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Experiences of Top-Level Nurses

Catherine Ann Tracey

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A thesis submitted in fulfilment of the degree of Doctor in Philosophy of the University of Dublin Trinity College

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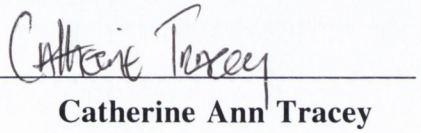
Signed 

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SUMMARY

Societal and scientific changes are shaping expectations of the future direction of healthcare delivery. These changes impinge on nursing, forcing it to study itself, to identify its place in the present and future healthcare arena. The purpose of this study was to contribute to the study of nursing by exploring, from their own perspectives, the experiences of top-level nurses holding the formal position of director of nursing. As little research exists to explain or give an understanding of those experiences and the effects of those experiences on top-level nurses, a grounded theory study of this area of nursing was applicable.

It was the contention of this study that top-level nursing cannot be studied in isolation from the context in which it functions. Therefore the aim of the study was to examine the experiences of top-level nurses in the context of nursing and the healthcare system, with the objective of discovering and understanding top-level nursing through the lived experiences of directors of nursing.

This nationwide study was qualitative in approach, using grounded theory methodology. Data was collected by means of the long interview with fifty top-level female and male nurses holding the formal position of director of nursing and representing general and psychiatric nursing. Interviews were audio-taped, transcribed and analysed. Data analysis was conducted in accordance with the principles of grounded theory methodology.

Data analysis found that the basic social psychological problem experienced by top-level nurses was 'positional marginalisation'. This was found to relate to professional identity development, nursing professionalisation, medical relations, organisational structures, industrial relations projects and internal organisation. For the participants in this study, nursing offered only one significant route to success: through its management structure. In order to succeed, these nurses had to show that they were 'good nurses', conforming and maintaining the status quo, and would manage nursing and nurses on behalf of the organisation. In return they achieved the ultimate position of success now titled director of nursing. In obtaining this position, directors of nursing were placed between nurses, medicine and general management. This in between positioning is referred to as 'marginal'. A marginal position rests on the boundary between groups. While it is affiliated to the groups it relates to, it does not belong to and is not fully accepted by any, including its own group.

Among the contextual factors that were found to influence the problem of positional marginalisation was that, while nursing is the major supplier within the healthcare system, it

continues to be a minor strategic player; other professions such as medicine and general management act as the major forces in strategic influence and decision-making. Within this system this study found that nursing has been and remains controlled and 'oppressed' by these dominant forces. This study also found that, while the Commission on Nursing (1998) did tremendous work to progress technical and practical knowledge in nursing, it did little to progress towards an understanding of nursing in terms of its own destiny. It further found that, since the national nurses' strike, trade unions are increasingly visible and active in all aspects of nursing.

Data analysis found that these contextual factors modified the basic social structural process of 'positional vulnerability', which involved primarily three major structures — nursing, unions and general management, and, to a lesser degree, medicine — and further modified the basic social psychological process of 'acquiescing to/adapting to/accommodating to' found in directors' of nursing cognitive recognition and reflections of the effects of 'positional vulnerability' and in their behavioural response to the process.

In summary, this study found that the position of director of nursing is vulnerable relative to others in nursing and in other relevant groups. It further found that the thinking and behaviours that brought success to participants are now serving to restrict them in their collective response to the imposed changes affecting their position.

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INTRODUCTION

Generally, nurses practise and work in a system that supports and recognises three major competing and complementary frames of *reference*: the medical model, the nursing model and the general management model. Nursing is influenced and affected by these models, in addition to the political influence on nursing (Downton 1997).

It is understood that, to provide an adequate theory of top-level nursing, it is not sufficient to focus the study internally; the subject requires to be studied from a perspective that includes all relevant influences, such as the organisation, culture and politics of the healthcare system, as all these factors impinge on nursing and its potential leadership role (Smith & Peterson 1988., Altieri & Elgin 1994., McNeese-Smith 1995., Porter 1995b., House & Aditya 1997., Shankar Pawar & Eastman 1997., Flynn 1998., Cameron & Masterson 2000). However, while this perspective has been a consistent feature of opinion articles, conferences and presentations, it is lacking in empirical studies (Mowinski Jennings 1995., Flynn 1998., Girvin 1998., Bowles & Bowles 2000), and thus a grounded theory study of this area of nursing is applicable, which provides explanation and understanding of the experiences of those in top-level nursing.

The researcher took, as the initial focus in this study (Glaser 1992), the concept of leadership as described by Zaleznik (1977), Burns (1978), Bennis and Nanus (1985), Bass (1990), Gardner (1990), Kotter (1990), Covey (1995), Handy (1995), House & Aditya (1997). The study was designed, as mandated by Glaser (1978), to be open and sensitive, to what would be found to have relevance and fit in the data and to the discovery of what did exist and what applied conceptually, irrespective of the initial focus or the researcher's professional perspective, with the understanding that, by using grounded theory methodology, the research problem will emerge (Glaser & Strauss 1967., Glaser 1978., Glaser 1992). The central or core issue or problem that emerged for this study's participants (Glaser 1978., Glaser 1992) was marginalisation of the position of director of nursing, in a context where from the perspective of this study's findings nursing does not hold a leadership position.

Placing Irish nursing in context, this study's findings revealed that, although nursing has a voice in the regulation of its profession, it does not have a controlling voice. In relation to nursing and political life, this study's perspective is that nursing and its professional bodies

lack political preparation, awareness and sophistication. It further emerged from the analysis that medicine continues to dominate and control nursing and that, while nursing seems to be caught in the current rhetoric of not being handmaidens to doctors, in its behaviour nursing does relatively little to demonstrate its emancipation from medicine. Further findings of the study show that nursing is also dominated by general management and that participants perceive that this domination is assisted by the Department of Health and Children. These findings reveal that participants see nursing as having an ill-defined relationship with itself that they perceive is demonstrated through internal disunity and serves to stymie nursing in its overall development specifically in relation to development of its own destiny.

The basic social psychological problem of 'positional marginalisation' processed out as participants' main concern. The problem was found in relation to professional identity development, professionalisation of nursing, medical relations, organisational structures and culture, industrial relations projects and internal organisation. The basic social structural process of 'positional vulnerability' was found to compound the problem. The current restructuring of the healthcare system for participants involves three contradictory moves: devolvement of their nursing authority, sharing with unions their positional authority, and demotion in the general management organisational reporting pyramid. The basic social psychological process of 'acquiescing to/adapting to/accommodating to' emerged as participants' cognitive and behavioural response to the marginalisation of their position.

Purpose of the Study

The purpose of this study is to contribute to the understanding of nursing by exploring from the perspectives of top-level nurses holding the formal position of director of nursing their experiences, with the objective of discovering and understanding top-level nursing and its place in the context of nursing and in the contemporary Irish healthcare system.

The study aimed to develop through the grounded theory method a system of putting participants' perceptions into a conceptual frame that permits a broader and deeper understanding than that which already exists, by bringing to the surface the hidden

meanings of the experiences of directors of nursing that may lie outside their conscious awareness (Chenitz & Swanson 1986).

Study Framework

The study is qualitative in approach, using grounded theory methodology (Glaser & Strauss 1967., Glaser 1978., Glaser 1992). It was designed to describe and explore the experiences of top-level nurses holding the formal position of director of nursing. The intention of this study was to understand from the perspectives of the participants their perceptions and interpretations of their experiences.

Data collection was by means of the long interview (McCracken 1988) guided by purposeful and theoretical sampling. To provide a credible view of top-level nurses' experiences, sampling took place across a variety of settings throughout the Republic of Ireland. The purpose of this sampling frame was to represent general and psychiatric nursing. Grounded theory methodology was used in data analysis.

Research Questions

In a grounded theory study the research question is not a predetermined statement that identifies the phenomenon to be studied. It is through the process of the study that the problem or central issue, and questions regarding the problem or central issue, emerge (Glaser 1992).

Thus the following broad questions initially guided the study:

How do directors of nursing perceive their experiences?
How do directors of nursing perceive the position of nursing in an Irish context?
How do directors of nursing perceive how organisational processes affect them?
How do directors of nursing perceive how conflicting demands affect them?
How do directors of nursing perceive how their support systems function for them?
How do directors of nursing perceive the influence of gender on their professional experiences?

How do directors of nursing perceive the place of nursing in the healthcare system?

How do directors of nursing perceive their preferred future for nursing?

Significance of the Study

This study is of significance to the development, research and practice of nursing as the theory that emerged is grounded in the perceptions of directors of nursing of their experiences as top-level nurses.

The study's significance is in the substantive theory developed, which conceptualises the extent to which the position of director of nursing is marginalised and vulnerable in the context of Irish nursing and in the healthcare system generally. The marginalisation and vulnerability of this position question the value attributed to the position by the profession of nursing. To the profession of nursing and healthcare generally, the marginalisation and vulnerability of this position in settings such as hospitals and services are of principal significance, as they serve to prevent those directors of nursing engaging in activities critical to the development of nursing and healthcare, fundamental activities such as questioning the present, taking risks, anticipating future trends and developing innovations to meet those trends.

The study is of further significance as it initially took as its focus the concept of leadership to explore and examine from the perspectives of directors of nursing the context of nursing as a whole and specifically the position of director of nursing but found that the concept of leadership did not process out. The central issue for this study's participants emerged as positional marginalisation. This gap in the findings (Glaser 1978) has major significance and implications for the manifestation of nursing's own destiny, in relation to the development of nursing itself and its present and future place in the healthcare arena.

The findings of this study can be used with other aspects when examining the future of the position of director of nursing in relation to the profession of nursing and in relation to nursing in the healthcare structure.

Definitions of Terms

ACEO: assistant chief executive officer in a hospital or health board

Acting director of nursing: refers to the temporary assignment to of the position of director of nursing.

An Bord Altranais: the Irish nursing board

CEO: chief executive officer in a hospital or health board

CNM: clinical nurse manager

DATHs: Dublin Academic Teaching Hospitals

HB: health board (one of the divisional management structures of the healthcare service in Ireland)

HSEA: Health Service Employers Authority

INMO: Irish Nurse Managers' Association

INO: Irish Nurses' Organisation

LAC: Local Appointments Commission

NHS: National Health Service, UK

The Commission: the Commission on Nursing

Top-level nurse: refers to directors of nursing or the acting directors of nursing in a hospital or service in the Irish healthcare system who participated in this study

VHI: Voluntary Health Insurance board (provider of private health insurance)

WHO: World Health Organization

CHAPTER 1
LITERATURE REVIEW: SOCIETY, CULTURE AND NURSING

1.1 Introduction

The literature review for this study is divided into two chapters and examines and places in context nursing, its development and role in society, and more specifically its role within the national healthcare system. It further examines the concepts of management and leadership, their development and their contribution to nursing. This chapter examines the effects of culture, gender, socio-politics and social transformation on the current position of nursing in the healthcare system and finds that the impact of these societal elements on the development and role of nursing as a predominantly female profession are profound. This chapter is presented in four sections: culture; gender in nursing; socio-politics and nursing as a constituent of the healthcare structure.

1.2 Culture

The culture of nursing is closely linked to historical social beliefs and therefore cannot be studied solely in terms of contemporary society. Its current structures and practices are influenced by traditions which are embedded in the past, and in some fundamental aspects nursing continues to embrace those traditional roots (Roberts 1983., Dyson 1994., Walby et al, 1994., Suominen, Kovasin & Ketola 1997).

Although nurses in the Western world make up the largest healthcare workforce, nursing has struggled to gain professional status (Roberts 1983); it is generally accepted that this is due to its historical foundation, which was influenced by the weak position of women in society. Historically, nurses, as women without the vote, were dependent upon supportive male politicians to push any agenda for nursing through parliament. This was not really successful, which left the influence of medicine over nursing untouched and in reality meant that nursing remained neither self-determining nor self-governing (Walby et al, 1994).

1.2.1 Modern Nursing

While the founder of modern nursing, Florence Nightingale, is accredited with using power and influence to transform nursing from a trade into a profession (Holliday & Parker 1997), she is also attributed with placing nursing at the mercy of medical supremacy (Salvage 1987., Kitching 1993). Nightingale cemented the subservient role of nursing to medicine when she restricted nursing services to being carried out only when medically prescribed, thus making nursing an occupation which is defined by its assistantship to medicine (Porter 1995b). This effect in terms of self-determination and self-government condemned leadership in nursing to history (Kitching 1993).

Placing modern nursing in a social context, Dingwall (1979) suggests that much of Nightingale's success was due to a receptive social climate in her time, where there was a lack of involvement in the care of the sick by any Protestant or Catholic religious orders. This gap provided Nightingale with the opportunity to create 'de novo' her brand of nursing (ibid,:200). Nightingale's opportunity was assisted by a demographic imbalance which had a reserve of unmarriageable middle-class women, a sizeable group with the required education and moral character, regarded by society as reliable and trustworthy, and for whom there were scant other socially acceptable occupations (Dingwall 1979).

Nightingale conceived her hospital structure as an extension of the successful Victorian household, where upper-middle-class male doctors were in charge of upper-middle-class female nurses, who in turn were in charge of lower-class female domestics (Salvage 1987). As a result, modern nursing is a product of Victorian social norms and values (Dingwall 1979., Salvage 1987), where the subservient role of nursing to medicine was ensured by the patriarch, who ensured that nursing was restricted to women (Dingwall 1979., Salvage 1987). This subservience of nursing was firmly rooted, and until recently, through the nursing socialisation process, student nurses learned by example to pay homage to the superiority of medical knowledge and medical behaviour (Cheng 1990).

1.2.1.1 Social Identity Theory and Disunity

It is suggested that the Victorian culture which conceived and developed modern nursing serves now to oppress nurses, and it is this oppression which directly contributes to the

powerlessness of nursing, a manifestation of which is disunity among nurses (Dyson 1994). Social identity theory (Ely 1995) serves to explain the underlying reason for disunity among nurses. Social identity theory is useful in providing explanations for individuals' perception of their group's social identity and status in relation to other relevant status groups in a particular social environment. Hewstone and Jaspers (1982:110) state that 'the relationship between group and self attributions is a complex one' and that 'at the very least, it is affected by...social status of the relevant groups (superior/inferior)'.

A basic assumption of social identity theory (Ely 1994, 1995) is that humans have a need for, and are motivated to develop and maintain, positive self-images. Social identity theory holds that, where status differences clearly exist and where the value system is clearly pervasive and understood in its support of those in the perceived higher-status groups, it may then not be possible for many in the lower-status group to hold positive group regard. The theory suggests that in such circumstances individuals may dissociate themselves from their group and may culturally and psychologically take measures to assimilate themselves into the higher-status group. Thus, according to social identity theory, nurses, in their effort to assimilate into the higher-status group of medicine, develop thoughts, feelings, behaviours and experiences at work to mirror those typically associated with the medical profession. This theory is consistent with Bell's (1990) findings, which demonstrate that individuals adopt this strategy of assimilation because it allows them to perceive themselves favourably in relation to what they see as the requirements for success while continuing to attribute relatively low significance to their own group.

1.2.1.2 Critical Social Theory

Nursing remains a female occupation intrinsically dominated by a traditional feminine culture (Moss 1995., Neubauer 1995), but it operates in a 'hegemonic organisational culture', a traditional masculine culture (O'Connor 1996:206). Despite the increased sexual equality in Western society, research suggests that the contemporary healthcare system continues to be both class-dominated and patriarchal (Sweet & Norman 1995). Nursing as a female occupation is similar to other occupations where women are in the majority, in that these occupations are paid less and have less training and a lower status than occupations where traditionally men are in the majority, occupations such as medicine and general management (Walby et al, 1994).

Using a critical social theory paradigm to explore the culture of nursing, Roberts (1983) suggests that the oppression of nurses contributes directly to the disunity found amongst them. Generally, through the process of oppression, the dominant group exercises social and political control, and part of this control is the differentiation in appearance and behaviour of the dominant group from the subordinate group (Roberts 1983., Dyson 1994). The healthcare system is dominated and controlled by medicine and general management; these two groups define the values, norms and organisational systems under which nursing functions (Dyson 1994., Lewis Lanza 1997a, 1997b). The perversity of this hegemony process has been facilitated by nursing. Nurses as a group through their socialisation have continued the process (Roberts 1983., Girvin 1996b); their failure to recognise the process contributes to their continued oppressed status and group disunity. This continued failure impinges negatively on their ability to influence the future place of nursing (Dyson 1994).

Nursing emotionally and cognitively remains tied to its Nightingale legacy, where the autocratic matron exercised control rather then leadership and perpetuated the 'good woman–good nurse' syndrome with military precision and regulation (Roberts 1983:28–29). In reality the matron's authority was more symbolic than functional, and the power and control was mainly over other women within the context of a male-dominated hierarchical healthcare system. The medical paternity allowed matrons to exercise this power and control as this ensured that medical orders would be carried out with military precision (Kitching 1993).

Classically, the thinking and behaviour of the traditional autocratic matron figure mirrored that of the present-day 'Queen Bee' (Staines, Tavris & Epstein Jayaratne 1974:55). The Queen Bee is a term used to describe a woman who has worked very hard to get where she is and like her male colleagues does not want competition from younger women, nor does she want them to have it easier than she did. The Queen Bee has a sense of having succeeded as an individual and chooses to ignore the psychological evidence that most people are products of their socialisation. The irony of the situation is that the Queen Bee, with her access to power and male favour, like the traditional matron, is best placed to advance the cause of nursing but prefers not to do so. Generally the Queen Bee prefers to identify her reference group as those in the upper echelons of the establishment and likes to support the status quo. This behaviour facilitates those in real power to continue to apply the classic rule of 'divide and conquer' (Staines, Tavris & Epstein Jayaratne 1974:60). Queen Bee behaviour can apply to members of either sex who hold the matron or

equivalent position, and it contributes to the perpetuation of oppression and disunity in nursing.

1.2.2 Socialisation

According to Baumgart (1999), the socialisation paradigm is the most general way of explaining the differences experienced by men and women in public life. The socialisation paradigm posits that female and male children are encouraged from birth to think and behave differently. For females, traditionally socialisation has been the preparation for 'private life', in the roles of mother, wife and homemaker, where the 'female' characteristics of dependence, emotional expressions of submission and passivity are necessary (Davies 1996., Baumgart 1999). The socialisation of men has been the preparation for 'public life', where the achievement of success requires men to demonstrate traits such as independence, assertiveness and a certain degree of aggression (Baumgart 1999).

The significance of gender to the nursing profession is observed when consideration is given to the position of doctors and nurses in formal industrial relations negotiations; it is here that gender becomes a vital concept for the position of nursing (Walby et al, 1994). The situation is further explained by the following:

> There was, then, a quite extraordinary contrast in the managers' eyes between the individual power of doctors and the collective feebleness of nurses; between medicine's influence at the highest levels and nursing's notional representation; between doctors' fierce syndicalism and nursing's massive internal hierarchy. But having drawn that contrast, it is crucial to see that the two are very intimately linked. Nursing's hierarchy stemmed not so much from within nursing itself, as from the many powerful forces — medicine, gender and the demands of an extremely labour-intensive industry — which had created, shaped and controlled the nursing trade. The effects of these three closely interlinked forces was to powerfully subordinate the entire occupation. As a consequence it had reproduced internally the structure of its external domination. Tight control from without meant rigid hierarchy within. Though many deeply resented it, nurses had been — and mostly continued to be — the handmaidens of the medical profession, a servant class (Strong and Robinson 1990:39)

1.2.3 Corporate Culture

Nursing in the healthcare system is part of a corporate culture that traditionally and currently defines nursing as powerless. Unlike most modern organisations, with their

flatter, less hierarchical organisational structures, most healthcare organisations still support the classical vertical hierarchical model. Nursing, as vast as it is within that culture, does not have well-defined hierarchical power and generally has no real power in the authority pyramid. In addition, top-level nurses, unlike their colleagues in medicine and general management, have narrowly defined authority which is generally restricted to nursing issues only; rarely do they have any real power over wider organisational matters (Moss 1995). Within that culture and in keeping with oppression theory, nurses as a group do not support each other, have unreal expectations of their leaders and strike out at their leadership (Roberts 1983., Dyson 1994). This leaves nursing divided within itself and unable to sustain strong leaders, which results in nursing remaining powerless (Davidson & Cole 1991).

1.2.3.1 The Glass Ceiling

The invisible barrier that nursing faces in the healthcare system may be referred to as a 'glass ceiling'. The term glass ceiling was first used to describe an invisible barrier that prevented women near the top of the corporate ladder getting to the top of the corporation (Morrison, White & Van Velsor 1992). The obstacle on the ladder to success is in reality gender discrimination and reflects society's male-dominated corporate culture; the strength of the glass ceiling represents the power structure of the male-dominated culture (Crawford 1993). Given the model of gender-based segregation in healthcare organisations, with the traditionally male occupations of medicine and general management and the traditionally female occupation of nursing, the issue of the glass ceiling in relation to the development of nursing is of the utmost importance (Keen & Malby 1992., Robinson 1992., Moss 1995).

In making moves towards removing the glass ceiling, nursing has in relation to management issues met with more opposition from general management than from medicine (Witz 1992., Labour Court 1999). However, in relation to nursing striving to move away from its 'assistantship' to medicine (May & Fleming 1997:1097), in primary nursing, nursing theories and research-based expertise are used to provide frameworks of care which are developed independently of medical direction (Keen & Malby 1992., Walby et al, 1994), and this creates a tension between medicine and nursing (Walby et al, 1994). Nursing traditionally is accustomed to pressure from medicine and general

management, but latterly it is experiencing new pressures from other healthcare professionals such as occupational therapists, physiotherapists and social workers and from care assistants (Walby et al, 1994), new pressures which Dyson (1994) cautions that nursing ignores at its professional peril.

1.2.4 Conclusion

Culturally the task facing nursing professionals as a group is to maintain and transfer its symbolic structure to the next generation of nurses. Its primary function is 'protecting and transferring knowledge' (Suominen, Kovasin & Ketola 1997:189). Strategies must be developed which empower nursing to move emotionally and cognitively away from the Nightingale model of nurses as pure, obedient, womanly, dutiful, skilled handmaidens of doctors (Witz 1992:65).

In order to crack the political, corporate and clinical glass ceilings, move to the top echelons of the healthcare system and effect real change, Fawcett-Henesy (1998) and Moss (1995) state that nursing needs to be proactive in developing educational, legal and organisational structures, to create its own opportunities and to change its behaviour.

1.3 Gender in Nursing

Historically, the Brehon laws in Ireland provided for hospital construction and the types of nursing care to be given within these hospitals. 'Nurse-tenders' were assigned to the care of the sick, and only males could be nurse-tenders. The Brehon laws in one edict to nurse-tenders specified that 'Dogs, fools and female scolds must be kept away from the patient lest he be worried' (Abdellah 1971:221). If we fast-forward to modern society, the outcome of the Nightingale and Fenwick (Mrs Bedford-Fenwick was a close associate of Nightingale and leading pioneer of modern nursing (Orr 1992., Nolan 1993)) programmes was to create a respectable female occupation, which has resulted in current society's assumption of the 'naturalness' of the caring role as a female domain (MacKintosh 1997:235). Although history indicates that men have had their place in nursing, the introduction of Nightingale-trained nurses or 'reformed' nurses created a non-religious nursing sisterhood on the European model (MacKintosh 1997). The British Nursing

Association, under the influence of Mrs Bedford-Fenwick, was particularly hostile to the suggestions that it should offer certification to male asylum attendants and draw the two branches of nursing together (Dingwall 1979., MacKintosh 1997). Meanwhile, male attendants worked in asylums and formed in Ireland and Britain the Medico-Psychological Association. In Ireland in 1920 the State Register for nurses was introduced, which held men and women in separate parts of the register, a rule that ended with the Nurses' Act 1985 (Ryan 2000).

1.3.1 Gender Influence in Nursing

The influence of gender in the workplace is a complex web (Walby et al, 1994). In nursing it might be assumed that, because approximately 90 per cent of nurses are female, equality in vertical job promotion exists; however, research shows that classical vertical job segregation exists in nursing (Borman 1993., Ryan & Porter 1993., Walby et al, 1994., Cianni & Romberger 1995., O'Connor 1996., Lane 1998).

Contemporary studies conceptualise patterns of vertical job segregation in terms of employment 'pyramids', which are generally found in both occupational and organisational structures, with women over-represented in the lower ranks and under-represented in the higher ranks (Dickerson & Campbell-Heider 1994., Crampton & Mishra 1999). This situation is described as women as being 'on tap' as opposed to being in the top echelons of the organisational structure (Ely 1994., 1995., Mani 1997).

Relative to their number in nursing, men attain a disproportionate number of top-level positions. In endeavouring to explain this, some suggest that the dominant male orientation of the healthcare system extends to nursing (Cheng 1990., Ryan & Porter 1993). Others suggest that being a woman in the healthcare system is a barrier to obtaining top-level positions, which reflects the wider gender differences found in the healthcare system generally (Borman 1993., O'Connor 1996). Other writers suggest that the examination of the career progression of men and women in nursing should be done against the wider social context, which sets specific cultural expectations of life-plans for men and women (Dingwall 1979). Ambition is embedded in male socialisation, while 'giving' is part of the female socialisation process (Baumgart 1999). Others suggest that for men the impact of ambition is strengthened by the degree to which nursing represents a significant social route for men (Dingwall 1979., Baumgart 1999). Males in nursing tend to be less well-

qualified and to come from lower socio-economic backgrounds than their female colleagues. It is said that nursing offers men a passage which enables upward social mobility (Dingwall 1979., Cheng 1990).

Many healthcare organisational structures continue to have highly rigid models of career development which are detrimental to the career progress of many women while supporting the career progress of many men (Clay 1988., Lane 1998). An Irish study(O'Connor 1996) to ascertain the views of women of promotional barriers in the Irish health service found in relation to nursing that men's chances of promotion generally were two to four times greater than women's and that only one in twenty-eight women had a chance of moving from permanent staff nurse to matron compared with one in fourteen men. Nurses perceived that, although facilitating the integration of work and family responsibilities was seen as an important symbol in the health boards, in reality the system did little more than pay lip service to this, and the barrier to women's promotion was the incompatibility of the organisational structure with their commitment to family life.

Ratcliffe (1996), in considering geographical mobility as a further barrier to women's promotion, suggests that because of family needs women are less likely than men to relocate for promotion (Lyness & Thompson 1997., Lane 1998). Ratcliffe (1996) suggests that this provides further explanation for the gender segregation evident in nursing and that within the patriarchal social structures the rational exclusionary criterion of geographical immobility conceals collective exclusion on the basis of gender commitments and, in terms of promotional opportunities, produces a de facto internal labour market for males. The 'internal market', according to Ratcliffe (1996), is characterised by rules which give employees within it certain privileges, such as organisational promotional opportunities, access to career mobility with continuity and security of employment. Females within the NHS and its micro-organisational structures form the external labour market. The external labour market lacks formal rules and is distinguished by poor career mobility, employment insecurity and job vacancies being filled from outside the organisation. This hidden gendered process creates a gendered structure which may assist in explaining the over-representation of males in the higher levels of nursing and their under-representation at lower levels (Ratcliffe 1996).

Lane (1998) examined the factors that affect women's poor career advancement in nurse management in the National Health Service (NHS) in the UK. It was found that women are failing to enter senior management because of gender-based disadvantage, which goes beyond male advantage. The study found that there was a part-time employment trap. Nurses working part-time are generally women with dependants and are found in the lower nurse grades; because of their part-time status they were excluded from nurse management irrespective of their qualifications and experience. The study also found that there is an imbalance of women without dependants in nurse management. The study basically identified three problems: the low status of part-time work, inflexible working practices, and management inertia to change in favour of those in part-time positions. Despite rhetorical support for the introduction of family-friendly strategies, none of the hospitals were found to have a formal policy on job sharing or any form of flexible working practice (Lane 1998). Similar findings are apparent in other studies, where slower career advancement of women with dependants was not explained by their having fewer qualifications or less experience but was the result of many being unable, because of family commitments, to commit themselves to full-time continuous employment (Clay 1988.,Walby et al, 1994).

It is likely that men's disproportionate success in nursing is, as Walby et al, (1994) suggest, the result of a complex interplay of factors. Whatever the reason, after initial training it takes men on average eight years to reach the grade of nurse manager compared with an average of eighteen years for women. This for women is only partly linked to child-care issues, as women who avail of career breaks take on average twenty-three years to reach the grade of nurse manager, while those who do not still take an average of fifteen years, considerably longer than men (Cheng 1990., Walby et al, 1994., O'Connor 1996., Lane 1998).

Many female nurses respect the courage of men who fight prejudice to work in a traditionally female job (Salvage 1987). However, others argue that men in nursing, rather than being of any great benefit to the profession, organise themselves so that their presence largely benefits the male agenda of control through attainment of senior positions or through producing a disproportionate share of the nursing literature, as opposed to any agenda to benefit nursing *per se* (Ryan & Porter 1993). Other nurses claim that men bring to nursing managerial know-how, industrial relations expertise and a willingness to fight for their rights which raises the status of nursing, while their presence challenges medical

domination. Some males claim that the growing political awareness in nursing is their achievement. While, both male and female nurses agree that male nurses are more likely to be heeded in multidisciplinary settings because of the bias inherent in the male orientation of the healthcare system (Cheng 1990., MacKintosh 1997). However, while many female nurses welcome males into nursing, this does not alter their unease about the disproportionate number of men in top posts, and they fear that the old domination by the matron is being replaced by the domination of female nurses by male nurses (Salvage 1987).

1.3.2 Conclusion

It has been argued that the female orientation of the term 'nursing' contributes to the genderisation of its status; and, further, within nursing itself, gender appears to be highly relevant in the inequitable distribution of seniority and power. Although females greatly outnumber their male colleagues, women are found concentrated in the lower levels, while men, although in the minority, hold a disproportionate number of senior positions. This situation is mirrored in scholarly literature, where men are found to publish more than their female colleagues and thus exert a greater influence over 'how nursing conceptualises itself' (Ryan & Porter 1993:265).

1.4 Socio-Politics

Nursing is an important constituent in Irish healthcare and Irish society generally, not solely because of its national pervasiveness but also because of the nature and diversity of the service it provides. The composition and construction of nursing are said to mirror the apparent 'natural' order in society. Thus any changes in the composition and structure of nursing may reflect changes in elements of society generally (Salvage 1992:25). Yet the evidence of a political contribution by nursing to public society is limited. This, nurses hold, is in part related to the worth that Irish society places on nursing and its products (Clare 1993). It is further said that this occurrence may reflect women's position in society: because nursing is a female-dominated profession, society contributes through its structures and processes towards preventing nursing from entering the political arena (Baumgart 1999).

Historically, nursing does not determine its own future but allows its direction and development to be shaped by others (Robinson 1992., Maslin-Prothero & Masterson 1998). The socialisation paradigm may assist in understanding the position of nursing, as a predominantly female profession, in political life. This paradigm holds that society's traditional specification of masculine and feminine roles deprived women of political education and hindered their interest and motivation to become politically active. This paradigm further holds that the socialisation process encouraged women to undervalue and underestimate themselves, resulting in women being psychologically and experientially disadvantaged for any participation in public political life (Baumgart 1999).

The nursing profession has always had difficulty in gaining access to political policy- and decision-making (Robinson 1992., Clare 1993., Chavasse 1998). In recent times probably the greatest development of healthcare services was in the setting up in 1949 of the NHS in Britain. This enterprise serves as possibly the best example of how nursing in the recent past allowed itself to be dominated by other groups in the political world. The then Minister for Health, Aneurin Bevan, in the formal strategic planning of the NHS did not include nurses in the negotiations; he did not consider nurses to be of sufficient importance to form any part of those strategic decisions or planning (Walby et al, 1994). The nursing profession reacted by not reacting: it did not take lobbying action (Rafferty 1992), which contrasted sharply with the action taken by the medical profession. At time the medical profession placed itself at the heart of policy-making, adopting a 'syndicalist' approach (Starns 1996:39): it formed with the Department of Health and politicians what was described as 'an iron triangle' (Hart and Walker 1997:42). This triangle proved effective in excluding nurses from the key decision-making process (Starns 1996., Hart & Walker 1997., Rafferty 1992).

The lack of action on the part of the nursing profession was noted at the same time in Ireland by the then Minister for Health, Dr Noel Browne, who, in addressing a nursing conference in 1949, said 'The apathy of the nursing profession surprised me...you nurses have made little effort to help me help you. Nevertheless I shall continue in my efforts to ensure that members of the nursing profession shall enjoy the conditions of service and status they deserve' (Ryan 2000). Strong and Robinson (1990) in studying the effects of management reforms on the NHS found that, although nurses make up one-half of the workforce and account for one-third of the pay budget, the culture in relation to nursing established at the foundation of the NHS prevails. Their reported observations were that

doctors and managers generally received most of the attention, while nursing was generally ignored. This situation is reflected in the Irish context, where many of the national health and strategy policies do not have nurse representation in the strategic apexes. Generally, if found, nurses are on sub-committees, and nurse representation is never relative to its numbers, its role and the extent of its services, a situation that is not replicated for medicine or management in national polices such as Planning for the Future (Department of Health 1984) and Shaping a Healthier Future (Department of Health 1994), Quality and Fairness (Government of Ireland 2001a), Report of the National Advisory Committee on Palliative Care (Department of Health and Children 2001b) and in more local structures such as the East Coast Area Health Board (2003). This is a situation that appears to be uncontested by nursing and its professional associations, demonstrating a long history in Ireland of a lack of political action.

Robinson (1992:5) noted this continued lack of interest by nursing in relation to politics and policy issues and labelled it 'the black hole theory of nursing'. In describing this term, she noted through her study that nurses were unable to view their own work within a broad policy context. They were instead magnetically focused on internal preoccupations and were practically never involved in any real policy decision-making processes. Importantly, what may have passed as nursing decisions were in reality nursing endorsements of others' decisions.

1.4.1 Politics

Politics, described as the process of accumulating power and influence (Skinner 1994), is about 'knowing your business and knowing how to present it' (Antrobus 1998:27). For nursing, being effective in politics means understanding how the agendas of powerful lobby groups affect the social structures that drive healthcare reforms, understanding political influence, and understanding the political agendas of power-brokers and their influence in securing resource allocations (Antrobus 1998).

Nursing is shaped by politics, and the political task facing nursing is to make visible the nursing agenda in healthcare policy and the broader political arena. It is said that, where nursing has been involved or has involved itself in political debate, it has generally focused on health and social need and health and social care funding, with little reference to policy-

making (Maslin-Prothero & Masterson 1998). To begin to have control of its destiny and nursing practice, nursing must engage in policy-making (Moss 1995). This political agenda requires leadership (Rafferty 1992., Salvage and Heijnen 1997., Fawcett-Henesy 1998) and political awareness (Dickerson & Campbell-Heider 1994., Taylor 1995., Antrobus 1998., Chavasse 1998).

Research suggests that, where nursing has attempted to influence policy, this has generally been undertaken by individual nurses. This individualistic approach has limitations; it does not harness the potential strength that nursing has in its ability to develop a collective, unified voice on issues of political importance (Skinner 1994., Antrobus & Kitson 1999). It is imperative that nursing is collectively represented by professional associations (Skinner 1994); to lobby for nursing, these associations need to understand and influence the contextual ideology which is shaped by the political process (Antrobus 1998., Fawcett-Henesy 1998., Antrobus & Kitson 1999). Nurses need to move away from the traditional power bases that are generally referred to as 'power over' (Antrobus & Kitson 1999:758) and seek to influence policy from a power base that sits more comfortably with nursing ideology, termed 'power to' (ibid,:754), to achieve objectives through an interpersonal process (Hokanson Hawks 1991., Antrobus 1998). By the development of power as a productive force, nursing will develop and establish itself in the wider socio-political world (Gilbert 1995., Taylor 1995). To be effective in the political world requires nursing to perfect the skills of 'politicking' (Skinner 1994:61). These skills include analytical critical thinking, articulation and opportunistic action (Antrobus 1998).

1.4.1.1 Nursing Policy Units

Recently most European nations have set up a Nursing Unit (Salvage & Heijnen 1997., Chavasse 1998). The Department of Health and Children in Ireland established the Nursing Policy Unit in 1998. Up until that time nurses in the Department had worked in different units and had demonstrated no unity in making a nursing voice heard by policy-makers (Chavasse 1998). This lack of unity is characteristic of nurses generally and is one of the major reasons for the dearth of policies and policy development (Salvage & Heijnen 1997., Chavasse 1998., Fawcett-Henesy 1998).

The setting up of these units might indicate that nursing has been successful in gaining a measure of recognition; however, recognition does not necessarily mean effective influence. Even though governments now consult nursing more regularly on policy issues, policy decisions with far-reaching implications for nursing services are still made without the input of nurses. Where input is sought and even where the views of nursing on particular issues are accepted, there remains a tendency to ignore nursing's policy solutions (Salvage & Heijnen 1997., Fawcett-Henesy 1998., Baumgart 1999).

Salvage and Heijnen (1997) found that most European nations, including Ireland, appointed nurses in an advisory capacity only. This function is carried out by the chief nurse or other senior nurses employed by the government. It was found that nurses in these countries reported significant difficulties in influencing policy. In response to this situation Fawcett-Henesy (1998:21–22) said: 'I'm not always keen on pushing for something for the sake of it. We've pushed for a government chief nurse in each country and didn't think that through as carefully as we might have. In some countries, the governments feel they have satisfied the WHO [World Health Organization] by having a government Chief Nurse and that's an end of it. What can then happen is that somebody is appointed for the wrong reasons and who does not have the qualities, the educational base, and the attributes to be an effective nurse leader. Sadly therefore they fail and it's very easy then for governments to say well, we've done what you wanted, she was useless'.

1.4.2 Socio-Economics

Ireland has recently experienced unprecedented economic growth and social changes. While economic growth may have slowed, social change continues. The employment market which opened up offered people new employment opportunities in more attractive areas, resulting in a general shortfall of healthcare staff and in particular nurses. The resultant impact on the healthcare system as a service-intensive industry in some cases is almost reaching crisis point, with the curtailment of some acute and chronic service provision. Socially, Ireland is experiencing movement towards greater public and professional accountability. In healthcare people are questioning the provision and quality of services across all sectors in formal enquiries such as the Lindsey Tribunal 2000.

During this time of economic wealth, nursing, through the Commission on Nursing (1998) and the national nurses' strike in 1999, brought about many developments for its profession. However, while the current shortage of nurses may be an important trigger for focusing government attention on the problems that nursing is experiencing, it is not in itself enough to ensure continued action and with measurable favourable outcomes for nursing. Nursing shortages may temporarily upset political and economic systems but they do not in themselves threaten public confidence in healthcare and so are unlikely to stimulate a serious response from the stakeholders of power (Rafferty 1992).

Consider the events leading up to Ireland's first national nurses' strike (1999). In the late 1990s Irish nurses felt that there was no official recognition of the changes that were taking place and of the constant irritation of under-staffing and overcrowded working conditions, combined with a lack of financial recognition for additional educational development and expertise. Nurses also had a sense that their needs were invisible to policy-makers, and all of these factors combined to bring matters to a head (Chavasse 1998). In 1997 Ireland averted a national nurses' strike with the establishment and commitment to results of the Commission on Nursing, whose mandate was to examine structural and work practices, specialisation within grades, training and educational requirements, promotion, and the evolving role of the nurse (Chavasse 1998). However, the government was rather slow in implementing some of the Commission's recommendations, and nurses voted for the first national nurses' strike in October 1999.

In earlier times the Lancet Commission in 1931 had been set up to investigate the gross nursing labour shortage in Britain at that time. The Commission concluded that 'the principal cause was diagnosed as chronic neglect of conditions of service and outmoded attitudes; nursing had failed to modernise and as a consequence was losing any previous competitive advantage over supposedly rival occupations such as social work and business' (ibid,:70). However, by the time the Commission concluded its work, Britain had entered an economic downturn and people had started turning to nursing for employment, condemning the recommendations of the Commission's to nothing more than a paper exercise (Rafferty 1992).

Ireland is currently experiencing a negative economic turnaround; should this turn in economic fortunes attract people into or back to nursing, it will be interesting to observe

whether the government will continue with its commitments to nursing made through the Commission (Rafferty 1992).

1.4.3 The Challenge

The challenge facing nursing is to continue to honour the ideology of nursing while empowering the nursing profession to develop its potential within the political domain.

Effective empowerment for nursing firstly requires studying the ways in which power operates in nursing, in healthcare generally and in the socio-political contexts. It is suggested that this study should begin by identifying the socialisation practices through which nurses are formed. Gilbert (1995), drawing on Foucault's work, suggests that it is these socialisation practices and their associated norms and values which nurses carry with them in their everyday lives and which impinge on their perceived professional power to act for nursing. Nurse education and professional development must establish in students and nurses an awareness of health and social issues and how these issues influence nursing and its practice (Tierney 1990). The accomplishment of this challenge will be reflected in nursing taking a meaningful place in the socio-political arena.

Gilbert (1995) in discussing the socio-political aspects of empowerment, chose Katz's political model. This model draws on the concept of 'synergy', that is, the effects of combined energies result in production of greater resources than would have been produced from the mere sum of the energies of the individuals involved. Thus nurse leaders need to be aware of the power they hold as a group, this power being based in their clinical knowledge, their knowledge of the healthcare services and their alliance with patients (Tierney 1990., Hokanson Hawks 1991., Valiga 1994).

1.4.4 Conclusion

The effects of politics on the socio-political life of nursing is immense, and it is therefore important to note that twenty-first-century political society is seeking to include all minorities, that is, those groups including nursing who have found themselves marginalised in the political arena. Thus the twenty-first century presents nurses and

nursing with a choice: determine your own future or continue to allow others do it for you and for your profession.

To determine its own future nursing must develop strategies to redress the imbalance of power which exists between itself and the powerful influential political groups. If nursing continues to collude in and acquiesce to its exclusion from political life, it will perpetuate its lack of control of the critical contingencies for self-determination (Ibarra 1992) and directly contribute to its own continued marginalisation in socio-political life.

1.5 Nursing as a Constituent of the Healthcare Structure

Current Western world trends are towards the development of cost-effectiveness in public services. These trends are influential in healthcare in the establishment of a dominant economics-driven organisational structure (Hurley 1993).

Nursing as a constituent of these structures is dealing with the uncertainty of these organisational and political issues (Taylor, White & Muncer 1999), in addition to dealing with societal changes, changes to professional nursing and educational structures in a national system which was up to recently dependent on a student nurse workforce (Hamill 1995). Also, at the micro level, nursing continues to work with traditional hierarchical bureaucratically organised structures, poor staffing levels and a lack of psychological support (Taylor, White & Muncer 1999).

For nursing there exist ambiguities and conflict about where its place should be within the healthcare structure. These ambiguities and conflict arise because things are different, unexpected or because they do not match accepted perspectives. It was found in countries identified as 'Western industrial countries' that role ambiguity and role conflict were greater sources of stress than role overload, while in countries identified as 'non-Western industrial countries' work overload was a greater source of stress than either role ambiguity or role conflict (Peterson et al, 1995).

Nursing itself is presented with a further challenge: the changing demography of the nursing population. Nowadays opportunities for men and women are diverse and plentiful; moreover, nursing in the past was undertaken principally by single women who devoted their entire

lives to the service. Now male and female nurses have lives outside the profession (Davidson & Cole 1991). These changes interrelate nursing to other aspects of nurses' lives, and nursing in its application to service provision now has to consider issues such as role complexity. Role complexity is related to an increasing convergence in the occupational and domestic roles and workloads of males and females (Swanson, Power & Simpson 1998). In studies on role complexity, the experiences of married men and women in relation to the conflict of work and family are similar (Doby & Caplan 1995., Swanson, Power & Simpson 1998).

1.5.1 The Psychological Contract

Organisation climate and organisational psychological climate are significant when considering staff wellbeing and are of particular note within the service-driven healthcare system, within which nursing represents 40 per cent of the entire workforce. Organisation climate has been widely defined as the shared perceptions of employees about a given workplace. The organisation's psychological climate is defined as the organisational climate felt at individual level. Climate may foster or inhibit certain outcomes such as positive job attitudes, job satisfaction and staff retention (Hemingway & Smith 1999).

In any organisation its members enter into an unwritten and often unspoken psychological contract (O'Boyle 2000., Coyle-Shapiro 2002). This psychological contract consists of a set of expectations which the particular employee and the organisation have of each other, and each employee has a different contract. The degree of fit between these two sets of expectations denotes the health and happiness of both. The organisation requires loyalty from employees, while generally employees' major requirements are to be taken seriously and to be treated with respect. While psychological contracts may alter as individuals' or organisational needs change, the relationship of loyalty to respect between the organisation and employee remains constant (Statt 1994., Northcott1996., Simpson 1998., Bakker et al, 2000).

1.5.1.1 Conservation of Resources and Dual-Level Social Exchange Theories

Inherent in the psychological contract are theories such as the Conservation of Resources Theory (Lee & Ashforth 1996) and the Dual-Level Social Exchange Model (Schaufeli,

Van Dierendonck & Van Gorp 1996). The Conservation of Resources Theory suggests that positive human outcomes occur when certain valued resources are adequate to meet demands or are found to be sufficient to bring anticipated returns. The major demands of work include role ambiguity, role conflict, stressful events, heavy workload, and pressure. The major resources include social support from various sources and job enhancement opportunities, such as control, participation in decision-making and autonomy. The theory states that behavioural and attitudinal outcomes may occur as a result of resource gain. The major behavioural outcomes have been found to include organisational commitment, job involvement, job satisfaction and employee retention (Lee & Ashforth 1996., Cordes, Dougherty & Blun 1997., Janssen, de Jorge & Bakker 1999).

The Dual-Level Social Exchange Model claims that social exchange processes at the interpersonal, as well as the organisational, level are based on the concept of reciprocity. Reciprocity is a general tendency in human relationships (Schaufeli, Van Dierendonck & Van Gorp 1996) and occurs when a person considers that the investment made by him or her and the outcomes of that investment are proportional to the other person's investment and outcome (Bakker et al, 2000). It is argued that social exchange processes similar to those in interpersonal relationships govern people's organisational relationships (Schaufeli, Van Dierendonck & Van Gorp 1996). According to the Dual-Level Social Exchange Model, these expectations may concern issues such as workload, autonomy and support from supervisors and colleagues. The basic position in the work relationship is that unmet expectations lead to a sense of inequity and may be perceived as a violation of the psychological contract (Van Yperen 1998).

1.5.2 Conclusion

It is thought that recent attention to psychological contracting may be the result of social changes regarding employees' expectations (Doby & Caplan 1995., Scandura & Lankau 1997). It would appear that these expectations are not met in the healthcare system, as employees of that system indicate that breach of the psychological contract is the norm and not the exception (Northcott 1996). Of note perhaps to the healthcare system is that 40 per cent of its workforce is nurses and over 90 per cent of nurses are female: studies have found that females reported higher levels of organisational commitment and job satisfaction if they were working for an organisation that they believed honoured their

psychological contracts (Bogg & Cooper 1994., Scandura & Lankau 1997). While attention to psychological contracts may not correct all healthcare organisational problems, it may provide a means of effecting positive morale, which for nursing would be a welcomed and positive outcome (Northcott 1996) and may assist the nursing profession in retaining nurses, attracting nurses back to nursing and encouraging new entrants into the profession.

CHAPTER 2
LITERATURE REVIEW:
ORGANISATION, DEVELOPMENT AND NURSING

2.1 Introduction

This chapter examines the impact of organisational concepts on nursing and how nursing used and uses these concepts to achieve its aim. It further examines how career patterns and development are enacted in nursing and finally examines what futurists forecast for nursing and its place in healthcare. The chapter is presented in four sections: leadership and management; career patterns; career development; and the future.

2.2 Leadership and Management in Nursing

Increasingly nursing is presenting leadership, and not management as the way forward (Clay 1984., Rafferty 1993., Malby 1996., Bowles & Bowles 2000). However, the concepts of leadership and management are not always clearly defined and are used sometimes interchangeably, without a clear understanding of the fundamental differences between the two concepts. It is therefore important in achieving organisational effectiveness that nurses understand and treat leadership and management as two distinct concepts, to see how they relate to each other and how best they may be applied in practice.

This section examines the concepts of leadership and management and presents the interrelationship between the two and how both concepts interact in nursing and in the provision of the nursing product.

It is acknowledged and recognised that, while the two approaches are based on deep conceptual differences, both leadership and management are crucial for organisational effectiveness (Bennis & Nanus 1985). In order to achieve this effectiveness it is sometimes necessary for leaders to be managers and managers to be leaders (House & Aditya 1997). The principal environment for most nursing service is in organisational healthcare, where,

according to Valle (1999), the purpose of leadership in public service is to train employees to anticipate problems by focusing on specific rules, procedures and policies for handling matters requiring organisational action. Rewards are granted to those who follow the rules, and effectiveness is judged by compliance to standards, rules and procedures. Much of Valle's (1999) description is about management and not leadership. Even in public service in the current climate, stability and predictability are side by side with change and unpredictability. Nursing in the current climate must attempt to achieve stability through the role of management, which is the responsibility for the management of the nursing organisation, for nurse clinical practice, for nurse education, for upholding policies, for managing resources and for maintaining morale (Manfredi 1996). But the leadership role is also vital, in providing a vision, anticipating the future, challenging the past and present, taking risks, introducing innovations and motivating staff towards achieving professional and organisational goals (Porter-O'Grady 1992., Klakovich 1994., Redmond 1995., Manfredi 1996., Buerhaus et al, 1997., Flynn 1998; Dwyer & Taaffe 1998., Cameron Masterson 2000).

2.2.1 Leadership

Despite leadership's profound and global effects (Manfredi 1996), it remains one of the most studied but least understood concepts of human ability and behaviour (Burns 1978). As in all other aspects of life, its impact on nursing is defining and profound (McNeese-Smith 1995). Despite this, definitions of leadership are not scientific but only reflective of political and academic trends (Bennis & Nanus 1985).

The study of leadership is as ancient as the study of human history. It was studied by the ancient Chinese, Egyptians and Greeks. The Egyptians identified leadership qualities as authority, discrimination and justice, while the Greeks identified justice, judgement, wisdom, council, shrewdness, cunning, valour and action as leadership qualities (Bass 1990).

In 1532 Niccolo Machiavelli published Il Principe ('The Prince'). These well-known writings on leadership are said to be Machiavelli's observation of public life during the Renaissance. Machiavelli analysed the balance between principle and opportunism, as observed by the actions of such leaders as Cesare Borgia. The modern-day management

term 'Machiavellian' was born from these writings (Smith and Peterson 1988., Girvin 1998). 'The Prince still stands as the most famous — and infamous — of books of practical advice to leaders on how to win and wield power' (Burns 1978:444). Burns (1978:445–446) in his Pulitzer Prize-winning book writes that 'At the core of Machiavellianism lay the most pernicious and inhuman concept of all: the treatment of other persons, other leaders, as things'. Burns (1978) suggests that the transforming leader will in the long run prove more effective than the Machiavellian-type manipulator. Smith and Peterson (1988) and Girvin (1998) contend that Machiavelli's analysis continues to offer much on the concepts of power and influence to the process of leadership.

2.2.1.1 Systematic Study of Leadership

Some first steps towards a more systematic analysis of leadership are found in the nineteenth century. Carlyle's 1841 discussion of heroic leadership and Galton's (1870) emphasis on the inheritance of leadership qualities were influential ideas in their time (Smith & Peterson 1988). The systematic scientific study of leadership began in the early 1930s and mostly reflects Western industrialised culture. The common characteristic of these earlier theories is that they viewed followers as subordinates to the leader and were primarily concerned with the relationship between leaders and their immediate followers (Smith & Peterson 1988., House & Aditya 1997). The systematic scientific study of leadership largely ignored the type of organisation and culture in which leaders function and the relationships between leaders and their superiors and between leaders and their peers, external factors and the type of service provided by the organisation (House & Aditya 1997).

2.2.1.2 Trait Theory

The first studies focused on the search for individual traits or characteristics that universally differentiate leaders from non-leaders. A natural implication of this approach to leadership is the notion that leaders are, to a substantial extent, born and not made. Trait theory fell into disfavour as critics concluded that it was insufficient to study the leader only. Both the person and the situation had to be included to explain the emergence of leadership (House & Aditya 1997).

In the early 1970s, interest in the trait approach re-emerged. In 1974 Stogdill, one of the most influential researchers to address trait theory, found that his earlier review of trait literature may have been incorrect in underestimating the fact that certain traits exhibited by leaders might not be universally found (House & Aditya 1997). Research into inherited personality traits continues, and among the current most influential studies is the ongoing Minnesota Study of Twins Reared Apart, commenced in 1979.

2.2.1.3 Behavioural School of Leadership

Following the disenchantment with the trait approach to leadership, there ensued a period of almost 30 years during which leaders were studied in order to uncover and describe the behaviour of individuals in positions of authority and to relate these descriptions to various criteria of leader effectiveness. Research conducted within this paradigm became known as the 'behavioural school of leadership'. During that period Lewin (1951) isolated common leadership styles, described as authoritarian, democratic and laissez-faire (Smith & Peterson 1988., Clutterbuck & Crainer 1990., Marquis & Huston 1996).

The major empirical contributions from the behavioural school are the identification by the Ohio State group and the Michigan group of two broad classes of leader behaviour: task-oriented and person-oriented. However, as with trait research, little thought was given to the specific role demands of leaders, the context in which they function, or differences in dispositions of leaders or followers. This oversight was thought to be the reason for the researchers' inability to identify leader behaviours that had universal or near-universal effectiveness (Smith & Peterson 1988., House & Aditya 1997).

New theories were developed, but these theories continued to be in the shadow of earlier theories in that they still focused on leadership in terms of the activities of the leader only as being central to the process. It was not until later that theorists began to develop leadership theory, which holds that both leaders and followers are central to the process. Contingency theories consider how situational factors alter the effectiveness of particular leader behaviours and styles of leadership. These theories propose that the effectiveness of any one style of leadership is contingent or dependent upon the work environment within which the leader operated. The key is to fit the leader's style to the situation in which he/she is expected to prove effective (Punnett & Shenkar 1996).

Among the major theories in this genre are Fiedler's Contingency Theory of Leadership (Fielder 1967), the Path–Goal Theory of Leader Effectiveness (House & Mitchell 1974) and Hersey and Blanchard's (1988) situational theory (House & Aditya 1997).

2.2.1.4 Transactional Leadership

Burns (1978) identifies two types of leadership: transactional and transformational. Transactional leadership approaches are based on the promise of reward or the threat of discipline, depending on followers' performance of specific and measurable tasks. Burns (1978) likens the transactional leadership style to that used by the traditional manager, who concentrates on daily operational activities, with the interactions between leader and followers being short-lived, sufficient only to complete the task (Trofino 1993., Dunham-Taylor 1995., Dunham-Talyor & Klafehn 1996) divide transactional leadership into two categories: contingent reward and management by exception.

Although transactional leadership style comes under the heading of leadership, it has many of the properties of management, in that it focuses mainly on short-term effects. It is an approach that, according to Girvin (1996a, 1998), McCarthy (1998) and Carney (1999), with its autocratic style, served nursing in the past. However, it is argued that it has also helped to place nursing in the crisis in which it finds itself today (McCarthy 1998., Carney 1999).

2.2.1.5 Transformational Leadership

Burns (1978) describes transformational leadership as leaders and followers raising each other up to higher levels of motivation and morale. The transformational leader is described by Bass (1990) as being a visionary who, in addition to achieving organisational goals, develops followers to achieve their own potential and goals. Within this approach, for the first time in leadership theory, followers and leaders are viewed as being equal contributors in achieving organisational goals. Basically, transformational leadership theory strives to move away from the traditional 'us and them' style to an all-inclusive style of leadership (Burns 1978., Mackie 1987., Altieri & Elgin 1994., DiRenzo 1994., Marcoulides et al, 1998., Laurent 2000). Developing a synergistic relationship between followers and leaders is viewed as crucial to the achievement of shared goals in the

execution of leadership (Trofino 1993., Royal College of Nursing 1995). Bass (1990) identifies four components essential to transformational leadership: charisma, inspiration, individualised consideration and intellectual stimulation.

Many writers on leadership in nursing advocate transformational leadership (Dunham & Klafehn 1990., McDaniel & Wolf 1992., Porter-O'Grady 1992., Young 1992., Davidhizar 1993., Trofino 1993., Altieri & Elgin 1994., Baker & Young 1994., Cassidy & Koroll 1994., Rost 1994., Stevens Barnum 1994., Wolf, Boland & Aukerman 1994., Dunham-Taylor 1995., Dunham-Taylor & Klafehn 1995., Dunham-Taylor & Klafehn 1996., Girvin 1996a, 1998., McCarthy 1998., Carney 1999., Bowles & Bowles 2000). However, adequate research to identify the relevant experiences and patterns of transformational leadership has not as yet been reported, and, further, it is suggested that contextual factors have a significant influence on the emergence, operation and effectiveness of transformational leadership (Bass 1990., Punnett & Shenkar 1996., Shankar Pawar & Eastman 1997).

Some writers advocate that balance be sought between transactional and transformational leadership and suggest that the crucial purpose for nursing is to understand the collective activity, involving the resources and motives of both the leader and the followers, to obtain their shared goals (Mackie 1987., Klakovich 1994., Rost 1994). Dunham and Klafehn (1990) state that, while transformational qualities are highly desirable, they need to be coupled with transactional qualities, which heed the day-to-day operations and the more traditional management style. This reinforces the notion that good leaders have a variety of styles and interventions available to them and can choose the most effective for the specific situation (Niehouse 1984., Girvin 1996a, 1998).

2.2.1.6 Other Leadership Perspectives

Leadership is described by Arndt and Daderian Huckaby (1980) from psychological, sociological and anthropological perspectives. The psychological perspective requires the leader to stimulate and motivate followers towards organisational achievement. The sociological approach to leadership is seen as one of facilitation: the leader is perceived as establishing goals, reconciling organisational conflict between followers, and exerting influence by performing these activities; the purpose of goals is to provide direction and

guidance to followers. The anthropological approach to leadership takes account of the values and purposes of individuals and examines the environmental culture.

In recent times, with more women entering and remaining in the workplace, some researchers have focused on feminine and masculine styles of leadership. Many describe the feminine style as one of sharing and inclusion, while the masculine style is described as being tough, bold and determined (Halgesen 1990., Rosener 1990., Stivers 1991., James 1998). The genderisation of leadership styles does not mean that men and women are excluded from adopting either approach, nor that one gender is more effective in leadership than the other. It was one of the earliest management theorists, Mary Parker Follet, who first suggested that leadership style should vary according to the situation or the employees, and she stressed the need for integration which involved finding a solution that satisfied both sides, without having one side dominate the other (Marquis & Huston 1996). Whatever the preferred style, leadership is described as having vision, providing inspiration and behaving in a manner that reinforces the vision and the values inherent in nursing (House & Aditya 1997).

2.2.2 Management

The emergence and growth of thinking on management, like leadership, started in the days when people originally set out to achieve goals by working together in groups (Koontz & Weihrich 1989). Modern operational management theory dates, like modern leadership theory, principally to the early twentieth century. The development of modern operational management theory is largely attributed to Taylor, Gilbreth, Gantt, Weber, Fayol, Hamilton, Guilick, Barnard, Burt, Follett, Mayo, McGregor and Argyris (Koontz & Weihrich 1989., Drucker 1992., Marquis & Huston 1996).

During the 1950s, leadership theory was developing separately from management science. It was not until the late 1960s that researchers began to understand how complex and intertwined management and leadership are (Stevens Barnum 1994). This complexity is currently reflected in the struggle that appears to exists in nursing as regards the separation of management and leadership as concepts and the rapid rise of leadership and rapid decline of management education (Irurita 1988., Department of Health Nursing Division

1989., Manfredi & Valiga 1990., Rafferty 1993., Terry 1993., Farrington 1994., Girvin 1996a, 1998., McCarthy 1998., Laurent 2000).

Management, according to House and Aditya (1997), consists of: implementing the vision and strategy of organisations; coordinating and staffing the components of organisations; administering the infrastructures of organisations; and handling the day-to-day problems that inevitably emerge in the process of strategy and policy implementation and ongoing organisational functioning.

Many of the leading theorists have sought to explain the distinction between the concepts of leadership and management. Management, according to Covey (1995), is efficiency in climbing the ladder of success, while leadership determines whether the ladder is leaning against the right wall. According to Bennis and Nanus (1985), management preserves the status quo, while leadership challenges the status quo. Managers asks 'how?' and 'when?'; leaders ask 'what?' and 'why?'. Leaders do the right thing, while managers do things right. Handy (1995) suggests that leadership is about trust and that the leader focuses on people and interpersonal skills to build trust, while the manager focuses on systems and structure in order to control. Watson (cited in Mullins 1996) used the 7S's organisational framework to describe the difference between management and leadership. He suggests that managers tend to rely on strategy, structure and systems to achieve organisational objectives, whereas leaders tend to rely on the 'soft' s's: style, staff, skills and shared goals. Zaleznik (1977) suggests that leaders are obsessed by their ideas: they are visionary and they stimulate and drive others to create their reality out of fantasy. In contrast, the manager is hardworking, analytical, tolerant and fair-minded, demonstrates a strong sense of belonging to the organisation, and takes pride in maintaining the status quo.

Although the two roles differ fundamentally, both are crucial (Bennis & Nanus 1985). In reality, for organisational effectiveness, it is important for managers to be leaders and leaders to be managers (House & Aditya 1997). The distinction is drawn between the new-style leader–manager and the traditional-style manager-only. The leader–manager, in contrast to the traditional old-style manager, emphasises vision, values motivation and renewal, and can cope with conflict (Gardner 1990). This notion is supported by Kotter (1990), who believes that both strong leadership and strong management are necessary for an organisation to function effectively but considers that most organisations are under-led

and over-managed. This is a criticism that has also been levelled at nursing (Clay 1984., Rafferty 1993., Bowles & Bowles 2000).

2.2.3 Conclusion

While the use of control is put forward as one of the central elements of the success of nurses as managers, it is equally thought to be one of the major contributors to their developmental failures as leaders (Laurent 2000). Others suggest that nursing's failure as regards the role of leader–manager lies in its inability to implement change (Clay 1984., Rafferty 1993., Rost 1994) and its maintenance of the status quo (Bennis & Nanus 1985). It is further suggested that nursing's failure in leadership is based on its over-reliance on the transactional approach. With its myopic emphasis on organisational goal achievement and little regard for employee development, this approach served nursing in the past but may also have contributed in placing nursing in its current crisis (McCarthy 1998., Carney 1999).

In recent times many writers on leadership in nursing, in seeking to steer nursing away from traditional management and towards the realm of leadership and/or the role of leader–manager, advocate transformational leadership as the ideal. They hold that the crucial focus for nursing is to understand its collective activity, involving the resources and motives of both the nurse leader and the nurse follower to obtain shared goals (Mackie 1987., Young 1992., Davidhizar 1993., Trofino 1993., Rost 1994., Wolf, Boland & Aukerman 1994., Dunham-Taylor 1995., Girvin 1996., McCarthy 1998., Bowles & Bowles 2000). However, Carney (1999) questions the ability of transformational leadership alone to meet the demands of the complexity of the current changes in nursing and in healthcare generally. Dunham and Klafehn (1990) support this concern and state that, while transformational qualities are highly desirable, they may need to be combined with transactional qualities, which focus on day-to-day operations and are geared towards the more traditional management style. This reinforces the notion that good leaders and good managers are nurses who choose styles and interventions most effective in the specific circumstance (Niehouse 1984; Girvin 1996a, 1998).

The nurse leader who is successful in the stable situation may not operate successfully in this changing environment without assistance to guide him/her towards adaptation and flexibility (Scase & Goffee 1990., Simpson 1998., Valle 1999). No leader today can

approach work without a recognition that the entire culture of work is being transformed from the work culture of the past. Thus, the developmental challenge facing the leader is leaving behind her/his old skills and embarking on a lifelong journey of learning (Porter-O'Grady 1992).

2.3 Career Patterns

The concept of a nursing career is defined as the sequence of events and experiences concerning employment in the years after qualification, and the way in which these interact with other life experiences (Robinson, Murrells & Marsland 1997). Few studies have addressed career patterns and development in nursing, and so little is known of how nurses make career decisions (Davies and Conn 1993., Robinson, Murrells & Marsland 1997), in particular how nurses decide to go in the direction of top-level leadership and management. The general study of career patterns and developments would appear to focus mainly on patterns and development in the private business sector, with few studies found in the public services sector. This section presents career patterns and developments in relation to the population generally and also shows how these patterns and developments are influenced by gender.

Throughout their careers people make choices and decisions that have strong implications for their career development. For women, generally, career choice will have less influence on success than for men, as the impact of that choice is reduced by organisational barriers to women's progression. For men, significant to their success at the start of their career is the economic, macro-societal opportunities affecting organisations at that time, whereas significant to women's success are career-based move decisions. Generally, career choices have strong effects on progress and success: good choices lead to positive effects and career success, while the negative effect of poor choices is hard to change, particularly in the later stages of a person's career (Melamed 1996).

2.3.1 Career and Social Structures

Important in the study of career choices is the freedom that individuals have in making choices and the limit to which they are curtailed by social and organisational opportunities.

Roberts (1983) argues that career patterns and developments are influenced and determined not by individual choice alone but also by the degree to which components of the social structure may influence, limit or determine an individual's choice, components such as socio-economic factors, educational achievement, gender and ethnic grouping, and organisational recruitment and retention policies. Melamed (1996) further states that career opportunities for individuals are determined in social contexts. Social contexts are classified on three influential levels: the macro-societal and industrial level; the intermediate–organisational level; and the micro-occupational level. The macro-societal level is demographic factors and the impact that these factors have on employment opportunities. The intermediate–organisational level is organisational career opportunities and the impact of organisational structures and strategies on employees' career development. At the micro-occupational level, career success is assessed by the type, influence and power assigned to a job within an organisation (Melamed 1996).

2.3.2 Career and Gender

In nursing, female nurses have a propensity to make lateral moves, often between training positions and staff nurse posts. They will spend some time as a staff nurse in a particular area of practice before taking up another training post and will then return to practise at staff nurse level. This is referred to as certificate-gatherer syndrome (Hardy 1983). Male nurses, on the other hand, tend to take a more linear route up the nursing hierarchy. Hardy (1983) confirmed this pattern in her study and suggested that lateral movement delayed the upward career mobility of women for an average of 9.4 years.

Gender career development differences are evident generally between men and women, and are evident specifically between men and women in the same occupations; these differences tend to remain throughout career life (Nicholson & West 1988). Generally, the most significant difference in career development between men and women has been found to take place in the age range of 30 to 50 years (Bardwick 1980). Women tend to experience strong career changes between the ages of 28 and 39, beginning their general move towards more autonomy between the ages of 40 and 50, which is the time when the demands of men's careers tend to be diminishing, with men becoming less autonomous and more sensitive to interpersonal relationships (Nicholson & West 1988). Men undertake most of their major career changes early in their careers, with job moves becoming less as

they age, whereas women maintain a higher degree of movement throughout their careers. In the early stages they are more likely to take career breaks, and throughout their careers they are more likely to take a circular rather than a linear route (Nicholson & West 1988., Melamed 1996). Women tend to reach equal status to men through different, more specialised, routes, and men reach general positions more readily than women (Nicholson & West 1988). Male and female managers make job moves of different kinds at different career stages, with women moving more often and with more radical switches between jobs, changing employers to achieve career progression (Melamed 1996).

As it is only in relatively recent times that women have begun to develop their careers in the workplace, it is important in exploring women's career development to distinguish between women of different generations and ages. Women in leadership positions in the 1960s and 1970s have had different experiences to those in the 1980s and the 1990s; social trends have changed. There is a significant difference between older single women and their younger married female colleagues. The former tend to describe their earlier work experiences as a series of relatively unrelated jobs which only after some years could be identified as particular patterns of progress; it is only then that they realised that such careers had implications for their personal lives. As members of a 'first generation' of female corporate managers, they became aware of these personal costs when, according to many of them, it was too late (Scase & Goffee 1990). Younger women, however, are more likely to plan their careers and to structure their personal lives around these plans. They establish careers before marriage and/or having children, choose work environments where gender-based prejudices are less pronounced, and as part of their plan they choose partners who will be more likely to assist rather than block their career plans (Scase & Goffee 1990).

Over the last number of years career success for women may have evolved to incorporate elements of self-sufficiency and independence (Ragins & Scandura 1997). However, generally women's preference is for bureaucratic structures where work roles are clearly prescribed and where career opportunities are specified. In these structures women know what criteria to perform against and how to develop career strategies (Melamed 1996).

2.3.3 Family Structures

Male career progress is less likely than that of females to be affected by parenthood and marriage, and these factors are less likely for males than for females to be taken into

account by employers when making recruitment and promotion decisions (Melamed 1996). Tharenou, Latimer and Conroy (1994) found that having a spouse and dependants at home added to women's employment disruption but increased men's career advancement. In a further study of the relationship between family structures and women's and men's managerial advancement Tharenou (1999) found that family structures determined managerial advancement for both women and men but continued to lead to employment disruption for women only.

Career advancement was lower for childless single men and for single fathers than for any other family structures; mothers with employed spouses, that is, post-traditional mothers, advance as much as other women. Marital status more than any other family structure is consistently linked to advancement for men and women. For men in particular, marital status, as well as parental status and spousal employment, is associated with their advancement

The most consistent finding in this study is that married men and married women, with or without children, with employed or unemployed spouses, advance more than single people without children. This is not, in terms of human capital, because of greater productivity; the reason was found to be unclear. Some possible reasons are: less financial need for single people, single adults not conforming to social adult life expectations, or lack of spousal support (Tharenou 1999).

2.3.4 Career Success

Career success is defined by subjective and objective career achievements and progress; it is assessed by comparison to a reference group based on labour market-related factors. Typical reference groups for nurses are other nurses, nurses or other persons of a similar age, and other healthcare professionals (Melamed 1996).

Morrison, White and Van Velsor's (1992) model for career success includes three components: challenge, recognition and support. These interact and sustain career progression over time (Smith & Hutchinson 1995). The model holds that the challenges of new situations and difficult goals prompt people to learn lessons and skills that will help them to perform at higher levels. It posits as well that both recognition - which includes

acknowledgement, rewards for achievement and the provision of resources such as promotions, salary increases and awards - and support - which involves acceptance and understanding - will help to integrate career and personal lives into rewarding experiences (Morrison, White & Van Velsor 1992). The weakness of this model is that it assumes that all three elements are throughout time in the same relative proportions (Burke & McKeen 1994).

2.3.5 Career Determinants

The determinants and influences on career achievement for employees can be classified into three groups: human capital attributes of the employee, career options taken by the employee, and opportunities structures open to the employee (Melamed 1996). The human capital approach views employees as a human resource with a defined labour market value. It assumes a relatively homogeneous and competitive labour force, in which individuals are rewarded for their work relative to their worth as human capital. The personal attributes of an individual are varying types and amounts of capital, which can be converted into rewards in the labour market. The human attributes can be classified into three types: job-relevant attributes are the components that provide for effective work performance at least 90 per cent of the time; job-specific attributes are the components that facilitate effective performance only in specific jobs; and job-irrelevant attributes are the components that do not add to effective performance. One job-relevant attribute is mental ability. This is important in affecting career achievement as it is fundamental to the pace and thoroughness of job-related knowledge; in new situations it enhances innovation and the quality of priority-setting and modifies motivational states. Personality traits are job-specific human capital attributes; although it is not possible to identify an ideal personality profile, there is evidence to suggest that people who advance on the managerial ladder across occupations share fairly similar personality profiles (Melamed 1996).

Career success requires gender-specific examination. It is suggested that men's success in the workplace comes from their focus on achieving a specific career goal or objective, whereas women generally have career objectives that are more diffuse and less goal-oriented. Men are more likely to view work as a means to an end, whereas women are more likely to see work as leading to personal growth and fulfilment (Crampton & Mishra 1999). Women tend to be concerned more with the inner aspects of careers, whereas men

tend to be externally motivated (Nicholson & West 1988). Unlike the traditional male route to success, women's success routes are characterised by job specialisation, interrupted careers and spiral career progress (Melamed 1996).

Traditional factors which influence men's career progress such as interests, aptitude and career maturity are less powerful in explaining women's career progress; women tend to be more influenced by role models and the opinions of others (Miller 1992). Career theories have typically been built on male models of success and work, in which there is an assumption of the significance of work to one's identity and the notion that career success involves separation from others. For women, however, attachment to others, and not separation, is a significant source of both identity and success; women's career development emphasises the importance of relationships, attachments and caring, and values links rather than detachment (Bardwick 1980., Burke & McKeen 1994., Smith & Hutchinson 1995., Crampton & Mishra 1999). In examining the influences on women's and men's managerial advancement, Tharenou, Latimer and Conroy (1994) found that gender appears to influence the career structure and power that enhance managerial advancement. Women's advancement is affected by the indirect impact of encouragement from superiors and peers, combined with the provision of training, but is hindered indirectly by the negative impact of domestic roles on work experiences. For men, work experience combined with training has a greater impact on their advancement than encouragement and training. Domestic roles generally impact less strongly in advancement for men than for women.

In studying men and women's unequal progression in management, it is suggested that women have a tendency to perceive their failures as resulting from their own lack of ability whereas men are inclined to believe that their failures result from factors outside their control. It is suggested that these polar opposite positions in the male and female processes of self-attribution, where the female tendency is to attribute failure directly to self while the male tendency is to attribute success directly to self, may be relevant to the unequal advancement of the sexes (Rosenthal, Guest & Peccei 1996). It is further suggested that women, unlike men, have not traditionally been socialised to pursue career interests as their primary objective and so do not develop through this process many of the skills necessary to succeed in organisational life (Betz & Fitzgerald 1987). This supports the position that socialisation of females may directly contribute towards women and women-

dominated occupations experiencing difficulties in reaching the top echelons of the organisational world (Baumgart 1999).

2.3.6 Conclusion

The tradition of career patterns appears to be clearly established for men. For women, however, it seems that the traditional approach to career advancement needs to be broadened. Particularly in nursing, with its majority female workforce, consideration should be given to the development of a career model. This career model should reflect the diversity of women's experiences in the organisational workplace and in the home and take into account the fact that women place varying degrees of emphasis on the two domains at different points in their lives and that, unlike men, they continue to engage in career progression throughout their lives (Burke & McKeen 1994).

2.4 Career Development

The value of the guidance of an expert in the development of the required attitude and capabilities for leadership and management in the neophyte (Collins & Scott 1978., Roche 1979., De Marco 1993) has a long history in the established male professions of medicine, law and business; however, predominantly female professions such as nursing do not share this rich history of development (Smith Hamilton 1981).

This section examines career development in terms of the place and value of mentorship and its relevance to the development of the neophyte. It further examines the role and value of networking in terms of ongoing development and support throughout a career.

There is a lack of research on the operation and outcomes of mentoring in quantitative or measurable terms; Smith and Hutchinson (1995) and Hale (1995) identify four deficiencies in the literature on mentoring: that it is largely descriptive, that it is not based in theory, that it is not concerned with differences between types of organisations, and that it does not help to answer questions crucial to advancing our knowledge of mentoring. This position is supported by De Marco (1993) and Blackwell (1996). There are, however, multiple studies that indicate the benefits of the mentor relationship to career success (Collins & Scott

1978., Roche 1979., Smith Hamilton 1981., Reich 1985., Noe 1988., Ragins 1989., Dreher & Ash 1990).

2.4.1 Mentors

Many writers feel that mentors do not in themselves create great people; however, these writers suggest that the value of mentors lies in their willingness and ability to nurture the greatness in their protégés, and in the provision of assistance to the protégé in achieving his/her dream (Zaleznik 1977., Levinson et al, 1978., Vance 1982., Merriam 1983., Darling 1985a., Davidhizar 1988., Fields 1991). They perform roles such as teacher, counsellor, guide and sponsor (Levinson et al, 1978., Kram 1983., Crampton & Mishra 1999). This position is supported by Roche (1979), who found that protégés gave their highest rating to a mentor's 'willingness to share knowledge and understanding'. However, Darling (1985b) warns against 'Toxic Mentors', who are divided into four categories — Avoiders, Dumpers, Blockers and Destroyers/Criticisers — and suggests that toxic mentoring may occur because the mentor is not equipped with the required attitude and/or skills or is stressed or 'burnt out' (ibid,:43).

2.4.2 Mentor Relationships

The mentor relationship is described as an intense non-sexual relationship between two adults where the older, more experienced person guides the younger person into the adult world (Fields 1991). It is a complex relationship and developmentally the most important in an adult's professional life (Zaleznik 1977., Levinson et al, 1978). Its influence lies in the process of role socialisation and career development (De Marco 1993). The mentor relationship process has two major functions: career and psychosocial (Kram 1983).

Career functions are those aspects of the process that prepare the protégé for career advancement, aspects such as exposure and visibility, coaching, protection and challenging assignments. The psychosocial functions enhance the protégé's sense of competence, identity and work-role effectiveness (Kram 1983).

Earlier mentor relationship studies found that protégés received greater psychosocial benefits than career-related benefits (Noe 1988., Arnold & Johnson 1997); however, Beech and Brockbank's (1999) study did not support these findings.

2.4.2.1 Mentor Relationship Types

Generally there are two distinct types of mentor relationships: informal and formal (Noe 1988). In both types the mentor is usually a senior, experienced employee who serves as a role model, providing support, direction and feedback to the junior colleague regarding career planning and interpersonal development, while also making the protégé known to the strategic decision-makers in an effort to increase the protégé's advancement opportunities (Noe 1988).

Formal mentoring relationships are usually part of an organisational strategy to develop better-socialised, more committed and more productive employees (Heimann & Pittenger 1996., Scandura 1998). To develop these junior persons, the relationship focuses on the socialisation process, particularly in relation to the given organisation's values, behaviours, and expected performances and outcomes (Heimann & Pittenger 1996., Buckenham 1998). The studies found that organisations generally assign mentors to protégés (Noe 1988), and this assignation is usually where there does not exist a direct line reporting structure between the protégé and the mentor (Fitt & Newton 1981., Haynor 1994). The effectiveness the process of mentor assignment lies in protégé achievement, benefiting both the protégé and the organisation, and it includes assessment of mentor effectiveness and mentor termination techniques (Ragins & Scandura 1997).

Informal mentoring relationships occur when there exists between a senior party and a junior party attraction and a significant sense of shared direction in important matters, 'a same world view' (Davidhizar 1988., Darling 1985a). The mentor has qualities that the protégé would like to develop, and the protégé is one whom the mentor sees as having potential (Fields 1991). Inherent in the relationship is trust and a willingness towards self–disclosure, with mutual emotional commitment (Kram 1983., Davidhizar 1988., Haynor 1994). The relationship usually lasts for a period of three to ten years (Kram 1983., Haynor 1994) and generally ends with protégé achievement (Roche 1979).

One of the key differences between formal and informal mentoring relationships is that formal mentoring usually takes place because of voluntary assignment or organisational matching of mentor to protégé while informal mentoring relationships develop spontaneously (Ragins & Cotton 1999). A criticism of formal mentor relationship programs is that they do not take account of the tenet that is fundamental to mentor relationships: that the two people involved should be attracted to each other and should have a wish to work together (Merriam 1983., Davidhizar 1988). Because of this fundamental tenet, mentors and protégés indicated a preference for the informal type of relationship (Noe 1988). Ragins and Cotton (1999) found that protégés with informal mentors received more compensation and promotions than those without mentors, but no significant differences were found between those with formal mentors and non-mentor respondents. However, where the formal relationship has been found to be useful is in overcoming the reported difficulties encountered in mixed-gender mentor relationships (Ragins & Scandura 1997).

2.4.2.2 Phases of Mentor Relationships

Kram (1983) identified four phases in the mentor relationship process: initiation, cultivation, separation and redefinition. The initiation phase starts at the beginning of the relationship and usually lasts for six to twelve months. This is followed by the cultivation phase, which can last for up to five years, and it is during this phase that most of the development work takes place. This is followed by the separation phase, during which time the established nature of the relationship is altered almost completely, usually by organisational changes and/or by psychological changes in one or both individuals. Finally, there is the redefinition phase, during which time either the relationship changes into a new form or it ends (Kram 1983:622). In studying the ending of mentor relationships, it was found that protégés have no difficulty in ending the relationship once it has served its purpose (Arnold & Johnson 1997., Ragins & Scandura 1997).

2.4.2.3 Mentor Relationships and Gender

Cross gender mentor relationships have value for both men and women in that both sexes bring to the relationship their different perspectives and experiences. However, because of

the nature of the mentor relationship, it is important for both parties to establish an appropriate balance of intimacy and distance that facilitates learning, growth and productivity development (Clawson & Kram 1984). The manifestation of sexual overtones is inappropriate in these working relationships between professionals and should be considered among the possible dysfunctional behaviours that can occur in a mixed-gender mentor relationship (Clawson & Kram 1984., Ragins & Scandura 1997., Scandura 1998).

In studying mentor relationships and gender, Ragins and Cotton (1999) found that male protégés with male mentors did not receive more mentoring than other gender combinations but they did receive greater monetary compensation than any other combination. Male protégés with female mentors were less satisfied with their mentors — in terms of mentor acceptance of their professional development and being given challenging assignments and exposure in the organisation — than female protégés with male mentors, similar to findings from Dreher and Ash (1990) and Scandura (1998). In cross-gender relationships where the mentor was a man and the protégé a woman, it was found that women reported sexual tension as an issue (Fitt & Newton 1981).

Until relatively recently the study of same-gender mentor relationships generally referred to relationships between male protégé and male mentor. However, as more women enter and remain in organisational life, it is now recognised that women-to-women mentor relationships require study. The significance of same-sex mentoring for women lies in the female-specific experience of personal and career lives. Despite increasing social equity, women generally still hold primary responsibility for the home and child-care (Reich 1985). As women are more likely than their male colleagues to have these responsibilities, female mentors tend to have the required understanding to assist female protégés in striking the balance between their dual lives of home and work. Female mentors, with their similar experience, can offer women greater empathy, leading towards increased self-confidence, while developing a good match between professional development and self-image (Ibarra 1992., Hale 1995., Saltzman 1996).

However, women have sometimes been reluctant mentors in same-gender relationships, citing the fear that a protégé's failure might reflect negatively on themselves (Saltzman 1996). There is also a generation issue in that senior women of an earlier generation have made different choices to younger women and they may fear being judged by the younger women for having made those choices (Scase & Goffee 1990., Parker & Kram 1993.,

Saltzman 1996), while junior women, perceiving those of an earlier generation as having made different choices, may fear either having to make such a choice or being judged for making a different one. Also, senior women may be envious of junior women's greater career and social opportunities (Parker & Kram 1993., Saltzman 1996).

2.4.2.4 Dysfunction in Mentor Relationships

Dysfunction occurs in a mentor relationship when the relationship is not effective for one or for both parties (Scandura 1998). Two of the identified causes of dysfunction would appear to be whether the mentor is an immediate supervisor and whether the relationship is perceived by either party as having been assigned (Scandura 1998). In assigned mentor relationships where the protégé has a direct supervisory reporting relationship to the mentor, the power dynamics may give rise to some dysfunction as the supervisory mentor may have control over assignments, career-enhancing development opportunities or even termination of employment for the protégé (Darling 1985b., Scandura 1998). Conversely, Beech and Brockbank's (1999) study found that, when a protégé had chosen a mentor based on level of expertise, as the protégé's competence increased, the protégé began to define the mentor as incompetent. Meanwhile, the mentor did not perceive that anything was wrong until the protégé had withdrawn from the relationship; the protégé had then replaced the relationship with a peer self-help group or 'peer mentoring' as described by Blackwell (1996).

Given the depth and the qualities of parenting involved in this type of relationship, both parties should guard against developing an unhealthy dependency (Vance 1982., Darling 1985b., Davidhizar 1988). Within this relationship, dysfunction has been found to range from disregard to disliking to anger and hostility, and, while it is argued that dysfunctional mentoring is not a common occurrence, when it does occur the consequences can seriously damage a protégé's career (Scandura 1998) and also have negative effects for mentors (Beech & Brockbank 1999).

2.4.2.5 The Effects of Mentor Relationships on Careers

Dreher and Ash (1990) found that both male and female executives who had experienced mentor relationships received more promotions and higher incomes and expressed greater

satisfaction with pay and benefits than those who did not have this experience. However, mentoring was not found to have influenced the pay differential between men and women: although women within this study earned more than other women, they still earned less than either group of men holding similar executive positions. Although Roche's (1979) study contained less than one per cent of women, the findings support the above study, as does Reich's (1985) study.

Vance's (1982) study of nurse leaders found that 83 per cent had had a mentor during their career: 79 per cent of the mentors were female, and 21 per cent were male. The leaders identified that having had a mentor was advantageous in their being successful in their field of nursing; these findings were supported by Young (1992), Dunham-Taylor, Fisher and Kinion (1993) and Redmond (1995). Fathers were found in Redmond's (1995) and Dunham-Taylor, Fisher and Kinion's (1993) studies to be particularly important as first mentors to their daughters, while most nurse leaders also identified having benefited from women mentors. Fields (1991) identified that historical nurse leaders, such as Florence Nightingale, Linda Richards, Mary Adelaide Nutting and Annie Goodrich, were all encouraged by their respective mentors of both genders to develop professionally.

2.4.3 Networking

While the concept of mentoring is appropriate at the early career stage, networking provides support to people as they progress through all career stages, and it offers effective ways of dealing with organisational and home life. Networking support in peer relationships cuts across hierarchical levels; it is the process of gaining advice and moral support, using contacts or gaining information useful to the work environment (Smith & Hutchinson 1995., Crampton & Mishra 1999). It is said to be of particular value to those who were not involved in a mentor relationship in their early career life (Burke & McKeen 1994).

Two types of networks are identified: organisational membership networks and core discussion networks (Carroll & Teo 1996). Organisational membership networks consist of ties that individuals have to organisations to which they belong professionally. This type of network facilitates those with similar professional experiences. Core discussion networks are more personal and are where people discuss important personal matters (ibid.).

2.4.3.1 Networks in Nursing

In the 1980s in the UK the King's Fund Centre identified a specific need for nurse networks, with the stated aims of developing the concept and practice of nurse leadership and influencing developments in healthcare. However, the networks for senior nurses compare unfavourably with those of many other professional groups and are less effective in representing members' interests (Lorenton 1992., Girvin 1996), a situation that mitigates against the development of nursing and of nursing leadership (Rowden 1998).

Organisationally, the past twenty years have seen the development of women-only networks, probably due the difficulties women reported in that they had limited access to or were excluded from the boys' clubs (Kanter 1977., Ibarra 1992., Smith & Hutchinson 1995). However, in recent times there has been a development away from 'homophilous networks' in recognition that interaction between men and women is a critical component to their mutual development and organisational effectiveness (Ibarra 1992:422).

2.4.4 Conclusion

Recently in nursing, mentoring and networking have begun to form part of an overall career development strategy and a professional leadership development strategy (Vance 1982., Smith & Hutchinson 1995). It is predicted that networking will become increasingly significant in the new type of 'boundary-less' careers which cut across traditional organisational boundaries and provide greater movement between organisations (Fedoruk & Pincombe 2000). To develop and establish the mentor–protégé relationship (Smith Hamilton 1981) nurses must develop their understanding of leadership and determine how its characteristics and traits can be nurtured alongside the development of the affective abilities referred by Woodrow (1994:816) as Benner's 'intuitive grasp'.

2.5 Future Directions

Western society is in the midst of transition from the modern period to the postmodern period, which is not expected to be completed until between 2010 and 2020 (Barker & Young 1994). This transition will, over time, affect political, philosophical, social,

environmental and cultural perspectives (Chinn 1991., Ritzer 1996). The modern period dates back to the beginning of the scientific revolution which found that the world was governed by the laws of physics. The twentieth century brought with it a change in scientific thinking which introduced us to the postmodern period. Scientific thinking in the postmodern period holds that the world is made up of minute energetic particles and waves which are identified by vibrations (Barker & Young 1994).

From a sociological perspective modernity was associated with the industrial society and liberation, characterised by monopoly capitalism, automobile assembly lines and explosive, expanding, productive technologies. Modernity's central dilemma was wealth and how it ought to be distributed. In considering post-modernity, Ritzer (1996) states that there is great diversity among postmodern thinkers and there are probably as many portrayals of post-modernity as there are postmodern social theorists. However, Fredric Jameson is generally applauded by his peers for his insights into postmodernism; Jameson, according to Ritzer (1996), offers a reasonably clear image of postmodern society. This image is made up of four basic elements. Firstly, postmodern society is characterised as a depthless, superficial world; secondly, it is a world of simulation, lacking in emotion and affect; thirdly, it is characterised by a loss of a sense of one's place in history; and, fourthly, postmodern society is dominated by implosive, flattening and reproductive technology and an explosion of culture in multinational capitalism and fragmentation.

In considering the differences between modernists and postmodernists, Ritzer (1996:609) offers an example: 'Johnson's war on poverty in the 1960s was typical of the way modern society believed it could discover and implement rational solutions to its problems. It could be argued that in the 1980s the Reagan administration and its general unwillingness to develop massive programs to deal with such problems was representative of a postmodern society and the belief that there is no single rational answer to various problems.'

2.5.1 Organisations

The global transition from modernity to post-modernity affects all facets of human life, including presumptions of how organisations successfully perform. The transition phase is bringing about organisational changes; as these new organisational changes are in

transition and still emerging, the old and the new exist side by side, creating differing levels of uncertainty and conflict in organisations (Barker & Young 1994).

It is predicted that a vertically integrated model of healthcare delivery will require the core business of the healthcare system to be redefined; this recasting will provide for a new configuration of service provision and staff (Booth 1995). The overall effect on organisations is the movement away from 'top down' delegation of authority to people networks (Barker & Young 1994).

2.5.2 Healthcare Transition

Throughout the transition phase the healthcare system will continue to be challenged by the advances in technology and increasing economic, political and social expectations (Neubauer 1995). While technological advancements will continue to challenge, so will the predicted increase in rates of suicide among the elderly and the young, as will increased incidence of chronic diseases and traumatic illnesses. With technological advancement will come an increase in the demand on hospitals from those with chronic and traumatic illnesses, and hospitals will start to resemble intensive care units. Acute care will occur more often in the home and the community (Pesut 1994).

During the transition phase there will continue to be increased co-ordination and networking among professionals; a team approach will predominate, and medicine will no longer be the master. The health economic perspective of the highest-quality care delivered in the most cost-efficient manner by multiple providers will continue to develop (Kitching 1993., Pesut 1994., Valiga 1994., Booth 1995., Fedoruk & Pincombe 2000).

The shift in significance from the healthcare professionals to the marketplace will continue, as will the politicisation and involvement of consumers in decision- and policy-making, with increased individuality and diversity of care (Valiga 1994). Consumers will take their place as fully informed participants in their health decision-making process; information provided to them and the collaborative decision-making process will be based on evidence (Fedoruk & Pincombe 2000). As a result, all healthcare providers, including nurses, will have greater accountability to consumers and their representative groups (Neubauer 1995).

2.5.3 Nursing

The nursing profession was born of a quasi-military, quasi-religious hierarchy which has evolved through decades of autocratic leadership and management, with values steeped in the concept of obedience: to be a good nurse was acceptance of and compliance with orders. To challenge the status quo was not permitted, and the value of a nurse was determined by his/her place in this rigid hierarchical pyramid (Rowden 1998). The transition is challenging to nursing: stability and sameness are replaced by diversity and uncertainty. There are role realignments; there is a shift towards specialisation; and new boundaries are being drawn for accountability and responsibility (Booth 1995). New frameworks for thinking are emerging, as are different players (Porter-O'Grady 1992).

Nursing faces a future of constant change and diverse employment patterns, with nurses changing career paths and pursuing new career options throughout the different stages of their careers. Nurses will experience increased work autonomy, with computers and robots doing routine tasks. Nurses will develop their vision and will not see work only as a means of earning a salary; they will require, and it will be required of them, to see the workplace as a means of personal growth and development also (Valiga 1994).

For nursing to survive the transition, it requires effective leadership (Kitching 1993., Booth 1995., Buerhaus et al, 1996., Ainsworth 1998), and the effectiveness of this leadership will be measured against the development of trust amongst nurses. Trust is a significant factor in determining the future outcome for nursing (Handy 1995). Effective leadership will be the guidance of nursing to a level of consciousness where trust is the basis of unity. In the process, nursing leadership will become generative and actively involved in the development of neophyte nurses (Valiga 1994), by encouraging self-sufficiency, critical thinking and continued learning (DiRenzo 1994., Valiga 1994., Handy 1995).

2.5.4 Conclusion

The future requires nursing to leave behind its insular approach (Kitching 1993., Booth 1995., Baerhaus et al, 1996., Ainsworth 1998) and to develop leadership philosophies based on the concept of the 'learning organisation' which espouses the empowerment of

staff and patients (Senge 1990). It requires leaders who can themselves evolve and develop their positions in the nursing world and beyond (Neubauer 1995). Acknowledging the diversity in nursing activities and unifying the nursing profession will raise the nurse leaders' coordinating skills beyond managerial competence towards leadership competence (Fedoruk & Pincombe 2000), with the capability of achieving a significant corporate aim of nursing: to present one nursing voice to nursing and to the world (Valiga 1994).

CHAPTER 3
RESEARCH METHODOLOGY

3.1 Introduction

This study explored the experiences of top-level nurses, holding the formal position of director of nursing. The study examined the experiences of male and female directors of nursing in general nursing and psychiatric nursing in the Republic of Ireland.

The phenomenon of experiences was examined through the qualitative data collection method of interviewing and then utilising the grounded theory method to generate a substantive theory which explained the basic social psychological problem encountered by the directors of nursing, the milieu in which the problem occurred, the basic social structural process in action and the basic social psychological process which directors of nursing used to deal with the problem.

This chapter describes the perspectives of realism and idealism, grounded theory, the ontology of grounded theory, the conceptual framework, the grounded theory variance, ethical considerations, data collection, sampling strategy, analysis methods and methods to ensure rigour.

3.2 The Aim of the Study

The aim of the study was to explore the perceptions of top-level nurses of their experiences and to identify factors that may positively or negatively affect those experiences.

3.3 Research Design

In considering research design, the method of investigation will, according to Duffy (1985), depend upon the phenomenon to be studied and the researcher's assumptions about society. Easterby-Smith, Thorpe and Lowe (1991) and Shih (1998) state that the decision to study a topic in a particular way involves a philosophical choice.

3.3.1 Realism and Idealism

The two major philosophical perspectives of realism and idealism dominate modern philosophy (Powers & Knapp 1995). The philosophy of realism is that the social world exists externally and its elements are measured through objective methods. From the realist perspective the purpose of quantitative research is to describe, to explain outcomes and to infer predictions (Powers & Knapp 1995).

In contrast, the philosophy of idealism, which influences most types of qualitative research traditions, holds that reality is subjectively — and not objectively — constructed. Its basic premise is that everything that can be known about the nature of the world is based on people's perceptions and experiences and on the interpretations or meanings that people give to their experiences (Easterby-Smith, Thorpe & Lowe 1991., Powers & Knapp 1995). It further holds that our understanding and preconceptions about the nature of reality are formed through our social interactions with others (Easterby-Smith, Thorpe & Lowe 1991., Powers & Knapp 1995).

Qualitative research traditions hold that knowledge gained is used to improve understanding (Geertz 1973), or to challenge existing beliefs (Powers & Knapp 1995), but not to infer predictions (Easterby-Smith, Thorpe & Lowe 1991). Underpinning this position are three beliefs: firstly, that reality is complex and is based on subjectivity; secondly, that in the research process the researcher is not separate from the research subject; and thirdly, that truth is best achieved by conducting the research process openly with subjects in their natural environments and without prior theorising (Lincoln & Guba 1985). It further holds that life events are ever-changing , and therefore it is not concerned with knowledge as a set of given laws (Berger & Luckman 1967). Thus, unlike the quantitative approach, it requires designs which are flexible and emerging. Its objectives are, in the natural environment, to explore unknown, or to re-examine existing, phenomena in order to contribute towards greater understanding of the nature and meaning of the chosen phenomena (Noerager Stern 1980., Sandelowski, Holditch Davis & Glenn Harris 1989).

3.4 Choosing a Research Methodology

The first step in any study is to obtain a good understanding of the subject matter and its set of related issues (Talbot & Davis-LaGrow 1995). The next step is to find the right

question (Sandelowski, Holditch Davis & Glenn Harris 1989); this will enable the researcher to choose a method that will provide theoretical relevance to the substantive area under study (Turner 1981). In this study, grounded theory was the method considered most appropriate to examine and provide explanations of the experiences of top-level nurses because, as Noerager Stern (1980:20) stated, 'the strongest case for grounded theory is in investigations of relatively uncharted waters, or to gain a fresh perspective in a familiar situation'. Grounded theory allows the guiding substantive theory to emerge from, and be grounded in, the data, as no *a priori* theory would have existed. The events found in the context of top-level nurses are explicable only in terms of other events in that context, as the intention of grounded theory is that it is responsive to contextual values and not to researchers' values.

3.4.1 Grounded Theory

The grounded theory method is a qualitative research approach developed by Glaser & Strauss (1967); its central aim is to generate theory (Glaser 1992). The goal of grounded theory is discovery, to generate from data a theory that is grounded in the data, hence the title 'grounded theory' (Merriam 2002). It promotes the development of theoretical accounts derived entirely from the situation being studied, the aim being that the theory is understandable to those people in the situations studied (Turner 1983).

Grounded theory methods are analytical strategies, not methods for data collection (Charmaz 2000). Grounded theory is a highly systematic approach for the collection and analysis of data for the purpose of generating explanatory theory that furthers the understanding of social and psychological phenomena (Chenitz & Swanson 1986). It assumes that knowledge is always moving: people are always undergoing change, and context functions to facilitate, hinder and influence humans and their social psychological processes (Benoliel 1996). The psychosocial and social processes are the focus of the grounded theory method, and information is drawn from multiple data sources, including listening to participants, reading and reflection (Noerager Stern 1980., Benoliel 1996).

The grounded theory approach to knowledge development is characterised by the simultaneous and ongoing collection, categorisation and interpretation of data. It is a recursive process where tentative theoretical explanations are continually generated on the

basis of incoming data, and the deliberate sampling of data is continually focused towards the confirmation or rejection of these explanations and to the ongoing use of measures to ensure the credibility of the study (Turner 1983., Sandelowski, Holditch Davis & Glenn Harris 1989).

However, grounded theory does not provide the whole picture or story. It provides data only about people's perceptions, and can only provide pieces of social life, paint a picture or tell a story of moments in time (Charmaz 2000).

3.4.1.1 Ontology of Grounded Theory

Glaser and Strauss's grounded theory has dual roots, one from the statistically oriented positivism of Glaser and the other from the symbolic interactionism of Strauss (Glaser 1992., Crotty 1998., Alvesson & Skoldberg 2000). The roots of grounded theory relate to the symbolic interactionists Mead and Blummer's pragmatist, or critical realist, view. Critical realism asserts that the social and natural worlds have differing realities but that both forms of reality can probably be explained, even if imperfectly (Annells 1996). The classic grounded theory method reflects this critical realist view concerning the nature of a 'real' reality (Annells 1996). This method seeks 'to bring concepts of reality' (Glaser 1992:14) 'for what is, not what might be' (Glaser 1992:67) while searching for 'true meaning' (Glaser 1992:55) and requires that the generated grounded theory 'really exists in the data' (Glaser 1992:53).

3.4.2 Conceptual Framework

In a conceptual framework, 'descriptive categories are placed within a broad structure of both explicit and assumed propositions' (Denzin 1989:49). The framework informs the methodological and substantive aspects, the entire process, with all of its elements. The theory of symbolic interactionism is such a conceptual framework (Chenitz & Swanson 1986., Glesne & Peshkin 1992). The conceptual framework for this study is the theory of symbolic interactionism.

Early in the twentieth century symbolic interactionism, a social psychological and sociological movement began with people such as Mead, a philosopher, whose interest was in understanding social processes (Greenleaf 1978). Hubert Blumer, a sociologist and a pupil of Mead's, devised the term 'symbolic interactionism'. Strauss, one of the founders of grounded theory, was a pupil of Blumer (Greenleaf 1978).

Symbolic interactionism is described by Blumer (1969) as a distinctive character of interaction which takes place between human beings. Mead, according to Blumer (1969:8), identified two forms or levels of social interaction in human society. The first is the 'conversation of gestures', which Blumer termed 'non-symbolic interaction', which is said to describe when a person reacts directly to another's action without interpreting that action. Mead's second form of 'the use of significant symbols' was what Blumer termed 'symbolic interaction', which 'involves *interpretation*, or ascertaining the meaning of the actions or remarks of the other person, and *definition*, or conveying indications to another person as to how he is to act. Human association consists of a process of such interpretation and definition. Through the process the participants fit their own acts to the ongoing acts of one another and guide others in doing so' (Blumer 1969:66).

Symbolic interactionsim, Blumer (1969) contends, rests on three premises. The first 'is that human beings act toward things on the basis of the meanings that the things have for them' (:2). Secondly, 'it sees meaning as arising in the process of interaction between people. The meaning of a thing for a person grows out of the ways in which other persons act toward the person with regard to the thing. Their actions operate to define the thing for the person. Thus, symbolic interactionism sees meanings as social products, as creations that are formed in and through the defining activities of people as they interact' (:4–5). Thirdly 'the use of meanings by a person in his action involves an interpretative process' (:5), 'meanings are handled in, and modified through, an interpretative process used by the person in dealing with the things he encounters' (:2).

The fundamental emphasis of symbolic interactionism is on social psychological processes interplayed with interpersonal interaction, the self and behaviour in social structure settings that constrain these processes (Stryker 1987). Central to most qualitative interviews are the principles of symbolic interactionism (Wilde 1992); these principles help in uncovering and examining the subjective world of thoughts, feelings, actions and experiences

(Noerager Stern 1980., Hogston 1995., Benzies and Allen 2001) and in assisting people to give life to their understanding of their world (Arksey & Knight 1999).

Symbolic interactionism, as it informs the grounded theory approach, is:

> 'the means of developing and sharpening [the researcher's] inquiry so that his problem, his directions of inquiry, data, analytical relations and interpretations arise out of, and remain grounded in, the empirical life under study. Exploration is by definition a flexible procedure in which the scholar shifts from one to another line of inquiry, adapts new points of observation as his study progresses, moves in new directions...The purpose of exploratory investigation is to move toward a clearer understanding of how one's problem is to be posed, to develop ideas of what are significant lines of relation, and to evolve one's conceptual tools in the light of what one is learning about the area of life.' (Blumer 1969:40)

Blumer (1969) states that, while this approach provides the researcher with the flexibility and freedom to explore new avenues as directed by the data and the researcher's growing understanding, it does not mean that the inquiry is without direction; it basically means that the inquiry's initial focus is broad but sharpens as the inquiry progresses. The purpose of the inquiry is to provide a multifaceted, integrated theory that must be relevant to the participant group (Keddy, Sims & Noerager Stern 1996).

3.4.3 Grounded Theory Variance

During the 1990s it became apparent that a split had arisen in how the two originators of grounded theory, Glaser and Strauss (1967), continued to develop their ideas. In 1990 Strauss and Corbin published the text 'Basics of Qualitative Research' (Strauss & Corbin 1990), which gave rise to Glaser's counter publication titled 'Basics of grounded theory analysis — emergence vs forcing' (Glaser 1992).

Glaser's publication is a detailed critique of Strauss and Corbin's text, in which he states that Strauss departs from Glaser and Strauss's (1967) original grounded theory approach. Glaser (1992:31) criticises Strauss and Corbin's overemphasis on preconceptions as a departure from the original grounded theory unbiased, open approach, for to go into a study with preconceptions will 'derail' the basic nature of grounded theory, which is based

on 'discovery' and not 'conceptual description'. Another departure as outlined by Glaser (1992) is the generation of categories from intensive analyses of a single incident rather than from the constant comparison of incidents with other incidents. Theory verification instead of generation is a further departure, and yet another is on rules in the research process, instead of relying on the free emergence of theory from data (Glaser 1992., Alvesson & Skoldberg 2000).

Strauss and Corbin did not reply to this critique in the form of a text, but they did in various writings address the issues; for example, 'the initial presentation of grounded theory in Discovery...has led to a persistent and unfortunate misunderstanding about what was being advocated...Many people still get their conceptions of grounded theory from the original book, and have missed the later more realistic and balanced modifications of that book's purposeful rhetoric' (Strauss & Corbin 1994:277).

Apart from Glaser, Strauss and Corbin's positions, other writers propose that in grounded theory there appear to be two schools emerging, possibly from an ontological split between critical realism and relativistic ontologies regarding the issue of objectivist/subjectivist epistemology. According to Annells (1996), relativism is apparent in Strauss and Corbin's work in their assertion that developed grounded theory is a rendition of 'a reality that cannot actually be known, but is always interpreted' (Strauss & Corbin 1990:22). This, according to Annells (1996) and Johnson (1999), differs from a Blumerian view of critical realism, which asserts that the social and natural worlds have differing realities but that both forms of reality can probably be explained, even if imperfectly. It is on this ontology that Glaser and Strauss (1967) based grounded theory (Annells 1996).

With regard to grounded theory methodology, Melia (1996) states that it is generally suggested that Strauss and Corbin's (1990) work in their explication of grounded theory method has, compared to Glaser and Strauss's (1967) original method, become quite programmatic and over-formulaic, a suggestion that she, Wimpenny and Gass (2000) and Hall and Callery (2001) support.

For the purposes of this study, highlighting the grounded theory variance is solely to place in context the grounded theory approach adopted for this study and not, as Melia states, to cast any judgement on the question of which is the 'real grounded theory' (Melia 1996:370). The approach adopted for this study is primarily based on what this researcher

understands as one of 'discovery' and 'emergence' as presented by Glaser (1978, 1992): 'grounded theory does not force, it has patience to let frameworks and models emerge...to discover grounded theory, just focus more simply on how participants process their main concern or problem' (Glaser 1992:64).

3.5 Ethical Considerations

3.5.1 General Principles

Research ethics have main areas of concern: the people involved in the research study, the scientific community and the people who use the results of the study (Singleton Jr. & Straits 1999). Research ethics presented by Leino-Kilpi and Tuomaala (1989) address the requirements placed on the researcher, the protection of human subjects and the publication of research findings. In addition to these ethical considerations are the ethics of data collection and analysis (Singleton Jr. & Straits 1999).

In research, the researcher's obligation is to be aware of sensitive issues and potential conflicts of interest between maintaining the participants' rights and gaining insight into the study's area of interest (Arksey & Knight 1999). While the researcher needs to work through the necessary research activities, she is cautioned that she must do so with sensitivity and respect for participants to ensure that the study proceeds within ethical and professional boundaries (Tutty, Rothery & Grinnell Jr. 1996).

In any research the ethical treatment of human subjects is underpinned by the principle of justice which refers to avoidance of exploitation and abuse of persons (Orb, Eisenhauer & Wynaden 2001). Four main areas of ethical treatment of human subjects have been identified: personal safety, informed consent, purpose of study and privacy (Singleton Jr. & Straits 1999).

3.5.2 Personal Safety

The first right as proposed by these writers is personal safety, that is, ensuring participants' physical safety, causing participants no personal embarrassment or humiliation and

psychologically protecting participants' self-esteem. Ethical considerations are intended to prevent the researcher from asking participants questions that prove threatening or embarrassing or from reporting information that would be found to be an invasion of privacy for participants (Singleton Jr. & Straits 1999).

3.5.3 Informed Consent

The second right is informed consent (Singleton Jr. & Straits 1999); this right arises from the value that society places on freedom of choice. For moral and legal reasons participants must be free to participate or not participate in a study. Prospective participants must be given sufficient information about the study subject to allow them to make their informed decision. Prior to participant involvement in a study the researcher must obtain participants' explicit written informed consent (Arksey & Knight 1999).

3.5.4 Purpose of Study

Thirdly, the researcher must clearly explain the purpose of the study, the institution under which the study is being conducted, the identity and background of the researcher, the proposed interview questions, the interview venue, how long the interview will take, the intention to seek permission to audiotape and, finally, how study interpretations will be used (Tutty, Rothery & Grinnell Jr. 1996). In addition, study findings should be made available to participants (Nelson Hagemaster 1992).

3.5.5 Right to Privacy

Fourthly, the right to privacy is the right to decide when, where, to whom and to what extent attitudes, beliefs and behaviours will be revealed (Singleton Jr. & Straits 1999). Anonymity and confidentiality form part of the right to privacy. Anonymity means that participants remain nameless. However, in qualitative interviewing, protecting this right poses difficulties because interviews take place face to face, and thus participants are known to the researcher by sight and by name (Berg 1998). Confidentiality in research is an active attempt to remove from research records any elements that might indicate

participants' identities. This requires that the researcher changes each participant's real name to a pseudonym or a unit number when reporting data. Confidentiality also directs the management and storage of material such as tapes, notes and transcripts and the destruction of these materials on conclusion of the study.

3.5.6 Researcher–Participant Relationship

The ethical considerations of research design, data collection, analysis and reporting raise issues such as, in the data collection phase, the researcher–participant relationship (Arksey & Knight 1999). The researcher–participant relationship poses difficulties as there are no guidelines to direct the researcher about questioning, or to demonstrate the difference between interview questioning and interrogation questioning. The ethical conduct of this relationship requires the researcher to develop self-awareness and the necessary interviewing skills. The subjectivity of qualitative research can make the researcher vulnerable, and, in addition to education in ethics, debriefing is advised to explore personal responses (Robley 1995., Arksey & Knight 1999).

3.5.7 Data Analysis and Reporting

Ethical considerations in relation to data analysis direct the researcher to be honest in searching transcripts for participants' reality, to provide authentic description (Robley 1995., Merriam 2002) and not the researcher's subjective interpretation of data (Arksey & Knight 1999). In relation to reporting of findings, it is the responsibility of the researcher to honestly report findings which promote general welfare (Singleton Jr. & Straits 1999).

3.5.8 Ethical Conduct of this Study

These ethical considerations underpinned researcher preparation, the design of the study, the conduct of the researcher and the management of all aspects of the study. To protect identity, case numbers were assigned to all interview transcripts, and only case numbers were made available to the supervisor. All tapes and transcripts were held securely by the researcher.

The researcher, during the planning stages of this study, undertook a short course in research ethics. Throughout the course of the study the researcher used reflection techniques and, with the ongoing development of self-awareness, took care to ensure that interviews reflected the participants' perspective and that analysis of the data was a true and fair reflection of participants' views. Where interview data were deemed by the researcher and supervisor to be highly sensitive and identifiable for the participant, these data excerpts were not included in the study's report but did serve to inform the study's findings.

3.5.8.1 Management of Informed Consent

In relation to the right of informed consent the researcher contacted potential participants through letters of invitation which provided information on the nature and purpose of the study, the institution under which the study was being conducted, the background of the researcher, participants' time commitment, the right to refuse to participate in the study, the right to refuse to answer any question at any time, the right to withdraw from the interview at any time, and the researcher's responsibilities (Polit & Hungler 1993). Participants were also informed that the interview transcripts would be held by the researcher, kept strictly confidential and made available only to the researcher and her supervisor. Participants were also informed that excerpts from the interviews would form part of the final research report but that under no circumstances would participants' identities be known. Included in the letter of invitation was an outline of the interview guide and a consent form that potential participants were asked to complete and return indicating whether they wished to participate in the study (Appendices 1, 2 & 3).

3.5.8.2 Management of the Researcher–Participant Relationship

To safeguard confidentiality and protect participants' identities, the researcher conducted all communication directly with participants unless participants instructed otherwise. All interviews were conducted at a time and location of participants' choice. The place, date and time of each interview were known only to the individual participant and the researcher. Throughout the process the researcher took great care to conduct each interview in a constructive manner and to terminate each interview positively, while also maintaining the utmost respect for each participant's perspective (Streubert & Carpenter

1999). When each interview was over and the tape recorder switched off, the duration of post-interview contact was at each individual participant's discretion (Holloway & Wheeler 1996., Crabtree & Miller 1999., Streubert & Carpenter 1999).

The researcher found that, in interviewing one's peers, a reciprocal relationship existed, where there appeared to be trust and where participants seemed comfortable in disclosing their perceptions. While it was difficult to be a 'cultural stranger' (Holloway & Wheeler 1996:93) in one's own group, it was crucial that the researcher did not impose shared assumptions, as this may have interfered with participants developing their own perceptions. Further, the researcher found that she had to maintain distance, which she did by not over-identifying or becoming overly involved, as distance was especially necessary when tough questions had to be asked (McCracken 1988). It was also crucial to the integrity of the study to listen carefully, as the study's purpose was to discover the emic view of 'what is it like for the participant?' (Streubert & Carpenter 1999:17).

3.6 Data Collection

The data collection for this study followed the normal procedures for field research. Top-level nurse participants were the primary source of data (Sandelowski, Holditch Davis & Glenn Harris 1989), the secondary source being literature. The researcher was the major instrument of data collection (Ragucci 1972., Schlotfeldt 1972) with a secondary instrument being interviews; using the long interview approach (McCracken 1988) and an interview guide (Appendix 3).

3.6.1 Secondary Instrument

Qualitative secondary instrument data collection is generally conducted through two approaches: observation and interview or interview only. The appropriate choice of data collection was crucial to the aim of the study. In selecting the appropriate data collection instrument(s), both data collection approaches were considered. The study considered the purposes of both observation and interview and found that observation as a data collection tool allows the researcher to become sensitive to the situation under study but does not provide for participants' perspectives (Glaser 1978., 1992). Observation is conducted in three phases: descriptive, focused and selective. Descriptive observation provides the

observer with an overview of the situation which allows for the discovery of what it is that participants do. Having generated discovery, the researcher then focuses his/her observation on specified aspects of what participants do. Thirdly, the researcher then conducts a more selective observation of participants' actions. The effectiveness of the process is dependent on highly developed skills (Streubert & Carpenter 1999). In conducting observation, Holloway & Wheeler (1996) and Streubert & Carpenter (1999) state that it is unrealistic to believe that the introduction of a researcher does not change the context of the relationships and activities observed, an effect which (Holloway & Wheeler 1996:49) describe as the 'observer effect'.

The use of interview as a data collection tool facilitates the study's participants' in providing a view of their reality, by sharing their stories in their own words (Arksey & Knight 1999., Streubert & Carpenter 1999); interview also allows the researcher to uncover unanticipated events (McCracken 1988). However, in order to capture deep and meaningful data, the researcher must have the skills to maintain the interview focus (Streubert & Carpenter 1999) and foster intimacy while at the same time manufacturing distance throughout the course of the interview process (McCracken 1988).

3.6.1.1 This Study's Secondary Instrument

In this study the approach of interview only was selected. In making that choice, the following overall considerations were taken into account: a commitment to participants' perspectives; the conduction of the study in a manner that would limit disruption to the natural context of the phenomena of interest (Streubert & Carpenter 1999); and the researcher's knowledge and understanding of the group from which participants would be drawn (Berg 1998).

The choice was made specifically the following reasons: the study's interest was participants' perspectives of their experiences and not to compare or challenge the researcher's observation or version of events with what participants' said; and that the researcher, through coding, comparing and analysing of participants' words, would learn to read the conceptualisation participants used in talking about what concerns them (Glaser 1978., 1992); secondly, because of the nature of participants' work, participants were familiar and comfortable with interviews as a communication event (Crabtree & Miller

1999); thirdly, interviews were considered to be least disruptive to the natural context in which participants work (Streubert & Carpenter 1999); fourthly, while the nature of qualitative design makes anonymity impossible — because the researcher can link participants with the data (Streubert & Carpenter 1999) — it was the researcher's intention to protect participants' identities in that no one but the researcher would know participants' identities (Streubert & Carpenter 1999).

Researcher observation was not chosen because: it would have interfered with the protection of participant identity, in that participants would have had to inform others of the researcher's presence in the work area and their participation in the study; it was further considered that the 'observer effect' (Holloway & Wheeler 1996:49) might have precluded the researcher obtaining rich and meaningful data.

3.6.2 Sampling Strategy

One of the major differences between qualitative and quantitative research approaches is that quantitative approaches usually involve probability sampling while qualitative approaches generally involve non-probability sampling. Quantitative research uses probability sampling because it values generalisation to larger populations, which is permitted by random, statistically representative samples. Qualitative research uses non-probability sampling because it values deep understanding, which is permitted by information-rich cases, not by the number of people *per se* (Sandelowski 1995). Representativeness in qualitative research is in the data and not in the sampling units (Sandelowski 1986).

Grounded theory employs two distinct non-probability sampling strategies: purposeful selective sampling and theoretical sampling. Purposeful and theoretical sampling strategies are fundamentally different in their determination. Purposeful selective sampling involves decisions made prior to the commencement of the study relating to the initial set of sample criteria, while theoretical sampling refers to the sampling decisions based on analytic developments through the course of the study (Coyne 1997).

Purposeful sampling is described as 'selecting information-rich cases for study in depth. Information-rich cases are those from which one can learn a great deal about issues of

central importance to the purpose of the research, thus the term purposeful sampling' (Patton 1990:169). Glaser (1978:45) states that at the start of a grounded theory study the researcher will sample groups that the he/she believes will provide more data on the research question and that he/she 'will also begin by talking to the most knowledgeable people to get a line on relevancies and leads to track down more data and where and how to locate oneself for a rich supply of data'. Purposeful sampling is generally applicable to all qualitative research approaches.

Theoretical sampling is central to grounded theory: 'the general procedure of theoretical sampling is to elicit codes from the raw data from the start of data collection through constant comparative analysis as the data pours in. Then one uses the codes to direct further data collection, from which the codes are further developed theoretically with properties and theoretically coded connections with other categories until each category is saturated. Theoretical sampling on any category ceases when it is saturated, elaborated and integrated into the emerging theory' (Glaser 1992:102). Therefore, in grounded theory studies it is not possible to predetermine the required sample size, as this is determined through the course of the study.

In grounded theory the responsibility for controlling the number of sampling units required to achieve informational redundancy (Lincoln & Guba 1985) or theoretical saturation (Sandelowski, Holditch Davis & Glenn Harris 1989) and for deciding which category of variation to maximise and which to minimise rests with the researcher (Sandelowski 1995). This is a major responsibility, as the adequacy of sample size determines the credibility of research findings. 'An adequate sample size in qualitative research is one that permits — by virtue of not being too large — the deep, case-oriented analysis that is the hallmark of all qualitative inquiry, and that results in — by virtue of not being too small — a new and richly textured understanding of experience' (Sandelowski 1995:183).

In qualitative research there are no published guidelines for tests of adequacy to estimate the required sample size to achieve saturation (Morse 1994). Nor do the originators of grounded theory, Glaser and Strauss (1967), provide advice on sample size. Few authors address this issue, but, of those who do, Morse (1994) recommends between thirty and fifty interviews, while Sandelowski (1995) suggests a minimum of twenty-five. However, for any researcher seeking institutional and or ethical approval, it is not sufficient to present an initial selected sample number, while leaving the final determination of the

sample entirely to theoretical sampling. Most institutions require clear specification of the kinds of subjects required for the study and an agreed minimum sample size (Coyne 1997). Institutionally for this study, it was agreed that a sample size of fifty top-level nurses holding the position of director of nursing would be required for adequacy, given that the aim of the study was to explore the experiences of top-level nurses in the whole of the Republic of Ireland. This sample size was primarily decided on through purposeful selective sampling, while the principles of theoretical sampling of participants and written data were guided by the results of ongoing reflection and analysis.

3.6.3 The Sample

The primary research area in this study focused on the experiences of top-level nurses in an Irish context. Top-level nurses holding formal director of nursing positions in the Republic of Ireland were drawn from the register of An Bord Altranais. Directors of nursing were representative of both genders and of the general and psychiatric divisions of the state register. The nationwide sample selection was made, in the public sector, from the Department of Health and Children's listings of general hospitals and psychiatric services and, in the private sector, from the Voluntary Health Insurance's (VHI) listings of hospitals. In the general hospital listings as supplied by the Department of Health and Children, hospitals are divided into five nursing categories referred to as 'bands'. These range from band 1, the largest acute hospitals, to band 5, the smallest non-acute hospitals. Neither psychiatric services nor private hospitals are banded.

In order to obtain as diverse a sample as possible, all directors of nursing on the listings provided by the Department of Health and Children and the VHI were invited by letter to participate. Exclusions were those directors of nursing professionally known to the researcher, one interview that was not audiotaped and one interview where the participant did not hold the formal position of director or 'acting' director of nursing. A sample of fifty directors or 'acting' directors of nursing, thirty-seven female and thirteen male, representing general hospital directors of nursing across all bands, psychiatric services and private hospitals was achieved. The selection of thirty-seven females and thirteen males was based on Flynn's (1998) ratio of female to male directors of nursing. The fifty nationwide interviews took place over a period of fifteen months.

3.7 Gaining Access

In planning access it is important to remember that rarely are researchers provided with access to participants solely for the love of science and knowledge. The gatekeeper is likely to consider such issues as: Is this individual worth supporting? Is the project politically sensitive? How are my time and resources affected? Does the study's institution have a good reputation? (McCracken 1988., Lincoln & Guba 1985).

For the purposes of this study and its target group a direct approach to gaining access was adopted. The approach was made through an introductory letter which provided institutional legitimisation; this letter gave details of the study (Appendix 1) and was accompanied by a returnable consent form to indicate whether the proposed participant wished to participate (Appendix 2). If within four weeks there was no reply, a second written invitation was sent (Appendix 4). No reply to the second invitation was taken as a wish not to participate. When a form consenting to participation was received, this was followed up by an acknowledgement letter and then a telephone call to arrange interview details (Appendix 5). These details were then confirmed in writing (Appendix 6).

3.8 Scheduling Interviews

As this study involved interviewing top-level nurses, interviews had to be arranged around their busy work lives (Mintzberg 1998). Most interviews were arranged weeks in advance. All were conducted on dates, at times and in locations to suit participants and, with the exception of one interview, all took place in the participant's organisation.

3.9 Literature Review

There is no agreement among qualitative researchers on when the literature review should be conducted; many researchers agree that it is in the interest of the research study that reviews are undertaken prior to, during and after completion of data collection (Noerager Stern 1980., Sandelowski, Holditch Davis & Glenn Harris 1989., Tutty, Rothery & Grinnell Jr. 1996., Smith & Biley 1997). The conventional approach suggests that the researcher should undertake a first review to highlight gaps and/or inconsistencies in the

literature and to assist in determining the rationale for the subject under study. Glaser (1978) holds that the researcher should have no preconceptions and as few *a priori* conditions as possible to allow an open approach in studying the subject. This is to allow the problem to emerge, and to maintain this open approach Glaser (1978) is not in favour of literature reviews conducted prior to a study's commencement. However, the researcher of this study holds that it is not conducting an initial literature review that develops preconceptions but the researcher's paradigm. This study's initial literature review found little research into the experiences of, and the effects of those experiences on, top-level nurses, which made a grounded theory approach particularly applicable to the subject.

In this grounded theory study the literature review served five purposes. Firstly, to stimulate the researcher's theoretical sensitivity to the study of experiences of top-level nurses, but not to funnel the research towards *a priori* conceptualisation of the phenomenon nor how it should be measured (Sandelowski, Holditch Davis & Glenn Harris 1989). Secondly, to place the study in context (Parahoo 1997). Thirdly, to aid in the development of the interview guide (Brenner, Brown & Canter 1985., McCracken 1988., Berg 1998). Fourthly, to direct theoretical sensitivity in the development of the emergent theory. Finally, on completion of the research, to serve as a supplementary validation of the accuracy of the study's findings (Noerager Stern 1980., Sandelowski, Holditch Davis & Glenn Harris 1989., Tutty, Rothery & Grinnell Jr. 1996., Smith & Biley 1997).

3.10 Interviews

Qualitative interviewing requires understanding and empathy and is based on the researcher's ability to establish and maintain rapport (Fontana & Frey 1994). The interview is the researcher's opportunity to probe and uncover clues that assist in opening up new vistas, to obtain clear and inclusive accounts based on participants' unique personal and professional experiences (Burgess 1982). Interviews also allow the researcher to find out things that he/she is unable to observe. Observation is not always possible, particularly of the meanings that people attach to what goes on in their worlds, of past events or of situations which do not allow the presence of an observer (Patton 1980). The purpose of interviewing is to allow participants, through the power of words, give meaning to how they as people experience themselves and others in their world and how they interpret those experiences (Crowe 1998).

Qualitative interviewing is considered an appropriate approach when (Easterby-Smith, Thorpe & Lowe 1991:74):

> it is necessary to understand the constructs that participants use as a basis for their opinions and beliefs about a particular matter or situation; and the step-by-step logic of the situation is not clear;
> the subject matter is highly confidential or sensitive;
> participants may be reluctant to be truthful about the situation other than confidentially in a one-to-one interview.

The purpose of the qualitative interview, unlike the quantitative interview, is not to discover how many and what kinds of people share certain characteristics (McCracken 1988), nor to determine the frequency of predetermined issues (Brenner, Brown & Canter 1985). Fundamentally, in qualitative interviews it is the categories and assumptions that matter, not who holds them (Glaser 1978., McCracken 1988., Glaser 1992).

3.11 This Study's Interview

The interview in this study was broadly based on a mix of peer and elite interviewing. Peer interviewing was involved because for ten years the researcher held the position of director of nursing. Elite interviewing was also appropriate because participants in this study held, in the clinical setting, the most senior nursing position. Their position allowed them to provide an overview of their respective organisations, including the histories, policies and future plans of those organisations (Marshall & Rossman 1999).

In the preparation for this study, the literature generally indicated an assumption that in interview situations participants and researchers are members of different groups, generally with participants holding some subordinate position to the researcher. Therefore interviewing one's peers presented a research situation far from typical, as this group were one's social equals in role and shared the same professional background, knowledge and subcultural understandings, making the researcher and participants not anonymous. While shared membership may be helpful in gaining access, it can make the normal distance between researcher and participant in an interview difficult and can result in assumptions being made where rationale and content do not need to be explained. The researcher had to guard against this problem because if it occurred it would have resulted in thin data and thus affected the quality of the study's findings (Platt 1981).

To develop trust and rapport in elite interviewing requires, at the very beginning of the interview, the establishment by the researcher of her credibility (Marshall & Rossman 1999). Credibility is established through the demonstration of expertise on three levels: healthcare, nursing and the issues of concern to the study (Arksey & Knight 1999).

The most appropriate interview approach for this study was based on the fact that there is no typical identified grounded theory interview (Chenitz & Swanson 1986); also, because of the study group and the researcher's position in relation to that group, a peer–elite mix approach was required. The approach to interviewing was thus based on Platt's (1981) and Thomas's (1993) advice. Firstly, Thomas (1993) advises the researcher to be well prepared because the opportunity of repeat interviews is rare. Secondly, participants prefer to be interviewed on home ground, at a date and time that suits them. Thirdly, they generally like some advance preparation, usually requiring sample questions in advance; a good strategy therefore is the development of a semi-structured interview guide (Thomas 1993). Platt (1981) gives advice in relation to interview structure and maintaining the required distance. In this study, because of the nature of the position of director of nursing, the researcher was given the opportunity of only one interview with each top-level nurse. Even the most willing participant would be able to give only limited time and attention, and thus the long interview was the approach of choice, as it is highly focused and gives the researcher access to participants' worlds without breaching their privacy or testing their patience (McCracken 1988).

3.11.1 The Long Interview

The long interview is one of the most powerful qualitative methods of inquiry (McCracken 1988:9). It allows the researcher to enter the 'lifeworld' of participants, to glimpse the categories and logic by which they view their world and to view the content of experiences as lived by participants. It allows the researcher to capture the data needed for penetrating qualitative analysis without participant observation that is without the researcher observing participants in action or prolonged contact (McCracken 1988). In relation to contact, some suggest that it is difficult to maintain participants' interest in long interviews that last more than two hours. Berg (1998), however, maintains that participants' interest is dependent on how interesting and exciting they find the interview. Tutty, Rothery & Grinnell Jr. (1996) suggest that the ideal length for both participant and researcher is one to one-and-half

hours. In this study the estimated duration of each long interview, based on the recommendations of Berg (1998) and Tutty, Rothery & Grinnell Jr. (1996), was one to one-and-half hours, with a few interviews being shorter and others longer.

3.11.2 Interview Guide

The development of an interview guide is one of the most important aspects of a research project, as data collected is dependent on the guide (Kumar 1996). This is particularly relevant to this study, as a guide would provide the researcher with structure and instrumental guidance (Platt 1981., Thomas 1993). The interview guide (Arksey & Knight 1999) serves as a framework for the main body of a qualitative interview and is focused on the key questions that the study is addressing. The difference between an interview guide and its main rival, the self-administered questionnaire (Arksey & Knight 1999), is that, with the latter, respondents simply read the questions, interpret what is expected of them and write down their answers (Kumar 1996), while the purpose of the interview guide is to provide a focus but not to impose uniformity or prevent participants giving their own perspectives (Parahoo 1997). Fundamentally, the interview guide is used solely to provide focus and direction but must not be allowed to pre-empt the 'open-ended' nature of, nor destroy the elements of freedom and variability essential to, the qualitative interview (McCracken 1988).

In addition to the interview guide it is vital that the researcher develops a level of skill appropriate to the human instrument, sufficiently high to guard against criticism on the grounds of instrumental inadequacy (Lincoln & Guba 1985).

3.11.3 The Interview Procedure

In this study it was imperative that the researcher took care to make sure that data were collected for all of the categories and relationships that had been identified as important, as the opportunity presented by each interview would not be repeated, and so what the researcher failed to capture would be forever lost. This was challenging because mistakes are easily made and, in this particular study, would have been almost impossible to rectify.

It took patience and care to capture data in a throwaway comment and to capture it completely (McCracken 1988., Easterby-Smith, Thorpe & Lowe 1991).

In organising an interview there are no rules of sequencing (Patton 1980). However, attention to the sequencing is important because procedure affects participants' willingness and interest, which in turn affect the quality of the accounts received (Kumar1996). Attention is needed in relation to subject matter, procedure, phrasing, level of language and general style of questions (Berg 1998).

The interview procedure for this study was largely guided by Robson (1996) and were as follows:

> ' "Warm-up": easy, non-threatening questions were used at the beginning to settle' the participant and the researcher' (Robson 1996:235), what Fontana and Frey (1994:371) describe as 'breaking the ice'.
>
> 'Main body of interview: covering the main purpose of the interview in what the researcher considers to be a logical progression...this order can be varied, capitalizing on the responses made (ensure "missed" topics are returned to unless this seems inappropriate or unnecessary). Any "risky" questions should be relatively late in the sequence so that, if the interviewee refuse to continue, less information is lost' (Robson 1996:234–5).
>
> ' "Cool-off": usually a few straightforward questions were used at the end to defuse any tension that might have built up' (Robson 1996:235).
>
> 'Closure: thank you and goodbye. The "hand on the door" phenomenon... Interviewees may, when the recorder is switched off...come out with a lot of interesting material. There are various possible ways of dealing with this (switch on again, reopen the book, forget about it) but in any case you should be consistent' (Robson 1996:235).

Some suggest opening an interview with biographical questions as this allows the researcher to ascertain the simple descriptive details of the participant's life and helps to cue the researcher to the biographical realities that may inform the participant's interview (McCracken 1988., Berg 1998). Others hold that biographical questions are boring and can be uncomfortable and embarrassing for participants, and they advise leaving sociological–demographic details to the end, when a relationship of trust has been built up. It is also suggested in qualitative interviewing that participants should be actively involved in providing descriptive information early in the interview and not become used to providing short answers, as this may affect their expansiveness and the quality of data obtained (Patton 1980., Tutty, Rothery & Grinnell Jr. 1996., Arkesy & Knight 1999).

3.11.4 Style of Questions

The verbal pattern of exchange in Western society involves one person speaking while the other person listens, anticipates and plans how to reply. Therefore, if the researcher indulges in long and involved questions, participants may not really hear the whole question as they will be preparing their answers, and so a reply to a long and complicated question is generally weak (Berg 1998). A further problem arising from answers to complicated questions is that they are virtually impossible to analyse (Berg 1998., Kumar 1996), as participants are generally confused in their replies.

An interview question is a stimulus that is aimed at generating participants' answers, so the researcher must consider how all questions affect the quality of the interview process (Patton 1980., Berg 1998). Questions must be, at least, open-ended, neutral, singular, clear and phrased in a general, non-directive way (Patton 1980., Tutty, Rothery & Grinnell Jr. 1996., Arksey & Knight 1999., Kumar 1996), as 'leading questions always collect inaccurate information' (Nightingale 1992:61). In the context of grounded theory the researcher must 'never, never [ask] the question directly in interviews as this would preconceive the emergence of data' (Glaser 1992:25).

3.11.5 Interview Conclusion

In this study, the interview guide was developed, with questions that were open-ended, neutral, singular, clear and phrased in a general, non-directive way, to guide the researcher by a gradual approach with the intention of leading participants into the themes of the study, starting with simple themes and moving to the more complex. The interview procedure was that provided by Robson (1996). At the beginning of the interview some background information was sought, solely to provide context to the interview and to act as an 'ice-breaker'. Biographical details were, in accordance with grounded theory methodology, left to the end of the interview. This was done so that, from the earliest stages, participants would view the interview as a discursive, expansive process as opposed to a closed, question-and-answer event (Crotty 1998). The chosen strategy for dealing with the 'hand on the door' phenomenon was to seek permission to switch the tape recorder on again. In all interviews, care was taken to give participants sufficient time and attention to tell their individual stories (Sandelowski, Holditch Davis

& Glenn Harris 1989), while the researcher took every step to ensure that each interview ended positively (Jones 1997).

3.12 Establishing Trust

Gaining participants' trust is essential to success in interviewing and, even when gained, may be destroyed by a mistake on the part of the researcher (Fontana & Frey 1994).

In an interview situation the development of trust may be assisted by a certain formality in dress, speech and conduct because these help to place the researcher in the role of a 'scientist', someone who can ask very personal questions not from personal but from professional curiosity. This formality may reassure participants that the researcher can be trusted and will maintain confidentiality (McCracken 1988). The development of trust is also assisted if participants perceive the researcher as having equal status (Easterby-Smith, Thorpe & Lowe 1991). It is further suggested that in order to build trust the researcher should share some details of herself; however, these details must not include opinions that may bias the study outcome (Tutty, Rothery & Grinnell Jr. 1996).

The researcher was aware that a lack of trust may not have meant that participants would not take part in the interview but simply that they would just want to get the interview 'over and done with' and so provide only enough information to allow the researcher think that she is getting something of value but without participants having said anything that touched the core of what they actually believe or care about (Jones 1997). Failure by the researcher to create a situation where participants feel at ease and free to talk poses a threat to the credibility of the study (Arksey & Knight 1999).

3.13 Credibility of the Interview

These issues of validity are of particular importance to the interview process of this study, as the researcher was the major data collection instrument (Ragucci 1972) and the interview guide the secondary instrument.

The literature suggests that validity is enhanced by using interview techniques that build rapport, trust and openness, which give participants scope to express the way they see things. Using prompts that encourage participants to illustrate, expand and clarify their initial responses and allowing for discussion in detail and about specifics also improve validity. Thus, it is important that the researcher develops a level of interviewing skills to enable him/her to adopt the techniques suited to each interview (Lincoln & Guba 1985). The development of these skills should guard the researcher against revealing any personal opinions, values or assumptions, as these may influence what the participant tells the researcher. If the participant requests an opinion of the researcher, the researcher should have developed sufficient skills to enable him/her to defer giving an answer until the interview has terminated (Wilde 1992).

In relation to the interview guide Robson (1996) suggests that steps towards ensuring content validity should be taken during the development of questions, making sure that each question is related to the phenomenon of interest. This can be achieved by developing questions based on concepts derived from literature on the phenomenon of interest, by asking experts to contribute to question development (Brenner, Brown & Canter 1985., McCracken 1988) and by drawing questions from the pre-test and pilot work (Arksey & Knight 1999).

3.13.1 Reliability

Consistency, according to Arksey and Knight (1999), is akin to reliability. Reliability is mainly concerned with trying to reduce researcher bias so that we can trust that the findings are neither the product of the interview guide nor the of researcher's quirks and improvisations. In qualitative research it is impossible to have a research tool which is one hundred per cent accurate, not only because a research instrument cannot be so but also because it is impossible to control the factors affecting reliability (Kumar 1996). The phrasing of questions, any ambiguity in wording, the fact that participants may interpret questions differently (from both each other and the interviewer), any change in a participant's mood when responding to questions, and the nature of the interaction between the researcher and participants can all significantly influence responses, thereby affecting the reliability of the process (Kumar 1996).

The dilemma of participant authenticity in qualitative research lies in the issue of whether to treat participants' accounts as truths (Ragucci 1972., McCracken 1988., Bailey 1997) or as participants' way of explaining something which otherwise would be inexplicable (Simmons 1995).

Thus the quality of the information is dependent upon several methodological, situational and participant-related factors and on the researcher's ability to control or minimise the effects of these factors in the process of data collection (Kumar 1996). In response to Patton's (1980) suggestion that for the purpose of legitimacy and credibility it is wise to develop an interview guide that can be shown to decision-makers and information-users, this study developed, in consultation with experts, an interview guide, a copy of which was given to each participant (Appendix 3).

3.13.2 Pre-test/Pilot Test

Berg (1998) suggests that ideally pre-testing should have two stages. The first stage involves the initial pre-test of the instrument. Once the researcher has developed the interview guide and is satisfied with the general wording and sequencing of questions, a first draft of the interview guide is developed and pre-tested, by submitting it for expert opinion to identify whether it is comprehensive in relation to the research area of interest (Brenner, Brown & Canter 1985., Robson 1996., Berg 1998).

The second stage of the pre-test is the pilot test (Glesne & Peshkin 1992., Fielding 1993., Tutty, Rothery & Grinnell Jr. 1996). The pilot study gives the researcher the opportunity to test interview techniques, voice tone, eye contact, posture, observational techniques and her reactions to emotional events in participants' stories, and it also gives the researcher the opportunity to assess her intervention timing and skills (Glesne & Peshkin 1992., Wilde 1992., Tutty, Rothery & Grinnell Jr. 1996). This is essential preparation for the development of interviewing skills (Brenner, Brown & Canter 1985), as it helps to prevent situations where participants react with long silences and confusion (Sorrell & Redmond 1995). If a formal pilot study is not feasible, the researcher should design a period of piloting during the early days of interviews with actual participants (Glesne & Peshkin 1992). It is important that a pilot test involving several practice interviews with participants as judges be carried out, to alert the researcher to questioning techniques used consciously

or subconsciously which may bias participants' answers (Fielding 1993) and to determine whether the questions will elicit the quality and quantity of data needed to answer them (Tutty, Rothery & Grinnell Jr. 1996).

In this study the pre-test phase involved the critical examination of the interview guide by experts, by directors of nursing not included in the study population, and by experts in questionnaire and interview designs, using Chadwick, Bahr and Albrecht's (1984) guide. In accordance with these critical assessments, corrections were made to the interview guide (Appendix 7).

3.13.3 Pilot Study

In the pilot study, volunteers were drawn from a group of top-level nurses; this group was separate from the study's participant group. The pilot study involved several practice interviews where volunteers were encouraged to be critical of the process and of the interviewer's skills (Appendix 8). Changes to the interview process and to the researcher's interview technique and skills were made according to pilot test recommendations.

3.13.4 Interviewer Bias

In qualitative research some writers suggest that the researcher should approach the interview with no assumptions formed; this in reality is not entirely possible. Others hold that the researcher should demonstrate, by means of a literature review, preliminary studies or other means, that he/she possesses some recognition of the area under study and suggest that, while the purpose of orientation is to sensitise the researcher to the phenomenon, the researcher should at the same time remain open-minded to new discoveries (Sandelowski, Holditch Davis & Glenn Harris 1989).

To assist in the prevention of researcher bias, the researcher is encouraged to consider the following. Firstly, the purpose of qualitative interviewing is to hear, understand and give voice to what participants think. Secondly, successful qualitative interviewing requires an understanding of culture, because culture affects what is said, how it is heard and the meanings that experiences have for people. Thirdly, researchers are not neutral: they, like

participants, are in an interviewing relationship, and their emotions and cultural understandings also influence the interview process (Rubin & Rubin 1995).

To assist in the prevention of researcher bias, the process of developing awareness and ridding oneself of one's own biases and assumptions is required. This is termed 'epoch', that is, development of one's own awareness of one's belief system and of how that system could impose itself on others. Before the researcher engages with participants, the goal is to have achieved as much epoch as possible (Tutty, Rothery & Grinnell Jr. 1996). This awareness allows the researcher to be as open as possible to new information while also being aware of personal assumptions and preventing those from biasing the interview process. The prevention of researcher bias is further developed through the process of reflection.

3.13.5 Reflection

Reflection is an activity that is prescribed in all qualitative research studies, especially throughout the data-gathering phase. With interviewing, it involves reviewing, analysing and making decisions at every step in the process and recording these issues in a personal journal which accompanies the interview transcripts and notes (Appendix 10).

Tutty, Rothery and Grinnell Jr. (1996) write about reflecting *in* action and reflecting *on* action. Reflection in action involves researcher awareness of oneself during the interview process, while reflection on action is described as the process by which one reviews the actions one has taken, as well as the underlying assumptions. Reflecting on actions at various time intervals in the interview process will add depth and perspective that will greatly enhance the study.

An important time for reflection on action is immediately after any interaction with a participant; other times include during regular personal journal-keeping, after discussions with research advisors or with other colleagues, or when any ideas or thoughts come to one about the study (Tutty, Rothery & Grinnell Jr. 1996). The challenge of interviewing is, according to Patton (1980), due to each interview event being unique to the area under study, to the individual participant and to the interviewer's style and there being no guide

which prescribes the single best way to interview or the single best style and wording of questions.

3.13.6 Tape-Recording Interviews

The grounded theory approach relies on data source exactness (Robson 1996), which provides for validity and reliability and serves in data analysis (Fielding 1993). To create an accurate account, the interview must be audio-taped with participants' permission and verbatim interview transcripts must be made (McCracken 1988). The advantage of audio-taping is descriptive validity (Sandelowski 1998); the disadvantages may lie in participants' perceptions of tape-recording as 'public'. Note-taking may be taken as a 'private' account, possibly resulting in participants providing a fuller account (Arksey & Knight 1999); however, the drawback to note-taking is that the researcher will not capture all of the participants' accounts.

In this study, institutional requirements were for audio-taped, verbatim accounts, and thus the letter of introduction to potential participants sought permission to audiotape all interviews. In the letter it was explained that audio-taping would ensure an accurate recording of participants' views. Confidentiality was assured, including on the issues of participants' identities, tape storage and tape destruction at the end of the study. Participants were informed that at any time in the course of the interview they could switch the tape recorder off (Appendix 1).

All participants in this study consented to audio-recording; case numbers were assigned to each recorded interview; and verbatim transcripts were made of all recordings. With the exception of one interview, all were audio-taped. In keeping with institutional requirements, the interview that was not audio-taped was excluded and replaced by a further interview. In the course of interviews some participants requested that certain accounts not be recorded; in all cases the recorder was switched off and was turned on again with participants' permission. At other times, in the interest of the participant, the researcher asked whether the participant wished to stop recording; sometimes the participant agreed, and sometimes the participant was happy to have the recording continue.

3.13.7 After The Interview

The period after the interview is according to Patton (1980) critical to the quality and validity of qualitative measurement. It is a time for guaranteeing the quality of the data, and not to do so seriously undermines the rigour of qualitative methods. This period after the interview is a critical time for reflection and elaboration (Patton 1980).

In this study, after each interview, the researcher made summary notes in her audio journal to capture any particular intrapersonal or interpersonal experiences that would affect making sense of the data. Verbatim transcripts were made of all interviews, and these, together with transcripts of the researcher's audio journal, were transferred to the data analysis computer program Ethnograph v5.0. Together these produced a set of notes containing the interview content and reflecting the interview process (Tutty, Rothery & Grinnell Jr. 1996).

3.14 Data Analysis

In this grounded theory study, data analysis involved a process; this process did not follow sequential, orderly steps, as in grounded theory it is the data and not the process *per se* that directs analysis (Leininger 1985). The process included: entering data in Ethnograph v5.0, the constant comparative method, open coding, theoretical sampling, saturation, theoretical sensitivity, theoretical coding, writing memos, discovering the core category, selective coding, sorting memos, developing diagrams and writing up.

The purpose of this analysis was to determine the categories and the relationships between the categories and to develop a core category of what informed participants' view of their world in general and their experiences in particular. This required the researcher to use the full powers of discovery inherent in the qualitative interview, to glimpse and systematically rebuild a picture which in the final analysis does not belong to the researcher, the literature or any one of the participant's lives but is the general properties of thought and action of experiences of top-level nurses (McCracken 1988). To achieve this, the researcher was guided by Glaser's (1992) description of conceptualising data: the researcher fixes continuing attention on the underlying patterns involved in the incidents coded, and then develops a category and proceeds to examine and discover emergent

properties about the category. This is done by constantly coding and analysing, which leads to the development of theoretical codes. These theoretical codes form connections between categories, which lead to hypotheses, which in turn suggest how incidents and categories may be related to each other. To broaden the depth and scope of the emerging theory, theoretical codes dictate through theoretical sampling further data collection and analysis. To begin this study's process of analysis, verbatim transcriptions were made of all interviews; transcriptions were then entered in Ethnograph v5.0 for data management, coding, sorting and retrieval; but the intellectual work of conceptualising was conducted solely by the researcher (Webb 1999) (Appendix 9).

3.14.1 Constant Comparative Method

The constant comparative method, another name for the grounded theory method, was employed throughout this study's analysis. With the constant comparative method, data are compared with other data and not with totals of indices. The method is employed to discover the core category that accounts for most of the variation in the data and integrates the data codes and the analytical and process memos accumulated during the course of the study. It involves going back and forth among data sets to determine the presence, variation or absence of patterns (Sandelowski, Holditch Davis & Glenn Harris 1989). It is a conceptual process, where the researcher decides what coded data belong in which categories and where the emerging hypothesis is verified or not through data collection, and if it is not verified it is discarded or modified and the process repeated (Leininger 1985).

The constant comparative method used in this study was guided by Glaser (1992:51). 'What is this data the study of?' 'What category or what property of what category does this incident indicate?' 'What is actually happening in the data?' and, lastly, 'What is the basic social psychological process or social structural process that processes the main problem that makes life viable in the action scene?' (Appendix 10).

3.14.2 Theoretical Sampling

Theoretical sampling was employed in this study as the process by which data collection was guided. It involved — from the start of data collection through constant comparative

analysis — developing codes from the raw data. These codes then directed further data collection, from which codes were further developed to categories and then connected to other categories until each category was saturated. Theoretical sampling on any category ceased when it was saturated, elaborated and integrated into the emerging theory (Glaser 1992)

3.14.3 Open Coding

Coding is the process through which data are organised into a theoretically meaningful structure (Lee 1999). The significance of using a codified procedure is in the auditability of the linkage processes in theory development (Glaser & Strauss 1967). Open coding is the first step in constant comparative analysis (Glaser 1992). It begins the data reduction process, where the substance of interviews is summarised, free from any theoretical framework (Sandelowski, Holditch Davis & Glenn Harris 1989); it refers to naturally recurring incidences (Lee 1999) and assists the researcher in managing the data (Knafl & Webster 1988) (Appendix 11).

In this study the researcher was guided in the open coding process by the work of Thorne, Kirkham and MacDonald-Emes (1997) and took care to prevent premature open coding, which is the development of superficial understandings at the expense of deeper and more meaningful analytical interpretations. This was done by the researcher repeatedly immersing herself in the data prior to beginning coding, classifying or creating linkages and concentrating more at this stage on the data than on sorting and coding. The researcher also avoided developing a complex coding scheme because, once developed, it is difficult to abandon, no matter what the finding. In this study open coding ended when a core variable was provided (Glaser 1992) (Appendix 12).

3.14.4 Selective Coding

Selective coding in grounded theory starts with the emergence of a core variable; it ends open coding and delimits coding to only those variables that relate to the core variable (Glaser 1992). It uses initial codes that reappear frequently to sort large amounts of data

(Glaser 1978., Charmaz 2000). In this study once the core variable of 'positional marginalisation' emerged, it guided further theoretical sampling and data collection.

3.14.5 Theoretical Codes

Theoretical codes evolve from open coding and are linkages within the data. Theoretical codes emerge when relationships between open codes are discovered and theoretical linkages are made that describe and explain the data (Sandelowski, Holditch Davis & Glenn Harris 1989). Emergent sorting by theoretical codes relates categories and their properties into an integrated theory around a core variable. In grounded theory, sorting by theoretical codes ensures that everything fits (Glaser 1992). Theoretical codes knit the fractured story back together (Sandelowski, Holditch Davis & Glenn Harris 1989). In this study theoretical coding was a process, involving context and conditions (Glaser 1978).

3.14.6 Saturation

Saturation was employed throughout the analysis phase and sought variation in occurrences and richness of data (Morse 1995). In this study saturation was achieved when further hypothesising, revising and data collection were judged not to be providing any additional insight and knowledge to the experiences of top-level nurses (Lee 1999). The principles of saturation as outlined by Morse (1995:149) were applied: selecting a cohesive sample, using theoretical sampling and giving attention to 'negative cases'.

3.14.6.1 Negative Cases

Negative or deviant cases are those cases which appear to weaken or contradict the explanatory process in the emerging evidence (Mays & Pope 1996); to achieve analytical thoroughness they must be recognised and explored (Mays & Pope 1996., Whittemore, Chase & Mandle 2001). The saturated negative cases found in this study are presented in Chapter 5: Basic Social Psychological Problem, under the terms 'corporate effect' and 'social capital'.

3.14.7 Memo-Writing.

An additional research strategy integral to grounded theory is memo-writing (Lester & Hadden 1980): the researcher writes memos as brought up by the emergent theory (Glaser 1992). In this study the researcher maintained a reflective journal (Lincoln & Guba 1985) in which analytical and process memos were maintained. Analytical memos were the researcher's notes on the ongoing efforts to theorise about the data (Sandelowski, Holditch Davis & Glenn Harris 1989). Process memos were the researcher's notes describing observations about participants, the interaction between the researcher and the participants, and decision-making about the study (Sandelowski, Holditch Davis & Glenn Harris 1989., Begley 1996b). The theoretical sorting of memos, key to the grounded theory process, was employed in the formulation of the theory's written presentation (Glaser 1992) (Appendix 10).

3.14.8 The Core Variable

The core variable is the heart of the problem or the guiding process in the situation (Leininger 1985). The goal of grounded theory is to generate a theory around a core variable as it emerges from constant comparative coding and analysing data. The core category has several functions: integration, density, saturation, completeness and delimiting focus, and it provides a study with relevance and workability (Glaser 1992). In this study the core variable emerged as 'positional marginalisation', which was found to account for the pattern of behaviour 'acquiescing to/adapting to/accommodating to' (Appendix 13).

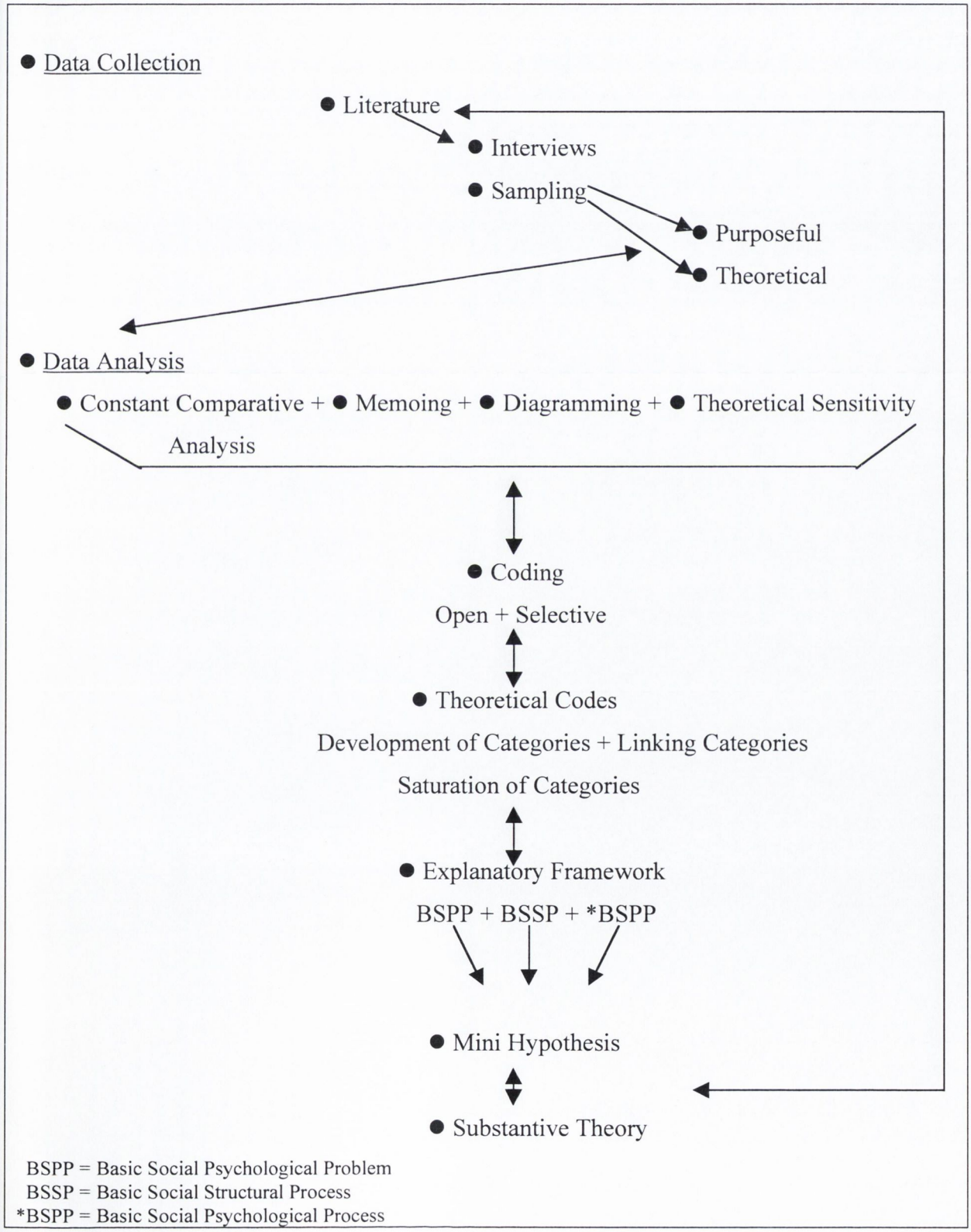
3.14.9 Theoretical Sensitivity

Theoretical sensitivity emphasises the reflexive use of self (Hall & Callery 2001). It refers to the researcher's knowledge, understanding and skill in theory development; its significance to grounded theory relates to the criteria of relevance, fit and work (Glaser 1978, 1992). However, it does not, according to Hall and Callery (2001), provide critical examination of the researcher's effect on data building. In this study the researcher ensured the development of theoretical sensitivity through the process of reflection, professional knowledge of the situation under study, supervision, expert and peer review and research background.

3.14.10 Diagrams

Diagrams are employed to display various combinations of elements of data and are useful in verifying interpretations of the data and in the appropriate linking of substantive and theoretical categories (Sandelowski, Holditch Davis & Glenn Harris 1989).

Figure 3.1—Research Process Procedural Steps



3.15 Rigour

Establishing the trustworthiness of a research study traditionally centres on the issues of validity and reliability (Lincoln & Guba 1985). As stated by Silverman (1993), the theoretical position of the researcher will influence interpretation, and therefore it is the responsibility of the researcher to demonstrate that interpretation is grounded in data collected.

In grounded theory, a well-constructed theory is expected to 'meet its four most central criteria: fit, work, relevance and modification' (Glaser 1992:15). Fit relates to the theory's accuracy regarding the realities of the data sources; work refers to how accurately the theory provides explanation; if the theory fits and it works, according to Glaser (1992), it has achieved relevance to the subject under study; and modification means that the theory is readily modifiable by the emergence of new data. In qualitative research generally, Lincoln and Guba (1985) present four factors in relation to testing rigour: truth value, applicability, consistency and neutrality. Truth value relates to credibility in the discovery of human experiences as lived and perceived by participants (Sandelowski 1986). Truth is based on the adequacy of the evidence given to support findings (Nolan & Behi 1995). Applicability relates to the fittingness of the study's findings to the data (Sandelowski 1986); and both truth value and applicability would appear to relate to fit as described by Glaser (1992). Consistency refers to consistency of findings, usually established by providing an accurate, detailed decision trail to allow others to audit the study process and the findings to establish comparability of conclusions (Lincoln & Guba 1985). Neutrality refers to freedom from bias (Sandelowski 1986); the criterion of neutrality in study findings is confirmation which is achieved when truth value, applicability and auditability are established (Sandelowski 1986). For grounded theory, 'a theory should be able to explain what happened, predict what will happen and interpret what is happening in an area of substance or formal inquiry' (Glaser 1978:4). Measures to ensure the rigour of this study's analysis have been woven into its design; these measures are the three verification approaches outlined below.

3.15.1 Verification

The three verification approaches used in this study were descriptive, interpretive and theoretical validity (Sandelowski 1993, 1998., Silverman 1993).

Descriptive validity refers to validation in relation to the interview content and the resultant transcript. In this study descriptive accuracy was achieved through audio-taping interviews and reproducing verbatim transcripts (Sandelowski 1993, 1998) (Appendix 9).

Interpretive validity refers to participants' experiences and the meaning that those experiences have for participants. In this study interpretive validity was achieved by obtaining each participant's individual perspective and discovering the meaning that his/her experience had for him/her (Sandelowski 1993, 1998) (Appendix 9).

Theoretical validity refers to the degree of accuracy between the researcher's interplay of data and theory, constant comparisons, theoretical questioning, theoretical coding and the accuracy of interpretation to the data collected (Sandelowski 1993, 1998,. Silverman 1993). In this study theoretical validation was achieved through engagement with participants, supervisor, experts and peers.

Although engagement with participants for the purposes of confirming the researcher's interpretation of participants' experiences, referred to by Hoffart (1991) as member checking, is generally highly recommended, experts such as Sandelowski (1993, 1998), Silverman (1993) and Nolan & Behi (1995) point to possible drawbacks of member checking in relation to theory development.

Sandelowski (1993, 1998) states that it may not be necessary to involve participants in order to ensure theoretical validity, as their views of the researcher's interpretations do not necessarily constitute evidence for or against this type of validity. Participants may not understand an interpretation intended for a particular audience, even though the interpretation may fit the data. In other circumstances participants may accept an interpretation because they do not wish to offend the researcher, or, conversely, they may not accept an interpretation that is unflattering or threatening to them. If theoretical as opposed to interpretive validity is the goal, then participants may not have greater claim than the researcher or the experts to getting it right. In addition Nolan & Behi (1995) state that if all findings have to be verified and agreed by participants this may bring difficulties to reporting critical or unpleasant findings.

This study initially chose, of the various approaches to member checking, to employ that suggested by Burnard (1991), that was: firstly, seeking participants' agreement to follow-

up and, secondly, returning transcripts and asking participants to note what they considered the main points in their interview (Appendix 14). This was done with the intention of comparing participants' list of comments with the researcher's and then making minor adjustments to the initial category system. However, this study found this approach to have drawbacks. Firstly, the response rate was poor: the researcher sent transcripts by post, but only one-fifth of participants responded. In cases of no response, a second transcript was sent, with poor response, and in terms of ensuring confidentiality the repeated posting of transcripts posed difficulties. There was also difficulty in making telephone contact. In addition, in relation to theory development, Burnard's (1991) suggestion was found to have drawbacks in relation to asking participants to identify their individual main points as this approach is problematic when a specification of grounded theory is the production of theory rather than simple description (Hall & Callery 2001). There is a risk, according to Silverman (1993), if member validation is overemphasised. As a result this approach was not employed beyond initial interviews and initial analysis.

In the interest of theory development it was decided to engage participants by following Thorne, Kirkham and MacDonald-Emes's (1997) suggestion of sharing conceptualisations representing the entire sample rather than engaging with participants about their individual transcript. This approach involved inviting six participants to examine the researcher's interpretation critically. Five participants were drawn from the general sector —each representing one of the five general hospital categories described as bands — and one participant was from psychiatry. Participants were invited by telephone to participate, and, with agreement, a written overview of the study's findings and recommendations was forwarded to each participant in advance of the meeting (Appendix 15). As with the interviews, the researcher then met with the participants individually. At each meeting, the researcher and participant discussed the study's interpretations and the participant's position in relation to those interpretations.

Theoretical validity also involved engagement with the researcher's supervisor. This engagement took the form of regular fixed meetings which were organised in accordance with the stages in the study's progress. Peer engagement involved sharing, deliberations, challenges, disputes and discussions with peers in the practice and research areas. Expert engagement chiefly involved scheduled institutional research seminars and meetings and an outside expert opinion. However, Sandelowski (1993, 1998) states that, while experts can guide and support researchers to improve their case for theoretical validity by acknowledging

that their theorising fits the data as presented to them, it is impossible for them to validate that the researcher's theorising fits all the data, as they would not have the same opportunity as the researcher in terms of time and access to study over time all of the data.

3.16 Conclusion

This study explored through the grounded theory method the experiences of top-level nurses. Data collection was achieved through interview, using the long interview semi-structured approach (McCracken 1988), and through the literature. Interviews were audio-taped, and verbatim transcripts were produced. The Ethnograph v5.0 computer program for the analysis of text-based data was used in the coding, sorting and management of data. Data were analysed using the grounded theory method as developed by Glaser and Strauss (1967) and Glaser (1978, 1992). The establishment of rigour was ensured by attention to the central criteria for grounded theory: fit, work, relevance and modification (Glaser 1992).

The findings of this study are presented in the following three chapters.

Chapter 4, Contextual Factors — Irish Nursing in Context. This chapter places nursing in context in relation to society in general and to the world of healthcare in particular. It found that nursing has an ill-defined relationship towards itself, that in society nursing is undervalued, and that in healthcare it is dominated by government, by medicine and by general management.

Chapter 5, Basic Social Psychological Problem — Positional Marginalisation. This chapter places the top-level position of director of nursing in the context of nursing and the healthcare system and found that the problem confronting this position is one of professional and positional marginalisation.

Chapter 6, The process is divided into two main sections: Part 1 — Basic Social Structural Process of positional vulnerability and Part 2 — Basic Social Psychological Process of 'acquiescing to/adapting to/accommodating to' positional vulnerability. In this chapter this study found that this position is confronting a structural process which contributes towards its professional and positional marginalisation. The study further found that the holders of

this position used the psychological processes of acknowledging and rationalising these changes and, finally, are in their behaviour 'acquiescing to/adapting to/accommodating to' these changes.

CHAPTER 4
IRISH NURSING IN CONTEXT

4.1 Introduction

Context, according to Dewey, provides the connection and unity that is inherently present in any given situation (Bernstein 1960); it allows one to consider situations as events that have connections to a 'contextual whole' (Schmieding 1993:240). The grounded theory approach supports this notion. Glaser (1992) defines context as a 'condition of overriding scope under which a set of related categories and properties occur', such as soldiers acting and interacting in a context of authoritarianism (Glaser 1992:65). Consequently, in this study the experiences of top-level nurses are examined within their historical and contemporary context (Hedin 1986), and nursing, and particularly the position of director of nursing, are placed in the contextual whole of healthcare.

Society, government, healthcare professionals including nursing, and general management are all members of the macro healthcare structure. Nursing within that micro structure, is, because of its numbers and pervasiveness, the major healthcare supplier; however, it is a minor player in terms of strategic influence and decision-making. Other professions such as medicine and general management hold power and act as the major forces in strategic healthcare influence and decision-making. Within that world, the internal culture of nursing has been, and largely remains, one of control and obedience.

Despite the recent internal changes in nursing, from this study's perspective the position of nursing within the healthcare system remains in some aspects relatively unchanged while in others it is losing positional influence. In relation to the major players, notably the government, the Department of Health and Children and medicine, the position of nursing remains unchanged, while it is losing positional influence to general management and trade unions. The study's findings also indicate that as well as these factors affecting the position of nursing in healthcare, these factors result, more specifically, in the marginalisation of the position of director of nursing in the contextual whole, while the current basic social structural process and the current basic social psychological process serve to further that marginalisation. The findings in this chapter are presented under five major headings:

nursing, gender and society; nursing, medicine and general management; politics and policy-making; nurses and economic and social change; and nursing: where to from here?

4.2 Nursing, Gender and Society

Modern nursing emanates from the early nineteenth century, a time when women positioned themselves as the guardians of morality and considered that men were to be controlled but at the same time obeyed (Phillips 2003). It is from this position that nursing as a female profession took its direction in relation to the predominantly male profession of medicine (Ohlen & Segesten 1998). Its behaviour towards the profession of medicine remains largely unchanged, a consistent behaviour described as the doctor–nurse game by Stein (1967). Later, in the twentieth century, another professional group, the principally male profession of general management, entered the world of healthcare. This group sought to establish itself and did so and continues to do so by dominating nursing, thus placing nursing in its current position of being dominated by medicine and by general management.

4.2.1. The Impact on Nursing of Gender and Society

In presenting directors of nursing perceptions and experiences on the impact on nursing of gender and society, this section identifies the gender of each participant quoted.

4.2.1.1 Nursing as a Career Choice

This study found participants generally feel that the impact on nursing of gender and society has been substantial. The fact that nursing is an almost exclusively female profession means that it is very much influenced by society's expectations of females at any given time or place. Modern nursing, founded in the nineteenth century, was very much a reflection of the position of females in Western society in that period. At that time the practice of nursing was a reflection of respectable female carers in the home, and so society viewed the work of nursing, because of its long hours and commitment, to be almost akin to religious orders and conveyed on it a vocational status.

However, it emerged from this study that few participants had had 'a calling' and most had entered nursing as a second choice to teaching or university education; this occurred particularly with female participants because they had failed to gain the required academic standard for teaching or university at their time of finishing second-level education:

> I always think when we were young there were three choices you had: you got a job in a bank, you went teaching or you were a nurse. That was just how I looked at things. I didn't obviously do a good enough Leaving [Certificate] to do teaching; we didn't know anybody in the bank that would facilitate the pull; so I took…[nursing]. (Female Director GF22; 327–336)

Both male and female participants concurred on family financial circumstances as being a barrier to university education:

> Probably I would have liked to go on to university at the time, but that wasn't an option…financially. (Male Director GM25; 330–333)

It was found that male rather more than female participants were attracted to nursing on economic grounds. The majority of male participants in both general and psychiatric nursing entered nursing because it was 'a job':

> No, nursing was an accident. I was put into the wrong interview queue at the time. Instead of being in the queue for hospital chef training, I was put into the student nurse queue...I'm not joking, no. I didn't know what queue I was in; it wasn't very well organised, you know. I think the need for nurses was greater than that for chefs. So that was that. So here I am. A job is a job; in 1965 a job was a job. (Male Director GM14; 88–116)

> Back in the '60s, if you got a job, you took it. There was no alternative at that time; nursing was looked at as reasonable, and it was a secure job and permanent. I suppose I had looked at it as well paid, but I don't think it was. I suppose most people back that time that went into psychiatric hospitals had alternative revenue; a lot had small farms around the country. The psychiatry hospital sort of supplemented their salary and gave them their steady income. (Male Director GM15; 240–253)

Some female participants unlike any male participants picked nursing as their first choice of career. Of the female participants who chose nursing, a very small number did so because they saw it as a good career choice for them: the greater number had chosen nursing because family members were nurses:

> It was my first choice because I felt that nurses were very brave people, and they are really aren't they? And the training was really good, and that they were really brave and courageous people, and no matter what you threw at them, and I would have had a few maternal grandaunts, you know, who were very highly thought of at home, you see. (Female Director GF19; 482–494)

As nursing was chosen as second best to another career, largely because participants found that academically they could not pursue the career of their choice, this study's findings may infer that there are issues to do with how nurses view themselves individually and collectively:

> I have to say that for nurses themselves, unfortunately a lot of nurses still feel the poor relation, and I think a lot of it has to do with our own feeling of inadequacy or insecurity or whatever. I certainly think that there is still unfortunately the notion that other people are better qualified to speak or whatever; there is this thing about not being a university graduate, and I find it enormously sad. (Female Director GF25; 2052–2069)

> 'Nice girls; she hasn't got the points but she's a nice girl and she'd make a great nurse'. I think that is generally what people think. I still think they believe that...Much the same way, I think if you take the fact that we're in college now, college educated, do you think they're equal Stephens?...They are not. Take even [third-level institution]; they are not equal students. (Female Director GF23; 2247–2272)

4.2.1.2 Gender and Marital Status

The development of modern nursing has been affected by the position of women in the workplace, which, until relatively recently, was very much curtailed. Women, unlike their male colleagues, who held only three per cent of nursing positions, had an imposed choice: stay single and keep the permanent position or marry and lose the permanent position, a situation that remained until 1977 (Ryan 2000). Generally, permanent positions bring with them a sense of security, commitment and ownership towards any profession. They generally also mean that, as the workforce matures and changes, this maturity and change are reflected in the development of the profession. Consider, then, the impact on professional development of an almost entirely female profession who, because of legislation, had to give up their permanent posts and with them any prospects of promotion. From the perspective of these participants, when some were starting out on their careers as nurses, there was still in place 'the marriage bar', which meant that women upon marriage had to give up permanent positions in nursing:

> If you got married, you had to leave. You got a marriage gratuity if you had worked in the service for five years...The gratuity was at the time £500, and I remember people looking forward to this £500 when they got married. What had happened in the meantime, from 1971 [sic], was the marriage bar was removed and people were able to stay on. (Female Director GF27; 104–116)

On the other hand, the three per cent of nurses who were men not only were entitled to keep their permanent positions upon marriage but also received a marriage allowance:

> I got married in [the mid-1970s], and when I got married I got a marriage allowance because I was a male and it was deemed....as a married man I couldn't support a wife on a salary that was geared for single women. So I got a marriage allowance to help me support my wife...Not to females, not to females, it applied to men only...I think that marriage ban went at around 1977 or 1978 when the equality legislation came in. (Male Director GM14; 283–293)

Male nurses at this time were also better paid. Up until 1974 there existed unequal pay structures: men were paid higher salaries than women for doing the same work (Ryan 2000).

> The only thing I found at that time about male nurses they were better paid than we were; the equality bill hadn't come in. Yes, at that time they got a higher salary than the female nurses...Now it changed in a couple of years; I saw the changes coming when I was there. It wasn't a bone of contention between the staff, but you kind of accepted it as the way things were; that was it. (Female Director GF30; 447–474)

While the legislation may have been changed to allow women to remain in the permanent workforce upon marriage, participants found that society's expectations and the expectations of nurse colleagues were slow to accept married female nurses in the permanent workforce:

> There was a poor attitude towards married women at that time: the marriage wasn't going well or there was something wrong. When I was a student, too, there was a bad attitude towards agency nurses who were married coming in. We've come a long way. (Female Director GF19; 315–326)

> In those days, if you remember, there was a marriage bar, and married women couldn't; if they were permanent they had to leave their permanency at that time...with the result that there was very few permanent staff; there was a fierce large temporary establishment of mostly married people. And I think on [a particular night] I was maybe the only permanent staff nurse on duty, so the matron came up to see who her...permanent staff were, and I was the

> permanent staff person, so I took charge of the hospital for about a week or ten days. It started that if the night superintendent was off or on holidays I was picked to do the night office. (Male Director GM14; 196–222)

This lack of equality meant that general nursing up until the late 1970s was made up of mainly young student nurses, single female matrons and a large temporary establishment of mostly married women. Psychiatric nursing was made up of mainly young student nurses, single female and married male matrons, permanent single and married male staff, and a large temporary establishment of married women.

Nursing was left to the guardianship of the 'matron', a person who had committed her life to the benefit of the institution, to ensure that these young nurses would deliver and obey:

> If you go back to the time when we had the old ward sisters, no man would dare say anything, but that was a different era; they had full control...I mean we had three, we had four of them in the general hospital, and they were really out of the dark ages, I mean nobody, the doctors and consultants were afraid of them...and I often thought what a very lonely life by the time they retired. When they retired they went from a position where they were lord over everyone, and they have nothing, absolutely nothing, you know, they ended up being very lonely women...[Their jobs] took over their lives, yes, took over their lives. (Female Director GF30; 1286–1312)

The implications of this legislation for nursing, as an almost entirely female profession, was that the majority of its members would upon marriage have to give up any prospects of promotion and permanency. The other professions in healthcare, which were almost entirely male, were able to enjoy such benefits as financial rewards and a maturing workforce. In essence it is only since the lifting of the marriage bar in the 1970s that nursing has been given any opportunity to develop its workforce and so move beyond the provision of huge numbers of apprentices, which largely benefited the institutions but not nursing nor its evolution. In real terms only in the last twenty-five years has nursing in Ireland been given the opportunity to develop itself:

> I don't think they [nurses] have got to that level yet...I think we are at an arrested teenage years of development; we have been treated as children, and we have rebelled against that, and we are coming...maybe towards eighteen or nineteen now...Even though we're an old profession, we're not a mature profession. (Female Director GF27; 2746–2774)

4.2.1.3 Men in Nursing

In considering how nursing as a female profession encountered the restriction society placed on it, it is relevant to examine the position that nursing has taken on encouraging male membership. The proportion of males in nursing remains relatively unchanged at approximately three per cent. This study found that, from the perspective of the male membership, nursing has done little or nothing to attract men; further, it is their opinion that measures to attract male members are less now than they ever were:

> I've always been used to being sort of the token male. In the class in psychiatry there were four of us…In general [nursing] I was the only male…I was the first male on the staff of the acute hospital when I went to work there. (Male Director GM20; 642–646)

> I'm 44 years of age, and there are very few male nursing colleagues, and there was nobody in the group that I trained in; there were no men at all. And certainly, when we came into management, your line manager would have been the ward sister, and I don't remember working with a male ward sister. (Female Director GF31; 1152–1160)

> There hasn't been any real, genuine effort to market the career. The job is well paid now, too, you see, relative to others…You see, nurses today, after their training and with premium payments, can get close to [£] 25,000 [31,743 euro] a year: it's a well paid job; somehow the message hasn't got across. (Male Director GM25; 1801–1818)

These participants also consider that, apart from the lack of measures to encourage males to go into nursing, the total femaleness of the profession offers little to encourage males to stay. Traditionally, nursing operated its own watchdog in relation to allowing males join. Some male study participants spoke about having to go abroad to train as general nurses, while others found it hard to get a position after training:

> I applied for jobs…I got back what an author would call rejection slips, and I am awful sorry I didn't keep them: 'Sorry, we are not considering males for this position.' (Male Director GM14; 1818–1823)

In psychiatry, participants contend that men were encouraged to leave, as employers thought that there would be less unionisation and that women would be easier to manage:

> They [men] were talked out of the system for many years because it was considered there were too many of them and that it would be easier to manage

> women, which is not at all true. They [women] would be less resistant to change and so on, which is not at all the case, and then they were discouraged for many years. (Male Director GM25; 1827–1835)

4.2.1.4 Female Identity

Society's identification of nursing as a female profession, particularly general nursing and midwifery, raises issues for nursing and for male nurses:

> There is a perception of nursing as a female profession, and maybe it...has something to do with people's perceptions, young fellows' perception of themselves, their masculinity. (Male Director GM25; 1867–1874)

> Probably in my day...if you went into general nursing, you were looked upon as a sissy. But, as somebody said to me one time, 'they are queer or they are sex maniacs, you can call it what you like'. I suppose I didn't want to be labelled like that, so I felt that psychiatric nursing was a much more manlier job, and that perception is wrong in a sense because it gives the wrong perception to the public. (Male Director GM15; 2153–2164)

However, male participants in both general and psychiatric nursing did not consider their own and other male nurses' identity to be different from the identity of their female colleagues:

> I've never been conscious of the fact that I'm a man in a female organisation. I've never been pointed out by the public as 'oh I didn't know that a man was a matron' and all this sort of stuff. It doesn't bother me, as professionally, amongst my colleagues, I've always been a nurse, the same as everybody else. (Male Director GM11; 1856–1864)

> I moved from there to matron in [hospital] because there was a psychiatric hospital [nearby] with a male senior nurse. It had absolutely no effect on people whatsoever; it never has, and I've always found it to be an advantage...I've definitely found it an advantage...I've always been comfortable with it. (Male Director; GM20; 124–147)

Within the workforce of nursing itself both sexes appear to respect each other and work well together:

> I've worked with both genders without having any problems. I mean, I would speak highly of both male and female genders...in both management and clinical positions...I mean, certainly [in my training] women were certainly in

> power; they were quite awesome; some of them [chuckles] would leave a lot of the [male nurses] standing. (Male Director GM21; 2387–2473)

> I have worked with some very good men, and actually I have a lot of respect for the guys I work with. (Female Director GF29; 1637–1643)

> I do think the male nurse opportunities are more; he gets more opportunities for development and promotion than a female because he's a man in a woman's world. And, even when he is in the same position, I think there is a different view of how he is looked at…I think it's our own making really, while we might pretend not to see it, I think we do look on men differently…I think that is probably a fault in us. I mean, you can see it, the male directors I would say have not half the problems a female director has…I've seen it. (Female Director GF34; 1626–1635)

This study found that participants indicated that for the development of nursing it is important to bring about an improved gender balance. It is felt that greater balance in the gender make-up of nursing will serve to improve it and its position in the workplace. Many feel that it is the femaleness of nursing that has prevented it from developing to its maximum potential:

> In fact I certainly think sometimes that nursing would be better if the gender balance were more even really…sometimes we get caught up as a profession in a lot of petty things, kind of 'bitchy' sort of things, and the rest of it, and I think that's to do from being a predominantly sort of female profession. (Female Director GF35; 575–1797)

> I think we still need a gender balance. I still think that in psychiatry, and maybe in general hospitals as well, you do need male and female. I think it's natural, it's normal. I think it's good to have an input from females and it's good to have an input from males. It brings more maturity to the whole service. (Male Director GM15; 2139–2147)

> I just simply think that we'll say, in the context of nursing in Ireland, there are not enough of them [male nurses] around. (Female Director GF32; 294–297)

4.2.1.5 Gender Imbalance

However, many participants feel that nursing, instead of trying to address the gender imbalance, has done nothing to actively recruit males. If anything, there were, according to participants, more males going into nursing in the past than there are today, a situation that most feel is to the disadvantage of nursing:

> It has been disappointing that there has been so few men taking up the profession in...nursing it would appear...From our own experience I can recall we have probably only had one or two male nurses apply in the last five years. On my recent recruitment not one male nurse applied, which makes me think that perhaps the percentage of men in the profession is not as high as one would have expected. And why is that? Is it that men don't see it as an attractive career, or is it still stereotyped as being a woman's career? (Female Director GF16; 2128–2153)

> If you look at nursing *per se*, it was always considered to be a female...Psychiatry was somewhat different in that it was nearly half-and-half male/female. I think things are changing a little bit if you look at the intakes into the universities for nursing at the moment; there seems to be a greater increase in the number of females. (Male Director GM24; 1540–1550)

Nursing as a predominantly female profession may also be affected by society's expectations of women. Within today's society, although females do not have to give up their permanent positions upon marriage, the expectation is that in any family set-up the female continues to have primary responsibility for childcare and home management:

> The reality is, if you are a woman with children, you are also looking after your children and also [your] husband. (Female Director GF13; 1469–1472)

> I think you just have to look at the nursing structure; within psychiatry, anyway, most of the directors of nursing are all males. Now I suppose you have to question how many women are actually applying for the positions...When you get to that career point as well, and you're talking maybe mid-thirties...women are also carrying all the issues of family life as well. (Male Director GM17; 2032–2045)

> Women are always seen as the people who look after the children and have children, or get married, or whatever; that makes a difference on your career. Certainly the man would be more focused on getting there, and if a child is sick, well it's the woman that looks after the child; it's never the man who will ring in to say his child is sick and he needs the day off...If there is an elderly relative, we'll say like a mother or father, that requires looking after, it's nearly always the girl that's seen as the carer. (Female Director GF33; 1211–1239)

As society generally holds that the primary responsibility of females is as carers, equally it holds the female to be the secondary provider. This places, for participants generally, the female's career in a secondary position to the males. For many participants this raised the issue of mobility. Generally it meant that females were less able than males to move as a means of career progression:

> The men were prepared to move; they had no problem. But I think for a woman it's different; it was at that time; it might not be now. You had children, the family unit and all of that. Then it depends on your spouse and what area of work they were in and how linked it was. The males could up and go. You had lots of nurses married to farmers; they're not going to sell up and go. But if you had the male who was head of the household, they can move freely, whereas there is not the freedom to move for the female. (Female Director GF27; 198–212)

> My wife didn't work outside the home until the children were grown up. It allowed me the flexibility of moving, so that's certainly a gender issue. If she didn't, hadn't, wanted to move...I wouldn't be where I am now,...The decision-making process that is used in most families is to support the main income, not the second income, so we are getting to the situation now where I spoke about the people only wanting to work Monday to Friday from 10 to 2...so that is a gender issue; it certainly affects how somebody's career develops. (Male Director GM20; 2619–2660)

While society's expectation is that the female is the carer and the secondary provider, it assigns the role of primary provider to the male. Participants felt that society's expectations are mirrored in nursing by the fact that, although males make up approximately only three per cent of nursing, their representation at managerial level is disproportionately high. Participants further felt that, while females may make up approximately 97 per cent of nursing (Flynn 1998), the whole work culture in nursing is male oriented and that orientation provides males with an advantage in reaching managerial level and thus facilitates their progress. It is felt that in this culture males intrinsically understand the politics of getting on better than women and so attain top-level positions even in nursing with less effort than their female counterparts:

> Men are better at networking and promoting themselves and investing in themselves And to get there...certainly men do push themselves. They don't actually put as much in; they are very good at imaging and talking to the staff...and promoting themselves, yes. (Female Director GF29; 1629–1660)

> They view things very differently than a woman...Men respond very differently, they do, and I think that's the key to their success. (Female Director GF34; 1666–1668)

Some participants felt that, in the wider health organisational perspective, male nurses were advantaged over female nurses:

> Possibly, if I was a man within the nursing context, I don't think I'd be sitting here in front of you: I'd probably be in the health board...Well, I think women

> don't naturally come to the top in the health board. (Female Director GF18; 1880–1887)

> I think I would be accepted more as a manager if I were a man, by men not by women...I think for the female staff, well, all the nurses are females, it wouldn't matter if I were a man or a woman, but I think with the CEO it probably would matter. (Female Director GF12; 1526–1534)

4.2.2 Conclusion

In conclusion, many of this study's participants view that nursing, although largely female, has female and male elements: female in that it sees itself as owning 'caring', but for every other aspect, in terms of organisational structure and culture, it is male in its approach. Although a largely female profession, it does not organise itself around woman-power planning but, like other professions, around man-power planning (Davies 1995). Participants generally feel that it does little to encourage men to join, but, once in nursing, that males tend to have an easier passage to the higher levels than females.

4.3 Nursing, Medicine and General Management

The healthcare structure traditionally functions with three separate management structures, involving medicine, general management and nursing. Although nurses represent the largest group, they are in practice asymmetrical to the other two in their power base. In recent times any changes in healthcare structures have done little to alter that imbalance of power between the medical profession, general management and nursing (Traynor 1999).

4.3.1 Nursing and Medicine

It is generally perceived by the participants in this study that, of the three structures in the healthcare system, medicine, nursing and general management, medicine holds and enacts the greatest institutional power:

> I think consultants wield huge power in terms of how hospitals are managed. They are really powerful. (Director 15; 2082–2085)

> Bed management, you can put anyone into bed management, but you cannot get a non-clinical person to challenge a clinical decision…If you don't have a clinical background, the consultant would make mincemeat of you. (Director 44; 460–469)

Traditionally modern nursing followed medical orders; this practice, although difficult for nursing to admit to, continues. This difficulty has resulted in nursing adopting ambivalence in how it perceives and enacts its relationship with medicine. At national level nursing subservience to medicine is enacted through the Nurses Act 1985, which provides for ministerial appointment of three medical practitioners to the Board of An Bord Altranais. These practitioners represent the areas of general nursing, psychiatric nursing and midwifery. In accordance with the Act, the recently appointed board continues to have three medical representatives (An Bord Altranais News 2003).

> I think a lot of nurses are not strong enough in making their views heard and in trying to influence policy. And I think they are weak, and I think a lot of the time they are cowed by medics and people that are on these policy boards. (Director 05; 1652–1658)

In 1998 the Commission on Nursing found that nurses were generally not happy with the level of centralised nursing power in the clinical area and thus recommended the decentralisation of nursing power. The Commission did not address the system and culture in which nursing operates. While many participants generally perceive the Commission's recommendation as laudable, they equally feel that the traditional institutional power structures of medicine's relationship to nursing remain unchanged:

> I am very much in favour of [managers] at ward level…to become much more involved in management…where [managers] would have much more control over the management of the unit. At the moment we have no control. Well, we have a certain amount of control but not proper control. To my mind it's stupid to see four or five consultants sitting in a unit in the morning; they are all looking for nursing personnel to serve them…The clinical director…is very much a doctors' man rather than a nurses'…he's medical. The fact of the matter is he feels consultants are the people that make the clinical decisions and he won't interfere with that. (Director 08; 1526–1575)

The Commission on Nursing recommended devolving the power of decision-making to clinical nurse managers, but in real terms it is a power that neither nursing nor its directors hold. The granting of power to nurses has traditionally been to allow disciplines such as medicine to function in its preferred manner. A difficulty from the perspective of many in this study lies in nursing's lack of awareness of these ingrained subtleties:

> We have a consultant who doesn't want rooming in...and who is very vocal about it...My biggest difficulties are in persuading the actual nursing practitioners to change. (Director 15; 1615–1630)

In 2000 in clinical nursing practice at national level the ambivalence continued, with An Bord Altranais, Requirements and Standards for Nurse Registration (An Bord Altranais 2000b), Holistic Approaches to Care and the Integration of Knowledge, stating that: 'the nurse plans care in consultation with the client taking into consideration the therapeutic regimes of all members of the health care team...[and] 'participates with all health care personnel in a collaborative effort directed toward decision making concerning clients' (:16–17). Most nurses in clinical practice, by virtue of how Irish clinical healthcare is managed, would consider 'therapeutic regimes of all members of the health care team' (:16) and 'all health care personnel in a collaborative effort directed toward decision making' to mean the planning of nursing intervention following doctor's orders. Nursing standards such as these feed the ambivalence which is evident in the practice of nursing:

> To work within...hospital structures...certainly, I mean, nursing is not autonomous, in that it has to operate in conjunction with...the other structures in the hospital...you know, with the medical model...So you have to function in that overall context. (Director 18; 1798–1809)

> They [doctors] have a major impact in the sense that...a lot of the services are consultant led. (Director 04; 1369–1375)

> There is still this thing of the nurse being the doctor's maid; I think there is still a lot of that around. (Director 07; 2266–2269)

In 2001 acknowledgement of this subservience was further endorsed, with the ministerial appointment of a medical practitioner to the National Council for the Professional Development of Nursing and Midwifery (National Council for the Professional Development of Nursing and Midwifery Newsletter 2001).

4.3.1.1 Nurses as Handmaidens

Participants in this study generally perceive that nurses seem to be caught in the current rhetoric of 'not being doctors' handmaidens' while doing little in their behaviour to demonstrate to themselves and to others this evolving emancipated view of themselves. This study found that the handmaiden practice continues in the recognised traditional areas

of clinical practice and nursing management, where directors of nursing in this study attend medical board meetings to report and give account of nursing activities.

Interestingly, some participants seem to be unaware that nursing practice has carried over its handmaiden role to the new area of policy and standards development. Nursing now dedicates itself to the development of policies not just for the practice of nursing but also for clinical practice generally. Having done the work, these directors of nursing then present their work to medicine for its approval and sanctioning:

> If the [policy] affected the medics, I would sent it to the Medical Council. [The infection control policy], that went to the Medical Council and that was approved, but it was our school of nursing that drafted that. (Director 37; 1166–1174)

> If I'm changing the drug administration policy, we would do it up, nurses would do it, it would be passed to me, and I would pass it on to the medical board for sanctioning, and they would be the ones who would sanction it or not, because it would affect their practice. (Director 36; 487–494)

This study's participants generally perceive that, despite recent educational developments in nursing and the recommendations by the Commission, there has been no visible alteration in how medicine treats nursing. While medicine and nursing operate together, and some nurses may wish to think that they operate in partnership, in reality medicine dominates nursing. In the context of nursing development, the behaviour of medicine toward nursing is primarily the responsibility of nursing. It is the responsibility of nursing to alter its own behaviour in the doctor–nurse handmaiden game:

> A lot of doctors here…would see the nurses as their handmaiden, and a lot of the nurses…would set things up for doctors rather than having the vision of: 'I could be doing this'…I think, until we change ourselves, we're not going to be able to change how other people view us. (Director 50; 1327–1345)

4.3.2 Nursing and General Management

As previously stated, the healthcare structure traditionally functions with three separate management structures, involving doctors, general management and nurses (Torres 1981). Participants generally perceive that in recent times general management has sought to increase its power base by expansion; it has introduced additional organisational layers:

> It's a new layer; it has come in the last three years...I don't know about the advantages of putting in another layer, how effective that is. I don't see huge changes in that...you would wonder about this layer. (Director 04; 961–992)

> I suppose all they have done with the new area health authority is they have decentralised...That's all they've done because the same key players are now in three areas, rather than all being together. (Director 41; 999–1005)

General management in seeking to increase its power base will have to take from the territories of the two structures of nursing and medicine (Hugman 1991). Of the two structures, nursing is the more vulnerable; despite supplying the greatest number of healthcare professionals and being the only discipline to provide total service at all times, nursing does not have power and influence (Ely 1994, 1995). Many of this study's participants perceive that the vulnerability of nursing in relation to general management is evident at strategic organisational level (East Coast Area Health Board 2003):

> It is very difficult to have a voice, and they [nurses] try hard and have representatives on all these boards, but it is very difficult to get their voice heard...I don't think they are listened to; they [the boards] take their advice alright but it is not acted on. It is not, and they try to have representatives on all of these, but it just doesn't seem to [happen]. (Director 38; 1297–1337)

> I think nurses have been invisible on health boards. We've always had nurses' representatives, but what impact did they ever make? (Director 32; 2559–2563)

Locally, from the perspective of many of this study's participants, general management dominates nursing. In the provision of nursing service, general management controls all resources necessary to the function of nursing, with the exception of nursing knowledge. Participants perceive that this domination is assisted by the Department of Health and Children, as the Department communicates with general management, which then dictates how nursing will receive information. Even in nursing matters such as the submission of applications for nursing grades, under the recommendations of the Commission nursing had to pass these applications through a whole chain of general management to access the Nursing Policy Unit in the Department of Health and Children:

> Sometimes you feel quite frustrated because you have all these reports to send to the coordinator and then on up the line again. There's control wanted there all the time. (Director 43; 736–744)

> I...wrote a four-paged account of what I do to the hospital manager, who will sent it to the programme manager, who will sent it to the Department. (Director 01;1221–1226)

General management, for many of this study's participants, reinforces this domination of nursing by making provision for its own group while excluding nursing from necessary training for role enlargement and performance. Having spent the resources on its own group, it then gives nursing the job to do:

> There's a few things the board still hasn't got right in relation to training...They send hospital administrators...on courses on *force majeure*...They sent them, the hospital administration staff, on that course, and they forgot about us. And yet the first decision that had to be made, they told me it was my [nursing] decision. (Director 28; 2370–2470)

There would appear to be conflict between nursing and general management. While participants generally view nursing as charged with the responsibility to deliver nursing service, they also perceive that conflict arises as power belongs to general management in its control and access to the resources necessary for the provision of those services, a perception supported by Torres (1981).

> What I do find is a difficulty is that being in management from a clinical point of view and trying to deal with people who haven't the faintest idea of what you're trying to do, and they're the ones that are holding the purse strings. They have come up purely from clerical experience and are trying to dictate what can and cannot be done. I think that's wrong. I also think that it's sad to think that there's a certain standard of education required from nurses to come into the service, and they can be dictated to by a person who needs a far lower level of education to get into a clerical job...I think that's sad...When you think about it, our service is there because of people; the people are patients; the patients need clinically delivered service. The people who know about that are both nurses and medical people. How just mere clerical people with no other background can make adequate decisions as to how the service should move, it beats my brain to try and rationalise that. (Director 11; 1624–1996)

4.3.3 Conclusion

In conclusion, the general perception of this study's participants is that, of the three management structures in the healthcare system, nursing is the most vulnerable. From the perspective of these participants and current evidence in relation to medicine, it appears that medicine continues to dominate nursing.

General management appears to present a different relationship, one in which the ground rules are possibly not well understood. In practice, from the perspective of this study, nurse education and socialisation provide only for the clinical world. So nurses' awareness of the relationship of nursing to general management generally does not become evident until the nurse enters the mature stage in a nursing career, at the level of senior clinical/administrative management or administrative nursing.

It is generally felt by many of this study's participants that, for nursing to develop its own destiny, it must win influence and power. This study's general perspective would support Torres' (1981) opinion that, in the natural order of the world, neither medicine nor general management is going to share its influence and power, nor are they just going to grant influence and power to nursing. The key issue is the willingness and ability of nursing to win influence and power for itself.

4.4 Politics and Policy-Making

Up until World War Two, Western governments had little involvement in the general provision of healthcare. It was not until after the war that governments began to take a controlling interest in the provision of public health services (Lynaugh & Fagin 1988). Ireland, like many other Western nations at that time, in 1947 established a Department of Health. With the establishment of the Department of Health, the government of Ireland took direct control over the nursing profession: both the then General Nursing Council and the Midwives Board were replaced by new statutory arrangements and a new governing body, An Bord Altranais (Robins 2000). The government of Ireland through its Department of Health and Children continues to hold control of the nursing profession.

4.4.1 Nurses Act, 1950

The Nurses Act, 1950, was reputed to give nurses a voice, but did not give them a controlling voice in the regulation of their profession. The new body of An Bord Altranais consisted of a board of twenty-three members: ten nurses elected by their own profession, six doctors and seven others appointed by the Minister. Provision was made for a special midwifery committee, which for the first time brought regulation of midwifery together with other aspects of nursing (Robins 2000).

4.4.1.1 Nurses Bill, 1961

The Nurses Bill, 1961, appears to have been prepared without prior discussion between the Minister and or his Department and An Bord Altranais. The president of An Bord Altranais at the time was angry that the contents of the bill had been published in the newspapers without any consultation with the Board. The bill ended the Board members' internal annual election of a president and replaced it with a provision under which the Minister for Health would appoint future presidents for the full five-year period. The majority of An Bord Altranais board members opposed the proposal and sent a deputation to the Minister. The Minister for Health ignored the Board and its deputation by refusing to alter the bill. The provision remained and was enacted in the Nurses' Act, 1961 (Robins 2000).

4.4.1.2 Nurses Act, 1985

The procedure for the appointment of president of An Bord Altranais remained unchanged until the Nurses Act, 1985, which restored to the Board the power to elect its own president. This Act provided for an increase in Board membership from twenty-three under the 1950 Act to twenty-nine. Seventeen are nurses elected by nurses, and the other twelve are Ministerial appointees, which include 'a number of members of the medical profession' (Robins 2000:58)

Generally this study's participants perceive that the controlling position of politics over nursing continues and is reflected in situations such as the drastic health cutbacks introduced by the government in 1987, when many services were reorganised and in some cases hospitals were closed. Nursing endeavoured to advise government that these cutbacks would have detrimental effects on nursing and on healthcare provision. However, the opinion of nursing was ignored, and many nurses were made redundant. As a result, many nurses took alternative careers. That loss of nurses continues to affect nursing and the provision of the nation's healthcare today. In addition, part of those cutbacks, and possibly the greatest threat to nursing at that time, particularly to psychiatric nursing, was the closure of a number of training schools. The result of that decision left the psychiatric services, in the latter part of the twentieth century and into the twenty-first century, bereft of registered psychiatric nurses:

> It was made very clear in the mid-'80s that closing the training school was the greatest disaster of all time...I don't know whether it was a move to get rid of psychiatric nurses or whatever at the time, or whatever the thinking of it was, but it certainly was a huge error of judgement at the time. (Director 04; 1128–1139)

> The ignorance by the Department of Health and Children of nursing is evident when consideration is given to the place of nursing in development of national health policies. It is evident that generally nursing does not feature as part of national health policy-making; as so eloquently put by one participant, 'nursing is deafening by its silence'. (Director 44; 1963–1964)

> Yes, well that is interesting because, if you look at the Strategy Group that is being set up in the Department, there is no nurse on it, and there is an International Group which is looking at international practice as part of that consultative committee, an international consultative committee, and the WHO nursing rep....is not on it, and she should be, she is the Irish rep., the WHO rep., and she is not on it. So it is interesting; I think we have a long way to go at a national level in the nursing arena...I think it is sad that we are not on the new health strategy in that sense, and even the chief nurse in the Department is not on it. (Director 37; 1781–1882)

From the general perspective of this study's participants, where nursing does feature in the formulation of policies, it is generally substantially outnumbered in relation to medical and administrative representatives:

> Well, I think that, I don't think we have been prominent enough in the past, I really don't. I mean, if you look at any of the things that have been set up, like even the cancer strategy, so many of them have left nursing out of it completely...If you look at any of the strategies that have been set up in the past, there has been very little nursing input. And I think to be recognised, I think we are being recognised, it's been very slow. (Director 50; 1448–1469)

4.4.2 An Bord Altranais

This study found that participants generally felt that An Bord Altranais does not have a strong voice. According to participants, the Board is little heard of in nursing except in relation to the recently introduced annual retention fee. The study further found that in public life An Bord Altranais is not known and it does not have a strong voice on health policies:

> No, none I think. Okay we have An Bord Altranais, who don't have a voice. Who ever hears them say anything? Most people have never heard of them;

> unless you are a nurse, you don't know who Bord Altranais are, and nurses know it purely because they pay their annual fee to stay on the register; that's the only reason that nurses know of them. They should be our voice; they are supposedly our professional body. (Director 03; 1831–1841)

The general perception of the reason for the lack of influence of nursing in political life is the lack of political representation of nurses by nurses from An Bord Altranais. This perception may stem from the fact that, although nursing has a voice in the regulation of its profession, it does not have a controlling voice:

> An Bord Altranais, I think the influence of An Bord Altranais has been disastrous; it has lost all credibility for nurses...I would say the Irish Nursing Board had an opportunity from the '85 act to promote professional development...It should have a major influence, it's a nurse's professional body, same as doctors have their Medical Council...but it is controlled by the Department of Health, and the Department of Health dictates the president of the board. They have twleve seats on the...existing board, and there are seventeen elected members. So, no matter how you do your sums, to bring together, out of a board of twenty-[nine] they want [fifteen] elected members to support them, and they control the whole thing. You see, that's the criticism I'd have about it, and that they cannot move on as an independent profession, and it hasn't done that...An Bord Altranais...has the same statutory regulatory and controlling areas as the Medical Council, but the difference is the Medical Council is controlled by the medical practitioners, the nursing council is controlled by the Department of Health, and it's more so controlled by the Department of Health today than it was twenty years ago. (Director 24; 2178–2256)

4.4.3 Nursing and Political Life

Although nursing and government are closely linked, for many participants this close relationship is not reflected in the political preparation or awareness in nursing and in professional bodies representing nursing: there appears to be a lack or weakness in nursing and nurses to develop politically (Salvage 1998).

> It's as a result of the lack of political awareness of the profession of nurses; they have no idea of how politics operates and how small groups of people control systems...[if you were to ask nurses] 'do you know anything about any discussions between Bord Altranais and the Department of Health about changes in the Nurses' Act?', there wouldn't be one who would know, yet it is well advanced...They [nursing unions] are all represented, but they keep their heads down too, and they are all there...you never hear a word from them. (Director 24; 2297–2303)

Overall participants generally perceive nursing to be limited in its political preparation. It was also found to be divided into small groups, which participants felt contributed to nursing ineffectiveness. Many said that the country is small; there are too many small organisations; and many of these organisations are centralised geographically and visionary-wise in Dublin. According to participants, nursing needs to develop itself regionally with a single-voice organisation. One main organisation representing nursing would, it was strongly felt, politically benefit nursing; it is 'too diverse and too dilute in order to actually develop national policy'. (Director 35; 2191–2193)

> I don't think that to date we have been as proactive as we might have been. People tend to go to these meetings and listen and debate what has come out and how it's going to be rolled out and the difficulties for people. I think we should be there with more vision in how we might be able to set the goals, set the standards. It should be a very powerful organisation, and I think, if we don't make it that, we'll only be the makers of our own demise. (Director 33; 1937–1960)

> Not structured enough or anything like that, without a doubt. I think we haven't, but they need to be much more proactive about what is actually happening and demand that their voice. So, I see the...associations need to be much more proactive about how they lead. (Director 40; 1884–1907)

4.4.4 Political Representation

Participants generally indicated that this lack of political sophistication is evident in how their professional associations deal with public issues. They generally feel that this lack of sophistication is in itself a reflection of the general disunity that exists amongst nurses:

> They should be a lot more proactive; nursing is deafening by its silence...The Association of Irish Nurse Managers, who have a long and strong tradition...but I certainly think they could be more proactive out there, dictating policy...Associations can be very powerful and a move forward for staff, but it's how they are used, and nurses do not come together easily. They want to be individualistic, and they want to be part of a group, but, to be honest with you, an individual cannot do a whole lot, but a group can raise the consensus of opinion, and I think, unless nurses proactively do that, then nurses won't have a voice. (Director 44; 1962–2010)

Professional associations are invited to submit proposals to the Department of Health and Children; however, participants feel that little weight is generally attached to these submissions:

> Our professional associations...get opportunities to produce documents to the Department of Health on many issues. They always get an opportunity to have an input, I think. That has to be positive...How much notice is taken afterwards is an issue. (Director 04; 2358–2366)

> I mean, national associations, we would have certainly a lot of truck with the Department of Health, who write to us regularly for, say, policies on different things. We would certainly meet An Bord Altranais for what it's worth; we meet the Department of Health as well face to face. They take views on, and certainly they would always look for views on, certain things if they're going to change the national policy...We've made a lot of submissions, the latest being the whole new Mental Health Bill. We would have lobbied a lot on that...not at all [effectively]...Certainly it is a bone of contention...Certainly it would appear on the Mental Health Bill that the medics have had a bigger influence. For a start the term psychiatric nurse is not mentioned in it...The Department's view is that the reason mental health nurse is not mentioned is that...the Mental Health Bill applies to dementia, [ignoring the fact that] it applies to mental handicap, so they're using the title, the generic title, of registered nurse. So a lot of people feel aggrieved...the title psychiatric nurse is not mentioned or mental health nurse, so we had to...swallow that one. (Director 18; 3007–3057)

> I think the danger in the past has been that they have been too involved in, and that's their job to be involved in, defending the role of the nurse...They have in the past begun to speak out on things like overcrowding, but they're doing that with an emphasis on overcrowding and the poor staff working there rather than overcrowding and the patients who are not getting good care, right, so I think that's slowly changing. (Director 16; 3460–3475)

4.4.5 The Commission on Nursing

In 1997 the Commission on Nursing was established by the Minister for Health, on recommendations from the Labour Court following a series of disputes between health service employers and the alliance of nursing unions. The Commission on Nursing terms of reference included the evolving role of nurses, the professional development of nursing, training and educational requirements, promotional opportunities, the nursing management of services, structural changes and changes in work practice (Ryan 2000., Clarke & O'Neill 2001). The establishment of the Commission on Nursing averted the strike action of 1997. The Commission on Nursing published its findings in 1998, and, while its recommendations were welcomed, it was perceived that the Department of Health and Children was slow to implement them, and thus nurses' and midwives' nationwide

industrial strike action took place in October 1999. Subsequently the Commission's recommendations formed part of the strike action's collective bargaining.

The Commission's recommendations discussed in this section are those that this study's participants chose to address. The Commission's recommendations for nursing have generally been welcomed and embraced by participants. Changes such as the additional posts, with their prospects of promotion, and the development of the clinical nurse specialist posts are viewed as positive actions for the continued development of nursing:

> They [the Commission] have created what I would see as very good...the specialist roles, like the clinical nurse specialist roles, where you can actually stay in the speciality you like and be recognised for it, both money-wise and grade-wise, but you're not going into management...They are the layers that are important, as against the manager layers. (Director 19; 2484–2506)

The Commission recommended the development of three grades of first-line management with the title 'clinical nurse manager' (CNM). In addition, the Commission recommended the decentralisation of nursing authority, which in effect increased the decision-making powers of nurse managers in the clinical area:

> They have given more autonomy now to the ward sisters; I think that's better as well. At least she's responsible for the clinical side of it, which is good. (Director 30; 322–326)

The Commission recommended that all matrons in large acute hospitals and chief nursing officers in the psychiatric services should be entitled directors of nursing. In addition, it recommended that directors of nursing should move away from the operational arena and into strategic management. This move, while welcomed by some participants, has caused concern for the future position of nursing management and raised suspicions about whether there was an agenda to follow the UK healthcare service model of general management:

> This title, director of nursing, was suddenly imposed or superimposed...I suppose...the fear a lot of my colleagues would have is that we'd suddenly end up reporting to a grade 5 or something that...it's a kind of a diminution...nursing is being boxed in...That's the fear that some of my colleagues would have...It's a lower grade in administration...so the fear is that it might follow the English model and have nursing just stuck down further down on the hierarchy. (Director 18; 34–85)

The Commission recommended the establishment of a Nursing and Midwifery Planning and Development Unit in each health board, and in line with this recommendation the creation of the position of nurse practice development coordinator of services was welcomed:

> A key appointment was our nurse practice development coordinator...who is responsible for the clinical practice coordinators going around the various clinical areas and supporting the staff and transmitting the theory to practice, has been highly successful in bringing staff on board and breaking down barriers, and [the] post is a key post. (Director 12; 491–501)

4.4.5.1 The Commission and An Bord Altranais

Included in the Commission's terms of reference was the examination and reporting of the role and function of An Bord Altranais generally in relation to education and professional development, regulation and protection of the citizen (Commission on Nursing 1998).

4.4.5.2 The Commission and Third-Level Education

One of the recommendations of the Commission called for the transfer of pre-registration nursing education into third-level institutions at degree level. This recommendation was accepted, and a four-year programme commenced for all pre-registration nursing at degree level in third-level institutions in the academic year of 2002–3. In 2000 the Nursing Education Forum was established by the Minister for Health to direct the transition (Robins 2000., Ryan 2000).

4.4.5.3 The Commission and the 'Scope of Practice'

Following the recommendations of the Commission, An Bord Altranais in 1998 initiated a project entitled the 'Review of Scope of Practice for Nursing and Midwifery'. The project aims were to review and to produce guidelines on determining the scope of practice for nurses and midwives. Following nationwide consultation, an interim report was published by An Bord Altanais in 1999 and in 2000 An Bord Altranais published Review of Scope of Nursing and Midwifery Practice Framework (An Bord Altranais 2000a). The framework provides for principles that should underpin decisions in relation to the scope and

development of nursing and midwifery practice. Of particular note is the emphasis placed on the individual accountability of the nurse or midwife in determining his/her competence to perform roles and the provision for expansion of nursing and midwifery practice in a flexible manner (Robins 2000).

Participants indicated their support for the 'Scope of Practice' and felt that it gives direction to nurses:

> Because from the feedback I'm getting now and the enthusiasm that young nurses have in wanting to develop their own career, they're hungry for more education. They do really want to get and be as good as the young nurses coming in who are trained to degree level. They want to advance into other advanced practices. They're absolutely very enthused by the whole 'Scope of Practice'. They want to know how they can initiate this, when are we going to get it up and going. Specialist nurses are absolutely fantastic, what they're at, and I think it's very positive. (Director 33; 331–346)

4.4.6 Nursing in Government

Throughout European countries there is extreme variation in the role of nurses in national policy-making. This variation ranges from countries such as Iceland, Israel, Spain and the United Kingdom, where nurses are actively involved and take a leading role in policy-making, to other countries where their role and function are at best advisory. Having a formal nursing position in central government is vital for nursing and its political life. The strength of nursing in government is important both symbolically and politically; it also gives a fair indication of the formal power of nurses in a given country (Salvage 1998).

In 1989 World Heath Assembly resolution WHA 42.27 urged member states to 'encourage and support the appointment of nursing/midwifery personnel in senior leadership and management positions and to facilitate their participation in planning and implementing the country's health activities'. In 1992 resolution WHA 45.5 urged member states to 'strengthen managerial and leadership capabilities and reinforce the position of nursing and midwifery personnel in all health care settings' and 'ensure that the contribution of nursing and midwifery is reflected in health policies' (Salvage 1998).

While most European states verbally express the importance of taking nursing issues seriously, only one-third of European states have a nursing unit at the level of Ministry of

Health; while most states have a permanent chief medical officer, only a few have a permanent chief nurse position. Where these positions exist, the terms of reference vary across countries, ranging from dealing only with state hospital nursing to tasks and responsibilities covering areas of nursing legislation, education and practice (Salvage 1998).

In Ireland the Commission on Nursing recommended the establishment of the position of chief nurse to the Department of Health and Children. It recommended that this position be on a fixed-term basis. Following these recommendations, the Nursing Policy Unit with the position of chief nurse was established. The function of the unit is to 'ensure that there is an integrated and strengthened nursing function within the department' (Shannon 2002). While many participants welcomed the establishment of the unit, concerns were expressed at its having only an advisory function, as opposed to being part of the decision-making process:

> Well if you look at the Nursing Policy Unit in the Department of Health, they are only advisors. (Director 46; 856–858)

> It's not anchored...Nursing in the Department of Health is advisory...Unless you are anchored into the decision-making loop... (Director 24; 2312–2315)

Concerns were also expressed about how independent the unit can be in its representation of nurses' views when it is part of the very department that it would be critical of if it were independently expressing contrary nursing opinions about health or nursing issues. It was also felt that to function within the Department it is necessary to behave as a civil servant as opposed to a nurse and that this benefits political interests over nursing interests:

> One would like to think that [nurses] are central to any policy issue, but where is the evidence of it? I am not that convinced, and I would have been much more hopeful when it was announced that we were going to have a nursing policy division in the Department of Health. But yet maybe behind the scenes there is a lot happening, a lot of preparatory work, but yet I would like to see that section being a lot more vocal about health issues. Who is going to push out the boat? Who is [going] to push out the agenda? It is very much a politically controlled situation; like, to be politically correct you have to work within it. Rather than being able to raise the issue, we have always wanted a department of nursing within the health service, but are they more free or less free working inside than if these people were outside it?...My preferred vision, I think we need leadership; I think we need people who will be able to articulate what is happening in nursing. I am not sure, if we have a department of nursing that is under the umbrella of the Department of Health, if we can

> achieve that, maybe they would be able to be more effective if they could be outside the present constraints. (Director 09; 2677–2743)
>
> There was the only nurse in the Department for a long time, and I argued all of the time even with her that she was no longer a nurse and had become a civil servant. (Director 16; 3514–3518)
>
> I know you have the policy unit in the Department, which is a very good set-up, but I think they have to manage very politically in terms of developing nursing and getting it heard at fairly high levels. I know nursing is part of the secretariat…The last thing you want is for nursing to become the secretariat for all these groups, you know. (Director 37; 1795–1814)

Participants further felt that the number of nurses assigned to the Department is not representative of nursing:

> There is the Nursing Policy Unit in the Department of Health, but, again, that is one or two people, it is not representative, I don't think…You see the odd flyer from the Nursing Policy Unit, but apart from that I would know very little about it. (Director 03; 1859–1869)

4.4.7 Conclusion

In conclusion, from the perspective of many of this study's participants nursing remains without a political voice. Participants further perceive that, while the profession of nursing is well regulated, it remains without political direction. While a number of participants welcomed the establishment of the Nursing Policy Unit in the Department of Health and Children, as recommended by the Commission, they expressed concern that its brief is one of advisor to that Department and that it does not form part of the decision-making grid.

4.5 Nurses and Economic and Social Change

This section places nursing in the context of changing Irish society and examines the national nurses' strike. It further analyses the issues of the image of the nursing unions, public esteem for nurses and the outcome of the strike action.

Ireland during the 1990s witnessed unprecedented social and economic change:

> Perceptions of nurses being nice girls or whatever...I think that is changing rapidly. There's so much more available to young people now: society has changed, nursing has changed, and I think the change that has been experienced even since I started working in Ireland, the change between the '80s and the '90s, the changes in that time are quite phenomenal, but it's not just nursing, it's everywhere, but the impact on nursing has been phenomenal. (Director 44; 524–538)

The economic boom of the 1990s was the greatest in the history of the state. This economic boom meant that increased numbers and types of occupations were available to people. This brought freedom to the workforce, allowing people greater choice of occupation, greater earning potential and greater freedom in their flexibility of work, with more people having the choice to work full-time or part-time or on an agency or locum basis. This economic change had a direct impact on labour-intensive services such as nursing; many participants experienced that institutions found it increasingly difficult to attract nurses who wished to work the traditional unsociable hours of nursing:

> It's a societal thing: people are changing. I think that one of the reasons why there's a downfall in the number of applicants to nursing is that we provide a 24-hour service; we work Monday to Monday; we work 24 hours a day...People want their time off; they're not interested in doing night duty...flexible working hours...I have eight applications in; most of them want to work Monday to Friday mornings from 10 to 2. Great; I am all in favour of being family-friendly; who's going to care for the patients for the rest of the day? (Director 16; 2352–2362)

In addition, numerous participants feel that Irish society, like other Western societies, is moving away from the notion of community interest towards the notion of self. This societal change, for these participants, has witnessed people becoming less interested in the greater good and more self-centred. Labour-intensive and caring occupations such as nursing have, according to these participants, possibly been more affected by these changes than those occupations more associated with the business world:

> It's within nursing. Nurses have become very selfish, and it's becoming increasingly obvious, and that selfishness is being compounded by legislation. Whereas it was 'I'm a nurse; my job is to give service to the clients; if I'm half an hour late it doesn't really matter', but not 'if I'm five minutes late I'm going to be looking for time-and-a-half. I don't really want to work 39 hours, so I'll go job-sharing or I'll look for permanent part-time or I'll take a day off a week parental leave, *force majeure*'. All these things are saying, 'nurses, not just nurses but workers in general, it doesn't really matter that you don't turn up anymore'. The loyalty towards colleagues is gone, to a very large extent...I

> think it's a cultural thing generally. But I'm surprised that nurses have got caught up in social change to the extent they have. (Director 02; 1967–1994)

4.5.1 National Nurses' Strike

While Ireland was enjoying its economic boom, nurses felt that their work conditions and pay structures had fallen far behind their counterparts in the private and public sectors. This led to industrial unrest, and in 1997, much to the surprise of the nation, including the nursing unions, nurses voted for strike action. This action was averted by the setting up of the Commission on Nursing. In 1998 the Commission concluded its work. However, by 1999 the government had still not implemented the Commission's recommendations. So, in late 1999 the state's nurses voted by a huge majority, 95 per cent, for industrial action. Thus in October 1999, for the first time in the history of the state, nurses and midwives in the Republic of Ireland engaged in national industrial strike action. This strike lasted from 19 October to 27 October 1999 (Clarke & O'Neill 2001).

In relation to the national strike, participants in this study generally agreed that working conditions, salaries and pay structures in nursing required urgent attention. It was also generally felt by, for many participants, there were issues in relation to nursing having to resort to industrial strike action. With few exceptions, it was felt that, given the nature, type and extent of the commitment of nursing to society, it was unfair that nursing had to resort to industrial strike action in order to improve its position in relation to work and pay conditions:

> I think [nurses] came from a very low pay. You know, the salary was very, very low, and I think if they are poorly paid that has reflected their career right down, and I mean I know the time of the strike and all that, I think it was sad that they had to go out on the street and have to fight for their rights, because they do work hard, and there is no other category of people that work as hard as they do. (Director 38; 819–829)

Participants had issues concerning nursing unions' commitment to nursing and the unions' ambition to establish positions of influence within the healthcare system. It was felt that if unions were operating for the greater good of nursing they ought to have been more circumspect in their strategic and operational management of the industrial unrest and should have resorted to strike action only if it had been absolutely necessary instead of as a

first choice. It was felt that other, less aggressive measures could have secured as much as the strike did. The overall effectiveness of the strike continues to be questioned:

> What did we get? Nothing. (Director 13; 908–912)

> I had huge difficulty in terms of, I felt that the nursing profession…were being advised by a very young and inexperienced union. I would have said at the time very strongly and I continue to say that I think as much or more could have been achieved without taking the position that we took. I think if there had been more of a work to rule or whatever, because…in the end…it wasn't that much of a strike…A lot of nurses are very disillusioned to this day, a lot of them. I mean, they say to me with constant regularity, when they see what they get for working from 6 to 8 in the evening and, when they see, you know, the whole process that's in place for filling additional senior 1 post and the rest of it, they say 'these are systems we walked up and down outside the gate in the rain for'. (Director 23; 1653–1687)

4.5.1.1 Strike Action and Public Esteem

A further issue in relation to the effectiveness of strike action is public esteem. This study's participants generally feel that nursing, although financially not well rewarded, has always enjoyed high public esteem. General public interpretation of nursing as a vocation was because of the nature of nursing work and nurses' dedication to duty. Participants also generally feel that the strike had in ways challenged this public concept of nursing as committed and caring:

> I think that it was seen as a hard job…I think the public are seeing that nurses are not committed…'If they were committed, how could they go out on strike? How could they stand outside the gate and see people sick inside and people not getting in?'. (Director 05; 1622–1633)

4.5.1.2 The Outcome of the Strike

In relation to the outcome of the strike, this study's participants generally feel that there were four main effects: the effect of the strike on nursing and on nurses; the question of the unions' commitment to the profession of nursing or their commitment to their own development; the development in nursing of political awareness; and the monetary value society places on the nursing product and its service. In relation to the effect of the strike on nursing and nurses generally, many participants considered that the strike had done little

to improve morale in nursing, and generally nurses were not satisfied with how the strike had been managed:

> I feel nursing is at a crossroads...I feel that the strike...did more harm than good, I really do, I think it lowered morale; it did a lot of harm. (Director 25; 3139–3147)

> I think it could have been managed differently, and I think it left...you know, there was a lot of sadness and hurt after it, and I think that is going to take a long time to heal. (Director 38; 849–853)

Many participants felt that the strike negotiations provided a quick-fix public relations exercise for the unions but did little to foster the professional development of nursing, which at the time of strike had already been examined through the work of the Commission on Nursing:

> No, it [the strike] didn't work for nursing. One of the very disappointing things was that I was at the launch of the Commission on Nursing and I was extremely disappointed to hear the unions coming out and blocking all the recommendations based on...pay. And I understand it, but at the same time I felt it was not doing nursing any great favours, that we had this Commission on Nursing launched and we couldn't implement it and it sat there for literally two years...I think, the strike, we were set up, I believe. (Director 46; 639–658)

They further felt that the unions, with their quick-fix approach, hindered in particular the development of mental health services. The unions sought and obtained monetary allowances which, according to participants, sent the development of mental health nursing back to the dark ages of institutional mental health nursing, in that these allowances were given to traditional areas of institutional mental health nursing when participants felt that they should be awarded to community-based developments outside the institutional walls:

> Professional development of nursing...I think what has happened with the recommendations from the strike, this is an important issue in the sense that I think there are positions given, there is money given out just to pacify. If it was for the good of the profession, I don't know. (Director 04; 2226–2233)

> The effect; well, they [unions] have sent us back into the dark ages again. (Director 34; 1638–1640)

In terms of developing political awareness, the strike was seen by some participants as having had a positive outcome. It was viewed that in the past nurses had not been as

effective in relation to policy matters as they could have been and that in this context the strike had been a positive turning point:

> I would say we have learnt over the last two years, from the strike and that, of our needs to get to the table and start saying what needs to be said and needing to be heard. It is probably one of our weakest, I mean nursing historically would not have been good at representing, up until a few years ago, if you asked nurses what it was they do, the strike was a turning point, when we sat down to look at what was nursing and what was non-nursing; it threw up a whole load of issues. (Director 20; 1705–1719)

While the strike negotiations did result in a settlement, it was felt by participants that this settlement fell short of positively positioning nursing in terms of financial reward and attractive employment conditions comparable with similar service providers in the private or public sector. While negotiations at the time were presented in terms of percentage increase and the final pay bill, there are other, fundamental issues that require consideration. Nursing prior to the strike was, compared to many other disciplines, financially marginalised in that its salary base was low relative to others. In relation to the final pay bill, nurses represent the single largest group of healthcare employees, making up at least forty per cent; they are the only group of employees that provide a full, 24 hours a day, 365 days a year, service. So, as the major service provider in terms of numbers and magnitude, it should be expected that its pay bill would, even prior to the strike, be the largest.

The perspective of many participants is that, in real terms for many nurses, the strike did little to redress the original salary imbalance. Many question the financial effectiveness of the strike and consider that nursing continues to be poorly rewarded for its commitment and service to society:

> I suppose the salary could be better for what you do and for what you put into it. It is a bit low...because you see people coming out with more than you...The differentials are very poor, and the staff nurses have fallen behind; they are only on the same level as a grade 4, which is my secretary...The grade 4 goes up to [£] 25,000 [31,743 euro] and starts at [£]15,000 [19,046 euro], and nurses start at [£]16,000 [20,315 euro] and go up to 25,000 [31,743 euro]...Even though everyone thinks the nurses got a great settlement, they are only at a grade 4. A grade 4 only needs their Leaving Certificate and computer skills. (Director 37; 1922–1942)

> For what has come out of that [strike]...I don't think nurses are well remunerated for what they do. (Director 23; 1910–1913)

4.5.2 Conclusion

In conclusion, the effectiveness of the strike continues to be questioned by many of this study's participants. In considering how the strike affected nurses, the sacrifices they made during the strike, the effects on the public image of nursing and the financial rewards, many of them feel that nursing could have achieved as much without resorting to strike action. They further feel that the unions convened the strike to further their own power base and not for the cause of nursing *per se*.

4.6 Nursing: Where to from Here?

It is generally felt by participants in this study that the responsibility for the change and development in nursing belongs in the main to nursing itself. Any internal change to nursing will of course be influenced by external forces, mainly society and the other groups in the healthcare system. In society generally there is a move away from deference to those in the long-established professions such as medicine; this societal change has had an influence on the practice of nursing (Hafford 2002). Within the healthcare system traditionally medicine has been nursing's closest working partner; this partnership has not been equal. It is generally well recognised that modern nursing played a subservient role to medicine through its foundation and development. Many participants felt that societal change is reflected in the change taking place in the relationship of nursing to medicine:

> The way nurses were treated in the past...they were to be seen, but they weren't to be heard…Now I think it's changing, and I think certainly younger nurses coming into the system are not going to be pushed around the way their colleagues were in the past, the interaction with medical staff etc. is a lot more open now. (Director 22; 1987–1998)

There is general acceptance by many of this study's participants that nursing is not politically sophisticated, and they further identify that for its own development nursing needs to redress this imbalance immediately. The general perception is that, while nursing can learn political skills and techniques, it is essential to eradicate its internal disunity. Disunity has been observed to be woven into the internal behaviour of nursing, and unless it is addressed nursing will continue not to feature effectively in the political realm:

> Nurses need to be much more political, though I think…they have to be a bit more united, you know. (Director 18; 3184–3197)

> In influencing national health policy, maybe we don't use our role sufficiently in influencing policy, but, again, we say we're not listened to. But I just wonder how much shouting we do, or how much we get people to listen to us, I don't think we're effective enough. I think, I think we're probably a little bit disjointed ourselves. (Director 48; 1341–1355)

For many participants, in relation to the politics and structures of healthcare organisation, nursing has many concerns. Participants generally feel that the Department of Health and Children has an agenda to support general management over nursing. In addition, they perceive that the recently unprecedented enlargement in general management administration layers has had effects on nursing:

> With general management coming in, if you look at what's happening in Ireland, every job that is being advertised in Ireland at the moment has a title like coordinator of this or coordinator of that, and they nearly will call it anything but a nurse. (Director 14; 958–964)

The general perception of participants is that nursing development and sustainability is the primary responsibility of nursing, and this concern requires nursing to examine its position. These enlargements, for many participants, require the profession of nursing to examine its external and internal positions in relation to general management and to develop from that examination its strategy in relation to the retention of its place in the healthcare system:

> I'm very seriously worried about nursing. I don't think the Department of Health has any commitment to nurses or nursing. I'm very seriously worried about it, I think...the health boards…the administrators around the country and the role of the matron, the role of the nurse, is going lower and lower…The best bits have all been cherry-picked. (Director 21; 2174–2201)

> I know people are saying 'do you need directors of nursing and do they need to be nurses?', that's the other side of it. But I think, number 1, nurses have the fundamentals; they have the basics. They really know what is going on in a hospital; they know the patients; they know the nurses; so I think the director of nursing position, yes, should be a nurse always. (Director 50; 1264–1273)

Arising from the Commission's recommendations for professional development and the transfer of nurse education to third-level institutions, it is a time of change in nursing. For the most part participants welcomed these developments, as they felt that for a long time there had been little movement in the internal professional development of nursing. As

with all changes, there is a degree of uncertainty about where nursing will evolve to and whether in its evolution it will lose those traditional aspects that are positive in the practice of nursing:

> I feel that it's those in their thirties that are most at sea...They're most at sea because they're not in the...flesh nor fowl, and they don't know whether it's worth investing all this money...particularly when they're married with small families. And...here in [a provincial town] it's difficult; there's the distance to learning; and there's the physical distance of trying to get somewhere and juggle the rest of your life as well...It is an awful nuisance...everything is based in Dublin. (Director 27; 1019–1046)

> I would say it's a very exciting time for nurses...I think that the education opportunities that are there and that are emerging at the moment are very exciting...I think really that nursing is evolving very, very quickly in recent years as a profession. I certainly think that we can look forward to better-educated, more enlightened and a more confident profession...in the future. (Director 23; 1899–1967)

For the continued viability of nursing, participants expressed concern about an ongoing trend in attracting and retaining people in nursing. While there appears to be difficulty in attracting people into nursing, the greater impact of this negative trend is in the retention of people in nursing (DATHs and St Luke's Hospital 2000). In nursing there are different state registers, such as general, psychiatric and intellectual disabilities. Participants' perceptions and experience indicate that these registers have experienced different degrees of difficulty in attracting new recruits, mainly in psychiatric and intellectual disabilities nursing, while all registers appear to have similar difficulty in retaining people:

> I'm not yet concerned with regard to people being attracted into nursing as a profession, not into general nursing anyway — mental handicap and psychiatry though are finding it rather more difficult. (Director 23; 1955–1961)

> I think it is an issue to keep people in nursing. I think there is a danger...there are still big numbers of...people going into nursing, but I think maybe there are a lot of people going out of nursing at the other end as well. (Director 49; 265–27).

4.6.1 Non-Emergence of Leadership

While this study took as its initial focus the concept of leadership as described by Zaleznik (1977), Burns (1978), Bennis & Nanus (1985), Bass (1990), Gardner (1990), Kotter

(1990), Covey (1995), Handy (1995) and House & Aditya (1997), in remaining faithful to Glaser's (1978) mandate the study was designed to be open and sensitive to what was found to have relevance and fit in the data and to discover what did exist and what applied conceptually, irrespective of the initial focus or the researcher's professional perspective. The study's design was further guided by Glaser (1992), who stated that more often than not the core variable that emerges from the data will not be the apparent issue or question that prompted the research. In accordance with Glaser's (1992) insight, this study found that the concept of leadership in terms of control, power, influence and strategic decision-making (Zaleznik 1977., Burns 1978., Bennis & Nanus 1985., Bass 1990., Gardner 1990., Kotter 1990., Covey 1995., Handy 1995., House & Aditya 1997) did not emerge as the central or core issue for participants. The central issue that emerged for this study's participants was the marginalisation of their position in a context where, from this study's perspective, nursing does not hold a leadership position.

In relation to contextual issues, from the perspective of this study, its findings indicate that, although nursing has a voice in the regulation of its profession, it does not have a controlling voice. In relation to nursing and political life, this study found that, although nursing and government are closely linked, this close relationship in not reflected in the political preparation, awareness or sophistication in nursing and in the professional bodies representing nursing. Participants perceive that, although their professional associations are invited to submit proposals to the Department of Health and Children, little weight is generally attached to their submissions. Participants further perceive nursing to be without political voice and that, while the establishment of the Nursing Policy Unit in the Department of Health and Children as recommended by the Commission on Nursing is welcomed, its brief is one of advisor to the Department and it does not form part of the decision-making loop.

In relation to medicine, it emerged from this study's analysis that medicine continues to influence and control nursing and that, while nursing seems to be caught in the current rhetoric of not being handmaidens to doctors, in its behaviour it does relatively little to demonstrate its evolving emancipated view of itself. Findings of this study indicate the domination of nursing by general management. Participants' accounts further identify that this domination is assisted by the Department of Health and Children, which communicates directly with general management, which in turn determines the format and timing of the department's communications to nursing. The marginalisation of nursing in

relation to general management is evident at strategic organisation level, where, according to participants, it is difficult to have a voice:

> Within the Irish context…there are a lot of really self-developed well-educated nurses, but for whatever reason they are not coming to the fore in the great numbers one would expect, given the amount of development and education that is available. Why is that we do not encourage it? Is it stymied? What is the problem? You would expect to have more leadership emerging. (Director 09; 2606–2620)

This study's findings further reveal that participants perceive that nursing has an ill-defined relationship with itself which is demonstrated by internal disunity; further, it is perceived that this disunity is woven into the internal behaviour of nursing and that addressing it would contribute significantly to the fundamental development of nursing.

4.7 Conclusion

This chapter places Irish nursing in context, from the general perspective of participants, and finds that participants generally welcome the changes in nursing but perceive that internal disunity remains a problem and that, although nursing has a voice in the regulation of its profession, it does not have a controlling voice. The study's findings further indicate that medicine and general management continue to dominate nursing.

In relation to society and gender this study found that, although nursing is largely female, it has male and female elements: it is female in that it sees itself as owning caring, but in every other aspect, in terms of organisational structure and culture, it is male in its approach, in that participants feel that nursing does not organise itself around woman-power planning but, like all other professions, around man-power planning. Both male and female participants generally feel that, while nursing does little to encourage men to join, once in males tend to have an easier passage to the higher levels than females.

In relation to economic and social change, participants question the value that society places on nursing, with particular reference to the national nurses' strike, where they feel that, given the nature, type and extent of the commitment to society, it was unfair that nursing had to resort to industrial action in order to improve its position in relation to work and pay conditions.

Regarding the strike itself, participants question its effectiveness, in relation to how the strike affected nurses, the sacrifices they made during it and the effects on the public image of nursing. In terms of financial rewards, participants feel that nursing could have achieved as much without resorting to strike action.

CHAPTER 5
BASIC SOCIAL PSYCHOLOGICAL PROBLEM — 'POSITIONAL MARGINALISATION'

5.1 Introduction

This thesis presents a grounded theory study of the phenomenon of the experiences of participant directors of nursing within the Irish healthcare system. The perspectives of directors of nursing in both general and psychiatric settings were explored and described. Data analysis revealed that participants were experiencing a basic social psychological problem in relation to functioning in a milieu where nursing is currently involved in its own professionalisation project and where the healthcare organisation is undergoing change. The problem identified as the core category was labelled 'positional marginalisation' of this grade of nurse in a hegemonic environment where medicine and healthcare general management take centre stage over nursing. Positional marginalisation refers to a position that does not belong to any group: it finds itself on the periphery of its own group, yet not a full member of the dominant groups, and has an ambiguous cultural identity (Roberts 1983). The problem of 'positional marginalisation' was found in relation to professional identity development for directors of nursing, professionalisation of nursing, medical relations, organisational structures and culture, industrial relations projects and internal organisation. The problem was placed in the context of contemporary Irish nurses as an oppressed group within the Irish healthcare system. These contextual healthcare conditions in which Irish nursing functions, modified by the basic social structural process and the basic social psychological process, were categorised under the headings: nursing, gender and society; nursing, medicine and general management; politics and policy making; nurses and economic and social change; and nursing: where to from here?

This chapter is presented under eight major headings: participant profile; the position of the director of nursing; professional identity development; professionalisation of nursing; directors of nursing and medicine; organisational healthcare structures and culture; industrial relations projects; and, finally, internal organisation.

5.2 Participant Profile

Descriptive statistics were used to provide summary profiles of participants (Sandelowski, Holditch Davis & Glenn Harris 1989). Fifty top-level nurses took part in this study; biographical data were collected at the end of each interview and entered for each participant on the study's face sheets (Appendix 16). Thirty-nine participants were from the general sector — twenty-four from the general acute sector and fifteen from the general non-acute sector — while eleven participants were from the psychiatric sector. Participants' experience in top-level positions ranged from twenty-six years to six months (Table 5.1). Of the fifty participants, forty-six held the position of director of nursing, while four held the position of acting director of nursing. Those who held the position of acting director of nursing had done so for periods of time ranging from six months to five years. No males held acting director positions. The average length of time between receiving first qualification and obtaining what participants considered to be their first management/leadership position was 5.9 years for males and 11.1 years for females. This differential supports the literature findings in that generally, with all factors accounted for, it takes females twice as long as males to reach positions of management in nursing.

Table 5.1 — Distribution of Participants by Years of Top-Level Experience

Years of Experience	General acute	General non-Acute	Psychiatry
<1	04% (01)	27% (04)	—
1–5	63% (15)	47% (07)	27% (03)
6–10	21% (05)	13% (02)	27% (03)
11–15	04% (01)	06.5% (01)	27% (03)
15–20	08% (02)	06.5% (01)	09.5% (01)
>20	—	—	09.5% (01)
Totals	100% (24)	100% (15)	100% (11)

Thirteen participants received their first nursing training in the United Kingdom, including Northern Ireland, and the remaining thirty-seven received their first training at various schools of nursing throughout the Republic of Ireland. Eleven of the thirty-nine participants with a second registration received their additional training in the United Kingdom, including Northern Ireland (Table 5.2).

Table 5.2—Participants' Countries of Training

Training	Ireland	United Kingdom	Total
First Training	74% (37)	26% (13)	100% (50)
Second Training	72% (28)	28% (11)	100% (39)

Forty-seven of the fifty participants held general nursing registration, and thirteen held psychiatric nursing registration (Table 5.3). The majority of those working in psychiatric nursing also held general registration, while the vast majority of those working in the general sector who held a second registration did so in midwifery, supporting the notion that, as participants said, in their day as a general nurse you were not really a nurse until you had your midwifery too. Only four participants had had, apart from their initial nurse registration, no other formal preparation. All other participants had, as Table 5.3 indicates, a wide range of additional preparation. The majority of participants who held diplomas did so in management and or in clinical nurse advancement. Of those educated to bachelor degree level, five held bachelor of science degrees and four held bachelor of arts degrees. Three participants held both bachelor and master degrees, while six held both master degrees and diplomas. Females, with the exception of one male, held all the degrees.

Table 5.3 — Participants' Level of Formal Preparation

Qualification	Percentage	Number	Total
General Registration	94%	47	50 (100%)
Psychiatric Registration	26%	13	50 (100%)
Midwifery Registration	48%	24	50 (100%)
Other Nurse Registration	08%	04	50 (100%)
Bachelor Degree	24%	12	50 (100%)
Master Degree	18%	09	50 (100%)
Post-Registration Diploma	62%	31	50 (100%)
Post-Registration Certificate	22%	11	50 (100%)

5.3 The Position of Director of Nursing

5.3.1 Responsibility

In any healthcare institution the position of director of nursing has a dual function. It is responsible for nursing and for nurses while also representing the interests of the employer:

the director of nursing is ultimately responsible for the standard and practice of nursing while being equally responsible for ensuring that organisational objectives are met:

> It is very, very difficult, but you have to sit back and think of what's best for the organisation, and you have to also think that, at the end of the day, you are accountable, and sometimes giving explanations to people and looking at other ways around it. I mean, there are always more ways of getting to a place than one way and getting to your objective than one. I firmly believe that sometimes I am letting the nursing staff down by...getting involved or by having to make certain decisions, and I know that is part of the job and there's nothing that can be done about it, but if you give a reasonable explanation and say 'well, look at it: this is the way it is. I know it's not to your satisfaction; maybe we could look at it another way', and keep both parties happy. (Director 48; 1574–1595)

Within nursing the director of nursing is the only position that stands alone, as all other nursing positions in any institution are generally in multiples and are part of a reporting structure. This position holds ultimate responsibility:

> You're part of a multidisciplinary team when you're in a ward area. You've got all your staff with you; you're working with the doctors, the consultants, the director of nursing, and you always have someone there to go to. When you come in as assistant director of nursing, well it's different for assistant director because you still have your director there, but when you get to the director's position there's nobody else after that; you're there...where do you go when you have problems? (Director 50; 525–563)

5.3.2 Professional Relationships

The position of director of nursing is strongly related to medicine and general management; these relationships are addressed in detail later in this chapter.

The purpose of this section is to set in context the relationships between the director of nursing and senior members of the professions allied to medicine. It emerged from the analysis of this study that generally these relationships are solely functional. Participants accounts do not suggest interaction on issues of professional or service development. In larger hospitals, participant directors of nursing meet with representative heads at only management board meetings. In smaller acute and non-acute hospitals they relate to each other solely about patient service delivery:

> I have to meet them all, really, the physiotherapists, the social workers...the other allied health professionals, radiographers and chaplaincy services, those kinds of services. (Director 16; 2163–2184)

5.3.3 Community Relationships

In considering the relationships between directors of nursing and the wider community, data analysis in this study showed that the position generally has a strong internal organisational focus. In the larger acute hospitals directors of nursing have no contact with the wider community. In mental health services and non-acute general hospitals they appear to have some wider community involvement. In mental health this relationship forms part of the decampment project from institutional-based care to community care:

> The voluntary sectors make a huge contribution to what we are doing and what we are going to do into the future, and I have a lot of involvement with voluntary organisations...I think they have a huge role to play, and its very important for me to be in there as director of nursing, and we are in the process of setting up user groups. (Director 04; 1412–1422)

In the non-acute setting, these hospitals appear to be part of the community, where local fund-raising activities are important, and the director of nursing is generally viewed as the hospital representative at these activities:

> A lot of the voluntary organisations would be very involved here. Maybe because I didn't have that experience before, but when you come out to the more rural areas, not that we're that rural, but there's a lot more community based-involvement than there was when I worked in [the cities]...you seem to spend a lot of time fundraising, and you are seen as the person who has to be there at all these functions, and you're the person who represents the hospital, so they want to see you there. We don't say 'no' to the money, so we can't say 'no' to appearing. (Director 43; 775–794)

5.3.4 A Life-Time Role

Traditionally the role of director of nursing, formerly titled matron, was considered a position for life, where the post-holder lived in the hospital in order to be available at all times for any emergency. In former times the matron would have committed herself to the life of the hospital:

> I suppose at matron level that has changed so much in the last twenty-five years. Our predecessors, they were married to their job, they lived on the premises, they were available for every call. (Director 09; 2311–2315)

In more recent times the life of the matron has changed, along with its title, to that of director of nursing. Directors of nursing no longer live on the job, and many participants in this study were of the view that it is now not considered a job for life:

> I don't think any of these posts [director of nursing] become a job for life anymore. You've got to get new people in, new ideas, and it's good to keep it in dynamic. I think that years ago, and...the matron figure, I think there are some really good things about the matron figure, and we shouldn't throw it out, but there really needs to be a dynamism, there needs to be, this whole leadership thing is extremely important. You've got to be seen to be contemporary with what's ever happening in healthcare. You've got to constantly be seen as dynamic, enthusiastic, have vision; all that requires so many competencies that you just need to be careful how long you can actually keep this going, and I think for, it's not so much that it isn't possible within the job, but...keeping that level...of competency in so many diverse areas can be very wearing. (Director 40; 306–336)

5.4 Professional Identity Development

5.4.1 Role Models in Training

Socialisation for nurses starts at student level and continues throughout their careers. These experiences combine to develop assumptions and beliefs about nursing and about how one behaves as a nurse (Heimann & Pittenger 1996). It is said that early experiences have an enormous impact, as emotionally and psychologically our need for acceptance is very high when we are young and we are highly dependent on those senior to us (Covey 1995).

This study found that generally participants' early experiences of nursing were devoid of any examples of mentors or role models who helped them to develop:

> No, I didn't have any role models...They were days when it wasn't all sunshine, as you well know, and training was very strict. Sometimes there's a lot of merit in strict discipline and guidelines. You had to keep on the straight and narrow, and that was it. There was a lot of that, and it's good to see that that's gone because it wasn't healthy. The only giants I ever had at my shoulder...You had to row in or row out, and that was it. (Director 33; 465–486)

Participants' introduction to nursing was generally through hospital-based schools of nursing and their tutors. Participants learned early on about the position of nursing in the healthcare system and how nursing itself helped to maintain that position. As students, participants knew a world dominated by having to live in, to follow rules and regulations and to seek permission:

> [My tutor] she was a very progressive type of person, and she was very good to the student nurses...In those days student nurses had to be in at such a time, and everything was granted through permission. She would have made representation to the authorities to relax some of these rules and really give us more responsibilities and treated us as normal people. (Director 45; 366–379)

Generally, participants had mixed tutor experiences, either having very high regard for their tutors and the school or stating that the tutor experience was something they got through in order to become a nurse:

> A tutor who taught us and again, I think, influenced me...What it was about those people is that they really were enthused; they had a lot of enthusiasm for the job, and I really admire people who are enthusiastic. It's very tough, and to keep that light within them and to inspire people to do that...and unfortunately within our services there aren't very many people like that. I haven't really come across that many. (Director 10; 571–584)

> There were no giants at my shoulder during my training. You are on your own. (Director 15; 1183–1185)

5.4.2 Role Models after Training

People in all aspects of life are attracted to role models, and nurses are no exception. In this study when participants referred to role models they spoke about how they perceived other nurses dealing with situations in a manner which participants found compatible with their beliefs about nursing values (Morton-Cooper & Palmer 1993).

> I suppose I saw them as role models really because I would have liked to have been like them. I saw them as very fair, equitable, approachable people. (Director 43; 302–305)

In the earlier part of their careers some participants had the good fortune to have had role models, while few reported that they came through the traditional nursing ranks with no role model influence:

> There was different nursing officers...around the services who certainly had an influence. There was one guy in particular...He was fantastic with patients; he really was fantastic. He was one of the old-style guys, but he had a fantastic way with people, a fantastic way with patients in how he dealt with them, how he dealt with medical personnel and how he dealt with everyone. (Director 04; 643–655)

> A ward sister, and I always strive just to take a few pages out of her book; she was just a wonderful lady...the way she treated people, and it didn't make any difference what class or creed they were, they got the same treatment. She spoke with great dignity and respect to patients, even the most difficult patient; she always found a way to get around them without ever raising her voice or, she was just an extraordinary, an extraordinary woman. (Director 28; 578–596)

> At this level, I can't think of anyone...Looking at managers all around, you might have picked up skills and techniques from them in relation to organising yourself, in relation to managing bits and pieces, but, for the most part, no. (Director 34; 564–581)

Covey (1995:169) notes that people are strongly influenced by the style of mentors and finds that most people are mentored toward management not toward leadership. Consequently, they think 'efficiency'; they think 'things'. They don't think 'people'; they don't think 'principles' — because they were not trained that way. Participants' experiences of mentoring varied greatly: some were positive and some were negative:

> [Matron] encouraged. If she saw that you had any qualities yourself, she would try and develop them in you and give you responsibility like that as well. She'd hand over tasks that she would normally do herself and get you to do them. (Director 11; 410–417)

One participant spoke of two contrasting experiences:

> Matron...had a lot of power and had the power to make people not feel good about themselves...Nurses if they are in that culture don't know how to sell ideas or how to develop, if you have never been allowed. (Director 19; 2338–2431)

> A director of nursing that I worked with...she was one of the people that said, 'if you have a problem, come and see me, but bring three solutions with you'...You could go to her and say 'well, look, I have this problem, I'm not too

> sure'. She wouldn't give me an answer, but she'd say 'have you thought of' or 'what do you think yourself?' and let you develop that way...She had a way of managing that wasn't dictatorial...There was [also] an assistant matron...who had learned to...cope with a lot of the industrial relations trouble who was a great support. (Director 19; 1244–1306)

Participants who spoke of senior colleagues who supported, guided, or influenced them referred to 'influence' in terms of career progression as opposed to personal or professional development. When they spoke of support, it was generally about guidance to help them 'to make the next move'.

5.4.3 Development after Training

Nursing until very recently provided little development or education beyond training towards state registrations. Unlike medicine, it does not have a history of developing its neophytes or even supporting its students, new graduates or those in continuing practice. Nursing provided no direction in terms of how people experienced nursing or how they developed as nurses. It was simply about compliance and getting the job done. According to this study's participants, development was left to the drive and ambition of the individual nurse and the particular circumstance.

The first position a nurse holds following state registration is that of staff nurse. As newly qualified nurses, participants' first experiences had helped to shape their expectations:

> In the earlier years it was difficult to move because some of the ward sisters were not very adaptable to change, and, if they heard you were going for another job, they would do what they could to stop you moving because any move meant change for them. So I learned not to say I was applying for posts. (Director 31; 302–310)

> [As a staff nurse], where I worked, the director of nursing, she was a very powerful lady, I also had great admiration for her, and I suppose that one of the key things with her was always her discretion and confidentiality...I think she'd never disclose anything, she was so confidential, so private...If you had a problem, you went to her; you could rest assured that she would...help you in every way possible and yet she would, it was strictly confidential...I mean, it's a huge quality. As well as that, I suppose, she always kind of...delegated responsibility to the staff nurses; she was a lady ahead of her time really...She worked in very difficult times and very poor times and I suppose managed a huge big hospital on her own. She was quite an extraordinary person really, I must say, very intelligent lady. (Director 29; 673–776)

> I found I got very frustrated as a staff nurse because I knew I had the ability. I was working under a command-and-control environment, which is truly important to say at this stage, where as a staff nurse I did not have the autonomy to do a doctor's round; it was done by a ward sister, and that was hugely frustrating...Totally restricted, totally undervalued...It's completely demoralising...I mean, I would describe myself at that point of my career as just being a damn good nursing auxiliary, not even a staff nurse; apart from the fact of the medications, I had no input into how the ward was run, no sense of decision-making, I was working for a ward sister who was very much of the command-and-control...It was very demoralising. (Director 20; 1259–1326)

5.4.4. Education after Training

This study found that participants' general experience was that not only did nursing not have a developmental support system but it made no provision for those nurses who wished to pursue further education. For the most part, it adopted a punitive approach and made pursuing further education a difficult task. Participants in this study who wished to further their education and development had to do so in their own time and at their own expense. For some, it proved arduous to get time off to further their studies, as was also found by Smith Hamilton (1981) and, more recently, by Dixon, Baker and Healthcare Risk Solutions Ltd. (1996) in their study of health and social services in Ireland.

> In nursing, no, I wouldn't say that anyone acted as mentor to me. Even to get study days were very hard to come by. (Director 06; 364–382)

> When I was [junior] nobody ever would suggest that I would do something. I went into [courses] in my own time. I had to wheel and deal to get Mondays off...to go to the course. (Director 21; 488–495)

> Any development I did, I did for myself, but, because I was moving into management and I was very well motivated, anything I did, I did in my own time, and I paid for it myself. And I sometimes think that people don't even value or realise how well off they are, but you can't be looking back. (Director 44; 1493–1501)

Nursing did not provide developmental interactive dialogue where participants could contemplate moving from accepting concrete, factual knowledge to demonstrating their abilities to deal with and solve complex problems as part of their continuing professional development (Morton-Cooper & Palmer 1993). This occurred despite the fact that all participants are responsible for the quality and management of nursing practice and service in their respective areas:

> It was just hit and miss and look at a book to see how it was done before. (Director 01; 1368–1370)

> I learnt management through the job, doing the job...There was no development of what it should be, and only that I had this other ward sister who became my mentor, and I used to keep running up to her...Now that's not the way to engender management within a profession. (Director 40; 1053–1071)

More than half of the participants in the study spoke about how they had learnt to do their job; without exception, they identified that the profession of nursing did not have any formal or educational input into how they would do the job of director of nursing. In relation to their employers, very few participants received training on taking up their positions:

> With nurse managers, you go into nursing and you train in general nursing for three years and midwifery; and, whatever you do, it really doesn't get you ready for all the different hats they put on you at different times. (Director 17; 2352–2358)

> I learned on the job, day to day...I did a management course myself; I did a diploma in management and industrial relations...So that would have been my theoretical knowledge, but apart from that I learned on the job. (Director 03; 551–561)

> It was learning on the spot. At that time I had no major training in how to manage a hospital, but I actually managed the hospital on the strength of how I had managed the ward. (Director 33; 2026–2030)

5.4.5 Conclusion

In conclusion, the general perception of participants is that this lack of insight on the part of nursing in not providing either informal or formal developmental systems (Morton-Cooper & Palmer 1993) disadvantaged them as neophytes and left them open to arbitrary experiences and encounters. This lack of attention to development is also found in other female-dominated professions (Betz & Fitzgerald 1987).

5.5 Professionalisation of Nursing

In recent times nursing, along with other occupations, has studied ways in which it can develop. An Bord Altranais has in recent years produced documents in relation to nurse education and professional development (An Bord Altranais 1997, 2000a, 2000b, 2000c,

2002a, 2002b, 2003a, 2003b). In 1998 the Commission on Nursing set down the blueprint for the development of nursing. The work of the Commission was extensive and has, through its recommendations and Department of Health and Children funding, been instrumental in many nurse development initiatives, for example the National Council for the Professional Development of Nursing and Midwifery. However, from the perspective of many of this study's participants, much of the work of the Commission centred on the education and development of clinical nursing, not on nursing management:

> I suppose it [the Commission] hasn't done a lot really...At our level what happened was the Office of Health Management took up the training and developed the competencies for nurse managers and developing training courses...The Commission itself, I suppose, really didn't look at management. (Director 49; 1508–1527)

The Commission on Nursing failed, from this study's perspective, to treat the position of director of nursing as a professional nursing development issue. It ignored the unique position of that role in nursing and in doing so, it would appear, ignored many of the recommendations of the then Irish Matron's Association (The Irish Matron's Association 1997). It failed to develop the leadership potential of the position at the level of service provision or at the political table. When the Commission addressed leadership in nursing, it spoke about the director of nursing; however, in its recommendations on leadership development, it proposed the establishment of the nursing policy unit in the Department of Health and Children, the nurse practice development units in the health boards and the centre for clinical nurse and midwifery research in the Health Research Board, with no recommendations on developing the role of the director of nursing in relation to leadership. These recommendations are endorsed by government funding, but no funding is provided for leadership development outside of the clinical arena.

Through the Commission's recommendations, it is now accepted that certain senior clinical positions require a master's degree level of preparation. One participant's recent experience would indicate that neither nursing nor the Department of Health and Children considers the position of director of nursing in the same educational league, even from a management perspective, as those clinical positions:

> I think a lot has come out of it [the Commission], an awful lot has. I mean, we've got the BNSs [bachelor of nursing science] being paid now; all the education programmes have come out of it. Before, you had to pay for everything yourself, and you did yourself, and I think it's brilliant the way

> we've got HDip [higher diploma] programmes coming now, and it's being paid back automatically to the nurses; so I think it's great. But I have to let you into one secret here: when I went to look for money for my master's they told me in the Department of Health that it's not a recognised thing for my job, so, in other words, I don't need it...The Department of Health told me...'no, sorry, you don't need a master's for director of nursing'...They just told me that it's not recognised, so I thought, that's very interesting...You need to be educated to do what you're doing. (Director 50; 1398–1432)

The Commission recommended that nurse management should be developed through the Office for Health Management. The primary function of the Office is to commission and facilitate management development programmes on behalf of employers in the health and personal social services. Its function is not to develop nurse managers for the betterment of nursing but to provide trained managers for the health service, a service that through its current emphasis on managerial culture is often found to be at odds with central nursing values (Traynor 1999).

The Commission on Nursing (1998:33) saw fit to allow another agency to define the management competencies of its 'top-level' position. Following the Commission's recommendation, the Office commissioned a study to identify the 'management' competencies required for nursing and midwifery 'management positions'. The study defined specific competencies for nurse managers, including what it termed 'top-level: director of nursing/equivalent'. The competencies defined in the study, in tandem with the primary role of the Office for Health Management, serve to develop on behalf of any health service provider the employee management skills of persons who hold the position of director of nursing (Rush, McCarthy & Cronin 2000).

The Office has commissioned development programmes for nurse managers, but the practicality for nurses pursuing courses open to all disciplines is that they must compete with others for places. This is a situation that is proving difficult, according to participants' experience, because, although nurses make up 40 per cent of the workforce, they are only allocated the same number of training places as every other discipline:

> They [nursing] have to provide management training; they haven't been very good at that. Now they have started, the Office of Health Management has been set up...we seem to find it difficult to get on it. They [nurse managers working with this participant] have applied for different things, but there are only so many places. Like, there was a higher diploma in management this year for the health board; it was limited to thirty places, and they weren't able to get on it. Hopefully they will get on it the next time. There was a master's in health

> management, and they applied for that, but that was limited to ten places for this health board; again, you know, they weren't able to get on that. (Director 49; 543–600)

The position of director of nursing had through socialisation and structure held the responsibility for the management of nurses. The Commission recommended the decentralisation of decision-making authority from the director of nursing to the clinical area. It took away the traditional role of this position and, with it, some believe reduced the traditional pervasive role of nursing to just another compartment within a hospital or service structure:

> Traditionally our role is matron and not director of nursing, and I think possibly the Commission shouldn't have hoisted that on us without examining our roles, what we did and what was the perception of it...Director of nursing has compartmentalised me a bit in that I'm the head of the nursing services, same as the head physio is the head of the physio services...whereas the matron, you were really the manager of the hospital...There is a difference. (Director 41; 1934–1962)

5.5.1 Conclusion

In conclusion, traditionally nursing provided few avenues of progress. There were chiefly two routes, one through education and the other through management. This study's participants chose the management route; as analysis has shown, they took this decision at a time when nursing was doing little to further its own development. Those who were fortunate to work with good managers learnt management of nurses and nursing but not leadership, for their predecessors did not have that experience. Some had no coaching or role-modelling experiences to call upon. Any educational development they undertook in order to pursue their chosen path was done largely at their own expense. Many gave up holidays and other time off to pursue their chosen development. Finally, as is evident throughout participants' careers, even in the current professionalisation project nursing has failed to provide any professional development for these nurses.

5.6 Directors of Nursing and Medicine

5.6.1 Prevention of Nursing Development

For the directors of nursing in this study, the traditional hospital structures in which they trained and worked closely paralleled the traditional nuclear family. The nurse (male or

female), like the traditional mother, was available throughout the day to attend to the needs of the patient. The doctor (male or female), like the traditional father, visited the ward occasionally, leaving in order to do work that was taken to be more important than the nurse's. The doctor maintained an authoritarian posture, leaving orders behind and always being consulted regarding all but the most insignificant decisions (Brodegaard 1982., Street 1995., Miers 2000). The nurse was expected to be capable of taking care of whatever problems arose within the hospital, regardless of the area in which they occurred (Dingwall 1979., Salvage 1987., Jolley 1994), while unquestioningly complying with medical orders and not overtly taking any independent actions without prior approval (Cheng 1990., Chandler 1995). Consequently, the expansion of nursing clinical skills in any institution is decided in essence not by nursing but by medicine (Hugman 1991., Walby et al, 1994).

The Commission recommended that directors of nursing should be instrumental in furthering the development of clinical nursing skills in their clinical area. However, this study's analysis revealed, in accordance with Walby et al (1994), that, where participant directors of nursing endeavoured to further clinical skills, those skills that medicine wishes to retain, it does retain, and, from participants' perspectives, medicine prevents directors of nursing from developing those same skills in nursing:

> We were thinking about changing the IV [intravenous therapy policy]...to the nurses putting [up] the IV here and the doctors not...and that never got off the ground because the paediatricians want the doctors to put up the IVs because they have to have the training...but we're beginning to question them [the doctors]. (Director 16; 1209–1220)

> I feel the medics want too much of an input into things [nursing issues] that shouldn't concern them at all. (Director 08; 426–428)

5.6.2 The Doctor–Nurse Game

Understanding the unwritten and unspoken rules of the 'doctor–nurse game' was vital to the career progression of any nurse and to the success of any director of nursing. Stein (1967) describes a complex behavioural interaction between doctors and nurses in which both avoid open disagreement to maintain their respective dominant or submissive roles. Both doctor and nurse win when their interaction results in an alliance in which the doctor gains the nurse's valuable assessment and intervention and the nurse gains a reputation as a

dependable nurse. Their interaction reinforces the structure and inhibits open dialogue. The communication patterns integrating the roles of doctors and nurses in hospitals are essential to the maintenance of the structure, and in this context the roles transcend gender, making no difference if doctors are male or female (Stein 1967., Sweet & Norman 1995). The following participants' accounts demonstrate their socialised intrinsic understanding of the game:

> One of the assistants [director of nursing] rang me one evening; she was frantic. We had two patients ventilated and a third person...who needed to be ventilated, and she was frantic...How this was going to be managed?...The consultant rang her and said 'get me this and get me the other'. I told her that he was frantic too and probably needed her support. They do depend on you more than you realise, you know, they really do depend on you more than we realise. And they might not always appreciate it. (Director 15; 2092–2107)

> It works okay. He [the doctor in charge] doesn't like to be told what to do or anything like that, but he has to be managed. I could say our relationship is good. (Director 13; 556–559)

> We have a very good relationship...We have built up the services together...If I wanted to change something, to start something...I would run it by her [the doctor in charge]and get her opinion on it and get her on my side...Its not something you would be trying to impose on them. (Director 25; 1814–1845)

Challenging the game can be a lonely and almost futile exercise, according to participants' accounts, a position endorsed by Stein, Watts and Howell (1990).

> I go to the outpatients, and there were I think a hundred people in for a...clinic. So I said something to the [consultant], and he didn't particularly like it...Anyway, I told him that we had a collective responsibility to get a better system going, and he wasn't impressed. I said to him again 'well, okay, round one to you, but we do have a collective responsibility'. But I haven't been brave enough to tackle him yet, but I will. (Director 21; 1503–1529)

Generally medicine requires that the position of director of nursing understands well the rules of the game. From this study's perspective, it requires the director of nursing not only to manage by example but also to ensure that all nurses are obedient and compliant to medicine, maintaining the doctor–nurse status quo:

> The consultant relationship can be a little bit rocky, challenging...One consultant...is head of a multidisciplinary team, and there are supposed to be protocols...I wrote a protocol for him. I put this protocol together about six times. I brought it to the consultants' meeting every month...He cleared it last

> month, so I circulated it. Today I got a letter saying 'I think you should change it to such...please amend. He cleared it at the monthly meeting and then had second thoughts...If I have to change it...I'll change it, I've no problem, but I have to circulate the whole lot again. (Director 28; 2597–2661)

This study's analysis shows that medical dominance and nursing compliance are so interwoven that the majority of directors of nursing in this study were by their accounts unaware of their compliance:

> Consultants, so I would have a good relationship with them, and the medical board have invited me on a number of occasions to go and talk to them in relation to what is happening in nursing, tell them about nursing education, at the recruitment crisis...I would attend the medical board about twice year and do a sort of presentation on what we're doing in nursing, where we're at and what developments we're doing. (Director 44; 715–734)

> I get on very well with the consultants...It has become standard practice that I go to the medical executive meetings every month. I just go in, give a report or discussion on whatever topics they want to ask me about, staffing numbers, what way I'm going, or any problems I think they should be aware of. (Director 36; 616–629)

> I attend a lot of informal meetings at ward level...at their request...I could eliminate myself from those informal medical meetings, but, by being present, consultants then have a better knowledge of what specialist nurses are about. How are they to know unless they are informed?...I then discussed job descriptions even for specialist nurses with them; that's only getting their feedback as to what they might fill in an area that I might have omitted. I wouldn't see it as them having a major input into it; it's as part of the team, and I feel it involves them, and they feel 'well this is great, we're all here together'. Why shouldn't they be involved?...If there was a speciality area, then I would feel I would need their input. (Director 33; 1484–1516)

5.6.3 Conclusion

In conclusion, from the perspective of this study the Commission did not address issues such as the positional power of medicine in relation to nursing, although, it did make recommendations on intrinsic nursing issues, such as the devolvement of nursing authority. In addition to the Commission's recommendations, institutional healthcare is introducing clinical directorates/clinical divisions; these directorates or divisions divide specialities into separate management areas and are usually headed by a medical consultant, a general manager and a nurse manager.

Traditionally, the position of director of nursing was ultimately responsible in any institution for all nursing care, while medicine retained ultimate authority over patient care, giving medicine real authority (Hugman 1991., Perry 1994., Porter 1995b). This responsibility and authority for patient care resulted in a close working relationship between the director of nursing and the medical profession and contributed to the sense of power of the director of nursing (Staines, Tavris & Epstein Jayaratne 1974., Roberts 1983., Ely 1994, 1995). Because nursing decisions are now to be made at the directorate/division level, this, from the perspective of this study's participants, places in doubt the need for the directors of nursing and their relationship with medicine.

5.7 Organisational Healthcare Structures and Culture

5.7.1 Background

The organisational structure and culture of healthcare has its own primary philosophy and values that significantly govern organisational behaviour (Harrison 1993). Within this framework, organisational structure determines formal roles, responsibilities and tasks, together with the systems and procedures by which directors of nursing work and the formal extent and limitations of their autonomy.

Organisational culture is intricately related to organisational structure; the culture relating to people in an organisation is typified by the way they are treated and managed. The corporate philosophy about people — the values, attitudes, styles of leadership and management, and social interactions — provide the framework which indicates how the organisation does or does not value self-esteem and self-direction and provides a respectful supportive environment to allow people to develop (Avillion & Abruzzese 1996). Within the organisation the position of director of nursing is unique in that it represents both its own profession and the organisational management structure.

Officially the position of director of nursing 'works in collaboration with other professionals and service mangers to achieve the service goals' (Department of Health and Children Job Description Director of Nursing 1999). The description addresses eight areas: Leadership and Accountability; Planning; Admission and Discharge Policy; Personnel Management; Finance; Education; Quality Assurance; and Key Performance Criteria.

Under the heading Leadership and Accountability, the job description states: 'Keep the CEO/Service Manager appraised of any significant development within his/her area of responsibility and perform such additional duties as may be assigned from time to time by the CEO/Service Manager (or other authorised officer)'. Under the heading Admission and Discharge Policy, the director of nursing must: 'Develop and implement (in association with Divisional Nurse Managers and Medical Consultants) operational policies, protocols, and guidelines for the utilisation of beds and a systematic audit of bed usage'. And, finally, under the heading Finance, among the duties of the job is to: 'Participate as a key manager in the overall financial planning of the hospital (health board/service) including assessment of priorities in pay and non-pay expenditure'.

Structurally, it emerged from this study's analysis that participants work in two different but not dissimilar organisational frameworks: the health board structure and the voluntary and private hospital structure. The health board structure is greater and conducts its business across ten health board areas, whereas the voluntary and private hospital structure is concentrated in discrete individual sites. Each individual voluntary and private hospital has one director of nursing. The number of directors of nursing under any given health board is related to the number of hospital sites.

Data analysis for this section was guided by organisational justice theory (Coyle-Shapiro 2002). Organisational justice theory suggests that, in defining justice, individuals consider not only the outcomes that affect them but also the procedures used to determine those outcomes. This theory identifies three types of organisational justice: procedural justice, distributive justice and interactional justice (Coyle-Shapiro 2002).

5.7.2 Organisational Structures

5.7.2.1 Management Meeting Structures

This section examines the position of directors of nursing in relation to formal strategic and operational management meeting structures. Analysis was guided by the concept of procedural justice. Procedural justice refers to formal organisational systems and procedures and to the evaluation of fairness that people make over time in relation to how

they are treated by these systems and procedures and by the representatives of the organisation (Lamertz 2002).

Analysis found the position of director of nursing in this study to be marginalised in terms of its allowed level of inclusion and participation in these structures. At best within the voluntary hospital structure the post-holder is an invitee to the board of management. While this may be taken to indicate that the position has a role in the authority of strategic direction, decision-making and management, in reality this is not the case. As an invitee, the director of nursing holds no voting rights and so does not form part of the formal decision-making authority:

> I am an invited guest; I am not a board member, but I attend board meetings. I am an invited member; that is how it is recorded...They don't make any decisions about the day-to-day management, you know. Ideas may be brought to a board meeting, and they might have suggestions one way or the other, but ultimately the decisions are made by the CEO and myself...I attend all board meetings as a guest, and I don't miss them. I make it my business to be at all board meetings. (Director 03; 323–407)

Within the health board structure, from the perspective of this study, the director of nursing is not included in a meaningful way in the formal strategic meeting structures. At best, it forms part of the local operational-level management team. These local management teams are usually made up of three representatives, from nursing, medicine and general management, and, it would appear from participants' accounts, function in isolation from the strategic management system. This situation is not supported by the Department of Health and Children's job description for directors of nursing nor the competencies identified for top-level nurse managers (Rush, McCarthy & Cronin 2000).

> The local management team would be made up of one of the senior executive officers, the administrator here, myself, but that would be it. It's very ad hoc. (Director 43; 468–472)

> We [directors of nursing] are not part of the board of management...We have no input into the senior board of management, where I feel that there should be somebody. (Director 08; 1164–1170)

It emerged from participants' perspectives that at worst the director of nursing manages a particular site without any formal management meeting structures. In some cases there is no history of any formal meeting structure, while in others meetings have stopped because

of intra-administrative conflicts or intra-medical conflicts. In these cases organisational expectations are that directors of nursing continue to manage and co-ordinate the provision of services:

> I have to say the plus side of not having management team meetings is that, if I want to do something, I have to go find a consultant, knock on his door and get to talk to him...So actually it builds up good, very good communication with the others, but, if you didn't do that, you'd be talking to none of them, and no-one would know what you were about. (Director 41; 1446–1457)

In some of these reported experiences not only were there no formal management meeting structures but directors had difficulties in even contacting the identified contact in the general management pyramid. According to these participants, the general management representatives were constantly unavailable to them and persistently did not return telephone calls despite promises to do so:

> I find that I'm just getting letters when the budget has gone over...'please explain why'...[The general manager] is never available ever to answer the phone. You have to make decisions...I find it impossible to get through to this person...This person is not available...I have requested in writing that I would [like] regular meetings. (Director 11; 630–735)

In other circumstances directors gave accounts of situations where, in structures that excluded the director, key decisions directly related to nursing were made in an arbitrary fashion with the expectation that the director would fully cooperate in executing these decisions, a situation that runs contrary to that recommended by Dixon, Baker and Healthcare Risk Solutions Ltd. (1996). As members of a profession that is dominated and influenced by the demands of the top-level administrator, some directors feel that they have little recourse but, as one participant said, to 'accommodate' the directive:

> If they're not involved in the plans, then they don't know where the organisation is going. If they value the position of director of nursing as it should be valued, then they should be part of that. (Director 42; 1658–1664)

Participants felt that by being excluded from the formal management meeting structures they were not empowered, valued, recognised or rewarded by the organisational hierarchy (Gordon 1998., O'Boyle 2000., Coyle-Shapiro 2002).

5.7.2.2. Corporate Effect

Analysis identified from participants' accounts a noticeable corporate effect in some participant directors who were invited to attend meetings. The 'corporate effect' refers to the psychological feeling that one gets from believing oneself to be included at the highest level. It has the effect of allowing directors of nursing to feel that they are part of the decision-making strategies at the highest level when in reality this is not so: just because one is invited to the table does not necessarily mean that one is part of the decision-making authority. This sense of inclusion creates a feeling of privilege and gives rise to perceptions of being valued as an accepted member of the organisation. It emerged from data analysis that some participant directors of nursing are likely to identify themselves with the dominant coalition because these social relationships symbolise valued membership and also the director's personal worth to the organisational in-group (Lamertz 2002).

> I'm an associate member of the management board...It means I don't have a voting right in any instance, but in my length of time on it I don't remember any incidents where there was a vote taken. Well, there may be on issues of specific posts or that, but I would have the same say and be listened to with the same attention as the full members. (Director 35; 358–371)

Some participants, as members of a profession that is dominated and influenced by the ideologies and demands of top-level administrators and other power groups, tended to model their behaviour on that of the dominant group, as Freire (1972) suggests, to achieve privileges and power similar to those exhibited by the most powerful groups (Torres 1981).

> Biggest challenges...Stepping up to the corporate agenda is a big challenge because my exposure had been hospital and nursing life, so stepping up to the corporate agenda and being able to contribute and working at that higher level, that's a challenge. (1392–1399)...When I meet with my nurse managers, I seem to be reverting back to the nursing issues, and I have to keep going back to the corporate side as well because, you know, bringing them along from that perspective...As a nurses [sic] we sometimes, we very much [hone] in on our own little nursing issues, so you're constantly having to be relating to others and coming very much from a business perspective and not be emotional. And nursing, you know, emotive argument and stuff like that; you have to put it in place. (Director 40; 914–932)

From the perspective of this study some participant directors may perceive that they are autonomous and free from the dominance of outside groups if they gain token and illusory autonomy within the structure of the institution (Torres 1981).

> I don't report to anybody as such. In relation to general things, I would keep the CEO appraised of developments; I wouldn't necessarily report to him, but I would keep him appraised of any changes and anything happening around, and we would have day-to-day contact. I don't really think I report to anyone. (Director 36; 591–599)

For some directors of nursing the effect of attending management meetings may be their continued domination in the management structure, as only those psychologically closest to the goal of freedom are concerned with their lack of freedom (Gordon Clifford 1992).

5.7.2.3 Reporting Structures

This section examines organisational reporting structures from the perspective of the director of nursing and finds that in recent times there have been alterations to those structures. Analysis in this section was guided by the concepts of distributive and interactional justice. These justice types were employed because distributive justice involves the discrete evaluation of specific decisions, while interactional justice involves perceptions about the quality of the interpersonal treatment that an individual receives from an authority figure during the procedural process (Coyle-Shapiro 2002).

Alterations to the reporting structures were generally perceived by this study's participants to have resulted from enlargement of the general management pyramid. Formerly, the director of nursing reported to the chief executive officer (CEO) or the assistant chief executive officer (ACEO) or its equivalent, and so the introduction of the additional layers had a direct impact on that reporting structure. According to participants, it was an arbitrary decision that the position of director of nursing would, in the enlargement process, downgrade its reporting status and report to the newly introduced lower position of general manger, and in some cases to the even lower positions of administrator or assistant administrator. Participants felt that this decision downgraded their position in the reporting pyramid, as in general management structures, the position of director of nursing is graded at level 8 or 9, while those of administrator and assistant administrator are graded 5 and 4 respectively.

Data analysis shows that a number of the participants in this study felt that the Commission and the nurses' strike in 1999 provided opportunities to challenge the downgrading of their position. However, many participants felt marginalised by the failure to challenge and negotiate the restoration of the position's original reporting structure, and this failure

resulted in fudging and ambiguity in their reporting structure, as demonstrated in their agreed job description: 'Keep the CEO/service manager appraised of any significant development within his/her area of responsibility and perform such additional duties as may be assigned from time to time by the CEO/service manager (or other authorised officer)'. Participants felt that general management used this situation to further its own course and effectively downgraded the reporting structure for directors of nursing:

> I don't know who I report to because [under] the original contract for matrons in this board they would have reported to the programme manager...Now the general manager has subsumed that role. So, I mean, it has actually lowered the director of nursing to some extent in my opinion, and it was not really thrashed out fully after the strike; it was contentious. (Director 15; 1475–1490)

> This was fudged by the Commission. When I was appointed, my reporting relationship was not to the general manager but to the programme manager...There is an ongoing battle with a small 'b' between the general manager and myself on those issues in this hospital. It's not a major problem because we work it out; in some places it is a major difficulty, so I would have a line responsibility to the board...that's how we got out of it. (Director 16; 1555–1574)

The vulnerability of their situation is exposed by the fact that, although directors in the study would state that they should report to at least the level of programme manager, in practice it appears that they are fearful of challenging the imposed reporting structure:

> I wanted something sanctioned, and I rang one of the programme managers and was asked what was the problem, and I told them, and he said '[the general manager] will sanction that', so I said 'fine', what else do you do?. (Director 21; 1245–1250)

> We have had issues about general managers looking to have directors of nursing to report to them, and some people have ended up with a lot of grief, and sometimes you are better off, you know, to work with them. I always say 'I work in partnership with you'. (Director 39; 1989–1996)

Where the relationship is poor, participant directors of nursing feel devalued:

> I went to a study day. I was requested to go, and she [the general manager] rang here and then rang me at the conference, and she wanted to know why I didn't inform her I was going on the study day. So she told me her matrons, 'my matrons', she said, 'I want to know where my matrons are'. I was so taken aback I didn't answer...[I] would like to be treated as an equal. (Director 01; 838–1388)

From this study's perspective the silence of directors of nursing and the lack of action on such treatment from representative organisations such as professional bodies or unions should set alarm bells ringing for participant directors. The silence of these directors may indicate to general management a validation of its appointments of these nurses to the position of director of nursing, as it could be taken as evidence of their allegiance to the status quo. For these directors of nursing this general wall of silence should probably be taken as a fair indication of their status, that of a marginalised group both within the organisation and within their own profession (Roberts 1997).

5.7.2.4 Social Capital

However, for some participants the issue is not the downgrading of their position in the reporting structure but the quality of the relationship that they have with their appointed general management representative.

Analysis in this sub-section was guided by the concept of interactional justice (Coyle-Shapiro 2002) using the construct of social capital (Lamertz 2002). Social capital is used as the key construct that provides directors of nursing with opportunities to search for social cues from the in-group in relation to inclusion and affiliation and creates the interpersonal context in which their self-esteem is measured. Social capital refers to the network of relationships in which the director of nursing is involved, the potential for acting as an equal, and the benefits that the director of nursing derives from the network. Social capital is conceptualised as the relationships that the director of nursing has with those in general management. These relationships bridge the interface between the director of nursing and general management and connect the director of nursing to higher-status positions that formulate organisational procedures; they represent access to upper levels of the hierarchy (Lamertz 2002), as data analysis revealed:

> I would have considerable autonomy, really. I suppose it is down again to the relationship that one has with people at senior management team and executive board level...At executive board level I would be the sort of person who would be probably described as having a helpful attitude rather an obstructive or destructive attitude of any sort. I would certainly attempt to hear, as they say, hear all sides of the argument. I think I would have fairly good vision for things. (Director 23; 915–927)

However, from this study's perspective the social capital effect, similar to corporate effect, may lead some participants to think that because they are with the power brokers they are

equal to them, whereas it is suggested that those nurses nearer to the coal face are possibly more aware of nursing's continued lack of freedom (Gordon Clifford 1992).

5.7.3 Organisational Culture

Organisational culture is described as the general pattern of behaviour, shared beliefs and values that members of an organisation have in common. Culture can be inferred from what people say and do; it involves learning and the transmission of knowledge, beliefs and patterns of behaviour over a period of time. It often sets the tone and implies covert rules for how people should behave in a given organisation (Koontz & Weihrich 1989).

This section presents the interpretation of organisational culture through the interpersonal relationships that directors of nursing have experienced with their colleagues in the general management pyramid. From this perspective, the analysis of this section was guided by the concept of interactional justice, as this justice type relates to perceptions of the quality of the treatment that an individual receives from an authority figure (Coyle-Shapiro 2002). The analysis was further guided by the concepts of positional empowerment (Deci, Connell & Ryan 1989., Schmieding 1993) and the psychological contract (Statt 1994., Northcott 1996., O'Boyle 2000).

5.7.3.1 Empowerment

Each position in an organisation has functional requirements to allow it to deliver at optimal capacity. Generally the functional requirements of a position titled 'director' are those of choice, non-controlling feedback, information, healthy interpersonal relationships and support; all these requirement are integral to promoting positional empowerment aimed at developing self-determining abilities in the position. Not to supply these requirements in effect reduces the capacity of the position to deliver (Deci, Connell & Ryan 1989., Schmieding 1993). In relation to these requirements, some participants in this study were neglected with regard to the need for respect, non-controlling feedback and information. Many participants outside of the larger acute general hospital structures indicated this in their accounts:

> I feel very much left out about decisions that are being made, that I don't know what's going on..I suppose poor communications with my [general manager]. I think there's a lot going on and that we're just, that I'm not being communicated with. (Director 17; 1036–1552)

> [The regional manager] tends to write to the hospital manager...on all issues...[and] would obviously look for my views through the hospital manager...Any information or anything he wants, he would write to the hospital manager...He does meet with us from time to time as well, but it's more or less on his terms quite a lot of the time. (Director 18; 1679–1773)

> Where do you go when you have problems? It is very hard, and probably because our CEO doesn't really work like that; if I want to go and make an appointment about something, she usually can't see me for another week or so. So by the time you actually get to see them, you've resolved it yourself. I suppose I've learnt that way, but...it is hard...You both have jobs to do, and how you can do that most efficiently and effectively is the most important thing, and I think good communication is of the most importance, I really do. (Director 50; 562–722)

Positional respect is customary within organisations. It may be taken that the level of respect shown to a particular position is an indication of the esteem in which that position, and where relevant the body that it represents, is held. In this study some directors felt that their interpersonal experiences with the newly appointed general managers were less than satisfactory and sometimes even disrespectful. There were also situations where directors had sought to meet with chief executive officers or lower grades but these requests had not been granted:

> My reporting relationship is to the assistant CEO, but I had indicated to the CEO that I had difficulties reporting to him [the assistant CEO], and would he see me. The very same as a staff nurse reporting to a ward sister, and, if she [the staff nurse] couldn't get on with her [the sister], she [the staff nurse] would come to me. So I was going through the correct channels of reporting, but he refused to see me. (Director 41; 1062–1071)

5.7.3.2 Psychological Contract

As individuals, directors of nursing have expectations of how the position and they as the post-holders should be treated. These personal expectations are referred to as the psychological contract; the central tenets of this contract are loyalty and respect (Coyle-Shapiro 2002). The Office for Health Management indicated that the psychological contract has significant value, particularly in a system such as healthcare. Because

healthcare is resource-constrained in the extrinsic rewards that it can provide, the contract is seen as having significant value in the validation of human resources (Office for Health Management Newsletter 1998b). However, Northcott (1996) and Taylor, White and Muncer (1999) found that, in traditional bureaucratic structures such as the healthcare structure, breach of the psychological contract is the norm and not the exception. Participants in this study also indicated that they felt that the psychological contract had been breached:

> [Official] finishing time here is 5.00 for me, but oftentimes you're here 'til [5.40, 6.25, 6.40 or 6.50].The hospital executive meets during the lunch hour on a Monday to facilitate the surgeons, who get a sum of money to compensate them for any private patients that are not seen but could be seen during that time, but we are not rewarded for that...[My colleague] used to say that, when you come to retire and you put in your forms to superannuation, it could be that you have 39 years and 3 months of service on your record, and they will make you buy back the 9 months of time, but they will never see all the times that you were at your desk, all times that you were phoned at home, all the worries that you brought home with you and sorted out in your own time. They will never add up that time to try and to balance it against the 9 months. You get your salary; that is all that you will get from the health board. (Director 06; 2032–2067)

> I suppose there's other things apart from money which I think would annoy me, would eat away at me...This board would make commitments to you, and they certainly would have made a number of commitments to me and would never have honoured them...That would annoy me no end, and it would be I suppose the biggest dissatisfaction factor in my career to date. (Director 28; 3563–3574)

In the healthcare system there exists a tradition of 'acting'. In relation to the position of director of nursing, this means that an individual may be in the temporary capacity of acting director of nursing. This acting is generally not restricted to a specific time scale, and usually the person 'acting' has an interest in being interviewed and obtaining the permanent director of nursing position. However, not all 'actees' are successful in gaining the permanent position. In this study, where participants had been 'acting' in a position of director of nursing, this 'acting' may have gone on for months or for some years. It was perceived by these participants that the employer's expectation was that, when a candidate who had been 'acting' was unsuccessful at interview, the unsuccessful candidate would take up a lower-ranked position to the one in which they had been 'acting'. This may have meant that the unsuccessful candidate was expected to resume duty in the same hospital where they had previously been the 'acting' director of nursing, without support:

> They don't have a back-up. For example, if [you] weren't successful, they don't have something in place like a mentor or somebody...to kind of help you...cross back into the section that you were, you know, that you were removed from. I mean, I'd been doing a job for four years very successfully...now, and starting a new post which I never had done, I found that transition very difficult...I found it demoralising actually. (Director 29; 3276–3301)

Generally participants felt that their organisation had not provided them with psychological or emotional support; they also felt, based on past experiences, that, should they require support now or in the future, it would not be forthcoming:

> Basically that area of not wanting support but not even knowing if it's going to be there if you want it...it is very, very demotivating and frustrating. (Director 02; 1654–1659)

> When difficult decisions had been made, people that should have been there to support you weren't there to support you, and I mean people at the top level of the boards; board members rarely came to the hospital. (Director 06; 1725–1731)

5.7.4 Conclusion

In conclusion, this study found that, structurally and culturally, participant directors of nursing may not be consciously aware of issues of organisational control, particularly where they are granted token autonomy. Data analysis for this study revealed that, regardless of the structure and culture, the domination of nursing by general management leads to control over directors of nursing. From this study's perspective, this lack of control is the antithesis of professional freedom and compromises the professional integrity of their position (Torres 1981).

This study also found that, in relation to the position of director of nursing, the healthcare organisation states that it values democracy but it rewards autocracy. It states that it values openness and freedom (Department of Health and Children 2003), but this study's analysis shows that it behaves in ways that demonstrate that it actually values closedness, hidden agendas and politicking. As indicated by Covey (1995) the main symptoms of this type of culture are interpersonal conflicts and poor interdisciplinary relations, as were found to emerge from the accounts of this study's participants.

5.8 Industrial Relations Projects

In Ireland nursing unions represent all nurses. For directors of nursing and unions there exists a dual relationship. With regard to industrial relations issues in any institution, it is the unions and the director of nursing who negotiate, with unions representing the interests of the nurse and the director of nursing representing the interests of the employer. However, should an industrial relations issue arise for these directors with their employer, it is generally these same unions that represent them.

The opinion of this study's participants is that, despite being union members, unions are not interested in their well-being because of their small numbers. The number of nurses occupying the grade of director of nursing is small compared to all other grades, so union membership and subscriptions in all other nursing grades are greater. For many participants, the greater focus of unions is on the larger customer base, providing support, developing products and services that best meet the needs of all other grades of nurses. Many participants felt that the energy of unions is focused on the needs of other members and not on the needs of the director of nursing:

> I have to say…that [not having union support] would not happen with nursing posts, or even up towards sister grades; the unions would be barking for them, but the unions have never represented us for this...The unions will do nothing about it. Remember we're very minority, we're a very minority subscriber; there's only, how many directors of nursing? 300 or whatever, so they are not going to worry about us. (Director 41; 1246–1888)

> You're on your own; it's isolated in that sense. You're not in the same club. If people [directors of nursing] get into difficulties, say difficulties around the country, there won't be any great problem with that, they being on an individual basis, whereas a staff nurse on the ward getting into difficulties, there is a whole gang behind them. So you're on your own. (Director 04; 2272–2281)

However, as managers, the majority of participants generally found union representatives to be very motivated in negotiating the interests of their other members but also found that sometimes these encounters were unpleasant and threatening:

> I think the biggest thing that has left a bitter taste with me are unions. Dealing with unions...I have sat here and been insulted, obnoxious people, one person in front of me, and I find that very difficult to deal with because I can't deal with people that are insulting or who will try to knock you just for the sake of

> knocking you, to get their own way. I find that very difficult; that's about the only thing I find it difficult. (Director 25; 2736–2780)

> Just the language…derogatory terms used, there were times when I used to think, 'oh please, I hope nothing will happen today that will involve the unions', and it kind of sets up a kind of fear. I hope when the phone rings it's not going to be one of the shop stewards with a problem because again...you could be berated on the phone like...I have never been spoken to in the whole of my life...It was heavy going. I don't know how people could have that power, and yet we were their supervisors, but when it came to the union issues...they were calling the shots. (Director 19; 1048–1067)

Generally, participants felt that unions had little interest in them as members and union representatives were disrespectful of their position as managers. In essence the overall feeling was one of marginalisation both as members and as managers.

5.8.1 The National Nurses' Strike

From participants' perspectives, the national nurses' strike seems to have been the vehicle which drove home to them the reality of their position in relation to unions. Participants' experiences of the strike highlighted three main issues for them. Firstly, it demonstrated the dual nature of the relationship between the unions and directors of nursing in relation to their position as both union members and managers. Secondly, prior to the strike participants and their respective unions had agreed that the function of directors of nursing during the strike would be as advisors and that they would not take part in picket duty; however, when the strike was convened the unions did not honour the agreement. Thirdly, union negotiations did not, according to participants, serve their best interests.

Firstly, the national nurses' strike seems to have raised issues for directors of nursing in relation to their dual role as nurses and as managers. As nurses, they were union members, but, as managers of nursing, they continued to feel a responsibility for nursing, while also having a managerial loyalty to the organisation:

> Well, we were caught during the strike, of course; to begin with, we were managers yet we were nurses, and that was a big issue for us and a very, I would say that was the most dramatic thing I had in my nursing career...We were part of it, and yet I was in management. (Director 30; 1583–1600)

Secondly, the nurses' strike caused participants a lot of disquiet about how the unions treated them in relation to their positions as managers. From participants' perspectives, there appear to have been broken promises: it would seem that directors understood from their particular unions that they, as managers, would for the duration of the strike be treated as managers. But, when the strike took place, according to participants, the unions reneged on their commitment:

> [The unions] said at the meeting that the directors of nursing would not have to go out on strike, but yet when it came to it they were just part of the strike...Well I think the big thing the last time was that they [directors of nursing] thought the INO [Irish Nurses' Organisation] was on their side, but when the actual thing happened they had to go out. And I was at meetings, and there were very hurt people there, very hurt people...I think even the directors of nursing, when the strike came on they couldn't stay in their office, they had to go into the line, which was sad because I think after all they were managers, and they should be allowed...so there is a lot of sadness and hurt out there still. (Director 38; 862–900)

The unions standardised all nurses to the rank of nurse, which essentially made all nurses equal in status. Management of nurses and nursing was handed over to the strike committees. According to participants, the majority of directors were not invited to be part of strike committees and had to go on picket duty. Where they would not go on picket duty, they were not allowed to enter the hospital. For some, the stripping of their positional authority proved a distasteful and painful experience:

> The strike was dreadful for me. I would not go outside the gate. I would not picket. I did not see it as right for the director to picket. They would not allow me in, so I had to manage from home...It was an awful experience. The strike committee and the INO would not allow me in. It took six months at least [to get over it], and I have a lot of hurt over it; to be banned from the hospital was too much for me...being the manager of the hospital and being restricted. [In] no other organisation would the manager be restricted. The association wrote to me way back...to say that the director would not be expected to be on the street; then it turned that upside down when the strike came about. So I was not happy to be a party to the strike...That was the worst experience of my whole career. (Director 13; 856–902).

In very few accounts, participants were part of the strike committee and were given the role of advisor to the strike committee and institutional management; this appeared to work well.

Thirdly, participants felt that the unions did not serve their best interests in negotiations in relation to the title change from chief nursing officer and matron to director of nursing and in the fudging of the reporting structure with general management. The Labour Court recommendation (No. 16261, 1999), which involved the four main unions, indicates that the court was not addressing the reporting structure as the main issue but how well the general manager, managed the relationship. Participants also felt that in negotiations between their unions and the Health Service Employers Agency [HSEA], they were not treated by their unions in the way that holders of the position of director of nursing should be:

> A lot of my colleagues aren't that happy, the way it [the change in title] was done, in that there was no sort of discussion...No, apparently it was due to the unions and the nurses' agreement and all that...This title director of nursing was suddenly imposed or superimposed. (Director 18; 17–36)

> Yes, well the job description is always changing. We are after getting another new job description...it has come with the new title...We had very little say into the job description. I was just querying that the other day, who drew up the job description...We are very easy [to get together], and we are very keen, and I think most of the directors of nursing work very closely with one another, but I feel that there should be much more consultation. (Director 08; 742–781)

Participants felt that the unions and the Department of Health and Children excluded them from negotiations concerning the future of their role; they were not given an adequate voice in these negotiations, and the change to their title and role was arbitrarily presented to them:

> The Department and the unions nationally have agreed to change it, but there's a lot still use the title [chief nursing officer] because we weren't consulted about that change. The directors of nursing down the country weren't asked about it. The unions went in nationally and agreed to this, and even the job description they issued at the time wasn't consulted about; we only got it after it was all agreed. So we've objected, and they're changing parts of it now. In effect, we have changed our titles ourselves...I don't see any significance in it at all. I don't know what the logic or thinking behind it was. If you want paranoid thinking, in relation to director of nursing, I think the reason...they wanted to change that title...they wanted the title of chief nursing officer for the Department of Health, and you see we were all holding that title. (Director 14; 11–80)

The strike seemed to crystallise for participants as a subscriber group their relative lack of significance to the unions. Participants consider that the unions did nothing for them and

that the strike was settled totally in favour of the majority subscriber groups but that they as a group gained nothing:

> The strike was really settled in favour of staff nurses because they had the majority. They wanted to get the staff nurses back into work. Like, I suppose like matrons, directors of nursing, we are a small group. (Director 49; 468–474)

> No, the nursing leaders had no input whatsoever, the HSEA and the nursing union which represents the general body. There was nothing in that last strike for nurse managers; nurse managers got absolutely nothing out of that last strike. Although the recommendations were there and we accepted them, I accepted whatever was going, but after the strike [we got] absolutely nothing. (Director 04; 2256–2266)

Participants were generally of the view that the strike provided the unions with the opportunity to focus the minds of nurses on the unions' strength. During the strike the unions, by returning all nurses to the rank of nurse, made clear who was leading and managing. The unions firmly cemented their position, a strategy that they successfully effected during the strike and continued, according to participants, to capitalise upon after the strike.

5.8.1.1 After The Strike

Following the strike, according to participants, directors were disenchanted with the unions' representation and treatment of them. However, they chose to remain as members of these unions which, according to participants, so poorly represented their interests at such a crucial time while capitalising on their own interests to establish themselves as the 'real' leaders and managers. It was said that following the strike directors of nursing spoke of leaving their respective unions; however, they were cudgelled into staying in those same unions by the establishment within the unions of a director of nursing section:

> Well, that was a rearguard action because they [directors of nursing] were walking out on mass and they [the unions] had reneged on the promises they made prior to the strike on what they were going to do for [directors of nursing]. (Director 02; 2230–2235)

> The nurse managers...since the nurses' strike...we have set up a nurse managers' sub-section, but again it is based [headquarters]. (Director 23; 1199–1216)

> I don't see being [a member] of the directors of nursing section in the [union] as being trade union activity; I see it as being keeping yourself professionally updated, plus there are issues of resources being decided, and sometimes the information chain coming from the health boards are [sic] very slow and cumbersome, and we will get from [the union] information on negotiations that went on at the HSEA...So it allows you to plan ahead. (Director 06; 1404–1418)

However, some participants suggested that the way forward is to establish, with a new union, one representative body, a body that would represent the interests of directors of nursing only. They felt that until this happens neither unions nor general management will take them seriously:

> The directors of nursing, they are not in any one representative body: they are in the INO; they are in PNA [Psychiatric Nurses' Association]; they are in SIPTU [Services, Industrial, Professional and Technical Union]. I think they are very disjointed. I think there should be a more common approach at the top level of management, because I think that, if you have numbers, you have power, and you are talking about a position where you get [heard] rather than a position of weakness, and I think people then would listen...If you have numbers and you have one voice, I think you are reflecting actually what the rest want, and I think that's important. At the moment we are not getting across what we need and where we're going as a group. I don't think we are taken seriously. (Director 08; 1815–1855)

5.8.2 Conclusion

From the perspective of this study, directors of nursing mistakenly, as was evident in the strike, thought that because of their organisational position the unions would support them as managers; according to participants, this had been promised to them by their respective unions prior to the strike. However, participants perceived that the unions reneged on their promise and throughout the strike took onto themselves the management function. From the perspective of this study's participants, the unions have undermined and marginalised the position of director of nursing, and yet it emerged in this study that directors of nursing choose to continue to be members of those unions.

5.9 Internal Organisation

This section examines how directors of nursing internally organise their work spheres. It is presented in two parts: comradeship with peers and self-determination in the workplace.

5.9.1 Comradeship with Peers

Directors of nursing have, like many groups of people, network systems whereby they meet up and share interests common to their profession and to their positions. Traditionally, there are two main and long-established network systems: the Association of Directors of Nursing, formerly titled both The Irish Matrons' Association and The Association of Nurse Managers, and the Association of Psychiatric Nurse Managers, formerly titled the Administrative Psychiatric Nurses' Association. While the Association of Directors of Nursing is exclusive to directors of nursing, the Association of Psychiatric Nurse Managers is open to both directors of nursing and those holding administrative nursing positions. Both associations have a tradition of informing members about new developments to enable them to carry out their functions as directors of nursing. These associations do not have a history of featuring to any significant extent in the political healthcare arena. These network systems are about directors of nursing meeting up and sharing issues related to their positions. Contrary to Torres' (1981) assertion that nurse managers typically hide behind their work and do not attend network meetings, this study found that most participants attend network meetings:

> It's great because it gives you the opportunity to meet other people in your own band and in other bands and where things are happening at a national level...I have to say that directors of nursing are very supportive of each other. I think particularly, if you go to a group like that and you've been in it a while, you only have to lift the phone, then, and you've made contact with people on a one-to-one basis, so they support you through a phone call or sharing information or whatever it is. (Director 43; 891–909)

According to participants' accounts, that these network systems were generally about functionality, ensuring that nursing in the practice setting is carried out in accordance with national nursing standards and meets the requirements of employers. These networks seem for the most part to be about giving members information on changes in healthcare, changes that affect nursing and changes in nursing itself. They provide forums where directors of nursing can share how these changes affect their respective services and to effect the standardisation of nursing practice.

In keeping with the concept of network systems, they offer members an atmosphere of conviviality, which it would appear for the most part gives participants a sense of security in sharing issues regarding the functionality of the position:

> The Irish Nurse Managers' Association...everybody together so...if there's new, say like the new nursing forum, anything like that...those things are discussed at a general level. It's just informing us of what's happening out there and what the association is doing. There's an annual conference, as you know, a very good conference...I mean, anything that's coming up in nursing, any of the future plans, you'd hear at that. (Director 50; 606–621)

> Only for networking, we wouldn't survive...the Association of Psychiatric Nurse Managers, and that's one that's senior level. So, yes, from that level that's an important organisation. I meet a lot of my colleagues around the country...We compare notes, and I think that's very important. (Director 04; 1461–1482)

Up until very recently the only network systems available to directors of nursing were the two previously addressed. Participants spoke of how, with the recent changes in the healthcare system, smaller, localised network systems have been set up in health boards and in general hospital bands. These systems seem to function much on the lines of the already established networks; how they differ is in addressing issues particular to an individual health board or general hospital band. While offering the conviviality of a network which for the most part participants appear to enjoy, they centre on the standardisation of nursing service delivery and cost-effectiveness. One participant described them as being like business meetings:

> We spend most of our time concentrating on budgetary matters, the staffing, the pay increases, how it's going to affect us. It's more or less like a business meeting. (Director 42; 1435–1439)

> The acute hospital matrons meet...Usually it will be something to do with [recent developments]...The matrons in the other...hospitals, we don't meet with them except if we're summoned to some presentation...Up to three years ago I was on my own. (Director 02; 1250–1289)

> We developed a working group at that stage; we meet every month, and we ring each other up, and I do think it's important that we try and standardise things...It's good to share, so we meet regularly, and it's an excellent support system professionally...And I think at our level we do need something because there isn't anybody else really to discuss issues with or whatever. (Director 36; 772–786)

These established and recently introduced networks systems, participants explained, provide them with an opportunity to socialise with colleagues and obtain information to enable them to carry out their functions as director of nursing. As the majority of participants spoke positively about what these systems offer, it might be inferred that these

networks are meeting the needs of the majority membership. However, there were a few dissenting voices that felt that the networks were not working effectively in examining, analysing and developing the position of director of nursing within nursing itself and in the healthcare system generally. They considered the associations to be non-assertive and disunited:

> The network system for nurse leaders...How dynamic that is is very questionable. We are all members...but I don't, I wouldn't be an advocate really...It is where we meet up, but in terms of any kind of assertiveness I wouldn't think it is the most effective. (Director 09; 1690–1699)

> The association...it was very political...There was one half on to the Department of Health, and the other didn't know what was happening, and I think it wasn't a very united front. Of late, now, its more holistic in the whole country; it was very divided. (Director 08; 1792–1801)

> There's a great potential for leadership, but sometimes they can come down to more of an informal network that's more supportive to the individual, but I think the potential is tremendous...I would have aspirations towards those bodies being leadership organisations, in forming their leadership approaches, but it doesn't always work out like that. (Director 32; 2280–2315)

This study analysis reveal that, while participants do meet as groups, these groups are functional and do not appear to provide any forum for directors of nursing to share their experiences in a narrative and reflective way (Ohlen & Segesten 1998).

5.9.1.1 Trust

While this study found that these networks offer conviviality and a sense of security in sharing functional aspects of the position, there does not appear to exist a level of trust whereby participants feel that they can with assurance of solidarity move beyond functionality into deeper issues. It would seem from participants' accounts that, for many, distrust lies at the heart of their relationships and affects the genuine quality of those relationships. According to Covey (1995), where there is little trust, there is closed communication, poor co-operation and little real problem-solving and teamwork, as exemplified by the following participant accounts:

> I think, if you have a problem, well maybe you trust some people more than others...There's one or two people that I just ring, and there are more people, then, I wouldn't ring, so that kind of describes that. (Director 29; 2235–2246)

> I could never make my situation known because some of those directors of nursing...there wouldn't be solidarity. (Director 41; 1362–1368)

> You have very little fellowship...Even though you read the literature from the health boards, it talks about a seamless systems [sic] and the rest of it, and we are all palsy-walsy, but it doesn't work like that. (Director 24; 1248–1276)

Trust is based on judgements about integrity (Coyle-Shapiro 2002), that is, the judgements of directors of nursing of each other as nurses. Like other oppressed groups, nurses exhibit self-hatred and dislike for each other (Roberts 1983., Chinn & Wheeler 1985., McCall 1996), although in nursing this behaviour is subtle and hard to recognise. It is, however, evident in the divisiveness and lack of cohesiveness observed in nursing groups. For participants the level of trust (Bent 1993) required to develop a sense of comradeship with peers does not, from this study's findings and as Torres (1981) identified, appear to exist. As also found by Roberts (1997), this prevents this study's participants from truly representing nursing on management teams and perpetuates their dependency on management teams for a power base, as exemplified by the following accounts:

> From the point of view of support, you know the way, to have somebody to listen to you or balance things off, there is none of that. I would say you literally have to try and make your decisions on your own and hope you might meet someone from another hospital that wouldn't quote you because there is a bit of that...I wouldn't talk to a couple of matrons...because I would be quoted. (Director 01; 303–317)

> There is the Association of Irish Nurse Managers, ANM, as they call it, and I mean, I have said this at the meetings so I am not being disloyal here. I think, as a newcomer, it is very hard…for the likes of me, who is still new in the post after [a few] years, it is very difficult to get to know people...It's difficult...It is a club; its hard to be accepted as a member. (Director 03; 1082–1116)

From the perspective of this study and as advocated by Brookfield, the fostering of critical evaluation of underlying beliefs and the challenging of long-held beliefs so may allow participants to gain, through trust and confidence, control over their position (Avillion & Abruzzuse 1996).

> Maybe we should get together more, and sit down and decide what the future is...support each other. (Director 50; 630–646)

5.9.2 Self-Determination in the Workplace

To be self-determining means to experience a sense of choice in electing and regulating one's actions (Deci, Connell & Ryan 1989). From the perspective of this study, and supported Wong's study (1998), it emerged that top-level nurses are powerless and lack influence in the determination of their own position in the workplace.

5.9.2.1 Temporary Capacity

Participants' accounts would indicate that, generally in nursing, and more particularly in the position of director of nursing, there is a history of many positions being held in a temporary capacity, a situation which directors of nursing seem to simply accept:

> It's a very long, cumbersome job to get someone in post...I suppose [we accept this situation] basically because the whole appointment procedure is not under our control...even though we do make representations...It certainly would make much better sense to have a director appointed before the previous incumbent leaves, which happens in administration and medicine as far as I know...But quite often the previous incumbent will be gone for a year or two before somebody comes in. (Director 18; 139–297)

In public non-voluntary hospitals, the Local Appointments Commission (LAC), the centralised national commission responsible for such appointments in public service as director of nursing, and the health boards appear to be instrumental in this delayed procedure, a procedure which, according to participants, their unions also endorse. Roberts (1997) holds that, even though nurses form part of the selection committees for positions such as director of nursing, they have so internalised the needs of the powerful that they automatically eliminate candidates whom they think are too nursing focused to be approved by medicine or general management.

5.9.2.2 Acting

Taking a position in a temporary capacity is generally referred to as 'acting'. According to participants, acting, does not refer to a position that is held on a fixed-term basis but one that is held for an indefinite period of time. Some referred to 'acting' positions as being

held for as little as months or extending into years. Participants explained that there is no appraisal or developmental process involved in 'acting': individuals take up 'acting' positions and carry out the functions of director of nursing until the organisation decides to appoint a permanent post-holder.

Participants seem generally not to agree with it, with the exception of one participant who felt that it gave candidates the opportunity to put their stamp on the job. For the most part, participants felt that 'acting' did not allow people to operate effectively in the position of director of nursing:

> I suppose there are a number of things. When you're in an acting position you're working at 130% all the time because you're trying to prove yourself and to prove you're good enough for the job. That having been said, there are certain things when you're acting that you don't want to do. You don't want to make major changes because you're conscious that you're only really holding the fort. So, [what] you're trying to do is make an impact on the health board, on the people that matter, and at the same time, you know, not do anything too dramatic that would sink the ship. So it's a balancing act all the time, and it does add pressure onto the job. (Director 19; 137–154)

As explained by participants, when the position is designated for permanency, it is not necessarily the individual who has held it in the 'acting' capacity who will be the successful candidate. In fact participants state that a mere 50 per cent of those 'acting' are successful in securing the permanent position, a position that they may have been 'acting' in for years:

> I have no guarantee I would get the job...I'm not going to be matron here, and suddenly not be matron here...I'm not going to take the gamble of not getting the job...You see, my problem is, if...I don't get it, I'm acting again and hanging around, and we all know that people who act don't get the jobs. (Director 41; 1188–1539)

This from the perspective of this study participants' is a dubious practice at the least, allowing an individual to act in the temporary capacity of director of nursing over considerable periods of time while considering that individual unsuitable for the post.

While this study's analysis identified that the Commission on Nursing addressed the theme of 'acting' generally in nursing and recommended that it should cease. The Commission also recommended that appointments of grades below those of director of nursing should

be made locally, however no such recommendation was made for the position of director of nursing.

5.9.3 Conclusion

It emerged from this study's analysis that the main issue for top-level nurses holding the formal position of director of nursing is marginalisation; the main issue of marginalisation was identified as the basic social psychological problem of 'positional marginalisation'.

Positional marginalisation was found in relation to how participants perceived their professional identity development, where their accounts indicate that nursing only provided them with registration training. When participants pursued further education and development, they found that nursing did not, either formally or informally, use resources to assist them. Positional marginalisation was found in the recent professionalisation of nursing through the recommendations of the Commission on Nursing, which focused mainly on the education and development of clinical nursing and not on nursing management. Positional marginalisation was also found in relation to medicine, where participants' accounts indicate that medicine's relationship to nursing has not altered in terms of authority and decision-making and that nursing must keep medicine appraised of nursing while medicine decides what clinical skills nursing will advance.

Positional marginalisation emerged in relation to organisational structure and culture, where participants felt that being excluded from the formal management meeting structures meant that they were not empowered, valued, recognised or rewarded by the organisational hierarchy. In relation to organisational reporting structures, participants also felt marginalised by what they perceived as the downgrading of their position relative to those in general management. Since those changes, participants further perceived an increase in interpersonal conflict and deterioration in interdisciplinary relations with those in general management.

Positional marginalisation also emerged in this study in relation to trade unions, which was made evident, from participants' perspectives, by the unions and their position during the national nurses' strike. From this study's perspective, marginalisation is further demonstrated by the fact that participants continue to be members of those same unions that they feel did not support their position during the strike.

Positional marginalisation was found, supported by Torres (1981) and Bent (1993), in that, despite the responsibility of the position, participant directors of nursing in this study were found to lack power to manage the position and its practices in accordance with professional boundaries. The study further identified that participants lacked control of the pace and context of their work in terms of justification and explanation of the requirements of the position or the structuring of their own appointment system. Positional marginalisation was also found in relation to trust and unity among participants; it was found from their accounts that, while they are comfortable sorting out business matters with each other, they do not engage on critical issues pertaining to their position because of lack of trust and unity.

CHAPTER 6:
THE PROCESS

6.1 Introduction

This chapter is presented in two parts: part 1, the basic social structural process — positional vulnerability; and part 2, the basic social psychological process — 'acquiescing to/adapting to/accommodating to' positional vulnerability.

The overall aim of this study was to investigate, analyse and describe the perspectives of directors of nursing of the experiences of this grade of nurse in the Irish healthcare system. Data analysis found that participants were dealing with the basic social psychological problem of 'positional marginalisation' in the context of nursing and, more generally, healthcare management. This marginalisation leads to positional powerlessness in the context of the current restructuring of nursing, the increasing strength of union involvement and the restructuring of healthcare general management, as described in Chapter 5.

This problem was found to be acted upon by to the basic social structural process of 'positional vulnerability', involving three separate, but for this position related, structures — nursing, unions and general management. The basic social structural process was found to advance positional marginalisation. For participants this restructuring involves three contradictory moves: devolvement of their nursing authority, sharing with unions their positional authority, and demotion in the general management organisational reporting pyramid with increasing centralised control. It was evident from the analysis that this group perceived the basic social structural process as dominant and themselves as powerless recipients of the process.

This study further found that participants used a basic social psychological process termed 'acquiescing to/adapting to/accommodating to' positional vulnerability. Participants discussing the structural process did so in an 'acquiescing to/adapting to /accommodating to' manner, even though their interviews gave the impression that they are generally not satisfied with the changes. At no time was there discussion by a participant of any action to contest the general situation. This 'acquiescing to/adapting to/accommodating to' may stem from reasons including their early socialisation into nursing and the health service

generally — as one participant said, 'that is just the way things are' — or because most directors of nursing are 'home-grown products' and thus more likely to be introspective as managers. It would appear to be difficult for them to contest higher management decisions and actions. Many see any contest as an open expression of 'not being loyal to the board'. In addition, other nursing grades are multiples of post-holders, whereas the position of director of nursing in any institution is a single post. Being that single post-holder and the nature of the job result in their having a sense of being 'on their own' and, according to some participants, unsupported, a feeling they freely expressed in relation to their unions: 'unions do not support managers'.

The discussion that follows describes the analysis of the data that reached this conclusion. Excerpts from the data are provided to support the analysis.

6.2 Part 1: Basic Social Structural Process — Positional Vulnerability

6.2.1 Introduction

The basic social structural process of 'positional vulnerability' involves three separate, related structures: nursing, unions and general management. The basic social structural process was found to have contributed further to group marginalisation, and the outcome of the process is positional vulnerability of the position of director of nursing. The process has two distinct phases: the position of director both before and after the Commission on Nursing, the industrial unrest in nursing, social partnership and the restructuring of general management. All of these major changes were cumulatively taking place from the mid-1990s through to the time of the study, a period of approximately six years.

This section details the basic social structural process under three major themes: restructuring of Irish nursing, unions 'filling the gap', and general management restructuring.

6.2.2 Restructuring of Irish Nursing

6.2.2.1 The Commission on Nursing

In recent times Irish nursing has been under considerable strain in relation to its viability and maximisation of market share. This weakness culminated in the late 1990s in nation-

wide industrial unrest and gross failure in staff retention. Irish nursing sought, mainly through the work of the Commission on Nursing, to reinvent itself.

As with any organisational restructuring, nursing identified its market-attractive products and took measures through the Commission on Nursing to maximise their development. To allow for restructuring, professional nursing further identified those products not essential to its viability. Among the essential products identified by the Commission were undergraduate education and the development of nursing practice in the clinical area. The Commission introduced the profession to undergraduate third-level education and the legislation for post-registration development and standards. The positioning of undergraduate education in third-level institutions affords nursing for the first time the same academic preparation as all other clinically related healthcare professions. The involvement of the profession in post-registration development and standards is a major new departure which provides for ongoing professional development. However, the Commission found that in order to actualise these developments it required the breaking up and passing down of certain existing components of other nursing positions, such as the authority, responsibility and decision-making powers of the director of nursing. The Commission sought in effect to restructure a system of hierarchical authority which has been in existence since the introduction of Nightingale's modern nursing while imposing a restructuring of the nursing organisational pyramid.

Among the recommendations of the Commission on Nursing (1998) that have implications for the structural dimensions of the position of director of nursing are:

> The Commission recommended that the Minister for Health facilitate the transition of pre-registration nursing education into third-level institutes at degree level. (5.19)
>
> The Commission recommended the establishment of a Nursing and Midwifery Planning and Development Unit in each health board...working in partnership with the Chief Nursing Officer in the Department of Health and Children in planning and policy development on nursing and midwifery issues. The Commission recommended that the Nursing and Midwifery Planning and Development Unit at health board level be headed up by a senior nurse...who would report to the Chief Executive Officer of a health board. (7.17)
>
> The Commission recommended that middle nursing and midwifery management should have a defined management role and not merely retain a 'gatekeeping' administrative function, have defined management responsibility

> with explicit delegation of authority from directors of nursing and chief nursing officers...(7.29)
>
> The Commission recommended that health service providers encourage nurses and midwives to seek opportunities in general management and that nurses and midwives consider pursuing careers in general health service management. (Commission on Nursing 1998: 7.51)

While the overall impact of these recommendations is to serve the development of nursing and enhance clinical nursing positions, they have done so almost entirely at the expense of the position of director of nursing. It would appear that all other nursing positions benefited from the Commission's recommendations, but, in effect, they stripped the position of director of nursing of many of its assets:

> The Nursing Commission has done a lot for nursing and improved things; nurse management is in a precarious position...the role of the director of nursing could be compromised in the future by depriving them of responsibility... (Director 39; 1765–1775)
>
> I see the director of nursing of the future...we've directors of nursing, not of nurses, and I don't know if that's the role I want. You know, I think, yes, I certainly would support anybody who is a director of nursing in fighting for nursing, but for me, for job satisfaction, I prefer a bit of administrative and still be managing the clinical side, and I see nursing, for whatever band we're in, going purely administrative...Our power will be eroded certainly...they got rid of the matron post; and...[the] power goes with that. The matron's post, the matron's title held more power than director of nursing, that's my perception. (Director 41; 1734–1824)

6.2.2.2 Pre-Registration Education

The Commission's recommendation for the transition of pre-registration nursing education into third-level institutions at degree level took place in 2002. Up until this time, schools of nursing were based in hospitals and were under the direction of the directors of nursing. The transition of pre-registration nurse education into third-level institutions meant that those directors of nursing would now not have the authority over and responsibility for the schools of nursing. This study found that almost all participants welcomed the transition of nurse education into third-level institutions. None of the participants made reference to their loss of position in this area, which in the context of this study had not yet occurred at the time of the interviews. The actual transition of schools of nursing from hospitals to third-level institutions took place on 1 August 2002. Participants were therefore speaking

of an event yet to happen, and so the reality of the situation may have brought different responses, but for the purposes of this study their general concern with regard to third-level education was not for their position but for the future of nursing itself:

> I think that the education opportunities that are there and that are emerging at the moment are very exciting...I would have concern, though, in terms of beholding to people who are actually going to stay in nursing in graduation...A lot of those see it as something you use to get your qualification and then you look for something else, so in that sense I do have considerable concern. I'm not yet concerned with regard to people being attracted into nursing as a profession, not into general nursing anyway — mental handicap and psychiatry though are finding it rather more difficult. I think really that nursing is evolving very, very quickly in recent years as a profession. I certainly think that we can look forward to better-educated, more enlightened and a more confident profession...in the future. (Director 23; 1913–1967)

6.2.2.3 Nursing and Midwifery Planning and Development Units

The Commission, in a new departure for Irish nursing, examined post-registration professional development. Prior to this the profession of nursing chiefly concerned itself with pre-registration nursing preparation. Post-registration professional development in reality was for the most part entirely left to individual nurses' own initiative and expense, both in terms of finance and time, while employers provided little encouragement or assistance. The Commission recommended the establishment of a Nursing and Midwifery Planning and Development Unit in each health board. These units would have the following functions:

> Strategic planning and quality assurance of nursing and midwifery services in a health board area.
>
> Co-ordinating the delivery of nursing and midwifery services and improving co-operation between health boards and voluntary bodies in the delivery of nursing and midwifery services.
>
> Working in partnership with the Chief Nursing Officer in the Department of Health and Children in planning and policy development on nursing and midwifery issues.
>
> Overseeing the detailed provision of continuing nursing and midwifery education within a health board area.
>
> Liaising with centres of nursing education within health service providers.

> Developing, monitoring and reviewing the co-ordination and development of multi-disciplinary nursing services within a community care area.
>
> Identifying inter-nursing disciplinary and inter-agency training needs and promoting the development of an inter-nursing disciplinary and inter-agency training strategy.
>
> Reviewing significant issues in relation to inter-nursing disciplinary and inter-agency co-operation arising from the handling of selected cases.
>
> Assisting in improving internal communication with nurses and midwives in a health board area. (Commission on Nursing 1998: 7.17)
>
> ...the Director of the Nursing and Midwifery Planning and Development Unit...would report to the Chief Executive Officer of a health board (7.18)

These recommendations sought to develop nursing and midwifery professionally and provide them with the development structures normally found in other, clinically related professions. Participants generally welcomed the Commission's recommendations and saw them as instrumental in the future direction and development of professional nursing:

> This nursing development unit established on each board...I think it is going to be very important as to how it will develop, and I think it will have a big bearing on nursing in time to come. (Director 11; 2105–2114).

6.2.2.4 Restructuring Nurse Management

The Commission, in addition to examining the composition of professionally agreed standards for each nursing role, examined general management requirements for effective role functionality. The Commission recommended a restructuring of the hierarchy of nursing authority and the restructuring of the organisational nursing pyramid. This represented a major departure for modern nursing, as, since Nightingale, the nursing hierarchical system of authority has been a major tenet in the management, direction and delivery of nursing. For the purposes of this study the Commission's recommendations in relation to defined authority and responsibility requirements for effective functioning of each nursing role are central to the continued position of director of nursing.

The Commission recommended that the responsibilities of senior nursing and midwifery management should include:

> Providing strategic and clinical leadership and direction for nursing and midwifery and related services which results in the delivery of effective, efficient, quality assured and patient centred nursing and midwifery care.
> Developing a shared sense of commitment and participation amongst staff in the management of change, the development of nursing and midwifery services and in responding to the changing health needs of patients.
>
> Developing the concept of care planning in collaboration with other professionals.
>
> Participating in the overall financial planning of the health service provided including the assessment of priorities in pay and non-pay expenditure.
>
> Ensuring that the appropriate in-service education programmes and on-going learning needs are met for all assigned staff.
>
> Ensuring that modern standards of clinical nursing and midwifery care are in operation and that regular monitoring of nursing and midwifery care is undertaken through audit. (Commission on Nursing 1998: 7.20)

The Commission recommended the development of the middle nursing and midwifery management. To enact this recommendation the position of director of nursing would devolve its authority, decision-making and responsibility to clinical management roles, which would:

> Have a defined management role and not merely retain a 'gatekeeping' administrative function.
>
> Have a defined management responsibility with explicit delegation of authority from directors of nursing and chief nursing officers.
>
> Have defined functional roles either in managing units of care or in the management of functional responsibilities such as bed management [purely a nursing function] and practice development co-ordination.
>
> Have the authority to manage their area of responsibility without constant reference to more senior management. However, as in all management, there should be effective communication with front-line and senior management. (Commission on Nursing 1998: 7.29)

The Commission further recommended the enlargement of the organisational pyramid by the proposed introduction of two management grades in addition to the traditional ward sister or clinical nurse manager. It recommended the development of three grades in first-line nursing and midwifery management:

> Clinical Nurse Manager 1 or Clinical Midwife Manager 1 [reporting to Clinical Nurse Manager 2 or Clinical Midwife Manager 2].
>
> Clinical Nurse Manager 2 or Clinical Midwife Manager 2 [in charge of a ward of unit of care].
>
> Clinical Nurse Manager 3 or Clinical Midwife Manager 3 [in charge of a department]. (Commission on Nursing 1998: 7.45)

The Commission further recommended that these grades should fulfil the following functions:

> Professional/clinical leadership
> Staffing and staff development
> Resource management
> Facilitating communication. (Commission on Nursing 1998:7.41)

6.2.2.5 Restructuring of the Position of Director of Nursing

The recommendations not only sought the restructuring of the authority of the position of director of nursing but also sought to place the position of director of nursing further away from the point of clinical delivery, generally accepted as being at staff nurse grade. In the nursing pyramid up until the Commission there existed for the most part two grades between the director of nursing and the staff nurse. The Commission's recommendations placed four grades between director of nursing and staff nurse, thus removing the director of nursing further away from the point of clinical delivery and from the patient. From the general perspective of this study's participants, this recommendation makes it difficult to enact some of the Commission's own recommendations, such as ensuring that modern standards of clinical nursing care are in operation (7.20).

> The reality is directors of nursing, if you read the job description, is more like an advisory role, which is what they [the Department of Health] want; they will always have a director of nursing. They will have this one [a director of nursing] out developing a unit; they will advise the board on all nursing policies and all the rest… (Director 14; 1051–1059)
>
> I find that you're fire fighting a lot, which is not what your job is about, and they have told me to keep hands off, but a knock comes on the door, 'we have 15 extra patients in casualty, what are you going to do about them?'. You're the admitting officer, so you have got to try and support people in trying to decide what to do — what nurses can we get, what services can we open, can we get x, y and z? That's pretty intense and ongoing. (Director 33; 1768–1780)

> There are always going to be professional issues, and I don't think anybody is more in tune with professional issues than a director of nursing; and, you know, planning and looking at quality and policies and procedures, that type of thing...[the position] it's very secure... (Director 48; 882–911)

6.2.2.6 The Effect of the Recommendations on the Position of Director of Nursing

The Commission recommended that directors of nursing shift their focus from the operational element of nursing practice to strategic and clinical leadership not only in nursing but also in related services. According to the Commission, this was to result in the delivery of effective, efficient, quality-assured and patient-centred nursing and midwifery care. From this study's perspective, a number of issues regarding these recommendations emerge, among which are language, resources, external forces and failure of definition.

With regard to language, this study found that, although the Commission's first recommendation for senior nurses spoke of strategy and leadership, the language used did not exemplify such concepts. The language of strategic leadership is more easily found in the previously presented recommendations for the Nursing and Midwifery Planning and Development Units, for example strategic planning, working in partnership with the chief nurse and reporting to the chief executive officer, compared to 'developing the concept of care planning in collaboration with other professionals', which in itself, without structural and cultural changes, is an almost impossible task.

In relation to resources, the Commission had in its foregone recommendations already provided for their deployment in the establishment of the Nursing and Midwifery Planning and Development Units.

Providing strategic leadership in the delivery of nursing and/or related services has never been a role that nursing has been fortunate enough to hold. In reality, nursing holds a subordinate position to external forces such as medicine and general management and can only provide strategic clinical leadership when allowed to do so. The Commission's recommendation in relation to the provision of effective, efficient, quality-assured and patient-centred nursing and/or related services is difficult to effect, as nursing does not deliver those services in isolation from its dominant partners — medicine and general management. In reality, these partners dictate the inclusion or exclusion of nursing from leadership and strategic echelons of the health services. As is presented elsewhere, the

findings from this study show that neither partner permits the Commission's recommendations to impinge on their territories or territorial strategies. The Commission's recommendations are admissible only where it suits their respective agendas. For the most part, medicine continues unchanged, and the general management quest for greater control continues to erode the position of director of nursing.

The Commission's failure to define 'related services' is an oversight not generally found in its recommendations in relation to all other nursing grades. Given the uncertain position of nursing in the healthcare structuring, this failure to define 'related services' may serve to fudge the clarity of the position of director of nursing and place the position in a precarious state.

6.2.2.7 Clinical Directorates/Clinical Divisions

The Commission on Nursing is not the only force affecting the position of director of nursing in relation to clinical management. The process of devolving authority within hospitals is continuing with the formation of clinical directorates, that is, groupings of similar specialities with their own budgets. It is an indication that authority is moving downward, closer to the wards and clinics where patients are treated, mirroring the Commission's recommendations. The practicalities of achieving good-quality service provision within defined budgets is the dominant theme, and this requires collaboration between groups of separately organised professionals and non-professional staff. If decision-making is to be devolved downwards — in the interests of both patients and workers — then a central issue is how professions that are independently structured can form effective inter-professional teams (Walby et al, 1994).

The recently introduced clinical management structures in the larger acute hospitals are called clinical directorates or clinical divisions, and they are usually managed by a consultant, a clinical nurse manager and an administrator or business manager. From a nursing perspective, clinical directorates or clinical divisions provide a clear demarcation between nurses and nursing practice, with a devolvement of responsibility for nurses from the director of nursing to the nurse manager of the directorate or division (Office for Health Management 1998). This is a structure that participants would appear to be divided on:

> When we started first we based our model on the RCN [Royal College of Nursing] model of the directorates...the nurse manager has responsibility for the nurses and I'm responsible for the nursing...that's an artificial divide. (Director 16; 3799–3811)

> The role of the director of nursing, though, I think is going to change because, as we move into directorates and decentralised management, she's going to be managing nursing...But I think that as managing nursing...there is more than enough...to keep directors of nursing busy for 20 years if they could just focus on what is their job. (Director 44; 1907–1925)

Nursing is one of the three represented professions in the clinical directorate/division management structure. It is the only one that has to compromise its professional composition. Medicine as part of a directorate/division does not alter its position, as the clinical medical manager continues to retain his/her consultant status and all that goes with that. General management in the directorate/division functions at the accepted grade for general manager and reports to the deputy chief executive. The director of nursing has had to accommodate to devolved authority and decision-making and the division of responsibility.

According to participants, the devolvement of authority, while reducing the influence of the director of nursing, allows the clinical nurse manager to manage the directorate/division as the traditional matron would have managed the traditional hospital:

> Directors, divisional directors of nurse managers, are really what the old directors used to be, directors of nursing, the old matron type of thing whereby they were over the service...I'm over patient care areas, the professional head of nursing...Operational issues should really go to the deputy CEO, who is for operational managers. (Director 40; 843–857)

> They work out quite well: any of the divisions that are up and running wouldn't go back, I think they feel they have a lot more autonomy and control over what they do...I think the divisions quite enjoy, if you like, the amount of control they have, the amount of information and the amount of autonomy that comes within the division. (Director 23; 195–213)

In directorates or divisions the nurse manager has a dual management relationship with the assistant chief executive and with the director of nursing. According to participants, there is a division in this reporting relationship, as the nurse manager reports to the director of nursing for professional nursing issues and to the assistant chief executive officer on general management issues.

> Because of this reorganisation...half of my job is going to be done by a lay business manager as part of this clinical directorate set-up. Because there will be a doctor, a nurse and a business manager. (Director 02; 1536–1543)

> The divisions...report to the executive management board. We have a five-person executive management board, the general manager, myself and three consultants...The nurse service managers who are based at this hospital, they and I meet [same morning and time each week]. (Director 23; 195–235)

6.2.2.8 Conclusion

In conclusion, since the beginning of modern nursing the position of director of nursing has not since its inception as 'matron' undergone such dramatic structural changes. It would appear, from the perspective of this study's participants, that the changes serve to devolve authority and decision-making down the nursing ranks. Unfortunately for the position of director of nursing, it has not, according to participants, been compensated for its losses in relation to its important assets such as authority, decision-making and staff management.

6.2.3 Unions 'Filling the Gap'

Traditionally, nursing work has always involved to some degree a working relationship with unions. This tradition has always been stronger in the psychiatric setting than in the general hospital setting. A change in that tradition has occurred, with unions now holding and developing greater power in how nursing works. Industrial unrest in nursing began to take hold in the 1990s, when there was the diverted national industrial action of 1997, which resulted in the formation of the Commission on Nursing in 1998. However, industrial unrest continued, culminating in Irish nurses voting for the first ever national nurses' strike in 1999. Since that time, and with the inclusion from the Minister of Health and Children of the notion of partnership, it would appear that unions are taking a stronger position in the management and leadership of nursing in the practice setting. From the perspective of many of this study's participants, this is an involvement which the unions have been eager to develop, resulting in them having greater power in the leadership and management of nurses post-partnership and after the national nurses' strike.

> In the past…there would be unilateral decisions made, and the unions wouldn't have been as strong...This notion now of partnership…which the Minister for Health is very keen on...you try to work, obviously, with the trade unions…the frustration. (Director 18; 1405–1465)

> They have a lot of power, the trade union bodies...There was a distinct policy in this country that the leaders of the profession, nurse managers in the profession, were to be ignored at all costs and they weren't to be given a leading role; it was to be the trade unions who had the leading role in representing staff. (Director 12; 2150–2160)

> We're in the process of developing...We have to do it in consultation with nursing unions...You can't do anything without consultation with the unions. (Director 04; 1223–1230)

The strength of the industrial unrest of the late 1990s, some participants would say, took even the unions by surprise, causing them to sit up and take notice. Many participants perceive that the unions seized the opportunity and moved swiftly to fill the gap, assuming a leadership position:

> With the Commission…there was a vacuum, there was a lack of leadership from a nursing perspective, and the unions took it because the directors of nursing were not being proactive in leading the profession. And then, because of that vacuum, the unions stepped in and pretended to be our professional leaders. (Director 40; 1018–1030)

> I suppose the union side has become more of a voice, but that is only since the strike. (Director 03; 1841–1844)

Since the industrial strike action and the partnership agreement, participants perceive that the unions have taken every opportunity to position and strengthen their presence in the clinical setting, including adopting an almost quasi-managerial role:

> They want the role of management without the responsibility and want to be accountable to nobody...It's very easy to come up with proposals and want to change the world; it's grand...But you have to be able to stand over what you're changing and be responsible and accountable. (Director 22; 1849–1857)

> I know that we need unions, but sometimes they can be such a blocking factor in something that's very positive that you feel like saying 'get off your pedestal and come on'. They're fighting for the rights of people who don't necessarily even want them involved, but because there is an issue they jump in, they're on the bandwagon, and you can't resolve it locally without their input...I think they have their own agenda. (Director 43; 1035–1085)

From the perspective of many participants, in some circumstances where nurses have a grievance, rather then going initially to their nurse managers, they now go directly to their union representative to manage the issue:

> At local level...if somebody has a problem you would much prefer that they would come and discuss the problem and sort it. But...they go to their trade union, who makes representation. (Director 22; 1859–1873)

For participants, on some occasions it would appear that the unions do not adopt a partnership approach when negotiating with directors of nursing. In some circumstances participants were of the opinion that unions are making a point of demonstrating their industrial relations power:

> As directors of nursing...we're not perceived as serious players...a union rep said to me. (Director 41; 1262–1283)

> What I find is...you are quite likely to find a letter from a union on your table because you didn't do something...I suppose my perspective is as limited as what I know...From my experience, staff would be in a union, but issues were dealt with by management; if somebody had a problem, they would come to you...I've learned a lot of how to deal through the mistakes I've made...None of the courses would have prepared me for anything like this...They will not prepare you for that confrontation...I have been across the table from union representatives, and the way they speak, the way they treat you...the language, the words...derogatory terms used. (Director 19; 884–1049)

The general perspective of participants is that, in flexing their developing strength over the profession of nursing, the unions 'cherry-pick' the aspects of the Commission on Nursing (1998) recommendations that best fulfil their plans, while leaving untouched those that do not serve to make an impact on the majority membership and might in some way dilute the power of the unions:

> I think the LAC [Local Appointments Commission] is a disaster. I think those posts are sent up to the LAC; I'd have no say, and that is wrong, I think. What has happened over the years is that a small group of people seem to have monopolised the LAC...the same chief nursing officers or directors of nursing services appearing on those panels...There is a tendency, then, 'well don't say anything to upset 'Mr X' if he feels a certain course of action is the way we should be going'...Then that's what you have to say at the interview, and that's wrong...We have to be professional enough to appoint the best people to the best posts and try and headhunt the best...The [union] are supporting the concept of leaving those interviews at LAC level...I can't understand it because it doesn't reflect [general] thinking...It's a recommendation of the

> Commission...they're dragging their feet on it because the LAC don't want to give them up and...its the [union] who seem to be supporting and sort of maintaining it in the LAC. There is a lot of politics going on. (Director 12; 794–874).

6.2.3.1 Inter-Union Rivalry

In some settings participants said that where previously there would have been only one union, in recent times, either by staff invitation or with new staff who already would have been members of other unions, the introduction of other unions has meant the opening up of competition. There now appears to be in these settings a turf dispute for power:

> There are two unions here now...At the end of the day there's no way you are going to get the two groups to agree because they come from two different political bases and it's not in their interest to meet with the other side. So therefore...whatever stance one side takes, they [the other side] take the opposite, because it's about membership and their right to exist; they are all the same, like political parties. (Director 24; 1668–1691)

> We have a partnership group here for change. I discussed with the unions that I envisaged a lot of change...I just explored the idea with them: would they be interested in forming a partnership for change?...They thought it was a good idea, so we formed a partnership...[with] both of them [the unions]. To get them both into the room was an achievement in itself. (Director 28; 3297–3350)

> This place would actually be an oasis in many ways of tranquillity...compared to some places, but...[We] only had [one union] here and the [other union] came in...The two of them...won't sit in the one room...From my point of view it makes life extremely difficult in the sense you try and reach agreement, and, if you reach agreement with one, I suspect the other will disagree with you. (Director 14; 1610–1656)

6.2.3.2 Conclusion

In conclusion, the general perspective of participants in this study is that, following the settlement of the national nurses' strike and the partnership agreement, unions have sought to capitalise on the greater involvement that these agreements afford them by increasing their visibility and building on their involvement in structures such as, staff deployment, staff negotiations and staff development.

6.2.4 General Management Restructuring

The late 1990s also brought the restructuring of the general management structure of healthcare services. Under this restructuring, general management introduced additional management layers, which has a direct effect on the reporting structure for the position of director of nursing. Up until the restructuring, directors of nursing generally reported to the assistant chief executive officer or its equivalent. Following the restructuring, it was the intention of general management that the position of director of nursing would downgrade its reporting relationship to the grade of general manager. In this study, participants were of the opinion that generally directors of nursing perceived this as a demotion and sought at the time of the industrial action to have their reporting relationship secured at its original grade of assistant chief executive officer or its equivalent. Agreement on the security of the reporting relationship was reached between the Health Services Employers Agency (HSEA) and the nursing unions. However, from the general perspective of this study's participants, employers for the most part have not honoured that agreement and have continued with what many participants perceive as their mission, which is at best demotion of the position of director of nursing and at worst erosion of it.

As part of its restructuring, the health service introduced new developments, particularly in the areas of health service planning and financial management. This departure was to make each service responsible for its own planning and financial management. The Commission on Nursing recommended that, in order to discharge their general management function more effectively, matrons of smaller hospitals should be given more explicit input into the determination of the budget and greater control and responsibility over its utilisation (Commission on Nursing 1998). From the perspective of this study's participants, while they are invited to contribute to service planning, the majority are not involved in budgetary decisions.

6.2.4.1 Empire-Building

This study's participants generally consider this restructuring as merely general management empire-building, with little effect on improving services, these additional layers serving only to further distance the organisational apex from the point of service delivery that is the patient:

It's about sending nice reports up to the Department; it's like feeding an elephant...They call them quarter reviews and performance indicators; I really don't know if anyone even looks at them...It's all empire-building; it's all down to empire-building...I saw general management being started in England. I...worked there at the time and remember it changing...I remember seeing it going from what I call the focus on the patient to the focus on the glossy books. (Director 14; 1159–1309)

The general manager...it's a new layer...the line of management structure is changing. I don't know about the advantages of putting in another layer, how effective that is. I don't see huge changes...you would wonder about this layer. (Director 04; 939–992)

They have put in another layer of general manager...There's layers and layers of management; there are coordinators; you couldn't find parking space for all of these, and all they are doing is generating paper and driving the rest of us mad...coordinator of services this and that. (Director 34; 970–980)

Participants were of the general opinion that the change in general management structures appears to have done little to strengthen the overall management of the health service. If anything, it seems to have diluted the overall management structures within hospital settings, according to these participants:

[I have] an assistant administrator, who is very new, who was never in a hospital set-up before. I see her, if I'm lucky, maybe for half an hour a week...I believe there's a general manager...we're in limbo here...I feel very much left out about decisions that are being made, that I don't know what's going on...Also, if I don't have a little hold on the purse strings, I mean I would say I need this and I need that, but it's like a mammy hiding the purse on someone. (Director 17; 855–1044)

In a sense there is a weak management structure, but...in a sense there is no management structure...I was answerable to the director of older persons services. Now all of that is changed; there is a manager for older persons services and then there is a general manager...I don't have management meetings at all...The general manager situation is about a year and a half [in operation], and the...general manager came here once. (Director 32; 1377–1467)

I would say the first thing that would really come to mind is the lack of communication with headquarters and the resistance that I have met with...I suppose the main one would be in recruitment; they won't advertise. I have jobs that are sitting vacant for x number of years, and I find that very frustrating. (Director 45; 1438–1447)

You have a mass of input of grade 6s and grade 7s and a whole lot of administrative staff, and I don't know what they do. To tell you the truth, I

> don't know whether they're advancing the service. I think the service should develop maybe outwards rather than at the top...Every time you go to the HB [health board] you see a different person. It's ludicrous actually; you deal with somebody in personnel today and they're gone tomorrow. Too much change is happening, and I don't think it's good; actually there is a breakdown in communications. (Director 08; 844–867)

Participants explained that formerly, in respect of the position of director of nursing, generally the hierarchy was: the chief executive officer, the assistant chief executive officer/programme manager and the director of nursing.

> You see the matrons in the old days were very powerful, influential people; weren't they when you think about it, the matron of a hospital, the matron of [the big city hospitals]...or even the county hospital...They were very powerful and influential people. Today I don't think that's the case...They were very powerful people in the system. (Director 24; 2126–2146)

> I used to be [involved in strategic management] much more than I am currently. When I reported directly to the programme manager he would discuss the overall plan for the hospital with me on a fairly regular basis. Since we've gone into this, we have a general manager...communications have deteriorated quite badly...Management systems...it's been done without any debate with the...directors of nursing...We're being ignored...We were told we were going to be pivotal to the whole change. (Director 02; 666–692)

> You would have [in the past] been very much left to your own devices; you were given your head and you were let get on with the job. The new structure would be slightly different in so far as they have different reporting systems. That isn't a problem because...Most hospitals anywhere would have a reporting structure, so that was not a problem in itself...It should [the hospital embarking on corporate plans involve the director of nursing]...but it hasn't to date. (Director 42; 659–683)

Participants said that more recently that structure has grown to chief executive officer, assistant chief executive officer, regional manager, general manager, administrator, assistant administrator and director of nursing. In relation to the positions of chief executive officer and director of nursing, before the enlargement directors of nursing were third in line to the chief executive officer. Under the recent enlargement directors of nursing were at best fourth in line and in some cases seventh in line to the chief executive officer. For the purposes of general management, there does not seem to be a uniform approach to the division of services. Some health boards divide their services along specialities, some along acute and non-acute programmes, and some on geographical lines. Whichever way the services are divided, there is for many participants uniformity in where

the position of director of nursing is placed, that is, as indicated by participants, further down the chain of general management.

> The reality is that the amount of contact with the programme manager now is very limited at this stage, and general management is getting in between. What has happened to us is that there has been another layer put in between, and it now takes longer to get a decision made than it did in the past…I certainly would have had much more influence and would have had a direct influence...It was much more rewarding in that sense, and you were more involved, and now you feel like you're out at a distance and being kept away… If you're not singing the [same] song, well the easiest way is to leave you out there singing it on your own…But I'm not so sure that leads to a better service for the patients…in fact, at times you say to yourself, you know, 'are these people really interested in what we are at?'. (Director 14; 1173–1211)

> I see the total erosion of nursing, and I look at it and think what's happened…is frightening...the changes…I was here as acting matron in the [early 1990s] you had the CEO of the health board and a couple of programme managers, and that was it. The matron here worked with the programme manager. Now there's about a million; it's a like a mini [fortress] here; there are so many layers of administration, and the matron doesn't figure in it...[The] newly designed structure…is designed to scupper general nursing...I genuinely believe we're [directors of nursing] on the out. (Director 21; 136–164)

6.2.4.2 Restructuring Reporting Structures

Under the above structure, participants explained that the directors of nursing were to cease reporting to the chief executive officer, the assistant chief executive officer or the programme manager and were to report to a lower grade of general manager. This situation was addressed in the nurses' strike, and, according to participants, it was agreed that the reporting structures for directors of nursing were to resume their original structure. However, there was some convoluted language used in the agreement, in that directors of nursing would resume their original reporting structures but, as participants explained, would 'communicate', or words to that effect, with those in general management:

> Different job descriptions, well, I would have been employed here under a different job description, but, when the negotiations took place in relation to the strike and that, a job description was issued by the HSEA...and we are supposed to operate from that job description. And in fact I was in there in the Health Services Employers Agency when we were negotiating that job description, and one of the things on that was that the nurse would be, or the director of nursing would be, answerable to the general manager or the CEO. But we fought that fight and it is still, you know, we still report to the chief

> executive officer. Now in reality that is not the case...I mean our general manager is coming here for the first time this morning, and...we would have a very good working relationship, and...they are very aware that we are not officially answerable to them, but for all intents and purposes we are working through them anyway...The reporting relationship is that I report to the chief executive officer in communication with, I can't exactly remember the wording, through other delegated officers. (Director 32; 1101–1804)

> I don't know who I report to because [under] the original contract for matrons...they would have reported to the programme manager...You sent in all your holiday requests to the programme manager. Now the general manager has subsumed that role. So I mean it has actually lowered the director of nursing to some extent in my opinion, and it was not really thrashed out fully after the strike; it was contentious. (Director 15; 1475–1490)

> When we came, we reported to programme managers, but now we're reporting to regional managers...[It is] a grey area in our business; my responsibility was to the programme manager, and now it's the general manager. (Director 24; 996–1026)

However, from the perspective of this study's participants, the strike agreement would appear to have left the reporting structure unclear and it seems has placed directors of nursing in difficult positions:

> I report to the assistant CEO, not to the general manager...I will work in liaison and cooperation with the general manager...I don't have a reporting structure to him...I would have a reporting structure maybe from operational issues...The directors of nursing...contract was to the programme manager as the person we reported to; the programme manager has changed into the assistant CEO...We were not going to report to the general managers because that would be reducing the status of the director of nursing. (Director 27; 1737–1812)

> That's highly controversial, and, as you know from the strike action that was taken, I report to the assistant CEO, so when I am going on holidays. I always write to tell him [the assistant CEO]that I am going on holidays...I will cooperate and liaise and facilitate as a matter of courtesy and etiquette. I will also send [the administrative manager] a copy of the letter, but I would not present a holiday form to him, seeking approval for going on my holidays, because you give that to your reporting officer. Everyone does that...to the person they are reporting to. So we [directors of nursing] are strict on that. (Director 06; 1214–1243)

Participants were of the general opinion that, although the strike agreement was that directors of nursing would report to a grade equal to that of at least programme manager, most general management structures have ignored the strike agreement and directors of nursing did not for the most part revert to the original reporting relationship. For participants generally, there now appears to be a practice whereby those managers of the

grade equivalent to programme manager or above choose to ignore the director of nursing and deal mainly with the administrative person in the hospital, indicating that their reporting relationship is with that administrative person and not the director of nursing:

> We would have a regional general manager as well who visits us [nursing] infrequently but visits the general manager frequently. (Director 16; 1103–1106)

> It's like everything; it's all evolving. The new managers out there are very happy to bypass us and not involve us. (Director 41; 1317–1320)

For many participants the result is that the strike agreement is ignored, because, from this study's perspective, they do not actively seek redress. Some participants fear that general management is slowly taking over the roles of nursing:

> The hospital administrator is local and manages the affairs locally. He would be the budget-holder…If [the hospital administrator] has a query, he rings [the general manager]; he never rings me...The general manager also rings the hospital administrator, no matter if it is a needle stick injury or if it is dyed in the wool clinical or it is business. But I have a feeling that the manager, that general management, is trying to manage nursing. (Director 15; 1448–1470)

In some cases where participants continue to report to the original level of at least programme manager this is not due to general management honouring the strike agreement but rather to internal general management industrial disputes:

> I report to the programme manager...They are trying to put in general managers, but actually they would have done it long ago except for actually the administrators objected through [their union]...to reporting to general managers nationally in psychiatry. So that's what has held that up; otherwise it would have gone ahead long ago. (Director 14; 1102–1113)

6.2.4.3 Financial Structures

The agreement that followed the nurses' strike and the production of a job description for directors of nursing by the Department of Health and Children and the nurses' unions, was that directors of nursing were to be involved in and manage the budget for their areas.

Many participants were of the opinion that general management is not fulfilling its part of the arrangement under the terms of the strike agreement and, if anything, since the recent

general management enlargement of structures, has reduced the flexibility of directors of nursing in that area:

> I have no say; I do not get a budget...What we do get is the over-runs on...overtime...but of what figure? You don't really get a true picture...you never get a figure...They're not giving us flexibility...we had far more flexibility years ago. (Director 10; 1524–1591)

What has happened, according to the majority of participants, is that they do not manage their own budgets, and many do not know what their budget allocation is:

> Several times we requested to have our printout of our budget, but we still haven't got it. I do not know whether I have two or two million pounds. (Director 45; 774–778)

> I'm not fully aware of my budget. I've asked...several times, 'could I please have my printout?'...I have not seen the printout. (Director 17; 965–970)

The nearest that most participants get to managing their budgets is by staffing numbers referred to as 'whole-time equivalents'. Nurse managers not given a budget are generally told how many whole-time equivalent staff they can estimate for in a given year; the estimate for the year is shown without revealing the cost to nurse management in number of nursing grades budgeted for in that year.

> The budget doesn't come directly to me; it comes via the administrator...who manages it...I manage the staffing...I know what my whole-time equivalent is; we try and maintain that. (Director 19; 1695–1707)

> In money terms, no, in hours, budgeting hours...yes...But you wouldn't have a lump sum of money to match against that. (Director 42; 690–704)

Whether participants know or do not know how much their allocated budget is, it would appear from what they say that they do not have control over how their budget is spent:

> I don't actually receive anything on my desk...because I think what may be happening...is that if we're running under budget then our money may be spent elsewhere, and I'm not really 100 per cent in agreement in that. (Director 11; 1294–1303)

> I have responsibility for the nursing budget...I have an input into...determining the budget...but there are external influences in the budget which I sometimes don't have control over...There's no money in the budget for nursing 'specials'...They're prescribed by our medical colleagues...I have very little

control over that area…[and] the health board don't budget for it. (Director 18; 1515–1566)

I don't have control over my budget...I would see the documentation...and I would see what our budget is. But I would not see...the breakdown of how it is spent. (Director 03; 426–435)

I don't have that much freedom. I have to ask the hospital administrator for a mileage allowance for an ACNO [assistant chief nursing officer] to go to a meeting or they won't be paid, even though myself I don't have too much freedom. I mean, I have a restricted travel allowance; it doesn't matter, you know, but...if I utilise my travel allowance and it's February and...I have no mileage till [March]...I have to apply for additional mileage to do my job...I just can't delegate it. I have to...look for permission to [delegate] and look for mileage for them [the delegated staff]...That's the way it seems to work here, and I mean if I sent somebody out to do a job and I didn't look for approval the board might decide not to pay them, so I couldn't do that to anybody, you know, so I have to go through the proper channels. (Director 28; 1379–1447)

6.2.4.4 Service plans

As part of the general management restructuring, and following the Health Amendment Act, 1996, the health service introduced 'service plans'. The function of these plans is to allow each service and each component of any service to commit to paper its future plans (Shannon 1999). As nursing is a major part in any healthcare service, its inclusion in these plans should be taken as given.

From this study's perspective, for the most part participants were invited to contribute to their respective service plan; however, there were services where not only were participants not invited to contribute but they were not provided with the plan. Where they were invited, most felt that, because they were not allowed have involvement in the financial management of their service, the exercise was without substance. Many further questioned the realistic value of service plans:

Service planning…didn't involve budgeting...I thought the service plan was quite prosaic...I felt there was a template that you used, and I just thought, 'this isn't really real', it was like going through the motions, almost. (Director 32; 1667–1688)

We did not do a service plan, and I was quite annoyed about it. I found that the hospital administrator did the service plan, and the state of the hospital

> reflected that because the hospital administrator was a grade 6. (Director 21; 1105–1111)

> The service plan...I think that's fictional...I think it probably comes from the hospital administrator. (Director 15; 1840–1867)

In relation to participants in the largest acute general hospitals and those in the mental health service, their commitment to service plan delivery forms part of their performance-related pay agreement:

> Service plan...would be embedded with ourselves...My performance-related pay would be related to my commitment to implement the bits of it that are relevant to me, and that would be evaluated at the end of [the year]...to see whether I deliver it or not. (Director 24; 1150–1160)

6.2.4.5 Conclusion

In conclusion, the general perspective of participants in this study is that the restructuring by general management of its organisational pyramid has sought to downgrade the position of director of nursing. Formerly, there was generally one management grade — assistant chief executive officer — between the chief executive officer and the director of nursing. With restructuring, there can now be, in ascending order of reporting structure: director of nursing, assistant administrator, administrator, general manager, area co-ordinator, assistant chief executive officer and chief executive officer, thus putting five grades between the director of nursing and the chief executive officer. General management has held firmly on to the power of the purse strings; whereas in the past some participants may have had some flexibility, which now seems to have been absorbed by the many new grades of management.

6.2.5 Conclusion: Basic Social Structural Process

Generally there are four major structures affecting the position of director of nursing: nursing, medicine, unions and general management. The general perspective of this study's participants is that, into each one, the position of director of nursing does not fit neatly. In relation to nursing, the position is removed from nursing team activity and clinical involvement; medicine requires the position to maintain the status quo of nursing activity;

unions view the position as representing management and not nurses; and general management views the position as nursing, representing the organisation in the management of nursing.

The general perspective of this study is that the combined impact, through the restructuring, of three of these forces has been to marginalise the position of director of nursing from the professional nursing structure, the nursing clinical decision-making structure, the management structure of nurses and union influence, and the general management structure.

6.3 Part 2: Basic Social Psychological Process — 'acquiescing to/adapting to/accommodating to'

6.3.1 Introduction

Participants in this study were found to have used a basic social psychological process termed 'acquiescing to/adapting to/accommodating to' positional vulnerability. The study identified that this process has three distinct phases: phase 1, participants recognise the effects of positional vulnerability on the marginalisation of the position; phase 2, participants reflect on the effects of positional vulnerability on the marginalisation of the position; and phase 3, participants adjust their behaviour to positional vulnerability.

6.3.2 Phase 1: Cognitive Recognition of the Effects of Positional Vulnerability

6.3.2.1 Cognisance in Relation to the Profession of Nursing

With regard to nursing and related services, the position of director of nursing held the powerful influence of the hierarchical reporting structure, providing the position with the possession of vast amount of local knowledge. Traditionally, nurses report everything through the hierarchical system to the director of nursing. In addition to reporting, there was the hierarchical decision-making structure, which meant that few decisions were allowed to be made without the involvement of the director of nursing. The present structural changes in nursing mean that the director of nursing has had to give way to devolved authority and decision-making, and the position's influence in nursing has been

reduced. A significant number of participants recognised and acknowledged how these changes in the delivery of nursing generally and in clinical directorates/clinical divisions in particular has eroded, and will continue to erode, the power of their position:

> You might just only have a professional role...The role is being deprived...Your responsibility area is less and less; whereas one role is expanding, another role is being deprived. Whereas years ago...my job when I came here, I ran everything in this hospital... And we have lost all that, and there is nothing to replace it. (Director 39; 2227–2248)

> You are only asked for your opinion from time to time; you don't have a direct management role...I think that's the big challenge...where the directors of nursing would only have a sort of an advisory role...they would have no current responsibility for the service...they are hived off into a consultative position. (Director 18; 2717–2759)

> I suppose it mirrored the job description at the time; it doesn't now. Okay, I am responsible for patient care and the staff, but I suppose in the beginning I had a much more in-depth knowledge of clinical issues, and I expected to have, and I don't anymore...I now say to the ward sisters and the assistant matrons, 'listen, it is your business'. (Director 05; 811–836)

> Some participants spoke of the system currently operated in the United Kingdom system, and how that system is from their perspective also eroding the role of the director of nursing.

> The only difficulty I have is that I think as directors of nursing that we are an endangered species...In the John Hopkins model [in the UK] the vice-president looked after nursing...really was only looking after complaints, right, and quality complaint issues...each floor had its own head. [The directorate] certainly has been used to dilute the perception of power that the matron had...If my role is only looking after quality, anybody could do that. (Director 16; 3663–4058)

> If you're going to be strategic...you will only do that by giving up the operational, but at the same time you have to balance being visible to your staff at grassroots level...In the UK, I think they have moved themselves away, and I think they may not see that they need to be visible because you will hear staff saying 'but we never see the matron or director of nursing', and it is important that they do see you and that they do know what you're doing and you keep a very close eye on what is actually happening, that you're very close to the pulse of what is happening at ward level because you cannot manage on your own in an ivory tower. (Director 45; 882–916)

6.3.2.2 Cognisance in Relation to Unions

Traditionally, the position of director of nursing would generally have acknowledged union involvement in the management of nurses and nursing. Participants were of the opinion

that, after the settlement of the national nurses' strike and post-partnership, the unions in nursing hold an increasingly powerful position. A concern expressed by participants was that this increased union influence is serving to erode the influence of their position:

> We have to get the balance right. There's no denying it, though, the unions are very powerful, but maybe, with the whole concept of partnership, the emphasis might change, and we might become better able to work together. I have no problem working with the unions, and I think partnership is a great way to go forward, but we all have to sing from a common hymn sheet. But, as long as we have hidden agendas, we'll never make progress. (Director 48; 1370–1382)

6.3.2.3 Cognisance in Relation to General Management

Traditionally, the three major groups represented in healthcare management are medicine, nursing and general management, nursing being represented by the position of director of nursing. Traditionally in hospital management, the director of nursing would work with the appointed general manager. Participants generally felt that in recent times general management has sought to increase its power base. In this endeavour general management has vied for positional power with medicine with poor results but has found nursing an easier target. This recent endeavour, many participants recognised and acknowledged, has resulted in their position being downgraded in its reporting relationship. This they perceived is a strategy by general management to erode the organisational position and influence of directors of nursing.

> I have to say, there is a drive from general management from the health boards that you have to put everything through general management, but we have resisted that because it takes the power away from the director of nursing…I have those personal concerns, but I don't think everyone sees it…but I do see a lot...being pushed down the line of general management rather than through the nursing director...I say to my colleagues 'watch out'; you would want to be wide awake. (Director 39; 1127–1858)

6.3.3 Phase 2: Cognitive Reflection on the Effects of Positional Vulnerability

In reflecting on the effects of positional vulnerability on their position, the majority of participants would appear to be experiencing a painful process in accepting the imposition of devolved nursing influence and authority. Their discontent is not expressed as clearly in

relation to the profession of nursing as it is in relation to the unions. In relation to general management, there are marked divided feelings: some participants felt strongly that the grading of reporting relationships is central to positional power and influence, while others viewed the actual relationship with their particular general management colleague as being more significant.

6.3.3.1 Reflection in Relation to the Profession of Nursing

Participants exhibited a sense of defensiveness concerning how they formerly enacted their authority. It would appear that they did not see themselves as being authoritarian but as being helpful to their junior colleagues and would present that they have no difficulty in empowering others.

> I would have no worries about it, and I'd have no problem about empowering people either, absolutely none. I don't believe in being territorial about something. I think that I'm very secure in what I'm doing, and I feel very strongly that there is a need for a director of nursing, so that's the road I'd go down. (Director 48; 911–920)

> With nurses, you don't know what they are thinking. It's not that you want to know what they are thinking, but it would be good if they showed some initiative, rather than them expecting you to be there all the time. I don't want to be there all the time, and you say 'what would you like to do?'. Its like policies; as I said at the last meeting, if you are interested in something like wound care, what is there to stop you starting the policy yourself in conjunction with the other nurses, but they kind of feel that it should be left to me. (Director 01; 1094–1109)

During the period of industrial unrest, according to participants' accounts, their junior colleagues sought to have greater autonomy and influence over their nursing practice. For these participants their junior colleagues have been granted what they sought but are, according to participants, reluctant to take on this new responsibility. Participants feel they that many of the issues for their junior colleagues related to autonomy and influence are largely based in traditional nurse socialisation. The process of nurse socialisation cemented in nurses this sense of not taking control. However, according to participants, this deeply ingrained socialisation of 'passing up' is proving to be a major difficulty for nurses in adjusting their thinking and behaviour to take on that which they sought and won.

> I think the level of morale in nursing is abysmal...I think we are the victims of our own success. In the strike we talked it [nursing] up so much that we

actually believed it ourselves...The level of commitment...it's affecting morale, getting nurses to accept responsibility for what they're doing and not hiding behind somebody else. So that's our greatest challenge, changing nurses' approach to what they're doing so that they actually accept responsibility as individuals for what they're doing, for their own professionalism...It was always an issue, but we used the hierarchy in the past to pass those things up...PTSs [new entrants to nursing] never did something unless they asked a first-year, who didn't do something unless they asked a second-year or a third-year, who didn't do anything unless they asked a staff nurse...I can remember being told as a student, 'you're not here to think'...I think the whole culture was there; we've come out of it, but we didn't prepare the people who've to come out...I think that's the greatest challenge that's facing us. (Director 16; 2195–2312)

We try to give the sisters full autonomy...But I find it very difficult because we are trying to push, push back to the wards and make them manage, but I find that they don't want to accept that, they don't want to take that. (Director 39; 1579–1588)

Many of the nurses are my age and older. They are trained in the traditional role. It is very difficult for them...to move from the whole nursing role and 'housekeeping', for want of a better word, to leave many of these things behind and move up into this pure nursing role, and I think they have great difficulty with it. And I think a lot of staff nurses have great difficulty managing people, and they have great difficulty saying to the care assistants, 'I want you to make a bed' or 'I want you to do A, B and C' and 'I want to be up here doing care plans' and all that. And I think they feel guilty about it, and it doesn't come easy to them. It wasn't the way they were trained, and they may think, 'I have ten or five years to go I can't really be changing into this role that you want me to change to'. (Director 05; 901–924)

6.3.3.2 Reflection in Relation to Unions

In making sense of the increased involvement of unions in the management of nurses, participants were for the most part clear about the effects of this in relation to their own position. It was generally felt that increased union involvement serviced two common agendas, that is, the squeezing out of their position by both the unions and general management:

One of the areas really as a manager, I suppose the most annoying area now...is the involvement of the unions. I think it's appalling. I've no problem really with the unions backing people up...but...the way I see it since the strike...we're sort of squeezed out. It's an agreement [with general] managers. (Director 17; 2209–2226)

> At the moment everything becomes an IR [industrial relations] issue. I have the highest regard for unions because they have a role and function if used properly. But they can also be very obstructive if used ineffectively. (Director 44; 2026–2032)

6.3.3.3. Reflection in Relation to General Management

Participants, in making sense of their position in relation to general management, were divided in their opinions. To some, the revised reporting structures were a downgrading of their position; for them, the securing of the previous reporting relationship was qualified by the current practice of many in general management to communicate solely with the administrative person *in situ*, even in relation to clinical matters. For these participants, this undermined their position. They also viewed the practice of not being involved in budgetary determination and management as a control mechanism.

> I get no budget...I would really get no actual budget...We're responsible...for the end product, but we have no authority...You are aware of money, and then suddenly it disappears someplace else...As a group...[what] directors of nursing are looking for...is spelled out in the job description [on budget management]...There's one good reason why they don't want to give budgets over to the chief nurses...when you give over money the importance of your job is at stake. (Director 08; 1233–1314)

> The general manager mainly holds the budget. You have to ask him for extra; he tells you there is no money; and then you find that actually he has gone off and given it to a doctor...That's the anomalies in the system and that's the anomalies that are reoccurring, you know, the power of the budget...the power game. (Director 39; 2160–2173)

However, other participants presented various reasons to justify how it is not the positioning of the reporting relationship that is significant but the quality of that relationship. This was true of those participants who are invited members of boards of management. Others felt that colleagues were overreacting to the issue of reporting structure and that perhaps reporting to the lower grade provides directors with a general management representative who is more in tune with the level at which directors of nursing work and how budgetary management would present difficulties:

> Personally speaking, I think it makes not much difference who we report to. I think actually if I was working in the community I would want to be working very closely with the general manager. The programme manager is part of the service too, but, if you are working closely with the general manager, it is a bit

negative; people [directors of nursing] think that you are losing power or that there's another strand of management above you, that my job is being eroded. I don't see it like that. I'd say if you are out there or if you operate in here [hospital] developing the service and he needs your expertise as much as you need his, and at the end of the day it doesn't make any difference who you report to. (Director 08; 1450–1468)

The reporting relationships are to the general managers, but it doesn't cost me any concern...If you are a competent person and you're capable of running your own service...the relationship would be very good. And he never interferes with anything I would do, and he knows me, I have worked with him in the past...I have no difficulty with that or no difficulty in defending the decisions that I do make. (Director 47; 917–964)

I think that sometimes reporting to a programme manager or a CEO way up...I don't think they know exactly the issues on the ground. I feel that if you are reporting to a general manager he knows the issues...he has a good understanding of the local situation. Now maybe every director of nursing might not feel that way. But I do feel...I have no problem reporting to him, and I do feel that I get a lot of support from him. (Director 49; 710–724)

6.3.3.4 The Corporate Effect

Where participants were members of management groups, along with members of the other two major disciplines of medicine and general management, the membership of such a group appeared to have a major impact on how the participant rationalised the influence and power of the position of director of nursing in relation to all other represented disciplines, this is termed the corporate effect. This effect generally occurs when members of a lower-ranking discipline are invited to the table with those in senior management; this proximity to senior management has the psychological effect of membership and a sense of oneness with those holding decision-making powers. From this study's perspective, such participants strongly endorsed the reporting of the position of director of nursing to the lower grade of general manager:

I think you can get hung up on autonomy, and it's a smokescreen. We all have more autonomy than we pretend to have at times, and we might use it as an excuse. I make my decisions, and that's it. But I have a healthy respect for the general manager post, so I would never overstep the mark. (Director 48; 1552–1560)

Now I have a general manager, there is a management team, and I'm part of that management team...That works very well. A lot of people have a problem at director-of-nursing level reporting to a general manager; they feel they should report up higher. Personally, I don't have a problem. I don't believe in

creating big issues about reporting; I believe in getting on as a team member, valuing each other for the roles you have…I'm very much part, I am an equal, of the team. I would have no problem in consulting with the programme managers. I would consult with the general manager as to what I would be doing. He would then consult back with me...I get support and they likewise...I've always worked well with people, my managers as it were, and I don't get too hung up on this business of 'I'm not going to discuss that, I'll go to head office'...it doesn't [make for] a very healthy relationship...I think it's better if you can consolidate your work practice and then your message goes out to the higher level in relation to how that fits into the bigger, greater plan. (Director 33; 1405–1451)

6.3.4 Phase 3: Behavioural Response to Positional Vulnerability

It would appear that, while many participants voiced their dissent and annoyance about the restructuring of their position, which processed out as positional vulnerability, they have in the final analysis rationalised the changes. Participants generally wished to portray behaviour of compliance with restructuring, which in effect implied their acquiescing to/adapting to/accommodating to positional vulnerability.

6.3.4.1 Behavioural Response in Relation to the Profession of Nursing

In relation to the Commission's recommendations, the vast majority of participants portrayed themselves as working very hard towards the achievement of handing on to their junior colleagues the powers of influence and decision-making. This they presented against a backdrop of reluctance on the part of their junior colleagues to accept the chalice, but participants are, according to their accounts, determined to follow the Commission's recommendations to effect change and to give their junior colleagues the responsibility they sought.

> What I am trying to do is make a manager for each area...It is trying to develop people and getting them to accept making tough decisions. (Director 09; 1922–1927)

> There was this awful clamour for the sisters to see the director of nursing, and I knew they wouldn't need to see me if they were getting information at the right level, [which] led me to go back to our managers and say 'there's something wrong with our management style; you're not getting this right', in that they [the sisters] still thought all the authority was coming from the director of nursing. I had a suspicion that, when managers were not managing something,

> they said they had to ask the director of nursing, so I was still the stick they were using to manage. So I gave it [my report] to the nurse managers [and]...to the sisters and we sat down and...we changed the structure of how they communicate with their staff; we created a communication strategy policy. (Director 44; 1116–1167)

> I don't believe in holding on to everything. The ward sisters should know as much as I do, as much as possible about management...They have to be involved, and I have no problem. And it wasn't getting rid of the jobs I didn't like doing; it was the jobs that were going to enrich the running of the management of their ward. (Director 02; 1705–1729)

While wishing to comply with the Commission's recommendations, their greatest problem was in remaining 'faceless': they found it difficult to be office-bound and not interact at floor level.

> I have learned the art of delegation at last. I found it quite difficult...I found it very difficult to let go of stuff...I felt it was like a bereavement, letting go stuff, which was foolish, but I have learned to delegate...I was speaking to staff members here; a lot of them...because they are an older culture here might say that I am not as accessible to them as I was, and of course I'm not. That comes with the change...and I have found that change rather difficult for me as a person because I am one of these people. I was nearly quicker to do the job myself than to be getting others to do it, but I had to learn to delegate it out. (Director 25; 1074–1115)

Although participants held mixed views about the effects of clinical directorates/clinical divisions on the position of director of nursing, all portrayed that they were doing their best to ensure the success of the directorates/divisions. However, some were anxious to show how they had fought to establish the place of nursing and the position of director of nursing in their directorate/division.

> My biggest battle...was in maintaining that absolute right to insist on nursing issues being referred to me...If it has a professional practice implication, I must be involved in it...[In] one of the first rows...I used that as the first battleground [because] it was changing nursing practice...Now we had a major battle over that, but it established the ground rules that, if it impinges upon nursing and the way nursing is delivered, I must be involved in it...In the end of the day it's consensus...Ultimately the buck stops with me because they have a professional accountability to me...They have a resource accountability to the clinical director...I'm trying to get the nurse to accept that...she is accountable...We're still labouring under the conception that we're handmaidens of the doctor. (Director 16; 3861–3949)

> We have...divisions in the hospital...We've a very much decentralised nursing structure. I may be the director of nursing, but I don't make all the decisions;

> the nurse managers do...I would meet the consultants and the medical executive, but I feel the work should be done at ground level...the nurse managers of that division with the consultants of that division, and that's what I'm working on at the moment. (Director 36; 636–652)

> The directorate nurse managers are a key link...so I would work with them; I work with them from the professional issues...I would have met some of the clinical directors with the nurse managers for those issues, but I don't want to be seen as encroaching on them...It's a bit of tooing and froing and takes a bit of getting used to...Its very important because the directorate system can be seen to be eroding nursing autonomy, authority, and...unless you have a strong nurse manager, a very strong nurse manager,...nursing would actually lose out, so it's very important that I'm there supporting. (Director 40; 832–881)

Generally participants would appear to have concern about their position becoming faceless, and so, while wishing to obey the Commission recommendations, they equally, it would seem, wish to preserve the visibility of their position in the clinical area:

> I would like people to know that there is a matron here...I don't think we should be office-based all the time, because you become faceless. It is very important. You are a figurehead for relatives, too, and families, so I think, where changes are made, they are the things that need a lot of consideration. (Director 13; 701–713)

> I know that directors of nursing do not do ward rounds now, but I think it is important to go to the wards to speak to the staff and the patients. And this gives value to people, not to go to the wards as if I am checking up on people, but to make them feel valued. It is easy to do it in a place like this. Just to let people know that you are still around if they need anything. (Director 31; 611–621)

> I try to combine the two as best I can. I cannot distance myself from what I see as important support for people on the ground, and I feel that, while it is virtually impossible to get out there, as I have said, I don't think that any nurse is going to appreciate a faceless director of nursing. (Director 33; 1250–1258)

6.3.4.2 Behavioural Response in Relation to Unions

For many participants the working relationship with unions has not been pleasant. However, they accept the partnership agreement as a done deal, and they perceive that they have no option but to work in partnership with the unions. Towards this achievement, many have sought to address their fears:

> One of my colleagues asked me if I had problems with the union representative...I suppose I have good union reps, and they will come and say to me 'if you don't do something about such and such a thing it is going to be a major issue' or 'can you do something about it'...I try to work on it...I have had union meetings but very few; we are very lucky here. (Director 05; 1020–1062)

> I think we have to work with the unions; like here in the evenings the nurses have asked me about filling in the INO [Irish Nurses' Organisation] form [form is filled if staff on duty feel that staffing is insufficient], and I said fine, I am not afraid [of the unions], we would have been before, but now if we see that unions can improve working conditions, what is the fear? I think, if we matrons are less afraid of the unions, that staff will see that, and they might come more to us and discuss the issues, as well as going to the unions. (Director 01; 1487–1500)

> Biggest challenges, biggest challenges, I suppose negotiating with...the unions...We sorted out the issues...I haven't seen sight or sound of them since, which is great, and I think that was a big challenge, and keeping them out is a big challenge. I know that, and being proactive and trying to deal with things locally, and I know that they may come in again and that people may have issues. And if that happens I know I am not as fearful of them as when I started, you know, and now I could deal with them in a way which wouldn't frighten me. (Director 37; 1576–1595)

6.3.4.3 Behavioural Response in Relation to General Management

Participants accept the general management reporting structure. Either they do not make an issue of it, as one participant said, 'you accommodate to it', or they try to establish some type of system that is workable for them. For some, the increased bureaucracy of general management is hard to accept, and, although they fight their corner, they find that they cannot beat the new system. And an exceptional few found the general management system such that they decided they had had enough and took the decision to leave.

> I have accommodated...I see my reporting relationship to the programme manager, but he doesn't...I suppose I accept it as it is, because it's too difficult to have it any other way. (Director 45; 209–679)

> I think the two senior posts I have are vacant because the health board haven't advertised them, which I think is unforgivable. I just feel it's unforgivable...I haven't sat down nice and quiet and waited...I've been on the phone and arguing...It is a total frustration, because you're not able to do your job properly...that's very disempowering because you haven't got the time then to tackle other issues. (Director 21; 319–366)

> I have now decided to leave, because the whole management structure for me has changed so much...My reporting relationship when I came here was to the programme manager...General managers were appointed, and my reporting relationship changed, and I was to report to this general manager...so I was dropping down a scale...Following the strike, our reporting relationship changed back up again...The agreement in the settlement was that you revert to your original reporting relationship, but you liaise and cooperate with the new management structures...I did take issue not with the reporting relationship but with the whole working structure that has so changed. (Director 05; 325–439)

6.3.5 Conclusion: Basic Social Psychological Process

In conclusion, participants generally recognise that the newly imposed structural changes are a major reduction in the influence of their position of director of nursing.

Many participants, in making sense of the effects of positional vulnerability, professed to find the imposed devolvement of their nursing authority and decision-making a difficult experience. In relation to unions, participants generally appear to perceive unions as having an agenda to take over the management and leadership functions of nursing. Participants are mixed in their perceptions of their position in relation to general management: some view general management as taking away from the position of director of nursing, while others seem to place more significance in their individual relationship with general management than any erosion of their position.

While participants voiced their displeasure and dissension in relation to positional vulnerability, they have in reality, as presented by themselves, done almost nothing to challenge the changes imposed on them. They by their own dialogue present a picture of 'acquiescing to/adapting to/accommodating to' positional vulnerability.

6.4 Conclusion

The basic social structural process of positional vulnerability identified in this study acted on the marginal nature of the position of director of nursing and served to expose the vulnerability of that position in terms of the profession of nursing, general management and the trade unions. From the perspective of this study, and as supported by Hugman (1991), the respective restructuring projects of nursing, general management and the unions were achieved at the 'expense' of the position of director of nursing (:222). Further,

in relation to medicine, from this study's perspective nursing's restructuring of clinical skills continues to be determined by medicine.

The basic social psychological process, as identified in this study, of 'acquiescing to/adapting to/accommodating to', was found, where many participants acknowledged and recognised that the structural process has served to further marginalise their position. In making sense of their situation, many participants voiced their displeasure, and, for some, hurt, at the change to their position; however, they appeared to rationalise the situation, as exemplified by one participant who said 'that's just the way things are'. Participants in this study were found to do little to challenge the changes confronting them; in their interviews they presented a picture of 'acquiescing to/adapting to/accommodating to' the structural process of positional vulnerability.

CHAPTER 7
DISCUSSION

7.1 Introduction

The purpose of this study was to examine and analyse the experiences of top-level nurses holding the position of director of nursing. Using grounded theory methodology, the study examines and describes from the perspectives of directors of nursing their experiences from their days as student through to gaining the position of director of nursing. The study focuses principally on participants' experiences in the role of director of nursing.

This chapter places in context the events relevant to nursing at the time of the study and presents theory development from Glaser and Strauss's (1967) perspective. It presents the substantive theory as developed by the study, of 'positional marginalisation vulnerability'; it focuses on nursing as an oppressed society and the position of director of nursing as a constituent of that society; it discusses the vulnerability of this marginalised position through macro-structural changes; it presents the behavioural processes of 'acquiescing to/adapting to/accommodating to' used by participants to deal with these changes; it places the study's theory in context with its relationship to current theories and literature, principally the theory of oppression; and, finally, it presents the challenges, the limitations and the recommendations of the study.

7.2 Contextual Events

This study took place in the aftermath of industrial unrest which culminated in the Commission on Nursing (1998) first ever national nurses' strike. These events are intertwined and have had a huge impact on Irish nursing. The then Minister for Health and Children, Mr Brian Cowen, expressed his commitment to nurses when at the launch of the Commission's report he invited professional nursing, trade unions, the Health Services Employers Agency, the health boards and the voluntary agencies to join him in the implementation of the report (Department of Health and Children 1998). However, it was not until nurses, tired of waiting for the implementation of the Commission's recommendations, took industrial strike action in October 1999 that any of the

aforementioned bodies proceeded to implement any of the Commission's recommendations.

In relation to the political and economic context, Minister Cowen made a statement that 'The Commission recognises explicitly that nursing is a self-regulating profession' (Department of Health and Children 1998:2); however, he failed to mention that nursing is not a self-governing profession. In this study participants recognised that neither the Nursing Policy Unit nor An Bord Altranais has a governmental position of authoritative decision-making nor a significant role in the legislation of the nursing profession, which has also been found by Hedin (1986). This situation continues with the overwhelming silence of all representatives of nursing and nurses regarding the newly proposed Nurses' Act before the Dáil (the Irish Parliament), an act which will replace the current Nurses' Act, 1985. This study further found, in support of Bent's (1993) findings, that nursing continues to be a profession without political voice in the allocation of resources.

During the period of the study, nurse education moved from hospital-based training to education at degree level in third-level institutions. Participants welcomed the move and hoped, as had participants in Hedin's (1986) study, that students would develop technical, practical and 'emancipatory' knowledge, as all three are necessary for the development of nursing. Equally, participants hoped that this new system would educate nurses to engage with the healthcare system and its structures critically. However, they did not wish to see an erosion of bedside nursing; they felt that this is where student nurses learn nursing assessment of patients' health status and the provision of nursing care, a view similar to that expressed by participants in Hedin's (1986) study. They would wish, as did participants in Bent's study (1993), which the educational changes would serve to develop in nurses' own esteem of their ideas, judgement, value and worth.

In relation to professional practice, participants equally welcomed the value of research, as did Nolan (1993), which they saw as allowing nursing and nurses to develop and use nursing's own evidence-based knowledge and also facilitating the move away from drawing on the knowledge base of others, as demonstrated by the recently published research strategy for nursing and midwifery in Ireland (Nursing Policy Unit 2003). They very much endorsed the move towards nursing taking responsibility for nursing standards in clinical practice (An Bord Altranais 2000a., Hafford 2002).

However, participants cautioned that nursing needs to be very careful not to embrace expert prestige and domination solely and to be aware of ascribing low value to 'basic' or traditional nursing patient care, echoing the sentiments previously expressed by Salvage (1987) and Davies (1995).

This study found that, while the Commission did tremendous work to further the technical and practical knowledge of nursing, it did little to progress emancipatory knowledge towards understanding nursing in terms of its general history as a society. Furthermore, the Commission did not examine nursing in terms of gender, its professional autonomy, the milieu in which it functions and the value that Irish society places on nursing care as the major defining product of nursing (Hugman 1991., Porter 1994, 1995a, 1995b., Davies 1995., Street 1995., Porter 1997). Examination of such factors would have allowed nursing to analyse seriously and consolidate its place in society (Gordon 1998).

7.3 Grounded Theory

Grounded theory allowed consideration, through participants' accounts of their experiences as directors of nursing, of macro-structural arrangements such as the healthcare system, the nursing profession as a constituent of that system, and the impact of those structures on the position of director of nursing. Micro or interpersonal relations within that system were also considered and their effects on the position of director of nursing discussed (Madoo Lengermann and Niebrugge 1996). The purpose of grounded theory, according to Glaser and Strauss (1967), is not to provide a perfect description of an area but to develop a theory that accounts for much of the relevant behaviour.

Fundamental to the grounded theory approach is the simultaneous process of data collection, analysis and sampling, specifically theoretical sampling. In this study data were initially collected through a literature review which guided the development of the interview guide. The principal method of data collection was then through interviews with participants, and these data were coded and analysed using the grounded theory methodology, whereby the problem emerges and the emergence of the problem dictates the sampling decisions, that is, theoretical sampling. According to the grounded theory approach, the theory generally emerges early in the analytical process. However, this did was not the case in the present study: it took time to find out what was going on, but, as

Glaser (1992) indicated, with patience the problem emerged from the data. This study started out, as is evident by the literature review, from the perspective of leadership, but through the process of interview data collection, analysis and reflection the theory that emerged was one not of leadership but of marginalisation.

The substantive theory of 'positional marginalisation vulnerability', developed through this research, serves to describe much of the relevant behaviour of directors of nursing in this study. This substantive theory relates to formal theories such as the theory of oppression, symbolic interaction in socialisation, exchange theory, feminist theory, role conflict, role theory, power dependency theory and cognitive dissonance theory.

According to Glaser and Strauss (1967), a theory is a theory because it explains or predicts something. In this study the substantive theory explains the vulnerability of the marginalised position. Glaser and Strauss's (1967) emphasis is on theory as ever-developing and not a finished product. Theory as a process presents the reality of social interaction and its structural context. A theory can be presented either as a well-codified set of propositions or in a running theoretical discussion, using conceptual categories and their properties. The discussional form of formulating theory presents the theory as developing and allows it to become rich, complex and dense, making its fit and relevance easy to understand. The theory should provide categories and hypotheses that are clear enough so that crucial ones can be verified in present and future research. Theory as a process can be presented in publications as a transient product; the theory is not frozen by giving the impression of no further development but is written with the assumption that it is still developing.

The substantive theory of positional marginalisation vulnerability was developed according to Glaser and Strauss's (1967) recommendations of allowing substantive concepts and hypotheses to emerge first, on their own, to ascertain which, if any, formal theory could help to generate substantive theories. Accordingly, the researcher was faithful to the data and did not force the data to fit a theory. This allowed the researcher be more objective and less theoretically biased. The researcher from the start did not apply categories at will but waited to see whether categories were linked to the emergent substantive theory concerning the experiences of top-level nurses.

According to Glaser and Strauss (1967), some analysts focus on verifying the new theory that emerges in their data. Thus, in their work, theory is generated, but its emergence is taken for granted, and what is intentionally worked for is the verification of this emergent theory. There is a preoccupation with checking out the emergent set of propositions. Their favourite techniques are to look for negative cases or deliberately to accumulate positive ones to gain further evidence for their hypotheses. Evidence and testing never destroy a theory; they only modify it, and so a theory's only replacement is a better theory (Glaser & Strauss 1967).

One canon for judging the usefulness of a theory is how it was generated. The evidence may not necessarily be accurate beyond a doubt, but the concept is undoubtedly a relevant theoretical abstraction about what is going on in the area studied. The concept itself will not change, while even the most accurate facts will change (Glaser & Strauss 1967).

7.4 A Theory of Top-Level Nurses: Positional Marginalisation Vulnerability

> I use the word nursing for want of a better. It has been limited to signify little more than the administration of medicines and the application of poultice. (Nightingale 1992:6)

The findings of this study have led to the development of a substantive theory of the experiences of participant directors of nursing. The basic social psychological problem identified was positional marginalisation, where the basic social structural process exposed the vulnerability of the position, while the basic social psychological process of acquiescing to/adapting to/accommodating to was used by participants to deal with the problem.

The basic social psychological problem was found to be based in nursing itself and also based in the reality that nursing resides in a culture where the healthcare system traditionally functions with three separate management structures: medicine, general management and nursing. Within this culture, nursing has the largest membership but the least power (Traynor 1999), and there is a persistent political failure to grasp the fact that healthcare services involve not only medical care but also nursing (Department of Health and Children 2003., Filkins 2003). This culture is also characterised now by relentless

micro management and utilisation review, which is causing a shift from caring towards policing and politicking (Gordon 1998).

The basic social psychological problem identified in this study was that nurses are an oppressed and marginalised group which resides in a culture of hegemony dominance (Ryan & Porter 1993., O'Connor 1996). Roberts (1983, 1996, 1997, 2000) identified nurses as an oppressed group because they have been controlled, as was also found in this study, where nurses were oppressed by others with greater power, prestige and status, such as politics, medicine and general management (Gordon Clifford 1992). It was also found that nursing lacks autonomy and control over its own profession and is marginalised from all power except within nursing, similar to results from the work of others (Bent 1993., Jolley 1994., Davies 1995., Traynor 1999., Filkins 2003).

The participants in this study spoke of a nursing culture where to be a good nurse was to be conforming, quiet, submissive, dedicated, self-sacrificing, deferring, not questioning or complaining but carrying out orders as directed (Roberts 1997). It emerged that importance was placed entirely on the completion of tasks and procedures and the management of the ward, without critical analysis or partnership in decision-making, again very similar to the results of other studies (Walby et al, 1994., Traynor 1999). In their initial nursing training, participants had learned solely by practice and by doing, where nursing did nothing more than provide trainees for the workforce and gave nurses no further training or education beyond basic registrations. Participants experienced a nursing system that rewarded nursing practice and education but did not reward nurses for developing the achievements of other nurses. The system that hampered the development of this study's participants also hampered the development of nurses and nursing generally, as found by Redmond (1995) and the Commission on Nursing (1998).

For the participants of this study, nursing offered only one significant route of success: through the management and control of nurses. The road to success as identified by Roberts (1983, 1997) was to impress not only those in nursing management but also those in medicine and general management. In order to succeed, these ambitious nurses had to show the powerful that they were better than their colleagues and would, on behalf of the powerful, keep other nurses in check. In return they received a nice title and were allowed to mix with those from the powerful groups of medicine and general management (Roberts 1983, 1997, 2000); the ultimate position of success was that of 'matron', now titled

'director of nursing'. In order to be successful in that position these nurses had to separate and distance themselves from other nurses and to become the gatekeeper for the powerful (Roberts 1983, 1997, 2000). In obtaining this ultimate position of success these participants placed themselves between nurses and nursing and between medicine and general management; this positioning is referred to as 'marginal'. A marginal position is one on the boundary between groups; its status in any of the groups is uncertain as it occupies an ambiguous position. The position is affiliated to the different groups but is not fully accepted by any, including its own original group of nursing (Krech, Crutchfield & Ballachey 1962., Roberts 1997, 2000).

As a marginal position, the director of nursing relies not on itself but on the other groups for its status and power (Krech, Crutchfield & Ballachey 1962., Roberts 1997). The basic social structural processes discovered in this study were that when the fully integrated groups altered their internal structures this directly affected the position of director of nursing. Perhaps because of this marginal position, the Commission recommending the restructuring of nursing generally gave least attention to the outcome of the restructuring on the position of director of nursing, and equally least attention to the role of the director of nursing itself. Further structural alterations in general management reduced the status of the position of director of nursing in relation to general management and medicine. As clinical directorates, clinical divisions or similar changes are further introduced, medicine will shift its reliance from the position of director of nursing to the designated nursing position, usually the most senior clinical nurse manager position. These structural changes serve to expose the vulnerability of the position of director of nursing, a situation identified by Hugman (1991) in relation to restructuring and power in the caring professions. The vulnerability of the position of director of nursing was further exposed by the fact that, as this study found, holders of this position, who had felt during the national nurses' strike that the unions showed little regard for the status of the position, continue to be members of those same unions. Positional vulnerability is further exposed in that there now exists in the healthcare system a culture where nurses, whose reporting relationship through the system is to the director of nursing, have since the strike become more union-managed. These findings are not supported by Filkins' (2003:47) study of nursing in eight European nations, in which Ireland was not included; a tentative conclusion in that study was that, from the perspective of nurse directors, developments across Europe 'point to a strengthening of the role of the nurse director'. However, two major findings of that study differ completely from those of this study in that Filkins (2003) found the positive effect of

having a budget to manage and the ability to influence strategy and quality. As Schmieding (1993) stated, budgetary control gives nurses decision freedom and empowers them towards achieving their vision for nursing.

Although emotional and role conflict are said to be an occurrence of the marginalised (Krech, Crutchfield & Ballachey 1962), this study found that the basic social psychological process used by participants to deal with the structural changes was 'acquiescing to/adapting to/accommodating to'. This behaviour of 'acquiescing to/adapting to/ accommodating to' as described by the participants is directly related to years of socialisation into the role of 'good nurse' by conforming to the status quo. Acquiescence and conforming were the behaviours that contributed to their success in obtaining the prestigious position of director of nursing and were now being used to confine them in their collective response to the imposed changes affecting the position.

7.4.1 Double Marginalisation

In essence this study found nursing to be an oppressed and marginalised society and in particular found the position of director of nursing to be further marginalised within that society. The substantive theory of positional marginalisation vulnerability is presented in Figure 7.2.

Figure 7.1—A Theory of Top-Level Nurses: Positional Marginalisation Vulnerability

Irish Nursing in Context

Nursing

- Gender and Society
- Politics
- Medicine and General Management
- Economic and Social Change
- National Nurses' Strike

Basic Social Psychological Problem: Positional Marginalisation

The Position of Director of Nursing

- Professional Identity Development
- Professionalisation of Nursing
- Relationship with Medicine
- Organisational Healthcare
- Structures and Culture
- Industrial Relations Projects
- Internal Organisation

The Processes

Basic Social Structural Process: Positional Vulnerability	*Basic Social Psychological Process:* Acquiescing to/Adapting to/Accommodating to
Restructuring of Irish Nursing Unions Filling the Gap General Management Restructuring	Cognitive Recognition of the Effects of Positional Vulnerability Cognitive Reflection of the Effects of Positional Vulnerability Behavioural Responses to Positional Vulnerability

7.5 The Theory of Positional Marginalisation Vulnerability in the Context of Current Theories and the Literature

This section discusses the theory in the context of current theories and the literature. The study found that the theory is linked primarily to the theory of oppression, and to a lesser degree to other theories.

7.5.1 Theory of Oppression

Roberts' (1983) theory of oppression is based on the works on colonised people by Memmi (1968., 1974), Freire (1972). Memmi (1968., 1974) and Freire (1972) found that the groups they studied could be said to be oppressed because they had been controlled and exploited by groups outside themselves; these outside groups had greater prestige, power and status. Freire (1972) identified that the major characteristics of oppressed behaviour stem from the ability of dominant groups to identify as correct their norms and values and to value negatively those of the subordinate group, while also having the power to enforce this vision. Those with the political and organisational power colonise the less powerful group by creating a frame of reference so pervasive that the less powerful group is drawn to evaluate its own activity and thoughts by the criteria of the powerful. The colonised take up the language and behaviour of the coloniser in order to behave in ways that will be recognised and valued by the powerful (Traynor 1999). Oppressed group members internalise these norms and values and in turn experience low self-esteem and self-hatred. They lack autonomy and control and behave in ways that lead to continued domination by the powerful (Schmieding 1993).

To maintain the status quo, the dominant group tends to reinforce the subordination of the oppressed group (Schmieding 1993). Mechanisms of reinforcement include reward for compliant behaviour and token appeasement (Bent 1993). Thus, members of the oppressed group who have the ambition to acquire money or positions of status achieve their ambition by proclaiming that the values of the dominant culture are correct. Token appeasement is the mechanism used when there is a threat of revolt, such as the nurses' strike; this involves the granting of some rights to appease and prevent a real revolt (Roberts 1983).

7.5.1.1 Nurses as an Oppressed Group

Roberts' (1983) theory of oppression identified, as previously discussed, that nurses are an oppressed group, for reasons such as economics, gender and culture (Traynor 1999). Nursing, as a female workforce, was directed by politics, medicine and, more recently, general management, all predominantly male workforces (Gordon Clifford 1992).

Although nursing has been in existence for some time, participants felt that it remains underdeveloped. Some suggest that this underdevelopment reflects women's role in Irish society, where, up until the passing of equality legislation in 1974, women upon marriage had to give up their permanent, full time, pensionable positions. Because nursing is an almost entirely female profession, this situation had a huge impact on Irish nursing, as it meant that the nursing workforce comprised a large body of student nurses, some temporary part-time nurses who because of their temporary status could not progress beyond the level of staff nurse, and a small body of permanent nurses who were there solely because they were single.

In the practice of clinical nursing, medicine continues to have a colossal institutional power base (McCall 1996., Traynor 1999., Roberts 2000., Filkins 2003), and, consistent with oppression theory, nurses' internalised belief is that it is medicine's right to control healthcare (Torres 1981), even, as Baumgart (1999) states, where medicine has no overt expertise. As this study found, medicine is careful to control the recommended extension to the role of the nurse of duties previously carried out by junior doctors (Walby et al, 1994). This study further found, as did McCall (1996) and Roberts (1997), that nurses in practice continue to acquiesce to this type of medical control. This study found that nursing continues to be dominated by the structures of politics, medicine and general management and, in more recent times, unions; consistent with oppression theory, nursing has internalised and accepted this domination.

7.5.1.2 Horizontal Violence

An adaptive strategy of oppressed groups is horizontal violence; this manifests itself as internal group conflict, where members of the group direct their dissatisfaction inwards, towards themselves, and towards those less powerful than themselves (McCall 1996).

While the oppressed feel aggressive towards the oppressor, they are afraid to express this directly. In the group there may be much complaining; however, when confronted with the powerful figure they are submissive. This fear results in passive aggressive behaviour, and this pent-up aggression leads to a lack of trust and infighting (Roberts 1997). Fear of aggression against the powerful figure(s) originally develops because of fear of what might happen if they were to object. This fear is the basis of the submission to authority. In this process a secondary fear develops, that is, the fear of change and a reliance on the status quo, no matter how oppressive (Roberts 1983).

This build-up of aggression can result in a tendency for the group to be in constant conflict, as this is the safest way of releasing built-up tension. Horizontal violence is not an inherent characteristic of the oppressed; it is a result of people being unable to confront the oppressor. However, it is given as proof of inability of the oppressed group to organise and govern itself efficiently (Roberts 1983). Within nursing, horizontal violence or internal conflict exists widely (McCall 1996., Commission on Nursing 1998., Traynor 1999., Roberts 2000).

Horizontal violence is an aspect of nursing behaviour that can be subtle and difficult to recognise; however, it is evident in the divisiveness and the lack of cohesiveness observed in nursing (Roberts 1983., McCall 1996). Equally, the basic consciousness of occupational loyalty is difficult to generate in nursing (Reverby 1987); as a predominantly female profession, nursing has not shown itself to be at ease with the changing role of women. Nursing used the willingness of women with dependants to work as a flexible back-up labour force but did almost nothing to support these women in the labour market, which, this study contends, concurring with Traynor (1999), has had a huge effect on nursing, given that it is made up of almost entirely female staff. This study found in relation to the position of director of nursing that nursing does not have a single agenda; this conflict means that unity in nursing is doubtful, a situation also identified by Traynor (1999). Unity, Stein, Watts and Howell (1990) suggest, is necessary if nursing is to confront successfully medicine's control of it; it is equally well acknowledged that to succeed politically nursing has to develop a single voice (Clay 1984., Strong & Robinson 1990., Auld 1992., Fawcett-Henesy 1998).

If it is taken, as proposed by this study, that Irish nurses are an oppressed group, then perhaps nurses' need for trade union membership is based on the two needs suggested by

Krech, Crutchfield and Ballachey (1962), power and affiliation. The powerlessness of an oppressed group may be ameliorated by trade union group membership, while it also provides an affiliation. By joining a trade union the individual nurse may seek not only to gain economic goals but also to satisfy his/her need to belong. Because of the extent in nursing of (albeit subtle) horizontal violence and the other effects of oppression, group affiliation is undermined, and trade union membership may serve to provide the affiliation which would, from this study's findings, appear to be lacking. The ambiguity of the position of director of nursing and the fact that the profession of nursing has failed to provide a strong sense of membership for nurses suggests that nurses had to look to the trade unions for their affiliation needs (Krech, Crutchfield & Ballachey 1962., Hugman 1991). Although initially the unrest witnessed in nursing in the 1990s caught even the trade unions off guard, they quickly seized the opportunity to increase their power. The resultant collective action of the trade unions served greatly in the establishment of their independence and power (Jones & Jones 1977), a position which this study found is now increasingly visible and enacted in all aspects of Irish nursing.

7.5.2 Symbolic Interactionism in Socialisation

Symbolic interactionism is applicable to socialisation, where socialisation is described as a lifelong interactive process of human development, including professional development and identity (Ohlen & Segesten 1998). Symbolic interactionism (Blumer 1969) holds that the organisation of a human society is the framework within which social action takes place but that the organisation is not the determinant of that action. Structural properties such as culture, social systems and social roles set conditions for people's actions but do not of themselves determine their actions. Established patterns of group life exist and are maintained through the continued use of the same schemes of people's interpretation and behaviour (Blumer 1969). From the perspective of this study, participants through their socialisation process developed a profound understanding of power but also, more importantly, as posited by Foucault (1982), a profound understanding of the power relationship, how power is used, the relationships structured around power and the relationships that produce power, a position supported by Hugman (1991); from participants' own accounts it is their own continued pattern of behaviour that serves the perpetuation of those power relationships.

Symbolic interactionism has further relevance to the socialisation process of this study's participants, as, according to Blumer (1969), fundamental to human society is group social action which shapes human conduct. Applicable to the socialisation process is the premise of symbolic interactionism that individuals act toward their world by the process of 'self-indication' (Blumer 1969:81), through which they develop their conduct by constant interpretation of each other's ongoing actions, where they continuously interpret and judge the fitness of norms and values, and where 'they are forced to direct their own conduct or handle their situations in terms of what they take into account...in the face of the actions of others one may abandon an intention or purpose, revise it, check or suspend it, intensify it, or replace it...One has to *fit* one's own line of activity in some manner to the actions of others' (Blumer 1969:8). In this study it emerged that participants' interpretation of a good nurse is where the actions of the nurse are acquiescence, adaptation and accommodation.

7.5.2.1 Exchange Theory

Exchange theory, as first developed by Homans in the 1950s, studies patterns of behavioural reinforcement; it holds that interactions are likely to continue when there is an exchange of rewards and, conversely, that interactions found to be costly are stopped (Ritzer 1996). It is generally accepted, as was found in this study, that conforming was the acceptable and tolerated behaviour in nursing; thus nurses were socialised and rewarded to believe that a good nurse was one who held attitudes and engaged in behaviour of conforming (Krech, Crutchfield & Ballachey 1962).

The essence of conformity is yielding to group pressures. The pressures from the group need not be explicit, that is, the group need not overtly threaten or coerce the individual. The mere existence of a group action which the individual perceives to differ from his own may exert pressures, arising out of fears of being wrong or of being out of step with the group, which may lead an individual to refuse to take action or take a stand in order to conform.

In traditional nurse socialisation, the more insidious form of conformity behaviour is that the nurse eventually comes not only to yield on particular opinions but to yield even his/her right to express an opinion (Krech, Crutchfield & Ballachey 1962). It continues to be legitimate for nurses to receive orders from members of the medical profession while the corollary continues

not to be the case. Nursing's work continues in the shadow of Nightingale's legacy; it operates in direct relation to medical orders (Porter 1992, 1995b). While the Commission brought to the fore the many tasks and special knowledge that make nursing unique, this study found that the conformity of nursing is still embedded in its subordinate relationship to the authority of medicine and, more recently, general management (Jones & Jones 1977., Hugman 1991).

7.5.2.2 Behavioural Processes of 'acquiescing to/adapting to/accommodating to'

Participants' behaviour was found to be one of acquiescing to/adapting to/accommodating to, if not collusion (although not consciously portrayed by participants), in maintaining the status quo. Collectively, participants in this study were found to be bound by tradition and to lack confidence to take risks, a finding supported by Traynor (1999). In this study, participants' careers, as was also found by Traynor (1999), developed in a nursing system that was hierarchical and rule-bound, which played a supportive and subordinate role to medicine, and where matrons' control came from medicine and not from the position of matron itself; this subservience led to compliant, dependent nurses. The profession was, and is, a body with few powers, where the rules it devised and, as this study found, devises have to receive medical approval and, where appropriate, ministerial approval. None of the participants indicated that they were actively involved in endeavouring to address the issues which gave rise to their oppression, and nursing continues to have no powers over salary and employment conditions, a finding which concurs with those of McCall's (1996).

7.5.3 Feminist Theory

Although this study was not guided by feminist theories, the substantive theory was found to be linked to the main propositions as developed by Madoo Lengermann and Niebrugge's (1996) fusion of feminist theories. This was particularly so since nursing, with its majority female workforce, is dominated by female culture (Neubauer 1995), and the focus of feminist theory is on human experience from a female-centred perspective (Madoo Lengermann & Niebrugge 1996).

Firstly, according to Madoo Lengermann and Niebrugge (1996), the practice of sociological theory must be based on a sociology of knowledge that recognises the knower

as embodied and socially located; this study is a reflection of directors of nursing, and all participants held the position of director of nursing, as had the researcher for ten years.

Secondly, macro-social structural processes are controlled by dominants who, acting in their own interests, set the rules which are executed by the subordinate, in this study, nurses and, more particularly, directors of nursing.

The macro structure of subordination is enacted through the behavioural process of 'adjustment' (Madoo Lengermann & Niebrugge 1996). As found in this study, behavioural adjustment was made to accommodate structural changes; as one participant stated, 'you accommodate to it'. This study further found that nursing, and in particular the position of director of nursing, functions in a healthcare system in which the patriarchal culture is endemic (O'Connor 1996); it is paradoxically both clearly visible yet hidden during the socialisation process (Nicholson 1996). The ways in which gender power relations are conducted within patriarchal cultures make gender a crucial component of power relations for nursing (Nicholson 1996). This study found that, in this genderised system, nursing is treated as a support function to medical care, in that the development of nursing clinical skills is related to medical sanctioning, as is evident from the macro perspective of the nurse and midwifery prescribing project (An Bord Altranais 2002a., National Council for the Profession Development of Nursing & Midwifery Newsletter 2003).

Thirdly, micro-interactional processes in the healthcare system facilitate the structures of dominant–subordinate power over nursing and contribute to the devaluing of nurses' contribution by showing disregard for their position and remuneration or idealising them as 'angels of mercy'. In this system, career development and woman-power planning has to fit into and is hampered by the man-power planning model of supply-and-demand derived from and orientated to the lifelong, uninterrupted participation of the male career (Davies 1995). This was evident in the past in the imposed restrictions of the marriage bar and now, as found in this study and by Lane's (1998) study, in society's continuing expectation for women to be the principal carers; this means that many women work part-time, and it is this part-time arrangement that contributes to preventing them climbing the corporate career ladder.

Fourthly, these conditions create in nurses' subjectivity a constant 'line of fault' that they must navigate. This fault line separates the patriarchal ideology and nurses. Nurses

navigate this line of fault in ways such as repression and accommodation (Madoo Lengerman & Niebrugge (1996:485). This study found that participants navigate this line of fault by mechanisms such as the doctor–nurse game, a finding not supported by Porter (1992) but supported by Filkins (2003). It is suggested that these different findings result from the fact that this study and that of Filkins (2003) were from the perspective of directors of nursing, while Porter's (1992) was from that of intensive care nurses, where medical dependence on nursing is directly related to medical outcome. This study further found that directors of nursing navigated this line by repression and acquiescence; what they did not do was rebel or attempt reform at micro or macro organisational level (Madoo Lengermann & Niebrugge 1996:485).

7.5.4 The Marginal Position

According to oppression theory, individuals who distance themselves from their oppressed group to take a role nearer to the oppressor are termed 'marginal', which basically means that they do not belong to either society (Roberts 1983:22). Becoming marginal means that one is no longer part of one's peer group, nor is one a member of the powerful group: one is on the margin of both (Krech, Crutchfield & Ballachey 1962., Roberts 1983). Ambitious individuals have a tendency to 'assimilate' and become more like the oppressor, but to do this they must reject their own group's characteristics (Lewin 2000:109).

Marginality leaves these people without a cultural identity (Krech, Crutchfield & Ballachey 1962., Roberts 1983). They tend to uphold the virtues of the dominant society and are rewarded for this by being granted status and respect from the powerful. However, their power is not their own; they are dependent for their power and status on those structures. In powerless groups, 'marginal leaders' have been noted to have negative characteristics such as being controlling, coercive and rigid (Roberts 1997), attributes that have been associated with the traditional matron and may be perceived as 'Queen Bee' behaviour (Staines, Tavris & Epstein Jayaratne 1974:55). This repressive type of behaviour leads to divisiveness and competition among nurses (Bent 1993., Roberts 1997) and results in powerlessness and ineffectiveness (Traynor 1999).

Traditionally, there were ambiguities in the position of director of nursing. The healthcare system, including the profession of nursing, made management the route to professional viability and visibility and also to institutional power (Jones & Jones 1977). From the

perspectives of nurses at the front line of an organisation, these ambiguities serve to distance them from the position of director of nursing and to align the position with institutional management. In effect this means that, although the position of director of nursing is institutionally the most senior nursing position, it in fact does not represent nursing but institutional management.

In this study, participants could be viewed as an elite but also a marginal group in nursing, who succeeded because of their allegiance and maintenance of the status quo; however, the marginal position that they occupy between cultures is an ambiguous one. The position of director of nursing is affiliated to nursing, medicine and general management but is not fully accepted by any of these groups, including its own original group of nursing.

7.5.5 Status

Status is a structural component of a social system. It is described as the rank of a position or a group in the hierarchy of an organisation; status is a process of symbolic interpretation, and it is this interpretation that gives a position its significance (Krech, Crutchfield & Ballachey 1962); generally it symbolises privilege and social or organisational hierarchical inclusion (Lamertz 2002). Status is, according to Atwater and Van Fleet (1997), directly related to the number of males in any occupation. The main criteria identified with status are achievement, authority and power (Krech, Crutchfield & Ballachey 1962).

Status is an important concept in the study of the position of director of nursing; it refers to a structural position within the healthcare system and in nursing. (Ritzer 1996). However, according to Jolley (1994), nurses hold a relatively low status within the healthcare system because nursing abides by and follows the rules made by the more powerful occupations.

7.5.5.1 Status Consistency

Status inconsistency is where there is a poor fit between the status of the position and the functionality of that position. Status inconsistency appears to apply to the position of director of nursing because, while the position would appear, because of its title, to hold a

high degree of status, its level of power and authority (Jones & Jones 1977) is not consistent with a position titled 'director'.

This study found that following the Commission's (1998) recommendations there now exists a further status inconsistency for the position of director of nursing. Status inconsistency was further found generally in relation to the behaviour of unions and their representatives towards the position of director of nursing in ordinary industrial relations' business and during the national nurses' strike. It was also particularly evident when participants spoke about difficulties with general management in relation to their position and personal issues; they felt that because of their status they should have been treated differently.

7.5.6 Positional Marginalisation Vulnerability

The marginal position occupies an ambiguous one between different cultural groups; the holders of the position may feel affiliated to the different groups, but they are not fully accepted by any of them (Krech, Crutchfield & Ballachey 1962). This study found that this lack of affiliation of the marginal position to the relevant groups becomes evident when the groups in question, noticeably nursing, general management and unions, regroup and develop restructuring strategies.

7.5.6.1 The Role

What is typically expected of a nurse holding the position of director of nursing constitutes the role associated with that position. A role can be perceived as the duties or obligations of a given position. Societies have shared expectations of the behaviours of persons who occupy given positions. Thus, directors of nursing in this study had been socialised by nursing and the healthcare structures to the role expectations of being emotionally neutral, valuing patient care, refraining from gossip, avoiding public criticism of their institution and conducting themselves in a professional manner in relations with nurses, unions, medicine and general management (Krech, Crutchfield & Ballachey 1962).

The role is said to encompass the rights of the position. The rights of the position of director of nursing, as a marginal position, are defined by the roles of related positions: nursing, medicine, general management and, more recently, unions. Clearly this system of roles regulates the relations between the director of nursing and persons in the related positions (Krech, Crutchfield & Ballachey 1962).

Traditionally, directors of nursing knew what was expected from the position; however, in recent times the role of director of nursing changed when the roles of nursing, medicine, general management and the unions changed. This study found that the role is in the process of major, albeit in some respects subtle, change, and the definition of its position and role in relation to its traditional structures is unclear (Krech, Crutchfield & Ballachey 1962). The restructuring of the clinical and management nursing decision-making authority involved the transfer of authority and influence from the hierarchy of the position of director of nursing and the schools of nursing to third-level institutions, with nursing development initiatives coming down from nurse practice development units to directors of nursing, with increasing control by general management and with perceived strategic encroachment of unions in the management of nursing and nurses.

7.5.6.2 Role Conflict

Role conflict is inherent in the position of director of nursing. Role conflict exists when an individual simultaneously occupies two positions with different roles. The individual may experience difficulty and be unable to perform either role completely (Krech, Crutchfield & Ballachey 1962).

The position of director of nursing represents two distinct and different approaches to healthcare. The conflict is between high-quality patient care and cost-effectiveness. The director of nursing must integrate nursing patient care with the general management perspective. This raises conflict for directors of nursing, as nursing is primarily concerned with demand healthcare, that is, responding to the needs of individuals and authorising the professional interventions and processes required to fulfil those needs. General management, however, is chiefly concerned with supply healthcare, that is, sourcing the most cost-effective resources, and with quantitative inputs, outputs and outcomes (Davies 1995., Rickard 1996). This study found that participants identified little psychological

discomfort in dealing with this dual responsibility. This finding concurs with other findings in this study, where participants accommodate to the responsibility by rationalising that it is part of the job and so it is their responsibility to do it.

7.5.6.3 Role Theory

The role of director of nursing can be examined from the two major perspectives of role theory, namely the functional, or structural, and the interactionist, or symbolic, perspectives, as described by Hardy and Conway (1988).

The functional/structural perspective holds that roles in society are fixed and have certain expectations and demands and that behaviours are learned responses which are communicated during the process of socialisation. The symbolic/interactionist perspective holds that acceptable cognitions and behaviour are learned throughout the socialisation process through social interactions with others. Participants in this study were socialised with the perspective that the position of matron/director of nursing was the most prestigious in nursing. The traditional hierarchical systems of nursing management have for many years ascribed to that position the functional mechanisms of positional power and authority in the management of nurses (Hardy & Conway 1988).

The role changes to the power and authority of the position of director of nursing started in 1992 when the then Department of Health approved a proposal for major organisational and management restructuring at one of Dublin's major hospitals. From a nursing perspective, this restructuring meant changing from an almost totally centralised hierarchical structure to a decentralised flatter structure. These decentralised structures are referred to as clinical directorates or clinical divisions and are generally managed by a clinical director, a nurse manager and a business manager. To a lesser degree there may in some directorates be a directorate manager; this single position subsumes the functions of both the nurse manager and the business manager (Flynn 1998., Office for Health Management 1998a). The effect for the position of director of nursing of this style of healthcare delivery is that the assigned directorate or divisional nurse manager is responsible for nursing and nurse management within that area. This reduces the functional power and authority of the director of nursing in these areas, a structural change that was

fully supported at the launch of the Commission's report by the Minister for Health and Children (Department of Health and Children 1998).

Further to the strategy for healthcare Shaping a healthier future (Department of Health 1994), the style of the healthcare management system changed from an administrative culture to a management culture. This changed the way in which healthcare is resourced and managed. In particular, it shifted focus from demand-side thinking to supply-side thinking. New structures were developed to increase resource efficiency and effectiveness: resource management is constantly reviewed, and health-care outcomes are continually evaluated. These changes resulted, according to participants, in reducing nursing's control or input into the use of resources and in an increased general managerial control. For many participants it also brought a distancing to their working relationship with management, a finding which Rickard's (1996) study supports.

7.5.6.4 Power Dependency Theory

Power dependency theory is applicable to the vulnerability of the marginalised position. Power dependency theory holds that dependency is created through an inverse exchange relationship were power is held by one party over another (Ritzer 1996). The vulnerability of the marginalised position is exposed when other parties in the relationship withdraw their support from the marginalised position.

The healthcare system, including the profession of nursing, made management the route to professional viability and visibility and also to institutional power, albeit limited. Promotion and salary beyond a certain level depended on upward mobility through only one route, management. The management route for some provided not only occupational but also social mobility (Jones & Jones 1977).

Structural changes in the profession of nursing, in general management and in medicine working at holding its dominant position serve to demonstrate the vulnerability of this marginalised position by each developing itself at the expense of this position. Although the majority of participants in this study did not overtly attribute to the profession of nursing any negative changes to their position, a finding supported by Traynor's (1999) study, which also found that nurses were reluctant to see the profession of nursing as

implicated in any disruptive changes to their positions. This study found the profession of nursing, through the work of the Commission, to be the major driver in the positional vulnerability of the position of director of nursing.

Prior to the publishing of the Commission's recommendations, it was noted in Management in the Health Services: The Role of the Nurse (Flynn 1998) that nurses in Ireland are managed by the director of nursing/matron. However, following the Commission's recommendations, as was also found by Strong and Robinson's (1990) UK study, the position of director of nursing was marginalised. The Commission recommended that directors of nursing should focus on strategic planning and quality assurance, curious recommendations given that this study found that the majority of directors of nursing are not invited to the strategic table and some directors are not even invited to a management table. Those directors responsible for quality assurance would appear, as Strong and Robinson (1990) found, to have a responsibility that warrants greater clarity. However, the Commission's (1998) greater and more extensive management recommendations struck at the traditional structural heart of the position of director of nursing; it was these traditional structures that differentiated the position of matron/director of nursing and gave it status.

> To meet expected future needs the Commission has recommended that pre-registration nursing education be based on a four year degree...and be fully integrated within the third-level education sector. (:4)

> Structural reforms within nursing and midwifery management are required. There needs to be greater devolution of authority to nursing and midwifery management at the unit of care level...Middle nursing management needs to be given clearly delegated responsibility such as in the management of an area of care or designated functional responsibilities. The Commission considers first line management as essential to the effective operation and on-going development of a high quality health service. First line nursing and midwifery managers have to balance management skills with clinical credibility...The Commission recommends the development of first line nursing and midwifery management to fulfil the functions of professional leadership, staffing and staff development, resource management and facilitating communication. (:5–6)

> The introduction of an additional layer between directors of nursing and the office of the chief nurse:

> The Commission recommends the establishment of a Nursing and Midwifery Planning and Development Unit in each health board. The Commission recommends the Nursing and Midwifery Planning and Development Unit have the following general functions:

> Strategic planning and quality assurance of nursing and midwifery services in the health board area;
> Co-ordinating the delivery of nursing and midwifery services and improving co-operation between health board and voluntary bodies in the delivery of nursing and midwifery services;
> Working in partnership with the Chief Nursing Officer in the Department of Health and Children in planning and policy development on nursing and midwifery issues;
> Overseeing the detailed provision of continuing nursing and midwifery education within a health board;
> Liaising with centres of nurse education and health service providers;
> Developing, monitoring and reviewing the co-ordination and development of multi-disciplinary nursing service within a community care area;
> Identifying inter-nursing disciplinary and inter-agency training needs and promoting the development of an inter-nursing disciplinary and inter-agency training strategy;
> Reviewing significant issues in relation to inter-nursing disciplinary and inter-agency co-operation arising from the handling of selected cases; and
> Assisting in improving internal communication with nurses and midwives in a health board area. (7.17)

Traditionally there was an understanding that the director of nursing was vital in the overall nursing structures of indirect and direct patient care. The devolvement and decentralisation imposed by the Commission's (1998) recommendations have resulted in directors of nursing no longer being the voice of institutional nursing (Redmond 1995., Department of Health and Children 1998).

In accordance with the Commission's recommendations, Minister Cowen stated that 'I look forward to seeing Directors of Nursing...focusing more on strategic management of the nursing resource and contributing to the corporate policy of the hospital' (Department of Health and Children 1998:7). However, both parties neglected to take cognisance of the healthcare culture in which nursing functions and the use of power in that culture (Foucault 1982), where this study found not only are many directors of nursing not invited to the corporate table but many are not part of any local management structure, and where the management of 'the nursing resource' translates into merely the management of 'whole-time equivalents'.

This study found decentralisation of nursing authority without changes in forms of power outside nursing serves to perpetuate disunity in nursing (Hugman 1991). The way in which directors of nursing treat their workforce might be examined by how much the rules of the healthcare setting or other organisations or professional powers limit freedom of action. The restriction is to such a degree that no amount of training in management could affect

the management styles of directors of nursing to any considerable extent. A prerequisite to any needed change to the behaviour of directors of nursing is a change in how nursing places itself, and is placed by politics, medicine and general management, in the healthcare system (Lewin 2000).

7.5.6.5 Cognitive Dissonance Theory

In 1957 Leon Festinger developed cognitive dissonance theory. The theory holds that two cognitions are in dissonance when one belief is not in agreement with another (Krech, Crutchfield & Ballachey 1962). If a person is led to express outwardly an attitude which is incompatible with his/her private attitude, a state of dissonance is created in him/her. The theory holds that being psychologically uncomfortable will motivate the person to try to reduce dissonance and achieve consonance by avoiding situations, issues and information that are likely to reduce consonance (Jones & Jones 1977).

The uncomfortable state of cognitive dissonance can be reduced by a shift in inner attitude so that it corresponds more closely with the outward expression. The strength of the external force has been found to relate inversely to internal justification and shift in perspective. When the external forces which require the person to act contrary to his/her attitude are very strong, the magnitude of dissonance will be minimal; if the forces are weak, the dissonance will be maximal (Krech, Crutchfield & Ballachey 1962).

Generally, to resolve attitude imbalance and conform the neophyte nurse in the process of socialisation, it was found that this study's participants learnt early on, and continue to employ, mental defence mechanisms as described by the theory of cognitive dissonance.

For this study's participants the state of inner conflict was found to exist for directors of nursing chiefly in relation to the profession of nursing, to general management and, to a lesser extent, to the trade unions and to medicine. The main sources of conflict arose from inconsistency between the socialisation and learned expectations of directors of nursing and the new expectations of the position. The need of participants to deal with the tension created by this conflict (Lewin 2000) and to restore cognitive balance was evident throughout the dialogue of participants in this study, and the mechanism generally

employed to restore acceptable balance was the learnt cognitive and behavioural adjustment of acquiescing to/adapting to/accommodating to.

7.6 Conclusion

This study initially started from the perspective of examining the experiences of nurse leaders in Ireland. However, as the interviews and analysis progressed, it began to emerge that, although participants held the most senior position in institutional nursing, they did not operate from a leadership perspective or position. Leadership in terms of strategic decision-making rested in public and organisational politics, in professional nursing, in medicine and more recently in the rearguard strategic mobility of trade unions.

In accordance with the grounded theory approach, themes emerged through the process of the study; the core theme to emerge was that the position of director of nursing was marginalised in relation to nursing as an oppressed society. The vulnerability of this marginalisation was exposed by the Commission's recommendations, by changes in the organisation of acute care delivery, by reorganisation of general management structures and by the trade unions building on their 'success' in the national nurses' strike. Although these changes had for most participants an overall negative impact on their position, they did little to challenge the changes and chose overwhelmingly to 'acquiescing to/adapting to/accommodating to'.

In essence, this study evolved into one of the experiences of top-level nurses holding the position of director of nursing and found that the position of director of nursing in Ireland is marginalised and that the holders of the position learnt well through the nurse socialisation process that a good and successful nurse is one who conforms and maintains the status quo as determined by others.

7.7 Limitations of the Study

The substantive theory of positional marginalisation as developed in this study reflects the experiences of top-level nurses holding the position of director of nursing. While the study

endeavoured to be as complete as possible, inevitably there are limitations, and these are presented under two headings: limitations and assumptions.

7.7.1 Limitations

The limitations of this study include the following

- The substantive theory developed cannot be generalised because, in keeping with grounded theory methodology, participant selection was through purposeful and not random selection.

- Those who chose to participate may have different perceptions about the experience of directors of nursing from those who chose not to participate.

- Directors of nursing who took part in the study may not be representative of top-level nurses holding the position of director of nursing.

- The study population was limited to fifty.

- In grounded theory, as in all other qualitative approaches, the researcher is the major instrument of data collection and analysis, and therefore the outcome is influenced by the researcher's 'VABA' — values, attitudes, beliefs and assumptions. The researcher's ability to create 'distance' and the robustness of the researcher's intuitive and analytical ability can affect the outcome of the study (Porter 1993).

- The interview data collected for this study were the verbatim 'true' accounts of the experiences of top-level nurses and therefore reflect not entirely the human experience *per se* but more so the meaning that these experiences held for participants.

- The findings of the study relate to the particular time period during which it took place.

7.7.2 Assumptions

Also, in this study the following assumptions were made.

- The grounded theory approach was the most appropriate to the area under study.

- The list of hospitals, with information on general nursing band categories and psychiatric services, supplied by the Department of Health and Children and the hospital listing of the Voluntary Health Insurance (VHI) are accurate.

7.8 Challenges

7.8.1 Challenges to Nursing

This study found that the challenge for nursing and nurses is to develop an understanding that they, like other groups, are involved in the maintenance of the traditional balance of power in the healthcare structure (Torres 1981., Bent 1993., Porter 1995b). It is for nursing and nurses to develop sufficient maturity and confidence to accept that freedom to control one's destiny is not freely granted; it is earned and won through the initiative of those who have vision, will and support to fight for that vision (Torres 1981., Bent 1993).

The continued oppressive behaviour of collusion and acquiescence is, as described by McCall (1996:31), 'the darker side of nursing'. The challenge to nursing is to unite and change the power structures, a challenge corroborated by Filkins's (2003) study. To do this requires nursing to move away from solely internally focused examination to examination of the complex powerful external forces and processes that affect the world of Irish nursing (Porter 1994., Davies 1995., Porter 1995a, 1995b, 1997).

The continued lack of nursing interest found in politics and policy-making and described by Robinson (1992:5) as 'the black hole theory of nursing' presents another challenge. That challenge is to develop an understanding of the dynamics underlying leadership of an oppressed group in order to develop an effective strategy for establishing nursing's public and organisational political positions and developing its policy-making abilities (Roberts 1983).

A further challenge to nursing — not the central emergent theme of this study but one that, given participants' views, requires inclusion — is, as part of the development process of nursing, to redress actively the gender imbalance in nursing and to consider a strategy that

would give life to the Commission's recommendations 'that the Board examine mechanisms of increasing the number of male candidates applying to enter the profession' (Commission on Nursing 1998:5.28).

7.8.2 Challenges to Directors of Nursing

The data gathered for this study indicate that directors of nursing are aware of the forces which contribute to their behaviour. It was further found that participants had generally a passive way of thinking and behaving in relation to their position in nursing and in healthcare generally.

The choices facing directors of nursing are how they wish to interpret the changes taking place and how they decide to respond to them. The structures within which directors of nursing work may for many not be ideal; however, this presents them with a challenge (McCulloch, Helsby & Knight 2000). Taking the challenge means raising consciousness to change their socialised attitudes and behaviours with the aim of developing towards unity, empowerment (McCall 1996., Roberts 1996, 1997, 2000., Filkins 2003) and control of their own position.

7.9 Recommendations

The recommendations made in this study are presented under two broad headings: recommendations to the profession of nursing and to the position of director of nursing.

7.9.1 The Profession of Nursing

7.9.1.1 Education

In order to develop public and organisational political awareness, nursing should introduce political awareness and political lobbying skills in its educational curricula.

Assertiveness and negotiating skills should be developed through education and practice within the pre-registration and post-registration curricula.

7.9.1.2 Research

In addition to identifying and funding the development of technical and practical evidence-based knowledge, nursing research should also identify and fund the development of emancipatory evidence-based knowledge.

7.9.1.3 Unity Versus Horizontal Violence

Fundamental to the development of nursing is that the profession of nursing fosters a culture of affiliation and inclusion. Nursing through its many and diverse routes needs to study, examine and break the entrenched and damaging evolutionary and development obstacle of disunity. In this context it is important to examine the robustness of trade unionism in nursing.

7.9.1.4 Evolution

Fundamental to nursing evolution is for it to become independent, to control its own destiny and to take its place at the strategic apex of decision-making in public and organisational political arenas.

7.9.2 The Position of Director of Nursing

The position of director of nursing should assertively define the interests of the position:

- by examining its place in 'new' nursing in Ireland;
- by developing network systems of inclusion and trust;
- by seeking funded academic development parity with other nursing functions;

- by seeking from professional nursing functional developmental parity with other nursing functions;
- by seeking funded research parity with other nursing functions;
- by expressing through its professional associations its voice, in professional nursing, in trade unions, and in public and organisational politics;
- by taking its rightful place in corporate management;
- by radically examining for itself, for its function, for its post-holders and for the professional development of nursing its part in trade unionism in nursing;
- by developing leadership skills and using them to lead the position and the profession of nursing into the future.

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Appendix 1

LETTER OF INVITATION

Director of Nursing
Hospital/Service
Town/City
County

Dear…

Re: Research Study —

I am writing to request your participation in a research project to study the experiences of those nurses holding formal leadership positions. The information gathered from the study will be used to inform nursing and the healthcare system of the realities of top-level nursing.

I am a research student of the School of Nursing and Midwifery Studies and am undertaking this study as the requirement for a Ph.D. ... is supervisor for this project. Formerly I held a position of director of nursing…

I wish to interview top level nurses to find out their experiences. I have focused my study entirely on the viewpoints of directors of nursing as they have experienced the opportunities and barriers to nursing during their careers and during this period of change in nursing and healthcare generally.

Information from the study will not focus on any one individual's views but on the views of all participants in the study. Extracts from interviews may form part of the final report of the research findings; in this event they will be used anonymously, with any identifying information being deleted or disguised.

A list of the research interview topic questions is enclosed for your consideration. The approximate interview time is one hour, and, with your permission, the interview will be tape-recorded. Your responses to the interview will be kept strictly confidential. The tape will be stored in a locked cabinet in my home. The tape will be coded so that your name does not appear on it. The coding of the interview facilities the transcription and analysis phases. All tapes will be destroyed at the completion of the study. Should you wish, you will be given the opportunity to view transcripts for accuracy. The study's results will also be made available upon request.

Your participation in this study is entirely voluntary. You have the right to withdraw from the study at any time; and, should you wish, you may abstain from answering any question. Your identity will be kept in strict confidence.

Should you require any further information please contact me at my home address or mobile…

Your help in this research project would be greatly appreciated. At your earliest convenience, I would be grateful if you would read and sign the attached form and return in the stamped addressed envelope.

Thank you for your time and consideration of this request.

Yours sincerely,

Encl: Consent Form

Appendix 2

CONSENT FORM

Informed Consent Form

Dear Researcher,

I the undersigned agree to voluntarily participate in the research study of the …, undertaken by…a doctoral student in the School of Nursing and Midwifery Studies, Trinity College Dublin.

I understand that participation in the study is entirely voluntary and I may withdraw from the study at anytime. I understand all responses will be treated and kept strictly confidential. I understand that my identity and that of all others participating in the study will remain confidential.

I confirm that quotations from the interview can be used in the final research report and other publications. I understand that these will be used anonymously.

Signature:

Date:

Dear Researcher,

I the undersigned do not wish to participate in the research study of the…, undertaken by…a doctoral student in the School of Nursing and Midwifery Studies, Trinity College Dublin.

Signature:

Date:

Appendix 3

INTERVIEW GUIDE
Research Study —

What title comes with your position?
How long have you held your current position?
Can you give a brief description of your hospital/service?

Career Planning
Was nursing your first career choice?
How did you plan your career?
How did you choose your current speciality?

Influence/Support
People sometimes refer to 'a giant at my shoulder' when describing someone who has influenced them. Did you have someone who guided/supported/influenced you in your professional life?
Would it have mattered to the relationship and to your professional development if that person were male/female?
How relevant do you think guides/supports are to one's career development?
What professional experiences were important/crucial to you in the development of your career?

The Position
How would you describe the official role/function of your position in your hospital/service?
In reality how clear is the role/function of your position?
Are you a member of the board of management?
If yes, how effective is that for you?
If no, why is that so?
How do you balance managing the daily routine while at the same time bringing about change?
How do you balance the organisational demands of your hospital/service with the demands made on you by nursing matters?
How are decisions affecting nursing development and service delivery made?
In your hospital/service how involved are you in decision-making, in the delivery of those services other than nursing?
What input do you have in planning your budget?
Do you manage your budget?
How did you learn to do your job?
How would you describe your preferred approach/style to getting the job done?

Professional Relationships
To whom do you report?
How do administrative reporting relationships impinge on your role?

How would you describe at your level the nursing/medical working relationships?
How do these medical relationships impinge on your role?
What other professional relationships are you involved in?
The network system with other nurse leaders: how does it function?
In your position what supports do you have?
Do you ever feel a sense of isolation in your position?

Career Experiences
Based on your career experiences:
What aspects of your work have you found most satisfying?
What have been your biggest challenges?
What are some of the experiences you did not find satisfying?
It is said that nursing is over managed and under led; what has been your experience?
Do you think gender plays any part in relation to career/professional experiences?

Personal Investment
What is your degree of personal investment in your work?
How would you describe the relationship between your work and your life outside of work?
Do you think the rewards you get from your work are proportional to your investment in your work?

Professional Opinion
What is your opinion of nursing at this time?
What are the important issues for nurse leaders today?
What is the role of nursing in the overall healthcare system?
The role of nurses/nurse associations in healthcare policy issues, what is it?
What is your preferred vision for nursing in the future?
What does nursing have to do to achieve that vision?

Concluding
Is there any aspect of your experience, as chief nursing officer/director of nursing/matron that I have failed to ask which you would like to share?

Biographical details
Age at entry into nursing training?
First nursing qualification obtained?
Country of first training?
Other nursing qualifications obtained?
Countries of further training?
Additional training?
Civil/Marital Status?
Length of time since first qualifying and obtaining first leadership position?

THANK YOU.

Appendix 4

REMINDER LETTER TO LETTER OF INVITATION

Director of Nursing
Hospital/Service
Town/City
County

Dear…

Re: Research Study —

Some weeks have passed since I wrote, seeking your participation in the study.

Perhaps you have not had the opportunity to consider your position in relation to the study or perhaps there are questions you would wish answered.

Your response to the study would be much appreciated. Enclosed please find a copy of the original explanatory letter, interview guide and consent form. Thank you for your consideration of this request.

Yours sincerely,

Encl: Letter of Invitation
Consent Form
Interview Guide

Appendix 5

ACKNOWLEDGEMENT OF RECEIVED CONSENT FORM

Director of Nursing
Hospital/Service
Town/City
County

Dear…

Re: Research Study —

Many thanks your letter received today. Your consent to participate in the study has been received with thanks.

Interviews are scheduled to take place in your area…
perhaps I could telephone next week to arrange an interview time, convenient to your schedule.

I very much appreciate your decision to participate in the study, as this allows the research to be as complete as possible.

Yours sincerely,

Appendix 6

INTERVIEW CONFIRMATION

Director of Nursing
Hospital/Service
Town/City
County

Dear…

Re: Research Study —

Further to our telephone conversation, thank you for agreeing to participate in my study. I confirm the interview date and time…

With appreciation,

Yours sincerely,

Appendix 7

PRE-TEST OF DATA COLLECTION INSTRUMENT

Research Study —
Pre-test — Data Collection Instrument — Interview Guide.

Thank you for agreeing to critically examine the enclosed interview guide.

The research questions are:

- How do top-level nurses engage in leadership in the given context?
- What experiences do nurse leaders have in their careers?
- How do organisational processes affect them?
- How do conflicting demands impinge on them?
- How do the support processes function at their level?
- Does gender impinge on professional experiences?
- What is the place of nursing in the healthcare system?
- What is the preferred future for nursing?

I would be grateful if you would critically examine the guide on the following:

- Has the researcher included all of the questions necessary to explore the research questions?
- Do you think the questions will elicit the types of responses anticipated?
- Will the language in the interview guide be meaningful to the intended participants?
- Are the questions clear?
- Are all questions free from double meaning or multiple issues within the one question?
- Are sensitive questions phrased correctly?
- Would the interview guide, as developed, motivate potential participants to participate in the study?

Thank your for agreeing to participate in the guide's pre-test and for giving your time.

Encl: Interview Guides

Appendix 8

PILOT STUDY OF DATA COLLECTION INSTRUMENTS

Research Study —
Pilot study — Interview Guide.

Thank you for agreeing to participate in the pilot study of the enclosed interview guide.

The research questions are:

- How do top-level nurses engage in leadership in the given context?
- What experiences do nurse leaders have in their careers?
- How do organisational processes affect them?
- How do conflicting demands impinge on them?
- How do the support processes function at their level?
- Does gender impinge on professional experiences?
- What is the place of nursing in the healthcare system?
- What is the preferred future for nursing?

I would be grateful if you would critically examine the guide on the following:

- Has the researcher included all of the questions necessary to explore the research questions?
- Do you think the questions will elicit the types of responses anticipated?
- Will the language in the interview guide be meaningful to the intended participants?
- Are the questions clear?
- Are all questions free from double meaning or multiple issues within the one question?
- Are sensitive questions phrased correctly?
- Would the interview guide, as developed, motivate potential participants to participate in the study?

I would be grateful if you would critically evaluate the research interviewer on the following:

- Use of opening salutations
- Questioning skills
- Listening skills
- Use of tape recorder and note-taking
- Ability to make interviewees comfortable and put them at ease
- Bringing closure to the interview

Thank you for agreeing to participate in the pilot study of the interview guide and the interviewer skills and for giving your time.

Appendix 9

INTERVIEW EXTRACTS

This appendix contains two interview extracts converted for data management and analysis by the text-based data program Ethnograph v5.0.

(i) Extract

Researcher: Are there any professional 85 -#
experiences that you think were 86 #
crucial in how your career developed? 87 #

Participant 0: I think my exposure to the 89 #
clinical teaching...and observing the 90 #
way in which we, ill-equipped nurses to 91 #
go out and deliver care...where much of 92 #
the style, you learned from somebody 93 #
else that you're working with, if they 94 #
happened to be a good nurse that was 95 #
huge, that's a great way to learn 96 #
nursing; if they're not good it isn't, and 97 #
looking back on it I suppose we can 98 #
all pick out four or five magnificent 99 #
nurses, I suppose is the best way to 100 #
describe it, who are really tops, but 101 #
the rest of us are run of the mill, 102 #
we're ordinary we don't stand out, and 103 #
I think if, if we're going to learn, I 104 #
think we should learn from the best. 105 #

Researcher: Okay 107 #

Participant 0: And that influenced my path 109 #
more than anything, the way we were 110 #
actually teaching people and expecting 111 #
them to deliver care. We were ill 112 #
equipping people to be able to go out 113 #
and care for somebody. Nursing to 114 #
me meant one word, caring. I think if 115 #
we expand on that word we find out 116 #
what we're actually doing. I think 117 #
in talking about the challenge we 118 #
have facing us, I think it is, in 119 #
defining what caring is, that 120 #
is the major professional issue. 121 #

Researcher: And do you think that 123 #
was missing in the way 124 #
nurses were taught? 125 #

Participant 0: Yes, I think we learnt a 127 #
whole lot of things by rote, we learnt 128 #
how to do a whole lot by rote. I 129 #
think the selection process was 130 #
unscientific; I think we selected a 131 #
whole lot of people who were very 132 #
caring without the ability to deliver 133 #
the care. I think we're now running the 134 #
danger of selecting a whole lot of 135 #
people who have academic 136 #
qualifications but don't have the 137 #
caring component. I have a major 138 #
difficulty with the way we 139 #
select students. 140 #

Researcher: Okay 142 #

Participant 0: I think we're going to 144 #
have to increase the number of people 145 #
we are training to allow for the drop 146 #
out of people who are not going to 147 #
stay. 148 #

Researcher: Mmm 150 #

Participant 0: All of that has and does 152 #
influence me professionally… 153 -#

(ii) Extract

Researcher: To progress your career, 195 -#
you took an option of moving…? 196 #

Participant 00: I would look at my position 198 #
in…as a management position because I 199 #
was managing a ward, managing 200 #
nurses…so I decided that I was going 201 #
to stick with management, because I 202 #
didn't really have any other option, 203 #
it was education or management as far 204 #
as I was concerned and I didn't want 205 #
to go into education full time. I knew 206 #
I needed a career change; I was…years in 207 #
the position. I knew I had reached all my 208 #
goals and my targets. I knew I had 209 #
done everything that I could do, and I 210 #
felt that it was time to move on. I 211 #
didn't plan to go to…I just 212 #
planned that my next position after 213 #
ward manager would be assistant 214 #
director of nursing, unit nursing 215 #

officer or whatever came in that line. 216 #
It just happened to be the first job 217 #
that came up. Then my move to director 218 #
of nursing, I had heard that 219 #
...was a nice hospital. 220 #

Researcher: You went for it? 222 #

Participant 00: Exactly, so that was my 224 #
plan. 225 #

Researcher: And were there people 227 #
along the line that influenced you or 228 #
supported you? 229 #

Participant 00: Yes, I worked with a 231 #
director of nursing once in the past 232 #
who was a very dynamic person. A 233 #
person that you needed to stay on the 234 #
right side of, but probably would 235 #
have guided me a lot when I was a ward 236 #
manager, and encouraged me to get 237 #
involved in lecturing, teaching, 238 #
education and would have, when I went 239 #
to do a diploma in management at that 240 #
time, because that was what you did, 241 #
would have given me the day's 242 #
release every week and paid for it and 243 #
that was back in…so I would have 244 #
looked on that director, yes, as a leader to put 245 #
me in the right direction. 246 #

Researcher : Were there any other people 248 #
you can think of? 249 #

Participant 00: I worked…with a consultant 251 #
at the time in the area I was in…and 252 #
…was very good as well, I must say. 253 #
…was very much involved in education 254 #
and nurses being involved in 255 #
education. So…probably would have 256 #
encouraged me down the research side, 257 #
and the director would have encouraged me down 258 #
the management side, so yes I would 259 #
have... 260 -#

Appendix 10

JOURNAL EXTRACTS

This appendix contains four journal extracts.

Extract 1

Participants' real thinking in a lot of the cases seems to be 'annoyance' at what they perceive as the poor treatment they receive from, for example, unions/union representatives. While this poor treatment seems to throw them, still they do not retaliate. In the course of the interviews they are not happy in relation to how they are treated, but on probing there is little evidence of any action taken in response to their objections or unhappiness. They seem to not go into/gloss over any crucial analytical examination of their situation.

It is the acceptance of the world they live in 'as that's the way it is'; I just get a sense of 'what can we do about it?' and the feeling that when they are confronted by unions, for example, it is like exposing the powerlessness of their positions, but they don't seem to be aware of that. They seem angry at the unions and the situation they find themselves in. Why is there fear/reluctance to confront these issues which appear very much to affect their position?

Extract 2

A question: if nursing sees itself as being at the margins in terms of its importance or place with other disciplines, why has it not sought to do anything about it for itself?

Point 1

Sunday, 17 February 2002, RTE, Radio One (11.45–13.00), Focus on the New Health Strategy. While doing this study I have become more aware of the position of nursing in making itself public or voicing its opinion on healthcare issues and find that it never seems to speak out on issues. I was aware of this during this radio discussion on the new Health Strategy. There were comments from the invited patient groups, general practitioners. No nurses took part either on the invited discussion panel or the telephone-in comments. Why?

In thinking about this, perhaps there are issues such as pre-1974, when women once they married could only hold temporary positions, leaving matrons (single) and mostly junior staff, so it wasn't like other professions where people stay and develop with the job. But 30 years have passed. How much does the pre-1974 marriage bar or such like affect the whole notion of nursing now in not being able to direct itself?. What it is: that is the question. Nursing just accepted the way it was then and now just accepts the way it is now!!!

Point 2

Directors of nursing seem not to be in control nor to take control in issues such as 'acting'; they seem to just wait for employers to appoint them.

Why have directors of nursing not questioned this nor how the changes affect their position, changes such as in order for a nurse to take up clinical management posts it is 'good' or required that the nurse have third-level qualifications. What is at play with the powers that be in nursing and or elsewhere that the position of director of nursing was not given the same weight in terms of development? It seems that to be a director of nursing these (additional educational) requirements are not necessary. Why have participants not challenged this?

Extract 3

Is it possible that participants are and feel 'on their own and isolated', unsupported by the nursing establishment, and are out of their depth when dealing with issues of importance to them? What is it about their preparation and training that did not prepare them confidently to deal with issues at this level, or is it the whole set-up in healthcare that contributes?

It seems to be a national habit that participants adapt when confronted with (certain) issues and they adopt, it seems, the lifelong position that nurses have learnt to adopt, that is; say nothing, get on with it, make the best of it. It would appear they don't want any trouble because the 'power of their own establishment will not be there to support them'. For example, they say that, if An Bord is asked a query about a nursing issue, An Bord says 'your organisation will sort that, not us'. Would that reply be accepted by any other group?

Extract 4

Glaser states GT [grounded theory] is about thinking; I am thinking constantly: am I on the right path and doubling back to the literature to see if I am. Then I have to remind myself that Glaser states 'leave the literature, it will still be there when you finish' — but I suppose my anxiety would be that I might be going on the wrong track, must check-in.

From many of the interviews, I am moving towards realising that a lot of the participants engage in possibly denial of what the situation is because it appears that they feel that, as the position is perceived as being more powerful than it is, what do they do? They feel they work in isolation, really; some say there is support, but trust,I think, is the magic missing factor in the groups. Some talk about some fellow directors being more 'in' with 'those in high places' and might tell 'tales', feedback stories from group meetings, the continued story of disunity, I think.

Appendix 11

CODED INTERVIEW EXTRACTS

This appendix contains two coded interview extracts; coding management employed the text-based program Ethnograph v5.0.

(i) Extract

Single codes were applied in this extract.

#-INFLU
Researcher: Just going back to when you 536 -#
were coming through your nursing 537 #
career or before and looking at 538 #
influences, which some people describe 539 #
as a giant at my shoulder. Is there 540 #
anybody that you remember influencing 541 #
you? 542 #

Participant 000: I suppose the biggest one that 544 #
would have influenced me in my career 545 #
would have been a woman called...and 546 #
she was a tutor in the hospital where I 547 #
trained in. She looked after us and 548 #
she minded us, I think she was, 549 #
she was just brilliant, she was a tutor 550 #
there. She retired there recently, and 551 #
we still have lots of contact with her, 552 #
we always do. So, she would have 553 #
influenced me hugely and continues to. I 554 #
remember being overseas and writing to 555 #
her for advice on…She was a huge 556 #
influence. She would have been the 557 #
biggest influence. If you were sick as 558 #
a student she took care of you, but, if 559 #
you pulled a 'sickie' and you weren't, 560 #
that was a different ball game, but you 561 #
wouldn't. To students who needed 562 #
help she was brilliant. 563 -#

#-INFLU RELV
Researcher: Do you think having someone like 565 -#
that is relevant to one's career 566 #
development? 567 #

Participant 000: Well, of course, now there are some 569 #
people who I work with, who trained 570 #
under her and feel that her loyalties 571 #
were..., but I think they were a 572 #
bit daunted by her. She was very 573 #
professional; you wouldn't do 574 #

something slap dash with her, you do 575 #
it right. I think she has made me look 576 #
out for staff the way she looked out 577 #
for staff. She was certainly a big 578 #
influence to me. 579 #

Researcher: And, do you think if someone had 581 #
come through training and didn't 582 #
have someone like that would it 583 #
make a difference? 584 #

Participant 000: I suppose everyone you meet 586 #
influences you, I suppose, oh I don't 587 #
know, I suppose if I had been dealing 588 #
with a battle axe who treated me badly 589 #
all the time, I don't know if I would treat 590
my junior colleagues like that 591 #-

(ii) Extract

In this extract single and multiple codes were applied.

#-TOKEN $ RELAT MED
Researcher: Are you an equal member of the 1166 -#-$
management team? 1167 #

Participant 0000: Yes, even though Doctor... 1169 #
would give me an argument on that 1170 #
because in accordance to the 45 Mental 1171 #
Treatment Act I should be accountable 1172 #
to the clinical director, who used to 1173 #
be the old medical superintendent, and 1174 #
[the clinical director] still sees the role very much that 1175 #
way. But that's a national problem 1176 #
for every CNO or matron or director. 1177 -#-$

#-ROUT V CH $-STYLE
Research: How do you balance that kind of 1179 -#-$
Issue, and while bringing in the 1180 #
changes? 1181 #

Participant 0000: I think I am a good 1183 #
Delegator; I am able to delegate a lot 1184 #
of work. I think that people work 1185 #
better when they are taking on 1186 #
responsibility and are operating 1187 #
themselves. I am available to them 1188 #
at all times, and so we meet once every 1189 #
day, at least once a day, to talk 1190 #
formally. We'd meet, usually in the 1191 #

morning at about…or so. We'd get 1192 #
together and meet, and that might take 1193 #
an hour or whatever. They run 1194 #
things past me, and I'd say okay or not, 1195 #
I would give reasons why not. 1196 #
Occasionally I say, 'look, try to 1197 #
handle this yourself, try to manage this 1198 #
yourself'. I let them know what hasn't worked in the 1199 #
in the past because of A, B and C. Then let 1200 #
them deal with it; they can come back. I 1201 #
think that sort of system works well. 1202 -#-$

...#-BUDGET MGT
Researcher: Do you manage your 1293 -#
own budget? 1294 #

Participant 0000: Not really. I have an idea from 1296 #
the beginning of each year. I don't 1297 #
get the budget. 1298 #
...What we do is I keep a 1315 #
weekly profile here of what staff we 1316 #
employ, the sickness rate, the 1317 #
overtime rate, the reasons why, 1318 #
especially if there is a great drain 1319 #
on our resources. 1320 -#

Appendix 12

SUMMARY OF FINAL CODING

This appendix contains all the study's codes. The codes are presented in three layouts:

(i) Coding Derived from Interview Guide
(ii) Interview Vivo Codes
(iii) Interview Vivo Derived Codes

(i) Coding Derived from Interview Guide

Opening:
Title-Length; Hosp/ser; Band

Career Planning:
Car choi; Car plan; Car path; Cur post

Career Experiences:
Exp sat; Exp chal; Exp nt sat; Mgt led; Exp gen

Influence/Support:
Influ; Influ gen; Influ relv; Influ exp

Investment:
Inv person; Wok lif ot; Lif ot wok; Inv p rew

Position:
Rol off; Rol real; Rol descpt; Role respbl; Or mgt str; Token; Rout v ch; Mgt nr; Rol auton; Outside nr; Budget pl; Budget mgt; Learn job; Style

Professional relationships:
Report; Relat adm; Relat med; Relat pro; Supt net; Supt org; Supt oth; Isolat

Professional Opinion:
Nr now; Facing; Nr rol hcs; Nat h pol; Vision; Vson ach

(ii) Interview Vivo Codes

Account; Acting; An Bord; Afraid

Bonus; Bullying

Care Assistants; Cardev; Carguid; Chin nr; Comm; Comp study; Cutbacks1980s

Definte nr

Empower nr; Erosion

Gdforme; Gen Mix

Finan rem

IT

Job interv

Lac; Lave post

Male; Marriage bar; Matron; Mgt compet; Men; Mentor staf

Nr Train; Nr appreciation; Nr ed; Nr policies; Nr clinical issues;
Nr train pre-late 60s; Nr leaders; Never

Old staff shortage; Othr se us; or mgt str

Pass up; Promot; Prp; Politics

Relat others; Relat staff; Role model; Rol hcs

Salmon; Self mgt; Serv struct; Scope of p; Serv plans; Sisters Seniority;
Stressful; Strike

Unions; Unnoticed

Women

1970s

(iii) Interview Vivo Derived Codes

Achieve

Before 1970

Change; Ch nr pr comm; Ch nr pt comm; Ch self; Ch rol; Ch org; Ch hcs; Ch pr; Ch society; Ch heal cr; Ch mgt st; Ch nr comtt; Clinical; Cl dtorate/cl dir; Compar; Comm

Dev hs; Dev self; Dev staff; Dev org nr; DoN Comm;; DoN Exp; DoN future; Dross

Future nr; Future

Gcom dev; Gender mix; Gen + Psy

Hb struct; H strat; Hosp Policy; Hosp struct;

Inv strg; Inv op; Invol comu

Lave post; Leader sup staff; Life span

Mal matron; Mobile; Mov adm

NHS; Nr impact; Nr struct

Old budget; Operate; Or sup ser; Or struct; Or mgt str;

Per achiev; Politics org; Present; Projects; Prop m/f; Psy

Reality; Rol des

Salary; Sup; Supt net p; Supt net t; Supt hb

Term; Third level

Work load

Diagrammatic Coding and Analysis

This appendix presents the study's coding and analysis:

The Context

Contextual Conditions: Irish Nursing in Context

Linkages	Categories	Codes Selected
Nursing Gender Society	Career Choice	Car choi; Car path; Rol hcs;
	Gender Issues	Marriage bar; Car path; Exp gen; Past; Nr now; Rol real; Nat h pol; Rout v ch;
	Men	Exp gen;
	Female Identity	Exp gen; Psy; Men; Influ gen;
	Gender Balance	Exp gen; Cur post; Car path;
Medicine	Medicine	Or struct; Nr now; Nat h pol; Relat med; Rol auton; Ch nr pt comm;
	Handmaidens	Rol auton; Budget mgt; Nr rol hcs; Pass up
General Management	G. Management	Nat h pol; Relat adm; Ch nr pt comm; Style; Unions; Mgt nr; Rout v ch; Exp nt sat;
Politics/Policy	Politics	Cutback80s; Nat h pol;
	An Bord	Nat h pol; An Bord; Unions;
	Political Life	Nat h pol; Nr now; Exp sat; Future; Nr role;
	Representation	Nat h pol; Unions: Ch nr pt comm; Vision; Relat med;
	Commission	Ch nr pt comm; Mgt led; Title; Comm;
	An Bord	Nr now; Scope of p; Ch nr pt comm;
	Government	Nat h pol; An Bord; Nr now; Vision; Politics; Unions; Ch nr pt comm;
Economic and Social Change	Change	Nr now; Ch society;Ch nrpt comm; Inv p rew;
	Strike	Strike; Exp nt sat; Nr now; Nat h pol; Nr rol hcs; Facing; Unions; Ch nr pt comm;
	Public Esteem	Nr now; Nr rol hcs; Strike; Nat h pol;
	Outcome	Inv p rew; Finan rem;
Where to From Here?	Future	Nr rol hcs; Vision; Psy; Nr now; Nat h pol; Unions; Salary; Vson ach; DoN Future; Ch nr pt comm; Finan rem; Facing; Comm;

Basic Social Psychological Problem

Linkages	Categories	Codes Selected
Position of Director	Responsibility Professional Relations Community Relations Life-Time Role	Mgt nr; Style; Isolat; Relat adm; Exp sat; Relat pro; Invol comu; Hosp/serv;
Professional Identity	Training-Role Models	Influ; Politics;
After Training	Role Models Development Education	Influ; Influ exp; Exp nt sat; Influ; Influ; Influ relv; Exp nt sat; Nr now; Learn job; Dev staff; Car path;
Professionalisation	Effects	Comm; Pass up; Nr rol hcs; Nr now; Unions;
Director of Nursing & Medicine	Prevent Development Doctor–Nurse Game	Style; Rout v ch; Relat med; Rol auton; Relat med; Exp sat;
Organisational Health — Structure	Meeting Structure Corporate Effect Reporting Structures Social Capital	Or mgt str; Serv struct; Acting; Relat adm; Facing; Or mgt str; Relat adm; Report; Strike; Report; Relat admin; Rol auton;
Organisational Health — Culture	Empowerment Psych-Contract	Relat pro; Exp nt sat; Isolat; Rol real; Supt net; Learn job; Relat adm; Relat med; Or mgt str; Inv p rew; Exp nt sat; Relat adm; Acting;
Industrial Relations Project	Unions The Strike After The Strike	Unions; Acting; Facing; Strike; Exp nt sat; Ex chal; Nr strut; Strike; Exp chal; Exp nt sat; Salary; Ch nr pt comm; Title; Prp; Title; Length; Supt net; Hosp/serv; Unions;
Internal Organisations	Comradeship-Peers Trust	Supt net; Report; Budget mgt; Mgt led; Supt net; Unity; Supt org; Acting; Relat med; DoN future; Nr rol hcs;

Basic Social Structural Process — Positional Vulnerability

Linkages	Categories	Codes Selected
Restructuring Irish Nursing	Commission Pre-Reg. Education Plan/Develop Units Nurse Management Restructure DoN Clinical Direct/Div	Comm; DoN future; Nr now; Finan rem; Facing; Facing; Comm; Relat adm; Comm; DoN future; Ch nr pt comm; Comm; Cl dtorate; DoN future; Style; Hosp Struc; Relat staff; Relat adm; Or mgt str;
Unions	Filling the Gap Inter-Union Rivalry	Mgt/struc nr; Unions; Rol auton; Comm; Influ exp/chal/relv; Nat h pol; Vson chal; DoN unity; Lac; Unions; Ch nr; Exp nt sat; Mgt led; Nr now; Exp gen;
General Management	Empire Building Report Structures Financial Structure Service Plans	Ch hcs; Or mgt str; Report; Budget mgt; Relat adm; Serv plans; Serv struct; Hb struct; Psy; Relat adm; Rol real; Nr now; Or mgt str; Report; Rout v ch; Rol auton; Ch nr pt comm; Budget mgt; Or mgt str; Serv plans; Psy; Serv plans; Rol auton; Prp;

Basic Social Psychological Process—acquiescing to/adapting to/accommodating to

Linkages	Categories	Codes Selected
Cognitive Recognition	Profession of Nursing Unions General Management	DoN future; Facing; Nr now; Rol real; Rol ch; Ch org; Serv plans; Relat nr; Unions; Nat h pol: Relat adm; Exp nt sat; Exp chal; Hb struct;
Cognitive Reflection	Profession of Nursing Unions General Management Corporate Effect	DoN future; Exp nt sat; Supt net; Dev staf; Ch heal cr; Strike; Unions; Nr now; Nat h pol; Budget mgt; Relat adm; Ch nr pt comm; Report; Rol auton; Relat adm; Token; Ch mgt str;
Behavioural Response	Profession of Nursing Unions General Management	Style; Rout v ch; Cl dtorate; Nr struct; Relat med; Ch nr pt comm; Relat pro; Unions; Nr now; Exp chal; Or mgt str; Supt hb; Exp nt sat; Influ; Influ relv; Influ gen; Erosion; Car path;

Appendix 14

VALIDITY CHECK — INTERVIEW TRANSCRIPTS

Director of Nursing
Hospital/Service
Town/City
County

Dear…

Re: Research Study —
Interview Transcript Validity Check

Thank you for taking part in the research interview on…and for your continued participation in this research study. The aim of this study, as you know, is to offer a glimpse of nurse leaders' own perceptions of their career experiences.

In order to give a valid account, the researcher in the analysis of the interview data is advised to take steps to ensure she remains close to the nurse leaders' own perceptions of their career experiences and to offset her own bias and subjectivity.

As the researcher for this study, I have chosen as one means of ensuring validity the method of returning interview transcripts to participants, with the purpose of requesting participants to identify their major/main points in their interview. The aim of this measure is to produce two lists of headings — the participant and the researcher's list. It is ideally recommended, that following receipt of the transcript from you, I would contact you by telephone to discuss the main/major points that emerged for both of us on reading your interview transcript, and, following discussions, adjustments may be made to the coding of the interview. However, the reality of your work commitments may determine that this part of the process is not a feasible option for you.

As agreed, please find enclosed a copy of your interview transcript. I would be grateful if you would (a) read through your transcript, jotting down what emerges for you as the main/major points of your interview and returning the transcript in the enclosed stamped addressed envelope and (b) indicate if you wish further discussion on your interview. Your continued participation in this study is very much appreciated. I look forward to receiving your thoughts.

Yours sincerely,

Encl: Interview Transcript

Appendix 15

VALIDITY CHECK — STUDY'S FINDINGS

This appendix contains two items: Letter of Confirmation and Summary Overview

LETTER OF CONFIRMATION

Director of Nursing
Hospital/Service
Town/City
County

Dear…

Re: Research Study —
Validity Check

Further to our telephone conversation, thank you for agreeing to meet with me to discuss the study's findings.

As agreed, please find enclosed a summary overview of the study's findings. Your continued participation in this study is much appreciated. I look forward to meeting you on…

With appreciation,

Yours sincerely,

Encl: Summary Overview

Appendix 15

SUMMARY OVERVIEW: EXPERIENCES OF TOP-LEVEL NURSES

This nationwide study's purpose was to examine, explore and analyse the experiences of fifty female and male nurse leaders holding the position of director of nursing. Using grounded theory methodology, the study examined and described, from the perspectives of directors of nursing, their career experiences. From these perspectives this study found that leadership is not enacted in Irish nursing, and thus the study's focus shifted from leadership to top-level nursing.

The study places Irish nursing in the context in the healthcare system, and the position of director of nursing as a constituent of that system.

Contextual Factors — Irish Nursing

This study found that nursing within the healthcare system continues to be the major healthcare supplier; however, it continues to be a minor strategic player. Other professions such as medicine and general management act as the major forces in strategic influence and decision-making. Within this system nursing has been and remains controlled and 'oppressed' by these dominant forces.

This study took place during a period when nursing was in transition. This transition started in the 1990s with industrial unrest. Although initially this unrest caught the trade unions off guard, they quickly rallied and established themselves. This study found that, since the national nurses' strike (1999), trade unions are increasingly visible and active in all aspects of nursing.

This study found that, while the Commission on Nursing (1998) did tremendous work to progress the technical and practical knowledge of nursing, it did little to progress towards an understanding of nursing in terms of manifesting its own destiny. During the time of the study, nurse education moved from training based in hospitals to education at degree level in third-level institutions. Overall, participants welcomed the move; their wish is that education would develop a belief system in nurses' esteem of their judgement, value and worth. However, they did not wish to see an erosion of bedside nursing as they felt that this is where student nurses learn nursing assessment of patients' health status and learn in 'vivo' the delivery of nursing care.

The Position of Director of Nursing

For the participants of this study, nursing offered only one significant route of success: through management. In order to succeed these nurses had to show that they were better than their colleagues and would, on behalf of the organisation, manage nurses and nursing. In return they achieved the ultimate position of success which was 'matron' or 'chief nursing officer', now director of nursing. In obtaining this position participants, were placed between nurses, medicine and general management. This in between positioning is referred to as 'marginal'. A marginal position rests on the boundary between groups. The holders of the 'marginal' position are affiliated to the different groups but they are not fully

accepted by any, including their own group. As a marginal position, this study found that the position of director of nursing is not central to any group, as indicated by changes such as:

- the Commission on Nursing, in recommending the general restructuring of nursing, gave least attention to the outcome of the restructuring on the position of director of nursing,

- the Commission on Nursing's recommendations provided for less development for the position of director of nursing than any other position,

- the structural alterations in general management reduced the status of the position of director of nursing relative to general management structures,

- clinical directorates/divisions or similar changes shift medicine's relationship away from the position of director of nursing,

- unions during the strike did not treat directors of nursing 'fairly' relative to other members.

In relation to how the position of director of nursing processed these changes, this study found that the mechanisms used by participants to deal with the changes were: 'acquiescence/adaptation/accommodation'. It further found that these processes as described by the participants are directly related to years of socialisation into the role of 'good nurse', where conforming and maintaining the status quo were the thinking and behaviour of a 'good nurse', and being accepted as a 'good nurse' contributed to a nurse's success in obtaining the prestigious position of director of nursing.

In summary, this study found that the position of director of nursing is vulnerable relative to others in its own and in other relevant groups. It further found that the thinking and behaviours that brought success to directors are now serving to restrict them in their collective response to the imposed changes affecting their position

Appendix 16

FACE SHEET

Code: **Date:**

Female/Male?	
Hospital Band/Psychiatry?	
Hospital Type (acuteness level)?	
Position title?	
Length of time holding current position?	
Age at entry into nursing training?	
First nursing qualification?	
Country of first training?	
Further nursing qualifications?	
Countries of further training?	
Additional training?	
Civil/Marital Status?	
Length of time since first qualifying and obtaining first leadership position?	