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**The Experiences of
Becoming and Being
a Nurse Leader
in Aotearoa New Zealand
in the 21st century**

**A thesis presented in fulfilment
of the requirements
for the degree of
Doctor of Philosophy
in Nursing**

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Glossary of Te Reo Māori

Aotearoa	New Zealand
Iwi	Tribe
Kaiwhakahaere	executive, leader, organiser
Kanohi ki te kanohi	Face to face
Kaupapa	Principles and ideas which act as a base or foundation for action.
Kuia	Grandmother or older woman with status within the family
Mana	Personal prestige, power, influence, charisma
Pākehā	New Zealander of European descent
Tangata Whenua	Indigenous people of the land
Tauīwi	A Māori term for the non-Māori people of New Zealand
Teina	Younger sister, junior
Te Reo	Language, an official language in New Zealand
Te Ao Māori	The Māori world
Tikanga	Correct custom, procedure and practice
Tuakana-Teina	Mentoring relationship between older and younger
Whānau	Family grouping, extended family, may include people without kinship ties
Whanaungatanga	A relationship through shared experiences that provides a sense of belonging.
Whakataukī	Māori proverb

Abstract

The Experiences of Becoming and Being a Nurse Leader in Aotearoa New Zealand in the 21st century

This thesis explores the experiences of current registered nurses who have attained leadership positions in Aotearoa New Zealand (NZ). A feminist deconstruction of gender framework serves as a lens to examine how masculine and feminine binaries affect the experiences of nurse leaders in a neoliberal environment that has commodified and devalued the act of caring. Particular attention was paid to the different challenges experienced by Māori nurses as the indigenous people of a post-colonialist Aotearoa.

The research employed a qualitative design using an exploratory, descriptive survey, grounded in a pragmatic philosophical approach. It was conducted in two phases: an online questionnaire followed by two rounds of interviews. In total 49 participants completed the questionnaire and 13 participants were interviewed. All participants held NZ nurse registration and had been in leadership roles in healthcare for at least three years, during which time they were responsible for overseeing staff. Respondents represented diverse practice backgrounds and localities.

The findings indicate that most participants achieved leadership roles primarily through chance and personal determination. In many cases, pursuing post-graduate education or serendipitous opportunities broadened their perspectives on nursing. The nurse leaders in this study realised they could have a significantly greater impact on the quality of care they wished to provide by stepping into leadership positions. However, they faced challenges related to nursing's strong association with femininity and often experienced subordination to the male-dominated fields of medicine and management. There is ample evidence linking empowered nurse leadership to effective care; however, nursing input in healthcare decisions is often overlooked due to the prevailing assumption that traditionally feminine traits do not significantly contribute to patient outcomes.

Despite the proven value and significance of nurse leadership, this research indicates that leadership is not adequately planned for or supported in a way that reflects the size of the nursing workforce. Post-graduate education has been shown to raise nurse consciousness, yet NZ healthcare systems and academic institutions fail to invest in or value the critical thinking and awareness needed for nurse leaders to function and contribute effectively in the current neoliberalist environment. This research suggests that preparation for leadership in nursing should focus on helping nurses gain an awareness of their identity within a gendered profession before developing their leadership skills. Highlighting nurses who have succeeded in roles beyond bedside care and providing mentorship and networking opportunities for emerging leaders will cultivate future nurse leaders who can advance the profession.

Key findings:

- gendered socialisation continues to impact the career trajectories of nurse leaders,
- neoliberalist environments create challenges for nursing autonomous practice
- ongoing issues of colonialism, racism and sexism influence the career pathways of nurses in Aotearoa

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My personal ways of knowing and viewing the nursing world have been reshaped through undertaking this research and hearing the voices of others on similar career

journeys. Initially, I had a very narrow worldview, but this has been challenged by the research process, particularly the reflective journaling that my supervisors recommended. Through journaling, I was able to develop my thoughts gleaned from observations, conversations and reading. Although the research process has been arduous, it has also been a time of personal and professional growth for which I am thankful.

Chapter one: Introduction and background

Kia whakatōmuri te haere whakamua, 'I walk backwards into the future with my eyes fixed on my past'. Author unknown

1.1 Introduction

This thesis aims to answer the question:

What are the experiences of becoming and being a nurse leader in Aotearoa New Zealand (NZ) in the 21st century?

The study focuses on the perspectives of a diverse group of nurses who have transitioned from direct patient care to leadership roles. This research examines the experiences that current leaders have faced in their career trajectories, enabling others to learn from the challenges they have encountered. Our current nurse leaders have faced numerous social and political changes throughout their careers. The research findings suggest that many nurses are unaware of the impact that gendered socialisation and a neoliberalist work environment have on their ability to function effectively as nurse leaders. Gathering insights from current nurse leadership experiences will help prepare and retain future generations of nurse leaders.

This research will contribute towards understanding what is necessary to sustain a career path in nursing leadership in an environment where the nursing perspective on health issues is given less importance than that of medicine, business or politics. For Māori nurses, there is also the added responsibility of carrying the expectations of whānau, hapu and iwi, which may conflict with organisational objectives. I will explore how nursing's historical roots influence current practice and the challenges posed by the neoliberal political environment governing healthcare in New Zealand in the 21st century. The findings will show the value of post-graduate education for raising nursing consciousness, but this does not always prepare nurses for the critical thinking and self-awareness required to be a leader.

In nursing, there are three spheres of leadership: clinical, organisational, and disciplinary. Clinical leadership is where nurse leaders typically begin their career paths, often by being recognised for their competence in quality improvement and direct patient care. Some nurse leaders may progress, either by chance or through deliberate choice, into roles within healthcare organisations or an educational setting, where they can influence nursing decisions at a strategic and organisational level. This research argues that organisational nurse leadership in the NZ healthcare system is threatened due to a lack of power and autonomy. Disciplinary leadership applies to those nurses who aspire to use their skills in serving the nursing profession on regulatory boards, government appointments or as leaders in professional organisations. Disciplinary nurse leaders play a vital role in shaping the future of the profession, yet they face the pressing threat of dwindling influence and numbers.

This thesis focuses almost entirely on organisational leadership, although it can be argued that many of the same challenges can be seen in other nurse leadership settings. In this study, I define leadership as the behaviour that inspires and influences others, regardless of their specific job roles or positions. One outcome of this study is to identify the skills nurse leaders use to pursue their goals for themselves and their patient groups and to explore how they inspire and motivate others to achieve similar successes. These skills may be transferable across the varied fields where nurse leaders are situated.

I also explore how the management responsibilities of nurse leaders intersect with their leadership aspirations. In a neoliberal environment, time and resource constraints often give priority to managerial tasks, which can hinder professional leadership within a team. When nurse leaders cannot achieve their personal leadership goals, they may feel frustrated or disheartened, and some might even contemplate leaving their positions. Amid a looming shortage of nurse leaders, this conflict between aspirations and responsibilities poses a significant challenge to retention.

1.2 Motivation for this research

One of the challenges impacting the healthcare system in NZ is a global shortage of nurses (World Health Organization, 2020); particularly those with the confidence, competence, and willingness to act as leaders (Al Sabei et al., 2018; NEJM Catalyst Insights Council, 2018). Action is urgently needed to address the forecasted deficit due to the impending retirement of the baby boomer generation. To proactively mitigate this challenge, it is recommended that healthcare organisations implement strategic succession planning initiatives aimed at identifying, mentoring, and preparing qualified nurses for key leadership roles within the industry (Bernard, 2014; Titzer et al., 2013). Additionally, to make nurse leadership an attractive career choice, it is likely necessary to challenge the social constraints that have historically limited nurses' potential, predominantly arising from the perceptions associated with nursing as a feminised profession.

The academic literature I read in preparation for this research identified a gap in knowledge regarding the influence of nursing's gendered past on the current challenges registered nurses encounter in pursuing a career pathway into leadership. The association of nursing work with the role of women as carers has led to power differentials that disadvantage the nursing profession (Durand et al., 2022). Additionally, a lack of recognition for nursing scientific and academic expertise may be acting as an impediment to the career aspirations of emerging nurse leaders (Topola & Miller, 2021).

Over the decades of my career, I have witnessed many changes in the NZ healthcare system, and more are imminent. Senior nurses play a crucial role both strategically and operationally, regardless of changing organisational structures (Rafferty, 2018). Strong nursing leadership is necessary to ensure that the focus remains on what is best for those in our care and nursing's right to self-governance (*mana kāwanatanga*). Without the autonomy and confidence to make decisions, I believe nursing risks losing its influence over patient safety, which ultimately affects the whole healthcare system.

The argument that will be developed in this thesis is that to make a positive impact on patient safety, nursing as a discipline and our NZ communities, we need to identify nurses with leadership aspirations, nurture their growth and development, and address gendered barriers to their career pathways. Effective and focused leadership development is essential if we are to empower individuals identified as having leadership potential and support them in their career journeys. Additionally, current nurse leadership should be visible and active as positive role models for nurse leadership in Aotearoa, New Zealand.

1.3 Background/Context

The health system in NZ is predominantly publicly funded with Government owned hospitals providing the majority of inpatient and emergency care. Government subsidies are available for private providers of primary care services and for some pharmaceuticals. The original framework for the NZ health care system was based on the Beveridge model, which had developed in other English colonial nations. The Beveridge Model is a healthcare system where the government uses tax revenue to provide healthcare coverage for the entire population. In the Beveridge Model, low healthcare prices are achieved by centralisation, eliminating competition in the market (Bey & Lega, 2023).

From 1983-1993 14 Area Health Boards (AHBs) were established under the Area Health Boards Act 1983, funded by a population-based formula. Power was decentralised away from the Department of Health to the regional AHBs with their locally elected board members. Following the 1988 Gibbs Report “Unshackling the Public Hospitals”, radical reform of the NZ health system disestablished the traditional triumvirate of Chief Nursing Officer, Chief Medical Officer and Hospital Administrator. A byproduct of this restructuring was a loss of senior health professionals and a disempowering of nursing professional leadership in most areas (Hughes, 2013).

In 1993, further reform came with the establishment of four Regional Health Authorities (RHAs), leading to a separation between the purchasing and provision of health services. A drive for economic efficiencies saw the setting up of Crown Health Enterprises

(CHE), which would compete against each other initially in a for-profit model. The 14 Area Health Boards were restructured into 23 Crown Health Enterprises (CHEs), which were organised as for-profit entities and governed by standard company law. The CHEs were later restructured as not-for-profit entities when it became apparent that the CHE model was not suitable for public health care organisations. Public health services were unbundled, and a separate agency, the Public Health Commission, was created to handle public health purchasing.

Following the election of the National-New Zealand First Coalition Government, the structure of the health system underwent further change. By 1998, the 4 RHAs had been combined into one national purchasing agency, the Health Funding Authority (HFA). In addition, the 23 CHEs were restructured as 24 not-for-profit NZ government companies titled Hospital and Health Services (HHSs).

A change of government in 2000 to a Labour-Alliance Coalition Government initiated more health system reform with the introduction of the Public Health and Disability Act. This marked the beginning of a new political ideology. The 21 geographically defined District Health Boards (DHBs) were formed, with Primary Health Organisations (PHOs) developed the following year to manage all primary care (Quin, 2009). PHOs were tasked with diversifying primary care beyond the traditional model of general practice. This shift should have benefited nursing by providing opportunities for innovation in practice and greater autonomy, but arguably it did not. Although the goal was to empower community participation, the dominance of the medical profession persisted, with governance of PHOs heavily influenced by General Practitioner (GP) interests (Reidy et al., 2025).

The next major restructuring came as an outcome of Pae Ora (Healthy Futures) Act 2022, which established Te Whatu Ora - Health New Zealand, a single health service that has taken over the planning and commissioning of services and the functions of the 21 former District Health Boards to remove duplication and provide national planning. Te Aka Whai Ora - Māori Health Authority was established to work alongside Te Whatu Ora to improve services and achieve equitable health outcomes for Māori but has since been

disestablished following a change in government. These further changes to the way healthcare is delivered will undoubtedly create both challenges and opportunities.

Since the 1980s, a neoliberal perspective has gained prominence, significantly affecting the restructuring of the healthcare system in New Zealand. Business managers gained greater influence over the management of healthcare organisations. This focus on efficiency and cost-effectiveness has influenced how healthcare is delivered, impacting the work environment for nurse leaders. The hegemony of healthcare systems became centred around economic decisions, predominantly austerity measures. Nursing is still perceived as the natural application of feminine caring skills (Burton, 2020) therefore, the work of nurses is afforded less fiscal value. As a profession that is primarily comprised of women, nursing is thus disproportionately affected by austerity measures both in professional and personal contexts (Rafferty, 2018). Under the influence of neoliberalism, the concept of care has been transformed into a marketable commodity, resulting in a significant rise in privatisation. Simultaneously, access to publicly available services is becoming more difficult, which has led to an increasing burden on families (Schwiter & Steiner, 2020). In this context, nurses, who are predominantly female, find themselves facing a dual challenge: managing the demands of care at work while also fulfilling their responsibilities at home. This creates a profound strain as they strive to balance both realms.

Over the past four decades, the constant restructuring of healthcare in New Zealand has seen an increasing shift towards generic leadership rather than clinical leadership. This change has created unclear lines of accountability (Hughes, 2013), leading to nurses largely losing control over their budgets and workforce decisions. Nursing has frequently become relegated to advisory roles, and there has been a failure to consult seriously on issues that have a major impact on nursing and their communities (Hughes, 2013 Rafferty, 2018). Topola and Miller (2021) commented that the perception that nursing is less autonomous and competent than other healthcare professions could directly affect career aspirations, as newer nurses may not see such disempowerment as attractive or desirable.

It is generally agreed that patriarchal systems still significantly impact healthcare services (Came et al., 2022; Katuna, 2019). It is therefore inevitable that nursing, which is still perceived as largely “women’s work”, would also feel the impact. Lingel et al. (2022) argued that gendered assumptions regarding nursing have hindered the attainment of professional respect and equal rights within the workplace. Nursing expertise is often underutilised due to regulations or organisational policies that prevent nurses from working to the full extent of their practice scope (Henderson et al., 2024). Pincha Baduge et al. (2024) believed that the assumption of financial constraints and gender-related bias toward nursing as a feminised profession limit opportunities for nurses to play a leading role. Fiscal austerity has reduced professional development opportunities for nurses, which has contributed to poor patient outcomes and decreased job satisfaction (Rafferty, 2018).

In the theoretical chapter, I will examine Derrida’s concept of gender binaries. I do this because the development of leadership in nursing sits at the intersection between the notion of a feminised workforce and a highly masculinist environment created by the adherence to neo-liberalism and the associated value system. Western society has traditionally maintained a binary view of masculinity and femininity despite the wide range of personalities and preferences that people may have (Durocher & Caxaj, 2022). Therefore, unwritten rules and stereotypes have developed regarding what is privileged and what is not. Alongside this are expectations of how men and women should behave to fit societal expectations of what is considered masculine or feminine. Cultural norms have positioned nursing leadership on the less privileged side of gender binaries, with females more commonly socialised to be carers and males conditioned to assume leadership roles. Although the number of male nurses in Aotearoa is increasing, they comprise only 10% of the NZ nursing population (Nursing Council of NZ, 2023). Yet, even though the nursing profession is predominantly female, the perception of leadership as belonging to the masculine binary privileges male members, giving them disproportionate access to high-level positions (Royal College of Nurses, 2020).

The gendered expectations placed on women in nursing leadership roles encompass their manner of dress, language, and behaviour. Thus, women nurse leaders are expected to maintain a feminine, nurturing image (Pullen & Vachhani, 2021). Women leaders who display traits that do not align with traditional societal expectations for their gender, such as dominance or assertiveness, are often perceived negatively. In contrast, when men exhibit the same traits, they are considered acceptable behaviours (Katuna, 2019). Dwivedi et al. (2021) argue that this discrepancy occurs because assertive performances are often seen as incompatible with the qualities traditionally expected of women, such as being socially sensitive and communal. Male leaders are permitted to be openly challenging, but female leaders must strive to maintain the good opinion of those around them (Burton, 2020). As a result, there is a dissonance between feminised normative behaviours and the masculine behaviours perceived as necessary for advancement.

Nursing education tends to reinforce nursing's position within the gender binary as a caring profession that gives service to others (Burton, 2020). Gendered socialisation is deeply embedded in the collective nursing mindset. Nursing has long been perceived as a feminised profession with its association to the maternal skills of caring and nurturing. These "soft" skills remain societal expectations when a nurse progresses into leadership. Overlapping these "soft skills" are the empathy and communication skills attributed to the feminine binary (Lingel et al., 2022). Therefore, female nurse leaders often find themselves assigned tasks traditionally associated with femininity, such as providing pastoral care or managing conflict, primarily because of their sex rather than their skill set. In leadership teams, women are often assigned the caring functions (Pullen & Vachhani, 2021) or the gender role of note-taking, which limits their ability to contribute effectively (Katuna, 2019). The expectation for them to take on a "mothering" role in the workplace can become an additional burden, contributing to an increased emotional workload for nurse leaders (Burton, 2020).

Society's perception of the work of the nursing profession has been narrowly defined in terms that relate to its function of giving direct patient care, rendering a great part of what

nurses do as invisible, unsaid and unacknowledged (Allen, 2014; Litchfield, 2021; Mourão Netto, 2024). Nursing's own insecurity generates an anti-intellectualism that undermines their work by using language such as "basic care" rather than recognising the synthesis of knowledge and experience required (Leary, 2017). Additionally, a dominant biomedical discourse inhibits the ways that nurses can deliver care (Adams, 2021). The blurred lines between caring and curing in current healthcare systems are a result of a history of gender bias and the monopoly of medicine (Ferguson & Anderson, 2021). Many nurses are aware of the power differentials between their profession and medicine, but choose to stay in roles that are paid less and disrespected due to job satisfaction in their specialty or the collegiality of their work environment (Loft & Jensen, 2020).

People are more likely to see themselves as leaders if they have role models who are like them (Lips, 2018). Traditional role models for nursing, such as Florence Nightingale, may no longer be relevant for emerging nurse leaders in New Zealand. While Nightingale exemplified many important leadership qualities, including advocacy and collaboration across disciplines (Nichols et al., 2020), her views on Indigenous people are no longer celebrated (Bates & Greenwood, 2022). Therefore, it would be beneficial to seek out other exemplary role models to encourage individuals to pursue nurse leadership as a career option. An example is NZ's recent female prime minister, Dame Jacinda Ardern, who faced criticism as a political leader and an unmarried working mother, yet she is highly respected internationally. Dame Jacinda Ardern embodied feminine characteristics of compassion and kindness whilst clearly being highly competent across the fiscal and policy requirements of government leadership. As such, she embodied a crossing of the binary divide.

In addition to gendered perceptions, Māori nurses face additional leadership challenges. New Zealand is a colonised country that still retains Eurocentric and patriarchal healthcare systems. Current models of healthcare leadership have not effectively served our indigenous population. Successive restructuring of the NZ healthcare system has yet to demonstrate any improvement in the poor health statistics of the tangata whenua of

Aotearoa. This is compounded by many Māori being afraid of seeking health care or feeling a sense of shame for their inability to self-manage (Came et al., 2022). Efforts to address healthcare inequities require Māori leadership at all levels of the healthcare sector (Davis et al., 2021). Achieving health gains for their people also increases the mana of a Māori nurse leader. Unfortunately, NZ healthcare systems and organisations do not make this easy to achieve, thus impacting Māori nurse leaders' role satisfaction and retention.

Māori nurses face challenges related to both implicit and explicit racism, as well as difficulties in balancing traditional values with modern work practices. Pihama (2020) argued that “whiteness” remains the standard in New Zealand nursing education, which leads to Indigenous knowledge being undervalued. Additionally, Kidd et al. (2020) observed that institutional racism is prevalent, resulting in Māori nurses often being marginalised and discriminated against. These factors contribute to added challenges for Māori nurses aspiring to leadership roles.

A Māori leadership style is that of a collective with inclusive decision-making. Māori have broad expectations of leadership that are based on traditional cultural values and practices (Barton & Wilson, 2008). Māori tikanga puts people first and provides opportunities for leadership growth from within the marae. This Māori model helps build self-confidence in the ability to lead. There has been limited growth in Māori RN taking up leadership roles in health (Longmore, 2020). Those who do take up leadership in healthcare may feel torn between organisational expectations and cultural responsibilities (Walker et al., 2016) without appropriate cultural as well as disciplinary support.

Despite targeted approaches, nursing struggles to attract and retain enough Māori nurses to match the NZ demographic of 17.4% (Nursing Council of NZ, 2020). In contrast, the number of IQN practising in Aotearoa (46.8%) is more than six times that of Māori RN (7%) (Nursing Council of NZ, 2023). NZ's growing reliance on internationally trained nurses not only impacts the number of leadership roles available for tangata whenua but also takes away potential leaders from the source countries (Stokes & Iskander, 2021). IQN seeking leadership positions must also navigate the challenges posed by systemic biases within

many healthcare organisations, which can impede their progress towards achieving such roles.

The study of nurse leadership takes place within a distinct and complex environment, characterised by a range of unique challenges. This setting not only shapes the dynamics of leadership but also tests the resilience and adaptability of those in leadership roles, creating a rich tapestry of experiences that are unlike any other. In summary, emerging nurse leaders arise from a highly feminised workforce and enter a context that is also significantly gendered in a manner that largely disprivileges the very aspects closely associated with nursing. Becoming a nurse leader means challenging gendered perceptions of what a leader is and the accepted behavioural norms imposed, especially on leaders who are women or Māori. Being a nurse leader necessitates overcoming gendered socialisation and neoliberalist thinking that limits the influence of feminised occupations and fails to acknowledge or value their specialised knowledge and skills.

1.4 Justification for the research

Evidence indicates that nursing views leadership as daunting, and generic leadership considers it unnecessary (Klarare et al., 2020; Topola & Miller, 2021). If proactive nurse leaders are not nurtured, the nursing profession risks further loss of autonomy and value within a neoliberal healthcare system. Current austerity and global factors have made nursing leadership roles in New Zealand unappealing to many. The country is already facing a shortage of experienced nurse leaders in various fields. Therefore, understanding how and why nurses become leaders is essential.

Henderson et al. observed that enabling nurses to utilise their complete skill set within healthcare systems would enhance access to safe, affordable, and equitable healthcare services. Effective leadership inspires strong teamwork, paving the way for safe and efficient patient care (Barcellos Morcelli et al., 2023; Murray & Cope, 2021). Moreover, nurses are more likely to remain in their positions if they experience job satisfaction from working with

proactive transformational leaders (Othman, 2022). Nursing leadership is therefore critical to patient safety, to a reduction in nurse turnover and thus fiscal effectiveness.

With 46.8% of nurses being internationally qualified, our nursing demographic does not accurately reflect the local population, which makes it more challenging to provide culturally safe care. It is crucial to identify the challenges to leadership pathways for New Zealand nurses, particularly for Māori nurses, so that effective solutions can be implemented. This research aims to gather data that will support the development of leadership training programs tailored to the specific needs of Aotearoa.

My research seeks to highlight the gendered inequities faced by emerging nurse leaders in a feminised profession. Male and medical hegemony are still very present in most environments where nurses are situated, both in healthcare organisations and external agencies. Nursing, with its culture of agreeableness, seems to accept the status quo to its detriment, with many emerging leaders unaware of how being a disprivileged profession impacts their career pathways.

1.5 My positioning within the thesis

I am a New Zealand European (NZE) woman, wife and mother, with a career spent mostly in the regional hospital in which I was initially trained. I come from a lineage of women with a strong Christian faith and set of values, carrying the responsibility to protect the vulnerable in society.

As a child of a parent with a mental illness, I overcame bullying through most of my school years, learning not to let others define who I could become. This attitude continued into my career as a registered nurse, where I had to overcome the challenges of a sometimes oppressive hierarchical structure to be able to use my leadership skills to their full potential. I came into what are considered leadership roles late in my nursing career, although I had always considered myself a leader. Throughout this transition period, I encountered gender-related and organisational barriers, which I came to realise were not unique to myself or my career pathway. I was fortunate enough to find a mentor who

believed in my ability and supported me until I gained confidence. This experience caused me to question what enabled some nurses to succeed in leadership roles and what barriers needed to be overcome to progress as a leader in the Aotearoa NZ healthcare environment.

1.6 Thesis structure

This initial chapter has introduced the background and context of the research and my positioning as the researcher within the study.

In Chapter Two, an integrative literature review is conducted to establish the groundwork for this research and to pinpoint gaps in current knowledge related to New Zealand and its unique differences. Some of the literature I reviewed used multiple methods in the methodological framework. This reinforced my decision that this would be a suitable methodology for this research.

Chapter three gives the theoretical framework that supports this research. Feminist deconstruction of gender (FDG) was used as a theoretical lens through which to view the data. In this chapter, I discuss the social constructions of masculinities and femininities and the influence they have on nurses as women. I also discuss the legacy of gender in nursing and the gendered relationship between nursing and medicine.

Chapter four outlines the methodological framework used for this research. A qualitative multi-methods methodology was chosen to enable the contextualisation of nurses lived experiences of their career pathways into leadership. This chapter explains the theoretical and philosophical positioning of the thesis and the rationale for the use of the chosen methodology.

Chapter five outlines the methods used for data collection in this study, which was conducted in three phases. The first phase involved administering a questionnaire that included long-answer questions to provide more depth to the descriptive Likert-type questions. The second phase consisted of two sets of interviews designed to further explore specific topics of interest identified in the questionnaire further. This chapter also includes the ethical and cultural considerations for this study.

Chapters six to eight describe the findings and the integrated analysis from the two phases of the data collection, supported by relevant academic literature.

In chapter nine, I discuss the themes and subthemes that came out of the integrated analysis using a feminist deconstruction of gender lens to explore the influence of nursing's gendered past and the current political environment on becoming and being a nurse leader in Aotearoa in the 21st century. A concluding chapter outlines concerns about the impact of the current positioning of nurse leadership. In this chapter, I explain how this research contributes to new knowledge and offer recommendations to assist with the future leadership career trajectories of registered nurses in Aotearoa.

1.7 Summary

This chapter has provided background information on the research conducted to explore the experiences of becoming and being a registered nurse leader in Aotearoa NZ, during the 21st century. The goal of this research is not to understand nursing leadership in New Zealand but the factors by which it is developed, influenced and directed.

This study examined the experiences of New Zealand nurse leaders through a feminist lens, focusing on their journeys into leadership and the barriers they encountered as leaders working within a healthcare system underpinned by neoliberalism. Using two different methods in this qualitative research design helped clarify the meaning of written and spoken words while providing context for the data collected. This data was then integrated, and the analysis of the findings was discussed under two overarching themes.

My research focuses on nursing as a gendered profession within a neoliberal healthcare system that is undergoing significant structural changes. I will demonstrate that as the structure and political priorities of the workplace evolve, progress in addressing nursing's status as a feminised profession remains insufficient to effectively attract and retain nurse leaders. It is hoped that through the lived experiences of Aotearoa NZ registered

nurse leaders in this study, knowledge can be gained that can be used to guide the career trajectories of the next generations of nurse leaders.

I have introduced myself as the researcher to ensure transparency regarding my experience and biases to the reader. The following chapter reviews the relevant literature for this study and highlights the knowledge gaps that this research aims to address.

Chapter two: Integrative Literature review

2.1 Introduction - problem identification

In the previous chapter, I stated that the integrative literature review was undertaken to ground this research and highlight gaps in existing knowledge specific to Aotearoa, NZ. The literature review aimed to explore what had been written about the various factors that influence a registered nurse in becoming and being a nurse leader and how this impacts their career trajectory towards becoming a nurse leader. Subsidiary aims were to explore what was currently recommended as preparation for nurses interested in a leadership pathway and what was available to support them in sustaining a leadership role. Due to the sparsity of NZ literature that met my search criteria, the literature review included international literature on the topic. Articles with a New Zealand focus were selected to highlight any unique aspects or specific considerations for nurses working in Aotearoa. This literature review will offer background information relevant to the research question: What are the experiences of becoming and being a nurse leader in Aotearoa New Zealand (NZ) in the 21st century?

2.1.1 Narrative literature review

I began my research with a comprehensive review of the literature from 2000 onwards, focusing on the experiences of nurse leaders. This review prompted me to reflect on the key issues that influence nurse leadership, helping me refine my research question by narrowing my area of interest.

Matheson and Bobay (2007) commented that nurses have been subjugated for so long that the roots of nursing's oppression have been forgotten. As a consequence, nurses tend to assume the values and practices of those in power. Wall (2007) agreed, noting that although nurses were aware of the inequities between themselves and other healthcare disciplines, they continued to accept them.

Research from Scotland found that the wide scope and lack of clarity around some nurse leadership roles were leading to role confusion and work overload. It was

recommended that nurse leader autonomy needed to be within a professionally and organisationally supported framework, with a formal career pathway (Booth et al., 2006). Leadership positions were more likely to be sought after if they were seen as roles respected by the organisation (Hoskins, 2009). This research showed the benefits of mentorship programmes and assistance with skill acquisition in influencing emerging leaders towards leadership positions.

Reedy and Learmonth (2000) expressed criticism of leadership development programmes that focus solely on competence or skills. They argued that such an approach undermines the value of nursing skills and knowledge, contributing to the tension between professional and managerial identities. Furthermore, they suggested that additional conflict arises from the perception of nursing as having a clinical identity that is feminised, in contrast to the traditionally masculine identity associated with management and leadership. Fletcher (2006) urged nurse leaders to move beyond the constraints of binary thinking so that innovation could occur and suggested a change in leadership style to one that embraced dialogue, collaboration and partnership.

Huston (2008) argued that there was an inadequate number of nurses with the skills needed to lead effectively in a healthcare environment that was becoming increasingly complex. Huston believed that nurse leaders needed to gain a worldwide perspective on healthcare and professional issues. Three years later, in her book **Transformational Leadership in Nursing: From Expert Clinician to Influential Leader**, Marshall (2011) emphasised that nurse leaders must possess both accountability and autonomy to foster a work environment that encourages best practice and achieves optimal patient outcomes. She also noted the importance of nurse leaders being responsive to both local and national policies, as this allows them to collaborate with other healthcare professionals to develop innovative solutions for healthcare challenges. Donovan et al. (2012) concurred, adding that nurses needed to gain an understanding of political language so that they could participate in policy-making more effectively, noting that the concerns of nursing are typically political concerns. Their research indicated that nursing needed leadership development to transition

from a service-based system to one that partnered with others to set the direction for NZ healthcare. This concept of collaboration with other healthcare professions was examined by (Beglinger et al., 2011) in their study of a USA hospital that transitioned from a traditional model to shared governance. One of their findings was that shared governance lessened the barrier between senior leaders and the workforce, making it easier to identify talent and develop emerging leaders.

The narrative review initiated my exploration of the experiences of nurse leaders in Aotearoa, NZ, introducing me to key ideas that, while I did not initially recognise them, became important factors in my later analysis and discussion.

2.2 Scope

A systematic search strategy began with electronic database sources: Massey University Discover, which includes the Massey University Repository as well as a collection of databases from EBSCO, CINAHL, SCOPUS, and Google Scholar. The search was later expanded to include hand searching by reference snowballing and tracking.

The search initially used key terms in combinations with “nurs*,” “Māori or IQN leader*,” “leadership pathway,” “leadership preparation”, “leadership career”, leadership development AND experiences, “barriers or enablers to leadership” and “influences to willingness to lead.” The search yielded 218 records initially, with the reference management software Endnote used for collating and removing duplicates.

Three additional articles were later obtained through reference snowballing. This integrative review was conducted before the research question was refined, so it is likely that some relevant literature was missed. Subsequently, a narrative review was necessary to gain background knowledge on neoliberalism and the health system reforms in New Zealand.

2.3 Criteria

Inclusion: The database search was conducted in mid-2022, focusing on scholarly (peer-reviewed) literature published since 2012, which was then within the last ten years.

The literature that was reviewed included original academic articles of qualitative studies, theses, books, surveys, and reviews conducted by other researchers. My key search terms included derivatives of the word nurse or leadership to narrow the field of enquiry to articles most relevant to the search.

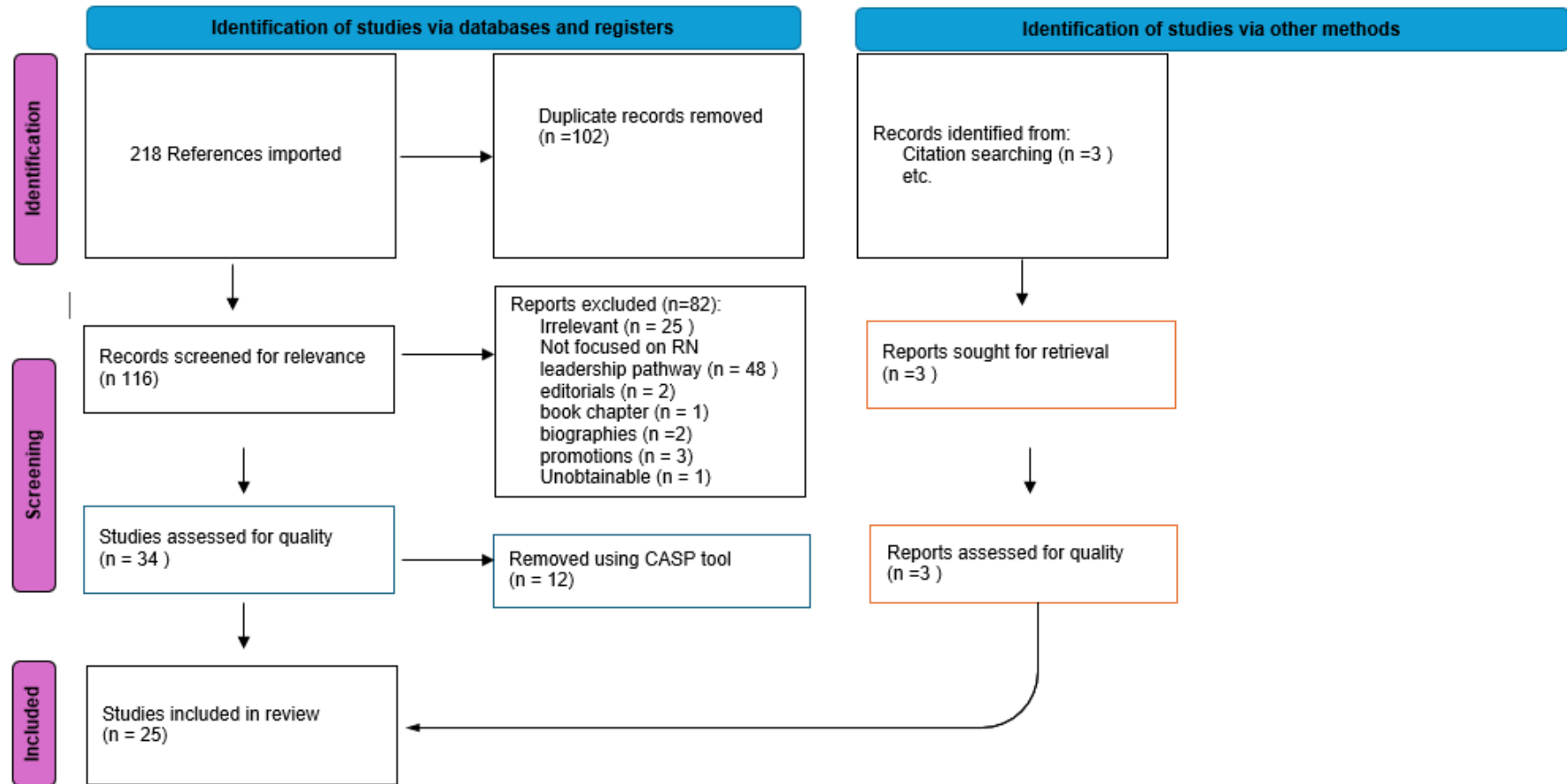
Exclusion: My search terms narrowed the study to only those articles concerning nursing and leadership or career pathways. Articles that were published in languages other than English were excluded. The initial search resulted in 218 references with 102 removed due to duplication. I reviewed the abstract of the 116 articles, and any unrelated to the research questions were removed from the list. This removed a further 82 articles for the reasons listed in Figure 1, leaving a total of 34 studies to be analysed.

The Critical Appraisal Skills Programme (CASP)(Healthcare, 2018) tool was applied to the remaining 34 articles, resulting in a further 12 articles being removed as they did not provide the rigour required for inclusion. Three articles were retrieved from citations and examined using the CASP tool, leaving 25 articles to review (figure one).

2.4 Data Evaluation

A CASP (Healthcare, 2018) checklist was used as a guide to assess the peer-reviewed articles and literature reviews in three main areas: validity, results and clinical relevance. The journal articles were likewise assessed using the Concordia University evaluating articles tool (Concordia University Library, 2022). In this way, each report was judged for its trustworthiness, value and relevance to the research question. Following this evaluation 25 documents were considered of sufficient quality to be included in the review: four journal articles, 16 peer reviewed articles and five literature reviews.

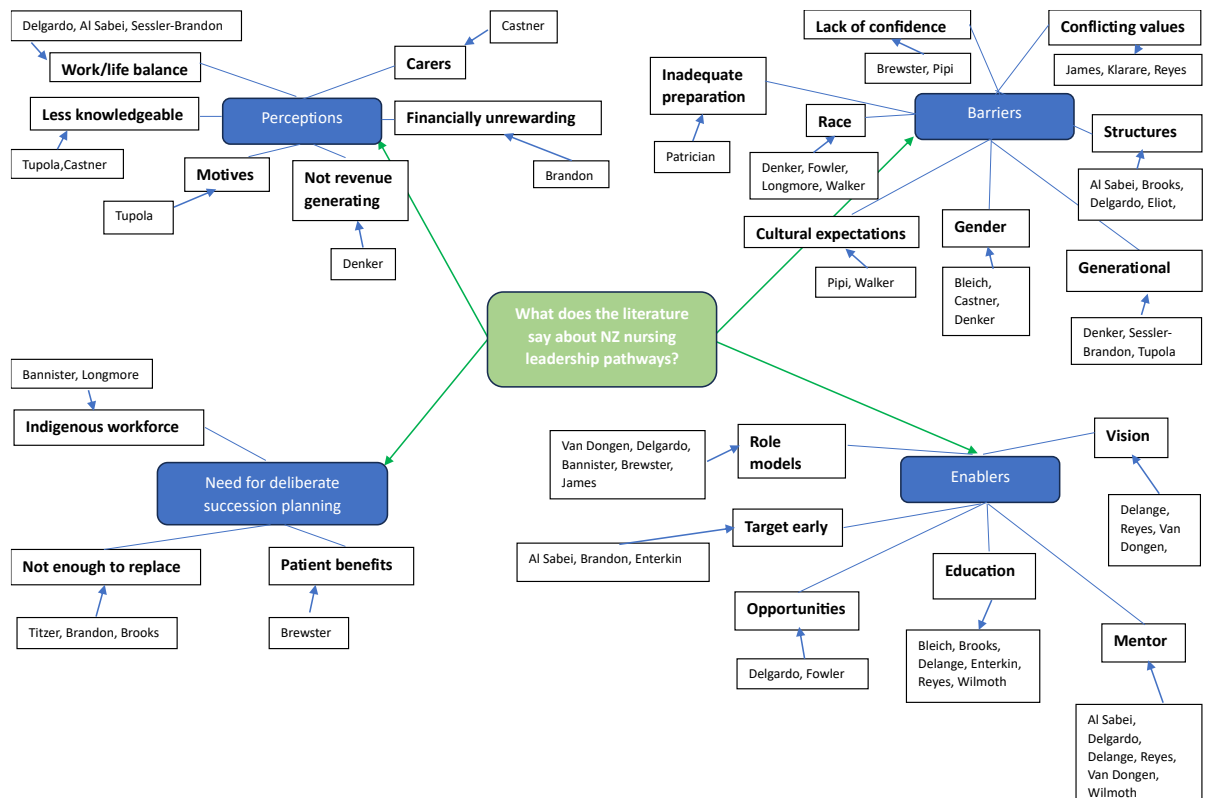
Figure 1 Preferred Reporting Items for Systematic Reviews (PRISMA) diagram



2.5 Data Analysis

Braun and Clarke's thematic analysis method (Braun & Clarke, 2021) was used as a guide to organise the articles thematically. This approach enabled the reviewer to thoroughly understand the literature by identifying patterns of shared meaning. Each article was carefully read, and relevant excerpts were coded according to their distinct meanings in relation to the research question. These codes were then summarised into data labels with some expanded to include greater meaning. Once all the articles were coded, the codes were written on post-it notes and clustered into groups or patterns of shared meaning that captured the central ideas related to the research question. These central ideas became the four themes to be explored in the review. A visual mapping technique helped with the theme development. I then re-engaged with the literature to check the validity of the themes and the message they conveyed.

Figure 2 Mind map



While reviewing the literature for themes I noted that several authors emphasised the importance of deliberate succession planning to prepare for the expected deficit in competent nurse leaders (Branden & Sharts-Hopko, 2017; Brooks et al., 2014; Titzer et al., 2013). Banister et al. (2020) and Longmore (2020) stressed that this was particularly important to achieve a workforce that matched the county's population in ethnic mix.

Several authors commented on the different perceptions that were held around nurse leadership that impacted career pathways. Nursing being seen as less knowledgeable or able to make a difference in health outcomes, lessened the attractiveness of career advancement (Castner, 2019; Topola & Miller, 2021). Branden and Sharts-Hopko (2017) commented on the perception that leadership roles were financially unrewarding while Al Sabei et al. (2018); Branden and Sharts-Hopko (2017); Delgado and Mitchell (2016) talked about the perception that those in leadership roles had difficulty maintaining a healthy work/life balance.

The barriers to a nurse leadership pathway were discussed at length. According to Brewster et al. (2020) and Papi et al. (2021), a lack of self-confidence or belief in one's abilities may contribute to registered nurses not pursuing leadership roles. This was compounded when additional barriers of race, gender and/or age were encountered (Bleich, 2015; Branden & Sharts-Hopko, 2017; Castner, 2019; Denker et al., 2015; Fowler, 2020; Longmore, 2020; Topola & Miller, 2021; Walker et al., 2016). Reyes et al. (2014); Brewster et al. (2020); Klarare et al. (2020); Papi et al. (2021) and James et al. (2022) discussed the personal and professional conflict when nursing values do not align with those expected of a manager in an organisation. Organisational structures themselves could also be unsupportive to those wanting to progress, with work environments seen as unfavourable to career progression (Al Sabei et al., 2018; Brooks et al., 2014; Delgado & Mitchell, 2016; Elliott et al., 2016; Van Dongen & Hafsteinsdóttir, 2021).

Several enablers to a leadership career were agreed on by the articles reviewed. De Lange et al. (2019); Reyes et al. (2014) and Van Dongen and Hafsteinsdóttir (2021) believed those embarking on leadership journeys needed to make conscious choices that required

vision. One of the choices that acted as an enabler was undertaking postgraduate education with Bleich (2015); Brooks et al. (2014); De Lange et al. (2019); Enterkin et al. (2013); Reyes et al. (2014) and Wilmoth and Shapiro (2014), commenting on the importance of continued learning. Role models that were similar to the nursing demographic (Banister et al., 2020; Brewster et al., 2020; Delgado & Mitchell, 2016; James et al., 2022; Van Dongen & Hafsteinsdóttir, 2021) and experienced mentors (Al Sabei et al., 2018; De Lange et al., 2019; Delgado & Mitchell, 2016; Reyes et al., 2014; Van Dongen & Hafsteinsdóttir, 2021; Wilmoth & Shapiro, 2014) were recommended as encouraging factors. A number of the authors also agreed that beginning a career pathway early (Al Sabei et al., 2018; Branden & Sharts-Hopko, 2017; Enterkin et al., 2013) and being offered opportunities to experience leadership activities (Delgado & Mitchell, 2016; Fowler, 2020) were useful for gaining confidence and correcting wrong perceptions.

In summary, the literature review identified four central themes, which will be explored in a logical order. Six of the articles emphasised the necessity of establishing an effective succession planning strategy, highlighting a growing gap in the supply and training of nurse leaders. Seven articles detailed the impact of perceptions regarding nurse leadership on registered nurses' aspirations to pursue a career path leading to becoming a nurse leader. An additional nineteen articles examined the obstacles to achieving and maintaining a leadership trajectory in nursing. Fifteen articles identified various factors that many nurses have found to be enablers or motivational elements in their advancement. These four themes succession planning, perceptions, barriers, and enablers are discussed in greater depth below.

2.5.1 The need for succession planning

Proactive leadership planning is crucial for the future of nursing as a profession and must be approached with conscious, deliberate actions (Titzer et al., 2013)

A common thread throughout the literature reviewed was that there is an increasing need to be proactive in the preparation of registered nurses for leadership roles to fill existing

and future deficits. The lack of clear succession planning for senior nursing roles is beginning to be problematic for nursing worldwide as there are not enough nurses preparing to replace the baby boomers who are retiring or reducing their workloads (Branden & Sharts-Hopko, 2017; Brooks et al., 2014). Investment in the preparation of RNs for future leadership roles is essential to recruit and retain the numbers needed for succession planning (Branden & Sharts-Hopko, 2017; Denker et al., 2015; Enterkin et al., 2013). According to a systematic review conducted by Titzer et al. (2013) which examined 13 articles regarding nurse leadership succession planning, it was found that many organisations lack focused nurse leadership development strategies in their annual plans. Titzer recommended implementing succession planning as a business strategy, as doing so helps maintain a pipeline of nurse leaders and reduces staff replacement costs.

Organisations are being directed to aim for a workforce that matches the demographic of the population they serve. This includes senior nursing positions. Since the 1990's, the development of a Māori nursing workforce including at leadership levels, has been a health system priority (Pipi et al., 2021). In an article for Kaitiaki Nursing NZ Longmore (2020) stated that a desired increase in the Māori nursing workforce was unlikely to occur until systemic issues of discrimination were addressed. Colonialism has resulted in under-resourcing generally for Māori. It was Longmore's view that growing an indigenous nurse workforce required a targeted approach with allocated time and resources (Longmore, 2020). Banister et al. (2020), in their study of 19 African American RN graduates of a leadership programme, agreed with this, stating that leadership training of minority groups was essential to meet the demographics of the population served. RN from minority groups are interested in leadership career pathways but are concerned over lack of diversity and equity in opportunities available (Fowler, 2020).

It is important to support potential nurse leaders from early in their careers to develop the necessary skills for advancing the nursing profession in a constantly evolving healthcare environment. In the past, nurse leaders were selected based on seniority or clinical skills, without formal leadership training. However, Branden and Sharts-Hopko (2017) observed

generational differences in aspirations and career goals among nurses. As nurses gain more experience, they tend to become less interested in leadership roles, often due to work-related stress and perceived role expectations. To address this issue, Enterkin et al. (2013) and Al Sabei et al. (2018) recommend targeting RNs early in their career and supporting their career pathway. Titzer et al. (2013) also suggested that healthcare organisations should take a proactive approach to identifying and investing in emergent nurse leaders.

Implementing a succession planning strategy can be an effective way to retain intellectual capital and ensure leadership continuity (Titzer et al., 2013). Current leaders have a strong influence on the motivation of their employees to follow into similar roles. Patrician et al. (2018) commented that a registered nurse's leadership journey could be significantly impacted by the guidance and support provided by their managers. Nurses are more likely to remain in an organisation if they feel that their career is advancing, and they are satisfied with their accomplishments (Basheer, 2020). Effective leadership succession planning can also result in positive patient outcomes and increased patient safety (Brewster et al., 2020).

2.5.2 Perceptions of what a nurse leader is and can become

Nursing's history is one of tradition and gendered stereotypes. Perception of what nursing is as a career often differs from the reality most nurses experience (Branden & Sharts-Hopko, 2017; Topola & Miller, 2021). This is also true of nurse leadership roles. Both positive and negative forms of role modelling and visual observation significantly influence the appeal of leadership roles to emerging leaders. Castner (2019) reported that nursing, as a caring profession, is often undervalued for its technical skills, scientific contributions, and unique knowledge. This perception makes a nursing career seem less autonomous and competent compared to other health professions, with fewer opportunities to influence decision-making. Denker et al. (2015) in their report on the Florida cross-sectional RN survey, acknowledged that current nurse leaders were concerned about a perception that the opinions of medical staff were given more value because they are revenue generators for the organisation. Likewise, an integrative review of 28 studies by Brewster et al. (2020) found

that in Intensive Care Units medical staff were accepted as the leaders and prime decision-makers, whilst nurses were viewed as leaders solely in the area of their clinical expertise, not because of any role title. These perceptions clearly indicate that nursing knowledge and opinions are undervalued compared to those of medical colleagues. This disparity significantly shapes nurses' perspectives on pursuing leadership as a viable career pathway.

The style of leadership varies across healthcare and impacts on how leadership is perceived. Nurses have both negative and positive experiences of leadership throughout their careers. However, those who experienced negative examples of leadership were often determined to be the opposite in their own practice (James et al., 2022). Medical articles reviewed by Brewster et al. (2020) conceptualised leadership as hierarchical whilst those authored by nurses tended to favour a more shared, group form of leadership. Klarare et al. (2020) believed that the style of leadership should be focused more on the needs of the team than on the individual characteristics of the leader. This type of shared leadership aligns more with the feminine binary and will be discussed in the next chapter.

Seemingly, many nurses still believe that the current healthcare structures within which they are employed limit their ability to make a difference, and therefore, they are content to accept the leadership of others. According to a study by Topola and Miller (2021), millennial nursing students do not consistently associate leadership with the role of a registered nurse (RN) because they do not perceive RNs to have the ability to lead within the hierarchical structure of the healthcare system. This was evidenced by some of their fourth-year student subjects perceiving leadership as "scary and undesirable," questioning an RN's ability to lead a multidisciplinary team due to power imbalances between healthcare disciplines. Although this cohort believed that an RN's influence on decision-making was important, they were not interested in exerting their own influence or participating in leadership activities and preferred to leave this to others (Topola & Miller, 2021). Leadership of nurses by nurses was seen to be important but not something they were aiming for in their own careers.

Observation of those who do attain leadership roles often shows an internal conflict between their personal and professional values and what is expected of them by the healthcare organisation in which they are employed (James et al., 2022; Reyes et al., 2014). This conflict is particularly felt by Māori nurses at all levels, with the challenge of negotiating traditional values with a Euro-centric way of working (Pipi et al., 2021). A desire to meet the expectations of their community can lead to a feeling of never being “off duty” (Walker et al., 2016). This added tension may deter some nurses from pursuing a leadership career if they perceive it as being stressful and all-consuming.

Peer opinions and the lack of adequate recompense influenced the perceptions of nurses about the benefits of following a career trajectory to become a nurse leader. These perceptions were further compounded by nurses' own experiences as to how they were treated and perceived as leaders.

2.5.3 Barriers to Leadership

Five key points were drawn from the literature related to barriers in a leadership career pathway. These points included cultural barriers such as race, organisational structure, gender stereotyping, conflicting values, and differing generational perceptions. Together or separately, these issues can impede or deter a registered nurse from attaining leadership roles.

Māori have broad expectations of leadership based on traditional cultural values and practices with their leadership style being that of a collective. A pre-requisite for a Māori leader is to know one's people and the wider community (Pipi et al., 2021). To meet community needs, they may have to cross professional boundaries and risk disciplinary action (Walker et al., 2016). This article further explained that wider whānau responsibility means that Māori nurses are often used to navigate healthcare systems to provide advocacy, frequently outside of their paid role.

Nurses from ethnic minorities reported that applicants for leadership roles were often picked based on favouritism and seniority. Their experience of a lack of equity in the work

environment included discrimination with both implicit and overt racism (Fowler, 2020; Walker et al., 2016). Fowler (2020) voiced concerns over the lack of diversity and inclusion in leadership development and career opportunities. This was borne out by Denker et al. (2015) who found that registered nurses from ethnic minorities had been denied leadership roles in the past for reasons other than their competency, such as ethnicity or gender. Some of the ethnic minority RNs interviewed by Fowler (2020) shared what was termed “survival skills” to overcome stereotypes and stay in an often-toxic environment to make it more inclusive.

It has been noted that nurses, particularly those from minority groups, must have the confidence to believe they can take on leadership roles as a lack of self-confidence can hinder nurses from seeking leadership positions (Brewster et al., 2020; Pipi et al., 2021). Some nurses may not view themselves as effective leaders and negative experiences can leave them feeling inadequate for such roles (James et al., 2022). Even nurses with advanced degrees may still feel unprepared for leadership roles if their work environment is not supportive and their leadership development experiences do not enhance their self-efficacy, as noted by Al Sabei et al. (2018).

Al Sabei et al. (2018) suggested that instead of basing recruitment on demographics, recruiters should look at creating favourable environments in which to lead. Current hierarchical organisational structures were viewed as being unsupportive of the ability of a registered nurse to lead effectively (Topola & Miller, 2021). In particular, hospitals were seen as medically orientated, which made it difficult for some RN leaders to fully utilise their skill set (Van Dongen & Hafsteinsdóttir, 2021).

Generally, opportunities to develop leadership skills are ad hoc and have inequitable access (Pipi et al., 2021). Cost and time constraints can be a barrier to continuing professional development as programmes can be difficult to manage alongside other commitments such as family (Brooks et al., 2014). Dutch postdoctoral nurses interviewed as part of a study by De Lange et al. (2019) commented that it had been challenging to manage academic achievement with the high workloads expected of them. Lifelong learning, whether formal or informal, requires support at an organisational level (Reyes et al., 2014).

Unfortunately, not all aspiring leaders experienced this, with some feeling a lack of support from both their colleagues and management (Al Sabei et al., 2018; Delgado & Mitchell, 2016; Elliott et al., 2016).

Social marginalisation can occur in all nursing fields towards individuals perceived as nonconforming (Castner, 2019). This marginalisation may be experienced by those who engage in studies beyond what is considered essential for their clinical roles. In a study by Delgado and Mitchell (2016), respondents reported challenges in maintaining collegial relationships and felt resistance due to their participation in leadership activities.

Leaders often find themselves burdened by financial responsibilities that mean fiscal restraints or external pressures influence care. They are expected to maintain a healthy work environment but may lack the skills or resources to do so (Patrician et al., 2018). This can lead to anger if it is perceived that budgets are causing an inability to meet patient or staffing need (Klarare et al., 2020). Thus, RNs were viewed as reluctant to apply for roles if they perceived the position to lack the authority to take action within the organisation. This reluctance particularly applied to positions being managed within nursing structures that did not report directly to the executive leadership team (Elliott et al., 2016).

Negotiating the binaries of leadership as masculine and nursing as feminine presents a further challenge for those who are becoming and being a nurse leader. The literature indicates that gender has an overarching influence on the predominantly female nursing profession. Benevolent sexism often limits access to traditionally male-dominated roles such as leadership, especially in educational settings and research (Castner, 2019). Additionally, Castner argued that gender can hinder the career advancement of some nurses, as their technical skills and scientific knowledge may not receive the recognition they deserve.

Another gender-related influence on a decision not to follow a career pathway into leadership may be difficulty managing family obligations in an inflexible work environment (Al Sabei et al., 2018). While many nurses may be willing to take on leadership roles, family obligations can discourage some from doing so. As women, nurses often carry the added responsibility of being primary caregivers for their family members. This dual role can create

a significant barrier to pursuing senior positions, as they face competing demands on their time and energy (Delgado & Mitchell, 2016). Furthermore, Branden and Sharts-Hopko (2017) found in their literature review of 31 articles that the extra responsibility of leadership is compounded by a negative perception of an increased managerial workload without adequate compensation. However, those who were able to balance work/life conflicts foresaw a satisfying career trajectory (Basheer, 2020; Delgado & Mitchell, 2016). Al Sabei et al. (2018) also noted that gender was not a predictive factor of an RN's willingness to lead, with male and female RNs in their study having comparable attitudes towards accepting roles.

Differing cultural perceptions can create barriers to becoming and being a nurse leader. While there is an expectation that nursing as a feminised profession will provide leadership in the areas of patient experience and models of care, Taiwanese nurses interviewed believed that female nurses speaking up on behalf of patients or advocating for a service could be seen as confrontational (Bleich, 2015). To manage this binary perception, Bleich recommended developing strategies to be able to communicate in a fact-based, assertive manner. Swedish palliative care team leaders interviewed by Klarare et al. (2020) reflected that they utilised assertiveness skills for conflict resolution when consensus about care decisions was unable to be reached. However, cultural norms may make assertiveness difficult for some RNs. The impact of colonialism on Māori women has led to an expectation that they be humble in male-dominant settings. While cultural timidity is being replaced by a more assertive nursing voice and perspective on concerns (Bleich, 2015) this is not yet universal. Similar to other indigenous groups, Māori nurses may also have the additional pressures of cultural responsibilities impacting their leadership, which are not widely understood within their workplace (Walker et al., 2016).

James et al. (2022) viewed professional values as an important characteristic of nurse leadership, with tensions experienced between being a caring profession and the expectations of the work environment. In healthcare, negotiating traditional values and a modern way of working is challenging. Māori nurses can feel torn between organisational

expectations and their cultural responsibilities (Walker et al., 2016). Klarare et al. (2020) noted that their Swedish nurse cohort felt distressed at having to do more with fewer resources. This internal conflict between professional values and organisational priorities can result in decreased motivation and job satisfaction (Reyes et al., 2014).

Generational differences may affect whether an RN chooses to pursue a path toward becoming a nurse leader. Topola and Miller (2021) discovered that their cohort of final-year nursing students considered the study of leadership irrelevant, as they viewed nurses primarily as facilitators rather than leaders. The millennial nurses (1981-1996) in their research, had less desire to obtain political acumen or participate in leadership activities, preferring to seek affirmation from their patients. A literature review by Branden and Sharts-Hopko (2017) also noted generational differences in career goals with millennials believed to be more afraid of failure and more likely to consider other career options.

Failure to recognise and address leadership barriers jeopardises the long-term sustainability of strategic roles. (Elliott et al., 2016). Branden and Sharts-Hopko (2017) concluded that for many RN the barriers to leadership outweighed the enablers. The pathway into leadership for a registered nurse is not always clear or understood so may be perceived as unachievable. Only some of the doctoral-prepared nurses in a Netherlands study had linear career pathways, whilst others described quite varied career trajectories (Van Dongen & Hafsteinsdóttir, 2021). From my reading of the literature in this study, I conclude that the barriers to becoming a nurse leader are many and need to be addressed to make options for a leadership pathway clearer.

2.5.4 Factors found to enable effective leadership development

Several key factors were found in the literature studied that enable effective leadership development. These factors include role modelling and mentorship, having a clear vision, ongoing education, and leadership opportunities. When these elements are present, registered nurses (RNs) feel more empowered on their path to becoming leaders and in their roles as leaders.

Positive role models were seen as an important influence, providing motivation and inspiration for aspiring leaders (Delgado & Mitchell, 2016; James et al., 2022). Additionally, James et al. (2022) stated that RNs with negative nursing role models in their early careers felt motivated to embody the opposite in their leadership practices. Role models are especially valuable when they are representative of minority gender or ethnic groups as their achievement can empower others who see someone who resembles themselves (Banister et al., 2020). However, when there is an underrepresentation of women in leadership, role modelling, mentorship, and the culture of the organisation are negatively impacted (Castner, 2019).

Wilmoth and Shapiro (2014) believed trained mentors should be provided to work alongside new leaders. This was supported by De Lange et al. (2019), who added that there was a need for more mentoring programmes. Without mentors to help new leaders develop political acumen and think strategically they may struggle to manage the role successfully (Reyes et al., 2014). Inconsistency in the availability of mentoring was seen as a barrier to advancement as mentoring inspires confidence to progress and apply for higher positions (Branden & Sharts-Hopko, 2017; Van Dongen & Hafsteinsdóttir, 2021).

In Aotearoa NZ specific leadership training offered by Ngā Manakura Apopo aims to bring empowerment to Māori nurses beginning a career pathway by giving them the belief that they can lead. This bespoke programme provides role models and mentors from within Maoridom demonstrating what can be achieved as a Māori RN. Graduates of this programme have progressed further in a leadership career trajectory, taking on more senior roles or joining national forums and governance groups (Pipi et al., 2021).

With a change of healthcare focus from illness to wellness, leaders have the opportunity to do things more collaboratively (Brooks et al., 2014). Longmore (2020) commented in her article for the NZ nursing journal Kaitiaki that groups such as Aotearoa NZ National Nurse Leaders provide a nursing perspective to health decision-makers. As a collaborative strategic group, they are able to focus on key priorities for nursing. However,

leadership is not tied to those in formal positions. All nurses need to feel empowered to follow a leadership pathway in their areas of interest.

Although some nurses believed that postgraduate study in leadership was irrelevant to their practice (Topola & Miller, 2021), there was a consensus that ongoing education was essential (Enterkin et al., 2013; Reyes et al., 2014; Wilmoth & Shapiro, 2014). Nurses who had achieved Master's level and beyond were believed to have a broader understanding of leadership and were able to integrate systems and management concepts into practice (Brooks et al., 2014). Post-doctoral nurses were noted to show considerable progression in their leadership career trajectories and considered their career development to be a serious conscious process requiring vision and careful choices (Van Dongen & Hafsteinsdóttir, 2021). RN in two Netherlands studies who had achieved higher levels of learning saw themselves as leaders and supported others on their leadership journeys (De Lange et al., 2019; Van Dongen & Hafsteinsdóttir, 2021).

Self-belief in leadership ability can be enhanced by providing opportunities for secondment (Brewster et al., 2020; Delgado & Mitchell, 2016). Al Sabei et al. (2018) agreed that experienced registered nurses should be prepared for added responsibility by engaging them in activities that develop their leadership skills. Both Brewster et al. (2020) and Basheer (2020) noted that registered nurses (RNs) with transformational leaders received support in making decisions and exploring new learning opportunities. Fowler (2020) recommended providing opportunities for RNs to shadow other leaders, as this can help correct any misunderstandings about the complexity of different roles.

2.6 Literature Summary

This integrative review included 25 examples of literature relevant to the research question: five literature reviews covering 110 articles, four editorials, and 16 peer-reviewed articles (see Appendix One). The timeframe covered items published from 2013 to 2022. The literature came from a variety of source countries with different healthcare systems but showing similarities in issues concerning the four themes of succession planning,

perceptions of nurse leadership, barriers to a leadership career trajectory and enablers to attaining and sustaining a nurse leadership role. Additionally, the literature included a diverse range of nursing practice areas, an important factor as nursing leadership is not confined to institutions or government organisations. Multiple methods were employed to gather data, including surveys, content analysis, and interviews.

2.6.1 Scan of recent literature

As an addition to this research, I have used the same search strategy to scan literature for the period 2023-2025. I could not find any recent studies that addressed my research question or contradicted my findings. Pincha Baduge et al. (2023) commented on the significant barriers to career progression for nurses, due in part to the dearth of focused leadership training and the availability of mentorship programmes. This article recommended systemic level change in policy to overcome barriers to women leading, as well as the provision of leadership opportunities for emergent leaders early in their careers. The authors also commented on a perceived lack of confidence and assertiveness in women leaders. A lack of confidence among leaders was examined by Lartey et al. (2023), who observed that when leaders have a strong belief in their abilities, they tend to grow in confidence and aspire for additional leadership roles. Their article highlighted the existing shortage of nurse leaders and emphasised the importance of supporting nurse leadership development through well-designed training programmes aimed at enhancing self-efficacy.

Björk et al. (2025) argued that nursing education needs to change to better prepare nurses for the increasing complexity and ambiguity of leadership roles. Continuing education to the PhD level, intentional mentoring and strong peer support networks remain key factors in strengthening a pipeline of future nurse leaders (Ladden et al., 2025). This article added that although many organisations perceive leadership development as a one-time investment, it needs to be cultivated throughout a career trajectory for maximum benefit.

2.7 Conclusion

This literature review has explored some of what is known about nurse leadership to provide a foundation for the research question about the experiences of becoming a nurse leader in Aotearoa, New Zealand, in the 21st century. One of the goals of this chapter was to identify the methodologies and theoretical perspectives suitable for this study. A range of qualitative and quantitative methods were utilised in the literature I reviewed, reinforcing my decision to adopt a multi-method research approach. Many of the chosen articles highlighted gender-related issues, which prompted me to select a feminist deconstruction of gender framework to make sense of the research findings.

Barcellos Morcelli et al. (2023); Narvaez and Kovar (2024) argued that the provision of high-quality healthcare is dependent on knowledgeable and visible nurse leadership. Effective succession planning is essential to ensure a pipeline of nurses is available that reflects the sex, gender, and ethnic diversity of the New Zealand population. However, unless the work environment is favourable, the motivation and retention of nurse leaders may be challenging (Basheer, 2020). Therefore, organisations must develop strategies for attracting and training registered nurses to fill the predicted number of leadership vacancies.

In many ways, the perceptions of nursing do not always align with the actual work involved (Branden & Sharts-Hopko, 2017). There is often a conflict between professional expectations and societal expectations. Despite acquiring scientific and technical skills, nursing is still considered a feminised profession and is associated with caring and submissiveness. Unfortunately, little value is given to a nurse's unique body of knowledge (Castner, 2019). This lack of professional recognition affects recruitment and succession planning for leadership roles. Accordingly, nurse leadership is limited by failing to acknowledge its true value as a highly skilled and knowledgeable profession.

The literature seems to indicate that there is more to deter an RN from becoming a nurse leader than to inspire this career choice. Several barriers have been identified that may explain the reluctance among some registered nurses (RNs) to advance into senior roles.

These barriers can be cultural (Walker et al., 2016) or related to the gendered nature of nursing as a feminised profession, which often operates under a masculinist leadership style. Fowler (2020) found that many individuals perceive senior positions as being filled based on favouritism and gender bias, which creates a barrier to their career growth. Another barrier can be a conflict between organisational expectations and personal values (James et al., 2022). Nurses come into the profession desirous to care for people but are confronted by fiscal restraints and managerial responsibilities when they enter leadership roles. Also, a lack of quality opportunities to experience leadership in a supportive way may lead to frustration that deters others from following a similar pathway (Al Sabei et al., 2018). The literature review indicates that the environment or organisational structure in which new leaders are developing may need to be adapted so that they can reach their full potential (Al Sabei et al., 2018). This is particularly important to accommodate the varying expectations of different generations. According to Branden and Sharts-Hopko (2017), jobs that provide minimal financial compensation for additional responsibilities tend to be unappealing to those generations who prioritise work-life balance.

To enable an RN to become and be a nurse leader, it is essential for current nurse leaders of all ethnicities and genders to serve as positive role models. By exemplifying the aspirations and achievements attainable within the profession, current leaders can inspire and guide future generations of registered nurses. (Banister et al., 2020). Mentors are similarly essential to support emerging nurse leaders as they develop self-confidence in their roles. More RNs would be able to reach their potential if a supported pathway into leadership like that offered by Nga Manakura o Āpopo, including equitable access to post-graduate education up to and beyond a master's degree were available. Experiential opportunities such as secondments, which were seen as helpful to an emerging leader's development, are serendipitous and not offered to everyone.

A relatively small body of literature describes the experiences of nurse leaders in Aotearoa NZ. I could not find any research that has attempted to explore the role of gender in leadership trajectories, especially in the context of New Zealand. The experience of nurse

leaders worldwide was examined, and it was inferred that this data would also be relevant in a New Zealand context. However, I could not find anything that specifically answered the research question about the experiences of becoming and being a nurse leader in Aotearoa New Zealand in the 21st century. Therefore, this knowledge gap has not been adequately addressed and requires further exploration. The themes identified in this integrative review informed the development of the research questionnaire for phase one of this study.

I will now move on to further discuss the theoretical framework selected as appropriate for this research. As outlined in this integrative review, some of the barriers to becoming and being a nurse leader can be related to nursing being a feminised profession. In the following chapter, I have used a feminist deconstruction of gender lens to view the multifactorial issues that a nurse leader encounters on her career pathway.

Chapter Three: Theoretical Framework

3.1 Introduction

This chapter outlines the theoretical framework that underpins this research. I have used feminist theory, particularly a deconstruction of gender, as a lens through which to examine the shared experiences of nurses who have been able to become leaders in health services in Aotearoa. The key theorists that frame my arguments and discussion are Jacques Derrida, a philosopher who focuses on the theory of deconstruction for the theoretical constructs around masculine and feminine binaries and Ann Oakly, a socialist writer in the feminist field to further explore the binaries in the context of gender in the workplace. Rosabeth Moss Kanter, a socialist focusing on women in the workplace been used as a seminal author on the concept of a “glass ceiling” women may encounter when seeking leadership roles.

Research needs a purpose - to whom will the new knowledge be distributed and what outcome is expected (Allmark & Machaczek, 2018; Lynam et al., 2020). An emancipatory theory, such as feminist theory, can be used effectively within a multi-method qualitative study to explore issues concerning marginalised groups (Creswell & Plano Clark 2018). I considered nursing and nurse leadership to be a relatively marginalised group for the purposes of this study; therefore, using this theoretical approach would enable their voices to be heard by comparing different perspectives, allowing each set of data to build on the other. Feminist theory is founded on the principles of social justice, making it a valuable framework for generating the knowledge necessary to achieve social justice goals. For this reason, it was an appropriate theoretical foundation for the study, as effective nurse leadership empowers nursing to implement changes in the healthcare system for the betterment of Aotearoa NZ communities.

Bressan et al. (2017) stressed the importance of a solid theoretical foundation. The theoretical framework is derived from the literature and points toward what is hoped to be learned from the study (Creswell, 2022), and it shapes and directs the research. In a

qualitative study, the theoretical model can play several key roles. It can serve as the initial framework for framing the study, guide the data collection and analysis processes, and ultimately help in interpreting the integrated findings (Haynes-Brown, 2023). For this research, the theoretical model was applied as a lens to the data collected as it was deemed a “good fit” to the data, allowing for comparison and organising the data to increase its credibility (Evans et al., 2011). A feminist approach is suitable for this research because it provides the flexibility needed in studies where gender is a central focus. Feminist theory encompasses a diverse range of intellectual and philosophical viewpoints rather than presenting a singular perspective. It includes theories related to gender reform, resistance, and rebellion (Lips, 2018). By employing a feminist lens, researchers can gain deeper insights into gendered experiences and highlight existing inequities (Finn & Brown, 2022).

Many people, including myself, often mistakenly use the terms sex and gender interchangeably. According to Sullivan and Todd (2023), sex refers to a biological category related to reproduction and is divided into two binaries: male and female. On the other hand, gender is a concept that is culturally or socially defined and relates to personal identity, which may differ from one's biological sex. Gender can also be understood as a hierarchy of power and privilege as it is used to define social status and economic value by giving one group of people power over another group of people (Richardson, 2020).

Society imposes gendered expectations regarding roles and behaviours for each sex, which can create constraints or inequalities. Feminist theory analyses the everyday practices where people find themselves defined by gendered expectations and subject to discourses that define or marginalise them. Gendered expectations influence the experience of all nurses, male or female, throughout their careers (Burton, 2020; Royal College of Nurses, 2020). Furthermore, gendered expectations are ingrained in organisational thinking and decision-making (Durand et al., 2022) as will be explored later in this chapter.

Despite these gendered expectations affecting both sexes, women are particularly impacted because feminine attributes such as caring and compassion associated with their gender are often accorded less value (Cleary et al., 2019; Daly et al., 2005; Royal College of

Nurses, 2020). Nursing, which is predominantly a female profession, reflects society's views on the worth of women. Nursing and feminist scholars share some common beliefs, both arguing that patriarchal oppression has devalued caring and consequently nursing as a profession (Ferguson & Anderson, 2021; Group & Roberts, 2001; Mourão Netto, 2024).

Current feminist and social psychology research has examined the privileging of the masculine binary in organisational culture (Caffrey, 2023; Schwiter et al., 2021; Williams, 2015) and offers explanations for the experiences of people whose professional background is strongly derived from a feminine binary. By exploring the neoliberalist structures in which NZ nurse leaders operate through a gendered lens I gained context that helped me understand how the masculine and feminine binaries have impacted the pathways into leadership for this group of registered nurses.

3.2 Feminism and Gender

Feminist scholarship has developed steadily over the last 50 years, and the complexities and nuances of that scholarship fall outside the domain of this thesis. Exploring the development of feminist approaches to gender and gendered performativity, however, provides an essential lens through which to examine the broad context in which registered nurses consider and experience a leadership journey.

The first wave of feminism was blind to gender and focused simply on the right to vote as a critically liberating move from societal oppression (Hines, 2020). Legal and political equality were sought, but as only men could stand for positions of power, this change brought limited gains. It was 26 years after NZ women gained the vote that they became able to stand as parliamentary candidates, and 40 years following that when the first female member of parliament was elected (Coleman, 2020). The first wave honoured the self-sacrifice of heroine nurses as a feminine ideal, an image that ignored the realities of most nurses.

The second wave of feminism began in the 1960s with the advent of liberal feminism. Early Liberal feminism had a limited focus on gender and was mostly concerned with

differences on a biological or sex level. Liberal feminists argued that the physiology of women did not make them incapable of higher education (Weedon, 1996) and that biological sex did not mean that people should behave in a proscribed way (Power, 2020). Liberal feminism stood against sex discrimination that gave men an advantage based on the belief that family commitments would negatively impact women's job performance. However, the sexism that slowed social transformation was not eliminated by allowing women to work alongside men (Federici, 2021). The liberal feminist slogan that "girls can do anything" saw women begin to take up paid employment in the public sphere whilst retaining full responsibility for domestic work in the home. The notion of the double shift of work and home responsibilities (Durville, 2025; Friedman, 2015; Ward-Griffin et al., 2011) was born and has implications for women to this day. Certain occupations, such as nursing, became feminised and regarded as suitable for women.

The second wave of feminists revealed the socially devalued characteristics such as caring that had become the definition of feminine (Budgeon, 2014) and called for collective action against personal disadvantages in the patriarchy of the home and the workplace (Schuster, 2017). Second-wave feminists sought merely to loosen up the impact of sex stereotypes (Malka, 2007) so did not fully grapple with the social construction of gender. Instead, they focused on the differences in opportunities for men and women in private and public life.

From the late 1960's several different feminist viewpoints emerged. Radical feminists focused on essentialist notions of gender, believing these notions to be as immutable as biological sex. They argued that femininity is vastly preferable to masculinity as a way of being in the world and opposed the war-like tendencies often associated with men (Grant, 2021). Their emphasis was on health and healthcare, highlighting the impact and consequences of patriarchal and paternalistic views on women.

Marxist or socialist feminists viewed society as divided into two groups: the bourgeoisie, who held power and resources, and the proletariat, who must work to survive. They recognised class as a major source of oppression and had a more limited focus on the

social construction of gender. Within the proletariat, women were seen as being exploited as unpaid or casual workers both in the home and in the community (Lips, 2018).

Post-structural feminism emerged in the 1990s as a critique of binary constructions, such as reason versus emotion or mind versus body. Proponents argue that these binaries often assign superiority or power to one side over the other (Elliott, 2021). Language was understood as a means through which power and meaning were assigned to the constructs of femininities and masculinities. Power and knowledge were seen as mutually dependent, with each able to generate the other (Arslanian-Engoren, 2002). Post-structural feminists acknowledged the importance of language in expressing women's experiences, providing an alternative perspective to the dominant societal discourse. This new wave of feminists, such as Judith Butler, Hélène Cixous and Bracha Ettinger, examined how language gave meaning to the world they lived in and could give power to some whilst subjugating others. Assigning natural characteristics to binaries of masculinities and femininities gave certain attributes a significance that suited societal interests and power relations (Weedon, 1996). Weedon stated that patriarchy, and thus male hegemony, are unnatural states produced by a society that assigns superiority based on a set of assumed characteristics linked to biological sex. Butler (2006) agreed, adding that language could be used to create hierarchies of power that wouldn't naturally exist.

The foundation of post-structural feminism is the understanding that masculinities and femininities are social constructs that evolve and are specific to particular historical and cultural contexts. Post-structural feminists argue that the pressure to conform to the norms associated with these constructs is oppressive for both men and women. Patriarchy is seen as being internalised as stereotypes of what is appropriate behaviour for a girl, and the feeling that women are less than men (Stock, 2021). Advocates believe that gendered discriminatory practices must be made visible so that they can be addressed and corrected (Foss et al., 2019).

I would argue that post-structural feminism explains the source of our experience as nurse leaders and what needs to be changed so that nursing can thrive. Thriving nurse

leadership leads to better patient care (Barcellos Morcelli et al., 2023). As previously mentioned, nursing in 21st-century Aotearoa remains assigned to the feminine binary, so struggles with its association with docility and submissiveness when trying to advocate in leadership roles. This requirement to behave according to the expected norms has become embedded in nursing culture, and many nurses are unaware of their implicit compliance (Pincha Baduge et al., 2024). To address the research question concerning the experiences of pursuing and holding a nurse leadership position, it was important to analyse gender as one of the factors influencing career choices.

Feminist thinking continues to develop towards a more complex understanding of gender and how gender is constructed by society and assigned expected patterns of behaviour. Many feminist scholars now recognise the performance of gender as affecting every structure in our world, including healthcare. For nursing, the notions of gendered performativity and the operation of gendered binaries in the organisational structure have been powerful forces in shaping the experiences of nursing's relationship to leadership.

3.3 Masculinities and Femininities

The concept of masculine and feminine binaries forms the basis for the value that society places on different attributes. French Theorist Jacques Derrida (1981) argued that language was a tool that expressed meanings beyond the actual words and that meaning was temporary and contextual. Over time and in various contexts, the meanings of words can be deconstructed and analysed to yield different interpretations. When applying this concept to the terms "masculine" and "feminine," we find a pluralistic understanding of what each concept signifies during a specific period. This pluralism is intertwined with opposing contexts, such as dominant and subordinate binaries. The characteristics of the masculine binary are often seen and experienced as the dominant binary and are privileged. Conversely, the feminine binary is viewed as "the other", so marginalised or positioned in a subordinate role (Wiley et al., 2024). This is demonstrated by a historical bias that was inherent in healthcare and health research. Until recently, health research has predominantly

been undertaken on males, and the baselines from health research have provided what is considered normal based on a male model (Stock, 2021). Any deviations from this norm were not addressed for female patients. Relevant to this research, masculinities and femininities were seen to be binary opposites associated with certain qualities or characteristics.

Applying Derrida's thinking on time and context, we can see how the masculine binary has arisen from the public sphere of rationality, objectivity, and production. In contrast, the feminine binary became aligned with that which involved the body: private, passionate, and weaker. Therefore, men became associated with strength and authority while women (especially those who nursed or cared for others) became aligned with softness and submissiveness, particularly associated with the body. Accordingly, nurses acquired a feminine nomenclature from the Latin *nutrire*, meaning "to nourish" (Do Carmo Carvalho, 2016).

Physicians, who were predominantly men, assumed leadership in healthcare due to the belief that they possessed desirable masculine qualities such as self-confidence, assertiveness, and emotional restraint alongside their alignment with the mind through scientific endeavour. In contrast, nurses, as women, were expected to be quiet, graceful, and dependent and assumed to be without a body of scientific knowledge to inform their practice. The social and political construction of gender creates and justifies this inequality by suggesting that women should play 'feminine' roles and men 'masculine' ones, and by valuing the latter more than the former (Sullivan & Todd, 2023).

Leadership is expressed along a continuum from masculine, power-oriented to feminine, empowering styles within a gendered social context (Yoder, 2001). An alpha style of leadership, where power is used to achieve goals, is more aligned with the masculine binary. In contrast, a feminist collectivist leadership style that relies on relationships is seen as weaker (Grossman & Valiga, 2016). Women leaders face the contradiction of being expected to embody masculine and feminine traits at the same time, or face being unacceptable to the masculine status quo (Pullen & Vachhani, 2021). However, the

attributes often associated with successful leadership may be judged negatively when displayed by a woman leader (Harper, 2017).

This double bind means that women leaders may have to negotiate tensions between being viewed as competent and being liked. A more masculine leadership style may be adopted to “fit in.” However, the irony is that when women leaders adopt a more masculine style they are seen as less friendly and others are less willing to comply with their requests (von Hippel et al., 2011). Conversely, a feminine voice in leadership is distinct and reflective of different motivations (Webb Farley et al., 2021). A feminine leadership approach is generally non-confrontational and encourages wider participation. Hoss et al. (2011) concluded that the disparities between masculine and feminine traits must be acknowledged, but both traits used in a balanced manner within leadership to enhance organisational performance.

3.3.2 Gender and Neoliberalism

Neoliberalism is the dominant theology of modern life in many countries, including Aotearoa, and its basic tenets are currently widely accepted. Under neoliberalism, competition and individualism are accorded significant value. People are seen as bearers of skills and experience that can be put to productive use in a competitive market (Garlick, 2023). This has led to the emergence of a new class of capitalists who acquire assets for financial gain, widening the societal gap between the wealthy and everyone else (Monbiot & Hutchinson, 2024). Since its beginnings in the post-war era, right-wing politicians have implemented neoliberal policies to manage the economy. These neoliberal policies were first introduced in New Zealand by a Labour government in the mid-1980s. Neoliberalist policy gave dominance to financial markets over industrial production and led to the privatisation of many government entities and state assets (Barnett & Bagshaw, 2020; Monbiot & Hutchinson, 2024).

Efforts to commercialise healthcare were initially met with resistance. In the 1990s, a new national government embraced neoliberalist thinking and restructured the New Zealand

health system to address perceived inefficiencies (NZ Parliamentary Library, 2009). The changes made which were primarily based on the 1988 Gibbs report (Gibbs, 1988), separated the purchaser and provider arms of the health boards to establish a market approach to health care service provision. One of the impacts of the healthcare reforms was the separation of health professionals from decision-making, prioritising guidelines over clinical judgment (Barnett & Bagshaw, 2020). Health professionals who were motivated to provide quality care without considering cost came under fiscal management (Kumarasiri, 2015) while aspects of care associated with the feminine binary were commodified (White, 2004) and entered the market. Healthcare was evaluated based on cost-effectiveness and predetermined quality indicators, rather than focusing on the moral dimension of meaningful health interactions with shared goals. Healthcare changes have had a significant impact on the context in which nursing leadership is experienced and expressed. Accordingly, this context warrants further exploration as it is germane to the situation in which nurses both consider and experience leadership of health services or settings.

Despite the proven economic value of safe staffing models in reducing adverse events Connor et al. (2023), caregiving has not been assigned a monetary value and therefore is seen as unproductive (Lynch, 2022). Not all the services provided by RNs can be assigned a monetary value. Similar to how women in households perform a variety of "invisible" tasks, nursing also involves many "invisible" responsibilities that extend beyond direct patient care. Decision-makers overlook the important role that nursing fills, seeing nursing as a service profession performing routine tasks (Leary, 2017). These organisational tasks are not simply distractions from the primary duties of nursing; they play a crucial role in ensuring safe and efficient healthcare, as well as enhancing organisational effectiveness.

Allen (2014) argued that nursing should be recognised for more than just metaphorical roles, such as "glue" or "oil" in the healthcare system. Instead, nursing should be seen as a vital mediator among the diverse components of the healthcare system. The economic value that can and has been measured by improved quality of care through

reduced length of stay, lower infection rates and Nursing Care Sensitive Indicators (NCSI)¹ is often overlooked (Aiken et al., 2017; Griffiths et al., 2021). For these reasons, organisations have persisted in viewing nursing as a financial expense to be constrained rather than a resource that warrants investment.

Nursing was a target for many of the changes brought about under the new market approach due to it being the largest health workforce and therefore a big budget item (Finlayson & Gower, 2002). In a neoliberalist society, nurses are regarded as functional units of work (Power-Horlick, 2023). Those managing healthcare systems wanted to continue using nurses cost-efficiently with low wage costs and efficient shift systems. The perception of nurses as an infinite resource led to underinvestment and further undervaluing of nursing, despite nurses being involved in all aspects of healthcare delivery, enabling services to meet their financial and delivery targets (Jackson et al., 2024).

Cost containment has led to an increase in patient throughput, resulting in more services being delivered within less time allocated. According to a study by Aiken et al. (2017), two-thirds of hospital-based UK nurses reported not having enough time to talk to patients about their concerns. Additionally, Hogan and Drentea (2023) found that some organisations required their nurses to simulate caring through the use of scripted text and behaviours. This has created tension between a financially driven healthcare system and the ability of nurses to provide compassionate care.

A gendered neoliberalist view that caring is a natural skill for nurses, takes for granted and undervalues the emotional labour invested. Nursing's roots in gendered family life have led to the expectations of "emotional labour" both externally and within the profession. Emotional labour also involves the regulation of feelings, body language, and expression to match a socially acceptable image (Royal College of Nurses, 2020). These expectations mean that nurses work within an ambiguity of dual demands of compassion and meeting workload demands (Traynor, 2019).

¹ NCSI are patient outcomes influenced by nursing care that are used to monitor the quality and safety of patient care.

There is an intersection between hegemonic masculinity and neoliberalism, which has emerged as a prevailing discourse in healthcare governance, due to their shared behaviours. Characteristics that define success under neoliberalism, such as competitiveness and emotional control, are also linked with masculinist stereotypes. The Neoliberal environment has perpetuated and exacerbated existing hierarchies to the disadvantage of women. Consequently, individuals exhibiting masculinist traits are more likely to achieve leadership roles, resulting in unfair treatment when positions are not awarded based on merit (Harper, 2017). Organisational power in most healthcare institutions continues to privilege the attributes most clearly aligned with the masculine binary with hegemonic masculinity being an accepted practice (Lynch, 2022). Favouring the masculine binary reinforces the disconnect between the labour of caregiving, predominantly carried out by females and the market value of that labour.

Neoliberalist thinking places particular value on masculine traits such as reason and logic. However, it does not necessarily link these traits to nursing as a feminised profession. Leadership is viewed as rational and orderly, making the elevation of these masculine attributes essential for effective organisational management (Feenstra et al., 2023; Kanter, 1977). It could be argued that nursing and nurse leadership have historically held tenuous power in health organisational thinking and action. However, the dismantling of the leadership triumvirate of nurse matron, medical supervisor and hospital manager removed a degree of defined leadership for nursing (Hughes, 2013). The advent of generic managerialism (McCloskey & Diers, 2005) and the later changes to senior nurse responsibilities that came about through neoliberalist thinking had repercussions for nursing. These changes enabled the gradual chipping away at nursing autonomy and eroded control of nursing financial budgets.

New nursing leadership roles were established that varied between organisations both in title, financial responsibility and accountability, often reporting to service managers with limited healthcare experience (Gauld, 2003). Thus, nursing lost authority over much of its own affairs to a management system more focused on cost efficiency and management of

the bottom line. The connections between professional and operational accountability became unclear, as some clinical nurse leaders were held accountable to both professional and operational managers. As a result, nurse leaders were tasked with managing budgets and resources but had limited control over what was allocated to them (Hughes et al., 2018). The potential negative impact of this move was known decades earlier. In her influential work *Men and Women of the Corporation*, Kanter (1977) noted that individuals in positions without control over resources or political influence may experience an increased sense of lack of control due to being responsible for achieving outcomes they did not help define. In her influential work *Men and Women of the Corporation*, Kanter (1977) noted that individuals in positions without control over resources or political influence may experience an increased sense of lack of control due to being responsible for achieving outcomes they did not help define.

As a possible consequence of these changes to nurse leadership status, a more pernicious impact of neoliberalism can now be seen in the disregard of the nursing voice on issues concerning nurse shortages and safe staffing. With nurse leaders mostly in advisory positions, effective deployment and collaboration are difficult. Conflict can occur when non-clinical managers do not understand the clinical demand of those providing the health service. Ng (2022) found that there is a different emphasis on value in healthcare, with nonclinical managers prioritising efficiencies in resource allocation, while clinical leaders focus on what is most important for patients.

Nurse leaders know the vast body of evidence showing that their knowledge and clinical judgment enhance the efficacy of nursing practice and the safety of patients (Power-Horlick, 2023). However, a study by Saifman and Sherman (2019) revealed that nurse leaders felt they were being set up to fail due to increased workloads and being removed from decisions they considered significant. Whilst committed to their leadership role the group of millennial nurse managers in that study regarded their roles as complex with competing priorities. As the provision of quality healthcare continues to be a motivating factor

for people entering nursing, many nurses choose to remain in clinical nursing as they perceive leadership roles to be time-consuming and powerless.

The implications of nursing being viewed as a feminised profession are pervasive and seldom acknowledged. Nurses seem reluctant to challenge the assumption that they are merely enablers of others' clinical judgements (Leary, 2017). Racine and Vandenberg (2021) believed that a neoliberal environment reinforced anti-intellectualist thinking in nursing. Although not well researched, a disdain for those in leadership positions or educational settings has become widespread within the nursing culture and impacts a leader's ability to influence. Practical skills and knowledge are valued more highly than critical thinking or research. The danger of anti-intellectualism is that nursing could be reduced to a task-based function in times of minimal staffing, further devaluing the nursing role.

Although health care in Aotearoa still operates as a taxpayer publicly funded health system based on the Beveridge model, over time the outputs and outcome requirements of the government of the day have and continue to change. The focus on financial accountability has resulted in negative consequences for the social responsibility of the healthcare system (Kumarasiri, 2015). In March 2024, the NZ government introduced health targets as part of its direction for the health system. These targets were not initially legally mandated but hierarchical pressure was applied for them to be achieved within six years. In June 2025 the Minister of Health, Simeon Brown, announced legislation that would enshrine these health targets in law, locking in accountability for all health strategies to give effect to these targets (Brown, 2025). Although health targets may be a positive driver for innovation and collective creative thinking, negative behaviours may also arise, detracting from the quality of care delivery (Tenbensen et al., 2016). Government policies leaning towards neoliberalism have escalated pressure on social and healthcare services worldwide, leading to unfair treatment of lower socioeconomic groups (Young et al., 2017). As a result, the human aspect of healthcare appears to have been disregarded in favour of financial efficiency. People are seemingly expected to take charge of their own health as consumers of healthcare services and products (Young et al., 2017). However, many individuals lack the

resources to make independent healthcare decisions, leading to increased disparities. When healthcare providers struggle to meet the health needs of their patients, it can create a sense of ethical distress. The frustration of wanting to help but feeling limited can weigh heavily. In this challenging environment, nurse leaders must navigate their career pathways whilst holding on to their core values and aspirations.

Nursing's historical legacy of self-sacrifice has added to how it is viewed as a career pathway (Racine & Vandenberg, 2021). Nurses are socialised to be "nice" alongside the docility and compliance expected of the profession. Speaking up or raising concerns can be seen as contrary to this expectation and suppressed, even by other nurses, to maintain the status quo. Thus, "niceness" has become a gendered tool to suppress the voice of nurses, even on critical issues such as safety (Jackson, 2022). Jackson speaks powerfully of the tyranny of such niceness because it acts to silence nurses in multiple fora. This culture inhibits nurses from accepting politicised professional leadership or challenging decision-making that conflicts with nursing values.

During the COVID pandemic, nursing was thrust more into public view. Unfortunately, the framing has remained as a caring profession associated with feminine characteristics of selflessness and compassion, not professional scientific knowledge (Carryer, 2020). At the height of infection, a lack of nursing resource alongside an increased workload meant a return to task-based nursing, reinforcing society's views of nursing as being more a physical than an intellectual profession. Employers assumed then (and still do) that nurses would persevere through the challenging times (Power-Horlick, 2023). Media continue to play a powerful role in their selective reporting of "gender appropriate" news items about nurses, whilst almost always associating doctors with science, leadership and decision-making (Gill & Baker, 2021; Mourão Netto, 2024). Nurses both individually and as a collective often reinforce this stereotype by behaving in a way that is expected of them (Royal College of Nurses, 2020; Van der Cingel & Brouwer, 2021).

The leadership trajectory of Aotearoa NZ nurses raises many issues central to feminist thought. The social perception of nursing as an extension of natural feminine

attributes is further compounded by the close proximity to medicine which enjoys entirely different societal expectations strongly associated with the masculine binary. I will now explore how the historical relationships of the two major professions in health care have impacted the current positioning of nursing and medicine.

3.3.3 The History of Gender Impact between Nursing and Medicine

Feminist deconstruction of binary thinking offers nursing an explanation of the hegemonic position in which it is situated in relation to medicine (Carryer, 2022). The binaries of masculinities and femininities are carried into the health setting through the persistent association of medicine with masculinity and nursing with femininity.

Predominantly male medicine and predominantly female nursing have a long history of strained relations. Although medicine and nursing work closely together, they are often perceived by each other as adversaries (Price et al., 2014). Any overlap in traditional functions, e.g. nurse practitioner (registered nurses who have expanded their role into previously medical territories), is seen as a threat (Adams, 2021). Historically, healing was a woman's role, but since the development of medicine as a commodity, it has become an enterprise in which men have taken the dominant positions. Even in situations where doctors are not predominantly male, the masculinities associated with medicine persist, and nurses and nursing knowledge are considered subordinate.

Michel Foucault identified the origin of medical power as flourishing from the 17th century as one of the "disciplines" (Foucault, 1981; Pritchard, 2017). Whilst the sex balance in medicine has altered significantly, medicine as a discipline remains aligned with the masculinist paradigm through its connections to mind, science, and rationality. As such, medicine is accorded a hegemonic leadership status. Throughout history, physicians have monopolised the management of healthcare and the role of healers. Physicians gained control over who could legally treat the sick and prescribe medications, bringing other healthcare professions under the authority of medicine (Pritchard, 2017). Providing medical care outside the family was not initially accepted by society, and women were often

ostracised and punished for doing so without the supervision of a physician. This image was transformed during the Crimean War when nurses became portrayed as physicians' assistants at the bedside of the sick and dying, overlooking the many other important tasks nurses perform. Nursing became established as subordinate to the male profession of medicine and was allocated more emotional, feminine tasks (MacMillan, 2012). Consequently, medicine has become synonymous with treatment and nursing with the provision of physical and emotional care. Therefore, from a neoliberalist economic perspective, medicine as a provider of treatment can acquire funding linked to specific outputs, whereas the act of caring does not have the same quantifiable outputs.

Because medicine held an undisputed position as the voice of authority for patient care, nurses were positioned as their servants (Lotan & Taiar, 2019; Price et al., 2014). Medical and administrative hierarchies created a cheap apprenticeship style of training for nurses, with physicians often as teachers of the scientific knowledge they thought necessary for nurses to acquire (Racine & Vandenberg, 2021). As nursing began to seek more autonomy and collaboration, physicians argued that nurses were abandoning their call to caring because of their desire for more recognition (Larson, 2012). Historically, physicians have often feared that knowledgeable nurses could challenge their authority, leading them to exert control over nurse training to maintain their dominance in the healthcare hierarchy (Bullough & Bullough, 2020). Whilst this control has been entirely removed, medicine still seeks to control nursing by obstructing developments at the medico-legal and regulatory levels (Pritchard, 2017).

An example of medicine attempting to control nursing is the lengthy battle to establish the nurse practitioner (NP) role. Prior to the advent of NPs, nurses did not formally provide diagnoses and were not employed for the treatment of patients, as this realm belonged to the masculine domain of medicine. NPs, by the nature of their role, traverse the traditional binaries of medicine and nursing and do not conform to the societal expectation of the traditional nurse. As such, they represent a challenge to the “natural order” and globally have been the subject of significant medical resistance and fearmongering (Pritchard, 2017). NPs

exemplify nursing clinical leadership designed by nurses, aiming to provide efficient and equitable healthcare for New Zealanders, regardless of the gendered socialisation within the profession.

The status of nursing as a feminised profession has been reinforced not only by neoliberal ideologies but also by its close working association with medicine. This dual influence creates a substantial impact wherein gender-based perspectives play a significant role. As Carryer (2022) argued, the persistent marginalisation of nursing knowledge and leadership can be most effectively understood through a feminist post-structuralist lens that analytically examines gender and gender performativity. Therefore, this type of theoretical framework is an appropriate tool for this research.

3.4. Relevance of Feminism to Māori in Nursing and Health Settings

This research is situated within the context of nursing in Aotearoa. Therefore, during my inquiry into feminist scholarship, I was intrigued to discover how Māori scholars perceive feminism. I spent some time in discussion with my cultural adviser to understand the difference between a Te Ao Māori viewpoint and that of the Western literature I was reading. From this further study, I came to a new perspective on how the role of women and the act of caring was viewed through the eyes of tangata whenua in Aotearoa. This allowed me to analyse the data from Māori participants in a more enlightened manner.

Initially, NZ feminism was imported from a northern ideology that did not match the experiences of Aotearoa NZ women, particularly Māori women. Literature regarding early Māori was written from a colonialist viewpoint and embedded misogynistic ideas of sex or gender. Māori women have a very different perspective of their precolonial status than that reported by pakeha males (Irwin, 1992). Precolonial Māori women were not treated as possessions but had sexual autonomy and were featured as equals in all aspects of life, as the survival of the whole was dependent on everyone (Mikaere, 2022). A colonising discourse impacted the way Māori women were viewed and marginalised them within society (Pihama et al., 2019). Early colonists perceived the autonomy of Māori wahine as a sign of

immorality and a lack of discipline. Since authorities dealt only with men, Māori women leaders were often overlooked (Mikaere, 2022). There have been many powerful Māori women leaders who have had an impact on Māori society, yet through subjugation by the dominant colonialist social structure have had their stories made invisible (Irwin, 1992). These leaders included those holding positions of military or political significance (Pihama et al., 2019).

In the early 1900s, a "by Māori for Māori" health service was envisioned, but cultural differences and racism created barriers to its success (Wood, 2022). Some Māori nurses were able to navigate the Pākehā-dominated health system despite the widespread perception that they were less efficient. Aotearoa has produced many outstanding Māori nurse leaders who serve as role models not just for Māori, but for all nurses. Notable figures include Ākenehi Hei and Dr. Irihapeti Ramsden. Emerging Māori nurse leaders seek to identify role models for their leadership styles and may find that Western leadership approaches do not resonate with the essence of wairua in their roles (Wiapo & Clark, 2022).

Many Māori women found it difficult to connect with Pākehā feminists, whom they saw as a privileged group defining them from colonialist perspectives. Mana Wahine has been adopted as a theory that affirms the mana of Māori women both individually and collectively. This theory provides clarity around the impact of colonisation and oppression, where Western feminism has proved inadequate (Pihama, 2020). Mana Wahine Māori focuses on describing the forms of oppression encountered and celebrating the resilience of Māori women. Māori women must challenge colonial ideologies of gender that deny the importance of their many roles. Mana is enhanced by collective relationships that support Māori women to perform certain functions and fulfil obligations. Similar to women of colour feminists, Mana Wahine do not necessarily want liberation from their traditions or community and can perceive 'women's' rights" as having a preoccupation with colonialist culture (Tong & Botts, 2018).

Palmer and Masters (2010) commented on the double disadvantage of being both female and Māori in a non-Māori environment. Colonised behaviour requires Māori women

to be whakaiti (modest and humble) in male-dominated settings. This creates an internal conflict when dealing with males older than themselves to achieve goals. However, some Māori women do feel empowered to speak when they feel called to do so and are protected by their mana and tikanga in this action. Unfortunately, this does not always occur in a healthcare environment. A Mana Wahine Māori viewpoint challenges Māori women to preserve the mana of women in a changing cultural context and see their traditional role as a source of strength (Irwin, 1992).

Māori women as a whole are economically disadvantaged (Ministry of Women, 2020), which impacts their ability to pursue further education or make risky career choices. Other factors influencing a Māori woman's career choices include their iwi affiliation, rural location, adherence to tikanga, and place in her family (Irwin, 1992). Indigenous registered nurses in New Zealand often come from backgrounds of educational and financial disadvantage, which means they may lack role models in their immediate whānau who understand the importance of focused study. Also, many indigenous nurses enter nursing at a later age and are likely to have family and community obligations, which can act as a barrier to further education. Their learning may also be compromised by a lack of whānau understanding of the work demand (Wilson et al., 2011). Komene et al. (2023) commented that Māori nurses felt that their cultural integrity could be threatened by the extra burden of caring for whānau as well as an assigned workload. They also believed that the expectation for indigenous nurses to take on additional responsibilities without compensation compromised their mana as Māori women.

Mana wahine moves beyond gender issues and colonial definitions of identity with its dualities of masculinities and femininities (Pihama et al., 2019). The nurses in this study identified first as Māori and second as a nurse. Māori nurse leaders are guided by a set of values and collective mentality that encompasses everyone so that all people benefit (Tipene, 2017). Mana is the essential essence of Māori nurse leadership, providing confidence as well as the ability to inspire and motivate others (Winiata, 2012). I would argue that for a Māori RN, building and preserving mana is an important factor in becoming and being a nurse leader.

3.3.1 Gender in the Workplace

Understanding the relationship between gender and sex within socialised binaries is crucial for comprehending their impacts on nursing and nurse leadership. Historically, women's careers have been significantly impacted by gendered perceptions of their appropriate roles in both the workplace and the home. Cultural and societal expectations that a woman's primary role is to attend to domestic duties restrict career aspirations and access to leadership positions (Pincha Baduge et al., 2024). In this context, nursing has faced limitations in its potential due to its perception as a feminine and caring profession.

Women were expected to care for the sick and infirm in their families. Historically, hospital management saw hospital nurses as substitutes for those who would have cared for the sick at home. Since these women at home would also attend to household chores, it was presumed that it was the role of nurses to do the same (Bullough & Bullough, 2020). Therefore, it became part of the nurse's role to attend to domestic duties such as cleaning, mending and laundry within the health service environment.

Although norms change over time and vary by location, there are persistent overarching gendered expectations. Western society often divides economic activities based on gender, with roles ranging from exclusively masculine to exclusively feminine. Males are more likely to be employed in high-prestige, high-income positions, while domestic work is mainly performed by women and tends to be less well paid (Manatū Wāhine Ministry for Women, 2023). This division of labour activities has been largely influenced by myths surrounding physical strength and the perceived demands of parenthood (Oakley, 2015). Feminists in the past have exposed the social devaluation of feminine characteristics such as caring, but failed to use domestic work as leverage against the disadvantage caused by patriarchy in the workplace (Budgeon, 2014).

The concept of masculine and feminine binaries forms the basis for the value that society places on different personal attributes. Characteristics associated with the masculine binary tend to be more privileged and highly valued in terms of authority and monetary

compensation. In direct contrast, those characteristics associated with the feminine binary are often overlooked and less well-paid. Busch (2018) theorised that there was a causal link between the feminisation of an occupation and a cultural bias that afforded less value to the work of women. Thus, attributing a gender stereotype to an occupation or role impacts on the status and remuneration of that role. Within the context of the gendered binaries, society still sees nursing as women's work, an extension of the role of wife and mother.

Feminists did not initially seek to eradicate the masculine-feminine binary but to lessen the impact of gender stereotypes (Malka, 2007). Recently, post-structural feminists have sought to deconstruct gender binaries. However, their scholarship has not yet significantly impacted organisational structures and processes. Hegemonic structures continue to constrain the advancement of nursing scientific and experiential knowledge (Sochan, 2011) while gender bias is perpetuated even by senior women professionals (Faniko et al., 2017).

Fletcher (2006) believed that the status of women in a society directly impacts the status of its nurses; that the experiences of nurses and women are intricately connected. Nursing often reflects society's expectations for feminised professions, and as a result, it is undervalued and disenfranchised. Rafferty (2018) commented on a frequently asserted public perception that nurses do not need to have degrees but only natural attributes such as kindness. Just this year, a Member of Parliament (MP) giving a speech in parliament referred to the need for nurses to have some skill and a big heart (Carryer, 2025). In line with dominant perceptions of femininity, the value of nursing is often seen as purely providing hands-on care (nurturing) and performing tasks requiring little clinical judgment (thus associated with the body, not the mind). The language used in this work, such as 'common sense,' reinforces the perception of nursing as a practical but not particularly intellectual endeavour.

The sources of power in our health systems may hold limited views of the economic value of the work nurses perform if they associate it with feminine binaries of selflessness, domesticity and caring. The Royal College of Nurses (2020) commented that the identity of

nursing is still being undermined by outdated societal beliefs and the failure to recognise its critical role in society. As a result, social perceptions of nursing as a profession are shaped by cultural and social constructs (Gill & Baker, 2021b), which are closely tied to views on women and their roles in the workforce.

Gendered expectations have an impact on nurses regardless of their sex. Men in nursing must navigate their masculine identity within a profession synonymous with femininity. Historically, there were groups of men, such as monks, Knights Templar or male attendants, who cared for male patients (Bullough & Bullough, 2020). In NZ hospitals as late as the 1980's there were unregulated men employed to attend to the personal needs of male patients, such as shaving and urinary catheterisation. However, in the Western world, only one in ten registered nurses currently identifies as male. Assumptions of effeminacy and same-gender attraction may marginalise men who enter the profession. The influence of patriarchy has shaped assumptions about male nurses and the type of care they should or should not provide. Cultural expectations of masculinity mean male nurses are more likely to emphasise technical elements of their career choice rather than a desire to care for or help people (O'Connor, 2015).

Hegemonic masculinity makes it easier for nurses identifying as male to access nurse leadership roles (Royal College of Nurses, 2020). Initially, men may face a loss of status by undertaking what is traditionally seen as women's work, however, they can later benefit from gender power networks, often referred to as the "glass elevator," to advance into leadership roles (Daly et al., 2015). Santos and Amâncio (2019) believed that male nurses distanced themselves from their female colleagues by using strategies aligned to the masculine binary to raise their status in the profession. Mao et al. (2021); Santos and Amâncio (2019) also found that male nurses used their masculine privilege to overcome barriers to professional growth. In contrast, a systematic review by Lyu et al. (2022) discovered that while men in nursing may have advantages in terms of career advancement, they also face negative effects of gender stereotyping, such as being expected to perform tasks seen as related to the masculine binary, like manual handling or managing aggression. Also, self-perceptions of

gender-affirming roles may limit male nurses to certain specialities in which the practice is considered less feminine, such as emergency departments, operating theatres, and managerial positions (O'Lynn et al., 2020).

Conversely, female nurses seeking career advancement may encounter what has been termed the “glass ceiling”, where advancement is inhibited due to the gendered expectations of their sex. The term “glass ceiling” refers to the social beliefs about women's leadership abilities that are prevalent in society and reflected in its organisations. These beliefs create distinctions between sexes regarding their capacity to perform organisational tasks, resulting in women having less freedom to express their leadership styles compared to men (Harper, 2017). Kanter (1977) commented that if women believed their chances for upward mobility were low, they were likely to disengage and withdraw from responsibility. This disengagement may be one reason that leadership positions receive few applicants. Anecdotally, some female nurses actively promote their male colleagues for leadership roles but do not apply for these positions themselves, as they feel the roles are already predetermined.

Van der Cingel and Brouwer (2021) argued that historical gendered perceptions of nursing have hindered the profession's development as a diverse and autonomous practice. These societal views are reflected in healthcare, where oppressive practice environments that devalue the feminine attributes of nursing have made nurses feel inferior, thus limiting their potential (Daly et al., 2015). New generations of nurses expect their workplaces to be supportive and accommodating (Dyess et al., 2016), which means they may be less attracted to leadership roles if they perceive a lack of support for career advancement. Views on gender roles concerning women in the workplace and at home have historically impacted their careers and created barriers to career advancement (Katuna, 2019). While nursing has struggled with its associations of femininity, the context for healthcare delivery has become increasingly hostile to this feminine binary, particularly with the advent of neoliberalism.

3.5 Summary

In this chapter, I have outlined the theoretical framework that underpins this research, which employed a feminist deconstruction of gender to explain how constructions of gender have impacted the socialisation of nurses and the social perception of the profession. Feminist scholars have a long and comprehensive history of progressive exploration of the relative positioning of men and women. For this thesis, I have utilised only the more recent scholarship which has particularly focused on gender and gendered performativity and moved well beyond notions of equality between men and women.

Using Derrida as a reference point I explored the social constructs of masculinities and femininities as binary oppositions, which in this thesis have been used to locate nurses as belonging to the feminine binary and leadership as a largely masculinist attribute. I then moved on to discussing how nurses are socialised as women and the devaluation of work typically associated with femininity. Drawing on the foundational ideas of Oakley, I explained how Western society assigns work roles based on gender, giving more value in terms of status and pay to masculine roles.

Neoliberalism reinforces the belief that attributes belonging to the masculine binary are to be favoured over those belonging to the feminine binary. In this section I examined the environment in which nurses attempt to become and be leaders in Aotearoa. Neoliberal efforts to commercialise healthcare to gain efficiency have undermined nurse leadership, holding them accountable for decisions beyond their capacity to influence, through being sidelined to advisory positions.

The leadership trajectory of Aotearoa NZ nurses raises many issues central to feminist thought. The social perception of nursing as an extension of natural feminine attributes is further compounded by the close proximity to medicine which enjoys entirely different societal expectations strongly associated with the masculine binary. I further explored how the social constructions of masculinities and femininities have set medicine and nursing as binary opposites of cure versus caring despite the evidence that nursing has

and continues to encompass both. Medicine has retained its dominant position with nursing as subordinate, despite nursing being the larger healthcare workforce and the increased numbers of men now entering nursing. Although public perception of nursing has altered over time, the privileging and power of medicine over nursing continues, especially concerning financial recompense and social status. As such, nurse leaders in NZ find themselves in a challenging context.

The final section explored the relevance of feminism to Māori in nursing and health settings. I explained the difference between a Te Ao Māori viewpoint and the Western perspective on the role of women and the act of caring. A colonising discourse has impacted how Māori women are viewed and has created additional challenges for Māori nurses seeking leadership positions in healthcare organisations.

Three main reasons guided me to use a feminist deconstruction of gender framework for this research. These reasons were: to frame the study by showing how gendered socialisation shaped the participants' career choices, as a lens to guide the data analysis which highlighted the impact of the masculine/feminine binaries, and to help explain the integrated findings. The next two chapters will describe the methodology and method that formed the structure of this research. A feminist deconstruction of gender lens was used together with a pragmatic philosophical framework in the gathering and analysis of the data collected to answer the research question.

Chapter 4: Methodology

4.1 Introduction

In this chapter, I will outline the methodology used to answer the research question: “What are the experiences of becoming and being a nurse leader in Aotearoa NZ in the 21st century”? Research decisions needed to be anchored to a methodological framework to ensure that the study meets quality indicators such as credibility and transparency (O'Reilly et al., 2024). Not all qualitative studies can be categorised into traditional research disciplines or fit specific typologies (Polit & Beck, 2022). Different methods can be used to explore a question; in this research, an exploratory descriptive survey is used together with in-depth interviews. This research was thus conducted using a multi-method qualitative approach.

4.2 Philosophical Positioning

A philosophical position, paradigm or worldview can be defined as the belief system that the researcher utilises to underpin the research. Scholars in the field describe methodology as using philosophical assumptions to guide both data collection and analysis (Creamer, 2018; Creswell, 2022). The most common philosophical assumption underpinning multi-method research is pragmatism, a stance that embraces multiple viewpoints or paradigms (Andrew & Halcomb, 2009). Pragmatism is pluralistic and orientated to what is most effective (Dawadi et al., 2021). Because pragmatism is not uniquely connected to any particular methodology, it is applicable in many contexts (Morgan, 2014). As such, it provides a solution that strikes a balance between different research paradigms (Doyle et al., 2016). Pragmatism emphasises finding practical solutions that work best for the research question (Creswell, 2022; Pole, 2007), with knowledge being acquired through a combination of reflection and action (Tashakkori & Teddlie, 2010). Throughout the research process, a pragmatic researcher adjusts their position based on the research outcomes and may modify their beliefs in light of newly acquired knowledge (Schoonenboom, 2019). In practice, this

means using quantitative data to derive objective findings and qualitative to help understand the situation (Dawadi et al., 2021).

A pragmatic approach to a research study seeks to understand experiences as the interaction of our perceptions and our actions (Morgan, 2014). This philosophical approach holds that knowledge is acquired through experience and can be unique to an individual or shared within a group. Pragmatism emphasises individuals' experiences and their connections in a societal context (Murry et al., 2023). Therefore, using a pragmatic paradigm for this research enabled the focus to remain on the respondents' experiences on a leadership trajectory, in the context of the Aotearoa NZ nursing environment.

According to Creswell and Plano Clark (2018), two other paradigms are suitable for the use of more than one method - the transformative emancipatory and the critical realist perspectives. The transformative approach is based on social justice and considers ethics and values in society from multiple viewpoints (McKenna et al., 2021). On the other hand, critical realist researchers use a stratified framework to analyse social phenomena, to better understand complex social behaviours by seeking causal processes (Schiller, 2016). I chose pragmatism rather than these approaches because pragmatism would allow the research question to guide the methods used and give greater flexibility, allowing for a more emergent study design.

Different non-eurocentric paradigms have also been recognised and used successfully. Some examples of these worldviews are the Asian Ying Yang, the Pacifica Fongafale, and the Aotearoa He awa whiria (braided rope). Indigenous philosophies such as these offer distinct ways of thinking that can provide fresh perspectives for integrating multi-method approaches (Martel et al., 2022). Creswell (2022) put forward the stance that there is no recommended paradigm for methodologies that use more than one method. Researchers should be free to use the worldview that best informs their study context and design.

Some research approaches can embrace a combination of different ontological and epistemological views (Ghiara, 2020), meaning that in some research, more than one paradigm is evident. An example of this would be the respectful integration of indigenous

research paradigms to add a different perspective to a study (Martel et al., 2022). While flexibility for the worldview to shift with different methods is important (Creswell, 2022), multi-method research, unlike mixed methods, generally adheres to a single viewpoint (Halcomb & Hickman, 2015). This research has used a single pragmatic philosophical approach.

The paradigm adopted by the researcher influences their interpretation of the data (Hall, 2020). Pragmatism accepts that the concept of truth is influenced by our beliefs and by the context in which it is sought. Therefore, there can be no completely accurate representation of knowledge, but truth based on agreement (Mayumi & Ota, 2023). A researcher's background and upbringing can also have a significant impact on how they approach their research. For instance, I realised that I might have been influenced by Western post-colonial ideologies, which could lead me to unconsciously select methods or methodologies that overlook the perspectives of individuals from other cultural backgrounds. Additionally, any socialisation and exposure to certain theoretical perspectives, such as feminism, can guide the way research is conducted, whether used as a theoretical framework or not. The researcher's socialisation can also affect their selection of participants and sample size. There was a risk that my personal biases, such as those based on race, gender, or power dynamics, could influence how I represented the participants' responses. To address this concern, this thesis explains the importance of reflexivity as a countermeasure against researcher influence.

In conclusion, using a pragmatic philosophy for this multi-method qualitative study enabled me to examine my respondents' experiences and the actions they took to achieve their leadership goals within the societal context of nursing and neoliberalism. New knowledge was gained through the interaction of their beliefs and actions in their specific circumstances. Pragmatism supported the methodology used and the theoretical assumptions underpinning the study.

4.3 Multi-method v Mixed Methods

Attending the 2019 Australasia & Pacific Regional Mixed Methods International Research Association Conference *Expanding Conceptual and Methodological Boundaries* inspired me to explore using multiple methods for this research. Whilst there have historically been criticisms against mixing methods in research, current shifts in thinking now believe that being able to accommodate data from different sources enables a deeper understanding of that data (Creswell, 2022; Tashakkori & Teddlie, 2010). Denscombe (2014) agreed, noting that by integrating different methods, researchers can gain a more complete understanding as it enables comparisons from different perspectives.

I found many articles I was reading confused between mixed-method and multi-method methodologies. Peez (2024) called his systemic review of the use of Mixed Method Research a multi-method study, yet defines this as research that combines both qualitative and quantitative data. Polit and Beck (2022) defined Mixed Methods research as the intentional gathering of quantitative and qualitative data in a study as a practical measure or to avoid the limitations of a singular approach. Multi-methods, like mixed methods, is a research process that integrates various data collection and analysis approaches. The key difference is that mixed methods use both quantitative and qualitative data, whereas multi-method studies use only one (Plano Clark & Ivankova, 2016).

Researchers who use multi-method approaches intentionally employ various strategies to explore complex issues. In a multi-method design, two methods from the same research paradigm are utilised to complement each other or to address different questions (Hesse-Biber et al., 2015). Each method can carry different weight or be weighted equally. In this research, an equally weighted dual qualitative design is employed, which helps to provide a clearer explanation and deeper understanding of the primary findings.

A qualitative multi-method approach can incorporate various techniques such as interviews, observation, focus groups, or open-ended surveys. Similarly, a quantitative multi-method approach might involve utilising data from multiple quantitative sources. Van Dongen

and Hafsteinsdóttir (2021), in their descriptive qualitative research, gathered curriculum vitae from respondents to collect demographic data and gain insights into their careers before conducting interviews. Similarly, Patterson et al. (2020) characterised their study of nurses in academia as a qualitative descriptive study, employing both group and individual interviews along with an open-ended questionnaire. Kasymova et al. (2021) used a research design similar to that used for this research. They referred to their study as a mixed methods design exploratory study, employing both an online survey with a free text section and follow-up qualitative interviews.

Although some of the data in the descriptive survey was quantified, the research reported in this thesis remained a qualitative study. As will be described in the method chapter, two complementary methods were used from the same paradigm, in two sequential phases.

4.4 Rationale for Using the Chosen Design

My rationale for using a multi-method qualitative design for this study was to gather data from several sources and combine them to improve the effectiveness of the research. A multi-method qualitative study was pragmatic for the time and place of the research. As will be further explained in Chapter Five, a global pandemic and staff shortages added difficulty to data collection by limiting the availability of nurse leaders who met the criteria. The use of a descriptive questionnaire enabled data to be gathered in the respondent's own time and place. The interviews that followed in phase two adhered to a preferred Aotearoa tikanga of face-to-face conversations, even though many of these were of necessity conducted online.

A qualitative approach is useful when the researcher wishes to collect information directly from those whose experiences form the study. Additionally, using description in a qualitative design acknowledges the subjectivity of participants' experiences and presents the findings as they are reported (Bradshaw et al., 2017) thereby providing clear descriptions of experiences and perceptions (Sandelowski, 2010). In this study, the first phase - an exploratory descriptive questionnaire was used to explore the characteristics of the participants to compare commonalities and differences in experiences. The interviews in

phase two of the study focused on the meaning of the experiences of the respondents by systematically using the selected method to help understand the context and personal lived experience (Klassen et al., 2011).

An exploratory literature search revealed various methodologies employed in health and nursing research. Topola and Miller (2021) utilised a similar research design by first conducting an online survey that included descriptive statistics. The outcome of their survey was then used to formulate focus group questions, allowing for a deeper understanding of their research topic. Brickley et al. (2024) used an environmental scan survey followed by online workshops in their multi-method study into general practitioner professional development behavioural change. Open-ended free-text questionnaire responses have been recognised as valuable data sources in qualitative studies (Kim et al., 2017). In particular, online open-ended questions can gain responses over a wide geographical area (Seixas et al., 2018). These examples demonstrated how other researchers were successfully using a multi-method methodology.

Qualitative study design often evolves while the study progresses, as the researcher makes decisions based on what they are learning from the data (Polit & Beck, 2022). In a multi-method study, data collected in one phase can and should inform the next phases. Data from each step in this study was used to develop the questions for the following steps. I used a descriptive questionnaire to inform two sets of purposive interviews that followed in the second phase of the study. By selecting a sequential design, data from the online descriptive questionnaire coupled with qualitative data from the interviews could be integrated to explore areas identified as worthy of deeper study (Andrew & Halcomb, 2009; Denscombe, 2014).

Although qualitative data collection is considered more difficult to undertake than quantitative data collection, the findings are generally easier to understand (Polit & Beck, 2022). An exploratory descriptive approach in qualitative research is designed to explore a topic and add to new knowledge by being inductive rather than deductive. This approach has been used to investigate less-explored areas in healthcare by defining problems that need

further study (Hunter et al., 2019). This methodology takes a flexible approach to using methods and aims to identify ideas or provide a broad insight rather than test a hypothesis (Doyle et al., 2020). Therefore, although much has been learned from the literature review and personal experience about the topic, the research method and methodology will allow for any unexpected findings. O'Reilly et al. (2024) believed that qualitative methodology could be used innovatively using multiple methods to address a research question's complexities.

Another reason for choosing a qualitative design using an exploratory descriptive survey was chosen as the approach was seen as flexible (Schoonenboom, 2019), it allowed for greater depth and breadth (Dawadi et al., 2021) and as this type of research is inductive it gave the option of an emergent research design. An emergent design arises due to issues that occur during the research process, necessitating a different approach to improve the trustworthiness of the data (Creswell & Plano Clark, 2018) and reflects the previously unknown realities of the participants (Polit & Beck, 2022). Designs such as the one used for this study have been used extensively in both healthcare and NZ settings to capture diverse views and increase participation due to their simplicity. This research design enabled me to use a pragmatic approach using the concepts being studied to guide the research decision-making. As I examined and reflected on the data I realised that the impact of gender was central to the research and so adopted a feminist theoretical framework as a lens for considering the emerging data.

4.4.1 Enhancement

Using multi-methods in a complementary manner helped to enhance and clarify the research findings (Andrew & Halcomb, 2009; Doyle et al., 2020). Collecting the data sequentially allowed for time to fully engage with the questionnaire data using pragmatic and feminist lenses to determine further areas of inquiry for the interview phase that followed. Use of more than one method provides the researcher with an opportunity to unpack some of the answers in the ensuing phase and enhance significant findings, thus optimising the sample. Additionally, combining findings from data collected by both types of methods

produces greater certainty of the outcome and gives a more complete view of the subject being studied (Dawadi et al., 2021).

A purposive sampling technique can be used to identify particular respondent groups whose differences may add to the inquiry but whose viewpoints may be overlooked in a larger dataset. This research design generally utilises purposive sampling to include individuals who possess expertise and experience in the relevant subject matter (Doyle et al., 2020). In the second phase of this research, purposive sampling was employed to select interview participants, ensuring representation from various demographic groups within nursing leadership.

The inclusion of descriptive data provides this research with an account of the characteristics of the study participants. Using the perspectives of those whose experiences shape the study, different subjective experiences can be explored that relate to the research question (Doyle et al., 2020). Crystallisation can occur through implementing multiple strategies to make sense of the various experiences of the research participants. These strategies may include the researcher's personal reflection on their role in the research process (Morgan, 2024). Therefore, I deemed this approach suitable for increasing understanding about becoming and being a nurse leader in Aotearoa in the 21st century.

4.4.2 Fit with Theoretical Framework

The theoretical framework utilised for this research has already been outlined in Chapter Three, where I explicated the rationale for employing feminist theory, particularly a deconstruction of gender and its relevance to the research cohort. My initial approach to data collection for this research was data-driven in response to literary assertions about declining interest in leadership and my curiosity regarding the challenges that make leadership unappealing for most nurses. As I began to analyse the data, I realised the significant role that gender played in the participants' decisions to become nurse leaders and the impact of gender on their subsequent career journeys. Adopting a feminist perspective proved to be an appropriate method for analysing the findings. In their paper, Nguyen et al. (2022) surmised

that a theoretical framework should be employed to refine the research question and objectives and to guide data collection. Although I did not fully develop and refine a theoretical framework until Phase Two of the research, the theoretical assumptions lend significance to the methods used and the desired outcomes of the study.

A theoretical framework is a useful tool that can guide the understanding of the inquiry phases in a research design. Nguyen et al. (2022) believed that the application of theory was just as important for qualitative research as for quantitative to guide the research process. A multi-method qualitative methodology allows the generation of knowledge that reveals new perspectives (Hesse-Biber, 2014). During data collection, participants had the freedom to respond to questions in any context they preferred. However, during the inductive exploration of the data, it became clear that gender played a significant role in the research findings. Therefore, applying a feminist lens for data analysis was deemed appropriate and suitable for the multi-method qualitative design.

4.5 Design Approach

Several approaches to multi-method research design are described in the literature but can generally be described as typology-based or interactive. Typology-based approaches focus on different decisions and features of the research design (Creswell & Plano Clark, 2018). Different disciplines use different terminology to describe these features. Emphasis can be placed on either the degree of mixing, the timing of the different phases or whether both approaches are given equal weight (Creswell & Plano Clark, 2018; Leech & Onwuegbuzie, 2009). McKenna et al. (2021) commented that multi-method research requires equal respect given to all components, with careful consideration given to the weighting or preference. In contrast, an interactive approach, as used for this study, focuses on the process of the study rather than the methods (Creswell & Plano Clark, 2018). I chose an interactive approach not based on typology as the research was emergent, using a partially quantifiable descriptive survey to explain and shape the qualitative methods that followed (Murry et al., 2023).

4.6 Limitations

All methodologies have their limitations in application, and the chosen research design is no exception. Any bias or power imbalance can have an impact on the validity of research outcomes. Personal reflection was used as a tool to limit the influence of bias or power imbalances at all phases of the research design.

There was no verified tool suitable for answering the research question so a questionnaire had to be designed. Issues concerning this tool are outlined in the method chapter. These issues related to the inexperience of the researcher at the time of the tool development.

Multi-method research requires expertise in different types of data collection and analytical skills to select the best research design for the research question (Eckhardt & DeVon, 2017). However, combining different approaches is not without its challenges. Several researchers agree that a multi-method study requires a greater investment of time and resources than a mono-method (Bainbridge et al., 2014; Murry et al., 2023). McKenna et al. (2021) argued that there is a danger that PhD students using multi-method research would graduate without in-depth skills in either approach. Qualitative research requires creativity and the ability to detect patterns (Polit & Beck, 2022) – areas in which I have an acknowledged weakness. As a novice researcher, I found that although time-consuming, a multi-method research approach helped me develop useful skills.

The chosen methodological framework does not enable generalisation of findings to other settings or periods. Instead, qualitative studies such as this, aim to offer a rich, contextual understanding of human experiences through in-depth examination of specific cases rather than generalisation of knowledge (Polit & Beck, 2010). Readers derive additional interpretation and meaning from the research based on their own experiences.

4.7 Trustworthiness

Qualitative data may be interpreted differently by various researchers based on their perspectives and experiences. Thus, the validity of qualitative research is assessed through

its trustworthiness (Stahl & King, 2020). Incorporating an exploratory descriptive questionnaire into a qualitative research design enhances the study's transferability and dependability. Additionally, utilising multiple sources of data allows for crystallisation, facilitating the comparison of findings to gain a greater understanding.

4.8 Summary

As an emerging researcher, I needed to select a methodology that would effectively address my research question while also supporting my personal and professional growth. By intentionally choosing a methodology that contrasts with both my personality and my professional role, I have successfully achieved this initial goal. I argue that the qualitative design I selected, utilising an exploratory descriptive survey and in-depth interviews, has facilitated the integration and contextualisation of data regarding nurses' leadership career pathways. By collecting data through different methods to explore the characteristics of the study cohort, I have achieved the aim of gaining a deeper understanding of the significance of their lived experiences.

This approach involved creating a survey tool based on the issues identified during the narrative and integrative literature reviews. These issues aligned with the research question regarding the process of becoming and being a nurse leader in Aotearoa in the 21st century. Consequently, interview frameworks could be developed, building on the knowledge gained in the earlier stages of the research. The adoption of a pragmatic epistemology allowed the focus to remain on the respondents' experiences and how societal expectations impacted them. These societal expectations could then be explored using a feminist theoretical framework to guide and give purpose to the outcomes.

Using this type of approach has provided a way for the voices of our current nurse leaders to be heard directly. Consequently, a richer understanding of their experiences has been gained that can be used by the profession to smooth the pathways of emerging nurse leaders. It is acknowledged that qualitative data is subjective and that there can be other interpretations than those of this researcher. Therefore, I have explained how transparency and reflexivity were used to ensure the credibility and trustworthiness of this research.

In Chapter Five: The Research Method, I will detail the methods employed in both phases of the research to gather the data, including the recruitment of participants. I will describe the analytic method used to develop the major and minor themes, as well as the steps taken to uphold the integrity of the data. This chapter will also discuss the personal and professional insights gained from the research process.

Chapter Five: The Research Method

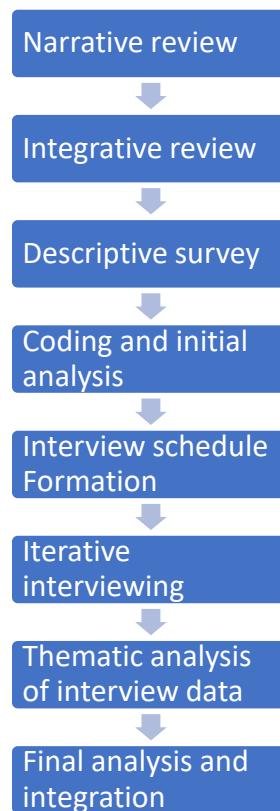
5.1 Introduction

As discussed in the methodology chapter, the research method employed a qualitative design that consisted of two methods in two sequential phases. The first phase consisted of an online questionnaire comprising 33 questions, of which 17 were Likert scale questions and 16 were descriptive, qualitative questions (refer to Appendix Two). Qualitative Interviews formed the second phase. Interview frameworks (refer to Appendices 3 and 4) were used that were informed by the findings of the gaps identified in the literature reviews and the descriptive survey. While the data collection was being undertaken, I developed a theoretical framework that used deconstruction of gender through a feminist lens. Analysis of the data followed Braun and Clarke's approach to thematic analysis.

5.1.1 The Study Design:

The sequential design used is depicted in Figure 3. To begin, I conducted a broad narrative review of the literature to identify gaps that would help formulate the research question. Following this, I carried out an integrative review to further narrow the issues and pinpoint specific gaps in knowledge. Drawing on insights from both literature reviews, I created a survey tool designed to assess nurse leaders' perceptions and understandings of the factors that influenced their decision-making regarding their career trajectories and experience of leadership.

Figure 3 Sequential study design.



I did not use a predetermined and validated tool for the survey data collection. Instead, my questionnaire emerged from a literature review, where I identified gaps in knowledge and subsequently created a survey tool based on those findings as I had not found a validated tool that met my requirements. This survey data then enabled me to design a semi-structured interview schedule for the interview phase that followed. As I reviewed the emergent findings from the data collection and utilising the philosophical lens, I determined that further interviews were needed to seek clarification and depth. I employed a predetermined qualitative tool, specifically Braun and Clarke's six-step thematic analysis approach, for analysis of the interview data. This interactive and emergent style of methods enabled me to answer my research question.

Table 1 Study design

Strategy	Sample	Goal	Analysis
Mixed Qualitative & Quantitative on-line questionnaire	RN in leadership positions	Obtain the demographics of sample. Explore similarities or differences with literature review.	Aligned with literature review findings but identified gaps in knowledge of the changing NZ context
On-line or in-person semi-structured interviews (n=13)	Purposeful selection of RN from different demographic groups and key nursing leaders	Expand on data gained from questionnaire with targeted questions to solidify/challenge data set Cross thematic analysis	Greater depth on themes seen in the phase one data – similarities or differences Confirmation or explication and expansion of findings from previous data sets

The last two data collection points were separated by over 12 months. The extended interview period was necessary because, although I initially believed data saturation had been achieved, further analysis of the collected data revealed the need for additional interviews later on to clarify some key findings. Table 5 shows a timeline of the process from ethics approval to thematic analysis. As time progressed and my confidence as a researcher grew, the data collection became more targeted to elicit information relevant to the research question. The four (4) interviews at the end of the data collection period sharpened the focus of the study to give a fuller and more situated understanding of the experiences of becoming and being a nurse leader in Aotearoa NZ in the 21st century.

Data analysis was conducted using the thematic analysis techniques outlined by Braun and Clarke (2022). Codes were brought together as patterns of shared meaning from which themes were selected, and meta-inferences were drawn. As I became more familiar with the data, I came to understand the career trajectories of my study participants as ones where they were coping with cultural, professional and organisational expectations. These expectations had to be negotiated in an environment where their gender and societal role impacted career choices.

My research goal was to explore the meaning of the data in the context of the respondents' experiences. To achieve this goal, a relativist ontology underpinned the thematic analysis of the data. Using a relativist ontology gave a subjective view of how this group of nurse leaders made sense of their experiences. Throughout the research, I used a reflective process to review any impact my own positioning had on analysis of the data collected.

5.2 Recruitment

As the research sought to identify registered nurses with experience in leadership roles in Aotearoa NZ, purposive sampling was used to recruit participants. The criteria for inclusion and exclusions were as follows:

Inclusion criteria

- Holds New Zealand nursing registration.
- Holds a recognised leadership position in a health, academic or professional organisation that requires others to report to them, where they are responsible for the work of others or in a senior academic/policy position.
- Has held that position or a related position at a similar level for at least three years. This time frame was selected to ensure the nurse leader had adequate experience in a leadership role to comment on being a nurse leader. Three years was a subjective period as leaders develop at different rates depending on many indeterminate factors.

Exclusion criteria

- Less than three years' experience in a senior leadership role.

Advertisements were published in the College of Nurses Aotearoa New Zealand online newsletter, Topūtanga Tapuhi Kaitiaki O Aotearoa New Zealand Nurses Organisation newsletter Kaitiaki and Te Whatu Ora's Health Central an online portal for healthcare information and services asking for volunteers who met the inclusion criteria. The data collection period ran from March to September 2020. Respondents who expressed interest were emailed an information sheet outlining the purpose of the study and a link to an

electronic questionnaire which included a tick box to identify those participants who were willing to be interviewed if required.

Following the analysis of the descriptive survey data phase in late 2020, interviews were planned to capture an in-depth understanding of the data. An initial nine interviews were undertaken from March to June 2021 with participants who had expressed an interest in being contacted. These respondents were selected because they were of a specific demographic, to elicit discourses from a variety of backgrounds and work environments. Four further targeted interviews were conducted in 2023 with registered nurses in senior nursing positions who had heard of my research and expressed an interest in participating.

Participation in the survey implied consent as outlined at the beginning of the Microsoft Forms questionnaire. Consent for the second phase took the form of signed consent forms from the participants interviewed in person or implied consent for those participants who joined an online interview. Additionally, verbal consent was gained for recording the interviews.

5.3 Participants

5.3.1 Sampling

The multi-method design I chose used random sampling for the descriptive survey phase and purposeful sampling for the interview phase. Purposive sampling in the second phase gave a direct connection/integration between the stages because some of the second group of respondents had contributed to both data sets (Murry et al., 2023). Sampling for the descriptive survey sought to obtain a sample that was representative of the study population. The population for this study consisted of NZ leaders in the healthcare system who were registered nurses; therefore, the request for respondents was distributed through nursing journals and nurse leadership groups. The demographics and characteristics of the participating nurse leaders were best collected through a descriptive questionnaire, including open-ended questions to capture their values and experiences.

Qualitative sampling is generally purposive and samples are generally small because the focus is more on direct interaction with participants than on the generalisability of the findings (Bradshaw et al., 2017). In purposive sampling, a specific group of participants is selected based on their characteristics (Lobiondo-Wood G, 2022; Moule et al., 2017). Purposive sampling was used as the target audience was nurse leaders currently working in New Zealand health settings. For this study, the participants to be interviewed were initially selected from those whose demographic or other information provided in the questionnaire raised further questions and indicated their willingness to be contacted. Further interviews were later conducted with those who, through colleagues, had shown interest in the study and met the research criteria. Purposive sampling was ideal for this research because it provided richness and diversity of data sources representative of a range of practice settings across NZ and enabled sampling using a defined set of criteria (Borbasi et al., 2008).

Table 2 Response rates

	Response rate (n)
Phase one Questionnaire	49
Phase two interviews	13
Total respondents	53 (9 in both phases)

5.3.2 Phase One: Questionnaire participants

As the advertisement for survey participants came out in print and via e-mail in early 2020, NZ went into its first lockdown for COVID-19. This resulted in few respondents, so the advertisements were re-sent when the pandemic restriction levels decreased, with a greater success rate. 93 nurse leaders replied to the advertisements and were sent information sheets about this research with an invite link to complete the survey. 49 participants completed the Microsoft Forms survey, representing 53% of those invited to take part.

5.3.3 Phase Two interviews: Participant selection

Nurse leaders who had responded to the survey were offered the opportunity to be contacted at the end of the survey if an interview was required. The participant's email address was kept separate from the survey results. Of the 49 respondents, 40 indicated in the questionnaire that they were open to further communication with me if required for this study. Nine participants who had expressed interest in this were contacted for follow-up interviews.

The initial nine interviews were conducted in 2021/22 to represent different demographic groups in nursing leadership. Phase two initially included three Māori females working in different roles in a DHB, one male NZ European from a DHB, two NZ European academics, two female internationally qualified nurses (IQN) working in government organisations and one self-employed NZ European female. I thought it important to select interviewees from different work environments as well as from various parts of the country, both urban and rural, to eliminate a potential variable of organisational bias and make the study outcomes more transferable.

Four further interviews took place between November 2023 and January 2024 with nurse leaders who, upon hearing about the project from a colleague and expressing interest in it, were contacted to determine their eligibility and interest in being interviewed (N = 4). While I had loose professional connections with two of these participants, I knew the others only by their names and accomplishments. This group of interviewees were all NZE but from different age groups and practice backgrounds.

The total number of interviews conducted with eligible participants was 13. All interview participants' names as per research protocol, were anonymised with pseudonyms. A semi-structured interview schedule was used to guide the interview to elicit depth from responses in the survey and provide an opportunity for wider discussion.

Table 3 Participant type: phase two

Role	Ethnicity	Gender
Self-employed	NZE	Female
ADON	NZE	Male
ADON	Māori	Female
Academic	NZE	Female
Other Government Organisation	European	Female
Academic	NZE	Female
Clinical Nurse Manager	Māori	Female
Nurse Manager	African	Female
Nurse Manager	Māori	Female
DON	NZE	Female
ADON	NZE	Female
Academic in service leadership role	NZE	Female
Senior clinician in service leadership role	NZE	Female

Table 4 Participant background Phase two

Pseudonym	Background
Erica	Self-employed 25+ years, service provider
Adam	Second career choice, hospital hospital-based
Jo	Hospital, Tertiary lecturer, Management in DHB
Anne	DHB, Tertiary lecturer, Researcher
Navarra	IQN Europe & Middle East, DHB, Outback Nursing, other government organisation
Connie	Midwifery, Public Health Nursing, Business management
Aroha	ED in DHB, Nga Manukura o Apopo graduate
Si	RN/Midwife in Africa and Australia, DHB – small rural centre & Public Health larger centres
Tuakana	RN Australia, DHB, Nga Manukura o Apopo graduate, Educator, Māori health
Kathryn	Other government organisation, DHB, Educational setting
Pip	DHB, advanced nurse practice, project governance, Educational setting,
Valmai	CCU NZ, UK, Australia, Educational setting
Julia	DHB, Clinical nurse specialist, policymaking, Nurse practitioner

5.4 Ethics

Ethical approval was sought via the Massey University Human Ethics Committee (MUHEC). This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics

Committees. The researcher(s) named in this document are responsible for the ethical conduct of this research (Ethics notification: 4000022131, 24 Jan 2020 see appendix one)².

5.5 Cultural Considerations

I approached a cultural advisor to plan, discuss and review the analysis of Māori participant interviews to ensure that they were correctly understood. The goal of this research was to specifically explore the characteristics, experiences and career trajectories of nurse leaders in Aotearoa NZ. Understanding any differences that Māori registered nurses experienced as tangata whenua was an important part of this goal. It was necessary therefore to ensure that as a non-Māori any inherent bias or misunderstanding I might have, did not influence the data collected from Māori participants. This ensured that the research data reflects cultural practices and is consistent with the worldview of the participants.

Throughout my research, I had regular contact with my cultural adviser when questions on tikanga arose. I also asked her to review certain sections of chapters in this thesis to cast a cultural lens over what I had written. My cultural adviser knew me professionally and understood the value of the research I was undertaking. She was encouraging and supported my personal growth in the areas of tikanga and Mātauranga Māori. Some of my understanding of wahine Māori was initially lacking in depth so I welcomed her guidance in capturing the essence of this concept correctly.

To further prepare myself I completed the New Zealand Certificate in Tikanga (Mātauranga Māori) Level 3. He Papa Tikanga gave me insight into a Māori worldview. I learnt about traditions, concepts, values and protocols to understand why some Māori prefer to do things in a particular way. Completing the course work challenged my thinking and caused me to reflect on how my own beliefs and values related to those of other cultures. As a researcher I was also aware of the need to take care that my research outcome did not

² For concerns about the conduct of this research that you want to raise with someone other than the researcher, please contact Director - Ethics, telephone 06 3569099 ext. 85271, email humanethics@massey.ac.nz.

negatively impact on the group it represented. In this I was guided by my own judgement as a nurse leader and also the combined wisdom of my supervisors.

5.6 Timeline for data collection and analysis

Table 5 Timeline

December 2019	Applied for ethics approval
February 2020	Received Ethics approval as low risk. The survey questions were drawn undertaking a broader narrative review and then an integrative review of the literature to understand the gaps
March-April 2020	A request for respondents was circulated with a minimal response rate. 25 March 2020 the State of emergency was declared in NZ due to COVID-19 and the national lockdown commenced.
June-July 2020	A repeat request for respondents was circulated with an overall 53% response rate.
August-September 2020	As respondents replied, information sheets with a link to the electronic questionnaire were sent by email. Further NZ lockdown announced 17 August 2020.
October - December 2020	Coding of questionnaire data began.
January/February 2021	Initial data analysis of questionnaire data to shape interview questions.
March/April 2021	Phase two interviews began.
May-August 2021	Coding and analysis of interview data.
November 2023	Second set of interviews qualitative interviews began.
December 2023- February 2024	Coding of final interview data. Thematic analysis and final integration of all three data sets to formulate findings and draw conclusions.

5.7 Phase One: The Questionnaire

5.7.1 Question Setting

An initial narrative review and then an integrative literature review identified gaps in knowledge concerning the experiences of becoming and being a nurse leader in Aotearoa in the 21st century. Based on my literature review and personal areas of interest, I created a custom questionnaire that included some Likert-scale questions, alongside open-ended questions for more detailed responses. This questionnaire was then refined following advice from my supervisors. No theoretical assumptions were made at this stage.

The questionnaire was designed to ascertain what support to become and be a leader the participants had both within and outside of their work environment. These questions explored whether participants had support through mentorship, professional

supervision, or influences from friends, family, colleagues, or religious and cultural factors. Respondents were asked if their current organisational structure affected their leadership and what opportunities for professional development were offered in their workplace. I also sought their views on the value of post-graduate education and nursing's involvement in governance structures.

Some of the questions asked about issues that might impede a nursing career such as perceived power imbalances and gender-related issues. These questions were developed from themes in the integrative literature review relating to barriers to a leadership career pathway. Respondents were asked if they had any experience with leaders who deterred them from becoming or being leaders and what challenged or made their role difficult.

The final question was designed to be female-specific and asked what women leadership role models the respondents had throughout their life and what advice they would give to others seeking to follow a similar pathway. This question aimed to determine if nurse leaders valued traditional nursing role models such as Florence Nightingale or were inspired by more contemporary women leaders from outside the profession.

5.7.2 Demographic Relevance

As previously mentioned, an information sheet about the research project with a link to the Microsoft Forms questionnaire was e-mailed promptly to everyone who replied to the advertisements for respondents. This resulted in the simultaneous receipt of data as the recruitment stage was still in process. Data was managed through a Microsoft Excel spreadsheet. The survey data determined the demographics of the study population, looking at how representative it was of the general nurse population in NZ. Most of the respondents identified as female (n=45) and/or NZE (n=36). NZ was the country of first registration for the majority (n=45) of the respondents. Internationally qualified nurses (IQN) made up 31%. The proportion of Māori nurses was less than IQN at 10% but greater than the current percentage of Māori RN in the NZ workforce. Most (n=33) were over 50 years of age, with 16% of that number approaching retirement. This showed that the demographics of the respondents

closely represented current nurse leadership demographics in New Zealand. The NZ RN population is 92% female, 70% NZE and 13% Māori. Over 43% of these RN are older than 50 years of age (New Zealand Nurses Organisation, 2018; Nursing Council of NZ, 2020). The volume and percentage of IQNS have increased dramatically and now comprise 46.8% of the RN/NP workforce in NZ (Nursing Council of NZ, 2023). Leadership statistics do not reflect this increase.

Each survey response was screened to ensure the respondent met the research criteria. All respondents were nurse leaders with a minimum of 3 years' experience in a leadership role that required others to report to them or were responsible for the work of others or in a senior academic/policy position. Not all respondents answered every question, but few questions were unanswered.

5.7.3 Phase One Data Analysis

Data analysis must be conducted in a systematic, precise and overt manner to be considered trustworthy. Polit and Beck (2022) believed that there were no agreed rules for qualitative data analysis which made the methodology challenging because of the amount of work required. This means that the research design can take many forms so processes need to be put in place to ensure the reliability of the outcome, as explained later in this chapter.

Although this was a descriptive survey, some statistics were collected to better understand the sample. All responses to the survey were compiled and graphed using the Microsoft Forms software employed for the phase one research questionnaire. Percentages were calculated by the researcher from numerical data for some of the questions. The descriptive qualitative questions from the questionnaire were both quantified and used as written.

The quantification of descriptive qualitative questions was achieved by assigning numerical values to the items on the questionnaire that utilised a Likert-type scale or short answer options. Additionally, some long-answer questions were quantified by counting the frequency of keywords, such as determining how many times a specific person was identified

as a role model. Three respondents did not provide an answer to one of the survey questions. The researcher did not consider this consistent enough to indicate that the question may have been ambiguous or unclear. All the open-ended questions asked in the interview were answered in full.

For the remainder of the data, coding was open and organic without a framework. I chose to code manually using a hard copy to engage more deeply with the data and allow time for insight and reflection.

5.8 Phase Two: The Interviews

5.8.1 Question Setting

As previously stated, the use of sequential data collection allowed initial findings from phase one, which involved an exploratory descriptive questionnaire, to shape the question framework for the subsequent semi-structured interviews. Furthermore, a concurrent review of pertinent literature and personal reflection identified several areas warranting further investigation. From these areas of curiosity, I developed a loose set of interview prompts to guide the conversations.

According to extant literature I had read, the general perception of Nursing remains largely focused on direct patient care. The crucial yet often unnoticed contributions of nurses are not appropriately recognised or valued. I was interested in learning whether this perception of nursing identity narrowed the lens through which a nurse viewed her career pathway. Programmes such as The Productive Series³ which I had been actively involved in, place emphasis on “direct patient care time”, which may encourage many nurses to believe that time spent on administrative or other tasks is not of the same worth. I wondered if some nurses were rejecting the idea of progressing into leadership because they felt that they would no longer be “real” nurses. For the sake of transparency, I want to acknowledge that I once held similar views.

³An NHS Institute for Innovation and Improvement programme that aims to improve quality, whilst making savings in productivity and efficiency.

In considering the trajectory towards leadership roles, I queried what motivates a clinical nurse to move into a leadership role away from the bedside. The literature had raised a number of possibilities as being relevant. Extant literature shows that postgraduate education expands the inquiring mind and may open an awareness of the possibilities that leadership roles can bring. Opportunities to try leadership positions such as secondments may give an RN a taste of what can be accomplished through these roles. I wanted to inquire if this had been the experience of the leaders interviewed and to explore in more depth how this process had unfolded.

This led me to wonder how we could identify potential nurse leaders and nurture their professional growth. I was curious about what had been useful for those who had experienced leadership, particularly their experience of leadership training programmes that were available. Of interest were their views on the benefit of postgraduate education and whether this group of leaders had undertaken nurse-specific or generic training programmes. The phase one questionnaire showed that nurses join the profession to nurse, not manage. Do nurse leaders believe this still holds true, or do new generations see a defined career path in nursing? In my experience, emerging leaders self-identified by their actions but didn't necessarily perceive themselves as leaders. I was interested to know if any of those interviewed had been identified by others as potential leaders early in their careers.

I was interested in understanding what empowered some nurses to advance in their leadership roles while others chose to defer or decline opportunities. Existing literature highlights the benefits of mentorship for nurses in leadership positions, but I questioned whether this practice is also common in the New Zealand context. If this proves to be the case, the data could support the implementation of funded mentorship programs for new leaders.

Another area of curiosity was how the type of leadership structure impacts aspirations. Nurses begin their careers in healthcare organisations that have a hierarchical structure and where nursing does not always have control over its model of care. Many options for nurse leadership exist outside of public hospitals, including self-employment.

Interviewing leaders from various healthcare structures might identify common barriers or innovative ways these leaders have overcome obstacles to their chosen career pathways.

I was also curious to explore more about the career pathway differences between women and men in nursing. Although only one male nurse leader was interviewed, his viewpoint could serve as a contrast to the perceptions of the other female participants interviewed. The perceptions regarding the ease of leadership progression for male nurses, or the “glass elevator,” were therefore opened up for discussion. Male nurses have had to overcome the barriers of working in a predominantly female profession, and I was interested in identifying any additional skills that have facilitated their career advancement.

My curiosity prompted me to ask this group about their views on why some nurses choose to omit the word “nurse” from their resumes or email signatures. While many nurses work outside of traditional healthcare settings, their job titles often don’t reflect their nursing background. Is this decision driven by a belief that the title “Registered Nurse” holds little (Pullen & Vachhani, 2021) value, or is it indicative of a lack of pride in that title? I wanted to understand from the leaders I interviewed whether they see the title of nurse as a hindrance to their work, or if they feel it affects how seriously they are taken or how they are treated in their roles. It may be that the requirement or lack of requirement for their role to be held by a registered nurse influences whether a leader advertises their professional status.

In Western culture, leadership is often associated with a masculine business model (Feenstra et al., 2023; Pullen & Vachhani, 2021). Since nursing is predominantly seen as a feminised profession, I wondered if many nurse leaders adopt a masculine leadership style rather than a more feminine approach. Furthermore, I aimed to identify the leadership skills used by this group of senior nurses to uncover any unique differences within the nursing field that others could replicate.

I aimed to explore the tension that had been alluded to in the literature between the responsibilities of a service manager and the professional duties of a nurse. As a manager, key performance indicators and resource constraints can limit their ability to lead their team effectively (Klarare et al., 2020; Reyes et al., 2014). Additionally, time pressures from heavy

workloads had been identified by Patrician et al. (2018) as hindering the manager's capacity to exemplify professional values and inspire the next generation of nurses.

Nursing has become increasingly visible in senior decision-making roles in health, such as on the executive team for Health NZ Te Whatu Ora or the Ministry of Health. Nursing may have a voice at the table, but is it an equal voice? I planned to ask if nurse leaders felt they had the authority to effect change or if they were mostly dependent on budget holders. New Zealand has nurses in important positions, but many, if not most, roles only provide advice without the power to act in the best interest of both nurses and the community. This conflict of interest has led to some resigning or having a short tenure in their positions. I was curious to know what limitations the participants believed were due to belonging to a feminised profession.

In the context of nursing in Aotearoa, it is important to recognise the additional barriers that tangata whenua nurses may have experienced in their career journeys. Colonialism and institutionalised racism must be overcome to progress in many organisations. There are also cultural and whānau expectations that guide a Māori nurse's career pathway. The impact of these factors on a Māori leader's workload and added extra stressors needed to be considered. I also wanted to learn about any specific strategies that those interviewed had experienced that supported tangata whenua in seeking leadership roles, in alignment with the NZ Māori health workforce strategy that plans to increase the number of Māori health care workers to match the NZ demographic.

The questions that emerged from the phase one data, as well as my extensive exploration of leadership literature were quite significant as outlined. I also recognised the importance of being receptive to unexpected perspectives and ideas and adapting my questions based on real-time responses (Sharma et al., 2024). Thus, no interview was formally scripted but was guided by feedback from the participants.

5.8.2 Interview method

Most of the interviews were undertaken using Microsoft Teams. The Microsoft Teams software enabled me to record the interviews for later transcription as well as having a video function so that both parties could view each other. Microsoft Teams' camera function also allowed me to detect any non-verbal cues such as enthusiasm or uncomfortableness with topics under discussion. Those interviews undertaken kanohi te kanohi (in person) were recorded using a cell phone and then later downloaded onto a secure hard drive. For these interviews, I was able to better observe body language that emphasised points under discussion. All the interviews were approximately 45 minutes in length.

To maintain consistency all the interviews were conducted by myself following the same format. I knew of some of those interviewed through their public profile or engagement in national meetings but no power imbalance existed at the time of the interview. Those interviewed were keen to participate and eager to tell of their own struggles in their respective career pathways. Their passion for nursing and nursing leadership was apparent, as was their willingness to help with the research and their interest in its outcome. This enabled the interviews to follow a friendly, conversational style. I reflected on how I interacted with each interviewee to build rapport, realising that we had much in common in our experiences. While conducting interviews, I reminded myself to be receptive to exploring new pathways and aspects that I may not have considered before and to truly listen to the experiences and insights of those RNs who had traversed a leadership pathway and been successful.

The interviews were recorded with the permission of the interviewee gained verbally at the commencement of the interview and transcribed verbatim by me. Later in the transcription process hesitation and repetition were removed unless they were indicative of contemplation or to emphasise a point, which improved the clarity of the data. I stored the interviews on a secure laptop until transferred to a separate secure hard drive. Notes were also made at the time of the interview so that key points could be recalled. Following each

interview, I reflected on what had been said and the context surrounding it noting key points in a journal. Journalling also helped me to recall my thoughts around the dialogue and any questions that arose for me. I later sought clarification on some of the points raised about their experience of leadership training by communicating again with some of the participants.

Sharma et al. (2024) proposed that the ideal number of participants in qualitative research studies depends on various factors, including the expertise of the researcher. A judgement was made to cease interviewing due to the sameness of the conversations. I initially determined that the size of the collection was adequate to cover the breadth and focus of my research question and had sufficient identity diversity. Bradshaw et al. (2017) noted that data saturation serves as a practical way to conclude data collection after carefully assessing whether the sample size adequately meets the research objectives. However, Braun and Clarke (2019) argue that the concept of data saturation is not meaningful; instead, they prefer the term "theoretical sufficiency." They suggest that data collection should continue during the analytic stage. According to them, deciding on sample size is typically a pragmatic task, and researchers should determine when to stop collecting data based on the purpose and goals of their analysis.

The final four interviews were undertaken following the same format as the earlier interviews but with a different set of prompts (Appendix Four). Initially, I had a relatively naïve worldview of nursing and the impacts of historical and societal pressures on what nursing was and could become. Through extensive concurrent reading and reflection during the data collection and analysis phase, I began to see and understand the world of nursing leadership in a different light; consequently, the interview question framework was adapted or developed further. The use of a feminist lens to the data, particularly with a focus on the deconstruction of gender developed and deepened my thinking and I came to understand the findings differently. Iterative analysis of the first two phases helped further refine the investigation into the career paths of registered nurses who pursue leadership roles. Specifically, it focused on understanding what drives these individuals to courageously embark on a career in leadership and remain committed to it.

For all interviews, I utilised the same approach to establish rapport, regardless of the relationship with the interviewee. My approach was based on the principle of whanaungatanga, which emphasises finding common ground with the interviewee and building a connection. Sufficient time was allowed for engagement with the participants to understand a little of their context and establish a relationship of trust so that richer data might be obtained. In both interview phases, a strong enthusiasm for nurse leadership was apparent as well as shared struggles with male medical hegemony and being part of an undervalued profession.

5.9 Integration

Integration of the data sets can occur during the design, data collection, analysis or interpretation stages (McKenna et al., 2021). In this research design, the data was collected and analysed sequentially, thus connecting/integrating both the descriptive survey and interview phases at the final analysis stage of the research process. Murry et al. (2023) considered integration to be a challenging aspect of reporting multi-method studies requiring time and planning to implement effectively but believed it could be achieved by ensuring all the connections between the different methods were identified at the final reporting stage.

Different philosophical views or disciplinary practices may influence the way the data sets are integrated (Bazeley, 2017). Creswell and Plano Clark (2018) suggested this could be done in three ways; either by merging, connecting, or embedding the data. Data merging or reduction occurs when findings from both methods are blended and compared, to substantiate the analysis (Murry et al., 2023). One way of merging data is by combining numeric data with qualitative text that supports it in a discussion chapter (Creswell & Plano Clark, 2018). Statistical and qualitative data can also be integrated by data transformation. Data transformation occurs when one data set is transformed into another method e.g., quantising qualitative data by counting code occurrence (Murry et al., 2023). Lynam et al. (2020) listed the outcomes of integration as an improved understanding and opportunities for

social change. These authors argued that desirable outcomes could still be achieved without full integration of the data.

During the research process, I decided to integrate data at various stages. In the initial phase, I developed some preliminary codes, which led to the creation of a list of core codes. To complement the questionnaire findings, open-ended questions were included to address pertinent questions. Additionally, some long-answer questions were transformed into quantifiable data to assess their relevance based on the frequency of key ideas mentioned. Reflexive thematic analysis was used to synthesise the data from the open-ended survey responses and the data from the two sets of interviews. Finally, I conducted an overall thematic analysis to select the key themes for discussion from the integrated whole.

5.10 Thematic Analysis

The Braun and Clarke (2022) process for thematic analysis was used as a guide to analyse the findings. Thematic analysis developed as a refinement of content analysis over several decades. It is a widely used family of approaches rather than a single method (Braun & Clarke, 2022). Thematic analysis is flexible allowing assumptions to be made about what the data represents with the depth of analysis determined by the level of engagement with the data. This process also has the flexibility to incorporate concepts and practices that represent Indigenous knowledge such as Mātauranga Māori (Māori knowledge). Thematic analysis goes beyond a literal interpretation of data to uncover relevant implications for the study. Coupled with a Feminist theoretical approach and a participatory lens, this allowed me to engage with the data in a meaningful way. There are three main schools of thematic analysis: coding reliability, codebook and reflexive (Braun & Clarke, 2021). Reflexive thematic analysis was best suited to this research as it aims to explore the reality behind participants' experiences within their social context.

5.10.1 Data Familiarisation

Qualitative research using thematic analysis necessitates the researcher becoming deeply involved with the inquiry (Polit & Beck, 2022). According to Braun and Clarke's (2020)

outlined process, the first stage of the analysis requires one to become familiar with the data by immersing oneself in the text to make sense of it. To achieve this, each response was read in full, and then the answers to each question were read together as a group. Interviews were listened to as they were transcribed then listened to again alongside the transcriptions. Once I had familiarised myself with the data I could begin with coding it, leading to the generation of initial themes, which help organise the data.

5.10.2 Coding

Familiarisation was followed by the next stage, where relevant or interesting pieces of text were given a code colour and label. Some of the data extracts contained multiple codes, which evolved over the course of the analysis and became broader to encompass similar ideas. Polit and Beck (2022) remarked that there was no right way to code and that two researchers are likely to code the same data at least a little differently.

5.10.3 Generating Initial Themes

The next stage of the analysis involved generating multi-faceted themes from the data by looking for meaningful similarities in the respondents' answers. Themes are not just tools to classify the data but to reframe and interconnect the data elements (Kiger & Varpio, 2020). Braun and Clarke (2022) recommend clustering codes initially into tentative themes that can be further explored to capture a core idea. The data from both phases of this study was combined to create complementary meta-inferences. The researcher then reflected on the rationale behind selecting those themes and their significance in relation to the research question (Thorne, 2020).

A definition was written for each theme to clarify what it was about. This made it easier to keep the theme within clear boundaries so that it remained specific. The data was more than merely words but expressed the memories and emotions from the lived experiences of this group of NZ nurse leaders. Therefore, it was important to capture this latent data in the theme definitions. These themes became known as meeting KPIs (negotiating the binaries in an organisation), a place at the table (negotiating the binaries as

a professional), and what we bring with us (gendered socialisation and colonialism). The overarching themes were the neoliberalist environment and the oppression of nursing. These themes were captured and explored using a thematic mapping process (figure 3).

The initial thematic map displayed the coded data divided into what I saw as four main themes or “voices”: oppression, workplace issues, nursing ideals and tikanga. These initial themes were then split into eleven subthemes that expanded on the ideas generated from the data. Creating a thematic map enabled me to begin the process of engaging with the data in a meaningful way.

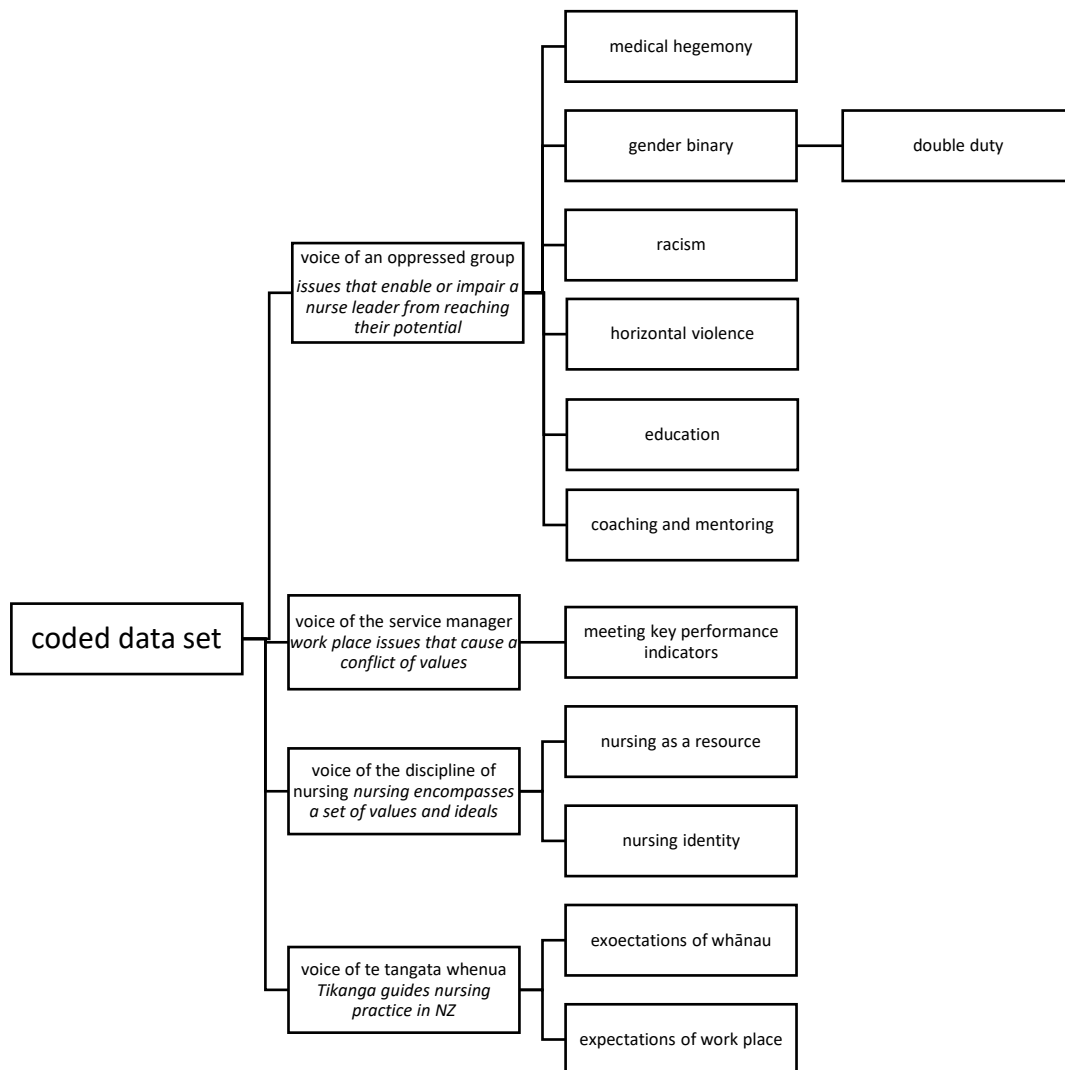
5.10.4 Reviewing and Refining Themes

After stepping away from the data for some time to reflect, I found that I was able to improve the quality of my analysis by engaging with it more deeply (Braun & Clarke, 2021). The interpretative stage is crucial to the research's validity. This stage is where conclusions are drawn from the data codes that have been reassembled into themes (Castleberry & Nolen, 2018). During the analytical stage, disclosing the theoretical framework used for analysing the qualitative data outlines the perspective from which assumptions are made (Evans et al., 2011; Adler, 2022). Inductive inference was used to form a general set of conclusions applicable to this cohort, though not necessarily universal. Induction is a process that works from the unknown to the known, developing explanations from real-world data. Inductive inference describes what is being studied and can contribute to new knowledge (Bradshaw et al., 2017).

Following the advice of my supervisor and the recommendations of Braun and Clarke (2022), I revisited the entire dataset and reviewed the coded extracts to assess the validity of my initial groupings. The meta-inferences were subsequently reviewed and refined before culminating in the final step of writing the analysis using a theoretical framework to contextualise the findings to answer the research question. Although my thinking had become more refined during this process, the themes I had identified remained the same. However, with the help of the theoretical framework and a better understanding of the

context, the themes gained more substance. With the aid of a feminist lens, I began to make connections between the inherited oppression of nursing and the gendered socialisation of nurses with the associated medical hegemony and the neo-liberal environment. I came to realise that it was nursing's' gendered socialisation and neoliberalism that had brought about the commodification of nursing care that my participants and I had experienced and that directed our career choices. These issues became the major themes for discussion under the headings *What it takes to be a nurse leader in Aotearoa* and *Negotiating the binaries in a neoliberalist environment*.

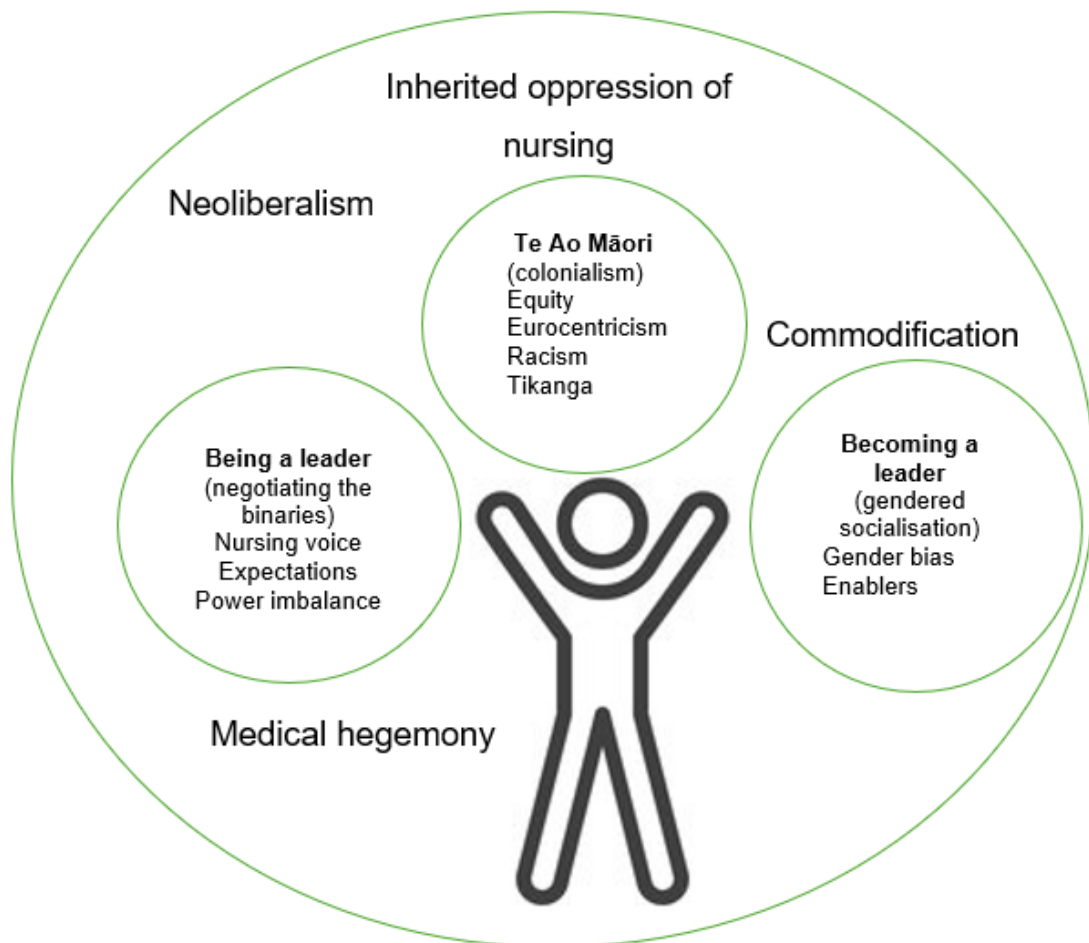
Figure 4 Initial thematic map



Final stage: preparation for writing up

Interpretation of the data begins with the familiarisation process but continues through theme development into the final writing up. The research question was used to form the foundation for interpretation, with the themes and their implications adding context. However, interpretation is subjective with no singular interpretation being more correct than another (Braun & Clarke, 2022). During the final stage of analysis and integration, the initial themes were further developed with the help of a thematic diagram (as seen in Figure 4). I visualised the themes as three "balls" a NZ nurse must juggle to become and be a leader amid neoliberalism, commodification, and medical hegemony. Some of the initial themes were split into sub-themes. These themes represented a pattern of meanings rather than individual experiences.

Figure 5 Final thematic map - nurse leader juggling expectations



The analytic approach was based on a relativist ontology, which means that it was subjective and situated. The aim was to demonstrate how participants made sense of their realities. Although thematic analysis is a method that is independent from theoretical assumptions theory must be taken into consideration in the final analysis (Braun & Clarke, 2022). As previously discussed a feminist deconstruction of gender lens was used to make sense of the findings and this theoretical framework aligned well with the themes that had been developed and the subject matter of nursing as a feminised profession.

5.11 Transparency

Rigour or validation is the traditional process that ensures research quality and trustworthiness. Rigour has been defined as strict adherence to standards or methods in a field of study and is more appropriate to the positivist paradigm. Qualitative researchers choose other processes, such as transparency. Transparency plays a crucial role in determining the reliability of qualitative data. This can be achieved by providing comprehensive details about the method and theoretical frameworks that form the basis of the research (Adler, 2022). By being transparent about the methodology and theoretical framework used and explaining why it was appropriate, the research gains credibility and trustworthiness. I ensured the credibility and robustness of the data through consistent and repetitive coding in all three phases. In two instances, I revisited participants to verify the points they made during their interviews, ensuring that I accurately captured their perspectives. This verification was crucial because one of these participants identified as Māori and the other as an IQN, and I recognised the cultural differences between us.

As multi-method research can mix elements other than method (e.g., epistemology, theoretical framework) a set of agreed standards has not been conceptualised (Leech & Onwuegbuzie, 2020). Therefore, there is no set way or standards to ensure validation in multi-method research. Assessment of research trustworthiness can be complicated due to the variety of designs and philosophical approaches. If the methods are assessed for rigour individually the essence of the integrated whole may not be appreciated (Eckhardt & DeVon,

2017). Several researchers have chosen instead to focus on rigour as an ethical issue examining to what extent the threats to the trustworthiness and authenticity of the study have been minimised (Leech & Onwuegbuzie, 2020). Doyle et al. (2020) considered researcher reflexivity to be essential to give clarity and credibility to the research. I have used reflexivity and reliability to demonstrate the trustworthiness of this research.

5.11.1 Reflexivity

Reflexivity is the process by which a researcher understands that new knowledge is shaped by their values and circumstances. It displays intellectual honesty regarding biases (Adler, 2022). Therefore when undertaking qualitative research the researcher must be reflective about and consider their own biases and perceptions, applying a critical lens to gaining knowledge (Ide & Beddoe, 2023). Olmos-Vega et al. (2023) talk of three types of reflexivity: personal, interpersonal, and methodological. Personal reflexivity concerns the researcher's conscious and unconscious bias that they bring to the research. Interpersonal reflexivity involves the relationship and power dynamic between the researcher and the participant. Methodological reflexivity is the impact of decisions made relating to what is discovered from the data or any unforeseen circumstances that occur.

For this researcher, personal reflexivity began from the initial exposure to the world of academia and nursing politics through undertaking post-graduate study. As a researcher, I was careful that my personal opinion did not guide the direction of the questioning or the formation of the themes. As a registered nurse with many practice years behind me, I could understand the challenges the participants spoke about in their trajectory towards a senior leadership role. The data I gathered confirmed that my experiences were not unique and that many others had faced similar challenges. Because of these shared similarities with the research participants, I was cautious not to let my own experiences cloud or give added weight to what was being shown by the data. I learned from Braun and Clarke's research (2023) that as an RN in a leadership position, I could never be a neutral observer during the thematic analysis process. Instead, I accepted that some level of researcher subjectivity

would be present in the research. My narrow understanding of the nursing world and the influences within continues to be challenged throughout this doctoral-level study. My perceptions have broadened to encompass the many nuances and meanings behind the various discourses in relation to their context.

Interpersonal reflexivity was a new concept for me, although one I subconsciously practised. Interpersonal reflexivity requires the application of a critical lens to the use of knowledge and power in a relationship, revealing any power imbalances (Ide & Beddoe, 2023). In my face-to-face interactions, I was mindful of potential power imbalances that could affect the participants' responses. As a researcher, I was aware of the "observer effect" that might have caused me to subconsciously influence the respondents (de Bianchi, 2018; Paradis & Sutkin, 2017). As previously mentioned, I reflected after each interview and ensured that there had been no power imbalance that might have impacted the information shared. I did not work directly with any of those whom I interviewed. However, upon reflection, I realised that some participants were people I respected due to their public profile or role. In these cases, I found myself perhaps less likely to ask deeper, more probing questions. I met with each interviewee as a peer, with one exception - an academic whom I perceived regarded me as a student seeking her expertise.

As an insider partly belonging to the group I was studying, I reflected on the various pathways to leadership taken by the respondents, and the different approaches they had to challenges along their journey. Each interview was approached thoughtfully, recognising their unique perspective and interpretation of what was being asked. I also reflected on how I interacted with the interviewees to gain a rapport and realised that we had much in common. This realisation made the interviews of those I held in some esteem less intimidating.

Methodological reflexivity meant critically considering the methodology, including understanding the philosophical and theoretical frameworks chosen for the research. As a reflexive researcher and guided by my supervisors, I was constantly making decisions regarding my data and unforeseen circumstances, such as the pandemic. Thus,

methodological reflexivity meant ensuring that decisions were ethical, rigorous, and aligned to the philosophical and theoretical frameworks. As part of the methodological reflective process, I have evaluated how I may have influenced the data interpretation, ensuring that this research has an acceptable level of subjectivity.

5.11.2 Reliability

Leech and Onwuegbuzie (2020) believed that rigour in multi-method research was an ethical issue concerning how any threats to the authenticity of the data had been minimised. Throughout this research, I have been transparent about how and from whom information was gathered and the process of coding and analysis to reach the findings and meta-inferences. The steps followed are clearly outlined to enable the research to be repeated.

5.12 Limitations

When I developed the questions for the phase one questionnaire, it was early in the research process, and I had not yet established a theoretical framework. Looking back, I realised that some of the Likert-type questions could have been phrased to elicit more focused responses. I also should have included questions that explored the gendered environment in which nursing leadership is situated more deeply. This realisation has been part of my ongoing understanding as the study has progressed, which has been an interactive process of growth and learning.

Interviewing participants was somewhat challenging due to the changing limitations imposed by the COVID-19 pandemic. Local interviews were conducted in person, maintaining social distancing so that masks did not have to be worn.

5.13 Summary

In this chapter, I have outlined the methods by which I collected data from the population of registered nurse leaders I wished to study. A qualitative methodology was chosen with an exploratory descriptive component, as it allowed me to explore the meaning behind the descriptive data by hearing the voices of the nurse leaders in an interview setting. This study utilises a multi-methods approach by collecting data through two methods treated

with equal importance: a questionnaire and focused interviews. The research has defined philosophical and theoretical frameworks within its research design.

The respondents to my request for participants were representative of the general nurse population in Aotearoa NZ and interviewees were selected who were diverse with points of interest to pursue. By being transparent as to the nature of the sampling those who read the research can make their own judgement as to its relevance (Campbell et al., 2020). A good description of the sample has been given to make the findings transferable to other settings (Polit & Beck, 2022) whilst maintaining the anonymity of the respondents. The data collection was undertaken in two phases with each new data set informed by the collection before it thus building on the knowledge gathered. Phase one was an exploratory descriptive questionnaire. Some of the open-ended questions were quantified by counting the frequency at which keywords appeared. The findings from the questionnaire were fully integrated with the next phase of the study. Although each data set was coded separately, the codes were integrated to find patterns of association which became the four foundation ideas or themes. Data was determined to have reached theoretical sufficiency.

Phase two consisted of two sets of semi-structured interviews. Semi-structured interviews involve using a list of topics or broad questions to guide the discussion (Polit & Beck, 2022). The questions asked were adapted during the course of the study to capture relevant issues as they emerged with a feminist deconstruction of gender guiding the question setting for the final phase of qualitative interviewing. Having a background understanding of the gender-related issues that had a potential impact on nurse leadership enabled me to focus the inquiry on what influence if any these issues had on the participant's choices around becoming or being a nurse leader.

By transcribing and analysing the data myself I was able to interact with the information to a greater depth which is reflected in the findings chapter. As the research progressed so did the understanding of the process which has led to a study that has greater depth and context. Thematic analysis gave me the freedom to apply the theoretical framework at any stage in the analysis, allowing me to locate the lived experiences of the

respondents within a wider feminist deconstruction of gender discourse. Throughout this process, I felt the weight of my ethical responsibility as a researcher to remain true to the essence of what was being described by the respondents. Care was taken to ensure that the data was recorded accurately, and that the analysis process was free of researcher bias.

Ethical standards were upheld in line with professional academic practice. Reflexivity has been demonstrated by looking for potential power differentials between the researcher and the respondents as well as the rationale given for data saturation. In addition, I have outlined how reflective practice through the research process has given me a greater knowledge and understanding of both a feminist and nursing worldview.

My research goal was to explore the meaning of the data in the context of the experiences of the respondents. The major themes of the socialisation of nurses both gendered and colonial and negotiating the binaries under neoliberalist systems will be used to shape the findings chapters that follow. My role as a researcher is to explain why these themes matter. The next three chapters will present my findings and their relevance to the research question of becoming and being a nurse leader in 21st-century Aotearoa.

Chapter Six: Phase One Questionnaire Findings

6.1 Introduction

In this chapter, I will present the results of the first phase of the research study, which involved administering a Microsoft Forms questionnaire consisting of 33 questions. A descriptive survey was selected for the first phase of this qualitative study to explore the characteristics of my study population using a semi-structured framework. This approach provided a broad overview of the respondents' career trajectories, including the factors that had enabled their progress and the barriers they had encountered. Based on the findings from the questionnaire, I was able to identify patterns that could be further explored in greater depth during the second phase.

Findings from the interviews that make up phase two of this study will be presented in two separate chapters. As mentioned in the previous chapter, the questionnaire had seven (7) questions related to the demographics of the cohort, and 25 exploratory descriptive questions designed to draw out information. The integrative literature review guided the development of the questions to gather valuable insights for the study.

A total of 49 responses were downloaded into a Microsoft Excel spreadsheet which was stored securely. On average, the respondents took 59 minutes and 35 seconds to complete the questionnaire. However, not all respondents answered all of the questions. As outlined in Chapter 5, the demographic data collected was similar in composition to the nursing population in New Zealand. I could not find data to reflect what percentage of the NZ RN workforce qualified for my study.

6.2 Demographics

Questions one to seven elicited basic demographic information. The sample for phase one consisted of 45 respondents who identified as a woman and four who identified as a man. No respondent identified as non-binary or preferred not to state their sex. The NZ RN

population is 90% female, and 10% male with 0.1% identifying as other gender (Nursing Council of NZ, 2023).

It was noted that at the time of the questionnaire administration, of the 49 respondents 25 respondents reported being in the 50-59 age group with 12 respondents aged 40-49 years representing the next largest group. In total 68% of the survey participants were over 50 years of age, with 16% of that number theoretically approaching retirement (table 6). This differs from the Nursing Council statistics of over 39% of NZ RNs being older than 50 years of age and 19% over 60 years of age (Nursing Council of NZ, 2023). However, the New Zealand nursing workforce has become younger in recent years because of an increase in the number of internationally qualified nurses coming to work in Aotearoa.

Table 6 Age band of respondents

Age in years	Number of respondents
Under 30	0
30 - 39	4
40 - 49	12
50 - 59	25
60 - 65	6
Over 65	2
Prefer not to say	0

Most respondents (n=36) identified as New Zealand European (NZE), although the workforce in Aotearoa is becoming more culturally diverse. The low percentage (10%) of Māori nurse leaders in this study reflects the smaller number of Māori nurses in the NZ nurse population (7%). The countries of origin of those listed as 'other' in the survey include RNs from the United Kingdom, Ireland, the USSR, Germany, Africa, and Australia.

The majority of the respondents (n=34) first registered in NZ, with the next largest group (n=10) registering in different parts of the United Kingdom. Most of the cohort (n=47) had been a registered nurse for over ten years, and the remaining two respondents between six and ten years. The tenure of the survey participants in a leadership position was greater than three years to be eligible for inclusion in the study.

To ensure a wide range of leadership environments were covered, respondents were asked in what type of organisation they were employed. Not all nurse leaders in the respondent group were employed by a District Health Board⁴. As expected, the group members worked in various environments, including four in educational settings, some in other government organisations such as the prison service, and several were self-employed or worked as a private contractor to other health care agencies. These different work environments meant that the respondents were governed by different organisational structures. None of the questionnaire respondents worked exclusively in a policy-making capacity.

6.3 Survey questions

The questions that follow were designed to explore more deeply some of the influences on a career pathway into leadership. Some of the quantitative questions were followed by long answer qualitative questions to expand on the Likert type response that had been given.

Q 8 In my current role I feel I am able to make a difference

Most respondents (n=47) agreed or strongly agreed that, in their current role, they were able to make a difference. However, the question did not allow for a text answer to specify the nature of the difference or the intended beneficiaries. Further questions suggest that the leaders perceived their ability to make a difference primarily in terms of evidence-based changes to care delivery. Respondents emphasised their role as patient advocates in ensuring patient safety and that patient-centred care was provided.

Table 7 Making a difference

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
I feel I am able to make a difference	23	24	2	0	0

⁴ At the time of data collection District Health Boards were still in existence.

Q 9 I receive adequate support in my workplace

Most of the respondents (n=43) agreed or strongly agreed that they received adequate support in their workplace. Those who disagreed (n=1) or strongly disagreed (n=1) worked for what was formerly referred to as a DHB, and both identified as Māori. This finding is of interest as it equated to 2/5 of the Māori respondents, although the sample size was too small to be statistically significant. However, it raises the question of whether our current district hospitals under Health NZ Te Whatu have adequate systems in place to support Māori nurse leaders. The respondents who neither agreed nor disagreed came from diverse ethnic backgrounds and workplaces.

Table 8 Workplace support

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
I receive adequate support in my workplace	17	26	4	1	1

Q 10 I have a good support network outside of my workplace

In line with the responses to the earlier question, 88% of the surveyed leaders reported having a strong support network outside of their workplace. Among those who disagreed with this statement, two were initially registered in a country other than New Zealand (IQN). Three of the respondents who disagreed with the statement in question 10 held positions in sectors other than educational settings, non-governmental organisations, or a District Health Board (DHB).

Table 9 Support outside the workplace

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Blank
I have a good support network outside my workplace	28	13	1	5	0	2

Q 11 I currently have or did have a mentor/coach/professional supervision

Interestingly over half of the respondents to question 11 had received or were currently receiving some form of mentorship or professional supervision. This type of career support is not available for all NZ RN and may be a factor that helped the respondents develop their career pathway. In both the previous questions, most of the participants had good support networks either in or outside of their organisation. The positive respondents to this question also indicated that they had good support networks outside the workplace. Out of 28 respondents who answered this question positively, two provided a neutral response regarding their support in the workplace, while the remaining 26 indicated they received adequate support.

Table 10 Professional support

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
I have or did have a mentor/professional supervision	17	11	5	10	6

Q 12 How much influence did your colleagues and/or managers have on your decision to take a leadership role?

Workplace colleagues and managers were thought to have some or significant influence on the decision to take on a leadership role. The qualitative responses to the following question further elaborate on how this influence was expressed.

Table 11 Influence from the workplace

	None	Slight	Considerable
Amount of influence	6	20	23

Q 13 If they did influence, in what way?

The majority of the respondents who answered the question mentioned that they received some level of support and motivation from either their colleagues or line managers to apply for a leadership role. This support was driven by different reasons, such as wanting

a familiar person to take the position, for roles where there had been no applicants, or to temporarily hold a role that was about to be disestablished. Respondents commented that they felt encouraged to apply for roles because they had colleagues or managers who believed in their abilities (n=5).

I lacked confidence and although I had the right qualifications, experience, and skills I doubted my ability due to being bullied in a previous position. My manager at the time encouraged and supported me in my current role. Jacaranda, Role: DHB

Other leaders inspired by demonstrating how good leadership could make a difference (n=3) and/or providing mentorship (n=3). Respondents were also influenced by those managers who provided them with opportunities to learn new skills (n=3). Conversely three respondents mentioned being influenced by poor leaders whose behaviour they did not want to replicate.

Q 14 What level of support/opportunities are there for leadership development in your organisation?

This question was not specific as to what type of leadership development was supported. As displayed in the table below, there are opportunities for leadership development, but these are variable depending on the type and size of the organisation. Respondents had undertaken a wide range of postgraduate education, including health economics, policy and clinical areas of interest. Although they may have been supported by their organisation to undertake leadership development, this appeared from the findings to be self-driven and inequitable. Of those respondents who commented that there was no support in their workplace, two worked for a DHB, one for a non-governmental organisation (NGO) and one was categorised as other. None of this latter group of respondents identified as Māori.

Table 12 Leadership development opportunities

	None	Slight	Considerable
Leadership development opportunities	4	23	22

Q 15 What value does postgraduate education have in preparing nurses for a leadership role?

This question did not identify which respondents had pursued postgraduate study, only whether they believed it was valuable for a leadership career pathway. Some form of postgraduate education was considered important by all but one respondent (NZE, female, role: other). Over half of the respondents who believed postgraduate education to be of considerable importance fell in the 50-59 year age band (n=14). Among those employed in educational institutions during the survey, three out of four considered postgraduate education to be of considerable importance, while one considered it of slight importance.

Table 13 Postgraduate education

	None	Slight	Considerable	Blank
Value of postgraduate education	1	19	26	3

Q 16 What is the value of having nurses “at the table” in governance structures?

This question received the most consensus with the majority of the nurse leaders (n=46) who responded believing that there was considerable value in nursing being represented at the table in higher level governance and political spheres of influence. The rationale they gave in question 17 was also fairly consistent.

Table 14 Being "at the table"

	None	Slight	Considerable
What is the value of having nurses “at the table” in governance structures?	0	3	46

Q 17 If you think they add value, in what way?

The key points coming from the long answers to this question were that nurses had insight into how decisions not only affected their profession but impacted on the holistic care of their patients and communities. Respondents commented on how being at the governance

level enabled them to advocate directly as the voice for the consumer for improved health outcomes (n=11).

Nurses bring a perspective to governance that few others can. They have grass roots experience of patient care, and they have an education steeped in the social model of health. They can bring this knowledge to the decision making table to ensure decisions and strategic direction is pragmatic and grounded in the reality of patient's lives. What they may initially lack in governance or business nous is more than made up for in their knowledge of the reality of people's lives. Sally, Role: DHB

A nursing perspective was thought to be unique and valuable in governance-level discussions (n=17). The group of nurse leaders surveyed, considered nurses to be critical thinkers who can come up with innovative and imaginative solutions, based on their experience of working in chaotic environments/systems. Some view nursing as having a more collaborative approach (n=6), where they can identify key individuals to work with, valuing all members of the healthcare team.

The nurse perspective is a major element in providing health care services. Nursing has... evolved into its own major discipline and is now separate from medical science. Thus, the input of nurses into health care and how services are provided becomes a key element in quality control, client, and customer service and therefore governance as well. Mark Antony, Role: other

Respondents mentioned the necessity of nursing as a profession being included in higher-level decision making especially if the decision would impact nursing (n=27). A power imbalance still exists in some organisations with medical hegemony remaining evident (n=5). One respondent (Female, IQN, Role: other) commented that nurses often had to be *annoying and resonant in society* to have their views considered. Another respondent (Male, NZE, Role: Educational setting) thought that nurses did not always represent their profession well, focusing on what was wrong rather than using a strengths-based approach to find solutions.

Q 18 Do you think the current structure of your organisation makes it possible to function as an effective nurse leader?

Responses to this question varied, with 55% of participants (n=27) feeling that they could effectively function as a leader within their organisational structure. In contrast, 24% indicated that the current organisational structure hindered their ability to act as a leader, while 21% were uncertain about the impact their organisational structure had on their functioning as a leader.

Table 15 Ability to function

	Yes	No	Unsure
The current structure of the organisation makes it possible to function as a leader	27	12	10

The following open text question (Q19) explored Q18 more fully.

Q 19 In what way does the current structure of your organisation affect your leadership?

Almost half of the nurse leader respondents (n=23) spoke positively about the impact of their organisation on their leadership ability. Overall, there was general agreement that leaders had a choice in how they allowed their organisation to impact their leadership. A culture of learned helplessness was seen to be holding back nursing from equity, amongst other leadership positions.

I think it is important that leaders are not passive but active in their relationship with the organisation. Connor, Role: Educational setting

Healthcare organisations in Aotearoa NZ were viewed by many of the respondents (n=16) as medico-centric with a business-focused operating model. This could make it difficult to function autonomously, particularly if not a budget holder.

The types of leadership structure could also impact whether nurse leadership was effective. Those working in organisations with a flat or interdisciplinary management structure felt that they had more influence (n=9). Smaller organisations were seen as more flexible and

those organisations that were flexible were considered to embrace positive change and be willing to consider alternatives.

Recognition of nursing skill and knowledge was considered important (n=7). Several respondents (n=5) mentioned the opportunities that their organisation provided them such as professional development, mentoring and the ability to lead projects that are important to nursing. In contrast, one leader mentioned difficulty in acquiring funding for further education or to attend conferences.

Organisations that had directors of nursing who were well respected in the management team felt nursing was well supported and had the opportunity to effect change by being involved in policy and service initiatives (n=5). These senior nurses were seen as role models. Other respondents saw nursing leadership roles as undervalued, commenting that nurses had to speak louder to be heard in their current structures (n=5).

We may sit at the table but are not listened to where there is a financial cost implication. Nursing needs to hold the nursing budget. Nahi, Role: DHB

Multiple reporting lines, layers of approval or silos within an organisation were thought to make communicating a nursing viewpoint difficult, especially if there were different governance styles (n=5). Several nurse leaders commented on the ineffectiveness or overlooking of the “nursing voice” and that sometimes the nurse in their title got in the way. However, one respondent felt that formalised titles could be both helpful and unhelpful (independent practitioner).

According to the respondents, nursing professionals were perceived as more operational, and decisions made by nurse leaders could potentially be superseded by predominantly male executive teams. Those with dual operational and professional responsibilities often felt conflicted (n=3). There was seen to be a risk that healthcare decisions could be made that were not inclusive of nursing or equitable.

Q 20 To what extent have the key people in your life supported you to take up **and** sustain a leadership role?

Support and encouragement from key people such as partners, parents, adult children, and other whānau members were thought to have a considerable influence on a nurse leaders career pathway.

The two respondents who selected that these people had no influence were both female, one NZE the other Māori, working in a PHO and DHB, respectively. One of these felt that her key people were not particularly interested in what she did at work.

Table 16 Support of key people

	None	Slight	Considerable
To what extent have the key people in your life supported you to take up and sustain a leadership role?	2	4	43

Q 21 if they have supported you, in what way?

Many of the survey participants expressed gratitude for having supportive partners who assisted them in managing the demands of their careers and studies. This support included child-rearing, household chores, and emotional assistance by listening and encouraging their self-belief (n=23). Participants found it valuable to discuss non-clinical issues such as leadership, management, staff management, and career aspirations with their loved ones to gain a different perspective outside of nursing (n=6). Whānau were seen as understanding the nurse leaders' capabilities both personally and professionally (n=5). These key individuals were also accommodating of the long work hours, time away, and work brought home that the nurse leader's role entails (n=8). Overall, whānau played a crucial role in keeping the nurse leader grounded and settled. However, Rachel's comment about her level of domestic support contrasts with the literature and the general gendered argument that women carry dual loads at work and home.

In everything, my husband is the stay-at-home dad. He makes my lunches for work and rings me to remind me to come home. He makes me dinner every night. He listens to my frustrations and gets excited in my successes. He takes the girls to all their activities and

helps them with their schoolwork. He does the food shopping, the laundry etc the list goes on. I could not do this job without him. He is my safe place. Rachel, Role: DHB

Q 22 Have your cultural or religious beliefs had any influence on your career choices?

Early hospitals had a strong moral foundation which persisted in the beginnings of healthcare in NZ. Some institutions requested a testimonial of good character before employing a nurse. I was interested to see if any religious influence from nursing’s historical roots remained. In alignment with an increasingly secular Aotearoa NZ, over half of the nurse leader respondents felt that cultural or religious beliefs did not influence their career choices. Three of the six survey participants who identified as Māori answered yes to this question, with another unsure.

Table 17 Influence of beliefs

	No	Unsure	Yes
Influence of cultural or religious beliefs on career choices	33	3	13

Q 23 In what way could they have influenced you?

This question had multiple interpretations - based on ethnicity, family, or practice. Only 25 respondents answered, with several commenting on their family tradition of women becoming nurses (n=6) and the feminine attributes associated with nursing of service and care (n= 5). One respondent commented that she was “made to do nursing” as a career choice. However, another respondent commented that her liberal feminist mother encouraged her to reach her full potential in whatever career she chose.

Family culture maybe... I think the influence of caring was there. Rosie, Role: other

Nursing was viewed as a profession that crosses multicultural and multi faith boundaries. Two respondents were raised in Catholic households where nursing was seen as a good vocation for women, while five professed a personal Christian faith which guided their leadership career choices. The career choices of other respondents (n= 4) were influenced by a sense of justice or equity.

A social conscience serves me well... "If it's the right thing to do let's find a way to make it happen. Mack, Role: PHO

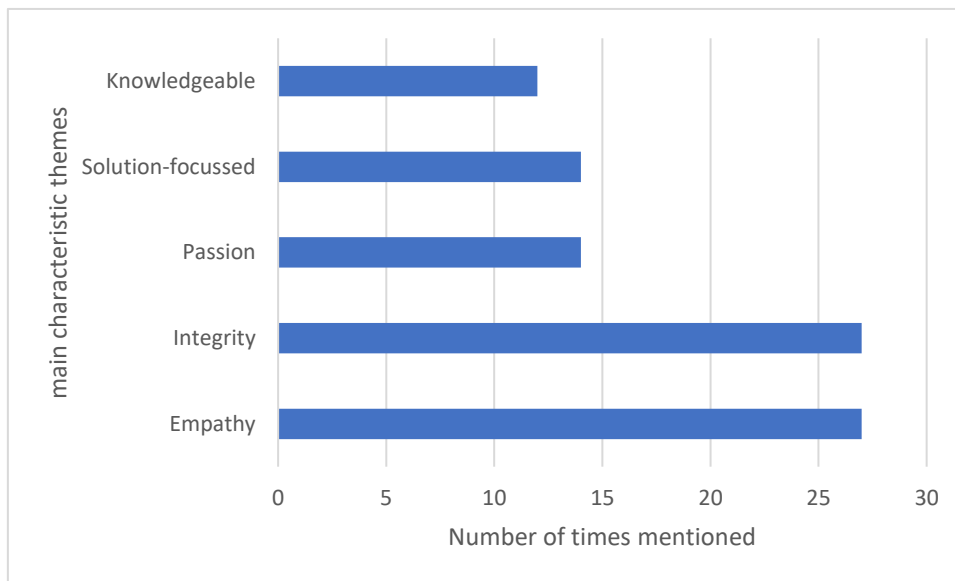
Tikanga and a desire to see other Māori succeed were cited as strong motivators by three respondents. One of these, Nahi, spoke of being a strong advocate for Māori and Pacific development wanting to lay a foundation for the next generation of nurses. Other participants mentioned factors beyond ethnicity, such as gender (n=4).

I am part of a minority cultural group and have a strong sense of equity and justice - this is best expressed through my work to build and develop health systems in which all diverse groups and individuals can receive care/services to improve or maintain well-being. TM, Role: other

Q 24 What characteristics do you value in a nurse leader?

In the survey, participants were asked about the qualities they believe a nurse leader should have. The analysis of the responses showed that the top five characteristics mentioned were empathy, honesty, passion, being solution-focused, and being knowledgeable. It's noteworthy that these characteristics align with the four core values of the NZ Nurses' Code of Conduct: respect, trust, integrity, and partnership. Haar et al. (2018) identified five common Māori leadership values as humility, generosity of self, collectivism, stewardship and tikanga, which helped a Māori nurse negotiate western-based organisations. These indigenous values whilst similar, focus more on others than the individual.

Figure 6 Characteristics valued in a nurse leader



Q 25 Describe the characteristics in nurse leaders you encountered that inspired you to follow in a similar role

As in the previous question it was emotional intelligence in the form of kindness, empathy and listening that respondents aspired to emulate (n=13). Inspirational leaders were seen as authentic, honest, trustworthy, and values-based (n=9). Respondents commented that the leaders they respected acknowledged the work of team, valued the work of others and gave credit appropriately (n=4).

Nurse leaders who acknowledge their team; the hard work, input into problem solving or quality improvement etc. When a nurse leader acknowledged a team member by name in either a formal or informal setting it always made me feel I had accomplished something prior to gaining a leadership position myself. I try to do the same now that I am in a position to give recognition to others. Jill, Role: other

Those who were bold, courageous, and innovative in their nursing practice were also considered influential. These risk-taker leaders were seen as adaptive and unafraid of taking a different approach (n=10). In apparent contrast to this were leaders valued for their ability to bring calm out of chaos (n=5). Three respondents valued leaders who "rolled their sleeves

up" to help, having maintained clinical knowledge and competence. Other respondents valued leaders for their vision and passion, both for nursing as a profession and as an advocate for staff, patients, and their communities (n=9).

I encountered nurses who were dissatisfied in their current situation and decided to do things differently to create change.... Nurses who said "I wish I could" then did it. Leaders who were interested in how I saw things, and wanted me to become a leader myself, create a new model. Heather, Role: other

Three respondents took a contrasting view of this question commenting on behaviours they did not want to emulate in their own leadership. These behaviours included autocracy, over emphasis on difficulties, and micro-managing. Another respondent stated that her career success had come from mentors in fields outside of nursing.

Q 26 Describe anything about a nurse leader you have worked with that deterred you from seeking career advancement

Eight respondents stated that they had encountered nurse leaders who appeared to be out for their own gain and importance, self-seeking individuals who would take credit for the work or ideas of others. Also mentioned was the misuse of power or hierarchical type leadership where little or no consultation occurred. In these settings bullying, exclusion and belittling behaviours were noted (n=8).

Remote. Micromanager. A gossip. Would delegate work but take the credit when completed. Never had anything good to say about people. ... Decision maker with little or no consultation with those directly affected by the decisions being made. Rosie, Role: Other

Poor role models of leadership exhibited a lack of core values and ethical standards (n=3). These leaders showed a lack of empathy, appearing distant or disinterested in staff (n=5). Respondents mentioned leaders they had encountered who had no clear vision, had become complacent, avoided conflict, and did not speak out on behalf of others (n=4). Other deterring factors were a lack of current nursing knowledge and lying to cover up inabilities (n=2). Self-destructive behaviour that could lead to burnout/stress was observed amongst

senior leaders with an expectation that this was the norm (n=2). Four respondents stated that it was the poor behaviours of nurse leaders they had encountered that influenced them to act differently and become the leaders they would wish to see.

It inspired me to become a leader and to do things differently avoiding behaviours that left me feeling a bit cold and alienated! Mack, Role: PHO

Q 27 Do you believe that there are any power imbalances/inequities in the NZ nursing work environment?

The prevailing power imbalance of a medical model of care and its associated masculine dominance was mentioned by eight respondents. It was seen that nursing often takes a subservient role and defers to medicine as a remnant of health's historical background. Four respondents noted that nurses are still perceived as handmaidens, and their voices are often not heard or valued.

The advent of neoliberalism has further increased the influence of business managers in the existing hierarchical structure. Nurse leaders reported that they were afraid to speak out in meetings for fear of being perceived as unintelligent (n=1).

The power imbalance is still around medicine and nursing. This can be seen at all levels of the healthcare system ... I have spent all my career justifying the contribution of nursing. JR, Role: DHB

Five respondents saw inequity within a nursing culture that was exclusionary at the top, with senior nurse leaders perceived to be gatekeepers of information and in their positions due to age not necessarily skill. Old ways of training and practice were thought to be more dominant (n=1). A small number of respondents suggest that old hierarchical notions of leadership and negativity etc influence the behaviours of some leaders still

I am sad that nurses continue to whine about being victims yet eat their young... Kiwi expat, Role: Educational setting

Healthcare organisations were perceived as patriarchal and Eurocentric (n=4). Senior leadership appointments were not always transparent and were perceived to be biased against individuals of other ethnicities or those who did not have favourable relationships with the recruiters (n=7).

The obvious (imbalance) is the lack of ethnic and gender mix...I guess colonisation, unconscious bias, sexism, and a deep rooted conservatism. Mack, Role: PHO

Māori RN and IQN were seen as being disadvantaged when it came to being appointed to senior roles. One respondent commented that there were few opportunities to advance based on merit and that people on secondments to roles were often overlooked when it came to appointment.

In general, it was felt that a power imbalance existed because nursing as a profession was poorly understood and undervalued. Pay inequity and limited access to financial resources for ongoing education exacerbated this belief (n=5). Some respondents felt that although we had come a long way from our militaristic roots a multi-generational change was needed to fully embrace all that nursing can offer.

Q 28 Describe any experiences where you consider that your gender enhanced or impeded your leadership advancement/influence.

Gender was used rather than sex as I was interested in whether self-identification had an impact on a career pathway. It was difficult to elucidate this from the answers given.

There were 44 respondents to this question, including males, and females, some of whom identified as members of the LGBTQ+ community. As depicted in Figure 5 (below), just over half (26/49) of those who answered the question believed that their gender did not affect their career trajectory, either positively or negatively.

Table 18 Gender impacted role

Yes	16
No	26
Unsure	2
Blank	5

In answering this question, several respondents commented on the masculinities and femininities associated with the different healthcare roles. Eight participants mentioned a perceived bias towards male nurses in terms of leadership and health. It is generally believed that men find it easier to secure leadership positions in nursing due to their sex, although some respondents challenged this perspective. The male nurse respondents believed that it was their leadership ability, rather than their sex, that enabled career advancement.

In nursing the gender discrimination is often the opposite where females dictate ... Nonetheless, the management positions are still mainly occupied by males. It could be also because in order to progress in nursing, males have to become really tough. Therefore, they develop stronger characters ... to advance their career. Navarra, Role: other

This perceived male bias, combined with medical hegemony, caused difficulties for some female leaders when interacting with senior male medical staff (n=5). This group found themselves defined by stereotypical feminine attributes that limited the impact of their nursing voice. During a meeting dominated by men, for example one female respondent described finding it challenging to demonstrate her ability to contribute meaningfully. She attributed this to the completely inappropriate behaviour of some men.

The male hospital manager told me I should wear black as it made my tits look good. The male doctors ... bullied me including shouting swearing. Anne, Role: other

In contrast three respondents wrote of feeling respected both as women and for their professional abilities. They believed that their knowledge, experience, or the uniqueness of their role negated any influence of gender.

Q 29 Reflecting on your leadership journey up until now, what has been the greatest enabler for you to progress to the role you currently have?

A number of the respondents (16/49) mentioned support and encouragement from whānau, colleagues and/or managers as a significant enabler in their career journey. A

further six respondents indicated having people who believed in them or who acted as a mentor, guiding them along the leadership pathway.

Pursuing further education or training was the second most frequently mentioned enabler to role progression (n=11). This education did not necessarily need to be in fields usually associated with nursing. Benefit was also found in training outside of a clinical pathway, such as business and economics. Seven respondents could look back and see how the breadth of opportunities and their varied career experiences had shaped their lives and led them to the role they now hold (n=7).

The variety of roles I have undertaken which has given me a breadth of knowledge and experiences. I have always had a career plan but invariably gone down a different path at each stage which has been very rewarding. It has opened my mind to other ways of thinking and challenged me. Rosie, Role: other

Another strong enabler was a leader's self-determination, having a passion and a strategic vision for what they wanted to achieve (n=7). Others (n=4) spoke of their self-belief that gave them the courage to challenge situations and be content with not always having a solution to issues confronting them.

No one enabler, a combination of many things: self-determination, recognition and support from colleagues and leaders. The system can very much enable your progression as long as you are prepared to learn, listen, and contribute. Mack, Role: PHO

Q 30 Describe anything that supports or encourages you in your role

Nurses who were surveyed identified their friends, peers, colleagues, and team as the greatest source of support (n=21) for their leadership role, followed by family (n=10). The results were consistent with the answer to question 20, which noted that support and encouragement from key individuals played a significant role in a nurse leader's career choices.

Having a great team around me and excellent colleagues within the organisation, as well as nationally and internationally. I think it is important for leaders to be well connected.

Connor, Role: Educational setting

Additionally, networking with other senior professionals, such as the Nurse Executive of NZ, was found to be helpful for both encouragement and the sharing of information (n=7).

Nurse execs of NZ are a great bunch of nurses, always willing to help. Zoe, Role: NGO

Another factor found to be encouraging was being able to make a difference through the work their role affected (n=7). The respondents noted that it was fulfilling to see people's lives transformed and to have an impact on their communities. Additionally, respondents appreciated having the autonomy to set their own goals or priorities and to work on issues they were passionate about, even though they didn't all hold the budget. Other supportive factors mentioned were recognition of good performance acknowledged and success (n=4). Three respondents particularly commented on the need to feel respected and valued in their organisation. Additionally, some respondents felt that the challenges of a senior nursing role encouraged personal and professional growth (n =9) through increased knowledge and understanding.

Being valued and being trusted with the freedom to work at the things that I feel really matter...I feel that I am now in a position to prioritise the work that I feel is important. JR,

Role: DHB

Q 31 Describe those things that challenge you/make your role difficult

This question appeared to elicit emotion from the respondents, judging by the type of language used. Emotive words used included *struggle*, *mixed messages*, *having to defer*, *bite my tongue*, and *juggling too many balls*. The role presented a multifaceted challenge with high expectations and unclear definition, leading to feelings of pressure among the respondents (n=7). Increased demands within an environment of budget constraints and limited resources caused frustration (n=4) and meant that sometimes

organisational requirements came into conflict with nursing or personal values (n=2).

Working in broken systems that were both bureaucratic and complex was difficult, especially amidst constant restructuring with the associated loss of skill set (n=5).

Job size was one of the major challenges faced by nurse leaders, indicating there was a lack of sufficient time allocated to complete the extensive amount of work (n=11).

Huge expectations to deliver while trying to balance a diverse and heavy workload due to understaffing and a lack of understanding from the organisation about the demands of the work, particularly at an advanced level. Anne, Role: Other

Not having enough time to do the work I need to do with a constant juggle of clinical, leadership and academic responsibilities. JR, Role: DHB

Competing demands, priorities and time constraints made it challenging to take time for reflection or proactive planning. Delegation becomes imperative, which means trusting others to complete the task. However, it can be frustrating if others do not fulfil their work obligations.

I have limited tolerance for incompetence, which is one of my weaknesses as a leader. I operate in a high-trust, high-accountability environment, so I find it difficult if others cannot be trusted to work as agreed. Connor, Role: Educational setting

Some survey respondents identified several issues within the nursing field that made their role more challenging. One of the main issues was a lack of cohesion and collegiality among nurses. Respondents observed that some nurses lacked emotional intelligence and did not seem to care for each other (n=6). This conduct often resulted in oppressive group behaviours such as the "tall poppy" syndrome (n=3).

I am assertive and opinionated (two traits I admire and do not apologise for). Other nurses can feel intimidated by vocal colleagues / tall poppies and won't/don't support me. TM, Role: Other

Another issue was the conflict between health unions and executive leadership, which was seen as a barrier by one respondent.

The politics of nursing make my role difficult. I work closely with the health unions, the ministry and executive leadership and sometimes feel these groups play each other off just for the sake of it. Sometimes it is the disagreement between these groups about something that causes a roadblock for my work. Sometimes I don't agree with these parties and have to bite my tongue just so I can get the work done. Jo, Role: DHB

Nursing was seen as an undervalued profession with their opinions not sought or heeded (n=2). Respondents felt a lack of acknowledgement and respect for their ability (n=2), with one commenting that non-nursing healthcare staff did not understand their role or capability.

I experience bewilderment from non-nurses, especially doctors, senior DHB/sector/ministry managers and lay people - they seem amazed that I can speak rationally and confidently, and I am aware I have changed their views of nurses and their ability to participate and contribute. I have been told I am not like any "usual/normal" nurses they know. This is both helpful but also hinders my being taken seriously at times - as if I can't speak for the profession or on behalf of nursing because I am not really like a nurse anymore. TM, Role: Other

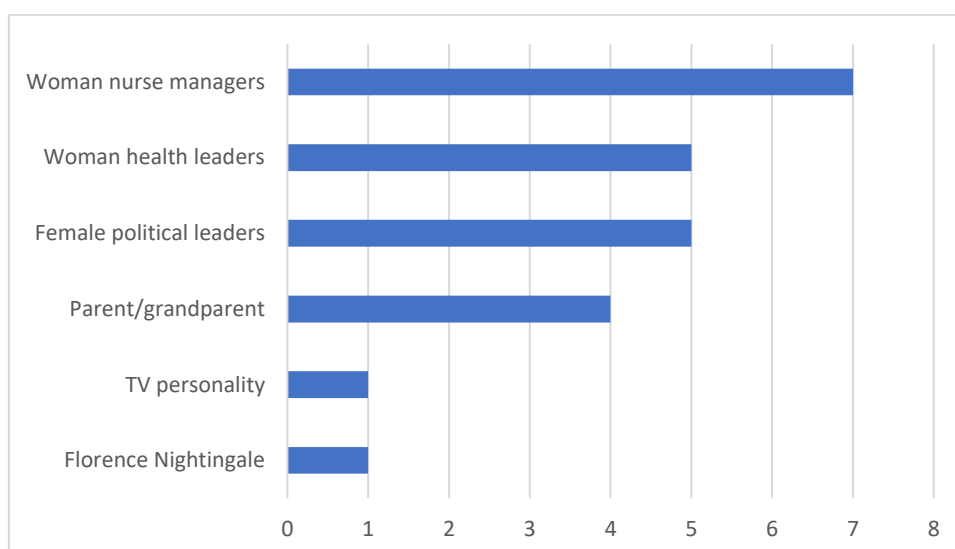
Q 32 FEMALE GENDER SPECIFIC

This was a two-part question and was answered by 21/45 of the female respondents

Part one: As a woman, what women in leadership role models have you had throughout your life?

In part one, several specific role models were mentioned and grouped into role type to be quantified. A popular choice was the then prime minister of Aotearoa NZ, Dame Jacinda Ardern. Only one participant mentioned Florence Nightingale, who has previously been regarded as a critical figure of importance in nursing history but whose influence lacks relevance to contemporary leadership.

Figure 7 Role models of study participants



Part two: What are your thoughts about the type of mentorship/guidance women need to achieve?

The second part of this question allowed the respondents to offer advice on factors that would help a prospective leader on their career trajectory. It was noted there were a variety of responses that covered a number of topics that concerned the respondents. The predominant factors raised in the text answers to this question are listed in Table 19.

Table 19 Factors raised in part two of question 32

Factor raised	Number of times mentioned
Mentorship is essential to becoming a leader and sustaining leadership	16
Value of ongoing education	16
Need to maintain a good work/life balance	10
Be authentic, ensure organisational values align with own	9
Develop self-belief so empowered to speak up	6
Need for high emotional intelligence in leadership	5
Need for personal integrity	4
Value in gaining knowledge outside of mainstream health	3
Reflect on the motivation for seeking leadership	2

Having a mentor was found by the respondents to be extremely beneficial for individuals in leadership roles (16/45). Mentors help their mentees to look at their roles objectively, reflect on both negative and positive aspects of their leadership, and gain confidence. Six respondents emphasised that a good mentor can also help foster a sense of self-belief that enables one to speak out and be heard. Mentorship can take many forms, including both formal and informal arrangements, and the mentor can change as leadership progresses or for different roles. TM had the benefit of several people throughout her career journey from whom she could draw wisdom.

The women mentors and role models I have profited from have been nurses, but also non-nurses, strong women family members, women in management roles and women from other health disciplines. Women particularly need mentorship that supports not only the development of leadership skills, but also how to confidently take their place and stand in the world and "take up space". TM, Role: Other

For women who aspire to leadership positions in nursing, ongoing education is highly recommended (16/45). Pursuing post-graduate education not only adds credibility but also challenges one's thinking. Additionally, three respondents found learning outside of the clinical nursing mainstream beneficial. Nurse leadership encompasses multiple aspects, such as the political, medicolegal, and business realms. Consequently, training in these areas is thought to be worthwhile, as specifically mentioned by the respondent Kiwi expat.

Undertake specialist management and leadership training - just because you are a nurse does not make you a leader. It is a specialised body of knowledge. Engage in political training - political acumen is critical to success. Leadership is a political activity involving aspects of advocacy, influence, negotiation and collaboration - these things are not taught in nursing school. Kiwi expat, Role: Educational setting

High on the list of priorities was the need to maintain a good work/life balance (10/45). Self-care in the shape of cultivating healthy relationships, exercise, and acceptance

that leadership would not always be easy was believed to help develop resilience to sustain a leadership role.

Don't be afraid to admit you've done something wrong, as you learn more when things are more challenging and don't go to plan. Rosie, Role: Other

Being authentic and aligning one's values with those of the organisation was considered crucial (9/45). To achieve this, a successful leader should possess both high integrity (4/45) and emotional intelligence (5/45). Two respondents suggested that individuals should reflect on their motivations for pursuing a leadership career and be self-aware of whether their choice is driven by ego.

6.4 The Basis for Phase Two Interviews

After analysing the phase one survey and reviewing the relevant literature, a semi-structured interview schedule was developed to explore topics of interest with nurse leaders who had indicated their availability for interviews. This formed the basis for conducting the second phase of the research. As I listened to participants and read concurrently, I came to understand the centrality of gender to their experiences as aspiring leaders in health service settings.

Leadership raises the question of nurse identity and its impact on career options. Manning (2022) described the identity of nurses as impacted by “entrenched gender inequalities” brought about by our militaristic and religious past. Historically, nurses have had to negotiate medical hegemony and other forms of paternalism to effect change in patient management. I wanted to understand what motivated current registered nurses to transition from their initial roles as bedside nurses and the experiences they had in their journey toward becoming a nurse leader.

The literature review in chapter two aligned with many of the factors outlined by the respondents to the phase one questionnaire, particularly the importance of post-graduate education in a registered nurse's career trajectory. Both the literature review and the questionnaire responses identified several factors that enabled nurses to pursue leadership

careers. One of the most important enablers was having a support system at work and home, which could help with household chores and family responsibilities. This finding warranted a more in-depth analysis using a feminist theoretical lens. Additionally, having a coach, mentor, or professional supervision was strongly supported. In order to guide leadership succession planning, this needed further exploration. Gathering further data on career enablers would strengthen the case for making them available to all RNs who are beginning a career pathway.

During the literature review and phase one questionnaire, it became apparent that male hegemony remained prevalent and acted as a potential barrier to nurse leadership. The current neoliberalist environment in which nurses are working also tends to reinforce and reward paternalism and masculinity. To get a better understanding of male nurses' views on any gender differences in career advancement and work challenges, I conducted a purposive interview with a male nurse leader. His perspective on the belief that male nurses have fewer career obstacles provided a more rounded viewpoint.

Another specific group that I wished to interview were Māori nurses. I had found only a small amount of literature concerning Māori nurses in leadership, and this was not included as a specific question in the survey. Some of the Māori nurses in the survey perceived their work environments as unsupportive towards them as Māori women. Strategies, particularly the NZ Māori Health Workforce Strategy, have been deployed to support our tangata whenua into nursing and to progress towards leadership. The particular influences and challenges to a career trajectory for Māori RN were of relevance to the research question and needed to be explored in greater depth.

The majority of the respondents believed that nursing should have more influence in the governance of the health system. However, organisational structures are perceived as a potential barrier to the ability of nurse leaders to bring about change. This raised the question of how nurse leaders manage the tension between their managerial duties and their professional responsibilities as nurses. Additionally, I was curious about how time constraints

due to workload pressures affected the manager's ability to model professional values and inspire the next generation of nurses so that succession planning was assured.

6.5 Summary

In this chapter, I have presented the results of the first phase of this multi-method study, the exploratory descriptive questionnaire. The questionnaire contained questions in both Likert-style with explanatory text and longer answer formats, which were integrated to answer the question. I have provided details about the participants' demographics, including the types of leadership roles they held. Additionally, I have shared data regarding the level of support they received from their family, friends, and colleagues, and what influence this had, if any, on their career pathway. I also explored whether they had received any form of mentorship or professional supervision in their career journey and discussed the value they perceived this to have. The final questions covered the top qualities that the respondents valued in a nursing leader and the type of person they considered a role model. The survey concluded with the opportunity for the respondents to offer advice to aspiring leaders on what factors had been found helpful to a leadership career trajectory. I concluded the chapter with some key learnings from the questionnaire responses that were used to inform the phase two interviews described in the next chapter.

Phase one highlighted the value respondents placed on postgraduate education and support at home and in the workplace in their journey to becoming a nurse leader. The respondents had been inspired by attributes such as empathy, compassion, openness and integrity – mostly qualities assigned to the feminine binary. Once they had attained their leadership roles some respondents had experienced power imbalances and organisational structures that impeded they're being a leader in the way that they felt appropriate. These sub-themes are explored in greater depth through the analysis of the interviews.

Chapter Seven: Integrated Findings - Gendered Socialisation

7.1 Introduction

I now move to present the integrated findings of this multi-method study. A nurse is generally defined as “a person (historically usually a woman) trained to care for the sick or infirm, especially in a hospital” (Oxford English, 2024). Like many, I entered nursing with that definition in mind as well as a societal perception of a nurse as an “angel of mercy” and a “Doctor’s handmaiden”. It was only after years of experience and further study that I came to realise how being raised in a eurocentric, gendered NZ had influenced my career choices and impacted my nursing practice. The findings of this research demonstrated that many other nurses are similarly influenced, although not everyone realised the effect gendered socialisation and the neoliberalist environment had on the way they practised.

In chapter five, I introduced the 13 nurse leaders interviewed for this research: Adam, Anne, Aroha, Connie, Erica, Jo, Julia, Kathryn, Navarra, Pip, Si, Tuakana and Valmai. Despite coming from diverse backgrounds and work environments, these nurse leaders have encountered similar experiences throughout their careers. Their experiences and those of the questionnaire participants will be examined further through a feminist deconstruction of gender lens.

The findings explore two main themes: gendered socialisation and negotiating the binaries in a neoliberalist environment. Gendered socialisation, the process through which cultural norms for each sex are learnt, provides the foundation for becoming a nurse leader. These expectations of what a nurse is and does are subconsciously part of the fabric of every entrant nurse and influence their decision-making. My second major theme, negotiating the binaries explores how the experiences encountered in a leadership journey are shaped due to the limitations of belonging to a feminised profession in a predominantly masculinist environment.

In this first qualitative findings chapter, I present the following subthemes: beginning the journey, disillusionment, and gendered impediments as the initial stages of an emergent nurse leader's career trajectory. The first subtheme, "Beginning the journey," discusses the concept of the caring bedside nurse as a stereotypical view that a nurse carries with them as they embark on their career. While some are content with this role, others become dissatisfied and seek ways to achieve career fulfilment. The second subtheme explores the disillusionment experienced when attempts to advocate for patients and uphold cultural and nursing values become challenging. Lastly, I will outline the gender impediments faced by nurses working in a feminised profession, regardless of their sex, including nursing's legacy of oppression from within the profession and the deference to medicine and areas related to the masculine binary. I will also discuss how these themes relate to the tangata whenua of Aotearoa. This chapter explores the challenges to overcome to become and be a nurse leader in New Zealand.

7.2 Beginning the Journey

As participants noted, people enter the nursing profession believing they will make a positive impact and provide a valuable service to their community. However, their perceptions of nursing are influenced by years of societal expectations based on gender, from within the family unit and from the wider community in which they are raised. Nursing has traditionally been associated with femininity, and the participants began their careers comfortable with being part of a predominantly female caring profession.

7.2.1 Being a bedside nurse

Just over a decade ago, Perron (2013) noted that nurses were socialised to believe that the essence of their profession lay in humble service and self-sacrifice. Erica strongly believed that when nurses of her generation began their careers, nursing was considered to be about devoting oneself to others.

Erica: I am of an age when nursing was a SERVICE career. We developed relationships with people in order to ascertain their needs and assist them towards recovery. My original nursing tutors taught me the value of person-centred care.

Although this notion of service is now considered outdated within the profession, entrant nurses are still influenced by stereotypical perceptions of what a nurse is and does, primarily as the benevolent doers of healthcare (Ferguson & Anderson, 2021; Van der Cingel & Brouwer, 2021). Society typically expects nurses to be caring and compassionate, and nurses also view themselves as kind and helpful individuals (Van der Cingel & Brouwer, 2021). Jo commented that career progression wasn't everyone's life goal and believed that few nurses entered the profession with a career pathway in mind.

Jo: I think some do, but the majority don't. They go in to provide care on the floor. I think, to be honest, it's influenced a bit by TV, by programs like Shortland Street, and most of them come in wanting to be a nurse on the floor.

Survey participants were asked whether they believed that considering nursing primarily as direct patient care limits some nurse's career ambitions. Connie explained this from her experience in various healthcare settings.

Connie: I think it depends on how they start off thinking about their career pathway. Some nurses see themselves as exactly the way you've described, and that's the world envisioned by many. That's their happy place and where they want to be.

Navarra thought a strong clinical foundation was essential for leadership, but acknowledged that bedside care could be an endpoint for some nurses.

Navarra: Most nurses prefer to have jobs that are hands-on, with direct care of patients. Unfortunately, the career paths for those people are very short.

Māori nurses have an additional responsibility as tikanga expects them to act as an advocate for their whānau and iwi as well as their personal career ambitions. Māori nurses do not practice as individuals but as a collective and carry the mana and expectations of their whānau, hāpu and iwi with them in their mahi. Wahine (female) Māori may have been

deliberately raised to be carers because of traits they were believed to bear. Kuia may identify and nurture a caring or leadership skill they believe a child has inherited from their tūpuna. That child then grows with the expectation that they will pursue a career pathway aligned to that skill for the benefit of their hāpu. This was certainly true of Tuakana, who was raised by her grandparents to be a nurse and follow both cultural and leadership pathways.

Tuakana: My nanny knew that I was pre-destined to be a carer of others and I was nurtured in that direction. Whakapapa is important and the work started by others must be continued by the next generations.

Thus, tikanga directs and guides their career choices. Māori nurse leaders interviewed keenly felt the dual accountability to both their iwi and their organisation. Aroha explained it like this:

Aroha: It's all on you (referring to whānau expectations), and because I was the nurse, it's like, you should be doing this and doing that. But actually, I had other aspirations.

When participant nurse leaders chose their career direction, they were clearly aware that they had chosen nursing as a profession because they felt comfortable with the nature of nursing as they perceived it. Adam was aware of the barriers nurses faced but still considered nursing an excellent career choice.

Adam: I love nursing, I really do. It's incredible. You are generally respected, and you can make changes to people's lives and go home thinking, "Man, that was cool!" There are not many other jobs you can do that.

7.2.2 Looking beyond the bedside

While many nurses are content to remain in direct patient care, others start to look beyond the bedside. The phase one survey data highlighted the significance that nurse leaders placed on postgraduate education in shaping their career paths. This theme was further explored in the interviews, where I discovered that all the participants had initially followed various clinical pathways. However, their experiences and postgraduate education

had broadened their horizons, leaving them both aware and desirous of new challenges. Connie and Anne, who both had worked in nurse education, discussed the benefits of ongoing learning for aspiring nurse leaders:

Connie: I think getting engaged in postgraduate education is definitely a key that unlocks lots of opportunities because it challenges our brains to think in a broader way.So, education and a desire to actually influence the system, but that desire to influence the system usually comes because of taking the step to do postgraduate education. I think the two are inextricably linked.

Anne: I think what I see in my students entering a master's program is that they have a very fixed idea of themselves, often around their current role, and can't really see beyond that. I think what postgraduate study helps them to do is to dismantle that kind of rigid view of themselves and to open up new possibilities for them in their thinking.

Participants essentially describe postgraduate education as an opportunity to see the entire service delivery from a perspective not overwhelmed by the demands of daily practice.

Valmai: I mean the thing about postgraduate education is that it gives you time to think. In the basic clinical world nurses are in there is not a lot of time for that stopping and reflecting -on what the literature might be saying, what others are saying because it is all consuming. You are doing a lot of critical thinking in clinical work, but the ability to stop and step outside of that is one of the great benefits of postgraduate education. The big picture, lifting your gaze to understand that there is a system, that nothing happens by accident. That there is a system that is working in order to effect change.

Postgraduate education encourages reflection, critical thinking, and access to a broad range of literature, making it truly enlightening. However, this study reveals that there is no established process to determine the reasons why candidates should undertake postgraduate education and whether they aim to enhance their clinical skills or follow a leadership path. Currently, all Te Whatu Ora/Health NZ organisations permit universities to

conduct on-site information sessions for their staff before workforce development funding rounds. Ultimately, it is the decision of registered nurses whether they choose to participate in these opportunities and at what stage of their careers they wish to do so. Although some continuous professional development is mandatory as part of maintaining nursing registration, these hours can usually be filled by organisational requirements.

As demonstrated by the findings, postgraduate education often serves as a catalyst for the professional growth of nurses by exposing them to a broader view of nursing's potential. As a result, these nurses may seek out leadership roles where they can better pursue their goals, or they may be fortunate enough to have a mentor who recognises their leadership potential and provides them with leadership opportunities.

7.2.3 Emerging as a leader

Early in their careers, some nurses identify as emergent leaders through their behaviours and the critical thinking they apply to enhance processes and care delivery. Both Adam and Julia as follows, describe a mix of identifying a need for change and being identified as a person who could be the agent of that change. Adam noted:

Adam: The reason I'm in leadership was because I was outspoken on the floor, I made some changes from the floor, and it was recognised. I was spoken to by the DON and asked, "Where are you going in your career?" So, it was picked up early by other people not from me. Now I don't believe it was a male thing. I think it was me just doing what was right instead of following the lemmings over the cliff. It was that simple, change a simple thing like that (equipment placement). It was like I'd taken on Armageddon seriously. I just persisted, and practice changed.

Julia describes being identified by a senior colleague as a potential leader.

Julia: I had an interest in x and got a position under an excellent role model. She was doing postgraduate study, which was unusual at that time and was active on the national scene. There was an expectation that I would follow. I had tapped into something I enjoyed

and was goal-driven, not ego-driven. I learnt the tools needed and gained skills to bring others on board, professional leadership, research skills, and higher-level policy work.

For Valmai, it was her innate curiosity that made her stand out among her peers.

Valmai: I'm curious about how the world works and how things are interconnected. I seek out that information so that's always been part of who I am. As I gained more experience throughout my career it's probably more deliberate that I built on those strengths.

None of the nurse leaders interviewed had foreseen attaining the roles they currently hold. The outcomes and choices made by this group of leaders seem to have been influenced by various factors. It seems that serendipity plays a role in a nurse being recognised by their organisation as a potential leader. For Adam and Julia, clinical leadership and role modelling led to them being recognised as having potential for more senior roles. However, this highlights the structural positioning of nurses who are often leaders in their clinical space but not necessarily in a structured positional role. Anne echoed my own experience that the work of emerging nurse leaders often goes unrecognised, is actively ignored, or the credit is given elsewhere.

Anne: We've got nurses doing leadership quite young, but I think we are not always good at calling that leadership.

Often, the participants' career trajectories took them in different directions from their initial visions. Kathryn mentioned catching up with an old classmate at the start of her new role and reminiscing about how, as a new practitioner, she would have never imagined achieving such a position. It was Kathryn's strong Christian faith that led her to believe that she was divinely guided on her pathway to becoming a nurse leader. She saw this as an act of obedience to the direction she felt led. Valmai felt serendipity, being in the right place at the right time had directed her career.

Kathryn: So even then, somebody else is tapping me and saying this is for you. So, it wasn't really a conscious decision at all. I guess I could have said no. But I've learned over time. You don't say no to God.

Valmai: They asked me to speak about my journey and I was sharing with them that when I look back on my career you could present it as a linear thing – I did this then I did this, but the title of my talk was “serendipity and nonsense” because it was about mostly being in the right place. I think there is an element though, even with serendipity that you have to be aware of the potential of the serendipity. A similar person in the same context may not see the same opportunities that I did because I was sensitised to knowing what to do.

While almost all aspiring nurse leaders express a desire to help people, only some come to see that their impact could be significantly increased from a leadership perspective. If their contributions are not acknowledged, they may become disillusioned, resulting in emergent nurse leaders feeling disappointed and unfulfilled.

7.3 Disillusionment

The traditional and gendered perceptions of what nursing is as a career differ from the reality most nurses experience (Branden & Sharts-Hopko, 2017; Topola & Miller, 2021). For some nurses, clinical roles do not fulfil their personal and patient care goals. As an educator, Jo has witnessed this shift many times, where nurses who become disillusioned begin exploring new options when given leadership opportunities.

Jo: We've got a lot of nurses, they go into the profession and truly love bedside nursing, and they're happy with that, and then you've got nurses who move into leadership roles because they want to make more of a difference.

7.3.1 Trying to advocate

In addition to performing bedside nursing tasks, many nurses enter the profession with the desire to advocate for their patients and communities. Valmai dared to speak up when she encountered practices that she saw as not centred on patients.

Valmai: I remember saying to the charge nurse "Why are we doing that? The people we are caring for don't live to serve the consultant".

Speaking up such as this example remains countercultural in nursing. Participants noted that the gendered socialisation in nursing, which emphasises being "nice," can hinder genuine communication, even on deeply personal issues. In the healthcare environment, speaking up often carries significant personal risk (Manning & Blair, 2022), as it can be seen as confrontational (Jackson, 2022). As a result, the nursing profession may struggle to advocate for itself, fearing it will undermine its reputation for selfless service.

Although the participants did not necessarily relate their lack of agency to the gendered role of nurses as women they did perceive that their status as a nurse carried less importance. Nursing is often undervalued because nursing lacks recognition as a highly skilled and knowledgeable profession.

Navarra: When I knew how to adjust patient treatment and couldn't engage the management in my attempts to improve the outcome for each person, I tried to contact other facilities or other providers myself. They would carefully listen to me and then would ask what my role is. As soon as they heard "registered nurse", there was an awkward short "I see" followed by ignorance. This is when I realised that if I want things to happen the way I want them to I must do it myself.

Persistent devaluation of nursing knowledge has, unfortunately, led to worse patient outcomes as evidenced by Adams et al. (2024) and McDonald (2022). Generally, nursing has been complicit in its silence instead of advocating for patients' best interests (Daly & Jackson, 2021). Several of the respondents expressed the frustration they experienced at being unable to deliver effective care in the environments where they were placed, necessitating making alternative career choices. As voiced by those interviewed, this group of nurses felt unable to care in a manner that used their professional knowledge for better patient outcomes. They began to look for ways to influence care delivery.

When the interviewees were asked what motivated them to move into a leadership role, the desire to provide better patient care was a significant motivation for this group of nurses. Julia recalled a troubling example from her early career where business decisions took precedence over providing the best care.

Julia: I was happy in the medical ward and advanced my clinical skills, but the ward closed and I was moved to surgical where I was now not as experienced and left to flounder. I had an autocratic ward manager - we had to use the ward Sellotape on wound dressings as we were not permitted to use the more expensive Micropore. [note: Sellotape more likely to injure patient's skin]

As Aroha and Erica describe in the following excerpts, both became aware that when considering the service from a patient perspective, there was much that needed to change. They recognised that taking on a leadership role might enable them to be a catalyst for improved patient care.

Aroha: Patients would come in, you'd want to make their discharge safer if they came into ED, and then they were for discharge, but it was just too fragmented and frustrating. So, moving into the leadership role, I found it was quite good, 'cause you kind of have that overview, and you can influence and make subtle changes or you have that greater influence with other services in there.

Erica: I wanted to provide person-centred, holistic nursing care. For me, it meant focusing on the client, not on the task. When I look back at the various jobs I've had as a registered nurse all of those roles were centred on understanding the person and what they believed they needed from their perspective.

For some like Pip, a motivating factor was that nurses are frequently overlooked when it comes to seeking their opinions on matters in which they are subject matter experts. This was noted in the repetition of the Woodhull study by Mason et al. (2018), which found that women were quoted half as often as men in health-related articles and were less likely to

be the source of the story. Pip believed that one reason for this oversight is that we don't promote ourselves well or effectively articulate our role in fostering safe care.

Pip: (throughout the COVID-19 pandemic) I never once saw talk about the nursing aspect of how we were achieving these things, the vaccination rates, how we were providing this care.

7.3.2 Holding to our values

It became evident to the participants that there was a difference between what the healthcare system professed and what they saw in practice. Interestingly, an NZ study by Kidd et al. (2020) noted that senior health management were consistently absent at cultural training. Interviewees concurred that tokenism towards organisational values was present and affected care delivery. This sentiment was notably expressed by the Māori nurse leaders, who viewed these values as taonga (treasures) that guided their clinical practice. It was implied that incorporating indigenous values, such as suggested by Haar et al. (2018) would lead to positive experiences for Māori staff. Aroha reflected on this in her comments.

Aroha: My values are similar to the organisation's, but my values I walk daily. The organisation values that I constantly have thrown at me in this role - I just find that a lot of the time, it's tokenism. So, for me, I find it really conflicting because if we are patient-centred, then whānau are very important.

The New Zealand healthcare system has been criticised for being based on a eurocentric model (Lowe et al., 2025; Moewaka Barnes & McCreanor, 2019; Palatchie, 2020), and despite the 2022 Health redesign, no effective changes have been seen as of 2025. The changes made under the new government's 100-day plan have yet to demonstrate any improvement in the poor health statistics of the tangata whenua of Aotearoa. The impacts of colonialism are not openly acknowledged when determining the inequities for Māori in our healthcare systems. Oftentimes, working in post-colonial, medico-centric systems created a conflict of values when it came to providing holistic care to patients. Haar et al. (2018) identified five common Māori leadership values: humility,

generosity of self, collectivism, stewardship and respect for tikanga, which impact how a Māori leader navigates western-based organisations. Te Ao Māori's values align with most organisations' values; however, in practice, conflicts can arise, particularly in resource-strained and time-poor environments. Post-colonial Aotearoa still carries the burden of institutionalised racism, which is often experienced in the form of judgmental remarks about Māori colleagues, patients and whānau. Aroha summed up her experience of dealing with the racism inherent in her organisation.

Aroha: We work in a pakeha system. We have to navigate this. The little snide remarks -people being quite judgmental about families “they should know what to eat” and oh, “they’re all so fat”. Now I don’t tolerate it, but when you’re a younger nurse and just starting out, you don’t say anything because you don’t want to go against the grain.

Thus, some Māori nurses find themselves unable to deliver culturally appropriate care in a manner that they feel is expected of them by their wider communities.

Not all Māori registered nurses (RNs) are deeply rooted in Te Ao Māori, as some have been raised in urban environments and European culture. However, this is changing with younger generations who have been through Kohanga Reo and Kura Kaupapa Māori education systems. In clinical practice, Māori RNs are sometimes expected to take on cultural responsibilities for which they may be inexperienced or unprepared (Komene et al., 2023). These additional duties are often expected by colleagues and the organisation without consideration or compensation. Tuakana recognised the need for having effective support systems in place for new Māori nurses and had championed pairing them with a more culturally experienced nurse in a “big sister” role.

Tuakana: Without the support of an experienced Māori leader, they may be placed in culturally unsafe situations. Models such as the tuakana-teina model provide support and encouragement in a culturally safe format, but this is not always available under the pressure of most organisations

Tikanga can also hinder a career trajectory. If a Māori RN does not feel the support of their peers, hapu and iwi they are less likely to put themselves forward for a leadership

position. Also, the Māori value of whakaiti/ humbleness means that Māori nurse leaders may not always take credit for their work. Therefore, their professional portfolios may not provide the evidence eurocentric systems require when applying for senior roles. A participant reminded me about a well-known whakatauki that explains the unwillingness of our tangata whenua to push oneself forward:

Connie: Kāore te kumara e kōrero ana mo tōna ake reka. The kumara does not brag about its own sweetness.

The Māori nurse leaders interviewed believed that they were working within a flawed system they had to navigate for the benefit of their people. Although they thought the wealth of inequity data available was valuable, they knew that it alone did not bring about any significant change. When they uncovered inequity, these Māori nurses themselves challenged medical staff and budget holders on the options offered to Māori patients.

Aroha: I can remember questioning doctors and saying, “How come Mr. Tangaroa can't go for an angiogram but (pakeha local figure) came in and poof! helicoptered off then and there.”..... We all know about institutional racism, but we want solutions. We don't want to hear about “there are so many of us in prison and dying”. I want solutions, and ever since I've come into nursing, that's all I've heard. Equity for me is like promising a little light in the sky.

Additionally, the Māori nurse leaders experienced immense pressure to perform exceptionally well in their work, as any misstep or oversight could reflect poorly not only on them individually but also on their entire whānau or iwi.

Tuakana: Our accomplishments are not recognised as readily as our mistakes by others in the workplace.

Unfortunately, colonial socialisation may not be past. A change of government in NZ has already enacted colonialist-type legislation that has challenged the use of te Reo Māori, the principles of NZ's founding document Te Tiriti o Waitangi and disestablished Te Aka

Whai Ora, the Māori Health authority. Nursing as a professional body raised concerns to the then Minister of Health, Dr Reti, about how the higher health needs of Māori and support for indigenous nursing students can be addressed. The effects of current changes in healthcare on the future generations of Māori nurse leaders are yet to be determined.

The interviewees faced regular challenges to their personal and professional values due to organisational requirements, especially in the neoliberal climate of austerity. As voiced by Navarra and Adam:

Navarra: There is a necessity to apply rules and policies that slowly shift the focus of the nurse manager from attempts to do everything possible for each patient and staff member to doing everything possible to please management, often at the price of the other.

Adam: My view is the patient has to be the centre of everything, but when politics and money are involved, it feels like it's the money that overrides the patient's needs.

Kathryn felt herself fortunate to work for an organisation with a very strong set of values given to them by their community that aligned with her own moral code. She believed these helped her with the decisions she had to make.

Kathryn: I can ground myself in these values, and when I'm called upon to do something that I don't think aligns with the values, then I can safely resist. These values align with nursing's values as well, so I am very confident in them.

Maintaining their values was seen as important, but often challenging due to the lack of visible support from management, colleagues, or teams.

7.3.3 Lack of support

Compounding the disillusionment felt by emerging nurse leaders is often a lack of visible support for their leadership from others, particularly non-generic managers. The data, as voiced by the research participants, agrees that the environment in which nurses strive to become leaders may be perceived as unsupportive, not only by the healthcare system but also by their professional colleagues. Nurses who find their leadership unsupported are less

likely to stay in their roles and have less mental resilience (Nagle et al., 2021). Without guidance, nurse leaders may struggle to balance the expectations of management and the needs of the team they lead. Valmai described this unenviable position as being like the meat in a sandwich.

Valmai: People, I think, see leadership roles and think that's a whole lot of work, see them as the sandwich between the upper orders coming down and the people who are working and wanting things. It doesn't look very attractive.

An impact of the complexity of nursing culture as an oppressed profession is a lack of support for those moving away from the stereotypical role of a caring bedside nurse. Once individuals achieved management or academic leadership roles, they often faced a lack of respect from their clinical nursing colleagues. Some were made to feel that they had "let the side down" by moving away from bedside nursing. Kathryn had even experienced clinical nurses trying to embarrass other leaders by exposing their lack of clinical knowledge.

Kathryn: Nurses look down their noses at people who work in leadership and management. Not only that, but they will also take every opportunity to expose your lack of knowledge and clinical practice. To shame you and to prove that they are better than you.

Oppressed group behaviour (Boston-Leary et al., 2024) may cause nurse leaders to struggle with a lack of support from those they are leading. Former colleagues may become opponents due to professional jealousy (MacLellan et al., 2016) and changed relationships (Doria, 2015). Si had experienced this type of behaviour in her role as a nurse manager.

Si : I found that there is tension, and the tension is actually so bad sometimes it's us against them, managers versus nurses, yet to me we are all supposed to work together. I don't believe I should be taken as not part of the team I'm working with.

The nurse leaders were passionate about their work, but often felt that their healthcare organisation was too paternalistic and authoritative. Some of the participants in

this study found it difficult to achieve their goals within a system that was not open to different models of care.

Erica: I think it drives them away. I know a lot of nurses in the community have ended up there because they didn't feel that they could deliver the nursing care the way they would like to within the [hospital] system. I had a trust and I did get government funding for that. My trust board was made up of all my patients and I was told "you need a VIP on your trust board". What would these people know about the trust? I think these (patients) are the experts!

Anne: I left basically because I had no way to go. The organisation I was working in didn't have any notion really of how they could work with me and the only pathway that I saw to more advanced work was in education and research.

Navarra: The system I work in is relatively strict and male dominated. It doesn't provide much room to accommodate spiritual or natural healing, forcing nurses to adopt a westernised way of treatment rather than promote traditional healing or a combination of both schools.

As the above excerpts highlight, the existing healthcare systems were not designed to accommodate new and innovative work methods. Whilst quality improvement was promoted, innovations were expected to conform to neoliberal efficiencies rather than what was best for patients or staff (Tenbensen et al., 2016).

Emerging nurse leaders often face a challenging gap between their ideal visions of nursing and the harsh realities of their actual work environments (Lessi et al., 2025). This disconnect can be disheartening, highlighting the urgent need for support and mentorship to bridge the divide and transform their aspirations into tangible outcomes. The disillusionment felt is further compounded by the impact of belonging to a feminised profession.

7.4 Gendered Impediments

In my theoretical chapter, I discussed the connection between nursing as a profession and the traditional perception of caring as women's work. Throughout history, societal expectations have largely positioned women as caregivers and nurturers. Nursing has long been associated with traditional feminine roles and has struggled to move beyond them. As a result, gendered traits have become deeply rooted in the identity of nursing. Despite efforts to establish nursing as a profession that is appropriately valued in healthcare, this gendered perception remains prevalent. Compassionate bedside nursing is accorded more value than scholarship or professional knowledge (Carryer, 2020).

Early gendered socialisation or positive interactions with nurses may influence the choice of nursing as a career (Araújo da Silva & Fernandes de Freitas, 2021). During the preamble to the interviews, it became evident that many participants had been expected to perform caring roles within their family situations. Some like Si had come from families where nursing had been a generational career choice for the women of the family.

Si: I was given the list to apply for nursing because I have nurses in the family. My aunt was in nursing, my sister and cousin also.

This aligned with the findings from the phase one questionnaire, where several respondents commented on their family tradition of women becoming nurses, as this was thought a suitable career for a young woman. Throughout history, nursing has often been seen as women's work, primarily carried out at the patient's bedside in a subordinate role. In contrast, Tuakana couldn't comprehend the Western lack of respect for caregivers. She had been brought up to believe that caring for others held great value. In Te Ao Māori, caring is seen as a reciprocal exchange within a whānau, with an expectation to deliver care. The task of caring bears mana and is considered an essential part of the well-being of whānau and iwi.

Tuakana: Fulfilling care obligations enhances the carer's spiritual attributes and standing within the whānau.

Speaking with Tuakana led me to understand that while Māori nurses who identify as women face gender-related issues, they perceive their role through a cultural lens as different, rather than of lesser status. As a result, they may view leadership binaries differently, with an acceptance that is not submissiveness. In certain situations, their mana, or standing, empowers them to speak out against unjust systems. However, within Eurocentric NZ society, gendered perceptions of caring and by association nursing, remain unchanged and continue to impact nurses whether or not they acknowledge them.

7.4.2 Gendered oppression

Even within nursing culture, there is a discourse of subservience that tries to restrict the ambitions of female nurse leaders. Over time, nursing developed its own culture as a way of adapting to the gendered oppression it faced within the healthcare system. This nursing culture sought to bring together nurses from diverse backgrounds and social status in pursuit of a common goal (Reverby, 1987). Unfortunately, as demonstrated in this study, instead of fostering a sense of sisterhood, nursing culture continues to perpetuate oppression within its female hierarchy. Early in their careers, this cohort of nurse leaders had experienced a hierarchical struggle not only between healthcare disciplines but within nursing. When nurses perceive their external environment as oppressive, they tend to exacerbate the oppression they experience themselves. This struggle continues to be experienced by emerging leaders in the form of tall poppy syndrome, where those who excel are 'cut down', usually through negative comments (Webb, 2023). The interviewees also commented on the lack of support from colleagues in the workplace for nurses moving up at a rapid rate, believing that the health culture often restricted ambitions. Jo commented on the competitive behaviour she had experienced:

Jo: It's like a dog-eat-dog environment. When you start to get into management, especially if there's an opportunity to go up the ladder, you'll find games and behaviours and it's still happening.

Cabral et al. (2018) supported Jo's view, highlighting this oppression within the nursing profession in their finding that promising staff were sometimes not supported to apply or actively discouraged from leadership roles due to an institutional desire to keep them in their existing roles.

As IQN, Si and Navarra felt this lack of support keenly, which they attributed to their accent and/or skin colour.

Si: Most people don't believe that I'm as good as they are just by looking at me...understand how hard it is for me to transverse through all those layers (leadership).

Navarra perceived feminine qualities as a weakness in her leadership role. She believed there was limited space for a feminine, accommodating style of leadership, particularly for a nurse seeking career advancement. This perspective may have been influenced by the highly male-dominated nature of her work environment.

Navarra: From my point of view, you have to be masculine. You have to push forward. if you try to be kind and intelligent you will be eaten up by others. Not by your colleagues who will probably love you for these qualities but by your bosses.

Aroha's past observations agreed with Navarra's view of the necessity to adapt to a masculine business style when working at a managerial level. Similarly, Adam had also been challenged to alter his preferred way of operating to one more direct and confrontational.

Aroha: When I look at leaders in our organisation - if you don't adapt to that approach, you get chewed up and spat out, even if those underneath you know you're a good manager. You must conform to what is wanted from those "upstairs".

Adam: I've been challenged here that I'm not aggressive enough and I've contested that. You don't have to yell and scream to get what you need. You actually can work with people because everybody's here to do a good job.

Being a nurse leader involves navigating gendered expectations within any organisation. The remnants of colonialist hierarchical structures within our health systems are

still dominated by males and medical professionals, which leads to power imbalances that nurse leaders must address.

7.4.1 Perceptions and expectations

Participants were asked questions that revealed their perceptions of how non-nurses view the profession. The rise of print and mass media has distributed images portraying nurses as overly sexualised objects, cold and heartless matrons, or angelic beings of mercy (Gill & Baker, 2021). Participants carried an awareness of this imagery, with Navarra noting:

Navarra: Due to the high objectification of the profession, the perception from society is that to say “nurse” means to say you are female, easy to get into bed, and who feeds people and changes bedpans.

Navarra captured the complexity of working as a highly responsible professional, making critical decisions for patient safety, while also being aware of the gender-based diminishing of nurses' work. Navarra had nursed in several diverse countries but found these perceptions to be universal.

Careful negotiation was sometimes required when male and female nurses alike encountered stereotypical views of nursing. Nurse scholars for years have noted the conflicting and stereotypical images of nursing equating young nurses with sexual availability and older nurses with fierce and unattractive images. (Gill & Baker, 2021; González et al., 2023). As voiced by Adam, men in nursing face challenges in navigating their masculinity in a profession historically and currently associated with femininity. Men in nursing may be inaccurately characterised as either homosexual, effeminate or having ulterior motives.

In the following quote, Adam captures the contradictions inherent in being male in a feminised profession. He believes his male status simultaneously suggests that he is other than a nurse, that he may be homosexual and at the same time that as a man he is at risk of misinterpretation and a potential threat during intimate care.

Adam: I always tread very carefully, especially when I was on the floor. I mean like it's the expectation as a male nurse, you are gay. Historically I'm talking, 20 years ago. You must be gay or you're a doctor, or you're an orderly. And when you do very intimate care, you're extremely careful.

The personal toll of trying to meet the expectations of others also impacted the leaders outside of the work environment. Gendered expectations and early socialisation, although not specifically mentioned, still played a significant part in their private lives. The double duty of managing family responsibilities with a role demanding “gifted” time often meant a poor work-life balance. These additional duties required skilful management and the understanding of significant others. This study highlighted the significance of having strong support systems at both work and home to maintain a career in nurse leadership. Those interviewed who were in stable relationships had reorganised their home lives, sharing the responsibility for childcare and household chores with their partner. One survey participant summarised the support she received.

Molly: They understand how much my role means to me and what differences I can make and support me every step of the way, even down to cooking the dinner in the evenings! Knowing that you have their backing makes a huge difference.

The lack of flexibility in work schedules and locations also posed challenges when trying to balance career goals and family responsibilities. In interviews with leaders, it was observed that the inflexible work environments in their healthcare organisations influenced their career decisions when starting a family. Some leaders mentioned taking a break from work, while others managed their caregiving responsibilities alongside their full-time leadership roles with the help of supportive family networks.

Valmai: When I had children I was looking for a role that had more control over hours, that was the illusion at the time and then [I] took up a role as an academic tutor.

Navarra: Unless females adopt a male lifestyle the likelihood of career building is not very high, that's what I see.....women who don't have children like I don't have children, of course, it's much easier.

7.4.3 Deference to medicine

Nursing contributions to healthcare decisions have historically been viewed as a female intrusion into a male domain. The growing presence of women in the field of medicine has not significantly altered the power dynamics, as it fails to challenge the traditional association of medicine with masculine traits such as logic, science, and rationality. The long-standing tensions between medicine and nursing present yet another challenge for nurse leadership. A deference to medicine, even subservience in some countries, did not sit well with those interviewed. This preferential treatment of medicine over nursing led to considerable angst in some circumstances as outlined in this recollection from Si.

Si: We had an incident where a patient died and there was an investigation. The surgical team had changed an urgent referral from a CNS to semi-urgent. The surgical team were supported in their decision but the CNS was censured for not following up on her referral.

Although many of the group had trained and started their leadership careers in an environment of assumed medical superiority, they did not perceive themselves or their patients to be of lesser status. Brewster et al. (2020) commented that although medical leaders were often the decision makers, it was nurses who emerged as the leaders due to their expertise, regardless of their job title. This was evidenced by nurses being strong advocates for those in their care, as revealed in the following comment made by Pip.

Pip: The difference between how medicine views discharge versus how nursing views discharge is really substantial because the nursing view is far more. It's about wrapping around the whole person and thinking about their needs, not - have we met our biometric measurements of discharge worthiness?

Medical hegemony often means seeking the approval of physicians to make any changes. Julia confirmed this in her comments that although medical hegemony was widespread, she had learned ways to work with it rather than struggle against it. This often involved enlisting medical colleagues to support her concerns.

Julia: I know how to work with people and bring them together; I see the long game. There's lots of male medical hegemony, they're socialised that way, so it is easier to use a male medical colleague - one of their peers

Being of the same sex does not necessarily reduce the conflict between physicians and nurses, as it is the power structure, and the gendered binary not the sex of the practitioners, that shapes their interactions. Female medical students have shared their challenges in adapting to the masculinist culture within medical schools and the medical profession where gender bias is still prevalent at all levels (Kramer et al., 2021). Kathryn believed that it was beneficial for medicine to maintain a discourse of medical dominance, but she had also observed a shift with medicine being disregarded in favour of economic interests that are at the heart of neoliberalism and managerialism.

Kathryn: The fact that medicine is also frequently disregarded might indicate something contrary to what we think in nursing - that we as a historically female-dominated profession, are disregarded more frequently than medicine. ... I do see medicine is not always valued. The default is to medicine but that's a very, very old model now, and why people still subscribe to it - you have to ask the question, who benefits and who doesn't benefit by that recurring discourse of medical hegemony. generally speaking, it serves medicine well to hold that position and it doesn't serve nursing well. So, medicine won't in general unpack that discourse and get rid of it, try to challenge it. They won't because it serves to benefit, that serves them best. And those who hold that kind of unofficial hierarchical position are in the best position to be able to hang on to it than those supposed usurpers like nursing and allied health who want to challenge it.

7.4.4 Deference to males

The current social environment in healthcare tends to favour men in leadership positions, creating a barrier for women to be heard at the leadership level. Betron et al. (2019) pointed out that women's voices are often not heard due to their under-representation in leadership or decision-making roles in healthcare. This lack of representation at the leadership level was highlighted as one of the barriers experienced by nurses, and it also contributes to the lack of confidence discussed in the literature review.

The interviewees commonly experienced male hegemony alongside medical hegemony. Many female nurses felt that there were disproportionately more male nurse leaders, and they perceived a "glass elevator" effect that helped male nurses advance more quickly. Both male and female leaders in this group believed that more men held leadership roles because male nurses were socialised to pursue such positions due to societal expectations of masculinity, as well as the consistent employment opportunities available to them.

Anne: Men don't usually take the time out for childbearing. They have consistent full-time service and I think that makes a difference. I think that's the reason why men tend to move into leadership positions. Perhaps, they have a sense of themselves as being capable of doing that, and some women may not be well socialised in that respect.

Connie: I think male nurses are often more ambitious earlier in their career and or they get sort of impatient and want to move along that pathway into leadership a lot more quickly than maybe some of their female colleagues may do... I don't know if there are any more or less barriers. I think that their intrinsic drivers in terms of their ambition and life might be different.

Interviewees were asked whether they believed male nurses in a predominantly female profession had any advantages. While female interviewees thought that males had advantages, they believed these advantages were situational.

Jo: It depends on where the person is working. I've seen instances where there has been no benefit for males working for females who don't believe in a male-dominant culture, but some female leaders are charmed by the males.

Jo believed that the advantage male nurses had depended on the work environment and how they were managed. She criticised female managers she had worked with, who were charmed by men and helped them advance. Si's experience was that male nurses were ambitious in advancing their careers quickly and less focused on providing direct nursing care.

Si: As a lecturer, I found that most of them (male nurses) came not to stay at the bedside nursing. They think that they will go up (into leadership)...Most male nurses don't stay too long in an environment of inpatient services.

Adam believed that being a male nurse gave him a different perspective, which sometimes gave him an advantage. However, this statement was not elaborated on in the interview, with the researcher assuming that he was referring to a masculinist way of viewing situations.

Adam: I didn't go into nursing to progress quickly, and I wasn't actually aware of any progression of male nurses earlier. But we know it's a nurse thing (the perception), it is definitely an unwritten belief. And as far as what I'm seeing, I would arguably say it's true. I would argue that I think differently, and as a minority in a female profession, my thinking is definitely different

The findings of this study demonstrate clearly that gendered expectations are embedded throughout organisational decision-making that can disempower nurse leaders and a learned discourse of selflessness often inhibits nurses from speaking up for themselves.

7.5 Summary

In this chapter, I have presented the analysis of the first major theme, gendered socialisation. This theme was identified from the integrated data obtained from the exploratory descriptive questionnaire and the interview phase of this multi-method qualitative study. During the analysis of the findings, I came to realise that nurse leadership was far more complex than most nurses, including myself, understood.

I began by discussing the beginning of a nurse's journey into leadership. I discussed how people enter nursing with preconceived ideas of what nursing is and does due to a legacy of stereotypical images based on nursing being a feminised profession. The desire of these nurses to have a greater impact on patient care outcomes led them to explore possibilities beyond their clinical sphere of influence. Post-graduate education proved a catalyst for many of the participants, allowing them to gain a broader understanding of the healthcare industry. Emerging nurse leaders identified themselves through their actions early in their careers. However, it is crucial that their efforts are acknowledged to prevent them from being discouraged from pursuing a leadership pathway.

As this group of nurses advanced into leadership roles, they became disillusioned by the systems and processes they experienced that were less than ideal. The participants shared their struggles aligning their professional values with the expectations of their roles in a neoliberalist environment that undervalued their professional knowledge. This was compounded by a legacy of oppression and a deference to medicine as aligned to the masculine binary. For Māori years of colonisation have shaped tikanga and created inequities, especially in healthcare. The participants felt compelled to be outspoken advocates for better patient care, especially when they perceived that the organisation's professed values were not reflected in the actions of senior leadership or conflicted with their own beliefs. Their actions on behalf of others sometimes stood them outside the expected norm of "niceness" and left them feeling unsupported.

As previously discussed, gendered characteristics such as “niceness” have become deeply ingrained in the identity of nursing. The strong association between nursing and femininity is evident in how nurse leadership is perceived, even among professionals in the field, as shown by the survey findings. I explored how gendered socialisation influences the decision to pursue a career in nursing. Nursing has typically been linked to femininity, and those who entered the profession initially felt at ease being part of a predominantly female, care-focused field. At times, male and female nurses had to navigate stereotypical perceptions of nursing based on gender expectations. Although Māori nurses face the same gendered expectations and barriers in nursing, there are distinct differences in the impact of their socialisation on their career trajectory. Regardless of sex or ethnicity, tensions arise when navigating the conflict between a masculine leadership environment and the expectation for members of a feminised profession to embody attributes such as caring and humility.

Chapter eight: Integrated Findings – Negotiating the binaries in a Neoliberalist system

8.1 Introduction

In this chapter, I will present the remaining qualitative findings related to the second overarching theme of negotiating the binaries in a neoliberalist environment. The chapter explores a number of subthemes: Nurses: Expense or Asset? Generic Leadership Preparation and Forging Their Own Way. This chapter will explore the challenges of being a nurse leader in Aotearoa in the 21st century, continuing to focus on the gendered environment and additional considerations for indigenous nurses.

Firstly, I will address how this group of nurse leaders endeavoured to lead care in their current environments. To do this they had to negotiate a neoliberalist system where nursing was often undervalued as a profession, given little authority, yet held accountable for health care performance. New public management/neoliberalism reforms required public sector organisations to deliver services similarly to the private sector rather than based on social justice (Kumarasiri, 2015). This ethos did not sit well with the participants' value systems and impacted their effectiveness. Compounding the impact of neoliberalism is the legacy of oppression and gendered socialisation that may limit a nurse leader's ambitions. New leaders inherently bring with them years of socialisation that impact how they are able to function in a neoliberalist, post-colonialist healthcare environment.

Next, I will outline the various ways participants attempted to acquire leadership skills but often found that their efforts were lacking in essential aspects. This experience led them on a journey of self-reflection and self-reliance, during which they forged their individualised pathways to leadership careers.

Finally, I will describe the various methods this group of nurse leaders employed to achieve their goals. These included establishing peer support mechanisms and finding

mentors aligned to their specific needs. In doing so they have become role models for others contemplating a similar career trajectory.

8.2 Nurses: expense or asset?

Nursing and neoliberalism are often viewed as conflicting binaries that need to be reconciled to provide cost-effective and patient-centred healthcare. Most of the interviewees had been nurses at the time of the 1988 Gibb report (Gibbs, 1988). Consequently, they witnessed many structural changes to the health system, each reform with its promise of improved and equitable services. Underlying most of the interview conversations was the understanding that in general nurses are women who are working in systems that deprivilege anything not associated with a neo-liberal focus on efficiency and cost efficacy. The current healthcare environment prioritises the values of rationality, fiscal prudence, and tangible outcomes. These traits associated with the masculine binary are privileged and widely accepted. In contrast, traits linked to the feminine binary receive significantly less value because they cannot be easily measured, quantified or costed.

In 1987, Susan Reverby, in her seminal work "Ordered to Care: The Dilemma of American Nursing," (Reverby, 1987) noted that nurses were effectively mandated to care within an environment that undervalued the act of caring itself. Although this book was written nearly 40 years ago, it could be argued that her observations hold even greater significance today, as the neoliberal emphasis on cost and efficiency has intensified. The shift towards generic management in service delivery is a long-standing trend based on the belief that non-clinical managers have a better understanding and greater skills in managing budget constraints. The replacement of clinical leadership with generic management has been a significant aspect of hospital structures since the rise of neoliberalism. Although it is often claimed that clinical leaders continue to shape patient care, their ability is limited by the lack of budget control and direct accountability for the clinical staff they oversee. Kathryn commented that the Directors of Nursing had lost control over the nursing budget and clinical

staff now came under the management of non-clinical service managers, which she felt created significant challenges for leading effectively.

Kathryn: like the other clinical leaders - allied health and medicine, it's not just nursing. We are often marginalised. We are often not consulted in decisions that impact upon nurses. We are often having to stamp our feet to get heard. It's really quite dismissive.

In this quote, Kathryn refers to critical decisions regarding nurse staffing and education, which, while rooted in budget considerations, are also significantly linked to clinical safety concerns. Mary's comment on her level of authority was almost cynical regarding the uselessness of not holding the budget for her service and the problems of generic management.

Mary: I generally have clinical autonomy so long as it doesn't cost anything!

Anne had experienced situations where her decisions regarding the safe practice of a student were ignored.

Anne: Education often has some different priorities. We find this most acutely in student appeals. Nurse educators will fail a student because they're not capable, they're not competent, and the leadership and the organisation who are not nurses allow their appeals. I think that as someone leading or managing a team of nurse educators, that's a very frustrating thing to happen

Nursing is the largest cost to most health service organisations. However, effective nurse leadership and appropriate staffing levels have been shown to improve patient outcomes and reduce length of stay thereby saving costs to the organisation. The comments from the study participants indicate that they believe the current healthcare environment in Aotearoa, under a neoliberalist government, does not facilitate effective nurse leadership. Although these nurse leaders hold high ideals for delivering quality patient care, they feel unable to voice their concerns because they believe their opinions are not valued and their knowledge is not recognised. Clearly, nurse leaders have an ethical duty to speak on behalf

of public safety. However, Adam expressed reluctance to speak out, which is common due to the fear that conflicting with decision-makers would make their role harder or even limit their career. Adam's comment illustrates the oppressive nature of some workplace environments, whether real or perceived due to nursing's historical roots.

Adam: there's very few meetings you go into that you could just freely speak and feel safe to do so with no ramifications. You sit there going, really? but to contest that you think "Oh I don't know if I should be saying anything"...

This reflects the doctoral work of Teekman (2012) who consistently noted the silence of nurses in clinical meetings where important decisions about patient welfare were being discussed. Socialisation into what is expected of a particular gender creates inequalities and power imbalances. Nurses reluctance to speak in meetings means that genuine advocacy for patient welfare may be lacking. This may allow concerns about budget and deficits to dominate decision-making. Nursing silence stems from a long-standing legacy of feeling unrecognised and undervalued in environments that prioritise other agendas. Valmai noted that this marginalisation poses a risk for the nursing profession, which is fully accountable for patient outcomes but lacks access to the necessary tools to influence care delivery.

Valmai: I think we are at risk at this moment in our history because our nursing leadership roles are so uncertain in the formal sense. We're in a system transformation that hasn't landed yet. There's quite a lot of chaos in the system and in those spaces sometimes without a mandate to speak for nursing, nursing gets spoken about.

The interviewees generally agreed that they felt torn between their desire to work as professional nurse leaders according to nursing values and the expectations placed on them as managers to achieve KPIs and manage limited resources. Those working in hospital environments particularly felt the struggle to perform at the top of their scope both as a professional leader and as part of a senior management team that didn't always share the same priorities. They found themselves speaking past others from differing agendas exacerbated by a neo-liberal focus of cost efficiency.

Researcher: how do you balance your organisational expectations with your professional expectations? Do they sometimes come into conflict?

Julia: there is always conflict, it can be very frustrating. I find workarounds and pick my battles, sometimes it's timing – wait and re-present. But sometimes it can take an incident or series of incidents to affect change.

Anne: I think middle management inside of our bureaucracies today is absolute killer territory. I think the demands it makes on people are just not OK. I do professional supervision with a range of nurses; some of whom are managers and the managers I see getting clobbered. In my organisation, I think that expectations of management roles, it's just not really doable.

Efficiency can have a different meaning for an administrator, who sees it as cost savings, and a nurse leader, who sees it as more effective patient care. Both Adam and Kathryn had experienced this ambiguity in their roles and felt it took a personal toll on them.

Adam: Massive tension. It keeps you awake at night ...It's easier if you don't support the decision if it's black and white, right or wrong. Then no, I can't do this because it's wrong, but when it's grey? Do I support this when I know they need more, but there is no more, the cupboards bare, and also those people that are telling me what to do are nowhere near the floor. You just sit there cringing, thinking decisions are being made with not ill-informed, but financially informed. I struggle with that.

Kathryn: These jobs are hard jobs. It takes a lot of passion and a lot of motivation. It takes up your thinking time. You're problem-solving all the time. How am I going to address this? What am I going to do? What are the resources that I can call upon to problem solve this wicked issue?

Whilst the neoliberal focus on cost efficiency has commodified and devalued nurses' work and marginalised nursing leadership, there is residual deference for medicine and medical leadership rooted in the dominant beliefs about the value and importance of

biomedicine in healthcare. Pip had found this organisational deference to medicine to be a hindrance in her current role.

Pip: Projects almost can't proceed until you've got the approval of medicine. It's not so much that they are viewed as the leaders of things, but rather, they still have this authority of approval that is really difficult to navigate, whereas we don't seem to need nursing's approval to make a change. But we do need medicine's.

It is understandable that being perceived as an expense, rather than having the value of nursing and nurse leadership recognised, can further disillusion emerging leaders, even if many are unaware of the source of their discomfort. Many seek additional training to address what they perceive as gaps in their knowledge. However, as noted by the participants, the available training often does not adequately meet the fundamental needs of nurses in Aotearoa.

8.3 Generic Leadership Preparation

Once a leader is identified, the opportunities for further skill development and support appear to be serendipitous. A study of senior nurse leaders by Cabral et al. (2018) noted a significant increase in the accountability of a leadership role, with limited opportunities for gradual upskilling or gaining experiential knowledge, especially for executive-level positions. In Valmai's experience, access to leadership training had usually been ad hoc, dependent on organisational support and tied to the needs of a role. Valmai summed up the need for greater focus as follows:

Valmai: If we were more purposeful with distributed leadership, and gave people opportunities to lead smaller chunks, where that's done well, it creates a culture where leadership is normal. Whereas, often in our system, leadership is extraordinary and abnormal.

In some cases, such as Kathryn's, post-graduate papers they undertook were assigned to them to align with the needs of their service. Funding is capricious, with those papers not required as part of an agreed goal being unsupported. It is not surprising, then,

that post-graduate education seems unattractive to many nurses if the subject matter is not able to be personally chosen.

Kathryn: You had to do a certain number of courses and meet certain KPI's within the timeframe given to you.

Navarra described the unfairness and lack of consistency as frustrating.

Navarra: leadership training isn't consistent and different sites; different regions provide different training. I know I am one of the lucky ones.

This practice may become more common as Health Workforce NZ funding is often linked to organisational requirements. For example, currently, Health NZ Te Whatu Ora expert RNs may be funded only up to a post-graduate diploma (4 papers) based on their service specifications or role (Health NZ Te Whatu Ora, 2024). Additionally, the current postgraduate programmes may disadvantage some Māori nurses.

Anne: I think the way programs are taught can disenfranchise Māori, and it can be iterated colonisation in the classroom simply because of the way things are taught. But I also think that it's about where these nurses come from, and their personal, social and cultural histories.

Higher education does not always reflect a readiness to lead, and some nurses may still feel unprepared to take on a more senior role (Al Sabei et al., 2018). The shift from operational level thinking to thinking on a strategic level is quite significant (Cabral et al., 2018). Like many nurse leaders, the interviewees reported that they received little preparation for their roles and minimal mentorship or supervision unless they faced difficulty. Despite repeated calls for increasing nursing leadership, no pākēha or tauwiwi participants described formal processes or pathways for becoming a leader. Support for emerging Māori nurse leaders is available as will be discussed further. Jo, whose role is in professional development did not know of a clear framework that a registered nurse could follow into leadership.

Jo: In New Zealand, we don't have good career pathways and good ways of picking and being clear specifically about what we want. And I think that's a problem. What we have is PDRP (Professional Development Programme). But I don't believe PDRP⁵ helps people develop career pathways.

Many leadership theories, trainings and models of care are in use throughout healthcare and nursing internationally, but these courses are almost exclusively generic. While some participants did not consider this to be an issue, others recognised that generic training did not meet their needs. Julia believed that nursing was flexible and broad enough to be able to adapt most leadership frameworks to meet the needs of a situation.

Julia: nursing is eclectic, we can draw on all models of care to inform our practice, all are helpful to our understanding. There are all sorts of models that we can use.

However, as demonstrated previously, nurses have some specific challenges to overcome in being effective leaders, largely due to being a gendered profession.

The literature review for this research showed that nurses with a master's degree or higher have a better grasp of leadership and can apply management concepts in their practice.

Formal training primarily involved university postgraduate courses. Some participants self-funded their education and selected papers that aligned with their personal objectives. However, not all studies were nursing related. Some participants opted to complete business degrees or leadership training specific to their non-health work areas, believing these would provide the skills they needed.

Erica: I completed a counselling diploma to learn how to communicate with clients in the most productive way possible.

⁵ Professional Development Recognition Programme (PDRP) is a national, clinically focused, competency-based programme for NZ nurses.

Navarra: I had a “Positive Safety Leadership” three-day modular training and had several days of “Junior Leaders” training focussed on managers, with a group project completion at the end of the course.

Si had attended many leadership courses at the recommendation of her managers but felt they hadn't taught her anything useful.

Si: It's just repetition of the same thing. Expensive courses funded by the ministry, it's the usual things – they just change the names and present it differently. There's so much wasted money in changing the names of what we're doing than actually working with us regarding our working ethics and how we are supposed to lead and carry people with us.

Si is speaking of numerous leadership courses run over previous years that are not discipline specific or openly challenge the negative socialisation of nurses as women. It is noted that none of the training available to emerging leaders addresses the gendered socialisation of nurses or how to lead in a neoliberalist environment. Interestingly, two of the leadership courses that participants found to be helpful have since ceased due to the healthcare system restructure and fiscal restraints. One of these, the Leadership in Action Management Project (LAMP) programme, appears to have been focussed more on what the organisation required as an outcome than on supporting a leader to develop a critical awareness of their personal development needs.

Si: I attended the LAMP programme, which was sponsored by the District Health Boards. What I liked was that the projects had to be current ones in the district annual plan. LAMP has since been stopped with the phasing out of the DHBs.

Aroha: The Public Health Leadership programme built leadership competencies and allowed participants the opportunity to discover their leadership potential. The training came to an end as the funding finished.

Connie believed that there was a need for targeted nurse leadership training and was currently involved in a national scoping project.

Researcher: So, you see the benefit of leadership training programmes.

Connie: Yes, but they need to be much more coordinated. There's a national, leadership capability project for the whole sector. At present, they've been doing the discovery stage for a much more cohesive, structured way of preparing people for leadership roles and management roles, you know whether they're professional, clinical leaders or more formal general management type roles.

However, this leadership project has yet to be progressed. In its absence, yet another leadership programme has come to NZ and is gaining in popularity. Leading an Empowered Organisation (LEO) teaches a framework by which to influence others to lead small-scale change. LEO was originally designed by an American nurse, Maree Manthey, specifically for developing leadership skills in nurses but has widened its scope to embrace other disciplines. Whilst individual leadership challenges are mentioned, the focus is on leading quality improvement and developing people management skills.

Kathryn's experience with leadership training was distinct from that of others, as it was highly structured and required meeting specific competencies to advance. The formal courses she attended examined historical leaders in practice, and these concepts were then applied to her field. Once emerging leaders were identified, they received support to pursue a full-time postgraduate diploma. Throughout her time in the organisation, all of Kathryn's leadership training was strongly aligned with the organisation's values.

Kathryn: The leadership training framework included learning about self before being trained in professional expertise such as political awareness.

It was Kathryn's belief that leadership training should be grounded in values, have a formal structure, and be assessed formally, with consideration given to linking it to remuneration.

Surprisingly, a number of the participants had little or no academic preparation with some having no formal training in leadership or management skills.

Pip: I have had not had any formal leadership training, but I have had some incredible mentors who lit my path.

Listening to participants has revealed that there are few clear or organised pathways to nurse leadership. The focus of current leadership courses appears to be on management tools and quality improvement techniques rather than on fostering authenticity or helping aspiring nurse leaders develop their unique leadership style. Additionally, this type of leadership training fails to provide an understanding of the political landscape in which healthcare is provided. James et al. (2022) found that many nurses who were taught leadership were unable to translate this training into practice. Only one leadership programme specific to nursing was found that encompasses all the facets that are needed to become a nurse leader in Aotearoa in the 21st century, Ngā Manukura o Āpōpō, which will be discussed further in chapter nine. Two of the nurse leaders interviewed strongly identified as Māori. Tuakana and Aroha were both alumni of this programme and strong believers in its benefits for their personal growth and Māori nurse leadership in general.

Researcher: Do you see any benefit then of specific leadership training programs?

Aroha: Nga Manakura o Apōpō absolutely. So, for me, that was a huge learning, and I think that is about the only leadership apart from my Master's papers that I found I could connect with.

Tuakana: Ngā Manukura o Āpōpō gave me the courage to go into management as this was never an area I wanted to be in, however, I knew that to make a change, influence and be part of the change, you had to be in a leadership space.

In the discussion chapter, I will argue that Ngā Manukura o Āpōpō should be used as a model of excellence to guide future leadership course developments in NZ.

It was not surprising to discover that there was no structured career pathway for registered nurses (RNs) seeking to advance into leadership roles. This left emergent leaders floundering and opting for whatever training opportunities were available. However, the

training programmes they opted for did not address the core issues of the legacy of nursing as a feminised profession or how to be a nurse leader in a neoliberalist healthcare system.

Anne: Getting them to widen their thinking about who they are as nurses is a really important thing we need to do with them.

Some leaders, like the participants in this study, demonstrated strong communication skills and independent thinking that empowered them to pursue educational opportunities and career paths aligned instead with their passions. This approach enabled them to seize opportunities and forge their own paths, yet often with a limited understanding of the root causes of the issues that had challenged them.

8.4 Forging their own way

As discussed in Chapter Seven, without a structured leadership pathway to guide them, emerging leaders can be left floundering trying to lead in a neoliberalist environment. Extant literature elaborates on the advantages of continuous learning for registered nurses. This aligns with Foucault's assertion that knowledge is power (Foucault & Gordon, 1980), as expanding their knowledge base through training and experiential opportunities empowered these nurses to pursue their areas of passion and vision for improved health outcomes. Knowledge attained also granted them the "power of credentials" when collaborating with other professions, allowing them to advocate for scientific nursing knowledge to contribute to the existing knowledge base. In this way, research participants used their Foucauldian power to achieve their goals. As expressed by nurse leaders, the current neoliberal environment poses considerable challenges for those aiming to practice authentic nurse leadership. To address these challenges, the interviewed nurse leaders found support networks to be beneficial.

8.4.1 Finding Supporters

Participants sought support within the workplace to supplement managerial skills found necessary but lacking. Gabutti (2023) noted that because nurse leaders have less

power in the healthcare hierarchy, they must increase their capacity to reach goals in alternative ways, aligning with feminine attributes such as persuasion. Connie used her collaborative skills to build positive working relationships with those who controlled the finances within her organisation.

Connie: So, what I'd say about the budget holders is ask for their help and say "I want to understand my budget and I want to do well at managing my budget, but I need your help. Come and sit beside me. Take me through it".it's saying "I want to partner with you because I don't have your skill set, but your skill set's important. And I will help translate for you on how the system works. If you help me with the financial side of things." And they usually love getting out of their office and coming and sitting. They become your colleague because, while the distance stays, they will always feel like they have more power than you.

While this kind of action may successfully achieve its intended goals, it can also be counterproductive. It risks reinforcing the perception that nursing is less aligned with a rational, scientific approach, which could undermine the profession's credibility. The need to build relationships with business managers also involves understanding the different terminology used. Just as nursing and medicine have their own languages, management has its own language, and accountants have theirs (Jones et al., 2010; Pop & Sim, 2025). Therefore, being able to navigate these different languages requires emotional intelligence, knowledge, and understanding.

Interviewees highlighted the importance of creating peer networks where they could openly discuss their concerns and seek support from others facing similar challenges. They found it valuable to be part of nursing professional organisations and other groups related to their areas of expertise, such as the College of Nurses Aotearoa, the NZNO nurse leadership group and the Australasian College of Health Service Management (Aotearoa). Being part of nursing peer groups provided a strong sense of belonging and helped to build confidence in advocating for the nursing profession. It also heightened their political awareness through participation in strategic conversations.

Connie: I think it's absolutely critical. To belong to your professional organisation, one for the networking, the support, the evidence, the direct involvement and influencing, but also to give back to your profession.

In phase one, it was found that 57% of the nurse leaders surveyed either had or once had a mentor or professional supervision. This form of support was reported to be extremely beneficial in helping with reflection and building confidence. Across the data set, the participants used emotive words such as struggle, frustration, and pressure, indicating that mentoring and supervision should be readily available for new leaders. Connie agreed that mentorship was essential for emerging leaders.

Connie: find a person in a senior role who will take you under their wing and mentor. I think mentorship is important and finding a mentor in my experience - very rarely do you approach someone and say, "Would you give me some mentorship" or "Give me some support" or "Help me with this thing I'm grappling with for the next few months because this is what my aspiration is" if – you pitch it in that way, very few senior nurses would say no, go away. And if they did, then they're not the right person to be a mentor anyway.

Connie's view is supported by Delgado and Mitchell (2016) where all the respondents in their study expressed a willingness to serve as mentors.

Leaders who were interviewed had sought support at various stages of their careers and found mentors who could provide advice at the times that they most needed it. Sometimes, this required them to look outside their current work environment to identify the right leader who could empower them in the next stage of their career journey, as experienced by Kathryn .

Kathryn: I spoke to the Chief Nurse at the time, and she recommended I approach S, that I would learn a lot from her. So, I did a secondment to [the hospital where S was DON]. Some nurse leaders benefit from a more formal supervisory approach. Pip found that having a professional coach assisted her practice, so she negotiated this into her contract when taking on a new role at a higher tier.

Pip: I have very intentionally arranged for a leadership coach to help me in the first year of my current role. I would say it is one of the most valuable things I have done for myself and those around me.

The nurse leaders interviewed believed in the importance of participation in mentorship or supervisory programs and fostering connections with peer support networks to overcome the challenges of “being” a nurse leader in Aotearoa. However, mentorship is largely serendipitous. Anecdotally, this is not due to a lack of suitable supervisors/mentors, but rather due to financial constraints by those who do not see its benefits.

8.4.2 Role Models for the 21st Century

Participants discussed encountering both negative and positive leadership role models in their nursing practice. Throughout their careers, this group of individuals has been influenced by leaders who demonstrated high standards in their leadership styles and exemplified professional values. They have also encountered leaders whose negative behaviour motivated them to adopt a different approach. This finding aligns with the literature review, particularly the work of James et al. (2022), which indicated that negative leadership role models inspire opposite behaviours.

Valmai: There's both a negative and a positive for me looking at how other leaders are. I've had the privilege of working with some really visionary nurse leaders - that relationship sometimes you have that's sometimes serendipitous, sometimes sought, with other leaders who have walked the talk, and done the things you want to do. I've also worked for some Wallies⁶ in my time.

They noted that historical nursing role models like Florence Nightingale may not always be suitable when viewed through a modern lens. Instead, they looked for role models within and outside the nursing profession who demonstrated the qualities and actions

⁶ Inept people

needed for specific situations. Pip and Kathryn explained their experiences as being a search for those whose skills or qualities they felt would add to their professional growth.

Kathryn: I think that's perhaps what we look for in our role models. We perhaps subconsciously do it. We're looking for what we lack to see if we can fill our kete with the things that we lack by watching others that we want to be like.

Pip: it's been the leaders who sit outside of the hospital setting that have most informed me. I've often found that those within the hospital setting have remained captured by the ideas of what nursing should and shouldn't be and where they do and don't belong, whereas those real critical academic nurses have absolutely shaped my understanding of the power that nursing has and should have in its future potential.

Pip makes a very interesting point here. She observes that the internal atmosphere of hospitals often reinforces traditional beliefs and behaviours of nurses, as well as the attitudes of those in leadership positions within organisations. Pip further notes that where nurse scholars feel free to speak, their words are often powerful and can inspire others with their vision. This supports the previous comments that postgraduate education often exposes nurses to different ways of seeing and understanding their practice environment.

Conversely, Adam spoke of the remorse he now felt for choosing his role models poorly in the past.

Adam: There's been some decisions I've made by following leaders or managers which I really regret - saying. Why did I ever follow that path? Because you assume that the person above you knows what they're doing, and sometimes they don't. And then you become a scapegoat, and someone gets hurt.

Now, a decade or more into their leadership careers, some of those who were interviewed were consciously aware that they had become role models for others by demonstrating what a nurse could achieve. The interviewees considered this as a

responsibility to be taken seriously. In the following excerpt, Valmai speaks of how she role models critical thinking and advocacy for the profession to her students.

Valmai: one of the things that I often say to the students - I ask them "do you think nursing is important, do you think we provide a service that is important?" So then how will anybody know that's what we do if we don't talk about it and then if we're not there what will happen?" We have a responsibility to talk about what we do, how we do it, and what skills and knowledge we will need to be able to do it well rather than just nursing, just assuming that people will understand that we provide care. Well, if we just provide care then anyone could do that.

Connie aimed to proactively identify new graduates with leadership potential, using her connections and experience to guide and support them toward a career trajectory in leadership.

Connie: I think it behoves our generation to be constantly looking for the people who have the intrinsic drivers to be good leaders, people who step up and take responsibility and have the willingness to be accountable.

The research participants universally agreed that Aotearoa has numerous outstanding examples of both current and historical nurse leaders. This group of nurse leaders believed that highlighting our local role models in nursing excellence and their achievements could better guide the development and composition of nurse leadership in this country.

8.4.3 Professional Leadership

As outlined earlier in this chapter, nursing is often not afforded its true value under a neoliberalist management structure due to a lack of recognition of the importance of nursing knowledge to health outcomes. One of the interviewees overcame the perceived lack of value in nursing knowledge through the power of credentials and became a respected authority in their field. Another nurse leader began showcasing potential directions for nursing as a profession. Overall, the interviewees agreed that registered nurses should

advocate for their profession. Instead of becoming disillusioned with the ongoing failure of the healthcare system, this group of RNs positioned themselves to make the most of the opportunities that arose. Connie was quick to respond with a quote she had heard to those who underestimated the effort it took to achieve the position she held.

Connie: people often say oh, you're lucky to work in a management role or a leadership role. Luck's got nothing to do with it. It is preparedness plus opportunity, so doing the hard graft, learning and the growth that comes from that and then seizing the opportunity. Preparedness plus opportunity equals luck.

Valmai and Adam commented on being a conduit for their teams.

Valmai: I have a very strong belief that my purpose is just to help others achieve what they want to achieve as well as follow the direction that needs to be taken... to have people feel they have some control, the ability to have a voice.

Adam: I don't like the word manager in my title.... Our job is to lead, role model, question, and set an example. The manager part never came into it.

As a profession, nurses possess a powerful voice but have been slow to recognise its value. Some of the research participants had been able to influence the direction of nursing and were confident in the positioning of key people to ensure that nursing was not overlooked. Other respondents like Anne held influential positions in an educational setting.

Anne: I think that at a national level, we do actually have a strong voice. I think we've got the College (of Nurses Aotearoa) and we've got NZNO, and I think they both speak into that ministerial place. They both strongly influence policy and I think if you compare the state of New Zealand nursing in terms of its advanced practice to other countries internationally, New Zealand has been faster and braver than many others.

While this group of leaders all aimed to be authentic in their approach and leadership styles, they considered vulnerability as a strength to be embraced rather than a weakness to be concealed. During interviews, participants were asked whether they incorporated feminine

feminised traits into their leadership style or if they felt the need to adopt a more masculine approach in certain situations. Most of the interviewees believed that their feminine attributes enhanced their leadership instead of being a handicap.

Valmai: I think the thing that we women are really good at is connecting with each other and building communities of trust. In my leadership work the most effective I have been is where we've shared information, we've strategized together working different parts of the system so that together we've been more effective. It takes trust to share information and I think women that I've worked with are generally very good at that. I haven't struck the same amount of ego-driven behaviour.

Pip: Approaching challenging conversations with that absolute calm, I will listen and then we will smoothly make our way to some decisions I do think at the moment people are gravitating toward that.

The participants widely acknowledged that nursing stood at the forefront of discovering innovative ways to provide care that was not only effective but also efficient. By engaging in meaningful collaboration and learning from various disciplines, this collective of nurse leaders gained a deeper understanding of the opportunities and challenges within their healthcare systems. This wealth of knowledge became a cornerstone in their goal to deliver patient and whānau-centred care—a compelling motivator for the Māori nurse leaders involved in this study, who had a strong commitment to their communities.

8.4.4 Emergent Māori Nurse Leaders

As explained in the phase one questionnaire findings, the proportion of Māori nurse leaders practising in Aotearoa remains low. The current neoliberalist health system, with its focus on health targets, has some advantages for Māori nurses seeking leadership careers. The previous New Zealand government supported processes to address inequities and encourage less reliance on overseas-trained nurses, which, if enacted, should have a positive impact on the number of nurse leaders who identify as Māori (Health NZ/Te Whatu Ora, 2024). However, the growth of IQN in the nursing workforce continues to outpace that

of indigenous nurses. As part of a historically oppressed group, Māori RNs are likely to start from less advantaged backgrounds and may struggle with lower self-esteem and need extra support. Jo's role gave her a working understanding of the remedial processes in place.

Jo: At the moment because we have a shortage of Māori nurses and we have such high Māori population health needs there's a huge benefit. There are opportunities for Māori nurses not just to get into nursing, but also to progress into being leaders and managers. We have NETP affirmative interviewing so all Māori nurses don't go through shortlisting, they go directly to an interview, we fund Māori if they apply for HWNZ funding, so they're a priority.

However, it remains to be seen if these benefits will remain in place under the change of NZ government. Tuakana agreed that opportunities had increased for Māori to enter nursing and become leaders but still saw some barriers.

Tuakana: the current pro-equity focus and workforce development plans are making it easier for Māori to become RN and see nursing as a career pathway. This is easier in some districts than others where they must compete against I.Q.N. for roles.

In certain areas of New Zealand, Māori nurse leaders have taken the initiative to establish traditional tuakana-teina mentorship models. By pairing up an experienced staff nurse with one who is new to the role these models aim to create a supportive and empowering environment that can promote innovation in delivering healthcare services to their communities. Aroha has reaped the benefits of this model and is now helping other Māori nurses realise their potential.

Aroha: the expectation is that you have been supported, now it's your turn to help others – and not just Māori.

All three Māori RN from phase two of the research chose leadership roles where they believed they could have the most impact by nurturing other Māori RNs onto a similar pathway. In doing so, they became role models for other Māori nurses in their work environments and communities. Tuakana and Aroha held several Māori nurse leaders in high regard for their accomplishments and the example they set for others. Some of these role

models they were privileged to have received guidance from through Ngā Manukura o Āpōpō.

Tuakana: having the two recent chief nurses as role models increases the aspirations of upcoming Māori nurse leaders.

Aroha: for me, it was good seeing the Māori role models in high up - in CEO positions but still grounded, still focused on improving health, especially for our Māori and supporting Māori clinicians.

Te Ao Māori continues to produce Māori nurse leaders who are well-grounded as individuals and respected in their nursing practice and as advocates for the people of Aotearoa, both nationally and internationally.

8.5 Summary

The interview conversations generally reflected the understanding that nurses, the majority of whom are women, work within systems that prioritise efficiency and cost-effectiveness, often to the detriment of other aspects. It is also important to note that the data for this research was collected before the change in government in New Zealand. In 2023, a National/ACT/NZ First coalition government with a strong neoliberal agenda was elected, increasing the healthcare sector's demands for cost savings.

The commodification of healthcare has created barriers to obtaining healthcare for marginalised members of society. In this context, nurse leaders have a unique opportunity to advocate for those with less political influence (Jenkins et al., 2022). However, neoliberalism's focus on financial management in healthcare organisations has led to a decrease in autonomy for certain aspects of nursing. As experienced by this cohort, there was a general assumption that nurses were better placed to do the less valued work of caring, whilst others, usually male were more suited to the managerial tasks. Business managers gained more authority as healthcare became more financially oriented. With the current intense scrutiny on presumed overspending, it could be supposed that these

pressures for nurse leaders have escalated significantly in the last year since data collection occurred.

Leadership in nursing in Aotearoa is not yet universally recognised as a standard practice, leaving emerging leaders without a clearly defined path to follow. Opportunities for upskilling were found to be serendipitous and inequitable. Available training was often generic and did not address the specific issues nurse leaders faced due to the profession's legacy of gendered oppression.

Mentorship and positive role models were strongly recommended by the literature review undertaken for this research (see Chapter Two) as factors that enabled a leadership pathway. Many of the interviewees viewed themselves as advocates for the nursing profession and had become influential role models for oncoming generations of nurse leaders. They found building relationships with others valuable in sustaining momentum for their goals and professional support. The individuals interviewed attributed their success to the support from people who believed in them and provided both practical and emotional encouragement throughout their journey. Support for nurse leaders is highly desired and critical for their job satisfaction and staying in their roles. This support is especially crucial for Māori nurse leaders, who carry the added weight of New Zealand's colonial history. Government strategies to increase the number of Māori and NZ-trained nurses in New Zealand will require time to positively influence the composition of nurse leadership roles.

Being a nurse leader in Aotearoa in the 21st century means challenging the gendered expectations of both nursing and leadership, addressing the engendered power imbalances and finding creative ways to have a positive influence on health decision-making. The nurse leaders in this study portrayed themselves as resilient individuals who had overcome cultural, societal and organisational challenges to reach positions where they could positively impact their profession and healthcare in Aotearoa. Generally, participants in this study were deeply connected to their communities' healthcare needs and aimed to proactively solve problems by focusing on finding culturally inclusive solutions to improve health outcomes. Additionally,

they found ways to leverage their gender to their advantage instead of allowing it to define them.

This chapter concludes the presentation of the findings from this research. In the next chapter, I will elaborate on the two primary themes identified through this multi-method qualitative research: gendered socialisation and negotiating binaries in a neoliberal environment. I will also discuss the implications of these themes for the development of emerging nurse leaders.

Chapter nine: Discussion

9.1 Introduction

This chapter summarises the thesis by highlighting the key findings and discussing their implications for maintaining nurse leadership in organisational environments. The themes *Gendered Socialisation* and *Negotiating the Binaries in a Neoliberalist System* highlight the significant challenges to becoming and being an effective and visionary nurse leader in Aotearoa in the 21st Century. The findings are particularly relevant given the current period of enforced austerity in Aotearoa, including proposed cuts to nurse leadership, and will be considered in this context. The chapter suggests ways in which the nursing profession, as well as its employers and funders of healthcare services, can better support nursing leadership.

9.2 Summation of findings

The participants in this study were a diverse group of nurses who had transitioned from direct patient care to leadership roles in healthcare organisations, private practice and some academic services. They all entered the nursing profession with the intention of providing care to patients and communities. However, they realised through various experiences that they could have a greater impact on care by moving into leadership positions. Most of them advanced to leadership roles through serendipitous processes, such as chance, opportunity, mentorship, personal determination, and often through a changed perspective following post-graduate education.

The transition away from direct care posed challenges for women nurses in terms of their personal socialisation as women. Both male and female nurses faced difficulties in establishing their position within work settings that were strongly associated with the feminisation of nursing and experienced subordination to the predominantly masculinised nature of medicine and management. These leaders have lived their careers during the rise of managerialism, which was initiated by the shift to neoliberalism in the 1980s. As a result,

they have witnessed hospitals in particular, becoming heavily bureaucratic, with a strong emphasis on cost-effectiveness and a constant drive to save money and safeguard the bottom line.

The data indicates that nurses enter the profession with a strong sense of caring, but they receive little formal training in leadership. As a result, they may be unprepared to handle the challenges of a leadership role and are also not accorded the same level of authority as their medical counterparts. In multi-disciplinary meetings, they are often unable to voice their concerns about patient care, safety, and well-being as other agendas and voices take precedence. The continual focus on the budget and cost savings may diminish or silence the voice of nurse leaders who are arguing for appropriate staffing and related patient safety.

Nursing's contribution to patient well-being and safety has been undervalued, perhaps due to the assumption that traditionally feminine traits cannot significantly contribute to patient outcomes. Despite ample evidence showing the link between strong nurse leadership and safe care, nursing input in healthcare decisions is often overlooked. A long history of research (see, for example: Aiken et al. (2017) Haskins and Roets (2022) Barcellos Morcelli et al. (2023) Dirik and Intepeler (2024); Uchmanowicz et al. (2024)) has demonstrated the connection between effective nurse leadership, nurse staffing and patient safety. Despite the proven value and importance of nurse leadership, the findings of this research show that this is not planned for nor resourced in a manner befitting the evidence.

Magnet[®] recognition is an organisational model that emphasises strong nursing leadership and can only be achieved by a hospital correctly staffed by highly skilled nurses with access to professional development and whose clinical expertise is valued. Magnet hospitals offer a safer work environment, which leads to greater staff retention due to increased job satisfaction (Rodríguez-García et al., 2020). This organisational model has most importantly, demonstrated better patient outcomes as measured by mortality and other care-sensitive indicator data (Connor et al., 2023; Rodríguez-García et al., 2020). The Magnet model was introduced to NZ early this millennium but failed to find sustained support, outside of nursing circles.

Although leadership and management are theoretically distinct, current leadership structures often combine these roles. This blending can create a confusion of responsibilities; nurse leaders in the study reported that this frequently led to personal conflict. Gabutti (2023) noted that the transition from vertical hierarchical structures to more horizontal, responsibility-oriented services has resulted in nurses taking on greater managerial responsibilities that require different levels of competency. He also pointed out that this change in role could lead to role ambiguity if nurse leaders are uncertain about how to meet expectations, or to role conflict if the leaders disagree with the expectations of their role. When a leader's personal and professional values are consistently challenged, it can create significant stress that may ultimately result in career changes (Larsman et al., 2024).

These findings raise concerns as they further support the assertions that nurses are increasingly finding leadership positions unappealing (NEJM Catalyst Insights Council, 2018; Sherman & Saifman, 2018). Tyczkowski et al. (2015) commented that some RNs did not seek leadership roles due to a perceived lack of support and the stress associated with such positions. The pressure of being held accountable for outcomes and the scrutiny faced by nurse leaders' decision-making were also mentioned as deterrents to seeking positions of leadership (Cabral et al., 2018; Royal College of Nurses, 2020). Additionally, the small variation in pay between nurse leaders and senior clinical nurses offered little financial incentive to progress (Royal College of Nurses, 2020).

It could be expected that emerging nurse leaders would be given preparation for these challenges. Where leadership courses have been provided or attended, they are usually generic in nature or not discipline specific. As such they do little to address the particular socialisation that nurses in general and especially nurses as women have experienced. Neither mentorship nor funding is ever formally guaranteed, and the degree of serendipity can be significant. In this context, the Ngā Manukura o Āpōpō model of leadership development for Māori nurses, as explored in chapter eight, offers a great deal from which all future nurse leadership development could be modelled. Ngā Manukura o Āpōpō has shown great success in developing nurse leaders who possess the personal insight to overcome the barriers of their

socialisation, draw strength from their cultural background and stand strong in their profession (Pipi et al., 2021).

The composition of the nursing profession remains persistently at approximately 90% female (Nursing Council of New Zealand, 2023). This suggests that despite the increased professionalisation of nursing alongside the close association with research and post graduate qualifications, it is still regarded as “women’s work”. The gendered nature of the work and the predominance of women in the profession offer complex challenges for constructive attention. As Carryer (2022) noted

Nurses are treated as “just women” in terms of their diminished engagement with critical decision makers yet simultaneously ignored as women with particularly gendered responsibilities. Women are mostly actively responsible for children, elderly parents and the bulk of domestic servicing, all of which conflict at times with their working lives and their career development. It is unusual for employers to make any particular allowance for the additional burdens that women often carry and to accommodate their needs in flexible working hours or available child-care services.

In reviewing this study's findings, it is particularly interesting to note what nurse leaders do not discuss or describe in detail. These registered nurses operate in a context shaped by the global shift toward neoliberalism and managerialism that began in the 1980s. This environment significantly influences their daily activities. While some do mention the basis for their challenges, many appear to lack a comprehensive analysis or deeper insight into the significance of the issues they face.

9.3 Loss of value and autonomy

The political influence of nursing has traditionally been limited, even with advancements in the field. The current neoliberal discourse surrounding austerity has exacerbated this feeling of disempowerment, as professional autonomy is constrained by multiple layers of regulation (Nairn, 2019). The priorities of the dominant voices in healthcare ignore nursing knowledge on issues such as adequate staffing, translating it into measurable

processes and quality indicators (Adams, 2024). Nursing autonomy has become entangled within a framework of rules designed to standardise practice and evaluate performance outcomes (Perron, 2013).

As a result, a lack of critical thinking and reflective practice is evolving due to the disempowerment of nursing ideals into mere tasks. When combined with inadequately staffed work environments, this deficiency in critical thinking has resulted in unsafe practices (Diatta, 2024; Teekman, 2012). The neoliberal environment has fostered an extreme aversion to any form of risk. Subsequently, nursing has adopted practices from other industries such as aviation, to enhance efficiency under the guise of making patient care safer (Chatzi & Kourousis, 2024). Senior nurses are tasked with reporting a substantial amount of quantifiable data to assess their effectiveness, while their professional concerns are frequently overridden by neoliberal priorities and targets (McKelvie, 2019). To meet these reporting requirements and risk aversion measures, a proliferation of nursing documentation has developed, which takes the place of critical thinking and adds to the anti-intellectualist views of non-nursing management.

The current coalition government in New Zealand is enforcing severe austerity measures, further exacerbating concerns regarding the equity and effectiveness of the healthcare system. Many countries have implemented austerity policies to address financial crises in their healthcare sectors. However, historical and international experiences have demonstrated unfortunate consequences on the quality of public health services and the subsequent erosion of equity (Guccio et al., 2024). Historically and currently austerity measures inevitably regard nurses and nurse leadership as a major source of potential budgetary restraint without consideration of the impact on patient safety and workforce sustainability.

As noted earlier, nurse leadership and staffing are always stringently pruned in times of austerity or budgetary restraint, in direct contradiction to advice from nurse leadership. Furthermore, austerity measures or many restructuring processes often seek to

position nurse leadership as advisory rather than with direct-line accountability (Hughes et al., 2018), replacing nurse leaders with generic service managers who control the budgets. Current restructuring in the NZ Health system, with its proposed four health regions similar to those recommended by the Gibbs Report (Gibbs, 1988) seems likely to decimate or disempower nursing leadership (Longmore, 2024). This demonstrates a lack of valuing nurses' capability to manage as well as lead.

Nurse leaders are held accountable for healthcare outcomes yet are frequently constrained by reduced resources and conflicting priorities (Klarare et al., 2020). As noted throughout this thesis nurses enter the profession wanting to deliver quality care. Society expects nurses to deliver care in a compassionate manner, but many healthcare systems tend to treat care delivery as a commodity and undervalue the way it is provided. Neoliberalism has driven changes to key nurse leadership roles, tasking them with the delivery of high levels of effectiveness (Gabutti, 2023) yet power structures continue to overtly or covertly exclude nursing from important front-line decisions such as policy-making and budget-setting (Adams, 2024). Therefore, nurse leaders, like the participants in this study, have the responsibility and accountability for care delivery but limited authority to implement the most suitable approach for the situation.

Directors of Nursing who do not have direct line accountability and budget holding find themselves in a challenging position because they lack financial control, yet they are held accountable for the quality and safety of nursing services (Hughes, 2013). A long time ago, Kanter (1977) noted that those with a position that lacks control over resources or political influence develop a heightened sense of lack of control, as they are required to produce outcomes they had no part in defining. This is particularly relevant today, as budgetary restraint is considerably more emphasised. Moreover, the expectations placed on nurse leaders have expanded to include additional responsibilities without extra resources allocated to fulfil these roles. As highlighted in this study, nurse leaders struggle to implement quality improvements because they cannot allocate sufficient resources for training and

initiatives. They increasingly find it difficult to balance operational duties with professional practice, often feeling that they are falling short in meeting the needs of both areas. This was borne out in the data, with participants voicing their angst following what was expected of them, particularly regarding staffing levels and restructuring.

Nurse academics face similar struggles competing for resources in a time of rapid change. Higher-level education has become big business, mirroring healthcare with its neoliberalist focus (Delgado & Mitchell, 2016). This focus has perpetuated a competitive culture that places value on publication and doctoral study, whilst undermining nursing scholarship (Divers, 2025). A survey by Delgado and Mitchell (2016) conducted in the United States of America (U.S.A.) found that some nurse participants who were researchers felt that other researchers were biased against them because they "had the wrong degree." Both male and female nurses have felt silenced in academic discussions and have been overlooked for high-status roles (Burton, 2020). Nursing research and knowledge are often undervalued and researchers report significant difficulty in securing research grants.

This lack of acceptance of nursing's scientific contributions can hinder clinical decision-making, especially when the underlying evidence is discredited. The current NZ Government is actively prioritising STEM (Science, Technology, Engineering and Mathematics) subjects in the belief that these will prepare a workforce equipped for economic competitiveness (Reti & Simmonds, 2025). This narrow focus is at the direct expense of humanities subjects, which are essential for a holistic understanding of health-related issues and of which nursing studies are a part. Participants reported that their nursing knowledge and experience were frequently overlooked due to their profession. These observations are backed by existing literature. A study by Walsh et al. (2023) found that nurses who engage in academic research are often underestimated by other health professionals and their nursing peers. Their contributions are frequently overlooked because their role is commonly viewed as an adjunct to the "real" work of medicine. This binary way of thinking tends to separate rational, numerical reasoning from nursing, which is often seen as more subjective or emotional. The failure to acknowledge the importance of nursing research

has contributed to a critical shortage of nurse researchers, as reported in Australia. (National Health and Medical Research Council, 2021).

In educational settings, as in other fields of nursing, there is a gendered expectation for nurses to be agreeable and exhibit other feminine attributes not associated with leadership (Katuna, 2019). Unsurprisingly, internationally, leadership roles in higher education, particularly in nursing educational settings, are disproportionately occupied by men, even though the nursing workforce is mostly female (Divers, 2025). Career progression in academic schools of nursing is also limited by gendered behaviour. Pastoral care of students is an expectation that may take time away from academic work and personal research goals. It has been observed that women in educational settings often undertake gender-normative roles, becoming caregivers for their institutions without adequate recognition (Katuna, 2019). This behaviour was particularly highlighted during the Covid-19 pandemic, where female tutors were frequently expected to address the psychological needs of their students, offering support for personal difficulties and social needs (Giulia et al., 2024). Such pastoral care was found to limit research opportunities, thereby affecting career advancement.

The public perception of nurses as caregivers of the sick, along with many nurses' own claims to that role, exists alongside a lesser emphasis on nursing's scientific knowledge, thus reinforcing traditional perceptions. Nursing in NZ, however, has numerous excellent role models who have made great achievements in scientific, academic or business arenas. New Zealand nursing was a pioneer within the British Empire, having established the first Chief Nurse in a government department and introducing several professional innovations, including reducing nursing shifts from 12 to 8 hours. Due to its geographical position, New Zealand fostered a unique nursing profession that contributed to social and political advancements (Wood, 2022). Yet these high-achieving role models are rarely given public recognition as nurses and are even unknown to many in the profession. Often, this is exacerbated by the failure of nurse leaders in non-traditional roles to claim their identity as a nurse.

Lack of engagement in the professional business of nursing means that many RN are unaware of high-achieving nurse leaders or have difficulty relating that status to themselves. Indeed, some RNs actively denigrate scholarship and leadership as being irrelevant to nursing practice realities. Whilst this attitude might be viewed as envy at others' achievements, it is also indicative of oppressed group behaviour where low self-worth leads nurses to turn on each other. The research findings reflect the importance of positive role models to a nurse leader's career pathway, particularly those of a similar ethnicity. However, these role models must be relatable if they are to counter the negative impact of former co-workers. A structured way of connecting emerging leaders to suitable role models, such as that undertaken by Ngā Manakura o Apōpō, seems advantageous.

Nursing's professional identity has become fragmented across many practice settings and hierarchies. This has perpetuated oppressed group behaviour and a dismissiveness of those in senior roles (Manning & Blair, 2022). Nurse leaders frequently navigate a complex dynamic in which they are viewed as managers by their staff and as nurses by their peers in management. This perception can lead to a sense of marginalisation, as was experienced by study participants. Instead of being agents for transformational change, many current leaders are seemingly angst-ridden, trying to do their best in work environments that have different priorities and do not accept them as an equal partner in care.

9.4 Gendered socialisation

Most of the research participants were only vaguely or peripherally aware of the strongly gendered issues that have shaped their careers and impacted their leadership. This makes them vulnerable in multiple ways. As discussed in chapter three, the gendered socialisation of nurses as women has resulted in many nurse leaders facing the double responsibility of caring in both formal and informal settings. The persistent societal expectation that a woman should be the primary caregiver and homemaker is a gendered impediment that needs to be overcome for women to sustain leadership roles. Pincha

Baduge et al. (2024) listed unbalanced home and parenting responsibilities as one of the challenges to successfully attracting nurses into leadership positions.

The research data aligns with the literature, demonstrating that workplace equality does not adequately account for the additional responsibilities that working women face. While the historical expectation that married women would leave nursing to focus on domestic roles has gone, a disparity still exists in terms of women's dual roles as income earners and as primary caretakers in the home and beyond (Durville, 2025). Where work is poorly remunerated it exacerbates the likelihood of the position holder attempting to “do it all” especially if a male partner has better remunerated work. Only one participant in this study described being genuinely supported and relieved of the dual accountabilities of home and work.

The study findings indicate that making workplaces more flexible around childcare and the care of elderly parents may seem appealing and long overdue. However, it could also perpetuate the long-held expectation that women should juggle multiple roles. For a shift to occur, significant societal change is needed to remove the gendered nature of household and family responsibilities. In addition, nursing needs to change its discourse of selflessness, which acts as a deterrent to nurses seeking a healthier work environment for themselves (Nairn, 2019). Nurses, especially those in leadership roles, historically viewed self-care as a weakness rather than a strength (Baker, 2022). However, there is a growing awareness of the importance of self-care for nurse leaders (Martin & Delehanty, 2024), as evidenced by the increasing number of podcasts, motivational emails, and motivational speakers at nurse leader seminars and conferences (Kowalczyk, 2024).

Generational differences may be the driver for the rising demand for self-care techniques. Participants in this study spoke of the expectation of long work hours without added recognition as a deterrent to a leadership pathway. Whilst these “gifted hours” appear to be a personal choice, heavy workloads and tight timeframes largely contribute. Organisational practice means that there are too many calls on a leader’s time. This

unhealthy pattern of working is unattractive to the new generations of nurses who seek greater work-life balance. Younger generations value flexibility in their workplaces, unlike earlier generations where the emphasis is more on self-discipline (Lingel et al., 2022; Tan & Chin, 2023). Some responsibility belongs to our current nurse leaders who seem to model this unhealthy behaviour. By perpetuating the habit of regularly working beyond paid hours without being noticed as taking time in lieu, an expectation is created that may be rejected by potential leaders of subsequent generations.

Not surprisingly, a sense of helplessness persists within nursing, along with a seemingly accepted set of gendered expectations tied to our assumed binary. Nurses seem to validate the prevailing discourse that portrays a lack of agency, leading many to believe that nursing is inferior to other health disciplines. Pincha Baduge et al. (2024) argued that effective nurse leadership is enhanced when the gendered expectations associated with the profession are acknowledged and addressed. It is crucial, then, to foster an equitable and supportive environment that enables individuals to embrace leadership roles. The challenges of becoming and being a nurse leader cannot be adequately addressed without comprehending the implications of belonging to a feminised profession in the current neoliberal climate.

9.5 Struggle to be heard as leaders

The attempts of nursing to address inequities in health care are limited by a lack of acceptance of the nursing profession as an equal partner to others in healthcare (Adams, 2024). Although nursing as a profession has long talked about finding a voice, little of this was evident in the research data. The discourse rather had a political naiveté.

Initially I, like the research participants, had a limited awareness of the impact of neoliberalism on nursing and so was rather timid in my career aspirations. Over time disempowered nurse leaders may narrow their interests and fail to see beyond the constraints of their immediate work environment. Additionally, an unspoken “niceness” discourse within nursing silences dissenting voices on important issues (Dillard-Wright et al.,

2023; Jackson, 2022; Nairn, 2019). The legacy of gendered socialisation, which promotes compliance and agreeability, has created an identity that disempowers nurse leadership and perpetuates the status quo. A “nice” nurse is often reluctant to challenge healthcare decisions or propose alternative approaches to issues. As the findings demonstrate, individuals who dare to voice their concerns often encounter repercussions, even facing disciplinary actions that can cast a shadow over their professional lives. Jenkins et al. (2022) commented that nurse leaders have failed to reflect and speak out on the ethics of organisational practices and their contradictions to the nursing ethos. Kerri Nuku, the Kaiawhakahaere for the New Zealand Nurses Organisation, recently noted a pervasive fear among nurses regarding speaking out on important issues. She expressed her concern that this fear could negatively impact the health of the nation (Nuku, 2025).

Feminist theory throughout its developmental stages has developed an increased understanding of the nexus between power, knowledge and language and the role played by gender in that nexus (Hines, 2020; Larregue & Nielsen, 2024). Feminists give importance to understanding all forms of power so as not to be blind to any opportunities for resistance. Some nursing scholars have been inspired by Foucault to use discourse analysis to examine the many assumptions impacting the profession (Frederiksen & Beedholm, 2017). Foucault (1981) saw power as “a complex strategical situation in a particular society”. He believed it was a two-way process, not merely the oppression of one to another. Foucault believed power operated through discourse about what is known. This knowledge generates power in the person (Foucault (1981); (Foucault & Gordon, 1980). Although Foucault never mentioned gender, numerous feminist scholars, (see for example McLaren (2002); Vintges (2017)) have taken his theories and applied them to gender issues including the construction of subjectivity for women.

Feminist scholars have also used Foucault’s theory of power to analyse patriarchal relationships. He saw power as circulating with everyone able to both exercise power or suffer because of its lack (Foucault, 1995). The study participants mostly experienced the effects of power as a barrier to achieving their personal and leadership goals and those held

on behalf of their patients. Daly and Jackson (2021) commented that it was nursing's gendered nature and position as inferior to medicine that kept the profession from reaching its full potential.

Historically, nurses' submission, subordination, and humility have not served the profession well. Despite being the largest profession in the healthcare system, nursing has not fully utilised its potential to wield influential power. In this study, some nurse leaders did not appear to understand how to leverage their power to achieve desired goals. Some study participants even relied on male medical staff for credibility, even when it wasn't necessarily justified. If nurse leaders were taught the complexities of power dynamics they would learn how to use power effectively to influence change (Daly & Jackson, 2021).

The relationship between knowledge and power is evident in specific situations. Knowledge must adhere to certain rules, while power requires a system of knowledge to support it. Language is a tool that reflects the impact of both power and knowledge. The influence of language as a form of power is particularly noticeable in the way concepts are labelled (Ristić & Marinković, 2023). Some of the terminology used in health such as “following orders” derived from our military past, reinforces the power dynamic in medicine and diminishes the significance of nursing (Fletcher, 2006). There are many examples of proactive behaviours in nursing but differing internal agendas have always slowed progress and enabled medicine to gain the upper hand. The privileging of medical knowledge over nursing knowledge ignores the experience and input of nurses, particularly in primary care (Adams, 2024).

In 2020 the Nightingale Challenge recommended upscaling successful models of practice where nurses were playing central roles in multidisciplinary teams (Bayliss-Pratt et al., 2020). Instead of trying to reverse the power dynamic with medicine, this study suggests that nursing should focus on developing collaborative leadership models with other healthcare professions. Nurses would then have authority for decisions that impact their profession through a shared governance model. Holloway (2016) recommended a team approach with nurses as full partners, working together with other disciplines to redesign

health systems. Holloway argued that nurse leaders are in a prime position to bring together individuals from various disciplines to consider diverse perspectives and address complex issues in healthcare, which often lack straightforward solutions. In some healthcare areas such as smaller specialty units this is already occurring on a limited scale. Given all that has previously been discussed in this chapter, it would be unrealistic to expect that this suggestion is realistic or could be enacted on a wider scale.

As reported by Teekman (2012) and others, a culture of silence on many issues exists within nursing, and this behaviour is not impacted by structural change. Changing the power dynamic in the model of care in most organisations would require a generational shift in attitude and practice. I would argue that new graduates currently have to focus on being accepted both personally and professionally in their new team culture, and so rapidly lose sight of the insights their education has given them. Likewise, emerging nurse leaders find their vision for change diminished by the realities of increased workplace expectations.

Achieving nursing impact in our healthcare system is challenging without politically aware nurses who participate in decision-making processes that influence care delivery. Instead of waiting for invitations, nurse leaders in this study firmly believed that nursing must take a proactive stance in defining its role. A common saying that highlights this point is “if you are not at the table, you are on the menu.” Participants emphasised the importance of having a broad understanding of the healthcare sector and political landscape to be able to effectively advise and support others. Schneider et al. (2016) noted that a historical consequence of women taking on roles focused on helping others is that they were less likely to develop attributes needed to compete in public leadership roles. The study revealed that while nurse leaders in Aotearoa may have some political awareness and the necessary skills, most lack the appetite, opportunity, or sense of safety to use them.

Additional challenges exist for intending or aspirational Māori nurse leaders. The continuance of colonialist-like systems perpetuates Pākehā power and privilege. There have been moves to increase the number of Māori nurses to match the demographic of Aotearoa, yet most recruitment practices have not adopted a Kaupapa way of interviewing. This

method has no set questions, instead taking on a conversation style where a support person speaks on behalf of the applicant preserving their humility. Culturally safe precepting and mentorship models have been introduced in some workplaces, but this practice is not widespread or well supported by all management teams. Although organisations have heightened awareness of the cultural responsibilities of Māori nurse leaders, this has yet to result in practical accommodations in many workplaces. In addition, Māori nurses still struggle against racism and inherent bias when applying correct tikanga in their practice and this is not always acknowledged or addressed.

9.6 Creating Empowered Nurse Leaders

Traditional hierarchical leadership models create barriers that lead to a disconnect and disillusionment with leadership amongst nurses. These leader-centric models of leadership are also no longer adequate to meet a more innovative-focused demand. The research findings demonstrated that the type of leadership structure had an impact on the effectiveness of a nurse's leadership, with those nurses working in organisations that had a flat or interdisciplinary management structure believing they had more influence. Ackerman et al. (2019) recommended the use of a team-based approach built on forming collaborative relationships. A collaborative approach would benefit by assisting senior leaders in coming to a mutual understanding of each other's viewpoints (Cabral et al., 2018). Shared governance is a collaboration within multidisciplinary teams that resembles the collective Māori leadership model and incorporates feminine relational leadership skills. Shared governance models are founded on partnership and empowerment (Kroning & Hopkins, 2019), feminine attributes that enable an organisation to thrive. Huber (2017) thought nurses to be capable of coordinating such interdisciplinary teams to deliver cost-effective systems of care if they felt empowered to speak up. As previously mentioned, Magnet® hospitals are a proven example of a shared governance model that has empowered nurses, resulting in better patient outcomes. Shared governance is also better suited to Māori models of leadership.

The history of nursing has been one of subjugation and submissiveness. Feminist deconstruction of gender theory identifies the impact of gender-related socialisation and oppression on nursing. This opens up an opportunity to imagine what leadership would look like if based on the feminine qualities of collectiveness, care and nurturing. Foucault said we should understand ourselves so as to lead an authentic life (Foucault & Pearson, 2001). Authenticity requires self-mastery of one's own desire and limits the ability to misuse power over others (Perron, 2013). Nurses contemplating leadership bring with them significant socialisation in the feminine binary but find themselves negotiating leadership in masculine organisations and processes. As outlined by the study participants, this can bring about inner conflict and require skills and support to overcome without losing the true essence of their nature. Nurse leaders may find themselves adopting more masculine leadership styles as coping mechanisms or to have their voices heard. This position is not a comfortable framing for many nurses, in particular Māori nurses. This research argues that specific nurse leadership education is needed that addresses our socialisation as women in a feminine profession. Education should also critically evaluate the concept of feminised work and an understanding of the binaries that underpin decision-making and resourcing in the healthcare sector.

The education of nurses traditionally focused on the nurse-patient interaction. Organisations tend to support only professional development that aligns with clinical need, which limits nurses' access to a broader range of courses. However, modern nursing also requires skills in advocacy, research, and innovation. According to nurse leaders in this study, training that emphasises building relationships through networking, professional supervision, and mentoring provides greater long-term benefits. Therefore, nursing needs to establish a clear career pathway for leadership that includes these enabling factors, which help develop self-awareness and identify areas for further growth.

However, nurse leader preparation in Aotearoa is currently inconsistent, nonspecific and lacks long-term effectiveness. Postgraduate education has been identified as a factor

that encourages the exploration of nurse leadership options due to exposure to a broader healthcare context. Many nurses now have master's degrees, but under neoliberalism, limited funding is available for further progression as little value is placed on nursing scholarship. Networking opportunities, such as conferences and seminars, which the nurse leaders in this study found helpful, are often funded for medical staff as part of their contracts but are frequently declined for nursing staff. Globally, the professional development of nurse leaders is given low priority (Warshawsky & Cramer, 2019).

Although postgraduate education raises an emerging leader's awareness, it fails to equip them with the skills needed to manage the healthcare environments in which they are required to lead. A lack of preparation for leadership roles creates confusion and stress for new leaders and may result in poor retention at that level. Study participants had rated integrity and empathy as qualities highly desirable in a nurse leader, yet it is often these qualities that emerging nurse leaders struggle to sustain when faced with the realities of their roles.

Miles and Scott (2019) defined leadership as a collaborative values-based process. To be a leader requires not only the possession of skills and knowledge of how to lead but also a leadership identity belief that they can lead. Current leadership training focuses on developing leaders who effectively manage their KPIs and can align service improvement with the organisational vision. On 18 June 2025, Health NZ announced to its employees that it had partnered with a postgraduate institute to design a leadership development programme aimed at supporting emerging and existing healthcare leaders to deliver on the healthcare targets (Health NZ/ Te Whatu Ora, 2025). In a time of fiscal austerity, job restructuring and staffing issues, this is seemingly viewed by Health NZ executive leadership to be a good investment of public money. The findings of this study indicate that these generic trainings may not be empowering emerging nurse leaders to develop the emotional intelligence and relational skills they need or to build self-confidence in their identity as nurses who lead.

Generalised training programmes may not address the political and broader context of nursing, knowledge of which was deemed critical by the research participants.

Emerging nurse leaders need a clear vision of their future direction and goals to commit to them fully. This aspirational type of pathway would empower them to develop their unique leadership style. Ngā Manukura o Āpōpō is demonstrating success in fostering a group of tangata whenua nurses who are confident in their belief in themselves as Māori and in their direction as nurses. As outlined in chapter eight of this document, I believe Ngā Manukura o Āpōpō to be a model of excellence that could be adopted and adapted for the training of all future nurse leaders. Graduates of this program have advanced in their leadership careers, taking on more senior roles or participating in national forums and governance groups (Pipi et al., 2021). The clinical leadership training provided by Ngā Manukura o Āpōpō is beneficial for the personal and professional development as well as the cultural identity of the participants. The training increases confidence, assertiveness, and better preparedness to handle challenging situations. Being part of a collective and a growing network of Ngā Manukura o Āpōpō participants and graduates facilitates the participants' growth in leadership. This network offers support, advice, and encouragement, especially when participants encounter challenges such as workplace racism or feeling isolated as Māori in a mainstream setting.

Nga Manukura o Apopo provides a framework for aspiring and experienced leaders to traverse their leadership journeys together. Cziraki et al. (2018) believed mentoring significantly influenced the development of leadership self-efficacy, indicating that support from others, such as encouragement from leadership mentors was an important factor for an RN developing confidence in their leadership abilities. Branden and Sharts-Hopko (2017) remarked on a “fear of failure” they had noted from millennial nurses studied. Leadership can be isolating, so coaching and mentoring can help nurses understand they are not alone in their career journeys. (Cabral et al., 2018). This form of support encourages continued self-development and a responsibility to share their learnings with others in the profession (Branden & Sharts-Hopko, 2017). Many of the nurse leaders in this study mentioned the

benefit of mentoring, but also of networking and building relationships across Aotearoa. Membership in Colleges, alumni and leadership groups were recommended both for advice and personal support. These networks improve a nurse leader's performance by advising on coping strategies for setbacks and challenges. It is noted that not all New Zealand registered nurses take advantage of the professional development opportunities offered by the professional organisations to which they belong. If they do use these professional bodies, it is usually for employment or legal support.

An effective way to help organisations succeed and reach their key goals is by enhanced leadership capacity. Investing in the leadership potential of upcoming generations helps an organisation to thrive and achieve success (Mariya et al., 2024). Instead of solely relying on recruiting strong leaders, organisations have started to focus on expanding leadership skills throughout the entire organisation. This process is often referred to as “growing our own”. An environment that is favourable to leadership development can be created by increasing opportunities for others to participate in a broader range of organisational activities (Al Sabei et al., 2018). The findings of this study support the idea of Jones (2018) that leadership is best learned through hands-on experience, guided by individuals with whom one has a relationship. [Jones \(2018\)](#) The study suggests that capturing the interest and commitment of aspiring nurse leaders is more effective than simply teaching technical skills or developing specific techniques.

9.7 Changing the focus

Nursing philosophy mirrors Te Ao Māori in its focus on social justice and holistic care (Adams, 2024). Neoliberalism has resulted in a more inequitable health system, which means that some people flourish at the expense of others (Nairn, 2019). Daly and Jackson (2021) argued that nursing has been complicit in its silence instead of advocating for patients' best interests. It is now more than ever, that nursing needs to uphold its key values and support the fight for social justice. Nurses have a professional responsibility to advocate for safe practices, but it's important for them to feel secure and empowered to do so.

Speaking up on behalf of others, known as parrhesia, can make nurse leaders vulnerable if they challenge the prevailing beliefs (Jenkins et al., 2022; Perron, 2013). However, Jenkins et al. (2022) proposed that a true leader understands that conforming or being liked is not an option if their silence impacts those they represent.

Carryer (2019) suggested that after more than a century of medical dominance in healthcare, with no resolution of global health problems, it may be time to shift focus towards nurse-led approaches that partner with individuals and communities. The current system's inability to provide optimal patient care reflects on nurses as the patient-facing deliverers of that care. Nurses are often frustrated over a lack of capacity to effect change in an environment that limits or prohibits autonomous decision-making (Stanley & Stanley, 2018). It was clear from this study that nurse leaders begin with a desire to make a difference for their patients and their whānau. Personal and professional values caused the nurse leaders to question the barriers they saw to efficient and effective patient management. Yet only some were courageous enough to stand firm for what they believed to be the best or most equitable practice.

Possessing leadership skills is of no benefit unless the nurse also perceives themselves to be a leader and attaches value to a leadership role (Miles & Scott, 2019). Kelly et al. (2023) found that even at an executive level, nurses often demonstrated professional low self-esteem that limited their influence. The nurses in this study took pride in their profession and the trust placed in them. However, as mentioned by research participants, some nurse leaders are hesitant to acknowledge their nursing background in business or political environments due to concerns of being at a disadvantage. These leaders feel that being recognised as a nurse does not confer the credibility that they seek from others outside the discipline (Thompson & Watson, 2021). This lack of authenticity, influenced in part by gendered oppression, does not promote the potential that nurse leadership offers. Neither does it help to instil pride in the unique identity of nursing amongst other health professions and the contribution nursing makes to healthcare.

9.8 Summary

In this chapter, I have discussed the themes from this multi-method qualitative research: “Gendered Socialisation” and “Negotiating the binaries in a Neoliberalist system” which arose from my data collection in response to my research question. I explored what the findings demonstrated about nurses as women and the struggle to gain an equal voice in healthcare systems that are aligned with the masculine binary. I also discussed the importance of nursing remaining true to our values so that future nurse leaders would be supported into a model of leadership that was authentic to the aims of our profession.

The research findings showed that NZ nurse leaders must first negotiate societal expectations of nurses as women, which leads to many doing double duty, balancing home and work expectations to pursue their career pathway. Once a leadership role is obtained, work-life balance continues to be negatively impacted by self-imposed extended work hours. This lack of work-life balance has been shown by extant literature and the research findings to be one of the barriers to seeking a nursing leadership role. Acceptance of this dual role was seen to be waning as new generations of nurse leaders focused more on self-care.

Currently, in 21st-century NZ healthcare, a neoliberalist and colonialist philosophy prevails, which has impacted nursing autonomy and effectiveness. The austerity measures currently being enforced upon the healthcare system have serious implications for nursing leadership. I argued that the autonomy of nurse leaders is being subjected to protocol and performance measures. Under neo-liberalism, care has been commodified into assessments and checklists that can be audited and measured. A generic emphasis on clinical experience and quality improvement has led to a deficiency in critical thinking skills. Furthermore, nursing's tradition of compliance has fostered acceptance of organisational practices that undermine professional judgment. The increased focus on risk aversion has led to a proliferation of checklists and tick-box forms, which serve as inadequate replacements for critical thinking. Academic nurse leaders are not immune to the effects of

neoliberalism and the prevailing anti-intellectualism associated with nursing as a feminised profession.

The quest for equal partnership in healthcare leadership means understanding and confronting existing power imbalances. Some of these power imbalances are self-imposed by the historical background of nursing as subordinate to medicine. The findings show that instead of empowering leaders to be agents for much-needed change and transformation, they are more likely to be dispensable actors on a bureaucratic stage.

Conversely, an authentic leadership culture begins with grounding nurses in who we are as a profession, acknowledging our feminine roots of subjugation, then recognising the binaries operating in our healthcare systems that must be negotiated to achieve our goals. It is then that emerging nurse leaders can be empowered to build careers that challenge the existing status quo while remaining true to the profession's values. A structured mentored leadership training pathway is recommended for registered nurses to ensure that progression is fair and intentional, rather than relying on chance and inequity. Ngā Manukura o Āpōpō has emerged as a leadership training model appropriate to the needs of nurses in NZ, that incorporates the desired practices of ongoing mentorship and networking opportunities.

The final chapter will conclude this research by issuing a warning about the future of nurse leadership in Aotearoa if changes are not made in how we prepare emerging leaders. I have outlined how the research findings contribute to new knowledge and provided recommendations for training and supporting future nurse leadership in Aotearoa.

9.9 Limitations

In any research process, it is essential to state the study's limitations clearly.

Reflecting on the research process, I have identified the following limitations:

- Data collection for this research began when the COVID-19 pandemic reached NZ.

National lockdowns and an increased nursing workload impacted the ability to collect

data in a timely manner. The researcher was also required to work full-time during this period to cover the shortfall of experienced nursing staff.

- The sample size was small, so generalisability is limited.
- The inexperience of the researcher meant that, on reflection, more probing questions could have been asked to increase the depth of some of the interview responses.
- I am aware that my ethnicity as an NZE may mean that I may not have captured the views of Māori nurses as adequately as they deserve.
- It is possible that the leaders I recruited are particularly invested in nursing and have a positive attitude towards the profession's ability to affect change.

Chapter 10. Conclusion

This thesis has explored the leadership challenges faced by the largest professional group in healthcare. It is written at a time when there is substantial and now longstanding evidence highlighting the importance of nurse leadership and adequate nurse staffing for patient safety and well-being, as well as for the retention of the nursing workforce. It is clear that neglecting patient safety and well-being ultimately incurs significant costs for the healthcare system, not to mention the impact it has on patients and their whānau. Despite this understanding, the research has shown that there is a lack of consistent and focused efforts toward developing nurse leadership throughout healthcare organisations.

Generic nurse leadership development is not meeting the needs of aspiring 21st-century nurse leaders. The development of clinical master's degrees has been critically important for producing senior clinicians in New Zealand. However, these clinical degrees have largely replaced the emphasis on critical social theory, social determinants of health, and health policy that characterised earlier master's programs. Leaders need this background along with programmes that acknowledge the heritage of nursing as a gendered profession and help participants develop strategies to overcome gendered expectations of subservience and docility. Nurse leaders require political awareness and strong verbal skills to understand the nuances of proposed changes to our systems and care delivery models, enabling them to participate effectively and powerfully in leadership settings.

By understanding the contextual environment in which the data was collected, inferences have been drawn regarding factors that can be addressed to better prepare and nurture emerging nurse leaders in Aotearoa. I will now argue how my findings contribute to contemporary knowledge and what they suggest about the future of nurse leadership in Aotearoa. I will conclude by presenting recommendations derived from this study.

10.1 How the Findings Contribute to Current Knowledge

This research has shown that the legacy of the gendered socialisation of nursing continues to impact the career aspirations and effectiveness of contemporary nurse leaders,

despite this being unrecognised or unacknowledged by many nurses. Leaders do recognise the challenges to practising autonomously in neoliberalist systems that disprivilege feminised professions such as nursing. However, the nursing “tyranny of niceness” often means at least overtly, accepting the status quo. This study contributes to the understanding of what is necessary to sustain a career path in nurse leadership in an environment where the nursing perspective on health issues is given less importance than that of business or politics.

Additionally, this research highlights the ongoing issues of sexism, colonialism, and racism in 21st-century healthcare systems. These biases need to be addressed to ensure that healthcare is culturally safe for both Māori and IQN staff (who currently together make up almost 60% of the nursing workforce), which is essential if they are to be retained and attracted into leadership positions. Such inequities continue to make it easier for male nurses to advance into senior nursing roles despite nursing being predominantly female. Organisational bias can also create barriers for individuals who challenge traditional gender roles, particularly when they speak out on issues related to safety or efficiency.

My research emphasises the significant benefits of cultivating professional networks specifically tailored for newly appointed nurse leaders. These networks should foster an environment of trust and mutual support to effectively enhance and sustain the career paths of nurse leaders. The evidence indicates that offering mentorship and coaching opportunities to all registered nurses—regardless of whether they are stepping into formal leadership positions or simply aiming to improve their practice—can profoundly impact their professional growth. This approach not only broadens their skill sets but also benefits others.

Aotearoa has a model of excellence in Ngā Manakura o Apōpō. This leadership training framework is cultivating empowered Māori nurse leaders who possess a strong grounding in their cultural heritage as Māori women. They receive career support while being encouraged to assist others in their professional development. Similarly, non-Māori nurses can also benefit from a deeper understanding of their personal socialisation, the

organisational perceptions of feminised work, and their learned responses to multidisciplinary settings.

10.2 What the findings suggest about the future of nursing leadership

The findings suggest that unless nurses are proactive and united in their focus, there is a risk of further loss of autonomy and devaluation of the nursing profession under the reforms of a neoliberalist healthcare system. Current austerity measures and global events have resulted in a working environment that makes a leadership pathway in NZ unattractive to many. New Zealand is already experiencing a shortage of experienced nurse leaders across various fields of the profession. Furthermore, our significant reliance on internationally qualified nurses (IQNs), who currently make up 46.8% of all nurses with an annual practising certificate (Nursing Council of NZ, 2023), has resulted in a nursing demographic that does not reflect our population. This lack of locally trained nurses in Aotearoa makes it more challenging to provide culturally safe care.

The shortage of fully prepared and engaged nurse leaders means opportunities for innovative healthcare practice may be missed, and patient safety will certainly be compromised. Bold changes are needed to create nurse leaders who are empowered to advance the profession and highlight our unique skills and knowledge. Nurse researchers have shown the impact nurses have on safe and effective patient care but this evidence will continue to go unheeded unless nursing research is given the recognition of other disciplines.

Despite the knowledge we have regarding the effects of gender and neoliberalism on the journey to becoming and being a nurse leader in Aotearoa in the 21st century, I would argue that many nurses remain unaware of these issues in their practice. Nursing education and leadership programs have not adequately equipped emerging leaders with an understanding of our history of oppression and gendered socialisation. As a result, the next generation of nurse leaders is ill-prepared to confront the challenges of a healthcare

system that does not recognise the value of their work, because it cannot be easily commodified.

Unless leadership preparation is changed, NZ will continue to appoint nurses to senior roles who may be poorly equipped to challenge neoliberal austerity measures as an advocate for staff, patients and whānau. Our leadership programmes will continue to produce nurses trained in quality improvement methodology and management skills, but with little understanding of their unique opportunities as nurses.

10.3 Recommendations for change from this research

I began the introductory chapter of this research with a Whakatauki and I will now conclude with one that has a similar meaning:

Titiro whakamuri, kokiri whakamua, look back and reflect so that you can move forward.

This research indicates that leadership begins with being grounded in our identity as individuals and as nurses, recognising our history of oppression as a gendered profession, and understanding the binaries that influence our healthcare systems. Nurse leaders should embrace vulnerability and not fear criticism stemming from the perceived status of their profession. Instead, they should have confidence in their ability to advocate for new and more effective ways to deliver care. Nurses at all levels of practice must actively acknowledge the crucial roles of academics, managers, and directors, recognising their value as essential members of the healthcare team. By working collaboratively and appreciating each other's contributions, we will be able to strengthen the nursing voice and enhance our impact on patient care.

As a profession, we should continue to highlight and celebrate the achievements of our colleagues in all areas of nursing, ensuring that there are visible role models to inspire others. Furthermore, those in leadership positions must be willing to share their knowledge and support others in their pursuits. Ongoing support through mentorship programmes and

formalised networking is essential if we are to sustain and retain the next generation of nurse leaders.

Nurse leadership training should ideally incorporate networking and mentoring, following the model of Ngā Manakura o Apōpō, which could be adapted to meet the needs of non-Māori nurses. The development and promotion of this training would require protected funding for it to succeed. Now is the time for nursing in New Zealand to focus on developing a self-aware leadership workforce equipped with the political insight needed to guide the profession into the next century.

10.4 Declaration of Conflicting Interest

When this research was undertaken, I was a full-time employee of Health New Zealand Te Whatu Ora, which was undergoing organisational structural change. During this time, I was seconded to different leadership roles and had colleagues who lost their positions or took voluntary redundancy. At the time this thesis was being completed, I had become a trainer for the L.E.O. programme at my place of employment, with three sessions being held for over 30 staff, mainly emerging nurse leaders.

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Appendix One: Literature Reviewed

Reference	Population	Design methods	Leadership type	Findings/Comments
Literature reviews				
Branden, P. S., & Sharts-Hopko, N. C. (2017). Growing Clinical and Academic Nursing Leaders: Building the Pipeline.	USA	31 articles	Organisational and professional	Dearth of qualified RN to step up into senior roles Critical shortage as baby boomers retire or reduce workload Pathway into leadership not always clear Barriers: lack of support, incorrect perceptions, inadequate recompense, inconsistent mentoring opportunities Barriers outweigh enablers
Pipi, K., Moss, M., & Were, L. (2021). Nga Manukura o Apopo: Sustaining kaupapa Māori nurse and midwifery leadership [Journal Article]. Kaitiaki Nursing Research.	NZ	Synthesis of 4 evaluation reports	Clinical and professional	Māori leadership is that of a collective Challenge negotiating traditional values and a contemporary way Prioritise family & community over status or power Opportunities to develop governance skills ad hoc
Brewster, D. J., Butt, W. W., Gordon, L. J., & Rees, C. E. (2020). Leadership in intensive care: A review	Australian	28 Quant & Qualitative studies	Clinical and organisational	Transformational style linked to positive experiences Leadership training and experiences seen as enablers Barriers = lack of confidence, poor communication skills Individual factors the biggest enablers or barriers to leadership
Elliott, N., Begley, C., Sheaf, G., & Higgins, A. (2016). Barriers and enablers to advanced practitioners' ability to enact their leadership role: A scoping review	Ireland	Literature review and content analysis of 34 articles	Clinical and professional	13 barriers to leadership identified at different levels Failure to respond to barriers places sustainability of strategic roles at risk Need full cooperation at higher levels to build leadership capabilities of practitioners
Titzer, J., Phillips, T., Tooley, S., Hall, N., & Shirey, M. (2013). Nurse manager succession	USA	5 step systematic review of 13 articles	Organisational	Deliberate succession planning should be in organisational plan -need a thriving leadership pipeline Deliberate strategies lacking, need proactive methods of identifying & developing

planning: synthesis of the evidence.				Ethical perspective of optimising patient outcomes
Editorials				
Brooks, B. A., Crawford, L. H., Nicklas, G. E., & Soldwisch, S. (2014). Nursing Leadership Education: An Innovative Executive Solution.	USA Nursing		Organisational	Not enough nurses preparing to replace retiring leaders Programmes difficult to manage with work/life/finance Master's level gave better understanding of leadership Change of focus from illness to wellness creates opportunities to do things differently
Castner, J. (2019). Healthy Environments for Women in Academic Nursing: Addressing Sexual Harassment and Gender Discrimination.	USA Educational setting		Organisational	Benevolent sexism due to being a caring profession Lack of acknowledgement of technical skills Social marginalisation within nursing if seen as non-conforming Predominantly female professions are undervalued
Longmore, M. (2020). 'Growing the workforce takes time, resources': The new Māori co-leader of National Nursing Leaders outlines the range of initiatives that are helping lift the number of Māori in the nursing workforce.	NZ Nurses	Interview with Māori Chief Nurse (grey Literature)	Clinical and professional	Systemic racism & discrimination need to be addressed Growing Māori workforce requires a targeted approach National Nurse leaders group provides a nursing perspective to health decision makers.
Wilmoth, M. C., & Shapiro, S. E. (2014). The Intentional Development of Nurses as Leaders : A Proposed Framework	USA	Proposal	Professional	RN promoted by clinical competence not leadership ability Recommends: investment in developing emerging leaders Ongoing leadership training & self-reflection Providing trained mentors for new leaders
Peer-reviewed articles				

Al Sabei, S. D., Ross, A. M., & Lee, C. S. (2018). Factors influencing nurses' willingness to lead	USA	Workforce survey logic progression modelling	Organisational and professional	Positions not attractive as work environment unsupportive – focus should be on creating a favourable environment in which to lead Identify early Visible nursing influence to increase interest mentored leadership preparation essential
Banister, G. E., Harris, A. L., Townsend, C., Raymond, N., Masson, P. R., & Dzurec, L. (2020). African American Nurses' Perspectives on a Leadership Development Program.	USA	Focus group 19 Afro American RN graduates	Organisational and professional	Scarcity of role models – if like self can identify self as able to succeed Leadership training of minority groups must be intentional Leadership ability enhanced by effective experiences
Basheer, M. A.-G. (2020). Transformational leadership, career adaptability, job embeddedness and perceived career success: a serial mediation model	Saudi Arabia	Quantitative	Organisational and professional	Transformational leaders grew RN with confidence to make decisions & explore opportunities Leaders have strong influence on motivation of employees to progress If organisational values match own, then can balance work/life conflict
Bleich, M. R. (2015). International Perspectives in Leadership Development: Part I	Taiwan nurse leaders	Interviews	Clinical and organisational	Challenge to get gender balance Advocacy can be confrontational Strong regard for life-long learning Cultural timidity being replaced by a nursing voice & perspective on concerns
De Lange, W., Kars, M. C., Poslawsky, I. E., Schuurmans, M. J., & Hafsteinsdóttir, T. B. (2019). Postdoctoral Nurses' Experiences with Leadership and	Dutch Nurses	Generic explorative qualitative interviews	Clinical and organisational	Postdoctoral students show considerable progression in their leadership Need for more mentoring programmes Challenging managing academic achievement & high workloads Career development a serious conscious process Need collegial support as well as home support

Career Development: A Qualitative Study				
Delgado, C., & Mitchell, M. M. (2016). A Survey of Current Valued Academic Leadership Qualities in Nursing	USA academic RN leaders	Cross sectional online survey	Organisational	3 key leadership qualities: integrity, clear communication, ability to problem solve Mentoring & on the job experiences the most helpful Barriers: time management, lack of collegial or managerial support Unrealistic expectations, lack of appreciation of workload
Denker, A. L., Sherman, R. O., Hutton-Woodland, M., Brunell, M. L., & Medina, P. (2015). Florida nurse leader survey findings: Key leadership competencies, barriers to leadership, and succession planning needs	USA	Cross sectional study	Organisational and professional	Major and minor barriers to leadership identified Nurses not seen as revenue gatherers Lack of visibility in policy making Public perception of role of nurse not always correct Absence of effective succession planning
Enterkin, J., Robb, E., & McLaren, S. (2013). Clinical leadership for high-quality care: developing future ward leaders	UK	Survey	Clinical and organisational	Recommend investment in RN preparation for future roles Postgrad education in leadership & management intrinsic to empower Need to target RN early in career
Fowler, B. A. (2020). Facilitators and barriers to leadership and career opportunities in minority nurses in public health departments.	USA Public Health	Qualitative interviews	Clinical and organisational	Systemic & organisational barriers – racism, outside influences Characterised, need more energy to stay Need diversified workforce Applicants based on seniority and “who you know”, lack of equity Recommend “shadowing” & mentoring
James, A. H., Watkins, D., & Carrier, J. (2022). Perceptions and experiences of leadership in	UK student nurses	Photo elicitation interviews	Clinical and organisational	Lack of clarity management & leadership Professional values viewed as important Inspired by role models If experience of negative leadership determined to be the opposite Tension between caring profession & expectations of environment

undergraduate nurse education:				
Klarare, A., Lind, S., Hansson, J., Fossum, B., Fürst, C. J., & Lundh Hagelin, C. (2020). Leadership in specialist palliative home care teams: A qualitative study	Swedish healthcare team leaders	Qualitative interviews	Organisational	Conflict in multilevel of leadership & accountability Care influenced by fiscal constraints Burdened by fiscal responsibilities Anger over inability to meet patient need
Patrician, P. A., Prapanjaroensin, A., Dawson, M., White-Williams, C., & Miltner, R. S. (2018). Mapping and Sustaining Leadership Development: An Innovation Academic Service Partnership.	USA	Evaluation pre & post structured interviews	Organisational and professional	Inadequate preparation for nurse manager roles High workloads, inadequate resources given to meet <u>the</u> expectations of organisation Leadership journeys are influenced by the amount of support/guidance from their managers Benefit in targeted training in self-reflection & goal setting
Reyes, D. J., Bekemeier, B., & Issel, L. M. (2014). Challenges Faced by Public Health Nursing Leaders in Hyperturbulent Times.	USA DONs	Qualitative semi-structured interviews	Organisational and professional	Need defined leadership competencies, mentorship opportunities Difficult to lead if lack of clarity Effective leadership focuses on relationships Internal conflict between professional & organisational values
Topola, L., & Miller, K. (2021). 'Do nurses really do that'? An exploratory mixed methods study of Students' willingness to lead.	Canadian nurses	MMR	Professional	Students entering for altruistic motives Nursing seen as less autonomous & competent Final year students believed postgrad study in leadership to be irrelevant Less desire for political acumen
Van Dongen, L. J. C., & Hafsteinsdóttir, T. B. (2021). Leadership of	Netherlands	Descriptive qualitative Interviews	Professional	Need more PhD nurses to build a scientific foundation Had vision for career & set goals, took initiative Mentoring gave them confidence to progress

PhD-prepared nurses working in hospitals and its influence on career development: A qualitative study.				Saw benefit in senior role models Some found it hard to progress in a medical-oriented hospital setting Characteristics: vision, perseverance, courage to stand out
Walker, L., Clendon, J., Manson, L., & Nuku, K. (2016). Nga Reanga o nga Tapuhi: Generations of Māori nurses	NZ	Descriptive Kaupapa interviews	Organisational	Wider whānau responsibility, used to navigate health systems Never off duty Work constraints & lack of understanding from management frustrating torn between organisational & cultural expectations
Recent articles				
Björk, M., Eriksson, I., Ekström-Bergström, A., & Nyman, V. (2025). The Evolving Role of Nurses in Hospital Settings—A Scoping Review. <i>Journal of Advanced Nursing</i> ,		Scoping review of 26 studies	Organisational and professional	Ambiguity among nurse leader roles Need to improve education to support nurse leader adaptability
Ladden, M. D., Kelley, H. J., McBride, A. B., Fairman, J., & Hassmiller, S. (2025). Preparing the next generation of nurse leaders in education, science, and practice: Lessons from four Robert Wood Johnson Foundation programs. <i>Nursing Outlook</i> , 73(1).	USA	Report	Professional and organisational	Intentional mentoring and peer support essential Support ongoing education to PhD level

<p>Lartey, S. A., Montgomery, C. L., Olson, J. K., & Cummings, G. G. (2023). Leadership self-efficacy and nurses' aspiration to leadership: An evolutionary concept analysis. <i>International Journal of Nursing Studies</i>, 143.</p>		<p>Concept analysis 23 articles</p>	<p>Professional</p>	<p>Self-efficacy supports leadership aspirations Need for appropriate leadership training programmes to increase self-efficacy</p>
<p>Pincha Baduge, M. S. d. S., Mousa, M., Garth, B., Boyd, L., & Teede, H. J. (2023). Organisational Strategies for Women Nurses to Advance in Healthcare Leadership: A Systematic Review. <i>Journal of Nursing Management</i>, 2023(1), 2678916.</p>		<p>Systematic review of qualitative and mixed method studies</p>	<p>Professional and organisational</p>	<p>Dearth of focused training programmes Recommended systemic-level policies to overcome barriers to women's leadership</p>

Appendix Two: Ethical approval

Date: 24 January 2020



Dear Dianne Kerr

Re: Ethics Notification - **400022131** - **The characteristics, experiences and career trajectories of NZ nurse leaders**

Thank you for your notification which you have assessed as Low Risk.

Your project has been recorded in our system which is reported in the Annual Report of the Massey University Human Ethics Committee.

The low risk notification for this project is valid for a maximum of three years.

If situations subsequently occur which cause you to reconsider your ethical analysis, please contact a Research Ethics Administrator.

Please note that travel undertaken by students must be approved by the supervisor and the relevant Pro Vice-Chancellor and be in accordance with the Policy and Procedures for Course-Related Student Travel Overseas. In addition, the supervisor must advise the University's Insurance Officer.

A reminder to include the following statement on all public documents:

"This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher(s) named in this document are responsible for the ethical conduct of this research.

If you have any concerns about the conduct of this research that you want to raise with someone other than the researcher(s), please contact Professor Craig Johnson, Director - Ethics, telephone 06 3569099 ext. 85271, email humanethics@massey.ac.nz."

Please note, if a sponsoring organisation, funding authority or a journal in which you wish to publish requires evidence of committee approval (with an approval number), you will have to complete the application form again, answering "yes" to the publication question to provide more information for one of the University's Human Ethics Committees. You should also note that such an approval can only be provided prior to the commencement of the research. Yours sincerely

Professor Craig Johnson
Chair, Human Ethics Chairs' Committee and Director (Research Ethics)

Research Ethics Office, Research and Enterprise

Massey University, Private Bag 11 222, Palmerston North, 4442, New Zealand T 06 350 5573; 06 350 5575 F 06 355

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Human Ethics Low Risk notification

Appendix Three: Phase one questionnaire

Career Trajectory of Nurse Leaders in Aotearoa

Participation in this survey implies consent. * Required

1. Please provide a pseudonym to be used for this research *

2. Sex: *

- Woman
- Man
- Non-binary
- Prefer not to say

1. Age band *

- Prefer not to say
- under 30
- 30-39
- 40-49
- 50-59
- 60-65
- over 65

2. Please indicate your ethnicity *

- Prefer not to say
- NZE
- NZ Māori
- Pacifica
- Other

3. How many years have you been registered? *

- 3 to 5 years
- 6 to 10 years
- over 10 years

4. In what country did you first receive nursing registration? *

5. what type of leadership role do you hold? *

- DHB
- PHO
- NGO
- Academia
- Policy
- other

6. In my current role I feel I am able to make a difference

- strongly agree
- agree
- neither agree nor disagree
- disagree
- strongly disagree

7. I receive adequate support in my workplace

- strongly agree
- agree
- neither agree nor disagree
- disagree
- strongly disagree

8. I have a good support network outside of my workplace

- strongly agree Agree
- Disagree
- Strongly disagree
- Neutral
-

9. I currently have or did have a mentor/coach/professional supervision

- strongly agree
- agree
- Neutral
- Disagree
- Strongly disagree

10. How much influence did your colleagues and/or managers have on your decision to accept a leadership role?

- none
- slight
- considerable

13. If they did influence, in what way

14. What level of support/training opportunities are there for leadership development in your organisation?

- none
- slight
- considerable

15. What value does postgraduate education have in preparing nurses for a leadership role?

- none
- slight
- considerable

16. What you perceive the value to be, of nurses being "at the table" in governance structures that impact on nurses such as Hospital or PHO Boards

- none
- slight
- considerable

17. If you think that they add value, in what way?

18. Do you think the current structure of your organisation makes it possible to function as an effective nurse leader

- Yes
- No
- Unsure

19. In what way does the current structure of your organisation affect your leadership

20. To what extent have/do the key people in your life (partner, parents, friends, adult children, whanau) encouraged/supported you to take up and sustain a leadership role?

- none
- slight
- considerable

21. If they have supported you, in what way?

22. Have your cultural or religious beliefs had any influence on your career choices?

- Yes
- No
- Unsure

23. In what way could they have influenced you?

24. What characteristics do you value in a nurse leader?

25. Describe the characteristics in nurse leaders you encountered previously that inspired you to follow into a similar role.

26. Can you describe anything about a nurse leader you have worked with that deterred you from seeking career advancement?

27. Do you believe that there are any power imbalances/inequities in the NZ nursing work environment? if so, please describe what you perceive to be the root of these

28. Describe any experiences where you consider that your gender enhanced or impeded your leadership advancement/influence.

29. Reflecting on your leadership journey up until now, what has been the greatest enabler for you to progress to the role you currently have?

30. Describe anything that supports or encourages you in your role

31. Describe those things that challenge you/make your role difficult

32. I am willing to take part in a follow-up interview if required

- yes
- No
- uncertain

33. FEMALE GENDER SPECIFIC

As a woman, what women in leadership role models have you had through your life?

What are your thoughts about the sort of mentorship, guidance and support women need to achieve in a leadership role?

If you were to offer advice to a woman interested in a nursing leadership role, what are the three key pieces of practice wisdom you would offer?

Appendix Four: Phase two interview framework

Clinical leadership

1. Nursing is predominantly associated with direct patient care and value is not given to the invisible work that nurses do. Does this perception of nurse identity narrow the lens through which a nurse views her career pathway?
2. What motivates a clinical nurse to move into a leadership role away from the bedside?
3. Does overcoming the barriers of working in a female predominant profession give a male nurse any skills to assist in career advancement?
4. Is medical hegemony easier for a male nurse to negotiate than a female nurse?

Organisational leadership

1. How does the leadership structure impact on aspirations?
2. Is there a tension between what is required as a manager of a service and the professional responsibilities of a nurse?
3. Why do some nurses omit the word nurse from their resumes or job titles?

Disciplinary leadership

1. Does the image of leadership as being a masculine business model mean that many nurse leaders adopt this style rather than a more feminine approach?
2. What has empowered some nurses to progress into leadership whilst others defer or decline opportunities?
3. How do we identify potential nurse leaders and nurture their professional growth?
4. Is there any benefit in leadership training programmes, generic or specific to nursing?
5. We may have a voice at the table but is it an equal voice
6. Do nurse leaders have the ability to affect change or are they mostly dependent on budget holders
7. Is nursing seen as a career platform?
8. Do male nurses begin nursing with a belief that their gender will give them career advantages?
9. what additional barriers have our tangata whenua nurses had to overcome in their career journeys?
10. what specific strategies have been deployed to support our tangata whenua into leadership?

Appendix Five: Framework for the second set of interviews

1. Did you see yourself as attaining a role like the one you currently have when you first became an RN?
2. What changed?
3. What part do you think serendipity plays in career advancement -being in the right place at the right time? Or do you believe it is self-determination
4. What would you say are your strengths as a leader?
5. Has this always been true for you or are these attributes something that you have developed on your career pathway?
6. How much do you think nursing culture shapes our career decisions?
7. Do you see the gendered socialisation of nursing as holding us back in any way
8. Do the values or lack that we see in our current and past leaders shape our thinking about senior roles?
9. What barriers to your leadership (if any) have you encountered and how have you negotiated these?
10. How do you use your feminine attributes in male-dominant or masculine environments? Is there a way that we can positively use our feminine attributes to bring about change particularly in m stop and actuallyexpectations with your professional/personal values?
11. What do you think nursing needs to do to create a pipeline of potential leaders for succession planning?
12. Is there a difference between the nursing voice and that of other professions in the health care system?
13. What are your views on Florence Nightingale as a role model for nursing today?
14. Are there role models more appropriate than Florence that we should promote/elevate?