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FOSTERING NURSING THROUGH MANAGEMENT

A Critical Approach

A thesis presented in partial fulfilment of the requirements for the degree of Master of Arts in Nursing at Massey University.

Lyneta Russell

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ABSTRACT

This study reveals for critique the philosophical and ideological forces which currently shape the perceptions of a small group of nurse managers in one acute care hospital setting. It has as its aim action to overcome constraints and to realize opportunities in the nurse manager position.

Nurse managers assume central ward management and clinical responsibilities. This study describes how they can adjust to changes in these responsibilities within a changing health care structure and at the same time maintain and foster a nursing focus within their work.

Using the research methods of critical social science this research explores central themes in the work and world of nurse managers. Through critical dialogue and reflection nurse managers are given opportunities to explore the social, political and historical forces that shape their understanding of their position, and to critique those forces. This critical process assists nurse managers to move towards a new understanding of their position and empowers them towards emancipatory action.

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Masters study and the undertaking of research are expensive exercises. I could not have completed either

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TABLE OF CONTENTS

CHAPTER ONE

BACKGROUND TO THE STUDY

An historical background is worthy for the story that is revealed but it also gives meaning to practices of the 1990's. Patterns in the earlier work of the ward sister, a changing health care system and changing societal expectations are likely to be relevant to the work of the nurse manager today.

The ward sister

The position of ward sister has its origin in the beginnings of nursing in New Zealand, late in the 19th century.

At this time the ward sister was responsible for the management of patient care within the ward including the overseeing of domestic arrangements such as cleanliness, linen supplies and meal distribution. Because nursing staff were largely untrained much of the work was concerned with the disciplining and teaching of probationer nurses. One of the main responsibilities of the ward sister was ensuring that probationers conformed to the expected character of the good nurse - obedient, conscientious, respectful and trustworthy (Rodgers,1987). These characteristics of the 'good nurse' were identical to those of the 'good woman' (Gamarnikow,1978; Rodgers,1987).

The ward sister's work mainly consisted of ensuring obedience because the highest order of discipline needed to be obtained for the satisfactory running of the institution (Maxwell & Pope, 1915:12). Likened to a family the medical superintenant and board members,

usually male, demanded that the right hospital environment was maintained.

> *If women were given responsibility for the moral and aesthetic environment of the home, then nurses were given no less responsibility for the moral and aesthetic environment of the hospital (Hughes, 1990:28).*

The dominant patriarchal ideology had to be maintained within the hospital, as it was in the home and family. As the ward sister was often the only trained nurse, other than the matron, this task usually became her responsibility.

Discipline was also seen to be necessary to open up nursing as a legitimate and respectable occupation for women (Baly 1973:73). Hughes,(1990) proposes that the ideology of domesticity and the ideology of professionalism have both powerfully shaped the evolution of nursing and that the domestic ideology could be seen to place the responsibility for the moral stability of society on the shoulders of women. Taking this argument further women as nurses were given responsibility for the moral and aesthetic environment of the hospital, an extension of the domestic requirements of the home and family, as this legitimized their involvement in activities outside the home while maintaining the oppressive conditions of a patriarchal society.

An enormous responsibility was therefore placed on the ward sister in the early years of nursing within New Zealand.

The ward sister as clinical nursing leader

Until the 1970's there was little change in the work of the ward sister. As she was often the only qualified nurse on the ward it was essential that she possess excellent clinical skills. She had responsibility both for control of the ward through the supervision of student nurses and for imparting practical skills and knowledge to the students. She was also the one to whom medical staff gave direction for patient care and she in turn was the one to have contact with medical staff. Often as the only registered nurse on a ward she was expected to know everything about all of the patients and to provide much of the care for these patients. She was undoubtedly the clinical nursing leader in the ward.

The influence of changes to nursing education

Following much debate on nursing education in the 1960's, the 1970's saw a major change in the way nurses in New Zealand were educated following the *Review of Hospital and Related Services in New Zealand (1969).* This review recognized that nursing schools had largely developed through expediency and were based on nursing service demands rather than on educational opportunities. There was considered to be severe restrictions placed on what students could learn because of service commitments to hospitals. It was considered that too much emphasis was placed on efficiency and technical competence for the supply of hospital services rather than consideration of the broad knowledge base required for nurses in all forms of health care, not only hospital care, in a rapidly changing society. For these reasons hospital based training was recognized as being inadequate.

Implementing the recommendations from the Review the movement of nursing students from Schools of Nursing to technical institutes necessitated more qualified nurses being employed within wards. Students could no longer make

up the bulk of the nursing workforce employed by hospitals when the majority of their education was within technical institutes. No longer were qualified nurses the minority, they were now essential for the nursing workforce in hospitals and the community.

The work of the ward sister changed to accommodate the larger numbers of qualified staff employed. The supervisory function and teaching responsibilities remained, but with a different emphasis than when the ward staff consisted primarily of students. The ward sister became a coordinator of the various hospital services such as nursing, medical, and physiotherapy.

The influence of the organization of patient care

Until the 1980's, the method of nursing care delivery was predominately task focused. A hangover from the days of students in the wards, different tasks to be performed for a patient were assigned to different nurses so that one patient had a variety of nurses involved in their care over a very short period.

However, during the late 1970's nursing came to be seen more as involving caring for the "whole person" rather than as being concerned with a number of tasks. By the beginning of the 1980's there was to be seen more emphasis in the New Zealand literature and at conferences and forums on primary nursing, accountability and autonomy (Binnie, 1982; Carter, 1982; Bull, 1983; Laws, 1983).

At the same time qualified nurses themselves were demanding more responsibility for the care they offered as professionals. They sought responsibility and accountability for that care and the increased satisfaction of caring for a whole individual rather than only being responsible for a certain number of tasks for an individual patient. Team and primary nursing, nursing

care modalities where individual nurses or a group of nurses accept twenty-four hour responsibility for all aspects of a patient's nursing care from the time of admission to discharge, developed in response to these demands and in recognition of nursing as a profession.

These changes in the methods of nursing care delivery in wards impacted on the work of the ward sister, whose title changed about this time to charge nurse. Although still expected to be clinically competent and to take overall responsibility for the care delivered in a ward, the charge nurse was expected to share at least some of this responsibility with other nursing staff, either the primary nurse or the team leader. In theory, at least, the charge nurse was no longer required to know every detail of all the patients in the ward. Rather an overview of the patients, their care and conditions was required.

Whereas the charge nurse had previously been the source of information required by the medical staff this slowly changed as other nurses assumed more responsibility for individual patient care. In areas committed to team and primary nursing medical staff were encouraged to direct all patient queries and patient care information to the team leader/primary nurse. In this environment not only had the work of the charge nurse changed in response to changing professionalism but the authority and kudos formed as a result of being the one with all the information was also being eroded.

Not all ward areas adopted the primary and team nursing approaches. Gradually, however, particularly because of other demands on the charge nurses' time and because of the need for qualified nurses to have greater individual responsibility for patient care, the charge nurse delegated responsibility to other qualified staff in a similar way to those areas that practiced team or primary nursing.

At the same time the teaching responsibilities of charge nurses decreased. While still involved with student nurses' education within the clinical area the largest amount of student teaching became the responsibility of clinical tutors attached to the teaching institutions. Another change in the work of charge nurses had occurred, often leaving charge nurses confused as to what their area of responsibility was in this changed system of nursing service and education where qualified nursing staff now made up the bulk of ward nursing staff.

However, despite the responsibilities for the organization and coordination within the ward, the charge nurse still did not function as a manager. For example, hiring of staff and budgetary control remained a central function performed by those much higher in the management structure.

The influence of changes to the New Zealand health care system

Further changes were still to occur, not within nursing education or within the nursing profession itself, but within the New Zealand health care system.

In 1988 the *Report of the Hospital and Related Services Taskforce (Unshackling the Hospitals)* identified, amongst other concerns, major deficiencies in the management of the health care system. Their recommendation was the establishment of Area Health Boards and the implementation of general management to replace the triumvirate management structure, a structure in which executive authority and responsibility was shared by a doctor, a nurse and an administrator, each with the power of veto (Report of the Hospital and Related Services Taskforce, 1988: 19).

Instead of a triumvirate management structure this report

suggested responsibility for decisions should be placed at the lowest possible level where a decision could appropriately be made as a means to achieve improved efficiency and effectiveness of the health care system. Recognizing a ward as a unit the charge nurse was the obvious choice for manager.

Impact of a clinical career pathway for nursing

Alongside the changes in nursing education and management within the health care service a clinical career structure for nursing received increasing attention in the 1980's. *Nursing Education in New Zealand: A Review and Statement of Policy* was published by the New Zealand Nurses' Association in 1984. It recommended the establishment of clinical career structures in nursing thus promoting the importance of maintaining experienced nurses in clinical nursing practice.

In 1988 certification of nurse clinicians and nurse consultants within New Zealand reaffirmed the move toward recognition of clinical expertise. Unfortunately, however, such a move was not recognized within industrial award structures creating some confusion as to where those certified would fit into the overall pay scale grading system of nurses within New Zealand.

A further report looking into clinical career structure was released early in 1991. Entitled *A Proposal for Clinical Development for Nurses in Clinical Practice* it proposed a structure for those nurses who desired to make clinical practice, rather than progression into management or education, their primary professional focus (New Zealand Nurses' Association, 1991).

The current situation

Within the past three years charge nurses have assumed increasing ward management responsibility as the general management structure has been implemented within New Zealand health care institutions.

Often their responsibilities involve budgetary control and personnel functions, the overall standard of patient care within a ward, education and staff development, research, mentoring and role modeling, and acting as a clinical resource (NZNJ, 1990:13). They are expected to hold a pivotal management and clinical leadership position within the ward and hospital structure. In some areas, in recognition of the change in their responsibilities, their title is being changed from charge nurse to nurse manager.

At the same time there has been a resurge of interest in the development of a clinical career structure for nurses within New Zealand. Frequently discussed in the literature and within nursing circles, clinical career structures are currently receiving increasing attention as a number of Area Health Boards have adopted such a structure and others are exploring the possibility of implementing them.

These moves indicate that there is considered to be merit in recognizing nurses who choose to remain in direct clinical care and in promoting such nurses to positions of responsibility within the institution.

Some discussion has already occurred on how these positions within a clinical career structure will impact on the work of the charge nurse/nurse manager. In 1990 a seminar was run for 24 charge nurses on the proposed clinical career path (NZNJ,1990:13). The outcome of this seminar was that the charge nurse should remain; that a clinical career structure and charge nurses were complementary to each other.

However, despite such an outcome, concern remains. In the midst of changing health care management, increased management responsibility for charge nurses/nurse managers, and proposed and actual changes to the clinical career structure of nursing, charge nurses/nurse managers are concerned about their future as the manager and the clinical leader in the ward. They may feel undervalued in their comparative worth to other unit non-nurse managers within the institution and frustrated in their inability to use their clinical expertise which historically has been their power base within the nursing profession. At the same time individual nurses are assuming increased responsibility for their own practice and relying less on the charge nurse/nurse manager for supervision and direction of their nursing practice.

While there has been regular discussion on clinical career paths there has been no research in New Zealand on the current Charge Nurse role as a part of the changing organizational structure. There is a paucity of knowledge in this area.

My interest in this area of research stems from my awareness of the frustrations and anger experienced by many charge nurses/nurse managers and the impact that this has on other aspects of the institution. As a nurse who has held various positions within the acute care setting in a major hospital for almost two decades I am also aware of what I believe to be the source of these frustrations.

It is therefore intended that this study reveal for critique the philosophical and ideological forces which currently shape the perceptions of charge nurses/nurse managers. The current conflicts between clinical and management leadership will be made apparent with the intention of moving toward a new understanding of the work of charge nurses/nurse managers.

Purpose of the Study

By exploring the actual work of a small group of nurse managers this study will describe their perceptions of the management and clinical aspects of their work in the acute care setting. It will describe their understanding of their contribution to nursing leadership and ward management. Through critical dialogue expectations and possibilities for future action will be explored.

Reality and expectations can each present constraints and opportunities in the nurse manager position. Through critical dialogue and reflectivity these need to be identified and explored within the context of history and the social and political situation. Perspective transformation and the desire for a change in the situation may then enable opportunity for emancipatory action.

There are inherent dangers in reaching a new understanding without the ability to act to overcome constraints and realize opportunities. Once understanding has been reached it is hoped that through this study, which has an emancipatory intent, nurse managers will be empowered to identify choices and take action which will overcome some of the constraints that currently inhibit their practice.

Therefore, the specific aim of this study is to work with a small group of nurse managers in an acute care setting to

1. explore their work realities and their expectations

2. assist them to identify and explore patterns, constraints and opportunities in their position.

3. reach a common understanding between participants of the parameters for nursing leadership in the current nursing and health care climate in hospitals.

4. empower participants to identify choices and to take emancipatory action to overcome the constraints and realize the opportunities

To achieve this purpose the theoretical position taken for this study will be from critical social science. The possibility arising from this approach is

> *for groups to comprehend that there are explanations for the ways in which they are experiencing the world other than the 'natural' explanations which have always been accepted (Grundy, 1987:112).*

Once this comprehension has been achieved it is possible that the participants may choose to act autonomously to achieve emancipation.

CHAPTER TWO

REVIEW OF THE RELEVANT LITERATURE

The particular focus of this thesis is the work of the nurse manager at the hospital ward level. The conflicts that may be experienced within this work, the values held by nurse managers, the management and clinical skills required, and nursing leadership at the ward level are all relevant. This chapter will examine these issues from a New Zealand and an international perspective in order to place the study within a wider context.

The title given to the person holding this position varies from country to country and even within countries. The North American literature usually refers to the head nurse, the British to the ward sister or ward manager, and the Australian to the nursing unit manager (Duffield, 1991:1247). For convenience, and to avoid confusion, those occupying a similar position in this study will be referred to by the title nurse manager.

Regardless of the title given, the work of the nurse manager has been well discussed in the international literature (Powers, 1984; Taylor & Kramer, 1985; Cameron-Hill, 1987; Hodges, 1987; International Council of Nurses, 1990; Lewis, 1990; Duffield,1991; Duffield; 1992). The New Zealand literature has been slower to contribute to these international discussions but has followed the international trend more so within the past five years as changes both within nursing and in the New Zealand health care service have evolved in a direction similar to that of North America and Britain.

The New Zealand debate

Within New Zealand the work of the nurse manager has, as previously discussed (refer Chapter One), changed considerably within the past decade. Laws (1990), after talking with a group of nurse managers, described it as currently consisting of acting as mentor, counselor, resource and role model for management skills and clinical practice, budgetary control, personnel functions, and quality assurance and control.

Laws suggests that only a small number of nurse managers are involved in providing 'hands on care' on a regular basis. The small group of nurse managers Laws talked with agreed that the

> *job content as outlined was too great, there was little preparation for the magnitude and variety of the demands, and a sense of support was often absent (Laws, 1990:14).*

Furthermore, they agreed that a clinical career structure was necessary and possible, even though it might mean the demise of the current nurse manager position.

Laws, in her report to NZNA, as a result of the seminar concluded that

> *The far reaching consequences of radical change to a structure which has existed for decades cannot be underestimated (Laws,1990:18).*

These conclusions support other New Zealand and some international literature.

In 1991 the New Zealand Nurses' Association produced *A Proposal for Career Development for Nurses in Clinical Practice*. In the Preface this proposal suggested that

> *New contexts and a focus on the centrality of clinical practice is likely to influence nursing career options in ways not yet contemplated.*

It further suggested that the 1990's would be a time for change in the New Zealand nursing profession.

Defining 5 levels of nurses within the clinical career structure it described nurse managers as being supportive of, rather than active in, clinical practice. The proposal suggested that the management components of that position often precludes the possibility of planned involvement in clinical practice but rather should be complementary to and supportive of clinical practice.

Bassett-Smith (1988:5), recognizing the importance of clinical career paths within the New Zealand nursing context, argued that clinical positions should be accommodated within a new nursing hierarchical structure rather than imposing an additional structure. Vital to this accommodation, she suggested, would be the support given by the organizational structure and practising nurses.

Paterson (1987:4) indicated the need for advanced clinical nursing positions in New Zealand, recognizing that traditionally any advanced educational programmes have emphasized administration and teaching rather than expert nursing care. She saw these clinical positions being incorporated alongside the present structure but warned that

> *quite radical changes in the structure of nursing services within acute care settings are required if truly professional practice is to be our goal (Paterson,1987:8).*

Both these writers argue that the existing nursing

structure within New Zealand must change to accommodate clinical career paths in recognition of the importance of expert clinical nursing care.

Despite discussion on clinical paths the ward or department nurse manager remains in a central position but the debate over the future of the nurse manager has already begun. For example, some discussion has occurred on whether or not first line managers within the New Zealand health care service need to be nurses. De Witt (1987) argues that nurses in this position are essential because they have a unique combination of experience, loyalty, clinical knowledge and management ability. Participants in a workshop which resulted in the discussion paper *The Nurse Manager in a Restructured Health Service: Options and Choices (1988)* reaffirmed this belief.

The Position of the International Council of Nurses

In their publication *Preparation of Nurse Managers and Nurses in General Health Management (1990)* the International Council of Nurses (ICN) recommends that organisations should look at new types of nursing positions that fit with new health structures sc that nurses can

> **retain control over the nursing function, i.e. professional nursing practice and the implementation of standards*
>
> **influence health planning, policy development and resource management in the broader health service (ICN,1990:15)*

They describe the nurse manager position as having a corporate (management) function and a professional nursing function and suggest that even those with line

responsibility should retain an up to date awareness of nursing knowledge, expertise and judgement because of the

> *advantages to the organisation and to nursing and to health care, and because if this is not demonstrable, then organisations undergoing change (e.g. to general management) may see no need to retain nurses in new nurse positions...(ICN, 1990: 40).*

From this publication it would appear the ICN's position is that nurse managers, even at ward level, should be skilled managers and knowledgeable nursing professionals who have a sound post-basic nursing knowledge.

The Australian situation

In 1986 the Royal Australian Nursing Federation implemented a new structure for nursing within South Australia in a move towards a clinical career structure for nursing. This structure involved five clinical levels and 2 each in management and education. This move was to encourage clinical expertise to remain at the bedside, enriching both caregiver and receiver. At the same time it recognized the complexity of the management and clinical responsibilities associated with the previous nurse manager role.

As a consequence the clinical responsibilities were evolved to the clinical nurse consultant and the management to the nurse manager position. The argument favoring this approach was that

> *professionals do not need to supervise each other, and therefore nurse managers were to undertake functions for which they were prepared, the management of human and material resources, leaving actual 'nursing' entirely to*

> *the advanced clinical roles. Nurse managers would 'manage' and not be involved in the delivery of nursing care (Koch,1990:872).*

However the structure described above by Koch is not unanimously favoured within Australia. The literature in that country suggests there remains differing opinions on the work of the nurse manager and the most appropriate person to fill the management and clinical responsibilities.

For example, Cameron-Hill (1987) argues that changes in career structures which divide the nurse manager role into ward manager and nurse consultant positions will not overcome the problems that have been experienced with the nurse manager position. She believes that the manager and clinical roles should be held by the one person and that this person should be the nurse manager. Although she does not mention budgetary and personnel responsibilities Cameron-Hill believes that other functions such as planning and evaluating patient care, counseling staff, patients and relatives, teaching staff and patients, staff management and nursing research are quite realistic and achievable providing the nurse manager is given the information and support to make decisions.

Duffield (1988,1989,1991,1992) has written extensively about nurse managers within the Australian context. Discussing changes in many ways similar to those currently occurring in New Zealand, such as the move towards a clinical career structure and greater demands on nurse managers to assume management responsibilities, she describes a lack of clear distinction between the management and clinical responsibilities expected of them, resulting in confusion as to whether they are manager or clinician (Duffield,1989 & 1992); describes the first-line manager as being required to have both technical expertise and input as well as management skills

(Duffield, 1991:1248); and as a result of her research argues that nurses are inadequately prepared for nursing management positions (1992). Nevertheless she says that it is essential that nurses remain the first-line managers in a ward.

The British situation

The British literature provides another facet of the argument. For example, a different perspective on the work of the nurse manager is provided by Lewis (1990) when discussing the hospital ward sister as the "professional gatekeeper". His view, based on numerous British research studies, is that the ward sister will set the tone of the ward and the care provided within it (Lewis, 1990:809). In the process of monitoring and assessing competence the ward sister maintains control, and through role modeling shows what and how things should be done. He describes the ward sister as having positional and expert power in that they are seen as the experts in nursing care. He sees the professional gatekeeping role as being possible because the ward sister is in a supervisory position to other nurses in the ward. However, a shift to a nursing structure such as is common in North America, he warns, could shift the professional gatekeeping function under the control of managers (Lewis,1990:816). Lewis implies that this "gatekeeping role", which is closely associated with apprenticeship type learning and modeling, is useful for maintaining the professional culture of nursing and is essential for good nursing care. It could also be argued that his definition maintains the dominant patriarchal ideology and with it the oppression of nurses.

Pickering & Fox (1989) also support the head nurse as the manager and the clinical leader in the ward. Referring to the British health service they argue for the head nurse as ward manager because the professional role of the ward sister is in no way undermined by the management

responsibilities (1989:24). But they do add that ward managers should be appointed because of their management ability and not because of other qualities that they might have. This is in contrast to the patterns of the past when ward sisters were appointed on the basis of their practical skills and this ill prepared them for the changes in responsibilities that they experienced as the result of the health service restructuring. Reflecting Pickering & Fox's concerns Barnett (1988), while arguing that the focus of nurse managers is very much with patient care, suggests that more emphasis should be put on management training and education within this group in preparation for future career moves.

The North American situation

The North American literature presents a more united picture which may be related to a longer time of commitment to clinical career structures which are supported by educational opportunities for nurses wishing to specialize in clinical nursing, administration or education. The nurse manager, in North American literature, is usually described primarily as a manager who maintains their clinical expertise (Hodges, 1987; Taylor & Kramer, 1985).

However, despite what could be described as a clearer vision for the position within that country, there continues to be discussion about the conflicts in the nurse manager position and how best to deal with these. For example, Taylor & Kramer (1985), researching the needs of nurse managers, identified the following problem areas

> *(1) an unclear conceptualization of the desired behaviours;(2) difficulty in assigning priorities due to conflicting expectations of self and others, specifically related to (1);(3)*

> *difficulty in appropriately balancing clinical and managerial role activities; and (4) generalized feelings of being out of control, overwhelmed, and powerless to change the situation.*
> *(Taylor & Kramer,1985:419)*

Conflicts in the nurse manager position

Numerous writers have discussed the conflicts, actual or potential, in the nurse manager position. Powers (1984), for example, describing the changes in one North American institution, established that the changed responsibilities of the nurse manager created serious conflict for staff nurses, medical staff, patients and even for nurse managers themselves when they maintained traditional expectations. Similar findings were reported by Hess & Drew (1990) in an examination of the tensions nurse managers reported in their positions.

> *Juggling the diverse interests and demands of nursing administrators, physicians, staff nurses and patients' families while striving for effective staffing on an efficient schedule presents innumerable occasions for misunderstandings and conflict (Hess & Drew, 1990:640).*

Conflict was also discussed by Gilbertson (1972) within the New Zealand situation. It is interesting that this discussion took place years before the recent changes in health structure necessitated changed responsibilities for the nurse manager, indicating that conflict within the nurse manager position is not a recent phenomenon.

Budgetary restraint and decentralization within health care institutions required the nurse manager who once functioned as the king pin of a unit, supervising staff

and taking responsibility for patient care, to assume the role of manager with the responsibilities such a position involves. Less time for clinical patient care results in decreased clinical expertise which may lead to lowered self-esteem. The nurse manager, being highly interactive with other staff, is influenced by their perception of her responsibilities and her enactment of them. Others, particularly staff nurses, not understanding the changed responsibilities, may resent the absence of the nurse manager from the provision of direct patient care. Medical staff may experience similar frustrations. Patients also hold a traditional view of the nurse manager as the 'expert' in patient care and the person responsible for the patient care in that area. Another perception in the changed environment is held by the administrator who expects the nurse manager to act as manager and to perform the functions that role requires such as budgetary control and personnel functions (Powers,1984, Taylor & Kramer,1985). In such a situation Taylor and Kramer argue that "the pressure group that pushes the hardest will be the one that the head nurse is most responsive to" (Taylor & Kramer,1985:415). In addition, as staff nurses take more responsibility for their own clinical work they come to rely less on the nurse manager and assume more responsibility for patient management, and this may overlap the nurse manager's function (Powers, 1984; Zander,1977).

Jennings & Meleis (1988) add another perspective to the origin of the problems within the nurse manager position which may create conflict. Traditional management theory, they argue, is inappropriate for nursing and health care where the issue is people, patients and professional staff, not products such as things, goods and commodities. To overcome this they suggest that

> *traditional management views must be blended and balanced with a nursing perspective (Jennings &*

Meleis, 1988:59)

Zander (1977) and Powers (1984) recommend that in order to succeed with the new responsibilities it is essential that nurse managers recognize potential conflicts and develop strategies for adaption. They must come to accept their role as a specialist in leadership and management, rather than in clinical nursing care, and must also accept the fact that staff nurses may be the experts in the provision of clinical patient care. Zander (1977:22) says

> *Unless the head nurse is fairly secure about her own professional identity as a clinician and a manager, she will be more threatened than challenged by primary nursing.*

Because the nurse manager is expected to be credible to both management and nursing staff Duffield (1991) believes that the greatest conflict for them occurs because of the uncertainty they experience over whether they should be providing direct patient care.

Values and how they create conflict for the nurse manager

A reason for this conflict is put forward by Scalzi & Nazarey (1989) who argue that the humanistic values once required in health service industries have been replaced with cost effective, product-orientated values. Values are divided in the nurse manager role as increasing management responsibilities are delegated to them and there is much potential for these to conflict with professional values. Because individuals also hold personal values there is potential for organizational, professional and personal values to conflict.

In the same article they describe three potential outcomes of value conflicts. Firstly, persons may be forced into behaviour that is inconsistent with their present value

system; secondly, new information may call into question part of their value system; and thirdly, persons may be made aware of inconsistencies that already exist in their value system (Scalzi & Nazarey,1989:586). They advocate conscious examination of value systems to determine possible inconsistencies and to reassess values held in light of situational and responsibility changes.

In conclusion they suggest that

> *There could be harm in rooting value judgments in the past when such rapid value shifts are occurring. Nurse executives must examine their values carefully in relation to the changing environment and decide whether or not they are still realistic and appropriate. The danger exists that values that should be retained are let go, and that those that should be expanded in new directions are left as they are (Scalzi & Nazarey,1989:590).*

Within the current changing work of the nurse manager and the changes within health care management in New Zealand this warning is timely, as this study will demonstrate.

Nursing leadership at the ward level

The literature on leadership is extensive and will not be explored within this study. Nursing leadership as exhibited by the nurse manager, however, has some unique features dominated by traditional expectations of nurses, clinical responsibilities and evolving management responsibilities.

Differentiating between management and leadership by the innovative and visionary approach required of a leader rather than the maintenance and administrative functions required of a manager , the International Council of

Nurses (1990) says that nursing needs nurse managers who are also leaders and that ward and unit nurse managers should not assume that leadership is only relevant to senior nurse manager positions (ICN,1990:39).

While it is generally agreed that the nurse manager holds a key leadership position both within management and within clinical practice (Stevens, 1974; Taylor & Kramer,1985; Hodges,1987;Irurita, 1988; Pickering & Fox, 1989; ICN 1990) there is also agreement that effective leadership is often lacking in the nursing profession (Blake & Towell, 1982; Irurita, 1988; Marriner,1990).

Marriner (1990:63) proposes three reasons for this. She argues that nursing attracts people with low self esteem and initiative who tend towards submissiveness. Unfortunately she gives no reason why this should be so although patriarchal ideology, where women are expected to be submissive to men, would explain this characteristic. Secondly, she states that nursing education to date has placed little emphasis on teaching leadership. Epstein (1982), Barnett (1988), Hess & Drew (1990) and Duffield (1992) have also expressed this reason. Duffield (1991:1250) cites the dichotomy between education and service as contributing to this problem. Various factors, such as a lack of involvement of senior administrators, contribute to a lack of application of management knowledge obtained from courses. Thirdly, Marriner argues that autocratic leadership, traditionally prevalent in nursing, contributes to nurses beings followers rather than leaders. Lees (1980) and Epstein (1982) also make this point.

Furthermore, Marriner (1990:63) argues that leadership is associated with aggressiveness which traditionally has not been considered a feminine characteristic. This is likely to be one reason why power, the ability to have impact into decision-making, is not considered positively by many

nurses. Power, as Willey (1987:25) says, conjures up images of manipulation and coercion which nurses have tended to consider unnecessary in obtaining professional nursing goals. As Garant (1981:192) says

> *Many issues of major concern to women in general are directly related to those concerns confronting the nursing profession. As a group, nurses are ambivalent about wanting, getting and retaining power. They are, perhaps, a mirrored reflection of a generation of women ... who are also grappling with the same basic growth and development issue of autonomy versus dependency.*

Furthermore, the bureaucratic and patriarchal structure of hospitals has affected nurses' self image and kept them powerless (Boyle,1984:195).

Summary

Within the literature there is general agreement that the work required of the nurse manager in a health care system which demands increasing management responsibility is both complex and essential, and that the nurse manager becomes more manager than clinician, particularly in health care institutions where there is a clinical career structure for nursing or when primary nursing care delivery is used. However, despite the increasing emphasis on management responsibilities within the literature there is also a warning that professional knowledge should not be forgotten once in a nurse manager position. For nursing to continue to influence both the profession of nursing and the development of health care policy within organisations it is seen essential that ward and unit managers are nurses and that these nurses should have current post graduate nursing knowledge.

The nurse manager position needs to be flexible enough to

cope with the management demands of changing health care structures and adaptable enough to cope with changing clinical structures brought about by the search of practising nurses for greater autonomy in their professional practice. The message the literature conveys is that traditional responsibilities, organisational structures and nursing education must be reviewed to ensure they fulfill changing health care structure and nursing service requirements. To achieve this it is also evident that there needs to be greater input into nursing management education and encouragement of nurses who display leadership potential into leadership positions.

The multiple, complex responsibilities of the nurse manager position combined with often opposing demands from other individuals and groups and conflict between professional, personal and organisational values which are not always in congruence are frequently mentioned within the literature as creating critical tension in the position. From this literature valuable information concerning these tensions can provide some insight into the New Zealand perspective while remembering that the changes occurring within this country are recent and unique.

Even the variety of titles given to the nurse manager position, as evidenced in the nursing literature, provides some evidence of the international dilemma surrounding one nursing position which has remarkably similar responsibilities worldwide.

A final note on 'role'

The observant reader may have noticed that throughout this review of the literature the word 'role' has not been used, except in direct quotations, despite frequent use of the word in the literature reviewed. Avoidance of its use has been deliberate.

Social structure prescribes the set of behaviours deemed appropriate for the occupier of a role (Rheiner,1990) who must change certain aspects of their behaviour to meet the role requirements. In this way the status quo is maintained as

> *an individual's social being depends upon the successful internalisation of the normative behavioural requirements attached to a position in a social group (Clare,1991:28).*

The individual must adapt to conform to the needs of the social group of which they are a member and in this manner take on the dominant ideological beliefs of that group. Within bureaucratic organisations, such as hospitals, this means that personal and professional values must often be compromised so that organisational ideology can be maintained.

Within Chapter Three of this study it will be argued, in keeping with the philosophy of critical social science, that ideological belief systems that are used to justify and legitimate social actions create oppressive conditions for the members of a group. As this study has an emancipatory intent, use of 'role' is therefore unhelpful and inappropriate. For this reason it will not be used.

CHAPTER THREE

THEORETICAL CONTEXT FOR THE STUDY

This thesis reveals for exploration and critique the perception that nurse managers have of their current position. This knowledge may lead to empowerment and action to overcome the constraints and realize the opportunities within their position.

Such a focus could possibly be achieved by a traditional empirico-analytical research approach aimed at describing and explaining the constraints and opportunities. However, the possibility for enlightenment, empowerment and emancipation would be severely limited because of the central tenets of this paradigm.

There are a number of beliefs and values about research which underpin this study. The nurse manager participants involved in this research have a legitimate claim to the knowledge they share and develop. Furthermore, there is an obligation to the participants to provide opportunities for understanding that knowledge and developing ideas about ways they can use it to improve their own position. Praxis, reflection and action, might then be possible. These values and beliefs are drawn from a tradition known as critical social science.

Research in the empirico-analytical paradigm

This paradigm assumes structure, universality and order. Lawlike regularities can be identified and manipulated, they are not context bound and they are independent of each other and of the whole. Critics of this paradigm suggest that it is inadequate because within it only one truth exists and this truth is value free and objective.

The researcher and the researched are independent and the researcher is expected to be distanced from the problem in order to obtain objectivity. Knowledge is factual, observable, generalizable, public, verifiable and common (Munhall, 1981; Allen, Benner & Diekelmann, 1986; Kramer,1990).

Most previous research, including nursing research, is predominately within this paradigm. However, increasingly nursing and other disciplines are adopting alternative research paradigms.

Criticism of the empirico-analytical paradigm

Within nursing there is growing realization that empirico-analytical research methods are inadequate for nursing's research purpose (Barnum Stevens,1990; Kramer,1990; Meleis,1985; Munhall,1981).

It is argued that empirico-analytical scientific methods are incongruent with nursing's adoption of an holistic and humanistic philosophy (Munhall,1981; Barnum Stevens, 1990; Kramer,1990). Furthermore, the methodology associated with this research paradigm is concerned with control and prediction which is antithetic to empowerment for nursing's clients (Allen, 1985).

As a means of knowledge development empirico-analytical science is unable to account for all the ways of knowing in nursing (Carper 1978). While it can assist empirical knowledge development it is less adequate in the development of esthetic, personal and moral knowledge because these ways of knowing are dependent on factors other than lawlike regularities and objective data.

In its search for 'truth' it has been argued that empirico-analytical science may be inappropriate in an area of concern such as nursing where there is a complex

of human experiences that may not be able to be defined within one truth (Schultz & Meleis, 1988:220). What is required is a view that

> *accepts values, subjectivity, intuition, history, tradition, and multiple realities; a view that is more congruent with nursing and its commitment to human beings (Meleis, 1985:68).*

This criticism of traditional science's usefulness for studying the phenomena of concern to nursing is similar to criticism from the wider scientific community.

Cohen & Marion (1985:24) describe the attack on the empirico-analytical paradigm as arising from its view of nature which excludes notions of choice, freedom, individuality and moral responsibility. In it's attempt to objectify and develop lawlike regularities it tends to dehumanize and depersonalize and therefore robs knowledge of richness and diversity which is a natural occurrence in living beings.

Another argument against empirico-analytical research methodologies is that this approach separates the 'subject' from the social, political, economic and historical context. A single form of explanation, as is required within this tradition, is not appropriate for all sciences (Comstock,1982; Lather,1991:21).

Others criticize research in the empirico-analytical paradigm for the use to which the knowledge acquired is put and the lack of recognition of subjectivity. This form of scientific knowledge, they argue, is largely used to advance technology and therefore leads to further oppression rather than emancipation of individuals (Thompson, 1981: 79; Campbell & Bunting, 1991:11). Dealing predominately with the technical aspects of social life, such as work, it has ignored other facets such as

interaction and communication (Mezirow,1981).

Carr & Kemmis (1986:71) offer yet another critical perspective of empirico-analytical science. They claim that the empirico-analytical conception of objective knowledge is a myth. Such knowledge is incompatible with the history of science in which subjective and social factors are crucial in the production of knowledge. Using education as an example, but the idea could equally be applied to nursing and other disciplines, they state that the main attraction of the empirico-analytical approach - objectivity - is in itself an indoctrination into the values and ideology of this paradigm (Carr & Kemmis,1986:75). Values, by this very argument, cannot be ignored.

The interpretive paradigm

Alternative paradigms have received increasing attention over recent years. Interpretive science is one such paradigm. Approaches within this paradigm are concerned with individuals, their views and their everyday experiences studied within their natural context (Cohen,1987), and in discovering the intentions participants have in doing what they are doing (Fay, 1975:73). They involve direct description rather than explanation and analysis. This description is concerned with the entirety of the experience in contrast to the empirico-analytical paradigm where a whole is usually reduced to parts for more thorough understanding (Stevens Barnum,1990). The major understanding underlying the paradigm is that

> *the study of activity, that is, everyday understanding and practices, and the study of relational issues are distinctly different from the study of objects, as in the natural sciences (Allen, Benner & Diekelmann,1986:28).*

However, this paradigm has also been the subject of criticism, often for the same reasons as the empirico-analytical.

Allen (1985:61) and Lather (1991:64), for example, argue that this paradigm fails to recognize the function of ideology (refer p.37) when understanding the responses of participants and their ability to participate in unconstrained discourse. Conscious or unconscious power imbalances may create a false consciousness which will affect their responses and hence the understanding that is developed. Because the interpretive paradigm accepts the explanations and descriptions of participants without seeking to examine the conditions which give rise to them, a host of social factors which are conscious or unconscious to the participants are not explored. The status quo therefore remains unchallenged. As Fay (1975:91) says

> *In a time of upheaval the interpretive model would lead people to seek to change the way people think about what they or others are doing, rather than provide them with a theory by means of which they could change what they or others are doing, and in this way it supports the status quo.*

Critical Social Theory

Introduction

In 1923 a group of scholars, rebelling against positivist science and its contribution to the oppression of the working class, founded the Institute of Social Research, later known as the Frankfurt School. These scholars revisited the earlier work of Karl Marx and German philosophers and the critical and holistic dimensions of their work (Thompson, 1981:73).

Dominating the critical theorists from the middle of the 20th century is Jurgen Habermas, a German philosopher, who provides a theory for communicative action, "an interaction of humans which leads to understanding" (Reeder, 1988:201). Habermas contends that knowledge obtained through empirico-analytical means, which he calls technical knowledge, is only one of a number of possible types of knowledge (Thompson, 1981:70). From the interpretation, explanation and intersubjectivity of the interpretive sciences, practical knowledge is acquired. But it is from critical social science that emancipatory knowledge, the knowledge required to bring about change in a situation, arises (Mezirow,1981). For understanding, essential for emancipatory knowledge, Habermas argues that communication must occur but that this communication can not be monologic, as it is within empirico-analytical science, but rather must be dialogic because communication is an intersubjective phenomena (Thompson, 1981:80).

Furthermore, Habermas describes language as a medium of domination and social force.

> *The medium of language...is only one moment of a social totality which also reproduces itself through the exercise of social control and political power (Thompson,1981:82).*

Knowledge within this view cannot be separated from social practice and the historical, political and cultural dimensions of that practice.

Paulo Freire, a Brazilian educator, is another who has written extensively about the social dimensions of knowledge and the oppressive, dominating forces within communication. Reflection and action are central concepts within his work.

Freire argues that the freedom of people is to be strived for but that

> *It is thwarted by injustice, exploitation, oppression and the violence of the oppressors; it is affirmed by the yearning of the oppressed for freedom and justice, and by their struggle to recover their lost humanity (Fay, 1977:21).*

Freire further contends that reflection by the oppressed on their situation leads to emancipatory action but that this praxis is not possible without the conscious involvement of the oppressed (Fay,1972:41). Development of the "critical consciousness" required for action is directly related to reflective understanding according to Freire (Van Manen,1977:221).

> *A deepened consciousness of their situation leads men to apprehend that situation as an historical reality susceptible of transformation (Fay, 1972:58)...Liberation is a praxis: the action and reflection of men upon their world in order to transform it (52).*

The status quo is maintained when the world the oppressors has created is not questioned by the oppressed (Fay, 1972:50).

Central to the critical theory of Habermas, Freire and other critical theorists are three theses:

1. Critical theories guide human action by producing enlightenment and emancipating agents from coercion
2. Critical theories are forms of knowledge,and
3. Critical theories are reflective thus differing in essential ways from natural scientific theory

(Guess,1981:1-2)

Fundamental to their position is opposition to the mechanistic and evolutionary conceptions of social change, arguing instead for the importance of subjective conditions for revolutionary transformation (Thompson, 1981,:75). The central idea of a critical social theory is enlightened emancipation leading to a more fair and just society.

Purpose and outline of critical social theory

One aim of critical social theory is recognition of the importance of the subjective aspects of knowledge in a scientific world where objective knowledge is often all important. Acknowledging that knowledge is political, the theorists advocate "that knowledge should be used for emancipatory political aims" (Campbell & Bunting, 1991:4), enabling transformation of society and liberation of the individuals within that society (Fay, 1987).

Critical social theory is at once an explanatory theory and an action theory. Its purpose is to explain the social situation in such a way that the consciousness of the society is raised. Once this enlightenment has occurred there is potential for emancipation from the oppressing conditions that have constrained the society.

Three central features of the theory are explanation, criticism and empowerment which make the theory at once scientific, critical and practical (Fay,1987:23).

Hegemony

Critical social theory provides theory for social action. The structure of a society, including the social and political influences, are therefore relevant. Hegemony refers to the ability of dominant groups to define and maintain social situations through influencing the consciousness of people to accept its dominant world-view

(Clare,1991:69). It is a state of oppression created by the exploitation of one person or one group over another (Freire,1972).

Hegemonious relationships are evident within health care. Examples are the oppressive exploitation of the medical profession over other groups such as nursing and over society as a whole (Torres:1981) and the position of nurses within health care structures and their lack of control over the service they offer which reveals their class position (Allen,1987:11). As Lovell (1980:74) says

> *Power is presently being used by the medical profession against the interests of nursing and society, yet most people are only dimly aware of what is going on. This lack of awareness, combined with a reluctance to question what is not understood, renders nursing and society powerless.*

By controlling information, political pressure, creating an aura of myth around the selling of medical services and the political abuse and exploitation of women, medicine has dominated and controlled all aspects of health care including the work that other health care providers, such as nurses, perform (Lovell, 1980). The world-view of medicine prevails within health care.

As this current study will reveal nurse managers are also influenced by organisational ideology. Denhardt (1981) argues that organizations form their own particular patterns of social domination and justification of those patterns.

> *such systems shroud themselves in an ideological justification based on growth and development, either personal or productive (Denhardt, 1981:149).*

To achieve this, submissiveness to the dominant objectives of the organisation are demanded, limiting opportunities for personal or professional growth, until technical rationality pervades.

> *As we come to see ourselves as objects, we begin to rationalize more and more of our own lives. We come to distrust our own capabilities and depend on others for guidance...Most important, we lose our capacity to experience the world subjectively, as a place in which our actions count (Denhardt,1981:151).*

Ideology and 'false consciousness'

Primary to the ability of critical social theory to accomplish explanation, criticism and empowerment is ideology critique. Mezirow (1981: 5-6) defines ideology as

> *a belief system and attendant attitudes held as true and valid which shape a groups interpretation of reality and behaviour and are used to justify and legitimate actions.*

Within a critical social sense Habermas refers to ideology as a "false consciousness", a situation in which members of a society are seen to be deluded about themselves, their position or their interests in some way.

> *It is in virtue of the fact that it supports or justifies reprehensible social institutions, unjust social practices, relations of exploitation, hegemony, or domination that a form of consciousness is an ideology (Guess, 1981:15).*

Within nursing false consciousness is exhibited in acceptance of the dominant medical ideology as previously

described in the section on hegemony. Instead of seeking autonomous nursing practice, traditional patriarchal relationships between medicine and nursing are perpetuated with nursing accepting and maintaining the dominance of medical practice. Within health care organisations there is acceptance of organisational ideology, loss of personal autonomy and the objectification that technical rationality requires (Denhardt, 1981; Hodgkinson, 1983).

The purpose of critical social science is to free people, such as nurses, from their delusions (Guess,1981:12) and to enable perspective transformation and transformative action thus enhancing practical action.

Transformative action and Praxis

Transformative action is dependent on self knowledge of one's history, values, beliefs, roles and social expectations (Mezirow,1981:5). Critical to transformative action is critical reflectivity, the "awareness of why we attach the meanings we do to reality" (Mezirow,1981:11), including reflection on restraining conditions that prevent action or that maintain ideologies.

Praxis is the intentional action that results from critical reflection on the origins of actions, their usefulness and their effectiveness. It involves reflection and action (Grundy,1987:104) which are dialectically related. The dialectical thinking required for praxis to occur involves the discovery of contradictions by reflection back and forth between all aspects of and elements within a situation (Carr & Kemis, 198:33).

Within nursing this involves the opportunity to reflect on the historical, political, personal and social factors that have impinged on the evolution of the social position of nursing and on nursing practice. Within the nurse manager position reflection on these factors in relation

to both nursing and organisations is required.

The crisis theory and resistance

Fay (1987:29) argues that the members of a society must be in a crisis stage before critical social theory can be enlightening and emancipatory. This is because unless there is quite a high level of discontent they are unlikely to be motivated to recognize the need for change in their situation. Even if motivated to seek a change in their situation the individuals or group may resist the critical social theory proposed because of the dominance and persuasiveness of their ideological belief (Fay, 1987:98).

Within this study of nurse managers this means that unless they recognise their discontent with their current situation they are unlikely to freely participate in ideological explanation and criticism or to accept any critical social theory developed.

Summarizing to date, critical social theory aims, through critical reflectivity, at perspective transformation and transformational action so that members of a society can be freed of ideological illusions. Explanation, criticism and empowerment are essential concepts of the theory.

Explanation

Before transformational action leading to emancipation, can occur the members must come to understand the oppressive conditions in their lives and alter their ideology. It is their ideological belief system which blinds the members of a society from their real situation (Geuss, 1982:3). And that real situation, meaning and truths, is interpreted within the context of history (Campbell & Bunting, 1991: 5) and all aspects of social

situations.

Allen (1985:62) likens explanation to 'informed consent'. However the information for this consent is not provided by the researcher but rather is a dialectical process between the researcher and the participants as explanations and understandings are shared. The researcher must "establish a dynamic unity with the oppressed class" (Connerton, 1980:34) in order to permit discussion which is not distorted by power imbalances between the researcher and participants (Allen, 1985:62). The explanation must take into account

> *personal meanings [which] are shaped by societal structures and communication processes and are therefore all too often ideologic, historically bound, and distorted (Campbell & Bunting, 1991: 5).*

Because explanation must take into account all aspects of a context, not just that which is current and factual, social, political, economic and historical antecedents cannot be ignored.

Criticism

Consciousness raising is possible by helping the members of a society to understand the oppressing conditions that have been part of their history and how these conditions effect their present situation. The researcher aims to show the members that

> *as long as they conceive of their capacities and interests as they do, and as long as they understand their social order as they do, they will be thwarted (Fay, 1987:29)*

but that there is an alternative to their current

situation.

Allen (1985:143) says the criticism must

> *provide a method to crack the ideologic mirror, a mirror that both reflects and distorts the material basis of social life*

As Kegan & Lahey (1984, in Foster, 1986:36) explain, people do not grow by confirmation of their realities. What is required is the opportunity to have them challenged and being supported to listen to that challenge rather that defending it. To enable criticism a supportive, dialectical relationship between researcher and participant where power imbalances are minimized so that both feel able to challenge the others viewpoint permits opportunities for critique and growth.

Empowerment

It is then the task of the researcher working with the members of the society to empower them towards transformative or emancipatory action which should result in emancipation from their oppressing situation as they take a new perspective on their situation (Mezirow, 1981:7).

> *The present is cast against a historical background while at the same time the 'naturalness' of social arrangements is challenged so that social actors can see both the constraints and the potential for change in their situations (Lather, 1991: 63).*

Empowerment is not however something that the researcher does to others; rather it is a "process one undertakes for oneself" by assisting others to come to recognise their own power (Lather, 1991:4& 5) recognizing that they are

autonomous individuals. Through the process of critical dialogue, attitudes and views are created and the motivation to action unfolds and is fostered.

Criticism of critical social theory

Fay (1987:58-64) acknowledges a number of criticisms of critical social theory which originate from opposing views on the nature of people and society. The first of these he calls "elitism" because this criticism claims that only a few people have the reflective abilities and willpower necessary for the theory to be successful. Rather than being an action theory for society it becomes a theory for a select few. The second criticism he calls "practicalism". It resists the claim that reflection can be a principal factor leading to emancipatory action. The third criticism, which Fay calls "anti-rationalism", argues that " the very idea of a critical social science, far from being a cure for the disease of people living in a crisis, is itself a symptom of this disease" (Fay 1987:60). The fourth criticism, "instrumentalism" denies that reflection can alter the desires of people. The fifth, "naturalism" is the criticism which originates in the notion that social arrangements are governed by regularities which are outside the human control.

The above criticisms stem from other perspectives of people and society which justify an oppressive societal organisation and technology, that which critical social science argues against as its basic foundation.

Perhaps the most common criticism relates to the subjective and often abstract notion of critical social research and other research undertaken within a qualitative framework (Lather,1991). When objectivity is a fundamental scientific aim, as it is within the empirico-analytical sciences, any method which allows subjectivity and dialogue between researcher and participant does not

fulfill the criteria of the underlying philosophy.

One question sometimes posed about critical social theory is how efforts to liberate perpetuate the relations of dominance (Lather, 1991:16). Care needs to be taken that in developing a critique of the participants' world other values and ideals are not imposed upon the oppressed in the name of emancipation.

Furthermore, the assumption that the participants are less emancipated than the researcher can bring criticism of paternalism (Campbell & Bunting, 1991:6).

Summary

Critical social theory enables a theory of action to overcome the oppressive conditions imposed by hegemony, ideological illusion and false consciousness. Through critical reflection and dialogue it moves beyond the limitations that research in the empirco-analytical and interpretive traditions imposes, permitting the researcher opportunity to participate in an emancipatory process through explanation, criticism and empowerment. The theory itself does not compel action, but provides the knowledge necessary for informed action to occur.

In the next chapter a description of the study is given. Methods of critical social theory used and particular concerns when using this methodology are discussed.

CHAPTER FOUR

DESCRIPTION OF THE STUDY

The specific aim of this study was to work with a small group of nurse managers in an acute care setting to

1. explore their work realities and their expectations

2. assist them to identify and explore patterns, constraints and opportunities in their position.

3. reach a common understanding between participants of the parameters for nursing leadership in the current nursing and health care climate in hospitals.

4. empower participants to identify choices and to take emancipatory action to overcome the constraints and realize the opportunities in their work situation.

The practice context

The hospital where the participants work is a large acute general hospital providing specialist services to a wide geographical area with one central urban area. Services offered include surgery, medicine, maternal and child health and psychiatry on both an inpatient and outpatient basis.

The management structure of the hospital and Area Health Board has recently changed from a triumvirate to a general management structure (refer p.6). This structure impacts directly on the responsibilities of the nurse managers which will be described in Chapter 5.

As is common in all acute areas the size of the nurse

managers' area of responsibility varied greatly between units from the smaller intensive care unit to the larger psychiatric area with both inpatient and outpatient services.

Nurse managers are directly responsible to the service manager of the appropriate service. Their professional link is through the nursing advisor to the general manager. In this case the advisor's primary responsibility is service manager of a large Area Health Board wide service. Her nursing advisory position is a secondary responsibility. This is the senior nursing advisory position in the Area health Board.

During the course of this study service nursing advisory positions were established. These positions were to be part-time positions, functioning alongside other responsibilities that the advisors might have. The function of these positions is to advise the general manager's nursing advisor on nursing related issues.

Planned, but not yet implemented at the time of the study, was the appointment of clinical nurse specialists, probably at a service level, although final decisions had not been made. Day time nursing supervisory positions had long since disappeared but afternoon and night coordinators for the nursing service remained.

Primary nursing had been initiated within the Board some years previously following an independent consultant's recommendations. All areas had changed to a primary nursing model (refer p.5).

Gaining access to the clinical area

Permission to undertake the study was initially sought from a senior manager, who was also the nursing advisor, of the Area Health Board from which the participants were

employees. She approached nurse managers at a regular meeting to ascertain interest. Further permission was then obtained from the Ethics Committee of this Area Health Board.

Identifying study participants

Interested nurse managers were invited to attend a meeting with the researcher to discuss the purpose and methodology of the research. Eight interested nurse managers attended this meeting.

At the completion of the meeting this group of nurse managers were given the information sheet for intending participants and a copy of the consent form. The nurse managers were given the opportunity to take some time after the meeting to consider whether they wan'ed to participate. All eight freely chose to consent to participation at the completion of this meeting.

Description of the study participants

Eight female nurse managers consented to participate in this study. All met the criteria of currently working in an acute care setting. Four of the nurse managers had less than two years experience as a nurse manager. A brief description of each individual participant is given below. Pseudonyms are used to protect confidentiality and to ensure anonymity.

Pat

Hospital based training. One year as a nurse manager. Prior to that Pat was a staff nurse in another area. No post graduate qualifications.

Eliza

Hospital based training. Eighteen months as a nurse manager. Prior to that Eliza was a staff nurse in another

hospital. No post graduate qualifications.

Jan

Hospital based training. Charge Nurse in the same area for 6 years. Automatically assumed the nurse manager position when hospital structure changed. Obtained an Advanced Diploma of Nursing in 1987.

Emma

Comprehensive nursing education. Nurse manager for 9 months. Prior to that Emma was a staff nurse in another area. Has undertaken some university nursing papers.

Bridget

Hospital based training followed some years later by a bridging programme to become a comprehensive nurse. Has had 13 years as a charge nurse in the same area. Automatically assumed the nurse manager position when the management structure changed. No post graduate qualifications.

Betty

Hospital based training programme. Has had 6 years as the nurse manager in the same area. Prior to that was a staff nurse in the same area. No post graduate qualifications.

Alison

Hospital based training programme. Has had 18 months as the nurse manager in the same area where she had worked previously as a staff nurse. Has an Advanced Diploma in Nursing.

Clare

Hospital based training programme. A number of years as the charge nurse in the same area where she had worked for some years as a staff nurse. No post graduate qualifications

Protection of the rights of the study participants

Study participants chose freely to participate in this study. Written consent to participate was obtained. Participants understood that they were free to withdraw from the study at any time.

A tape recorder was used to record all interviews. Tapes were transcribed using pseudonyms. Interviews were transcribed onto computer hard disc and then, once transferred to written transcript, were transferred to floppy disc and secured by the researcher. With the exception of one interview, all interviews were transcribed from tape onto computer by the researcher.

Because of the method of selection and the group interviews participants were known to each other which necessitated the understanding among participants that they would probably be identifiable to each other within the final thesis.

Frequent mention was made during the interviews to people not directly involved in this study. The researcher made every attempt to preserve the anonymity of those people while preserving the content contained within any excerpts from interviews.

No additional ethical issues were identified during the course of the study.

A copy of the consent form and information sheet for intending participants is included as Appendices One and Two.

Data collection

Data collected for this study was obtained largely from the verbal accounts given by the nurse manager participants within the individual and group interviews. A

small amount of data was obtained from the diaries that the nurse managers kept prior to the first interview.

Data collection took place during three individual interviews with all but one of the participants. This participant was unavailable because of work commitments for the first interview and thus only participated in two individual interviews. Further data was collected in two group interviews. In the first group interview all participants were present. Unfortunately sickness meant that two participants were unable to attend the final group interview and another was prevented from attending because of work commitments.

Diary keeping

Prior to the first interview all participants were invited to keep a diary of their work and thoughts for a period of 2-3 weeks. The main purpose of keeping a diary was to encourage nurse managers to reflect on their work and their work world and to provide the researcher with an introduction into this work. Most participants experienced some difficulty with keeping a diary, appearing uncomfortable with written reflection, and tended to keep an account of their activities rather than their reflections. Such difficulty is in keeping with the oral tradition of nursing (Street, 1989). Nevertheless, the diaries provided some information which could be explored further in the first individual interview.

Individual interviews

Three individual interviews were held with seven of the participants. The eighth participant was only available for two interviews.

Interviews were held in the place of work of the participants and were recorded on tape recorder. They were scheduled at the mutual convenience of the participants

and the researcher. Interviews lasted from 50 minutes to 90 minutes. Time was allowed at the beginning of each interview for informal conversation but the participants appeared eager to commence the interview without such groundwork.

Data collection took place over a period of two and a half months from the middle of July until the beginning of October 1992. There was a period of two to three weeks between each interview to allow time for transcribing the tapes and for time to reflect on the interview.

The interviews were largely unstructured and aimed at being "co-structured", as described by Tripp (1983). In this type of interview the participants and researcher are given joint responsibility for structuring the interview. Each possess equal rights to challenge the others viewpoint (Tripp, 1983,:33). In this way each participates

> *in the creation of attitudes and views by taking an active role in a series of discussions*

In the first interview participants were initially invited to share their backgrounds with the researcher. Clarification and further discussion followed on from this beginning. The second and third interviews were based on particular issues identified by the participants and the researcher from the previous interviews.

A similar process was used for the two group interviews. The final group interview also included termination of the research process.

Transcripts of each individual interviews, with some comment by the researcher, were returned to each participant before the following interview. In this way participants could reflect on the interview and identify

any particular areas for discussion at the next interview. This was in keeping with the researchers personal belief that the information belonged to the participants and that they should be involved in the data analysis.

Data Analysis

Data was analysed by adapting the method of critical social research as described by Comstock (1982) and Lather (1991). The processes involved in this research were:

1. The development of an understanding of the participants world (Lather,1991:63).

2. Study of the historical development of the social conditions and the current social structures that constrain the participants actions and shape their understandings (Comstock,1982:381).

3. Description of the social processes and structures that gave rise to particular understandings and that presently serve to reinforce or maintain meanings, values and motives (Comstock, 1982:383).

4. The researcher helps the participants to see how present intentions are unrealizable in the context of changed circumstances (Comstock,1982: 385).

Comstock (1982:386) describes a further phase involving participation in a programme of action which will change social conditions. Resource constraints, in particular time constraints, prevented the researcher following this study to this point.

Because of the necessity for ongoing dialogue to affirm that the researcher's interpretation of understanding and critique was as intended by the participants much of the analysis occurred as the research proceeded. It is not

possible, nor is it intended, in this type of research to separate data analysis from the practical intent of this emancipatory research.

Nor is it intended that this type of research provide a separation between the researcher and those being researched, as is required in sciences that require objectivity. Mutual negotiation of meaning and understanding between researcher and participant within a relationship of co-participation is a necessary part of critical social theory. The language used to write about the process should reflect this co-participation.

For this reason any reference to myself as researcher within this study will be made in the first person because of the crucial input I had in the shaping of explanation, criticism and empowerment. This position is in keeping with the position taken by some other social scientists (Swanson-Kauffman, 1986; Webb,1992) who believe that the "use of the neutral third person obliterates the social elements of the research process" (Webb, 1992:747).

Methodological issues relevant to the critical social research design

As with any research it is necessary to attend to issues associated with the process and the content of research. Within traditional empirico-analytical research this would refer to the achievement of reliability - the replicability of findings, validity - the accuracy of findings, and objectivity. Within emancipatory social research Lather (1991:56) refers to three issues; the need for repricocity, the stance of dialectical theory-building versus theoretical imposition, and the question of validity in praxis-oriented research.

The need for repricocity refers to the "mutual negotiation of meaning and power" (Lather, 1991:57). Tripp (1983)

provides an example of this when he describes the co-structured interview which allows both participant and researcher equal rights to challenge the others viewpoint, ask questions and structure the interview so that researchers become not so much owners of the information as majority shareholders (Tripp,1983:39). In this way meaning can be challenged and confirmed outside of a relationship dominated by the power and authority of the researcher.

"The stance of dialectical theory-building versus theoretical imposition" refers to the danger when researchers impose meanings on situations in the name of emancipation, rather than constructing meaning through negotiation with participants (Lather, 1991:59). The theory must arise from the data. To achieve this participants must be involved in the construction and validation of meaning.

The issue of validity refers to the credibility of the data and the freedom from the distorting effects of researcher bias, at the same time acknowledging that the researcher, within critical social research is very much part of both the construction and interpretation of that data. As Robinson & Thorne (1988:70) say, "even the process of reflecting upon an experience under the guidance of a skilled interviewer can have a powerful impact on the [participants] view of the event". However,the credibility of the data rests in it presenting what the participants experience and believe (Sandelowski,1986). The researcher's description and analysis must be acceptable to the participants. They must trust the researcher and the explanation that is offered (Lather, 1991: 52). Furthermore, it must be presented so that the logic behind it can be understood (Webb, 1992).

Within this study particular attention was paid to each of these issues in a number of ways. Because the interview

was an interpersonal encounter effort was made to establish understanding, rapport and trust between myself and the participants. Opportunity was allowed for getting to know each other and for general conversation prior to each interview. Participants were invited to turn off the tape-recorder if they wanted dialogue withheld from the data. Transcripts were returned to the participants before the following interview to allow opportunity for reflection on the data. Participants were invited to clarify meaning contained in the data at subsequent interviews and, if necessary, changes were made to the data if such changes did not change the meaning made implicit at the time of the interview. This requires further explanation. Some factual changes to the transcript, such as dates, were readily altered by the researcher as requested. However when a participant made a comment such as "I didn't really mean that" no changes were made but I noted the participant's comments. Data in these situations was not deleted because the particular comment was made in the context of the dialogue at the time and was therefore relevant to the meaning implied by the participant.

As researcher I commenced this study with personal perceptions of the work of the nurse manager. These perceptions were noted in a personal diary kept during the study. From time to time I reflected on these and added to them as dialogue with the participants and colleagues, background reading and reflection altered my perception of the world and work of the nurse manager. As opportunity arose within the individual and group interviews my perceptions were shared with the participants, providing the opportunity for these perceptions to be known to the participants and challenged by them, in keeping with the notion of interviews as being 'co-structured'.

Analysis of the data occurred concurrently with the interviews. As particular themes were identified within

the data examples, both confirming and questioning the themes, were explored within the study data, compared with other data sources such as the literature, and discussed with the participants. In this way 'triangulation' of data sources occurred.

Description of findings

The following four chapters constitute Part II of this thesis and provide the critical dimension of this study.

Key to Transcripts

[ ]	Researcher comments to provide clarity, explanation or to ensure anonymity
[.....]	Quotations from the transcripts
[name, x: y]	Quotation with name of participant, no of interview and page number
[G, x: y]	Quotation from group interview, no of interview and transcript page number

CHAPTER FIVE

THE PARTICIPANTS' WORLD

As argued in Chapter Three, it is the purpose of critical social science to understand society in order to alter it (Fay, 1987), the ultimate aim being action at the sociopolitical level. Therefore, before commencing the critical element of this study it was essential for the participants and myself as researcher to form a picture of their world and their world view.

This world view contained concepts, ideas and beliefs, rituals and attitudes about the participants' history and the present, relevant to their work as nurse managers. This account of the participants' sociopolitical situation and their understandings then formed the basis for the critical aspect of the research outlined here.

Perspectives on the nurse manager world

In the course of the individual interviews, particularly the first, a picture of the world of the nurse manager participants began to emerge.

This world was busy, demanding and forever changing. It was sometimes rewarding and frequently frustrating. Individual participants placed emphasis on different aspects of their world and work depending on their particular concerns at the time of the interviews and depending on their perspective of the work of the nurse manager. For this reason their worlds are presented as a mosaic.

Individual perspectives on the work of the nurse manager position were varied. While some viewed it predominately

from a management focus others saw it as being both management and clinical with different aspects being the focus at particular times.

On initial analysis of the data it appeared that the previous position held by the participants influenced whether they perceived the nurse manager position as primarily management or clinical, or as a combination of both. Those who had taken on the nurse manager position from another position either as a staff nurse in another area, or who came from outside the organization, placed most emphasis on the management aspect of the work. Those who had been a charge nurse or who had come from a staff nurse position in the same area gave more emphasis to the clinical aspects of the nurse manager position.

Eliza and Pat were the most obvious of the group who concentrated on the management responsibilities of the position. They had made a conscious decision to focus on management as a central feature of their work and throughout the interviews they placed most emphasis on the importance of this.

Clare, Bridget and Betty remained clinically active in their areas although they had assumed and accepted the management responsibilities of their position. Such was the clinical workload in her area Clare missed two appointments for interviews.

Alison, Jan and Emma were less decisive about whether the clinical or the management focus was dominant in their work.

The decision to accept a nurse manager position

Those nurse managers who had experienced a broad background with varied experiences both within and outside nursing cited the need for autonomy and responsibility as

helping them to decide to accept the position.

> ...I needed to get out and be my own boss, in charge of what I wanted to do and to have some say in the future of the department (Pat,1:5).

Eliza expressed similar motivations

> ...The challenges of the new management stuff, the budgets, control, the personnel work and I guess to be in control of the situation of the staff...anyway I can set things up the way I want them...I see myself as the manager, very much as the manager (Eliza,1:5).

For them having this autonomy and the responsibility remained very important aspects of their work.

For others like Bridget, Clare and Jan taking on the nurse manager position had been a less conscious decision. Previously charge nurses when the change to a general management structure occurred, they automatically assumed the nurse manager position. With this they had to adjust to the changes that a change in organisational structure required.

> I took over in the beginning of '86 in the charge nurse clinical role and didn't have to worry about budgets,rosters- had a super life with a supervisor who told me what to do and when to do it (Jan,1:1)...but I think that coming from a clinical to a management role was not that hard (1:2).

Whether the initial motivation for taking on the nurse manager position was primarily to take on management responsibilities or whether it was a modification from their previous work influenced how the nurse managers perceived their position at the time of the interviews.

For example, Eliza saw herself as a manager who brought to the position her nursing background. She saw the nurse manager position primarily as a management position. Pat

explained her position similarly.

> I was going into something entirely different and because I'd done management before I knew what I was going into and I wanted to do that. I did not want to get into the patient side as such, I wanted to do management...I'm still a nurse I suppose but I see myself as a manager, not a nurse manager. I basically see myself as a manager (Pat 1:5&6).

Both these nurse managers had come from previous experience as staff nurses in other areas. The nurse manager position was a complete change in terms of area and type of work from this previous experience.

Jan, Alison, Bridget, Emma, Clare and Betty placed more emphasis on the importance of their nursing backgrounds, at the same time recognizing that they held a management position within the hospital. This different perception from that held by the first two participants appeared to be associated with their previous experience in the charge nurse position or to having worked in the same area before being appointed as nurse manager.

From their different perspectives of the position being primarily management, primarily clinical or a combination of both, a description of their work appeared.

The clinical world

Clinical resource

The main clinical work was acting as a resource person for nursing staff in their area. However, for different nurse managers being a clinical resource often meant diverse things.

Sometimes they had continued with their clinical work because they considered that they had clinical expertise that was not otherwise available in the area.

> ...I'm still the one that knows how to put up all the complicated tractions because orthopaedics is something that you have to be in for ye›rs and years and years (Jan,1:3).

> ...I see myself as the clinical resource person for the staff because I have got the most clinical experience by far of any of the other staff members probably (Clare,2:5).

A different perspective of the resource responsibility was the empowerment of other nursing staff to take responsibility for their work and their decisions.

> ...They don't often ring me at home. I haven't set up anything because that is not giving them credit for any intelligence. And they are just as trained, intelligent and senior as I am (Alison,1:11).

> ...And to me that is being a manager- you develop the people that are there and you give them the opportunities. But I can take some responsibility for helping them grow and at the end they will feel satisfied and I will feel good about what I have done (Emma,2:11).

This demanded knowledge of when to hand over responsibility to others and knowing when to let go. Usually nurse managers who held this view had made their position clear to the other nursing staff in their area, often with some resistance.

> ..And I said I had the knowledge and background but that it had been a few years but that I hadn't come in to be the clinical expert. I put it down right at the beginning that they were the ones with the clinical skills (Emma,1:4).

Eliza made a similar statement about her work as a clinical resource person for the nursing staff

> ...That while I was the nurse and that enhanced my management skills and my understanding of what they were about and what they were

> doing the clinical was their baby....It was really very empowering of the staff, they were really very frightened and it took some time for them to realize that I was actually there to empower them, they were the clinicians (Eliza,1:5).

Eliza saw this had had positive effects for her staff. Because the previous nurse manager had assumed the position of clinical expert, nursing staff in that area had little confidence in their own clinical competency, always looking to the expert for guidance. Efforts by Eliza to empower the nursing staff, initially met with resistance, eventually resulted in increased confidence in their own ability as nurses.

> ...their confidence is just 10 fold. When I arrived they had little self confidence because there had always been an expert sitting around who knew how to do everything...they were feeling really vulnerable and really oppressed (Eliza,1:12-13).

Using clinical expertise and knowledge

For most, even those who initially denied having clinical responsibilities, their clinical expertise and knowledge was related to their management work. The knowledge and expertise that they had gained as a practising clinical nurse was used to assist them to make management decisions and with other aspects of their work which they considered to be management.

But for those who saw their responsibility as primarily management "letting go of the clinical" work was not always easy.

> I didn't realize that it would be so hard for the staff to see me let go of the clinical though and I didn't realize that I would find it hard to let go of the clinical either (Emma,1:6).

They described how, despite these feelings, they had

successfully managed to combine their nurse manager responsibilities with clinical nursing. Often they would undertake what could be described as primarily clinical responsibilities but with a management purpose in mind.

> ...So I do sort of hit the ward and basically help with beds and rounds until about 10 in the morning because that is my way of knowing what the patients are at and what the nursing care is at, what the whole atmosphere of the ward is....if I am going to do effective staff reviews I really need to know what they are all about...it is just my personal management style but the girls like it and appreciate it and they know that is the way I tend to be (Alison,1:3).

Difficulties in continuing clinical work

For those such as Clare and Bridget who chose to continue to utilize their clinical skills and spend additional time in clinical work, additional difficulties in their work were frequently encountered. Often they found that there was not enough time for all the clinical and management tasks that had to be done.

> ...I'm not the sort of person to say look I've got to get this report out and then I would spend to 7 or 8 o'clock at night getting my reports done (Bridget, 1:2).

> ...but I do realize that if we are busy then I am not going to be able to do those things for the day [management things]- I have to put them aside and be a clinical nurse and maybe take a patient (Clare,2:6).

By putting aside their management work Bridget and Clare inferred they considered clinical work to be more important than management. When they felt it was required, usually because of staffing shortages, they put aside their management responsibilities and helped out with patient care, maybe even taking responsibility for a patient workload as did Clare above.

In similar situations of staffing shortages other nurse managers made their position very clear. By assisting with patient care and the clinical workload they did not see that they were benefiting the ward or themselves. These nurse managers saw their responsibility in such situations as ensuring that staff were found to cover the shortage.

Advocacy

Although most nurse managers encouraged staff autonomy and accountability many saw that they had both staff and patient advocacy responsibilities.

> ...And relatives too, it is very hard to pin medical staff down sometimes. There used to be this terrible system before where relatives had to make an appointment to see them [medical staff]. Terrible. Now I just say if you are in the ward by 9.30 to 10 and sitting down next to your relative the doctor will be around. And the medical staff are a captive audience then you see. And I usually tell them [the medical staff] about 5 minutes before we get to the room that the relatives are there. Enough time to warn them but not enough time for them to disappear on me. Quite often I will stick around to make sure that the concern that has come through to me from the patient or the relative or whatever are coming through to the consultant too. I prime people up with bits to say because you have still got consultants who think that patients don't need to know it all..(Jan,2:11).

Jan perceived herself as being in a position to advocate for and to empower patients. One aspect of this was ensuring that those in the position of authority and control, the medical staff, were not able to ignore the needs of patients who were in the dependent, relatively powerless position."By maintaining the client's ignorance the physician is in control" as "controlling and withholding information can be powerful tools of paternalistic deception" (Lovell,1980:81).

In relation to nursing staff Alison discussed her advocacy

responsibilities from a different perspective. Acknowledging nurses as professionals, Alison saw herself as enabling nursing staff rather than advocating for them.

> ...I see myself as their support- to create the environment so that they can get what they want. To say I am their advocate is really taking the professionalism away from them (Alison,2:5).

Summary of the clinical world

Although there were marked differences in the way they perceived their clinical work and responsibilities there was no doubt that for most of the nurse managers clinical nursing continued to have an influence in their everyday lives.

This clinical work mainly involved acting as a clinical resource person, empowering nursing staff to accept responsibility for their professional work and acting as a staff and patient advocate. Some of the nurse managers continued to assume a patient workload, particularly when there were staffing shortages. Clinical skills, knowledge and expertise were used by the nurse managers to assist them with their management responsibilities as they contended that often management decisions required a clinical understanding.

The Management Work

While it was not always possible for a clear distinction to be made between the clinical and management work of the nurse managers some aspects of their work were commonly described as management.

> ...I probably think of it as anything that doesn't involve hands on care- the backup sort of thing like the rosters and checking up on the computer on the information that comes back, the product committee stuff. Anything that is not clinical I look at those as sort of

> management. Its difficult isn't it? When you come down to what it is (Betty,2:3).

Budget responsibilities

Responsibility for the ward/area budget was one such management responsibility. With the exception of one nurse manager (Betty) all had responsibility for the budget of the clinical area. This included nursing and clerical staff budgets and the ward expenses budget. This responsibility extended beyond just keeping to a set budget to actually setting the budget and to developing business plans for their area. The nurse managers were also totally responsible for capital estimates and for the arrangement of maintenance including, for one nurse manager, the complete redecoration of her ward including the interior design.

But even in the management responsibility of dealing with budgets the nurse managers considered that a certain amount of clinical knowledge was required.

> ...I like to know the changes that go on, particularly in orthopaedics because techniques and things are changing and I like to know because when we were doing the business plan we had to put aside money for new instruments and that sort of thing so I think it is important to my management role to keep my clinical reasonably up to date (Jan,2:10).

Being a resource

Nurse managers also saw themselves as a resource person. Not a clinical resource person but a person to whom others could come for all sorts of information.

> ...I can put them onto the various areas where they are wanting information, they come to me as their support person (Pat,2:6).

However some also saw that nursing staff had to be encouraged to be independent.

> ...[The ward] should be able to run on its own. Thats one of the things-if I'm not there- what to me is a good manager is when it manages when you are not there but you have to put in the tools for them to do it. But that takes time- it doesn't just happen overnight (Emma,2:9).

> ...But I consider that my staff are accountable and I expect them to be accountable. I expect to wear the wrap for the overall running of the ward, thats what I'm paid to do but I don't expect to wear the wrap for bedside decisions- that is what they are doing and that is what they are paid to do and that is what they are accountable for. Bedside care is their responsibility (Alison,2:9).

Coordination

All the nurse managers saw that their management responsibility included coordination within the ward. Often this required broad knowledge of what was going on clinically within the ward area. For example, Jan describes the nursing knowledge that she requires in order to manage the ward effectively

> ...When I come on I like the staff who got the report to tell me things like if any post ops have gone off, or how many admissions we have had overnight and what their status is, whether they feel that staffing is adequate for the day you know because of something that has happened overnight or whatever...But just a general overall picture of the ward. I need to have a - I don't need to know if someones bowels have moved but I need to have an overall picture of what is going on (Jan,2:5).

Staff employment

Another responsibility was the employment of the nursing and clerical staff in their area. This sometimes created

some conflict with other staff.

> ...but I thought hang on here, I'm in charge of the nurses employment in this area so I'm going to have a battle with her. She really wants to have hospital aides or just people off the street (Bridget,1:5).

While Bridget felt that the employment of nursing staff in her area was her responsibility others appeared to want to interfere. Bridget's professional knowledge and management authority were being challenged.

24 hour responsibility

A responsibility that all the nurse managers shared was the day to day staffing of their area on a 24 hour basis. This involved the adjustment of staffing levels according to workload including making staff from their area available to other areas if their own area was quiet.

> ...I act as a manager. I won't run one nurse over. If I come on and there are 4 on I ring and get one sent away which doesn't make me popular because no one wants to go out there but we can't afford to have people sitting on pretty numbers...(Alison,1:7).

For some this 24 hour responsibility was a major shift from charge nurse and staff nurse duties.

> ...I never used to think about work at home when I was a staff nurse...But now I am a nurse manager it all comes back in the wee small hours of the night (Betty,1:15).

And the staff expected that this 24 hour responsibility often be taken to extremes which placed additional stress on the nurse manager's work and personal life. For example, when Alison returned from holiday

> ...She said the next duty list isn't out.You always do it when you are on holiday. Why haven't you done it. I thought oh no. They still expect

> me to go on holiday and come back with the duty list done (Alison,1:19).

The expectation from other nursing staff was that the nurse manager was always available to fulfill management responsibilities.

Implementing change

Usually as the manager of their area the nurse managers were given the responsibility of implementing changes to the area. This, on the whole, they accepted as part of their work although as one nurse manager put it

> ...the only problem that I have with the changes is that the time frames are too short. You don't have a chance to do all that nice theory of change (Jan,1:8).

Communication and negotiation

Relating to people was considered a very important aspect of the position by a number of the nurse managers. Whether those people were other hospital staff, nursing or medical staff or the public, "people skills" were mentioned by a number to be vital to the management work of the nurse manager.

Negotiating relations of power between professional staff fell within the work of the nurse managers. Talking of ward decision-making in relation to medical staff one nurse manager said

> ...he has to make it that its his decision all the time, whereas he's not really the best person to make these decisions...But it's these games. Of course I have the final say...(Pat,1:2).

Pat here is describing the 1967 'Doctor-Nurse Game', as related by Stein, Watts & Howell(1990). In this game open

disagreement between medical and nursing staff is avoided when recommendations are made and accepted through subtle suggestion. Nurses maintain an apparent subservient position and medical staff preserve their traditionally superior position to nursing staff. However, whereas Stein et al suggest that the game had changed by 1990 to reflect more collegial relationships between medical and nursing staff, this change was not evident in Pat's description.

Policies and procedures

Setting up ward policies and procedures was another responsibility that the nurse managers had assumed. While previously the inservice education department had coordinated many policies on a hospital wide basis, with the demise of the department this had largely been left to individual wards.

Staff development and motivation

Motivation of nursing staff in their area was another responsibility that the nurse managers saw as belonging to them. Often this consumed a great deal of their time and a great deal of effort.

> ...You know my only argument to that is that nurses like everything handed to them on a plate....I get really disappointed, I mean of all of mine I have only one nurse that is actually out seeking to go to level 3. Now I should have all my staff wanting to go there. But I can't get them to go there. No matter how many challenges you put in front of them they say they will do it and then they go back and sit in their hole again (Alison, 1:14).

Staff development was one of those areas that was neither solely management or clinical- most nurse managers described it as having elements of each. Nevertheless most saw this responsibility as an extremely important aspect of their work.

> ...Staff development is extremely important because if you don't have that then you don't have good patient care (Pat,2:5).

Summary of the management work

Overall the nurse managers saw that they had similar responsibilities to any manager in any business.

> ...We are doing what a manager does in any business around town, or any company, we are managers (Pat,1:14).

These responsibilities involved ward budget management, acting as a resource person, 24 hour staffing and coordination of their area, the employment of ward staff, implementation of change, professional and interdepartmental communication including negotiating power relations, motivation of staff, staff development and the establishment of ward policies and procedures. For these nurse managers conflict and personal sacrifice were an inevitable part of management.

Relationships with other staff

Through dialogue it became evident that nurse managers shared relationships with almost all other staff in the hospital. Close communication was required in order to manage complex ward/department areas and to maintain interdepartmental co-operation. "People skills", as previously mentioned, played a very important part in this responsibility.

Relationship with nursing staff

The relationship of the nurse managers with the nursing staff varied greatly among the participants. For some like Bridget and Clare the relationship was one of dependence in many matters with the other nursing staff relying on

the nurse manager for clinical and/or management assistance. Others described the autonomy of the nursing staff

> ...They have a lot of autonomy. I don't want them to have to rely on me to pick up the pieces or find out how to do something (Pat,2:6).

Relationship with medical staff

The relationship of nurse managers with medical staff deserves particular mention because the participants repeatedly referred to it. This relationship ranged from cooperation to open hostility in some areas where the medical staff did not appear to have accepted the responsibility changes that were associated with the structural shift from ward sister/charge nurse to nurse manager. Acceptance by medical staff appeared to take some time

> ...Manager now, yeah. Prepared to take it from me what I will or won't let them do and they are quite amenable to me telling them that I have to get people out before they can get people in and they come and discharge some. Its still evolving. Its been built on respect, that they saw what I was doing was OK. I had to earn that. Until I earned that we didn't get anywhere (Alison,1:6).

The nurse manager position inferred an authority not present in the previous positions. For medical staff this involved changing their perception of who was in charge of the ward. In the traditional hierarchical structure medical staff were superior to nursing staff within the ward structure (Stein et al, 1990) with medicine practising paternalistic deception on nurses to lure them into believing that nurses and physicians can work as a team, with the physician as the 'team captain' (Lovell,1980:84). This position of nurses in the ward was analogous to the position of the wife/mother in the family where she undertakes the menial chores under the direction

of the husband (Lovell, 1980:85).

When given management authority for the ward the nurse manager had to make her changed position clear to the medical staff.

> ...That it no longer was their ward, that I was the manager of the ward and they had obviously medical input but I was the manager and it was my patch and we would work as a team (Eliza,1:8).

The change required the breaking of old habits like the medical staff requiring the nurse manager to do the ward round, the time when medical staff visited the patients under their care, discussed their treatment and issued instructions. Often the nurse manager was no longer available for this traditional charge nurse/ward sister duty because of other responsibilities and because of primary nursing.

Summary of the responsibilities associated with staff relationships

Relationships with other staff were an important aspect of the nurse manager work relying heavily on "people skills" for successful interdepartmental and multidisciplinary communication. Traditional relationships, although still apparent, were being challenged as structural changes necessitated alterations in established hierarchical power and communication styles.

A Summary of the Participants World

A picture of the world of the nurse manager including work patterns, attitudes about the work, frustrations, relationships and rituals from both an historical and current perspective has been presented. Nurse managers placed varying emphasis on different aspects of the clinical and management responsibilities depending on

their motivation for accepting, and their perspective of, the position.

As each nurse manager developed her position alongside wider organisational management changes they encountered personal value conflict and professional opposition from nursing and medical staff.

Pervading this picture are descriptions of traditional expectations for nurses and medical/ nursing staff relationships and examples of domination from those in higher positions of power within the organisation. It is likely that these are ideological beliefs which have formed within the history of nursing, health care and society and which have created oppressing conditions for nurses and nurse managers.

The picture formed in the worldview was not static but rather changed and developed as the study progressed and as participants and myself as co-participant/researcher had opportunity to reflect on the content and the process that was occurring.

The remainder of the data analysis portion of this study will be a critical presentation of these changes within the main themes identified by the researcher as the nurse manager story unfolded.

CHAPTER SIX

VALUING MANAGEMENT

Introduction: Themes from the dialogue

Throughout the dialogue that occurred with the participants some common themes were identified. These themes were particular areas of concern to either the participants, myself as co-participant/researcher, or both.

These themes became the central concepts around which critical dialogue occurred as the interviews progressed and as critical reflection and the dialogic relationship between participants and myself developed to a point where each felt able to challenge the others' perspective and ideologies.

Another dimension to this critical dialogue was added when group interviews were held after the individual interviews with the participants. Group interviews provided the opportunity for further critical reflection and discussion within a wider group perspective.

It was within the first group interview that I as researcher shared my perspective of the common themes to the nurse manager participants. This in itself provided the opportunity for another facet of the dialogue to occur.

Three common themes were identified within the course of this study, valuing management, "letting go of the clinical", and a changing nursing structure. This and the following chapters will present a discussion of the critical dialogue that occurred around these themes and the emergence of an emancipatory awareness of the

situation of nurse managers in the acute care setting.

VALUING MANAGEMENT

Early in the interviews participants shared their positive thoughts about the amount of resources that the Area Health Board had put into management training for nurse managers. They felt proud that they had been given management opportunities and responsibilities that were the envy of some nurse managers in other areas around the country.

Initially there was a shared commitment amongst the participants to do their best with this important responsibility that they had been given.

However, later in the dialogue some participants shared certain concerns and frustrations about these management responsibilities. Opportunities provided for critical dialogue and reflection had raised the consciousness of the participants to a new awareness of their management and other responsibilities.

I also had concerns about the emphasis that management responsibilities were receiving from the participants and from the Area Health Board when there appeared to be little emphasis from either group on some of the professional aspects to the nurse manager position.

It is only since the change in the management structure of the Area Health Board where the participants are employed that management responsibilities have assumed a larger part of the work of nurse managers. Prior to this change the charge nurse position was perceived to include few management responsibilities. As Pat (1:13) said "I don't think it was seen as a management thing". Rather, as all participants described the charge nurse position at one

time or another, it was primarily clinical.

It appeared that the Area Health Board had devoted a large number of resources to preparing the nurse managers for the change in their responsibilities. They had been given many opportunities to attend management education sessions and continued to receive a lot of support and encouragement from more senior managers.

However, despite efforts by all involved, concerns and frustrations about the nurse manager's work surfaced as dialogue continued. While there was an initial appearance that management was the most highly valued of the nurse manager responsibilities this interpretation of their work was constantly reviewed.

The participants' perceptions were that nursing staff appeared to place little value on the management work of the nurse manager although in some areas, with a lot of hard work from the nurse managers, this was changing.

The employer, while providing a lot of support and encouragement for management development, did not always allow the management freedom the nurse managers believed a manager should have. Nurse managers themselves often blamed this on the 'nurse' in the nurse manager title. When their autonomy was taken from them the nurse managers became frustrated.

The nurse managers themselves, while valuing management aspects of their work and recognising that their management tasks were necessary, shared mixed feelings about valuing management with the sacrifice of clinical involvement.

Development of the Manager

Throughout the interviews participants shared with the

researcher opportunities they had been given to develop their management skills and knowledge. They had been sent on numerous courses, had sessions bought in for them, and had received support and encouragement from Board management.

The nurse managers considered themselves fortunate that they had been given these opportunities although, as Jan below indicates, judging their fortune was relative to how they viewed their worth to the organisation. Jan infers that nurse managers were not really worthy of the money spent. By saying and thinking this she was participating in her own domination and undervaluing herself and other nurse managers.

> ...Well they have been down here before and done their executive management stuff with all the corporate heads and [the nursing advisor] decided that she would get them to spend 2 days with us. We didn't ask too many questions because it costs a lot of money and I think we were very lucky (Jan,1:10).

Other management staff had also helped development of the management focus. Many of the nurse managers spoke positively of the encouragement they had received towards this focus from the person who had been their service manager and who had recently taken on a larger service manager/nursing advisor to the general manager position. As a support person and a motivator she was frequently referred to within the dialogue, as in this extract from Eliza:

> ...if no one has changed under the mentorship of [the nursing advisor] then it is their own fault (Eliza,1:11).

Even the general manager appeared to take a close interest in how the nurse managers were adjusting.

> ...Mind you they are wanting us to be good managers- they are

> expecting a lot of us. The general manager rang me last week and said have you put any of those managerial skills you learned into practice yet. Well I said at the moment I am working on team building for my staff nurses. He did talk to me about it. It is costing them a lot of money -of course they want to see what we do (Bridget,3:8).

In this conversation Bridget accepted as natural the 'put down' from the general manager. His assumption that Bridget had to learn management skills before putting them into practice negated experience gained in her years as both a nurse and as a charge nurse/nurse manager.

Giving all this attention to the management focus appeared to reinforce to the nurse managers that management was the most important aspect of nurse manager work. And the dialogue of most of the nurse managers reflected this. Eliza, Pat, Alison, Emma and Jan were very clear in their conversations that they were managers first, nurses second. Nor was it only in their immediate work as nurse managers that they placed most importance on management. There was recognition that management is valued outside of the health care system, within wider society.

> You see we live in a culture and we work in a culture where management is far more valued than any other area and that's not just in nursing- right across its far more valued. In most other professions people aspire to get some kind of management position. I have a son who is an accountant who is looking to go, he is doing his masters in business administration now because he wants to go into management because that's where you go. That's the ultimate to be in management so its not just the health system that is valuing management (Jan,G1:24).

Some of the nurse managers, thinking of their future, saw that management held the most opportunities for them. Nursing on the other hand was seen to be able to offer only an uncertain future for them personally and for many

other nurses. Because of this Jan would offer the following advice to any young nurse

> ...Get as much clinical experience as you can but as well as doing that do management papers- build up on the management papers... In this climate you are probably better doing business studies papers. Really you need your accounting skills and your personnel skills and industrial relations and all those sorts of things (Jan, 3:8).

These words reflect that even amongst nurse managers such as Jan who valued her nursing background, management skills were the goal to aim for. They were the skills most sought after and most valued by the organisation and by society.

Feeling valued as a manager

Some of the participants, such as Alison below, shared feelings of being valued as a manager when they were given the autonomy to act as a manager.

> ...I really feel that I do get autonomy and that is something that I have always said that I have been surprised at how much autonomy I have been given right from the word go in all sorts of things...(Alison,3:15).

Not all of the nurse managers however felt that they were given this autonomy. Eliza commented on this feeling

> That's interesting in a group because some of this autonomy is a wee bit of a fallacy. It is true to a certain extent that I have found that since I have been in the job that the autonomy is there if you want to grab it but if you are not so sure then you can go with the flow and let someone else make the decisions for you (Eliza,3:14).

Eliza perceived that the autonomy was there for the taking. Those who had not found autonomy in their positions had not taken advantage of the opportunities offered.

On the whole nurse managers did not feel valued by other nursing staff for the management work they did. Many comments came through in the dialogue which reflected the nursing staff's attitudes about their work. For instance, Pat said:

> I think they saw me as somebody that sat in the office sometimes, somebody that wore nice clothes, that talked a lot, but didn't actually do any clinical work. A nurse that wasn't a nurse (Pat,1:8).

The commonly held picture of a nurse is of one who is at the bedside doing 'hands on' clinical work (Avery, 1981; Aber & Hawkins,1992). This picture has an historical origin which persists today. Pat felt that she did not meet this image expectation. Instead she felt that even her own colleagues undervalued the management work she did because she was not doing the work of a nurse and did not look like a nurse. Yet because of 'nurse' in her title she was supposed to be a nurse.

The value that nursing staff placed on management was also made apparent in the lack of interest nurses showed in taking on such a position sometime in their future. Many of the nurse managers cited examples where nurses had told them that the nurse manager position held no interest for them.

> The interesting thing is that they say that they wouldn't have my job for the world. Five or six years ago every senior staff nurse wanted to be a ward sister or charge nurse but they are not queuing up at the door for the job now (Jan,1:11).

> I was asking her why she came to work and things like that- and I said where to from here for you and she said well if the charge nurse role was around I'd be interested in looking at something like that but I don't want to touch the job that you've got. I don't want that sort of job (Eliza,3:2).

While nurse managers like Jan encouraged other nurses to undertake management studies (refer p.79) as preparation for their future, nurses themselves appeared to place little value on the nurse manager position. Because of the artificial boundaries imposed on this study this anomaly was not explored further but it is likely to be related to the image nurses themselves hold of a nurse being at the bedside.

While management might be valued by nurse managers and other senior managers it would appear that nurses placed little value on this aspect of the nurse manager work.

Frustrations as a manager

While all of the nurse managers realized the importance of their management responsibilities and most of them felt valued because of the increased autonomy and responsibility given them, a number also expressed some frustration about various aspects of their management work.

These frustrations were not so evident in the earlier interviews when the nurse managers had not had the opportunity to reflect on their position and responsibilities. But as the participants developed a critical consciousness through the opportunities for critical dialogue and reflection that this study provided, they began to see the limitations of their position and felt able to express their frustrations. As Bridget said

> ...we've got the title of manager but I don't believe they think we are managers. They keep saying that but they don't treat us like that (Bridget,3:10).

One of the most common frustrations for the nurse managers concerned staffing numbers. While they felt they had been given the budget to manage the nursing staff for their area often they were not the final decision makers. For

example, Pat discussed one situation that had caused her particular annoyance.

> ...I just got a note yesterday what my establishment was for the next year and they have not given me that 0.2 and I just said to [the nursing advisor] and she said `Oh no, yours was one of the ones that was dropped'. No explanation, nothing. Now that is really annoying, frustrating and everything else ..... Apparently I was over budget but why take money off me when I had established the fact that I needed it- but it was just dropped. The worst fact was that I wasn't given any explanation (Pat,2:13).

This example illustrates that while Pat believed she was given the budget to manage her area, in the end the decision was taken from her. Being one of the nurse managers who valued the autonomy she believed that the nurse manager position offered, Pat was particularly frustrated when her perceived rights as a manager were removed from her. Furthermore, she appeared to accept that she was powerless to demand an explanation or to change the decision made because no action to overturn the decision was planned. As a member of an oppressed group Pat yielded to the power and authority of higher management. Nevertheless, despite these and other frustrations Pat and the other nurse managers continued to place value on their management functions.

The value of a nurse manager

During the time interviews were taking place the nurse managers negotiated their contracts with their employer. A financial value was being placed on their individual worth for the first time.

These nurse managers generally felt that they were worth more but because they were perceived to be primarily nurses their management worth was not being recognised.

> Its frustrating- I just don't think that they will listen to us. The majority of us have got a strong case. You know we are doing a lot more than most other nurses in NZ. We did our own budgets this year, the business plan...(Bridget,1:5).

Pat, as a result of a conversation she had with the general manager, thought that he saw nurse managers as nurses that happen to be managers, not as managers that might happen to be nurses. This attitude, she believed, undervalued the worth of nurse managers to the organisation. In fact, Pat's words also reflect the lower value she places on nurses

> ...but he did see us basically as nurses who were into management. I don't think we can get that role changed in his mind and that to me is the worrying point about our contracts. Because if they saw us as managers, then they would perhaps be able to listen to us on a different level. They are not listening to us on the level of management. They are listening to us on the level of nursing (Pat,1:13).

Putting value on management rather than clinical also came out in initial discussions about where the clinical nurse specialist would fit in the reward structure. There was a strong feeling among some of the nurse managers that the nurse manager should be paid more than the nurse specialist. Eliza (3:5), for example, saw that the nurse manager should be paid more because they were the clinicians' controlling officer. Nursing experience and nursing qualifications appeared irrelevant to this decision.

Summary of valuing management

From a position which was primarily clinical to a position where management responsibilities assumed greatly increased importance the charge nurse to nurse manager

transition evoked mixed reactions amongst the participants and nursing colleagues. These reactions were closely associated with the common image of a nurse held by nurses and others, and organisational and wider societal valuing of management work.

Pervading 'valuing management' are numerous examples of nurse managers as an oppressed group and of nursing as an oppressed profession. Taking on the values of the dominant group the nurse managers were initially proud, even defensive, of the management responsibilities they had been given. Accepting the ideology of management dominance nursing concerns were given secondary importance by themselves and by the organisation. Nursing was even seen to be one of the reasons why nurse managers did not perform as 'real' managers.

Even when nurse managers were frustrated and angry they accepted this dominant ideology and by their inaction to overcome the constraints imposed upon them demonstrated their powerlessness.

CHAPTER SEVEN

"LETTING GO OF THE CLINICAL"

Alongside valuing management was "letting go of the clinical" - a phrase used by one of the participants. Whether nurse managers saw their work as predominately management, predominately as clinical, or as a combination a certain amount of "letting go of the clinical" had occurred.

Primary nursing, wearing a uniform, the attitude of other staff and the image of a nurse were some of the central concepts discussed within this theme.

Considered alongside 'valuing management', "letting go of the clinical" prompted questions from the participants and myself about the future of nursing professional and clinical leadership. For many it was a dichotomy they had pondered at some length both personally and within the nurse manager group.

A lot of critical reflection and dialogue occurred around this central theme throughout the individual and the group interviews.

"Letting go of the clinical"

For all of the participants involved in this study taking on the nurse manager position involved "letting go" of some or all of the clinical nursing responsibilities that they had previously assumed either within their work as a charge nurse or in their work as a staff nurse in the same or a similar area. These responsibilities included such clinical tasks as taking a patient workload, accepting medical instructions for patient treatment, accompanying

medical staff on patient 'rounds' and dealing with relatives.

This change meant different things for the individual participants. For some the change had been a conscious decision made easier by the desire to enter a management position. For most the change had been a gradual transition not yet fully achieved because of a number of factors pertinent to each participant.

"Letting go" of the clinical was identifiable within all the dialogues with the nurse manager participants, often with them using the actual words "letting go". But for each it took a different path and had different meanings reflecting both the work variety in the diverse areas where the participants worked and the different stages each was at in relation to accepting the management responsibilities their work involved.

"Letting go of the clinical" occurring within nursing first line managers when they have assumed more management responsibility has also been widely identified within the nursing literature (Zander, 1977; Powers, 1984; Taylor & Kramer, 1985).

This chapter will discuss what meaning "letting go of the clinical" had for the participants involved in this study.

"Letting go of the clinical" created a lot of uncertainty for many of the nurse manager participants. It was tied up with valuing clinical knowledge and skills, role modeling, rewards and others' attitudes and beliefs about nursing and what a nurse should be. For some it was something they felt they had to do because of the changed structure. For others it was a natural progression into the nurse manager position.

Bridget was one participant who appeared to have quite a

lot of conflict with letting go of the clinical but who felt that it had to be.

> ...Well its a bit difficult. I don't feel very good about it but think it is something I have to do (Bridget,2:5).

Within this comment Bridget indicates the powerlessness she feels about her situation. Although she has difficulty with the change and is not happy about it, her perceived position as an employee and as "just a nurse" (1:6) forces her to reluctantly accept it. She does not see her position as being as powerful as that of those who have brought about the change. Not only does Bridget appear to be oppressed by those with more power but the value she places on her own worth prevents her from expressing her concerns. In this way distorted communication (refer p.40) reinforces her acceptance of the change as inevitable.

Bridget's' main concern was that she was no longer as available as a role model for nursing and other staff. Her staff had also expressed this concern

> My staff brought up at that meeting- they said Bridget we think it is such a shame that you are not available in the clinical field- you should be a clinical nurse specialist....Thats where your skills lie. You are our role model and thats where we learn (Bridget,3:5).

While Bridget expressed this as a personal conflict she also stated that given the choice she would accept a clinical nurse specialist position so that she could use her clinical skills (3:5) rather than continue in the nurse manager position. Her clinical background was the most important to her but current circumstances, with a perceived lack of choices, had limited her options and created a dilemma for her. Bridget felt that "letting go of the clinical" was the expectation for nurse managers but it was not something that she or her staff wanted. In

saying this Bridget was unknowingly maintaining the dominant ideology and demonstrating the perceived powerlessness of her position as a nurse manager.

While not always explicitly stated many of the other nurse managers also shared this dilemma.

> Yes. And I do miss the nursing. And I always will...What I really miss, you know when you have those primary patients and you take them through something really important. You make a lifelong friend. I recognise that the staff get that. There are still people that you get rapport with but it is never the rapport of primary nursing. And it is the primary nurse that should get it. I shouldn't (Alison,1:16-17).

Sometimes the nurse manager group itself appeared to add to this dilemma for individual nurse managers.

> ...3 months ago I sort of felt that other nurse managers felt that I should be letting go of some of the clinical. I do feel more comfortable with it now....I think there was a little bit of subtle pressure- perhaps from some of them who felt that it was purely a management role, they'd never ever do any clinical stuff and they felt that some of us that were still doing some clinical stuff were perhaps downgrading the role or something like that...So I do feel that perhaps there was some pressure, not particularly directed at me but I felt it was there (Clare,2:11).

Although most pressure to let go of the clinical came from the demands of the position the above discourse hinted that the nurse manager group also applied subtle pressure to achieve conformity amongst its members and that this pressure added another aspect to the dilemma that many of the nurse managers faced. The perception of those that felt this pressure was that others had no clinical input and that they were letting the group down.

For Eliza and Pat, in particular, the conflict in "letting go of the clinical" was less apparent than that

experienced by Bridget, Clare,Emma, and Jan. Both Eliza and Pat initially appeared to have accepted the ideology that the nurse manager position was a management one and this illusion had shaped their perception to exclude clinical responsibilities. But as the interviews progressed and as they reflected on their work and became involved in more critical dialogue clinical work was acknowledged.

Eliza, although recognising herself as a clinical resource person within her area, said that she had let go of clinical responsibilities before taking on the nurse manager position. This, however, was not always in congruence with other dialogue reflecting that Eliza had taken for granted her belief that the nurse manager position was a management one. For example Eliza described her perception of clinical work as

> doing a dressing, taking a patient load, helping with IV drugs (Eliza,2:15).

While she said that she did not involve herself in these functions Eliza agreed that it was her clinical expertise that was often called upon and that she actually enjoyed this aspect of her work.

> Medical staff use them [skills] as well if they want someone else involved or they will sometimes come and sound off something, what would you do with this or that. Especially with the longer term patients. I quite like being involved with that sort of thing (Eliza,2:15).

Pat was another who said she had no clinical responsibilities in her nurse manager work. However her dialogue described a number of situations where her clinical skills were called upon, for example, assisting with bronchoscopies as described later in this chapter (refer p.94).

Therefore, while "letting go of the clinical" meant different things for the individual participants all described the conflict they had at various times in "letting go". For some like Bridget and Clare the conflict was conscious and painful. For others like Pat and Eliza the conflict was lessened by acceptance of the management ideology and denial of their clinical responsibilities.

Clinical rewards and being valued

For many nurse managers "letting go of the clinical" also meant "letting go" of many of the rewards that they would receive as nurses involved with regular clinical hands on nursing care. As Eliza said

> ...I don't think that the people that initiated nurses into management really thought about what losing the clinical thing would be for some people. It is very traumatic for a lot of people (Eliza, 2:9).

> ...A lot of nurse managers feel cheated of that clinical role and as long as they are feeling like that they will always be envious of those providing the patient care and therefore they will never find other satisfactions and rewards because they are not looking for them. They are looking for that reward you get with 1:1 patient care and I think that is a problem....they feel like they are being cheated and that they have to be the top clinical person, they have to be the one that has it all and they have to be the one with all the experience. And its really important to them that the staff see that and they feel like that because they can see no other rewards for themselves (Eliza, 2:9).

Being the top clinical person was the traditionally held position for the nurse in charge (Taylor & Kramer, 1985). With this position came the power of being the one with the most knowledge. Nursing and medical staff, as well as patients and others, recognised the importance of the person who held this position.

Emma was one who did express that she felt cheated because staff did not always recognise the importance of her work

as the nurse manager.

> ...it was like I felt undervalued that they couldn't recognise, that they couldn't see that what I was doing was also important. They seemed to have tunnel vision, they couldn't see. They see that they do the glorified things but someone has to do the other too (Emma, 2:18).

Although management skills are valued by many both within the health care system and the wider community, as discussed within the previous chapter, within nursing clinical hands on care is more highly valued. In this study this was expressed by many of the nurse managers when talking about nursing staff's attitudes towards their work and is evident when nurses undervalue other nurses not involved in such care, such as educators, researchers and administrators.

Clinical care involves both intrinsic and extrinsic rewards so that when the clinical is let go of, as these nurse managers were experiencing, other rewards must take their place or the nurse manager will be left with feelings of dissatisfaction, regret and confusion (Zander, 1977).

Some of the nurse managers had found rewards in different ways from those they had experienced in the past. Alison described the rewards she experienced as personal rather than external.

> There are not many external rewards in the nurse manager role at all. I don't get a lot of pats on the back from my staff. People don't come to me and say we think you are doing a good job. But that is human nature.(Alison,2:5)...The rewards have to come in the staff developing. Although it is hard to measure them (2:12).

Some, like Jan and Eliza placed most value on the personal rewards and on the importance of valuing the self which they saw as occurring more often as nurse managers than

when a ward sister

> And I think thats something that as nurse managers we probably value ourselves more now than we did when we were ward sisters. I know that I do. I feel far more valuable to the organisation in the role that I am doing now than the role I was doing in '86 because the role I was doing in '86 was virtually what my staff nurse coordinating for the day is doing really....So I feel more valued now. You have to feel valued yourself (Jan,3:6).

> Its a self esteem thing. I think to myself quietly at times, especially if everyone has been busy, when I'm driving home I think I really did a good job today. I really achieved a lot- thanks Eliza. Because no one else will say it (Eliza,2:14).

As with other issues, individual nurse managers were at different stages of recognising their value for themselves, and in having this being recognised by others. The traditional image of what a nurse does, traditional expectations for nurse managers, and traditional expectations of the rewards nurses could receive had helped shape an ideology. To feel valued in a changed organisation nurse managers had to confront this ideology and learn to value themselves and find other, non-traditional rewards in their work.

The image of a nurse

"Letting go of the clinical" was seen by myself as researcher to be linked to the commonly perceived image of a nurse. This image has been widely discussed in the nursing literature (Avery, 1981;Aber & Hawkins,1992) and has been shaped by a long history of nursing being women's work and involving action rather than intellectual activity (Eisenstein,1981).

Many of the participants, such as Eliza below, described

this image as someone who is at the bedside doing the work a nurse is supposed to do and who is wearing the uniform of a nurse.

> ...But you ask someone on the street what a nurse does and they will say a nurse washes patients and showers patients, does dressings and gives injections and things like that...Most peoples' expectations of a nurse that is wearing a uniform- doing those things with the patient at the bedside... (Eliza,3:16).

This perception of what others think a nurse should be, whether or not it is the actual image held by these others, influenced not only how nurse managers viewed their work but how they believed others viewed it also. For example, Betty when talking of how other nurses in her area described what nurse managers did, said

> ...If they are not there then they must be at a management something. Because they are not actually dirtying their hands as such (Betty,2:4).

While this may have been what the nurses did say it is also possible that this was the nurse managers' perception of what others were thinking based on their own expectations of what a nurse does. Regardless, it reflects an attitude to nursing as 'dirty' work and management as 'clean' work but at the same time valuing the hands on clinical work. This attitude once again is based on a historical nursing tradition. Nurses were responsible for cleansing wounds, laying out of the dead, often doing those jobs that others found undesirable. Nursing was 'dirty work', lowly work and women's work.

While some accepted that they did perform clinical work others denied this aspect of their work.

> ...I'm not doing any nursing-I'm not doing any clinical work at all. As a matter of fact there is only one time when I may. I can do bronchoscopies- there is only 2 other staff- I might put on a uniform

> or a gown and go up and do them. One of the clerical staff said to me one day 'oh you are actually working today'....It feels to me like a real put down. So I don't put on a uniform- I now just put a gown on. I'm not going to be seen putting on a uniform to go up there and do a job. They will see me arrive up there as the manager and I'll just put on a gown over the top (Pat,2:16).

While denying that she performed clinical work Pat was simultaneously acknowledging that she still works as a clinical nurse. But at the same time she wanted to deny the nurse in her doing this- really she wanted to be seen as a manager with a special skill. In a later interview this was explored further

> ...If they see me as a nurse it negates my position as manager of the department because I have had problems with them not understanding my role and I have told them I am not a clinical person. I am not a clinical manager...So therefore if they saw me in uniform they would think well what have we got. Have we got someone who says she's not clinical but yet she's going away and doing a clinical role...So it is that conflict there. So I decided they wouldn't actually see me go up there in uniform. I would just put on a gown when I was up there and even just putting on a gown would state that I am actually a manager but I will put on a gown and I will help you out but I don't really want to do it (Pat,3:1-2).

For Pat not being seen in a uniform was perceived as being very important in being seen and accepted as the manager. The uniform was too closely associated with being a nurse.

The uniform and letting go of the clinical

Only two of the nurse managers who took part in this study wore a nurses' uniform in the course of their daily work. This uniform consisted of a white uniform with epaulettes denoting status on the shoulder. The decision not to wear a uniform was frequently discussed as having an important place in the transition to a nurse manager position and in "letting go of the clinical".

Jan was one nurse manager who had quite strong feelings about what the wearing of a uniform did for nurses and for nurse managers. She had made the choice not to wear a uniform soon after assuming the nurse manager position.

> ...The uniform makes you anonymous. People only see the uniform. And people relate uniforms with being a nurse. I remember when we tried to get caps removed years ago you were told you couldn't be a nurse without a cap. You are told that you can't be a nurse without a uniform. I think the uniform makes you anonymous. All of a sudden medical staff stopped seeing me as a nurse in a white uniform and had to look at me as they look at any other person in management. Nurses rely on their uniforms as much as patients (Jan,2:14).

The image of a nurse as one who performed bedside care in a uniform had to be discarded if the management side of the nurse manager work was to be taken seriously by others, particularly medical staff. Being seen as a nurse involved certain expectations which the nurse managers were trying to shed in their effort to gain acceptance and recognition as managers.

There were also other reasons why a choice not to wear a uniform was made. Jan, for example,felt that not wearing a uniform was less threatening for patients

> ...That's a power thing isn't it- you do as I tell you. So I think probably- hmm I hadn't thought of that- that's probably why the patients are very comfortable with me not in a uniform (Jan,2:15).

The opportunities this study provided gave Jan the chance to reflect on her reasons for not wearing a uniform. During this reflective process she was able to make a new discovery about the relationship of wearing a uniform to her interactions with patients.

Eliza talked of the power associated with the wearing of a uniform.

> ...It gives nurses a power that they shouldn't necessarily have as human beings. It gives them the ability to walk into a situation and be able to do things and say things without sometimes thinking (Eliza,2:20).

However Eliza also referred to the power of not wearing a uniform, one of the reasons why she had chosen not to wear one

> I really wish to be taken seriously as a manager. I always attempt to dress professionally and I power dress if it suits me and I wish to do something that I want to impress for...(Eliza,1:6).

For Alison taking off her uniform was not easy. For her it was a security and a means of others identifying her as a nurse.

> ...I was helping someone the other day, putting a patient on a commode and it was right on lunch time. As I started to do it the nurse aide walked in and the patient said "there is a nurse". The nurse aide was much more of a nurse than I was (Alison,2:4).

"Letting go of the clinical" meant "letting go" of the nurse and with that peeling away some of that which identified the nurse. The image of a nurse as one in a uniform is a stereotype portrayed by the media and accepted by the public and by nurses (Szasz, 1981; Aber & Hawkins, 1992). It is a perception which assists in the creation of the self image a nurse holds. When nurse managers discarded their uniform it involved a loss of recognition of the nurse within the nurse manager which created some mixed feelings within individual participants.

Betty, who usually wore a uniform unless she was going to do management things such as going to meetings, described what she thought wearing a uniform did

> ...I think the nurse managers felt that civvies put them on a more equal level with other people, the uniform puts them down to being a nurse (Betty,2:15).

Reflecting on the later part of this comment in a subsequent interview Betty talked about medical staff wanting to keep control and if nurse managers are "just a nurse" by wearing a nursing uniform then keeping this control is much easier for them.

Clare was one of the two exceptions within the group of participants. She still wore a uniform, usually even to meetings and thought this was probably due to the area in which she worked and the need to continue to assume quite a clinical component in her work. But there were other reasons also

> ...I see that it is appropriate that I wear a uniform. And I am more comfortable with my staff when I am in a uniform (Clare,2:6).

Clare's comfort was probably also associated with the image she held of what a nurse did and wore. Reluctant to "let go" of her clinical work she was also hesitant to discard the uniform she perceived gave her permission to be a nurse.

The wearing of uniform for all of the nurse managers was closely associated with the perceived image of a nurse. Some chose to discard the image so that they could "let go" of the clinical more easily and be seen as managers. For others the choice was made to wear civvies but this sometimes created a conflict, especially when there was an expectation from others that they should be seen as a nurse. For Clare there was no conflict. Wearing a uniform was important for her in recognition of her large clinical input.

'Nurse' in the nurse manager title

In all the interviews, and by all the participants, there was a lot of discussion about dropping 'nurse' from the nurse manager title. Some of this discussion was prompted by myself when it became apparent that there was considerable variety of opinion amongst the participants as to whether this should happen and that this opinion was an important aspect of "letting go of the clinical".

When changes were made to the Area Health Board structure that resulted in the change to having nurse managers there was, as Jan discusses, some debate about taking nurse from the title. As a group the nurse managers fought to have it retained.

> ...When the role first started and they tried to take nurse out of the title we all said no we wanted the word nurse in it because we felt that if they took the word nurse out then it left it open straight away for a non nursing role. So we fought for that (Jan,3:10).

At that time it was very important for the group that 'nurse' be retained. However through dialogue with participants during this study it appeared that there was no longer common agreement and that the change in opinion held by some was aligned with "letting go of the clinical" and their view as to whether the manager position needs to be filled by a nurse. But there was a lot of uncertainty around this issue and with reflection on previous discussions many of the participants questioned their earlier stance.

Retaining nurse in the title was closely bound up with the debate as to whether any manager could do the work of a nurse manager. If the position was taken that a manager is a manager and a nurse manager is primarily a manager then dropping nurse from the title appeared to be a natural progression. However, even those that adopted this position were less certain about dropping the title when

challenged about the impact this would have on both the clinical and the management leadership in the area.

Reflection, seeing words written within transcripts, and critical dialogue about this issue revealed uncertainty and concern not always apparent in the initial discussion around this theme.

Pat was one participant who was strongly in favour of dropping nurse from the title in the first interview.

> ...I mean I hate to say it because I think probably nursing experience is valuable, but basically in the job as it is I don't think there needs to be a nurse (Pat,1:6)...Its probably a double image. People see you in civvies yet they see nurse there so they are a bit confused as to what the role is perhaps (Pat, 2:15)... I think that the word nurse has clouded the issue in lots of instances (Pat,1:14).

However, in the second interview, after some thought, she had changed her position to seeing that the position required someone who had come up through the hospital system. When challenged about this, because she had clearly stated that a manager is a manager, Pat said

> ...Yes I have said that. But I'm reflecting on it. I think that to get quality management you don't need someone that's a nurse but you probably need someone who has come through the system or else that person would take quite a while to settle in and would take some time to find out the system (Pat,2:10).

On further reflection Pat took yet another position recognising that what a non nurse manager or non health care system manager didn't know they could find out from other resource people. Pat came to the point of thinking that neither a nursing nor a health care background were important for managing a clinical area.

A similar process of reflection occurred for some of the

other participants who had obviously thought a lot about this issue both individually and as a group. Alison, although she described herself as being a manager before being a nurse manager(1:6), was one who wanted to see the nurse in the title retained. She placed value on what a clinical nursing background offered to the nurse manager position while at the same time arguing that

> ...95% [of care] is given by nurses therefore it should be managed by nurses. Run by nurses (Alison,2:14).

Clare, the participant who retained a large clinical input, fiercely defended retaining nurse in the title as for her it was not possible to separate the clinical and management aspects of the nurse manager work.

> ...I think there is something about having a nurse in that position. Aside from having to do actual clinical hands on I think you need an understanding of the clinical role of the nurses (Clare,2:12).

For, as Betty said in her second interview, "no-one understands another nurse like a nurse" (Betty,2:16). Emma took a similar position on the importance of understanding from a nursing perspective

> ...I still think that yes it does need to be a nurse. I believe that the service that we are providing, that you need to have the broad perspective that you can't get unless you have been there. Or some understanding of....(Emma,3:15).

This was saying that the management decisions made were influenced by the clinical knowledge held. As Jan said

> ...Coming back to what I said last time about patient safety and priorities, if I didn't have a clinical background and I wasn't looking at it from that perspective I may make different decisions by just looking at the balance sheet. I could make a different decision than I would looking at patient safety (Jan,3:8).

However by the third interview Betty, while looking at other positions around the hospital, had done some reflecting on this. Using the manager of laboratory services as an example Betty said

> ...And you had to have had 5 years I think in the health service and you had to be able to be competent in decision making, communication skills, budgeting, writing reports, staff management and control. It doesn't say a lot in there about laboratories does it? (Betty,3:7).

From this example there came for Betty the realization that to manage a nursing area you probably don't need a nurse.

"Letting go of the clinical" and dropping nurse from the nurse manager title required an acceptance that the nurse manager position was primarily a management position and with that acceptance of the dominant ideology. The participants were at various stages of working through the implications of this for both themselves personally and for the service offered.

Primary nursing

Some years previously primary nursing (refer p.5) had been implemented in all wards within the particular hospital. The dialogue with nurse managers confirmed that primary nursing had played a major part in assisting the nurse managers to "let go" of some or all of their clinical work. As Jan describes

> ...They [primary nursing and the transition to the nurse manager role] sort of ran along together...we couldn't give up a lot of our responsibility unless there was other people to take them on and primary nursing was our vehicle for them to take on those things ...(Jan,2:6).

Before primary nursing Jan describes how she would not have been able to leave the ward for long periods of time - her clinical input was required as she accepted responsibility for the clinical care in the ward. Primary nursing, which involves a change to individual nurses accepting that responsibility for patients in their care, meant that nurse managers could "let go" of that clinical responsibility and fulfill other responsibilities of their position. But it also meant that no longer was the nurse manager the centre of what was going on in the ward.

> It has taken me a couple of years to give up everything. No. I found it very hard. Before that I was the be all and end all. Like I talked to the relatives and I talked to the doctors and it went on and on and on. And all of a sudden 90% of that was being done by somebody else (Jan,2:5).

Eliza saw this change as being very empowering of the nursing staff. She saw that the primary nurse should be involved in all aspects of the patients care and actively works to ensure this happens, as the following example describes.

> Recently we had a wee guy who was terminally ill and his parents were coming in for a chat - a really intense session with the paediatrician who asked me if I would be involved and I said I would be happy to be but that I really thought the primary nurse should be the one who was involved. He did a bit of a double take and said but she is not on duty. I said no but she is at home on the other end of the phone. In fact she did come in...they are the ones who are involved and who are responsible- I am ultimately I guess- but I am not involved in the day to day bits and pieces (Eliza,2:15).

This example illustrates acceptance of "letting go of the clinical", recognising that the clinical nurses are the experts in the daily care and that to allow them this responsibility is empowering of them and allows the nurse manager to fulfill other responsibilities of the position

to which she was appointed.

Not all the nurse managers had accepted this although primary nursing was also the model used in their area. Bridget, for example, acknowledged that she had difficulty letting go of the clinical supervision of the nurses in her area. Reflecting on the previous interview she said

> ...and I looked at my role, at the role of the nurse manager as we were taught and I thought I'm not doing that. I'm a half pie. I'm not a manager and I'm not a nurse. I'm trying to fix things all the time running around...I'm filling in all the time because the other nurses are busy. And then I'm pushed back into the managers role...(Bridget,2:1).

Bridget realized that she was not meeting the expectations of higher management. But at the same time she had become aware that she was neither a nurse nor a manager, as perceived by herself and others. This realization, an example of emancipatory knowledge, was made possible because of the opportunity for dialogue and reflection on her position and her work.

Efforts by Bridget to use the nursing staff as primary nurses were met by a lot of resistance from the medical staff

> ...the nurses are getting a lot of flack. In fact the other day one of the consultants came over and I went in with him and I said that I would get the primary nurse and he said `Oh yes, the primary nurse, the primary nurse- that is what's the trouble. Nobody knows anything but the primary nurse and when the primary nurse is not here no one else knows', insinuating that the whole place has gone to the pack (Bridget,1:9).

The responsibilities described by Bridget were like the supervisory work more commonly associated with the charge nurse/ward sister position. Bridget continued to maintain a vigilance over the care provided by other nurses in the

area and to speak for the nursing staff in communication with the medical staff. It created clinical and management difficulties for Bridget and was less empowering of the nursing staff. In the course of group discussion she realised that the nursing staff continued to rely heavily on her to negotiate patient care with the medical staff and to attend to day to day clinical concerns within her area. Also the medical staff's expectations of her were not being met as she described them as not being sure of what she was supposed to be (3:1).

But Bridget was at one stage in a process of "letting go of the clinical". This process was not easy for her or for the other staff with whom she had regular contact. The other nurse managers described similar difficulties in implementing primary nursing and in their position transition but most had reached a point where the benefits could be counted both personally and in terms of their work responsibilities. For Bridget this was yet to come.

Summary

"Letting go of the clinical" involved acceptance of the dominant ideology of the nature of management. However, in accepting this position other ideologies had to be abandoned, such as the wearing of a nurses' uniform. In examining their beliefs and perceptions through the process of critical reflection and dialogue nurse managers demonstrated they were at various stages of "letting go of the clinical" but that they had not abandoned clinical work and responsibilities altogether.

CHAPTER EIGHT

A CHANGING NURSING STRUCTURE

Introduction

Within the past few years not only had the nurse manager positions changed, as already discussed, but numerous other changes in the nursing structure within the Area Health Board had occurred.

All of these changes impacted to a varying extent on the work and world of the nurse manager. How these changes were perceived by the nurse managers was closely related to their perceptions of the past, present and future.

The changes that had occurred

Associated with the changes in the nurse manager position were other changes to the nursing structure within the Area Health Board.

The Chief Nurse position had disappeared leaving the senior nursing position for the Board, and for the hospital, being filled by a nurse whose primary responsibility was as a senior manager. Nursing supervisor positions, which were middle management positions, had largely disappeared with the out of hours supervisory positions being filled by coordinators/circulators for the nursing service. The nursing inservice education department had been replaced by the staff development unit which had responsibility for all Area Health Board staff rather than just for nurses.

These changes also impacted on nurses at the bedside who, because of a Board wide decision, now practised nursing under a primary nursing model. As already discussed (refer

p.101) this change for nurses also meant change for nurse managers.

While on the surface it would appear that structures had been replaced there was no doubt that the nurse managers felt that the changes held enormous implications for nurses and nursing.

The previous structure

Nurse managers had many comments to make about the previous structure. Reflection on what this structure had meant for the nurse managers, and ideas about what being without it would mean were explored so that the participants could proceed towards further understanding of their current situation.

The charge nurse/ward sister position was largely perceived by participants to be a powerless position, closely associated with the matriarchical ideology and the image of a nurse as a handmaiden. Whereas they were 'in control' of ward and patient information, were the 'expert' nursing clinical resource for an area and were often held in awe by patients, nurses and medical staff they held no legitimate power by current standards, as Eliza below discusses.

> I mean trotting around after the staff like a handmaiden, having no financial control, not hiring and firing, that sort of thing. Really purely a clinical resource, supervisor type of role (Eliza,1:3).

> It was a very interesting position...it was quite a warped power and in a sense it was - there was no legitimate power in the charge nurse position, they were given no resources to do what they had to do...(Eliza,2:5-6).

In this last excerpt, Eliza equates power with being given resources to manage. The resources charge nurses/ward

sisters were given to manage were patients, other nurses, doctors, linen and clinical skills. Eliza puts more value on other resources, for example, financial. Her judgment of the charge nurse position is from her current nurse manager framework reflecting acceptance of the management ideology.

Alison gave a somewhat different perspective from Eliza's when she commented on the relationship of the ward sister with other nursing staff.

> ...They took the blame for everything. But that is also very demeaning for nurses, that you should take the blame for them, you are not crediting them with any intelligence. You are saying you do the work and I'll take the blame. It is a really demeaning attitude (Alison,2:9).

While it was seen that they took the blame for everything it was also seen that the charge nurse maintained power by keeping information and knowledge to herself, a hegemonic relationship whereby her superiority was able to be maintained by holding this knowledge and information.

> I visualize power with someone up the top and they are not giving anything out- they're not allowing. Like the charge nurse in the old system- they kept it there. Everyone came to them (Emma,2:16).

Both Pat and Eliza associated much of the way the ward sister/charge nurse functioned as matriarchal and felt this was outdated within modern nursing.

> ...I don't like the idea of a stern, motherly, matronly figure there at the helm (Pat,2:8).

Bridget, however, appeared to feel that there was still a need for that figure, not only for the nursing staff but for other hospital staff as well.

> ...This is what's happening. The Doctors- they are lost. [A Doctor]

> said that "all my training there has always been a sister there. A sister to fix it, she knows everything". And they find that really difficult...If you wanted anything done you went to the charge nurse. She would make sure it gets done. They are missing out on that role too. They are feeling the loss. They like the system that she is always there (Bridget,3:6).

Medical staff required, it would seem, a motherly figure who would always be there. Resembling the patriarchal family this is part of an ideology built on a sexual division of labour where nurses emulate the good woman, wife and mother (Gamarnikow, 1978) and where a responsibility of the woman is to be there to serve the family, in particular the males.

There was a perception that the old structure offered a protection for nurses. As Pat said nurses

> were told exactly what to do, when to do it and how... you know that person is going to pick up the pieces for you (Pat,2:11).

Coming through, once again, is the motherly image of the charge nurse/ward sister. Eliza, however, referred to the previous structure as a series of 'theys'.

> It has always been so much easier to blame someone else when you have a 'they' somewhere above you that you can blame. It is human nature to blame someone else. But I think that the thing is that the staff can now see their nurse managers can actually achieve things that the 'theys' often couldn't achieve (Eliza,2:19).

It was thought that the language that was used and understood by nurses helped this to happen. That there was always someone higher up who would understand from a nursing perspective. Like a mother the 'theys' would interpret so that others could understand.

For most of the nurse managers the past structure was not

desirable from the nurses' or the organisational perspective, nor from the perspective of the charge nurse/ward sister. Reinforcing patriarchal ideology it did little to enhance a professional image of nursing.

The present

The structure of the present brought different concerns from those associated with the past. But with these concerns was also pride about the responsibility they had been given and the differences they were making. Changes to the hierarchical structure brought many changes for the nurse managers, and for other nurses. While some of these changes were welcomed there were also some concerns.

> When you were in nursing you reported to nurses, and those nurses reported to nurses. So you had this narrow communication. Now we're communicating across. We've flattened that management somehow and we're actually now reporting to other services in the hospital and they are going to find out what we're all about and we'll find out what they're about. I don't think that's a bad thing (Pat 1:9).

But out of the changes arose one of the main concerns - the lack of clinical support.

> ...its the clinical support that's missing. Even the staff development unit, the nursing input has been cranked right down and so we have lost that nursing input there. And you've lost everything higher up. There is a real crater (Alison,1:14).

> There is nobody in this hospital that can give my nurses or myself support (Bridget,1:4).

There were also concerns expressed about the loss of professional support - not just within the hospital but within the profession nationally. With changes to the overall structure of health care in New Zealand came concern that professional links would no longer be so

accessible.

> ...unfortunately that is because the role is changing in a different way and at a different rate in different health boards...Everybody is working at different levels and everybody has different responsibilities and we all see our roles differently throughout the country. This worries me a bit. As much as I see each health board needs to be autonomous I would like to see more similarity between nurse manager roles throughout the country so people knew where they were at (Jan,1:15).

These examples from the dialogue demonstrate that among the nurse mangers there were some angry feelings about the nursing structure put in place. Particularly strong were the feelings about the loss of the Chief Nursing Officer and the loss of a full-time Board nursing advisory position. The following group dialogue indicates the strength of those feelings..

> ...You look at someone else who is the manager of [a service] who is a nurse who really is no more a nurse than fly to the moon but she is actually our spokesperson. And I'm sure that she is not quietly picking up clinical skills in the middle of the night somewhere. They have all gone...I know that she is still a nurse and that she has taken that with her but she is miles away from nursing (Eliza,G1:17).

> She wouldn't be a nursing consultant if she hadn't been a nurse. I think I agree with what has come through. It worries me that [she] is the nurse consultant because I don't think she sees that as her primary role. Her primary role is manager- being the nurse consultant is not her primary role and I think that we need somebody there (Jan,G1:17).

> She doesn't say that though- she says she is a nurse (Bridget,G1:17).

> I think that what [she] says is immaterial, it's what we think and I think we need someone who sees themselves as a nurse speaking as a nurse consultant to the GM (Jan G1:17).

> I don't see that as her primary role. That person should come up through the ranks of the nurse specialists (Pat,G1:17).
>
> ... stated that there was not going to be a specific position of the nurse advisor. We lost the battle there (Alison,G1:17).
>
> But there should be (Pat,G1:17).
>
> But we all put submissions in and... (Alison,G1:18)
>
> We lost that battle, that position was lost because somebody who was the Chief Nursing Officer of the Area Health Board didn't think it was important enough to fight for a few years ago and thats why nurses lost that position for nurses. Nobody took that, management didn't take that position away. Nurses lost that position for nurses (Jan,G1:18).

Although very supportive of the current advisor there are strong feelings that she cannot do justice to the importance of the advisory position while she has another primary responsibility. The nurse managers all think that nursing deserves a full time voice and are angry because their perception is that nurses took that from nurses. The acceptance of responsibility as nurses that the Chief Nurse position was lost, rather than thinking that it could have been an organisational decision outside of nursing's influence, is another example of the oppressive nature of nursing's position.

The group felt that they had lost their nursing leader, their spokesperson and their nursing support

> And a protection that if it's not a nurse up there then you're it. Despite wanting autonomy and all that that I think nurse managers want someone somewhere who will carry the can for them and stand up for them (Betty,2:16).
>
> And if you get to a position where [the nursing advisor] is. Yes, she is

> a nurse deep down to the core but she is so far away from it now ...she is so far away from it now that she relies on other people (Eliza,3:15).

And with this concern came a concern about professional standards.

> One of the things that came out at our meetings before we moved over to service management was that we were worried about the professionalism of nursing and nursing standards because we felt as though we were being split up and there was nobody there. And I think that is an area. If we felt that nursing standards were slipping or something- I just can't think of an example- but I just know that if we felt that the nursing profession as a whole was suffering because of this transition to service management...and I can see that if service managers start to undervalue nursing we would be looking at it as a group (Jan 3:5).

Because of the gaps in the structure and the expressed feelings of being all that is there the nurse managers had formed a support group which met regularly. Clare, speaking of this group said

> I think it has developed that cohesiveness over the last couple of years. We do stick together...There's no one [else]. When the structure changed again just recently that was one of my concerns. Where do you go to? That responsibility- it's all mine now (Clare,2:3).

However for Clare the togetherness this group provided sometimes created a pressure to conform. For her this occurred when she felt that the group wanted her to be more of a manager and less of a clinical nurse in her area (2:11).

As with any group, norms had developed that dictated the individual behaviour of group members. This was demonstrated in the following dialogue with Eliza

> We had a nurse managers' peer support meeting at lunch time today and this new person was actually there. It was really interesting...I was watching and you could just feel the vibes of a lot of people saying OK what is this young lady going to come up with. She's been brought in to be a trouble shooter and lets just stand back and watch her to see if she can produce the goods sort of thing. It was really interesting. I thought, Oh darling if you only knew that everyone is really sizing you up. Probably a lot of envy that she was chosen and brought in from outside and she is fairly young...You need to shape up or you would be in a lot of strife I would imagine (Eliza,2:17).

Nurse managers themselves had an expectation of the characteristics of a nurse manager and of how a nurse manager should perform. Any challenge to this expectation would be a challenge to their ideology and to their own performance.

But another conversation with Eliza indicated that the group was perhaps not as cohesive as they would like others to think.

> ...and it is not easy when the entire team of nurse managers does not feel the same, does not present themselves in a professional manner, do not behave in a professional manner and do not think the same things about the job. We are all individuals but we all need to believe that the world needs to take us seriously (Eliza,1:6).

Although the group was felt to apply some pressures to individual nurse managers there was no doubt that the participants saw the group as a positive, uniting influence in the changing structure.

Clinical nurse specialist and advisory positions

Planned but not yet in place were clinical nurse specialist positions and while the study was proceeding service nurse advisors were appointed. Both of these positions invoked further comment from the nurse managers.

The nurse managers did not appear sure where the clinical nurse specialists would fit into the structure. Pat, for example, saw that this person would be the go-between between the clinical and the management, a liaison person (3:2). She also saw that clinical nurse specialists would be the next step up from the staff nurse in the professional excellence programme (3:16).

Emma expected that the clinical nurse specialist position would take the clinical load from the nurse managers and leave them free to get on with their management responsibilities (3:12).

> If they take the clinical off us and our work load as nurse managers is such that your clinical as your focus comes off then we have to replace that with something and that's where I think that the clinical educator or the clinical nurse specialist has to come in. They can't take that clinical off the nurse managers and not give the staff back something. And that's where I think the clinical nurse specialists are making that representation. You have to have it. You can't ignore- can't take that clinical focus off until we have got a replacement...(Emma,3:12).

Overall the introduction of clinical nurse specialists was looked upon as a positive effect of the changed structure by all the nurse managers. However their understanding of just how the position would evolve and fit in with their own work and the value that this position could offer was unclear to all of them.

For me this indicated a lack of consultation with the nurse managers about this position which was of concern when the nurse managers were the "only ones left" in the nursing structure.

Introduction of the service nursing advisor positions while the study was underway enabled frank discussion about the place of these positions within the structure, particularly as two of the participants had been appointed

as nurse advisors as well as continuing in their nurse manager positions.

Generally nurse managers saw these positions as very necessary to fill the professional void between them and the Board nurse advisor.

However, because the nurse managers who had been appointed to the advisor positions had made it clear that they were managers first and nurses second I challenged them as to why they felt they should accept the nurse advisor position.

Alison seemed less sure of her suitability for the position when viewed in this light.

> You get to the point where you are directed whatever happens really. You go from being strictly nursing to being totally non nursing and we've accepted that reasonably well I think, so we probably just view this as the same sort of thing (Alison,3:3).

Alison indicates her feelings of powerlessness within the changing structure. Somewhat reluctantly she has accepted the changes that have occurred and appears to accept the advisor position as just another one of such imposed changes.

Eliza's reasons for accepting the position of nursing advisor were particularly interesting. One of the strongest of the nurse manager group for her management responsibilities, declaring that neither a clinical nor a clinical nurse specialist position interested her at all (3:11-12), she accepted this position to have a look around with a view to the future, all the time believing strongly in her own ability to do the job well.

> [The nurse advisor] actually explained it to me as an interesting way of getting to look at things from a broader perspective - have a better

> look around and I said well I'm not actually sure where I am heading but I'm not going to be where I am forever and she said that this would help me have a little look around (Eliza,3:13).

Staff development

Changes in the staff development unit was another modification not particularly acceptable to the nurse managers. Not being run by nurses for nurses any longer the nurse managers felt that there was lack of understanding of the particular problems experienced by nurses in attending ongoing education.

> Because it is not being run by nurses anymore it is hard to explain that you can't just take a nurse out of a ward for an hour and a half for a session without covering that person. They have nurses there but they don't make the decisions....They look at it from a management perspective- they look at it from a different angle when they are used to working with people in offices who can leave their work until they come back. So probably that would be a thing that annoys me- irritates me and one of the things that reinforces that if you are going to make decisions about nurses you have to know where nurses are coming from (Jan,3:16).

Summary

Discussion about the changing nursing structure uncovered a number of concerns about the future of the nursing service in this Area Health Board. While it was agreed that the structure of the past was far from ideal the present structure was seen to exist within a professional void.

With the changing nursing structure the patriarchal ideology of the past was being replaced by a management ideology. A new consciousness was replacing the old and with it new customs, rituals, activities,expectations and norms were being formed. But while some of the past was

happily relinquished there was shared concern about the lack of clinical support and nursing professional leadership indicating that there was some reluctance to accept this new ideology.

For me the changing nursing structure, combined with "letting go of the clinical" and 'valuing management' signaled the end of a professional nursing structure as it has been known for over a century and a half in New Zealand.

From this perspective, along with concerns expressed by the participants about all 3 themes, the central issue of this study appeared to be whether the nurse managers fully realized the changes that were occurring and whether or not they felt able to have an impact on their future and the future of the nursing service.

The next chapter will discuss the process involved in assisting the nurse managers to reach an enlightened awareness of their current situation and the process of empowering them to reach out towards a future of their choice.

CHAPTER NINE

FOSTERING NURSING THROUGH MANAGEMENT

Within the last three chapters on the themes identified in the individual interviews it is possible to see the diversity of opinion on central nurse manager concerns. In the group interviews many of these themes were brought together within a critical dialogue to centre on the main theme of this study - fostering nursing through management.

The necessity for nurse managers

In the individual interviews nurse manager participants held a variety of opinions on whether or not the manager of a ward area needed to be a nurse (refer p. 98). But in the group interviews a different perspective was reached with agreement that to be a nurse was beneficial, if not essential, for the work required. This perspective was similar to that discussed in some of the literature reviewed in Chapter Two where it was found to be beneficial to combine the clinical and management responsibilities of the nurse manager position (De Witt, 1987; Cameron-Hill, 1987; Pickering & Fox, 1989; Lewis, 1990).

For nurse managers such as Alison, Jan, Bridget and Emma their position on this issue remained largely unchanged throughout all the interviews. For Pat and Eliza reflective dialogue appeared to assist them to reach a new understanding of the importance of a nursing background.

While there appeared to be a shared understanding that the nurse manager position did require a nurse, all

participants were concerned that there were gaps in the provision of clinical and professional leadership and that they were not keeping up to date with current clinical and professional knowledge.

Keeping up to date

In the earlier interviews participants felt they were keeping up to date with clinical and professional nursing issues. However, the opportunity for reflection, assisted by challenges from myself as to how they were keeping up to date brought a different understanding for the nurse managers.

> [Pat] In the letter Lyneta has put educational programmes, increase your management knowledge and competency and I think it is really important that we should all do this but she has also said that I haven't heard of many of you recently participating in nursing educational programmes. Well that would be right.
>
> [Alison] Scary isn't it.
>
> [Pat] Because I see myself as management I am already doing enough without taking on nursing. I can't take on both (G1:12).

From thinking that they were up to date some of the nurse managers, such as Pat and Alison above, and Jan below came to a realization that there were gaps in their knowledge.

> Because for me at the moment I haven't got a clue where to start and find out anything...We have to know what is happening in nursing in New Zealand and who is writing what...They [the NZNA] are still working on a clinical level. I am losing my network. Up to this year I had lots of contacts at a clinical level. But we need that networking at a professional level, not a clinical level...That's what we need. I mean, I need to talk to people about professional things (G2:19-20).

It seems unlikely that this realization would have occurred if the nurse managers had not challenged each other, and been challenged by myself about their current knowledge. Because they had believed that the management responsibilities of their position were the most important and they themselves and their employers gave most value to this aspect of their work, the nurse managers had unknowingly neglected the professional aspect of their responsibilities. They were uninformed about many aspects of what was happening within the nursing profession both within New Zealand and internationally. For example, they had no knowledge of recent developments to establish a College of Nursing. It appeared that it was not until I shared some professional issues with the participants that they became aware they were not up to date.

Realisation that they were not keeping up to date with professional knowledge brought with it concerns about the clinical and professional leadership within the hospital.

Gaps in clinical and professional leadership

Gaps in the professional and clinical leadership had been identified by individual participants within the individual interviews (refer p.109). However in those instances the link between this and their own knowledge deficits and the demands placed on them as managers and nurses had not been formed. But within the group interviews a connection was made by the participants.

> ...There is a huge gap, a really big gap and for me thats a concern (Emma,G1:13).
>
> [Bridget] But don't you think we are filling that gap?
>
> [Emma] Well I can't do it in 2 areas.
>
> [Pat] I don't think they can do it in their area if they are trying to do

the whole lot (G1:13).

Whereas previously the nurse managers had tended to think they could provide the leadership, deeper understanding of their own responsibilities as nurse managers and realisation that there was an obvious gap in the provision of this leadership brought them to a further point of questioning what nursing leadership was being provided for nurses in their area. However, as apparent within the following group dialogue, there was some confusion about who were the nursing leaders in the hospital where they worked.

[Me] So who are the nursing leaders here?

[Eliza] You are looking at them.

[Me] So you are the nursing leaders.

[Alison] No. You are the managers of nurses.

{lots of conversation and chatter here}

[Pat] I am not a nursing leader.

[Me] You are not?

[Pat] No, I am not.

[Me] OK. Are the rest of you nursing leaders?

[Alison] No.

[Bridget] Are you talking about our own areas or

[Jan] About nursing in {the Area Health Board}.

[Eliza] All the nursing staff in the hospital look at us

[Pat] I'm not a nursing leader...its what we feel we are that you are asking. They might perceive us as such or they might see us as such but I know that I'm not.

[Jan] Who do we see as the nursing leaders in {the Area Health Board}?

[Alison] I see myself as a leader in nursing in my area. I see myself as a role model and my staff see me as a role model.

[Pat] I am a leader but not a nursing leader.

[Jan] Yeah, in our own areas and a role model.

[Me] OK. And Eliza?

[Eliza] We are all leaders.

[Me] You are all leaders. You see it like that?

[Eliza] Well we lead a group of nurses so we have to be don't we. If we do a good job doing what we are doing then we are leading nurses (G1:21).

This dialogue reflects much of the confusion that the nurse managers were experiencing identifying who were the clinical leaders. It is likely that this confusion stems from the value conflicts that the nurse managers were experiencing, as identified in the literature (Powers, 1984; Hess & Drew, 1990), and their uncertainty about the reforming structure. While they were being encouraged to value the management responsibilities in their position the conflict they experienced in "letting go of the clinical" indicates an uncertainty. Aware that those in power wanted them to be managers they nevertheless resisted abandoning their clinical responsibilities altogether. They were aware but not fully conscious of the importance of their clinical work and the impact this had on nursing staff and nursing.

For me as a co-participant this was of real concern. If the nurse managers were unsure of whether they were the nursing leaders, who in the meantime was providing that leadership for other nursing staff. The nurse managers shared this concern and together we reflected on what it meant for nursing and what, if anything, they could do to ensure that nursing leadership was being provided. Reflection and critical dialogue about responsibilities as nurse managers and on what nursing leadership was needed bought them to a new awareness of their own nursing leadership position.

The need for separate nursing leadership

Early in the group interviews Pat expressed her view that nursing leadership should come from nursing positions.

> But I would sooner the nursing leadership comes through from the nursing when we have these nurse specialists or nurse clinicians or whatever we like to call them (G1:1).

Recognising herself as primarily a manager Pat had no difficulty in casting others into the nursing leadership positions.

Nurse managers like Emma,Alison and Bridget who continued to value their clinical responsibilities took more time and reflection to decide who should be the leaders. But gradually they came to realize that it was unrealistic to be both manager and the clinical/professional leader - that each responsibility required a large commitment.

> [Eliza] It's (for one person to be manager and clinical leader) unrealistic especially if you are working in a busy acute setting- it is completely unrealistic (G1:2).

> [Emma] I agree that nursing is really lacking now. I'm not keeping up my skills but I can still maintain life and I can still do things to help

> the others...I can't do all those things...(G1:10).

> [Pat] We have been left with this awful gap between us and our staff. We have to be good managers because no business can be efficient without that there but we are being told we must be everything to everybody and you can't possibly do that...(G1:11).

Particularly for the nurse managers who continued to place value on their clinical responsibilities this was quite a change from their previous stance. But to me it appeared that the opportunities that the individual and group interviews allowed for reflection on their responsibilities, their work and their achievements helped these nurse managers to critically examine the possibilities for the nurse manager position. In doing so they realized that they were not keeping up to date professionally and clinically and that there were large gaps in the professional and clinical leadership offered in their areas. From a perspective of themselves as the centre for professional, clinical and management leadership they reached a new awareness of other possibilities.

Other nursing positions

The position that the nurse manager group discussed most as filling the clinical and professional leadership gap was that of clinical nurse specialist. This position had been discussed in the individual interviews by all of the participants although as previously discussed (refer p. 114) there was some confusion about the position. While some saw it as a coordinator position, responsible for clinical coordination within an area, others viewed it as having education and role modeling responsibilities. Failure to keep up to date with the nursing literature and lack of consultation about the position from more senior staff appeared to have helped create this confusion.

While there appeared to be acceptance that the clinical nurse specialist position could be used to fill the professional/clinical gap, there remained a concern amongst the nurse managers that clinical nurse specialists for each area would not be resourced. This concern emanated from their association of the clinical nurse specialist position with medical specialities, believing that there would need to be a clinical nurse specialist for orthopaedics, surgery, psychiatry, paediatrics and so on. Rather than seeing the position from a nursing perspective the nurse managers were viewing it from a medical perspective again reflecting their undervaluing of nursing.

> [Pat] And do you see a nurse specialist as being important for orthopaedic and also one for paediatrics...
>
> [Alison] But it's impossible that [x],[y] and [z] [wards] could share one. I think that orthopaedics is pretty relevant to surgery.
>
> [Jan] They would have to start feeling their way towards skills and things like that so that they could educate people on spinal injuries care and
>
> [Alison] Yeah. Maybe a specialist for orthopaedics
>
> [Pat] Then you could say that paediatrics acute is the same because then you have got surgical and medical down there too but it's not, well they have but I mean it is just so totally different (G1:27-28).

Aware that the participants were having trouble understanding how the clinical nurse specialist position could work I shared my perspective of a clinical nurse specialist as a specialist in nursing rather than as a specialist in some defined medical speciality and urged the participants to think in terms of the nursing expertise the clinical nurse specialists could offer rather than thinking in terms of their clinical expertise.

I also sent the participants an article on the clinical nurse specialist position with the transcript of the first interview (Storr, 1988).

Talking about the clinical nurse specialist position appeared to assist the nurse managers to reach a clearer understanding of what the position was, as the following dialogue in the second group interview illustrates.

> [Eliza] But the clinical nurse specialist is not just at the bedside.
>
> [Emma] No. But their role is in, for example, education. It is definitely not finding staff. They can be used to be asked look can we cope with someone less experienced today but I would certainly never put them in the position of having to get on the phone and do the asking [for staff] (G2:3).

Another position to fill the professional void was that of the service nursing advisor. While the nurse manager participants appeared to welcome this position in view of the gaps in their professional knowledge, which they themselves identified, I was apprehensive that this position could provide the professional leadership it had as it's aim.

Appointments to this position had been made from among nurse managers. Nurse managers themselves indicated that they were out of touch with professional issues and that as nurse managers they could not be both clinical/professional leaders and managers (refer p 120). I was therefore concerned whether the nurse managers appointed to the advisor positions would be able to find the time and be knowledgeable enough to provide this professional leadership. This concern was shared with the participants within both the individual and the group interviews and further reflection encouraged.

Eliza and Alison were the two nurse managers amongst the participants who had been appointed to the nurse advisor positions. Eliza appeared to see the position as an honour in recognition of her value to the organisation, and as an opportunity to look around and see what career prospects were available for her in the future. She felt able to perform well in the nursing advisor position as the following dialogue illustrates.

> [Me] It's a nursing position because it's a nursing advisor, but yet you see your role as management. Don't you find that interesting?
>
> [Eliza] Well I think it would provide a good balance because it actually necessitates a lot of work in the coordination with the service manager ...Yeah, I know what you are saying but {the nurse advisor to the GM} feels very strongly about nursing and I don't really know why she has done it...
>
> [Me] I find it fascinating really. There seems to be so much movement to separate the management and the clinical and I think that has come very much from {the advisor to the GM} into making nurse managers into managers. And then this nurse advisor position is very much- its saying I want you to be a manager but I also want you to advise on nursing. So really you have to keep in touch, very much [with nursing]...
>
> [Eliza] Well I don't actually have trouble with it. Do you want to hear the specifications for it?
>
> [Eliza then read the job description]
>
> [Me] I think it is a really good job description. It is really important. I guess that I see a contradiction there though...
>
> [Eliza]I think this will change a lot for me really...I can't see myself where I am now forever at all...
>
> [Me] You don't know which direction you are going to take?

[Eliza] No, well not really.

[Me] You seem to be clear that you are heading in the management direction though.

[Eliza] Yes, certainly not clinical. I will never put my uniform back on and become a staff nurse again or a clinical nurse specialist role just doesn't interest me at all...[Eliza,3:8-11).

Throughout this dialogue Eliza appeared somewhat resistant to the challenges being put to her. She remained confident that she would do well in the advisory position yet continued to refute an interest in a future in a nursing professional position, choosing management instead. However, the discomfort that was apparent during this conversation indicated some uncertainty in her beliefs and indicated to me that Eliza was reflecting on her position.

Alison, the other nurse manager participant chosen to be a nursing advisor, was less confident about taking the position in view of her predominately management responsibilities in the nurse manager position.

[Me] But you have put yourselves very much into a management position but you see this as being another step up nursing wise.

[Alison] Hmm. It is definitely being recognised as that.

[Me] But isn't that an

[Alison] anomaly?

[Me] Yes. That on the one hand you are managers and on the other hand you are nurse advisors and required to have very much a nursing focus...

[Alison] You get to the point that you are directed whatever happens really. You go from being strictly nursing to being totally non nursing

and we've accepted that reasonably well I think. So we probably just view this as the same sort of thing.
[Me] So it is a compromise?

[Alison] I don't know. I don't think it was meant to be a compromise...Well I really looked at the fact. I think those positions will grow and I think probably we will have a reasonable lot of input into whether they are successful or not depending on how well we put them together so I see that as a challenge...Immediately I said no I am not interested. I have another job and I don't need it. Then when I looked I thought you are only given one chance and it is a challenge and it is a challenge to make it work into something that is respected and not demeaned. If they put in someone else and I don't like them I am going to be sitting here thinking I wish I had accepted (Alison 3:1-6)..

Alison's motivation for taking on the advisor position was quite different to Eliza's. Accepting that there were some contradictions in a nurse manager taking on the position she had weighed up the benefits for the nursing service against the anomalies and decided that it was her challenge to make the position successful. However, Alison also felt that she really had little choice in the matter. This was yet another example of where nurse managers verbalized the oppressed nature of their position

Regardless of the motivations for accepting the nurse advisor positions there was acceptance by Eliza, Alison and the other nurse managers that the clinical nurse specialist and the nursing advisor positions would provide separate nursing leadership for the nursing service.

[Eliza]..and I think that the nurse advisor positions will help as we are bringing in a structure that doesn't exist at the moment that will maybe fill some of the gaps.

[Alison] Basically on nursing issues.

> [Emma] ...We can identify who the nurse advisors are so if you have an issue that you fell needs to be discussed then you know the appropriate
>
> [Jan]...The rest of us, the nurse managers and the staff, will drive those positions. We can see them working for us (G2:10).

Recognising that separate nursing leadership other than the nurse managers was needed brought the nurse manager participants to the point of discussing what, as a group, they could do to ensure that these positions provided the leadership that was needed.

How to act to change their current situation

Despite some feelings that the group of nurse managers put some pressure onto "non-conforming" nurse managers (refer p 113) there appeared to be a feeling of cohesion among the nurse manager group. This was frequently expressed by participants within the individual interviews.

Within the group interviews I, as co-participant assisted the participants to realize the impact they could have as a group and how they could use this to act to change the current situation for nursing and for themselves. Initially they demonstrated powerlessness when confronted with the possibility of initiating a change, but once they realized that they had the strength as a group they planned ways to make it happen, as the following dialogue demonstrates.

> [Me] What in the group are you going to do? Are you going to let this transition happen the way somebody else wants it to happen or do you think you can in any way impact on it and make it happen the way you want it to happen?
>
> [Jan] I don't think we can do anything at the moment.

[Pat] Well we would hope that when you had the job description for the nurse specialists

[Emma] They are still in the pipeline.

[Jan] But they are going to be attached to staff development unit.

[Pat] Is that right?

[Jan] That's why we have decided to ignore them really and they might go away because we are going to have no input really (G1:25).

This dialogue illustrates the powerlessness that individuals were feeling. Not only did they feel that they couldn't do anything about the clinical nurse specialists positions but they felt that because the clinical nurse specialists were under the staff development unit there was not any point in even trying.

However I challenged their expressions of helplessness because as individuals they had expressed the positive impact they felt they could have as a group. This challenge brought a renewed group spirit to the group and a determination to have an influence.

[Me] But hang on. That's not on because haven't you all, at practically every interview, told me that as a group if you saw something that you thought was really affecting nursing as a group you could make an impact?

[Bridget] No we couldn't.

[Eliza and Jan] Yes we can.

[Me] If you can then why aren't you doing it? Isn't this important enough?

[Pat] As a group of people we could...

[Betty] Yes, but we were told we couldn't have a nursing service as such and we have lost something- we have lost some direction I think.

[Me] You have lost something on paper..[G1:26]...Isn't this like anything else where there are informal structures and formal structures and informal and formal communication and isn't it well known that it is the informal that is the most powerful in these things. And so it seems to me that regardless of what structure they are putting up for you the structure that you decide on yourselves, and decide that you are going to make work for yourselves, is going to be the most powerful.

[Jan] Oh yes...Yes, I think you could be right and I think that the first thing we should be looking at is these clinical nurse specialist jobs going to be under the staff development unit.

[Pat] I think that's just terrible

[[Bridget] That's worth fighting for

[Emma] Perhaps that would be a good job for the new nurse advisors (G1:27).

In the above dialogue I reminded the participants of what they had previously stated in other conversations. With this assistance out of the hopelessness that they were expressing came a renewed enthusiasm for challenging some of the problems they were facing.

In the second group interview I reflected on the process that had occurred in the above dialogue to discover, from some of the participants, that the desire to foster nursing had flowed over into the larger hospital nurse manager group.

[Me]...And you were all coming together and seeing something that when even though you all knew that you were different this was something common for all of you. For me that came out quite a bit in

the group interview. I don't know whether it did for each of you.

[Betty] And that has extended quite a bit out of this group into that meeting we had on Monday afternoon.

[Jan] Yes.

[Betty] We hadn't had a meeting for quite some time and got to discuss those issues.

Not only had the participants expressed commitment as a group to fostering nursing but they demonstrated that they felt able to share this commitment with fellow colleagues. They had begun the process of assisting a transformation of consciousness of others in their commitment to act to change their current situation.

Fostering nursing through management

From this stated commitment and increased feeling of being able to have an influence as a group the group began to place more importance on the necessity of retaining a nursing focus and valuing nursing and nursing positions. From my perspective on the process that was occurring it seemed that some of the participants had found a freedom to again value nursing whereas previously they had felt compelled to place most value on the management responsibilities of their position.

Retaining a nursing focus implied valuing the professional aspects of nursing, including nursing education and research, as well as clinical nursing.

[Emma] One of the things that I really thought about when I read the transcript and looked at the things that we were talking about and what came out for me was make sure that you don't lose that nursing focus. You really emphasized about nursing education...

[Me] I guess that's what I see and what I'm wondering if you see and if you think is important is the difference between the clinical and the education about thinking nursing....I'm not talking about clinical, I'm talking about the wider sort of philosophy of nursing and I just wonder- I agree that you have heaps of clinical things going but I'm concerned about the professional, the thinking nursing. That's what my concern is and I would like to see that you have got that support.

[Alison] I don't give any encouragement to go off and do those sorts of things these days. When my staff come to me and say do you think I should go and do some Massey or my diploma I don't encourage them. It doesn't get them anywhere.

[Me] But isn't it up to people like yourselves- employers, to value that sort of thing and only when that happens can we

[Jan] I think we really- I'm very aware of what you are saying and I was talking to someone else about this the other day and it is a real concern because they need to think of nursing as an autonomous profession. You are right, I think of nursing as an autonomous profession but your concern is very real. I think that we have got to push...

[Emma]...When I look at a career I have to decide where are my best opportunities and where my experience has been. But since doing this talking and thinking and you saying hold on, this is a really important part that is at risk of being lost here because of the pressures and because of the organisational structure, and because of the lack of recognition. This has all been good for me because I've started thinking well hold on, those are worthwhile. But they are being beaten down because of everything else.

[Jan] I think it is really important- I think that the moment we stop valuing ourselves as nurses and the staff stop valuing us as nurses - the moment I stop valuing and standing up for nursing and what nursing is all about then I am going to get out. It is very important for me to be valued as a nurse.

[Eliza] But what you are employed to do is the issue.

> [Jan] I know but to me..
>
> [Eliza] You are employed to be a manager.
>
> [Jan] To me and my own self esteem how I think of myself is important but the bottom line is how I value myself as a nurse (G2:10-13).

Within the above dialogue Emma and Jan are clearly expressing their commitment to foster nursing and to ensuring that they retain a nursing focus. Emma, who in an earlier interview had stated that pursuing nursing held little benefits for her personally or for other nurses, had come to a point of recognising that for her personally nursing was worthwhile. While Jan, who had been strong on her nursing background throughout the interviews, reaffirmed this for the others to hear.

Furthermore Jan and Emma, along with Eliza stated that fostering nursing had to come from the top - from the leadership (G1:15) and that they, as the nurse managers, were in the best position to define positions such as the clinical nurse specialist.

Through reflection and the opportunities this study provided for critical dialogue and for the participants to express their real beliefs and values they had moved from a point of placing most value on their management responsibilities to wanting to foster nursing through their management responsibilities.

Eliza, continuing to place most value on the management responsibilities of her position, retained her management focus. Regardless of what her true beliefs and values toward her clinical responsibilities may be, and much of her conversation illustrated that she continued to function in and value these responsibilities, she stated that she was employed to be a manager and reaffirmed her

valuing of these responsibilities.

But for Emma, Alison, Jan and Betty (the other four participants present at the second and final group interview) there was a freedom to express what appeared to have been present in many of their previous conversations but which they seemed hesitant to acknowledge. Given the opportunity to reflect on their responsibilities, nursing, and their values and beliefs they confirmed for themselves, and for others present, that they would foster nursing through management.

The final dialogue of the third interview is an appropriate point to end this chapter and to demonstrate the process of critical social research.

> [Me]If I have helped you to keep grounded in nursing and to see the importance of nursing in all this change then I think it has been worthwhile and I hope you agree.
>
> [Alison] And that's what Bridget said too.
>
> [a few] definitely
>
> [Jan] Definitely. And I think that some of the things that I have said here today have shown that.
>
> [Me] They have.
>
> [Jan] It has definitely done that for me. Yeah- where are my roots? **My roots are nursing** (G2:22).

Summary

Fostering nursing through management evolved from reflection on the world and work of the nurse manager. Through critical dialogue participants reached an agreement that the nurse manager position required a nurse

because of the complimentary clinical and management responsibilities required in the position. However, with the multiple demands on the nurse managers' time, there was little opportunity for them to keep up to date with current professional nursing knowledge. Recognising that their knowledge deficit in this area assisted in the creation of gaps in the professional and clinical leadership within the ward and the organisation they explored alternative leadership positions. For these positions to be effective the participants, through the processes of co-participation and critical reflection on their beliefs, history and responsibilities, reached a point of determination to have an influence on the nursing structure within the organisation. Moving their focus from primarily management to include nursing would enable nursing to be fostered through management.

Fostering nursing involved a successful challenge to management ideology. Throughout previous dialogue management concerns were prevalent. Regardless of whether or not nurse managers felt happy with their management responsibilities, they felt powerless to change their situation and had little insight into the impact their management focus had on nursing. But within the group interviews a new awareness of nursing and their impact as nurses emerged. From this awareness developed a renewed commitment to foster nursing within their individual areas and within the organisation.

CHAPTER TEN

REFLECTIONS ON THE STUDY

In critical social science the researcher's description and analysis must be developed with and be acceptable to the participants and the participants must trust the researcher and the explanation that is offered. Together, then, they can mutually negotiate both meaning and power (Lather,1992:52 & 57). In keeping with this an important aspect of this study was reflection on the critical research process and the meaning this process had for both the participants and for myself as researcher.

Reflections of the participants

By having a copy of the interview transcript sent to them prior to the next interview participants had the opportunity to reflect on the discourse that had occurred and the meaning this dialogue had for them. I then invited comment on the previous interview. As early as the second interview participants began to share their feelings about the study with me.

> ...it is really interesting to me to look back at the paper [the transcript of the first interview] and see what you are actually prepared to give to somebody else - and I actually went home after, I felt good after this last time, and I thought that's really good. I went home and I thought I can't believe how easy it actually is to share this stuff. You know, just to willingly give it up...perhaps it's because you are from out of the system. It might well be the good thing about it all because I am actually quite careful about to who and what I communicate...It is quite interesting that I actually talked about all this stuff and I certainly would not have shared it with a lot of people...(Eliza,2:3).

This dialogue demonstrates that Eliza trusted me enough to

discuss issues that she would not normally. She thought that my position as an 'outsider' from the organisation may have contributed to the ease she felt and described this as a positive aspect of the study.

While on reflection Eliza was able to describe the trust she felt in being able to share her feelings and concerns with me, for Bridget reflection on the study dialogue influenced her thoughts and actions, as the following demonstrates.

> I thought your comments about me probably mothering were probably quite true. I looked at that- I run around trying to keep everyone happy. Life's not like that really. People just have to stand on their own two feet sometimes...I really think that I have taken on too many of the staff problems- I can't fix everything...So this week I have really done a lot of good. Things that I have put off because I manage my time more. I say I'm sorry I'm not available...So this week I have done that and it is good...And actually you putting some of those things down. That was good. It made me look at myself more. I thought you really hit the nail on the head with some of those things. It often takes something like that to make you sit up and look at yourself. I could really get stuck in that rut, wear myself out and not really get anywhere (Bridget,2:1-4).

Bridget, reflecting on her performance as a nurse manager, appeared almost too eager to accept as true challenges I put to her. The confusion that Bridget was experiencing within her work caused by the conflicts she experienced between her management and clinical responsibilities appeared to make her susceptible to any suggestions. This reflected her feelings of powerlessness within her situation and as researcher I had to be careful not to take advantage of her uncertainty and impose my opinions and beliefs upon her. Nevertheless she appeared to spend some time reflecting on interview dialogue and my comments on the transcripts and was always positive about the study and it's impact on her.

Clare welcomed the opportunity for comment and challenge which she felt were timely

> I enjoyed your comments- as you said at the end- challenging. I think that is really good because I think that I am at the stage of evaluating where I am and where I am going so, yeah, I think this has come at a real opportune moment really (Clare,2:1).

However, in the one group interview that Clare attended she remained silent. It is likely that the pressure Clare felt that the nurse manager group exerted on her to conform to their expectations influenced her willingness to participate in the group dialogue. Clare's silence was likely to be a result of the dominating influences of the group.

Jan commented positively on the dialogue and also demonstrated that she had spent some time reflecting on the dialogue that had occurred, as the following example from her third interview demonstrates (Jan 3:1).

> [Me] I think there was some really good stuff too. Can you remember last time I was trying to remember something really special that had come through- I thought it was really interesting. It was that bit on p.15 when you were talking about the uniform.
>
> [Jan] Yes. You made a real comment on that. I went away and thought about it.
>
> [Me] At the time you were really reflecting and thinking about it and coming up with that yourself.
>
> [Jan] This is what I am finding interesting [when] talking to you because it is making me think about things that I had just really accepted and I hadn't thought about that uniform situation until I discussed it with you...[Jan].

From the above examples it would appear that for the

participants this study was timely and that they were eager to have the opportunity to participate in dialogue and to have their ideological beliefs challenged. All appeared comfortable and relaxed within the individual interviews and appeared to have a trust in me which allowed them to disclose feelings and thoughts. It would be presumptuous to assume that an ideal free speech situation had occurred within these three individual interviews but critical reflection and critical dialogue was welcomed by all.

Participants initially felt less comfortable with the group interview situation, as the following dialogue reveals (G2:1-2).

> [Eliza] I think the group interview was a bit jumbled. Its not very...
>
> [Alison] Where are we going? When we started I thought it was to be what is the role of nurse managers.
>
> [Eliza] You see I don't think that the way I think has changed so much. The interview was about us and our nurse manager role. That's what we were to talk about- not nursing as a wider role- our role as the nurse manager, the manager role. Then we talked about nursing as a wider issue and what the nurse manager role meant for that.
>
> [Alison] That was the brief- the role of the nurse manager.

However, as the group interviews progressed the participants appeared more at ease with the direction that the dialogue was taking. They expressed trust in me to present their world within this study (Jan,G2:21) and appreciated the timeliness of the study at a time when so many changes were occurring (Eliza,G2:22 ; Alison,G2:22).

My reflections as researcher and co-participant

The first individual interview was really a sharing of backgrounds. Initially in this first interview I felt the participants were very defensive about all the good things that the Area Health Board had provided for them, especially the amount of training and support for their management responsibilities. At this time I identified this as a form of oppression - that the management role of the nurse manager was receiving all the attention but that little emphasis appeared to be being put into the clinical/professional aspects of the nurse managers' work.

In the second interview I felt that, despite all the differences between participants about how they perceived the work of the nurse manager (i.e. as primarily management or clinical),they were all united in their concern about the lack of nursing leadership within the Board at a ward, service and corporate level. For me, this concern became the central theme within both the second and third individual interviews. There was a recognition amongst most that nursing leadership was needed. The 'nurse' in the nurse manager began to appear whereas I felt that earlier it had been pushed aside a bit in favour of the management.

About this time I began to reflect on my own preconceptions and assumptions. During the literature review for this study I had been exposed to a number of models for ward clinical and management leadership. Whether this leadership should be provided within the one position or within separate clinical and management positions was a central concern for me. I wondered what was the 'right' leadership model for the New Zealand health care system.

Exposed to the positive sides of a predominately management position in the first interviews, I considered that this might be the direction that should be taken.

That clinical and management responsibilities should be separated into two positions. However the second and third interviews prompted me to re-examine this belief.

The nurse managers described their management world as being very dependent on their clinical backgrounds. The two were inseparable. So within a changing health care system and new nursing structures it seemed important that in adopting the new all of the old was not discarded. Much of the old and traditional could be safely abandoned but care needed to be taken that those aspects which helped to ensure nursing's unique and important service remained. Therefore, it seemed more likely that a leadership model should incorporate the two recognising that the clinical/ professionl/management leadership model provided comprehensive ward leadership.

As the nurse managers expressed their concerns about the gaps in the nursing structure, I shared these concerns, and also developed a deep concern about the provision of professional nursing leadership within the Area Health Board. Not only were there gaps within the professional structure, but there appeared to be limited opportunities for professional development and little, if any, valuing of this development.

In the group interviews this theme was explored further with participants and myself challenging perspectives the other held as I encouraged the group to move towards a new understanding of their situation.

As a co-participant in this study I was not in the empirico-analytical researcher position of being an objective observer on the process that was occurring. As I participated in critical dialogue participants challenged my own ideological beliefs. Rather than merely describing their dialogue I had to reflect on what that dialogue meant to me and present these reflections to them for

further critique.

At the same time I had to acknowledge my influence on their understandings. Very aware of their uncertainties about their current situation there often seemed to be a fine-line between presentation of my reflections and the promotion of an alternative ideology. However, I remain hopeful that the participants, as mature adults and successful nurse managers, were able to decide for themselves. Furthermore, I believe that the trust that developed between myself and them contributed to a situation where the participants felt able to participate in free dialogue and the formation of their own, not enforced, understandings, in keeping with the emancipatory intent of critical social science.

CHAPTER ELEVEN

FURTHER DISCUSSION AND INTERPRETATION

The aim of this study was to work with a small group of nurse managers in an acute care setting to

1. explore their work realities and their expectations

2. assist them to identify and explore patterns, constraints and opportunities in their position

3. reach a common understanding between participants of the parameters for nursing leadership in the current nursing and health care climate in hospitals

4. empower participants to identify choices and to take emancipatory action to overcome the constraints and realize the opportunities.

This chapter will discuss the fulfillment of these aims offering further interpretation of the study where necessary. Recognising that the theory developed is likely to have relevance outside of the immediate context within which it was developed, the implications for nursing practice, education, research, professional networking and hospital management will also be discussed. Lastly, limitations of the study will be presented.

Discussion and interpretation

This study provides a detailed picture of the work realities of nurse managers in one acute care setting. The diversity of the work undertaken by the participants and the conflict that is experienced between the clinical and management responsibilities of the position are similar to that discussed in much of the nursing literature (refer

Chapter 2).

While patriarchal and management ideological foundations for the conflict are also well documented (for example, Gamarnikow, 1978; Lees, 1980; Lovell, 1980; Epstein, 1982;) there is little discussion available on nurse manager group ideology and management ideology with particular reference to the New Zealand health care system.

Nurse manager participants within this study described the formation of a cohesive nurse manager group to support each other during organisational change. This group developed norms which it expected all members to adhere to with subtle pressure for conformity being applied to non-conforming members. Outside the immediate scope of this study was understanding of the effect of this nurse manager group ideology and the influence it would have on various aspects of organisational culture and the nursing service. But because of the effect it appeared to have on one member in particular, resulting in her lack of participation in the group interview, it would appear that another oppressive structure was developing. Such structures within nursing management would be worthy of further study in order to gain understanding of their effect both on nursing and on health care management.

The participants in this study were oppressed by the dominant management ideology. This was apparent in much of the dialogue, for example, the reluctance to question higher management decisions and the desire to be more clinically involved but knowing that this was not what senior management wanted. It is likely that this oppression stifles the knowledge, expertise and wisdom of nurse managers and in so doing limits their contribution to health care. Furthermore, the effect such oppression has on other nurses should not be underestimated as the oppressed takes on the features of the dominant group and

becomes an oppressor of others.

Within this study this could be identified in the encouragement nurse managers received to further their management education at the expense of their nursing education. The nurse managers in turn offered little support to nurses wanting to pursue tertiary nursing education, instead encouraging them to gain qualifications in management which would offer them a more secure future. When the nurse in the nurse manager was undervalued, nurse managers themselves reacted by undervaluing nursing.

Through critical reflection and critical dialogue constraints, such as those mentioned above and opportunities in the nurse manager position were identified. Such an example was the opportunity to influence nursing structure within the organisation by advocating for the clinical nurse specialist position. There was not always agreement amongst the participants as to what were opportunities and what were constraints in the position. This reflected the different stages that each participant was at in understanding the influences on their work and world, their particular concerns at the time the study was undertaken, and the restricted time frame available for the data collection part of this study.

However, despite these limitations there appeared to be movement toward a common understanding of the parameters for nursing leadership in their current nursing and organisational environment, as discussed in Chapter Nine. Such a conclusion may be premature as this movement developed within the final group interview when only five of the eight original participants were present. However, the direction that previous dialogue had taken indicated that this group of nurse managers believed it essential that managers of hospital wards in the acute care setting should be nurses. They believed that the unique

combination of clinical expertise and knowledge required to effectively manage such an environment was vital. Furthermore, they came to realize that with the various demands upon their time they were unable to provide the clinical ward leadership traditionally associated with their position. From this point they were able to identify alternative positions, such as that of the clinical nurse specialist, that could support nurses professional and clinically.

After the identification of choices available to them the final phase in the process of developing an emancipatory social theory should have been the empowerment of participants to emancipatory action and researcher participation in this emancipatory process. Unfortunately such emancipatory action was not achieved in this study. While impetus for action was apparent within the final group dialogue time constraints prevented my ongoing involvement in the cycle of critical analysis, education and action, as described by Comstock (1982:387).

Limitations of the study

As this study focused on the work of a small group of nurse managers in one acute care setting the findings are not necessarily generalizable. While there is likely to be some similarity between the particular understandings of the nurse managers in this study and nurse managers from other areas it was not the purpose of this study to present a critique of the philosophical and ideological forces which shape the perceptions of all nurse managers.

Another limitation of this study was caused by resource limitations which prevented my involvement in the emancipatory action phase of the study. It is not possible to ascertain whether the research process was sufficient to empower the participants towards emancipatory action. If it was not sufficient this could have led to further

frustrations for the nurse managers as new motivations were thwarted.

Implications of this study for nursing practice, education, research, professional networking and hospital management

Practice

Nurse managers have a major effect on the empowerment of nursing staff to achieve independence and autonomy in their everyday practice. Nurse managers who were more confident in their position and who saw their position not as the 'clinical expert' but rather as a resource, provided numerous examples within this study to indicate that nursing staff responded positively to being given more responsibility in their practice. In contrast to this nurse managers who experienced insecurity in the nurse manager position maintained a greater clinical input, limiting opportunities for other nurses to assume responsibility. This resulted in nursing staff being more dependent on the nurse manager for direct guidance in their daily clinical practice rather than assuming full responsibility for their personal practice. As will be discussed later in this section such findings have implications for the support hospital management provides for nurse managers.

The importance of nurses supporting each other is another implication uncovered in this study. Nurse managers often expressed feelings of feeling unsupported by nursing staff in their areas when those nurses undervalued the nurse manager's contribution. Examples of nurses feeling unsupported by nurse managers were also provided. Patient care is dependent on supportive collegial relationships within the ward environment and all nurses have a responsibility to foster the development of an environment which supports this. Hospital management has a similar

responsibility. If nurses do not value the contribution that other nurses make to health care then it is unlikely that others will value this contribution either.

Education

The literature review for this study revealed that there is a serious lack of preparation for nurses in management positions at both a basic and at an advanced level (refer Chapter 2). More management education within the basic nursing education programme is not only likely to directly benefit nursing practice as management skills are an essential component of that practice, but also to contribute to nurses placing more value on other nurses who choose to enter nursing management positions.

This study also reveals that a traditional image of nurses and nursing persists among both the public, other health care workers and even amongst the nursing profession itself. Education is necessary to change these perceptions so that the knowledge and skill required in a diverse variety of situations in which nurses work, not just at the bedside, can be fully appreciated and valued.

Hospital management

Conflict within the nurse manager position was increased because of the emphasis hospital management put on the management responsibilities of the position, undervaluing the nursing responsibilities. As long as nurses are appointed to the position of nurse managers there will be a need for recognition of the clinical and professional responsibilities such a position requires. Hospital managers should ensure that nurses in management positions are supported to maintain their clinical and professional knowledge base to support their responsibilities.

Hospital managers should also ensure that nurse managers

are supported as they experience conflict between professional, personal and organisational values. By the provision of opportunities for discussion, encouraging networking and assisting ongoing education, hospital management can facilitate conflict resolution.

Frustration was felt by the nurse managers in this study when they were expected to manage and then a management decision affecting their area was made by higher management without consultation with the nurse manager. If nurse managers are expected to be the managers of their ward or area then they should be given the responsibility and autonomy to manage their area without unnecessary interference and with the support necessary to achieve this. Hospital managers must clearly define the areas of responsibility that nurses managers have and then support them to manage independently within this defined scope.

While it is important that hospital management prepare nurse managers for the changes in responsibility that health restructuring necessitates, it is vital that nurse managers are encouraged to maintain their clinical and professional knowledge.

Equally important is the development of a hospital structure that is seen to support the professional and clinical responsibilities of nurses. This study has revealed the gap in the provision of clinical support for practising nurses and the perceived lack of professional support for nurses in senior management. While traditional nursing hierarchical structures should be examined for their relevance to current health care environments it is important that a supportive clinical and professional nursing structure is not overlooked.

Professional networks

Concerns present in this study provide a challenge to

professional organisations and to individual nurses to maintain professional networks, particularly during times of rapid change. As competition within the health care sector is encouraged and as different organisations develop individual structures relevant to their particular concerns it will be increasingly difficult for professional networking to occur. But it is through such networking that ideas are generated and shared. This activity should be encouraged and fostered and every opportunity taken to ensure professional communication between different organisations and geographical boundaries.

Research

This study has revealed a number of areas which would benefit from further study, particularly within the New Zealand context.

As health care restructuring necessitates even greater emphasis on efficiency and cost-effectiveness the management responsibilities of nurse managers is likely to increase. How this will affect nursing practice at the ward level will need to be carefully monitored to ensure that professional and clinical leadership, once the responsibility of the ward sister, is maintained.

Research into the competencies expected of nurse managers, on a similar scope to that undertaken by Duffield (1991;1992) would assist the development of educational programmes specifically suited to the requirements of this position and assist career planning for those nurses wishing to plan for a future in nursing management. Until recently nurse managers were appointed to their position on the basis of their clinical competence rather than their management ability. While it is now recognised that management ability is also necessary there is often uncertainty as to just what management abilities are

required. Research, as outlined above, could also assist this process.

Because nursing hierarchical structures have largely been replaced by nursing advisory and senior clinical positions, or have been removed altogether, it would be timely to undertake a study of the effect, if any, such a change has had on nursing practice and nursing management. While change is an inevitable aspect of modern life it's effect must be monitored to ensure the positive effects of previous structures are not abandoned in an effort to remove the undesirable.

APPENDIX ONE

CONSENT FORM

As a participant in this research you will not be identifiable in any written documentation and all tapes will be confidential. As this kind of research has the potential to change your usual practice sufficient time will be available for informal discussion. You will be free to withdraw from the study at any time and if so all material relating to you will be destroyed.

Declaration

I have had the nature and likely consequences of the proposed research fully explained to me and have read the attached explanation. I understand that as a participant in this research I will not be able to be identified in any written material and that my right to privacy will be respected such that I can divulge as much or as little information as I myself decide. I also understand that I can discontinue my participation at any time and if I do so all material relating to me will be destroyed.
I therefore give my informed consent to participate in this research.

Date.....

Signed.....(Participant)

.....(Researcher)

APPENDIX TWO

INFORMATION SHEET

Nurse managers and their work in an acute care setting

Dear nurse manager
I am a final year Masters student with the Nursing Department at Massey University. To complete my thesis I wish to study nurse managers and their work in an acute care setting.

Nurse managers involved in the study will initially be asked to keep a log of their activities over a period of 2-4 weeks. Over the following two months individual and group interviews will be held with the nurse managers based on their actual activities as recorded in their diaries and their expectations of what those activities should be. To allow for exploration of particular issues, confirmation of my interpretation and critical reflection by the nurse manager and myself four interviews, each of one hour duration, will be anticipated. It is possible that more time might be required.

It is important that the nurse managers involved in this study do not feel coerced to take part, that their rights to privacy and confidentiality are protected and that they are able to voice their concerns about any aspect of the study. I will ensure that there is sufficient time given to exploring the ethical aspects of our relative positions in relation to this research with the nurse managers who volunteer. It is also important that we reach a common understanding of the use to which the outcome of this research may be put. This will be discussed before the research and an agreement reached.

If you take part in this research you will not be identifiable in any written documentation and any audiotapes used will be confidential. You will be free to withdraw at any time and all material relating to you, including audiotapes, will either be destroyed or returned to you.

If you are interested in participating please contact me- phone [redacted] collect (home- after 8.30pm please). I will then arrange a time to meet you and answer any questions or concerns you may have. We would also discuss the conduct and outcomes of this research until you are satisfied that you want to participate.

Thank you for considering participation.
Lyneta Russell

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