

1. Subject: I think the power that is given to you by nature of your position is an insignificant one within the profession.

The entire nursing group was identified as a powerful force within the institution by one subject.

1. Subject: Nursing has a phenomenal amount of power in the organization. More than I ever realized. And that doesn't necessarily emanate from the administration of nursing. It is by virtue of the fact that they are the key component. Now we know that the other departments are necessary, but the agency still functions without them in many places. I mean you can see that under crisis conditions like strikes or like major crises. It's the nursing department that carries that through. So the power is there, what you have to do is learn to harness it.

Two other types of power were identified: information power and the power that comes from recognition from others.

1. Subject: I think is, there needs to be a lot of power that is attained through recognition from other people, what you are capable of doing and what you have done. I think that power, it's a recognition that the individual has the confidence of the people that are reporting to them, or the people that are relating to that individual. There's a sense of confidence that the individual is taking them in the right direction and I think that the way that confidence, that power-base is filled is by constant verification by that individual's own experience, the individual's own sense of what is significant, so it's constantly validated by the individuals, but I think that power system is the most significant one.

2. Subject: I do feel that people do look to me for answers. I know because I am asked directly, but that took three years to build up.

3. Subject: I had access to information that they wouldn't necessarily have, and being able to use that information in a facilitating capacity, not a destructive capacity, and nobody would go out purposely go out and do something destructive, but you certainly have to know when you can move in and out of a situation, and maintain the confidentiality of your colleagues. My colleagues now are senior administration. When I had to move from a different course, so for me that was something that influenced my leadership style, because it meant that I had to reorientate myself not only as a nursing end of it but as a leader in the agency.

Pattern 3: Society

Public organizations, such as health care institutions, exist to meet the needs of the general public. Public organizations are funded by the government. Issues within the context of society impact on organizations and the leaders within those organizations. The three categories or societal factors that were identified as impacting on nursing leadership are: Needs/Demands, Health Care Funding and the Status of Women.

Category 1: Needs/Demands

The needs and demands of society focused on both the provision of a health care service, changing patient demographics and the provision of basic human rights.

1. Subject: We are here to serve the public, and sometimes they need to be listened to and we should be able to provide the services that people are wanting.

2. Researcher: The subject identified that consumerism has impact on her job. Patients hear about new procedures and consult physicians. With any procedure there are costs involved.

3. Subject: The whole issue of poverty and the homeless, particularly the homeless concerns me. To me that is a basic right of the individual so I'm involved in that.

4. Subject: There is going to be a lot of demands placed on us when we have this aging population needing beds and hospitals and I think if you are well versed in terms of how to deal with these people then it will affect your leadership abilities and capabilities. So that is something as leaders we have to keep in mind.

Feedback from clients was also identified as important to nursing leadership to either reaffirm the value of nursing or make you aware of problems. The feedback could be negative or positive.

1. Subject: Showing me that nurses are a valued profession. I know that, but it doesn't hurt to have it reaffirmed. I get letters all the time from families, certainly we have the occasional ruffle, but I get many letters thanking the nursing staff their relative has received while they're here.

2. Subject: The influence that the clients have on the way that they institution is described. The avenues that they pursue in order to get things done, their way outside. And I think for example, the services that we offer at our institution, if they're not pleased with the services, we might have jolly-good reason for doing things the way we do but I get letters saying I was in your hospital, I was dissatisfied about so and so. They criticize, so that of course, it has outside influence, it has influence on the work that I do here because you have to sit up, you have to take notice in what the clients are saying. If they're not happy with the services then they can go to Health Services Commission, it can go to the government, for a raise in power, and they write lots of letters. So therefore you have to be very aware of the public influence on your institution. That's one of the things.

Category 2: Health Care Funding

Two of the subjects identified that a lack of government funding has impacted on their leadership as needed equipment cannot be bought

and the operating budget, which includes nursing staff costs, cannot be changed.

1. Subject: You always have to be so money conscious. Equipment that we need, we're not able to buy it because we do not have the funds. The Service Commission won't give us the money. You have go out and get the money from an independent source. Health Services Commission tells you, you don't need that equipment so we won't fund the depreciation. So that of courset is going to influence your leadership role in the hospital because it is hindering you from being productive in terms of what you want to do now.

2. Subject: Government changes, government focus, budgets, are controlled by forces outside of my domain. They have a great deal with what I can and cannot do here because if I need new equipment I can't buy it. Then it has some ripple effects on what kind of a job, what kind of product we're, what kind of a department I'm running. The budgets are ever present, operating budgets as well as capital.

Category 3: The Status of Women

The status of women in society does impact on the role of nursing leaders. The opinions have others have made advancement difficult, have contributed to the negative image of nursing and have stereotyped nurses as the physician's followers.

1. Subject: In the healthcare society the status of women again. The status is always mediocre status. It is always men on the top and I think this frustrates many nursing executive, especially if they have the education and the knowledge and I've talked to some of them who are in a higher position and they feel very frustrated because they'll never get to be a chief executive officer. Nine times out of ten they have more education than the chief executive officer, but, it is a male world. There isn't one hospital in the city where you have a woman who is a chief executive officer.

2. Subject: We're still led around in many ways by female roles. The problems with the physician's assistant, subservient type role and that we could really tap on that resource as a collective group. I don't think there is anything that could stop us. In fact there are those other contributing factors, women's issues etc. that are barriers to realizing that power.

3. Subject: The more I interfaced with other women's groups the more I realized that my profession was being maligned by other women's groups and that there was a lot of work that needed to be done to bring nursing into synchronicity with the women's movement. The women's movement saw nursing as continuing to perpetuate the ghettoization of women's employment and I didn't accept that but on the other hand I realized that a lot of things in nursing, in fact, was doing exactly that.

When asked, all nursing leaders responded that they viewed themselves as successful in their leadership role. This adds credibility to the findings about the nature of leadership in nursing because the results are related to effective rather than ineffective leadership.

The majority of the data presented is related to concepts of leadership and to a lesser extent prerequisites to leadership and factors affecting leadership. This would indicate that the leadership process itself is the primary focus or primary area of interest to the nursing leaders.

Summary of Findings

On the basis of the analysis of data, factors related to leadership were identified. Factors or categories were grouped to form patterns which related to the research questions. The factors identified in this chapter are data based. The number of factors identified is limited by the small sample size.

1. <u>What factors contribute to the development of nursing leaders as identified by nursing leaders?</u>

Past experiences were significant in the development of all of the nursing leaders. Factors related to experiences that were identified included: family, education, clinical nursing background, role models and previous leadership roles.

2. <u>What are the key concepts associated with nursing leadership as identified by nursing leaders?</u>

Nursing leaders were found to have certain characteristics, skills, values and to perform certain duties in their leadership role. Defining characteristics identified were: creative, knowledgeable, flexible, intuitive, persuasive, empathetic, confident, risktakers, visionary, agents of change, and committment.

Values perceived as significant were: patient care, status/image of that nurse, collegiality and a balance between professional and personal life. Necessary skills identified by nursing leaders included: communication, interpersonal, information gathering, strategy, decisionmaking, collaboration, problem solving and management. The five duties of nursing leadership were identified as: defining the boundaries of nursing, role modelling, teambuilding, ongoing self-development and developing others.

<u>3. What are the factors affecting nursing leadership as identified by nursing leaders?</u>

Nursing leadership was affected by followers, the organization and society. Aspects relating to the follower as a person and the follower's experience were significant. Unionism, structure and history were organizational factors that affected nursing leadership. Societal factors included: needs/demands, health care funding and the status of women.

This chapter has included a description of the subjects, the analysis of data and the identification of factors related to the nature of leadership. The next chapter shall discuss the findings in relation to relevant leadership research, the implications of the study and recommenadations for future research.

CHAPTER V

SUMMARY AND DISCUSSION

In this chapter, the results of this study will be compared to previous findings from leadership research conducted in business and nursing. The findings will be discussed in relation to the research questions. Limitations and implications of the study will be presented. Recommendations for future research shall be addressed.

LEADERSHIP DEVELOPMENT IN NURSING

Prior experience was the only pattern identified that related to the research question: What factors contribute to the development of nursing leaders as identified by nursing leaders?

Prior Experience

Nursing leaders identified five experiences that contributed to their development as leaders: family experiences, educational experiences, clinical nursing background, experience with role models and experience in previous leadership roles. All of the findings are supported, to some extent, by previous research.

The nursing leaders in the study do not fit the traditional pattern of female socialization. Spengler (1976) noted that females are encouraged to be passive rather than independent. Either through

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parental influence and/or youthful experiences all leaders, in this study were encouraged to be independent and to follow their own path. On the basis of research findings, Hennig and Jardim (1977) believe that the individual development of leaders should be assessed in terms of experience, feedback and encouragement to seek non-traditional roles. The findings of this study would support the findings of Hennig and Jardim, although it could be argued that nursing is a traditional female occupation. A leadership role in nursing, however, is not congruent with the typical image of the nurse as direct caregiver.

Ireson and Gill (1988) noted that education influences occupational choice. In this study, university education was identified as important to leadership development; however, no direct link was made between education and the selection of a leadership role in nursing. The present nursing trend that has established master's preparation as minimal preparation for nursing administrators at a director's level or above does provide encouragement for nurses with advanced preparation to seek these roles (Leatt, 1981). In a study of nurse influentials done in the United States, Vance (1977) found that 95% of the subjects had master's or doctoral preparation so leadership roles and graduate education would seem to be related.

Hanson and Chater (1983) found that graduate students who were interested in management roles showed a greater interest in their occupation. Nursing is a practice based profession so the finding that a clinical nursing background was important to nursing leaders is not

surprising. This is supported by Vance (1977) and Kinsey (1986) who both found that nurse influentials had professional expertise and credibility.

Role modelling, in the context of the family or within the profession was identified as significant in the development of the nursing leaders in this study. Studies of female leaders in business and nursing have recognized the role of mentoring in the development of leaders (Vance, 1977; Keown & Keown, 1982; Kinsey, 1986). Role modelling and mentoring are not identical relationships; but are similar in that one individual either directly contributes or indirectly contributes to the development of another individual.

In this study previous leadership experience was found to contribute to leadership development due to the competence and confidence that comes from having practical experience. Yura, Ozimek and Walsh (1981) noted that previous research has demonstrated that leadership is transferable from one situation to another.

Implications

The finding that prior experiences are significant to the development of nursing leaders has significance for nursing practice and the preparation of the nursing leaders of tomorrow. Practicing nurses aspiring to leadership roles in administration should be aware that university based education at a baccalaureate and master's level will

contribute to the development of leadership skills. Practicing nurses should be cognizant of the value of their practical experience as a sound basis for a future leadership role in nursing. Practicing nurses should identify both negative and positive role models in the profession to identify behaviours that could be emulated. Experience in leadership roles either within the profession or outside the profession should be sought to develop leadership skills. Nurse administrators who identify leadership potential in practicing nurses should encourage the individuals to enter a baccalaureate or masters program. Nurse administrators should act as positive role models and provide leadership experiences for this group.

Recommendations for Future Research

While all of the experiences are supported to some extent in the literature, clearly more research is needed that focuses individually on all of the categories - family experience, educational experiences, clinical nursing experience, experience with role models and experience in leadership roles - and their impact on the development of nursing leaders.

Family experiences or childhood socialization patterns requires further research as one could speculate that the foundations for nursing leadership roles begin during this period. Why nursing, a female profession, was chosen as the career of choice for women whose characteristics are incongruent with characteristics considered

traditionally female needs further study. With the present decline in nursing school enrollment, the importance of understanding why non traditional females were attracted to a traditional profession needs further research.

While the findings of this study have identified that university education contributed to leadership development, there are many nursing leaders in administrative roles who do not have a baccalaureate or masters degree. Future research should focus on the experiences that have developed that particular group of nursing leaders and compare the findings with the results of this study.

Role models and prior leadership experience were found to be significant in leadership development in this study. Future research could address what types of modelled behaviours and leadership experiences are significant to leadership development.

KEY CONCEPTS OF LEADERSHIP

Four patterns were identified that related to the research question: What are the key concepts associated with nursing leadership as identified by nursing leaders? The four patterns are: characteristics, values, skills and duties.

<u>Characteristics</u>

Nursing leaders identified eleven personal characteristics that are necessary for individuals in leadership roles in nursing. Individuals should be creative, knowledgeable, flexible, intuitive, persuasive, empathetic, confident, risktakers, visionary, agents of change and committed.

Most characteristics identified by the nursing leaders as being significant are supported by previous research related to descriptive theories of leadership and to a certain extent research in the nursing profession. Creativity was identified as a characteristic of leaders in business (Bass, 1982; Pepper & Ryan , 1986). Vance (1977) and Kinsey (1986) reported similar findings from their studies of influentials in nursing which supports the findings of this study.

In this study, three types of knowledge: self-knowledge, organizational knowledge and knowledge of nursing issues were identified as important. Bennis and Nanus (1985) called self-knowledge the deployment of self and described deployment of self as one of the four competencies of leaders. Keown and Keown (1982) found that female leaders perceived themselves as self-knowledgeable. Bennis and Nanus also found that knowledge of the organization was a critical skill of leaders. Vance (1977) and Kinsey (1986) both identified that professional credibility was a source of influence for nurse influentials. Knowledge of issues within the profession would be related to professional credibility.

The findings of this study that recognize flexibility as a significant characteristic for nursing leaders is well supported by leadership research in business. (Barrow, 1977; Bass, 1982). Yura et al. (1981) found that flexibility was inherent in the leadership process in nursing.

Nursing leaders in this study addressed the importance of intuition and that intuition does have a place in nursing leadership. Benner (1984) noted that intuition is not a magical phenomena but is based on past experiences of nurses. The relationship between leadership and intuition, however, has not been addressed in leadership studies in nursing or other disciplines.

The finding that persuasiveness is a characteristic of nursing leaders is supported by Bass (1982) in his comprehensive review of leadership research. Keown and Keown (1982) also noted that female executives used a selling style of leadership most often.

In the literature, empathy is recognized as a characteristic of business leaders (Pepper & Ryan, 1986). Nursing has long been associated with empathy and caring (Watson, 1979; Benner, 1984; Knowlden, 1988; Hernandez, 1988). Caring has also been identified as a factor in female development and a priority in a woman's life (Gilligan, 1979). The results of this study that have shown empathy as a characteristic of nursing leaders is congruent with research focusing on women, nurses and leaders.

Confidence, as a characteristic of leaders, is well established in studies of male business leaders (Barrow, 1977; Bass, 1982; Pepper & Ryan, 1986). Moore and Rickel (1980) found that nurses in high level positions were more confident in their skills and abilities than nurses in lower level managerial positions. Leaders in this study, however, viewed confidence as a result of experience rather than organizational position.

Although leadership on male business leaders does not directly identify leaders as risktakers, descriptors such as non-conformity and learning through mistakes were identified (Bass, 1982; Bennis & Nanus, 1985). Nursing leaders noted that risktaking may result in failure and is not always supported by others. Their description of risktaking includes non-conformity and making mistakes. Vance (1977) and Kinsey (1986) both found that nurse influentials were willing to take risks. The role of the leader in developing followers or in this case nurses to be risktakers is not well documented in the literature.

Nursing leaders have a vision for the profession of nursing. The vision is futuristic with the ultimate endpoint being that nursing is a respected and clearly defined discipline. The vision is related to knowledge gained through education and experience and part of the leader's role is sharing the vision with others. Bass (1988) found that transformational leaders had a sense of vision that was effectively communicated to followers. Bennis and Nanus (1985) recognize vision as one of four competencies of business leaders. Their definition of vision incorporates knowledge of the past and present, both within the

organization and external to the organization, as well as a view of the future of the organization. Bennis and Nanus' findings are similar; however, in this study organizational knowledge, organizational history and the impact of external variables on leadership were not clearly identified as part of the vision. Vision is not well described in the leadership literature in nursing.

Nursing leaders in this study characterized themselves as agents of change. An administrative position was viewed as a vehicle for implementing change. Change is inevitable as the health care needs of society must be met. Bennis and Nanus (1984) also emphasized change as a critical factor in leadership and that change must occur to meet changes in society and the organization.

Committment to goals, beliefs and/or the profession was found to be a characteristic of nursing leaders. Leaders in business were also described as committed or persistent (Bass, 1982; Pepper & Ryan, 1986). Vance (1977) and Kinsey (1986) did not clearly identify committment as a characteristic of nurse influentials; however, one can assume there was committment by virtue of their activities. Nurse influentials were politically active, worked long hours, wrote articles and books.

Many of the characteristics of leaders or nursing leaders are supported by previous research. More research is needed to validate the findings that nursing leaders are intuitive, visionary and are agents of change. Future research should be done to determine how nursing leaders develop followers to be risktakers.

<u>Values</u>

Nursing leaders valued: patient care, the status/image of the nurse, collegiality and a balance between professional and personal life. Yura et al. (1981) also found that the values of nursing leaders influences leadership.

The status/image of the nurse was a concern to the nursing leaders in this study as they valued their profession. Quality patient care was also valued. This is appropriate as patient care is the essence of nursing. In this study, leadership development of nurses has been linked to prior clinical experience.

Collegiality as support and influence between leaders and followers is identified in the business literature (Tannenbaum & Schmidt, 1973; Barrow, 1977). In the nursing literature, Larsen (1984) found that collegial support was valued by nursing leaders and Kinsey (1977) described collegial support as a source of influence.

The value of a balance between personal and professional life is well documented in the nursing literature. Vance (1977), Yura et al. (1981) and Larsen (1984) all found that family or personal relationships were significant in the nursing leader's life.

Professional values such the status/image of the nurse and quality patient care as they relate to nursing leadership are not clearly

identified in the literature. Collegiality with followers, in terms of influence and support, has not been an area of previous research in nursing leadership. As collegiality, the status/image of the nurse and quality patient care were so clearly identified as important in nursing leadership, further research should be done with a more indepth focus on each area.

Skills

Nursing leaders identified eight skills that are needed in leadership roles: communication, interpersonal, information gathering, strategy, decision making, collaboration, problem solving and management. Leadership skills have been identified by descriptive theorists, behavioral theorists and situational theorists. The skills of nursing leaders have been the focus of researchers in nursing; however, only to a limited extent.

Communication skill is well supported in both the general and nursing literature (Vance, 1977; Bass, 1982; Bennis & Nanus, 1985; Pepper & Ryan, 1986; Kinsey, 1986). Writing for publication as a method of communication is supported in the nursing literature (Vance; Kinsey). Communication was recognized as a vehicle for sharing information. A study by Donnel and Hall (1980) found that females were less likely than males to share information with followers. On the basis of this study it is impossible to measure the amount of information that is shared between leaders and followers so whether this finding applies to

female nursing leaders is unknown. White (1971) found that nursing leaders who share information with subordinates are viewed as most effective.

Interpersonal skill is generally accepted as a necessary skill for individuals in leadership positions in business and in nursing (Barrow, 1977; Vance; 1977; Bass, 1982, 1985b; Hanson & Chater, 1983; Bennis & Nanus, 1985; Kinsey, 1986; Pepper & Ryan, 1986). In the nursing literature, interpersonal skill was found to relate to the concept of caring (Horner, 1988; Knowlden, 1988). Previous studies of female leaders have found that women describe themselves as being open and willing to get along with others and that success is attributed to interpersonal skill (Van Der Merwe, 1978; Forsyth, Schenker, Leary & McCown, 1985).

Information gathering is described in the business and nursing literature. Bennis and Nanus (1985) found that leaders pay attention to details. White (1971) noted thateffective leaders use the ideas and expertise of subordinates.

Strategizing, which includes goal setting, is well documented as a skill of leaders. Bennis and Nanus (1985) and Bass (1988) see strategy as part of the vision. The behavioral theorists identify role structuring and a focus on goal achievement as critical strategies of leaders to ensure task completion (Fleishman & Peters, 1962; Bergeron, 1987). The situational theorists view leadership as the arena where leaders

develop strategies to achieve personal and organizational goals (Fiedler & Chemers, 1974; House, 1975). Informational gathering is related to strategy as leaders must determine the characteristics and abilities of followers, the nature of the task and organizational influences (Gibson et al. 1985; Blanchard & Hershey, 1982). Transformational leadership's strategies focus on setting standards of performance and determining the activities of followers (Bass, 1985b). Strategizing is not well identified in the nursing literature.

Nursing leaders identified that they use three separate styles of decision making: independent, collaborative and delegating. All nursing leaders identified that they made independent decisions. Two subjects clarified that even what they considered to be independent decisions were not made in isolation from others. These statements imply that the involvement of others is a critical variable in decision making in nursing leadership. The research of Tannenbaum and Schmidt (1973) supports the variability of responses from leaders in this study in regards to independent decision making. Tannenbaum and Schmidt identified three types of independent decision making. Leaders make the decision without input, leaders make the decision and sell it and leaders make the decision and invites questions. Two studies on female leaders have identified that independent decision making and selling the decision is favored and dominance is important (Keown & Keown, 1982; Bartol, 1974). This study does not support their findings.

Tannenbaum and Schmidt (1973) described the collaborative decision style in leadership. Leaders can present the tentative decision and incorporate follower suggestions or include followers in the entire decision making process. Their findings are congruent with the finding of this study.

Tannenbaum and Schmidt (1973) noted that decisions may be delegated within limits defined by the leader. Nursing leaders, in this study, identified that they must be kept informed of decisions made by followers.

Collaboration, as a skill for nursing leaders is supported in the business and nursing literature. Collaboration with followers is well documented by the descriptive theorists, the behavioral theorists and the situational theorists. (Barrow,1977; Pepper & Ryan, 1986; McGregor, 1976; Tannenbaum & Schmidt, 1973; Gibson et al., 1985). Collaboration is congruent with the concept of caring in the nursing profession (Watson, 1985; Horner, 1988). A collaborative style was found to be effective in nursing leadership (White, 1971).

Nursing leaders identified that they must be skilled problem solvers and problem solving is often done in collaboration with others. Tannenbaum and Schmidt (1973) found that leaders may present problems to followers to facilitate the problem solving process. Bass (1985b) noted that transformational leaders are skilled problem solvers and enable followers to analyze and solve problems. Watson (1985)

reports that problem solving is one of ten factors related to caring in nursing. Research in nursing leadership has not focused on the skill of problem solving.

Nursing leaders did not report consistently as to whether management skill is necessary in a leadership role. All subjects in the study were employed in an administrative capacity so this may account for the disagreement since they may have some difficulty discerning between aspects of their leadership role and aspects of their managerial roles or there may be areas of overlap. In the leadership literature this problem is also evident as often the terms manager and leader are used interchangeably.

The leadership skills of strategy and decision making have not been the focus of previous studies in nursing leadership. Future research should be directed to the study of these two skills of nursing leadership.

Duties

Five duties of nursing leaders were identified: defining the boundaries of nursing, role modelling, teambuilding, developing others and ongoing self-development. The duties of leaders are described by descriptive theorists, behavioral theorists, situational theorists and to a lesser extent researchers in the area of nursing leadership.

Defining the boundaries of nursing was seen as difficult task because the practice of nursing is poorly defined. Defining the boundaries of nursing is not well documented in the nursing literature. Watson (1979) sees nursing as the science of caring, but she does not identify the actual role of the nurse. Defining the boundaries of groups is also poorly documented in the general leadership literature. In the business setting, boundary definition is discussed as job design rather than in relation to leadership (Gibson et al. 1985). Included in defining the boundaries of nursing was protecting the boundaries. Leininger (1979) identified that leaders must be aware that other groups or disciplines will try to infringe upon nursing's boundaries or may already have been successful.

Role modelling is supported in the leadership literature. Bass (1985b) noted that transactional leaders must be a model of integrity. Kinsey (1977) found that nurse influentials usually acted as a mentor to others.

Teambuilding was identified as an important component of leadership. The term teambuilding is not identified in the leadership literature; however, many other names have been applied to this activity. A focus on building relationships with followers to achieve goals is called a democratic style (McGregor, 1976), consideration (Fleishman & Peters, 1962), employee-centred behaviour (Bonaquist, 1986; Luthans, 1981), relations-orientated behaviour (Fiedler, 1972) and high-supportive behaviour (Blanchard & Hershey, 1982). Past

researchers also found that trust was significant in building relationships with followers (Barrow, 1977; Bass, 1982; Bennis & Nanus, 1985). In nursing studies, trust and supportive behaviours were found to be related to effective leadership and follower satisfaction (White, 1971; Duxbury, Armstrong, Drew & Henley, 1984).

Developing others is a duty of a nursing leader. Bass (1985b) found that transformational and transactional leaders developed followers by sharing knowledge and expertise, providing experiences that contribute to individual development, assisting followers in reframing their thinking and enabling followers to analyze and solve problems. White (1971) found that nursing leaders who focused on staff development were judged to be effective by subordinates.

Ongoing learning or self-development is necessary in a leadership role in nursing. Bennis and Nanus (1985) saw development as part of the vision process as a leader must continually be aware of changing circumstances in their environment. Bennis and Nanus also found that leaders viewed mistakes as part of their ongoing learning process. Ongoing self-development in the workplace is not identified in the nursing literature.

Further research is needed that is directed towards the role of the nursing leader in defining the boundaries of nursing, role modelling, developing others and the ongoing development of self.

Implications

The findings of the study have implications for nursing leaders and nursing educators. Nursing leaders in administrative positions should reflect upon their present perspectives on leadership. Personal characteristics, values, skills, and duties should be reviewed to determine if they are appropriate to their leadership role. Nursing educators, in universities and service settings should focus their efforts on developing the necessary leadership skills for nurses in leadership roles in administration or aspiring to leadership roles in nursing. Courses on issues in the nursing profession, organizational structure and behaviour and elements of research should be seen prerequisites to leadership roles and their relationship to nursing leadership should be clearly identified. The link between educational knowledge and application of that knowledge in the practice setting should not be neglected.

In job descriptions for nurse administrators, specific duties of nursing leaders should be more clearly addressed. Nurse administrators should be aware that their role must go well beyond that of a manager. Collaboration, collegiality, teambuilding, the development of self and others, role modelling and determining what is within the scope of nursing must be emphasized. Nurse administrators, because of their position in the hierarchy, are subject to scrutiny by followers so must present the ideal of both a nurse and administrator.

<u>Recommendations for Future Research</u>

Future research should be undertaken that looks at family, educational, clinical experiences and experiences with role models and in leadership roles to determine how these experiences specifically contribute to the development of characteristics, skills, values and duties of leadership.

FACTORS AFFECTING NURSING LEADERSHIP

Three patterns were identified that related to the research question: What factors affect nursing leadership as identified by nursing leaders? The three patterns are followers, the organization and society. The relationship between leaders and followers is well articulated in the literature, however, the impact of the organization and society on leadership has not been well researched. The identification of society and the organization as factors affecting nursing leadership shows that leadership in nursing must be viewed in a broader perspective than that of descriptive theorists, behavioral theorists and situational theorists. Nursing leadership is more congruent with the systems perspective of leadership that is supported by Tannenbaum and Schmidt (1973) and Yura et al. (1981).

<u>Followers</u>

Nursing leaders viewed their followers, nurses, as persons with

distinct goals, values, beliefs, needs and feelings. Robert House (1971) noted that follower characteristics, perceptions and motivators should be considered so the appropriate leadership style can be selected. Bass (1985b) found that transformational leaders respond to the needs of followers on an individual basis and provide experiences for followers based on needs. Yura et al. (1981) found that the leadership process in nursing is affected by follower personality, character and needs. Sensitivity to the nurse followers was found to be a contributing factor in leadership effectiveness (White, 1971).

The educational and practical experience of nurse followers was found to affect nursing leadership. Kerr and Schriesheim (1974) found that follower expertise, experience and competence were factors leaders considered in determining what leadership behaviours would be most effective. Hershey and Blanchard (1982), in their Life Cycle Theory of Leadership, call educational and practical experience job maturity. Job maturity is a factor in determining the choice of leadership style. Several nurse researchers have utilized the Hershey and Blanchard model and found that maturity was a consideration in determining the leadership style of nursing leaders (Goldenberg, 1980; Lucas, 1986).

Organization

The impact of unionism on leadership is poorly described in the literature. Tannenbaum and Schmidt (1973) adapted their leadership

continuum model because they recognized that unions have become a powerful force in organizations and do impact on leadership. Other researchers, in both business and nursing, do not seem to have addressed the impact of unionism on leadership.

Bennis and Nanus (1985) found that leaders must be aware of the culture and traditions of the organization. No nursing studies have been done that identify the relationship between nursing leadership and organizational history.

Organizational structure, which includes philosophies, goals, policies and lines of communication were viewed as having a negative influence on nursing leadership. Kanter (1977) found that organizational structure, is the key determinant of behaviour. The conclusion to be drawn is that leaders learn to behave in a way that is compatible with the structure of the organization in which they work. Conforming to tradition appears to be incompatible with the findings of this study which has characterized leaders as risktakers, visionaries and agents of change. The power of nursing leaders within the organization was identified as important in the leadership role. Yet organizational structure would seems to severely limit the leaders power to effect change. Tannenbaum and Schmidt (1973) leadership continuum model identifies that the organizational power of a leader impacts on leadership. Yura et al. (1981) believe power is inherent in the entire leadership process.

Society

The needs and demands of society, health care funding and the status of women in society were identified as having an impact on nursing leadership. Tannenbaum and Schmidt (1973) altered their leadership continuum model so the relationship and interdependencies between the leader, the organization and society were identified. Leadership is viewed as an open system. Yura et al. (1981) developed a systems model of nursing leadership, similar to Tannenbaum and Schmidt's that recognizes the impact of society on nursing leaders.

Implications

The findings have implications for nursing administration and nursing education. Nursing leaders should reflect upon the affect their followers, the organization and society have on their leadership. Issues specific to nursing that affect leadership should be clearly identified so their role is truly that of leader in the nursing profession. Educators should go beyond traditional leadership education and begin to emphasize the impact of society and the organization on leadership. Knowledge of the all of the variables affecting leadership, rather than a select few, will better prepare leaders to deal with the constraining influences of the organization and respond and adapt to the changing needs, opinions and concerns of society.

Recommendations for Future Research

Future research is needed to identify other organizational and societal factors that impact on nursing leadership and further describe how these factors impact on nursing leadership. A study of how the leadership of nurse administrators varies according to the experience and educational level of followers would be appropriate.

Summary of Discussion

The findings of this study show that descriptive theories, behavioral theories and situational theories can all contribute to a better understanding of nursing leadership. Nursing leadership, however, needs to be viewed in a broader perspective that considers the development of leaders, the impact of society, the organization and issues in the nursing profession on leadership as well the major concepts of nursing leadership. Further research is needed to ensure that all categories related to leadership development, concepts of leadership and factors affecting leadership are identified.

IMPLICATIONS OF THE STUDY

Education for individuals in leadership roles or aspiring to leadership roles should go beyond theories borrowed from the study of male business leaders. No one of these theories provides a broad enough perspective for leadership in nursing. Rather a systems perspective

should be the focus that identifies the impact of the organization and society on leadership. Leadership education should focus on nursing issues and leadership rather than just leadership.

Nursing may be viewed as a profession that is evolving with the health care system of which it is a part. Some of the specific characteristics of leadership may need to change over time to accommodate these changes.

RECOMMENDATIONS FOR FURTHER RESEARCH

Further research, using a similar methodology is warranted. The small sample size and the complexity of the leadership construct has contributed to incomplete saturation of categories. Clearly a larger sample size is needed. A study, using theoretical sampling, is appropriate at this stage so a broader range of subjects could be studied. Nursing leaders without degrees and nursing leaders in non-administrative positions may bring a perspective that either supports present findings or adds further categories under each research question. The problem of differentiating between management and leadership could be addressed through the inclusion of leaders in non-administrative positions.

A series of studies that addresses each research question individually would ensure that all categories related to leadership

development in nursing, key concepts in nursing leadership and factors affecting nursing leadership are identified. Because of the complexity of each category, all of the categories identified in this study could be the focus of individual studies.

LIMITATIONS

The data generated is limited by the small sample size. All patterns and categories related to leadership in nursing may not be identified. Leadership is a complex construct so a study such as this is constrained by the broad scope of the subject itself. The results of this study are generalizable only to specific population from which the sample was obtained. Because the researcher has had prior experience in administrative/leadership roles there is a possibility that bias may have been introduced into the analysis. Bias was reduced by having external auditors review the data.

The fourth subject was not observed in the workplace so data that was best gathered through observation was lost. The final validation process, however, provided the fourth subject with the opportunity to agree or disagree with the findings from the observations of other nursing leaders and to add additional information.

SUMMARY

The results of this pilot study indicate that leadership in nursing cannot be totally described by theories generated from the study of male or female business leaders. This study has supplied some tentative answers to the research questions. Nursing leaders were found to develop through prior experiences. Nursing leaders were found to have specific characteristics, values, skills and duties in relation to their leadership role. Leadership in nursing was found to be affected by nursing followers, the organization and society. Further qualitative research is needed that validates the findings of this study and identifies further categories that may be critical to leadership in the nursing profession.

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APPENDIX A

LETTER OF PERMISSION TO THE MANITOBA ASSOCIATION OF REGISTERED NURSES

Mr. David Gregory
Chairperson, Research Committee
Manitoba Association of Registered Nurses
647 Broadway Avenue
Winnipeg, Manitoba
R3C 0X2

Dear Mr. Gregory:

I am a graduate student in the Nursing Program at the University of Manitoba and am presently working on the thesis component of the program. The focus of the study is nursing leadership and a grounded theory approach shall be utilized. The study is being supervised by Dr. Alice Jope. Approval for the study was given by the Ethical Review Committee at the University of Manitoba on DATE.

I am requesting permission to obtain the participants for my study from the list of registrants at the Manitoba Association of Registered Nurses. The following criteria were specified for inclusion in the sample:

1. The individual must be female.
2. The individual must have, at minimum, educational preparation at the masters level or above.
3. The individual must be presently employed in an administrative role and have, at minimum, three years of administrative experience.
4. The individual must directly responsible for a specific area of nursing practice, research or education and be employed in a health care institution, a school of nursing or a community health agency within the boundaries of the City of Winnipeg.
5. The individual must be in a middle management position (supervisor or coordinator) or above.

I have included two copies of the research proposal and documentation that verifies that the proposal has been approved by the Thesis Advisory Committee and the Ethical Review Committee at the University of Manitoba. The research committee can be assured that the rights of members of the association shall be respected. My proposal identifies steps that will be taken to ensure anonymity and confidentiality for all participants. I have read the MARN policy on release of membership names and will work within those guidelines.

I would be prepared to meet with the committee if it is deemed necessary. Should the committee have any questions, I can be reached at 474-8266. Thank you for your consideration. I look forward to hearing from the committee in the near future.

Sincerely,

Debra Vanance

APPENDIX B

TELEPHONE INTRODUCTION TO POTENTIAL SUBJECTS

Hello. My name is Debra Vanance. I am a student in the Masters of Nursing Program at the University of Manitoba. A thesis or research study is a requirement of the program in which I am enrolled. I would like to conduct a research study in the area of nursing leadership. My thesis advisor is Dr. Alice Jope.

I have been given your name by the Manitoba Association of Registered Nurses. You have been identified as a suitable candidate for my study because:

1.   You are female.

2.   You have educational preparation at the masters level or above.

3.   You are presently employed in an administrative role and have, at minimum, three years of administrative experience.

4.   You are directly responsible for a specific area of nursing practice, research or education and are employed in a health care institution, a school of nursing or a community health agency within the boundaries of the City of Winnipeg.

5.   You are in a middle management position (supervisor or coordinator) or above.

Would you be interested in hearing more about the research study? The purpose of the study is to describe the concept of nursing

leadership as defined by nursing administrators. The study design requires participants to spend a total of approximately three and one half hours in interviews. The first interview shall be one hour to one hour and a half in length. The final two interviews will be approximately one hour in length. Each interview shall take place at three separate times and shall be tape recorded. I would spend approximately five days with you at work during which time I will act as a non-participant observer. I shall take field notes that describe your leadership behaviors. I shall confine interactions to seeking clarification only. I wish to stress that your anonymity would be protected and any information provided to me would be kept confidential. Do you have any questions? Would you be interested in participating in my study?

(If the response is positive)

I shall be mailing you an written explanation of the study. Could I have please the address to which you would prefer the explanations be sent. I have included my name and telephone number on the explanation form. Please call if you should have any questions.

I shall be calling in one week to establish a mutually convenient time for the initial interview. Thank you for agreeing to participate in the study.

(If the response is negative)

Thank you for your time and attention.

APPENDIX C

DESCRIPTION OF THE STUDY

Thank you for agreeing to participate in a study of nursing leadership. Your name was provided by the Manitoba Association of Registered Nurses. The study is being conducted by myself, Debra Vanance, a registered nurse in the Masters of Nursing Program at the University of Manitoba. The supervisor for the study is Dr. Alice Jope. You have been selected to participate in this study because you are a nursing administrator with experience in a leadership role.

This study will attempt to describe the critical attributes of nursing leadership from the perspective of nursing leaders. While much research has been done in the area of leadership within other disciplines, research in nursing leadership is in its fledgling stage. The majority of nursing literature available, pertaining to leadership, has relied on research from non-nursing disciplines. This study will use a fresh approach to investigate the concept of leadership. The researcher shall attempt to develop a framework of leadership based on the perspective of nursing leaders. New knowledge will be generated that may support or refute previous research findings. Through a better understanding of the concept of nursing leadership, nursing administration may become a more attractive career alternative for nurses.

To participate in the study, individuals must meet the following criteria:

1. The individual must be female.

2. The individual must have, at minimum, educational preparation at the masters level or above.

3. The individual must be presently employed in an administrative role and have, at minimum, three years of administrative experience.

4. The individual must directly responsible for a specific area of nursing practice, research or education and be employed in a health care institution, a school of nursing or a community health agency within the boundaries of the City of Winnipeg.

5. The individual must be in a middle management position (supervisor or coordinator) or above.

The data collection shall consist of three taped interviews. The first interview shall be approximately one hour to one and a half hours in length. The final two interviews shall each be approximately one hour in length. Time and place shall be based on the participant's preference. Interview questions shall focus on demographic data, factors associated with and affecting nursing leadership and factors contributing to the selection of a leadership/administrative role. The researcher shall spend a period of approximately five days observing the nursing administrator at work. The researcher shall ask questions only when clarification is needed and shall take notes. Participants may ask

the researcher to leave at any time. Participants have the right to refuse to answer any question and to withdraw from the study at any time without explanation.

All tapes and field notes shall be identifiable by a code number only. Code numbers and names shall be kept in separate locked drawers. Tapes shall be erased and field notes destroyed after transcription. Anonymity and confidentiality are assured. Participants will not be identifiable in the written report of the study. If you desire a summary or copy of the study will be sent to you upon completion.

Please call if you have any questions. I can be reached at 474-8266.

APPENDIX D

CONSENT FORM

This certifies that I,_____

having met the conditions, agree to participate in the research study conducted by Debra Vanance, a Masters student at the University of Manitoba. The study is being supervised by Dr. Alice Jope, who is a professor at the University of Manitoba.

I understand that the purpose of the study is to describe nursing leadership from the perspective of a nursing administrator in Winnipeg. I have been informed that my name was obtained from the roster at the Manitoba Association of Registered Nurses. I am aware that I have been selected because: I am employed in an administrative capacity in a line position in middle management or above; I have at least three years administrative experience; I am female; I have a masters degree or higher. I have been provided with a written explanation of the study and have been given the opportunity to ask questions. I have been informed that the study is comprised of three separate interviews. I am aware that the first interview shall be approximately one hour to one and a half hour in length and the final two shall each be approximately one hour in length. I am aware that the questions I will be asked shall focus on demographic data, factors associated with and affecting nursing leadership and factors contributing to my selection of a leadership/administrative role. I am aware that the researcher shall spend approximately five days observing me at work. The times and

place shall be determined by my preference. I have been informed that I may decline to answer any question and may request that the researcher leave. I understand that I may withdraw from the study at any time without explanation or penalty to myself. I am aware that the study will not have a direct benefit to me.

I understand that tapes and field notes shall be identifiable by code numbers only. Code numbers and names shall be kept in separate locked drawers. I am aware that tapes shall be erased and field notes destroyed after transcription by the researcher. I have been assured that I will not be identifiable from the study. I am aware that the raw data shall be reviewed by two auditors and the thesis committee, who will not be informed of my identity. I understand that information I provide will be confidential. I understand that I will be provided with a copy of this consent form. If I request, I understand that a summary or copy of the study will be available to me upon completion of the study.

If I should have any questions, I am aware that I am may call Debra Vanance, at any time, at 489-7079 or 474-8266.

My signature below indicates that I have read and clearly understand the preceding information and am willing to participate in this study.

Participant   Researcher   Date

I would like a copy of the results   Yes_____ No_____
I would like a summary of the results Yes_____ No_____

APPENDIX E

DEMOGRAPHIC DATA & INTERVIEW GUIDE

The purpose of this study is to determine key factors associated with nursing leadership. I have developed a series of questions to for you to answer. These questions have been formulated to provide only a beginning to our interview. Your responses and recollections of personal experiences shall direct the majority of the interview as your personal perspective on leadership is the key to this study. During the course of this interview, I shall ask you to expand upon and clarify your responses.

You are free to refuse to answer any questions or to stop the interview at any time.

DEMOGRAPHIC DATA

I shall begin by asking you some questions about yourself.

1. Age: _____ years.

2. Marital status: Single_____ Married_____

    Separated_____ Divorced_____ Other_____

3. Children: Number_____

        Ages____;____;____;____;_____;_____.

4. Education:

    Diploma in nursing_____   Year graduated _____

    Undergraduate   Degree: Discipline_____Yr.   graduated____

    Masters   Degree: Discipline_____   Yr.   graduated____

    Doctoral Degree: Discipline_____ Yr. graduated_____

    Other   certificate   _____Yr.gr.   _____

            programs   _____Yr.   gr._____

                                   _____Yr. gr._____

5. Years of employment:

    General duty experience_____ years

    Clinical nurse specialist _____years

    Total teaching experience_____years

    Total research experience_____years

    Total administrative experience:_____years

    Present administrative position:_____

    Years in present position: _____

6. Administrative employment history:

    Title:_____ # of yrs. in position: _____

    Title:_____ # of yrs. in position: _____

    Title:_____ # of yrs. in position: _____

    Title:_____ # of yrs. in position: _____

    Title:_____ # of yrs. in position: _____

    Title:_____ # of yrs. in position:_____

7. Professional activities:

a) Are you actively involved in the activities of MARN?

    Yes___ No___

b) Are you active with the CNA? Yes___ No___

c) Other professional activities:

d) Have you had books\articles published? Yes___ No___

    If yes, how many books? _____ articles?_____

e) Have you given presentations at conferences? Yes___No___

f) Number of professional journal subscribed to _____

g) Other professional affiliations:

INTERVIEW GUIDE

I would like you think back to your initial entry into an administrative role in nursing.

1. What were your reasons for choosing a career in nursing administration?

2. What qualities did you see in yourself that led you to believe that you would be successful in this role?

3. What prior personal and professional experiences had prepared you for your future role as a leader?

4. Were there any significant others who prepared you for your role as a leader? If yes, how did they do this?

I would now like you to consider your years of experience in a leadership role in nursing.

1. What previous experience has influenced your behaviors or philosophy in your leadership role?

2. What personal qualities or characteristics have you identified in yourself that contribute to your leadership abilities?

3. What external or societal factors affect your leadership role? How do they affect that role?

4. What institutional opportunities or constraints affect your leadership role? How do they affect that role?

5. In leading others, what do you consider? How do these considerations affect your leadership?

6. Describe your relationship with your followers/ superiors/colleagues?

7. How does your relationships with your followers/superiors/colleagues affect your leadership behaviors?

8. How would you describe your leadership behaviors?