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**Nurse Managers' Ethical Conflict with Their
Health Care Organizations:
A New Zealand Perspective**

**A thesis presented in partial fulfillment of the requirements
for the degree of
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ABSTRACT

Immersed in a context of constrained health resources, nurse managers are at great risk of the experience and negative consequences of values clashes and ethical conflict, such as burnout and attrition. Replicating a qualitative descriptive study previously conducted in Canada (Gaudine & Beaton, 2002) this research is aimed at increasing knowledge of the experience of nurse managers' ethical conflict with their health care organizations in New Zealand. Semi-structured interviews were used to gather data from eight nurse managers in New Zealand, which was analyzed using a general inductive approach to qualitative research. The experience of advocating for values that may be shared by both nursing and the health care organization, such as safety, teamwork and quality patient care, were revealed in the conceptual category of *Nursing Management Advocacy*. As with their Canadian study counterparts, *Isolation* was revealed as a key factor that made the experience of ethical conflict worse and involves the social experiences of silencing, employment barriers and invisibility. *Support* describes the factors that mitigated the experience of ethical conflict and involves personal, professional and organizational support, and are likewise similar to the experiences of Canadian nurse managers. The *Bottom Line* describes a focal point of the experience of ethical conflict where the health care organizations predominantly fiscal bottom line was confronted and challenged by nurse managers, and where the nurse manager might reach their own bottom line and choose to leave the organization. *Being and Becoming Nursing Leaders* describes the outcomes of ethical conflict for nurse managers who were not only transformed into nursing leaders, through learning, reflection, and growth but also counted the costs of nursing leadership. This study concludes that supportive colleagues, organizational structures and culture are essential to mitigating the experience of ethical conflict and isolation which nurse managers encounter. The study also concludes that reducing isolation and supporting nurse managers will ensure that nursing values are appropriately represented and articulated in the health care organization's decision making systems and processes.

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CHAPTER 1 – INTRODUCTION

As with many of its international counterparts, New Zealand's public health care system and services have undergone 20 years of significant and continuous reform and restructuring (Gauld, 2003; Seedhouse, 1995). Indeed, not only does New Zealand have the most restructured health care system in the world (Gauld, 2003), changes have gone further and occurred faster than any other developed country (Davis & Ashton, 2001). Underpinned by rapid and broad neoliberal economic reform, the initial key policy driver in the transformation of New Zealand's public health system was cost containment (Health Benefits Review Committee, 1986; Treasury, 1984). With emphasis on structural, administrative and fiscal management to produce more effective and efficient utilization of health resources, particular change activities have included the separation of funding from provision of health care, population based and capped global budgets, and the institution of generic management structures and practices into health services (Ashton, 1995; Ashton, Mays & Devlin, 2005).

The embrace of *managerialism* in New Zealand's reformed health system has, and continues to have, a marked impact on nursing (McCloskey & Diers, 2005; Ashton et al., 2005; Gauld 2001; Wells, 1999). A reflection of market place business ideology, *managerialism* emphasizes efficiency and effectiveness in service delivery (Gower, Finlayson & Turnbull, 2003; Gauld 2003; Finlayson & Gower, 2002; Beardwood, Walters, Eyles & French, 1999; Wells, 1999). Restructuring of health services and hospitals to achieve efficiency, resulted in the collapse of many nursing structures, reduction of nursing numbers, and in many cases the loss of nursing control over clinical budgets (McCloskey & Diers, 2005; Gower et al., 2003; Gauld 2003; Carryer, 2001).

The role and responsibilities of the nurse manager in the reformed and restructured context have not only enlarged but offer new challenges (Thorpe & Loo, 2003; Wells, 1999; Ingersoll, Cook & Fogel, 1999). Managing service redesign, restructure and re-engineering activities, managing and auditing clinical standards, assuming corporate responsibility, managing quality of service, recruiting and retention of specialist nursing staff, and managing the frustrations of staff are but a few of the new challenges facing today's nurse managers (Thorne & Loo, 2003; Wells, 1999; Ingersoll, Cook & Fogel, 1999).

Thus, contemporary nursing managers have been reinvented (Thorpe & Loo, 2003; Wells, 1999). Not only do they embrace the core and essential caring and humanistic values of their profession, they also embrace the values of the health care organization in a fiscally prudent and socially responsible environment. It is a duality of values however, that is fraught with tension and ethical conflict (Gaudine & Beaton, 2002; Gaudine & Thorne, 2000; Wells, 1999).

This study, *Nurse Managers' Ethical Conflict with Their Health Care Organizations: A New Zealand Perspective*, is unquestionably motivated by my own experiences as a nurse manager in the reformed and restructured New Zealand health care system. My first role as a nurse manager was brief (a mere 15 months), fractious, painful, distressing and disappointing. I believed, perhaps naively, that over 20 years experience as a Registered Nurse, and significant advanced study in nursing and management would provide me with the requisite competence for nursing management practice. However, there was little consistency between my nursing management job and what I had studied – and I believed it was more than a mere theory-practice gap. Moreover there were few who could or would help me to understand inherent inconsistencies, in all facets of the role. Frequently I would say, 'I just cannot win'. On the one hand I would focus on ensuring that the

patient's needs were met as best as possible within the scope and resources of my role. On the other hand, to do so would earn me tremendous criticism from the clinical nurses whom I managed, my nursing management peers and my own general managers. Even though it might have been my responsibility to do so, taking a firm stand in particular circumstances, balancing all the necessary demands, expectations and values, was often met with treacherous repost. I began to wonder if my colleagues and bosses existed in a different world from me; were they protecting their own professional aspirations, were they trying to win accolades from the organization, and did they in fact apply any values, nursing or otherwise in their practice. In the end, my decision to leave my first nursing management role was based on keeping my professional integrity intact, and the belief that I was hitting my head against brick walls and sustaining injuries that I simply did not have to. There would be other opportunities, but there were things that I needed to know and understand first. This research project is therefore an endeavor of great professional and personal importance, and as the study will demonstrate, I have not been alone in my experiences.

Stepping out and away from the day to day struggles of nursing management provided me with the opportunity to reflect on my nursing management experience and to formulate important questions:

- Why was there so much conflict in nursing management and was it always a question of fiscal limits?
- Were the organization's values consistent with professional nursing?
- Why did I not feel supported and who should have been supporting me in my nursing management role?

This study addresses all of these questions and many others, by investigating the experience of nurse managers' ethical conflicts with

their health care organizations. I was fortunate to find a previous qualitative study (Gaudine & Beaton, 2002) conducted in Canada in 2001-2002, that tackled many of my concerns and questions, and helped to place my inquiry into a meaningful framework. It has thus provided the foundations for this study and is discussed in some detail in the review of the literature in Chapter 2. After outlining the political and economic context and consequences of reform and its effects on the public sector, Chapter 2 then specifically addresses the effects of reform on health policy, health care structures, professional nursing and patient care outcomes, both in New Zealand and internationally. Values in professional nursing and reformed health care systems are outlined next. A review of empirical and theoretical literature concerning ethics in nursing and health care generally is provided, followed by a detailed examination of the concept and experience of ethical conflict in nursing and nursing management.

Chapter 3 sets out the methods for the study. Replicating the qualitative descriptive approach of the study by Gaudine and Beaton (2002), this part outlines the methodological underpinnings for the current study. This chapter also addresses participant recruitment and selection, followed by data collection and analysis. An outline of the establishment of research rigour and ethical considerations is provided.

A detailed presentation of conceptual, descriptive and thematic findings from data analysis is provided in Chapter 4. Following this, Chapter 5 provides a comprehensive discussion of the study findings including comparison and contrast with the foundational study and other literature. Conclusions and implications of the study are set out in Chapter 6.

This study is grounded in a context of ideologically driven political and economic reform, which has transcended health policy, health systems

and health care structures, to affect the roles, responsibilities and experiences of nurse managers. It is therefore not a study concerned with ethics, values, conflict, nursing or management individually per se, but the transcendence and intersection of all these things within the social experience of nurse managers, immersed in managing and leading nursing care in contemporary health care organizations.

CHAPTER 2 – REVIEW OF THE LITERATURE

The objective of this chapter is to review several dimensions of the literature as it pertains to the experience of nurse managers' ethical conflict with their health care organizations. The first part places the study into a context of political and economic reform from 1980-1999, and is aimed at highlighting the political ideological foundations of reform and restructuring in the public sector. Following this, a review of the consequences of reform on the New Zealand health sector is made, including health policy, health system and health services structure. Next, a review of the impact of reform and restructuring on professional nursing is made drawing on both theoretical and empirical sources. International and New Zealand based literature is outlined with a focus on the impacts of change to nursing services and the nursing workforce, the quality of nursing care and the effect on patient outcomes.

The review then narrows its focus to outline how reform has affected the values of health care services, in particular the interface of health professional and health care organizational values. Ethics in nursing practice and the phenomenon of ethical conflict and its implications for nursing and most importantly nurse managers is introduced. At this juncture ethical conflict is defined, along with its implications. To support the current project, a literature search was conducted to identify both theoretical and empirical literature which specifically addressed the concept and problem of ethical conflict in nursing. The method for this literature search involved five electronic databases, Web of Science, Medline, CINAHL, Academic Search Elite, and Medical Databases on Ebsco Megafile, using the search words, ethics, values, nursing, management and conflict in the abstract and topic fields, and limited to the period of 1995 onwards. Literature was selected for its academic accessibility as well as relevance to the topic. of nurse managers' ethical conflict with their health care organizations. The chapter is

concluded with a summary of the literature that has been reviewed, followed by the identification of the rationale for the present study.

2.1 THE ECONOMIC AND POLITICAL CONTEXT OF CHANGE

The Labour movement that grew throughout the world from the 1930's, defined its role as one addressing the inequities of the rewards of capitalism (Castles & Shirley, 1996). In both the post war periods, New Zealand citizens were concerned with economic, strategic and social security issues, in times of sickness, old age or unemployment (Gustafson, 1997). Michael Savage's first Labour government in the 1930's, did much to appease these concerns by the introduction of social security and a universally accessible largely tax-payer funded health care system (Gustafson, 1997). The tenants of social security transcended the ideological refinements of succeeding liberal and reformist National governments, to maintain the ideals of an egalitarian society (Blank, 1997).

Orthodox Keynesian economics, which dominated not only Labour but National party politics prior to the 1980's, is based upon the principle that markets cannot automatically maintain stable activity at full potential (Gustafson, 1997). Where the "...market is clearly failing to foster growth or cope with temporary economic crisis to deal with social inequalities, then the government should intervene to achieve the desired result" (Gustafson, 1997, p.6). When Great Britain entered the European Community in the 1970's however, New Zealand's insular and protective Keynesian economic policies faltered (Sautet, 2006). Some concessions for a failure to reform dramatically, may rest upon the fact that the third Labour government took office during an economic cycle upturn, and it was a time of relatively full employment (Rudd, 1997). After the first of the oil shocks in 1974, and a prolonged and difficult stagnation in agricultural exports, particularly wool, policies of economic

diversification proliferated in an attempt to combat the growing economic recession (Easton, 1997). The end of New Zealand's golden era of prosperity provided the platform for extensive and rapid political and economic reform (Sautet, 2006; Aberbach & Christensen, 2001).

The era of neoliberal transformation of New Zealand has been well documented and critically examined by political and legal analysts and academics (see for example: Castles, Ferritsen & Vowles, 1996; Easton, 1997; James, 1997; Kelsey, 1993; Kelsey, 1997; Miller, 1997). With philosophical roots in the Chicago School of Economic and Political Thought, neoliberalism and monetarist economic policy have dominated New Zealand's political landscape from the mid 1980's (Brook Cowen, 1997). Neoliberal theory involves classical liberal and economic philosophy combined with present day market orientation (Brook Cowen, 1997). Neoliberalism advocates, *inter alia*: responsible economic policy and fiscal rectitude, free and deregulated markets and trade, privatization, utility maximization, minimalist labour laws and restricted welfare provision (Rodrik, 1996; Tenbensel & Gauld, 2001). Ideologically, monetarism espouses the superiority of the market place over government, competition over co-operation, and self-reliance over community responsibility (Brook Cowen, 1997). Aimed at deprotection and deregulation of the economy, key macroeconomic changes of the era of 1984-1990 included a series of tax reforms, alongside divestment and corporatisation of government assets (James, 1997).

Yet not only did abandonment of Keynesian economic management reduce government intervention in the market place, it also considerably altered political commitment to an egalitarian society (Boston & Dalziell, 1992). The value of human dignity, distributive justice, and social cohesion, gave way to a more limited state, the pursuit of efficiency, self-reliance, and fiscal balance (Boston & Dalziell, 1992). Whilst New Zealand was indeed gripped by a then global economic recession,

reform came surprisingly at the hand of a Labour government, previously entrenched in the ideals of egalitarianism and the amelioration of social injustices (Castles & Shirley, 1996; James, 1997; Street, 1997).

Political economics were therefore imperative, but the impact of these considerations on social policy, in particular health policy, was tempered by the mould of Labour's egalitarian predecessors and to a lesser extent Prime Minister Lange's refusal to allow economic policy to spill over into social policy (Rudd, 1997). However, in December 1990 a newly elected National government released an economic package aimed specifically at reduction of the fiscal burden of the welfare state (Scott, 1994). It was considered that the massive rise in social spending was regarded as a principle cause of New Zealand's large debt burden (Scott, 1994).

To the extent that the Fourth Labour Government had resisted significant reform of social policy, the National Governments of 1990-1999 (including a coalition government with the populist New Zealand First party) did not (Miller, 1997a; Wood, 2001). A more targeted approach to social services and security was born out in areas of education, housing and health (Scott, 1994). Simultaneously, further deregulation and liberalization of the economy occurred through reductions in government assistance in industry, alongside the deregulation of banking, finance, energy and telecommunications (Scott, 1994).

To facilitate reform, it was also necessary to systematically deregulate and alter industrial relationships through laissez faire legislation such as the Employment Contracts Act 1991 (Walsh, 1997). The Act replaced centralized wage bargaining with decentralized entrepreneurial bargaining, weakened unionism, and gave employees and employers the choice of individual or collective contracts (Walsh, 1997; Sautet,

2006). Because labour is the primary factor in all businesses, the Act was therefore a key mechanism in shifting the locus of labour market control and with this, the social prosperity of the workforce, to the entrepreneurs of the business sector, where the ability to exploit the workforce for productivity and efficiency was realized (Sautet, 2006). The Act has since been replaced by the Employment Relations Act, 2000, that in principle, promotes the creation of employment relationships, and good faith in those employment relationships (Brown, 2005).

The shift from government regulation of economic growth and prosperity to the private sector was institutionalized not only through macroeconomic policy and change, but also the influence of human and organizational theory in the organization and management of the public sector. Public choice, agency, and new public management theory or *managerialism* have been highly influential in contemporary New Zealand public policy and reform (Boston, Martin, Pallot & Walsh, 1996; Tenbensel & Gauld, 2001). Public choice theorists posit that the primary factors motivating people are self-interest and personal gain (Tenbensel & Gauld, 2001; Brook Cowen, 1997). In order to counter these motivations, public choice theorist advance restrictions on the constitutional power of politicians, policies that restrict and split government bureaucracies and policy processes free from the influence of interest groups (Mitchell & Simmons 1994, cited in Tenbensel & Gauld, 2001; Brook Cowen, 1997). Agency theory views the world in terms of the economics of organizations and relationships, and focuses on the establishment of written contract relationships to ensure delivery of the requirements of the relationship (Tenbensel & Gauld, 2001). *Managerialism* draws its influence from the management of private organizations and is a response to perceived administrative shortcomings in public organizations (Tenbensel & Gauld, 2001). The proponents of *managerialism* see no difference between the

management of public and private organizations, "...arguing that public agencies will be more efficient and responsive if private management practices are adopted" (Tenbensel & Gauld, 2001, p. 37). *Managerialism* is thus built around the idea that management is a function that is the same regardless of the organization or persons to which it related (Wells, 1999).

At the institutional level, these theories have had a marked impact. The public servant is no longer the apolitical agent providing their ministers with policy advice (Martin, 2001). Aided by the State-Owned Enterprises Act 1986, the State Sector Act 1988, and the Public Finance Act 1989, the centralized machinery of government has been transformed (Martin, 2001). Alongside the devolution of public sector activities into the private sector, public servants now operate in an entrepreneurial, results-focus business environment (Martin, 2001). The common themes in a global movement of public sector transformation are efficiency and effectiveness with focus on outputs not inputs, and performance measured in quantitative rather than qualitative terms (Martin, 2001). The devolution of management responsibilities to chief executives is a hallmark of New Zealand's public sector reform (Martin, 2001).

2.2 HEALTH POLICY, SYSTEM AND STRUCTURAL REFORM

In the two decades prior to the neoliberal reform era, New Zealand's dominant coinciding demographic trends were: increased net migration, particularly from Europe; decline in mortality rates generally and in particular in the Maori population; record fertility rates; and lastly a steady increase in the population aged 65 years and over (Poole, 1991). As a consequence these demands were reflected in the health sector by a marked increase in overall public health expenditure (Department of Health, 1969), increased hospital inpatient treatment (Department of Health, 1972), and increased hospital bed capacity (Department of

Health, 1975). In no small way can the rising cost of funding health services, improved mortality rates and an ageing population be attributed to the advances in medicine and technology such as antibiotics, modern surgical procedures, chemotherapeutics and many others. All these factors, alongside the social and economic prosperity that New Zealand enjoyed in the post World War II period, impacted on the health system. Indeed, creating a scenario where the availability of medical treatment was reinforced as a fundamental human right, in a regime of politics that saw its mandate resting in an open ended commitment to universal health care for all citizens (Blank, 1997).

Health policy changes in the pre 1980's reform era included increases in the general medical, physiotherapy and dental benefits schemes (Basset, 1976). Greater regulation and coordination of health sector efficiency was reflected in changes to hospital administration (Department of Health, 1969). Planning for the transfer of control of mental hospital to Hospital Board control was commenced and continued through Labours' government in 1972 (Department of Health, 1975; Truman, 1984).

In 1975, during the term of the third Labour Government, the Department of Health in New Zealand telegraphed principles of important reform of the health system by way of the *White Paper* (Department of Health, 1975). These principles, which remain influential today, are summarized as: a shift to community responsibility for health needs; the alignment of financial and administrative control of health services; the organization and administration of services on the basis of community health needs; functional integration of health service components; rationality in planning and future development; and a national health service (Department of Health, 1975). Yet reform did not automatically follow the policy advice at this time, waiting another decade to be initiated.

The pre 1980's organizing structure of locally elected hospital boards was coupled with the triumvirate management model: the chief executive, the medical superintendent and the chief nurse (Ashton, et al, 2005; Jacobs, 1994). A natural product of hospital development rather than planned management, the triumvirate model was seen as a desirable and efficient structure that appropriately reflected the multi-disciplinary nature of health services, and the equal status of team members and consensus decision-making (Jacobs, 1994).

During the term of the Fourth Labour Government, two significant policy reviews of health sector structure and performance were undertaken, 'Choices for Health Care' (Scott, Fougere & Marwick, 1986) and 'Unshackling the Hospitals' – the *Gibbs Report* (Gibbs, Frazer & Scott, 1988). The reports placed emphasis on the structure and funding of primary and secondary services, inefficiencies in the hospital system and hospital management (Scott, et al., 1986; Gibbs, et al., 1988; Scott, 1994; Jacobs, 1994; Ashton et al., 2005). The *Gibbs Report* in particular recommended replacement of the triumvirate management model with a single general manager responsible for all aspects of performance (Gibbs et al., 1988). The rationale provided was that triumvirate management stifled leadership, diluted accountability, resulted in poor management relationships and consequential ignorance of management responsibilities (Gibbs et al., 1988; Jacobs, 1994). Furthermore the report suggested that professional groups could unduly influence decision-making without balanced consideration of the goals and priorities of health services.

The influence of organizational theories such as public choice, agency and new public management is clearly manifest not only in the aforementioned policy advice but also in a raft of structural changes in New Zealand's health system. It was also evidenced in international trends in health care system reform, such as those of the United

Kingdom, Spain and Sweden where market led reform significantly, although more slowly, underpinned political and economic transformation (Laugesen, 2005; Seedhouse, 1995). In New Zealand, local hospital board governance structures were replaced by fewer and larger Area Health Boards, and triumvirate management was replaced with general management (Scott, 1994; Gauld, 2000). The objectives of change were dominated by the need to contain health spending through emphasis on structural, administrative and fiscal management to produce more efficient and effective utilization of health resources (Jacobs, 1994; Ashton et al, 2005). However the introduction of generic managers to traditional social services has been criticized as a fallacy, "...that a foodstuff CEO may make an admirable hardware CEO does not mean that inevitably he or she will make a competent health services CEO" (Easton, 1997, p. 166).

Under the wing of National and National-New Zealand First Coalition Governments from 1990-1999, the ideological commitment to a competitive market in the health sector was further realized (Ashton, 1995; Ashton, et al., 2005; Scott, 1994). A central feature of the health system restructuring in this period was the division of the purchaser and provider roles previously carried out by Area Health Boards (Ashton, 1995; Ashton et al., 2005; Scott, 1994). Purchasing of primary and secondary health care was devolved from the Ministry of Health to four Regional Health Authorities (RHA's), that were amalgamated into a single Health Funding Authority (HFA) in 1998 (Gauld, 2000). Both community and hospital health services were reconfigured into 23 Crown Health Enterprises (CHE's). Required to act as independent, profit seeking, contractually bound businesses, CHE's were subject to the payment of tax and dividends to the government (Ashton, 1995). These particular changes were aimed at enhancing competition between providers of health care in order to improve productivity and enhance performance (Laugesen, 2005). In 1996 the harsher

profitability agenda of CHE's was modified, since profitability never really gained traction within the organizations, the health professions and public opinion at large (Laugesen, 2005). By 1998 CHE's were again reformed as Hospital and Health Services with the intention of reducing mounting hospital debts and improve deficits in service provision (Gauld, 2000). A Public Health Commission was established to purchase and coordinate public health services, and was disestablished after 18 months in 1995 (Gauld, 2003). A National Advisory Committee on Core Health Services (NACCHS) was established in 1992 to advise the Ministry of Health (MOH) on what services should be provided and prioritized (Scott, 1994). Lastly, but by no means least, a regime of income testing and targeted assistance was introduced to facilitate and monitor access and support to social and health services for low income groups (Scott, 1994).

The health reforms pursued in the 1990-1999 era were in part designed to reduce fiscal risk by cost shifting to individuals, employers and providers of health care (Ashton et al., 2005; Gauld, 2000). However little of the complex program of reform introduced through the 1990's survived into the new millennium, other than the NACCHS, renamed the National Advisory Committee on Health and Disability in 2000, expanding its brief to include disability services (National Health Committee, 2007). Under a Labour-Alliance Coalition Government and then Labour Government to this point, health system design has returned to structures similar to those of the 1980's. The commercial and competitive model of heath system management was replaced by a model based on the principles of cooperation and collaboration (Ashton et al., 2005). Elected District Health Boards (DHB's) hold the budget for both secondary and primary health services and reflect a middle-ground mediation between regional and local health service governance (Ashton et al., 2005). Guided by Ministry of Health strategies and priorities for improving health outcomes in their populations, DHB's are

funded on a capped population basis, and must provide health services themselves, or purchase them from non-government providers (Ashton, et al., 2005).

Four key strategic policy programs underpin New Zealand's current health sector environment: The New Zealand Health Strategy (MOH, 2000), The New Zealand Disability Strategy (MOH, 2001), The Primary Health Care Strategy (MOH, 2001a), and He Korowai Oranga – Maori Health Strategy (MOH, 2002). The key policy directives in this framework are: health promotion and disease prevention with particular emphasis on the development of the primary health sector; equitable public health service access including a focus on the development of Maori health services and the Maori health workforce; high performance health services within a framework of quality improvement; community engagement in all levels of the health sector; population health objectives specifically targeting the major causes of ill-health in our community; and lastly, a targeted approach to the development of disability services that reduce barriers to access and promote the quality of life of disabled people.

Many elements of structural change to New Zealand's health care system have been continuous throughout the era of reform (Ashton et al., 2005; Campbell, 2006). Themes of centralized vs. local control, cooperation vs. competition, integration vs. a funder-provider split – have existed through the various periods of reform. Despite the engaging rhetoric that these policies and directives entail, healthier individuals and communities will in the future reduce the demand for publicly funded health and disability services (Ashton, 1995; Ashton et al., 2005; Davis & Ashton, 2001).

2.3 THE IMPACT OF REFORM ON NURSING – AN INTERNATIONAL PERSPECTIVE

The impact of continuous reform on health care systems has taken a significant toll on the health professions, particularly nursing, whose sheer size in the health workforce has made them a natural target for efficiency gains and cost restraints wrought by generic management practices and objectives (Campbell, 2006; Gower et al., 2003; Finlayson & Gower, 2002; Carryer, 2001). Specific reforming strategies and activities involving nursing services include: downsizing, restructuring, reengineering and mergers (Campbell, 2006). Whilst downsizing involves reducing staffing numbers and or bed numbers by eliminating services such as particular units or hospitals, restructuring concerns changing the infrastructure of an organization including channels of authority, spans of control and lines of communication (Campbell, 2006). Reengineering encapsulates process redesign such as modification of clinical staffing work assignments and skill mix – for example through the use of unskilled or ancillary staff to take on patient care, and mergers involve the combining of two or more organizations to improve financial or market positions (Campbell, 2006).

In this part of the literature review the aim is to outline the impact of reform and restructuring on professional nursing from an international perspective, in two key areas. Firstly, the impact of reform and restructuring on nursing leadership structures, roles and responsibilities, and secondly, the impact of reform and restructuring on nursing services, the nursing workforce, the quality of nursing care and patient outcomes. The ensuing part of the review presents selected literature that outlines the impact of reform and restructuring on nursing in New Zealand.

Nursing leadership structures, roles and responsibilities

In the early years of health reform in the National Health Service (NHS) in the United Kingdom, hospital restructuring set general managers or administrators alongside the traditionally powerful matron structure, and resulted in a decline of the matrons' influence, as well as significant role variation (Wells, 1999). In turn this lead to growing insecurity for nurses and negative attitudes toward management (Wells 1999). Studies conducted in the United Kingdom between 1960 and 1980 found "...that nurses viewed management, nurses in management and the management role negatively" (Wells, 1999, p. 60). Ward sisters became immersed in conflict between their clinical and management roles (Redfern, 1981). Nurses were alienated from management by a perceived industry oriented approach believed irrelevant to clinical focus (Lathlean & Farnish, 1984). A study by Wilson-Barnett (1973) confirmed a general perception amongst nurses, that colleagues promoted on the basis of their clinical ability from ward sister to senior nursing officer, no longer utilized their clinical expertise.

A reflection of bureaucratization, the ward sister's role became increasingly an administrative one (Wells, 1999). Emphasis on resource management, devolved budgeting, cost-effective interventions, clinical governance and commissioning "...change the identity and focus of work for nurses who take on those responsibilities" (Wells, 1999, p. 77). Changing the ward sister or charge nurse job title to ward manager reflects a focus on responsibility and accountability for the ward budget as well as the link to maintaining standards of care by way of auditing activities (Wells, 1999). A consequence of this refocus was possibly that the nursing manager became more dominant rather than inclusive in management style, and in order to conserve resources, changed their relationships with their patients and staff (Wells, 1999). When resources became strained one was "... more likely to find the ward manager

arguing for less patient throughput than for more money to meet patient demand" (Wells, 1999, p.74).

Elsewhere in the world, nursing leaders at all levels of health care organizations have had their roles transformed. Gelinas and Manthey (1997) conducted a five year long study of more than 5000 executive nurses in the United States regarding the impact of organizational redesign on nurse executive leadership. These researchers come to two important conclusions from their study; that the extent of redesign on nurse executive roles and functions is massive, and that nurse executive involvement in the process of redesign is enormous (Gelinas & Manthey, 1997). To be successful they describe that nurse executives must understand how to: lead across cultural, functional and department boundaries; promote and build effective teams; manage their personal growth by challenging their own behaviors; tolerate ambiguity; and promote the continued development of the nursing profession (Gelinas & Manthey, 1997). In summary, the expectations of nursing leaders are broad and their learning needs are great (Gelinas & Manthey, 1997).

In a qualitative study also conducted in the United States, Ingersoll, Cook and Fogel (1999) sought to understand the implications of redesign on the roles and responsibilities of mid-level nurse managers. These researchers found that the magnitude of change has resulted in nurse managers struggling to keep pace with the demands of change and with recognition of the importance of remaining committed to uncertain institutional goals (Ingersoll et al, 1999). Nurse managers were frustrated by their perceived inability to fix situations and meet multiple staff needs (Ingersoll et al, 1999). The researchers conclude their study by asking what must new nurse managers without a similar level of education and experience be going through? (Ingersoll et al., 1999).

Thorpe and Loo (2003) investigated and identified the major challenges impacting on first-line nurse managers in Canada. The term first-line nurse managers is defined by the study as individuals who oversee the daily operations of nursing units, regardless of their titles (Thorpe & Loo, 2003). This triangulated research (investigator, methods and data) identified several challenging themes in the first-line nursing management role, including: job enlargement; emphasis on efficiency; focus on human resources; staffing and retention; and management of staff frustrations (Thorpe & Loo, 2003). After concluding that professional and personal life balance is essential for first-line nurse managers' job satisfaction, the researchers recommend that health care administrators and nurse educators give closer attention to the provision of adequate resources, training and development and a more supportive work environment (Thorpe and Loo, 2003).

The Nursing Workforce, Quality of Nursing Care and Patient Outcomes

Five studies conducted in Canada that concerned the impact of reform and restructuring on nursing include: the effects of hospital restructuring on nursing employment (Cummings & Eastabrooks, 2003); flexible labour and casualisation in the nursing workforce (Grinspan, 2003); nursing staff attitudes to the health care organization following restructuring (Burke, 2003); dimensions of control and nursing reaction to hospital amalgamation (Armstrong-Stassen, 2003); and nurse absenteeism, stress and workplace injury (Shamian, O'Brien-Pallas, Thomson, Alksnis & Kerr, 2003). A brief outline of these Canadian studies and their findings follows.

Some of the main effects of hospital restructuring on nurses were identified in the systematic review by Cummings and Eastabrooks (2003) and include: significant decreases in job satisfaction and ability to provide quality care, affects on the physical and emotional health of nurses, and increases in nursing turnover. After a review of employment

theories and empirical evidence, Grinspan (2003) proposes that whilst the move to part-time and casualization of the nursing workforce during the 1990's was intentional, it is doubtful that it was intended to reach such high levels, indicating that employers lost control of their own strategies (Grinspan, 2003). The poor outcomes of casualization and part-time working structures include: nursing shortages; decreased professional satisfaction of nurses; reduced organizational performance; and negative impacts on patient care and outcomes (Grinspan, 2003). Burke (2003) evaluated nurses' perceptions of organizational support during a period of hospital restructuring. Examining the variable of perceived organizational support (POS), the study revealed that levels of POS remained unchanged or declined slightly during the study period (Burke, 2003). POS was found to mediate the relationship between restructuring process and job satisfaction (Burke, 2003). The study by Armstrong-Stassen (2003) highlighted that the ways in which nurses perceive control (personal, job and organizational) during a hospital amalgamation, were vital to the effectiveness and process of change. A study to determine how job strain (including staffing and workload) affected the health of nurses, revealed that adequate staffing and reasonable workload were the most important interventions in improving nurses' health and reducing absenteeism (Shamian et al., 2003).

It has also been highlighted that in Canada, *managerialism* alongside *consumerism* in health care (including the power of the public in disciplinary processes) have reduced nursing autonomy and made it difficult to meet professional nursing standards (Beardwood, Walters, Eyles & French, 1999). Of the empirical evidence in general regarding the Canadian health and nursing restructuring experience, Burke (2003a) suggests that restructuring in order to contain costs, had at best, mixed success. Nurses were demoralized, the profession was in crisis, costs had not been reduced and the quality of patient care had deteriorated (Burke, 2003a).

Other international studies, including some cross-national studies, have evaluated the relationship between registered nursing staff numbers, education and skill mix and its relationship to the quality of nursing care and patient outcomes (for example see: Aiken, Clarke, Cheung, Sloane & Silber, 2003; Aiken, Clarke & Sloane, 2000; Aiken, Clarke, Sloane, 2002; Aiken, Clarke, Sloane, Scholaski, Busse, Clarke, et al., 2001; Aiken, Clarke, Sloane, Scholaski & Silber, 2002; Blegen, Goode & Reed, 1998; Blegen & Vaughan, 1998; Cho, Ketefian, Barkauskas & Smith, 2003; Czaplinski & Diers, 1998; Needleman, Buerhaus, Mattke, Stewart & Zelevinski, 2001; Sheward, Hunt, Hagen, McLeod & Ball, 2005; Tourangeau, Giovanetti, Tu & Wood, 2002). Key implications from this growing and important body of nursing research may be summarized in three themes. Reduction in registered nurse staffing levels, skill mix, professional experience and education, reduces the quality of patient care provided. Whilst average length of stay (ALOS) of patients has decreased, patient outcomes such as morbidity and mortality are negatively associated with reduced ALOS, nurse staffing and skill. Increased job stress, burnout and injury in nurses are related to increased workloads and reduced nurse staffing.

Given the literature and research implications set out above, it is not surprising to identify a global shortage of nurses that has gained momentum in the past 20 years (International Council of Nurses, 2006; Buchanan & Calman, 2006; Heinz, 2004). Poor working conditions and experiences such as work injury, burnout and job dissatisfaction contribute to higher rates of turnover in the nursing workforce (International Council of Nurses, 2006; Buchanan & Calman, 2006; Heinz, 2004;). Thus, health care reform has implications on nursing and its workforce well beyond the boundaries of hospitals and national health systems, but also the ability of health care systems internationally to meet the needs of populations (International Council of Nurses, 2006).

2.4 THE NEW ZEALAND NURSING EXPERIENCE OF HEALTH REFORM

Finlayson and Gower (2002) were members of a large team of researchers who undertook a project examining the links between hospital restructuring, patient outcomes and nursing workforce issues in New Zealand (Hospital Restructuring: Patient Outcomes and Nursing Workforce Implications Study). The three research strands examined by the team were: mapping the hospital restructuring; identification of a range of patient outcomes; and a survey of all New Zealand hospital nurses (Finlayson & Gower, 2002). The New Zealand hospital restructuring project is itself associated with an international program of research (a number of which have already been identified in the preceding part of this review) across at least sixteen other countries. The first two of these strands of the New Zealand project are discussed here.

Aimed at identifying the impact of hospital restructuring on nurses, the study by Gower, Finalyson and Turnbull (2003) involved 16 New Zealand hospitals, and 20 individual informants. This study reported several incremental structural changes to nursing services on three tiers. A central feature of hospital reorganization was the dismantling of the centralized nursing and triumvirate management structures evident in hospitals prior to 1988 (Gower et al., 2003). Principal Nurse positions were disestablished and replaced with the position of Nurse Advisor who in many cases had no management authority over provision of nursing services, and in some instances reported to chief executives in the provision of advice over nursing-related issues (Gower et al., 2003). Some Nurse Advisor positions were then also disestablished and not replaced, resulting in a four to seven year period where there was possibly no centralized nursing leader at all (Gower, et al., 2003). By 1995 hospitals began to establish the position of Director of Nursing, and whilst similar to the nurse advisor role, they are executive positions

within a general management structure (Gower et al., 2003). However, the Director of Nursing may still have lacked the infrastructure to provide appropriate professional support and leadership (Gower et al., 2003).

Second tier nursing management pre-1988 consisted of Nursing Supervisors whose positions were also disestablished, although in some cases the role was retained for after hours patient services management, reporting to general management (Gower, et al., 2003). Traditionally known as Charge Nurses, the third tier of nursing management pre-1988 was responsible for the efficient and effective delivery of nursing services at ward level and had been subject in some instances to multiple rounds of change (Gower et al., 2003). Line accountability to the Principal Nurse was lost when these positions were disestablished and as a consequence Charge Nurses may have been the only remaining nursing management position in the health care organization (Gower et al., 2003). Financial responsibility previously held at the second or third tier of the nursing management structure was devolved to general managers at a service level (Gower et al., 2003).

Reflecting a great deal of intra and inter hospital variance, the new third tier of nursing managers have expanded roles and responsibilities reflected in a raft of different titles such as "...unit nurse manager, clinical coordinator, clinical nurse leader or team leader" (Gower et al., 2003, p. 131). The nurse manager's attention was divided between general management and clinical leadership responsibilities, with general management tasks taking precedent. In particular this research highlighted that the new third tier of nursing managers experienced great difficulty working with and reporting to general management who lacked an understanding of the complex responsibilities involved in nursing and ward management (Gower et al., 2003).

Service managers were not necessarily people with health backgrounds. It caused quite a few problems. They had no understanding of nursing. There was no nursing leadership at service level. We seemed to have a succession of general managers with no experience of the health system. (Gower et al., 2003, p. 131).

The loss of nursing leadership and its influence in hospital structures and services have resulted in a raft of issues for the nursing profession in New Zealand. Gower et al. (2003) identified the following themes in their study: lack of nursing involvement in management changes; reorganization of nursing career pathways; loss of senior nurses – sometimes to general management or out of the hospital sector completely; lack of hospital-wide strategic workforce planning, recruitment and retention; changes to the composition of the workforce including casualization; and significant variations in the quality and availability of professional development and education of nurses.

McCloskey and Diers (2005) advanced the investigation of health reform impact on nursing in New Zealand to patient outcomes as well. Utilizing data from all adult medical and surgical patient discharges in New Zealand hospitals between 1989 and 2000, this study determined ALOS and adverse clinical outcome rates, including mortality (McCloskey & Diers, 2005). Corresponding nursing workforce data was also examined between 1993 and 2000. The findings from this study in summary are: a decrease in nurse FTEs and associated work hours of around 36%; cost effectiveness and process efficiency resulted in a 20% decrease in overall ALOS; and a marked increase in adverse clinical outcomes rates, with mortality rates remaining stable or decreasing. McCloskey and Diers (2005) explain that lowering nurse staffing levels and increasing workload results in hurried, delayed, omitted and fragmented care that precipitates errors, and reduces opportunities to detect and report errors. These researchers assert that "...the introduction of New Zealand's health care reengineering policies

significantly influenced the frequency of adverse outcomes among hospitalized patients with the effect occurring at the same time the nursing workforce decreased in size" (McCloskey & Diers, 2005, p. 1145).

The case study by Campbell (2006) examined the impact on hospital nurses of organizational change at Auckland District Health Board from 2001-2004. The study utilized secondary data arising from the Survey of New Zealand Hospital Nurses conducted in 2001 and 2004 which was part of the broader research program in New Zealand noted above. Campbell (2006) describes that the objectives of the change program in this health care organization included: building of a new hospital, integrating services to improve care for patients and the environment for staff, improving nursing skills match to patient workload and the standardisation and integration of management roles. The change program occurred in a context of "...constant pressure to deliver quality health care within a substantial budget deficit and increasing fiscal constraints" (Campbell, 2006, pg1). Whilst the nursing workforce was not downsized during restructuring, the number of inpatient beds was (Campbell, 2006). Several sets of selected variables impacted by organizational change were investigated that enabled the comparison between 2001 and 2004 data, including: job satisfaction, management support, perceptions of quality of patient care, intention to leave, staffing and model of nursing care, and the hospital and work environment. Selections of the key findings are set out next.

Despite the introduction of a team nursing model intended to improve staffing and workload issues, the study found that this change did not alter the nurses perceptions about staffing between 2001 and 2004, with only 40% of nurses agreeing there were enough registered nurses to provide quality care (Campbell, 2006). There was also no significant change in nurses' ratings of job satisfaction, levels of burnout and

intention to leave between the two study dates, with nurses reporting being moderately or very satisfied with their jobs (Campbell, 2006). The researcher suggests that this finding may be a consequence of a new physical environment and effective charge nurse leadership (Campbell, 2006). The only statistically significant finding from the study was that associated with management support, where nurses' ratings demonstrated perceived lack of management responsiveness to nursing concerns and limited nursing participation in decision-making (Campbell, 2006). As well, loss of line nursing manager and leadership roles increased the distance between Charge Nurses and nurse leaders such as the Director of Nursing, and in so doing resulted in lost opportunities for open dialogue and the development of meaningful relationships (Campbell, 2006).

As a precursor to a longitudinal national cost of nursing turnover study (also part of an international research program), a survey was undertaken of current practices and policies related to turnover of nurses in New Zealand's public hospitals (North, Hughes, Finlayson, Rasmussen, Ashton, Campbell et al., 2004). The key objectives of the longitudinal study, still in progress, are to document and determine costs associated with nursing turnover and to identify nursing turnover as a key performance indicator in New Zealand health services that is calculated and reported consistently (North et al, 2004). Aimed at providing descriptive information, data was collected from 20 Directors of Nursing in 20 of New Zealand's 21 District Health Boards (DHB) (North et al., 2004).

The study found that nursing turnover (rates normally between 12 and 25%) was a problem for at least 13 of the 20 participants, or was becoming an increasing priority, with at least five DHB's reporting nursing turnover rates greater than 20% (North et al., 2004). Some of the negative impacts of turnover were identified as nurse shortages and

consequential bed closures, restrictions on elective surgery, emergency department service restrictions and reduced inpatient admissions (North et al., 2004). The study found that little information on reasons for turnover was being collected, with only three DHB's routinely collecting and collating data (North et al., 2004). Strategies being used to improve retention and reduce turnover focused on retention by way of professional development, introducing Charge Nurses and nurse leaders where there were none previously, and improving the working environment by way of family focus and flexible rostering (North et al., 2004). Recruitment policies and initiatives were focused on new graduate and international recruitment, with the use of temporary internal staffing pools one of the activities employed to manage nursing vacancies (North et al., 2004). Strategies for improving the nursing workforce diversity were also identified in the study, including a targeted approach to recruitment and retention of Maori and Pacific Island nurses (North et al., 2004). The study reported that in almost every DHB there were tight controls over recruitment of new staff including a review process, and in some instances freezes on recruiting registered nurses (North et al., 2004)

Cobden-Grainge and Walker (2002) undertook a survey of 300 registered nurses in New Zealand with three key objectives: to identify career paths of registered nurses and factors influencing job choice and post-registration education; to describe relationships between these factors and the career choices made; and to analyze the implications of career paths and influencing factors. Some of the key findings from Cobden-Grainge and Walker's (2002) study, of relevance to the present literature review are concerned with evaluation of working conditions, aspects of work, and working relationships. Concerning working conditions, the study found: that only 42% of respondents were satisfied with the ratio of permanent staff to agency staff on day and night shifts; there was a moderate level of satisfaction of 53%, with availability of

equipment and resources; and that over 53% of respondents indicated dissatisfaction with their pay in relation to level of responsibility (Cobden-Grainge & Walker, 2002). In relation to aspects of work, the study found that only 53% of respondents were satisfied with opportunities to provide quality care (Cobden-Grainge & Walker, 2002). In relation to working relationships, the study identified that only 54% of nurses were satisfied with the level of support they received from their Charge Nurse or Unit Manager (Cobden-Grainge & Walker, 2002). When asked to identify aspects of practice in their job that research participants would change, themes highlighted were: patient care, organizational systems, communication and professional development (Cobden-Grainge & Walker, 2002)

Motivated by concerns regarding the reintroduction of second level (enrolled) nurse training into the health sector, Carryer (2001) offers a perspective on the New Zealand nursing workforce that considers many of the features and impacts noted previously and offers other insights as well. Carryer explains that the reintroduction and training of more enrolled nurses (previously discontinued in 1994) was part of the response of the health sector to nursing shortages by way of a cheaper and less skilled nursing workforce option (Carryer, 2001). The effect of restructuring has taken a considerable toll on nursing, whose workforce is ageing, whose clinical and professional confidence was destroyed and whose education had been underinvested (Carryer, 2001). Nurses are visible and invisible simultaneously, greatly respected by the public, yet poorly paid, struggling continuously to be seen, valued and effectively applied to healthcare services, beyond the handmaiden of doctors' image, and beyond the grasp of generic management (Carryer, 2001). Resistance to nurse prescribing and reluctance to nursing autonomy in the primary health sector mainly from the medical profession, are examples of the external pressures to keep nursing confined (Carryer, 2001). According to this commentary, a strong

climate of *anti-professionalism* transcended the health sector forcing many nurses to abandon their profession and oppressions, some into generic management positions, in the belief that their contribution to the health workforce was not taken seriously (Carryer, 2001). In summary, Carryer's opinion may be seen as a professional response to reform and restructuring and its effects on nursing in New Zealand, by placing emphasis on reinvigorating clinical nursing leadership, as a central means not only of addressing nursing workforce issues, but also the health needs of communities.

The environment in which nurses now practice in New Zealand and elsewhere is marked by the objectives and activities of neoliberal political reform that has transcended the economy, politics and public organizations. Market sector values and objectives aimed at ensuring efficiency and effectiveness of health service delivery have impacted on nursing structures, roles, clinical experience and effectiveness, as well as nursings' future contributions to health care in the community. This new environment, its demands and culture, challenge professional nursing values, and in so doing have important implications for the nursing profession and health care organizations.

2.5 VALUES AND ETHICS IN HEALTH CARE ORGANIZATIONS

Health care organizations require the ethical management, of self, professional, organizational, patient and public interests and values (Young, 2003; Weber, 2000). Llewellyn (2007) explains that health care leaders who have ethics as the core of their values, will ensure that they meet their social contracts and ethical obligations to society, communities and patients, employees, and the health care professions. Ethical health care management practice therefore involves more than clinical, professional and personal ethics and values, but also focus on

the provision of care, the needs of citizens and the employment of people (Weber, 2000).

Values have been defined as "...relatively independent human creations that are used to guide, evaluate and justify human action" (Sarvimarki & Sandelin Benko, 2001, p. 131). Values have the power offer rational explanations for human activities (Sarvimarki & Sandelin Benko, 2001). Since professions represent one of several sets of competing group value premises and ideologies that may transcend organizational values, there is a possibility of ambivalent values relationships at the organizational level (Bullis, 1993). Wells (1999) describes that the impact of *managerialism* on the NHS has been to draw clinicians into the management life of the organization and inevitably has an impact on professional values and interprofessional relationships.

It seems possible that there has been a change in the traditional self-image, perceptions, values and roles of individual health professionals...Moreover, health care professionals may find themselves in a position of role and value ambiguity, caught between meeting managerial targets and continuing to function within the parameters of their clinical traditions. This may lead them to act in ways which are aimed at managing their consequent anxieties rather than carrying out the tasks envisioned by senior managers and policy makers... it is plain that such an important shift in focus and autonomy has affected the culture and philosophy of the various professions, including nursing, within the NHS. (Wells, 1999, p59-60).

So what are the values of health professionals and health care organizations? To an extent, public sector management values of efficiency and effectiveness in resource utilization have already been identified. Alongside this social responsibility, fiscal prudence, outcomes focus and accountability have also been noted.

In a triangulated study set in Ireland, Carney (2006) identified eleven key values (some positive and some negative) active in the health care

organization that were held by both health care clinicians and non clinical managers. Excellence in patient care was the highest ranked value identified in this study (Carney, 2006). Values driven, the second highest ranked value identified by the study, concerns trust, integrity, caring, loyalty, compassion, justice, quality, advocacy and dignity (Carney, 2006). The third ranked value was managerial receptiveness - identified as a caring and supportive approach by senior managers resulting in staff feeling valued for their contributions (Carney, 2006). Organizational dependability, as an identified value, indicated that a strong public ethos was active in the context (Carney, 2006). The value of equity in care delivery highlights accessibility and timely care delivery (Carney, 2006). Negative values identified by the study include: lack of peer cohesion, power groupings, lack of managerial receptiveness and lack of organizational dependability (Carney, 2006).

The values of health care organizations may be explicitly stated, for example, in formal communications either within the organization or to the public and communities whom they serve. A search of New Zealand's 21 District Health Board websites found that at least seven (Auckland, Counties Manukau, Waitemata, Bay of Plenty, Hawkes Bay, Hutt Valley, and Southland) shared their values on their website, or were at least easily accessible to the public via this medium. An array of values were set out on these websites and included: *Openness, Integrity, Compassion, Customer Focus, Respect, Supporting Wellness, Patients Come First, Serving Our Community, Helping Each Other, Best Practice, Taking Responsibility, Striving to Improve, Working Together With Passion Energy and Commitment, Can-do by Leading, Innovating and Acting Courageously, Trust, Striving for Excellence, Making a Difference, Teamwork, Learning (Mohiotanga/Wairuatanga), Caring (Manakitanga), Professionalism, Flexibility, Innovation, Responsibility, Partnership, Collaboration, Accountability, Effectiveness and*

Acknowledging Cultural Values (Mana Atūa / Mana Tūpuna / Mana Whenua/ Mana Tangata).

Despite the somewhat cursory, if not distant approach to identifying the values of these health care organizations, it is at least possible to point out some valid features. Firstly, aside from reference to accountability, responsibility, effectiveness, and collaboration, these values do not tend to indicate a market place model orientation. Rather, they suggest a humanistic organizational model, linked to the needs and culture of their workforce and community, in particular Maori culture and community. This is not to suggest that these health care organizations are without focus on their fiscal responsibilities, since there were undoubtedly references to ensuring financial accountability in some mission statements on the websites. Instead, these values, publicly declared, demonstrate shared commitments to health care delivery by all members of the health care organization.

In the opinion of Faithfull and Hunt (2005) the values of nursing are:

[T]hose basic assumptions about what is of value in the practice and profession of nursing: what is of fundamental importance in nursing. Together they constitute the organizational culture of nursing. Values are guiding principles, often implicit, that inform perceptions and standards of what is right, or wrong, appropriate or inappropriate, worthy or unworthy, acceptable or unacceptable in our behavior, important or less important. Values may be individual or collective or both; they embrace ethical values, but are somewhat wider (p.441).

Emerging values in professional nursing have been identified as: respect for human dignity, cultural and sexual differences and choices; continuity and trust in caring relationships; organizational openness; nursing role flexibility; enhanced professional autonomy; timeliness; working with uncertainty; and therapeutic support (Faithfull & Hunt, 2005).

Professional nursing values may also be located within statements of professional practice, codes of ethics and conduct. The International Code of Ethics for Nurses (International Council of Nurses, 2006a) encompasses values of the nursing profession which include: caring, maintaining human rights, family and community respect, social responsibility for the health and social needs of the public, responsibility and accountability for practice, competence and continual learning, sustaining and protecting the environment from pollution, maintaining patient confidentiality, alongside managing and implementing acceptable standards of clinical, management, research and education in nursing.

The Code of Conduct for Nurses established by the Nursing Council of New Zealand (2005) likewise embraces core professional nursing values. Using a framework of principles, the code specifies: that nurses must be legally compliant in terms of registration, competence and practice; that nurses act ethically and maintain standards of practice including requisite nursing knowledge and skill; that nurses respect the rights of patients/clients, including the patients individuality, right to informed consent and culturally safe practice; and finally that nurses justify public trust and confidence, such as ensuring that duty of care has been met (Nursing Council of New Zealand, 2005).

Bioethical principles underpinning health professional practice are also an important expression of the values of health professions. Autonomy, beneficence, nonmaleficence, self-determination, veracity, justice, and fidelity, create an ethical framework for health professionals including nursing (Shirey, 2005; Johnstone, 2004). Autonomy and self-determination reflect the acknowledgement of a person's individual choices which stem from personal values and beliefs (Shirey, 2005; Johnstone, 2004). Nonmaleficence expresses the imperative that we should do no harm in our health care endeavors by ensuring that error is reduced and adequate staffing is provided to ensure vigilance in

nursing practice (Shirey, 2005; Johnstone, 2004). Beneficence, is the obligation to do good in our caring work and ensuring that others are engaged in doing good in society and work also (Shirey, 2005; Johnstone, 2004). Veracity represents the value of telling the truth to patients and colleagues, as well as not deceiving others, values considered fundamental to ethical relationships (Shirey, 2005; Johnstone, 2004). "Justice refers to the fair and equitable distribution of benefits and burdens in society" (Shirey, 2005, p.61). This principle may also be identified in management behavior to incorporate truthfulness and respect (Shirey, 2005). Fidelity reflects the value of faithfulness to ones commitments and in all nursing, this is to patients and the nursing profession (Shirey, 2005).

It is not necessarily the case therefore, that professional nursing values, which include ethical values, are at odds with those of the health care organization. Indeed many appear to be shared, such as respect, flexibility, responsibility, teamwork and best practice. It is also possible that the professional nursing values identified here are shaped by and are responsive to contemporary health care climates that emphasize social responsibility; in particular the prudent use of resources for meeting the health care needs of whole communities. Yet a conundrum remains evident; the needs of individual patients or the needs of patient collectives such as diagnostic or nursing service bounded collectives, which clinical and managing nurses pursue, may be subsumed in the broader efforts and purposes of health care organizations, required to meet the health needs of whole populations within significantly controlled fiscal limits. Nurses may become frustrated and exhausted because the organizational contexts in which they practise may make it difficult to fulfill their ideals of good patient care (Gastmas, 1998). It is a conundrum that manifests as ethical conflict for health professionals, and most importantly for the purposes of this research, nurse managers.

2.6 ETHICAL CONFLICT FOR HEALTH PROFESSIONALS AND NURSING

Because of their dual professional and organizational roles, health care professionals are at great risk of experiencing ethical conflict (Gaudine & Thorne, 2000; Gaudine & Beaton, 2002). Increased responsibility for the allocation of scarce resources has in particular, spawned a raft of dilemmas for health care professionals in management positions in their attempts to balance the financial and human aspects of service delivery (Lemieux-Charles & Hall, 1997). New institutional arrangements arising from reforming health care systems also place these clinical managers in situations or circumstances where their broader professional and organizational commitments conflict with those of their clinical peers whose practice is affected by their decisions (Lemieux-Charles & Hall, 1997). Individual health care managers may feel that they are required to make ethically difficult decisions alone, and "...without support from the organization, may become defensive and isolated" (Lemieux-Charles & Hall, 1997, p.59).

Ethical (moral) conflict for health care professionals has been defined as:

"...a situation involving a clash of values within the practitioner, among practitioners, and/or between practitioners and patients, concerning what was the morally right action to take, or as a situation in which the duties and obligations of health professionals were unclear" (Redman & Fry, 2000,p.362).

Ethical conflict may also occur between the health professional and the health care organization, where their respective values differ, or where some mutually shared values take precedent over other values (Llewellyn, 2007; Gaudine & Beaton, 2002).

Faced with the constant array of ethical conflict, health care professionals can burn-out from the stress of trying to do the right thing the right way, and may be consumed with a downward spiral of defeat

by the pressures and burdens of ethical conflicts (Rodney & Starzomski, 1993; Gaudine & Thorne, 2000, Llewellyn, 2007). Other possible consequences of ethical conflict include: moral dilemmas (when an individual sees more than one right thing to do); moral uncertainty (when an individual is uncertain of which moral principle to apply); and moral distress (when an individual knows the right thing to do but is prevented from doing so) (Jameton, 1993, cited in: Corley, 2002; Kalvemark, Hoglund, Hansson, Westerhold & Arnetz, 2004; Corley, Minick, Elswick & Jacobs, 2005). Moral distress for nurses has been further defined as:

[P]ainful feelings and/or psychological disequilibrium that occurs when nurses are conscious of the morally appropriate action a situation requires, but cannot carry out that action because of institutionalized obstacles: lack of time, lack of supervisory support, exercise of medical power, institutional policy or legal limits (Jameton, 1984, cited in Corley, 2002, pg 637).

Some of the possible outcomes of moral distress include: impacts on the patient such as increased discomfort or suffering, impacts on the health professional such as resignation, burn-out and loss from the profession, and impacts on the organization such as loss of reputation or accreditation, and difficulty in recruiting nursing staff (Corley, 2002).

Sundin-Huard and Fahy (1998) utilized interpretive research methods to study the relationships between moral distress, nursing advocacy and burnout in nurses. They found that when clinical nurses attempted to advocate for patients in morally troubling situations, their experience of moral distress was heightened, and with this the risk of professional retribution and burnout (Sundin-Huard & Fahy, 1998).

In a series of opinion based articles focused on limited health care resources and its relationship to moral distress, Arlen (2001, 2001a,

2002, and 2004) draws attention to the pervasiveness of the phenomenon of moral distress in nursing and its relationship to scant resources and the burgeoning problem of nursing shortages. Arlen proposes that resource restrictions and nursing shortages have caused nurses to question whether patients are receiving quality care and whether patients are the first priority (Arlen, 2001a). Nurses increasingly see themselves as ineffective advocates for their patients and feel paralyzed by their situation (Arlen, 2001a). Moreover nurses are concerned about how others are making decisions that nurses should be making and the subsequent lack of control that they have over their practice (Arlen, 2001b).

Nurse Managers' Ethical Conflict with Their Health Care Organizations

Whilst the significance of nurse managers' ethical conflict with their health care organizations is acknowledged, it has not been particularly well researched and is an area of nursing administration practice that had remained largely silent until the mid 1990's (Brosnan & Roper, 1997; Gaudine and Beaton, 2002). Knowledge of the issues and the experience of this problem are essential in order to "...work towards the resolution of ethical conflicts and towards the mitigation of negative outcomes for nurse managers, their organizations and the nursing profession" (Gaudine & Beaton, 2002, p. 19).

A Canadian based study of nurse managers ethical conflict with their health care organizations (Gaudine & Beaton, 2002) provides the theoretical and methodological foundations for the present research project and is discussed in some detail presently. The literature search noted in the introduction of this chapter yielded several articles of relevance to the topic, most of which are introduced and discussed here.

Literature reporting both theory and research of ethical conflict and dilemmas as it impacts on decision making and clinical care for practising clinical nurses (e.g. staff nurses) was identified in the search (Butz, Redman & Fry, 1998; Gaudine & Thorne, 2000; Redman & Fry, 1996; Redman & Fry, 2000; Redman & Hill, 1997; Redman, Hill & Fry, 1997; Redman, Hill & Fry, 1998; Sandman & Nordmark, 2006; Von Post, 1996; Wagner & Ronen, 1996). The search also produced one research report on ethical conflict in a multidisciplinary setting (Kalvemark, Hoglund, Hansson, Westerholm & Arnetz, 2004), and one research report regarding ethical conflict experienced by nurses conducting utilization reviews in managed care practice (Bell, 2003).

In a systematic review of five studies concerning clinical nurses' ethical conflicts, Redman and Fry (2000) sought to capture the character, similarities and differences in the experience of ethical conflict, as well as resolutions and themes of ethical conflict. The major character of ethical conflict identified by this review was disagreement with the quality of medical care provided to patients (Redman & Fry, 2000). There were identifiable differences in the focus of ethical conflict arising from the different clinical specialty services in which studies were set, e.g. nephrology, rehabilitation, pediatrics (Redman & Fry, 2000). For example, pediatric nurse practitioners described the most dominant ethical conflict as child/parent/practitioner relationships, particularly in pursuit of protection of the child's rights (Redman & Fry, 2000). In contrast, rehabilitation nurses experienced ethical conflict in relation to over and under-treatment of patients. The major themes identified in the review were: harm/good of life-prolonging aggressive therapies; and inadequacy of resources for care (Redman & Fry, 2000). In their conclusion, Redman and Fry (2000) point out that there was wide variation between professional, corporate and societal definitions of adequacy of care.

One key Canadian study located by the literature search, investigated ethical conflicts which practising clinical nurses had with their employing organizations and professional associations (Gaudine & Thorne, 2000). The major themes of ethical conflict revealed in this qualitative study were: safety and the quality of patient care; the value of human resources; and ineffective or inappropriate actions (Gaudine & Thorne, 2000). This research reports that nurses perceived their employers as more interested in balancing their budgets than the welfare of patients (Gaudine & Thorne, 2000). The participants in this study also described that nursing was not a valued human resource in the health care organization when compared with medicine (Gaudine & Thorne, 2000).

Other studies and literature revealed by the literature search explored challenges to nursing values, ethical dilemmas, moral problems and uncertainty in clinical nursing practice more generally (Gastmas, 1998; Nathaniel, 2006; Woods, 1997; Wurzbach 1999). Further research and literature has examined ethical activism, assertiveness, virtue ethics, and enactment of ethics in clinical practice (Arries, 2005; Doane, Pauly, Brown and McPherson, 2004; Dodd, Jansson, Brown-Saltzman, Shirk & Wunch, 2004; Peter, Lerch Lunardi & Macfarlane, 2004; Varcoe, Doane, Pauly, Rodney, Storch, Mahoney, et al., 2000).

Peter, Lerch Lunardi, and Macfarlane (2004) conducted a review of 18 studies involving ethical dilemmas and conflict in nursing practice, which identified that nurses resisted in situations where they experienced ethical conflicts in relation to the actions of other health professionals, however there were also instances where they did not. Where the nurse did not, it was reasoned as a possible result of internalized oppression (Peter et al., 2004). Acts of nursing resistance such as challenging and confronting decision-makers, were evidence of important ethical action and exercise of power, which contracts to passivity and silence (Peter et al., 2004).

In a grounded theory study of experienced registered nurses in New Zealand, Woods (1997) explored everyday moral decision making in clinical practice. Findings from this study revealed the core variable of 'maintaining a nursing ethic' which is intrinsic and enduring throughout a nurse's career (Woods, 1997). This nursing ethic arises from antecedents such as moral development, upbringing and social experience which guide moral decision making (Woods, 1997). This researcher also concluded that context, alongside individual shared perceptions of moral events influence the degree to which nurses will become involved in ethical situations (Woods, 1997).

Nathaniel (2006) also undertook a grounded theory study in the US, exploring nurses' struggles with morally troubling patient situations. The substantive grounded theory of moral reckoning arising from this study highlights that moral distress is a narrow concept that fails to explain the long-term and ongoing processes that nurses may experience from morally troubling patient care situations (Nathaniel, 2006). In summary, the grounded theory of moral reckoning proposes that:

After a novice period, the nurse experiences a stage of ease in which there is comfort in the workplace and congruence of internal and external values. Unexpectedly, a situational bind occurs in which the nurse's core beliefs come into irreconcilable conflict with external forces. This compels the nurse into the stage of resolution, in which he or she either gives up or makes a stand. The nurse then moves into the stage of reflection in which he or she lives with the consequences and iteratively examines beliefs, values, and actions. The nurse tries to make sense of experiences through remembering, telling the story and examining conflicts (Nathaniel, 2006, p. 419).

The meaning of ethics and the enactment of ethical practice in nursing have also been explored through nursing research (Doane et al., 2004; Varcoe et al., 2004). The latter of these studies found that:

Being a moral agent and enacting moral agency involved working within a shifting moral context; working in-between their own identities and values and those of the organizations in which they worked; and working in-between competing values and interests. They described a process fraught with professional struggle and deep personal struggle as they sought to sustain their identity as moral agents by doing what they saw as good while contextual forces constrained their ability to choose and act in ways they deemed ethical (Varcoe et al., 2004, pg 319).

In a survey of 175 nurses in the United States, engagement in ethical activism (trying to make hospitals more receptive to nurses' participation in ethics deliberations) and ethical assertiveness (participation in ethics deliberation even when not formally invited) was found to be strongly influenced by existing organizational receptivity to nursing involvement and ethics training (Dodd et al., 2004). These researchers conclude that nurse leaders must ensure receptivity of clinical nurses' ethical concerns, and that ethical advocacy is encouraged (Dodd et al., 2004).

A recent approach to the resolution of moral dilemmas in nursing practice was offered by Arries (2005) who describes the application of virtue ethics in clinical nursing practice. Based on *Aristotelian* thought, virtue ethics places emphasis on the character and disposition of the moral agent, in contrast to emphasis on duties, rules or principles approaches (Arries, 2005). The virtues applicable to the nurse as a moral agent include: reflection, empathy, fairness, honesty, dedication, responsibility, trustworthiness, integrity, discernment, compassion and conscientiousness (Arries, 2005). Armed with these virtuous characteristics, the nurse as a moral agent is able to provide a more holistic analysis of moral dilemmas in nursing, which in turn facilitate flexible and creative solutions to an array of ethical conundrums in nursing (Arries, 2005).

Literature arising from the search that concerned nurse managers, including executive, mid-level and clinical nurse managers, was particularly limited and mainly opinion in nature. For nursing executives, failure to provide services of the highest quality due to economic constraints determined by the organization, was the most consistently identified and important ethical issue identified in a survey conducted by Cooper, Frank, Gouty and Hansen (2002). Whilst no particular solution to this dilemma was proffered by these authors, they nonetheless stress that education and preparation of those dealing with ethical dilemmas in the health care organization is a central concern (Cooper et al., 2002).

In contrast, Shirey (2005) identifies numerous strategies that nursing leaders (infers all nurses in leadership roles) may pursue to promote an ethical climate for nursing practice that ensures congruence between caring nursing and caring organizational missions. For example, one strategy proposed is engagement and reflection by the nursing leadership team as to how an organization's mission interfaces with nursing (Shirey, 2005). Another strategy suggested is the establishment of a leadership training program in ethics, with emphasis on ethical decision making from the perspective of the organizations caring mission (Shirey, 2005). In Shirey's opinion nursing leaders must undertake these strategies to ensure the fostering of employee morale, organizational commitment, engaged nurses and their retention in the workforce (2005).

Dissatisfaction with their nurse managers and perceptions of abandonment of basic nursing values by nurse managers was a perspective of practising clinical nurses identified in the literature (Kellen, Oberle, Girard & Falkenberg, 2004; Gaudine & Thorne, 2000). Whether these perceptions are a reflection of an actual change of the nurse managers value system, or misunderstanding of how the nurse managers values are being lived is an area of debate, since the nurse

manager may be charged with fiscal stewardship and for ensuring public health care dollars are utilized to the best advantage, alongside their core professional values (Kellen, et al., 2004).

Identification and analysis of values conflict for nurse managers was undertaken in a survey of 75 Israeli nurse managers (Hendel & Steinman, 2002). This research project explored three different value sets applicable to nurse managers in a changing health care environment: personal, professional and organizational values. One of the core findings from this study is that personal values (e.g., power, wealth and respect) and professional values (e.g. patient centered care) rated much higher than organizational values (e.g., competition, risk-taking and status) (Hendel & Steinman, 2002). Arguably these organizational values are private sector for profit based values as opposed to public sector not for profit values. Nonetheless and according to these researchers, education efforts are paramount to ensuring that nurse managers internalize organizational values (Hendel & Steinman, 2002).

Foundational study

Gaudine and Beaton (2002) undertook a qualitative descriptive study of nurse managers' ethical conflict and values differences with their health care organization and professional associations (Gaudine & Beaton, 2000). Interviews were conducted with 15 nurse managers utilizing a semi-structured interview guide which asked for descriptions of ethical conflict with their health care organization and professional associations, factors that eased or worsened ethical conflict and the personal outcomes of ethical conflict. Even though they sought descriptions concerning ethical conflict with both the nurse managers' health care organizations and professional associations, their report does not explicitly set out nor compare findings from both these relationships. Indeed this researching duo mostly found that their

participants had no ethical conflicts with their professional associations (Gaudine & Beaton, 2002).

The findings from Gaudine and Beaton's research, establish four themes of ethical conflict between nurse managers and their health care organizations. The theme of *voicelessness* was related to lack of collaboration, invisibility, hiring nurse managers who would 'toe the party line', and exclusion from decision making in the health care organization (Gaudine & Beaton, 2002). The theme of *where to spend the money*, reflected differences in the mission and values of the health care organization and the nurse manager, exemplified by budget cuts in staff development (Gaudine & Beaton, 2002). The theme of *the rights of the individual versus the needs of the organization*, concerned the valuing of individual rights, and the feeling of being caught between divergent needs (Gaudine & Beaton, 2002). *Unjust practices on the part of senior administration and/or the organization* represent descriptions such as unfair promotions and terminations, unfair workloads, and the organization failing to act even when aware of a problem (Gaudine & Beaton, 2002).

Factors that eased or mitigated ethical conflict are summarized as *support, problem-solving and growth, and refocusing* (Gaudine & Beaton, 2002). *Support* was received by other nurse managers, hospital administrators, ethics committees, staff nurses, family and the public (Gaudine & Beaton, 2002). *Problem solving and growth* was summarized as occurring with those who had provided support. *Refocusing* described the experience of hope, focusing on personal goals and high quality care, and on positives to arise from the conflict (Gaudine & Beaton, 2002).

Factors that worsened the experience of ethical conflict were significant and are summarized by the researchers under four headings: *fallout*

from decisions the nurse manager did not agree with, inability to resolve ethical conflict, situational factors and factors relating to the nurse manager (Gaudine & Beaton, 2002). *Fallout* was related for example, to poor or unsafe patient care and increased complaints about nursing care. *Inability to resolve ethical conflict* concerned an inability to speak out or act and to make the needs of nursing understood (Gaudine & Beaton, 2002). *Situational factors* included fear of escalation if the nurse manager spoke out, poor communication because of the organization's size and the opinions of physicians more valued than those of nurses. *Factors relating to the nurse manager* concerned needing mentors, uncertainty about what is right, and inability to inform their nursing staff of efforts to resolve issues of concern to them (Gaudine & Beaton, 2002).

The outcomes of ethical conflicts for nurse managers personally were identified as: *negative feelings, turnover, and learning to remain silent* (Gaudine & Beaton, 2002). *Negative feelings* included frustration, anger, fear, stress, burnout, loneliness, demoralization, powerlessness and lack of fulfillment. *Turnover* was reflected in loss from the profession and position. *Learning to remain silent* is as it suggests, an oppressive and detrimental outcome for the nurse manager and the health care organization.

In summary, the researchers comment that the theme of voicelessness had disturbing implications for hospitals wishing to attract and retain excellent nurses in management and bed-side roles, since, being voiceless, goes against nursing values of collaboration and inclusion (Gaudine & Beaton, 2002). Distress, frustration and wanting to resign as a common outcome with their participants similarly raises concerns regarding stability and recruitment of the nurse manager work force (Gaudine & Beaton, 2002).

The values identified and at issue in Gaudine and Beaton's (2002) study are summarized as:

[P]roviding quality care, or doing what is best for each client, family or staff member, and the fair treatment of nurses and nurse managers in the work place. These values reflect the ethical principles of beneficence and non-malifecence – or the moral imperatives to do good to others and to not cause harm to others ... and justice. The nurse mangers described their hospital's values, in contrast, as balancing their budgets and protecting their legal position (Gaudine & Beaton, 2002, p. 29).

The researchers conclude that if quality nursing care is to be provided hospitals and nurse managers need to understand each others values and perspectives (Gaudine & Beaton, 2002). To do so, these researchers advocate for workshops which bring nurse managers, direct care nurses, administrators and board members together in order to share perspectives and to combine with organizational reform that ensures decision making processes are more visible and structured in a way that allows all parties a voice and respect (Gaudine & Beaton, 2002).

2.7 LITERATURE REVIEW SUMMARY AND RATIONALE FOR STUDY

Underpinned by a marked political ideological shift from egalitarianism to neoliberalism, the first part of this review has outlined the context and processes of rapid and broad economic and political reform in New Zealand from 1980 to 1999. Transcending public policy and structure, neoliberalism has in its wake transformed social policies and structures to fundamentally alter the organizations, objectives, processes and values of New Zealand's health care system.

Manifestations of neoliberalism in the institutional context, public management theories applied in New Zealand's public institutions, such

as agency, public choice and new public management, along with their political and economic objectives and activities, spawned repeated restructuring of the health sector in New Zealand between 1984 and 2001. New public management theory or *managerialism* in the health sector, both in New Zealand and other countries, has had and continues to have a marked impact on health care organizations. Derived from the entrepreneurial context of the private sector, *managerialism* focuses on outputs, effectiveness, efficiency, social responsibility and fiscal prudence in the utilization of public health resources. *Managerialism* in the health sector has not however been without significant criticism.

As the largest and most visible profession in health care, nursing has been greatly affected by reform and *managerialism*. Professional nursing in New Zealand as elsewhere in the globe has been restructured several times in the last two decades with a number of consequences. Nursing leadership structures at all levels of health care organizations have been weakened, and at times completely abolished, resulting in a threatened and vulnerable profession. The quality of nursing care has been eroded and patients have suffered the affects to their health by way of poor health care outcomes. Nurses have been personally affected by reform, including ill health, injury and burnout, to such an extent that there is now a global nursing shortage. Nurses who remain in health care service, and those yet to come, practice in a context fraught with tension between the values of their profession and the values of the health care organization charged with fiscal accountability and stewardship for health resource utilization. It is a context that renders nurses and in particular nurse managers, vulnerable to ethical conflicts as they strive to provide the care they and their profession believes is right and necessary for their patients.

Ethical conflict arises from values differences or clashes between the health professional and health care organization, and may have a

number of implications for both patients and nurses. Whilst patients may experience increased discomfort or suffering as a consequence of poor care, impacts on the health professional include resignation, burn out and loss from the profession primarily as a consequence of suffering moral distress. A review of the literature on ethical conflict in the nursing revealed both empirical and theoretical insights that primarily focused on the experience of ethical conflict and moral distress for clinical practising nurses. One study was located which explored ethical conflicts which clinical practising nurses have with their employing organizations, and only one study to address the concept and experience of nurse managers' ethical conflicts with their health care organizations.

The study by Gaudine and Beaton (2002) revealed that nurse managers' experience ethical conflict as one that renders them voiceless in their attempts to determine how best to meet the competing needs of individual patients and the health care organization. It was also an experience that may result in unjust practices on the part of the health care organization such as unfair workloads and terminations (Gaudine & Beaton, 2002). Factors that mitigated this experience for the nurse manager include support from other nurse managers, hospital ethics committees and the nurse managers' families. Factors which made the experience of ethical conflict for nurse managers worse include fallout from unsafe nursing care, and an inability to resolve situations. The outcomes of ethical conflict revealed by this study included negative feelings, turnover and being silenced. Key values at issue and identified in this research concerned the quality of patient care and fair treatment of nursing staff.

Rationale for the present study

Contemporary emphasis in the management of health services toward efficiency and effectiveness in public health resource utilization situates

nurse managers in an inevitable context of values tension. This context creates risk of the experience and negative consequences of ethical conflict for nurse managers, patients, nursing staff and health care organizations. This chapter has revealed that whilst the concept and problem of ethical conflict is understood, it has not been well researched from the perspective of nurse managers; with only one qualitative study found in the literature search that particularly addresses the phenomena from this view point (Gaudine & Beaton, 2002).

When little is known of a particular phenomena and experience, qualitative descriptive studies assist in defining and conceptualizing that experience, as well as describing dimensions and variations of that experience (Polit & Tatano Beck, 2006). Replication studies in the quantitative research paradigm are of central importance for the verification or refutation of results or findings of some prior study (Ellis, 1994; Page & Meyer, 2000; Polit & Tatano Beck, 2006; Bryman & Bell, 2003). Replication also underscores the desire to check on cultural or ideological bias on the part of the researcher (Ellis, 1994) as well as providing the substance for systematic and meta-analysis (Eden, 2002). Whilst the usefulness of replication studies in qualitative research is almost ignored by the literature, perhaps on the basis of subjectivity in findings and severe limitations of generalizability of findings, this study is concerned with knowing and understanding more about real experiences others have encountered, and others have researched, but clearly to a very limited degree. Indeed Gaudine and Beaton advise that "...future research could examine ethical conflict as experienced by nurse managers working in other settings" (2002, p.32). At the very least, there will be broad points of contrast and comparison between the findings of the two studies from which refinement of concepts may proceed. It may also, from the perspective of triangulation in research, be usefully considered a second source of informants from which

conclusions may be drawn regarding the knowledge and findings generated (Bryman & Bell, 2003; Polit & Tatano Beck, 2006).

The research presented in this report is thus aimed at building on and enhancing knowledge of the experience of nurse manager's ethical conflict with their health care organizations, in a New Zealand context. As previously noted by Gaudine and Beaton (2002) knowledge and understanding of the phenomenon is essential to resolution of ethical conflicts and mitigating its negative consequences. In contrast to the foundation study, this research did not seek to describe the experience of ethical conflict that nurse managers' had with their professional associations, since the participants in this earlier study, mostly experienced no ethical conflict with their professional associations (Gaudine & Beaton, 2002).

CHAPTER 3 – METHOD

The purpose of this research is to build and enhance knowledge and understanding of the experience of nurse managers' ethical conflict with their health care organizations. In order to achieve this purpose, this study seeks rich descriptions, themes and patterns of the experience, and to do so by replicating the qualitative descriptive approach of the study by Gaudine and Beaton (2002). Consistent with these research purposes, this chapter presents the methodological underpinnings, participant recruitment and selection, data collection and analysis for the study. It also sets out important ethical procedures and considerations, as well as an outline of the establishment of research rigour for the study. Some brief criticisms are made of the methods used in the foundation study, and as a consequence the adapted methods for analyzing qualitative descriptive data for the current study are set out.

3.1 METHODOLOGICAL UNDERPINNINGS

This study followed the qualitative descriptive approach to research utilized by Gaudine and Beaton (2002). Qualitative research seeks to contribute to "...a better understanding of social realities and to draw attention to processes, meaning patterns and structural features" (Flick, von Cardoff & Steinke, 2004, p.3). Descriptive research "...sets out to describe a phenomenon or event as it exists without manipulation or control of any element involved in the phenomenon or event under study" (Page & Meyer, 2000, p.22). Description draws upon the ordinary vocabulary of people to convey ideas about things, people and places, including what is, or was going on, as well as what people are involved in, and or do (Strauss & Corbin, 1998).

It has been noted that some qualitative research reports do not identify a specific research tradition such as ethnography, phenomenology or

ethnology within which the study is located (Polit & Tatano Beck, 2006; Thomas, 2003, 2006). Gaudine and Beaton (2002) likewise, do not situate their study within a particular research tradition. Instead, they refer only briefly to the use of selected aspects of grounded theory methods in both their data collection and analysis, emphasizing that "...events and feelings are best described by the person who has experienced them" (Gaudine & Beaton, 2002, p.19).

Three key criticisms of the foundation study methods and report are noted here. Firstly, the published report of Gaudine and Beaton's (2002) study provides limited rationale for the influence and methods of grounded theory. Secondly, experts and proponents of grounded theory may consider the tacit inference to the methodology and methods in the report, a slur on the strengths and value of the grounded theory. Finally, the emphasis on thematic findings in Gaudine and Beaton's (2002) study and report is inconsistent with grounded theory methods and presentation of findings.

Consequently, this study has applied a general inductive approach to qualitative data analysis (Thomas, 2003, 2006). This approach to qualitative data analysis provides a convenient and less complex means of condensing large amounts of raw data for many research purposes where there is no underpinning research tradition (Thomas, 2003; 2006). This method enables the establishment of clear links between research objectives and findings derived from raw data with focus on presentation and description of the most important categories (Thomas, 2006). Whilst most similar to grounded theory methods, the general inductive method does not explicitly separate the coding process into open and axial coding (Thomas, 2006). The key steps and processes of the general inductive approach are: close reading of the text and immersion in the data; coding of transcripts for recurring topics, processes, substance and themes; creation and sorting of codes into clusters and categories; revision, integration and refinement of

categories; and relating categories and themes to one another (Thomas, 2003, 2006). Findings from data analysis using this method are inevitably shaped by the experiences and assumptions of the researcher, and decisions regarding what are more or less important in the data (Thomas, 2006).

3.2 PARTICIPANT RECRUITMENT AND SELECTION

Gaudine and Beaton utilized a convenience sample of 15 nurse managers in an eastern Canadian province to inform their study (Gaudine & Beaton, 2002). In contrast the current research utilized a mixture of convenience and purposive sampling, with a resultant eight nurse managers recruited. Whilst convenience sampling involves the selection of the most readily available persons, purposive sampling involves selection based on judgment on who will be most informative (Polit & Tatano Beck, 2006).

Two key methods were utilized to recruit participants. In the first instance, recruitment involved professional networking, which involved advertising the research by way of an electronic notice on the website of the College of Nurses Aotearoa. Prospective participants responded directly to the researcher via this method. The second method utilized invitations to participate in the research that were distributed by mail-out with the assistance of the Nursing Council of New Zealand. Around 75 registered nurses across several regions whose job classification was nursing management or administration were sent research invitations, directly from the Nursing Council of New Zealand, ensuring that the process maintained the privacy of the possible recruits. Again, participants responded directly to the researcher. A copy of the invitations distributed via these methods and two different nursing organizations are set out in Appendices I and II.

The uptake and response to the invitations was particularly slow. Over an eight month period (including network advertising, and invitation mail-outs), only 11 responses were received by the researcher. Thus, three respondents were not recruited or selected because they did not fit the selection criteria, or they chose not to participate in the study at a later stage. Despite the much lesser number of recruits from that of the foundation study, the interviews and subsequent transcripts rendered an extremely large and rich data source that proved ample for the study's purpose.

Each respondent to invitations was sent a copy of the research information sheet (Appendix III). At times, respondents automatically followed up with a tentative agreement to participate in the research, at other times the researcher followed up by phone call or email to determine what their decision was in regard to participation. These potential participants were provided with an opportunity for more detailed elaboration and discussion of the study with the researcher prior to seeking their written informed consent. When the respondents had made the decision to participate in the study, they were asked to complete a written consent form (Appendix IV).

In their published report, Gaudine and Beaton (2002) have not made explicit their criterion for selection of participants, other than noting that selection of participants was based on convenience. In the present study, the criteria for selection were three fold:

- Current registration with the Nursing Council of New Zealand
- Current practising certificate issued by the Nursing Council of New Zealand
- At least one year of experience as a nursing manager in a primary, secondary or tertiary health care organization in the last five years within the New Zealand health sector

The term and professional title 'Nurse Manager' was not central to a participant's selection into the research. Indeed many of the participants did not actually have the professional title 'Nurse Manager'. The participants and the researcher approached the term functionally, rather than specifically. By functional application is meant that the participants all had professional responsibilities that involved the management of nursing services and practices. Any implications of the functional use of the term Nurse Manager have been noted in the final chapter of this report.

3.3 DATA COLLECTION

Two methods of data collection were utilized in this study; a biographical data collection form and semi-structured audiotaped personal interviews. It is evident from Gaudine and Beatons' (2002) report that data was collected from their participants regarding age, gender, professional experience, qualifications, and areas of nursing practice and characteristics of their health care organizations. They do not however, identify how this information was collected. For the purposes of the present study, a biographical data collection form was distributed to participants who had consented to the study (Appendix V). The purpose was to elicit a broad understanding of the participants biographical and professional characteristics. The findings from a very general analysis of the information provided by participants on these forms are summarized and set out here.

At the time of their interviews, all the participants in this study were practising as nurse managers, across five different District Health Board regions in New Zealand, and seven different employing health care organizations. Three of the participants were practicing in the primary health sector, whilst the other five were employed in the secondary health sector. Two of the participants were engaged as clinical nurse

managers, two in professional nursing development management, one in operations management, and three in senior nursing administration positions in their health care organizations. The participant's specialty areas of nursing practice, including that of past nursing management roles, were: eldercare, primary health, emergency, cardiac, general medical and surgical, and mental health. Two of the participants in this study were over 50 years of age, with the remaining six aged between 41-50 years. All but one of the participants was female. The mean number of years experience as a nurse manager was 8 years and one month. The total number of nursing management positions each participant had held varied significantly from one to nine positions. One of the participants had a tertiary education based qualification of Registered Comprehensive Nurse, whilst all others commenced their professional lives as Registered General and Obstetric Nurses from hospital based education. All but two participants had completed post registration qualifications including bachelor's degrees, certificates or diplomas in nursing, health science, or business. At least two of the participants held masters degrees. Three of the participants were engaged in tertiary study towards diploma or masters level qualifications at the time of their interviews.

Interviews are the most common self-reporting method of gathering data in qualitative research (Polit & Tatano Beck, 2006). Semi-structured interviews are "...used when researchers have a list of topics of broad questions that must be addressed in an interview" (Polit & Tatano Beck, 2006, p. 291). The interview schedule (list of pre-determined questions to be answered) ensures a measure of consistency in participant interviews as well as a measure of focus in the ensuing dialogue (Bryman & Bell, 2003). However, this interview method also provides significant leeway in how the participants reply and indeed how the researcher may clarify, probe or explore particular or general responses (Bryman & Bell, 2003). The interview guide utilized in this study is

exactly the same as that utilized by Gaudine and Beaton (2002) and is presented in Appendix VI.

The interviews were conducted in locations of convenience to the participant where privacy was able to be carefully maintained. Prior to commencing the interview, some time was spent ensuring the participants comfort and confidence in the process. It was also an important opportunity to review the purpose of the research, the participants understanding of the process and to check through consent forms. The interviews in this study varied significantly in length from 45-120 minutes, dependant on the length of participants' responses to questions, and the number of examples that they were able to provide.

All interviews began by asking participants to describe any ethical conflict they have or have had with their health care organizations. Ethical conflict was defined in the interview schedule and again at the start of the interview as any situation where the nurse manager's values differed from those of the organization and the nurse manager experienced conflict as a result (Gaudine & Beaton, 2002). Participants were then asked to describe factors that eased and worsened the ethical conflict they had described. The final question posed concerned the description of outcomes of the ethical conflict. Whilst Gaudine and Beaton (2002) focused this on personal outcomes, in the present study this question was posed to include personal, professional or organizational outcomes. The purpose in doing so was to identify a fuller range of possible interaction consequences and outcomes between the nurse manager and the health care organization.

The audiotaped interviews were transcribed verbatim by the researcher as soon as practicable following their conduct. The transcripts were carefully checked for possible identifiers (such as names or places) that were deleted or replaced with terms that ensured anonymity of the

participant. Each transcript was then sent to the participant for review. This practical procedure enabled the participants to ensure that the transcripts accurately reflected their dialogue and meanings, as well as providing an opportunity for them to ensure that their anonymity was maintained in the transcripts.

3.4 DATA ANALYSIS

Gaudine and Beaton (2002) utilized the following techniques in the analysis of data for their study:

- First-level coding – review of transcripts according to the areas covered by the interview guide
- Second-level coding – identification of themes and categories
- Exploration of the data for patterns
- Step-wise replication where each researcher separately analyzed data then cross checked their emergent categories, themes and interpretation

In comparison there are several points of difference in data analysis between this project and the foundation study. Firstly, this project involved only one rather than two researchers as was the case in Gaudine and Beaton's (2002) study, and it was therefore not possible to use step-wise replication. Secondly, the interview schedule was not engaged in data analysis until refinement, comparison and relating categories, and the presentation of findings. Finally, and has already been mentioned, a general inductive approach for qualitative data analysis has been utilized to guide the steps and processes of data analysis.

Alongside the general inductive approach to qualitative data analysis, research supervision provided important guidance throughout the

analytic process. The steps and processes in data analysis for this study are as follows:

- The first step of data analysis involved a process of immersion in the data through listening to each interview recording several times then reading and rereading of transcripts in order to become completely familiar with them, as well as gaining an understanding of recurring events, topics, themes and processes.
- The second step involved coding of transcripts for recurring events, topics, themes and processes. This coding process resulted in over 500 codes that were transcribed (cut and pasted electronically) onto separate cards with identifiers (e.g. A/6/18 – participant/page/code number) used to link the code to the exact source of text from which the code was derived.
- The third step involved sorting the codes into 20 different clusters or categories, by way of comparing and contrasting the codes and their related transcript. The clusters were then labeled, with key dimensions and properties memoed.
- In the fourth step, the categories were also then compared and contrasted and as a consequence all but two of the categories were integrated. This integration of categories was based on consideration of the purposes of the research as well as the different questions in the interview schedule. This process resulted in the emergence of 6 key conceptual categories. The integration into conceptual categories involved moving, or conceptualizing up from, and abstracting the clusters into a larger and cohesive conceptual whole.
- Once these conceptual categories had emerged, they were labeled, with dimensions, themes and relationships to other categories memoed.

Two types of memos were used to support and progress data analysis. The first type, coding memos, were primarily concerned with identifying the dimensions and themes of categories. The second type of memo concerned the research and analytic process as a whole. These memos, which were kept in a researcher diary, facilitated the identification of ideas and hunches regarding what the participants were experiencing as well as identifying relationships and patterns between codes and categories. Memos were thus an important part of remembering and understanding why and how codes and categories developed and played a significant role in moving and abstracting up from the data. These memos also helped to check on researcher biases during the analytic process.

3.5 ESTABLISHING RESEARCH RIGOUR

The framework for this brief discussion on the establishment of research rigour is that proposed by Lincoln and Guba (1989). The criteria of this framework address credibility, dependability, confirmability and transferability in the research process.

Credibility or confidence in the truth of the data and interpretations has been addressed by two methods; prolonged engagement and member checking. This study has not been undertaken quickly, and indeed the collection of data as previously noted, occurred over an eight month period. The analysis of data was also a lengthy process with several phases which built on each other in terms of the robustness and clarity of analytic technique. Participants were asked to check their interview transcripts once transcription was completed, and thus provided the opportunity for feedback at this time. This process ensured that the participant was able to reflect on the questions asked and answers given during their interviews, and any misinterpretation whether by the researcher or the participant, was able to be identified and rectified. A

second member checking process was engaged which asked two of the participants to review analytic findings. In both member checking processes the participants' feedback was in agreement with the transcripts and data analysis presented.

Dependability and confirmability of the research has been addressed by ensuring that all materials arising from the study have and will continue to be available to the research supervisors and assessors at completion of the study. Dependability and confirmability have also been supported by way of the processes of research supervision.

The criterion of transferability refers to the "...extent to which the findings from the data can be transferred to other settings or groups and is thus similar to the concept of generalizability" (Polit & Tatano Beck, 2006, p336). In the present study, transferability has been promoted by ensuring concise and accurate detail of participant sampling and selection as well as concise and accurate description of the data analysis process.

3.6 ETHICAL CONSIDERATIONS AND ACTIVITIES

Prior to undertaking the research a human ethics application was made including the submission of all pertinent documentation to the Massey University Human Ethics Committee in March 2006. This process required that the researcher be cognizant and compliant with the Code of Ethical Conduct for Research, Teaching and Evaluations Involving Human Participants (Massey University, 2005). Approval for the study was received in May 2006 from the Massey University Human Ethics Committee: Southern A, Application 06/17.

Two other important ethical matters were considered and addressed in the ethics approval and research conduct process; the possible

psychological effects that reliving the ethical conflict experience may have on the participant, and the possibility that the dialogue revealed incidents with possible legal implications. Both of these matters were raised and addressed with the participants in the information sheet. Sensitivity to any display of distress or anguish during interview was acknowledged and responded to appropriately. None of the participants demonstrated the need for or requested further psychological counseling. No dialogue raised legal concern; had this occurred it would have been addressed consistent with the procedures set out in the study information sheet.

CHAPTER 4 - DATA ANALYSIS

The objective of this chapter is to present the findings from data analysis. This is achieved through presentation and discussion of a framework of key conceptual categories, their dimensions and themes and relationships to one another, along with selections of interview transcript. The six key conceptual categories of the framework are: *The Health Care Organization, Nursing Management Advocacy, Isolation, Support, the Bottom Line, and Being and Becoming Nursing Leaders.* The presentation and discussion of the first conceptual category, *The Health Care Organization* does not include transcript excerpts, since the majority of the data it represents were one or two words, and to an extent are identifiable in the remainder of the presentation. The chapter concludes with a brief summary of the data analysis.

Presentation of findings in this chapter is also supported by the diagrammatic representation of the framework offered in Figure 1. Each of the key conceptual categories arising from data analysis is found within the diagram, which includes the dimensions and themes inherent in each category. The *Health Care Organization* is conceptualized in the diagram as a broken line that depicts the openness of the health care organization to its health system environment and aspects of that environment such as other health organizations, other people in health care organizations, health policy and broader health system processes. The large arrows in the diagram, demonstrate direction and relationships between categories. For example, the experience of *Nursing Management Advocacy* is influenced by both the experiences of *Isolation* and *Support* and the conceptual category and experience of the *Bottom Line* is a result of all three of these other categories in the framework. Experience of the *Bottom Line* leads to *Being and Becoming Nursing Leaders.*

4.1 THE HEALTH CARE ORGANIZATION

The analysis of data revealed that the health care organization was not merely an employer, or involving executive management - although these two entities and descriptions were evident. Rather, the health care organization was people, positions, structures, systems, processes and culture. Moreover these dimensions and experiences crossed the boundaries of individual health care organizations to other health care organizations, into the community and its representatives, and in relation to Government, particular policy and funding systems and processes.

The experience of ethical conflict also occurred with particular people, such as immediate managers, service managers or general managers (most non-clinical) and at other times executive managers such as Chief Executive and Chief Operating Officers. The health care organization was also revealed as other nurses and nurse managers, including professional nursing leaders and Directors of Nursing. At times the health care organization was medical or clinical directors. Most frequently the health care organization was referred to as managers or general managers or the structure of managers, at times phrased merely as "they". One of the more distinctive structures of the health care organization was governance based, including District Health Boards (DHB's), and primary health organizations (PHO's) Boards.

The health care organization was also portrayed by participants as a culture, including: a culture of bullying, the culture of medicine, and the culture of primary and secondary health services. Lastly and particularly a result of having participants who practiced in primary health care, the health care organization was described as a business or firm concerned with financial sustainability.

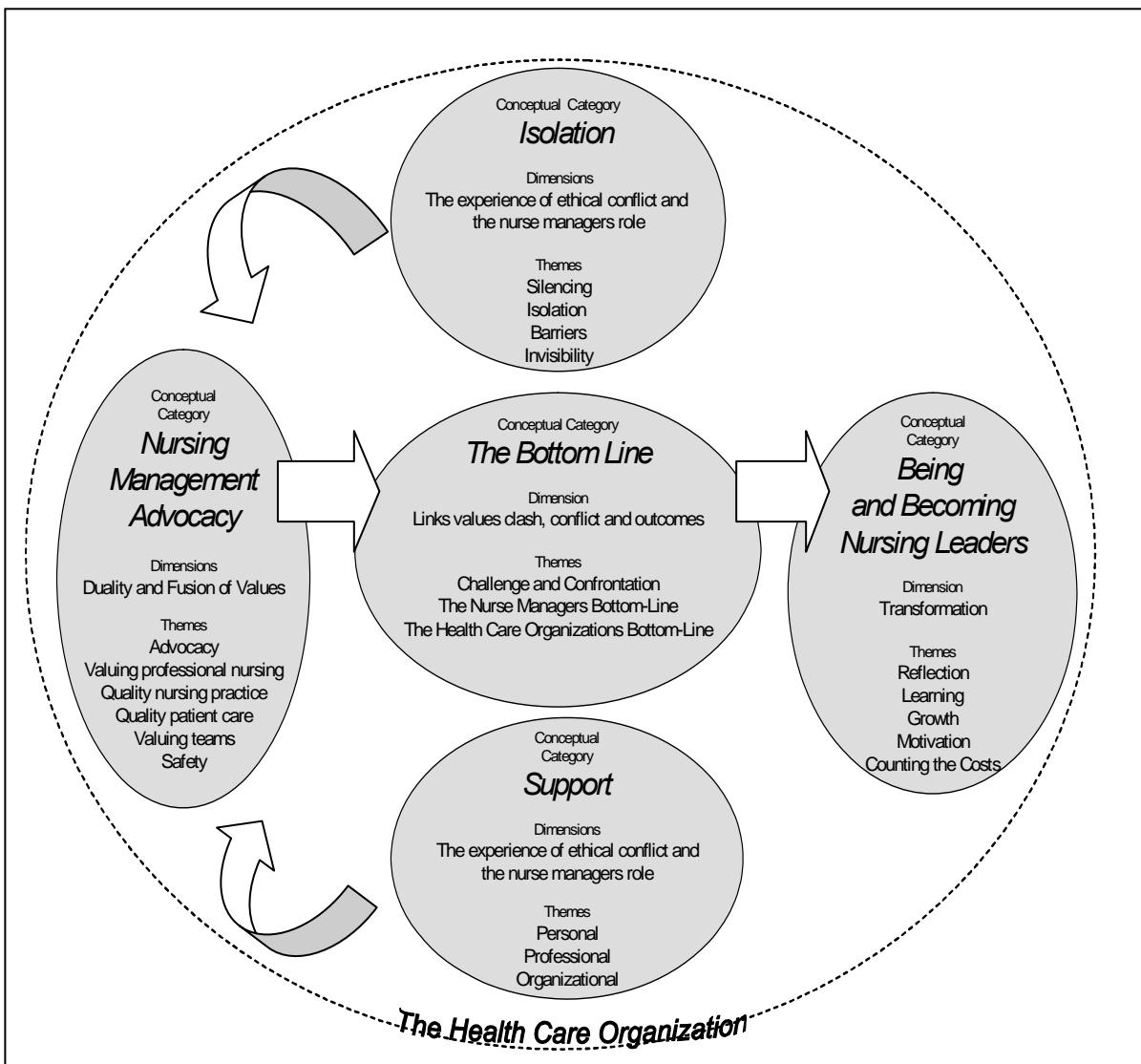


Figure 1. Framework of analytic findings: conceptual categories, themes, dimensions & relationships.

The health care organization was also described and experienced as a complex weave of systems and processes. Examples of this less tangible and less personal dimension of the health care organization include: human resource, performance management, funding, planning, decision-making and risk management systems and processes. Descriptions also included nursing education and professional nursing development systems and processes within and between different health care organizations.

4.2 NURSING MANAGEMENT ADVOCACY

The key conceptual category of *Nursing Management Advocacy* is central to the many and varied descriptions that participants shared in their interviews, when asked to describe their experiences of ethical conflict with their health care organizations. *Nursing Management Advocacy* has the important dimension of both duality and fusion of nursing and management values in the participants' descriptions, which did not necessarily represent polemic values stances between the nurse manager and the health care organization. Rather, that at times the descriptions also portrayed the nurse manager experiencing a fusion of nursing and management values in their perspectives, roles and activities. For example the participants experienced ethical conflict when the organization did not live up to their stated and agreed upon values. Describing this experience as 'cognitive dissonance', one of the participants portrayed the ways in which they had encountered managers who did not demonstrate empathy or compassion for their staff:

I think that cognitive dissonance comes up hugely for me as well as the organization...I guess there is, the dissonance for me is when management, some managers, have, they espouse the nice words, they talk about it, they use the latest lingo, but they don't walk the talk. Okay, so they don't, they don't then act on it, they are last minute and reactive in their own style. They don't really demonstrate empathy and compassion for the people they are working with, so people loose trust and respect, because they can't see the process. They know what is required and it's even covered in our collective agreement for nurses, this is how we will manage change, and its like a breech of all of that.(H/5/14&16).

The fusion of values in descriptions was also evident when participants recognized the broader objectives, priorities and responsibilities of the health care organization. For example, Participant H expressed an awareness of the different demands influencing general managers and their actions, by describing:

So I think, generally the people directly above me have been going in a line with me, but they often get pushed off the line. Then they have always explained to me why they have changed direction. I think the level above is just not aware of where the line is. (H/12/28).

In the following discussion, the participant demonstrates a sympathetic understanding of the issues and values inherent in managing health care organizations in the primary care sector and their ability to function financially:

I think the fact that its always been a private business, its really difficult, and I have to say I have some sympathy for GP's, they're running a business at the end of the day. They are not running a charity, and to have the government come along and say actually no we're not going to let you do that is a bit hard for them too. And I can see the down side of that, if I were running a business I would get pretty hacked off with them if they told me I couldn't charge more if I thought my time was worth it. But at the same time you can't have your cake and eat it. You can't get money from the government and charge the patient. So you have to meet somewhere in the middle. (B/16/42).

The theme of advocacy involved feeling, observing and identifying, then communicating or working with the health care organization regarding problems, issues, dilemmas, bug-bears, and circumstances that challenged their values. For example, advocacy involved activities such as, raising issues, asking questions, lobbying, influencing, reporting problems, escalating, speaking out, sending emails, confronting, challenging, pushing for, writing memos and fighting for what they believed was the right thing for the health care organization to do, or concerning what they believed was wrong. Advocacy is clearly yet differently expressed in each of the following three transcript extracts. In the first example Participant D demonstrates the way in which they utilized their nursing management position to advocate for change and

improvement in the nursing service. The second example involves a manager practising in primary health care, and is a very general but important statement of nursing values. The third example concerned the participant's involvement in restructuring of a clinical service where beds numbers were being reduced.

Where I can improve things or have the potential to improve things ...for professional peers, and the patients themselves, and I am lucky enough to be in a position where I can work towards speaking out or improving the processes that are currently in our organization which are causing their conflict. (D10/26).

I think, being an advocate for the patient. I think that that is what nursing is all about, and I think when you stray away from that and become employed by GP's or anybody else, you can loose sight of the fact that that is what you are actually there for. In fact we had a panel of nurses talking to nursing students recently, and we were talking about getting political and being strong, being knowledgeable about what is happening in nursing. One of the nurses pointed out that if you are a strong advocate for the patient you can actually be a strong advocate in other areas, and you can actually be strong politically, so I think it all starts with being a really strong advocate. (B/14/36-37).

And, despite advocacy in which I tried very hard behind the scenes to try and change the direction that this conversation was going, the paper went out and everyone just went into chaos in the teams that were being dispersed. (G/1/4).

The other themes of the category are indicative of the core functions of the nurse manager's professional role and values. Valuing professional nursing, describes the nurse manager's active pursuit and development of the roles, responsibilities, and respect for the broad and specific contribution of professional nursing in their health care organizations, as the organization in turn pursues its health service objectives.

One of the ones that I still get conflict with the organization, is the valuing of nursing. Primarily where it shows up to me most is in the horizontal violence, bullying sort of field. (H/8/18).

What happened with the professional development program conflict was that briefly we all came together, we put aside our PHO differences and we worked on a very professional, development level...and I don't think we have to ask our PHO's permission to get together. I think we can get together and actually talk about professional development in our own time if necessary. (B/17/44-45).

Valuing professional nursing was also encapsulated in descriptions where the nurse managers enhanced professional behaviours and culture within their own nursing teams. For example, Participant F described members of the nursing team lacked real interest in the elderly patients for whom they cared, and then change to this attitude in the facility:

In the, when I first started here, I started as the RN and I noticed that, how can I put this nicely, that my colleagues were just kind of looking for a job, they would do the minimum, I was on from Monday to Friday, and you wouldn't believe the stuff that got left for me, because they weren't really interested in old people. That's changed now, um, we are, the RN's that were have got on, have got here now all want to make a difference. (F/8/16).

Other examples of the value of the nursing profession are expressed in the following two transcript extracts. Whilst the first example very broadly concerns the struggles associated with lack of respect for professional nursing within the health care organization, the second reflects the ways in which resource allocation decisions, in particular decisions regarding the funding of professional development for nurses, made at a governance level, have implications for the nursing profession.

I think there is something deeper there, which is actually nurses being seen as hand-maidens and being told what to do by somebody, and if its not a doctor telling you what to do, its somebody else, it may be a CEO who wants to tell you

what to do. I think there is an element of nursing not being seen as respected or owning its own professional development.(B14/35).

[T]he worst thing the parliament, well the government ever did, was take away that nurse subsidy, because that was the only capped money we had within a primary care setting to say you have to pay these nurses this much, or this bucket of money, even if they had kept the whole practice nurse subsidy in a bucket, we could have then have a voice to say we know you have got \$40,000 in there for education. (E/13/28).

This latter participant also went on to describe the promotion of professional nursing, as changing the culture of health care to one that is led by nurses, in contrast to a medically driven culture of health services. This example is not only about a nurse manager advocating for professional nursing, but also describes their congruence with this value.

Its all about culture, its about the culture of secondary, the culture of primary, the culture of medicalized health care, the culture of nurse-led health care. Now in our organization I developed, and I say I, because I did, and then with the help of an every increasing expanding team, developed a nurse led culture and it worked really effectively, And people are starting to recognize this.(E/22/47).

The term quality is used to describe both nursing practice and patient care, since the descriptions reflected responding to the communities health needs, the pursuit of evidence based practice, and improvement in standards of nursing care and practice. Advocating for quality nursing practice was expressed by all of the participants through their pursuit of the appropriately qualified and educated nursing staff, specialized nursing staff and enough nursing staff to meet the needs of patients in their care. All of these issues concerning the quality of nursing practice were a significant and persistent cause of ethical conflict for participants as they shared their experiences in their interviews. One example

provided by participant A, concerned needing nurses who were skilled in the care of mental health patients in acute general settings and then advocating for this over an extended period of time.

But the nursing of these patients per se is not often as good as it should be. Often there are just no comprehensive nurses around. If they ask for a psych special we will try and get a comprehensive nurse or a psych nurse....I have been trying to do something about that for a long time. I've probably still got some of the emails I've sent.(A/15/34).

Quality nursing practice also involved thinking and acting strategically in nursing resource development. The nurse manager's advocacy in this regard may be about convincing or proving to the health care organization that nursing resource use and development was essential. The following extract captures the nurse managers' ongoing advocacy for the development of the nursing team they were responsible for.

As a nurse manager and leader I often had the problem of having to prove that a certain strategy was best in the long run even though in the short term it may cost. Often non-clinical people are managing nurses and do not understand some of the thinking behind strategies such as staff retention. The concept that 'a nurse is a nurse is a nurse' was often the feeling you got from managers who were not nurses. Thus strategies to improve retention and seniority of staff were often seen as increasing cost rather than increasing value. The need to pay for staff overtime and extra resourcing to prevent staff turnover and training costs was an example. (H/5/11).

Quality patient care, whilst closely aligned to that of quality nursing practice, has as its focus what is right and what is necessary for meeting the health care needs of the patient. For example, Participant A describes the inappropriate use of untrained health care assistants for care of mental health patients:

They have basically gained their experience by osmosis really, they have no training but they have been exposed to a fair lot of mental health patients...its wrong, its wrong. (A/17/41).

When asked why they believed that the issue was ethical, they replied:

Well it's a human right, that's what it states in the booklet that they get, that they get the right care, in the right time in the appropriate place by the appropriately qualified people. (A/17/42).

The quality of patient care also concerned advocacy for the best care delivery models. For example, after describing the pitfalls of one nursing model, the participant then describes advocacy for a better model of care delivery where the focus was more on the providing better quality care for the patient than the organizations drive for efficiency in nursing resource use.

Would they like to go to a primary nursing model, and there was also strong support to go to a primary nursing model. There are a number of other questions that were asked in that proposal but the submissions for those two areas have given us an impetus to change the way things occur. So we have this opportunity to bring in a primary nursing model which will increase the number of RN FTE and reduce the number of health care assistant FTE. (D/4/11).

Advocating for quality patient care was also pursued by the nurse manager with other members of the nursing team. For example, the following dialogue demonstrates reciprocal exchanges between nurses, concerning quality patient focused care delivery systems.

I did a presentation to them yesterday and I said you people I think, don't quite realize the effort of living in this community...The girl today I was working with she said, you really overrate that transport problem, its not an issue.. and I said to her go back through your notes, and this poor guy had about six appointments

in two weeks. I have said to people, being sick in places like this is a full-time occupation ... and at the end of the day most of them are ineffective, they don't make any difference to the health outcomes. So yeah, I push for taking it back to the people, you know.(E/21/45).

One of the unique examples described, involved re-development and re-design of a health service. The participant's description in the following piece of transcript alludes to lack of focus on patient and community needs and the possible effects of service redevelopment and redesign on the community as a whole. Importantly this example also demonstrates the value of holistic health care inherent in nursing, as well as evidencing the participant's intensive process of advocacy to retain services that were believed most appropriate for community health needs.

The continuing care residents are all locally born and bred people....their families live there, they had spent time there in the past in their younger days and the families wanted them to come back, and all these families had put in money and time into the community and hospital, all the equipment was donated by these people. So it meant that somebody who had been there for more than one generation, in their 80's was suddenly going to be uprooted, and just shipped off because the DHB did not see that - money-wise, that was not going to work for them. They did not care about socio-economic factors for the community, because apart from uprooting these poor people and shipping them away from their families...it meant that ... people would have lost their jobs directly as a result. So, I had a huge problem with it...for the next year....we fought the DHB ...to retain the services. (C/2/4-6).

In another of the unique examples, evidence based clinical practice as it contributes to quality patient care was at the heart of the participants' advocacy. Multiple values sets are identifiable in this description.

The ethical conflict for me was when I realized that the pediatrician was prescribing Ritalin for children, because the parents wanted that for their child,

and yet he would actually document that there was no clinical rationale for the Ritalin. That was a huge dilemma for me...There are clear guidelines as to how Ritalin should be prescribed and what it should be prescribed for and the clinician had documented that it had no clinical rationale, but the parents had requested it.(D/13/38)

The theme of valuing teams was expressed along a number of dimensions including nursing, clinical (multidisciplinary), and organizational teams. Undervaluing the role of teams in the health care organization were a source of ethical conflict for the nurse manager and included the way in which change would affect not only individual team members, but also the benefits of teams to achieving health care management goals.

I guess what I felt, just in relation to that team stuff, is that people don't often value that teams working well together can make huge benefits to the management team. They make things happen that would normally not be achievable, not just a series of individuals that come to work - its that whole team spirit, that whole culture that makes things work. And, I felt that management was seeing this as just people that could be dispersed anywhere, and they weren't giving value and respect to the people. But I also felt that there was this whole stuff - the dollars have to be managed in a pretty straightforward way- and this isn't just like a closing of a factory; there are people attached, and patients attached, and a whole raft of reasons.(G/3/9-10).

Valuing teams also involves the inclusion or engagement of teams in decision-making. In this particular example the participant relates teamwork to extant guidelines in the health care organization, as well as specifying the risks that failure to include and engage teams has for the health care organization.

So I have huge ethical dilemmas when decisions are made, I can see what's needed to be achieved, but the way they go about the decisions leaves the organization very vulnerable... For me there are very clear guidelines about how

this should be happening. If a problem exists you sit down with the people involved and you say we have got a problem, lets think about some options and solutions, so that everyone is feeling as if, along the way, right from the very beginning they understand what is happening.(G/4/14).

The theme of safety, concerned the safety of patients and staff, as well as legal safety. When standards of care are compromised because of lack of resources, or poor clinical decision-making, systems and processes, the health care organizations patients and staff are not safe. These processes in turn heighten legal risks for the health care organization. There were many examples from the interviews that concerned the fundamental theme of safety, and most often linked to lack of appropriately skilled clinical nursing resources, but also unsafe clinical equipment. The following three selections of dialogue demonstrate how participants raised safety concerns and the possible consequences of lack of safety for patients, nurses and the health care organization.

And therefore we had to keep the organization safe in terms of HR process, go through a lengthy process of managing this person and basically giving her the opportunity to upskill, to relearn what was basic care in a lot of ways and still keep the patient safe, was my side of things. That was quite a conflict because I new that any period, or very quickly I learnt that any period that she was involved in patient care which was unsupervised, she was likely to do something that was dangerous.(H/1/2).

We had one standing hoist, that was, I considered, to be dangerous, and because it didn't look it, the advice that I got was that it didn't matter which sling you used, they could still slip out of it. So I took it out of operation and I went to my manager, and she was in agreement, she said right were going to get a new one, and the word came back from the Board, no you can't. (A/1/1).

There is an issue that keeps recurring and has recurred since I've been with the organization in a variety of roles. I have seen it written from nursing staff on the

floor ... it's an issue and it's around the safe staffing and the use of unregulated care givers. So it's a resourcing issue, it's definitely to do with both the level and number of registered nurses on the floor and the skill mix. (D/11/2).

4.3 ISOLATION

The conceptual category of *Isolation* emerged from data analysis as a key and important intervening influence on the process of *Nursing Management Advocacy*. Four themes were identified: silencing, isolation, barriers and invisibility.

Participants described experiences which silenced their advocacy, and in particular different forms and channels of communication such as emails, memos, reports, meetings and representations to the health care organization. Silencing was inherent in both the nurse managers own behaviors when managing an ethical conflict and organizational response to the nurse manager's advocacy.

It was interesting one of the nurses said the other day... she said she didn't want any secrets anymore. And I thought, yeah right, when is the next one going to happen. So there is a lack of understanding from some of the staff as well, which makes it really, really difficult. They knew that things were going on, but they didn't know what. So there were a lot of secrets, I did have a lot of secrets from them, because I wasn't able to tell them. And it was just this comment that one of the nurses made the other day and I thought that it really is interesting, that they know that there are secrets, and what makes it hard is that they don't understand that they are secrets and I can't talk to them about it. (C/8/39-40).

Before the next general meeting, a couple of the general managers were talking to me, they didn't say anything specific, but from a couple of the general managers, I got the distinct impression, that I needed to keep my mouth shut, you know shut up or think about whether you like your home as much as you thought you did. (C/3/15).

It was really hard. I guess there are some things that happen, that you can't say a lot. But there is a difference between not saying things and lying about it.(C/4/23).

The participants also experienced silencing in the context of bullying, or horizontal violence. The two examples of horizontal violence provided by the participants in this study included a specific conflict event and a more general and ongoing experience of bullying involving medical professionals and a nursing team. In the extract which follows, concerning care that was not based on clinical evidence, the participant was silenced by an immediate manager and more specifically by a medical member of the clinical team which they experienced by way of personal threat.

And I took it to my manager who basically told me that because there was trouble recruiting medical staff that thank you for sharing it, but, it would probably be something that would be left alone and not dealt with. However it was addressed with the pediatrician, so A) I was identified, and B) the pediatrician was informed of my concerns and personally came to my office and threatened me after hours when I was working late one night. (D/12/33-34).

The theme of invisibility concerned where participants were actively addressing situations where there were values clashes and ethical conflict, but doing so in ways or circumstances where they were not always seen by their colleagues, both nursing and management. Practising invisibly, by way of quiet influence, is possibly also indicative of not wishing to be seen to be in support of nursing.

Behind the scenes is not a negative context so much. A lot of people work behind the scenes. A lot of nursing is done behind the scenes. Because the caring quiet moment is not always something in front, that everybody is visible... It just means there is a lot more one on one stuff. There is a lot more quiet influence. (G/26/74).

It doesn't mean I don't say anything, but you may not see the forum in which I deal with it. I will deal with it at different levels on different days all the time, and I never let go. It's just, it may not be confrontation. (G/30/89).

Using a metaphor based on how one might surreptitiously influence their husband, Participant C describes the invisible hand of an advocate:

I have to perhaps sew the seed so that people think it's actually their idea...like you do with your husband, sew the seed, they think it's their idea and then it's all fine. And you do have to do that a bit with your bosses I think, make them think that they're really clever. (B/5/17).

Barriers between the participants and the health care organization as an employer, between participants and professional groups or departments, and between different health care organizations contributed to the participant's isolation. For example, one participant described how their newsletter to nursing colleagues in different practices of a PHO was stopped prior to its distribution by their practice manager.

And it is really difficult being micro-managed. We had an example this week, I advertised something in our weekly bulletin to the practices, and I worded it very carefully, and I didn't want to rock any boats and I passed it by somebody else, and reworded it and it didn't go out, it was stopped at the gate. I thought gosh I thought she had better things to do with her time than read what I had put in the weekly newsletter. Obviously not. (B/18/48).

Employment barriers were clearly felt and experienced by participants. In the process of advocating and challenging the planning of a service restructure at the governance level of the organization, including the Director of Nursing at this level, the participant expressed on three occasions the risk to their employment with the health care organization.

I thought my job was sitting on the line with a lot of this. (C/3/13)

I know my job was on the line several times, because I did go to the line with what I had said to people,(C/4/22).

And I also felt that they are never going to give me a job...because I'm too much of a stirrer.(C/5/22).

Another of the participant's described that reporting significant events arising during the course of their work, such as the consequences of inappropriate nursing resource allocation was about sending messages to the "hierarchy" (A/8/15). This implicitly expresses organizational structure and culture as a barrier to their advocacy. Lack of structure in contrast, may in turn result in an inability to advocate, although it is evident that this does not inhibit nurses from actually raising the issue of lack of structure.

We have a body of nurses who feel very disempowered in our organization because they have been silenced through the lack of nursing structure, and they are quite vocal about that. (D/9/22).

Organizational structure was experienced by the nurse manager as a cultural norm with specific behaviors aimed at helping keep things secret, although clearly not unnoticed. Talking generally about relationships in their health care organizations participant F explains:

Well I got on quite well with our last service manager, we had these quite nasty discussions at times, but looking back it wasn't a very happy place here. Just because things seemed to be secret...Because the service manager, the general manager and the board member, would come here, and close themselves off in the office there. And I would be told "Do not disturb us, nobody is to disturb us". Okay, so they would stay in there for most of the day, poke sandwiches at them now and again, um and then they would go away, and there would be absolutely

no idea what they were doing, but I knew that they were making decisions about the budget.(F/13/23).

Isolation evolved from data analysis as its own theme, either perceived by the nurse manager or exercised by the health care organization in response to ethical conflict or as a consequence of it.

A lot of the nurses sort of disappeared, it is probably my imagination, but walking down the corridor...I felt that people would see me coming and duck into a door somewhere. They probably didn't, but it felt like that.(C/6/33).

Health is really patch protective and it doesn't matter where you are really because its always the same... so we were all in our little offices being told by our CEO's to keep our heads down keep out mouths shut and it will all blow over.(B/4/13-14).

The conceptual category of *Isolation* therefore describes experiences that impact on the process and substance of *Nursing Management Advocacy* and on the role more generally. It is poignantly summarized, including the risks to employment in the following extract.

For me personally, yes there are risks, we have a culture of bullying in our organization, and if you speak out you are silenced, through any number of means and one of them could be that your job is disestablished. I'm not naïve enough to believe that it's the only organization that does that either, I've seen that occur, and yes that's definitely a possibility... But if it happens, it happens, and I will deal with that, so the risk is loss of income really.(D/10/2-28).

4.4 SUPPORT

The conceptual category of *Support* similarly, influences the experience of *Nursing Management Advocacy* and is readily identified as the result of the interview schedule that asked the participants to describe those factors which made the conflict easier. *Support* was described as an

influence not only on the nurse managers ability to advocate, but also on the performance of the nurse managers role generally.

The major sources and forms of support for nurse managers were personal and professional. Family members and friends were identified as a key resource people for the participants, particularly when the nurse manager struggled with the emotional burdens or indeed physical illness arising from their experience of ethical conflict. When asked what made two particular examples of ethical conflict easier, Participant C and Participant D replied:

I've been thinking about that, and I can't, I guess the only thing I can think of that made it easier, was the support of my husband and the chair of the community group... The staff were scared to say anything; they didn't know what was really going on. (C/7/37-38).

My husband went through that with me and he still brings it up a lot about how much support he had to give me at the time. My children also went through that with me. (D/16/44).

Professional support, primarily from other nurse managers, was sought, at times given and received by participants in order to gain other perspectives, or supervision of management activities, or to show a united approach to an ethical conflict. This dimension of professional support is reflected in the first extract to follow, which involved several nurse managers across different health care organizations in the primary health sector. It was also described more broadly by participants, and as the second example demonstrates, in terms of coaching.

We then as Nurse Managers sent letters of support to her bosses outlining what had been said at the meeting, that we felt quite clear that there was no bullying

happening at the meeting, and that this was a joint decision between all of us and what we actually wanted.(B/2/6).

I can think of two professional leaders primarily, that have really coached me to develop, and that made a huge difference. Because again they had a bigger picture, they understood some of the things I didn't at that stage understand, and probably still don't. But they coached me to be able to achieve what I wanted to do within the system. Where that professional leadership has not been available it's been much harder to learn.(H/6/14).

The theme of organizational support has two key dimensions. Firstly, the health care organization may, in a specific circumstance or in a broad sense, support the nurse manager in the midst or aftermath of ethical conflict. Secondly, organizational support also reflects when the participants support others in the organization:

When the manager told him that she had ordered one, he laughed, and just said well good for you, but don't do it again....Yes, it would have stopped dead if she hadn't been supportive. And I would have been left absolutely outraged, because I had been let in.(F/2/5).

When the nurses get into that sort of predicament, they're frightened, they're scared. They don't know how they are going to cope and basically what you do is use your good communication skills and put out other options, and then help them to choose the right mode of how they are going to work for the rest of the night.(A/4/8).

Perhaps in irony, this final slice of transcript describes a circumstance that has already been introduced, where one participant nurse manager, advocating for quality patient care, specifically the appropriate use of medication, was bullied by a medical team member, then was unsupported by an immediate general manager, yet in the aftermath was supported by the health care organization to relocate elsewhere within the organization.

No the organization was extremely supportive of my decision, but personally I think that part of that was because I was a very outspoken person and I think another part of it was they had identified the strengths of me professionally and that's why they put me in there in the first place and so they did look after me afterwards. They seconded me to a position until I felt I could see something else in the organization that I wanted to go to. So I did feel supported by the organization post event. (D/15/42).

4.5 THE BOTTOM LINE

The conceptual category of *the Bottom Line* has three themes that overlap: confronting and challenging, the health care organization and the nurse manager. The theme of confrontation and challenge is about heightened advocacy or a focal point of ethical conflict. At the end of the day, ultimate choices and moral positions were felt, expressed and responded to in reciprocal fashion. In terms of its relationship to the other conceptual categories and to the questions asked of participants, this category has the dimension of linking values clash and ethical conflict to outcomes. *The Bottom Line* describes and represents both reflexive and at times inevitable social interactions and experiences of ethical conflict.

I really left my previous position because at the end of the day I think I was fooling myself that I was making a difference for the nurses. At the end of the day I had to actually wake up to the fact that the health, where I was working was the epitome of the constant, we were perpetuating the continuum of health disparity.(E/26/58).

There are some things you can fight and some things you can't. So sometimes what I will do is give a context to things, like I will think, is this the battle or is this the war? So sometimes it is absolutely essential that I fight this one, this is absolutely bottom line and I will not let some things go. (G/9/30).

Challenge and confrontation by or of the health care organization's fiscal bottom line may be particularly direct and acute; as one participant described "quite terse and difficult" (G/4/12). Yet at other times the descriptions tended to express fiscal restraint as an inevitability that was unchangeable by the nurse manager.

At least at the end of the day you have done everything in your power. I mean in the health care systems of today, I don't expect it's anywhere different in the world, certainly in Australia they have got the same sort of things. Fiscally as well as what is going to happen in the future, I don't know. I think at the end of the day nurse managers, again, can only go as far as their budget will allow them.(A/8/6).

Again it's a monetary thing; they just don't want to pay. (A/15/35).

The Bottom Line was not only about fiscal restraint and the limited resources of the health care organization, but also about the relative respect that the health care organization had for professional nursing which is consistent with the theme of valuing professional nursing that has already been presented. Some dialogue expressed intense exchanges between the nurse manager and the health care organization, as well as possible changes as a consequence of the nurse manager's advocacy for the profession. For example both participant D and H described their experiences of challenging the organization in relation to the value of the nursing profession as follows:

The Chief Executive Officer stated at a staff briefing that he would like to introduce more senior professional leadership nursing roles; however, he has not got the funding to do that. I challenged him in that briefing, that if they know it's the right thing to do, how can they afford not to do it, financially? And he did grin and say that's a very good question. (D/25/61).

The conflict for me comes, when that individual happens to be a medical professional, that the reverse tends to happen, and the organization tries [to] quiet it rather than take it through a process and I find that quite frustrating. So much so, to the degree I have heard one manager say that the medical staff are too important to risk losing. I have to say that was challenged. But that is certainly the impression you get when it comes to bullying. I have seen it a number of times now, and I have escalated medical bullying to as high as I possibly could. (H/8/19/20).

Where the nurse manager could no longer tolerate values incongruence and clashes with the health care organization, and the position which the health care organization had taken, it was evident that the nurse manager would or may leave their nursing management positions in response. It was also evident that the health care organizations bottom-line did in fact occasionally change, sometimes as a result of the nurse managers' advocacy, as the examples below will show. Importantly, this concept highlights reciprocal social processes that pivot around values clashes.

I think the way I cope with it is I have decided I have the ultimate choice. Which is I can move on. So basically no matter what an organization asks of me I can choose to accept it and meet the challenge, or I can walk away if I believe its an unreasonable ask. If I think there are things I can do and I'm supported to change things then fine. When it becomes from my perspective an organization saying they are not going to change, and I don't think it's acceptable, then my perspective is I can't support the organization, therefore I can't work with the organization. (H/15/34/35).

And, probably the thing that did change the mind of the managers was, A) a commitment that we would try and hold the beds as much as we could, in terms of closing of beds, but also that we needed those side rooms, for the patients that needed side rooms, and we used that clinical ethical consumer focused route, but also infection control, and a whole lot of other dimensions to defend it and that stood. (G/2/7).

This year for the first time we have got a decent amount for, in the budget, for resources, for education. Yeah, because, the service manager feels that they are actually changing the way they are thinking, that they can't concentrate on, solely on the bottom line, or they can, but its going to be a smaller bottom line.(F/23/36).

I guess, you know I have made a big change to leave an organization a number of years ago, because I couldn't work with the values of the organization. I think you reach a certain point in your leadership role where you have to work in an organization where the values are consistent with your own; otherwise you just can't work in that organization. And I made that decision having been part of very big picture leadership decisions that had been made, and I felt more and more uncomfortable about the money that was being spent to create a vision, the lack of kind of connectedness to the community and what was really offered to the community, and also the way in which people were being talked about in terms of widgets.(G/14-15/43-44).

4.6 BEING AND BECOMING NURSING LEADERS

This conceptual category describes a transformation dimension, and various elements evident in transformation, as it relates to the experience of and outcomes for ethical conflict for nurse managers. The transformation of nurse managers to nurse leaders is not a blunt instrument, nor is it about different roles or levels of nursing practice. Rather, *Being and Becoming Nursing Leaders* is an evolving career long process where reflection, learning, growth, motivation and counting the costs of nursing leadership are experienced. One of the early memos written by the researcher during data analysis provided a vision of nursing professionals who were on different roads of the same journey of moral and professional development:

A couple of things have sprung to mind listening to all the tapes and reading all the transcripts together. First of all, everyone is on a different road, but on the same journey.

Secondly, they have all changed over time and experience, not just from their nursing management roles, but also from their clinical nursing experiences, and in particular when they were engaged in moral dilemmas. (Researcher diary memo - May, 2007).

Whilst it was evident that some of the participants identified distinctions between the terms nurse manager and nurse leader, a constant factor was the way in which their nursing careers and experience of ethical conflicts had contributed to their development as nursing leaders. In the following extract the participant has described an ethical conflict and its meaning and influence simultaneously.

Yes, I think if there was one example when I was thinking through what you might ask me there was one clinical ethical conflict when I was very early on as a professional. When I was working permanent night shift on an area, there was a doctor whose practise I didn't feel comfortable with, and I had been to management and said I felt this person was not following things up and was neglectful. There was this one patient, a young chap, he deteriorated on my shift and then the next day I came on and still nobody had really done anything about it. On the third day I came in early, because I felt something was wrong, and went in and he was on the verge of arresting and dying. And I was then left with this huge dilemma as to what to do. I had already notified management and they had done nothing about it in terms of my concerns about this doctors' safety, and, they didn't want to deal with it. I was at such a dilemma as to what to do, I nearly left nursing at that time. (G/13/37).

The first theme in this conceptual category is that of reflection on the experience of ethical conflict.

I felt quite undermined; I actually went away and thought why am I doing this job?....because if I don't have a remit to actually go and make these decisions on behalf of the nurses, then what am I employed to do? It really makes you sit

down and think, what is my job? And that happens quite a lot in health and I have certainly faced that quite a lot in my life. (B/4/15).

...twelve months from removing myself from the team, to me stating okay I'm ready for another role, these are the sorts of roles I'm interested in...huge damage, in terms of self doubt really, about whether I could have done things differently, which I probably could have...there was an awful lot of reflection on my part. (D/16/43).

Reflection can also provide a foundation for career motivation and moral development. Motivation was therefore not confined to being a nurse manager, but also has its origins from earlier parts of nursing careers.

I made an active decision to stay because I thought if I am a relatively strong person in terms of my beliefs about things if I can't deal with it, how on earth would my colleagues deal with it. I needed to stay so I can change it. And that's been, I made an active decision to stay because I was on the verge of going. If managements not prepared to deal with poor practice that actually kills patients then how can I work in an organization in a profession that doesn't feel like it can make a difference? And so I actively changed it, and what I changed, I went back onto that same ward as a charge person, and actively created the opportunity, where people could speak out about poor practice. (G/1/-38).

Learning from their experiences of ethical conflict was a repeated expression of these participants; indeed “*there is no etiquette book that tells you how to manage these circumstances*” (G/12/35). Learning other managers, important processes, techniques, lessons, and about themselves is an important part of *Being and Becoming Nursing Leaders*.

A positive might be that you learn to work the system. And that you actually learn to be subtle in your approach. I'm a very direct person and that does not go down generally very well. I find it difficult to couch things in nice round soft terms and tend to go to the heart of the matter. (B/5/16-17)

It was about; it was more about learning individuals, and learning how to speak in a way that they wanted to hear things. It was more about learning how to read other peoples styles and use those styles to get what you wanted. (H/6/13).

I think any nurse who's looking to go forwards in their career, obviously we all learn from experience, and part of the reflective thinking is to reflect on an experience and learn from it...So I learnt from every experience. (E/4/7).

Where there was learning, whether from an ethical conflict or the role of nurse manager more generally, there was also identification by participants of their personal and professional growth.

As I've said, I've actually grown with this job. (F/23/35).

I learnt a hell of a lot out of it, I've grown as a person and more confident in what I do. When I'm not really stressed out and I can see the trees out there...I've got a lot of confidence now, and its made me also think about nursing and management and where do I want to go with it, its made me look at my career and future more clearly too. (C/5/29).

I mean I still get very emotional about it. But would I do it again, absolutely. Would I do it slightly differently? Possibly. I've learnt from what I went through, and hindsight is a wonderful thing. Would I hope it to change the outcome? No. No I wouldn't. I think I make better decisions because of what I have been through and hopefully so would of that doctor. (D/18/50).

The final theme describes the process and experience of counting the costs of nursing leadership. The participants paid the cost of detriment to their health and well-being including stress and burnout, as well as physical and psychological pain.

One of the struggles is you're fighting on the inside and your fighting on the outside. I have said to a lot of people, there is only so much time you can do that...because you do burn out. (B/19/51).

I can actually see an awful lot of wins from the pain that I went through with that team. (D/18/49)

That I hadn't realized the difficulty, the constant weight on my shoulders, you know its like, because every minute of the day was in an advocacy role because they were, they were, such a disparate group, and they just needed such strong advocacy. (E/16/36).

Nonetheless, the participants were aware of the costs they paid for their efforts as nursing advocates and leaders.

Because there is a cost to leadership. The cost of leadership is massive and I think, people don't always realize it, they think its exciting to be a leader. It is, but I think it's also, there is a cost. (G/19/58).

Now, I lost power, relationships, kudos, respect, dignity, everything within that whole group... So, even though they might have thought that it was unjustified, they were beholden to stay supportive to their colleague, which I could understand, I didn't like, but I had an understanding of them and I can understand where they are coming from. (E/6-7/12-13).

I guess the one thing that I am really aware of and we have already touched on it is that there is a personal cost. I think particularly for nurses, I can't speak for non-nursing. (H/13/31).

Despite the costs, the participants described persistence in their nursing management careers, at times in the same health care organization that had caused them a degree of pain:

Part of my healing for me, was that I decided to go back into mental health in a different role...and I felt I needed to do that for my healing and I think it was very worth while. (D/16/45).

I just sort of realized how lonely my job is....I know that I'm not liked down their now, by the senior managers.... And I thought if that is what its like at that level, then I don't want to be at that level. I want to be where I am, even though

it's hard and it does what it does to you, I prefer that to being up there.
(C/8/40/41).

I guess its this thing again I feel that I have an opportunity because of the position I hold in the organization, and one of the projects that I have been tasked with is designing a primary care model. I see that as an opportunity and in there I will be able to make the statement about how patient care is utilized. They may not listen to what I have to say, but I have the opportunity to put the case forward, bringing in all of those issues that I have mentioned. (D/26/63).

4.7 SUMMARY OF DATA ANALYSIS

Whilst for the most part the *Health Care Organization* was experienced and described as particular management personnel, in particular roles, it also encompasses management structures such as general, clinical, governance and nursing. As well, the *Health Care Organization* was described as systems and processes, including policy making, decision-making and funding systems and processes. The participants also experienced conflict with the profit based business dimensions, as well as cultural dimensions of the health care organization, such as bullying and medicalization.

The conceptual category of *Nursing Management Advocacy* describes the experience of nurse manager's ethical conflict with their health care organizations through its integration of a variety of conceptual, descriptive and thematic findings. The participants in this study described both duality and fusion of nursing and health care organization values. Their descriptions and experiences of ethical conflict concerned either unique circumstances, or were part of the everyday activities and responsibilities of their nursing management roles. Nurse managers identified and then advocated for quality nursing and patient care, the value of teams, the value of professional nursing and safety in the health care organization. This conceptual category

also fuses the particular values which clashed with those of the health care organization and the role components of nurse managers.

The conceptual category of *Isolation* encapsulates the major factors that worsened the experience of ethical conflict for these participants. *Isolation* concerns the themes and processes of silencing, invisibility, isolation and barriers that impeded, and weakened the ability of the nurse manager to advocate and practice according to their nursing values. In contrast, the conceptual category of *Support* describes those factors that improved the nurse manager's experience of ethical conflict with their health care organization. The key sources and forms of support which the participants experienced were personal, professional and organizational.

The Bottom Line is a conceptual category which involved the processes of challenging and confronting, either the nurse manager's or the health care organization's stance on a particular or broad ethical conflict. It also describes when the nurse manager established their personal and professional bottom-line about an ethical conflict, or context of ethical conflict, from which they might decide to leave the organization, or stay and work with it in order to try and improve it. Lastly, this conceptual category describes circumstances when the bottom line position that the health organization took, was not actually the bottom line, and there was change or the possibility of change as a consequence of the challenge and advocacy that the nurse manager undertook.

Being and Becoming Nursing Leaders conceptualizes career long experiences of ethical conflict in nursing, as well as the outcomes of ethical conflict described by the participants. The themes of reflection, motivation, growth and learning describe how nurse managers changed from their experience. Counting the costs of nursing leadership reflects the negative outcomes of their experiences, including the detriment to

personal health and well-being, as well as the negative impact on their professional standing and respect.

CHAPTER 5 – DISCUSSION

The objective of this chapter is to provide a comprehensive discussion of the findings from data analysis highlighting the ways in which this qualitative descriptive study, enhances or challenges existing knowledge and understanding of the experience of nurse managers' ethical conflict with their health care organizations. To achieve this objective, the chapter reviews of each of the key conceptual categories, their themes and dimensions, providing comparison and contrast with the descriptive findings from the foundation study by Gaudine and Beaton (2002). This chapter will also explore data analysis findings alongside other key and relevant aspects of the literature presented in Chapter 2, and any new literature salient to the discussion. In particular this chapter will situate the study and its findings within the framework of reform that has marked implications on health care management, and the ways in which reform has impacted on the values of health care services and the ethical conflict which nurse managers' experience.

5.1 THE HEALTH CARE ORGANIZATION

There is no comparative analytic finding in Gaudine and Beaton's (2002) research to the key conceptual category of *the Health Care Organization*. This may simply be because Gaudine and Beaton analyzed their data based on assumptions regarding who or what was the health care organization, or narrowed their coding and data analysis in such a way as to exclude this conceptual finding. Nonetheless, the present study identifies that the health care organization with whom and which nurse managers experienced ethical conflict is for the most part, concerned with non-clinical general management personnel and structures. This finding is consistent with many aspects of the literature that alluded to the dominant role that non-clinical managers and management values now play in health care services (for example see,

Gower et al, 2003; Wells, 1999). However, medical staff, other nurses and nurse managers, such as the Director of Nursing, is also the health care organization with which the nurse manager experienced values clashes and ethical conflict. This finding suggests not only that the experience is truly values driven, but also that the experience is about more than a clinician versus management phenomenon.

The identification of ethical conflict with governance structures may well be a product of health system design in New Zealand, where structures such as the Ministry of Health, DHB's and PHO Boards oversee and influence health service delivery strategies and funding decisions on behalf of patient populations. Individual nurse managers may not address these dimensions of the health care organization on an interpersonal professional level. There is a consequent emphasis on the effectiveness of nursing executives and nursing organizations that work at these broader levels, to bring the values of nursing to the forefront on behalf of their nursing colleagues and profession. Perhaps most importantly, this finding highlights that individually, nurse managers may be persistently frustrated in their efforts to ensure quality health services and nursing care, because of the organizational distance from decision or policy-making structure and process.

Arguably this description also reflects the devolution and influence of public choice theory in health system management, as outlined in Chapter 2. For example the separation of interests groups, like nursing, from policy and fiscal decision makers such as the Ministry of Health, DHB's or PHO Boards. To do so ensures that decisions are apolitical and unfettered by the perspectives and needs of clinical groups or professions. Consequently, nurse managers experience, although may not always recognize, that broad fiscal decisions are designed to be beyond their influence as individual professionals within the health system.

Nurse managers' may also experience ethical conflict with the systems, processes and culture of the *Health Care Organization*, and because of this, it may render the experience one where the nurse manager is unaware or unsure of what to address in order to find resolution. For example, when the values clash and ethical conflict concerns a culture of medical bullying, it requires cultural and behavioral change in *the Health Care Organization*, and not merely interpersonal address and change. It seems that even though a health care organization might espouse the values of respect and teamwork in their employees, they may not in some instances be actualized via interprofessional relationships.

Organizational culture relates to the assumptions, values, attitudes, and beliefs that are shared among significant groups within an organization...culture is concerned with the common and accepted ways of doing things within an organization as well as the shared ways of thinking about and making sense of an organization that percolate among its members (Davies, Mannion, Jacobs, Powell & Marshall, 2007, p.47).

The relationship between organizational culture and organizational performance, in particular senior management team culture in health care, was investigated by Davies, Mannion, Jacobs, Powell and Marshall (2007). This study found that there was a strong correlation between the dominant culture of an organization and its performance and more specifically that those aspects of performance valued by the dominant culture are those aspects at which an organization excels (Davies et al., 2007). Hence, if health care organizations value medicine over nursing and endorse medical bullies, the organizations performance may well reflect the exalted attrition of nurses from its services. Likewise, if a health care organization values more greatly the need to stay within tight fiscal constraints, in contrast to growing quality and effectiveness, they may well succeed. However this may be at

greater cost in the long term, arising from the constant demand to recruit new nurses who may invariably leave that organization. It is a conundrum that is validated by a severe world wide shortage of nurses (International Council of Nurses, 2006; Buchanan & Calman, 2006; Heinz, 2004).

At the very least, this conceptual category has demonstrated that the experience of nurse managers' ethical conflict with their health care organizations may be deeply and systematically entrenched in health care organizational culture and design along with human and professional relationships, which are in constant ethical tension. Furthermore, it is not difficult to posit that this tension is devolved from the whole of New Zealand's health care system and its complex quarter century of reform which has focused on reducing the burden of health care spending on the fiscal resources of the state.

5.2 NURSING MANAGEMENT ADVOCACY

There is no thematic comparison to duality and fusion of values in Gaudine and Beaton's (2002) findings, however their report does list that "...hospitals stated values (e.g. integrity; consultation) are not upheld by administration and board" (p. 22). It may be a consequence of that study's participants providing only descriptions of values differences and clashes. Or, alternatively, it may be a consequence of more intense socialization to the health care organization's values and the expectation that they will be manifested and practised in the New Zealand context.

This dimension raises concerns about how nurse managers may effectively balance competing values. For example, how may a nurse manager ensure that they remain within their ward or service budgets and be fiscally responsible, whilst at the same time ensuring appropriate

clinical nursing education to ensure the appropriate quality of nursing practice? Where a nurse manager reduces education for nurses in his or her service, it may appear to the nursing teams they lead, that they have forsaken their basic nursing values. This perception, introduced and discussed in Chapter 2 (Kellen et al, 2004) is partly a product of the different contextually driven ethical frameworks which inform nurse managers and practising clinical nurses, such as staff nurses. Kellen, et al (2004) propose that staff nurses and nurse managers therefore need to engage in learning and dialogue about their differing ethical obligations and perspectives, and how these influence their decisions and actions. Whilst this strategy may not completely abrogate the tensions that exist, it may go some way in reassuring clinical nurses of their nurse managers' values.

Likewise this dimension also highlights whether and how the health care organization ensures that its practice is values congruent – how it ensures that it 'walks the talk' of teamwork, collaboration and patient focus, for example. As with the different ethical perspectives and obligations of staff nurses and nurse managers noted above, general managers and CEO's may unquestionably have different and even broader values to appease. However not all the values clashes at this level of the health care organization are concerned with the allocation of scarce resources. As this research has demonstrated, failure to consult, or failure to respect the contributions of different professional groups and teams in health care organizations, is equally concerned with respectful and inclusive decision-making process, rather than a mere monetary decision.

The theme of advocacy is an important one, which transcended much of the participants' interviews. Whilst there is no comparative theme to advocacy in the foundation study, one example of the outcomes of ethical conflict in Gaudine and Beaton's (2002) report included when

nurse managers spoke out. Indeed the major theme of *voicelessness* which arose from Gaudine and Beaton's (2002) research, tends to reflect an opposite experience to the theme of advocacy. That the nurse managers in this study engaged in strong advocacy for their values, suggests that they found such positions morally and personally preferable and tolerable in their relations with other staff. Again in contrast to the perception that nurse managers had abandoned basic nursing values (Kellen, et al, 2004), the theme of advocacy and other findings in the present study such as invisibility, suggest that they may not have.

Advocacy involves standing up for what one believes in, for self or for others (Allen, 1990), and in nursing is a process most commonly aimed at promoting client independence and autonomy (McGrath, Holewa & McGrath, 2006). The nursing advocate role "...is to become actively involved in representing the patient to others in the health care environment" (McGrath, et al., 2006, p395). Yet as previously noted in the review of the literature, advocacy may carry with it the risk of professional retribution and burnout for nurses (Sundin-Huard & Fahy, 1998).

There are also some similarities between the theme of advocacy in this study, to the concepts of ethical activism, assertiveness, ethical resistance and the enactment of ethical practice in nursing, that were introduced in the literature review (Dodd et al., 2004; Peter et al., 2004). The finding of *Nursing Management Advocacy* arising from this study reinforces the inherency in the nursing profession to speak out, stand up and resist things that they perceive or believe are morally wrong. In doing so however, nurse managers may be taking employment and professional risks that make them extremely vulnerable, whilst at the same time contributing to their moral development as nursing leaders.

Valuing professional nursing, and advocating for such, may be a result of the ways in which the nursing profession has struggled to maintain its integrity and effectiveness throughout rapid reform, repeated restructuring and its aftermath in New Zealand. This study found that nurse managers advocated for professional nursing for a variety of reasons, such as providing innovative and effective care delivery in developing primary health care services or in response to medical bullying. This theme also concerned the professional development of clinical nurses, and ensuring the appropriate professional attitude in nursing teams in order to deliver the right care to the patient at the right time. This strong focus on conflicts concerning the value of the nursing profession is also evident in Gaudine and Beaton's (2002) work for example, "...several participants believed that administrators did not want to understand nurses and did not intend to act on nurses' needs" (p23) and also in that study's theme of voicelessness which identified that nursing is not valued or understood. Similarly, the study by Gaudine and Thorne (2000) identified that practising clinical nurses experienced an undervaluing of nursing by the health care organization when compared to the medical profession.

This study has identified that advocating for professional nursing was also one of the social responses to medical bullying. Yet it was also evidenced in this study that the health care organization might choose to ignore medical bullying behaviors and culture towards nursing. Whilst there is no particular evidence of medical bullying in Gaudine and Beaton's (2002) report, they do identify that opinions of physicians are more valued than those of nurses in the theme of *situational factors* which worsen ethical conflicts. The foundation study also identified that the organization may fail to act even when aware of problems in the theme of *unjust practices on the part of senior administration and or the organization*.

There is certainly awareness of the prevalence of bullying in health care organizations both in medicine and nursing specifically (Field, 2003; Hutchinson, Vickers, Jackson & Wilkes, 2006; Lewis, 2006; Randle, 2003). Bullying behavior in organizations is described as a detailed and complex issue that has been linked to the concept of oppressed group behavior (Hutchinson et al., 2006) with bullies being highly articulate, and mostly aware of what they are doing (Lewis, 2006). The most probable reason for bullying behavior is that it is learned within the workplace and with this the reinforcement of the dominant norms of bullying behavior in the organizational workplace, particularly health care organizations (Hutchinson et al., 2006; Lewis, 2006). Needham (2003) likewise suggests that bullying in the workplace occurs because "...leadership and management of the organization is allowing it to happen" (pg, 18).

This analytic finding therefore highlights the dominance, and particular bullying behaviors of the dominance of the medical profession in health care, as well as portraying the social consequences of this dominance for the nurse managers who experience it. Introduced in Chapter 2, Carryer (2001) identified that professional nursing and its potential contribution to health care has been neatly appropriated by both medical resistance to autonomous nursing practice, and the systematic erosion of clinical nursing leadership wrought by *managerialism*. Consequently, the experience of bullying of nursing managers that is featured in this study may be the result of the complex interplay of a vulnerable and oppressed profession practicing within a culture of health care that reinforces the dominance of medicine and of generic management practices.

It may also be argued, that nursing and indeed medicine represent the professionalisation and institutionalization of health care, in contrast to individual, family or community driven health care. Perhaps the

undervaluing of the nursing profession is a means by which the health care organization, and to an extent the health care system as a whole, sets one profession against another; enabling one seemingly powerful and influential group (medicine) to dominate the other seemingly less powerful group (nursing), avoiding recognition of the dominance of *managerialism* culture altogether. This phenomenon shifts emphasis, knowingly or otherwise, from publicly funded professional health care, to personally responsible health care by way of disease or illness prevention for which individual society members take responsibility. To do so would undoubtedly contribute to cost containment in the public funding of health economies.

Some of the conflict experienced by participants in the foundation study described the health care organizations failure to value quality nursing practice (Gaudine & Beaton, 2002). Given the evidence outlined in the literature that links the quality of nursing practice with patient outcomes (for example, Aiken, Clarke & Sloane, 2000) it is therefore not surprising that the nurse managers in the current study described rigorous pursuit of this value. A manifestation of the ethical principle of beneficence, quality nursing practice is an imperative for nursing managers who would be accountable for when the nursing care delivered in their respective services is not of an appropriate quality, and poor patient outcomes result.

Emphasis on the value of quality nursing practice identified in this study could be considered a manifestation the tension between egalitarianism and neoliberalism, and the ways in which this tension devolves to the health care organization and service level. Nurses and nurse managers may therefore be seen to embody the inherent tensions between limited resources and achieving quality nursing practice; doing as much as possible within a limited budget. At least as far as the descriptions in this study have revealed, when this tension is no longer personally or

professionally acceptable to individual nurse managers, the *Bottom Line* may be experienced.

Advocating for quality patient care extends the nurse managers' experience of ethical conflict, beyond nursing practice, to other professions and the health care organizations' activities as a complex whole, for example when redesigning a health service. It also places patient and community health needs central to the activities of the organization and is an important nursing value. This finding is indicative of national policy directives which link health care service activity more closely with the health needs of the patients and communities. That nurse manager's experience conflict based on advocating for quality of patient care reveals a broader lens on the organization and a strong socialization to health policy and quality management practices. Gaudine and Beaton (2002) refer similarly to the sacrificing of quality, in the theme of *where to spend the money*, for example when nurse managers sacrifice quality patient care when there are insufficient resources to achieve it. Patient and community stakeholders may be surprised and disappointed by decisions which health care organizations make that may ultimately lower the quality of patient care they receive. Yet another layer of values and ethical frameworks is at play; those of patients and community at large. It might at least ease the experience of ethical conflict for the nurse manager, if not raise public awareness, if the Chief Executive Officer, or Board Chairman, has made public and demonstrates accountability for decisions at this level, that may ultimately impact on or reduce the quality of patient care.

The theme of valuing teams and advocating for them demonstrates nurse managers understanding of teams as a key social structure necessary for meeting the objectives of the health care organization. When teams and their members are not valued by the health care organization, it may not achieve its full potential as well as result in the

loss of valuable people and knowledge to the health care organization. Failure to value teams in health care organizations is also contradictory to the stated emphasis it received in the health care organizational values outlined in the literature review. It is thus understandable that the nurse manager not only values teams and what teams can do, but also the process of engaging them in relevant decision-making processes in the health care organization. There is no equivalent thematic finding or substantive description to valuing teams in Gaudine and Beaton's (2002) findings and report.

Likewise, there is no equivalent in the foundation study of the theme of safety; however there is reference to unsafe patient care in Gaudine and Beaton's (2002) list of factors that worsen nurse managers' ethical conflict with their health care organizations. There is also reference in their theme of *rights of the individual versus needs of the organization* which favors the legal position of the health care organization over individual employees (Gaudine & Beaton, 2002). This theme, safety, is a reflection of the do no harm ethical principle of nonmaleficence which underscores health care professional practice. In many respects nurse managers have no choice but to advocate for safe practice and patient care – their professional ethics and legal responsibilities demand it.

Currie and Watterson (2007) explain that patient safety is a prominent issue in health care services in the United Kingdom. In particular, nurses in the United Kingdom stress how inappropriate nursing workloads effects patient safety (Currie & Watterson, 2007) and as presented in Chapter 2, this problem has a direct relationship to patient outcomes alongside staff satisfaction and morale. Nurses who work at the 'sharp end' or caring interface, are more capable of articulating the challenges in delivering safe patient care (Currie & Watterson, 2007). Improving the safety of patients receiving health care requires a cultural

change in the health care organization that includes the prioritization of safety over efficiency (Currie & Watterson, 2007).

Likewise, the most recent multiemployer contract for registered nurses and midwives in New Zealand, emphasizes the requirement for safe staffing and healthy workplaces, and a number of activities designed to achieve this requirement (New Zealand Nurses Organization, 2007). The finding of advocating for safety arising from this study is therefore a confirmation of the role that nurse managers play in pursuing safety, for nursing staff in particular, in their working environments and in the broader context of the health care organization.

5.3 ISOLATION

Isolation is an important social experience for nurse managers, which contrasts to the expectation that health care organizations foster openness, collaboration and respect for its member's opinions and contributions. It is also evidence that patient focused and professional nursing values may not find their way into the decision-making processes of the health care organization. Moreover, the study findings allude to deliberate isolation practices on the part of the health care organization, almost as if it was important to prohibit the nurse manager from participating in decision-making.

A possible microcosm of public choice theory, this conceptual category is an important validation of Gaudine and Beaton's (2002) research finding of *learning to remain silent*. Isolating the nurse manager thus isolates the values for which they stand and in so doing may mean that the health care organization is not in touch with the patients' health care needs, and the nurses who must meet these needs. The experience of *Isolation* described in this study may also be a consequence of reform

activities where restructuring of health care organizations has removed vital nursing leadership structures.

Employment as a barrier is highlighted in Gaudine and Beaton's (2002) study and report which is entitled 'Employed to go against ones values: Nurse managers' accounts of ethical conflict with their organizations'. As the title suggests, the nurse managers in the foundation study reported practice that was inconsistent with their values, whereas in the present study, nurse managers practiced consistent with their values, but did so with cognizance of the employment risks and isolation. Whilst the participants in the present study did not experience *voicelessness*, a theme in the foundation study, their advocacy may have been silenced and in a sense made voiceless and isolated as a result. The theme of invisibility in the present study is also similar to Gaudine and Beaton's (2002) finding that nurse managers may be hired to be both invisible and 'toe the party line'.

The conceptual finding of *Isolation* arising from this study, sheds light on the social dimensions of employment; including that nurse managers may self impose isolation, for example by keeping secrets or invisible practice. Participants were aware that they were taking risks in their advocacy which could have detrimental consequences such as job loss. Isolation when managing ethical conflicts, both by the health care organization and self imposed was noted in the literature review to be a possible consequence of ethical conflict when the manager was not supported (Lemieux-Charles & Hall, 1997).

Isolation is a critical finding arising from this study that describes a social reality and experience related to reform of the health care system that may contribute to burn-out and loss of nurse managers not only from the health care organization but also the profession. Perhaps too, the experience of *Isolation* is a symptom of workplace bullying.

There is a responsibility to be shared amongst nursing leaders and their general management and medical counterparts to ensure that nurse managers are not isolated in their work, and that their contribution is valued. As highlighted by Gaudine and Beaton (2002) bringing nurse managers, nurses, board members and other administrators together is important action required to ensure that decision making processes are more visible, and structured in a way that allows all parties a voice and respect. Failure to do so not only risks the loss of valuable nursing professionals, but also risks missing essential communications about the implications of decisions and change on nursing practice and the patient.

5.4 SUPPORT

The major factor which made the experience of ethical conflict easier for the nurse manager was *Support*. This factor was relevant not only in relation to the ethical conflicts themselves, but also in relation to the nurse managers' role performance generally. The key forms of support identified from data analysis were family, professional and organizational. If family members are assuming or needing to assume such a supportive role, it indicates how much the experience of ethical conflict and the nurse managers' job, impact on their social life. Whilst it is understandable that family support occurs, it is perhaps a burden that is not justifiable. Therefore nurse managers do not necessarily leave ethical conflict work issues at work and the result may be that it consumes far more of the nurse managers' personal energy than it deserves which in turn may result in an unhealthy work-life imbalance and burn-out.

Consistent with the recommendations from the study by Thorpe and Loo (2003), that it is essential for nurse managers to maintain a healthy professional and personal life balance, this finding has two key

implications. Firstly that reliance on the support of family may be a result of lack of support from others, such as nursing colleagues. Secondly, it suggests that nurse managers have assumed positions that have unsustainable workloads, and hence requires careful consideration of whether this will result not only in an ineffective nurse manager, but a deeply overburdened nursing professional who may invariably burn-out and give up their work.

It is pleasing to identify within this study, that other nurse managers and the health care organization may be supportive in the midst or in the aftermath of ethical conflict. Although support may not negate the experiences and consequences of *Isolation* in its totality, this finding suggests a degree of understanding, and need to provide nurse managers with professional support in the face of, and in the aftermath of ethical conflict. The findings from Gaudine and Beaton's (2002) study likewise identify the theme of *support* as a key factor which mitigates ethical conflict.

One of the aims of this study was to identify what may be done to reduce the outcomes of ethical conflict for nurse managers. This research finding has clearly identified that provision of support is a key factor in reducing burn-out and attrition of nurse managers. Alongside this, stronger nursing leadership structures and performance will enable the values of the profession to manifest in the key systems and processes which impact on the services which nurse managers accept immediate responsibility for.

5.5 THE BOTTOM LINE

Other than pointing out an example that nurse managers' work with a limited amount of money, and that one of the outcomes of ethical conflict may be that nurse managers leave their jobs, there is no

comparative theme to the conceptual category of *the Bottom Line* in the foundation study (Gaudine and Beaton, 2002). The bottom line is a metaphor which in business and accountancy parlance concerns an organization's sustainable financial performance (Pava, 2007; Waddock & Graves, 1997). The term and its focus on financial performance has more recently been expanded to 'the triple bottom line' which includes social and environmental performance (an organization's people and the planet) in order to achieve market or business sustainability (Li-Chin & Taylor, 2007; Norman & MacDonald, 2004; Pava, 2007; Waddock & Graves, 1997).

The Bottom Line experience revealed in the current study, reflects as a starting point, the presence and challenge for nurse managers' of financial sustainability in their health care organizations. However, if the major factor driving health care organizations is financial sustainability, this study has shown that a consequence may be that it does not sustain its nurses and nursing managers. Secondly, from the perspective that nursing contributes to achieving health service goals and improved health outcomes for populations, this finding also demonstrates that the health care organization may not meet the social needs of the patients and community they serve.

Financial sustainability cannot therefore be the ultimate measure or yardstick of performance for health care organizations; a triple bottom-line framework is undoubtedly essential, at a funding, policy, organizational and service level. New Zealand's public health system may well be free to its citizens, but the quality of services that is provided may not necessarily be of an acceptable standard within the communities of the health professions and patients. Indeed in the opinion of the present Chief Executive Officer of Counties Manukau District Health Board, "...managing the quality of care of the acute patient, is more important than the bottom line" (Martin, 2008).

Use of the bottom line metaphor in some of the participants' descriptions is surely an indication of the way in which the language of neoliberalism and business has transcended the social and professional dialogue of health care organizations. Whether it was being used rhetorically or factually by the participants in this study cannot be shown. Notwithstanding, continued emphasis on policies of cost constraint in New Zealand's health sector, has been clearly revealed in the social experiences portrayed by the participants in this study.

Professional nursing is founded on the values of human caring and morality, clinical excellence and competence, as well as social and community responsibility. Yet this conceptual category demonstrates that nurse managers may experience a professional context and relationships that are deeply troubling and ethically conflicting. On the one hand they endeavor to function with financial limitations and ensure that they have utilized their resources efficiently and are accountable for this. On the other hand, to do so may invariably lead to circumstances where the quality of nursing practice and patient care is not safe or is not of a standard necessary to meet patient needs effectively. In this study therefore, the bottom line has also become a social experience.

The descriptions captured by this category provide an indication that when nurse managers can no longer tolerate their experiences of ethical conflict that they would leave the organization. This is also an important indication that moral distress was evident in the experiences that were provided, as well as validation that ethical conflict may have the consequence of loss of nurses from the organization. This finding reinforces the need for health care organizations to actively address the impact that ethical conflict has on individuals such as nurse managers.

5.6 BEING AND BECOMING NURSING LEADERS

Gaudine and Beaton (2002) highlight learning as a factor which mitigates ethical conflict, and identify turnover, burnout and negative feelings as possible outcomes to their experience. Even though participants in the present study were enabled to describe the outcomes of ethical conflict as it pertained to patients, staff and the health care organization, they did not directly do so and tended to focus on the personal and professional outcomes for themselves. This may be attributable to lack of comprehensive knowledge of what these broader outcomes sets might actually be, or related to fear that revealing these matters was not appropriate.

The five key themes of this category – reflection, learning, motivation, growth and counting the costs of nursing leadership have a transformational dimension that concerns not merely nursing management, but also career long experience of the moral dimensions of nursing practice. Because of this, the category implies that ethical conflict changes and develops nurses; from nurses, to managers and to leaders in their profession. Analogously, the study by Woods (1997), pointed out enduring career long ethical development in nurses, and Nathaniel (2006) similarly identifies that moral distress is a long term and ongoing process which traverses many stages of nurses' careers.

The costs of nursing leadership identified in this study included physical, and psychological costs and have a consistency with the concept of moral distress. Gaudine and Beaton (2002) similarly identified that their participants experienced moral distress. As previously explored by Arlen (2001, 2001a, 2002, 2004), moral distress is pervasive in nursing. The vital message from this finding is that nurse managers suffer on a personal level for their patients, profession and staff. Whether this experience is recognized or understood by health care organizations is a matter that may only be addressed by further strong advocacy from

the profession, alongside concerted efforts on the part of the health care organization to mitigate the causes and ensure provision of support for those who experience it. This conceptual category, and the earlier finding that at times the health care organizations bottom line did change, highlights that nurse managers who are transformed into nursing leaders by ethical conflict, may also ethically transform the health care organizations in which they practice.

At least a decade ago, Soffareli and Brown (1998) explained that professional nursing required more than competent, organizing, rational nursing managers to survive in the rapidly changing world of health care. Rather, what was required, in their opinion, was nursing leadership and nursing leaders, able to transform health services through a focus on empowering people (Soffarelli & Brown, 1998). The nurse leader of the new millennium would need to focus on people and valuing those people, challenging the status quo, and demonstrating highly ethical behavior (Sofarelli & Brown, 1998). Thus, although management skills such as planning and control are important, it is nursing leadership which will shape the future of health care. This conceptual category attests not only to these propositions, but also challenges *managerialism* and the notion that management is a function that is the same regardless of the organization or persons to which it relates (Wells, 1999).

CHAPTER 6 - CONCLUSIONS AND IMPLICATIONS

I wish to conclude this thesis in the manner in which it began in the introductory chapter; by writing in the first person, and by responding to the questions that I pondered from my experience as a nurse manager in New Zealand, namely:

- Why was there so much conflict in nursing management and was it always a question of fiscal limits?
- Were the organization's values consistent with professional nursing?
- Why did I not feel supported and who should have been supporting me in my nursing management role?

As well, I will set out what I believe are the key research, education, nursing management and health care organization implications from this study.

The Study and its Findings

My own experience as a nurse manager in New Zealand was an important motivation for this research. In this study I have investigated nurse managers' ethical conflicts with their health care organizations, and have done so by replicating a qualitative and descriptive Canadian study (Gaudine & Beaton, 2002). My investigation of the social experience of eight New Zealand nurse managers was aimed at gaining a deeper understanding of and enhance existing but limited knowledge of values differences or clashes between nurse managers' and their health care organizations that result in ethical conflict.

Nurse managers experience ethical conflict because of the duality of professional and organizational values that their roles encompass. It

has also identified that nurse managers are immersed in a contemporary context with fiscal limits and management practices and objectives which challenge and at times defeat both of these value sets. The participants in this study revealed that the values which underpin their ethical conflicts with the health care organization concern: the valuing of their nursing profession; the need for and pursuit of quality in nursing practice; the pursuit of quality patient care; the valuing of teams in the health care organization; and safety. I can attest to the importance of and pursuit of these values in my own practice and the persistent feeling that I was not valued by my nursing management colleagues and general managers.

This study has also revealed that whilst the values of nurse managers and health care organizations do differ and clash in some respects, they may also be shared. Thus, when the health care organization does not practice according to its values, nurse managers respond by advocating for those shared values. As I reflect again on my experience, I can now identify the failure of the health care organization to act in congruence with its stated values. Rather, they had become very much rhetoric.

Because nurse managers are advocates who are strongly influenced by professional values, it brings them into conflict with a number of dimensions and people in the health care organization such as non-clinical managers, other health care professionals such as medicine, other nurses, as well as the less tangible systems, processes and culture of the organization. The advocacy process may be impaired by the isolation which nurse managers' experience. At times the nurse managers' isolation may be a consequence of organizational structure, and culture, or it may be a deliberate social response to a situation, such as failure by the health care organization to include the nurse manager in important or relevant decision-making. When experiencing ethical conflict, nurse managers need and sometimes receive support

from their families, friends, other nurses and nurse managers or non-clinical managers. Support is an important factor which mitigates or improves the experience of ethical conflict which nurse managers encounter. I know now that I was severely isolated in my nursing management work and did not receive the support that I needed from my colleagues, both nursing and general management.

When confronting and challenging the health care organizations' bottom-lines, such as fiscal limits, professional group preferences or inappropriate processes of decision making, the nurse manager may in turn encounter their own bottom line. As a consequence nurse managers may leave their jobs for other nursing work, or other health care organizations. I see now that I also left my first nursing management role for all these reasons and that this experience has been shared by other nurse managers.

A continuation of moral experiences throughout their careers, values clashes and ethical conflict transforms nurse managers to nurse leaders, who may in turn have an impact on the ethical life of the health care organization. Nursing management advocacy should therefore be seen as an important if not vital contribution to the ethical development of the health care organization; giving substance and expectation to the values which the health care organization espouses.

It is evident that some of the nurse managers in this study described experiences consistent with the concept of moral distress, for example when they experienced physical and psychological suffering, barriers to their participation in decision making, or social isolation in their roles. Certainly not all of nursing management ethical conflict issues may be easily or effectively resolved, however the ability to raise the issues and advocate in a meaningful way, with strong support from colleagues, is necessary in order to prevent nurse managers suffering the

consequences of moral distress. In my own way, despite leaving my first nursing management role, undertaking this research is part of my own professional and personal ethical transformation.

Research Limitations and Implications

Recognizing that the strengths of qualitative research rest in the identification of meaning, insight and conceptual development, I was still somewhat disappointed that eight months of recruiting endeavors only provided eight participants for this research. I have considered that perhaps even though anonymity was assured for prospective participants, given the findings in this study, there were risks in 'revealing', that other prospective participants were not prepared to take. Further possible reasons for the low number of participants might be that nurse managers are generally too busy to participate, or they would prefer not to dwell on that which already causes them great anxiety and that they cannot fix. It may also be the case that many prospective nurse managers do not experience ethical conflict or do not recognize that this is the case. Nonetheless, the findings from this research coupled with many key similarities to the descriptive findings in Gaudine and Beaton's (2002) study, and multiple insights identified in the literature review, mean that some conceptual generalisability is appropriate, particularly concerning the values at issue, alongside the themes of advocacy, isolation, and support.

I have noted in Chapter 3 that the term nurse manager was used functionally in the recruitment process, rather than in a role or title specific manner. Because nurse managers work at different structural and influential levels of health care organizations, it may have implications for the findings from this research. For example, nurse managers practice in different clinical, operational or strategic levels, and there may be different experiences for those who are perhaps practicing further up the nursing management hierarchy. In this regard

future research could examine and contrast the experiences of ethical conflict that nurse managers have when they are situated at different hierarchical levels of the health care organization, or have different levels of fiscal accountability.

Other future research implicated by this study is an examination of the health care organizations infrastructure, with a view to identifying communications, decision-making and support mechanisms or barriers for nurse managers. Another area for future research is nursing managers in primary health care. There were three managers in this study who practiced in primary health care, and it is relevant to consider how this different health sector context implicates nurse managers' experiences of ethical conflict. Future research could also examine the extent to which health care organizations actually 'walk their values talk' or whether espoused values are simply rhetoric and not practised.

Since bullying of nurse managers in the health care organization was highlighted by this study, in particular by their medical counterparts, there is undoubtedly a need to investigate this experience and its prevalence more closely. In particular future research should examine bullying and its relationship to the experience of ethical conflict and moral distress in health care organizations. Future research could also explore power group culture and behaviors in health care organizations and the possible experiences of oppression in different professional or organizational groupings more specifically.

Education

Health service managers who do not originate from a clinical profession, have much to learn in regard to health professional values, including how and why these are manifest and critical to an effective health care organization. In a very real sense, the nurse managers' descriptions in this study gave context to values in health care management. Clinical

professional managers, such as nurse managers, also need to learn that perhaps their general management peers lack knowledge and understanding of the values upon which clinicians practice. General Managers may themselves be unable to influence improvements beyond the scopes of their fiscal resources. The implications of this however, rest unequivocally at a health system funding and policy level.

I am conscious that nursing has its own share of nurses who bully, however, there is also further organizational learning needed to address organizational culture and its relationship to the social experience of bullying. Education, which has as its focus, respect between and amongst professional groups is a vital step, necessary for achieving substantive change in a culture of bullying which may be present and very destructive in health care organizations.

I have considered why it may be that health care organizations may not act in congruence with their states values. Firstly, it may be an individual problem of lack of knowledge of these values; consequently education is implicated. Secondly, it may be a problem of implementation. In this regard, the learning is perhaps about how a health care organization manifests or operationalizes its values. Some learning needs to be contextualized in order for it to make sense to a learner. Finally, it may be an issue of chosen ignorance. This thesis itself perhaps will provide a valuable learning tool to address this.

Nursing Management Implications

This study has helped to identify that values clashes and ethical conflict may well be an inevitable occurrence in nursing management practice and perhaps answers the question of why I personally experienced so much conflict in my own nursing management role. A key implication for nurse managers, is not to feel as though it is a personal and negative experience. Rather that the experience is part of an organization wide

ethical development process, within which the nurse managers play an important role in the development of an ethically sound health care organization. The second major implication for nursing management practice is the need to enhance peer and professional support for nurse managers, for example by ensuring that nurse managers are able to articulate their values and ethical conflict experiences with other nurse managers, including other more senior nursing managers. A third nursing management implication and closely related to the second is the need to evaluate nursing and general management infrastructure for elements that may exacerbate the experience of isolation. Nurse managers with appropriate and effective support will have some of the effects of ethical conflict mitigated.

Health Care Organization Implications

Rather than silencing nurse managers who advocate, or placing barriers in the way of their participation in decision-making, health care organizations must recognize that nurse managers' represent the values of quality nursing practice and patient care and safety. These views and values are essential to the achievement of the health care organizations objectives. This is not to say that others do not bring these view points forward, but to emphasize that nursing is driven by its patient focused values, and to ignore them is to risk ignoring patient needs.

Since this study has described that nurse managers may play a critical role in the ethical development and soundness of health care services, there is a need to evaluate organizational structure and culture, and the ways in which these may impair nursing management advocacy. Failure to do so may result in the continued and unnecessary attrition of valuable nursing leaders from the health care organization and profession as well as the values which they demonstrate the willingness and ability to represent.

APPENDICES

Appendix I: Invitation to participate in research distributed by the Nursing Council of New Zealand

Appendix II: Invitation to participate in researched listed on College of Nurses Aotearoa website

Appendix III: Research Information Sheet

Appendix IV: Participant Consent Form

Appendix V: Biographical & Professional Data Collection Form

Appendix VI: Interview Schedule

APPENDIX I



Private Bag 11 222
Palmerston North
New Zealand
Telephone: 64 6 356 9099
Facsimile: 64 6 350 5661

AN INVITATION TO PARTICIPATE IN RESEARCH - NURSE MANAGERS' ETHICAL CONFLICT WITH THEIR HEALTH CARE ORGANIZATIONS

DEAR COLLEAGUE,

- It is my pleasure to invite you to participate in this qualitative research, concerning Nurse Managers' ethical conflict with their health care organizations. My name is Linda Chalmers, and I am a RGON currently studying for a Master in Management (Health Service Management) at Massey University; this research project fulfils part of this degree.
- The research aims at generating increased knowledge and understanding of the phenomenon that is of importance to Nurse Managers, the nursing profession, and other key health care stakeholders.
- Approximately 15 participants will be selected for the project who will be registered nurses with the Nursing Council of New Zealand, hold a current practising certificate and have at least one years experience as a Nurse Manager (or analogous title) in the last 5 years within the New Zealand health sector.
- Collection of data is by way of completion of a brief written questionnaire and personal tape recorded interview. The next round of interviews will be conducted from July to October 2006.
- Should you wish to have further information regarding the research, or you wish to participate, please phone or email the researcher Linda Chalmers: Email: l.chalmers@inspire.net.nz Phone: (09) 276 5844.
- Ethics approval – this project has been reviewed and approved by the Massey University Human Ethics Committee Southern A: Application 06/17. If you have any concerns about the conduct of this research, please contact Dr John O'Neill, Chair, Massey University Human Ethics Committee: Southern A, telephone (06) 350 5799 x 8635, email humanethicssoutha@massey.ac.nz.
- This invitation as been sent with the kind assistance of the Nursing Council of New Zealand; no personal information or contact details have been revealed to the researcher in this undertaking.



APPENDIX II

Private Bag 11 222
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- The research aims at generating increased knowledge and understanding of the phenomenon that is of importance to Nurse Managers, the nursing profession, and other key health care stakeholders.
- Up to 15 participants will be selected for the project who will be registered nurses with the Nursing Council of New Zealand, hold a current practising certificate and have at least one years experience as a Nurse Manager (or analogous title) in the last 5 years within the New Zealand health sector.
- Collection of data is by way of completion of a brief written questionnaire and personal tape recorded interview, the second round of which will be conducted from September to December 2006.
- Should you wish to have further information regarding the research, or you wish to participate, please phone or email the researcher Linda Chalmers: Email: l.chalmers@inspire.net.nz Phone: (09) 276 5844.
- Ethics approval – this project has been reviewed and approved by the Massey University Human Ethics Committee Southern A: Application 06/17. If you have any concerns about the conduct of this research, please contact Dr John O'Neill, Chair, Massey University Human Ethics Committee: Southern A, telephone (06) 350 5799 x 8635, email humanethicssoutha@massey.ac.nz.
- This invitation as been established on this website with the kind assistance of the College of Nurses Aotearoa; no personal information or contact details have been revealed to the researcher in this undertaking. The College of Nurses Aotearoa is not a part of the research project other than to assist with recruitment.

APPENDIX III



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NURSE MANAGERS' ETHICAL CONFLICT WITH THEIR HEALTH CARE ORGANIZATIONS RESEARCH PROJECT

INFORMATION SHEET

Researcher Introduction

Thank you for your interest in this proposed research project. I am Linda Chalmers, a Registered General & Obstetric Nurse who is currently a full time tertiary student completing a Master of Management (Health Service Management) through the Department of Management, College of Business, Massey University.

This qualitative research project aims at describing the experiences of Nurse Managers' ethical conflict with their health care organizations, and replicates a study undertaken in Canada in 2002. The findings from this research will facilitate growth in both knowledge and understanding of the phenomenon that is of importance not only for the nursing profession but to other stakeholders in the health sector.

Participant Recruitment

Participants have been recruited with the support and assistance of two professional nursing bodies in New Zealand. Approximately 15 participants will be selected for study who will meet the following criteria:

- Current registration with the Nursing Council of New Zealand
- Current practising certificate issued by the Nursing Council of New Zealand
- At least 1 year experience as a nursing manager in a primary, secondary or tertiary health care organization

Whilst there may be benefits for you associated with reflections on ethical nursing management practice, it may be possible that you experience some psychological distress arising from your recollections and reflections of ethical conflict. If this occurs, then measures will be suggested to help you to cope with this distress.

Participants should be aware that the disclosure of information during interviews that relates to an illegal or unlawful act, may under certain circumstances be subject to referral to the appropriate legal or disciplinary entity.

Should you choose to be a participant in this research you may be reimbursed for the reasonable cost of travel which you incur to attend the research interviews.

Project Procedures

- You will be invited to complete a brief written biographical and professional questionnaire that will gather information required to broadly describe the biographical and professional characteristics of the study group.
- You will be invited to attend a personal interview with me lasting approximately 60-90 minutes. The interview will be tape recorded. The key questions that you will be asked during the interview will include:
 - i) Describe any ethical conflict you have had with your health care organization in your role as a Nurse Manager.
 - ii) Describe the factors that eased the conflict.
 - iii) Describe the factors that worsened the conflict.
 - iv) Describe the personal, professional and organizational outcomes resulting from that conflict.
- The tape recording of our interview will later be transcribed to written form by myself. This transcript will be posted to you for verification prior to data analysis.
- All data gathered from interviews or the written questionnaire will be treated with confidentiality. Each participant will be referred to throughout the project by pseudonym or letter. Your name and any other identifiable data or materials will not be available to anyone other than the researcher and the research supervisors identified below.
- A summary of the research will be made available to you at the end of the study.
- A masters thesis will be written from the completed research and may be followed by academic papers, articles or conference materials.
- Data or materials arising from the study will be maintained by the researcher in a secure place throughout the duration of the research project. Once the project is completed, research tapes will be returned to you should you desire or will be securely stored alongside all other research materials arising from data collection and analysis for a period of five years by the Department of Management, Massey University Palmerston North. After this period these materials will be destroyed following usual research protocols.

Participants Rights

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- Decline to answer any particular question
- Withdraw from the study
- Ask any questions about the study at any time during participation

- Provide information on the understanding that your name will not be used unless you give permission to the researcher
- Be given access to a summary of the project findings when it is concluded
- Ask for the audio tape to be turned off at any time during the interview

Thank you for your interest in this research project and for taking the time to read this information sheet. If you would like to take part in this research, or you would like to discuss your participation in more detail, please contact me by phone or email at first instance using the following contact details:

Linda M Chalmers
Ph (09) 276 5844
Email: l.chalmers@inspire.net.nz

Should you need to, you may also contact the following research supervisors:

- Dr Craig Prichard (Senior Lecturer)
 Department of Management
 Ph (06) 3569099 Ext 2244
- Dr Denise Wilson (Senior Lecturer in Nursing/Albany Campus Co-ordinator)
 School of Health Sciences
 Ph (09) 414 0800 Ext 9070

Ethics Approval

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application 06/17. If you have any concerns about the conduct of this research, please contact Dr John O'Neill, Chair, Massey University Human Ethics Committee: Southern A, telephone (06) 350 5799 x 8635, email humanethicssoutha@massey.ac.nz.

APPENDIX IV



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NURSE MANAGERS' ETHICAL CONFLICT WITH THEIR HEALTH CARE ORGANIZATIONS

PARTICIPANT CONSENT FORM

This consent form will be held for a period of five (5) years by the Department of Management, College of Business, Massey University, Palmerston North.

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree/do not agree to the interview being audio taped.

I wish/do not wish to have my tapes returned to me.

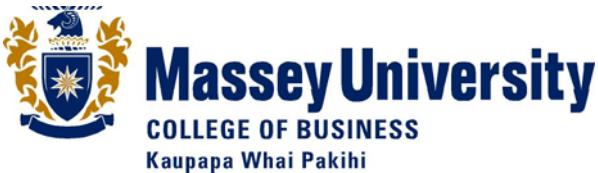
I am aware that disclosure of information during interviews that relates to an illegal or unlawful act, may under certain circumstances be subject to referral to the appropriate legal or disciplinary entity.

I agree to participate in this study under the conditions set out in the Information Sheet.

Signature:
Date:

Full Name – printed:
.....

APPENDIX V



Private Bag 11 222
Palmerston North
New Zealand
Telephone: 64 6 356
Facsimile: 64 6 350 5661.

Nurse Managers Ethical Conflict with their Health Care Organizations Biographical and Professional Data of Research Participants

Dear Research Participant,

Thank you for volunteering to participate in this research project and for providing me with your written informed consent to do so. Please complete the following biographical and professional data collection form, and return to the researcher on the day of your personal interview. The information will be utilized to broadly describe the biographical and professional characteristics of the group of participants under study. Please be assured that any unique characteristics that may identify you or your employer will not be included in data analysis, the research report or any other research publication. If you have any questions or concerns about this data collection form or any other aspect of the research please do not hesitate to contact me.

Thank you.

Linda M Chalmers.

(Please complete the form using a biro).

1. *Title of your current nursing position and area of practice:*

(position will not be reported).

2. *Gender: (please specify).....*

3. *Age (tick one box): Under 30 years 31 - 40 years
41- 50 years Over 51 years*

4. *Nursing Qualification(s) (tick one or more boxes):*

*RGON R Comp Nurse Diploma of Nursing
 Bachelor of Nursing Other (please
specify).....*

5. Other completed tertiary qualifications (tick one or more boxes):

Bachelors Degree (please specify type).....

Post graduate certificate (please specify type).....

Post graduate diploma (please specify type).....

Masters Degree (please specify type).....

Other (please specify).....

6. Please specify any tertiary qualifications that you are currently enrolled in and working towards.....

7. How many years in total have you practiced as a registered nurse (tick one box):

Under 5 years 6-10 years 11-15 years

16-20 years 21-25 years 26-30 years

31-35 years 36-40 years Over 40 years

8. Please list the Nurse Manager positions you have held, including any currently held, the areas of nursing practice of those positions, and how long you have held or had held that position (e.g. - Charge Nurse Manager, Critical Care, 3 years 6 months; Team Leader, Medical Nursing, 2 years) (you need only specify your last 3 different Nurse Manager positions):

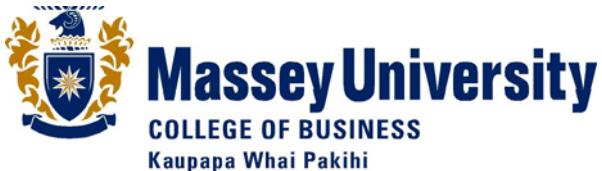
i) Title:.....Area of practice:.....Years held:.....

ii) Title:.....Area of practice:.....Years held:.....

iii) Title:.....Area of practice:.....Years held:.....

9. Please specify the total number of years experience you have as a Nurse Manager:.....

APPENDIX VI



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NURSE MANAGERS ETHICAL CONFLICT WITH THEIR HEALTH CARE ORGANIZATIONS

INTERVIEW SCHEDULE

Participants will be interviewed utilizing a semi-structured and an open-ended method based on the following four questions:

- 1).Describe any ethical conflict you have or have had with your health care organization in your role as a Nurse Manager.
- 2) Describe the factors that eased the conflict.
- 3) Describe the factors that worsened the conflict.
- 4) Describe the personal, professional and organizational outcomes resulting from that conflict.

The definition of ethical conflict provided for participants if required will be:

- Any situation where the nurse managers' values differed from or clashed with those of the health care organization and the nurse manager experienced conflict as a result (Gaudine & Beaton, 2002).

Gaudine, A. P., & Beaton, M.R. (2002). Employed to go against one's values: Nurse managers' accounts of ethical conflict with their organizations. *Canadian Journal of Nursing Research*, 34, (2):17-34.

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