

NURSING LEADERSHIP
CAN IT MEET THE MARKETPLACE NEEDS

CENTRE FOR NEWFOUNDLAND STUDIES

**TOTAL OF 10 PAGES ONLY
MAY BE XEROXED**

(Without Author's Permission)

PATRICIA DOWNTON



NURSING LEADERSHIP. CAN IT MEET THE MARKETPLACE NEEDS?

by

Patricia Downton

A thesis submitted to the
School of Graduate Studies
in partial fulfilment of the
requirements for the degree of
Master of Education, Administration Studies (Leadership)

Department of Education
Memorial University of Newfoundland

February 14, 1997

ABSTRACT

NURSING LEADERSHIP. CAN IT MEET THE MARKETPLACE NEEDS?

by

Patricia Downton

This study consisted of audio-taped interviews with ten nursing administrators from ten work sites in St. John's Newfoundland. The research design combined critical ethnography and critical theory, which together comprised an "intensive research design" outlined by Morrow (1994). This design allowed a small number of case studies (ten) to be considered in terms of a great number of individual properties in order to examine nursing leadership for its potential, skills and use within the health care systems. Nursing is undergoing social change and increased pressure from the government, nursing associations and the marketplace making it imperative that nursing meet a mandate for leadership.

The thesis is divided into six chapters. Chapter one gives the introduction; Chapter two provides a literature review; Chapter three, the research design and methodology; Chapter four is comprised of the lived experiences of the informants; Chapter five is an interpretative analysis of chapter four and includes document analysis; and, Chapter six provides a more intensive analysis of chapter four. Bolman and Deal (1991) and O'Toole (1995) provide a critical theory in-depth analysis of nursing leadership in organizations affected by change. Recommendations are included.

The research study showed that nurses are providing leadership in multiple settings but nursing leadership is difficult in the present times of change. There were indications that nurse leaders still face asymmetrical patterns of power and privilege, with dominance exercised by the medical profession. This dominance was cited as a key factor in nurses ability to determine their future roles in the emerging new structures of health care delivery.

The study could not fully address nurses' ability to meet the current marketplace needs because the changes to health care are still too recent, with rapid changes still occurring. Two themes did arise from the study. Does the health care system want or value nurses as leaders? Do nurses and the health care system realize the potential of nurses as leaders?

LIST OF TABLES

Table 6.1 Overview of the Shifting Marketplace.....	pg. 207
Table 6.2 Environmental Pressures for Change.....	pg 223
Table 6.3 Beliefs, Attitudes and Assumptions of Administrators.....	pg 229
Table 6.4 How Administrators Described Leadership.....	pg 231
Table 6.5 Characteristics of Leaders.....	pg 237
Table 6.6 Structural and Human Resource Frame of Leadership.....	pg 239
Table 6.7 Political and Symbolic Frame of Leadership.....	pg 240

LIST OF FIGURES

Figure 6.1 Relationship Between Social Forces, Working Conditions, Nurses Opportunities and Barriers.....	pg 208
Figure 6.2 An Overview of Nursing Education.....	pg 209

Acknowledgements

I would like to give a special thank-you to my husband, Ed who has helped me to find the time to accomplish this task, acted as proof reader and offered encouragement.

I would like to give special thanks to the ten administrators who allowed themselves to be interviewed, and shared their views on nursing leadership freely with me. Without their valuable contribution this thesis would not have been possible.

I offer my sincere thanks to the faculty of education, who have given me a greater understanding of leadership, by academic exposure and through example.

I offer a final special thank-you to my supervisor, Clar Doyle who offered the best example of an educator that I have met and provided positive support and encouragement for this research project.

TABLE OF CONTENTS

	<u>Page</u>
Abstract.....	i
List of Tables.....	iii
List of Figures.....	iv
Acknowledgements.....	v
 Chapter I - Introduction.....	 1
1.1 Statement of the Problem	2
1.2 Purpose of the Study.....	4
1.2.1 Research Questions.....	4
1.2.2 Significance of the Study.....	5
 Chapter II - Literature Review and Theoretical Framework.....	 6
2.1 Gender Issues Affect Leadership.....	6
2.2 The Political Economy and Nursing Leadership.....	8
2.3 Do Nurses Know How to Politick?.....	10
2.4 Why Should Nurses be Leaders?.....	11
2.5 Nursing Education Affects Leadership.....	12
2.6 Creating a Preferred Future for Nurses.....	16
2.7 Factors Influencing Nursing Leadership Attainment.....	17

2.8 Leadership or Management.....	21
2.9 Definitions for the Study.....	24
2.9.1 Nursing Administrator.....	24
2.9.2 Leadership.....	24
2.9.3 Management.....	25
2.10 Theoretical Framework.....	25
 Chapter III - Research Design and Methodology.....	 29
3.1 Research Sample.....	30
3.1.1 Rationale for Administrators.....	31
3.1.2 Research Interview.....	32
3.2 Research Analysis.....	34
3.3 Research Limitations.....	38
 Chapter IV - Nurse Leaders Dialogue on Nursing Leadership.....	 40
Section A - The Reality of Political Forces on Hospitals.....	41
4.1 Down-sizing Hospital Services.....	41
4.1.1 A Change Agent.....	42
4.2 Program Management - Changing the Organization.....	43
4.2.1 The Program Management Model.....	43
4.2.2 Leaders and Professional Issues.....	47
4.2.3 Removal of Department Structures.....	51

4.3. Nurses Input into Restructuring.....	55
4.3.1 Power Imbalance Between Medicine and Nursing.....	57
4.4 Resistance to Program Management.....	58
4.4.1 Doctors Resistance.....	59
4.4.2 Nurses Resistance.....	61
4.5 Nurses Reactions to Restructuring Health Care.....	63
4.6 The Vulnerability of Nurses.....	64
 Section B - Restructuring Health Care Systems.....	 71
4.7 Restructuring Long Term Care.....	71
4.7.1 Beginning Restructuring.....	71
4.7.2 Input into Restructuring.....	72
4.7.3 Changing Roles.....	73
4.7.4 Multi-Level Population.....	74
4.7.5 Economic Benefits.....	74
4.8 Restructuring Front-Line Staff.....	75
4.8.1 Separate Roles.....	76
4.8.2 Staff Ratio Differences.....	76
4.8.3 Staff Ratios Affect Working Conditions.....	77
4.8.4 Staff Ratios Questioned.....	78
4.8.5 Clinical Job Security.....	79
4.8.6 How Nurses View the Changing Role.....	79

4.8.7 Nurses Need a New Vision.....	80
4.9 Restructuring Community Health	81
4.9.1 Services to the Community Decentralized.....	81
4.9.2 Input into Restructuring.....	82
4.10 Restructuring Nursing Education.....	82
4.11 A New Education Direction.....	83
4.11.1 A Visionary Change Agent.....	83
4.11.2 Students as Change Agents.....	84
4.12 Shifting from Conformity	85
4.12.1 The Task Orientated Nurse.....	86
4.12.2 Removing Rules and Regulations.....	87
4.12.3 From Trained to Educated.....	88
4.12.4 Creating an Independent Nurse.....	88
4.13. Education Barriers to Leadership.....	90
4.14 Why a University Education.....	91
4.14.1 A Universal Education.....	91
4.14.2 Changes in Society.....	92
4.14.3 There Will be Growing Pains.....	93
4.15 Factors that Affect Nursing Education.....	93
4.15.1 Over-Supervision	94
4.15.2 Supervision Creates an Expensive Education.....	95
4.15.3 RNs Seek a Degree.....	96

4.15.4 Low Numbers in Graduate Programs.....	97
4.15.5 Inadequate Education.....	98
4.15.6 Insufficient Preparation for Roles.....	99
4.15.7 Student Collaboration.....	100
4.15.8 Unequal Faculty Positions.....	100
 Section C - Leadership in a Changing Marketplace.....	 102
4.16 Factors that Affect Nurses Leadership Roles.....	103
4.16.1 Nurses Value to the Health Care System.....	103
4.16.2 Nursing and the Caring Model.....	105
4.16.3 Nurses Lack Role Articulation.....	106
4.16.4 Role Conflict Between Doctors and Nurses.....	107
4.16.5 Family Responsibilities.....	111
4.16.6 Personal Factors.....	111
4.16.7 Compensation for Services.....	112
4.16.8 Nurse Abuse in the Workplace.....	113
4.16.9 Working Conditions Affect Nurses Roles.....	115
4.16.10 Barriers Between Disciplines.....	117
4.16.11 Casual Work-Force.....	118
4.16.12 Apathy and an Aging Work-Force.....	120
4.17 Factors that Develop Leadership.....	122
4.17.1 Benefits of a Higher Education.....	122

4.17.2 The Influence of Role Models.....	123
4.17.3 Experience, Initiative and Ability.....	124
4.17.4 The Fit Between the Leadership Role and Family.....	125
4.17.5 The Benefits of Professional Involvement.....	125
4.18 How Administrators Define Leadership.....	126
4.18.1 Professional Association Leadership - Interview Five.....	127
4.18.2 Union Leadership - Interview Nine.....	129
4.18.3 Mental Health Leadership - Interview Six.....	131
4.18.4 Gerontology - Private Sector - Interview Eight.....	132
4.18.5 Gerontology - Government Sector- Interview Seven.....	133
4.18.6 Continuing Care Leadership - Interview Two.....	135
4.18.7 University Leadership -Interview One.....	136
4.18.8 Community Health Leadership - Interview Three.....	138
4.18.9 Hospital Acute Care Leadership - Interview Four.....	140
4.18.10 Corporate Leadership - Interview Ten.....	140
4.19 Front-Line Leadership Abilities.....	143
4.19.1 Community Health - Interview Three.....	144
4.19.2 Continuing Care - Interview Two.....	144
4.19.3 Professional Association - Interview Five.....	145
4.19.4 Mental Health - Interview Six.....	146
4.19.5 Nursing Homes - Interviews Seven and Eight.....	147
4.19.6 Nurses' Unions - Interview Nine.....	151

4.19.7 Corporate - Interview Ten.....	153
4.19.8 Acute Care - Interview Four.....	155
4.20 The Public's View of Nursing Leadership.....	157
 Section D - Current Marketplace Dictating Nurses Future.....	 160
4.21 Empowering Nurses - Changing Leadership Role.....	160
4.21.1 Increasing Decision-Making.....	161
4.21.2 Increasing Input into Decisions.....	162
4.21.3 Increasing Clinical Skills and Confidence.....	164
4.21.4 Increasing Nurses Roles.....	164
4.21.5 Enhancing Working Relationships.....	165
4.21.6 Empowering Nurses Through Research.....	166
4.21.7 Empowering Student Nurses.....	167
4.21.8 Changing The Perception of Nursing.....	168
4.22 The Direction of Health Care.....	169
4.22.1 What are the New Leadership Roles?.....	169
4.23 Concluding Statement.....	173
 Chapter V - Documents Compared to Current Marketplace.....	 175
5.1 The Challenge for the Nursing Profession.....	175
5.2 The Evolution of Nursing Administration.....	175
5.3 Rapid Change.....	179

5.4 Supporting Professional Nursing Practice.....	187
5.5 Questioning Change - Some Tools.....	189
5.5.1 A Chief Executive Nurse.....	189
5.5.2 Nurses Participate in Strategic Planning.....	189
5.5.3 Nurses Participate in Decision-Making.....	190
5.5.4 Nurses Collaborate.....	190
5.5.5 Nurses Set Standards.....	191
5.5.6 Quality Improvement.....	191
5.5.7 Impact on Nursing.....	191
5.5.8 Nurses Participate.....	192
5.5.9 Nurse Contribution.....	192
5.5.10 Resource Utilization.....	193
5.5.11 Staff Development.....	193
5.5.12 Educational Linkages.....	194
5.6 Document Two - The Nursing Symposium Report on Leadership.....	194
5.6.1 Recommendation Forty-Eight.....	195
5.6.2 Recommendation Forty-Nine.....	195
5.6.3 Recommendation Fifty.....	196
5.6.4 Recommendation Fifty-One.....	196
5.6.5 Recommendation Fifty-Two.....	197
5.6.6 Recommendation Fifty-Three.....	197
5.7 Discussion and Recommended Action Plan.....	198

5.8 Concluding Statement.....	200
Chapter VI - Research Conclusions and Recommendations.....	201
6.1 Theoretical Framework.....	202
6.1.1 The Structural Frame.....	203
6.1.2 The Human Resource Frame.....	203
6.1.3 The Political Frame.....	203
6.1.4 The Symbolic Frame.....	204
6.1.5 O'Toole and the Effectiveness of Leaders.....	204
6.2 Organizational Change - Research Findings.....	205
6.3 Environmental Pressures for Organizational Change.....	210
6.3.1 Effects of Globalization.....	210
6.3.2 Effects of Information Technology.....	210
6.3.3 Effects of Deregulation.....	211
6.3.4 Effects of Demographic Changes.....	211
6.4 Leadership Within the Human Resource Frame.....	211
6.4.1 Change and Altered Power Bases.....	216
6.5 Leadership Within the Structural Frame.....	218
6.6 Leadership Within the Political Frame.....	220
6.7 Leadership Within the Symbolic Frame.....	221
6.8 Leadership and Nurses Place in the Marketplace.....	224
6.8.1 Behaviour, Beliefs, Attitudes and Assumptions.....	225

6.8.2 How Leadership is Defined.....	230
6.8.3 Commonsense Definitions of Leadership.....	230
6.8.4 Leadership is a Relationship.....	232
6.8.5 Leadership and Position.....	234
6.8.6 Personal Characteristics of Leaders.....	236
6.9 Framing Leadership Roles.....	238
6.10 Shifting Nurses in a New Direction.....	242
6.11 Summary and Conclusion.....	246
6.12 Recommendations.....	248
6.12.1 Recommended Actions.....	249
6.13 Conclusion.....	253
6.14 References.....	256
Appendix A.....	262
Research Questions.....	263
Letter of Consent.....	264
Consent Form.....	265

Chapter One

INTRODUCTION

Today, resources in health care are moving to the community, hospitals house only the very sick, and organizational structures are more complex due to fiscal restraints, restructuring and increasing technology. Our aging population needs services and our consumers want participation. How is nursing meeting these demands?

To meet these demands, reforms are occurring in the health care delivery, the nursing workplace and the nursing curriculum. But Booth (1995) states, in order to deal with this tri-dimensional change, nursing needs leaders who can provide vision, inspiration and direction, and nursing needs to rise to this challenge (p.52). Altieri & Elgin (1994) explain that nursing represents the largest health care discipline and they need leaders to utilize the potential power they possess and to become more empowered (p.75).

Change occurs in times of turbulence. The nursing profession is experiencing distress and pressure from within and without for change in leadership. The Nursing Human Resource Committee was directed by the Provincial Minister of Health to make recommendations to the Government of Newfoundland and Labrador following discussions on the National Nursing Human Resource Symposium Report. The recommendation emphasized the need for nurses to develop leadership skills (Nursing Human Resource Committee and Symposium Delegates, pp.31-34).

The Canadian Nurses Association (CNA), which provides direction for nurses across Canada states that nursing roles are changing and today nurses require skills in negotiation,

collaboration, group process and communication. The CNA alleges that this will provide nurses with increased opportunities in administration and leadership and the future will need nurses who understand the "business of nursing" and the "business of health service delivery" (Haines, 1993, pp.4-5).

The Association of Registered Nurses of Newfoundland and Labrador alleges that today's focus is on the marketplace and meeting its needs (P. Earle, 1995, personal communication). Change is redefining the marketplace and this change requires a stronger role for nurses in leadership that will help it meet the new challenges of the future and define new roles for nurses. But Irurita's (1994) research study showed that nursing leadership is retarded due to an extended period in history in which nursing leadership was delayed, hindered, impeded, in terms of its development, progress or accomplishment (p.62). This study was conducted in Australia, but is it true for Canada?

Booth (1995) states that nursing leadership is essential to manage change, to establish linkages with other health professionals, the public and the political system (p.52). How is nursing fulfilling its leadership role? Can it meet marketplace needs for nursing leadership?

Statement of the Problem

Nursing is undergoing social change and increased pressure from government, nursing associations and the marketplace, making it imperative that nursing meets a mandate

for leadership. Nursing is at a critical point in its history and is undergoing reform in health care, the workplace and nursing curriculum. Bandman and Bandman (1988) state nursing is in the process of redefining its purposes, its educational preparation, its practice, theory, research, roles, its relationship to medicine, and its social mandate (p.2)

Are these major changes that are occurring in nursing related to restructuring of health care delivery? Does nurses need to reposition themselves in society in order to have an effective leadership role in the new health care organizations? Popkewitz (1991) states that shifting views of pedagogy are coupled with changes in social organizations (p.66) and reforms of professions and pedagogy are tied to the changing problems of knowledge and regulation in society. He reiterates that what counts for reform are responses that tie knowledge to larger issues of social transformation and power (pp.76-77). Will the nursing profession be able to transform itself and its leadership? Does it need to?

Leadership presents a complex problem in nursing because it is carried out in multitudinous settings, under countless conditions, at many educational levels. The issue is, can nurses meet the marketplace needs of leadership? The nursing literature questions the ability of nursing to perform within this changing leadership role, while other nursing literature states this is the time to take advantage of the changes occurring in the health care system and to establish a new position for nursing leadership. Is nursing fragmented in its views of moving toward a stronger role for nursing in leadership?

The Purpose for the Study

The general purpose of this research is to gain insights into what nursing administrators describe as the leadership role for nursing in today's turbulent health care system and to explore whether nursing has the ability to meet marketplace needs for nursing leadership.

Research Questions

This research will examine the present societal role of nursing in providing leadership and if nursing is developing the leadership skills, or has the opportunity to develop the leadership skills, needed to move toward the goals outlined by the Nursing Human Resource Symposium and the Canadian Nurses Association.

The following broad question will be used to guide this research process. Are the leadership potentials and skills of nurses developed and used in the health care system? Additional, more specific questions will be used to guide and develop the study. These questions include the following.

1. What is the nurse's definition of leadership?
2. What is the nurse's perception of their leadership potential and skills?
3. Is nursing administration potential and skills developed enough to meet the marketplace needs of the health care system?
4. What are the opportunities and barriers to nurses seeking full leadership potential and

development of their leadership skills?

5. How are nurses leadership skills used by the health care system?

6. Does nursing need to transform its perceptions of leadership in order to empower nursing leadership?

Significance of the Study

This is an auspicious time to inquire as to the way nursing is accomplishing its potential and skills for leadership in the present marketplace of turbulence and change. The key people in nursing administration are involved in this change and are providing their vision of how nursing needs to change to meet the needs of the restructured health care system. Their viewpoints can provide insight into how nursing is meeting its leadership potential and the development of leadership skills for the new marketplace.

Documents from the Nursing Human Resource Committee and the Canadian Nurses Association position paper have outlined the need for nursing leadership, and key nursing leaders can highlight if nurses share these views. The analysis, dissection and questioning of the assumptions, reasons, and implications of nursing leadership from the viewpoint of nursing leaders and policy makers can stimulate and illuminate each position and provide a clearer understanding of nursing leadership. This will allow the knowledge gained to be tied to the larger issues of transformation and power that nursing is currently pursuing.

Chapter Two

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

The literature review will be presented, followed by the theoretical framework. The researcher will accentuate the many issues that are affecting nurses' leadership abilities, potential and development of leadership, because all factors impinge on nurses attaining leadership positions and/or being effective leaders.

Gender Issues Affect Leadership

Borman (1993) declares that being a woman is a barrier to obtaining leadership positions in health care systems. This is illustrated by few women being in top-level hospital management, and this occurs because the top-level administration is male. However, leadership, as it relates to gender, has not been well studied in health care (p.34).

Collinson (1989) contends research evidence indicates that when men's and women's careers are matched, women and men are remarkably similar in characteristics, abilities and motives. Collinson asserts, women consciously or subconsciously stop short of planning for top-level positions. Women are not ready to help other women climb to the top, or, accept other women as bosses (pp.4-7). Gaining entry into lower-level management positions is not a problem for women, but barriers exist for advancement to higher administration positions, due to discriminatory practices in organizations (Cianni & Romberger, 1995, p.353). Moss (1995) contends, some nurses educationally outrank their

chief executive officer, but few nurses ever make it to the top-level positions (pp.41-42).

Nurses inability to rise to the top in health care systems has been attributed to the social history of women, which failed to accept career roles for women. Moss (1995) explains; nursing as a female profession is affected by its Victorian roots, which has contributed to the belief that women are serfs; and relegated women to the role of child bearing and home management, and not accepted in the outside world of men. Women as serfs was a concept deeply rooted in health care, where the power structures of hospitals were male, and medicine kept nurses subservient. Even today if nurses are in positions of power, they are often reluctant to use it (pp.42-44).

Social practices influenced nursing culture. Dyson (1994) alleges that the culture of nursing is closely linked to social ideology, and our social patriarchal ideology has forced nursing, as a female profession, to struggle for professional status. In our patriarchal society women's work is undervalued, including the work of nurses. This is why the male-dominated medical profession is more important (p.29). Neubauer (1995) holds a similar view and quotes research by Belenky, Clinchy, Goldberger, and Tarule (1986) to state a female profession, such as nursing, is dominated by a female culture. Women in this culture "struggle to find their voice" in an organizational culture dominated by male authority. In this culture, women have a learned response to receive knowledge from male authority figures, and have difficulty when describing or reflecting on themselves (p.25).

The Political Economy and Nursing Leadership

Health care reform is occurring in Newfoundland, due to budget reductions in 1996-1997 (Newfoundland and Labrador Health Care Association, 1996, p.2). "Staffing has been the most frequent target of reform initiatives". Economic constraints in Newfoundland has reduced nursing positions. Nurses [79%] believe the provincial government is having a negative impact on health care, and cutbacks has resulted in reduced levels of staffing. When the union surveyed nurses, many [75-87%] said they had unsatisfactory input into health care reform, with small variations across the province. St. John's had 86% dissatisfied (Newfoundland and Labrador Nurses Union, 1996, p.8-29).

Dyson (1994) declares nurses inability to affect decision-making has resulted in the massive lay-offs of nurse leaders. This needs to be addressed, because the loss of positions affects nurses ability to influence health care changes, and shape and direct the future of the nursing profession. Dyson states that nurses failure to support one another is a reason why so many senior nursing positions have been lost. Dyson explains that this lack of support originates in the nursing culture, which oppresses nurses. This oppression has contributed directly to nurse disunity. Nurses, who feel powerless and under-valued form an oppressed group who expect superhuman qualities in their leaders. Therefore, nurses often strike out at the very people's role that can support and promote them. Dyson contends that nurses lack of economic power is because the nursing model is based on "caring". Dyson alleges that the 'concept of caring' is a difficult product to measure in the health care marketplace, and many nurses feel that a large part of their practice is undervalued and unrecognized, as a result

(pp.28-29).

Nurses not only contend with layoffs, but have low wages. Dickerson and Campbell-Heider (1994) alleges that nurses have a long history of suffering from wage compression and a social undervaluing of nursing. These social and economic factors affect the income and status of nurses, and can limit the number of students who will want to enroll in nursing programs. To correct this would require a major over haul of the health care system, with changes to the economic and social power of physicians. But current assumptions, such as, medicine is the "captain of the ship", and hospitals exist primarily to execute the medical regimen inhibit changes to the status of medicine. The existing laws and licensure of nurses help maintain this physician control of the health care system (pp.265-269).

Nurses are undervalued for their expertise and nurse positions are threatened by employees with lesser skills. Dickerson and Campbell-Heider (1994) related that in the United States the introduction of a lesser trained worker was by the dominant physician group, who relied on societal ideologies rather than facts, in order to promote the resolution of the nursing shortage crisis. Physician control over health care supports a profit-making ideology, which motivates physicians and hospitals [controlled by physicians] to keep institutions running with low-waged employees. Nurses in this situation "are viewed as an expense verses an income generating resource" (pp.265-269). Dyson (1994) maintains that nurses need to be proactive, otherwise, non-nurses will initiate change with far reaching ramifications for nurses (pp.28-29).

Do Nurses Know How to Politick?

Dickerson and Campbell-Heider (1994) insist political agendas of powerful interest groups affect the social structures driving health care reform (p.269). Skinner (1994) describes politics as a process of accumulating power and influence in an organization and the process of change is influenced by a knowledge of the political culture in an organization and the forces driving change. The forces driving change are decreasing resources and the management of hospitals by business. Nurse leaders need to increase their responsibilities and influence within hospitals, but nurse leaders are unable to affect organizational change because of their inability to politick effectively within organizations (pp.58-61).

Irurita (1994) questions if nurses can increase their influence in hospitals. Irurita states that nurses have limited participation in policy and healthcare decisions, despite nurses being the largest occupational healthcare professionals. This occurs because nursing leadership is repressed and nurse potential is not being fully developed, or used by the health care system (pp.61-69). Clare (1993) contends the nursing profession has always had difficulty gaining access to policy and decision making at the government level. This occurs because nurses fail to value their professional concerns about nursing, or the wider social and health care issues. As a result nurses often do not forcefully present their ideas politically, resulting in nursing knowledge little understood or valued in comparison to other health professionals. Nurses' contribution to society is limited by nurses' own views of their relative worth, and by nurses' preconceptions of the worth of others, who do have greater access to policy making (pp.1033-1034).

Why Should Nurses be Leaders?

The Canadian Nurses Association has called for leadership skills for nurses (Haines, 1993). The Newfoundland government has requested that nurses be educated in leadership (Nursing Human Resource Committee and Symposium Delegates, 1992). Clare (1993) maintains that the political and economic reforms have changed the underlying philosophies and structures of health care and education, resulting in political, social, and cultural upheavals affecting the lives of everyone. There is a devolution of responsibility and funding for nursing services, and this has changed the way nursing services are provided (p.1033). Because nursing services will change, Redmont (1995) declares that nurse leaders must have high level competencies, and must restructure patient care, in order to maintain quality and reduce cost (p.63). Nurse leaders, have been perceived as resisting organizational change. Skinner (1994) contends that resistance to change is attributable to nurse leaders wanting to ensure that nursing practices of accountability to society are carried out. Nurse leaders will react when ill-conceived plans threaten nurse standards and practices, and when change threatens the values of caring and nurturing of patients. Change is also inhibited by the fear of risk-taking (pp.58-61).

Not all nurses agree with the need to focus on nursing leadership roles. DiRienzo (1994) asserts that 70% of our lives is spend as followers and only a small percentage of the population is capable of functioning in a leadership role. DiRienzo claims that nursing needs effective followers, and without effective followers nursing leaders can face severe limitations. Educators and current leaders must promote enlightened followship in nursing

(p.26). However, this view was not the most prevalent one.

Anderson (1993) sees health care reforms creating radical changes for patient care delivery, which will affect roles, practices, and responsibilities of providers and citizens alike (pp.10-11). Altieri and Elgin (1994) alleges that nurses, physicians, politicians and consumers are aware of the national priority of health care reform, which has created an urgent need for empowered, visionary leaders. Nurses represent the largest health care discipline, and they must utilize their potential power, by positioning nurses in key roles in policy-making, health care administration, advanced clinical practice and education (pp.75-76). Richardson, Valentine, Wood, Godkin (1994) agrees, and states nurse leaders are needed who overtly practise cooperative, collaborative style of leadership because the new structures will require a climate of negotiation and collaboration, and nurses can lead in this area. This leadership style is intrinsic to women's groups (p.93).

Nursing Education Affects Leadership

Nursing education has shifted from a diploma program to a university degree, but is this sufficient to empower nurses for leadership roles? Has nursing education prepared nurses for leadership roles? MacLeod & Farrell (1994) insist that the central theme in curriculum reform is to change the practice system of nursing to create a new world view of their practice (pp.208-209). Curriculum revolution is expected to create more effective leadership. MacLeod and Farrell (1994) purport that health care reform is driving a curriculum revolution to prepare graduates with new and different perspectives and abilities for

leadership, so that they can function in the rapidly changing health care structures. However, revised structural and power relationships between nursing education and nursing practice are needed to support these curriculum changes, such as a change in student evaluation processes. MacLeod and Farrell maintain that the literature for curriculum reform addresses the need for a transformed power relationships between students and teachers. As well, practice settings must change so that hospitals allow nurses to exercise the new ways of being [leadership roles, autonomous behaviour] (pp.208-213).

According to Clare (1993) nursing education is a key factor in nursing leadership. But nursing education is a political process that reproduces traditional practices, and contains many dominant ideologies, which shape educators and students alike toward conformity, and compliance, with the established practices of hegemonic institutions. Clare declares, the realities of professional ideals of autonomy, empowerment and reflective practice are often different from the realities of the classroom, or the clinical practice. Cultural reproduction, maintain and perpetuate the conditions of nurse domination; and limit the ability of nurses to exercise autonomy and self-determination. Nurses need processes, and ways to act, in order to transform social structures that limit nurses autonomy in their practice, and in their education (pp.1033-1037).Chapman contends that nursing hierarchies and rituals practices protect nurses from anxieties provoked by their encounters with human suffering.(p.13). Holland (1993) asserts, that every human group creates its own culture and what needs to be examined through nursing research is the difference between unsafe outdated practices, and the ritual that exists in a cultural sense (p.1461).

Previous socialization affect leadership. Eason (1990) asserts that the power held, used and desired by leaders is influenced by their previous socialization, but socialization starts at the student level and this has been curtailed by undergraduate nurses not having sufficient ways to formally operationalize leadership and management concepts (p.188).

Sufficient ways to develop leadership has been hampered, by how nursing education was delivered in the past. Moss (1995) maintains that past practices in the nursing culture has resulted in nurses' education being exploited by hospital apprenticeships programs, with free labour being exchanged for hospital training. Nurses' education has also socialized nurses to care, resulting in the view that others are the managers and the leaders. Traditional nurses' education has perpetuated this belief by omitting leadership and management from nursing education, because it was considered irrelevant. Many nurses in senior management positions are educationally unprepared for their leadership roles (pp.42-44).

Nurses have had difficulty obtaining an adequate education to prepare them for their leadership roles. Irurita (1994) highlights societal and organizational factors prevent nurses from keeping abreast of other health professions. Nurses opportunities are affected by the socialization of females, the culture of medical dominance, and paternalism in the health care system. This prevents a large nursing profession from having adequate educational opportunities, and keeps nurses oppressed as a group. The result is, nurses' leadership potential is not used or fully developed in health care systems (pp.62-70). Dyson (1994) also maintains societal factors affects leadership, but declares that oppressive attitudes, often unconsciously learned by nurses, do not create an environment that promotes, or recognizes

women as leaders (Dyson, 1994, pp.28-29)

Nursing education is seeking ways to empower students and create more leadership opportunities. Preceptorship and mentor relationships are strategies that provide opportunities to develop leadership. Reider & Riley-Giomariso (1993) purport that students need a one-to-one relationship in the clinical area to develop leadership abilities and this can be achieved by preceptorship alliances with staff nurses better than in group interaction with faculty (p.127). Heinrich & Scherr, (1994) favour peer mentoring by students for all levels of nursing education [graduate and undergraduate], and contend this will enable students to develop more leadership skills. Mentoring relationships is an important method for women's professional development, and traditionally, nurses have not viewed themselves as mentors (pp.36-37).

There are new future roles. According to Valiga (1994) the future trends are community programs and services, health promotion and self-care. Nurses need to prepare for these future roles (p.86). Kersbergen (1994) states that by the year 2000, the population that is over 75 years will increase by more than 48%; and the cost of health care will increase accordingly. Primary care services will require nurses to be educated at the graduate level, but today less than 2% of nurses have this level (p.13). Jacox, (1993) maintains that there is a serious shortage of nurse prepared for administration, teaching, advanced practice, nursing specialities or research (p.45). Jennings (1995) claims, nursing research often focus on the clinical practice of nursing, and has created a narrow focus, with a void in nursing administration research. This should be developed and used to influence health care policy,

and influence how the organization affects patient and organizational outcomes (pp.9-10).

Nursing leadership is seeking opportunities by developing independent practice based on a new paradigm of caring, health and healing. Watson and Phillips (1992) contends that even though nursing is looking to alternative medicine for both graduate and undergraduate programs, in order to grow as a profession, nursing has failed to introduce formal professional academic preparation in these areas (pp.20-21).

Creating a Preferred Future for Nurses

Nurses are hoping for new future, but do nurses understand the factors influencing their leadership roles? Chinn (1991) asserts that nurses will be better prepared to move into the future if they have been informed of their past, analysed the present and have formed a vision for the future (p.251). Neubaaurer (1995) asserts that a significant amount of needed change is about individuals changing the essence of how they see themselves, the world and how they work with other people (p.23).

In the year 2000, Chinn (1991) sees changes occurring in technology, scarcity of resources and increasing complexities in all aspects of life. What she feels is less likely to change is patriarchal dominance, nurses oppression, and the yearning of nurses for a better quality of life, and a connection to meaning and relationships with others. Chinn claims that

the one thing that we can do something about, with some assurance of certainty for the future, is to closely examine what we ourselves are doing now, carefully assess how that is or is not serving us well, and begin to craft our own actions, thinking, and practices to shape the future we prefer (p.254).

Valiga (1994) describes how an intentional focus on the future creates an opportunity for a preferred future for nurses. She contends that to manage change and to create a preferable future nursing needs individuals that will take on the challenge of leadership and fulfil the role effectively for the profession, for the employers and the community (p.89).

Factors Influencing Nursing Leadership Attainment

Altieri and Elgin (1994) states a review of the current literature identifies three groupings for leadership which includes: (1) predicting leadership, with the focus being leadership characteristics and behaviour; (2) developing leadership, with the focus being on educational curricula or continuing education; and, (3) effectiveness of leadership, with the focus being on the profiles of leaders (pp.75-78). All three of these domains addresses nursing's opportunities, barriers, and the development of their leadership, which are factors in nurses attaining positions of leadership.

The nursing literature echoes the nursing profession's desire to have an expanded role in leadership. Nursing is challenged to meet the new marketplace needs, but barriers to leadership positions exist, with little authority or influence in health care decisions. The current organizational changes in health care impact on nursing leadership, making effective leadership difficult; but new opportunities do exist (Chapman, 1983; Chinn, 1991; Collinson, 1989; Dickenson & Campbell-Hierder, 1994; Dyson, 1994; Holland, 1993; Irurita, 1994; Millar, 1991; Moss, 1995; Neubauer, 1995; Richardson, Valentine, Wood, Godkin 1994; Skinner, 1994; Stivers, 1991).

Nursing literature cites many challenges to nursing leadership both for attainment of these positions and nurses qualifications for leadership positions. Nursing research indicates it is unclear if nurses are able to develop, or use their leadership potential, or provide for the present health care system needs for nursing leadership. Nurses lack opportunities in health care systems, and this affects the development of their leadership potential (Irurita, 1994; Kirkwood, 1988; MacLeod & Farrell, 1994; Richardson, Valentine, Wood, Godkin, 1994; Walsh, 1995).

Leadership is a critical factor in the effectiveness of an organization, but nurses have had limited academic preparation for leadership positions and nursing education has not been in the forefront for the development of leadership skills, making their leadership development and potential difficult to predict (Altieri & Elgin, 1994; Heinrich & Scherr, 1994; Jacox, 1993; Jennings, 1995; Kersbergen, 1994; MacLeod & Farrell, 1994; Manfredi & Valiga, 1990; Reider & Riley-Giomariso, 1993; Watson & Phillips, 1992).

Powell (1988) contends organizational, individual, and societal factors influence career development (Walsh, 1995, p.263). Organizational change brought about by health care reforms is affecting the effectiveness and value of nurses' leadership abilities. Downsizing of hospitals due to budget cuts has reinforced the hierarchal nature of Canadian health care agencies. Those leaders who are left are coping by "putting up with" and "not rocking the boat". While nurses were described as needing to change their attitudes about leadership, this was considered difficult because they are worried about retaining their jobs (Richardson, Valentine, Wood, Godkin, 1994, p. 94).

Other organizational barriers exist. Walsh (1995) declares that at first glance women's prospects for a career in health administration are good, because half the people who graduate from programs in health administration are female. But, research shows that opportunities for women for promotion and financial benefits decreases in relation to men, as their career progresses and expands. Collinson (1989) addresses individual factors, such as family responsibilities, lack of a career path, and trying to be super women, keeps women from delegating and nurturing each other. Women are not taught about power (pp.3-6).

Moss (1995) describes hidden organizational barriers based on social and paternal values prevent women from advancing beyond middle management. Traditional health care structures are dominated by male administrators and physicians, who place less value on female work, which affects nurses' leadership value within organizations. As well, nurses often enter management from staff, rather than line positions, which limits their formal authority and resources in organizations. Despite a trend toward flattened hierarchies, most health care structures are still dominated by the military model that is vertical, and nurses in these structures have no real power. Moss contends that while barriers affect all women, they are particularly prevalent in female professions (p.41).

Other factors affect nurses' leadership abilities. Neubauer (1995) advances the idea that nursing is dominated by a female culture that affects the executive nurse. The nurse leader of the 1990s faces isolation, loneliness and frustration because there are few opportunities to discuss approaches to problem solving and strategic planning with peers. Nurse executives have women's development needs which include, finding their voice,

developing self-esteem, learning in the absence of authorities, learning to share, and receiving affirmation from sharing their experiences (p.25).

Nurses do not have authority in their roles, which limits leadership opportunities and development. Simms, Price, Ervin (1994) maintain that the authority of hospital nurses has not advanced since World War II, even though nurses possess most of the clinical expertise, and often make most of these judgements in the absence of physicians. Nurses have a strong working relationship with physicians, but nurses are subordinate to physicians by custom, and law, with nurses traditionally second in command on hospital units. Nursing leadership is affected by nurses' authority not being redefined and this has contributed to the devaluation of nurses expertise and decision-making abilities. The nursing profession has failed to fully communicate what nurses can do, which is the reason their clinical background is not recognized. Nurses' occupational culture is a tradition of pride in manual skills, which has produced an apprenticeship approach to defining these skills and nurses' legitimate authority. This presents a barrier to promotion in health care systems (pp.329-330).

Others see the profession of nursing as having internal problems that affects nursing leadership roles. Millar (1991) declares that the nursing profession is powerless and divided within itself, and is therefore unable to sustain itself. Nursing does not have strong leaders, which keeps nursing powerless and divided. Nurses themselves are unable to speak out, and if a nurse does speak out she is unsupported by colleagues, who ostracise her. Medicine does not have these problems (p.24).

Nurses will have more opportunities for leadership. Barker & Young (1994) see a

postmodern period developing for leadership that will emphasize feminine values and beliefs, which they insist will balance patriarchal values (p.17). Borman (1993) maintains that even though the health care system was taking on new forms that capitalize on the strengths and values of women, many barriers still remain for women and nurses within health care administration (p.34). Stivers (1991) argues that despite the new organizational theories of leadership, it is still culturally masculine, with tensions still existing between the expectations about leaders, and the expectations about women. Women seeking organizational leadership face a complex task of self-definition. If they display the expected characteristics of leadership they are classified as masculine (p.47).

Leadership or Management

Leadership as good management is no longer enough to explain what is happening in organizations and a new paradigm of leadership is needed (Rost, 1994, p. 3). Chinn (1991) addresses this by saying that it is time to reinvision the past and reconstruct its lessons by critical analysis of our present (pp.255-256).

Leadership and management often do not have clarity of definition separation in the literature (Manfredi & Valiga, 1990; Rost, 1994). Similarities exist between management and leadership, but many researchers state they each have distinctions (Hibbard & Kyle, 1994; Manfredi & Valiga, 1990; Rost, 1994). Nursing has often failed to recognize these distinctions (Hibbard & Kyle, 1994; Manfredi & Valiga, 1990; Reider & Riley-Giomariso, 1993). Much of the nursing literature focused on specific leadership traits (Barker & Young,

1994; Eason, 1990; Haynor, 1994; Hibbard & Kyle, 1994; Rost, 1994; Ryan & Hodson, 1992; Valiga, 1994).

Manfredi and Valiga (1990) contend that leadership is a relationship of influence, and management is a relationship of authority. "Leaders create and managers regulate". Leaders want and enjoy ambiguity, but managers prefer predictability. Zaleznik quoted by Manfredi & Valiga (1990) state managers are problem solvers who emphasize rationality and control. Leaders, however, are driven by ideas, possibilities and not assurances (pp.4-5).

Haynor (1994) declares that many leadership theorists believe that developing followers is an important responsibility of leaders. In work situation the leader-follower relationship is a boss-worker relationship. A leader has positional power, organizational resources that informal leaders do not have access to. The leader uses relationships skills to structure win-win situations for the organization, management and employees (pp.31-40).

Rost (1994) challenges the most common ideas concerning leadership, in which leadership is considered impossible to define and people know leadership, when they see it. Rost states, there is no agreement in scholarly or popular literature and most people assume there is no universal definition of leadership. However, Rost maintains that leadership as common wisdom is about leaders doing great things, and they have certain preferred traits. Common wisdom sees leaders as goal orientated and goal driven. This creates the concept of leadership as "good management", which Rost refers to as an "industrial paradigm" of leadership. Rost disagrees and states; that leadership is an influence relationship among leaders and collaborators, who create changes that reflect mutual purposes (pp.1-3).

Eason (1990) declares that nursing students study concepts pertinent to leadership, but often are not socialized into the real world of economic, political, social and professional forces that affect nursing leadership (pp.188-189). According to Ryan and Hodson (1992) new graduates sometimes lack assertiveness/ confrontation skills and self confidence and this could be corrected with a stronger focus on leadership skills (p.201). Reider & Riley-Giomariso (1993) asserts that nursing students in the clinical area need clarification of the leadership/management role. Students feel like leaders when they give and receive reports, make patient assignments, discharge patients, do reports etc. These are skills valued by employers (pp.130-131). Manfredi and Valiga (1990) question if these are leader skills.

Manfredi and Valiga (1990) state that nursing faculty generally use leadership and management interchangeably and the emphasis in most nursing programs is management. The lack of conceptual clarity about leadership has implications for preparing individuals for leadership roles (pp.4-5). Leadership has been confused with management. A research study done by Ryan & Hodson (1992) assessed university students for their leadership roles. The study confused nurse graduates leadership skills and management skills. For example, the abilities to direct others and delegate tasks are considered leadership skills, rather than management skills (p.200). Manfredi and Valiga (1990) insist that the lack of clarity about leadership and how to distinguish it from management is common among educators and this has implications in preparing individuals for their leadership roles. The mandates and expectations require that the nursing profession prepare for leadership roles and nurses must be clear on what leadership and management differences are. Failure to make these

distinctions result in nurses studying management theory, therefore, nurses cannot be expected to be exhibiting leadership behaviour (pp.5-8).

Definitions for the Study

From a synthesis of the literature review and to have clarity during research analysis certain terms are defined.

Nursing Administrator

Many nursing titles often apply to executive nursing positions and the title nursing administrator will be used to create clarity and consistency for the research project, and will be in keeping with the respective roles and responsibilities of the informants. This title refers to the senior executive officer of a department of nursing, within the health care system.

Leadership

It is a process that is interactive, whereby nurses affect the actions of others in mutual goal determination and achievement. Leadership occurs in any setting and is not tied to the organization. The role of the leader is facilitator to influence others, shape the future, lead others, influence others, encourage growth of others, and promote personal development of group members.(Manfredi & Valiga, 1990, p.6).

Management

A process directed toward organizational maintenance. It occurs in the context of an organization and its emphasis is on organizational goals. A manager's role is to manage subordinates, direct others, maintain the present, exercise authority, role model for others and promote development of personnel (Manfredi & Valiga, 1990, p.6).

Theoretical Framework

Critical theory and critical ethnography will form the theoretical framework for this research project. Critical theory, used with critical ethnography, can address the many issues that surround nursing leadership.

Nursing leadership literature addresses the many gender issues that impinge on nursing leadership, especially as it relates to the imbalance of power between nurses and doctors. LeCompte and Preissle (1993) states men and women inhabit a world filled with contradictions, asymmetrical patterns of power and privilege. Critical theory examines the sources of inequality and oppression in society, and allows the experiences of individuals within social organizations to be studied for asymmetrical patterns (p.131).

Nursing leadership was described as operating in multiple settings [hospitals, nursing homes, community, schools] and at multiple levels of meanings, contradictions, and asymmetrical patterns of power and privilege. Reforms in health care and hidden political agenda are accentuating these asymmetrical patterns of power and privilege. Dickerson and

Campbell-Heider (1994) advocates that nurses should understand how the political agendas and powerful interest groups are directly or indirectly driving the health care reforms. They maintain that critical social theory can liberate people by providing an understanding of "taken-for-granted" ideologies that oppress certain groups. Ideologies serve the dominant beliefs that influence the power structures in society (pp.265-269).

Nursing has been described as a female profession that is oppressed. LeCompte and Preissle (1993) states that critical theory focuses on "resistance, human agency, oppression, hegemony, domination, subordination, subjectivity, political economy, consciousness (true and false) stratification of power by race, class and gender deconstruction" (pp.128-131). Nursing is predominantly a female profession that is being affected by many political agendas. LeCompte and Preissle (1993) maintain that critical theory allows the experiences of individuals in social organizations to be examined (p.131) Critical theory, allows for the analysis of multiple issues and levels of power and privilege, and puts the problem at the core of the inquiry. This allows knowledge to be viewed for its emancipatory or repressive potential (McLaren and Giarelli, 1995, p.2). Frasher (1989) maintains that critical theory cannot be used just to treat gender as incidental to politics and political economy. A critical theory framework can place gender, politics, political economy as internally related to each other (Morrow, 1994, pp.275-276).

Nursing is seeking a new direction for its education, research, and practice, but nursing has a long history of being subservient to medicine. McLaren (1995) asserts that the role of critical ethnography is to redefine agency and political activism outside the notion of

unitary, and the monolithic subject of history. McLaren attests that the discourses of ethnography research emerge out of social conventions, but they are always profoundly implicated in the question of ethical formation of self and others. McLaren states those field sites, like subjects, are not unified wholes but borderlands and zones that can best be understood from rhetorical criticism (pp.276-277). LeCompte and Preissle (1993) states critical theory can highlight the degree that humans achieve autonomy in the context of social oppression (p.131).

The research study will focus on ten nursing leaders, who together comprise ten case studies that will examine nursing leadership. Morrow (1994) stresses that . . . "case study analysis is at the heart of a number of research strategies that has been central to critical thinking." Morrow (1994) states that "interpretive structural explanations are the basis of theorizing in critical theory" which can be coupled with a normative framework for assessing the relations of domination revealed through the investigation. "Critical theory . . . makes reflexive methods a central concern of social inquiry and attempts to link them up to more visible issues of empirical techniques and strategies of inquiry" (pp.222-244).

The study will explore two documents; (1) *Leading in a Time of Change. The Challenge for the Nursing Profession. A Discussion Paper* (Haines, 1993); and (2) *National Nursing Symposium Report to the Minister of Health (Nursing Human Resource Committee and Symposium Delegates)*. Because many documents present knowledge from a singular, monolithic, concrete point of view, critical theory can be used to examine nursing leadership both from the perspective of nursing leaders, and the policies that call for leadership

development. Critical theory will allow the micro level, which consists of the viewpoints of the leaders, and the documents to be examined at the macro level of social analysis. By using critical theory and critical ethnography nursing leadership can be more fully unmasked, because leadership in nursing operates in a multilogical system. Paul (1984) described multilogical as having "more than one logic, or alternative structures of rationality" (Bandman and Bandman, 1988, p.3). Critical theory will allow any discrepancies in the case studies and the documents to be examined from the view point of the lived experiences of the leaders. Critical theory analysis will allow for a stronger "explanatory" focus of nursing leadership than traditional ethnography and does not necessarily depend on detailed participant observation (Morrow, 1994, pp. 252-254).

Critical thinking helps to focus and sharpen awareness and allows for the reflection on one's place in the world. A critical theory approach would focus awareness of and on nursing leadership and sharpen awareness regarding the present position of nursing leadership. This would provide the means to tie this knowledge to the larger issues of transformation and power that nursing is currently pursuing. McLaren and Giarelli (1995) state that ... "the justification of ... social science have always been linked to their capacity to join theory and warranted knowledge to enlightenment, and the liberation of the individual and society". Positivistic science cannot fulfill this social purpose (p.1).

Chapter Three

RESEARCH DESIGN AND METHODOLOGY

Yin (1984) states "a research design is the logical sequence that connects the empirical data to the study's initial research questions and, ultimately to its conclusions" (Morrow, 1994, pp.250-251). Critical theory is the driving force behind critical ethnography which will be used in this research. The research design is based on what Morrow (1994) describes as an "intensive research design" which allows for a small number of case studies to be considered in terms of a great number of individual properties. The primary question is to explicate the operations of casual processes and meaning structures in a single or small number of cases and involves using qualitative methodology techniques, but not exclusively. The concept of variables is employed but not in a statistical defined way. This method differs from traditional ethnographies because of a stronger focus on "explanatory" as opposed to an interpretive focus and is not dependent on detailed participant observation (pp. 250-251).

This research design provides an alternative to "abstracted empiricism and positivist grand theory . . . critical theory attempts to avoid the extremes of interpretive reduction of explanation to meaning descriptions and the positivist search for invariant laws" (Morrow, 1994, pp.249-250).

Morrow states that considerable ambiguity has surrounded the relationship between ethnography and critical theory due to the concerns of ethnography appearing distant from critical theory, but the exception is when ethnography is linked with immediate social

practice (p.254). This research will attempt to link nursing leadership to nursing practice and to the greater community of the health care system. Morrow alleges that this allows the researcher to be confronted through ethnography with "live" events whose meaning has immediate practical [political] significance (p.254). "Case study methods", according to Morrow, when coupled with non-statistical comparative case studies, are most compatible with research problems identified by critical theory and its concern with "intensive research designs" (p.253). To describe a case, a sense of the type of cases and their shared properties must be known.

Research Sample

The research sample was ten female nursing administrators selected from ten different work settings because leadership is a complex problem in nursing. Leadership is carried out in multitudinous settings, under varied conditions, and at different educational levels. Nurses perform leadership roles in acute care institutions, long term care institutions, community health agencies, health care boards, the nursing union, and professional organizations, etc. The sample focused on as many workplaces for which access was possible, with one participant selected from each workplace. The workplaces in the sample included the areas of acute care, mental health, rehabilitation, corporate management, diploma nursing school, university nursing school, nurses union, professional nurses association, one private and one government nursing home.

A purposeful sampling of multitudinous settings was expected to provide the many conditions under which leadership occurs in nursing and the purpose was to have a more representative view of nursing leadership requirements for the marketplace. By using this sampling method a more realistic analysis of the different forms of leadership carried out in nursing can be obtained. This can also provide more insight and analysis into nursing administrators perceptions of their potential and skills in different workplaces, thus extending the scope of the study. The sample was not intended to represent all nursing workplaces or to represent particular personal characteristics of nursing leadership. This will not be required with the research design of the study.

The criterion for selection was set that all participants in the study hold a senior nursing administration position in their respective workplaces. The sample was obtained by asking senior nursing administrators to participate until ten participants from ten workplaces form the study. The workplaces were selected from the telephone directory and some participants were recommended by other participants.

Rationale for Administrators

Nursing administrators practice and work in a system that supports and recognizes two competing and complementary frames of reference, the medical model and the nursing model. Nursing leadership is influenced and affected by this division. Health cares issues also affect and influence their leadership for growth or hindrance. Nursing itself has been subjected to gender and subject marginality. Nursing administrators who have attained

positions of leadership have "lived experiences" of the opportunities and barriers to these positions.

Nursing administrators perform a critical role in determining the vision for the workplace, the professional organization and in setting the climate for changing practice. Therefore, nurse administrators may be expected to provide insights into nursing present position of leadership within the health care system.

Research Interview

The administrators were interviewed to obtain their perspectives on the questions outlined previously. Each interview comprised a case study of the phenomenon of leadership from their personal lived experiences. The interviews were tape recorded and consisted of a minimum of one hour for each nursing administrator. All but one interview occurred inside office workplaces because the participants requested they be done there, rather than in a neutral setting. The interviews were done separately. The participant confidentiality was assured by arranging the time and place of the interviews personally with each administrator, carrying the tape recorder in and out of the offices in a brief case and not disclosing the nature of the visit to support staff at the work sites. Each participant was given a copy of the questions to be asked during the interview two or more days before the interview in a sealed envelope marked personal. The questions provided a guideline for the interview and were given to each participant, along with the general purpose and nature of the thesis research, which will focus on nursing leadership.

The interviews were semi-structured and a topic guide was used by the interviewer that consisted of a list of area questions, as outlined previously, and was used for each respondent. Minimal participant observation was used, and only related to the interview situation. This is in keeping with the research design, outlined in the methodology. The interviewer's function was to encourage each respondent to talk freely about all the topics questions related to nursing leadership. Additional questions were added as the need arose during the interview process.

Demographic information was not requested, but many volunteered information during the interviews. This information indicated that the education levels varied; two administrators had a diploma in nursing, with additional courses in administration; seven had a degree in nursing, with one participant indicating no administration education; four were completing a master's degree; and three had completed a master's degree, one with administration at the master's level. All but one had been initially educated in a diploma nursing school. One administrator, while stating she had been initially educated in a diploma school did not indicate her current level of education.

The work experience varied from five years to thirty, with two indicating that they had only worked at one workplace. Three indicated they had been president of their professional association (ARNN), two had been president of the nurses' union and three had worked at diploma nursing schools. Five administrators were employed by the Health Care Corporation of St. John's. Two of these administrators were sure of new positions with this organization and three indicated that their positions would be redundant after the restructuring. During one

interview the administrator was anxiously waiting to hear about a position for which she had applied.

One administrator, who was the only one educated exclusively by the university, was younger than all others administrators and had less work experience [five years]. This administrator presented a very positive picture of reorganization at her workplace, with most of it accomplished by the former administrator before coming under the Health Care Corporation. Her views varied widely from her colleagues (Interview Six).

Five administrators held positions that have not been affected by restructuring at the time of the interviews, with another unsure if her position would be affected later. The interviews had a limited time frame for collection purposes and were obtained over the three-month period [May-July, 1996] due to time restrictions of the researcher.

Each informant in the interviews will be identified in the research study by code names of Interview One to Interview Ten in order to ensure confidentiality.

Research Analysis

In line with the qualitative data collection strategy, the analysis will primarily focus on the information collected in the interviews. Critical ethnography will be used, which Thomas (1993) states "is a type of reflection that examines culture, knowledge and action ... and this ... allows the researcher to describe, analyse, and open to scrutiny otherwise hidden agendas, power centres, and assumptions that inhibit, repress, and constrain" (pp.2-3).

Morrow contends that critical ethnography refers to deeper sources of ethnography and probing deep-seated issues through intensive analysis concerned with interpretive understanding, casual analysis and critique. The potential for this analysis lies in its capacity for ideology critique and defamiliarization, not its immediate link with political causes. Defamiliarization is a cross cultural juxtaposition used to offer an upfront kind of cultural criticism (Morrow, 1994, p. 256).

The researcher's intention is to use the lived experiences of the participants to identify and illustrate multiple issues surrounding nursing leadership. In keeping with the design each interview is not presented in its entirety. Each informant's views are used to build a story that allows for the examination of multiple issues, social forces, levels of power, privilege and politics to emerge. This will allow nursing leadership to be examined for its opportunities and barriers and its leadership role.

This strategy of juxtapositioning of participants' lived experiences can also be used to compare and contrast the participants' lived experience with the document mandates for nursing leadership, but this tactic alone could focus in an unsympathetic criticism of nursing leadership. Nursing leadership has many complex issues which will involve critical theory analysis to provide an intensive analysis of what the informants say. But this must be combined with interpretive understanding, the development of the casual relationships and a fair critique of both positions, [informants and documents]. Thomas (1993) states "the researcher collects, categorizes, and patches fields of synecdoches, or parts of the whole, which are then used to help understand the whole (p.15).

Morrow asserts that the focal points of critical research strategies are (1) structural analysis of system integration; (2) interpretive analysis of social action by individual and group agents; and, (3) mediational analysis that reveal the operation of agency and structure as simultaneous events. A well done critical research, even if it focuses on any one of these domains, will always try to remain conscious of the other two (p.276).

The research data and analysis will be presented in the next three chapters. Chapter four will provide a presentation of the data and will be divided into four sections because the data collected was extensive. In keeping with the research design Section A and Section B will focus on the structural analysis of system integration. Section C and Section D will focus on the interpretative analysis of social action of individuals and groups. Chapters five and six will focus on the mediational analysis that reveal the operation of agency and structure as simultaneous events.

In keeping with the analysis outlined in the methodology, defamiliarization is used to tell the informants' story. By juxtapositioning each informant's views with others something new is created that allows the microcosm to become the macrocosm. This method allows for the data texts to be examined and decoded for asymmetrical power relationships in nursing, constraining ideology from administrators shared assumptions, beliefs, norms and other forces that promote or block nursing leadership roles.

Every methodological strategy has problems. The researcher acknowledges that she is an active participant in displaying the data texts of the informants and has tried to refrain from imposing her values and ideology by subverting some views from the analysis.

However, the presentation of the data using this method will allow social implications to be brought forward. Care has been taken to provide as accurately as possible all views, without exclusion and by allowing their words to tell the story as much as possible. The intention of the researcher in combining informants viewpoints is to create a greater voice for the multiple issues raised in the interviews. This will not be done exclusively. The definitions of nursing leadership and management will guide the process of how administrators define nursing leadership.

Morrow states the potential problem of focusing on some aspect of reality using the micro-macro split can reflect informants' reality as "sliced-up" portions of social reality, but is necessary in order to create manageable portions of inquiry (p.269). McLaren (1995) contends that the discourses emerge as social conventions. Truth of the work is not to render knowledge as discoverable, "but rather as social texts that are relationally produced in multiplicity of mutually informing contexts"(p.276). Bennett & LeCompte (1990) states that a nonobjective view of knowledge is taken that challenges certain ethical standards and imperatives of the dominant culture (McLaren, 1995, p.282).

Morrow states the concept of ideology cannot suspend judgement necessary for the understanding of the beliefs of others, and critical theory presupposes quasi-casual laws that are not given attention in critical ethnography (p.257). The potential of critical theory used with ethnography would allow for a more complex presentation of nursing leadership and its potential for transformation. McLaren states that we construct ourselves and our identities, through past and present events, and possible futures. The parameters of the human subject

vary according to discursive practices, economies of signs and experiences engaged at historical moments by individuals and groups (McLaren, & Giarelli, p.285).

Nursing leadership is being forced to reevaluate itself due to fiscal restraints and restructuring of the health care system, while plagued with a past that has marginalized its development and progress. Nursing is seeking a new future in a turbulent health care system. This research design can provide an opportunity to look at nursing leadership's place in meeting society's needs for nursing leadership and can provide an opportunity for follow-up studies that can be corrective if research shows this to be necessary.

Research Limitations

The research analysis will be focused in both critical ethnography and critical theory. Morrow (1994) states that critical ethnography which can be argued to be . . . "realistic analysis of cultural forms, even when carried out in empirically grounded ideology critique, has its limits" (p.255). For this research project the following limitations are outlined.

1. The nursing research is delimited to nursing administrators in one Canadian province and one Canadian city which limits generalizability.
2. The informants in the study were invited and willing to participate in the study, which could be said to select the data collected. The data collected only came from the interviews which were semi-structured, with the direction of the interview sometimes determined by the interviewees, as much as by the researcher.

3. Only informants who work in nursing administration were selected, which limited leadership from being viewed from nurses working in other positions, or women working in administration in other settings.
4. The interviews and analysis were undertaken by a single inquirer and are limited to the skills of this inquirer.
5. The inquirer is a nursing critical researcher and this presents a possibility of bringing a professional bias to the research study by delving more deeply into professional issues that have significant importance from the researcher's professional experiences and personal perspectives.
6. Nursing has not associated itself with feminist theory, therefore the social issues that arise in this work have not been addressed with feminist theory, but have been addressed with nursing literature and organizational theory.

Chapter Four

NURSE LEADERS DIALOGUE ON NURSING LEADERSHIP

To present the data clearly and in keeping with the research design, the Chapter will be divided in four sections. Sections A and B will focus on the structural analysis of system integration. Section A. The Reality of Political Forces on Hospitals will include: downsizing of hospitals; the changing organizational structures; the input of key players in restructuring; and, nurses' reactions to restructuring of the hospitals. Section B. Restructuring Health Care will present the restructuring of long term care, community health; and nursing education, its attainment and development.

Section C. Leadership in a Changing Marketplace will present the factors affecting nursing leadership roles, how administrators define leadership, and what administrators consider the leadership abilities of front-line staff. Section D. Future for Nurses in a Changing Marketplace presents how administrators are empowering nurses for their changing leadership roles. The intent is to show that a relationship exists between the restructuring of health care and the empowerment of health care providers. The rapidly shifting marketplace is hoping to create new opportunities for nurses. Many of the hopes for nurses are contingent on factors outside the control of nurses and this will be presented. Sections C and D are in keeping with the interpretative analysis of social action of individuals and group agents. The mediational analysis that reveals the operation of agency and structure as simultaneous events will be the focus of the next two chapters.

Section A

THE REALITY OF POLITICAL FORCES ON HOSPITALS

The main focus of the interviews was the new approach to patient care delivery brought about by a hospital administration reorganization called program management. This model was extensively discussed by all informants. As the physical structures of hospitals were being reduced, little attention was given to this factor, the exception being Interview Ten who highlighted how it would provide considerable economic savings. This section, therefore, provides a brief overview of hospital downsizing and an extensive overview of program management.

Downsizing Hospital Services

We are probability in the biggest change that we have ever experienced in our lives or probability other people's lives before us. We are having a massive reorganization of services within this province (Interview Two).

In St. John's, Newfoundland, the hospitals are undergoing restructuring through a series of mergers of health care services. There has been a merger of all St. John's hospitals, brought about by the government buy out of the two privately owned hospitals in St. John's, St. Clare's Mercy Hospital and the Salvation Army Grace General Hospital. All government owned hospitals in St. John's and one hospital on Bell Island have been placed under the auspices of the newly formed Health Care Corporation of St. John's. The Health Care

Corporation will deliver health care at eight sites: General Hospital Health Science Complex, Janeway Child Health Center/ Children's Rehabilitation Center, Leonard A. Miller Center, St. Clare's Mercy Hospital, Salvation Army Grace General Hospital, Dr. Walter Templeman Health Center [Bell Island] and the Waterford Hospital (Telephone conversation with the Human Resources Department, Health Care Corporation).

These sites will downsize. "You have to remember these eight hospitals will be down to five hospitals" (Interview Two), with a possible 100 extra hospital beds removed "because already we have studies that show that it is a bed utilization issue and we could take down 100 beds because of inappropriate bed utilization" (Interview Ten).

In the past year a merger of the Janeway Child Health Center and the Children's Rehabilitation Center occurred and a future physical move is planned for both of these, along with the Grace General Hospital. "If the Grace and the Janeway they all move to the Health Science and they are not all moving into the current Health Science's. There has to be accommodation [new building] made for them to move in" (Interview Two).

A Change Agent

Hospitals were being downsized and restructured by outside agents and this practice was questioned. Elizabeth [Davis] was cited as the main change agent behind restructuring of the hospitals for the Health Care Corporation. "Well everybody knows, at least in this corporation [Health Care Corporation], that we have been in a state for the last two years, since Sister Elizabeth started. It will be two years this fall" (Interview Ten). It was stated

Sister Elizabeth was not a nurse, "maybe an educator, maybe administration" (Interview One). The role of restructuring by Sister Elizabeth was brought into question in Interview one, who contended, "it is awful" some nursing positions are being lost to other professions and people are making decisions for nursing who are not nurses, but were also "making decisions for all kinds of groups."

Program Management - Changing the Organization

The hospitals were downsizing but received few comments. Interview Ten stated it would bring economic benefits. The main focus in the interviews was the new approach to patient care delivery called "program management." The informants outlined what program management was, why it was introduced, how it will affect patient care delivery and how it will affect their leadership roles.

The Program Management Model

Program management is the delivery of health care services to patients from a multi-disciplinary team approach. Its introduction is to provide health services to hospital patients at a reduced cost, while maintaining the quality of these services. Health care practices are to be based on research. The ratio of the health care workers, from each discipline, will be determined by current needs of the patient populations in the hospital. These ratios are flexible. Doctors share a leadership role with a program manager in a new organizational

structure. This is a shift from department structures for discipline.

Program management being developed for hospitals in St. John's was described as a "new model," that is not without difficulties for operationalizing. "From the CEO's perspective co-leadership is where this organization is going and operationalizing it is going to be a challenge unto itself." The structure of the program management model is complex. Physicians, however, were able to have access to the top decision making bodies that was greater than other health care professionals. They are part of the professional practice employee stream, but also have their own medical advisory committee stream, and this arrangement may exist for three to five years.

So that there are five streams that there is an employee stream, that there is a professional practice stream, that includes medicine, that there happens to be a medical advisory committee stream at this stage. I would suggest that is a three to five year kind of thing (Interview Ten).

There is a board sitting at the top, "the one thing that we have got that pulls everything together is a professional advisory council" . . . which is . . . "the decision-making body" and is "almost like an extended senior management" (Interview Ten).

The professional advisory committee is senior management, with program management the next level. All health care disciplines are organized within one program, which has the dual leadership of the physician and an administrator. Every program "will have an advisory committee both internally and externally to it." This committee consists of, "the stakeholders, nurses, physio, OT (occupational therapists), physicians and consumers. When you get out of the individual program at the professional advisory

committee, which will be the last." Unlike physicians nurses may not have a place at the professional advisory committee level because the professional practice coordinator positions will not just be for nurses. The professional advisory committee will include "a sampling of professional practice coordinators, and maybe nursing will be there and maybe it will not. You will have a sampling of physicians, a sampling of corporate departments and a corporate team" (Interview Ten).

A program will have two levels of management. Interview Two gave the following example of how this model would exist in a rehabilitation work site. There will be a program for rehabilitation that has a program leader and a doctor and the next level there will be a divisional manager. "A program may have four divisions with it. We have the injured worker program, work skills, inpatient rehabilitation, and outpatient's rehabilitation, so there are four divisions." These four divisions may have two divisional managers who were reported, "they may or may not be nurses."

Interview Two indicated "We are going to program management and we are divided into thirteen programs," with three of them at her work site. However, the number of programs a hospital will have, is not fixed. "We will start with seventeen (programs) and that may be down to ten next year or it may be twenty-five." She further elaborated that other centers had started with more programs, but had amalgamated them as time went by and they saw that they could.

Interview Ten stated there have been marketplace pressures that have created a need for change. "We have to be research based, we have to be quality based, we have to be

consumers focused and consumers have to be brought into this because it has to have value to consumers.” The administrator stated outside organizational pressure has occurred from the Council for Health Services and Accreditation, making it necessary to develop team approach patient care. “The council has the right idea in terms of you should have a stroke team, or maybe it is a surgical team, or it is a same day admit team.” The administrator pointed out that this approach by the council was further developed and has led to the development of programs. “You have all the players to look at all the issues, to develop the program along and to get the buy-in.”

The move to program management is considered advantageous to giving patient care in these times of fiscal restraint by removing the rigidity that existed in the traditional departments. Before program management it was difficult to replace staff in certain departments, in order to increase staff in another discipline. The attitude by structural departments was stated as non-patient focused.

You got to get to the point of talking about what the patient needs. So if in fact you need three more physios on the orthopaedics floor verses nurses, so that the patients can get the better care, then nurses will tell you that nurses have lost in this and physio has gained. But neither has lost nor gained because the patient has gained (Interview Ten).

Before program management, staff in another discipline could only be increased with extra funding. “That is if you had a Department of Nursing and you put three more physios on orthopaedics it would be because extra money came into the organization.” This situation was explained. “Because what I think has happened over the years is that nursing has

become one of the structures . . . and they have not responded as well as we should to patient needs." This move to nonfunctional departments is tied to the economy."But the bottom line is that we are going into a shrinking economy and the only way to get extra physio on orthopaedics is going to be to rearrange the pot"(Interview Ten).

The old structure was described as hampering the utilization of staff. "Every time you go to rearrange the pot in the old structure it would be that nursing lost and physio gained." This territorial stands by departments would not occur under program management and staff positions would be more fluid. "So if orthopaedics needs more physio and it has to come out of nursing or social work, than it comes out of nursing or social work and that is the difference" (Interview Ten).

Leaders and Professional Issues

Doctors will automatically be one of the program leaders, and share this role with a co-leader. This co-leader will not necessarily be a nurse, but may be from any discipline. Therefore, new reporting structures have been created for all disciplines. Professional issues are expected to arise from this arrangement, therefore, professional practice coordinators positions have been created to resolve these issues. The positions are not at each hospital site, and this was questioned. The number of nursing professional practice coordinators positions is questioned.

Program management positions were posted with "the understanding . . . these people would have all the disciplines reporting into them" (Interview Ten). This created a

need to "post professional practice coordinators" because the reporting structures for each discipline will be changed (Interview Four). "We in the new structures have identified professional practice coordinators to handle some of what they call professional integrity issues and standards". Professional practice coordinators will "ensure to the extend that they can see that the standards are carried out in the organization from a nursing perspective. So it is not anywhere like before." The professional practice coordinators' role is "a kitchen sink" because it will include; recruitment, to selection, to supporting, to professional standards; being role models and mentors, to assisting the new program leaders in understanding the dimensions of nursing, helping program managers to understand what it is that nursing can do for them, helping them set standards; and, as well, they are to support nurses (Interview Ten).

Each discipline has a professional practice coordinator, but nursing has three appointed for psychiatric, paediatric and adult because of the size of the workforce it represents, approximately twenty-three hundred nurses and additional support staff of RNAs dispersed at eight sites (Interviews Five; Ten).

The professional practice coordinators' positions are unique management positions. "It is more of a management position, but I would not have a department, or a budget, or any people reporting to me. I would be responsible for maintaining the standards of social work practice, if I was a social worker practice coordinator" (Interview Six). These positions will have a different reporting structure, "they will report to a vice president" and "they will work with the team but will not report to the management team of that program," therefore,

"they are separate from the management team" (Interview Two).

Professional Practice Coordinators are not sites based (Interviews One, Two, Six, Ten). They "are not going to be able to do the work of nursing office" (Interview Ten). This created doubt in the program leader's ability to solve problems for nursing staff. "I don't know what they are going to do. If they had a problem right then, you might end up going to a social worker about it. It might be something so simple as these new IV drip bags. What do social workers know about that?" (Interview One).

One administrator felt that three professional practice coordinators were not enough. "We understand that there is the potential that will not be enough. I see that three would only be a starting point and you drastically need more than three." The administrator gave a reason for her opinion based on the numbers other disciplines have in comparison to nursing. "Three will be thinly spread. When you look out and say that there might be twelve speech pathologists in the whole system and you got one speech pathologist practice coordinator." This contrasted with nursing. "You probably got three thousand nursing employees including RNAs and PCAs and whatever, and three nurse professionals practice coordinators. So as I said it is only a starting point" (Interview Two).

There was expressed a need to have strong nursing leadership in the practice coordinators' positions because "I would look to those people to be very strong advocates for nursing, with good leadership in those positions" (Interview Nine). There was positive feedback regarding the present choice for these positions. "I was certainly pleased with the selection of those leaders" (Interview Seven).

Program leadership is to occur through co-leadership, with the physician [clinical chief] and the program leader (administrator). "Everything that happens in that program is going to be because of the collaborative relationship between the program leader and the clinical chief. There is no one of these individuals deemed to be the leader." This is "a new relationship for physicians" and "the co-leadership is one that is not recognized across the country. It is something new" (Interview Ten).

The leaders share the responsibility differently for the program. The role of the physician on the team is, "there for the medical side," which will include medical quality care because "medical quality care cannot be off loaded to non-physicians." But "everything else that happens within that program is the responsibility of the physician and the program leader," with decision-making occurring jointly because "neither one of them has veto power over anything." This will include budgets, standards, quality and "whatever way they are going to split it, it is going to be a dual responsibility" (Interview Ten).

The program leader will work five days a week but the "reality is that the physician is going to be working one to three days a week within a particular program" (Interview Ten). Nursing administration has experience in budgeting, administration, and the operational side of administration (Interview Two). But the physicians on the teams do not have the skills in budgeting, administration, in the operational side and "they are quite aware of it." To correct this "they [doctors] are going to be going off to school [because] they cannot slough off all the rest of it." Nursing leaders will also receive additional training. Operationalizing programs falls more with the non-physician leader. "So it is going to be up

to the program leader to make sure that they [physicians] get involved" (Interview Ten).

The program management model's intention is to remove the traditional hierarchical structures by removing the traditional functional departments, which will move decision-making outside of disciplines. "That nonhierarchical structure in nursing will mean that if you are a nurse working in orthopaedics you go to your program leader, who goes to the program leader for surgery, who may or may not be a nurse. Decisions are made in that context and not on your discipline, but based on the needs of the patient" (Interview Ten).

Removal of Department Structures

The new structures will remove the department structures that each discipline operated within. This will change the leadership roles, and how leadership is provided. The leadership roles for nursing were changing because "there is going to be no structure" (Interview Ten).

Nursing leadership has taken on a whole new meaning. Locally, that is, provincially, it has taken on a whole new meaning in the last couple of years as more and more organizations are getting into a program-based approach (Interview Six).

The hospitals in St. John's have traditionally been organized into functional disciplinary departments such as nursing, pharmacy, physiotherapy and social work, etc. "There always had to be at the head of a department of nursing, there had to be a qualified nurse, that was accreditation standard. That is not going to be any more" (Interview Two). The restructuring will replace departments and department heads with programs. "The Director of Nursing

position will be no more, as well as the Director of Social Work; there will be no more functional departments anymore, it will all be rolled up into a program" (Interview Two). Program management will be based on a multi disciplinary team approach to patient care (Interviews Two; Six; Ten).

Under the old system each functional hospital department was autonomous and responsible for matters pertaining to its own services. Under the present hospital structure the highest position for nursing is the Director of Nurses. The structure of this department gives nursing its leadership role within the hospital, but its leadership does not extend beyond nursing. "The way it is right now, at this moment, I am only responsible for this section, that is nursing, nurses, registered nursing assistants [RNA] and personal care attendants" [PCA]. This is about to change. "Now that will change when this new structure starts and the program comes in. That management team for the program will be totally responsible" (Interview Two). Nursing has been conditioned to a bureaucratic leadership that occurs through formal structures, "the hierarchal thing is very developed, and it is very difficult to change that." Under program management "nursing will not exist in the structures that we are used to. Nursing will exist as one of many disciplines that provides care for patients." The work of nursing offices will be changed and "will be dispersed within programs, within the people and within the nonhierarchal structure" (Interview Ten).

This has changed not only the leadership roles, but the competition for these roles and the availability of administration positions. "There are going to be no traditional ladders in any of the disciplines that we have, that the ladders will probably be in a unionized

position, from a team leading kind, for the coordination of care" (Interview Ten). When asked if this was flattening nursing leadership back to the clinical role, the administrator stated, "Yes it is, if you think about it." She felt that "power is in the care that you provide. Power is in whom it is that needs to provide the care at the individual patient center level, so that you have to get away from the concept of nursing as a power base." The power bases that each department had "in the past had put us in stove pipes" (Interview Ten).

Program management will change nursing leadership roles in administration, away from nursing leadership. "We are doing something different, and as a corporation [Health Care Corporation] we are moving to a program-based approach of care which sees all the disciplines working around the patient. That is a bit different than saying you are a nursing leader." Program management will change the administration role "because the focus is not nursing leadership, or social work leadership or physio leadership, but patient focus care and it is whatever you need for the patient." The administrator strongly emphasized, "the first thing that you have to understand about this organization is that we are not putting [forward] nurse leaders' interests, we are putting leaders in place." Nursing leadership in hospital administration was described as no longer appropriate for today's marketplace where the leadership role will not only be concerned with nursing, but all disciplines in the program, "but the idea of leadership is not in control and whatever. It is allowing the people who work with you, to empower them to be able to get on and do what they do."

This has flattened nursing leadership. "The question is, who are your nurse leaders within this [Health Care Corporation] organization. The leaders have to be the nurses who

are working on the floor . . . the leaders that happen to be at the clinical level." The leaders selected will have a broader role to play and "will provide leadership to nursing, to occupational therapy, to physiotherapy, medicine" (Interview Ten). The leader's role is multi-disciplinary. "Not only will that [program] divisional managers have nurses and RNAs reporting to her, she will have the rest of the team as well, with responsibility and accountability for them as well" (Interview Two).

The job title will change. "You will not be called a nursing manager. You will be called a divisional manager" (Interview Two). The divisional leader will "have responsibility for everything that goes on in their particular geographical area." An example was given. "If you are talking about surgery, they will have a divisional area, that can have thirty beds that can have everything into it." Corporate responsibility is for standardized care, "but corporate wide responsibility for developing orthopaedics within the organization from a standards, from a policy so that the Health Science [Complex] is doing exactly the same as here, those kinds of things." The only nurse leaders the corporate administrator reported remaining at a senior level were the three Professional Practice Coordinators of Nursing. "The only thing that ties them together for me in nursing wise is the practice coordinators for nursing who reports to me. They are leaders because of the role that they will play and because they carry a responsibility for a lot of things" (Interview Ten). Each discipline has an opportunity to apply for the program leadership positions. This is a change in the leadership roles, "so the social worker, physiotherapy etc. that is a change even for the seasoned manager, and you could have it vice versa in which the social workers report to nurses" (Interview Two).

Nurses Input into Restructuring

Administrators expressed concerns with nurses' ability to influence restructuring of the health care system. While some questioned nurses lack of input at the senior levels, such as on health care boards, one administrator disagreed with her colleagues.

The Association for Registered Nurses of Newfoundland and Labrador (ARNN) had to struggle for a board appointment. "From the perspective of the ARNN when all this restructuring started there really were serious concerns about the role of nursing based on the action of a couple of boards."

One board did not have a nurse on its senior management team and another would not appoint a nurse initially. The ARNN did get a nurse representative, when they lobbied every board chair and every CEO across the province. They wanted three concessions: (a) That nurses had to report to a nurse in order to maintain professional practice standards; (b) nursing needed a voice at the board table in order for sound decisions to be made for nursing because nursing represents 80% of the workforce. The board decisions were impacting either directly or indirectly on that workforce; and, (c) that direct caregivers needed more opportunity for making decisions over their own practice. Two boards tried to go with a team of nurse administrators with no real nursing leader, subsequently no one would get to the board table. "Both of these (boards) found following those discussions and within a very short time found that they had to have that" (Interview Five).

Interview Six had a different view of nurses' role at the board level.

I differ a lot from many of my nursing colleagues and nurse leaders, when people say that they believe that we have to have a nurse at the board level. I don't believe that person has to be a nurse. I believe that person has to be a leader (Interview Six).

The administrator stated, "in exact numbers you are not going to have a nurse at the board level," but this was not necessarily going to "cause suffering in nursing." But "I think you can have an incompetent nurse at the board level that will cause nursing suffering." The position at the board, whatever it is, "a vice president of patient care services, the position is not a nurse"(Interview Six).

Nurses were concerned for being omitted from an automatic place of leadership in the program management model. Nurses described that nurses and doctors traditionally shared this role, a role that now would be shared with a doctor and another discipline. Nurses questioned why this had happened and if the new model would work.

Interview One stated nurses did not have a strong voice in the restructuring, "no, not at all. I think they knocked out all the nursing leaders and then they worked it out." Doubt was expressed about the organization of the program management model with nursing not having an automatic place on the management team. "I think that if you do some reading on the program management around one that really works, like the Mayo Clinic, where they have a doctor on every team and they have a nurse on every team and than a manager."

Interview Two related, "there might be a nurse eventually" but right now in "these programs there is a doctor on the leadership team but not necessarily a nurse and I think that is sad." She reported nurses would not be completely omitted, "I do not think that will

happen and nurses will get their fair share of these programs."One administrator reported nurses would have as much input into decision-making as before. "But why should it be any different? The majority of employees work in clinical care with this organization, about 80% are nurses" who can still have unit meetings to discuss work issues (Interview Ten).

Nurses questioned the unity of nurses, their ability to influence decisions, and why they have no great influence in the decisions being made in health care delivery. Nurses unified organization membership is a factor in not having a voice. "We have all tried to develop it in our own small way, but we need to keep at it and be a united front" (Interview Four). Lack of assertiveness is considered a factor. "We got to stand up and be counted. We have to be aggressive and assertive. I think a lot of people back off" (Interview Four). "Nursing has to be really pro active to ensure that we continue to be a real influence" (Interview Five). It would be nice for all programs to have nurses, but nurses could not restrict their thinking that way; however, if other people are there "nurses will just have to be very vocal as to what nursing means, for this program to work" (Interview Four).

Power Imbalance Between Medicine and Nursing

Medicine had more social power and prestige, than other health care workers, and this enabled medicine to have a greater voice in the restructuring than other disciplines. As well, doctor were not losing positions, but nurses were having massive cuts to nursing positions. Nurses addressed the issues that created this imbalance in power.

Medicine was described as having a voice that nursing and the other disciplines

could not get, and were not having the same decisions made for them."But medicine went forward and said you have to have someone on everyone [program] and they objected to the program coming in. They dragged their feet on it until they agreed to put a doctor on every program." Nurses did not have the clout that doctors had because "nurse managers were let go before the process began." She felt that leaders do still remain "but they didn't have as strong a group as medicine" (Interview One).

The Newfoundland and Labrador Nurses Union reported they were very active in speaking out against the cuts to nurse positions, in relationship to the current restructuring. The union related how the budget to health care would remain the same for the next three years but "nursing in the last five years has been cut drastically in acute care." Interview Nine stated nurses are speaking out against inadequate community resources, and the early discharge of patients from hospitals because the community resources are not there to look after the patients. The voice is not visible, "a lot of the lobbying has been behind the scenes."

Resistance to Program Management

When an administrator was asked if she could see problems with program management she stated, "I don't see problems with this. But I know at the end of the day a lot of people do" (Interview Ten). The participants addresses doctors and nurses resistance to program management and how and why each was seen as resisting its implementation.

Doctors Resistance

Doctors were able to take action to ensure that they had an automatic place in program management. This action was from two groups. "There were two sets of physicians as you are aware who did not buy into it, the program model, the anaesthetists and the surgeons." This group had to be convinced to become a part of the program model, but did so on their terms.

We spend four months and they eventually came on side, but named their program leader. Every other program leader in terms of clinical chief had an interview process, through a selection panel that was physician, staff and corporate team member. There were no automatics in this (Interview Ten).

Doctors will be cast in the role of team players. However, doctors are described as poor team players. Doctors resistance to a multi disciplinary approach to patient care was linked to their attitudes toward their work and the work of other disciplines. "I think doctors for all intents and purposes still believe that they have responsibility for everything that happens to the patient and they direct what goes on." This was seen to be particularly true in hospitals, where "until that changes you are not going to change much." As well, it was seen as a problem for individual doctors. "What you generally have are individual physicians who either work as a team or don't work as a team. I would not want to put a percentage on that, the number who work as a team" (Interview Ten).

Doctors have a traditional role of being the one who decides what will be done with the patient. Under program management, even though he will share a co-leadership role with another, he will still remain the one who makes patient care decisions. For example, in the

traditional hospital setting patient care is often a team focus, such as in orthopaedics where you have "physicians, physio, OT, nurses, whatever, and it is what we need to do for this particular patient." The physician is "the team leader" but his role, "it is only to pull the human resources together." However, what nurses do for the patient is often not given respect by physicians.

You have a number of surgeons who come in and the nature of the practice is, this is what I do, and you do what I tell you to do. Thank-you very much and the patient goes home in five to six days. Very little respect for what it is we are doing (Interview Ten).

This attitude was described as one in which everyone on the team is there for the support of the doctor's role. "It is a set of tasks numbered A, B, C, D, and you do it and I am doing this, I cut and I remove and I set this." However, she felt that once the surgeon had done the technical part in the operating room, "the physician gets out of the picture." However, this was reported as not only a nursing problem but one shared by other disciplines.

If I was sitting on the other side of the fence and I was talking about social workers and discharge planning and complicated cases, they would be saying the same thing that nurses are saying. That the physician holds the power and that they are tugged based upon the physician and the physician does not respect anything that they do. There was no recognition for anything other than concrete services (Interview Ten).

Some of the younger physicians were not seen as different in their ability to work as a team member. "Some of the new guys coming up are no different than the old guys." The new team leader's ability to work with doctor resistance was seen as necessary to make

program management work. "If you got good front-line leaders working with physicians to make team functioning, then it happens" (Interview Ten).

This adversarial relationship was shown to exist back to the student level of doctors and nurses. "I have had [nursing] students come to me and say they have had words with a clerk or intern [student doctor] because they were looked down on when they asked why." The student nurse is asked to be a team player, the student doctor is not confronted. "We have not done a very good job on collaboration" and the students have been told "you are a student and they are a student and you work together as a team" (Interview Nine).

However, not all doctors were seen as resistant to working as a multi disciplinary team. "We have teams that work very, very well and where we have had the buy into a multi disciplinary team." Doctor autonomy was seen as enhanced by program management.

All that does is that it enhances, so that everybody is working in the same direction. At the end of the day the physician does not have to think about the itty-bit stuff that normally he has to worry about now, and that delays discharge, delays teaching (Interview Ten).

Nurses Resistance

Nurses were not described as resisting the implementation of program management, but were reported to be having difficulty with passing on a higher leadership role to front-line staff, which was making the implementation of program management more difficult.

A lot of people in nursing have tied into the formal structures of the nursing office and the bureaucratic kind that goes from one level to the other and finally someone said, yes, you can deal with it. Then it goes down. Now to try to break some of these barriers to allow front-line leaders or front-line supervisors to believe that they have the ability to be able to control and look

within their budgets, to move staff around, to hire, that has been difficult in a traditional setting and some of our institutions it is much more difficult than others (Interview Ten).

The new leadership role was embraced by some, but was difficult for others because "all our paradigms are that somebody has to be the boss." There was difficulty with allowing leadership to arise from the front-lines and allow them to be "boss." "If somebody who is the boss is the person who is on the front-lines, who is providing the care, who is making the decisions, who is coordinating the care" then the role of management is "just a facilitator to allow them to do their work." Some decisions need to be made by a corporate team or senior executive, others were not. "We have not passed that down and we have to get down at front-line leaders, but they have not translated very well from front-line leaders to staff" (Interview Ten). Nurses were described as not having control over their work lives and program management was seen as a solution that was going to take time for nurses to develop. "From the empowerment so that they can feel that they can have some control over their work lives. That I would say is another five years away" (Interview Ten).

Reluctance to embrace program management was linked to "people are generally not risk takers. So they do not want to put their head on the block to make some changes and then to have it fire back on them." This was true for those who "had a good track record and those kind of things." There were people who "have been moving along with the system and making the changes. "These people are still doing it." Those that could not move along were seen as leaders who "have looked to leaders (strong emphasis) to tell them what to do. So they have operationalized what leaders have told them to do" (Interview Ten).

Nurses Reactions to Restructuring Health Care

If you were to say three years ago that nursing would not have a department, would not have some kind of an organizational relationship where there was a clinical at the top who had responsibility for nursing care within the organization, they would say that you were crazy. That it cannot happen (Interview Ten).

Restructuring of hospitals to program management brought a wide range of responses from the high positive to the high negative. "So much of what you are hearing in reform is real positive for nursing" and "what we are working in right now is a system that is paralyzed" (Interview Five). Another took a cautious stand. "I am not comfortable totally with it [program management] yet, because there is a lot about it that they do not understand yet, as to how it is going to work" (Interview Eight). Program management was used in several places in Canada, but is viewed with some scepticism. "Some people say it works really, really well and other people say that they have had to put it by the way side and go back to the more traditional, functional departments" (Interview Two). Restructuring of health care is viewed as an opportunity to create new roles and a new health care direction for nurses. "I see happening much that creates so much opportunity, new roles, replacing physicians in areas they are not willing to go, and all that nursing can offer there. Focusing on health, not illness" (Interview Five). Another saw the restructuring of health care as dire for nursing. "Nursing is in a very vulnerable position as a profession" (Interview Two). Another felt that this was true of all disciplines. "I think right now nursing is in a very vulnerable position, as is any discipline in a vulnerable position" (Interview Four).

The Vulnerability of Nurses

Much of the vulnerability of nursing centered around: the changing leadership roles; the lost of traditional departments; reductions in administration staff and front-line staff; replacement of nurses by para-professionals; the ability of nurses to compete with other disciplines; and, the ability of the profession to redefine its nursing role in the changing health care system (Interviews One - Ten).

The nursing office has traditionally been there to give voice and direction to staff nurses. Fear was expressed that nurses would not have someone to give them direction if they have problems, and there was doubt that other disciplines could provide that direction. "I feel leaving the nurse off here [program management] - nurses are not going to know who to go to when they have a problem" (Interview One).

Nurses felt threatened by the new reporting system that would be created by the multi disciplinary approach because "there will be program staff [who] will not have nursing management" (Interview Two). There was distress with the reporting system impact on the profession and patient care. "We do believe that there are going to be nurses reporting to non-nursing. What does that mean for the profession? What does that mean for patient care?" (Interview Five). Interview Two was troubled about nurses' acceptance of other disciplines directing nurses, "I think nurses will have difficulty with this at this point in time".

Not all felt threatened professionally. For some it is an opportunity for empowerment and a broader leadership role for all disciplines. "I don't believe, therefore,

that I can only post positions for nurses, or that nurses have to be in those positions above all else" (Interview Six). Interview Nine felt that nurses had to be open to others taking these positions, she felt that "it is very important that they are aware of the nursing issues".

Nursing status and its relationship to medicine was questioned. "It will be interesting to see how this will pan out in program management because nurses would not be at the hub. They will be at the hub of care, in terms of actual care at the bedside." This was seen as a change from the previous relationship with medicine. "Usually it was nursing and the physician that carried this through. This is not going to be so any longer. It could be the social worker and the physician" (Interview Four).

Program management was supported for its multi-disciplinary approach to leadership, but nurses had mixed views on who should provide the leadership. One administrator contended, the leader had to be the best one that could provide leadership to the program and did not have to be a nurse, but "if it benefits client care, it has to be right." However, the same administrator felt that "the best possible candidate is going to have a nursing background nine times out of ten" (Interview Six).

The professional qualification of nurses was not a problem for one administrator, but the professional role of advocating for nursing by nurse leaders was not welcomed. "I would suggest that in excess of 80% of the divisional leaders in this particular organization will be nurses." However, she felt that place was not nursing leadership. "But are they going to take a nursing leadership role? [Very strong emphasis] "Unlikely! They are going to have social work, physio, etc. and they are going to lead people, to empower them to do whatever it

is that their competencies, skills and acts allow them to do" (Interview Ten).

The loss of many senior people from the system was viewed with distrust and the motives were questioned. "I think it has been a planned strategy to reduce the influence of nursing in the system" (Interview Five). Another expressed concern for the loss of management jobs, with "a lot of people got displaced and some who were quite good got squeezed out of the system" (Interview Seven).

The restructuring created a flattening of the administration structure, "this seems to affect middle and senior management more so than front-line staff" (Interview Seven). This was a one time event. "It is going to happen one time. A lot will go out of the system at one time. After that it will stabilize, unless programs get rolled into each other" (Interview Two).

Job loss and insecurity about future roles was a major concern for many administrators. "I will be gone then. If I have a new job in this system it would not be as a Director of Nursing or it would not be as Program Director of whatever program I get. If I get either one" (Interview Two). The fears of where their future careers were going, created reactions of apathy. "Some of us have a lot of apathy" (Interview Four), and "what we are working in right now is a system that is paralyzed. There is so much happening. There is so much threat within the system for job security" (Interview Five).

This insecurity was affecting decision-making. "People are saying why should I invest a whole lot of myself when I can be gone tomorrow. Why bother to embark on something new when I don't know where all this is going" (Interview Five)? Job loss was reported as more difficult for management people because they could not apply for staff

jobs. "You will not get in as a staff nurse because managers cannot apply for union jobs, or be accepted for union jobs" (Interview Four). This was affecting people emotionally. "There are a lot of people who are really discouraged and really upset over what is happening" (Interview Four). Interview Two indicated one displaced nursing management person is working in a casual position.

Additional education was not seen as helpful in job competition (Interview Four). A surplus of management people in the system has been created, which in turn is affecting hiring procedures. "I think there will be so many managers out of jobs. The jobs were limited to management people, at least for this point in time." There were limited opportunities for management roles. "If I was a nurse out there and I thought I had the ability to manage the continuing care program, I would not have a chance, no matter how good I was" (Interview Two).

Job loss in all the disciplines has created greater competition for jobs. "We are all out there now trying to get what we can from this system. Jobs are at a premium, salaries are not wonderful, and people don't care any more as long as they have a job" (Interview Two). Job loss and competition created anxiety about nurses' ability to obtain these positions. "Every area will lose nurses and it will be interesting to see how many of the program managers will be nurses" (Interview Two). Many reactions were summed up by, "you either end up with no place for nursing or nursing runs it all" (Interview Seven).

Nursing education, work experiences and skills became key factors in the discussion of who qualified for positions. "Your management skills, your experience and your

education have to be top notch in order to manage in this time of fiscal restraint and change." Nursing education was frequently questioned. Many are in a dilemma because "a lot of nursing administrators have their RN and don't have their BN or higher levels . . . and they are going to apply for and compete with the social worker who when she graduated from her program automatically had a degree" (Interview Two). Others state this concern is unfounded. "I think the Health Care Corporation has taken a stand here and have hired nurses who do not have their degrees in program director positions" and "there have been people hired who have had their RN and the experience " and "that anxiety is unfounded" (Interview Six).

There is frustration with competing for limited positions and questioning of who is chosen for the positions. "We have one gal who is BN prepared and is a really good leader and has gone around twice and has not been accepted. That is very difficult, and someone who is less prepared gets a job" (Interview Four).

Nurses in a union position who have the education and experience and could apply, would not do so. "Young people are looking at the managers being totally eliminated from the system and saying why would I want to give up the security of a union position to take something like this." This was creating the "loss of a generation of nursing leaders" (Interview Five). If nurses had a union position, they would not think of giving it up to take a management position because "the union will protect them. But the managers are the ones who are not protected. They can say you are going and you can be interviewed, if you get through. If this doesn't work, you are out the door" (Interview Four).

Other alternative employment was seen. "But the people who have been in leadership roles have to look at their associate roles, to continue in unit management level. or look at community or look at education" (Interview Four).

Anxiety existed around the clinical role and whether there would be some changes in the number of nurses used for patient care. "I don't know if the nurses' role clinically will be any different and there will still be, I suppose, the same number of nurses, maybe not" (Interview Two). Another stated, "We have not seen despite what you hear out in the system, we have not seen a lot of layoffs of direct care-givers" (Interview Five). However, any job loss that will occur with the hospital amalgamations will be according to a pre-arrangement with the nurses' union (Interview Ten).

The possibilities of staff reduction and substitution with para-professionals are contingent upon economics, "that will be a decision that the budget will dictate, the ratio of nurses to RNA. That may change, but their role at the bedside should not change, nor should anyone else's" (Interview Two). Another disagreed. "So the leaders are to some extent the leaders that happen to be at the clinical level."

The change in leadership was necessary because the focus of these roles was changing to a multi disciplinary approach. "The leadership is taken around what the different needs of the patient and that is a different thought around leadership, because we are all here for the patient at the end of the day" (Interview Ten). But questioning occurred as to who will be there to provide the care. Nurses see their roles threatened by para-professionals because of what is happening in other provinces. "I think he [hospital administrator] is a

CEO for a hospital in Edmonton. They said they were replacing sixteen RNs with fourteen LPNs [Licensed Practice Nurses] and that really concerns me" (Interview Four).

This action was threatening to nurses professionally because nurses were trying to become empowered, more skilled and higher educated at a time when the health care system can use a person at a lesser level, who is cheaper and can provide the same care. "Our own government has said that. The former Minister of Health, Mr. Kitchen, said that. That bothers me." The administrator did see a place for nursing assistants "but I don't see the trade off" (Interview Four).

The economic climate was a factor in many decisions being made, as well, others did not understand what nurses' role and value was to health care. "A large part of it is the economic climate today that is making people say as long as we can get the job done, and get it done as cheap as we can, that is most important" (Interview Four). Nursing is upgrading when the economy is seeking a cheaper workforce. This is creating a difficult "environment and you have to be able to espouse what nursing is and what nursing can do. You have to be able to sell yourself more and more" (Interview Four).

Another agreed. She felt nursing was being forced to review its position as a profession. "But if we try to hang onto all these things that only a nurse does catheterization. That is where we will lose it." This was an issue because nurses at the bedside were threatened with job loss. "If my job was on the line, I would be crying out as well as the next one." However, she explained, "we got to get reeducation of the profession that we have a whole lot more to offer here and I do think we are the best value" (Interview Five).

Section B

RESTRUCTURING THE HEALTH CARE SYSTEMS

This section provides an overview of the restructuring of the health care systems [long-term care, community health and nursing education]. The informants were focused on their own work sites, with the exception being nursing education. The contexts of individual work sites and how the work sites varied is evident in this section.

Restructuring Long Term Care

Many nursing homes in the St. John's area deliver long term care and are gerontology- based. Some long term facilities have senior citizen apartments, cottages and a nursing home unit as part of the one operation, while others are exclusively nursing homes. Some acute care facilities (hospitals) have long term care residents or geriatric units. All nursing homes, except one, are privately owned and rely on government funding for the nursing home part of the operation (Interviews Six, Seven, Eight).

Beginning Restructuring

Restructuring of long term care is beginning with changes to the nursing home boards. Six nursing homes boards will be amalgamated into one board, with each organization having equal representation. "We will have two representatives on the new

board, the same as every other nursing home." The change is to occur soon. "We have a new board and we have been told by the Minister of Health that board has to be in place and operational by October 31" (1996). There was concern that a strategic plan and management structure could be determined so quickly, "I don't know if it is possible." Some operations will not be affected. "It will be the six nursing homes. The cottages and the apartments will not be part of the merger" (Interview Eight).

Input into Restructuring

Nurses' place at the board level and nurses' ability to influence decisions were unknown. "It is hard to say now because the new board will function differently." The changes that could be expected were uncertain. Her future role as administrator and other people's roles could change.

I will say it will start as they did with the Health Care Corporation with financial and put all that under the one umbrella. What that will mean for many of us nobody really knows yet, because nursing homes are not really top heavy with management people (Interview Eight).

Nursing homes had input into the restructuring, but only for the physical operations. "Yes, we have had some input over the last two or three years," which occurred through a series of meetings to decide "what we will be impacted upon. For us we have the cottages and apartment operation that are not government funded and the nursing home which is." It was unknown if the present financial arrangements with the government will be affected. "So the nursing home buys a lot of maintenance and services from the cottages and

apartments, I don't know if we will be able to go on doing that" (Interview Eight).

Changing Roles

Interview Seven worked in a large government nursing home and she did not feel that her role in administration would be changed with the restructuring of nursing homes.

Interview Eight related it was possible that her role would change because the administrator's role included cottages, apartments and a small nursing home. The cottages and apartments would be under a different administration structure because this part of the operation does not receive government support and the nursing home does. "As an administrator it would be more like a site manager and you may have different responsibilities as a site manager in a nursing home." This role could become broader and "I may be responsible for every department, whereas, right now each department has a department head and because of my nursing background I would be capable of looking after the nursing department, as well as, dietary, laundry or whatever" (Interview Eight).

It was unknown if nursing homes would be implementing program management. "I suppose it could. We use all the different services, physiotherapy, occupational therapy, speech pathology, psychology, all these different disciplines to care for our residents. I suppose it is possible." However, not many programs are possible. "It would be a senior's program with residents divided into groups, with the young disabled adults, the frail elderly or the elderly who are stricken with strokes and need rehabilitation" (Interview Eight).

Multi-Level Population

A reorganization of chronic care would occur, with gerontology not being the only reason for admission to nursing homes, but nursing homes will admit a multi-level population.

If you require long term care whether you are geriatric or the young disabled, you can find yourself in the confines of a nursing home because we do not have any other chronic care facilities to look after these people. This is a change because our mandate was always for the geriatric population. We never had anyone under sixty-five (Interview Eight).

There will be a new arrangement with the board and it was uncertain who would make admission decisions and it was questioned if the board should make those decisions.

Yes, that could be a problem because right now we try to match up our residents as best we can. Our social worker does sit on the assessment and placement committee and that down the road may not be the case (Interview Eight).

There was concern in losing control over who was admitted to the nursing home. "I would not want to take young people and put them in amongst our elderly. For their needs, we would not be able to meet them because we do not have the programming for young disabled adults." Some decision-making was expected to remain. "I think we will have. Right now we are able to say who we will take and who we will not take" (Interview Eight).

Economic Benefits

There were positive economic benefits expected from the restructuring. "I can see that we can benefit a lot from joining other institutions and availing of different human

resource people, education, financial" (Interview Eight). These benefits would include physio because buying it on a contract for one institution is more expensive. "We entered into an agreement with another nursing home and got it half price and were able to up our hours that we were providing physio." This could be extended to other services, such as, occupational therapy and speech pathology. "Whereas if the six of us were together you could pay for it that way and everybody could benefit"(Interview Eight).

There was apprehension with the restructuring process due to uncertainty. "I am not comfortable totally with it yet because there is a lot about it that they do not understand yet as to how it is going to work." The reduction in leadership was positive. "I know they will have few chiefs and a lot more Indians, which I think can be a very positive thing, as long as there is a lot of cooperation and coordination in the environment." This move was described as needed because "I think our system has been designed with too many chiefs and there was a lot of duplication which was unnecessary" (Interview Eight).

Restructuring Front-Line Staff

There were concerns with how the front-line staffs will change. Front-line staffs are made up of registered nurses (RNs) and registered nursing assistants (RNAs) and personal care attendants (PCAs). Interview Seven stated, "I am in long term care and I do not feel threatened because I am in an administration role. I don't understand why our RNs feel so threatened, but they certainly do."

Separate Roles

The role of the nursing assistant was described "as an assistant to the nurse" and RNAs provide direct patient care. Nurses also do patient care. "They work along with them, not saying that the nurses don't do the things that nursing assistants do because they generally do nursing care." There are role differences. Only nurses can do "making rounds with doctors, taking off (doctors) orders, arranging (patient) transportation, (patient) assessment in regards does someone need to go to the hospital for some reason and they give out medications" (Interview Eight).

Staff Ratio Differences

The number of RNs to RNAs varied somewhat with work sites. One nursing home consisted of two RNs to five RNAs (Interview Eight). Another nursing home had 500 nursing staff, with 22% RN's and she indicated "we would like to see more professional RNs because that raises the quality of care and that has been shown in research." But she felt satisfied with the present ratio, "reasonably speaking 20-80 is pretty good in the marketplace" (Interview Seven).

Interview Two described the rehabilitation work site as using fewer registered nurses than acute care and often had one nurse on for a whole shift or for a whole day. The other workers are para-professionals, RNAs or PCAs. Interview Six was not satisfied with the ratios for mental health. At this work site the administrator stated, "it is almost a 50-50 ratio and that presents its own challenges." This work site had 70 acute care beds and 144 long

term residents. The acute care section there was three to four RNs to two RNAs, but on hospital units that had long term residents there was one to two RNs and five RNAs. Only one unit had more than one nurse on the night shift.

Staff Ratios Affect Working Conditions

Interview Six reported that the staffing structures of RNs to RNAs in her work site dictated working conditions, such as isolation and poor peer support for the RNs. "There are a large number of nurses in the hospital, who may not be working together all the time on the same shift, on the same unit." This lack of peer support created administration concerns for nurses ability to speak up, give direction to RNAs or to take a leadership role because they relied on the RNAs for social support.

They were the only nurse and not only was that difficult for them to be socially involved with the staff and extremely difficult for them to take or to have taken a stand on anything and to come forward if something needed to be communicated to administration (Interview Six).

The RNs' work role required greater leadership because "they may be the only professional on for a whole shift or for a whole day" (Interview Two). Having to work frequently as the only nurse on a unit for some shifts was common to all four work sites that used a large number of RNA to low ratios of RNs (Interviews Two, Six, Seven, Eight). The leadership role was necessary "to direct and delegate tasks to other para-professionals."

During a nursing assistant strike Interview Six questioned nurses' ability to get support from her coworkers.

And we were worried for nurses, because after the strike was over they had to go back and work together, and often they were the only one not of that bargaining unit on their floor. We were concerned as to what was happening on night shift, just that they were not getting the support that they needed.

The administrator wanted to increase its complement of nurses, but could not. This has created a situation of over-work for the nurses because their responsibilities are increasing, while working with a nursing assistant workforce that cannot assume some of their responsibilities or be replaced. "We have in here a collective agreement that dictates the number of nursing assistants that do not exist anywhere else in North America." This was about to be challenged in negotiations again but "it is something that we have never been able to negotiate out." The administrator pointed out "I may have one to two nurses and five nursing assistants. So there are differences and unfortunately it depends on the collective agreement and there is not a whole lot we can do about it" (Interview Six).

Staff Ratios Questioned

The ARNN participated in a research study with the Council for Nursing Assistants, which examined what nurses and nursing assistants do. The ARNN research data indicated they should not change the ratio of RNs to RNAs and they should not allocate additional duties to RNAs "because they did not have the knowledge base, and they listened to that study". However, the nursing assistants will be trained to give medications in September 1996. "So they listen to you but they don't always pay attention to you" (Interview Five).

Clinical Job Security

Job security is tied to the changing roles of nursing assistants and nurses because nursing assistants if allowed to give medications may replace nurses, especially in nursing homes. "There are nursing homes on the mainland where they got one RN for one hundred residents" (Interview Eight). Interview Seven was asked if she thought this might happen in Newfoundland. She replied,

I hear that all the time and I have not actually seen it. I understand it is happening in Ontario and down in the United States where they are replacing nurses with multi-skilled workers. But in my employment I have not seen it.

How Nurses View the Changing Role

No one completely disagreed with nursing assistants giving medications, but they agreed with reservations. "I don't think you will see the day that nursing assistants will give all the medications. I think there will be some they will not be allowed to give" (Interview Eight). Interviews Two, Six, Seven, and Eight were concerned with the RNAs' curriculum for medications.

Administrators were concerned the medical background possessed by nursing assistants and how this low education level would affect their RNAs' ability to assess clients for drug interactions, especially geriatric clients. Another stated, "right now one of our issues in here is geriatric clients and poly pharmacy." She further commented, "I am not comfortable with that right now. So the answer is, if a lot of things were satisfied right now, I could see nursing assistants doing that role." However, she would not give over the role

easily but stated, "I would not be against it based on the fact that they are not nurses" (Interview Six).

Nurses Need a New Vision

Nurses were described by Interview Seven as not needing to be concerned about the nurse's role in long term care. "To me a person who is threatened by the role of the nursing assistant just sees their role as giving out pills and taking off orders." She stated, "you need to give them a vision." Nurses had a more self confident role to play, which includes providing leadership, direction, and setting the tone for the workplace. Some nurses were seen as not giving the direction and leadership from themselves. Nurses, however, were reported to have limited opportunities to express their leadership.

Interview Six stated nurses put too much significance on medications and that was "not what we are about." Interview Five alleged the medications and who should give them had become an issue "because it is such a safe issue and has always been so central to our role and something that we are very well prepared for." However, she too felt that to truly be a nurse was to be responsible for assessing all the clients needs and nurses "really need to expand our horizons in order to do that. Then we can take on the other roles of the nurse".

Patient assessment belonged to nursing and not para-professional, "what we got to get clear is that supervision, monitoring still rests with nursing." The tasks, of how to do a procedure, could be turned over to others but "I as a nurse cannot give that individual responsibility for assessment" (Interview Three). The giving of medications by nurses was

seen by Interview Seven as interfering with the true nursing role. "All the observations you could be making on the residents and getting their day off to a good start and setting the tone." Nurses were tied to a medication cart and "the nursing assistants are the ones in there interacting with the residents."

Restructuring Community Health

A shift in community health services has occurred, through a series of provincial boards, which have been implemented at different times for different regions of the province. "The first community health board was established three years ago this summer, going into its fourth year. The other regions were like two and three years. The last region was only a year ago" (Interview Three).

Services to the Community Decentralized

Many health care services are moving to the community, with the number of services increasing due to early discharge of patients from acute care facilities. "The largest component of employees in these regions is nursing" (Interview Three).

Restructuring has resulted in decentralized decision-making, with decisions made at the regional level "because that is where the needs' assessments are completed. At the regional level the needs of the community, the needs of the region and the needs of the staff are determined." This is different from having them determined at the provincial level. "But

what we can do is support these decisions if we feel they are reasonable, and most of the time they are because these are the people providing direct service.”

The administrator described her role at the departmental level of community health as one that allowed her to have input into policy making, whereas the decision-making was decentralized within the regional offices (Interview Three).

Input into Restructuring

Interview Three indicated that community health had input into the restructuring. Community health nurses have a lot of independence, initiative, organizational ability, and time management. The majority of the programs are carried out by public health nurses at the preventive and continuing care levels, and “the majority of care is done or supervised by nursing.” It was felt that from the perspective of being the largest component of care givers and program providers “nursing would have a bigger say” in restructuring.

Restructuring Nursing Education

Three nursing diploma schools, located at the Salvation Army Grace General Hospital, St. Clare's Mercy Hospital and the General Hospital, will graduate the last students to have a diploma nursing education within the next two years. The three diploma nursing schools have merged to form the St. John's Center for Nursing Studies and will offer a university program starting in September 1996.

Future nursing students will receive a university education at three sites, Memorial University of Newfoundland (MUN), the St. John's Center for Nursing Studies and a site in the city of Corner Brook. The three sites have separate administration, but share a university curriculum under a collaborative agreement with Memorial University. The university program will reduce the time needed to obtain a degree from five years to four years, "but summers will be free" and "in the long run it is about the same as the three-year program" (Interview One).

A New Education Direction

There were few comments on the amalgamation of the nursing schools. The participants reported on a new direction for nursing education, beginning with a universal university curriculum. The university education was expected to eliminate conformity, create a more independent nurse, give nurses an equal professional status with other health care disciplines, and develop nurses who would be knowledge workers.

A Visionary Change Agent

Peggi Earle, a nurse employed with the ARNN, is credited with bringing about the shift to a university education. "Peggi Earle was the one who kept the idea persistent because we were all busy with our work and she made us focus and in the long run we are all going to benefit from it" (Interview One).

Students as Change Agents

Nursing education is being changed by the women and men who seek nursing education, as much as it is by the change in the education process. "I think that it is not just the nursing education, but the people who come into nursing" (Interview One). These students are "not directly from high school. We are getting young adults, single parents, applicants who have two degrees and have worked in other disciplines and are into career changes", with different "life experiences" and have to be acknowledged "as mature students who have been very independent in life." Students are more assertive and ready for more independence. "You got two factors, one you got a university educated teachers who are promoting that independence and the older student who are ready for it" (Interview Five).

These students are different because they are less compliant with rules and regulations and more questioning of authority.

We cannot make nurses conform. Years ago that was how it was or you were out on your ear. Like I am finding personally that one time you could say be here at nine o'clock and people would go along with it, but now you find they question more and they are not afraid to stand up on their feet and express their opinion (Interview One).

Conformity was not needed in nurses today. "You cannot do that today, there are too many changes, there is no control, and change is a constant." Today students are described as more critical thinkers because they cope with different stressors than other generations, "I think they need to be, out there in today's world." By developing critical thinkers it produced a stronger nurse and "critical thinkers will last longer in nursing" (Interview One). Interview Five stated some students were critical thinkers , others needed to be encouraged.

Shifting from Conformity

Education at diploma nursing schools, especially thirty years ago, created a conformist nurse. Conformity was also representative of the society, "but conformity was not only unique to nursing. It was just expected." The administrator related the diploma school had "a rigid code of who was who, with a rigid pecking order." Interview Seven shared her experiences in the diploma school. "You were told what to do and life was conforming to the hospital rules and regulations." Skipping classes or clinical were not allowed and missed time had to be made up. There were few options and no credit given for other courses completed before nursing school.

There were differences in the education approach of diploma schools and the university. Twelve years after graduating from a diploma nursing school an administrator completed a university nursing degree, and at that time the diploma schools were a little freer, "but not as free as in the university" (Interview Five). Former nursing education did not encourage nurses to speak out and nurses were met with resistance if they did. "It was a culture type of thing, and probably a female role as well, in terms of their submissive role as nurse" (Interview Nine).

Nurses educated in conformity find leadership difficult today. "How can you make people who conform to everything suddenly stand up and speak their own?" She described this as "like you are to go three hundred and sixty degrees around and do something differently" (Interview One).

The Task Orientated Nurse

Nursing education in diploma schools was described as highly tasks oriented. Interview Nine explained. "I think in times when students were required to give service to the hospital, especially in their third year, they were forced into that mentality." This was attributed to students having to assume staff roles. "They [students] were sort of necessary to do tasks, and it probably was the only way they could get through their day because it was so overwhelming." This created a "combination of education and work environment that put nurses in that train of thought, that thinking."

The clinical component of nursing education has been closely tied with giving service to the hospital, which focused on meeting the clinical needs of the hospital as opposed to developing a questioning, inquiring nurse. The students' education in the last five years is not under the control of hospitals and students are supported more, "which lends itself to a more inquiring mind" (Interview Nine).

The diploma program was criticized for developing a task oriented nurse. The university program was criticized for not concentrating enough on the practice tasks of nursing (Interview One). Even though the route was going to be a university degree, "there should still be a clear emphasis on the clinical aspect." The clinical aspect was what makes the nurse the "expert" (Interview Three). Changing the curriculum was going to create a stronger and more articulated nurse who will be better prepared, but the clinical components were still important for both the hospital and community setting (Interview Four).

Students are educated in the general tasks of the hospital and in the practice of

nursing, but this cannot take the responsibility from the employers to prepare nurses after graduation for particular work sites. An administrator, initially educated in a hospital environment, explained that her basic nursing education prepared her for the practice of nursing, a practice that could not encompass all the tasks that a work setting would require. "I think that is something we really need to keep reminding ourselves" but it "does not prepare you for the setting." This point needs to be recognized, as well as the point that nurses will need intensive orientation when they begin to work, as she did when she worked in labour and delivery and again in surgery. "I received an intensive orientation, which was really the equivalent of an education program, and then I was prepared for the setting" (Interview Three).

A new balance was reached in 1990 between academia and clinical. "I think partly because we did bring in the new curriculum in 1990 and we saw what was valued in the RN program that we didn't have was the practice, so we adjusted it." This adjustment was accomplished through preceptorship courses and "students are more confident in their clinical skills and RN results went way up" (Interview One).

Removing Rules and Regulations

Interview One explained that while nursing education has moved from requiring the clinical component to be service to the hospital, certain amounts of time spent in the clinical area was required for graduation.

When we got into this particular curriculum we had someone come from

away and show this about this student who had broken her leg and they did an assessment. They said you meet all the objectives, but you have to come back because you have missed some time. But the student said if I had met all the objectives, why do I have to come back to make up time loss. It was because that was the rule there that you had to have so many days in the clinical and that was it. If you have met all the objectives, no matter how long you have spend in the clinical, it is really the students' ability, knowledge.

The removal of a compulsory clinical is making nursing governed by "less rules and regulations" (Interview One).

From Trained to Educated

Nursing education, according to Interviews Two and Five, was referred to as "trained." Interview Five explained this has all the connotations that go with the word trained, "that it is rote, that you did it and you didn't think about what you were doing and you just got out there and did it." Interview Two reported the negative connotation of "trained" denoted compliance and stated the word trained "didn't do nurses any justice." Other professions refer to themselves as educated, but for her "once you think of trained, well you train a monkey." The word "trained" was inappropriate, "people have changed, society has changed."

Creating an Independent Nurse

Leadership is a small component of their education program in diploma schools and it is taught in the third year. This was considered inadequate and "I think leadership has to

start right from the beginning and I do not think it is something you can wait to develop.” However, all nursing education is slowly changing away from compliance into a more independent role (Interview Nine).

Leadership is not taught as a specific subject in the university program, but “it runs through the whole curriculum.” The curriculum intention is to develop strong independent thinkers. “Our approach right from the first year is showing that they have to make decisions on their own” and “we cannot make nurses conform.” Students are taught that they have to “stand up for advocacy, to stand up for your patient” (Interview One).

Courses in diploma schools “are designed to encourage critical thinking,” which is considered essential “in terms of future nursing” because “the majority of students who come into nursing are not natural critical thinkers, but are more feelers because of the caring nature of this profession.” Critical thinking needed to be developed. “It is not an obvious process with nurses who are so intuitive” (Interview Five). Nursing courses at the university “are designed that way to encourage critical thinking”. These courses include counselling, followed by other courses such as teaching and learning, with each student participating in a teaching session and documentation of same; nursing issues and nursing research courses offered critical questioning and problem solving; student presentations; a management course; and, preceptorship program for nurses in four different work sites.

The new curriculum will help students focus on community needs and assessment which will promote confidence and independence. Students will do
a teaching project and they are going to be assigned to an agency, for

example the home for battered women, to identify the need, figure out what they are going to do, what is needed for health promotion. They have to develop it (Interview One).

Interview One indicated the new university curriculum reflected this. "That is the theory in the model. That is the approach this time, critical thinking in a caring environment." The new direction is for student independence and cooperative learning. "To quote the new curriculum the faculty member, instructors, the students are equal partners in the education process, so that there is a give and take."

Students are encouraged to develop leadership by being involved in their professional organizations, union and the Nursing Society. "As soon as they were encouraged, it takes off, and they need that encouragement in the beginning." In the past year the school reported, "We have someone who became president of the Atlantic Canadian Nursing Student Association . . . and someone else secretary of the whole student union" (Interview One).

Education Barriers to Leadership

Educators create barriers to students who are developing leadership because educators are sometimes threatened by students who "are vocal and trying to be leaders and trying to be different and questioning" because "it threatened what we had been doing for years." However, there is a shift toward "students having more independent work, more independent study and not being spoon fed" (Interview Nine).

The clinical role of university faculty was not to provide leadership. "You go into the

clinical area with your group and you give them a pass or fail, and make sure you are doing it on the same lines as everyone else, but there is no real leadership" [strong emphasis on leadership] (Interview One).

Why a University Education

Factors, such as a fragmented nursing education and a changing social world, created a need for knowledge workers and more education credibility with other professions.

A Universal Education.

The shift to a university-based education was creating a "universal education" by the "year 2000 that will empower nurses to be ready for whatever faces' them. Right now we have a fragmented education from two to five years across Canada." Nursing education in Newfoundland was offered at two levels, a three-year diploma and a five-year university degree program, with Newfoundland being one of two provinces that had a five-year program for a degree (Interview One).

The diploma and university students wrote the same professional certification examination for licensure as registered nurses (RN) and worked at the same level in all work areas except community health. Community health, Interview Three stated, has required nurses to have an additional diploma in community health or a nursing degree as a requirement of employment. Nurses fragmented, education was described as creating

confusion to the public and other disciplines (Interview Six).

The goal is to unify the profession, and reduce the number of nurses being educated because "we are producing too many nurses." Professional creditability would be achieved because "very few professions have less than a degree as the standard," which would put nursing on an equal footing with other health care disciplines, such as a university educated physiotherapy and speech pathology. "To be credible you have to have a BN" [Baccalaureate of Nursing] (Interview One).

Changes in Society

The increase in the standard of nursing education was being forced by outside societal forces according to Interviews Three, Four, Five, Six and "it was a force that needed to come" (Interview Three). Interview Five reported at present "less than 5% of nurse leaders are prepared at the baccalaureate degree, not only in this province but across the country." Interview Three contended if it is only because of the restructuring of health care, otherwise nurses would not "have been anxious to advance their education" not only at the "masters' level but more evident at the undergraduate level." Interview Four agreed. "I see a lot of people going back to school and developing their skills because they know they have to, even though they are being forced to."

Pressure was being exerted for higher degree preparation of all health workers, therefore, knowledge workers in nurses were seen as necessary by Interview Six. "We want nurses to have their BN "for front-line positions" because

when I am hiring a social worker, she has to be master prepared, if I hire an OT he or she has to have a baccalaureate, if I am hiring a psychologist at least master's if not PhD. Why would I not require a degree of a nurse?

The administrator also stated that "if you are not in the system, we want nurses who have their BN." for front-line positions not management (Interview Six). Interviews Four agreed, that "from an educational point of view nurses should get out there and get their degrees." She alluded that nurses had stayed with a diploma program longer than other disciplines and nursing now had to get the education and skills and "get out of the old ways of doing things, the traditional role" (Interview Four).

There Will Be Growing Pains

Interview One saw some problems with the education at three sites and there may be problems with the diploma schools implementing a university curriculum.

The curriculum will be more research based, self directed, with more expected of students. "We are all taking some period of adjustment. They are trying to figure out how to teach something that was much longer and now have to do it in a shorter teaching time."

Factors that Affect Nursing Education

Several factors affected nurses' education: how students were supervised; the cost of nursing education; the large percentage of nurses seeking nursing degrees; an increase in the number of nurses seeking a master level of education; inadequate education and

preparation for their roles; insufficient collaboration with other disciplines; and an, unequal faculty relationship between medicine and nursing.

Over Supervision

Interview Five commented, "We are the only profession in the system that over supervise our students" Interview Nine agreed. "I think that they [students] have a perception that they are supervised very closely." This has created a situation in which "everything that they do is criticized or has an opportunity for criticism." Self confidence is affected by this over supervision. To counteract this situation changes have been made. "One of the things that we have done in the last two or three years is peer tutor experience, in order to bring about that notion of learning from each other." This has received "fantastic feedback" and "they work together. I think that we have got to start doing more of that" (Interview Five).

The administrator related that, educators verbalize the positive to students "that as a nurse you are important to the system", but their actions often show the opposite. "I think we verbalize the positive, but I see a distinct difference in saying you are good and showing you are good." Students are over criticized by "nit picking on care plans and nit picking you on assignments and standing over you and evaluating every little thing that you do." This was viewed as "my actions say I don't trust you. So you are getting mixed messages, so we are not empowering them in that" (Interview Five).

Students are taught to transfer skills, which Interview Nine maintained, allowed students to develop independence and more accountability. Before they had "to be passed

for injections, dressings and everything." Interview Five stated that students are often passed on clinical skills in a laboratory situation, but doing the same skills with staff members in the clinical area has not always been encouraged. "We have to believe that the staffs are as qualified to tell the student if that is safe or unsafe practice." Faculty members "will say I don't like the way she is doing it." This should not be the issue. "Everyone has a right to practice their own way as long as it maintains the principles of safe practice. They are licensed and that is my biggest argument."

Interview Five contended this distrust in staff's nursing abilities, created barriers to students turning to staff. Students could learn from each other and staff. "I really believe the best learning situation is to put the student in there, give them responsibility and let them learn from each other, be it student or staff." This was beneficial. "I think from an educator perspective, I do not think we are current . . . I may be able to give you theory . . . if I have not been out there I cannot bring that nuance of what is really happening." When students go out in the clinical practice in their last year, they "consistently tell me that they were not prepared for the reality of what they had to deal with."

Supervision Creates an Expensive Education

The nursing approach to clinical supervision of students in the clinical setting was reported as "our approach is more expensive than anyone's." One nursing student's education cost "thirty-two thousand dollars and for a social worker the cost is eighteen thousand dollars." This is due to nursing supervising their students in the clinical area by clinical

instructors on a "one to eight ratios."

Other disciplines have a different arrangement. "Over here in Medicine they are doing neurology, then they go with a person who has his practice and he will take a student along with him." Therefore, they are paid differently, "They may get some kind of honorarium, but not very much." Social workers use a preceptorship program with students where they are placed with a social worker. "The faculty member is the clinical coordinator and they just visit all the students" (Interview One).

RNs Seek a Degree

A nursing diploma education for registered nurses is three years, but if they desired a baccalaureate degree" you had to go another four years," which made taking a degree seven years, whereas other disciplines only did four years for their degrees (Interview Two). Distance education and more flexibility for courses have helped more people to get their degrees (Interviews Two, Five, Six). The bachelor of nursing program is now offered by distance education (Interview Five).

Factors, such as what nurses could get university credits for, a higher academic workload than other disciplines, had made it difficult for nurses to do their nursing degrees. The attitude of nursing to its academic requirements was described as over-proving themselves

I think it is nurses doing it to nurses. We have to prove to ourselves how good we are, we have to prove to the rest of the community how good we are, subsequently we make it very difficult for each other (Interview Five).

Another barrier, was non-practice hours for education. Interview Nine stated nursing education does not count for RNs as practice hours for licensure, but instead, "When you fill out your form and education is over here and it is deduced how much time you spend in school." Interview Nine asserted, "but when you think of the perception that is creating. It is like, well we want you to be more educated, but we are not recognizing these hours as being valuable in terms of licensure." This creates an impression for nurses of "how important can it [education] be?". This could affect the casual workforces who are struggling to get enough hours to maintain licensure, but cannot afford to lose time for education because the hours are not recognized (Interview Nine).

Interview Eight described that many nurses have been out of school for a period of time and lacked confidence, "it is a fear of going to something like that and not knowing what to expect having been out of school for a long time." However, she contended nurses shift work and little funding by employers also created barriers. The administrator stated "whether we (employers) do enough is based on resources and everyone's budget has been cut so much in the last few years." A flexible work schedule is offered when possible.

Low Numbers in Graduate Programs

Nurses today have greater opportunities to obtain a Master's education in nursing "because there are so many educators out there who have to have a master's degree in order to keep their job. So in the past couple of years they have put that type of education in place." The low number of graduate students in classrooms was seen as economically

unfeasible. "I think the day of having five or six graduate students in a classroom with a professor is gone. I don't think we can afford that any more." She further contended that "We have to do it the least expensive way" and distance education was seen as a viable alternative (Interview Two).

Inadequate Education

Interview Four indicated that the university had failed to provide "courses for nurses in administration. I believe that is the one thing lacking". As for lobbying for these courses she stated, "I wouldn't. But I also hope others would". Interview Six addressed the lack of administration courses, and commented on their lack, "as none what-so-ever and no courses at a university level" and "I would like to be able to avail of these kind of courses and do that kind of work." She reported that people had to go out of the province for this education. This created a gap in education for nurses. Interview One indicated one administrator had done courses in administration at the School of Business, MUN, through the MBA program.

Interview Five stated the ARNN lobbied Community Medicine and the School of Nursing at Memorial University of Newfoundland (MUN) to create a graduate master's program in Health Administration, with options to branch to nursing administration or community health administration. This proposal was not supported by the Hospital Association and not enough employers supported it. The administrator commented on the failure: "I always say it is the old adage, keep them bare foot, pregnant and in the kitchen. What they didn't want was for nurses to be educated." She reported nurses are in charge of

units, the largest department budgets in the hospital and "you say to me I can do that and do that effectively without some business background." Interview Five contended "You just go in there and fly by the seat of your pants and you can't do that any more. I don't think we have done near enough to solve this issue." Interview Eight stated, "it is a problem" but it had not affected her role as she had availed of whatever was out there. Interviews Two, Four, Five, Six agreed that it was a problem for them.

Insufficient Preparation for Roles

Women's feminist issues have not been tackled in nurses education and support awareness could be taught through the study of feminist issues. "The female students are coming in already with their preconceived ideas in terms of where they fit in society, and in women's roles." This was seen to impact on where they go with their leadership roles (Interview Nine). Nursing has not identified with women's liberation. Nursing needs to produce stronger students but not because of women's liberation issues. "I think that not because I am a woman's libber" but "by the nature of the fact that we are a predominately female profession. That assertiveness does not come naturally to us and it is a skill that has to be nurtured among nursing students" (Interview Five). Interview Nine commented not much has been done to help students with "their own personal growth" and that this focus "has been significantly lacking in some nursing schools." Growth and development of students were fostered by a course in personal effectiveness, an experiential course in assertive behavior, conflict management, and self insight (Interview Five).

Student Collaboration

The interdisciplinary approach between medicine and nursing was not there because "we have not done a very good job on collaboration" (Interview Five). Interview Nine stated "I have had students come to me and say that they have had words with a clerk or intern [student doctors] because they were looked down on when they ask why." The attitude was, "It is as if you asked them to jump off a bridge, how dare them to ask a question or to question." While nursing is promoting to its students that they were part of a team and "we get students going to an interdisciplinary area and getting that kind of reception." The administrator stated there has to be changes here, and "maybe the collaboration there at a student level might help that."

Interview One stated student collaboration and interaction has not been actively developed between the disciplines. Pharmacy, medicine and nursing share the same building, computer facilities and student lounge area. The students started their own association called MUSH, which stands for nursing pharmacy, medicine for better health, but they have other professional societies that are separate. There are future plans and hopes to help medicine, social work, pharmacy and nursing to get together to create a joint unit where the disciplines can do presentations on a case study, for example AIDS. This may help create awareness among the disciplines as to what each brings to patient care.

Unequal Faculty Positions

The School of Medicine was described as "having loads of money when compared

to nursing." This is because they are "from medicine" and they are funded differently than the rest of the university. "The rest of the university gets money from the Department of Education and medicine gets it from the Department of Health, so we never know how much they get." But when you look at the "budget for Newfoundland and you look at the section for medicine, there is a section for the School of Medicine and they do get totally different salaries."

Medicine accepts fifty-two students and MUN School of Nursing accepts fifty. Therefore, they are equal for enrolment. Medicine has a much larger budget and larger research sections, with less teaching required by their research faculty than nursing, who "have to spend hours on end in the clinical with students." The teaching faculty of nursing requires 40% teaching, 40% research and 20% community service.

Students in the faculties of nursing, social work and pharmacy do not share any courses of study and "we are far from that here." There is little interaction by medicine with the other three disciplines because "medicine goes all year around and does not follow the university calendar, which is totally different from the rest of the university, so they are really separated out." (Interview One).

Section C

LEADERSHIP IN A CHANGING MARKETPLACE

This section is divided into four topic areas. (1) Factors that Affect Nurses Leadership will present the many factors affecting nursing leadership roles. The informants' views will be combined into a collective voice in order to illustrate the processes affecting nursing leadership; (2) The Factors that Affect the Development of Leadership will present the lived experiences of the informants as they describe the factors that influenced their leadership development. (3) How Administrators Define Leadership presents the informants individually as they describe their leadership role. (4) Front - Line Leadership Abilities presents the informants individually as they describe the abilities of their front-line staff.

An examination of the data revealed that nurses have very different leadership roles depending on the organizational setting in which it occurs and nurses' abilities for leadership varied widely depending on who was describing nurses. For these reasons the informants needed to be presented individually. Individual case studies will allow more accurate conclusions to be drawn on nursing leadership. This change is in keeping with the methodology in which it is stated "a research design allows the logical sequence that connects the empirical data to the study's initial research questions and ultimately to its conclusions" (Yin, 1984, quoted in Morrow, 1994, pp.250-251). As well, the study using critical theory allows for the casual processes and meaning structures to be examined either from the perspective of a single or small number of cases (Morrow, 1994, pp.250-251).

Factors that Affect Nurses Leadership Roles

The exact question in your research, nursing leadership can it meet the marketplace needs? I think it can, but it is going to need some work (Interview Eight).

Many internal and external factors were reported, which affected nurses' ability to move into new and more valued roles in health care. These factors create the conditions under which administrators and front-line nurses work. These factors could have a profound influence on the way nurses and administrators view their leadership roles. These factors may create opportunities to attain leadership or they may create barriers to leadership.

Nurses Value to the Health Care System

Nurses are undervalued and supported by fellow colleagues, by physicians and by other disciplines; as well nurses' levels of expertise and education are questioned by themselves and others. "I think what has to happen in the profession is that sense of value in terms of - the one thing is to appreciate their value to the system" (Interview Five).

Nurses are competing with physicians, while undervalued for their expertise: "we can do equivalent work at less cost than other professionals, especially physicians." Nurses are valued for the tasks they perform, but it was essential to be able to show the health care system that they have greater value, "that we do all these tasks, but that we have a good education, . . . a broad base . . . skills, like critical thinking, that we can be innovative" (Interview Five).

Interview Four commented nurses needed to learn to work together “especially in this environment,” but she doubted if nurses are appreciated by others. “I don’t think they (other professions) had an appreciation for what anybody could do”. Interview Five shared a similar view. “Other professions do not have a lot of respect for us” and nurses are “unequal to other disciplines,” because “there are different levels of education in nursing, that is a barrier to that equal professional status.”

Nurses are the “only group to provide 24 hour care, seven days a week and we are the only one that addresses the individual in total” (Interview Five). Nurses “have more clinical skills than anybody recognizes and they are equal to any of the other disciplines.” Despite this, other disciplines do not recognize what nurses do. “We have a whole set of skills and competencies that nobody recognizes” (Interview Ten).

Not all nurses value their nursing background. At a conference Interview One witnessed a nurse who became a program manager and denied she had obtained the position because she was a nurse. “I was a nurse when I came into it, but I am not here because of my nursing.” The administrator commented, “You would never hear a doctor say that.” She explained, “if a doctor became the program manager, he would assume it was because he is a doctor and has a medical background.” Nurses without a degree question their value. “I am so concerned some how nurses don’t feel valued if they don’t have their BN. We are not saying that nurses with their BN are more valued than nurses without their BN. All nurses are valued. But just go and get your BN, if you can.”

The administrator contended nurses do not value all the roles of nurses.

I believe nurses don't give credit to the voice of nursing unless it comes from a nurse who is doing, not only at the bedside, but doing twelve hour rotation. You have to be that impatient nurse on the unit doing twelve hour rotation and experiencing nights and weekends and this sort of thing (Interview Six).

The roles nurses undervalued are, "the people who work days and people who work programs and who are in community" (Interview Six). Nurses undervalue each other's role. In gerontology the demands of the role are not known by nurses who work in acute care and "nurses who do not work in gerontology do not recognize it is just as demanding a role as it is in a medical unit, in an acute care hospital" (Interview Eight).

Nursing and the Caring Model

Nursing practice is based on a Caring Model, and differs from the medical paradigm. The Caring Model may not adequately describe the nurses' role, and nurses could not promote themselves as the only ones that care.

What does caring mean? Every health care deliverer out there cares, your plumber cares. What we are saying is, what is it about nursing that makes us valuable to the system and caring is not the way to go (Interview Five).

Interview Six stated, "we cannot hold ourselves up as the only one that cares." While the Caring Model is a factor in nurses' empowerment and articulation of whom they are and what they are, Interview Six related "in order to be able to [articulate their roles], I think they are going to need a broader base." The Caring Model is described as encompassing two

different perspectives, (1) a philosophy, and (2) knowledge and expertise, but she commented, "We ourselves [nurses] probably are not as clear on what caring means".

Nurses Lack Role Articulation

Many reported nurses could not articulate their nursing roles (Interviews Two, Three, Four, Five, Six, Eight, Nine). "I think that is one of our big problems as a profession is that we cannot articulate what we do and what we do differently from other people." Other professions do not have this problem. "You will never hear a physiotherapist say that or an occupational therapist" but "nursing it seems we are so global that we can do everything and what specifically do we do differently than everybody else" (Interview Two). "We have to get the evidence that first of all shows that what nurses do is different" (Interview Five). Nursing roles are difficult to articulate because of the "the complexity of their job" (Interview Nine). Another related, "I think we have a harder time deciding what we don't do" (Interview Six).

Nurses inability to articulate their roles was attributed to a need to understand their roles, "as a nurse you are accountable for what you can do, what your standards are, and what your ethical values and principals are." But nurses do have a code of ethics and standards that "give clear direction to nursing as to what nursing can do" (Interview Four).

A lack of role articulation affects nurses position in society, and the way other professions see nurses. "They do not even know the decision-making process they go through when they are faced with a situation. They just do it automatically." This creates an

impression of a task-orientated nurse. "When they talk about what they did today, they talk about, well I did this, this and this. They do not talk about what they put into effect in order to make all these decisions" (Interview Nine). Role articulation is not happening because "nurses take a lot for granted and nurses are not interested in publicizing themselves, or they don't like a lot of ceremony or like to draw attention to themselves." The nurse's role is "part of their job" and "something they should be doing." This creates a disadvantage, "people don't understand, especially now, where there are so many different roles for nursing than there were, particularly in the community" (Interview Three).

Role Conflict Between Doctors and Nurses

Doctors are depicted as the controllers of nursing practice, while nurses are described as unable to achieve independent practice.

We believe we are working underneath the physician, when in fact we have a practice, a set of skills and a set of competencies that most of us don't use. Most nurses do not believe they have any independent practice, that everything is tied to physicians orders (Interview Ten).

Interview Three related doctors are reluctant to release roles to nurses due to economic competition brought about by "too many people competing for the dollars and cents, the economy has changed all of us, especially the physicians group." Doctors are unwilling to give up some patient care because they will sustain a cut in pay. "Nurses roles have really contracted within health care delivery rather than expanded to comply with the demands of physicians since MCP." The way doctors are paid is a factor and could be

corrected. "If doctors were on a salary, we would not have the same concerns or the same issues defining roles and what nurses can do, there would not be that competition." There are roles doctors do not consider a threat, i.e. "foot-care, holistic nursing" because these are areas in which "they [doctors] would not make enough money." Doctors are not only limiting nurses' roles, but impinging on nurses' areas of practice. "Nurses are not practising medicine but, physicians are practising nursing" (Interview Three). Another agreed. "I just believe that physicians are doing things that are part of the nursing role and we have just not taken it" (Interview Six).

Doctors have more power over nursing practice than nurses, "because in some places nurses are still considered the handmaiden focus of health care" (Interview Nine). Another stated that, nurses need to stand up to doctors and others who restrict their practice and indicated that when they do, they are successful. "We have gone against a lot of things . . . despite physicians, despite administration, despite people who didn't want to be involved, but we persevered and we did develop it. Now we got everybody involved" (Interview Four).

When nurses want to change doctors orders, they meet resistance. Nurses have used research data to counteract resistance. Physicians are "the ones' nurses have the most trouble with, until you come up with the data that says, hey, this practice is not doing any more than something else. So you force the accountability on them" (Interview Five).

The medical profession is "the head of the team in people's minds and nursing is not" (Interview Three). However, another related, "personally sometimes the doctor is the leader of the team," but nurses were described in this relationship as "we have a lot to contribute

and we are the only ones that know all the time what is happening to the patient.” Doctors have more political power and “a long tradition” and “they have a long time when they have been looked on as the head of the group” with “a lot of friends in government” (Interview One). This according to Interview Three enables doctors to dictate to nurses, “So they still continue to tell nursing where its skills lie.”

Doctors were reported to constrict nursing roles and resist new roles for nurses, a resistance that neither the ARNN nor the nurses’ union has been successful in overcoming.

We have four thousand nurses in this province and we have a union that looks after labour issues . . . and . . . we have an Association of Registered Nurses that licences all the nurses for the province . . . they have tried to make some inroads to stake out the territory and the profile for nurses . . . but they have not been successful either (Interview Three).

However, the power base of doctors is weakened by the restructuring. “They (doctors) are frightened for their lives out there in the system and they are the ones whose power base is being striped significantly” (Interview Five). Interview Ten agreed that the medical profession was vulnerable to cuts with restructuring. While doctors fear for their base of power, they have run some successful ad campaigns, “They are very good ads and nurses could be doing the same kind of things” (Interview Three).

Nurses are a viable alternative to physicians and could provide initial care to consumers. However, the consumer will choose a doctor over a nurse. The average consumer is more concerned with “losing a funded health care system.” They would “love a doctor, but if they cannot, they would love a qualified health care practitioner” (Interview Five).

Primary health care was considered a viable alternative but there are draw backs.

"You got to have friends in the community and a whole different organization, and you got to be a friend of the government too, to be able to do something this way" (Interview Four).

Administrators describe nursing in a vulnerable position that has put nursing at a crossroads, due to restructuring, loss of nursing roles to other disciplines and the need to assume a higher level of client care (Interviews Two, Four, Five). Interview Six agreed with the problems, but saw it not so much as a doctor issue, as nursing needing to refocus itself, "I agree. And the way nurses have to move is toward what we currently see physicians doing, and nurses don't feel comfortable doing that." She stated nurses had the education background, "I don't know if it is a confidence issue or/and I think we are spending too much time worrying about what the RNAs are taking from us, than in advancing our practice."

Interview Nine stated there are differences in collaboration between nurses, other disciplines and doctors, which could affect their working relationships. Physio and OT (occupational therapist) attend doctors rounds, but if nurses have rounds "you do not see any doctors showing up." Other disciplines, "maybe the occupational therapists, the physio" go to nurses rounds because of "greater collaboration."

Nursing according to Interview Four needed to move away from the medical paradigm and establish a new relationship with medicine.

I do believe that it should be a more political relationship and more of a consultation role . . . more of a colloquial atmosphere and I believe that is where it should be and everyone should work together. That you should be able to respect me for what it is I do, and I should be able to offer you the same respect.

Family Responsibilities

To pursue management positions or higher education you "have to want it badly." Women put their families before their career. "If you have a growing family, let's face it and you are married with children in the end it's your responsibility for these children." Women took more responsibility than men. "Even men who are helpful, if you really question them about what happens in the family, they say they are helping their wives, as opposed to being responsible for" (Interview One). "How much opportunity do you have to take on this third role?" (Interview Five). Interview Four agreed.

There is a lack of social support to young women with children, such as day-care in hospitals, where many nurses work twelve hour shifts. "And as a profession we have not taken a leadership role in facilitating that development in our young nurses. Also "I am really surprised that the union has never pushed that forward in terms of facilitating work." Nurses who are younger and do not have family responsibilities take on leadership roles. Nurses "once the children are raised are ready to move onto something else, so they start getting themselves involved into professional issues and take on more leadership roles" (Interview Five).

Personal Factors

There were personal factors, internal to the individual, which prevented nurses from assuming leadership roles.

"Other barriers, a lot of them are within the person (Interview Two). Interview Six

contended that nursing is "the backbone of the organization, it is the largest department . . . has the biggest budget . . . most clout . . . nurses have great power in organizations and the only barriers that they ever create to creating positions for themselves in administration, is within their own mind." Interview Nine agreed. "One barrier is nurses themselves. We have to really believe in ourselves that we can take on this role and we have the skills, we have the ability, we have the knowledge, we have it all. We just have to use it." Interview Five stated, nurses are not comfortable with the challenges. Nurses are not comfortable with debate, and being challenged; we tend to take it personally."

Compensation for Services

Nurses have a negative perception of their monetary value, which affects compensation for their services and their working relationships. "It astonishes me that we are paid so poorly and we value ourselves too little." Low salaries are "because there are so many of us, if you put up the salary for any nurse at any level then it becomes a big chunk out of the budget." Nursing is from "a tradition where you went into nursing because you were dedicated and you cared about people. Wanting money was crass."

Nursing faculty salaries were unequal until "the union came in and with the union everyone got a lot more expensive because everyone's salary went up." Nurses are not concerned with salary issues, "I don't think they even care about the money," but this may change because nurses "have money to pay back and nursing education is costlier and you are going to have people who are going to demand more." Nurses are paid less than

professions with men. "Social workers came from a tradition of men and women, so they had more voice." It was hoped salaries would become more equal, "as more men were going into nursing and more women were getting into medicine. I think things will eventually progress so that there is less of a gap in the salaries. But I think we have a long way to go." Nurses poor salaries made them less empowered, but it did not affect how society sees nurses, but how "the other health care team [do]" (Interview One).

Nurse Abuse in the Workplace

"I remember the traditional days where everybody stamped, yelled and screamed at you" (Interview Four). Interview Nine reported, "I think there is research that shows that nurses are more than most in terms of a women's group are abused in the workplace, but also are in abusive relationships." Nursing as a profession created and perpetuated values that made the women in them susceptible to abuse because the profession attracted women who wanted to care for others. "Like a nurse, because she wants to care for people. This draws this kind of person into nursing."

Workplace abuse is a gender issue. "As nurses you get paid for doing it and it is a thing women do and we should do it." Nursing attracts "women to mercy who want to help and nurture people and they want to make them better." This drive creates a person who will

... bend over backward, they will do anything to make the patient better, and those types of values create in that person that they will do anything to make their personal relationships better, they will do anything to make their relationship with the physician on the floor better, with the coworkers, or with family members who are yelling and screaming at them every day or the

patients who are sometimes physically or verbally abusive (Interview Nine).

This is changing. "But I think we have come a long way, but we still have a long way to go in that" (Interview Four) and "it might be getting people aware that they have that need and not get caught up in it" (Interview Nine).

Nurses do not know how to care for themselves and "that is one of the areas we have fallen down on in training nurses is to care for ourselves." This is a problem because nurses "first priority is to the patient or the family." Very passionately she related, "it is like it is self serving to care for me. Care for me! What look after me! But I have to make sure the patient is all right." Nurses need awareness. "You have to start with yourself and then broaden it from that. We have done a very poor job in that." Nurses' inability to care for themselves affected their leadership ability. "Sometimes neglected are nurses caring for themselves and that may mean taking on a leadership role and speaking out on issues that are caring for me." This has led to nurses "putting up with poor staffing, the abusive patient, the abusive family, or the abusive doctor, which has been done traditionally" (Interview Nine).

Nurses are susceptible to abuse because they are not supportive of each other. "But in hospitals we are the ones that say that we are the ones that can do this and we are quick to criticize each other rather than give each other a pat on the back." The administrator related, "I have seen it first hand, and I am seeing it right now in this setting and we do not always do justice to ourselves" (Interview Four).

Working Conditions Affect Nurses Roles

Administrators had to grapple with workload problems. Interview Six stated nurses' workload was "something that we are constantly discussing, when nurses get upset in here, that is the issue that they are upset over" and it was particularly an issue "on weekends and when staffing ratios are different." Nurses work loads and the ratio of nursing assistants to nurses prevented nurses from using their higher level skills to assist patients.

It is, I was the only nurse on, or me and so and so were the only nurses on and we had a patient in crisis who we wanted to spend time with, and we had an admission and we had medications to give out and none of these things the nursing assistants could help us with.

Staffing is a problem because of the large number of tasks nurses have responsibility for, "because they are responsible for medications, they are responsible for orders, and anything else going on." New technology is increasing, rather than decreasing workloads. "Also, we are computerized and our care plans are on the computer. So they spend a fair bit of time at computer terminals" (Interview Six).

Interview Nine stated nurses in the workplace are pressured by administration when they complain about staffing, it becomes a "self-serving" issue. "The comments have been, can't you cope? What is wrong with you? They could cope earlier today." This "was putting the problem back to the nurse, verses that the patients' needs on the floor have changed" or "different things had happened," changing the staffing needs. "If nurses are going to be made to feel it is my fault and if nurses are going to be seen as not coping well, they are not going to be seen speaking out." The staffing becomes "their issue" not the employer's.

Staffing is a concern for nurses because, "staffing out there is less than adequate." Staffing in health care is "outrageous and I think they (nurses) are coping the best way that they can with it because they have no other choice." Staffing is not only an issue in the hospitals and nursing homes, but also in public health. "Most of the public health nurses that I talk to are just over whelmed. They see such needs out there and they cannot cope with what they are seeing and they just do the basics."

Nurses are unable to counteract administration putting staffing issues back to them because, "if nurses hear it often enough, than we believe it," especially if nurses are not supportive of each other in the workplace. Nurse's work roles are considered difficult. They are often not fully prepared for them. "I think we expect so much in terms of dealing with life, death, sickness and responsibility and work loads." She questioned if "we have given them tools that they can use personally to enhance coping with that" (Interview Nine).

The ARNN research survey "showed the impact of the restructuring on health care. The minister was pleased to hear that nurses were satisfied, but they are telling you that if you cut any further you are asking for problems." The study was listened to "because it was a scientific study. He really did pay attention to it" (Interview Five). Interview Nine disagreed. The (1993) research study done by the nurses' union showed nurses "were very dissatisfied with staffing, to the point that under staffing was a major safety concern for themselves, their patients and the quality of care."

The administrator stated there was some public outcry but the reason why more has not occurred is because "for nurses the number one priority is their patient" and "when we

talk about staffing they have to make sure they link it to patient care." Patient care is a "positive problem" but "for them to actively speak out, . . . they are afraid it will look self serving to say that they do not have enough people working here." Nurses are in a "particularly difficult situation in terms of speaking out against the employer." As far as what the public heard is determined by what group is getting media attention. This is determined by "what the issue of the day is" (Interview Nine).

The low staffing is affecting the number of injuries that nurses sustain. Research from worker compensation files do not reflect this, "because of changes to worker compensation, that workers who are injured on the job will not get their full salary." This is "66-70%" so workers are "going off on sick leave" because "they can get full salary."

To help empower nurses to take action against low staffing the union is asking nurses "to fill out forms when staffing is inadequate, so that administration can look at it." The union will often look at it and extra staff may be brought in (Interview Nine).

Barriers Between Disciplines

The traditional setting of hospitals created barriers between disciplines, which are now being removed.

I have seen this hospital go from a traditional role to the complete opposite. To a role where people were allowed to talk to everybody and one time you couldn't talk to the administrator here. The culture here now is more colloquial culture. People go across the system and talk to whoever they like. They work together a lot better (Interview Four).

The attitude of nurses to other disciplines is creating an organizational feeling that

"everyone else is against nursing" but other disciplines had to be recognized, that they "bring something to clients that nursing cannot do" and they may see nursing "as having too much power" (Interview Ten). Interview Six agreed and related the ARNN promoted nurses to the determinant of other disciplines. "They used to have on their letterhead, 'ARNN' and then at the bottom nurses, 'health care's most valuable resource' and I took exception to that" [great emphasis]. Interview Six disagreed because

I don't think we should be putting a value on resources and on different disciplines don't know what kind of message that sends out when nurses say we want to develop partnerships and we want to be on equal footing here and develop partnerships and develop interdisciplinary teams . . . and they have that written on their stationary, that they are the most valuable. If they are in health care, they do care.

She stated, "we need to look at how we can work together as a team, not only from a nursing point of view, but from everybody, in a multi disciplinary framework" (Interview Six) .

Casual Workforce

There have been very few permanent positions or permanent staff hired in the last five years and one of the biggest issues for nurses is job security (Interview Nine).

Casual nurses do not have constant full time work positions. There has been an increase in the casual workforce and "I would say that about 20% of our leadership is casual workforce, which would be about six to eight hundred nurses being casual."

Many casual nurses get full time hours, but do and have the security of full time positions (Interview Nine). "Casual nurses for the most part are called back in order of

seniority, that is not contractual, because they do not have to" (come in when called). The workplace tries to even up the number of shifts they get, but some favouritism can occur in some workplaces. "For acute care they have casual lists for each floor and therefore, that can happen" (Interview Two).

Casual work creates major problems because "they have no home life, they have no security." She explained, they can be called out in the middle of the night and be expected to be to work in one hour. This is affecting self esteem because "you are like a puppet on a string, work wherever they put you, and cope the best way that you can." The casual workforce presents other problems. "It also presents problems as far as continuity of care" because "you may not have been there for the last two or three weeks, you don't know the patients and the floor, the routine." This situation creates greater stress on regular staff, as well as the casual staff (Interview Nine).

Casual nurses working excessive hours between different institutions are possible, but will be corrected when all hospitals come under the one payroll. "Where we are going to be one-payroll wise, except for nursing homes, all across the city, I don't know if they will be able to do that because you could have someone working there for seventy-five hours and here for seventy-five hours" (Interview Two).

Casual nurses are used to perform "a generalist role" in long term care or may work on a particular floor "in acute care they have casual lists for each floor." They may be used between long term and acute care institutions. "There are some who are working at the Health Science Center and didn't get enough shifts, so we provided them with some

orientation and when they were not needed up there we could use them here." Some casuals work within special units, for example, "you have your own casual list for cardiology."

The casual role is affecting commitment. "If you are working casual, I don't know that you would have the same commitment to that particular floor, or that particular service or program, as if that was where you worked all the time" (Interview Two).

Apathy and the Aging Workforce

No, it is apathy and what we are working in right now is a workplace that is paralyzed. There is so much happening. There is so much threat within the system for job security (Interview Five).

Poor relationship between nurses and management made nurses reluctant to assume leadership or committee positions. This is attributed to "apathy" and that "some people do not relate well to management either" (Interview Four). Interview Nine indicated apathy developed because "traditionally when they tried to take it on [committee work] it was looked at negatively, looked at as, she is just a staff nurse, she does not understand the bigger picture." Committee work only occurred in recent years. Only in the "last three or four years that we really pushed to have nurses as part of these committees." The apathy developed over the years and "it is going to take a lot to change that at the staff person level" (Interview Nine).

Reluctance to be involved in committees extended "to the professional organization, and not attending meetings, but does not extend to patient care. "They are focused within the clinical area." The reason that was given is that "some saw the bigger picture the

majority did not." This workplace expressed a negative view of nurses by stating nurses lack of involvement in their union, professional association, education and attending meetings are considered signs of apathy, as well, "like all the nurses' journals that come out, I think they go in the garbage for the most part. I don't think people even read or anything" (Interview Four). At another workplace it was said that they, ... "just want to work to get a pay check" and "they want things as uncomplicated as possible." These nurses, "they may not like the routine and they may think it boring and the same every day and dreads going to work, but yet you would not get them to change" (Interview Seven).

Age was considered a factor in apathy. "I really get frustrated with the nurses who just come to work and do as little as possible and are just waiting for retirement." The older nurse who had been in the workplace for a long time has been subjected to environmental influences. "You do not know what kind of influences she may have been subjected to. She may have had all the potential brow beaten out of her. She just sort of gave up" (Interview Seven). Age influenced seeking an education. "They are not seeking it as much as before and maybe the workforce is getting older and they don't feel they have a long time to put into the workforce." The older nurses are good role models for staff, "but often do not see it." Age affects motivation. "As far as changing them you can only keep whittling away" ... "they are forty or more and are a bit apathetic with studying any more and as an older person they cannot do it any more" (Interview Eight).

Factors that Develop Leadership

There were many factors that contributed to the development of leadership. These factors can be used to highlight how leadership is developed and to make recommendations for leadership development.

Benefits of a Higher Level of Education

University education was considered a factor in developing independence which was needed in a leadership role.

I came out of this school (diploma nursing school) I was very much your average student and intellectually I am still your average student, however, having gone to university and been given the freedom to direct my own education and being expected to determine what I want . . . I gained a lot . . . and discovered there was so much more to my profession than being at the bedside (Interview Five).

Other informants stated that university education helped promote their career. "But at the time I was one of the very few who had the educational qualifications (Interview Three). Interview Six agreed. "I am in this position because I focused my academic requirements, focusing them from the university point of view. I got my BN and then the next thing I did was I went back to get my masters." Interview Two also supported education. "Education it is true, doing continuing education myself I really see the benefit of it. Education certainly helps you develop all around, to have more global skills."

The Influence of Role Models

Role models were major influences for others. One administrator had a significant role model experience from an administrator with a business administration background, who was in the process of leaving the organization.

He was not a traditional administrator. He left the Health Care Corporation because he didn't see a role for himself in this organization and this organization has shown itself to be fairly traditional in the way it has set itself up and the way it has looked for leaders and program directors and so forth (Interview Six).

The administrator's definition of leadership was changed by her work experience with this non-traditional administrator who she described as a "transformational leader," who came "six years ago" and had successfully restructured the hospital to program management before the other hospitals. "We had program management two and a half years ago for our community program divisions and we have had a number of changes internally." The day of the interview "was his last day." The experience with the administrator had changed her views on leadership and how change should be accomplished.

At one point in time I would have described the nurse leader as someone who was in a position of influencing other nurses and therefore had the initiative, and the motivation, and they were able to empower nurses to rise up and reach their fullest potential and develop common goals and work toward a common vision (Interview Six).

This view of leadership was no longer adequate. The administrator stated, "if you are looking at change and trying to lead people toward a vision of change" you are doing it on "so many multi-levels" and "there are a whole number of areas that is changing simultaneously." In terms of leadership, "transformational has become what we strive for

and we promote in our leaders" (Interview Six).

Another administrator's style of leadership was influenced by a lawyer.

He was not what you call a natural leader, but I learned a lot from him in how to deal with situations. Everything was a negotiation to him. I learned a lot from that. So now, when I go into a challenging area or something, I say to myself everything in life is an negotiation (Interview Seven).

The encouragement of a supervisor helped another assume a leadership role.

When I first came into management, at a first-line supervisory level I was really encouraged to take that job and I found it difficult to make that decision because I didn't want to leave the job I was in and the area I was working in. Yes, I would have to say my supervisor encouraged me (Interview Three).

Leadership skills are learned from role models. "I know you can learn leadership skills, especially if you can pattern yourself from somebody, that you can role model yourself after" (Interview Two).

Experience, Initiative and Ability

Natural ability combined with education prepared another for a leadership role.

I would say mostly experience and I did nursing management and department management courses and some administration. I sought them myself and I think most people with initiative do that. I have been in a leadership role since 1970 and I have not looked back. I always felt that I was able to do those things for whatever reason, natural aptitude or whatever, but that it was always something that I enjoyed (Interview Eight).

Another supported that your own initiative helped develop your leadership. This when combined with a political interest and the ability to successfully attain leadership roles were factors in who assumed a leadership position. "All my life I was in a leadership role.

I think right back to elementary school. I was always sort of political . . . every time I ran for something I usually got president" (Interview Seven). While another agreed on initiative, she had not pursued a leadership role through academic degrees.

I geared myself toward administration even though at heart I am a nurse, but I would develop in that direction. I like the business side of it. I am one who came from a traditional role and into where I am now. I think some of us have come out of the traditional role and worked very well (Interview Four).

The Fit between the Leadership Role and Family

The ability to fit family responsibilities into a leadership role was an important factor for another administrator. She described her faculty position as one that allowed a leadership role that would not have been possible for her if she worked long shifts.

The university time table because we do not have a time table . . . when the kids were young I went home and made lunch. You couldn't do that when your timetable was set. In a hospital say seven-to-seven. I don't know how women do it there. Here it is more flexible. Mind you are still doing things on the weekend and at night because you have to get your job done, but it lends itself more to being helpful in family (Interview One).

The Benefits of Professional Involvement

Interviews Four and Five stated involvement in the ARNN had contributed to their leadership development. Interview One stated leadership was provided by the faculty at the ARNN. But Interviews Six and Ten were not actively involved in the ARNN. Interviews Seven and Nine stated involvement in the nurses' union had developed their leadership skills. Interview One supported involvement in the ARNN and the nurses' union as a way for

students to develop leadership. Interviews Four, Six, Seven, and Eight supported involvement of the staff in the union as a way to develop leadership. However Interview Four stated nurses were often indifferent to assuming a leadership role in either the union or their professional organization. Interview Eight stated nurses were not strong union advocates at her workplace. Interviews Seven and Six stated nurses were strong in their union membership.

Interview Nine stated a union position was a recognized leadership role by the ARNN and the president of the union and the labour relations officer received practice hours toward licensure by the ARNN. As well it was assumed that other leadership roles, such as J. Alyward, a nurse who is now Minister of Social Services, would be recognized by the ARNN for her leadership role, by receding practice hours toward licensure.

How Administrators Define Leadership

Nursing leadership was given a definition in all interviews. There were common and different views on leadership. Leadership was described as good management, management and leadership often occurred together, and there was a focus on specific leadership traits. There was one description of transformational leadership.

Leadership is a critical factor in the effectiveness of an organization and how the leadership role is described may have implications in how the leadership roles are passed onto front-line staff and nursing students, as either leadership or management. How

leadership is perceived by management may determine how leadership is developed and used in the workplace and may influence the roles that front-line staffs are allowed to assume in their workplaces.

The definitions of leadership and management outlined in chapter two, page 12, will be used to guide how leadership and management are defined in this topic section.

Each informant is presented individually, because each informant described leadership from their respective roles and work places. By using this method to present the research data a more accurate description of the work site setting and the leadership role will be provided, as leadership roles varied with the setting. This will allow for greater accuracy in the research conclusions which will be drawn in chapter six. This is in keeping with the methodology as outlined earlier.

Professional Association Leadership- Interview Five

The leadership process is in the context of the professional organization and the professional view of nursing. "My definition of nursing leadership is someone who has a view of, that broad view of nursing, a vision for nursing." The leadership process is directed toward professional organizational goals.

I don't think that it is necessarily important that you have skills or knowledge in all areas of nursing, as much as you see what nursing can be within the bigger system. We cannot be reacting to situations. I think it is important that we have a good sense of what is happening out there in the bigger system and what it means for nursing and to be out in advance of and state right out front where we see nursing in any given change.

The leadership process is interactive, and promotes group members interests.

I don't think we do that by ourselves, within the office. That comes from the nursing community, therefore, we have to create an environment and mechanisms whereby we hear from nurses and we know what they are dealing with and are able to come up with strategies that first ensures that nursing has a powerful voice in health care and also that nurses are allowed to practice within a quality environment.

The leadership process is interactive, whereby nurses affect the actions of each other by having the opportunity to contribute in their area of expertise.

I believe the leader is someone who works with people, but is not knowledgeable in all areas of nursing, but has the security within yourself to draw on another's expertise and the ability to give people the opportunity to contribute in their areas of expertise.

The leadership role is shaping the future of nursing, directing others by setting standards and influencing others. "You see what the role of nursing can be within the bigger system. From the view of the association our responsibility is to the establishment of standards, but from leadership we have to be proactive." The leadership role is to lead others and to exercise authority by influencing others.

The association . . . is the ones mandated to set the standards and we are the ones who do the documents on what is appropriate professional practice . . . this is what the ARNN will support. We do not have the authority to go in the workplace and say, do it. It does not serve an employer well to ignore it, because if anything was to happen legally he would be seen as ignoring the standards of the profession and in court that would not serve him very well.

The role of the leader is facilitator and influencing others in order to shape the future. A leader . . . "has the ability to get people to come on side, facilitating them to be able to work with you in order to move ideas forward."

Leadership is not confined to any setting, "I think you can see leadership in very young children."

Leaders have specific characteristics.

Leadership is someone who clearly has to be a risk taker, open to new idea, willing to go with them, has analytical ability to be able to weight the pros and cons, benefits and implications, but doesn't allow things to hold them back. Someone who is innovative and is not stuck in the old mode . . . I believe a leader is someone who works with people.

Leadership is not a born quality but is an innate quality. "I don't think you are a born leader, from my perspective I have to believe that potential was there" (Interview Five).

Nurses' Union Leadership-Interview Nine

Nursing leadership is an interactive process, occurs within the context of the organization, and the emphasis is on organizational goals.

I think it is a lot of consensus building and it is collaboration with the board to make decisions. It is not just decisions that I make, but we make them as a board. In my leadership role it is bringing people together and hearing both sides and making sure that all sides are heard and then a discussion around that and then a decision made. Then making sure people are comfortable with the decision within the bigger picture.

As leader of the union I feel it is very important to be in tune with what nurses want and I use our research a lot in terms of that. It is a challenging role . . . but it gives such great opportunity to speak out on behalf of nurses. I am speaking on their behalf, not what I think. This is not my issue or my perception of it, but it has to be what they perceive as being the issue.

Nurses at the unit level have an interactive process in their leadership. "Their team work qualities make them good leaders" . . . "they are good team players and work well

together in groups of other people."

Nursing leadership occurs in any setting and is not tied to the organization. "I think nursing leadership is a quality all nurses have, and nurses individually use it, some to a greater extent than others." Leadership is not tied to administration. "Definitely not. I think that leadership can be in the individuals, who use it in different settings in different ways."

The leader's role occurs in the context of the organization and involves understanding subordinates.

I want nurses to feel that I am one of them, that I understand where they are coming from, where they work, what their work situations are like and making connections with them on a one-on-one, that I understand and that I am someone that they feel they can come to and be listened to. I may not always agree, but at least I will listen to them.

Leader's role is to lead and to direct. "They also expect you to speak on their behalf, but they also look to you for direction." A leader's role is tied to decision-making.

The leadership in terms of decision-making is a very important component. Leadership is very important to nursing because of the decision-making nurses have to part-take of in their daily lives, that independence of thought, that questioning though and that makes good leaders.

A leader's role is to advocate for group members. "It is important for me to be their advocate and be that strong voice. They look to the president of a union to speak on their behalf." Advocacy is not tied to the union. "It might be the patient, or another nurse, or the floor manager that is the advocate for the issues of the floor."

Leaders have certain characteristics.

Communication is a major key . . . and listening. Verbal and written communication need to be well developed. In terms of communication they

have to be approachable and it depends on where the leader is coming from and at what capacity. Professionalism which goes hand-in-hand with leadership and they expect the leader to be very professional . . . and I try to portray that (Interview Nine).

Mental Health Leadership - Interview Six

The leadership process of transformational leadership is interactive, with mutual goal determination and achievement. "He didn't come in and say, here is where we are going. He said, where do you want to go. He gave us the end result, but not how we got there."

The role of the leader is to shape the future, to lead others, and influence others.

He just said, look we need to be smaller, we are going to be smaller, the client is the focus and we got to provide services that the client wants and we have to strive for excellence.

He encouraged growth and personal development of the group members. "So he gave us some parameters, and then it was go to it." The role of the leader is facilitator. Decision-making was encouraged by all.

Well, if we want to do this ..., this is what we should do and they would outline a program, something they had always wanted to do, but there was never the momentum to do it in the past.

Decision-making is expected and accepted.

We would move in that direction. As a result we all felt that we were all on the same wavelength and we were able to make many changes on many different levels throughout the organization.

There were concerns with change. Change is not imposed.

There was a lot of anxiety about because we were not sure of the direction we were going in. He is not someone who came to us with his vision and sat down and wrote out goals and objectives and expected people to perform and

do these kind of things.

The leader promoted personal development without self compromise. "He found out what they believed and he knew what his role was and he expected everyone to have a role and be involved".

The leadership role is not confined to administration. "He really got involved with clinicians and recognized their expertise and therefore, people were empowered and theirs was a shared vision" (Interview Six).

Gerontology Leadership - Private Sector - Interview Eight

The leadership process is directed toward organizational maintenance and organizational goals by providing direction.

I like to have a participative leadership and everybody has some say into how decisions are made and you are basically the person who guides these people into making appropriate decisions and whatever they are you live with them.

The leader's role allows authority to be exercised.

If I have something that I want them to do or try or whatever, I will run it by them first and tell them how I see it and how I see it can work, then I get whatever input from them that is necessary.

The leadership role is to manage subordinates, direct others, maintain the present and role model for others.

I would define it as a person's ability to guide and direct someone's action, but ensuring that you only guide and direct and ensuring that they get the positive attitude through yours to carry on and do the work.

Decision-making is influenced by the leader.

I would say that I influence them by the way that I lead. Like I do not believe in telling them that they have to do something, but I believe in telling them that I would like to see if this works (strong emphasis on works) and do they see any reason why it wouldn't (strong emphasis on wouldn't).

Leadership is "not a born quality" but leaders had certain characteristic, such as,

... initiative, they like change and they are willing to do whatever it takes and working with people to make sure that happens. People skills are very important and I don't think you can be a leader without people skills (Interview Eight).

Gerontology Leadership - Government Sector - Interview Seven

The participant had been involved in the nurses union, where she had a strong leadership role. She described her views on leadership from the perspective of this role.

Leadership is in the context of vision and organizational goals.

My personal definition is somebody who has a vision, who has good ideas and can get them put into effect. I saw it as kind of looking out for the long term interests of the organization.

The style of leadership is described as "I am a fairly pragmatic person. I look at what can be done." Getting things accomplished is not through mutual goal determination.

You try to bring them around to the way you want them to go. I am kind of stubborn that way. If I got an idea of how I want to see something done I will not give up. I keep going back and going back, until I can see something going according to my vision of it was.

The vision is described as involving the people around her. "Oh, yes, I never wanted to be a lonely leader." To facilitate her vision -

I would look at what was achievable, like you might have an idea and not see a way to get it accomplished, so you might mull it over and one day a little

light comes on, and you see how you can get it pushed through.

The accomplishment of goals requires getting others involved. "You take it and you talk to people about it and get them on your side and the next thing you know it starts to fall into place." There has to be support to accomplish goals. "I used to say when you look over your shoulder and if there is no one behind you, you might as well forget it."

The leadership role involves development of others.

I always had the idea that I was not going to be there forever and that I had to make sure that other people were capable of filling in when I left. You sort of picked someone out whom you thought you would like to take on the role when you finished.

The leader's role involves the development of personnel, . . . "the next two or three persons may make a good president someday, so you encourage them along and get them to the meetings and seminars to get them exposed to other people's ideas." This is carried over into her present role. "Where I am now, I look at each individual nurse for their individual abilities to contribute to the organization."

Leadership is tied to the organization but not to a particular position within the organization. "So you can be a manager, in which you do the day-to-day running of the organization and you can be in a high position, but anybody can be a leader." What distinguishes a leader is the giving a vision to others. "I want to work with someone who got a vision and want to take you there and got some good ideas on how to get there."

There are natural leaders who have personal influence,

... who other people will follow. It could be someone on the team on the unit, it is someone whom others look to. Everyone looks to see if that is okay, to

what kind of questions we are going to ask . . . are we going along with this (Interview Seven).

Continuing Care Leadership-Interview Two

The leadership process is interactive, whereby nurses affect the actions of others. "Nursing leadership is the use of your skills to influence other people to do the best of their abilities." The leadership process occurs in the context of the organization and involves the development of personnel, with leadership not confined to administration.

To be able to take that team as a team leader or as a clinical leader, forget about being in management, to work with people, to use their interpersonal skills to motivate these other members to do their best, to use their skills to the best of their abilities.

Leadership process is directed toward organizational goals and maintenance, as well as interactive.

I manage a six million-dollar budget for the nursing department, which is developed on a yearly basis with other nurse managers . . . and . . . monitored on a regular basis throughout the year to see that we remain on target.

The leadership process is not tied to administration, "I don't see management as the ultimate end to people who have leadership abilities." Leadership is not exclusive to administration.

I see leadership as being separate from management . . . I suppose you can be a leader, obviously be a leader without being a manager. I do not know if you can be a manager without being a leader.

A leader's role is to influence others. "Nursing leadership is the use of your skills to

influence other people." The role of the front-line nurse leader is to manage subordinates.

It is necessary for them to have leadership ability and be able to direct and delegate tasks to other para-professionals such as RNAs. I think their ability to lead other people, other nurses, and other disciplines is good.

The leadership role is restricted to nurse positions and not RNAs,

... they may have just graduated with limited experience and therefore, if they are working with the RNA who has been on the floor for twenty years there are times that leadership ability doesn't come out in that graduate at that time. But when it happens, the nurse really can't direct that team she is working with that day.

A leadership role occurs in a particular setting.

But their clinical skills are superb and their abilities to be leaders among themselves and within their group is good. I don't know that they could manage in administration in terms of change that we have right now to be nurse managers (Interview Two).

University Leadership-Interview One

Leadership is a process that is interactive, whereby nurses affect the actions of others. "We solicit information from everyone as to the kind of changes they want to see, then you put it together and meet with them. This is not to say that you cannot influence the decision." Personal development is encouraged. "Faculty have academic freedom, you can recommend how they teach, but they have the freedom to do whatever they want with it." Leadership is self-directed management. "University nursing faculty positions are considered independent, with independence encouraged, everyone is their own management"

Leadership process occurs in the context of the organization and its emphasis is on

organizational goals and involves influencing others. "Leadership is getting people to follow what you want them to do. You have to convince them this is best for the program." The leadership process is directed toward organizational maintenance.

The faculty is into developing research skills, clinical skills, participating in these kinds of outside activities. Most faculty members are not into leadership/management that is being in charge of a group of people. Hardly anyone is involved or interested.

A leadership role is tied to the organization and occurs in the context of organizational maintenance.

Here you have autonomy and you may teach with a group, but you go into the clinical area with your group of students and you give them a pass or fail, and you make sure you are doing it along the same lines as everyone else, but there is no real leadership.

The leader's role is to lead others, manage subordinates and maintain the present.

Everyone else is getting pleased, but the person in the managerial position has to report to those above and there are other workers who you have to help lead, so it becomes that you are the person in the middle.

A leadership role is facilitator and can involve exercising authority. "Leadership involves getting them involved in decision-making, and people do not always want to participate because they are too busy and you just have to make the decision." The leader's role is tied to teaching and expertise and is to lead others, "It is knowledge leadership and they participate because others do not have these particular skills. You have to teach a class, that is leading a group."

The leadership role is to promote the development of nursing personnel. "C.S.

developed a program for leadership through the ARNN.”

Leadership is from the manager's point of view,

We talk about leadership, but it is really from the manager's point of view, first-line manager, the head nurse what kind of things that person would be thinking about, doing evaluations, time management. Other schools of nursing are more influenced by management . . . through a nursing course 5700 . . . which is nursing management. That is pretty straightforward about various skills that the students may look at, for instance, going for interviews . . . we cover the material and that is about all (Interview One).

Community Health Leadership- Interview Three

Leadership process is interactive, whereby the nurse affects the action of others in mutual goal determination and achievement and is not tied to the organization.

Nursing leadership is the ability to develop staff to take responsibility, to take the lead role in their job, and the ability to facilitate both personal and professional development in staff. In an all round kind of way it is that whole opportunity for both professional, as well as, personal development, to allow them to grow in their careers and in their responsibilities.

The leadership process encourages the growth of others. “I see nursing leadership as being the ability to provide staff with the opportunities to enhance their growth in their careers at whatever level it may be.” The leadership process occurs in the context of the organization and its emphasis is on organizational goals, but encourages the growth of others, and facilitates others.

I think the most important thing in leadership in nursing is being able to empower people to take responsibility, and empower them to be confident in their role, and make decisions with confidence and they can go and do that. To me that is what real leadership is about.

The leader's role is to act as mentor to promote personal development.

I find by mentoring some of these individuals I can provide that leadership. I think that is how I use my own leadership skill. I think by encouraging these nursing managers to develop themselves and to be creative in their jobs.

The leadership role influences others, "I think the closer you are to staff the better the opportunity you have for instilling and for using your leadership qualities." Nursing leadership develops personnel. "Nursing leadership is the ability to develop staff to take responsibility, to take the lead role or leadership role in their job, in their work." The leader's role allows her to shape the future, lead others, influence others and promote personal development of the group members.

We also have opportunities to have input into policy making at the departmental level. In my role as consultant I am in a place where I can encourage those managers to develop those opportunities and those skills in the nurses and to built up their expertise. In building expertise, you can develop leadership skills as well.

The leader is a role model. "It is showing leadership, taking a lead role, being a good representative, being a good role model."

Leadership is expertise "and they can demonstrate their leadership skills and abilities through the performance of their skills." Leadership is not autocracy. "I don't think leadership means being autocratic, and I sometimes think that autocracy gets caught or mixed up with leadership and I don't think that is a good thing." Leadership "involves risk," and "the ability to work with people and to be fair with people

Leadership is a born quality. "I think you are born to be a leader. Some of it is innate and it can be nurtured and developed to be stronger if somebody has that ability in the first place" (Interview Three).

Hospital - Acute Care Leadership-Interview Four

The leadership process is directed to professional organizational maintenance.

I believe that nursing leadership is that we have to empower nurses to espouse what nursing is and to be able to articulate that to the public, government, medical staff, to who ever. I would like to see nursing in the forefront.

The leadership process occurs in the context of the nursing organization and its emphasis is on the professional goals of the membership.

I think we need to know what nursing is all about. From an educational point of view, nurses should get out there and get their degrees, get involved in nursing practice, nursing administration, nursing research and be able to develop their skills enough to articulate them. I think that is what we are lacking.

The role of the leader is to maintain nursing's present position, exercise nursing authority and promote growth of the nursing profession.

I do think we allow other people to take over our roles and in terms of RN's verses nursing assistants. Don't get me wrong. I do believe there is a place for nursing assistants, but I believe there is a greater role for nurses. But I believe nursing is allowing other people to take on their roles.

Nurses' role is to shape the future of nursing and help others see the role of nursing.

So now more and more you need to be able to say what you as a nurse are accountable for. I think you have to stand up and be counted for and be able to articulate that. You have to be able to tell others what it is that you can do (Interview Four).

Corporate Leadership - Interview Ten

Leadership is not exclusive to nursing nor different for nursing, but belongs to all

disciplines.

I don't think you would define nursing leadership any different than you would define leadership in a general sense. Whether you are in business, social work or physio , when you look at nursing, nursing is just another discipline.

Leadership is interactive, but toward the organizational goals, by empowering people to make decisions.

If someone comes to me with a problem or whatever . . . I say to them what is it that you want to do. Have you thought of all the implications? Here is what I know from the bigger sense and here is where I think you are going to run into problems. Now think about how you are going to get around that and then go on and do it.

Leadership involves organizational maintenance and was part of the traditional role of nursing. "The other thing you have to do apart from making them responsible is formal reports, objectives, performance appraisals, evaluation, these kinds of things."

Nursing leadership is both the same as other leadership but is also different because it has a dimension directed toward professional goals of nursing. "Leadership is leadership and nursing leadership has a dimension that tries to move the profession that is multifaceted forward and that is very, very difficult."

Leaders have skills to influence others and shape the future through a vision. "The skills that you require are skills of vision, the ability to communicate, a teacher, trying to move forward and get people to buy into a vision."

The leader's role is to encourage growth of others and promote personal development

I give them the ability to work, to take ownership for themselves and if something happens and it doesn't go right, then you are not there as a controller. You are there to say what happened here? If we were to do this the next time, what have we learned from this and you have to use that kind of leading, teaching, mentoring kind of thing.

The role of the leader is to promote organizational maintenance and goals. "I am there to support the structures, to advocate for certain kinds of structures to take place, and then to just go from there."

The leader gives direction, but does not involve exercising authority. "I provide direction, but the idea of leadership now is not control. It is allowing the people who work with you to empower them to be able to do what they do."

There are different leadership roles depending on position. Front-line leaders' role is "visioning and role modelling and engendering the staff to do the best that they possibly can." Administration is to lead and manage subordinates. "It is managing to get them there. There is no one way that they all go."

Leadership is tied to position. Leadership for front-line staff is different from administration. "When you think of front-line leadership in nursing, that might be different, where you need to have the clinical skills in order to engender respect of the staff." Leadership is different at the administration level, "you need to be able to work with team, see the entire picture, understand the business side, understand the patient care side, the quality, those kind of things" (Interview Ten).

Front - Line Leadership Abilities

I think they [nurses] know they have the ability to perform clinical skills, but I don't think that all of them would see their clinical skills as being leadership skills or all would perceive that those clinical skills make them leaders (Interview Three).

Nurses have great pride in their nursing skills and set a high standard for patient care, which they carry out (Interviews Two, Three, Eight, Ten). There were divergent opinions on how nurses use their clinical expertise in a leadership role and many questioned if nurses were able to recognize their leadership roles. Administrators' views of the perceived abilities of front-line staff can provide insights into how leadership roles are passed on to front-line staff, and how leadership will be used and developed in workplaces. The administrators own roles may affect how they perceive and describe the roles of front-line staff.

To ensure accuracy in drawing conclusions in chapter six each informant is presented individually in each work place. This will allow the front-line leadership role to be contrasted with the administrator's leadership role. This method will enable the researcher to present how each workplace uses front-line leadership. This is in keeping with the methodology outlined earlier.

Interview One is not presented, because the role of front-line nurses was not addresses by this participant. The participant outlined how students are prepared for leadership roles in Section B [Nursing Education], as well as, how faculty use leadership [How Leaders Define Leadership], therefore it is not repeated here.

Community Health-Interview Three

Nurses in the community setting are employed in "a solo practice and assigned a geographical area and are often in a one person district." The number of nurses in a district is determined by the "size of the community. Usually you do not get more than two nurses per district. You get two or three or four at a regional level."

In the community setting nurses "have built in abilities for leadership without them calling it that" and "I think they are very proud of their communication skills." Communication skills are necessary for a successful community health role. Other skills are present, "I think they have skills in community development, . . . in empowering people to take responsibility in their own health."

Public health nurses are facilitators, "good public relations people to interact and bridge gaps between physicians and other health care providers and other community providers." They are "leaders in their own right," who have additional responsibilities for "in-service, workshops and opportunities for getting new knowledge out" (Interview Three).

Continuing Care - Interview Two

Within this setting nurses are reported to have the "ability to lead other people, other nurses and other disciplines" . . . and it is . . . "one of the assets that nurses have." Its use by the organization is questioned. "Sometimes it is not always put to good use."

Younger nurses are not prepared for a leadership role and are "more intimidated by people who have been around longer than they have," and often the nursing assistant will

be leading on the floor, rather than the new graduates. "This happens less as they gained confidence, education and experience."

Interview Two stated nurses have good leadership ability on their units, but this could not be transferred to the new program management model.

I don't believe that the nursing staff here, but I may be surprised, but their clinical skills are superb and their abilities to be leaders among themselves and within their groups is good. I don't know that they could manage in the times of change that we have right now, to be nurse managers.

Professional Association - Interview Five

Nurses possess "strength and power in our numbers and we have never learned to use it effectively." Nurses do not have a good perception of their leadership skills, "I think it is not good and if you talk to the majority of nurses they really feel powerless, and you hear a lot of discussion among nurses as to what is happening out there."

Feeling powerless contributed to changes in behaviour, "you get a lot of dysfunctional behaviour where they talk a lot, complain a lot, but they really do not take positive constructive action." Nurses, "tend to look to others to do for them," which is encouraged by the nurses union. "I think from a unionized perspective the union has supported that kind of activity and if I go and complain they will address it on my behalf." The ARNN viewed nurses' problems from a different perspective than the union. "Now if you have an issue with professional practice in your workplace it has to be dealt with by you, and it is only if the agency does not effectively deal with it, the professional association is permitted to step in." Nurses in the workplace are described as "not assuming responsibility

for dealing with their problems," but nurses are asking someone else to deal with them. Nurses needed to "assume ownership for their problems." While the ARNN is a resource to nurses "I am going to them to get some help, but I don't expect them to do it for me."

Nurses have a limited view of their roles. "I find they are really good managers and good clinicians but in terms of looking at nursing from the bigger picture, I mean from within the system, not a whole lot of people." Nurses have a limited perspective in defining nursing. "It goes back to how we define nursing, as giving out injections, giving out pills, doing dressings." This perception is incorrect.

Nursing is the ability to analyze, to be able to critically think, that intuition that is build into decision-making, the evaluation, the ability to do assessment and the ability to put a whole load of data together and come up with a sound clinical judgement and that is how we have to start measuring ourselves . . . and they do not recognize it (Interview Five).

Mental Health - Interview Six

Interview Six stated, "We rely on them [nurses] heavily. They are utilized to the maximum." Nurses had excellent potential for leadership.

I think being prepared to be nurses helps you to work very well with people, and that is half the game, being able to work with others toward common goals. And nurses naturally have an excellent background and an excellent foundation from which to build leadership skills.

The nurses' clinical role does not involve patients "in a bed requiring medical and physical care." Nurses work in a multidisciplinary team approach because clients require "a lot of psycho-social intervention. We work very closely with psychiatrists, social workers,

occupational therapists, psychologists."

There are many leaders in the organization. "You can inspire leadership in others and I have found that when nurses are given the opportunity and are given the tools and given the infrastructure they can thrive and they have thrived and become leaders." Unlike Interview Two nurses and nursing assistants share a clinical leadership role. "I have a nursing council and that council is made up of nurses and nursing assistants from throughout the hospital." Nurses provide other leadership outside the domain of the nursing assistants.

Other committees within the department, like policy and procedure, quality initiative, quality assurance and these types of committees have mostly nurses on them and they submit reports and report to the nursing council.

Union involvement is promoted, and the work site has a strong union (Interview Six).

Nursing Homes - Interview Seven and Eight

Two nursing homes participated in the research study; one is operated by the government and is exclusively a nursing home; and the other is a private organization, that has a small nursing home and a larger apartment complex, all part of the one operation. The two interviews are combined for comparison purposes. The front-line staff work in comparable work settings, but there are similarities and differences in their leadership roles.

Interview Seven stated nurses' ability to use leadership in the clinical area is different from one nurse to another. "Some of them see themselves as leaders and some of them don't. Some see being a leader is doing what you are told and passing it back to the rest of the group." Others, "they got ideas and they got plans for how to make things better." Interview

Eight described nurse's leadership in the clinical area "as good for the present structure and population of gerontology patients," but would need to be developed "with regards to different types of leadership now, being able to guide someone through program management" and nurses "would need more training in specific areas" to function within a multi-level population. "Looking after the brain injured is a whole different ball game" . . . "and they would need training for specific things like that."

Interview Seven reported decision making is through committees and some nurses "volunteer for a committee and carry it though. I don't want someone to join up on committees just because it gets them off the unit for a few hours, and I do see that."

Nurses are encouraged to participate in committees, but some had difficulties with their leadership role, especially putting ideas forward. "They will come forward if they are relaxed enough and sometimes it will take two or three meetings or more before you get people relaxed to put forward their ideas." Interview Eight indicated nurses contribute to decision-making differently. Front-line staffs meet with the Director of Nursing and "she meets with me if there is anything she is concerned about in relation to nursing. Nurses also have input "through staff meetings and nursing rounds and things like that." Management people had a different arrangement, which did not include their front-line staff.

All the management people meet monthly and discuss everything and if I have something I want them to do I will run it by them first and tell them how I see it and how I see it will work, then I get their input from them if necessary. They may have some idea that I over looked (Interview Eight).

Interview Seven stated nurses receive extensive in-service. "There is a huge amount

in the facility and sometimes I think there is too much. I wonder when the work is getting done on the units." The in-services involved "three to four days a week. Some of it is strictly clinical, such as, how to deal with aggressive behavior, medication interactions."

Nurses had limited opportunities for continuing education, and it is not always positively received. Continuing education is posted, but nurses did not select the topics. "I discussed it with the Director of Nursing and we felt that there were lots who could benefit from it", and "we have not had one person ask to go." Administration encouraged staff and their rejection was described as apathy. "We would ask if anybody is going to apply to go. You can only lead a horse to water." Restructuring is a way to correct apathy. "I think sometimes there is a bit of apathy amongst nurses and maybe this reorganization is what nurses need to give them a bit more initiative and interest" (Interview Eight).

Interview Seven reported nurses receive direction for patient care. "We have two nurse clinicians in our agencies and they are the clinical leaders." The patient's problem is assessed

if they see a resident with problems, it could be a skin breakdown . . . and say I got some thoughts on the way to deal with this and they will discuss it and ask them to try it. If it works, that is another trick that they got.

Nurses are asked to solve resident problems, but their ability to do so is somewhat doubted. "We do it. We try" (Interview Seven). Interview Eight reported the work site has no clinical specialists, but felt "that would be nice," and "larger institutions are going that route" but describe her staff as "making good clinical decisions for resident care."

There are two types of nurses described by Interview Seven. "I have a leadership role

to play, the nursing assistants and personal care attendants report to me so I can set the tone here, give direction and leadership." This is reported as, "a person with self confidence who would talk like this." Other nurses are described as putting "themselves in with the nursing assistants and say well we got to do this because the boss tells us we got to," which prevent them from giving direction directly from themselves. "I have to agree and I heard this several times, there are different kinds of nurses. There are nurses who work to get a pay-cheque" and they want things as uncomplicated as possible." Age and experience are factors. "Sometimes I think it is older nurses who are more set in their ways, but younger ones are more open to change. But that is not true." Older nurses are willing, "come on and lets try it," while younger nurses "are so nervous and so insecure that the least little disruption in their day and they are all in a flap." Interview Eight have limited younger nurses (two) and mostly an older work force. The younger nurses are characterized as "more enthusiastic and they are more willing to come forward with their ideas. They are more assertive." Older nurses "are less assertive and just go with the flow."

Interview Eight indicated the work site is "a branch of the nursing homes but rarely will they take up for an issue of great importance," while Interview Seven indicated her work site had a strong union, which she encouraged.

Interview Eight attributes a leadership role to the nursing assistants and Interview Seven supported a leadership role for nursing assistants. Interview Eight stated the organizational structure at her work site is small and the size of the nursing home affected how the staff is used.

So the nurses do assume a leadership role. They guide the nursing assistants ... are preceptors for nursing students, and the nursing assistants guide new staff and show them the way that things are done. We have very high standards ... where we are small we are able to carry it out.

Interview Eight stated staff at her work site are "interacting well with one another and with the resident. They never excluded the resident from the conversation. They included them as part of it." Nurses are perceived to "have a good perception of the leadership role," where "they assist with orientation. They have done different education programs and presented to staff. They are preceptors for nursing students and use their skills every day."

Nurses have independent decision-making after hours when the day staff goes home. "Like when I am not here the nurse in charge is the person who is in charge and she takes on my role." She can seek "advice and she will call me rarely. They mostly handle everything." Nurses have responsibility for their own actions and "they have lots of different incidents they have had to handle at the time and then involve other people as appropriate and they have handled it quite well." However, nurses have questioned the level of independence they have. "Now if you spoke to them, they may feel it could be better used or more of their leadership skills could be used." However, the administrator related, "my point of view, they use their skills pretty well" (Interview Eight).

Nurses Union - Interview Nine

Nurses, according to Interview Nine, have a limited view of their role and "are very

focused on where they work, their day-to-day lives are working as human instrument" which affects how they see their roles. "I have to do this and this to get through the day. They do not always see the bigger picture about what is happening around me." The larger role is passed to the union, where "they look to the president to present that to them."

Nurses, in general, "think that leaders are people in management, people in higher positions." This needs to change so that they see "that they can lead in small and different things. It does not have to be leading large groups of people." Nurses have apathy in the leadership role "for a number of reasons" of which "one is they still need some training in it, some continuing education in terms of developing that."

The structure of institutions is a factor in how nurses use their leadership role. "I think they get into a system that is entrenched in this authoritarian type of style. It is very difficult to break out of that." Leaders are affected by the organizational structure, "if you are in there trying to do different things and if you are not sort of towing the line and doing what everybody else is doing." There are stressors, which affected their actions. "They have to conform and traditionally the decisions have been made from the top down and by the time the person at the front-lines hears about it the decisions have already been made."

Decision-making is done without front-line input. "Well they have not looked to input into how decisions should be made." This is attributed to "the traditional set-up of the hospital structures". The institutional-based structures need "to be reformulated so that information comes from the bottom up, as well as, the top down before decisions are made."

The administrator reported, "in recent years they are looking for more input by

having nurses on committees, but nurses still feel that the decisions are made before they get there." This is creating frustration. "They are talking the talk and that is frustrating and more frustrating than when they were not asked before." Nurses involvement in committees is creating a distrustful relationship, "as they sound like they are giving you opportunities where the nurses look at it. But they are pretending they are, but they are really not."

The lack of decision-making extended beyond committees. "In nursing when you look at the board area right from the institution, even at the government level where decisions are being made, staff nurses have very few inputs." This created non-nursing decisions but "policy decisions are made based on how the health care system perceives it." Nurses decision-making potential is not used. "No one asks the nurse who is right at that level, who would know if that would actually work if they tried it." While nurses have "a bit more input at the board level," but big decisions are made by "people who have not worked at the bedside for years" . . . "and have never been inside a hospital door are making these decisions for health care" (Interview Nine).

Corporate - Interview Ten

Front-line nurses in hospitals are "good practitioners" but have never "felt what they do is valued and they have always looked and followed direction from somebody else, when in fact their training allows them to set their own direction." This is not the case with other disciplines. "You do not see physio going back to the director and saying, should I do this, can I coordinate care or whatever?"

Nurses ability to function in the changing marketplace is a problem for nurses, who are "dependent on structures, on physicians, without any sense of questioning what it is that we really do." Nurses' beliefs about their roles prevent independent practice. "We believe we are working underneath the physician when in fact we have a practice, a set of skills and a set of competencies that most of us don't use."

Nurses' roles are tasks oriented, which affected how others perceive nurses. "Nursing in most people's mind does not have a set of skills and they are there twenty-four hours a day and they do the technical tasks." Many nursing tasks are unquestioned. "There is a whole host of stuff that we are doing because we have always done it, we have been directed to do it, and we do it because it is part of the routine."

Nurses researchers are not discouraging a doctor directed tasks oriented nursing practice, but are focusing on it. "That is the other thing that keeps coming up whether you are talking about the nurses' union or ARNN and their research." The administrator described the latest research as focused on nurses meeting physical care needs and "the psycho-social and all those kinds of things, they believe if they cannot continue to do, the quality of care that the patient receives will go down the tubes." The administrator reported nursing has another problem. "They are so fearful around the acts that they have to do, when in fact most of the acts, 80% I would suggest is not research based."

Nurses do what the doctors order. "We should not be doing them anyway and that by the end of the day the physician says dressing change four times a day, when in fact it probably only needs once a day." Nurses are working in a practice that is not research based

and prevents nurses from individualized care and self-directed care.

We have very little research base to our practice. We have very little questioning of what we do and at the end of the day we do the same thing for everybody, instead of individualizing for the patient we got in front of us." This would be "the independent part of what we do.

Nurses, whether in administration or front-line, are reported to be tasks oriented individuals who have very little independent practice. This is considered an incorrect assumption by nurses and other disciplines. "Most of the stuff we do have nothing to do with the physician." There are areas that are physicians directed, "orders for drugs, the physician does the surgery, and initiates treatment." Other areas such as patient education, self-care, physical care, psychological and social needs are not physicians directed. A change in the relationship is expected and "hopefully will change as a result of working in care teams, and developing critical paths, or guidelines for care" (Interview Ten).

Acute Care - Interview Four

Nursing leadership in the staff nurses' role was tied to their ability to understand and articulate their nursing roles and their position in health care.

Nurses were described as not knowing enough about nursing and "I think we need to know what nursing is all about." Nurses didn't know because ... "we don't involve nurses enough to be able to develop them enough to do that." Nurses were described as needing to

... from an educational point of view ... get out and get their degrees, get involved in nursing practice, nursing administration, nursing research, nursing education and be able to develop their skills enough to be able to articulate them. I think that is what is lacking.

Nurses' inability to articulate would be increased with a university education. "Yes, I do believe they will be better prepared. However, I do believe there is a place in the hospital setting and a place in the community where they need to develop and enhance their skills in that respect." Nurses would have a stronger voice in society if they could articulate their roles, but the ability to do so was tied to their education levels and their nursing skills. "By in large, provided they had the education and skills in order to be able to do that."

Nurses at the clinical level needed to have an awareness of their roles and positions.

Definitely. I think that is where their accountability lies. Their accountability lies to the consumer.... from the staff nurse to the patient, to the government, to whoever you associate yourself with. I think nurses should be able to articulate their roles at the bedside. From my personal perspective that is my accountability and it always has been.

Nurses were described as having a lot of apathy. "I think there is a lot of apathy in some nurses, not all nurses ... we have a lot of good people in the system. But I think there is a lot of apathy". Nurses showed their apathy by not being involved.

How many people get involved with their association, or get involved with their union. That is a different kettle of fish. But they don't get involved at all. They don't want to go to meetings, they don't come to education.

Nursing administration expressed difficulty with employee relations and getting employees to serve on committees. "Some people do not relate well to management either. They believe that management are the ones that have taken over the committee work and they are the ones who are going to do all the work." There were efforts to improve relations with employees. "So some of us had to change this around and say, look, this is here and available for you, so we expect that you come here and you do this and do something else."

Not all employees were resistant to management efforts.

But there are other people who will go the extra mile and go beyond expectations and do whatever it is they have to do to develop the skills. That they can be able to articulate what it is that we are accountable for.

To accommodate nurses and address their concerns a survey was done because "we were having a lot of drop off at the committees and we wondered if it was a sign of the times, where people are saying it doesn't matter anymore." Nurses were scheduled on their days on and the number of committees were reduced. "I believe that sometimes they (nurses) don't have power, although we have tried to develop that over the years, to get them involved, to get the staff developed." Nurses' influence was being increased because they are having "opportunity for input" and are satisfied "for the most part."

Nurses did not receive the respect that they should from other disciplines and nurses did not assert their abilities enough.

I believe that from working with social workers and various other disciplines that they believe that they are the ones that have the skills to be able to do everything, which in actual fact nurses have that skill. But nurses allow people to do that.

Nurses allow this to happen because "we have been taught to work on team, and to be able to work together, to work on corium, but I believe nurses have some of the skills that other people espouse, and they have been silent.

The Public's View of Nursing Leadership

Nurses, believe it or not have, a very positive public image (Interview Nine).

One time nursing was a very honoured profession and a very noble career. I am not sure that is the same any more, that nurses have that same respect and profile from people any more (Interview Three).

Administrators have divergent views on the nursing public image but agreed the public misunderstood the role of the nurse.

The public's perception is a "very naive view of nursing as tender loving care." The nurse is "one who mops my brow, that angel of mercy notion" (Interview Five). This misunderstanding is attributed to the public's contact with nurses and . . . "the area you are working in and the nurse you know. For some it depends on if their mom is a nurse, what they think the role of the nurse is, or what nurses do" (Interview Six). Another agreed that the public image of nurses is reflected by where the public sees most nurses working because the emphasis in the health care system has been "on the institutional health or illness." This affects not only their perception of the nurses' role, but how the public looks at health. "I think that is the way the public perceives health as well."

The public can understand "what the nurse does for them physically" and sees nurses as "someone who can fix them and do things. So they may understand that part of nurses' role, they probably do not understand the community role as well." This misunderstanding is affecting public support. Nor has public's support been preventive health. "The emphasis has not been there on prevention and promotion because you do not see the results right away" (Interview Three). This is creating difficulty in the public trying to understand the shifting role of nursing from the hospital to the community.

Interview Three stated the public has difficulty seeing the full range of

responsibilities of nurses. The administrator attributed the public perceptions to "the only time the public knows what nurses do is when they have been in contact with them, particularly when they have been badly traumatized or other severe cases." Interview Eight agreed. "It is only if they have relatives and they are coming back and forth here all the time and seeing the care that their relatives get." This makes the public view according to Interview Three "relevant to that situation," but was also influenced by the perceptions other "professions and society" have of the role of the nurse. The poor public profile of nurses is attributed to nurses "not in the business of marketing their skills and they are not in the business of publicizing what they do."

Nurses are characterized as not being public about what they do. Interview Three stated nurses "take so much for granted and they just assume this is what they do." Nurses do not because, "it's a confidential relationship between the nurse and the patient. You don't go out talking about what you did for somebody." A change in professional image is recognized. "That is something that nurses as a group should be working on."

Section D

CURRENT MARKETPLACE DICTATING NURSES FUTURE

The restructuring of all sections of health care has made it essential for the nursing profession to examine their nursing roles and find a place for themselves in the new structures. The informants discussed the shift in the direction of health care and indicated that measures were under way to empower nurses for their changing nursing and leadership roles. This section will present how nurses are preparing for leadership and will present the nursing roles they envision for themselves.

Empowering Nurses for a Changing Leadership Role

I think the system has recognized the need to develop leadership skills in nursing and now the system has developed a program [non credit] that is being offered to younger graduates to try to develop that leadership, if it is there, to develop it within the clinical setting (Interview Five).

The work sites reported that changes had been initiated to develop and empower stronger leadership skills in nurses , in front-line positions and administration. The changes have included increasing : decision-making; input into decisions; confidence and clinical skills. Efforts are being made for changing nurses' perceptions of their leadership roles; developing leadership qualities in student nurses, front-line staff and administration; enhancing nurses working relationships with administration; developing nursing research; and enhancing nursing's public image.

Increasing Decision-Making

Interview Four reported nurses have increased decision-making power in hospitals "Nurses have a lot of decision-making power within their realms. More so than they did." It could be developed further but measures have been taken, "we have developed front-line leadership programs and team leaders." Interview Two stated, "in the past few years nurses have been empowered more so then ten years ago." To empower nurses decentralized decision-making was introduced two and a half years ago at her workplace. This gave nurses more independence in making decisions. "Instead of having someone there who you could call upon and say, yes, this is what you should do". Now, the decisions are made by the nursing staff. This was done "not for budgetary reasons, but to help empower nursing staff."

A nursing home increased decision-making by changing the infrastructure of the nursing units. This was done by first increasing their leadership abilities, clinical skills and confidence through a leadership program, before the infrastructure was changed, "because we felt our nurses didn't use their leadership skills and this was going to be hard on them to be all of a sudden be cast into this role of having to be the leader." Three hour sessions in leadership were offered, which included "assertiveness training, group leadership."

The changes were to the infrastructure to give a leadership role to more nurses.

We changed our structure on a couple of units on a trial basis. We divided the unit into modules, three or four and if there were two RNs on in the day they would each have two or one and a half modules, that they were taking care of.

Before this change the team leader had control of the whole floor and the nurses were "under the thumb of the team leader." This relationship did not allow nurses to have

any decision-making power and they "had to check with the team leader and she might say yes and she might not." The expanded leadership role was considered positive, "some of our nurses just blossomed under that kind of a set-up." The nurses preferred the arrangement. "I have the nurses themselves say to me, I had no role and some days I was second nurse and some days I was a nursing assistant" (Interview Seven).

Increasing Input into Decisions

Interview Six indicated her work site has introduced a nursing council that "has been instrumental in approving a number of decisions" for the nursing department and is "the most senior committee in the nursing department." Interview Six indicated input into decisions occurred by using a democratic process, and involved giving nurses the opportunity to decide on changes before implementation. Primary nursing care, and team leaders were introduced but "they had to vote on it and it had to be up to them."

Interview Four allows decisions to be made by staff. "The nurses in this building developed their own in-charge module and these were the staff nurses. We have nurses who chair committees and we involve staff nurses too." To provide greater opportunities for front-line staff, the work site uses team leaders, a front-line leadership program, and nurses who act as preceptors for students.

Committee work was viewed by management as a way to empower nurses and increase their input into decisions (Interviews Two, Three, Four, Six, Seven, Nine). Interview Seven stated, "my own experience is that we do have enough leaders among us"

but they do not get enough opportunities to express their leadership. They have it and they want to put it into use." Committees provided nurses with leadership opportunities.

There were differing views on the success of involving nurses in committees. Interview Six reported high success, while Interview Seven stated some nurses had difficulty with it, and Interview Four states nurses were reluctant to participate on committees. Interview Nine reported nurses' role on committees was a new role for them and would take time to develop and trust needed to be developed.

Interview Six stated when nurses were provided with the opportunities "to get involved, they have become involved and it made a big difference." Nurses were as leading change through committees, change that could not have occurred otherwise. "There were certain practices and standards we were not overly comfortable with and until nurses saw that we were not able to bring it forward. It would have been very difficult to change." But change occurred "with their support and them leading the change." This occurred through "committees that we called 'traditional practice committees'. Nurses led them, chaired them and they changed a lot of things that was happening at the unit level." Committees increased working relations. "It brought a lot of nurses together and this made a big difference."

Interview Seven stated committee work was used by her work site, "you get people who sign up and they got ideas they want to share with the group and you like that." Nursing assistants were reluctant to speak-up in meetings. "A lot of the nursing assistants will hang back a bit, it depends on the environment and who is there."

The committee environment can be one of collaboration, and a place that fosters

leadership in staff nurses. "They can go back to the other nurses and say this is what we did and this can not help but foster leadership and personal growth" (Interview Nine).

Increasing Clinical Skills and Confidence

Nurses skills in a nursing home were developed to increase confidence, and increase nurses awareness that they have more abilities than RNAs.. Interview Seven stated

we try to give them advanced skills so that they know that they are different (from RNAs) and they have more education that they have more assessment skills, they are familiar with the different medical conditions, they have greater tools to use to deal with different clinical situations that come up.

Interview Five indicated the system has recognized that leadership skills need to be developed in nursing, particularly for the younger graduates and is now offering a non credit correspondence leadership program in the clinical setting. Interview Four indicated "we try to develop them as much as we can. We have provided education days. These are days that you would normally set aside to come to work and we have done that all over the building." Other strategies were used. "We get them to present. Some are keen on it. Some of them are shy. Not everyone is going to come out in front and say this is what I want to do."

Increasing Nurses Roles

The ARNN is gathering public support from communities and seeking to change the public's perception of the nurses' role. "We have done visits to communities and we have initiated think tanks across the province with consumers." Consumers were involved

because "that is where our support is. That is where the votes are, and that is who politicians listen to." Consumers have been asked to define what roles they will accept for nurses. "We have asked, what do you see nurses doing? What would you like to see nurses doing? What are you prepared to let her do?" The public response, "they are positive, but they really believe that nurses can provide them with quality health care services, as well as the physician" (Interview Five).

Enhancing Working Relationships

Interview Four stated resistance to management efforts to empower nurses through committees occurred because of poor working relations between staff and management. "Some of it is not only apathy. Some people do not relate well to management either." Reasons for them feeling this way were offered.

I believe that they don't have power sometimes. They believe management are the ones who have taken over all the committee work and they are the ones who do all the work, right. But we have to get away from that and we have to empower them to become involved.

A solution was found by scheduling nurses for committee work when they are working because "they have home commitments, or they are not interested enough to come in, there are various reasons." The number of nurses on committees was reduced by putting "more programs under one committee. So we can have those that really want to participate and be able to come and be developed."

Interview Four contended those nurses at her workplace have "for the most part"

been satisfied with management taking their suggestions. This has occurred "because over the years we have said to them, look you develop this for us now and we will talk about it. You have given them the opportunity for input." However, management relationships with staff needed development so they could involve the staff more effectively. "All the managers did a leadership program . . . and we worked together as a team . . . that has helped us get down to the staff and involve them." To further develop staff, "we hired some team leaders and front-line managers" which were given the same leadership training. This helped "to bring staff along, to get ideas from the staff and to be able to deal more effectively."

Interview Six described nurses as isolated on their units and not seeking or using other colleagues or other professional disciplines for peer support which created a negative view of the nurses' ability. "Ten years ago you would hear people in here say that nurses and nursing assistants are the same. You don't hear that any more." Nurses "are looking not only to nursing assistants, but to other disciplines because they are working more with them in programs and therapy groups" and "also to other nurses." This increase in peer professional support allowed the nurses to take stronger leadership roles. "I think they are a very strong group in here and they are coming into their own." There have been smaller gains in leadership ability at the staff unit level. "We are seeing a little more leadership coming from them now than from what we have had in the past."

Empowering Nurses Through Research

Nurses, according to Interview Five, were "not heard as well as we should be. That

is why I think it is very important why we should get into research.” The administrator commented that from her experience with government, research was respected. “They listen to you and they don’t argue with you and they probably agree with where you are coming from.” This was described as the only time nurses were listened to by the government. “The only times that I have known them to take real note was when we had gone in with research data.” Interview Four stated nurses were “looking at all the scared cows” and “nurses in this building are looking at site-based research.”

Empowering Student Nurses

Student nurses are encouraged to develop confidence and independence. Senior students [diploma nursing school] use “peer tutor experience” which is “one of the requirements.” They participate “by preparing a lab or work with a group of students in the clinical area, in order to bring about that notion of learning from each other.” This has had a positive response from the students. “The feedback has been fantastic from junior and senior students.” This has reduced stress on the students because they can say, “I really don’t know what I am doing here. They will say that to them, but they wouldn’t to a faculty member.” This has increased students working together (Interview Five).

Students are placed in a clinical area with a nurse working on a unit who acts as her preceptor. “We have nurses who are preceptors all the time and that is developing nursing skills.” The role is for “people who volunteer to do this and who are willing to volunteer.” This made them “more accountable for what they do[and] they put more into it” (Interview

Four). Many others agreed that the role of preceptor increased leadership for both nurses and students (Interviews Two, Three, Five, Six, Eight, Nine). Students (basic and post RN) do a nursing management course, N5700, but not a specific leadership course (Interview One).

Changing the Perception of Leadership

Changing nurses' perception of leadership was seen as a way to empower nurses, but only if nurses are given the opportunity and support to take on these roles. "If they tried it and it works [and] it is given the opportunity to work, they are given the support, then they will say they can do that." Nurses' perception could be changed by "fostering the skills that are there, as well as, having the tools around me in that role." This has the potential to create a snowball effect. "When you start and you have the support, it is accepted and valued, then they [nurses] will start to do more and more" (Interview Nine). Interview Seven agreed. "If they are supported" their potential can develop. This is needed because "some roles can bring out the best, and others you fall flat on your face." This increases "confidence and if empowered in the job, you realize you can make a difference" (Interview Nine).

Interview Seven reported front-line staffs are aware of the need to change the perception of nurses' roles. Two nurses on the front-lines approached the administrator because "they wanted to support each other that we are worth more than giving out pills. We have a more important role to play."

The Direction of Health Care

The direction of health care "is moving toward community-based services" and "toward a greater health focus, health promotion, illness prevention, which nursing supports" (Interview Five). Another agreed. "I hope the system is changing and nurses in Newfoundland want the system to change very much to a preventive, which is helping the client help themselves" (Interview Nine).

Consumers want a voice and participation in their care. "It's my community, I know my health needs, therefore the doctor or the nurse should not be telling me what to do. Lets work it out" (Interview Five). The economic times make it necessary for the consumer to take more responsibility, "We cannot afford a health care system anymore that is looking after you, people have to look after themselves" (Interview Nine). Consumers are "much more informed and we are in an information seeking society" (Interview Three).

What are the New Leadership Roles?

I think that has been the focus of our health care system to care for the client and it has been an illness focus. I hope that system is changing . . . hopefully that will change the education of nurses. That will be a very important component as the system moves in that direction, nursing and nurses also move in that direction (Interview Nine).

Nurses are actively seeking to redefine new roles for the changing marketplace, and as the marketplace focus shifts it is necessary to examine how nursing roles are shifting.

Community health roles needed to expand into greater health promotion and

prevention. "I think we could be one of the major leadership roles for nurses are to do that. To actually get out and motivate people because who better to do that than a nurse." Consumers needed the "education to make themselves better and they need to feel personally that I can do this, and it is my responsibility and my role."

Nurses were well positioned for the community role and nurses were described as one of the "best groups." But nurses' role is recognized by the public for "giving of acute care verses what is being done preventively, with "90% of nurses working in acute care." However, "I think prevention is one of the strongest areas that nurses can take a leadership role within the next few years (Interview Nine). Community health is a place displaced hospital workers will seek employment. "I think the community is where a lot of people will lean to" (Interview Four). Community health received the greatest endorsement for new roles for nurses (Interviews Two, Three, Four, Five, Six, Nine) and is the only workplace that has not reported job loss, but an expanding role.

A stronger community role for nurses could be developed, as the first health providers' patients see. "I think nurses should be the entry line into practice, like in Ferryland District" (Interview Two). "The entry in the health care for the most part should be through the nurse" (Interview Four). "The community health centers are an issue now." However supports "have not been given" and a "lot of lobbying is being done for that through the government" (Interview Nine). The primary health community project co-piloted with Denmark was described as a leading role. "I think that we provided the leadership across the country" and "I think we should be able to do more [in Newfoundland]" (Interview Four).

Though the Ferryland project had received world wide recognition, the under development of such roles for nurses was attributed to nursing needing "a spokesman with government, to articulate that with government, to get them to see the benefit of this." The administrator pointed out, "there are on- going talks with the ARNN and community to get more projects" (Interview Four). Interview Ten reported that the nurses' union was advocating for health centers, but "the government is not interested at this stage of the game." An explanation was given. "We have piloted this stuff for years and there never has been the political will to move that along and that is due to the paradigm of medicine."

While most saw their new roles in community, others saw independent practice and advanced nursing practices (Interviews Five, Ten). There were examples of nurses in independent practice, such as foot care and holistic nursing "because these are area that doctors don't want to work in" (Interview Five). Interview Four stated, "there will probability come a time when you will have to become a nurse specialist" and "new opportunities are opening up for nurses as the nurse practitioner, nurse midwife."

Interview Ten declared that "nursing had growth and skill in certain areas, but advanced nursing practice has not happened because we have had structures, whether they are with the ARNN and you get delegated medical acts, or whatever." Independent practice was an area that needed to be more quickly developed because "we think about the patient in the front focus, we really have not because if a patient needed this we spend two weeks figuring out if we could do this, instead of just doing it." Nursing has been prevented by "fear of the unknown and because of risk of ligation and we can't get into that."

Nurses were losing future roles. "By the time we decide to somebody else has picked it up and has done it or we have figured out another way to it." Nurses were described as "having an act to work within" and so did medicine, but the boundaries "are fluid" for medicine and as technology moves, the physician moves in that direction. Nurses, however, have been slow to pick up the pieces that medicine moves away from and nurses "are the most practical ones to do it" (Interview Ten). Two of the biggest new roles created recently were because of the new model of program management, with program directors or leader positions and the professional practice coordinators positions. While the program positions are available to all disciplines, each discipline had its own professional practice position with nursing having three positions (Interviews Two, Six, Ten).

Program management will create opportunities for nurses at the unit level. Program management "will be more structured and focused in terms of their program, managing their program and the responsibilities of their program." This allowed a change in the unit level leadership. "Before you were only one small part of this big conglomeration and you did not know where you fitted in or where your role was" (Interview Nine).

The new leadership opportunity was "for nurses to have more leadership in developing programs and doing things at the unit level which will have a significant impact on the program." But doubt was expressed whether nurses saw the potential. "I think nurses will need to be helped with that to recognize it" (Interview Nine).

New roles had been created in Mental Health that extended the hospital care out into the community, into community programs with four positions created in conjunction with

community health. "We have isolated four nurse positions and send them to community health, a crisis project run by community health."

A greater primary care role for nurses was expected for psychiatric residents. "We could be taking on a much larger primary role with clients. We do not look at their total health needs. We have some very heavy smokers in here. How much are we involved in seeing that they check their breasts regularly?" Nurses were seen as effective coordinators of the health care team and of unit care. It was considered a legitimate role and "one of the few identified roles" and it was a role that was not maximized" (Interview Six).

Concluding Statement

Political forces [driven by budget cuts to health care in 1996] have resulted in reforms and the restructuring of health care services in Newfoundland. The way nursing services will be delivered in health care has been changed. This has resulted in massive layoffs of middle management and administration positions; with greater leadership responsibilities for leaders that remain, and increased leadership responsibilities for staff nurses. The reforms that are occurring in health care are related to the larger social issues of economic constraints, with the ideas of business being introduced into social systems, to remedy the provincial concerns with health care costs. The reforms of nursing education and nursing practice appear to be a response to tie the knowledge of the larger issues [health care reforms] to the nursing occupation, in order to gain transformation and power.

Chapter 5

DOCUMENTS COMPARED TO CURRENT MARKETPLACE

Two documents will be explored, (1) Leading in A Time of Change. The Challenge for the Nursing Profession. A Discussion Paper, developed for the Canadian Nurses Association (J. Haines, 1993). (2) National Nursing Symposium Follow Up Report to the Minister of Health, with only Section VI - Leadership being reviewed. Section VI includes recommendations forty-eight to fifty-three for nursing leadership, and a Discussion and Recommended Action Plan (Nursing Human Resource Committee (NHRC) and Symposium Delegates, 1992, pp. 31-34). These two document will be used for a document analysis. As outlined in the methodology, the researcher will use the lived experiences of the informants. Chapter four will comprise the lived experiences of the informants. In this section page numbers are included for the interviews. Page numbers refer to the research data in chapter four and have been included here for accuracy and to enable the reader to refer to the area in chapter four that is being compared and contrasted. This method of compare and contrast will provide a more interpretative understanding of nursing leadership and the marketplace in which it is occurring.

This chapter highlights the third dimension of the research study, the mediational analysis that reveal the operation of agency and structure as simultaneous events. In this chapter the primary focus is structure, with the primary focus of chapter six being agency.

The Challenge for the Nursing Profession

The document aims "to capture forces influencing patient care delivery today and provides tools for questioning whether resulting changes are for the better." The document is for administrators "who are charged with providing leadership and creating environments that result in quality nursing service" (Haines, 1993, pp. iii).

The Evolution of Nursing Administration

Nursing has had more than 350 years of history, within a variously structured health care system (Haines, p.3). Nurses first worked in private homes and then in hospitals. The shift to hospitals occurred because of the "advances in science" and the "quality of care in hospitals could equal care provided in the home." During the Great Depression "fewer people could afford to be cared for at home" (Gibbon & Mathewson, 1947 in Haines, p.4). World War II created "military hospitals in Canada" (Gibbon & Mathewson, 1947 in Haines, p.4). The federal government "created more than 46,000 new hospital beds between 1948 and 1953" (Taylor, 1987 in Haines, p.4). The number of military hospitals and the creation of hospital beds shifted nurses from the home into hospitals (Haines, p.4). The number of nurses who work in hospitals increased over time. "In 1930, 25% of nurses worked in hospitals, in 1960, 59%." (Hall, 1964 in Haines, p.4). Today, "90% of nurses work in acute care", which is hospital focussed (Interview Nine, p.170).

Haines contends the 1950's rapid increase in hospital beds created "a rapid growth need in the number of hospital-based nurses" with "a corresponding need for nurse administrators, but little time to adequately prepare them for this role." To address this "the Canadian Hospital Association established the Nursing Unit Administration Program," which today is being transferred to McMaster University School of Nursing (p.4).

Changes in administration needs are occurring once more at a rapid rate, but not because there is a growing need for more administrators. Today there is a surplus of administrators due to hospital restructuring (Interviews Two, pp.66-67; Ten, pp.42). Participants indicated administration practices have expanded, with new organizational structures expanding these practices again (Interviews Two, Six, Ten, pp.51-54). Nurses today still question why they are not prepared for their administration roles (Interviews Two, Four, Five, Six, Eight, pp.98-99). Administration education in Newfoundland was lobbied for by the ARNN but was not supported by enough employers. An administrator commented on the failure. "What they didn't want was for nurses to be educated. You just go in there and fly by the seat of your pants and you can't do this any more" (Interview Five, pp.98-99).

Other changes have occurred. Haines states environmental influences from popular theorists for "new organizational approach of participative management," resulted in "shortened lines of communication, greater head nurse responsibilities, more complex director of nurses roles, with more knowledge needed in areas of management theory, finance, policy development, and labour relations" (pp.4-5). These skills were needed more than ever today (Interview Two, pp.67-68). However, directors of nurses roles are not

needed, nor is nursing leadership desired in the leadership roles. What was described as needed is a multi-disciplinary approach to leadership that is not power-based, with team building and collaboration abilities (Interviews Two, Six, Ten ,pp.51-54; Ten, p.54).

Hospitals were influenced by religious orders and the military structures, which produced "top-down leadership, multiple layers of administration with communication and decision-making slow to respond to staff and patient needs" (Lemieux-Charles & Wylie, 1992 in Haines, p.4). In St. John's health care was provided by two hospitals associated with two religious denominations, Roman Catholic and Salvation Army. This influence is no longer present as both are now government owned and under the auspice of the Health Care Corporation (p.26). Many nursing homes are still under the auspices of churches and private organizations, for example, the Masonic Masons have a senior citizen complex, as do many churches (Interview Eight, p.71).

The marketplace is shifting again, while the past may have contributed to the administration structures, there are new influences today. Marketplace pressures, such as fiscal restraint, consumer participation, the need to be research and quality focused and a need for patient focused care is transforming hospitals (Interviews Ten, pp.43-44). Transformation of hospitals is occurring through downsizing and changing administration structures (Interviews One, Two, Four, Five, Six, Ten, pp.46-54; Two, p.42). These changes are creating increased workloads in the community and a possible reduction in hospital beds (Interviews Nine, p.58; Ten, p.42). Many nurses are underemployed in casual positions (Interview Nine, p.118-120). Middle management positions are being cut creating a surplus

of nursing administrators, while staff nurses fear the loss of their roles to para-professionals staff (Interviews Two, pp.66-67; Two, Four, Five, Six, Seven, pp.69-70).

Patient services are shifting, it "is moving toward community-based services, toward greater health focus, health promotion, illness prevention" (Interview Five, p.169). Nurses are preparing for the changes by shifting nursing education to the university level to create a "universal education" and to prepare them for "whatever faces them," but fewer will be educated because "we are producing too many nurses" (Interview One, pp.91-92).

Nurses today cope with environmental changes of "altered funding bases, rapidly changing technology, growing consumer participation and complex organizational structures." Nurses need attributes of the "pioneer nurse," such as "resourcefulness, flexibility and adaptability" to cope with a rapidly changing health care environment. Individual and collective rights have gained prominence and the style of management has changed to "democratic" which requires skills in negotiation, collaboration, group processes and communication." Nurses must know the "business of nursing" and the "business of health service delivery" (Haines, p.5).

The participants reported hospitals are removing the bureaucratic structures and nurses are having difficulty because "all our paradigms are that somebody has to be the boss." A more democratic approach is being advocated. Interview Ten related that the boss

is the person who is on the front-lines, who is providing the care, who is making the decisions, who is coordinating the care, everybody else is just facilitator to allow them to do their work (p.62).

Rapid Change

Haines maintains the combined forces of technology, financial constraint and global competition are generating change unseen in history (p.9). Interview Two agreed. "We are probably in the biggest change that we have ever experienced in our lives, or probably the lives before us" (p.41). Haines declares "that change has touched every society and every level of society - shaking convention, creating uncertainty, creating opportunity" (p.9). This was very evident as nurses reported the effects of the restructuring of health care. Comments of disbelief showed how convention had been shaken. Interview Ten related that

if you were to say three years ago that nursing would not have a department, would not have some kind of organizational relationship where there was a clinical at the top, who had responsibility for nursing care within the organization, they would say you were crazy. That it cannot happen (p.63).

Haines affirms organizations small and large have reevaluated and restructured, placing emphasis on cost containment, greater efficiency and increasing quality (p.9). The informants reported restructuring was occurring at all levels of health care, from nursing education, to community health, long term care, continuing care, and acute care, with the goals of cost containment, efficiency, and quality (Interviews One, Three, Six, Seven, Eight, pp.71-82; Interviews Two and Ten, pp. 41-47; Six, pp.131-132). Other factors were reported as driving change, such as the need to be patient care focused, and having a health care system that was of value to the consumer (Interviews Six, pp.131-132; Ten, p. 43).

Haines states the health care system came under scrutiny in 1983

the need for change was underlined by a wave of federal and provincial health care commissions and task forces ... sparked by concerns over; rising health care costs, dissatisfaction with the organizational structure of health care delivery, human resource requirements, diffusion of technology, and quality and accessibility of care (Agnus 1991 in Haines, p.10).

Recommendations have resulted in reforms of provincial health care systems. The, reforms include decentralization of administration and political authority. Decentralization is a "shifting of authority and responsibility downward in the organization, with decisions taken where they have major impact." Costs are reduced by eliminating middle management (Haines, pp.10-12). The St. John's hospitals are in the process of removing middle management in the hospitals and are decentralizing decision-making. Hospital decision-making now includes front-line staff on committees and more decision-making is outside the hierarchial structures and into the hands of the program leaders (Interviews Two, Six, Ten, pp. 50-51; Interviews Two, Four, Six, Seven, Nine, pp. 160-164). Decision-making is moving downward to the clinical level. " Who are your nurse leaders within this organization? The leaders have to be the nurses who are working on the floor" (Interview Ten, pp.53-54).

Decentralization of decision-making is occurring in Community Health with decisions being made at the regional level as opposed to the provincial level. An expanding role is developing for the community. It was the only work site that had reported no job loss (Interviews Two, Three, Four, Five, Six, Nine, p.170). Political authority of health care has been established by the elimination of the private hospitals and subsequent hospital mergers, by mergers of nursing homes under boards and the establishment of regional boards for

community health (Interviews Two, pp.41-42; Three, pp. 80-82; Eight, pp.70-71).

Haines explains that change is affecting patient care delivery by a redesign of organizations along lines other than traditional ones, such as finance, nursing, medicine (p.10). Financial services have been amalgamated (Interview Two, p. 119; Eight, p. 72). The relationship of nursing and medicine to the organization will be changed by program management, each with a new relationship to each other and the organization. This is evident in the co-leadership role that doctors and administrators share, with this role not confined to nurses (Interviews Two, p.55; Four, p.65; and Ten, p. 59-60).

When program management is superimposed onto traditional hospital management structures, it often replaces it. This means that discipline-specific infrastructures and line authority are eliminated and disciplines are absorbed into the program structure. The chief executive nurse has been eliminated entirely (Haines, 1993, p.12). The St. John's hospitals will have decentralized patient care approach to health delivery through the program management model, with the [director of nurses] chief executive nurse eliminated. The traditional discipline-specific departments will be removed and all the disciplines are absorbed into programs, with line authority changed for all disciplines. There will be no director of nurses or other discipline directors (Interviews Two, Six, and Ten, pp.51-52)

A shift in how power is exercised in the organization will occur (Interviews Two Six; Ten pp.50-51). The power shift occurred by removing departments within the hospital and creating fewer boundaries between disciplines, as each discipline may be directed by another discipline, except medicine (Interview Ten, pp. 50-51). The power base of medicine will be

more powerful than other disciplines. Physicians will automatically be one of the leaders on all programs and have direct access to the board level. "There will be a medical advisory stream" (Interviews Two and Ten, pp.43-45; Ten, pp.49-50).

Haines affirms that in hospitals where program management is used each program has its own budget and its own team consisting of a physician chief or chair, a nursing director and administrator. The chair may report to the chief executive office or to a vice president level in the organization. This approach assumes the physician as the gate keepers of the system and they should have sole decision-making authority for resource allocation (p.12). Newfoundland has taken a new approach to program management (Interview Ten, p.43). This approach has resulted in major restructuring of the St. John's hospitals. Program management will have like groups of patients, for example, rehabilitation. The goal is "a program approach of care which sees all the disciplines working around the patient" (Interview Ten, pp.44-47). Each program has its own budget but corporate responsibility is for standardized care (Interview Ten, p.54). All functional departments will be removed and replaced with programs (Interviews Two, Six, and Ten, p.52-54).

Physicians' chiefs have been appointed to head the programs, who are there on a part time basis, with a co-leader who is full time. The co-leader may or may not be a nurse because the position is open to other disciplines. Nurses are not automatically part of the leadership team, but physicians are, because medical quality care cannot be off-loaded to non-physicians. The physician chief does not have sole decision-making authority, but shares the decision-making role equally the co-leader (Interviews Two and Ten, pp.50; Ten, p.43).

This approach to program management has similarities with what Haines describes as patient-centred. Patient-centred care is another model of patient care delivery that has emerged in Canada and used by only one Ontario hospital. This approach resulted in major restructuring of the hospital, replacing it with a decentralized system organized around the patient. The hospital's eight units were collapsed into three, which are led by a full time vice president of operations and a part-time vice-president medical - a physician. The vice-president of operations may be a nurse, but not necessarily so. Each clinical unit is made up of like groups of patients, and each is accountable for its budgets (Haines, 1993, p.13). The St. John's model does not neatly fit program management or patient-centred care.

The St. John's model was reported to have dual reporting for administration structures and for leadership roles. "There is a board sitting at the top and a professional advisory committee that is the senior management decision-making body." This senior advisory committee will include "a sampling of physicians, a sampling of corporate departments and corporate team" and "a sampling of professional practice coordinators" and "maybe nursing will be there and maybe it will not."

The second administration level is the program. Every program has an internal and external advisory committee, consisting of "the stakeholder, nurses, physio, OT, physicians and consumers" (Interview Ten, pp.44-45). Within the programs there are two levels of management, the first headed by the co-leadership of the physician chief and an administrator (who may or may not be a nurse and the second level is the divisional manager, who may or may not be a nurse (Interviews Two and Ten, pp.44-45).

Patient-centred care, according to Haines, "was broadly defined as the design of patient care so that the hospital resources and personnel are organized around the patient rather than around various specialized departments" (p.13). This is comparable to the St. John's hospitals. The hospitals will have programs that allow a fluid structure for personnel resources because they will not be organized around specialized departments. Personnel will be determined by the discipline needed to provide services (Interview Ten, pp. 45-46).

Haines states there are basic tenets to patient-centred care, such as decentralized services moved closer to the bedside, cross-training to create multi-skilled workers, work redesign and grouping of similar patient populations (p.14). Three of these are present in the St. John's model of program management. However Interview Seven indicated cross-training of staff at the front-lines is not evident (p.79). But fears were expressed that nurses will be replaced with para-professionals when they have been trained to do medications (Interviews Two, p.69; Four, p.70; Seven, p.75-76; Eight, p.79). Other hospital expenses will be cut by amalgamation. The Children's Rehabilitation has already moved into the Janeway Children's Hospital. The Janeway and Children' Rehabilitation, along with the services of Grace Hospital will be relocated to the Health Science Complex. (Interview Two, pp.41-42).

Haines indicates that there is a shift in resources to community-based care, with more emphasis on health promotion and disease prevention (p.10). The informants indicated that health care was shifting to the community, but sufficient resources had not been allocated to cope with an expanding role in community health (Interviews Three, Five, Nine, pp.169; Nine, p.58; Nine, p.116).The effectiveness of the trend to community health should be

questioned because community health is underfunded and understaffed (Interview Nine, p.58; Nine, p.116). The expanded community role desired by nurses was through community health centers, similar to the one piloted at Ferryland (Interviews Four, Nine, Ten, p.170). It was indicated health promotion and disease prevention was a needed trend, but a mental health work site reported this has not been fully developed into their programs. But mental health has moved services from the hospital to the community (Interview Six, pp. 172-173).

Haines state there is a growing public knowledge and expectations, strategic partnerships and a consumer participation movement (p.10). Growing public knowledge was indicated (Interviews Three, Five, p. 169). Strategic partnerships occurred when a group of nursing homes brought health care services such as physiotherapy (Interview Eight, pp.74-75). Other strategic partnership have been achieved by amalgamation of the Janeway and Children's Rehabilitation (Interview Two, p.42). Nurses education programs use strategic partnerships with hospital nursing staff through preceptorship programs (Interviews One, Two, Four, Five, Six, Seven, Eight, Nine, p.167). Greater consumer participation was indicated by Interviews Five and Nine (p.169). Consumers today have a greater role in hospitals and are being appointed to advisory committees (Interview Ten, p. 44).

There is greater emphasis on outcome and continuous quality improvement (Haines, p.10), which Interview Ten agreed with (pp. 45-45). Haines asserts that role redefinition among health care workers is occurring (p.10). This is evident with the boundaries between disciplines being removed by removing functional departments and by disciplines receiving direction from other disciplines (Interviews One, p. 64; Two, Six, and Ten, pp.50-51).

Haines asserts that technology is particularly evident in computerized information systems that increasingly control health care delivery and "will revolutionize organizational design by providing an alternative to hierarchy as the primary means of coordination" (p.10). Administrators indicated hospitals will have standardized policies and procedures, coordinated financial services, with one work site indicating that patient care plans are computerized (Interviews Two, p.119; Six, p.115; Eight, p.72; Ten, p.54)

There is a trend toward alternative medicine and an aging population (Haines, p.10). The participants reported nurses were looking toward holistic medicine and alternative medicine for independent practice (Interview Five, p.171). The aging population was not addressed, but the aging workforce was. (Interviews Seven and Eight, p.120). The future nursing homes will have a multi-level population, not restricted to the over sixty-five years old (Interview Eight, p.74). This will occur at a time in history when the demand for these beds by the elderly is increasing. If there is a reduction in the ratios of nurses to para-professional staff in these work sites, it would occur when the acuity of patients is increasing, due to longer life expectancy and the multi-level patient populations.

The key architect in organizational design, the chief executive officer, has undergone a revolution as well. Armitage and Bain (1992) states "there has been a pronounced trend toward hiring generalists - candidates with cross-industry and cross-functional experience - as opposed to those within the specific industry" (Haines, p.11). The informants indicated two change agents who were both outside of health care. Interview Six indicated the transformational leader at her workplace had a business background (p. 123) and Interview

One indicated Sister Elizabeth [Davis], who was restructuring the hospitals, had an education or administration background (pp.42-43). Haines contents "that some of the provincial health care reviews suggested looking to private-sector management techniques" for improving efficiency. This appears to be the case in Newfoundland.

Other models such as managed care systems were not directly discussed by any participants. Ferryland District Health Care Center may be considered an alternative health care delivery system that would fit under this model. Haines states a managed care approach is subject to the management of providers and the users of services. This involves the application of a management policy or procedure that affects either the delivery of a service or a specific goal. Ferryland provided primary care to consumers in a rural area (Interview Four, p.170). Case management falls under this model and the aim is to coordinate care and reduce the length of stays in a hospital, which was alluded to when a mental health hospital extended care out into the community from the hospital (Interview Six, pp.172-173).

Supporting Professional Nursing Practices

Haines maintains all approaches are "touted as antidotes to the health care system woes" and are promising "streamlining, cost efficiency," because traditional hierarchies were "slow to respond to patients and staff." This Interview Ten supported (pp.43-44). All models promise decentralization of decision-making on the front lines and more responsive care focused squarely on the patient, which was also emphasized by Interview Ten (pp.43-

44).

Haines asserts that all models will "translate to significant changes to health care professionals - whether they work in institutions or community." This was also evident in the study (Interview One-Ten, pp.43-101). Haines maintains this will decentralize decision-making for staff nurses and can enhance their professional role, which was supported by Interview Nine (p.172).

These models can affect administrators by putting perpetual pressure on them to maintain the bottom line which can "threaten a shift away from human values on which nursing is based" (Haines, p.19). The concerns voiced by administrators focused on the implications of removing department structures, reductions in administration and front-line positions, the ability of nurses to compete with other disciplines, the ability of the nursing profession to redefine its nursing roles, and the effects of the changing leadership role on patient care quality (Interviews One, Two, Four, Five, Six, Seven, Nine, Ten, pp.64-70).

Nurses are one of only two constants for patients in all health care settings and are qualified to speak out on the issues of both cost and care. The World Health Organization identified nurses as the health professionals' greatest potential for ensuring cost-effectiveness (Haines, p.19). Some informants stated that nurses had little input into restructuring of hospitals or institutions (Interviews One, p.56; Five, pp.55-57; Five, p.66; Eight, p. 72). Interview Three was not dissatisfied with nurses input (p.82)

Questioning Change - Some Tools

The Canadian Nurses Association outlined twelve principles which can be used to question how change is being accomplished and stated "restructuring and new models of patient care delivery engender excitement and concern" (Haines, pp.22-32).

A Chief Executive Nurse

The presence of a chief executive nurse was considered "one of the most visible marks of a supportive environment." Meilicke (1990) states an executive nurse represents the profession, professional standards and professional accountability within the health care organization. This executive is a role model, a mentor, a coach, and creates an empowering environment that fosters risk taking and growth. The executive improves knowledge of boards of directors and non-nurse managers regarding nursing enterprise (Haines, pp.22-23). Within the new hospital structures three professional practice coordinator positions were established that fulfil this role. The role allows the professional practice coordinators to provide knowledge to non-nurse managers, but they may not be able to improve knowledge of boards because they have no automatic place there (Interview Ten, p.45; Ten, pp.47-49).

Nurses Participate in Strategic Planning

Nurses participate in strategic planning at the board and executive level. "Active nursing involvement in decision-making at the board and executive levels recognizes nurses'

pivotal role in patient care delivery" (Haines, pp.23-24).

Nurses successfully lobbied every board and chair to have a place at the board level where decisions on restructuring were being made (Interview Five, pp.55-57). Nurses, however, do not have an automatic place in decision making at the senior levels of hospitals and may not be part of the leadership team for all programs as outlined earlier (Interviews Four, Six, Ten, pp.55-57; Ten, pp.43-47). Nurses participate in strategic planning through committees (Interviews Six, Four, Nine, pp.162-164).

Nurses Participate in Decision-Making

Nurses participate in decision-making at the organizational level (Haines, p.24).

Nurses are included in committees where organizational decisions are being made (Interviews Two, Three, Four, Six, Seven, Nine, pp. 162-163). However, if nurses are included in 80% of the program leadership positions, they may be excluded from some organizational decision-making in the other 20% (Interview Ten, p.65). Nurses had increased independent decision-making (Interviews Two, p. 161; Seven, pp.161-162).

Nurses Collaborate

Nurses collaborate with other health professionals in determining standards of patient care (Haines, pp.24-25).

Mental Health has introduced a nursing council and traditional nursing practice committee that enabled nurses to influence patient care standards (Interview Six, p. 162).

Nurses Set Standards

Nurses determine the standards of nursing practice (Haines, p.25).

Nurses have a set of practice standards and a code of ethics, at the provincial and national levels, as nursing is a self regulating profession (Interviews Four, p. 106; Five, p. 128). These standards cannot be enforced within the workplace (Interview Five, p.145).

Under the program management model practice coordinators will have responsibility for informing managers on the professional standards and practices of nurses (Interviews Two, Four, Six, Ten, pp. 48-50). But three practice coordinators were considered inadequate for the size of the nursing workforce (Interview Two, p.49). The three positions were further questioned because they would not be site-based (Interviews One, p.49).

Quality Improvement

Quality improvement is a major focus for the 1990s, Early efforts emphasised measurement, occasionally comparison with a standard. Today the focus is continuous improvement (Haines, p.25).

Quality improvement was not discussed extensively by the participants, but was stated as part of the organizational structure (Interviews Six, pp. 146-149; and Ten, p.45).

Impact on Nursing

The organization analyzes the potential impact of all decisions on nursing (Haines, pp.25-26).

Nurses were reported to have input into decision-making on committees (Interviews Two, Three, Four, Six, Seven, Nine, pp. 161-164). However Interview Nine indicated many decisions are made without front-line input and many committee decisions are made "before they [nurses] get there." Staff nurses have very little input at the board level or government level and many policy decisions are made "based on how health care perceives it" by people who "have not worked at the bedside" (pp.152-153). Nurses were reported as reluctant to be involved in committees (Interview Four, p. 156).

Nurses Participate

Nurses actively participate in the selection and assessment of new technologies (Haines, p.26).

This was not discussed by any of the participants, nor was the topic brought up during the interviews.

Nurse Contribution

Nurses contribute to the development of clinical and management information system (Haines, pp.26-27).

There was only one work site that disclosed nurses used computer technology for their care plans, but it was reported as increasing rather than decreasing the workload (Interview Six, p.115). Other information systems were not discussed. It was not disclosed if nurses were involved in the selection of the care plan technology or if their assessment of

it was considered. This did not become a topic during the interviews.

Resource Utilization

Nurses have a key say in resource utilization (Haines, p.27).

There were complaints voiced about workloads for nurses, but the data system available to administrators to determine workloads was not discussed by the participants, nor was the subject addressed in the interviews (Interviews Five, Six, Nine, pp.115-117). Administrators indicated they were involved in long range budget planning, but they did not report on the availability or accessibility of nursing data relevant to the decisions to be made (Interviews Two, p.135; Five, p.99).

Staff Development

Nurses shape their own staff development and professional education programming (Haines, p.28).

Three work sites indicated they offered continuing education to nurses. Interview Seven offered a substantial amount and Interview Eight offered a small amount. No work site indicated that nurses themselves were involved in the selection of staff development education, with Interview Eight stating administration determined what was offered (Interviews Four, p. 157; Four, p.164; Seven, and Eight, p.149).

Educational Linkages

The organization fosters and supports nursing linkages with educational institutions (Haines, p.28).

Interviews One, Two, Four, Five, Six, Seven, Eight and Nine indicated nurses participated with student nurses' education by allowing staff nurses to act as preceptors for students (p.167). Interview Eight indicated employers have limited funds available for education, but they support nurses who seek education by flexible work schedules. Distant education courses has increased education linkages with nurses (Interview Five, p.98).

Document Two - The Nursing Symposium Report on Leadership

The Nursing Symposium report originated in 1990 from the National Nursing Symposium Report sponsored by the twelve Canadian Health Ministers. The purpose of the Symposium was to "explore cooperative and creative solutions to address changes in nursing practice in Canada and the way nurses provide care within the health care system"(p.i) Newfoundland's Minister of Health, the Honourable Hubert Kitchen, requested the following document as a provincial response to the National Nursing Symposium Report by the province's Nursing Human Resource Committee (NHRC, p.i) .

The document analysis will explore recommendations forty-eight to fifty-three of the Nursing Symposium Report because these recommendations are specifically aimed at nursing leadership. This exploration will provide insights into the present level of

implementation of these recommendations, as well as an understanding of how these recommendations have been implemented. The participants lived experiences, outlined in chapter four, will be used to draw conclusions. Once again Interview page numbers will refer to chapter four.

Recommendation Forty-Eight

That ministers of health provide financial support for programs in post-secondary institutions as well as the workplace so that nurses can develop leadership and managerial skills (NHRC, p.31).

The participants stated that health/nursing administration at the graduate level was not available in Newfoundland. To obtain administration they would need to attend MUN School of Business, which one informant had done (Interview One, p. 98). Financial assistance was limited (Interview Eight, p.97). Administrators have been given additional training for program management, and team building (Interviews Four, pp. 166; Ten, p. 50).

Recommendation Forty-Nine

Employers provide nurses with practical experience in leadership and managerial responsibilities within their health care organization (NHRC, p.31).

Health care facilities were providing nurses with practical experience, through involvement in committees (Interviews Two, Three, Four, Six, Seven, Nine, pp.162-164). Interviews Two, Four and Six indicated front-line staffs were making decisions that were once the domains of management (p. 162). Interview Seven indicated a three-hour leadership

program was provided to the staff before changing the infrastructures. Interview Four indicated nurses provided leadership as team leaders, preceptors for students and they have developed their own in-charge module (pp.162).

Recommendation Fifty

That professional nursing associations and unions support the development of leadership and management programs for their members (NHRC, p.31).

The ARNN is offering a non-university credit leadership course to new graduates (Interview Five, p. 160). Involvement in professional organizations, such as the ARNN and the union were encouraged and considered a reliable way to develop leadership (Interviews One, Four, Five, Six, Seven, Eight, Nine, pp. 125-126). However Interview Four stated nurses have apathy in assuming leadership roles in professional organizations (p.126). The nurses' union did not give any specific examples of programs available to nurses for leadership development. Nurses employed by the union in leadership positions receive nursing practice hours for licensure (Interview Nine, p. 126).

Recommendation Fifty-One

That educators develop programs to provide nurses with knowledge they need to assume clinical and first-line leadership positions by including interdisciplinary study of leadership, organizational behaviour, managerial, and financial management concepts essential to nursing practice (NHRC, p.31).

Leadership is not taught as a specific subject in the university program but "it runs

through the whole curriculum" by educating nurses toward independence and critical thinking (Interview One, pp.88-89). The faculty does not focus on leadership. "Most faculties are not into leadership/management that is being in charge of a group of people. Hardly anyone is involved or interested." Nurses receive some management skills

through a nursing course N5700 , which is nursing management. That is pretty straightforward about various skills that the students may look at, for instance, going for interviews .We cover the material and that is about all.

We talk about leadership too, but it is from the manager's point of view, first line managers, the head nurse, what kind of things that person would be thinking about, doing evaluations, time management (Interview One, p. 138).

Involvement in professional associations was considered ways for students to develop leadership (pp.87-89). One faculty member developed a leadership program through the ARNN (Interview One, p.137-138).

Recommendation Fifty Two

That educators offer these programs through instructional schedules to accommodate shift rotation and use distance education techniques to reach nurses in rural and remote locations (NHRC, p.31).

The post-basic BN program is by distance education (Interview Five, p.96).

Recommendation Fifty-Three

That nurses look for opportunities to serve in leadership positions by participating in committees, boards, councils, in their place of employment, their profession, their union, and their community (NHRC, p.32).

Part of the university job description for faculty members includes community

service [20%] and some faculty members offer expertise in a certain field, "it is knowledge leadership"[which involves using their expertise in a project or committee role] (Interview One, p. 99; p.137).

Nursing students are encouraged to participate in their unions, professional associations and the Nursing Society with students appointed to leadership positions (Interview One, pp.87-89). Others supported union involvement at the work sites for leadership development (Four, Six, Seven, and Eight, p 126). Interviews Seven and Nine stated involvement in the union had helped them develop leadership skills (p.126). Interview Six and Ten stated they were not actively involved in the ARNN, but Interviews Four and Five stated involvement with the professional association helped them to develop leadership skills (p.126).

Nurses were supported for involvement in committees, councils and boards. (Interviews Two, Three, Four, Five, Six, Seven, Nine, pp. 162-164; Ten, p.44) Interview Eight did not indicate nurses were involved in committees at her work site.

Discussion and Recommended Action Plan

The Nursing Human Resource Committee (NHRC) state that a number of strategies are under way, such as the nursing schools having leadership skills incorporated into their curricula but this should be considered basic leadership. A proposal was under way aimed at offering specific leadership skills to staff nurses and first-line managers. It is not known

if this is the present program offered by the ARNN.

Lobby efforts to obtain university credit for Nursing Management: A Distance Education has met success. Haines (1993) stated this is now being offered by McMaster University (p.4). Nurses need to be educated in health care policy and economics, even at the basic levels. Nursing administration courses are not available at the university level (Interview Four, Six, p.98). Efforts to obtain a Master in Health Administration have been unsuccessful in Newfoundland (Interview Five, pp.98-99). However no participants indicated that health care policy and economic courses were a part of the BN program.

Four recommendations were outlined and are presented with the research data.

1. Funds be available for nurses who wish to pursue education in leadership and/or administration at the Master's level.

No participants indicated this has occurred. Interview Eight stated limited funding was available to employers for staff development (p.97).

2. The NHRC lobby for a generic administration program at the master's level, at Memorial University for the health related disciplines.

There is no program as of this writing (Interview Six, p.98) .

3. The NHRC write the Basic Education Advisory Committee requesting that specific curriculum content in health care policy and economics be included in future nursing education programs.

The participants did not indicate that this was a part of the present nursing curriculum.

4. The NHRC develop an in-house nurse manager mentorship program to allow inexperienced nurses to set goals and work with an experienced management nurse.

No administrators indicated this was available or has been developed.

Concluding Statement

Kincheloe (1995) contends that every historical period produces rules that dictate what we see as researchers. Kincheloe states data credibility can be achieved by systematic approaches to reflective methods and involve the researcher and the researched (pp.75-80).

The document analysis provided a highway that the researcher travelled in order to have a systematic reflective view of nursing leadership, and the factors that are creating opportunities and barriers to leaders' roles. There were political, social, educational and economic conditions found, that were affecting individuals and organizations. These factors make nursing leadership difficult. As well, nursing leadership development is still restricted by unfilled promises to promote its development, especially in education which is restricted by government funding.

Chapter Six

RESEARCH STUDY CONCLUSIONS AND RECOMMENDATIONS

The research study design is based in critical ethnography and critical theory. In using Morrow's research design and critical theory, complex realities can be examined through complex approaches. Bolman and Deal (1991) Reframing Organizations. Artistry, Choice and Leadership were chosen for the largest component of the theoretical framework for this chapter, with O'Toole (1995) Leading Change. The Argument For Values-Based Leadership forming the other component. The theoretical framework is used to draw conclusions, O'Toole will guide the conclusions on the effectiveness of leaders, while Bolman and Deal will allow a deeper understanding of the multiple realities of nursing leadership. Recommendations will follow the conclusions.

This chapter will highlight the third dimension of the research design, the mediational analysis that reveals the operation of agency and structure as simultaneous events. The chapter will focus primarily on agency within the changing organizational structures of health care.

Conclusions will be taken from the research data contained in chapter four. Page numbers will accompany the interviews in this chapter. These page numbers refer to the research data in chapter four and are included for accuracy, and to enable the reader to refer to some of the areas in chapter four from which conclusions are being drawn.

Theoretical Framework

Nursing leadership can be given an in-depth analysis by using Bolman and Deal to examine individuals in social organizations because their approach allows for a synthesis and integration of major theoretical traditions in the field of organizational theory (p.309). Bolman and Deal show "how the same situation can be viewed in four different ways" in order to understand organizations as multiple realities, and to provide a means to find simplicity and order in the midst of chaos. They view leadership as artistry, which is neither exact nor precise, but allows experiences to be reframed, for deeper understanding of what is and what might be.

These writers state that much of the existing literatures focus on one or two traditions, and give a biased and incomplete picture, which fails to provide an overview of organizational theory and research (pp. xii-xx). Bolman and Deal state that they "have drawn the insights from both research and practice into four major ways in which both academics and practitioners make sense of organizations" (p.15). Theories generally emphasize a single approach which can offer incomplete maps in either research or practice and limit the ability to understand or manage organizations (p.309). Bolman and Deal state that organizations should be considered from four frames of reference - structural, human resource, political and symbolic frames because each represent "a slice of life". To create clarity for the conclusions the four frames of organizational behaviour need to be understood. The definitions for the frames are derived from Bolman and Deal, 1991, p.15.

The Structural Frame

This frame emphasizes the importance of formal roles and relationships, which can be depicted with organizational charts. Organizations allocate responsibilities through the division of labour, and create rules, policies, and management hierarchies to coordinate diverse activities. "Problems arise when the structure does not fit the situation." This is corrected with reorganization.

The Human Resource Frame

This frame emphasizes that organizations are inhabited by individuals who have needs, feelings and prejudices, but also skills and limitations. Individuals have great ability to learn, and a capacity to defend their old attitudes and beliefs. The key to effectiveness is tailoring the organization to the people by finding an organizational form that enables the people to get the job done, while feeling good about what they are doing .

The Political Frame

This frame views the organization as an arena, with different groups competing for power and limited resources. Conflict is everywhere because of differences in needs, perspectives, and lifestyles of groups and individuals. Bargaining, negotiation, coercion, and compromise are part of organizational life. Coalitions form around specific issues, which are subject to change. Problems arise when power is concentrated in the wrong places, or dispersed. "Solutions are developed through political skill and acumen"(p.15).

The Symbolic Frame

This frame treats organizations as tribes, theatre, or carnivals, with organizations viewed as cultures, propelled by rituals, ceremonies, stories, heroes, and myths, rather than by rules, policies and authority. In organizations as theatre, actors play out the drama inside the organization, while outside audiences form their own impressions of what they see occurring. "Problems arise when actors play their part badly, symbols lose their meaning, or symbols lose potency". Rebuilding is through symbols, myth and magic (p.15).

O'Toole and the Effectiveness of Leaders

The effectiveness of leadership needs to be addressed, as nurses' ability to meet the marketplace needs was the main question for the study. There were many indications that the informants had to provide leadership in an environment of change and change was a dominant influence affecting nursing leadership.

O'Toole (1995) states there are many "cookbook procedures" that fail to address the common underlying cause of failure to bring about successful and meaningful change: ineffective leadership. O'Toole states that "we naturally search for some process, some guidelines, some sure-fire set of rules that will tell us how to get others to carry out our will". Transformation efforts seldom fail because the procedures were flawed, or because the steps, stages, and the rules experts prescribe have not been followed, and it seldom fails because of lack of know-how or how-to or inadequate or rusty managerial skills. Change fails at a deeper level that is rooted in behaviour, beliefs, and assumptions (pp. ix-xii).

By using O'Toole to examine nursing leadership a more critical reflective understanding can be obtained regarding the effectiveness of leadership, because O'Toole examines leadership as "a multidimensional phenomenon; in contrast with the prevalent uni-dimensional mode of assessing leaders on the singular measure of effectiveness." O'Toole maintains that the radically altered scope, scale, and speed of modern life has complicated the challenges of leadership, and created more varied and numerous sources of resistance to leadership. Corporations must not just change, but must be transformed by effective values-based leadership, that provides motivation and acts as a source of unity and coherence across fragmented firm boundaries (pp. xvi-3).

Organizational Change - Research Findings

Bolman and Deal (1991) state that human organizations are complex and can be exciting as well as challenging places; illustrated by the challenges of each informant in each work site surveyed for the research study. Many of these challenges were created by the changing structures [addressed in chapter five]. The research study indicated changing organizational structures and new challenges altered behaviours. Interview Five stated it had decreased leadership and forced nursing to reevaluate its position in society (p.43; p.70).

Bolman and Deal contend the ability to predict human behaviour is limited because of the many extremely complicated interactions between different groups and organizations. It is also hard to predict the outcome of decisions or initiatives in an organization, and

yesterday's problem often creates impediments to getting anything done in the future, with possibilities that these problems will create new possibilities for disaster (p.25). The study illustrated many problems within nursing that were rooted in the traditional setting and roles within the health care organizations. Bolman and Deal maintain that taking any action in an organization is like firing a cue ball into a large and complex array of billiard balls. So many of the balls will bounce off each other in any number of directions, that it is hard to know what the final outcome will be (p.26).

Many of the final outcomes of restructuring health care may not be possible to predict. The study identified changing patterns and practices in the health care system that are creating a shift in the marketplace. There are significant variables that affect the way health care will be delivered, such as population, changing consumer health needs, shifts in the focus of health care goals, changing organizational staffing patterns and changing organizations structures. An overview of this shifting marketplace is displayed in Table 6.1.

Nursing leadership roles were affected by internal and external social forces, and working conditions, often dictated by policies and traditional roles. These factors combined to create opportunities or barriers for nurses. An overview of the relationship of social forces and working conditions on nurses opportunities and barriers is displayed in Figure 6.1.

Nursing education was shifting to meet a new nursing future in the restructured organizations of health care. There were factors that influenced the student populations, the development of nursing education, and deficiencies in nursing education programs. An overview of nursing education is displayed in Figure 6.2.

Table 6.1

An overview of The Shifting Marketplace

Population	<ul style="list-style-type: none"> • Aging Population • Changing populations in nursing homes to multi-levels • Changing population needs in the community due to early patient discharge from hospitals
Health Needs	<ul style="list-style-type: none"> • Shift from illness to wellness model • Emphasis on prevention / health promotion
Health Goals	<ul style="list-style-type: none"> • Cost containment • Quality • Consumer participation • Health care that meets the consumer needs • Research based
Health Services	<ul style="list-style-type: none"> • Requires more community health services • More health care centers (Ferryland Health Center) • Independent nursing practice and specialization • Care decentralized - moved closer to patient needs
Staffing Patterns	<ul style="list-style-type: none"> • Increasing roles of para-professionals • Increasing need for education for nurses • Removal of boundaries between disciplines • Multi-disciplinary leadership • Co-Leadership role for physicians with other disciplines • Removing middle management positions
Organizational Structures	<ul style="list-style-type: none"> • Shift to program management • Downsizing of hospitals • Central boards • Regional boards • Strategic partnerships

Figure 1.
Relationship Between Social Forces,
Working Conditions,
Nurses Opportunities,
and Barriers

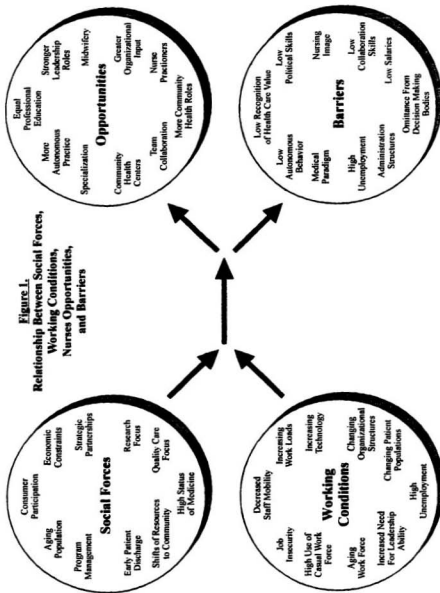
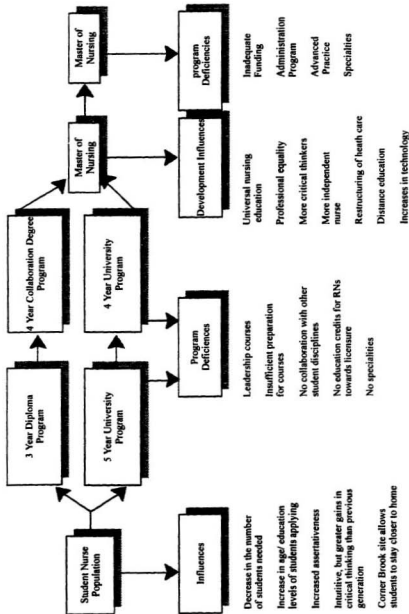


Figure 2.
An Overview of Nursing Education



Environmental Pressures for Organizational Change

Hospitals have amalgamated under the Health Care Corporation: community health services under regional boards; nursing homes under central boards; schools of nursing have downsized from five sites to three (Interviews Two, pp. 41-42; Three, pp.81-82; Eight, p.71). Bolman and Deal state change is driven by environmental pressures of globalization, information technology, deregulation and population demographic changes (pp.371-375).

Effects of Globalization

Globalization refers to powerful forces now affecting both corporations and governments and creates marketplace pressures to alter existing structures, policies, patterns, and practices (Bolman and Deal, p.371) The forces of globalization are impacting on health care services. The driving forces behind restructuring are organizational complexity and duplication of services. The changes will bring economic benefits, standardized policies and decentralized decision-making (Interviews Three, p.82; Eight, p.74; Ten, pp.46-47).

Effects of Information Technology

Hospitals' services, such as finance were being combined (Interviews Two, p. 119; Eight, p.72). Increasing information technology has made it possible to decentralize departments and services in hospitals, to amalgamate nursing home boards and decentralize community care within regional boards.

Effects of Deregulation

Deregulation will remove the department structures of hospitals, allowing a fluid utilization of staff (Interview Ten, pp.45-47). This will increase the need for leaders to take a multi-disciplinary approach to leadership and to be more flexible, as they will be directing other disciplines in addition to their own (Interviews Two, Six, Ten, pp.51-54). Deregulation will enable consumer participation and allow the health care system to respond to patient needs, while meeting economic restraints (Interview Ten, p.45-47).

Effects of Demographic Changes

There is an increasing aging population, and an aging workforce. Nursing home utilization will include a multi-level population, which is a shift away from the present gerontology focus (Interview Eight, p.74; pp. 120-121). Community health roles are increasing due to early patient discharge, creating increased community health workload, while services are underfunded (Interview Nine, p.58; p.103). There is a shift to casual workers (Interviews Two, Nine, pp. 118-119). Reorganization is creating job insecurity, with layoffs in middle management (Interviews Two, Four, Five, Seven, pp. 64-70).

Leadership Within the Human Resource Frame

Globalization presents new challenges for human resources and creates possibilities for conflict between professional, semiskilled and unskilled personnel by redefining roles.

There is conflict between doctors and the organization, nurses and doctors, other disciplines and doctors, nurses and para-professional staff, nurses and other disciplines. There is high level of competition for positions and roles due to the new structures and fiscal restraints (Interviews Two, Four, Five, Seven, pp.64-70).

Change causes people to feel incompetent, needy and powerless, therefore, individuals need to develop new skills, have opportunities for involvement and be given psychological support (Bolman and Deal, p.377). The study revealed that nurses are experiencing feelings of powerlessness and difficulty with taking action on their own behalf (Interviews Five, p.145; Nine, p.112). Nurses reported that others doubted their expertise and abilities, and nurses themselves were unable to recognize their leadership roles (Interviews One, Four, Five, Six, Eight, Ten, p.103-105). Efforts are being made to involve nurses at the committee level and leadership training is occurring for front-line staff and management (Interviews Two, Three, Four, Six, Seven, Nine, pp.162-164; Ten, p.51). Administrators reported that nurses were not supportive of each other in the workplace, which could limit available psychological support (Interviews Four Nine, pp.115- 117).

Bolman and Deal state that changes in organization practices, procedures or routine patterns undercut people's ability to perform with confidence and success, and if people are feeling insecure about their income, this will heighten their need for support (pp.378-379). The work environment [for management and front-line staff] is challenged by job insecurity, with reduced permanent positions, a high use of casual staff, and increased workloads (Interviews Two, Four, Five, Seven, Ten, pp. 64-70; Five, Six, Nine, pp.115-117).

Support for nurses was undermined by administrators [employers], who challenged nurses if they requested additional staff support for patient care by accusing nurses of not coping with their nursing roles (Interview Nine pp.115-117). This work environment fosters conditions that prevent nurses from providing or getting support from each other.

Nurses may be reluctant to share their feelings because of the risk of being perceived as unable to cope with their roles, and management may be perceived as not coping with the transition. For management or front-line staffs, who are still unsure of their future roles, this will put additional pressure on them, affecting their leadership abilities and self confidence. Nurses who work as casual staff were reported to be constantly under these working conditions and low self-esteem, decreased commitment, and lower leadership abilities were reported (Interviews Two, Nine, pp.118-120).

Decentralization of hospitals will occur by removing the departments and bringing in program management (Interviews Two, Ten, pp. 43-47). Program management will require multi-disciplinary skills and collaboration, and will provide a greater leadership role for management and front-line staff (Interviews Nine, p.172; Ten, p.54) This will create power shifts from the departments to programs, and remove the bases of power from disciplines. Leaders will not focus on disciplines, but on who is needed to provide the patient care (Interview Ten, pp.43-54). In community health power will be decentralized from the provincial level to the regions, and for nursing homes power will be increased as boards are amalgamated under central boards (Interviews Three, pp.81-82; Eight, pp.71-75).

The traditional department has been removed, but the territorial stand of disciplines

has a long tradition (Interview Ten, pp.46-47). Conflict issues are possible. Interview Ten stated doctors had difficulty with team leadership because "doctors still believe they have responsibility for everything that happens to the patient and they direct what goes on" (p.59). However, it may be reasonable to assume that others may feel the same about their areas of expertise. The introduction of many different disciplines into leadership roles created difficulty because they will be directing other disciplines. Other disciplines are able to care for the patients, and be leaders, but each discipline brings a different expertise and orientation to their leadership roles (Interview Six, p.64-65).

Role position conflict is possible. Physicians were reported as having low ability to work as team players, but will share an equal co-leadership role with another discipline (Interviews , pp.59-61). However, this power is unequal, with more responsibility on the non-physician leader. "If you got good front-line leaders working with physicians to make team functioning, then it happens" (Interview Ten, p.61). However Bolman and Deal contend that it is very difficult to make systematic changes within the organization because of the culture of professionals . Professionals respond slowly to changes because of their autonomy and rarely do efforts succeed by standardizing their performance by policies etc. Control in professional bureaucracies is provided mainly by professional indoctrination of their members (p.88).Medicine has a long history of being the dominant group and this may be why they resisted program management. Nursing has a history of being subservient. Their resistance was in their inability to assume a stronger leadership role (Interview Ten, p.59-62).

Nurses were reported to be the dominant group in relation to other health

professionals, due to their broad scope of practice and size (Interviews Five, p.55; Six, p.112). Nurses would get 80% of the leadership roles and other groups viewed nurses as having too much power (Ten, p.64; Ten, p.118). Despite nurses receiving the majority of positions, administrators reported a great sense of loss for nursing's position in health care. Participants attributed this positional shift in power to nurses not being able to articulate what they do, and to the under-valuing of nurses roles by other health professional, the public and themselves (Interviews Two, Three, Four, Five, Nine, Ten, pp.106-107; Four, 155-157). Bolman & Deal explains that changes create feelings of loss within the previously dominant group, and feelings of alienation or oppression among the emerging groups (p.374). But these reactions could be clashes of professional cultures with and outside agent's [Sister Elizabeth Davis] agenda of health care reforms. Bolman & Deal maintain clashes in culture can weaken the old culture, and create profound challenges for cohesiveness, shared values and a common mission (p.374).

Clashes in culture were evident as nurses spoke of the removal of departments, changes in the reporting structures and job titles, as well as changes to their leadership roles (Interviews Two, Five, Six, Ten, pp. 51-54). The old traditional culture is significantly weakened and the participants spoke of the health care system as paralysed, full of apathy and uncertainty, with subsequent decreases in their leadership (Interviews Four, Five, p.66). This may be hampering the development of a common mission. Difficulties in operationalizing the new structures were reported. Common purposes do not exist between the disciplines. The structures are moving to a program management, that was alien to most

doctors, and other health professionals (Interviews One, Two, Four, Five, Six, Ten, pp.46-65). Professional practice coordinators were expected to provide cohesiveness within the organization because traditional leadership will no longer exist. Cohesiveness may be difficult. Nurses reported they had inadequate representation by three practice coordinators, considering the size of their workforce (Interview Two, p.48). Enough time may not have been spent building cohesiveness, due to rapid implementation (Interview Eight, p. 72).

Change and Altered Power Bases

According to Bolman & Deal (1991) a common strategy used to generate change in organizational structures is to import new people, or to try to change existing people (p.375). Sister Elizabeth [Davis] and an unnamed business executive were reported to be the outside change agents (Interviews One, pp. 42-43; Six, p.123). However, they will seek to lead and change the existing people, with few positions available to outside people, and people unwilling to seek positions because of job insecurity (Interviews Two, Five, p.67).

Bolman & Deal state another common strategy to change organizations is to redesign the structure of the organization, only to find people are unable or unwilling to carry out their new responsibilities (p.375). Doctors were unwilling initially to carry out program management and nurses' resistance was because of their inability to fully carry out their role responsibilities (Interview Ten, pp.59-62). Workplaces were dealing with this dilemma by offering administration training to both doctors and nurses (Interview Ten, p.50). However doctors are there for one to three days a week, while the co-leader is five days a week

(Interview Ten, p.50). Bolman and Deal state it is not unusual in a professional culture to insulate the key players [doctors] from formal interference so that they can concentrate on using their [medical] expertise (p.88). Interview Ten stated, doctor autonomy was enhanced by the new structures by removing; "itty-bit stuff that normally he has to worry about"(p.61).

Bolman and Deal state, change affects more than roles and skills, it can alter power relationships and undermines agreements and pacts (p.375). Power relationships were changing, but not significantly enough to remove medical dominance. Interview Four reported medicine and nurses' relationship to each other will change. Nurses will not share this role with the doctor, but will compete for this role with other disciplines (p.65). But, nurses and other disciplines have an unequal status because doctors are the dominant group (Interviews One, Three, Four, Five, Six, Nine, Ten, pp.107-110). A new shift in power will affect all groups, including doctors, who will be expected to adopt a team approach to their leadership (Interview Ten, pp.50).

These changes will intrude into symbolic agreements and ritual behaviour which Bolman and Deal state can undermine the social tapestry and threaten the organization's collective unconscious and existential character (p.375). The social tapestry may be threatened. Nurses reported that they were not unsupportive of program management, but they questioned the arrangement of having a pluralist leadership team; having only three professional practice coordinators for nursing who are not site based; medicine having a high status; doctors inability to be team collaborators; and, nurses input into decisions relegated (Interviews One-Ten, pp.43-61) . However, a more colloquial relationship was

hoped for between doctors and nurses (Interview Four, p.110).

Bolman and Deal state change agents can often underestimate opposition and drive conflict underground. Effective change requires a recognition of competing interests and the opportunity to air and negotiate their differences (pp.376- 401). Interview Ten reported that surgeons and anaesthetists did negotiate for who would be the physician program leaders, but others were selected by an administration committee selection process (p.59).

Leadership Within the Structural Frame

Bolman and Deal contend that change alters the clarity and stability of roles and relationships. Therefore realignment and renegotiation of formal patterns and policies is necessary (p.377). However, Interview Eight reported that she would not know what structural changes were to occur until they were ready to be implemented. This could imply that many of the patterns of renegotiation and policies were being done behind closed doors, and out of sight of those most affected by the proposed changes (p.72). Doctors were able to negotiate, by refusing to cooperate until their demands were met (Interview Ten, p.59).

Formal structures of organizations are what provides clarity, predictability and security in organizations because the structures are what prescribes the duties, and how work is to be carried out. Therefore, change undermines these structures, and creates ambiguity, confusion and distrust. People become unsure of what they or others are expected to do (Bolman and Deal, p.381). Administrators supported Bolman and Deal. Predictability

and clarity no longer existed, but instead there was ambiguity in nurses' roles, with confusion and distrust in the workplace. Ambiguity was shown by many administrators attributing the problems being experienced by nurses, to nurses lack of role articulation, which affected how other members of the health care team saw nurses' roles and abilities. Role articulation was considered a factor in nurses value to the health care system, and their movement into other roles. Clearer role articulation may be related to the realignment of formal patterns and policies, which now make it necessary for nurses to compete with medicine, and other disciplines for positions and new roles (Interviews One- Ten, p.103-107).

There were comments of distrust in how the reorganization was being carried out. "Nurse leaders were let go before the process began" (Interview One). Another stated "I think it has been a planned strategy to reduce the influence of nursing in the system" (Interview Five). There was distrust for their degree of decision-making authority on committees, and that important decisions were made before they got to committees (Interview Nine, pp.152-153). Front-line staff had difficulty with their committee responsibilities and leadership roles (Interviews Three, p.143; Five, p.145; Seven, p.148; Nine, Ten, pp.151-153). Nursing supervisors had difficulty passing authority down the line and nurses were unsure of whom they will report to, or how decisions will be made (Interviews One, Ten, pp.61-62). Bolman and Deal maintain, problems such as these are common, as people no longer know what their duties are, how to relate to others, and who has authority to make decisions (p.382)

Leadership Within the Political Frame

Bolman and Deal maintain that change creates conflict, and creates winners and losers, which can drive conflict underground (p.377). Doctors were considered bigger winners than other groups and this affected the other groups ability to have autonomous practice, illustrated by comments that doctors were hampering nursing roles and performing nursing roles; doctors had political clout, and more decision-making authority (Interviews One, Three, Four, Five, Six, Ten, pp.107-110).

Bolman and Deal contend "changing the organization creates division and conflict among competing interest groups" (pp.54-55). Competing groups had conflicts. Conflict existed between the professional association and the government bodies, shown by nurses being omitted from major boards, but eventually admitted (Interview Five, pp.54-55). There is conflict between nursing and para-professional roles, which has increased because there is a possibility of losing previous nursing roles to other groups, notably lesser skilled workers (Interviews Two and Four, pp. 69-70; Seven, p.75; Seven and Eight, p.79). Bolman and Deal state many changes can fail if managers are unwilling to spend the time and money on human resources. Realignment of roles and relationships need to be negotiated in a formal way to reduce conflict (pp.376-388). Interview Five indicated, nurses had to lobby in order to have a voice at the board level (p.55). Any front-line positions that will be lost with down sizing will occur as per agreement with the nurses union. Management had no protection or agreements, which may contribute to apathy (Interviews Four, Ten, pp.53-54).

Leadership Within the Symbolic Frame

When individuals experience change it can create a loss of meaning and purpose, and people will experience difficulty in letting go.(Bolman and Deal, p.377).This was supported. Many participants were experiencing difficulty with letting go of the traditional structures and accepting the changes to their profession and leadership roles (Interviews One-Ten, pp.64-70). Some administrators doubted if the change was for the better (Interviews One, Two, Four, Five, pp.63-64). One participant was positive and negative (Interviews Five, pp.63-64). Nurses were portrayed as having great opportunities for expansion, with stronger leadership roles in the new structures (Interviews Five, p. 63; Nine, p.172; Ten, p.62).

One participant had a different view of restructuring than her colleagues, and presented the strongest view for new roles for nurses in the new structures. This participant was the youngest interviewed [five years experience], and the only participant exclusively university educated. The participant reported job security [a new leadership role in program management], and a successful experience with restructuring by another administrator, before coming under the Health Care Corporation (Interview Six, pp.131-132). However, the administrator who was responsible for the successful restructuring was reported to be leaving. The organization has been placed under the Health Care Corporation and

he didn't see a role for himself in this organization and this organization has shown itself to be fairly traditional in the way it has set itself up and the way it looked for leaders, program directors and so forth (Interview Six).

It is not possible to determine if the positive experience Interview Six had with

restructuring influenced her views of her leadership role, nursing's future and restructuring. but her views varied widely from other participants regarding who should have leadership positions and sit at the board table (pp.55-56; p.64-65; pp.131-132). O'Toole states that the only element powerful enough to overcome centripetal forces is trust, which emanates from leadership that has a shared purpose, shared vision, and especially shared values (p. xvii). These components were present in this administrator's description of the former administrator (Interview Six, pp.131-132; Six, pp.146-147). Bolman and Deal contend the symbolic frame centres on meanings, beliefs and faith and sees organizational events and processes as important for what they express to individuals (pp.244-245). This may help explain how the positive experience with restructuring could have influenced this participant to have a higher level of trust [in the restructuring] than her colleagues.

The symbolic frame assumes the organization is full of questions that cannot be answered and problems that cannot be solved (Bolman and Deal, p.253). The nursing profession is coping with layoffs and the high use of casual workers, while nurses are experiencing feelings of powerlessness, as outlined earlier. In the midst of this uncertainty nursing is seeking to redefine its practice and direction (Interviews Three, Nine, p.169). However nursing efforts are restricted by the 'medical paradigm' and the 'nursing standard acts' of their provincial and national association. This was cited by Interview Ten as one of the greatest barriers to nurse autonomy (p171).

The environmental pressures for change and the major problems within each frame are summarized in Table 6.2. (adapted from Bolman and Deal, 1991, p. 372).

Table 6.2.

Environmental Pressures for Change

Force	Problems Within Each Frame			
	Structural	Human Resource	Political	Symbolic
Globalization	Complexity and duplication of services, too many structures, no standardization of policies	Professional, semi-skilled and unskilled workers	Conflict between disciplines and management goals	Building cohesiveness through professional practice coordinators positions
Information Technology	Decentralization of departments and services. Downsizing of hospitals and boards.	New leadership skills and roles required.	Power shifts from departments to operating units of program management and central boards.	Meaning of work is in the area of expertise and empowering workers to do what they do.
Deregulation	Structural shifts to respond to consumer needs and meet economic constraints.	More fluid utilization of staff.	Internal power shifts to co-leadership, greater power for medicine than other disciplines. External shift to consumer participation.	Redefinition of hospital culture from bureaucracy to multi-disciplinary. Redefinition of policies and mission to standardized across the system for hospital and nursing homes.
Demographic Changes	Aging population, aging work force, multi-level population in nursing homes. Increased utilization of community resources.	High casual work force. More training required for new structures. High level of job insecurity.	Conflict between medicine, poor collaboration between medicine, nursing and other disciplines. Resistance to change.	Old timers feel sense of loss and many experiencing layoffs. Newcomer alienation due to casual work and job insecurity.

Leadership and Nurses Place in the Marketplace

O'Toole states that leadership is a multidimensional phenomenon and cannot be evaluated only on its effectiveness. Executives have to struggle with unprecedented leadership challenges in a world of pluralism, diversity, and the imminent collapse of recognizable boundaries between organizations, business units, and functional disciplines. (pp .xvi - xix). All of these factors were highlighted in chapter five and this chapter. O'Toole asks, "indeed, how can any leader effectively transform an organization in the midst of competitive, technological, social and political chaos" (p.7).

This research project initially set out to examine the ability of nurse leaders to meet just such a marketplace challenge, not only at the organizational level, but as a profession. The role and ability of nurses for leadership was to be reflected in the ability of the profession to respond to the shifting needs of the marketplace. The marketplace needs are revealed by the changes to the organizational structures, such as program management, new boards, strategic partnership, and a university education. However, many of these changes are so recent it is impossible to judge how successful the restructuring of health care will be, or if nursing leadership was or was not an important element in its success or failure.

The participants identified the changes to health care delivery, the changing roles of front-line nurses, and their own changing roles. Nursing leadership is occurring in multiple settings, all affected by health care restructuring, with profound effects on the leaders beliefs and attitudes.

Behaviour, Beliefs, Attitudes and Assumptions

Today administrators believe that they are struggling with unprecedented change, with a leadership that is challenged to create internal strategic unity within a chaotic external environment. They believe that they must create strong, shared corporate values in order to unite their increasingly decentralized operations, but they feel this is easier said than done in a world of pluralism, diversity and other fragmenting forces (O'Toole, p. xvii). Interview Ten reported that her leadership role had these challenges (pp.140-141; pp.153-155).

Other participants were concerned with the "know-how" of leadership and reported frustration with the fact that nursing administration programs were not available at the university level which could affect their leadership abilities (Interviews Two, Four, Five, Six, pp. 98-99). Interview Two, who was facing a possible layoff, questioned nurses abilities to compete with other professionals who had a university degree (Interviews Two, p.68). Interview Ten said the Health Care Corporation was accepting leaders who did not have a degree (p.68). Interview Four stated education was not helpful in obtaining a position(p.68).

Graduate health care administration was questioned because it was not available in Newfoundland (Interviews One, Five, Six and Eight, p.98).However, two major change agents for reforming health care were reported not to have health administration, nor were they from the health care disciplines (Interviews One, p.43; Six, p.123).

Not all participants were affected by the removal of their department structures, and this was reflected in how they saw their leadership role. For example, only three participants stated leadership had to refocus away from nursing leadership to a multi-disciplinary

approach. All three would see their nursing departments removed (Interviews Two, Six, Ten, pp. 51-52). Others participants' focus was on nursing leadership, with many reactions to the removable of this role (Interviews One, Two, Four, Five Six, Nine, pp.51-54). Apathy was described as a factor in assuming and performing leadership roles (Interviews Four, Five, p. 66) Apathy may be related to a lack of hope for their careers (Interviews Two, Four, Five, p.66). O'Toole contends the "the basic requirement for change is hope" (p. 26). Job insecurity was cited as a factor for not seeking leadership opportunities (Interview Five, p.66) Bolman and Deal maintain that ambiguity and uncertainty can make it difficult for leaders and followers to use rational approaches to problem solving and decision-making, with events becoming meaningless (p.244). Ambiguity and uncertainty may be reasons for the high levels of apathy and low levels of involvement in committees that were reported .

O'Toole states that successful completion of ones short term mission is not the clearest sign of effective leadership, but lifelong consistency (p. 25). Interview Ten stated that some administrators were reluctant to embrace program management because people are not risk takers, and this was also true for people with a "good track record". However, there were people who were moving along with the changes and others who were not. Those that could not were classified as people who had "looked to leaders to tell them what to do" (p.62). O'Toole maintains that resistance to change is inherent if the change does not involve the innovation of followers themselves (p.45). Interview Six reported a positive experience with change that did involve the innovations of the followers (p.132) Interview One, Five and Nine reported that this was not true for all leaders (p.55; p. 64; p.150-152).

Good leaders listen to their followers and encourage dissenting opinions (O'Toole, p.29) Interviews Three, Five, Nine and Ten indicated that they listen to the membership: Interview Five and Nine by surveying the membership, Interview Three by mentoring and Interview Ten by empowering them to take action. Interview Nine stated she listened to each nurse's concerns, but she could not always respond to these individual concerns because she had to consider the whole membership (p.138; p. 127; p.129; p.141). O'Toole states that the best leaders listen to the people they serve, but are not prisoners of public concern (p.29)

Besides listening O'Toole maintains, that the best leader has the sense to pick good men to do what he wants to do, and the self-restraint to keep from meddling with them while they do it (p.31). This was evident in the description of a leader by Interview Six and in the leadership of Interview Ten (p.132; p.141). Leaders need ideas and leaders must be able to communicate what they want, why they want it, in order to get the necessary support for their ideas. (O'Toole, pp, 33-47). Interview Seven supported the need for ideas (p.133). Ambition is another requirement (O'Toole, p. 34).

O'Toole maintains that "when change fails to occur as planned, the cause is almost always to be found at a deeper level". This level involves the beliefs, attitudes, assumptions and behaviour of leaders and "effective change begins when leaders effectively begin to change themselves" (p. x). There were many indications in the interviews that nurses are attempting to change their behaviour to meet the changes occurring in the organizational structures. Management was reported to be taking leadership training, while involving staff in the democratic process of decision-making through committees (Interviews Two, Four,

Six, Seven, Nine, pp.162-164; Ten, p.51). It was hoped that a more fundamental change would be accomplished for nursing with the introduction of a universal university education (Interviews One, p.91).

Administrators were also returning to graduate school to prepare for new positions (Interviews Two, p.98). However, there were no comments in the interviews that other disciplines were educationally upgrading for the new leadership roles. Interview Ten stated that leaders, including physicians, selected for program leadership positions received a leadership course (p.50) Interviews Two, Four, Five, Six, Seven, Nine indicated that leadership training and strategies were being developed to prepare front-line staff and students for their increased leadership responsibilities (pp.161-164).

O'Toole states that the leadership of change does not depend on circumstances but on the beliefs, attitudes, assumptions, values and actions of leaders. These factors affect both the taking of a leadership role and the way it is used (pp.10-11). Many beliefs, attitudes and assumptions that may affect nurses taking a leadership role and how they exercise their leadership roles were identified. Some of the major factors identified are summarized in Table 6.3. Nurses indicate they do not have strong leadership opportunities or sufficient development of their leadership abilities because; of the medical paradigm; working conditions; family responsibilities; job insecurity; political indifference, by them and others; and, the under valuing of nurses as leaders (Interviews One-Ten, pp.103-121).

There were many social forces and working conditions that were summarized previously in Table 6.1, p.208 and will not be addressed here

Table 6. 3
Beliefs, Attitudes and Assumptions of Administrators

Nursing leadership can meet the marketplace needs, but needs some work.

There is a high level of apathy in the marketplace that is making it difficult to provide leadership.

Apathy is caused by an aging workforce, work overload, constant change, job insecurity and poor relationships with management

Nurses are under valued and unsupported by fellow colleagues, physicians and other disciplines.

Nurses question their level of expertise and education preparation.

Nurses roles were not easily articulated and therefore were misunderstood by themselves, other disciplines and the public.

Physicians control nursing practice, interfere with nurses achieving new roles and they can do this because they have greater clout and status than nurses.

Most nurses are women and they put family before career, but health care organizations do not provide any services on the premises for child care.

Nurses have great political powers in their numbers (4300) but fail to use it effectively either in the workplace, the professional association, union or government due to underdeveloped political skills and lack of interest.

Nurses have low salaries and poor working conditions as a profession, which are tolerated by nurses because they are taught to care for others not themselves.

Many physicians are not team players, but will automatically have this leadership role in program management.

Nurses have no automatic place on any major decision-making bodies in the Health Care Corporation, even though they will form the larger sector of the health care workforce

How Leadership is Defined

Nursing leadership was defined as good management (Interviews Eight, pp.132-133). Management and leadership occurred together, confirming the literature review that though leadership and management are different, the two are often confused (Interviews One, pp.1136-138; Two, pp.1135-136; Three, pp.138-139; Five, pp.127-129; Nine, pp.129-131; Ten, pp.140-142). Nursing leadership was a political process (Interview Seven, pp.133-135). One example was given of transformational leadership (Interview Six, pp.131-132). Interview Four defined leadership as maintaining the present position of nurses (pp. 140).

Common Sense Definitions of Leadership

Bolman and Deal (1991) explain that there are many common sense definitions for leadership, with the most prevalent being, leadership is the ability to get others to do what you want. This definition equates leadership with power, and force, but omits values, visions and leadership relationships. A second lay definition is that leaders motivate people, influence more by influence, persuasion, and example more than by force and seduction. This is true, but puts leadership in the context of its products and misses purpose and value. A third lay definition is vision, which adds meaning, purpose and mission, but assumes the vision is the creation of the leader, and can omit if anyone likes the vision. A fourth definition is leadership is facilitative, participative, democratic and empowers people to do what "they" want them to do. This idea that leaders act and followers react (p.405). All of the Bolman and

Deal examples appeared in the definitions and more than one applied to each participant. The participants definitions are summarized in Table 6.4 (Interviews One - Ten, pp. 127-142).

Table 6.4
How Administrators Described Leadership

Leadership Definition	Interview Responses
The ability to get others to do what you want them to do.	#1, #2, #5, #7, #8, #10
Leaders motivate people to get things done.	#1, #2, #3, #4, #5, 6, #7, #8, #9, #10
Leaders provide vision.	#5, #6, #7, #10
Leadership is participative, facilitative and democratic	#1, #3, #5, #6, #8, #9, #10
Leaders have specific characteristics	#3, #5, #8, #9
Leadership is not confined to a setting or position	#2, #5, #6, #9.

Bolman and Deal contend that most of the above information in Table 6.4 can provide definitions of leadership, but these concepts of leadership indicate that leadership is controversial and diffuse. These definitions focus on power, authority and management. Leadership needs to be distinguished from these images. While most images of leadership are that leaders get things done, get people to do things, and that leaders are powerful, many images of power are outside of leadership. Leadership also should not be equated with just power. Leadership is distinct from authority, though leaders possess authority (pp.405-406). The concept of authority and distinctions in its use was illustrated by Interview Five, who exercised authority by influencing others (p.116) and Interview Eight who exercised authority

authority by directing the actions of subordinates (p.120).

The above definitions are not sufficient to define leadership. Bolman and Deal quote Gardner (1989) to state that leadership and management offer too sharp a contrast (p.407).

Leadership is a Relationship

Bolman and Deal maintain that leadership is a relationship in which leaders shape or are shaped by constitutions and leadership is always situational and relational. Leadership is not simply what a leader does, but what occurs in the relationship between the leader and followers. (pp.406-409). The study was able to confirm a relationship between the leader's behaviour and followers. For example, Interview Five and Nine indicated that the nurses' membership [followers] influenced the ARNN and the nurses' union mandates (pp.127-131)

In organizations the influence of individuals is often over emphasized and the significance of context under emphasized. 'Context' refers to the organizational structures and the factors within these structures which can affect leadership behaviour. This context influences what the leader must do, and what they do (Bolman and Deal, pp.408-409). The research study included administrators from different workplaces in which the organizational context varied. It was possible to confirm that a relationship existed between the administrators' roles and followers roles. The followers leadership is often dependent on the organizational policies, mandates and perceived power. Nurses leadership abilities were described with wide variations, depending on who described them. Nurses potential for leadership was affected by the policies of the workplace and by the potential power that the

leaders had in the workplace. There were many examples provided.

There were differences in how the professional nurses association and the nurses union saw their roles, which affected the way they surveyed the membership on the same issues of workload and working conditions. The professional association perceives workload from the perspective of adequate resources to ensure safe patient care, because they set the standards for nurses (Interview Five, p. 127-128). The union perceives workload as affecting working conditions because working conditions are a part of the union mandate (Interview Nine, p.116; p.130). There was tension and conflict within the two positions. Interview Five reported "they [nurses] tend to look to others to do for them" and are "not assuming responsibility for dealing with their problems" which was encouraged by the union (p.145). These differences had produced different research results when the membership was surveyed for the same issues of workload and working conditions.

How leaders view the abilities of front-line staff is reflected by the context of their individual roles. Interview Five reported the ARNN does not have the power to tell employers what to do, but sets the nursing practice standards. Interview Five reported that nurses had great power in their numbers, but the majority of nurses felt powerless (pp.145-146). Interview Nine saw nurses' leadership affected by the working conditions and institutional structures, and reported that the union can take action to dictate practices (p.116). Interview Nine, described nurses as having good team building skills, that made them good leaders, but nurses could not see the bigger picture. Nurses therefore, look to the union to speak out on their behalf and to give them direction (pp.152) Interview Five and Nine described

themselves as leaders, with a role that is distinct from the membership, and greater than the individual member, but influenced by the membership.

Educational organizations can influence the taking of a leadership role. Interviews Two, Three, Five and Six stated that their university education prepared them to assume a leader's role, but it did not prepare them for the administration role (pp.122-123). Interview One stated, the university did not focus on leadership, but on critical thinking skills to create a more independent nurse. Interviews Three and Five agreed and stated this was their experience (One, pp.87-88; Three and Five, p.122).

How leaders view the leadership role in the organization can influence how they assess front line staff abilities. Interview Two described the workplace as a difficult place for administrators today, with a high level of administration skills required (p.145). Interview Two recognized her staffs' ability to lead within their own groups, but did not see them having the ability to transfer that ability to the new leadership role in program management (p.145). Interview Three and Six reported a strong personal leadership role and attributed this ability to front-line staff roles (Interview Three pp.138-144; Interview Six, pp.131-132, pp.146-147). Interview Four will experience the greatest number of changes, as a result of down-sizing and restructuring. She was the most ardent advocate for nurses taking a strong nursing leadership role to maintain the professional status of nursing (pp.140; pp.155-157).

Leadership and Position

It is common to equate leadership with position and leadership as being the job of

administrators (Bolman and Deal, p.410). Interview Nine reported nurses see leadership as a job of administrators (p.140). Nurses who see leadership as a position of administrators may also link leadership with management. Leadership was often confused with management when the leadership roles were described and generally equated leadership to maintaining organizational goals. Workplaces with high numbers of RNAs to RNs state that nurses need leadership to direct and delegate tasks of the RNAs. (Interviews Two, Six, Seven and Eight pp.76-78). Leadership roles are unequal and according to levels of professional expertise. RNAs had leadership roles, but less than nurses, and doctors have a greater leadership role than nurses (Interviews Six , p.77, p.147; Seven, p.77; p.147-151; Eight, p.150; Ten, p.59). Bolman and Deal state when leadership is equated to position this encourages managers to try to do everything and relegates everyone else to the passive role of follower (p.410) This may help explain medicine, which is the dominant group, seeing themselves as responsible for everything that happens to the patient (Interview Ten, p.59).

Bolman and Deal maintain that leadership is a relationship between leaders and their constituents and is therefore interactive when it is a mutual influence serving the purposes and values of both the leader, and the follower (Bolman and Deal, p.410). Interviews One, Two, Three, Five, Six, and Nine indicate that the leadership relationship is interactive. Interviews One, Five, Six, and Nine indicate leadership is influenced by followers. Interview Four see leadership influencing the position of nurses. All participants see the leadership role as influencing others (Interviews One-Ten, pp.127-142).

Personal Characteristics of Leaders

There were many characteristics associated with both the leader and leadership. Bolman and Deal state that the most common premise about leadership is that good leaders have the "right stuff" and good leadership is situational. He contents both are correct, according to recent research (p.411). Interview Three stated that leadership was a born quality, that could be developed if it was innate in the first place (p.139). Interview Five stated leadership is not a born quality but innate, but she believes that personally for her it was present (p.129). Interview Seven and Nine stated that nurses needed the opportunity and the support to develop and change their perception of leadership. Nurses have the abilities, but leadership has not been supported, nurtured or valued enough to be developed (pp. 167-168). Interview Six stated that leadership can be inspired if the opportunity, the tools and the infrastructure are present to support its development (p.147).

Bolman and Deal state vision was the only characteristic of effective leadership that was universal in the research studies. "Effective leaders help to establish a vision, to set standards for performance, and to create a focus and direction for organizational efforts". Vision needed to be communicated effectively to others (pp.411-412). Vision was identified by four informants, however only Interview Six outlined a shared vision (Interviews Five, p.126; Six, p.132; Seven, p.133; Ten, p.142).

Commitment to the work of the organization was identified, and nothing is as important as doing that task well (Bolman and Deal, p.412). All interviews focused on organizational goals (Interview One -Ten, pp.127-142). The strong commitment of front-line

staff was reported by Interview Eight (p.151). A third characteristic was the ability to inspire trust and build relationships (Bolman and Deal, p.412). Interviews Five and Nine stated each sought feedback from the provincial nurse's membership. But, despite each doing this, their research studies were at odds with one another (pp.127-131). This could create distrust in the membership. There was evident distrust regarding the motives of those doing the restructuring and for the organizational goals (Interviews One, and Four, p.58; Five, p.56;). Bolman and Deal state "beyond the ability to establish and communicate a vision and the capacity to inspire trust consensus breaks down" (p.412).

Bolman and Deal contend there are many characteristics of leaders identified in the literature including, risk-taking, flexibility, self-confidence, interpersonal skills, task competence, intelligence, the understanding of followers and courage (p.412). Table 6.4 lists the characteristic of leaders stated by the informants (Interview One - Ten, pp. 127-142).

Table 6.5
Characteristics of Leaders

Risk-takers	Innovative	Initiative
Analytical	People skills	Communication
Advocators	Decision-makers	Listeners
Professional	Facilitators	Vision
Have influence	Direct	Lead
Courage to act	Understanding	Authority
Collaboration	Manages Others	Courage
Likes change	Gets the job done	Role Model
Understanding	Personal influence	Mentor for others
Promotes group interests	Leadership influenced by followers	
Promotes development of others		

Framing Leadership Roles

Bolman and Deal state that there are four frames; structural, human resource, political and symbolic frames that offer different perspectives on what leadership is, and the way it operates in an organization. The frame is not what makes organizations effective, but how the skills and processes are used. Effective leaders understand their frame and its limits and also use multiple frames for a more comprehensive and powerful style (pp.444-445).

Bolman and Deal maintain leaders fail if they take too narrow a view of the context in which they are working. They need to be flexible about organizations. To do this requires multiple angles in order to deal with the wide range of issues that leaders face. Each of the four frames have certain characteristics that indicate successful leader and leadership characteristics (pp.422- 450).

To determine the multiple angles used by administrators, the positive characteristics of leadership and leaders' strategies have been selected from the literature and developed into a table, for each frame. The table format can illustrate the leadership styles of the participants, in order to gain a more in-dept analysis and understanding of their leadership abilities and effectiveness. Table 6.5 is made up of the characteristics for the structural and human resource frames, and Table 6.6 comprise the characteristics for the political and symbolic frames (adapted from Bolman and Deal, pp. 422-444). Each administrator is placed as a response, if they have outlined this characteristic when they described their leadership. The responses are obtained from Interviews One -Ten, pp. 127-159).

Table 6.6
Structural and Human Resource Frame of Leadership

Structural Leadership	Interview Response	Structural Leader	Interview Response
Decentralization of the organization	#2, #3, #10	They do their homework	#5, #9, #10
Centralized planning	#3, #5, #10	They develop new models of the relationship of structure, strategy and environment	#3, #5, #10
Resource allocation	#2, #10	Focus on implementation	#5, #10
Decentralized decision making	#3, #5, #10	Continually experiments, evaluates and adapts	#3, #5, #9, #10
Human Resource Leadership	Interview Response	Human Resource Leader	Interview Response
Focus on personal relationship between supervisors and subordinates	#1, #2, #3, #4, #5, #6, #7, #8, #9, #10	Belief in people and communicates that belief	#1, #2, #3, #4, #5, #6, #7, #8, #9, #10
Argues for listening, mutually, coaching, participative, empowering	#1, #2, #3, #4, #5, #6, #7, #8, #9, #10	Are visible and accessible, they empower	#3, #4, #5, #6, #8, #9, #10
		Move decisions as far down the line as possible	#1, #2, #3, #4, #5, #6, #7, #10
		Increase participation	#1, #2, #3, #4, #5, #6, #7, #8, #9, #10
		Provide support	#1, #5, #6, #7, #9, #10
		Share information	#1, #2, #3, #5, #9, #10

Table 6.7
Political and Symbolic Frame of Leadership

Political Leadership	Interview Response	Political Leader	Interview Response
They never let what they want cloud what is possible	#7	Clarify what they want and what they want to get	#7, #8, #9, #10
Think carefully about the players and their interests and power	#7, #9, #10	Access the distribution of power	#3, #5, #7, #9, #10
Ask questions about whose support do I need	#5, #9, #10	Build linkages to other stakeholders	#3, #5, #7, #9, #10
Value personal contact	#3, #5, #7, #9, #10	Persuade first, negotiate second and coercion if necessary	#7
Power is essential	#3, #4, #5, #7		
Symbolic Leadership	Interview Response	Symbolic Leader	Interview Response
Organization is a stage and everyone has a part to play	#1, #2, #3, #4, #5, #6, #7, #8, #9, #10	Interprets experiences as to what is happening in the world, what mission is worthy of our loyalty and investment	#5, #6, #7, #9, #10
Communicates the right impression to the right audience	#3, #4, #5, #9, #10	There are visionary leaders with passion, purpose and meaning	#6
		Transactional leader approach with an eye for trading one thing for another	#7
		Transformational leader bring out the best in their followers	#2, #3, #5, #6
		Use symbols to capture attention Do something visible to let people know change is on the way	#5, #9
		Frame experience to provide plausible interpretations of experience	#3, #5, #9, #10
		Tell a vision about us, our present, our past, our future	#4, #5, #9

Nurse administrators do use many frames of references, but mainly view leadership from the human resource frame. Nursing is based on a "caring model" (Interview Five, p.105). The human resource frame emphasizes human needs, such as the organization exists to serve human needs (Bolman and Deal, p.121) This may be why this frame is used most by nurses.

The restructuring efforts focus upon the changing organizational structures, a frame one half of the sample used, to varying degrees. Interview Ten, [corporate leader] used it consistently for all areas of leadership, and for the outlined strategies of the leader's role. Interview Ten was a key player in the restructuring process. Interview Five [ARNN], was only interested in centralized planning, and decentralized decision-making. She used all the strategies for the leader's role. Interview Nine [union] was interested in centralized planning and used two of the strategies of the leader's role. Interview Three [government level] was interested in decentralization of the organization, centralized planning and decentralized decision-making, and used two strategies of the leader's role. Interview Two spoke of the decentralization of the organization, the need for centralized planning, and resource allocation, but did not use this frame for the leader's role. This could indicate an awareness of the restructuring, but not active involvement in it by this particular participant. This administrator's position would become redundant.

Political leadership frames were moderately represented, which may be the reason why nurses have difficulty influencing decisions and getting the membership to act in unison. Interviews Seven, Nine and Ten, [former union, union and corporate] were the biggest users of this frame. Interview Three [ARNN] used the frame moderately.

The symbolic frame showed that all administrators saw their leadership as giving them a part to play within their organizations, but only Interviews Three, Four, Five, Nine and Ten [Government, Hospital, ARNN, Union, Corporate] were concerned about the image they portrayed of this leadership. The strategies of the symbolic leader were not well used by any, including Interview Ten [corporate]. The low use of these strategies by Interview Ten could affect the morale of the employees who are undergoing restructuring change, with further repercussions on their acceptance of the structural changes.

Shifting Nurses into a New Direction

There has been a successful movement to define and validate a higher education for nurses. Nursing education, with two programs, had created a pecking order between those who are hospital diploma school trained and the university educated. There is evidence that this division is creating insecurity for nurses without a degree (Interview Two, and Five, p.88). Professional identity and professional cohesiveness are threatened by the division in nursing education and nursing education is a method of bringing credibility and cohesiveness to the nursing profession (Interviews One, Three, Six, pp.91-93). Nursing education is difficult for the present nurse population with a diploma, if they want to upgrade to a nursing degree. Nurses do not receive credit for work experience toward their nursing degree. Tremendous progress has been made in making education accessible to shift workers through distance education (Interviews Two, Five, Six, Nine, p.96-98; Nine,). Students entering

nursing programs today show shifting demographic characteristics that will impact on nursing and promote it. (Interviews One, Five, pp.84).

Women have more career opportunities than before. Nursing is and has typically been a woman's career, but some men are pursuing a nursing career. There are still sexist barriers to women in nursing, and nursing has a long tradition of coping with sexist barriers, and unassertive behaviour. As opportunities continue to expand for women, students coming into nursing will demand more (Interview One, p.84). But nursing may cease to be an attractive profession for women.

Participants reported poor working conditions, low salaries, no employer support to women for day care, an oppressed working role, and nurse abuse (Interview One, Four, Six, Nine, pp.107-117). As nursing moves toward a higher education, with higher entrance requirements, combined with the high cost of nursing education, and low salaries for nurses, many women may not want to enter or stay in the profession. This has not been a concern at the present because the health care cuts have resulted in the under employment of nurses. However, as the population and the workforce continues to age, and technology continues to increase, the high calibre student may not see nursing as an attractive career choice.

The research identified many questions about what nurses are allowed to do and not allowed to do, which are presently being guarded by the ARNN and medicine. There is increasing momentum to question what nurses should be able to do in their practice and if medicine is the sole guardian of quality for patient care. The question being asked, is there a recognizable general category of health care services that nurses belong in, or have

responsibility for? There is an increasing need to more clearly define these roles, as other workers are being considered for many of nurses current responsibilities. Role redefinition is necessary because the value of nurses in health care is not recognized (Interviews One - Five, Six, pp.103-110; Two, Four, p.70; Four and Five, p.166-167; Five, p.103).

Nurses are challenging their position in health care and they plan to seek opportunities for a more valued role. There are still many barriers to nurses because of the high status and positioning of physicians. The patronage of physicians continues to exist through the regulation and funding arrangements with the Department of Health and MCP. This has created a hierarchical health care system that promotes medical professional dominance over other health care disciplines (Interview Three, pp.107-108). There were reports of a greater government funding commitment for doctors' education, more access to funds for medical research than for nursing research, more allocated work-time given to doctors for research, and more freedom to determine what other disciplines roles can be or should be (Interviews One, pp.100-101; One-Ten, pp.107-110; Ten, pp.59-61; Ten, p.171). The province, and indeed Canada, has legalized medical dominance and has legally limited the resources, and the access to resources of the other members of the health care team, including nurses. This is class dominance at the macro level of health care, that has been reflected at the micro level of relationships between nurses and doctors.

Nurses want a new relationship with medicine and they have expressed the need to move away from the medical paradigm. Nurses practice operates under the Caring Model, which is not fully understood by others or themselves. There was evidence that nurses as an

underprivileged group are attempting to join the more acceptable group. This was evident by one nurse denying that she had obtained a program director position because she was a nurse (Interviews One, p.104; Four, pp. 107-110; Five and Six, pp.103-105).

Consumerism is impacting on health care and this was identified as an important political force, that the ARNN was lobbying for support of, in order to increase nursing roles (Interview Five, p.154). Consumerism is important because what the public will support could influence if nurses are prepared for new roles, especially for services in community health, primary care and midwifery (Interview, Five, p.171). This effort to gain public support and move into independent practice could increase nurses' position in health care and facilitate the movement of nurses outside the medical dominance, that exists in the hospital structures. However, efforts have been frustrated by the medical paradigm and nurses lack of political power (Interviews Three, Four, Five, Six, Ten, pp.107-110; Ten, p.171).

Though nurses were described as having public support the public has lost sight of what nurses could do and of their capabilities, especially in the community. This could affect public support for preventive health (Interview Three, Eight, Nine, pp.157-159). The community was identified as a place where most nursing roles would be, but many nurses today do not have the education levels, since community health roles require a nursing degree or community health diploma (Interviews Five, p.91).

Participants stated that nurses had become sensitized to the need to have political skills and were more politically involved. The nurses' union employees received licensure hours for union work and it was considered a valuable leadership role. However, nurses were

reluctant to participate in the political process. Lobbying to influence the decisions of government officials was used, especially through research and the media. Most of nurses' lobbying was reported as occurring behind the scenes (Interviews Four, Five, Nine, pp.55-58).

Summary and Conclusion

Ambitious efforts to improve health care delivery are being pursued in all the areas of health care surveyed in the St. John's area. Bolman and Deal (1991) state that there is only one basic challenge that all leaders face. "How do you match the right idea to the right problem, at the right time, and in the right way?" The leaders who are restructuring health care were outside the domain of health care [Sister Elizabeth Davis] and face this challenge.

The nursing administrators interviewed were confronted with this challenge, since they had to cope with constant change. Their concerns, were directed at the effects that change was having on the value of nurses to health care, nurses' abilities to be effective in the new structures, the changing roles for nurses, the loss of control of their professional status and an increase in the competition between the medical model and the nursing model, which has developed into an adversarial relationship with medicine, as nurses and doctors roles become redefined.

There is resistance to the loss of nursing roles and it is too early to tell if change agents have underestimated the opposition to the new structures, or if the conflict has been driven underground in order to move the restructuring along at a faster pace. Areas of conflict

were noted, as well as indications that changes are being imposed on nurses, rather than making nurses initiators of change.

While leadership is an accepted cure for organizational ills, it is widely misunderstood, with unclear distinctions between leadership and management. Administrators use many frames to establish a more powerful leadership style, but the majority of administrators prefer the human resource frame. The research study related that leadership cannot be viewed just from the context of what was happening in a turbulent health care system, but leadership was "relational and contextual and it is not simply a matter of wielding power or occupying positions" (Bolman and Deal, 1991, p.421). The setting of the leadership role and the leadership positions of administrators influenced the way they described staff positions.

The research initially sought to answer the question "can nurses meet the marketplace needs for leadership?" The study exposed many factors impinging on nursing leadership, other than those traditionally associated with nurses' leadership roles, such as gender. The medical paradigm, a traditional barrier to nurses, was reported as restricting nursing practice, but this is now being challenged more, but is still a major barrier to future opportunities.

The recurring themes in the study were, 'does the health care system want and value nurses as leaders?' 'Does nurses and the health care system realize their potential as leaders?' While nurses face many workplace barriers to leadership, they also see many opportunities. The barriers that nurses face, such as the medical paradigm, is an issue for all disciplines, and not just nurses.

Further research needs to be done to determine the continuing effects of the health care restructuring and the roles of nurses in the new structures. A research study involving front-line staff could help to determine the effects of this restructuring on their leadership, and if they see themselves as given an expanded leadership role in the new structures. The importance of front-line leadership was identified in the research study because a stronger leadership role is indicated for front-line positions in the new organizational structures.

Recommendations

Davies (1995) contends that the present health care system undermines the confidence of the nurse, is restrictive to the contribution of nurses and constantly questions the abilities of nurses, resulting in the practice of nursing work being trivialized by the practical concerns of business. The reality of the organization of nursing work shows how it devalues the work of nursing and undermines and demeans the nurse. Salvage (1989) states it is therefore important that nurses not fall into the trap of blaming individuals for faults in the system, but what is needed is an examination of the structure and its dynamics to understand and solve the problems (Davies, 1995, pp.95-96). With these points in mind the recommendations are directed at the structures rather than individual administrators and are derived from the interview data and the areas identified by the Nursing Symposium report that have not been implemented.

Recommended Action

1. Increase nursing education opportunities to promote team building by: (a) developing a multi-disciplinary approach to student education by involving all disciplines in a presentation project and through participation in joint classes; (b) having students work collaboratively on assignments in order to become familiar with the dynamics of working in a group of peers and with other disciplines (c) providing education that is specifically focused on team building exercises; and, (d) offering a course specially aimed at understanding leadership and the role of leaders.

2. Nursing education should enable students to support one another (a) by encouraging students to work together in the clinical area and to seek peer support from floor staff; (b) providing opportunities for students to offer feedback to each other; (c) continuing and further developing the present mentorship relationship between junior and senior students; (d) by continuing to use the preceptorship program and by increasing this role; and, (e) examining the way supervision is carried out for other disciplines and reviewing how nursing is presently supervising students in the clinical areas to determine if alternatives supervision practices can be developed or improved.

3. Nurses degrees will be obtained in the same time frame as a diploma previously (Interview One), yet nurses who were educated in the three year diploma program receive little credit toward a nursing degree. (a) Decrease the amount of time required to complete a degree from

a diploma; (b) recognize work experience and additional courses with university credits, to promote a faster upgrading of nursing education to a degree status; (c) provide practice hours toward licensure for registered nurses upgrading their education; (d) make flexible scheduling more available for registered nurses seeking education; and, (e) provide free time for nurses to attend university classes.

4. Increase nurses' leadership abilities by providing opportunities for nurses to participate in: (a) assertiveness training; (b) conflict management; (c) leadership skills; (d) communication skills; and, (e) political skills. These could be promoted through tele-conferencing and distant education, in-service programs and seminars.

5. Reduce administration stress by: (a) providing stress and time management courses to all nurses as needed; and, (b) establish a support group for management.

6. Improve working conditions by: (a) creating more permanent positions; (b) examining how requests for additional staff are handled; (c) review how staffing needs are evaluated and improve staffing levels and patterns to reflect patient/client needs and staff safety needs; and, (d) provide booking for casual staff, when possible to reduce last minute call backs.

7. Reduce stress to line-staff by: (a) eliminating the myth a nurse-is-a-nurse by not over utilizing nurses in a wide variety of work settings and using casuals nurses in disproportionate

numbers to full time nursing staff; (b) eliminate non-nursing duties where possible so nurses can utilize their higher level skills; and, (c) encourage input from floor staff to determine the appropriate mix of casual staff to full time staff for the patient care needs.

8. Increase effective decision-making by: (a) providing formal structures to solicit feedback from staff both before, during and after changes; (b) providing the opportunities to serve on more decision-making bodies; and, (c) providing training to nurses involved in committees.

9. Increase leadership development by: (a) developing mentorship strategies for new staff to help them become integrated with existing staff; (b) increasing orientation of staff in clinical areas by using floor staff as mentors; (c) improving orientation programs for casual staff who have to work in many areas; (d) increasing the opportunities for nurses to develop speciality skills by providing staff education and funding for education; and, (e) providing opportunities for nurses with specialty skills to work on special projects and serve as resource people to staff.

10. Increase lobbying by: (a) lobbying MUN for administration education; (b) lobbying the government to respond to nurses need for administration; and, (c) lobbying the public for more support for the goals of nursing and their expanded roles.

11. Increase nurses' self image and the public's perception of nurses by: (a) having a public

relations plan promoting nurses through the media, to make nurses concerns more visible to the public; (b) capitalizing on the positive image of nurses and enlarge on this to include other roles; and, (c) continuing to monitor the image of nursing and seek media coverage to counteract any negatives and to promote even further the positive images of nursing.

12. Promote better collaboration between the nurses union and the ARNN in order: (a) to ensure that they are not working at cross purposes to each other; (b) to use more effectively the political power of the membership; and, (c) to develop joint research projects and public relations programs.

13. Create a concept of women's empowerment to overcome nurse [woman] as victim by: (a) identifying and studying issues that are not only a concern to nurses, but are relative to other women's issues ; (b) studying the political dynamics behind the women's liberation movement to understand how nursing roles fit in a society and are influenced by the society; and, (d) by becoming aware of politically active women and the way they have and are creating change.

14. Nurses need to make a difference in their own lives by: (a) developing more political skills; (b) learning to network with other disciplines; (c) developing political allies; (d) learning about the political process from conception of policy to implementation and how to influence this process; (e) influencing nursing image with the government, public and other

disciplines and becoming aware of unrecognized support for goals; and (f) learning to effectively lobby.

15. Nurses can use research and develop it further by: (a) lobbying employers to understand the patient care benefits and cost saving benefits of such research; (b) forming coalitions with other hospitals, universities and nurses to further clinical research; (c) encouraging original research by graduate nursing students; (d) lobbying for funding for research and make nursing research as important as medical research to establish a practice based on research; (e) gaining support for a research based practice, which can benefit health care delivery and create an independent practice for nursing.

Conclusion

My reason for selecting nursing leadership was questioned many times during my research study. One person asked, "what is the subject of your thesis? When I replied, "Nursing leadership. Can it meet the marketplace needs?" His reply was, "You're pulling my leg, right? Nurses are not leaders." I explained to him that indeed nurses are leaders, since they represent major parts of the administration structures of health care systems. However, what was more ironic was when nurse colleagues had the same reaction to my research project and I was giving them the same explanation. This raises the question, how is nursing going to transform itself and assume a more empowered leadership role?

Popkewitz (1991) contends that shifting views of pedagogy are coupled with changes in social organizations and reforms of professions and pedagogy are tied to the changing problems of knowledge and regulation in society. Reform is often a response to larger issues of social transformation and power (pp.66-77). Economic constraints are creating many reforms to health care. The changing organizational structures have forced nursing to reevaluate its knowledge, and how it is regulated by its professional organizations, the medical profession and by social expectations.

Nursing is attempting a social transformation of its historical oppression and conformity by promoting a more independent and empowered nurse, who is capable of giving strong leadership, accomplished by a universal university education. However, this education has failed to make leadership a key component for its faculty or its curriculum. Nurses transformation will not be accomplished by nurses who have failed to understand the importance of their leadership roles, and its value to society. Nursing leadership is under tremendous pressure for change. However, a more powerful force for change may be needed.

The symbolic role of the nurse receives general public support, but the reality of being a nurse is often misunderstood by the public and the role of leadership by nurses. Nursing leadership is provided by nurses who operate in organizational structures that treat them as an under privileged group, who can demonstrate successful leadership by learning to work with the dominant and privileged medical group (Interview Ten, p.61). Doctors are seen as offering a valuable resource, however, the pressures of resource restraints have not impacted on medicine to the degree it has on nurse administrators.

Nurse administrators practice and work in a system that recognizes and competes with two complementary frames of reference, the medical model and the nursing model (Caring Model). Nursing is being influenced and affected by this division. Nursing administrators who have attained positions of leadership cited this as a key obstacle to their attainment of future opportunities in the new structures of health care.

Nurses as an underprivileged group attempt to join a more acceptable group. This was revealed by an administrator who had attained a key leadership position in program management and stated she had not been given this leadership role because she was a nurse (Interview One, p.91). A similar stand by administrators will not facilitate the removal of the obstacles that nurses face in their leadership roles. There is a need for nurses to understand the processes by which groups are willing to endure oppression and the way nursing may be contributing to this oppression, in order for society and nurses to gain a greater understanding of their value to the health care system.

There is a questioning of the worth of nurses, as indicated by the over riding themes in the research study. Does the health care system want and value nurses as leaders? And do nurses and the health care system realize their potential as leaders? Leadership is a complex problem in nursing and will be very much influenced by the ability of the profession to transform itself. There were many indications that attempts are being made, but nurses still face asymmetrical patterns of power and privilege, and this has a great impact on how they are able to exercise leadership in health care systems.

References

- Altieri, L. B. & Elgin, P.A. (1994, October). A decade of nursing leadership research. Holistic Nursing Practitioner, pp. 75-82.
- Anderson, R. (1993). Nursing leadership and healthcare reform. Part I: Patient care delivery in a reformed healthcare system. Journal of Nursing Administration, 23 (10), 10-11.
- Bandman, E. & Bandman, B. (1988). Critical Thinking in Nursing. Norwalk: Appleton & Lange.
- Barker, A. M. & Young, C. E. (1994). Transformational leadership: The feminist connection in postmodern organizations. Holistic Nursing Practice, 9 (1), 16-25.
- Bolman, L. G. & Deal, T. E. (1991). Reframing Organizations. Artistry, Choice, and Leadership. San Francisco: Jossey - Bass Publishers.
- Booth, R. Z. (1995). Leadership challenges for nurse practitioner faculty. Nurse Practitioner, 20 (4), 52-58.
- Borman, J. S. (1993). Women and nurse executives. Finally some advantages. Journal of Nursing Administration, 23 (10), 34-40.
- Cainni, M. & Romberger, B. (1995). Interactions with senior managers: Perceived differences by race/ethnicity and by gender. Sex Roles: A Journal of Research, 32 (5/6), 353-373.
- Chapman, G. E. (1983). Ritual and rational action in hospitals. Journal of Advanced Nursing, 8, 13-20.
- Chinn, P. L. (1991). Looking into the crystal ball: Positioning ourselves for the year 2000*. Nursing Outlook, 39 (6), 251-256.
- Clare, J. (1993). A challenge to the rhetoric of emancipation: Recreating a professional culture. Journal of Advanced Nursing, 18, 1033-1038.
- Collinson, V. (1989, April). Women moving into administrative positions. The Canadian School Executive, pp. 3-7.
- Davies, C. (1995). Gender and The Professional Predicament In Nursing. Philadelphia: Open University Press.

- Dickerson, S. S. & Campbell-Heider, N. (1994). Interpreting political agendas from a critical social theory perspective. Nursing Outlook, 42 (6), 265-271.
- Di Rienzo, S. A (1994). Challenge to nursing: Promoting followers as well as leaders. Holistic Nurse Practitioner, 2 (1), 26-30.
- Dyson, L. (1994). Where have all the leaders gone. Nursing New Zealand, 2 (9), 28-29.
- Earle, P. (Personal communication, October, 1995). St. John's, NF.
- Eason, F. R. (1990). Leadership by the pros for the novice. Journal of Nursing Education, 29 (4), 188-189.
- Haines, J. (1993). Leading in a time of change. The challenge for the nursing profession. A discussion paper. Ottawa: Canadian Nurses Association.
- Haynor, P. M. (1994). The coaching, precepting and mentoring roles of the leader within an organization setting. Holistic Nursing Practice, 2 (1), 31-40.
- Heinrich, K. & Scherr, M. W. (1994). Peer mentoring for reflective teaching. A model for nurses who teach. Nurse Educator, 19 (4), 36-41.
- Hibbard, J. & Kyle, M. E. (1994). Nursing Management in Canada. Toronto: W. B. Saunders Canada.
- Holland, C. K. (1993). An ethnographic study of nursing culture as an exploration for determining the existence of a system of ritual. Journal of Advanced medicine, 18, 1461-1470.
- Irurita, V. F. (1994). Optimism, values, and commitment as forces in nursing leadership. Journal of Nursing Administration, 24 (9), 61-70.
- Jacox, A. (1993). Estimates of the supply and demand for doctorally prepared nurses. Nursing Outlook, 41 (1), 43-45.
- Jennings, B. M. (1995). Nursing research. A time of redirection. Journal of Nursing Administration, 25 (4), 9-11.
- Kersbergen, A. L. (1994). Reinstating nursing administration graduate study in federal nurse traineeships. Journal of Nursing Administration, 24 (7/8), 12-14.

- Kincheloe, J. (1995). Meet me behind the curtain: The struggle for a critical postmodern action research. In McLaren P. L. & Giarelli, J. (Eds.), Critical theory and educational research (pp.71-89). Albany: State University of New York Press.
- Kirkwood, R. (1988). The development of university education in Canada, 1920-1975: Two case studies. Unpublished doctoral dissertation, University of Toronto, Institute for Studies in Education, Toronto.
- LeCompte, M. D. & Preissle, J. (1993). Ethnography and Qualitative Design in Educational Research, Second Edition. Dan Diego: Academic Press, Inc.
- MacLeod, M. & Farrell, P. (1994). The need for significant reform: A practice-driven approach to curriculum. Journal of Nursing Education, 33 (5), 208-214.
- Manfredi, C. M., & Valiga, T. M. (1990). How are we preparing nurse leaders?: A study of baccalaureate curriculum. Journal of Nursing Education, 29 (1), 4-9.
- McLaren, P. L. (1995). Collisions with otherness: "Traveling" theory, postcolonial criticism, and politics of ethnographic practice - The Mission of the wounded ethnographer. In McLaren, P. L. & Giarelli, J. (Eds.), Critical theory and educational research, (pp. 271-300). Albany: State University of New York Press.
- McLaren, P. L. and Giarelli, J. M. (1995). Introduction: Critical theory and educational research. In McLaren, P. L. & Giarelli, J. (Eds.), Critical theory and educational research, (pp. 1-22). Albany: State University of New York Press.
- Millar, J. (1991). A crisis of leadership? Nursing Times, 87 (2), 22-30.
- Morrow, R. A. with Brown, D. D. (1994). Critical Theory and Methodology. Thousand Oaks: SAGE Publications.
- Moss, M. T. (1995). Developing glass-breaking skills. Nursing Administration Quarterly, 19 (2), 41-47.
- Neubauer, J. (1995). The learning network. Leadership development for the next millennium. Journal of Nursing Administration, 25 (2), 23-32.
- Newfoundland and Labrador Health Care Corporation (July, 1996). Model for a redesigned health care system in Newfoundland and Labrador. Paper prepared by the Newfoundland and Labrador Health Care Corporation, St. John's, Newfoundland.

- Newfoundland Labrador Nurses Union (1996). Newfoundland and Labrador Nurses Union. Nurses views on healthcare reform. Summary of nurses' views. (Available from Newfoundland and Labrador Nurses Union, St. John's, Newfoundland).
- Nursing Human Resource Committee and Symposium Delegates. (1992). Nursing Human Resource Committee and Symposium Delegates. Follow up report to the Minister of Health including recommended action plan. Prepared by the Nursing Human Resource Committee and Symposium Delegates for the Province of Newfoundland and Labrador.
- O'Toole, J. (1995). Leading Change. The Argument For Values-Based Leadership. New York: Ballantine Books.
- Popkewitz, T. S. (1991). A Political Sociology of Educational Reform. Power/Knowledge in Teaching. Teacher Education and Research. New York: Teachers College Press.
- Redmond, G. M. (1995, February). "We don't make widgets here". Voices of a chief executive nurse. Journal of Nursing Administration, 25 (2), 63-69.
- Richardson, S., Valentine, P., Wood, M., Godkin, D. (1994). Leadership: A nursing perspective. Journal of Nursing Research, 26 (4), 85-96.
- Rider, J. A. & Riley-Giomariso, O. (1993) Baccalaureate nursing students' perspectives of their clinical nursing experience. Journal of Nursing Education, 32 (3), 127-132.
- Rost, C. R. (1994). Leadership a new conception. Holistic Nursing Practice, 9 (1), 1-8.
- Ryan, M. E. & Hodson, K.E. (1992). Employer evaluation of nurse graduates: A critical program assessment element. Journal of Nursing Education, 31 (5), 198-202.
- Simms, L. M., Price, S. A. & Erin, N.E. (1994). The Professional Practice of Nursing Administration (2nd ed.). Albany: Delmar Publishers Inc.
- Skinner, M. D. (1994). Getting to X. Nursing Administration Quarterly, 18 (3), 58-63.
- Stivers C. (1991). Why can't a women be less like a man? women's leadership dilemma. Journal of Nursing Administration, 21 (5), 47-51.
- Thomas, J. (1993). Doing Critical Ethnography. Newbury Park: Sage Publications.

- Valiga, T. M. (1994). Leadership for the future. Holistic Nursing Practice, 9 (1), 83-90.
- Walsh, A. (1995). Gender differences in factors affecting health care administration career development. The Journal of the Foundation of American College of Health Care Executives, 4 (2), 263-277.
- Watson, J. & Phillips, S. (1992). A call for educational reform: Colorado nursing doctorate model* as exemplar. Nursing Outlook, 40 (1), 20-26.

Interviews

- Interview One (speaker). (1996). Audio cassette recording of dialogue on nursing leadership. (transcribed and conducted by Patricia Downton). In writer's collection, to be destroyed on completion of research project.
- Interview Two (speaker). (1996). Audio cassette recording of dialogue on nursing leadership. (transcribed and conducted by Patricia Downton). In writer's collection, to be destroyed on completion of research project.
- Interview Three (speaker). (1996). Audio cassette recording of dialogue on nursing leadership. (transcribed and conducted by Patricia Downton). In writer's collection, to be destroyed on completion of research project.
- Interview Four (speaker). (1996). Audio cassette recording of dialogue on nursing leadership. (transcribed and conducted by Patricia Downton). In writer's collection, to be destroyed on completion of research project.
- Interview Five (speaker). (1996). Audio cassette recording of dialogue on nursing leadership. (transcribed and conducted by Patricia Downton). In writer's collection, to be destroyed on completion of research project.
- Interview Six (speaker). (1996). Audio cassette recording of dialogue on nursing leadership. (transcribed and conducted by Patricia Downton). In writer's collection, to be destroyed on completion of research project.
- Interview Seven (speaker). (1996). Audio cassette recording of dialogue on nursing leadership. (transcribed and conducted by Patricia Downton). In writer's collection, to be destroyed on completion of research project.

Interview Eight (speaker). (1996). Audio cassette recording of dialogue on nursing leadership, (transcribed and conducted by Patricia Downton). In writer's collection, to be destroyed on completion of research project.

Interview Nine (speaker). (1996). Audio cassette recording of dialogue on nursing leadership, (transcribed and conducted by Patricia Downton). In writer's collection, to be destroyed on completion of research project.

Interview Ten (speaker). (1996). Audio cassette recording of dialogue on nursing leadership, (transcribed and conducted by Patricia Downton). In writer's collection, to be destroyed on completion of research project.

Appendix A

TOPIC RESEARCH QUESTIONS

1. What is your definition of nursing leadership?
2. How would you describe nurses perception of their leadership potential and skills?
3. Do you feel that nursing administration potential and skills are developed enough to meet your workplace needs, in light of the present changes in health care?
4. Do you feel there are any barriers to nurses seeking their full leadership potential or the development of their leadership skills for administration positions in your workplace? Do you feel there are opportunities for nurses to develop and use their leadership skills in your workplace?
5. How are nurses leadership skills used by your workplace?
6. Do you feel that nurses in general need to change their perceptions of leadership? Do you feel this will empower nurses if they do?

July 4, 1996

Dear -----:

I am a graduate student in the Faculty of Education at Memorial University of Newfoundland, who is doing a research project as partial requirement toward a Master in Educational Leadership. Dr. C. Doyle will supervise this research project.

I will be interviewing nursing administrators within the province of Newfoundland to obtain their views on nursing leadership. A list of the interview research topic questions is enclosed for your consideration. I have focused my research project on nursing administrator's viewpoints because of their "lived experiences" of the opportunities and the barriers to nurses attaining leadership positions. Also administrators can offer insights into nursing's present leadership position.

Your participation is completely voluntary and you have the right to withdraw from this study at any time. A resource person, not directly associated with this research project, is available to you, Dr. Patricia Canning, Associate Dean, Graduate Programmes/ Research and Development. She may be contacted if you have any questions or concerns regarding this research study at 737-3402.

You may refrain from answering any questions you prefer. The interview will be one hour, and will be tape recorded. The taped interviews will be transcribed. You will be given the opportunity to view the transcription for accuracy, if you so desire. All tapes will be destroyed following completion of the research project.

All information gathered in the study is strictly confidential and at no time will individuals be identified. This study will not focus on individual views, but on the views of nursing leadership from the viewpoint of all participants in the study. This study has received the approval of the Faculty of Education's Ethics Committee. The results of my research will be made available upon request.

If you have any questions or concerns please contact me at 722-7479. Thank-you for your consideration of this request.

Yours Sincerely,

CONSENT FORM

I _____ agree to participate in this study on nursing leadership, undertaken by Patricia Downton. I understand that participation is entirely voluntary and I may withdraw at any time. All information is strictly confidential and no individual will be identified.

_____Date

Signature



