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**THE ROLES, RELATIONSHIPS AND LEADERSHIP STYLES
OF LEADERS AND MANAGERS OF NURSING EDUCATION IN
THE MIDDLE TO LATE 20TH CENTURY.**

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Thesis

THE ROLES, RELATIONSHIPS AND LEADERSHIP STYLES OF LEADERS AND MANAGERS OF NURSING EDUCATION IN THE MIDDLE TO LATE 20TH CENTURY.

This thesis is concerned with the observable tensions within, and about, leadership of the nursing profession. Specifically the tensions between the leaders of nursing service and of nursing education is the focus of the investigation. Although both groups within the profession have a shared experience of socialisation; learning professional nursing values; professional control, and leaders careers regularly embrace both segments, never-the-less conflict between the two has been a consistent feature of the profession for most of this century. In order to explore these tensions qualitative data collected via in-depth interviews with 51 people who held leadership positions in nursing education between 1948 and 1995 are presented.

This thesis analyses those factors which have contributed to the current situation. An exploration of the career pathways of those interviewed is undertaken and the influences of their individual attributes, knowledge, beliefs and values on the way in which they undertook their leadership roles are examined. Also explored are the ways in which other people were significant in affecting their careers and their approaches to professional life and work. In addition the environment in which they performed was a notable feature of consequence to them in developing the techniques of management used. From an analysis of these factors the ways in which they responded to and coped with changes in health care delivery in the period studied, through developing or adopting different leadership styles, is derived.

This analysis suggests that in the period studied nurse managers used one of three main styles of leadership to achieve their goals. Some nurse leaders acquired positions of power in order to shape and develop nursing and nursing education; some pioneered innovations in nursing and nursing education, especially in the higher education environment; and others sought to motivate colleagues and peers through education, enabling and empowerment.

The current tensions within nursing leadership are attributed to differences between their conceptions of nursing; their caring values; and the styles of leadership they developed in order to achieve their aspirations to provide the best possible quality of care for patients and of education for students. One of the chief sources of tension appears to be the juxtaposition of these two, sometimes competing, aims. Finally recommendations which refocus nursing as a caring occupation, whose practitioners act in partnership and cooperation, rather than autonomously and in competition with its various stakeholders, and the implications of this on the future recruitment, selection, education and preparation of nursing leaders are made.

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AUTHOR'S DECLARATION

I certify that this work has not been accepted in substance for any degree, and is not concurrently submitted for any degree other than that of Doctor of Philosophy (PhD) of the University of Greenwich. I also declare that this work is the result of my own investigations except where otherwise stated.

Signed

Date

GLOSSARY OF ABBREVIATIONS USED.

A.H.A.	Area Health Authority
B.T.A.	British Tuberculosis Association.
C.A.T.S.	Credit Accumulation and Transfer System.
C.C.E.T.H.V.	Central Council for the Education and Training of Health Visitors.
C.M.B.	Central Midwives Board
C.N.O.	Chief Nursing Officer
D.H.A.	District Health Authority
D.H.S.S.	Department of Health and Social Security
D.M.T.	District Management Team
D.N.E.	Director of Nurse Education
D.N.O.	District Nursing Officer
D.O.H.	Department of Health
E.N.B.	English National Board for Nursing, Midwifery and Health Visiting.
G.N.C.	General Nursing Council
H.E.	Higher Education.
I.H.S.M.	Institute of Health Service Management
J.B.C.N.S.	Joint Board of Clinical Nursing Studies.
MIND	National Association for Mental Health
N.A.W.C.H.	National Association for the Welfare of Children in Hospital.
N.O.	Nursing Officer.
N.H.S.	National Health Service.
N.H.S.E.	National Health Service Executive
N.S.C.N.M.	National Staff Committee for Nurses and Midwives.
P.N.O.	Principal Nursing Officer.
R.C.M.	Royal College of Midwives.
R.C.N.	Royal College of Nurses.
R.G.N.	Registered General Nurse.
R.H.A.	Regional Health Authority.
R.M.N.	Registered Mental Nurse.
R.N.M.S.	Registered Nurse for the Mentally Subnormal.
R.N.O.	Regional Nursing Officer.
R.N.T.	Registered Nurse Tutor.
R.N.T.C.	Regional Nurse Training Committee.
R.S.C.N.	Registered Sick Childrens Nurse.
S.N.O.	Senior Nursing Officer.
S.R.N.	State Registered Nurse.
S.T.D.	Sister Tutor Diploma.
U.K.C.C.	United Kingdom Central Council for Nursing, Midwifery and Health Visiting.

CHAPTER ONE.

THE RESEARCH QUESTION.

This thesis is concerned with the observable tensions within the leadership of the nursing profession. Specifically the tension between the leaders of nursing service and of nursing education is the focus of the investigation. Although both groups within the profession have a shared and overlapping experience of socialisation, learning professional nursing values, professional control, and leader's careers regularly embrace both segments, nevertheless conflict between the two has been a consistent feature of the profession for most of this century. In order to explore these tensions qualitative data collected via in depth interviews with 51 people who held leadership positions in nursing education are presented.

The background is both contemporary and historical. Contemporarily those nurses responsible for leadership in the delivery of nursing care in hospitals, the primary sector, continuing care and care of the elderly face more demanding patient care needs at a time when economic stringency is paramount (Hunt, 1992; Department of Health, 1995). It is essential that nurse leaders in these situations are able to articulate the standards and manpower requirements for care in ways which influence health care policy makers. Hunt argues that nurses should also aim to influence the direction of change so that it is 'congruent with our values and attitudes and provides opportunities for our careers and development' (1992:13).

Nurse educators, recently removed from National Health Service employment into that of Higher Education, are faced with educating nurses to meet and cope with the demands of the current situation and, at the same time preparing nurses who are able to adapt to future changes and play their part in determining future health care policy (Department of Health, 1995). For as Rafferty argues 'education lies at the centre of professional work and expertise and occupies a pivotal position in the shaping of occupational culture and the politics of nursing' (Rafferty, 1997:Introduction), Arguably the conflicting requirements of the need to meet health service delivery demands whilst satisfying nursing students educational requisites

have never been greater and at this time nursing leaders from both groups should be working together to ensure that their different, but closely interlinked, objectives can be met. However the conflict between the two groups is particularly problematic at this time because the challenges to nursing leadership are even greater than at any time during the last century.

Nursing leadership faces a need to influence the direction of the profession at a time when, it is often argued, nurses are considered to be unimportant and insignificant to health care policy makers (White, 1985; Clay, 1987; Rafferty, 1993b; Robinson, 1993). It has also been claimed that nurse leaders are marginalised (Beardshaw and Robinson, 1990; Rafferty, 1993b) and that rank and file nurses are disheartened and discouraged by their seemingly invisible and largely undervalued position in the division of health care labour (Davies, 1995; Williams, 1995). There are concerns that by the end of this century there will be a severe shortage of nurses through failure to recruit and retain sufficient numbers of nurses to replace those leaving for other work or through retirement (Scott, 1995; R.C.N., 1996).

The position is further complicated by the fact that nursing education itself has been subject (1989 to 1996) to the greatest re-organisation since the time of Florence Nightingale. In April 1992, when this study began, nursing education was poised to leave N.H.S. management and was on the brink of wholesale incorporation into higher education. The author of this study, then the leader and manager of a nursing education college which was in the process of forming links with an establishment of higher education, with a regional and national network of colleagues who were also going through these experiences considered it important that nurses should reflect on the decisions that our predecessors had made in order to better understand how and why we were in this position. In addition this process of reflection might assist current and future leaders and managers of nursing education in their decision making processes. The decisions being made at this time appeared to affect every aspect of nursing and nursing education on a scale which was unprecedented.

Changes in N.H.S. management structures introduced in 1989 were taking effect as N.H.S. Trusts were formed. These changes were beginning to affect the relationships between nurse leaders with responsibility for nursing within the Trusts

(service Provider nurse leaders), those with responsibility for commissioning health care services (service Purchaser nurse leaders), those with responsibility for commissioning the provision of nursing education (education Purchaser nurse leaders) and those responsible for delivering nursing education (education Provider nurse leaders).

Major change in the organisation, structure and content of the pre-registration nursing curriculum was also being experienced as the effects of the recommendations of the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (U.K.C.C.) became more widespread. This body, inaugurated in 1983, had set out its proposals for significant reformation of the curriculum in 1986 (U.K.C.C., 1986) and phased implementation of the proposals had begun in 1989 (D.O.H., 1989). By the spring of 1992 most colleges of nursing in England had been allocated funds to introduce the new course (Project 2000) and plans for its implementation in Northern Ireland, Wales and Scotland were also well advanced.

Historically the tensions between major segments in nursing has been described throughout this century. Successive investigations into problems with regard to nursing and the training and education of nursing students have suggested the need to separate the management of nursing 'service' and 'education' (Lancet Commission, 1932; Horder, 1943; Wood, 1947; Platt, 1964; Briggs, 1972; R.C.N., 1985). The bones of contention between these two groups of leaders appear to stem from the status of the student nurse as worker rather than learner and from the subordinate position of the nurse education leader vis-a-vis the nursing service leader. Manifestations of the divisions between the groups are described as the 'gap' between theory and practice or the schism between 'education' and 'service' (Bendall, 1975; Jolley, 1987; Gallego, 1983; White, 1985; Strong and Robinson, 1990; Dale 1994). Other ways in which these tensions are demonstrated are through the low esteem in which nurse educators are held within the profession (R.C.N. 1983a; R.C.N. 1983b; Gallego; 1983) and an 'anti-education' bias in the profession at large (White, 1985).

Divisions between different segments of nursing and the resulting dissension

between these groups was documented by Carpenter (1977) who describes the differing aspirations and values of the 'rank and file' nurses, their 'new managers' and the cadre of 'new professionals'. White (1985) classifies these groups as 'proletarians', 'managers' and 'professionals' and comments on the futility of attempting to treat nursing as a unitary system for the purpose of policy making, whilst Melia (1987) describes the effects of the differences between the two major segments of the nursing profession 'service' and 'education' on the professional values learnt by nursing students. Smith (1997) comments on the 'troubled history of British nursing' and that 'achieving consensus about nursing and nursing education is a perennial problem' (1997:437).

Thus conflict between groups of nursing leaders has been a feature for most of this century. Abel-Smith (1960) refers to the 'battle' over registration, similar clashes between groups of nursing leaders recurred over proposals for educational change, such as the Platt report (Baly, 1980), again in the period leading up to the passing of the 1979 Nurses Act (Clay, 1987), and in the phase between the setting up of the new statutory bodies and the introduction of Project 2000 (E.N.B., 1985; R.C.N., 1985; U.K.C.C., 1986).

This thesis therefore sets out to examine some of the factors which have led up to this situation of tension between nursing leaders, in particular the friction between different segments of the profession, and the part which leaders ¹ of nursing ² education played in this conflict from the inception of the National Health Service (N.H.S.) to the present time. The research questions to be investigated concern the impact of successive organisational changes within the N.H.S., and the ways in which other environmental factors affected how these managers perceived their roles. The study also analyses how the leader's work relationships with significant others affected them as individuals, especially with regard to their preparation for and response to these changes.

Four questions stem from this aim:

1 Throughout this thesis those influential within the profession will be referred to as leaders and/or managers

2

Nursing will usually be used in a generic sense to encompass nursing, midwifery and health visiting, unless there is a need to be more specific to make a particular point about differences within the profession.

1. What were the effects of changes in health care delivery occurring in the late 20th century on the roles and relationships between different leaders and different segments of the nursing profession, and different leaders within it, especially those with responsibility for nursing education?
2. What situational or environmental factors affected the ways in which those in leadership and management positions within the different segments of nursing perceived and carried out their roles? In particular what were the effects of changes in the organisation and management of the National Health Service, from inception to the present, on the roles of nursing service leaders and on working relationships between them and their managerial counterparts. How did these changes, coupled with the effects of the strengthening links and subsequent movement of nursing education into higher education, affect the roles and working relationships of nursing education leaders, especially vis-a-vis their nursing service colleagues?
3. How did past leaders of nursing respond to and cope with changes in the organisations in which they worked, and what were the effects of altered relationships between work colleagues, both within and outside the nursing profession, on the way in which they perceived and carried out their roles?
4. What recommendations based on these findings might be made regarding the most appropriate organisational and management structures and systems for the delivery of nursing and nursing education in the 21st century, and the preparation, development, recruitment and selection of the future leaders and managers of nursing and nursing education?

Thus this investigation sought to discover those factors which had influenced the decisions made by nurse leaders in the past, and through analysis of and reflection on the issues of importance to them, to better understand the present and to inform policy making for the future. The investigation will reveal that these nurse managers responded to and coped with the changes by developing a distinctive leadership style which differed significantly according to the segment of the profession in which they chose to work.

A variety of research approaches were used to obtain data during the study. Chief amongst these were discursive in-depth interviews with fifty-one men and women who had been leaders and managers of nursing in the period 1948 to 1995. The second most significant source of data was through the researcher's use of reflective journals concerning her own management role and of the research process.

In the second Chapter of this thesis a review of the sources of tension and conflict between nursing leaders is made, particularly with reference to the differences between nursing service and nursing education leaders. Chapter Three describes the research methods used and the processes by which the conclusions drawn from the data obtained are recounted. Chapter Four, the first in which data from the interviews are presented, profiles the careers of those interviewed through an analysis of the similarities and differences between these past leaders of the nursing profession. Data used to illustrate the correlation and discord between them are offered via selected extracts from the interview tapes. The selection is based on those excerpts which give the clearest and most succinct description of the sources of assent and dissent between those nurse leaders interviewed. At best they are snapshots of their opinions and perceptions, vignettes from the past, which bear on the present and future of nursing leadership. Chapter Five continues the analysis and evaluation of the factors which affected the roles and relationships of these nursing leaders through a consideration of the influence of significant others. Chapter Six considers the situational and environmental factors which affected their nursing leadership roles and Chapter Seven describes the ways in which leaders from the different segments of nursing coped with the changes in their roles and relationships through the development of a distinctive leadership style. Chapter Eight begins with a summary of the findings from the study and finally some recommendations designed to attempt to overcome some of the tensions and conflicts between nursing leaders in the future are made.

CHAPTER TWO

LEADERSHIP OF NURSING, WITH PARTICULAR REFERENCE TO NURSING EDUCATION: A REVIEW.

Introduction.

In Chapter One the tensions in nursing leadership were outlined and the research questions to be considered in relation to these tensions were stated. Contemporary tensions are considered to stem from the introduction of the culture and ethos of business management in the delivery of health care and an internal 'market' for nursing education at a time when nursing education was moving from N.H.S. management into establishments of higher education. Historically the tensions are seen to stem from the dual status of student nurse as workers and learners and from the subordinate position of nurse education leaders to nursing service managers.

It is considered that these tensions can best be understood through an analysis of intra-professional differences, for instance the divisions between the different segments of nursing (Carpenter, 1977; Melosh, 1982; White, 1985; Melia, 1987) and the resulting conflict between these groups. Conflict which has been a feature for most of this century, as described by Abel-Smith (1960) as the 'battle' over registration, a battle which Rafferty (1997) points out was not 'a single-issue contest but a protracted struggle involving a series of skirmishes and issues stretching over a thirty year period' (1997:43). Similar clashes between groups of nursing leaders recurred over proposals for educational change, such as the Platt report (Baly, 1980); in the period leading up to the passing of the 1979 Nurses Act (Clay, 1987), and in the phase between the setting up of the new statutory bodies and the introduction of Project 2000 (E.N.B., 1985; R.C.N., 1985; U.K.C.C., 1986). This chapter considers some of the reasons for these clashes, such as the divisions between 'education' and 'service' and 'theory' and 'practice' which have been widely reported (Bendall, 1975; Jolley, 1987; Gallego, 1983; White, 1985; Strong and Robinson, 1990).

The conflicts between these two groups is seen as stemming from the nursing education leaders' subordinate position to the nursing service managers in the division of responsibility for the training of student nurses and the most usual focus for the tensions between the two groups of leaders is the 'employee' and worker status of the student. Differences between other groups and individuals have also been noted, for instance White (1983) describes 'proletarians', 'managers' and 'professionals' and claims that the R.C.N. failed to represent the views of the majority of its members, the 'proletariat', a charge which Clay (1987), then General Secretary of the R.C.N., strongly refutes. Robinson (1991) reports the differences between the value base of these two nursing leaders and compares their views of nursing with that of Salvage (1987) who is considered to have offered a third perspective on the 'disagreement within nursing' (Robinson, 1991:281). These disputes are seen to stem from different 'values derived from his or her system of ideas', this review will therefore analyse the different conceptions of nursing during the period studied to tease out the various ideological and epistemological approaches which were developed. Beattie's model of health ideologies (1981, 1995) is used to structure this review of the different conceptions of the nature of nursing in section 2.2. of this chapter.

Another increasing source of anxiety for nurse leaders, particularly in the latter part of the period studied, have been increased tensions between nurses and their patients. With the rise in the expectations of patients regarding their health care and with the introduction of 'consumerism' the nurse as one of the most prominent 'front-line' workers is often the recipient of criticism by patients when the system fails to deliver what they expect (Peters, 1995). Also the way in which nursing care has changed has brought in notions of partnership between nurses and their patients and of the nurse's role as patient's advocate. As will be seen later this has resulted in alterations in the power differential between patients and nurses and has challenged the roles and relationships between nurses and doctors and other health care workers and managers (Pearson and Vaughan, 1986; Melia, 1993; Greenwell, 1995; Kendrick, 1995; McLeod, 1995).

Other factors which are considered to have caused strain in the relationships between nursing leaders are gender differences, especially centred around the male nurse

managers more rapid rise to positions of authority than female nurses since the passing of the Salmon report (1966). This phenomenon has been researched and commented on frequently in the period studied (Austin, 1974; Jones, Crossley-Holland and Matus, 1981; Nuttall, 1983; Hardy, 1983, Hardy, 1986, Hardy, 1987; Davies, 1990; Ball et al, 1994; NHS Women's Unit, 1995; Davies, 1995) but despite positive attempts to increase the numbers of female managers, such as Opportunity 2000 (NHSME, 1992; Rafferty, 1993b; Ball, 1995; Nursing Times, 1995) the pattern seems little changed. Class and race have also been highlighted as elements which contribute to tensions within nursing and its leadership (Hicks, 1982; Baxter, 1987; J. Robinson, 1991; K. Robinson, 1992; Rafferty, 1993b; Rafferty, 1997b). Whilst these intra-professional issues are seen to have influenced the ways in which nursing and nursing education developed during the period studied they cannot be considered as if in a vacuum. There were also inter-professional conflicts, between nurse leaders and the medical and para-medical professions, although the most likely cause of tension usually centred on the relationships between nurses and doctors. In what has come to be known as the 'doctor-nurse game' (Stein, 1967; Stein et al, 1990; Mackay, 1995) issues to do with the relative power between the cure and care modalities have been extensively explored. As well as the growing strain between these two groups changes in the roles of hospital administrators and in the way in which the health service has been managed over the past four decades have created tension between nurse leaders and health service managers (Tattam and Thompson, 1993; Ackroyd, 1995).

At the beginning of the period studied nurse leaders were seen as being 'politically naive' in relation to their medical and administrative counterparts (White, 1985; Rafferty, 1992a). Changes in the way in which the N.H.S. was managed, changes in the role of nurse managers and in the ways in which they were prepared for these roles resulted in increased political awareness by nurses and their nursing leaders. This was evident during the middle part of the period studied by increasing trade union activity by nurses and in the last 15 years of the period studied there was overt conflict between nurse leaders and the managers, and between nurse leaders and the government of the time (Clay, 1987; Tattam and Thompson, 1993).

In view of the range of intra-professional and inter-professional issues which have

the potential to contribute to the current tensions between nurse leaders which is the focus of this study this literature review is divided into three distinct parts. The first part examines some of the differences between the segments of nursing, particularly between nursing education and nursing service leaders, and between nurse leaders and health service managers. The second part considers the different conceptions of nursing during the period studied, especially the ways in which changes in the delivery of nursing care affected the relationships between segments of the profession, between nurses and doctors and between nurses and their patients. These two parts are summarised so that the potential sources of observable tensions between nursing leaders are drawn out. In the final section previous studies of nursing leaders and nursing leadership are examined in order to develop a framework upon which to base the decisions to be made in the design of this research study.

2.1. The Divisions Between The Leaders of Nursing Education.

It is necessary at the outset to specify the level of leadership or management with which this study is concerned as the role of all registered nurses is considered to have both teaching and management components (Department of Health, 1995). As was described in Chapter One all those who were interviewed had held significant leadership and/or management posts in the disciplines of nursing, midwifery and health visiting. Only nurses who had been in positions of public prominence were selected as it was considered that through these roles they would have influenced the development and management of nursing education, and thus helped to shape the current position of nursing leadership. This influence was considered to have been through a direct leadership role as a senior nurse education manager, for example as Principal Tutor, Principal Nursing Officer (Education), Director of Nurse Education (D.N.E.) or Principal of a College of Nursing, or the equivalent roles in establishments of higher education.

Others influenced nursing education through their line management responsibility for the previously listed group, for instance Matron, Chief Nursing Officer (C.N.O.), District Nursing Officer (D.N.O.). A further group were in positions of authority in which they had responsibility for the totality of nursing within a

Regional Health Authority (R.H.A.) or nationally as Nursing Officers (N.O), Principal Nursing Officers (P.N.O.) or Chief Nursing Officers within the Department of Health and Social Security (D.H.S.S.) (or its Scottish equivalent or successors). Others would have been influential through their positions as officers or members of professional organisations or statutory bodies. A further group were considered to have been instrumental in effecting change in nursing and nursing education through research and/or journalism, publications, public speaking or similar activities. Nursing education has been subject to multiple lines of accountability and some of the tensions in nursing leadership stem from the nursing education leaders more lowly position in the hierarchy than that of the nursing service manager for most of the period studied.

2.1.1. The division of responsibility for nursing education between nursing service leaders and nursing education leaders.

The divisions in nursing, especially that between nursing service and nursing education, is of long standing. White, (1985) considers the effects of the N.H.S. on the nursing profession, especially the matrons, from 1948 to 1961. She highlights the three streams of nursing, with 'disparate ideologies and roots', which entered the health service in 1948. These three streams, the voluntary hospital nurses, the municipal hospital nurses and the Poor Law nurses, were divided further into factions, the generalists and specialists or 'proletarians' and 'professionals'. White (1983) also identifies three major interest groups, the clinical nurses, the nurse teachers and the managers within these factions, and concludes that nursing is a pluralist system with several primary groups each with its own value system.

At the hospital level the nurse leaders at the time of the inception of the N.H.S. were the matrons who were responsible for all aspects of nursing care delivery and the education and training of nurses within their hospitals. However the term matron covered a wide range of roles and responsibilities. Watkin (1982) points out that in a voluntary hospital the matron would be directly responsible to the board or committee, whilst in a municipal hospital she would usually be responsible to a medical superintendent, and in a mental hospital would only have charge of the female wards. The male wards were the responsibility of a chief male nurse whose

position was lower in status than that of the matron. The title matron was used whatever the size of the hospital, for instance the matron could be the only qualified nurse on the staff but in larger hospitals she might be responsible for several hundred nurses, the school of nursing and for the linen room, catering and domestic services. In the larger hospitals matron would be assisted by a deputy matron and one or more assistant matrons. The deputy matron normally deputised for matron across the whole range of her duties and the assistant matrons often took functional responsibility for certain aspects of the administration of the hospital, for example control of the domestic staff; linen and laundry; preparing off duty rotas; or the allocation of students. Also in larger hospitals the post of administrative sister was created to assist with a range of these activities. The Salmon Committee (1966) commented that 'often their duties and responsibilities are ill defined and far removed from the work of nursing patients' (D.H.S.S., 1971:4). The wards were run by ward sisters and staffed by qualified and unqualified nurses, ward orderlies and/or domestics. In addition the hospital was managed at night by a night superintendent, sometimes assisted by a deputy and one or more night sisters.

When the NHS came into existence schools of nursing were each headed by a principal tutor, who was responsible to the matron. These were attached to individual hospitals, they were therefore numerous. Baly (1980) reports 987 small training schools with the purpose of providing the majority of the hospital's workforce through the nurses in training. Although the title Principal Tutor would seem to indicate an important role in the education of nurses in reality the range of responsibility which the incumbent might assume was as varied as that of the matron. Over the period studied the organisation and management of schools of nursing and the role and responsibilities of the nurses in charge of them, particularly vis-a-vis those of the senior nurse managers, were the subject of scrutiny (Bradbeer, 1954; Platt, 1964; Salmon, 1966; Briggs, 1972; R.C.N. 1981, 1983a, 1983b, 1985; E.N.B. 1985; U.K.C.C. 1986). During the period covered by this study perceptions of leadership and management have changed, this is especially true of the N.H.S. and of nursing leadership. In the early years of the period which this study covers it was unusual for the term management to be used. For instance the Bradbeer Report (1954) considered issues to do with the 'Internal Administration of Hospitals'. The role which nurses, especially the nursing leaders, might play within

hospital management appears not to have been fully recognised. The committee comment that 'the contribution which the matron and her nursing staff can make towards hospital administration is not always fully appreciated by some hospital authorities' (1954:46). However the report seems to have done little to help in raising the status of the matron, amongst the recommendations they state that 'only medical men are to be appointed as members of the governing body' of hospitals and that attendance at meetings of the governors should be by the 'chairman of the group nursing advisory committee or some other matron chosen by the matrons of the group to represent them' (1954:70). This meant that all aspects of a matron's role, including the organisation and management of the school of nursing, might have to be represented to the governors by another matron without the detailed knowledge of the issues.

One of the major issues with regard to the provision of the nursing service was the use of the student nurse to provide nursing care whilst receiving training and, arguably, this is one of the root causes of the tensions between nursing education and nursing service leaders. The unsatisfactory nature of these arrangements was recognised by the Platt Report (1964) which comments on the conflict between the needs of the service and the educational needs of the student. One of the solutions proposed by the report was the separation of the management of hospitals from that of schools of nursing. They envisaged that these separate schools, headed by a Principal responsible for the 'administration and management of the School and for the conduct of all educational activities' (Platt, 1964:18), would be governed by a School Council. In order for the scheme to work there would need to be 'effective co-operation between the school council and the hospital authorities' (Platt, 1964:19) and liaison between the teaching staff of the school and the nurse administrators. However, Matron and her senior nursing staff were to retain 'the ultimate responsibility for providing the right climate for clinical nursing education (Platt, 1964:19). As will be explored later in this chapter and will recur throughout this thesis nursing service managers and the leaders of nursing education within the N.H.S. seem not to have been able to resolve the tensions between the service managers dual responsibility for the provision of patient care and an appropriate learning environment for students in clinical areas.

The Platt proposals were not new, successive reports over the years before the setting up of the N.H.S. had suggested the need to separate the 'service' and 'education' functions (Lancet Commission, 1932; Horder, 1943; Wood, 1947). In this respect Platt (1964), like its predecessors, suffered the fate of the other reports, in that 'reports are not self-executive' (Baly, 1980). There were some nurse leaders who 'perished for Platt' (Baly, 1980: 321) but the fact that the General Nursing Council, whose nursing membership was dominated by hospital matrons, considered that there was no need for reform 'as drastic as that envisaged by the report' (G.N.C., 1965) damned the Platt report. It is interesting to note that the General Nursing Council's representative on the committee, Miss B.N. Fawkes resigned before the publication of the report. As well as the divisions between the nursing education and nursing service managers at hospital level it is obvious that there were divisions between groups of leaders at national level which were to be repeated following the Briggs Report (Baly, 1980; Clay, 1987) and following the setting up of the U.K.C.C.. At this time three 'rival' proposals for the reform of nursing education were published (E.N.B., 1985; R.C.N., 1985; U.K.C.C., 1986) which highlight some of the differences and tensions between nursing's leaders. This point will be returned to later in this review.

Over the 18 years following the setting up of the N.H.S. there were few changes in the roles and responsibilities of matrons and other nurse administrators until the Salmon Report in 1966 recommended that proper career structures for nurses should be identified and preparation given for management posts. The report distinguished between levels of management to which new titles and numerical grades were allocated (Salmon, 1966). Management of nursing and nursing education were separated, the responsibility for hospitals went to the Principal Nursing Officer (Service) and for education to the Principal Nursing Officer (Education). However in this partition the position of the educationist was still below that of the service manager. As Allsop comments: 'there was also to be a division between nurse managers and nurse teachers with the higher ranking posts going to the former' (1984:59).

The need to separate the roles of the nursing service and nursing education leaders was reiterated in 1972, with the publication of the Briggs report. This report

recommended the total separation of nursing education from nursing service management through the formation of autonomous Colleges of Nursing and Midwifery. A governing body with powers equivalent to colleges of further education or colleges of education was envisaged. The College of Nursing and Midwifery was to be managed on a day to day basis by a Principal accountable to the governing body. These recommendations were not enacted so that whilst the title of the leaders of nursing education changed with the Salmon (1966) report there appear to have been few changes in their roles until the reorganisation of the N.H.S. in 1974. At this time Directors of Nursing Education were given a wider range of responsibilities than they had previously held. In addition to their responsibilities for basic statutory training, they became responsible for the provision of all post-basic and continuing in-service education to nursing and midwifery staff (R.C.N. 1983b).

The educationists appointed to head up these larger and more complex organisation were, in the main, drawn from the ranks of the existing Principal Nursing Officers (Education). Even in this role though the manager of nursing education was still accountable to the nursing service manager, the District Nursing Officer (DNO). Smith (1975) considered that:

The college of nursing organisation should obviously be a means of accomplishing high standards of nursing education which will inevitably promote excellent standards of patient care. There can surely be few educational organisations that have such a challenge.

(Smith, 1975: 140)

Despite the challenges posed and opportunities offered by the leadership posts in nursing education grave concerns were being expressed, in the Royal College of Nursing, about the continuing low pay, status and conditions of nurse teachers, including the leaders of nursing education which was resulting in wastage and lowered morale (RCN, 1981). The R.C.N. considered that the forthcoming further reorganisation of the NHS and the implementation of the 1979 Nurses, Midwives and Health Visiting Act provided an ideal opportunity to set up new mechanisms for the management of nursing education. The solutions proposed were to improve the career structure and pay for nurse teachers; establish School Education Committees

to which Directors of Nurse Education would be accountable and to separate the funding of nursing education from that of nursing service (RCN, 1981).

As with previous reports, such as the Lancet Commission (1932), Horder (1943), Wood, (1947) and Platt (1964), the R.C.N. once again foresaw the possibility of independent Colleges of Nursing and Midwifery and the need for higher education and higher management skills for nurse teachers was recognised, (R.C.N., 1983a). However there was continuing concern about shortages of nurse teachers resulting, in part, from low pay differentials between nursing service and nursing education and between nurse teachers and teachers in further education, primary and secondary education and the professions supplementary to medicine (R.C.N. 1983b). All of these factors seem to have had detrimental effects on the way in which nursing education was managed. Strong and Robinson (1990) evaluated the impact of the introduction of the Griffiths report (1983a) with regard to the management of nurse education and concluded:

most nursing schools were in fact tied, until relatively recently, to the specific manpower demands of particular hospitals, to the service of local doctors and to the views of the local matron...students were still heavily used as cheap ward labour. Moreover, the extraordinarily complex funding arrangements for nursing schools still reflected the domination of particular service demands...One fundamental difficulty was that training depended on tutors who were no longer in clinical practice - and were thus remote from the practical concerns of the service... The problems caused by such divisions were compounded... by the weight of the past, by the sheer novelty of nursing's attempts to develop its own serious educational traditions and by the extraordinarily low standards from which many of the new schools had started.

(Strong and Robinson, 1990:42-43)

Thus the divisions between what Melia (1987) terms the major segments of nursing, 'service' and 'education', appear to have resulted in role confusion and role conflict for nurse educators, especially for those in leading positions in nursing education. Smith (1975), then a District Nursing Officer but previously a Principal Nursing Officer (Education) describes college organisation, management and curriculum with an emphasis which is very much on administrative details. The important issues for the Director of Nurse Education to be aware of were seen as college organisation

(structure and committees); college size and administrative arrangements, such as the correct format for letter writing and the importance of filling in forms for 'indexing' nurse learners with the then statutory body, the General Nursing Council for England and other administrative details such as recruitment and personnel policies. With regard to educational matters; the curriculum, classroom and clinical experiences; and the preparation and development of nurse teachers were seen as important, rather than the D.N.E.'S role and responsibilities in managing a wide range of internal and external stakeholders. However by the early 1980's nursing education managers were beginning to explore the tensions surrounding their role. Collins (1980), a D.N.E., examines the diffuse nature of the nurse educator's responsibilities and comments on the need for nursing service managers to accept responsibility for their role in the 'training' situation in respect of the selection of trained nurses who would act as role models for the nursing student and of the areas where the student were to learn to nurse. This highlights one of the major tensions for nursing education managers who had responsibility, but not accountability, for the provision of appropriate clinical learning environments (Boylan, 1984; Rider, 1984 cited in Miles et al, 1988).

Nurse educationists were considered to be administrators and teachers rather than managers and leaders (R.C.N. 1983a) and in pay and status terms they were less highly regarded than nursing service personnel. The result being that many potentially able leaders left nursing education to return to service posts or to teach in further and higher education (RCN, 1983b). This position gave rise to much concern over the years covered by this study and successive committees and working parties were set up to address problems of nurse teacher recruitment and wastage (Department of Health, 1954; Dutton, 1968; Raven, 1970; Lancaster, 1971; General Nursing Council, 1975; RCN, 1981; RCN, 1983a; RCN, 1983b).

The concerns about the management of nursing education were so great that in 1984 the National Staff Committee for Nurses and Midwives (NSCNM) set up a project to examine the role of the DNE and to institute appropriate training for those aspiring to the role. Involvement in this project contiguous with a senior management development programme inspired Miles (1988) to examine the Director of Nurse Education role using the ten managerial roles identified by Mintzberg

(1973) as the framework for her analysis. She suggested that the analysis might help to explain some of the controversy and problems of nurse education of that time. At the time that Miles undertook her study (1984) the management changes within the N.H.S. proposed by Griffiths (1983a) were about to be implemented, and with the suggested demise of the Chief Nursing Officer role at District Health Authority level managerial responsibility for nursing education was under intense scrutiny. At the time it was envisaged that the D.N.E. might become managerially accountable to the District General Manager or to the Director of Personnel, alternatively a move to higher or further education management was proposed. Some of the difficulties which might accompany a move from N.H.S. control were seen as:

the separation of nurse training and education from the managerial structures of the N.H.S. by placing learners within Colleges of Further and Higher Education..... Two major drawbacks to this proposal exists. They are the questions of funding for nurse learners' salaries and the necessity for nursing to be learnt in practice situations as well as in theory.

(Miles, 1988:57)

This quotation highlights some of the polarised views that there were at that time about the possible move of nursing education into higher education. Akinsanya considers various changes in the NHS in recent years and concludes 'educating nurses away from their professional colleagues has been detrimental to their progress in the current administrative and management organisation of the NHS' (Akinsanya,1990). He goes on to argue that nursing education must be incorporated within higher education in the 21st century. However, this was not an uncontroversial or uncontested position. The English National Board (1985) recommended that 'links' be made between nursing education and higher education, whereas the Judge report (1985), commissioned by the R.C.N., was for the wholesale move of nursing education into higher education. The U.K.C.C. (1986), the only one of these bodies which was able to determine policy, opted to side-step the issue, recommending:

the way forward for educational institutions in some instances will be re-establishment in advanced further and higher education, in others it will not.

(U.K.C.C., 1986:58)

The committee did, however, opt for 'joint professional and academic validation' and it was pursuit of this recommendation, along with the changes in the organisation and management of the N.H.S. following the passing of the National Health Service and Community Care Act (1990), that led to the incorporation of nursing education into higher education (Ramsammy and Humphreys, 1994).

The move into Higher Education which started in the early 1990's required that Directors of Nurse or Midwifery Education, Principals of Colleges of Health or their equivalent were faced with the necessity of acquiring new knowledge, new skills and attitudes and of gaining acceptance in a new culture in order to perform their new roles as Heads of School, Department or Faculty. This transition period for the leaders of nursing education coincided with the introduction of the 'internal market' in health care and with the removal of the binary divide in higher education. Nursing education leaders were therefore moving from one destabilised system into another (alien) destabilised system. The difficulties facing the nursing education managers in this new context were summarised by Bailey and Humphreys who assert that 'in the context of limited opportunities for re-emphasis or diversification colleges of health care education are being exposed to competitive contracting-funding directly with the monopoly purchasers of their service'(1994:94) and that 'in the new market environment that the government seems determined to impose on the health service, the colleges/faculties of health care studies will be confronted by more challenging circumstances than those experienced in 'mainstream' education (1994:95). Some of the conflicts and tensions that these new funding methodologies have posed for nurse education leaders, especially vis-a-vis their nursing service and managerial counterparts, have since been documented (Webster, 1990; Booth, 1992; Burke, 1995; Clifford, 1995; Humphreys, 1996a and 1996b; Burke, 1997; Holliday and Parker, 1997).

Leaders of nursing education were thus divided in their views as to the purpose of nursing education and the best venue for that education to take place. Along with this, until the early 1990's the most senior nurse educationists, charged with managing the enterprise, were always accountable to a nursing service manager, whose priorities for nursing education were usually secondary to the priorities of patient care. Lower levels of pay and status than nursing service managers did little

to attract and keep able and well qualified nurses in management of nursing education, so that, by the time they faced the opportunities of implementing Project 2000 and of forming closer links with higher education there was a history of disregard of their educational needs which some of the efforts of the late 1980's had done little to overcome. Added to these factors tensions within and about nursing leadership are considered to stem from the nurse leaders own inability to influence policy. In part this has been attributed to the political naivety of past nurse leaders although the lack of regard by policy makers for nursing is seen as a contributory factor to the current situation.

2.1.2 The political naivety and powerlessness of past nursing leaders.

White (1985) refers to the apparent failure of nursing leaders to gain professional authority and an appropriate degree of power in health service politics, a failure which she ascribes, in part, to the government's view of nursing as on a par with domestics and to the disparate educational, social class, and ideological backgrounds of the nurses. Rafferty concurs with this point when she highlights that the government's 'rhetoric of priority for nurses failed to translate into participation in the N.H.S. advisory and policy making machinery' at the inception of the N.H.S. in 1948 (1992a:382-383).

White (1985) indicates that this situation stemmed back to the start of the National Health Service. She goes on to suggest that the title matron encompassed as heterogenous a group as that of nurse and that only the matrons of teaching hospitals could be considered as having any real power as they reported directly to their boards of governors. Following the inception of the N.H.S. she suggests that the power of the matron diminished because she had to share authority for the management of non-nursing services within the hospital with administrators. The grouping of hospitals and the formation of Regional Hospital Boards and Hospital Management Committees led to further diminution of the matron's influence as she was not represented on these policy making committees. The grouping of nurse training schools and the rising specialism of nurse tutors resulted in a subsequent further weakening of the matrons' sphere of authority. Rafferty (1992b) suggests that, in the period immediately before the formation of the N.H.S. and in the phase

between the nationalisation of nursing and the introduction of the Salmon report, nursing issues only reached the public agenda when they were transformed into crises. Using the problems of recruitment and retention as a focus she points out that nurses themselves played little part in either setting the agenda or in the process of formulating policy. Both White and Rafferty agree that the nurse leader's power to influence health care policy making was diminished following the inception of the N.H.S. White (1985) concludes that nurse leader's political naivety was the main factor contributing to their ineffectiveness:

the political ingenuousness and social inexperience of the matron enabled the doctor or administrator to out-manoeuvre her too easily.

(White, 1985:61)

Rafferty (1992b) extends a similar argument when she claims that nurse leaders failed to take adequate cognisance of the context in which policy decisions were being made. She cites the Platt (1964) and Briggs (1972) reports as examples of assumptions that 'nursing would be reconstructed to fit the new system rather than being planned with it'. Other analysts of the effects of changes instigated by government on the power of nurse managers have commented on their powerlessness, for instance Bellaby and Oribabor (1980) claim that nursing leaders have been dominated by the state. Writing more recently Robinson (1991) points to the 'upsurge of interest' in the 'politics of nursing' and concludes that nursing is 'relatively unimportant to government and managers in comparison with medicine'. She sums up that:

nursing remains in the social equivalent of an astronomical Black Hole...even when nurses themselves were trying to actively break free from the negative gravitational force of tradition, and not all of them were, others on the outside showed little interest in trying to harness, or even to understand, the frustrated energies locked deep within the occupation of nursing.

(Robinson, 1991:273).

Those nurses who were not trying to escape from their invisibility to politicians may well have been held back by another of the factors which is considered to have

contributed to the tensions in nursing leadership, namely the repressive leadership styles adopted by some nurse leaders.

2.1.3. Repressive leadership styles.

In the writer's opinion, whilst all of the foregoing factors may have contributed to the way in which nurse leaders were perceived, what appears more important is that, in the face of the situational and environmental demands of the time, some nurse leaders developed a particular style of management. The matron's style was believed to be repressive, autocratic and authoritarian (Salmon, 1966; Briggs, 1972; Lorentzon, 1990) and an 'archaic mode of leadership' (Briggs, 1972). The Salmon report (1966) was overtly critical of female styles of authority (Carpenter, 1977; Lorentzon, 1990) the solution for which was a 'rational management' model (Lorentzon, 1990) based on 'quasi-military' structures.

The 1974 re-organisation of the N.H.S. gave an opportunity for nurse leaders to engage in more participative and democratic styles of management and, as will be demonstrated later in this thesis, most of those working in the N.H.S. at that level at this time seem to have found this a satisfying period of their career. However nurse managers were considered to have 'failed' to deliver what was necessary (Strong and Robinson, 1990) and with the introduction of the Griffiths report their authority to manage nursing directly was removed. Although the style developed may have helped them to cope with the challenges from the 'rank and file' and with the demands and expectations of their doctor and administrator peers and colleagues it appears to have limited the ability to develop the profession in a way which satisfied either group. The management styles developed have been criticised by those outside and within the profession and the nurse leaders came to be seen as part of, if not the main cause of, the 'problem' of nursing. Strong and Robinson (1990) describe the nurse managers in their study as unconfident, hesitant and deferential. They point to weaknesses in basic nursing education and the lack of preparation of nurse managers for their enormous task as factors which contributed to their sense of inadequacy and to the derision of others. Rafferty highlights the 'muted' nature of nursing in key policy-making areas and attributes this, in part, to the 'gendered' and 'second-class' citizen status of the profession (Rafferty, 1993b:5). Davies

(1995) points out that:

underlying the lack of developed expertise and the defensiveness and uncertainty of nurse managers themselves is surely a failure to acknowledge that there is a management job to be done.....without this acknowledgement, nurse management becomes transformed into reactive coping - a matter of ensuring that 'pairs of hands' are in the right place at the right time.

(Davies, 1995:165)

The perceived failure of nursing leaders is attributed by Strong and Robinson (1990) to incompetence and incapability. Another alternative conception put forward is that the values they espoused were inimical to those of other managers (Rafferty,1993b). Faced with demands for subservience and reactive 'coping' (Davies, 1992) and in order to avoid marginalisation by their management colleagues, most nursing service leaders appear to have developed styles which enabled them to function alongside their medical and administrative colleagues rather than opposing them.

Alternative attempts to explain why nursing leaders did not encourage the development of other nurses range from the reactive to the repressive, from the misunderstood to the myopic, and from the valorous to the vindictive. Faugier (1992a) comments on the 'tall poppy syndrome', the propensity of the nursing profession to 'chop down' any of its own members who attempt to rise above the others, which she sees as detrimental to the survival of nurses and nursing. Another explanation given is that nurse leaders were exemplars of the 'Queen Bee' syndrome. White (1986) concludes that the 'Queen Bee' syndrome has a negative effect on the organisation either because the leader fails to train subordinates and share her expertise with them or because she works to maintain the status quo. Halsey comments that 'while succeeding as a contemporary role model, the Queen Bee supports the traditional female model for other women and opposes the aims of other career-motivated women within her role system' (1978:233). Berry and Kushner (1975) argue that the Queen Bee is a high achiever who needs few rewards from others in order to gain satisfaction from what she does. They claim that it is logical for the 'Queen Bees' to identify with the male reward system as they have been a victim of 'psychological sabotage from other women'. Therefore it may be that female nurse leaders were seen to be failing through such gender attributes as

'bitchiness' and this may be one of the reasons why it was considered that attracting more men into nursing management would help to overcome the problems of the profession.

If the repressive leadership styles used by nurse managers coupled with subservience to other members of the hospital administration team are causal factors of the current tensions regarding nursing leadership then it is important to consider the role of pre-registration nursing education in the formation of these approaches. As intimated in the introduction to this chapter the picture here is one of further disunity as during the period studied there were multiple views of nursing, what the nurse's role should be and how nursing should be practised. Thus the knowledge base which nurse educators were called upon to transmit was a source of conflict between leaders of nursing, especially between service and education leaders. This, coupled with the fact that there were multiple versions of professional values and ideals, served to increase tensions between nurses and their leaders, and between leaders from the different segments of the profession. Beattie (1981) and (1995) provides a useful way of analysing and categorising these differences so that the implications for nursing leadership becomes clearer.

2.2. Different conceptions of the Nature of Nursing during the period studied.

Beattie (1981) suggests that changes in the structure of nursing knowledge, and thereby the development of new skills, reflect changes in underlying ideologies of health. Using Bernstein's (1975) concepts of classification and framing, Beattie (1995) claims that it is possible to place these health ideologies in one of four main areas, and that from these views of health arise 'a realignment of the boundaries of health work, in terms of four contrasting models of 'practice paradigms' (Beattie, 1995:19). These four models, the 'ecological'; 'biopathological or biotechnological'; 'biographical' and 'populist or communitarian' will be used to focus a review of the literature concerning management, practice and education in nursing during the period studied, in order that the possible sources of tensions within nursing leadership might be established.

Ecological model of health.

in which the concern is with the risks and hazards of human environments, and which seeks social intervention to reduce risks and protect the vulnerable.

(Beattie, 1995:19)

Florence Nightingale and other nurses at the end of the 19th. century and in the early part of the 20th. century were convinced of the importance of hygiene and the environment in the eventual recovery of the patient. Some of the difficulties which currently face nursing and nursing leadership can be seen to derive from the system of training set up at St.Thomas' Hospital in 1860 (Nightingale, 1980). Davies (1980) comments that these arrangements:

represented a minimal allocation of resources and a minimal change in the status quo....This form of nursing education was a compromise based on the existing institutional framework of the hospital. It neither challenged the doctors' status nor made demands on the hospital administrators for resources.

(Davies, 1980:104)

The legacy that this system of training left for nursing education is one which has had far reaching effects for the majority of the next one hundred and thirty years as nursing was considered to be an adjunct to medicine and nurses were subservient to doctors. The first nurse training programmes reflected this, the theory that nurses were taught was mainly 'simplified medical knowledge' taught by physicians (Jolley, 1987). This system survived into the early parts of this century, lectures to nurses were, in the main, delivered by doctors and only revision classes were given by sister-tutors (Bendall and Raybould, 1969). It was assumed that practical nursing would be taught by ward sisters as the probationers went about their duties. However, even from the beginning of this system of training, the teaching given by ward sisters was seen to be inadequate (Jolley, 1982) and a source of tension between service and education.

One of the solutions to the problems of nurse training created by medical dominance, on the one hand, and the inefficiency and ineffectiveness of the apprenticeship system, on the other, was to create a separate role for nurse teachers. Commentators such as Jolley (1987) and Strong and Robinson (1990) argue that this separation of the roles of the practice of nursing from the teaching of nursing has

caused some of the tensions surrounding nursing education. A 'service-education' divide was established which led to conflict between nursing service managers and nurse educators. The resulting theory- practice schism was exemplified by the low correlation, in the view of the students, between the 'ideal' situation (as taught in the school) and the 'real' situation as experienced in the clinical area (Bendall, 1975). Additional consequences of this system of nurse education have been the low esteem in which the teachers of nursing have been held in the view of their students (Gallego, 1983), and an 'anti-education' bias in the profession at large (White, 1985).

Another of the major difficulties for the nursing profession which has been laid at the door of those who taught nurses is the way in which this teaching was carried out. From the very earliest days of formalised nurse training there was emphasis on obedience and adherence to rules and regulations, both within the overt and the hidden curriculum (Beardshaw, 1981). The nurse was also taught 'self discipline and etiquette - crucial to the tradition determining the standard of correct behaviour to the medical profession and her patient' (Rafferty, 1992a:358). Whatever the reasons it is seen to have stultified personal and professional growth for many years. As Bendall points out:

As long as 'knowledge' is taught in the classroom, 'skills' in the clinical situation and 'attitudes' in the general social context the learner will never be educated only trained, and not very well at that.

(Bendall,1975:22)

It has also been commented that the teaching methods used at this time were more suited to the development of bureaucratic behaviour patterns (Gott, 1982). In addition much of the emphasis of nursing education during the time in which those interviewed in this study were in training, as described in the next Chapter, was on housewifery. Generally this was translated as students being responsible for the housework in the Preliminary Training School, in preparation for their cleaning duties in the ward. Sick room cookery was also taught, as was making and applying bandages (Dodd, 1973; Miles, 1979; Gallego, 1983). Nurse's work was thus very much allied to perceptions of women's work (Salvage, 1985; Rafferty, 1993a), which was seen to be an 'extension of women's natural sphere in the home' and 'not

demanding or skilled enough to require much reward' (Salvage, 1985:138). The demands on students in terms of hard work and trying to find time to study were exacerbated by low status and low pay (Salvage, 1985) and Rafferty (1997a) argues that the early emphasis on 'character' training in nursing re-inforced the anti-intellectualism stance which served to exclude women from professional work. Thus the way in which nursing was taught and the view of nursing as on a par with domestics may have led to the combined 'repressive to juniors and subservience to seniors' style of some past nursing leaders.

Contemporary authorities, for instance, Kitson et al report 'depression at how little nursing has changed' (1993:57). It appears from this evidence that it may have been hard for nurse leaders to escape from this 'weight of tradition' (Davies, 1992). Arguably this legacy is still with us, Kitson et al (1993) report that tensions remain in contemporary nursing surrounding the conceptions of 'woman's role as subordinated moral agent, ministering to the physical, spiritual and emotional needs of mankind, as opposed to the image of woman as independent, autonomous professional, working in partnership with medical colleagues' (1993:57). An additional source of tension for nurse leaders is seen to be between the 'hospital medical model of care and the more community-based social hygiene model of intervention' (Kitson et al, 1993). This review, in keeping with the framework proposed by Beattie (1981, 1995), now turns to an examination of the rise of the 'medical model' of care in order to better understand the issues surrounding these tensions.

Biopathological or biotechnological model of health.

which focuses on 'mechanical defects' in the individual human being, and sets out to rectify these in the light of biomedical sciences and technologies.

(Beattie, 1995:19)

From the 1920's onwards technological advance provided the doctor with a wider range of treatments and thus more chance of offering cure to patients (Miles, 1987). The nurse's role in this 'medical' model was seen as assisting the doctor and carrying out some of his discarded tasks (Miles, 1979). Nursing knowledge at this

time concentrated mainly on anatomy and physiology, and the aetiology, pathology and treatment of disease. Nursing practice was based on a system of task allocation (Bevis, 1978; Hollingworth, 1985) and the nurse was seen as subservient to the doctor, 'an assistant to him in his important work' (American Nurses Association, 1907 cited in Hollingworth, 1985). Much actual care delivery was divided into specific tasks, for which minimal on-the-job training was devised and carried out by other workers. Nurses acted as teachers and supervisors and nursing care was organised around the needs of the physician rather than on the nursing needs of the patient predominated. Terminology such as 'medical nursing' or 'surgical nursing' predominated and patients were seen as disease entities rather than people (Schurr and Turner, 1982). The 'medical model', as it has come to be known, was the approach to health care delivery which was most prevalent in the 1950's, 1960's and early 1970's, when all of the nurse leaders interviewed in this study were trained. Criticisms of the medical model are that nursing care was based on the medical diagnosis or the particular whim of the doctor (Schurr and Turner, 1982). Nursing care consisted of routine, ritualised practice (Perry, 1993) and thus was mechanistic and impersonal (Benner, 1984; Dunlop, 1994). Patients were socialised into passive, sick roles (Perry, 1993; Greenwell, 1995) and there was a focus on physical tasks 'done' to patients with a small amount of interpersonal interaction between nurses and their patients. As a reaction to these approaches it is suggested that nursing's adoption of humanistic and holistic philosophies (Bevis, 1978) brought with it some profound changes in the role of the nurse and her relationships with doctors and patients (Hollingworth, 1985; De la Cuesta, 1979).

Biographical model of health.

which focuses on troublesome life events that are personally significant for the individual, and aims to help the person develop strategies for coping with these.

(Beattie, 1995:19)

The advancement of a patient centred, individualised approach to nursing care was the reaction to the mechanistic and depersonalised systems of the immediate post-war era (Bevis, 1978). An increase in community care (Bevis, 1978), along with increased expectations of health care workers by society (Watkin, 1978; Miles,

1987), and developments by those nurses whose aim was to professionalise the occupation of nursing (Carpenter, 1977; Melia, 1987), are cited as reasons for this change.

Nursing practice in Britain during the 1970's focused on the development, introduction and evaluation of the nursing process. Arguably this approach has been the greatest influence for change in most, if not all, areas of nursing in this century (Hollingworth, 1985). It is claimed that the nursing process is a 'problem solving approach to nursing' (Kratz, 1979) and that this systematised and individualised approach demanded different knowledge (McFarlane, 1977), skills (Hollingworth, 1985), and working practices, especially vis-a-vis medical colleagues, (De la Cuesta, 1979; Keyzer, 1988), to those previously acquired by nurses. Hollingworth claims that nurses using the nursing process:

are no longer doctors' hand-maidens, they are confident, professional, autonomous decision makerspatient-centred care has far reaching implications for social relations in health care, and raises profound issues of power and control in nursing.

(Hollingworth, 1985:29)

Adoption of the nursing process shifted the practice of nursing from task allocation to team nursing (Matthews, 1982; Schurr and Turner, 1982), and subsequently to the development of primary nursing (Thomas and Bond, 1990; Wright, 1991; Pearson, 1992). Kitson (1993) summarises changes in theorising about nursing during the period studied and, drawing on the work of Meleis (1985) who analysed developments in nursing theory between 1950 and 1980, she links the nurse theorists with the paradigmatic origins, major orientation, and major concepts of their theories and also points out the deficiencies of their models. Once again tensions between nurse leaders emerge as a plethora of nursing theories and models were developed, Kitson (1993) concludes that the needs-based theories, such as Henderson (1969), Orem (1971) and Roper et al (1980) were reductionist and too nurse and illness focused. As a reaction to these deficiencies interactionist-theories were developed. Peplau (1952) is seen as in the vanguard of this movement, which emphasises the centrality of the nurse-patient relationship, and an eclectic assortment of other nurse theorists, such as Orlando (1961), King (1971) and Travelbee (1971)

are subsumed under this heading. It is claimed that the third, current group, of nurse theorists (the outcome, or holistic, theorists) overcome the perceived weaknesses of the interactionist theories, the lack of attention to the environment and physical needs of the patient. Theorists such as Rogers (1970) and Riehl and Roy (1974) are included in this group.

Bolstered by theory acquisition some nurses have claimed authority to act independently of doctors, as nurse practitioners, behavioural psychotherapists and in nursing development units (Pearson, 1992); and more recently to nurse led and patient-focused care units (Nursing Standard, 1994). However, despite the wide spread claims for changes in the practice and education of nurses as a consequence of the introduction of the nursing process, there is a substantial body of evidence to show that these developments have been slow to take hold. A variety of reasons have been put forward to account for this, all of which are further manifestations of, or can be said to contribute to, tensions between nurses and their leaders or tensions between nurse leaders themselves. The difficulties which nurses have faced in achieving the change in nursing practice which the nursing process requires have been attributed to the problems that they have in conceptualising the changes; the changing power relations between nurses and patients and nurses and doctors; and issues concerning nursing's quest for professionalisation. Each of these arguments will be examined in turn later in this chapter when the analysis of the nature of nursing during the period studied, using Beattie's framework (1981, 1995), is completed. In this fourth segment the notion of partnership and cooperation with other groups concerned in health care issues is stressed.

Populist or communitarian model of health.

in which social groups and social movements mobilise to share their health concerns and which engage in cooperative advocacy and campaigning for health.

(Beattie, 1995:19)

This model places an emphasis on 'person-to-person' relationships and the importance of the individual and society in the causation of problems and disease (Miles, 1987). This is evidenced by an increased interest in health education,

preventive medicine and self-care. Once again the role of the health care professional and, in particular, that of the nurse is changing.

The development of these new approaches to nursing appear to have been recognised by the G.N.C. in the early 1980's in the publication of the 1982 syllabi for Parts 3 and 5 of the professional Register (G.N.C. 1982). The syllabus for Part 3 of the register (Registered Mental Nurse) stresses the importance of psychiatric nursing as 'a human activity'. Human relationships, self-awareness and individualised care are identified as key concepts. Within the section of the syllabus concerned with professional studies, the 'populist' model of health care is recognised as 'De-professionalised; encouraging client autonomy and the formation of client support systems; changing attitudes to mental health' (General Nursing Council, 1982). Increased involvement in the planning and delivery of curricula by 'consumer groups' such as the Royal Society for Mentally Handicapped Children and Adults (Mencap), the National Association for the Welfare of Children in Hospital (NAWCH), and the National Association for Mental Health (MIND) are examples of other ways in which the 'populist' movement has and is influencing change in nurse education. Contemporarily, Rose (1997), describes partnership in nursing care delivery between parents and nurses in paediatric care which exemplifies developments in this area.

The notion of professionals sharing power with users and with other groups of professionals working in the health service seems to be one which is growing, however Sines (1994) argues that 'few managers and leaders of nursing have fully appreciated the complexity of the task involved in moving from a seemingly professional led service to one that is based on a true sharing of power between clients and their supporters' (1994:894). Notions of partnership between nurses and their patients and of nurses acting as advocates on patient's behalf can bring rank and file nurses into conflict with their managers (Hockey, 1987; Tattam and Thompson, 1993) and nurse leaders into conflict with managers of hospitals and Trusts (Tattam and Thompson, 1993; Ackroyd, 1995). Hence each of the four models of health and the conceptions of nursing which accompany them have the potential for conflict and tensions for nurse leaders.

As was suggested earlier it appears that all four models of health, and the practices of nursing which accompany them, were in evidence during the period studied. It was implied that the reasons why nurses found it difficult to change their practice were concerned with their difficulty in conceptualising the changes; the changing power relations between nurses and patients and nurses and doctors, and issues concerning nursing's quest for professionalisation. Evidence for, and against, each of these propositions will be examined and the implications for nursing leadership, especially as potential sources of tension, will be highlighted.

Nurse's difficulties in conceptualising changing models of health and the accompanying changes in nursing knowledge and practice.

With regard to nurse's difficulties in conceptualising these changes Smith (1992) found that the nursing process was hardly used by both teachers and students. She speculates that tutors had difficulty in conceptualising and using the nursing process as a basis for teaching because they had 'trained and practised as nurses in the pre-nursing process era' and therefore found 'difficulty in conceptualising nursing as people-oriented knowledge' (Smith, 1992:39). She quotes one tutor who claimed that the medical model was much more 'logical' and 'scientific' for use in the school, Smith (1992) reaches the conclusion that the 'nursing process is limited as a conceptual device' and she goes on to claim that it has been superseded by a number of nursing models. However there is evidence that many 'rank and file' nurses, particularly those working in hospital wards, find it difficult to use nursing models in practice (Webb, 1993; Bellman, 1996). A possible reason for this difficulty has been suggested by Reason, (1994), who claims that nurses often neglect to make the bridge between practical knowledge and propositional knowledge, namely that of the development of presentational knowledge.

Practical knowledge is acquired through practice, knowing 'how to' do something, and is demonstrated through a skill or competence. Whilst experiential knowledge is considered to be gained through direct encounter, face to face with persons, places or things. For the nurse in clinical practice this might be in wards, clinics, surgeries and patient's own homes. For nurse leaders and managers experiential knowledge would be gained through day to day problem solving activities on the

job, similarly experiential knowledge for nurse teachers would involve their experiences of classroom and clinical teaching. Thus experiential knowledge is usually converted into practical knowledge through practice in the real situation. Propositional knowledge, that is knowledge about something, is expressed in statements and theories and presentational knowledge is described as a two step process; firstly as ordering tacit experiential knowledge of the world into spatio-temporal patterns of imagery and then symbolising the sense of their meaning into movement, sound, colour, shape, line, poetry, drama and story (Heron, 1992). As was discussed earlier it has been suggested that for many nurses there was a gap between their 'practical' knowledge and their 'theoretical' (propositional) knowledge of nursing (Bendall, 1975; Jolley, 1987; Gallego, 1983; White, 1985). Dale (1994) indicates that failure to make the connection between propositional and practical knowledge might account for the theory-practice gap in nursing. She suggests that experience is the key to linking propositional and practical knowledge together, and to facilitate learning teachers of nursing, be they practitioners or lecturers, need to be fully conversant with both propositional and practical knowledge. She goes on to propose that a theory - theory gap exists between the knowledge of lecturers and that of practitioners and that this may be a key factor contributing to the often researched and written about phenomenon of the failure of nursing students to relate theory to practice (Bendall, 1975).

Many nurses indicate that during the course of a days work there is little time to think as 'getting through the work' assumes priority (Clarke, 1978) and time to give care is subordinated to completing tasks (Mackay, 1988). There is some evidence that student nurses prefer routine and ritual (Melia, 1987; Wilson and Startup, 1991), perhaps in order to cope with the stresses associated with the 'emotional' labour of the work and staff shortages. These factors, coupled with the anti-intellectualism which prevailed within nursing, resulted in many nurses who had abundant practical and experiential knowledge but who did not go through the process of developing presentational knowledge. For this to occur there is a need to draw on the arts and humanities disciplines, areas which were not much included in nursing curricula until fairly recently.

Kitson (1993) offers another reason for nurses difficulties in conceptualising when

she argues that 'the relative inertia in nursing thought and concept formalisation is related to the continued confusion that exists between concepts of nursing and concepts of care' and goes on to expand on three phases in the development of conceptualisations in caring (as related to nursing); caring-as-duty, caring-as-a-therapeutic-relationship, and caring-as-ethical-position. She links the three groups of theories of nursing which were referred to earlier to these conceptualisations of caring and argues the need to move nurse's thinking from caring-as-duty through the other phases and to move them from a needs based conception of nursing to a holistic model.

Critics of Kitson's (1993) analysis question its applicability in practice, particularly when to shift nurse's work to that of autonomous and independent practitioners would bring them into conflict with those who hold greatest power within current health care organisations (Kitson, 1993). Research by Hollingworth (1985) and Keyzer (1988) appears to prove that in reality nurse leaders, both educationists and service managers, did not appear to have the power to change the status quo in respect of nursing practice. This is explored in the following section.

Changing power relations between nurses and patients and nurses and doctors.

Various authorities claim that developments in the practice of nursing in the 1980's and 1990's have increased nurse's power (Wright, 1993) through their ability to determine nursing care without reference to doctors. Salvage (1992), among others, coins the phrase 'new nursing' to describe these changes. It is claimed that adoption of the humanistic existentialist philosophical approach (Bevis, 1978) carries with it a different relationship between the nurse and the patient or client than that which exists when a medical model of care is practised (Hollingworth, 1985). In the latter case the nurse is seen to be in a more powerful position with the patient ascribed to a more subservient and dependent 'sick role' (Kelly and May, 1982; Kelly, 1992). With the adoption of 'new nursing' it is assumed that greater control in the interaction passed to the patient, who is considered to be a partner in deciding the pattern and timing of care delivery. Where the patient or client is seen to be unable for some reason to participate in this way nurses have increasingly taken on the role of patients advocate (Beardshaw, 1981). However the patient may not understand

or appreciate the 'power' that they have been given. A student nurse commenting on the reactions of patients to the introduction of the nursing process states 'to some, the offer of organising treatment around their routine seemed superfluous, to others it indicated a certain lack of professionalism on behalf of the nurse. One gentleman, I remember, regarded it as sheer inefficiency!' (Brooks, 1978:125).

The new approaches to nursing encourage nurses to become involved with their patients in ways which were previously discouraged. The exhortation to retain social distance whilst caring for patients poses one of the most fundamental paradoxes of the work of nurses. Nurses are urged to care for and about patients. This means getting to know them, becoming involved in their lives and therefore attached to them, while, at the same time, they are told to have a 'professional' relationship with patients. Professional meaning, in this context, a detached relationship.

Dunlop (1994) refers to the way in which nurses are taught to both 'link' with patients in their care and at the same time 'separate' from them. She quotes Benner (1984) being cautioned in nursing courses against becoming too involved and her own similar experiences of learning to nurse in Australia where she was warned against involvement while also being asked to put herself in place of the patient and/or relatives. The author's own early experience of a ward in which young and middle aged men dying of heart and liver disease were being nursed and wondering how they and their female relatives coped offers a similar example. The memory of crying with a patient's wife and daughter (about the same age) and then of being reprimanded by the sister for 'getting too close to patients and their relatives' came flooding back. Smith (1992) too found that:

It seemed that because student's feelings were rarely acknowledged in the open arena of the ward that they were likely to develop distancing strategies which kept them from personal involvement. They recognised that, as they progressed through their careers, they might become hard. But they also recognised that if they hardened and distanced too much they would be unable to nurse with feeling.

(Smith, 1992:110)

These words have the all too familiar ring of Menzies (1960) findings which suggest that the practice of allocating tasks, rather than patients, to nurses served as a

mechanism for coping with the stress that dealing with the sick and their families causes. It seems that the new approaches to nursing practice might increase stress levels amongst nurses. There are also difficulties with patients who do not play their anticipated 'sick role'. The patient who does not submit as anticipated, often one who challenges the power of the professional, is labelled unco-operative, manipulative, obstructive, ungrateful. This presents a contradiction to the nurse who may be tempted to ignore the needs of such patients. These issues of power and control in the relationship between nurse and patient have the potential to generate stress and anxiety for both groups and this section has shown that nurses have dealt variously with their anxieties.

Findings by Buckenham and McGrath (1983), in a study in Australia, suggest that this anxiety is likely to be heightened if the nurse is expected to challenge the doctor on behalf of the patient. These researchers found that although nurses embraced the professional rhetoric of putting patient's needs first, tangibly their main loyalty was to the professional health team and they would only act as a patient's advocate if this did not endanger team membership. At the ward level there is a body of evidence that suggests that the new approaches to nursing break down in the face of the power of the medical profession and increased work loads (Buckenham and McGrath, 1983; Melia, 1987; Proctor, 1989; Salvage, 1992).

Salvage reviews research which has attempted to measure patient satisfaction with 'new nursing' and asserts that 'the evidence that patients want partnership with nurses of the type being advocated is rather mixed' (1992:19). She questions the motives of the nurses behind this movement and asks whether the power gained is for the benefit of the nurse or the patient, she advises 'the leaders of New Nursing to guard against the seductive assumption that empowering nurses is the route to empowering patients' (1992:22). She claims that a 'truly patient-centred model would challenge the boundaries between the roles of the doctor, the nurse and the informal female carer' and draws on Keyzer's (1988) claim that 'it is unlikely that such a model....would be welcomed by those whose power it seeks to remove' (1992:21). Thus heightened tensions and conflict accompanied the bid to professionalise nursing and brought nurses into conflict with doctors as attempts were made to alter the distribution of power in the relationship.

Issues related to nursing's professionalisation.

Larkin (1983) suggests that divisions in medical work can be seen as either the direct product of technological innovation or as boundaries drawn between doctors and other 'para-medical' occupations, that is those occupations which 'poach' aspects of the doctors work or to which are delegated 'unpleasant' tasks or those which lack 'esteem'. It is claimed that the source of characteristics which separate the organisation of work in the industrial state are contrasts between hand and brain (Braverman, 1974) or male and female work (Stacey, 1981). Further to this distinction it is argued that caring professions are embedded in patriarchal social structures (Davies, 1995; Hugman, 1991:180; Walby, 1986, 1988; Hearn, 1987) and that this determines the lack of power and the invisibility of nurses (be they men or women) in the division of labour between nurses and doctors. This division of labour is seen to mirror that of the home, with nurses seen as the 'housewives' of medicine (Gamarnikow, 1978; Hugman, 1991).

Similarly, it is claimed that 'professional carers' of all kinds: nurses; remedial therapists; social workers; and primary school teachers, have been controlled from their beginnings by the 'prototypically (white) male professions' which:

exerted definitional power over the boundaries of the emerging professions through access to resources and legitimacy, controlling them in both the material and ideal spheres.....the occupations of nursing, the remedial therapies and social work have been under the power of the more established professions and the state.

(Hugman, 1991:13-14)

The professions numerically dominated by women, such as nursing and teaching, are seen as inferior because women form the majority of their members (Hugman, 1991:181; Dex, 1985). Thus they are adjudged subordinate. The inferior status of these occupations is confirmed through being rated as less skilled and their contribution accorded less value than that of medicine. In these ways their unimportance is confirmed. Davies (1995) argues that recent work on masculinity and femininity allow a better understanding of the dichotomy and the tensions and conflicts engendered:

masculinity and femininity....must be understood in constant reference to each other; they are not separate and complementary; rather they wrench apart the diversity and richness of our human qualities, assigning the masculine set a privileged status and containing, denying and repressing the feminine.

(Davies, 1995:21)

The inequality in the gender relations between the caring professions and the curing profession is compounded by the difficulty that many women have in 'making their voice heard' (Belenky et al, 1986). In part this may explain the 'invisibility' of nursing (Davies, 1995) and the 'black hole' (Robinson, 1993) in which nurses operate. An examination of care and caring and the relationship between caring and nursing helps to cast light on the palled nature of the work of nurses. Some of the problems associated with attempts to claim that nursing is a profession appear to revolve around the nature of the division of health care labour, the fact that most nurses are women, and that nursing's work is that of caring whereas that of the doctor is characterised as more to do with curing.

As stated earlier the introduction of the nursing process was seen to offer an approach to the planning and delivery of nursing as a profession equal to that of medicine. When searching for reasons for the extravagant claims made for the nursing process, which seem to have failed in face of the reality of nursing practice, it is interesting to consider how many of the early exponents of the nursing process were community nurses, especially health visitors. Esland claims that health visitors were one of the 'latest of a number of occupational groups which have begun the process of professionalisation and gradual enlargement of their domain of practice and concern' (1980:251). He goes on to suggest that the group of 'personal service' professions, to which health visitors were aspiring, were engaged in the 'highly political process' by which moral and political questions are converted into technical problems. Esland raises a serious question about the applicability of the technological rationality of the approaches adopted by these professions to the work of nurses and others whose work is 'caring, healing and helping' (1980:273). He suggests that:

It is arguable that the professions themselves need to have built into their curricula a view of their practice and social position which does not take the

mythology and rhetoric of professionalism for granted but which underlines the very distinct structures which they are helping to maintain.

(Esland, 1980:278).

Thus it is considered that nurse proponents of professionalism adopted the medical (and masculine) technical and scientific approach but, rather than furthering nurse's claims for autonomy, this approach has formed a legacy from which contemporary nurses have 'yet to break free...the emphasis of the so-called 'new nursing' on individualism, humanistic psychology and the personal characteristics of the nurse, echoes the essentialist arguments of an earlier period and debate' (Rafferty,1993a:57). Beardshaw (1981) accurately pinpoints some of the contradictions inherent in the term 'nursing professionalism':

how can individual autonomy be reconciled with the obedience nurses traditionally owe to the medical profession and their superiors in the nursing hierarchy.....'a profession waiting for orders', where emphasis on obedience to authority dilutes the professional responsibility of individual nurses.

(Beardshaw,1981:56)

If this is the case one questions where the impetus for change in nursing practice originates. If not from the 'rank and file' (Carpenter, 1977) then presumably from the leaders of the nursing profession. The leaders though appear to be somewhat divided on this issue as well (Keyzer, 1988). Perhaps the crux of the problem lies in the desire of some of its leaders to change the perception of the work of nurses in order to raise its status. In their attempts to achieve professional status some nurse leaders have been concerned to raise the status of nursing by means of occupational mobility and occupational closure and in so doing have lost some important aspects of their work.

Hughes (1958) assumes that delegation of dirty work to others is an integral part of occupational mobility and that nurses delegated work to attendants and cleaning staff in an attempt to increase the prestige of their occupation. Whilst Wollacott argues: 'doctors do delegate much dirty work to those of lower status, and over time have rid themselves of their tasks in this respect' (1980:195). 'Basic' nursing (Goddard,

1953; White, 1985), for instance attending to patient's toileting needs, is sometimes seen as low status and not proper nursing so, in order to raise the status of nursing and hence nurses, these aspects have been passed to 'untrained nursing auxiliaries' (Salvage, 1985). In this way the work of the professional nurse was seen to move up the occupational ladder. Similarly the professional nurse could lay claim to a need for a greater level of knowledge than the untrained nursing auxiliary. The notion of closure is used to explain 'territorial claims on knowledge' (Hugman, 1991:94). 'Internal' closure is created through the formation of subgroups which 'allows the would be profession to lay increasing claims to higher-status activities' (Hugman, 1991:95). Nurses thus were able to lay claim to a level of skill which matched the knowledge base which they were attempting to demonstrate. However these moves towards claims of professional status were not universally accepted by all nurse and their leaders (Green, 1978; Melia, 1987; Salvage, 1988; Jolley, 1989; Sandall, 1993) and was a source of further tension between nurse leaders.

Whilst passing 'non-nursing duties', such as patient's diet and nutrition, to other health care workers, nurses have lost opportunities to be in contact with patients. Sometimes at their most intimate and vulnerable times, when much of the caring work of nurses takes place. The emotional labour which nurses carry out during these private encounters with patients is often invisible to those who are not receiving it and consequently what is not seen is not valued. Emotional labour also causes difficulty and sometimes distress to those who are giving it (James, 1992; Smith, 1992). Smith makes the important point that nurses 'not only laboured emotionally for patients, but also for each other' (1992:8), and James points out that there is virtually an 'inverse law of status and skill in emotional labour' (1992:503). The least well qualified and well paid, the nursing auxiliaries, were observed to be those most likely to be involved in emotional labour. Thus attempts at occupational mobility and closure have seemingly robbed registered nurses of a most precious aspect of their work, either through deliberate devaluation or through profligate neglect. Critics of the philosophies underpinning some of the 'professionalising' developments in nursing claim that the movement is based on a gendered conception of profession (Malinski, 1988; Davies, 1995) and as such fails to ensure that the role of the registered nurse is directed towards the delivery of nursing care. The espousal of the quest for professionalism by some nursing leaders which led to the

development of theories of nursing in an attempt to prove that nursing had a body of knowledge and expertise; were specialists not generalists; and practised autonomously, does not appear to have furthered the development of nurses and nursing in the ways anticipated. It is now claimed that these definitions of profession were gendered and that by following this route nurses and nursing were in a 'triple bind' situation:

First, nursing aspires to be a profession when the concept expresses a gendered vision that is a denial of the feminine values of nurturing that nursing seeks to espouse. Second, nursing aspires to be a profession when its own work is part of a gendered division of labour that helps to sustain 'profession' for medicine. Third, nursing has seemed, almost despite itself, to be deeply engaged with bureaucratic forms of organising, which are also flawed by the gender division.

(Davies, 1995:62).

In Chapter 4 of this thesis the different views of nursing; the role of the registered nurse vis-a-vis the 'untrained' nurse; non-nursing duties; and nurse-doctor roles and relationships held by the past nursing leaders interviewed are explored. The tensions and conflicts between individual nurse leaders and different segments of the profession are also highlighted in Chapter 4. Chapter 6 describes some of their views of bureaucratic forms of organising. In these two chapters some of the deep differences between nursing leaders and their views of nursing in the period studied, which this review has attempted to outline, are examined.

Currently there is evidence that some nurses and others have begun to question the applicability of the traditional model of professionalism to their work (Melia, 1987; Jolley, 1989; Davies, 1995). This claim will be further developed in the final chapter when the implications of adopting a 'caring trade or craft' approach to nursing is explored. A 'caring trade' model will shift nursing more firmly into a partnership and co-operation model of health care, and more firmly into the fourth segment, the 'populist or communitarian model of health, of Beattie's (1981, 1995) model. As was explored earlier adherence to this model is not without its own conflicts and tensions for nurse leaders but at least they would be in a position of equality with the rank and file nurses and their patients rather than a domineering one.

2.3. Summary of the possible causes for the current tensions in nursing leadership, with particular reference to leadership of nursing education.

The factors highlighted in this review so far have had, and continue to have, important implications for nursing leadership. Views of health, nurses and nursing (particularly vis-a-vis medicine and the patient/client) have undergone profound shifts in the period studied. In particular developments in the theory and practice of nursing since the early 1960's are considered to have enhanced the professional status of nursing and nurses, but their beneficial effects on patient care, have yet to be fully realised. There is also some evidence that not all nurses subscribe to these changes in nursing practice and Kitson (1993) questions the ability to 'survive in a pluralist nursing system with a variety of concepts and theories of nursing and caring' (1993:30).

There is evidence that all four models of health and the ward and nursing practices which accompany them are practised currently. Nurses report that they use task allocation, team nursing and primary nursing (Seccombe et al, 1993). There are also proponents of a wide range of nursing models and of views about the nature of nursing and nursing work. Thus the review so far suggests that one of the possible reasons for the perceived current dearth of nurse leaders (Rafferty, 1993b; Dean, 1994 and 1995), and the way in which they are viewed by medical and managerial colleagues is to do with the divided nature of nursing. Internationally the potential for disaster in the divisions between nurse leaders are emphasised by the nursing scientist to the World Health Organisation:

Disagreement often makes the situation so bad that the devil further widens the communication gap and one cannot expect anything but ruin, or at best, stagnation for the profession.

(Mojekwu, 1992:31)

She goes on to stress the need for nurse leaders to agree on the role of the nurse and the most appropriate level for pre-registration education of the nurse in order to meet changes in concepts of health and health delivery systems. However even on this point nursing leaders differ, Tattam and Thompson (1993) report that Christine

Hancock (General Secretary of the R.C.N.) exhorts criticism and healthy disagreement between nurses as a means to genuine empowerment, they conclude that dissent and conflict amongst nurses will enable them to 'effectively challenge the political decisions behind cash limiting care, and the use of health issues as a political football' (1993:111).

Whether or not one agrees with the sentiments expressed by the above authors these examples serve to illustrate that there were and are disagreements and tensions between nurse leaders and also tensions between them and rank and file nurses. In a study of American nurses Melosh (1982) highlights the dangers of assuming that the views of nursing leaders and those of the 'rank and file' were synonymous. She considers that nursing history has been built on notions of the leaders as 'dedicated reformers' struggling to establish nursing as a reputable profession. She claims that there is another history of nursing which:

Reveals that leaders faced considerable opposition in their own ranks: the ideals and goals they set forth were hotly contested by nurses themselves. Such conflict emerged as a consistent and pervasive theme in nursing history....indicating deep divisions among nurses.

(Melosh, 1982:4)

There are similarities between the claims made by Melosh (1982) and those of White (1983) who asserts that the Royal College of Nursing failed to represent the views of the 'generalist' or 'proletariat' nurses. Robinson (1991) compares the views of nursing of White (1985), Clay (1987), and Salvage (1985) and concludes;

Here, in simplified terms we see some of the fundamental roots of the disagreement within nursing ...each of these highly credited authors puts forward values derived from his or her system of ideas; we hear the views of the professional trade union; the representative of a professional elite; and the voice of the worker on the ward.

(Robinson, 1991:281)

To conclude this section of the review a range of intra-professional tensions between nurse leaders have been explored. Nurses from different segments of the profession, for instance service and education, hospital and community, are shown to have been

in conflict during the period studied. Similarly differences between nurse leaders and the rank and file have been exposed as have the tensions between male and female nurses. The different views held of nursing, especially the differences between the nurse as 'practical' or 'professional' or 'academic', have also been examined. Some of the inter-professional conflicts, especially those between nurses and doctors of managers have been highlighted. It seems that tensions did exist for nurse leaders, and there is some evidence that many of these tensions are still prevalent. Some factors which could have contributed to these tensions have been highlighted. The individual leader's own professional background, especially the conceptions of nursing and value systems underpinning these, are seen as important in forming their approaches to their leadership role. The organisation in which they worked and their relationships with a range of 'stakeholders', especially how they dealt with the 'macro' and 'micro' politics associated with their management role, are also seen as crucial. In addition the ways in which they coped with and resolved conflict would appear significant issues. In this final section of the review previous studies of nursing leadership will be analysed in order to establish a framework for the remainder of this study and to guide the decisions to be made regarding research design considerations.

2.4. Previous studies of nursing leadership.

Previous research studies carried out into nursing leadership by nurses in Great Britain have considered different aspects associated with the leadership role. Hardy (1983) concentrated her study of female leaders of the nursing profession on characteristics of the individuals whereas Rafferty (1993b) took as her starting point the current situation regarding the perceived lack of nursing leadership. Whilst Hardy (1983) concentrated on the individual careers of the leaders her findings reveal a great deal about the environment in which their careers developed and about their relationships with significant others, especially senior members in the profession. In a study of Chief Nursing Officers at a national level Splane and Splane (1994) also suggest that the individual leader or manager will be affected by a range of situational or environmental factors and that other people are amongst the most significant influencing forces. Similarly Mintzberg (1973) claims that any manager's work is 'determined by the influence that four 'nested' sets of variables

have on the basic role requirements and work characteristics' (Mintzberg, 1973:102). The nested variables are environmental, job, person and situational.

Goldenberg (1990) studied nursing education leaders in the U.S.A. drawing on situational leadership theories (Keenan et al. 1988), which are based on the premise that an effective leader's decisions are consistent with the needs and demands of the environment and of the individuals who are to be led. She suggests that leadership style is influenced by situational variables; such as the leader's associates, followers and superiors, and that span of control, cultural, community and time factors are important considerations in examining the roles of leaders of nursing education. She also identifies a range of constraints, for example college management, professional associations and licensing bodies, clinical agencies, advisory committees, collective bargaining groups, alumni, students, faculty, government regulations and finances, which should be taken into consideration.

Adaptations of Mintzberg's (1973) research had been used previously by the author of this current study of nursing leadership to record work activities; to analyse the role of Director of Nurse Education (D.N.E.) and to compare the work of a D.N.E. with that of the five managers studied by Mintzberg (Miles et al, 1988). A self reported management activity analysis of five aspects of the work of a Director of Nurse Education was undertaken over a three week period. The five aspects of work were desk work, scheduled and unscheduled meetings, telephone calls and tours or visits. In addition the purpose of the activity was recorded against Mintzberg's (1973) ten roles of a manager categorised under three main headings, interpersonal, informational and decisional. Miles concludes that:

the significant was interspersed with the trivia without any rhyme or reason. The numbers and varieties of activities that a manager undertakes is, of course, interesting but tells us little about what the manager was doing and whether the activities undertaken were useful in achieving the goals of the organisation.

(Miles et al, 1988:48)

Each of the researchers reviewed used different approaches. Goldenberg (1990) used a measurement scale, Hardy (1983) used a standard questionnaire supplemented with

interviews with some of her sample. Miles (1988) used self-report and a work diary, whilst both Rafferty (1993b) and Splane and Splane (1994) used interviews. As will be seen in the next chapter the chief method chosen for this present research study was interviews therefore those studies which used the interview method, wholly or partly, will be described in more detail.

Splane and Splane (1994) describe models of the **position**, the **person** appointed to that position, and the **broad setting** in which the position is situated to analyse their data. From interviews with a range of Chief Nurses they describe three models of positional authority. The first, or optimum position of the executive type, is where the CNO exercises line authority over nurses and nursing services throughout the jurisdiction in question. They go on to describe the advisory model, in which the Chief Nurse does not have line management authority, but does have reporting relationships to a senior level of government. The third model, that of dispersal, describes a situation in which there is no Chief Nurse, nurses are dispersed into multi-disciplinary teams and, although relatively senior, they are at a distance from central policy making.

With regard to the person in the C.N.O. role they identify the background, attributes and personal capabilities of the optimal CNO. From a list of thirteen attributes they isolate education, previous professional experience, and an ability to communicate as essential pre-requisite qualifications for appointment. Qualities which determine the successful performance of the role are related to the individual's 'vision of, and commitment to, the optimal roles of nursing within and beyond the health care system' (1994 : Chapter 8:7). With this goal in mind the C.N.O. uses personal and professional networks to determine policy and set nursing standards, to foster research and education, and to represent nursing nationally and internationally. Additionally the C.N.O. manages goal directed activity, within a wide range of settings, to achieve these aims. With regard to the setting in which the Chief Nurses work the key factor is the country in which the position is established. Splane and Splane (1994) go on to suggest that political, economic and demographic factors are the most important in determining the way in which the role is carried out. They identify three further constellations of factors or constituents of the setting which affect the nursing leader's role. The cultural and

social factors they describe include human rights, the status of education, the status of women, feminism, and the status of nurses both individually and organisationally. The second cluster of factors relate to the organisation of the health system and include the relations of nurses with members of the medical profession and the body of professional managers. The third group of factors are the scientific, technological and attitudinal factors which promote change in defining and addressing health and illness.

Whilst the study by Splane and Splane (1994) was of leaders of nursing at a national and international level Hardy (1983) focused on the early years in the professional careers of her sample of thirty-six female leaders of the nursing profession in England and Scotland. She proposes that their career pathways could be categorised as a 'steady climb' up the career ladder; as a 'fast move'; as 'lateral move' followed by 'joining' the hierarchical career path; as 'pioneers'; and 'mavericks'. Apart from stressing the homogeneity of gender she did not differentiate between her sample according to the segment of the profession in which they were working. She does though examine the educational, social, and cultural background of her sample and, as they were all women, focuses on theories of sex-role stereotypes particularly as they affected the school years and the career preparation phase. She comments that these girls were educated for roles as wives and mothers and that the teacher's focus in schools was more likely to be on boys than girls. She discovered that they 'spent much of the early period of their career making side-stepping moves which were not conducive to career development' a phenomenon which she labelled as 'lateral move syndrome' (1983:226). Hardy's explanation for this phenomenon was somewhat negative suggesting that it occurred because there was a lack of career structure, support and counselling, so that obtaining 'promotive' qualifications and moves to posts above ward sister followed a pattern of between six to twenty-five years after initial nursing qualification. She concluded that 'few of the respondents could be labelled as 'high fliers'(Hardy, 1983:222). Thus Hardy (1983) considers that the way in which the nursing profession is organised is a barrier to progress and comments that the most important factor which acted as a block to career progression, according to her sample, was a 'weakness of the profession'. To achieve personal career advancement through gaining qualifications and experience was a battle against lack of vision, lack of support (financial and personal) and lack

of insight, the 'professional ethos was one over which one attempted to triumph' (Hardy, 1983).

Hardy (1983) also comments on the difficulties which individuals may face in career development terms within the hierarchical structure of the NHS. She reviews organisational factors and their effects on nursing and nurses and criticises general hospital settings for the hierarchical structures which create an atmosphere which stifles creativity and encourages routine approaches. She points out that the status differences occurring between professions and within nursing itself may have been responsible for the comment by one of her respondents that she was treated as 'less than an adult' (1983:116). Hardy (1983) comments that status differentials can be rigidly enforced when authority and power have been formally attributed and workers are kept in their places a sentiment which Kanter endorses in her conclusion that those without power do not have the freedom to achieve (Kanter, 1977 and 1993).

The other major environmental factor which Hardy considered influential in the career development of her sample were the 'official and unofficial policies of the profession'. Educational opportunities sanctioned by the profession were those which did not develop the skills which may have been identified during the initial training period. Successive apprenticeship periods were encouraged and the career process was not thought out logically. Additionally the attitude of the profession itself to promotion which was seen as removing oneself from 'proper nursing' was seen as detrimental to career development (1983:303-304).

As was described earlier sex and gender are important factors to consider when reviewing the literature regarding the work of nurse leaders. Hardy followed up her study of female nurse leaders with a study of male nurse leaders and discovered distinguishable differences between them. Her second sample of 13 men, were younger than their female counterparts, and were from working class rather than middle class backgrounds. The men made fewer 'lateral moves' and gained less additional qualifications on their moves up the career ladder. They therefore reached positions of authority earlier. Hardy concludes that women's self image, expecting to serve others, not themselves and the direct influence of others, especially

mentors, in combination are factors which lead to men's domination of the top posts in nursing (Hardy, 1987).

In a recent survey of nurse managers it was discovered that male nurses were over represented in senior management roles compared to their female counterparts, 47% of the top managers from a nursing background were men even though the overall percentage in the profession is only 10% (NHSE, 1994). The fact that men make up a small proportion of the total nursing population, about 10%, but have achieved a large number of top posts in the profession has been noted (Austin, 1974; Jones, Crossley-Holland and Matus, 1981; Nuttall, 1983; Hardy, 1983 and 1987; Davies, 1990; NHS Women's Unit, 1995; Davies, 1995). Nuttall (1983) questions whether this phenomenon represents 'female give-away or male take-over'. Rafferty (1993) refers to Hardy's pioneering work in the career histories of leading female and male nurses which highlights their different perceptions and experiences. Female nurses in the study tended to be more highly qualified than men but took longer to reach the top. They followed a tortuous career path and realised relatively late in their careers that they had leadership potential.

Davies and Rosser (1986:12) study of career development opportunities revealed a similarly 'gendered' pattern of job and promotion policies. They argued that the operation of a 'male career path' in the N.H.S. accounted for the structural inequalities and sexual discrimination in the NHS workforce. Consequently the preponderance of men at the top in nursing was out of all proportion to their numbers in the workforce.

What is particularly interesting about gender differences in nursing leadership is the educational profile which accompanies the gender differences. Hutt (1985) reports that male nurse managers were less well qualified than female nurses at the point of entry to the profession. In more recent studies the numbers of senior nurses with academic qualifications has risen, but the pattern of the female nurses being better qualified than the male continues. Forty-four per cent of female nurses studied held bachelors degrees or higher degrees compared to 40% of the male nurses (I.H.S.M., 1995). Comparable data were also noted in the survey of top managers in the N.H.S. with 73% of the women and 67% of the men holding bachelor

degrees or higher. Successive research into the educational levels of senior nurses comments on the differences between them and comparable doctors and administrators. Dixon and De Metz (1982) surveyed chief officers in the N.H.S. and report that there were striking differences in the previous length and range of experience between administrators, community physicians, nurses, treasurers and works officers at regional, area and district levels. Measured by these two indicators nurses were the most experienced of all the groups but with regard to academic qualifications nurses were less well qualified than doctors or administrators. Professionally the nurses were better qualified, both in terms of management course and more specialised course attendance. At face value this data could be taken to reveal that the environment in which nurse leaders worked was one which prized men over women, even when these men were less experienced and less well educated. If the man was a doctor or an administrator then they were more likely to be in a position of more power than the nurse, even though the nurse may be better prepared to hold a management position. To work in an environment like this would surely have a profound effect on the way in which the nurse manager viewed her role and the style which she might adopt in its performance.

The existence of different styles and approaches to nursing leadership was recognised by Rafferty (1993b), who considers the effects of current environmental and situational factors on nursing leadership. The prevailing perceived lack of nursing leadership in the N.H.S. provides the key situational focus and Rafferty (1993b) categorises the interviewees according to their perspectives regarding leadership and management in nursing. 'Sceptics', who view the 'so called crisis in nursing leadership' as a device used by the 'powers that be' to encourage compliance with the changes made in the service. 'Idealists', who 'set a moral example, inspire trust, demonstrate integrity, and act in good faith not for personal gain', and 'pragmatists' who advocate that nurses should 'work with what you have; and go with the flow of the government of the day, whilst trying to wrest the maximum political advantage' (Rafferty, 1993b:5).

Rafferty's respondents raise important questions regarding the way in which nurse leaders are prepared for their roles and of the possible effects of hierarchy and bureaucracy in the N.H.S. and particularly within the nursing profession. As

indicated in the introduction to this Chapter nurse leaders are currently adjudged by some authorities as ineffective and insignificant in health care policy making. This review has highlighted the importance of several factors to which this phenomenon could be attributed, however no one factor seems entirely convincing as crucial in determining this largely negative view.

Previous research into nursing leadership thus highlights important relational, individual and situational factors to be considered in designing this research study. In addition there are some omissions in previous research which this study should seek to address. It seems vital that any study of nursing leadership should not treat the sample as an homogenous group but should examine the differences between nurse leaders and attempt to isolate those factors which contribute to their views of nursing leadership and possible explanations for the tensions between segments of the profession. Rafferty (1993b) does not differentiate her findings according to the professional backgrounds of her sample so one is left to wonder if there were any differences in the responses between those from different segments of the profession or between men and women. This thesis argues that nurses and their leaders do not constitute homogenous groupings and that the styles of leadership adopted or developed differ according to the prevalent view of nursing within particular segments of the profession. Another important factor which needs to be encompassed in research into nursing leadership is a consideration of the effects of the role of government, politics and policy making on nursing leaders. Analysis of nursing leaders and the environment in which they worked will therefore need to take account of the power and influence which they had, both individually and in groups. The professional organisations and statutory bodies to which they belonged and their networks seem to be of most significance in this regard.

Hardy's (1983) study encompassed the person variables and touched on some aspects of the environmental and situational variables but had major omissions in this respect. Whilst she raises the importance of examining the nursing hierarchy for an understanding of the possible effects on the careers of nurse leaders she did not expand on it and one is left with a sense of frustration about the unexplored aspects in the lives and careers of the influential women she investigated. Thus the organisation in which nurse leaders worked, the way in which the nursing hierarchy

operated and their position in the hierarchy are all important features to explore as factors which would have an effect on their careers and leadership styles.

The environment in which nursing service managers worked in the period studied was one in which their skills were seemingly unrecognised and undervalued and progressively their power and influence appear to have been stripped away. Arguably at the time when clinical nursing was being exposed to even greater demands in terms of economy and efficiency leadership above the level of the ward manager was denuded. At the same time the clinical nurses unique position in the health care team has been obfuscated. Changes in the distribution of duties between nurses and doctors, for example the reduction of junior doctors hours, the widening of the nurses' scope of practice and 'nurse prescribing', has coincided with blurring of professional boundaries between nurses and other health care and social care professionals. This is especially evident in the continuing care areas such as care of the elderly and care of people following strokes and in care of the mentally ill and learning disabled. Skill mix changes have resulted in a reduction in the numbers of registered nurses to deliver care and there are also suggestions that the benefits and satisfactions of primary nursing, for both nurses and patients, will be unrealisable due to resistance by the medical profession (Harrison and Pollitt, 1994) and lack of opportunities for nurses who have to work part-time (Robinson, 1992). The Audit Commission (1991) comment:

Over the past decade, nurse managers and nurses in every hospital in the Audit Commission sample have had to contend with major change in almost every aspect of their work.... First general management, and then the re-organisation of management at sub-unit level into clinical management groups, have had a fundamental impact on nursing management structures.... In many hospitals managers have found it difficult to co-ordinate the number and control the pace of change impacting on nursing.

(Audit Commission, 1991:58)

However it is only in some relatively recent studies that the link is made between the work of nurses and the success, or otherwise, of their leaders. For instance Hardy (1983), in her otherwise seminal work, dissociates the leaders she studied from the work they did in almost cavalier fashion. She argues that the research

remit was restricted by many of the models of nursing which were developed in the 1960's and 1970's in which the patient is located as the centre of nursing care. She concludes that these models are more theories about patient care than about nursing and that the concentration on the patient has meant that there have been few studies on the personal lives and careers of nurse. She therefore locates her study firmly on the lives and careers of the women studied and excludes consideration of the effects of the work they did on their careers. This seems an important omission based on a somewhat spurious argument. One should ask who the models are for, the nurse or the patient?. Dingwall et al (1988) suggest that the models are for the nurse, if this is the case then the study of nursing careers cannot be divorced from consideration of models of nursing. Even if the models are for the patient, to exclude an analysis of nursing work from a study of nursing leadership would seem short-sighted.

The range of measures introduced by government since the start of the N.H.S., in particular over the past fifteen years, in the view of some commentators has served to alienate professionals from lay managers. Managerialism followed by the introduction of the 'internal market' are considered to have increased the potential for conflictual relationships between managers and professionals (Harrison and Pollitt, 1994) and between professionals on different 'sides' in the purchaser-provider relationship. Thus there is competition between both managers and professionals in different 'provider' organisations and inter and intra-professional 'rivalry' in both 'purchaser' and 'provider' spheres. The potential for conflict in the 'harsh, cut and thrust climate of the new order' (Rafferty, 1993b) is seen as one reason why there is a current lack of nursing leaders. In the early days following the introduction of the NHS the nurse manager had a specific and clear, although subordinate, role in the organisational hierarchy (Gamarnikow, 1978; Strong and Robinson, 1990; Ackroyd, 1992). Latterly though changes in the management structure accompanied by the development of 'new' nursing, which has placed the nursing profession in direct conflict with doctors on the one hand and government on the other, the role of the nurse manager is less clear (DOH, 1996). The successive changes have thus had destructive effects on nursing and nursing management.

Gender differences between nurse managers are also an important factor to consider when examining their lives and careers. Gender differentials between nurse leaders and their administrative and medical counterparts are also important. Finally in order to obtain a reasonably rounded view of the work of nursing leaders the character of those led and the work they did should also be included.

2.5. Summary.

The range of literature about nursing and research studies in nursing leadership reviewed suggests some possible causes of or explanations for the current tensions between nursing service and nursing education leaders. Situational factors such as hierarchy and bureaucracy in both the organisation of the N.H.S. and in the ways in which nursing is organised (Beardshaw, 1981; Salvage, 1985; Rafferty, 1993b; Sines, 1994) are seen as having been detrimental to the development of nurses and nursing. The long standing division between the clinical practice, 'service' managers and nurse educators accounts for some of the problems currently facing nursing leaders. This division affects what nurses learn to consider important (Melia, 1987) and have led to a 'service-education' divide with resulting conflict between nursing service managers and nurse educators (Jolley, 1987) and an 'anti-education' bias in the profession at large (White, 1985).

Nurses and their leaders are considered to be 'second-class' (Rafferty, 1993b) and invisible (Davies, 1995) in the division of health care labour. Nursing leadership is marginalised (Beardshaw and Robinson, 1990; Rafferty, 1993b) and weakness in basic nursing education coupled with lack of preparation for management have been attributed as causes for their failings (Hardy, 1983; Strong and Robinson, 1990). Individual characteristics such as education, politics, faith, class, race and gender are important considerations. Gender in particular has been attributed as the cause of the current muted nature of nursing and nursing leadership (Rafferty, 1993b; Davies, 1995). Nursing has long been linked with women's work and women are not considered to have leadership attributes or abilities. The leadership style adopted by nurse leaders has been described as 'reactive coping' (Davies, 1995), repressive, autocratic and authoritarian (Salmon, 1966; Briggs, 1972; Carpenter, 1977; Lorentzon, 1990) and an 'archaic mode of leadership' (Briggs, 1972). On the other

hand the link with women's work and the caring, nurturing aspect of nursing has been offered as an explanation for differences between nurse leaders and their doctor and general manager colleagues. It is suggested that the values they espoused were inimical to those of other managers (Rafferty, 1993b).

2.6. Conclusion.

The issues of significance to be explored in the following chapters are to do with nurse leaders conceptions of their own roles and the relationships they had with other nurses and other managers. Their views of the role and work of nurses and the nature of nursing expressed particularly through their knowledge base and values will also be sought. The analysis of nursing in the latter part of the period under study, 1948 to 1995, focused on the nature of caring and the antithetical nature of managing nursing and providing leadership in a divided profession (Carpenter, 1977; Melosh, 1982; White, 1985) in a society which seems not to value caring (Reverby, 1987; Davies, 1995). Those interviewed entered nursing from the late 1920's to the 1950's (this span of years was inevitable if those who had been influential in the profession between 1948 and 1995 were to be surveyed). As will be examined in greater detail in the next chapter their experiences during these years had a profound influence on their views of nursing and on their subsequent leadership careers and styles. Kitson points out that how nurses arrive at the 'conceptual mix that makes up our understanding of nursing and care has been influenced by personal experience, both good and bad, our education, and a range of historical, social, political and psychological factors' (1993:30).

Thus the structure of this thesis is such that the impact of each of these factors on the leaders of nursing, particularly those with responsibility for nursing education is assessed. To reprise the aims of this study and the research questions to be addressed, this study sought to discover the impact of successive organisational changes within the N.H.S., and what other environmental factors, affected the way in which past leaders of nursing perceived their roles. The ways that their relationships with significant others affected them as individuals, especially with regard to their preparation for and response to these changes is also analysed. How the research study was designed and carried out is described in the next Chapter.

Chapter 4 is concerned with the roles carried out by the nurse leaders and the similarities and differences in their individual approaches to their work, especially related to different conceptions of nursing and the role of the nurse as a source of tension. Chapter 5 describes the effects of changes in health care delivery occurring in the late 20th century on the roles and relationships of leaders of nursing, especially focusing on sources of conflict and tension and also on the support and help given which helped them to develop their coping styles and mechanisms. In Chapter 6 the situational or environmental factors which affected the ways in which those in nursing leadership and management perceived and carried out their roles are analysed, the structures examined are those of the N.H.S, H.E. and the statutory bodies. In particular the effects of changes in the organisation and management of the National Health Service from inception to the present are explored. Chapter 7 goes on to recount how the past leaders of nursing responded to and coped with changes in the organisation in which they worked. The effects that changing relationships had on the way in which they perceived their roles is depicted through the leadership styles developed throughout the study. Finally Chapter 8 draws out recommendations based on these findings regarding the most appropriate organisational and management structures and systems for the delivery of nursing and nursing education in the 21st century, and the preparation, development, recruitment and selection of the future leaders and managers of nursing and nursing education as a way or ways of helping to overcome or decrease sources of tension.

CHAPTER THREE

RESEARCH DESIGN AND THE PROCESSES OF THE RESEARCH STUDY.

Introduction.

Given the range of influences which were identified from the literature review as important factors to consider when determining the effects of changes in health care delivery in the late 20th century on the roles and relationships of leaders of nursing it was decided that the research approach which would best capture the range of changes and their impact upon the individual nurse leaders was that of phenomenology. In the past nurses have been accused of insularity and tribalism (Strong and Robinson, 1990), and research into the organisation and management of nursing as mechanistic and relying heavily on the positivist tradition (Read, 1989). However more recently there has been a recognition that the techniques of qualitative research have much to offer in the study of nursing (Leininger, 1985). In addition literature drawn from the fields of management theory and science, organisational theory and behaviour, health service management, nursing and nursing education, general education, social science, philosophy and history was thought to be an important research design consideration.

3.1. Research design considerations.

In order to obtain the views and perceptions of the effects of the changes which had occurred within the N.H.S. since its inception on the roles and relationships of nurse leaders it was decided that a sample of nurse leaders representing the various segments of nursing should be interviewed. As the literature review showed the main theoretical focus for the research design was previous studies of leadership and management, particularly nursing leadership, so a review of these studies was used to develop the interview schedule which would guide the questions to be asked during the interviews.

3.2. Development of the interview schedule.

During the interview it was necessary to draw together the individual characteristics of the leaders studied; the situation, context or environment in which they worked; the people with whom they worked who were significant to them; and the task or job to be performed, in order to meet the aims and objectives of the study. This accords with Goldenberg's (1990) view that the body of research into leadership increasingly is being viewed as:

a complex situation involving leaders, followers, situations and all the variables that impact upon them.

(Goldenberg, 1990:1326)

An interview schedule was devised which aimed to survey the range of factors which it was considered would prove influential on the careers of those studied. The schedule was divided into three parts (Appendix 1).

The first section of the schedule concentrated on the individual and the job or jobs that they had undertaken. In this part of the interview the aim was to discover what leadership and management roles had been undertaken by the respondents and their perceptions of the factors that had influenced the ways in which they had performed these roles. The opening questions therefore were straightforward in order to ascertain information,. "When did you first enter a management or leadership role?", followed by "What subsequent management roles did you hold up to leaving the service?"

Respondents were then asked to identify the most important or influential role that they had held; the key responsibilities of that position; and the factors that determined how they had undertaken this role. It was recognised that these final three questions, in this section of the interview, might be more difficult than the previous two for the respondents and that prompts might be necessary. The factors which it was considered might be mentioned here were their own leadership style; the leadership style of those around them; the requirements of the job and the skills and experience of subordinates. These potential prompts had been derived from

personal experiences in management and from some of the previous studies of leaders and managers (Mintzberg, 1973; Hardy, 1983; Miles et al, 1988; Goldenberg,1990; Rafferty, 1993b; Splane and Splane, 1994).

In the second section of the interview issues surrounding the setting in which the nursing leaders in the sample had performed their most influential role/s were explored in more detail by asking them to reflect on key national and international issues. If prompts were needed it was envisaged that these might be by reference to politics and government of the time; significant reports or events in nursing and midwifery; and social, economic or technological changes.

The interviews were designed to go on to find out more about their perception of their personal influence, often by referring to something that they had accomplished in their work, or a notable publication; a working party or enquiry of which they had been a member; or a piece of research that they had carried out. Finally in this section the influence of other significant individuals and groups was discussed. How this 'influence' network worked, for example through informal contact; membership of statutory bodies and/or professional groups ; or through some other mechanism, was also explored.

The third part of the interview was specifically focused on the setting of nursing and midwifery education at the time that they were influential and the key features of this educational provision. If prompts were needed reference was made to the current General Nursing Council (G.N.C.) syllabus, or whatever regulation was in place for the approval of nursing/midwifery education and training. The structure, organisation and management of the N.H.S. was another reference point, for instance before or after the introduction of the N.H.S.; before or after Salmon; or the 1974; 1982; 'Griffiths' or 1989 're-organisations'. Also useful were references to significant reports of the time which specifically altered the delivery of nursing and midwifery education, for instance the Platt report (1964); the Briggs report (1972); the Judge report (1985); or 'Project 2000' (UKCC,1986).

In the final section of the interviews the respondents were asked to give their views of current issues in nurse, midwifery or health care education and to speculate on

the future and the possible challenges for nurse leaders and managers. As the literature review showed the ways in which the occupational socialisation of student nurses is experienced through pre-registration nursing education were important factors which affected the ways in which the nurse leader's careers developed. It was considered vital to examine the occupation of nursing through their eyes. First, because they had all worked as nurses and this would have affected their subsequent approaches and second, because nursing, or more usually a specific segment of it, was the target for their management role. As the research study aims to explore and explain tensions between the leadership of different segments of the profession an examination of the way in which those interviewed described the influences of nursing and nursing education on their careers was considered important.

In order to examine the 'emergence and relativity' (Arthur et al, 1989:12) of their careers a qualitative research approach was selected for this study as it was considered that the leadership and management experiences of these nurses could only be fully understood in the context of their own stories and perceptions. It was decided that the individual characteristics of the respondents studied would be ascertained through their descriptions of what they considered nursing to be and their perceptions of their roles as nurse leaders. This would encompass statements they made which indicated the ways in which they thought about and articulated their knowledge base, their attitudes and values and the ways in which they performed the roles which they had held. This analysis should also encompass some of the ways in which they interacted with other significant individuals and groups within the N.H.S. In the main this analysis was confined to those in 'powerful' positions in relationship to themselves, for example the Matrons, Doctors and Administrators, although their peers and subordinates also proved significant at times. In addition the institution in which they worked for most of their lives, the National Health Service, was surveyed, in particular through reference to its organisational structure. There was also a commentary by some of those interviewed who worked in the higher education sector on its culture and environment.

The interviews would therefore form a substantial oral history of nursing during this century. Leininger (1985) makes a case for qualitative methods of studying nursing care and the recipients of this care, particularly in different cultural groups. For

similar reasons it was felt that the research approaches proposed were also appropriate in the study of the leaders and managers of nursing and nursing education. Leininger (1985) emphasises that qualitative historical research methods are important in revealing nursing's cultural and social inheritance. It seemed that as the culture of the Health Service was changing so radically in the 1990's and that nurse leaders and managers in service and education positions were at the same time entering the new cultures of 'business' and higher education the approach which would best capture the meanings and interpretations of the range of people that had contributed to and were being affected by these changes was that of 'naturalistic inquiry' (Lincoln and Guba, 1985).

It was considered appropriate to undertake an historical approach to the study for in understanding the present and future an analysis of the past is judged important, as Akinsanya (1990) states :

society must know what its past history is, if it is to see the future in the light of the lessons of the past. For nursing, therefore, if we do not know where we are coming from as a profession, it is difficult to know where nursing is supposed to be going in its future development.

(Akinsanya,1990:745)

3.3. Oral History.

The main method of data collection was through semi-structured interviews with past leaders of nursing. As indicated earlier it was considered that interviews with past leaders of the nursing and midwifery profession would provide an insight into the meanings and perceptions that they had of the influences of the changes in health care delivery and the issues arising for themselves, their colleagues and health care services. The interviews also provided the opportunity to explore with them the motivation for and the influences behind the decisions that they and others made and to explore with them the sources of intra and inter-professional conflict and tension. Similar data could have been obtained through correspondence with them and through analysis of documents however it was decided that semi-structured interviews would allow significant points to be followed up more easily. As responses were seen and heard there were often non-verbal signals which could be noted or followed up at an appropriate point in the interview.

Topical oral history (Gluck, 1984) was sought through the focus on events related to the N.H.S. and nursing management and education and biographical oral history (Gluck,1984) through the concentration on the individual and their reflections on and perceptions of the effects of changes and developments on them and on the nursing profession more widely. Autobiographical oral history (Gluck, 1984) was a feature as they examined elements of their professional lives and in the declarations made it was often difficult for them to separate the professional from the personal. Questions such as 'how personally influential were you?'; 'who or what influenced you?'; 'how did you manage a demanding job and work long hours?'; 'who or what provided support?' often provoked intensely personal reflections and comments. Sometimes a wistful regret for opportunities missed; often a positive comment about a significant individual or event in their lives; frequently a reluctantly admitted sense of achievement and pride and, on one or two occasions, a cathartic and distressing reaction.

Church and Johnson (1995) comment that life review is often used interchangeably with the concept of oral history and that life review is generally viewed as a technique that is therapeutic or at least one which focuses on the benefit to the narrator rather than on the information obtained. As a researcher the experience of these phenomenological interviews was challenging. It is obviously important that researchers who consider that the techniques of oral history will best satisfy their research questions are aware of and able to deal and cope with the reactions that life and career review of this sort may have on their respondents and on themselves.

3.4. Other sources of data.

In the early stages of research design development a range of methods for obtaining data were considered, for example obtaining reflections based on critical incidents in the careers of 'past' leaders of nursing, or using Delphi study techniques to develop predictions regarding the future of nursing and nursing education from current leaders in the profession. Comparative multi-case and multi-site studies, (Bogdan and Biklen, 1992) were also considered. It was envisaged that these multiple methodologies would allow for a range of other managers to be studied and for in-depth, on-site confirmation of the importance of the data which was arising from

the interviews. However at an early stage of the research collection of these data through the methods mentioned was discarded. Erlandson et al (1993) make the point that in naturalistic inquiry the research design emanates from the research itself and that the researcher should regularly re-examine the tentative design. New information and new conditions raise new questions that require the researcher to change plans and strategies. This was the case as this study proceeded. It had originally been anticipated that a Delphi study would be necessary to obtain the views of current nurse leaders regarding the possible future of the health service, of the nursing and midwifery professions and of the education needs of practitioners. In this way current and future tensions in and for nursing leadership would have been highlighted. However several occurrences during the early part of the study indicated that this would not be necessary. Firstly, it had been envisaged that those interviewed would be out of touch with present issues as they had 'retired'. However it was soon discovered that many of them were still very active in the current health and education sectors. Many of them are still in extremely influential positions and therefore well able to survey the current scene and to make reasoned assumptions about the future. Secondly a new Chief Nursing Officer to the Department of Health was appointed shortly before the start of this study. Following her appointment she set up 'think tanks' of current nursing education and service leaders to prepare documents setting out strategic visions of the future (D.O.H. 1994a; 1994b; 1994c; D.O.H. 1995; D.O.H. 1996). In addition the Department of Health was also very active in publishing a range of documents related to future views of health and the health service (D.O.H., 1991; D.O.H., 1992; N.H.S.M.E., 1992; N.H.S.E., 1996a; N.H.S.E, 1996b), as was the W.H.O. (W.H.O., 1987; 1994). It was therefore considered that analysis of these documents would serve as useful predictions of the possible future and the need for a Delphi study obviated. Thirdly, personal work experiences and reading, attendance at conferences, and discussions with colleagues were proving a very rich sources of material, as were the initial analyses of the interview transcripts. It was therefore considered that a Delphi study and/or multi-case, multi-site studies would be an extremely resource intensive way of obtaining data, and that the current sources of information would suffice to examine the research questions posed.

The role of the researcher was also an important part of the research design.

Erlandson et al (1993) summarise the key features of research based upon the assumptions of the naturalistic paradigm and Read (1989) cites Lincoln and Guba (1985) in describing the features of naturalistic enquiry which formed the basis of the research design for this study. Common to both is the importance of the researcher as primary research instrument. The context in which research takes place is seen as a vital component of naturalistic inquiry (Erlandson et al, 1993; Schutz, 1994) and a much debated issue is the role of the researcher in the context of the research. Researchers using the positivist paradigm argue for objectivity and for the researcher to distance herself from the data, whilst the proponents of the naturalistic inquiry stress the need to consider the researcher as a part of the study (Schutz, 1994).

As a manager of nursing education throughout the majority of the study it was impossible to separate the research from everyday work and indeed it was considered a strength rather than a weakness in the research design. However it was seen as important to express the viewpoint of the researcher so that any biases were laid open to scrutiny. A short statement of these personal views appears in Appendix 1. In addition reflective journals of both the research process and the researcher's own management activities was maintained. Strong and Robinson (1990) describe how managers in their day-to-day work carry out a form of ethnography, so keeping the reflective diary of the issues that were encountered during the course of work, and involvement in a variety of work related learning situations, have been captured throughout the research study. Extracts from the reflective journal of research are recorded in the later description of the data analysis process. It was decided that these data should inform the development of the research design as it progressed and be incorporated into the research findings as they are reported. These methods of connecting findings are similar to those advocated by Fielding and Fielding (1986). Where appropriate the reflection on management issues is also included here, the full reflective management diary is not included separately due to the very personal, and sometimes confidential, nature of some of the entries.

3.5. The sample.

An important consideration was to select a sample from which it would be possible

to obtain the information needed in order to answer the specified research questions. The people selected would need to have held prominent positions in the disciplines of nursing, midwifery and health visiting in order for them to fulfil the criterion of having helped to shape the current position and circumstances of nursing. In addition it was vital to select nurses who had influenced the development and management of nursing education. The criteria for the choice of those selected to be interviewed for the study were detailed in Chapter 2 (Section 2.1.). Purposive sampling using criterion based selection was used in choosing participants to be interviewed. All those invited to participate met the criteria of being considered expert, knowledgeable and influential in the field of nursing service and/or nursing education, and had fulfilled a leadership and/or management role.

Miles and Huberman (1994) describe an investigative process of social research which helps guide the researcher towards other samples of persons to be interviewed or situations to be observed. This was the technique used in this study. Initially a selection of people falling into one or more of the following categories were approached:

- * Those known to the researcher as previous 'bosses' or people influential in the profession since the inception of the N.H.S., and who had retired or were about to retire, in the period studied.

- * Nursing leaders who were members of working parties which considered issues concerned with nursing and nursing education during the time studied. For instance the Bradbeer Report (1954), the Platt Report (1964), the Salmon Report (1966), the Briggs Report (1972), the Judge Report (1985), and the two major policy documents from the United Kingdom Central Council for Nursing, Midwifery and Health Visiting - Project 2000: A New Preparation for Practice (1986) and The Report of the Post Registration and Practice Project (1990).

- * Those identified from their own writing, publications, speeches and so on during the past five decades.

* Those who had received honours or recognition from the state and/or the international and national nursing profession.

Forty-five individuals were identified in this first round, making initial contact was through previous social and professional connections. The first tranche were able to point to further contact addresses for those people selected, as well as suggesting the names of a few more who met the criteria. The Royal College of Nursing were able to work out a way of contacting those in membership with them without disclosing addresses. In all thirty three people were traced and were sent a letter asking them to participate in the research (Appendix 1).

3.6. Making Contact.

Thirty of the people contacted in the ways described above were willing to participate and were interviewed. When the first thirty interviews had been completed and preliminary analysis of the transcripts had been undertaken this number was considered too small a sample from which to draw conclusions so a further twenty-one interviews were conducted. The sample for the additional interviews was obtained mainly through personal contact and recommendation from those interviewed in the first stage. The second stage interviews were targeted to include more leaders from a nursing and midwifery service management background and more men. A total of fifty-one interviews was carried out between August 1993 and September 1995.

3.7. Preparation for carrying out the interviews.

At the start of the research process I identified that the relationship between myself and those to be interviewed was an important methodological consideration. Read (1989) and Strong and Robinson (1990) identify the effect that being in a peer relationship with those studied had on their research. Rew et al (1993) comment that in qualitative methods of enquiry the researcher not only collects data but also serves as the 'instrument' through which data are collected and claim that the researcher should provide 'a judicious description of the aspects of self-as-instrument' (Rew et al, 1993). These aspects are considered to include

appropriateness, authenticity, credibility, intuitiveness, receptivity, reciprocity, and sensitivity. In order to enhance my own ability to demonstrate these qualities during the interviews I prepared myself by reading or re-reading articles or books written by the individual to be interviewed, and also noting some of the key achievements during the career. I considered appropriateness of dress and manner to be important with respect to my own credibility and my letter of introduction was designed to enhance this. I established my current position and place of work, I always used University of Greenwich notepaper in my first contact as I felt this would help to establish my credibility and the bona-fide nature of the research. It also served to demonstrate the University's support for the study I was undertaking.

With the respondents who already knew me I did not consider that establishing credibility was too much of an issue, subsequently I discovered that many of them 'vouched' for me with their friends and colleagues who had not previously known me. Also, in cases where this was not possible, some prospective respondents had 'researched' me prior to granting me an interview. With regard to intuitiveness, receptivity, reciprocity and sensitivity I endeavoured to demonstrate these attributes during the interview process and in the continued contact that I had with many of those interviewed afterwards. During the interview I encouraged the participant to reflect on their experiences and, if possible, to analyse and interpret the influencing factors for themselves. I became increasingly conscious of the use of language in the interviews and of a recurrent pattern of interaction in many of the exchanges between myself and the interviewee. At this point a record was made in the reflective diary of research regarding the use of language. This is described more fully later in this Chapter.

3.8. Arranging the interviews.

Organising the interviews was reminiscent of a military operation, most of the respondents lived a fair distance away and therefore this involved a lot of travelling, work commitments had to be juggled to try to fit the interviews into the participants often very busy work and leisure schedules. As well as getting into the vicinity of the prospective interviewee a suitable venue for the interview had to be arranged, for example somewhere comfortable and quiet, with chairs, a table and a nearby

electric socket.

When a great deal of travel was involved interviews were arranged which captured as many interviewees as possible. This had the benefit of minimising travel, time away from work and expense, but was not always the most suitable arrangement from the point of view of the research. On three occasions this meant that interviews were carried out with one respondent after another without a break and on two occasions three interviews were carried out consecutively. This had the effect of creating extreme tiredness on my part and almost certainly the last of the interviews was not as crisp as the first. It also meant that there was not time to reflect in depth after each interview, although a little time to collect my thoughts and do a short reflection was usually engineered.

3.9. The interview process.

Erlanson et al (1993) suggest 'in naturalistic research interviews take more of the form of a dialogue or an interaction'. The interactions or dialogues with those interviewed in this study were of a very specific nature and were influenced by a variety of factors.

3.9.1. Starting the interview.

At the start of the interview each respondent was offered the opportunity to hear more about the research study, all of them took up this offer. The reasons for carrying out the study, the research approach being taken and the format and anticipated length of the interview were all explained. At this point their permission to tape the interview was ascertained. The opportunity was taken to reaffirm confidentiality regarding their contribution and to explain how the interview content was to be transcribed. They were also told that a verbatim transcription would be sent to them for their verification, additions, and correction or amendment.

Throughout the explanation contributions from them in the form of questions or feedback was encouraged. The process usually took about five minutes and gave us both the opportunity to begin to feel more comfortable and at ease. At an

appropriate juncture the tape recorder was switched on and a check was made that it was working and that the playback quality was adequate. Once the playback had been checked the recorder was switched back on and the interview started by collecting biographical data using a standard format (Appendix 1). This provided essential information regarding the individual and the role/s they had held during their career. It was also useful in that those interviewed were talking about something they knew well, their own career, although sometimes one or two were hazy on dates. As they described their careers it gave an opportunity to probe more deeply into the areas which were most pertinent to the study and to note, for later on in the interview, issues that should be explored in more depth. During the interview process some respondents took the opportunity of showing me pictures or other memorabilia and giving me books or documents relevant to the research.

3.9.2. The venue for the interview.

Breakwell (1990) identifies that the physical setting of an interview may determine its whole outcome. In the first round most of the interviews were conducted in the respondents own home or in the home of a friend, at their invitation. Two interviews were carried out in the hotel in which I was staying, one in the respondents place of work and one in my work place, and for four interviews a room in a local College of Nursing was used.

Carey and Hawkes (1994) identify that getting the seating arrangements right proved to be important for successful interviewing. This certainly was a factor in this study no matter which venue was chosen. In a respondents own home or in the home of a friend of theirs this often meant rearranging furniture prior to the start of the interview. I would arrive, often after a long journey, laden down with interview paraphernalia usually to be shown into a sitting room, where the furniture was arranged in typical fashion. For a successfully taped interview two chairs, near a table set at about 45 degree angles, close to an electricity socket were required. I was acutely aware that it is not usual for a perfect stranger to walk into someone's home and start rearranging the furniture and unplugging the television. However this was successfully achieved in all cases, and certainly for some of the interviews it was felt that it helped put the interview onto a more formal footing as the

respondents had started to 'chat' as I arrived and I considered that I was at risk of missing some 'pearls of wisdom' that it would be important to consider in the interview.

3.9.3. Relationships between interviewer and interviewees.

In the first round of interviews many of those interviewed were already known to me (fourteen out of thirty). All of the individuals had influenced my own development and career progression, either directly or indirectly for example through their overall leadership position in the profession, through articles and books which they had written, and through their personal support and mentorship. Consequently the effect that carrying out the interviews has had on me has been profound. Although I am now in a leadership and management position myself I was often quite nervous before an interview. Many writers stress the importance of establishing equality between the interviewer and interviewee, more usually implying that the interviewer is seen to possess the more powerful role in the dialogue. This was not always the case in the interviews that were carried out in this study. Bailey (1987) reports that it is possible for the respondent to intimidate the interviewer, I only felt intimidated by two of the respondents during the interview process, one who had been a very powerful and influential person for the majority of her career, and had been my ultimate boss a few years previously, and one who had been a very highly respected academic. The feelings of intimidation that I had were restricted to the early stages of the interview, and disappeared as I relaxed and concentrated on the interview process rather than myself.

In order to achieve the necessary sense of partnership careful thought was given to how I should present myself to those interviewed. Barriball and While (1994) emphasise that self-presentation of the interviewer can help to overcome the potential for 'demand-characteristic' bias in the interview situation. Demand characteristic effects are considered to be those where the interviewee responds in what they see to be the socially acceptable or expected way rather than the way that they really think and/or feel to be true. I decided that I should always present myself dressed as I assumed the respondents would expect a Dean of Faculty to dress, for instance smartly attired in a dress or suit, wearing discreet make-up and

with well coiffed hair. In respect of etiquette and manner I addressed those interviewed by their title and surname, unless I knew them well and had previously been on christian name terms. As all of those interviewed were older than me I was respectful of their age and maturity, particularly as many of them were 'old style' nurses who had occupied important positions in the profession and I assumed that they would expect to be treated in this way.

All of the foregoing are factors which could distort the research findings so for the reasons which have already been mentioned in a study such as this it is important to prove the reliability of the research itself.

3.10. The reliability of the Research.

Guba and Lincoln (1981) declare that a study is credible when it offers faithful descriptions and when co-researchers or readers confronted with the experience can recognise it. Koch (1994) advises of the importance of establishing rigour in qualitative research by leaving a clear, auditable decision trail, she comments on the sparseness of literature recording the interviewer's experience as data in qualitative research and claims:

Existential phenomenology relies on recording influences while generating data such as significant literature, media reports, my value position and journal data.

(Koch, 1994:976)

Thus it was also deemed significant that in designing the approaches to the research, particularly the approach to data analysis, a clear and rigorous audit trail should be present from the start so that the trustworthiness, and hence the dependability and confirmability of the study should be readily confirmed. Six classes of audit trail materials can be identified (Lincoln and Guba, 1985:319-320).

3.10.1. The audit trail.

1. Raw data.

In this study the following raw data are available: the interview schedule; the interview tape; the verbatim transcript of interview; the biographical notes about the interviewees, for example Who's Who entries, professional and statutory body 'write ups'; the interviewees own publications; documents provided by the interviewees either during or following the interview; correspondence between myself and the interviewees; and notes and recordings made in reflective journals.

2. Data reduction and analysis products.

Examples in this study are the comments made by interviewees on the returned verbatim transcripts; the expected and emergent category sheets (Appendix 1); analytic notes made during the process of coding; diagrams and figures produced during the data reduction and analysis process. The 'issues arising' file (see section 3.11.2.) and Figure 1 which draws together factors which were considered to be possible influences on a nursing education leader's role (Figure 1 - Situational and Environmental Influences on the Role of the Nursing Education Leader) are also examples of data reduction and analysis products. The diagram was derived from a previous small scale study carried out by the researcher (Miles et al, 1988), and from an analysis of the first few taped interviews in the early stages of the research. The model thus derived suggests that the role of the nursing leader and the way in which he or she undertakes this role will be affected by individual variables and the structure, culture, ethos and values of the immediate and wider environments. In addition the relationships she or he has with the 'boss', peers, colleagues and subordinates will also be significant. In the process of writing this thesis data of this kind is also evident.

3. Data reconstruction and synthesis products.

Examples here are diagrams, such as the career pathway diagrams (Appendix 2) the development of which are described in section 3.11.; reports (such as progress reports) extracts from which appear in section 3.11.2.; reflective journal entries which are reported more fully in section 3.12.; and data analysis papers.

4. Process notes.

The above description which accompanied the development of the diagram which helped to explain factors which affected nurse education leaders is an example of a process note. In addition the reflective journal and 'issues arising' files are typical examples of this kind of data, as are notes made during transcript analysis.

5. Materials relating to intentions and dispositions.

The original research proposal, some of the correspondence between myself and the interviewees and myself and my supervisors and advisers, my reflective journal and progress reports would fall into this category.

6. Information relating to any instrument development.

Correspondence between myself and peers, and notes during and following conversations would be the main source in this category. Summary notes and files relating to the development of the career pathway diagrams and the leadership styles developed are also pertinent.

In addition to the above forms of audit trail materials it was considered important that data which could be verified by others was subject to some form of scrutiny. This was partially achieved by sending copies of transcribed interviews to the participants for their agreement and comment. In addition two current nursing education leaders had agreed to be advisors to the project from the outset. They were sent information relating to the study in the early stages. Subsequently one of these leaders became ill and dropped out from his advisory role. The second advisor retired from her educational leadership role and was subsequently interviewed in June 1995. After her interview I sent her copies of the progress report prepared for the transfer from MPhil to Phd so she was able to confirm and comment on the emerging leadership style typology and on the issues arising and their effects on nursing leadership. In addition, at about the halfway stage in the research, I undertook an interview with a current Executive Director of Nursing, in which I explored with her the current issues which she perceived to be of importance. It was again possible to discuss with her the preliminary findings of the study as described later. Also, in the second round of interviews many of the respondents asked about

the progress of the research and it was sometimes possible to outline initial significant data analysis products without distorting the interview process. In these ways as far as was possible data was verified and scrutinised without jeopardising the confidentiality of the individuals interviewed.

3.11. Data Analysis.

This involved the cyclical activities necessary for the development of grounded theory, the discovery of theory from data (Glaser and Strauss, 1967). In order to generate theory throughout a research study it is suggested that the researcher should approach the field with as few preconceived ideas and theories as possible, with an open and sensitive mind and should avoid filtering events through pre-existing hypotheses (Read, 1989). Whilst this approach is advocated it was not considered appropriate to the philosophical approaches of the study and also it would have been extremely difficult to achieve in my case because of my previous background and my constant personal and professional involvement in the phenomena that were being studied. I considered therefore that it was important to state early on in this report of the study my own stance and preconceptions, as far as I was able to recognise them, on the range of phenomena being studied (see Appendix 1). Extracts from progress reports and from reflective journals which appear later in this chapter illustrate how the significant factors affecting the careers of those interviewed, and contributing to tensions in nursing leadership, were identified from the texts. The ways in which these data were isolated and analysed is described in the following sections.

3.11.1. Data Sampling.

In grounded theory techniques both quantitative and qualitative data are subjected to constant comparative analysis to generate concepts (codes), which are then developed and elaborated with successive purposive and theoretical samples. These sampling techniques, according to Goetz and LeCompte (1984), will assure comparability and transferability of data and will provide a foundation for inferring similarities and differences amongst the groups chosen. Purposive sampling was used during data collection, as demonstrated through the 'cascade' approach used

to obtain successive interviewee samples for this study. Theoretical sampling, according to Goetz and LeComte (1984), involves a careful search for the theory that best matches the existing data, through a process of comparing, contrasting, replicating, cataloguing and classifying. Campbell (1979, cited in Goetz and LeComte 1984) describes this as a sequential selection strategy designed to reduce biases in analysis. In this study this was achieved through the cyclical approach used during data collection; individual analysis of transcripts; grouping of codes; isolation of paradigm cases; further literature searches and reviews, followed by further thematic analysis, as described in the following section.

3.11.2. The Process of Data Analysis.

Early stages of data analysis.

Sometimes this felt like going 'up the garden path'. As these processes were developing and as thoughts and ideas were coming to me I was also trying to read as much as I could on these additional and emerging aspects to ensure that I wasn't missing any important leads. At about this time I was also applying for transfer from MPhil to PhD and had to produce a progress report of about 5,000 words. At this point in the research everything seemed to me to be a total muddle, I was doing so many things at once. I began to think "this can't be how it is done, I must be doing something wrong". At this stage I was heartened to read:

Data analysis is the process of bringing order, structure, and meaning to the mass of collected data, it is a messy, ambiguous, time-consuming, creative and fascinating process. It does not proceed in linear fashion; it is not neat. Qualitative data analysis is a search for general statements about relationship among categories of data; it builds grounded theory

(Marshall and Rossman, 1989:112)

Approaches to interview analysis.

Prior to undertaking the interviews it was thought that certain issues would prove

to be important to the respondents. These were termed 'original codes' (Appendix 1). Each of the issues identified as original categories had been derived from an initial literature search; previous knowledge of the history of nursing and of the N.H.S.; and personal experience as a leader/manager of nurses, nursing and nursing education over the last 30 years. Once the interview had been transcribed, and three copies made, one copy was immediately returned to the interviewee with a letter reminding them that the transcription was verbatim and asking them to comment and amend. The remaining two copies were printed double spaced and with a two inch right hand margin.

Analysis of the interview started during the interview itself, particularly in respect of some of the later ones, when it was possible to highlight some of the recurring issues or themes and reflect them back to the interviewee, often for verification or for more in depth analysis and comment. This process is referred to as theoretical sensitivity (Glaser, 1978), its purpose is to develop an awareness of the theoretical potentiality in the data, it also assists in ensuring that all the data are subjected to analysis and avoids the researcher bypassing alternative interpretations. This process was particularly pertinent in the second round of interviews when it was possible to reflect some of the findings from the first round of interviews, for example the development of the concept of different leadership styles to the respondents for comment.

It was discovered that the process of data analysis continued during transcription and listening to the tape for the first time after the interview, when it was useful to have a pen and paper handy to jot down ideas as they arose. These were filed in an 'issues arising' file. Once the transcription was printed out a further initial scan was carried out to ensure continued sensitivity to all relevant topics. As described later this overview analysis led to one significant finding, that of very distinct 'styles' emerging as the interviewees recounted their career patterns. The next stage of data analysis was line by line analysis or open coding, sometimes referred to as substantive coding. This process of separating items of data then scrutinising, comparing, conceptualising, and codifying them is essential to achieve a detailed interpretation of the data and to unravel the complexity of the concepts that underlie them (Charmaz, 1983; Strauss, 1987; Strauss and Corbin, 1990). It is also

necessary for capturing the intricacy of the phenomenon under study and making persuasive sense of it (Wainwright, 1994). Corbin (1986) describes the process of open coding and Wainwright (1994) gives examples of it in action. This process was adopted as the first step of substantive coding in this study, hence the need for double spacing and a two inch right hand margin. As the transcript was read notes were made in the margin about data related to the original codes or to identify additional emerging categories.

The next stage in data analysis was to search each of the transcribed interviews, using the search facility of a word processing package, for the concepts and issues that had originally been considered to be important. The sections of the interview which contained these original codes were then printed out and collated. Each extract which referred to that concept was then analysed for emerging themes. Additional emergent themes were developing from this process of constant analysis and comparison and these were introduced into the later interviews. These were termed 'emergent codes' (Appendix 1).

Erlandson et al (1993) comment on this process as the 'inseparable relationship between data collection and data analysis' emphasising that this is one of the major features which distinguishes naturalistic research from traditional research. They again stress the importance in this process of the researcher:

The human instrument responds to the first available data and immediately forms very tentative working hypotheses that cause adjustments in interview questions, observational strategies, and other data collection procedures. New data, obtained through refined procedures, test and reshape the tentative hypotheses that have been formed and further modify the data collection procedures. This interactive refining process never really ceases until the final report has been written.

(Erlandson et al,1993:114)

Some of the categories emerging from the data were described in a progress report written in May, 1994 an extract of which is presented here. This will enable some of the decisions taken during the data analysis process to be explained and for the

audit trail to become clear. ³

Extract from First Progress Report. 4th. May, 1994.

Introduction.

During the period from registration to date I have attempted to identify the key issues facing leaders and managers of nursing and nursing education using a variety of techniques. I have drawn heavily on published work, books, journals, newspapers, reports and official documents in the relevant areas. In addition I have used my own work experiences and reflection on those experiences and discussions with colleagues in health care education, health service management and higher education. From a preliminary analysis I identified a constellation of factors which were likely to affect the leadership and management roles of senior nurse educators.

Analysis of the process of the interviews and the ways in which those interviewed related their personal history and career reveals insights into both personal and cultural aspects of the leadership roles which will allow for a more in depth study in the next stage of the research. In this next section I will illustrate my current thinking regarding both approaches with reference to some of my original conceptual categories and to some of those emerging.

Preparation for Management.

I had identified this as an important area prior to beginning the first round of interviews. My own experiences of entering management and preparation for the management role was that it was extremely haphazard. It was decided that I should find out from those interviewed what sort of preparation they had for the leadership and management roles they had undertaken and what sort of preparation had proved to be the most effective. All of those interviewed were asked which of the roles held during their career they considered to have been their first in a management capacity. Most considered that the role of ward sister/charge nurse, where they had held such a position, fulfilled the definition of management, although this was not always the case. Some respondents considered that they became managers only when they entered teaching or when they took up a

³ The extract is presented in italics, indented and single spaced to identify it as data, or the product of data analysis or arising from the process of analysis, this convention is followed throughout the remainder of the thesis. Extracts from the interviews, from progress reports and from the reflective journals are presented in the same way.

position where they were responsible for a group of wards.

What became clear from many of the interviews undertaken is that there was little or no preparation for the leadership/management role prior to appointment, and that few respondents had undertaken formal preparation specifically for managers. Many described being 'thrown in at the deep end' as preparation, and of 'coping', 'bluffing' or 'muddling through' as the ways in which they dealt with this situation. Without exception they described actually performing the job as the most powerful means of learning. Where formal management courses were undertaken they were often seen as the means by which a more 'senior' management post might be obtained, rather than as preparation for, or enhancing performance in, the current role. Certain institutions were highlighted as having contributed significantly to personal preparation, most notably the Kings Fund College, the Royal College of Nursing's management preparation courses, and Battersea College's nurse teacher and manager courses.

Some roles themselves were considered to be a useful preparation for more responsible jobs. For instance, night superintendents posts for those who became senior nurse or service managers, and principal tutors posts in charge of the preliminary training school or of a smaller school for those who went on to Director of Nurse Education or Principal's posts. This does not appear to have been the case though for the small number of those interviewed who went on to undertake leadership roles in higher education. Finally in this section on preparation for subsequent leadership the importance of earlier influences was highlighted, this ranged from childhood influences, (upbringing, nannies, parents, siblings, and school work) to experiences prior to entering nursing. These were often cited as having shaped subsequent career interests and choices, recognition of individual personality traits, such as, 'being bossy' or 'always wanting to know why', were ways in which this was expressed. Early nurse training experiences, particularly their first training school and their tutors, were highlighted as important and subsequent colleagues and peers were seen as having significance. There were frequent instances of role models, mentorship and networks as important to preparation, and often these factors were recalled as having been instrumental in obtaining leadership and management posts.

Performance of the leadership role.

It is already possible to identify a range of variables that those interviewed have cited as important factors which influenced the way/s in which they performed their leadership/management roles. This constellation of factors includes:

The individual: aspects here included their age, gender, previous education and training, experience, job maturity, personality and leadership style;

Relationships with a range of key 'stakeholders' for example the 'boss', the 'followers', peers and colleagues were seen as having a profound influence. Most often the relationship with the 'boss', or 'bosses' was mentioned as a facilitating factor, in a couple of instances where the interviewee was an educationist and the boss a service manager the relationship was seen as a necessary evil. Occasionally the relationship was one which had caused the interviewee concern or distress, the most frequent outcome being that the individual left the post. Often the relationship with followers was seen as extremely rewarding and one which contributed to the leader's success, although some cited difficulties with followers mainly in relation to the implementation of change. The follower's expectations of the leader and of the job and their own abilities were considered as both positive and negative factors in the leader's own performance. Peers and colleagues seem to be evenly matched as both facilitating and constraining factors. The factor which was cited most often as one which caused tensions was the relationship between education and service. Relationships with other professions, particularly with medicine, was frequently given as an example of difficulties encountered in achieving change, whilst relationships with administrators (non-nursing) were generally seen as helpful.

The job itself emerges as an important variable, for example where it was and its range, scope and size. The local work environment, particularly such things as internal and external rules and regulations which facilitated or constrained job performance were also identified as important, perhaps the most often mentioned factor here was that of finance or the lack of it.

The wider environment, for instance, the Health Service or Higher Education environment; regional or national pervading influences such as political, economic, social, educational and technological factors. European and international aspects were given by many of the respondents as important influencing factors.

Many of those interviewed mentioned how important their professional networks were in enhancing their role performance, the General Nursing Council and Royal College of Nursing being those most frequently referred to. The statutory body, whilst contributing positively in this respect, was also seen as a constraint to development by certain individuals. As previously mentioned in the section on preparation for leadership the influence of the wider 'network' of role models and mentors was also considered an influential factor in role performance.

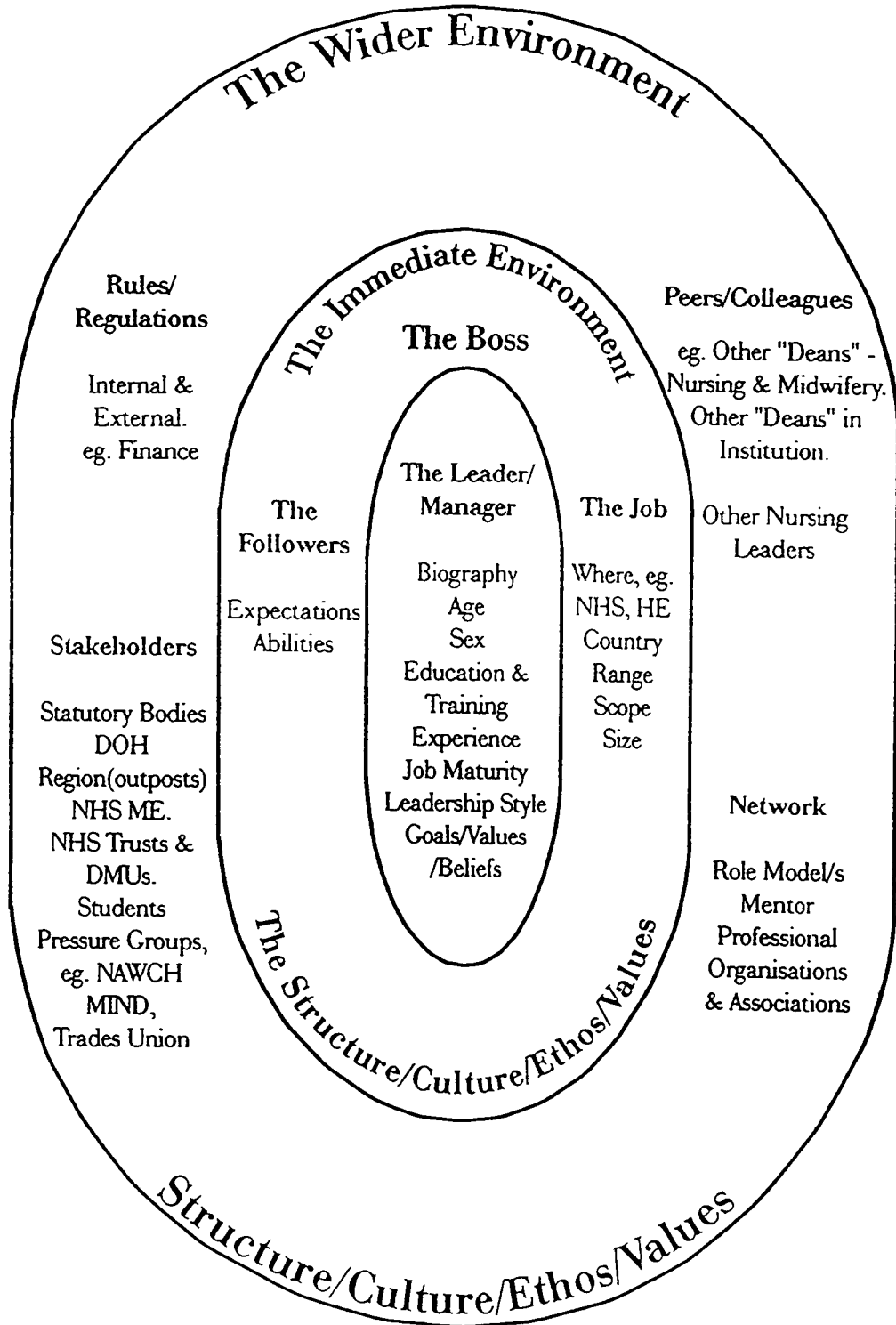
Organisational Culture.

A recurrent theme that is emerging from the interviews and in concurrent data analysis and reading is the importance of the concept of organisational culture. The concept of embedded cultures is one which I have devised from analysis of data to date. It seems that life within a College of Nursing and Midwifery managed within the National Health Service is very different to life within a Faculty, School or Department within Higher Education and that the different cultures of these organisations are having, and will have, a profound influence on the future leadership of nursing education. Figure 1 (Situational and Environmental Influences) draws together these factors.

This model (Figure 1) which appears on the next page will be used as a framework for data analysis, it assumes that three levels of environmental influence might be perceived: the 'macro' environment, the institutional environment and the local situation.

Figure 1.

Situational & Environmental Influences



The macro environment is considered to encompass the international and national influences to which nurse leaders were exposed at a general and specific level. It was thought that general influences such as education, the economy, and employment would provide a 'backdrop' or context in which their work was carried out and would be mentioned rather than prove significant. This was found to be true, for instance many talked of the attitudes to women and education when they discussed their reasons for entering nursing. Others talked of economic issues and the employment situation when they discussed their involvement with recruitment of student nurses. For some the influence of technology, particularly in relation to patient care and to data handling, were significant. Certain periods or occurrences also featured more prominently than others in their recollections. The most significant feature for those who had lived and worked through it was the Second World War and there were graphic accounts of nurse training and conditions in nursing and hospitals which are somewhat outwith the scope of this study. With regard to international influences there was evidence from the career pathway diagrams (as will be seen in Chapter 4 and Appendix 2), and from the interview transcripts that many had travelled and worked abroad following their initial nursing training. This was usually described as 'satisfying wanderlust' rather than deliberately planned to enhance their careers, but all commented on the valuableness of the experience. Later in their careers many had been awarded travelling scholarships to study or carry out research. The country most often visited was the U.S.A., although some had experience of Antipodean nursing and some of continental Europe, mainly through work on the E.E.C. Directives for Nursing (1977). A few had also been members of, or worked for, international bodies such as the International Council for Nurses and the World Health Organisation.

At the institutional level the two most significant aspects of the environment in which they worked were the succession of re-organisations, restructurings and reforms of the N.H.S. and the series of reports which affected the statutory framework for nursing and nursing education. Syllabus and curriculum changes were also important to the careers of most of those interviewed. The local situation or the environment closest to them, the hospital, the ward, or the school of nursing, most notably affected the way in which they worked. In the main this was through their interpersonal and social relationships with significant others. This will be discussed

in chapter 5. The notion of 'embedded' cultures or environments which was developed in the early days of the research was most noticeable in the interface of nursing education with higher education where the different ethos was remarked upon.

As data analysis progressed theoretical notes, that is short notes about the codes and where it was considered that they might be leading, were being recorded. As the research progressed categories or groups of codes or 'axial coding' were developed and analytical notes or 'memos' about the emerging categories were made. These were often further developed by diagrams which helped the linkages between codes and categories to become clearer. Later diagrams began to assist in perceiving the relationships between categories, for example the career trajectory path which will be described in section 3.13. The use of the processes described in this section was aided by the process of keeping the reflective journals.

3.12. Reflective Journals.

For reasons specified earlier it was decided that reflective journals should form part of the research methodology. There are however essential features of journal keeping which have significant methodological considerations. At the start of the study it was decided to maintain a daily reflective diary, it was soon discovered that this was impractical mainly in terms of other commitments which left little or no time to maintain a daily record. What was much more easy to maintain were two records, one of management reflections and one of research reflections. It was important to get into the discipline of writing in the management reflections on a weekly basis, usually at the weekend reflecting on the previous week. Reflections in the research journal were carried out after interviews; on significant areas in the literature reviews; during the process of data analysis, synthesis and reconstruction; and on significant occurrences in the life of the research. These latter reflections were often related to the overlap areas between work and the research. For instance something might happen in the course of a day or week at work which, on reflection, affected the way in which an interview was prepared for or gave another angle to pursue in data analysis. The reverse process was also the case, some aspect of the research, often part of the interview process, would cause reflection on an

issue at work and sometimes the issue would then be viewed in a different light. This became increasingly true of the tensions which were experienced by and between predecessor nurse leaders and which were and are a recurring theme of current nursing leadership. The reflections, as well as being an integral part of the research process, also provide a notable component of the audit trail and extracts from the journals illustrate decisions made during the process of the study.

3.12.1. The Process of Reflection.

Reflections on the interviews.

After the first interview.

On reflection I felt that my management of the interview timing was not good. I was aware that I had specified that the interview would take between an hour and one and a half hours and that during this time I wished to cover all sections of the interview schedule so I was fearful that allowing the respondent too much 'freedom' to reminisce was taking up too much time; was tiring the interviewee and not necessarily achieving the purposes of the research. In part it was considered that this was due to my unfamiliarity with using the interview tool, I was aware that I was referring back to the tool fairly often rather than allowing the interview to flow.

Before the next interview I therefore revised the layout of the tool to make it more user friendly. The first interview was an exciting landmark. I had spent so long on the literature review and on developing the interview tool that I had lost impetus and was considering deferring the study. A change of supervisor and encouragement to start collecting data was helpful. I was struck by the candour of the first interviewee, especially in his descriptions of the tensions between him (a nursing education leader) and his nursing service colleagues.

After the first round of interviews.

When reflecting on the first round of interviews it was considered that the venue had made a difference to the interviews, on the whole it seemed that the interviews carried out in the respondents own home were more relaxed, but the interviewees,

and on occasion the interviewer, were more easily distracted from the process. The distractions ranged from telephone interruptions, stopping the interview to make drinks and moving around during the interview to get books/ articles/ photographs.

Once the interview was terminated prematurely because of ill health (on the part of the interviewee) and on another occasion the interviewer terminated the interview early because the respondent was failing in her memory. The interviews carried out in a neutral venue, by contrast, were considered to have been more impersonal and perhaps more businesslike, although perhaps less rich in additional material.

Having made this reflection during the latter part of 1994 I was more aware of the effects of venue and seating, as well as the need to clearly remind and signal to the respondent the purpose of my visit from an early stage in the interaction. The second round of interviews, wherever possible, were arranged for neutral territory.

Where the respondents own homes were used, after brief greetings and preliminary social niceties had been observed, I started off by setting up the tape recorder and preparing for the interview, often commenting on the unusual nature of a perfect stranger coming into their homes and doing this. In the majority of cases this seemed to work well, although it did throw into some confusion the lady who had prepared for me to do the interview in the garden because the weather was so nice.

Reflection during the interview process

As data analysis was concurrent with carrying out some of the earlier interviews important facets of the situation in which the respondents worked, their relationships with 'significant others' and their own individual characteristics were being isolated. For instance the use of language emerged as important. During the interview I encouraged the participants to reflect on their experiences and if possible to analyse and interpret the influencing factors for themselves. I became increasingly conscious of the use of language in the interviews and of a recurrent pattern of interaction in many of the exchanges between myself and the interviewee. The entry in the diary read:

I have become increasingly aware over the past two or three days of work on the interviews of the use of language in the interviews. When I was transcribing the interviews I was surprised at first by what seemed to me to be a large number of unfinished sentences, often by me, as the interviewee launched into an answer before I'd finished the question. Sometimes though I noticed that I started on another question or line of questioning before they seemed to have finished an answer. On superficial reflection I thought, "Oh well, either I'm a lousy interviewer or they aren't listening."

However, when this was repeated a few times I began to question my superficial assumptions and to look more deeply at what was happening in the interviews. This more in depth analysis led me to consider the use of metaphors in nursing, about which there is a growing body of literature. Metaphors liberally sprinkled the conversations which I was analysing and, as I was to discover metaphors and other tropes, such as simile, analogy, forms of irony and rhetoric, are used as symbols which expand and illuminate what we, human beings, are trying to express to our fellows. Thus in illness metaphors have been used to describe conditions such as cancer as 'the enemy', or AIDS as 'plague' or 'judgement', (Sontag, 1989).

As will be seen later I likened this to the use of metaphor in my own work, particularly, in the descriptions of the 'storyteller' styles, for example the 'battle' between service and education. It seems important to consider the effects and uses of language in future work on leadership and management in nursing education, for:

Midway between the unintelligible and the commonplace, it is a metaphor which most produces knowledge

(Aristotle, Rhetoric 111)

Returning to this theme in September, 1995 this entry in the reflective diary captured the importance that the notion of individual styles and how important language was in their descriptions of their leadership style. As these extracts from the reflective diary demonstrate:

I think this may be one of the pivotal concepts of the study. Quoting from Wright:

The vision expressed by different values. Nursing as a demonstration of a 'different kind of heroism', one which has characteristics of quiet, persistent, perseverance. On the otherhand, Joanne Rule has referred to those nurses who see themselves as martyrs or victims and

*thereby adopting a 'whinging' style of behaviour and language.
(Wright, 1993:6)*

This quotation draws together the original codes of vision and values and links them with the 'styles' or 'typologies' emerging and also encompasses the language and behaviour elements of the styles. Language was an issue which recurred in the Power Bases for Nursing document given to me by Barbara Pearson (pseudonym) ⁴. What was considered of particular importance was the need for nursing language uncontaminated by the language of others such as management, educationists and social scientists.

(Reflective Diary, September, 1995)

I was increasingly aware of the fact that when interviewing nursing educationists we seemed to speak a shared language but that this was not always the case with past nursing leaders from service backgrounds. I began to reflect on the occasions in my career when in the course of my interactions with nursing service managers, and sometimes with administrators, the use of what they considered to be educational jargon had got in the way of what we were trying to achieve. The points in my career which stood out were the introduction of behavioural objectives and the E.E.C. requirements (G.N.C., 1977); the 1982 syllabi in mental health and mental handicap nursing (E.N.B., 1982); the introduction of Project 2000 (especially the budgetary and manpower implications); and the transition to higher education. This last change had brought with it a whole new language and jargon, A.P.E.L. and A.P.L.; C.A.T.S.; the language of validation; of quality assessment and evaluation; and of funding, all of which served to heighten tensions and misunderstanding between nursing education and nursing service leaders.

As well as language another concept which was isolated as important and analysed in some depth was that of the 'career pathways' of the past nursing leaders. Early in the research process the notion of career trajectories, in which it would be possible to trace the way in which the nurse leaders studied had got to their positions of influence and the factors which had been significant along the way was developed. In depth analysis of one 'career trajectory' was generated and from this

⁴ Each of those interviewed was given a fictitious name at the start of the transcription process and they are referred to by this name throughout this thesis. Similarly hospitals and health districts or health authorities are given fictitious names where necessary to preserve the confidentiality of the participants in the research process.

the idea of career pathways was further refined. The 'career trajectory' analysis highlighted the significant 'critical phases' in one individual's career and the factors from which it was possible to infer how and why this individual had become the type of leader in the kind of institution in which she had spent the majority of her later career. This inference was not purely speculation on my part but was deduced from the examples that she gave of factors which she considered important career decision points or career development opportunities. It was decided that career pathway analysis for all those interviewed should be carried so that common themes might be discerned. In order to analyse their careers in this way it was necessary to find a way of comparing the relative importance of very disparate posts over a fairly long period of time. This was achieved through the use of Jaques (1978) levels of work as will be described in the next chapter.

The career pathways of the individuals interviewed are described in diagrams which are presented in Appendix 2. A description of how the pathway diagrams were produced and the analysis which accompanied their production appears later in this Chapter. The profile of the individual leaders which appears in the next Chapter was derived from these diagrams. Some reflections on the process of analysis and decision points in the research are described here.

It was considered that in the descriptions of how and why they entered nursing elements of what I had started to call core concepts (section 3.13) were emerging and this led on to further thematic analysis. For instance:

Another set of values on which individuals seemed strongly polarised are the orientation to work espoused by the respondents. Three main approaches can be demonstrated from the data; an orientation towards a career; towards a profession; and an orientation towards a job of work. A fourth, less dominant, approach is towards a vocation.

(Reflective Diary, September 1995)

In describing the analysis of the texts for the themes of career; job; profession and vocation orientations extracts from the interviews of individuals who are considered to provide exemplars of similarities and differences were used. Benner (1994) claims:

Once the interpretive researcher has identified a pattern of meaning, common situation, or embodied experience, exemplars may be extracted from the text to demonstrate the similarity or contrast. Exemplars convey aspects of a paradigm case or a thematic analysis.
(Benner, 1994:116/117)

As indicated in section 3.11.1. and discussed later (section 3.13) the process of data analysis included isolation of paradigm cases, exemplars and thematic analysis. A journal entry towards the end of 1995 concluded that:

Julia Menton (interviewee 13) exemplifies an individual who had given thought to the effects of the experiences she gained and choices she made in terms of her own career development. Others were equally definite that their careers, particularly in the early stages had been unplanned, for instance, Mary Shilton (interviewee 42). Similarly, Althea Turner (interviewee 17) refers to almost everything in her career as 'accidental'.

In October 1995 the reflective journal recording reads:

The final stages of the data analysis process are considered to be the identification of a core category (a potential core category might be that each manager's life and work, thus the way in which he or she carries out the role, rides the bad times and copes with/deals with the external influences is exactly like the naturalistic research process? Maybe the best form of preparation for management would be early introduction to this process and developing the skills of reflective practice - this is a very early tentative hypothesis). In retrospect the skills necessary may be those of the reflective professional. You need to do a literature search!

4.10.95.

Following the literature search initiated by the note early in October and further analysis, the following questions were posed;

How did my sample learn from work ?

How can the next generation be helped to do so?

Most of my sample seem to have gained the skills, mostly by themselves through work experience, although mentoring (not in the formal sense), role modelling and networks have played a part for all but a small minority. They seem to be afraid that the new forms of nurse education (Project 2000 and the move into higher education in particular) will rob nurses of the opportunities to do so in the future. On the whole PREP and flexible opportunities to build portfolios and receive credit (through CATS and APL/APEL) were welcomed, but some were wary of not letting standards

drop through these processes.

(Reflective Diary. May, 1996)

These questions and reflections on them, allied with further analysis, were used to illustrate the Chapters in which the leadership styles developed are described, and in the final Chapter where recommendations for the future preparation of nurse leaders are made. The data analysis process, the career pathway analysis and the processes of reflection led to the isolation of core concepts of leadership and eventually to the three leadership styles, 'powerful', 'pioneer' and 'enabler', which are described in the next section.

3.13. Data Reconstruction.

The later stages of data reconstruction and in developing the leadership styles which are presented in Chapter 7 was again a cyclical process. To assist this process the three narrative strategies of interpretive phenomenology (Benner, 1994) are used. Findings from the data are described using these strategies: paradigm cases; thematic analysis; and exemplars.

According to Benner (1994) paradigm cases, strong instances of concerns or ways of being in the world, are the most usual point of entering the dialogue with the text:

The interpretive phenomenologist seeks to understand the language used by the participants...By using whole paradigm cases, the interpreter offers the reader an opportunity to engage in the practical world of the participant and come closer to the lived experience, the understanding of the transition as it unfolds...the text is meaningful in that it participates in and flows from multiple traditions, particular language, a socially ordered set of practices, and a variety of experiences, all of which form a community and a culture.

(Benner, 1994:114)

This approach to data sampling was adopted early in the research as the interviews and concurrent analysis progressed. When all of the interviews had been undertaken and following the processes of open and axial coding which were described earlier

sixteen core concepts related to leadership were identified. These core concepts describe some of the ways in which the nursing leaders studied described the ways in which they viewed nursing; their attitudes towards nursing and their colleagues and how they approached their work. Thus the core concepts identified from the data had cognitive, values and behavioural components. The following list details these sixteen core concepts.

* 'dedicated spinster or committed'- this was characterised by a commitment to the job which allowed time for few activities out of work. The term 'spinster' was used although this approach was not the sole prerogative of unmarried women. Men also demonstrated dedication and commitment as did married nurses and those with other family commitments.

* 'steadfast'- patience, perseverance, tolerance and persistence depicted this approach;

* 'modest or diffident'- one who found it difficult to accept praise or recognition for their contribution, often attributing success to luck;

* 'pioneer'- someone who was in advance of the main body of nursing thinking or practice; an originator of policy or strategy; one who prepared the way for others to follow;

* 'innovator'- one who carried out new ideas or practices but who was not necessarily the originator of the idea;

* 'visionary or missionary'- characterised by an idealistic, theoretical, prophetic approach, able to foresee future nursing theory or practice;

* 'zealot or enthusiast'- one with intense enthusiasm and passion regarding nursing;

* 'crusader or battler', here fighting, campaigning, struggling, conflict and confronting with grit, spirit and determination to succeed are the principal

distinguishing features;

* 'opportunist or entrepreneur', one who took advantage of chance occurrences to further themselves and/or their work.

* 'non-conformist'- one who did not always obey and abide by the rules and rituals of the time;

* 'powerful, controller or dominator'- one who consciously used their position; and/or their knowledge, expertise, or network of similarly influential individuals or groups to influence others. Influence was usually exerted through policy making or through monitoring systems used to regulate, check or direct the actions of others;

* 'enabler/facilitator'- one who helped others to achieve, who smoothed the way and made things easier for others; one who empowered and gave authority to others;

* 'democrat or sharer'- one who encouraged the participation of others through persuasion and cooperation;

* 'survivor'- one who had overcome a problem, faced a difficulty or challenge and come through it;

* 'victim or casualty'- this is identified by the individual having fallen foul of the system, having been or felt fooled or cheated, or considering themselves scapegoated in an incident;

* 'blamer or disapprover'- one who found fault with, criticised or censured others.

Each of the interview transcripts were then searched for instances of these core concepts. When instances were isolated from the text these were noted on file cards and the excerpt from the interview transcript was extracted, collated and recorded.

When this process was completed for all of the texts the instances of each of the core concepts which had been recorded on the file cards were noted and the collated extracts were further analysed for similarities or differences. This thematic analysis led to synthesis and reduction of data. Paradigm cases and exemplars were again identified and the transcripts and extracts further scrutinised for similarities and commonalities as well as for unusual features and differences.

In the later stages of this process sub-categories of the core concepts were collapsed. For instance the divisions between the pioneer and the innovator approaches to work, originally conceived as two discrete techniques of leadership, were difficult to separate, it was unusual for a pioneer not to implement an innovation. The initial definition of the steadfast mode of operation was encompassed in the approaches to their work by many of those who were exemplars of the three styles of leadership classified from the data. For instance the 'powerful', 'pioneer', and 'enabler' approaches to work all contained elements of perseverance and tolerance. The 'modest' or 'diffident' approach similarly was not considered to be a single strategy but was the way in which many of those interviewed played down their own influence or importance to the profession. What was conceived of as the original disapprover typology also ran as a theme through many of the interviews, not necessarily in an attempt to attribute blame but in an attempt to analyse and explain some of the issues and tensions of the time.

In the process of collapsing the sub-categories it was also discovered that whilst describing one approach to their work as leaders individuals often referred to more than one of the core concepts. This led to further thematic analysis to identify the possible origins and elements of the three styles of leadership discerned from the data and to the identification of three main components of the styles. These three styles, the 'powerful'; 'pioneer' and 'enabler', were considered to comprise three major components. The first of these was considered to be the 'knowledge' or 'ways of knowing' component, the cognitive elements of the styles especially as this related to nursing. The second component of the styles the 'ways of behaving' was usually expressed by the leaders interviewed as their action tactics in carrying out their nursing leadership roles. The final component, 'values and commitments' were judged to describe the ways in which what they thought about nursing and

their subsequent approaches to leadership were directed by underlying ideologies and philosophies. The paradigm cases, exemplars and thematic analysis used to identify the epistemological and ontological determinants of the styles led to the conclusion that these three components or elements of the way in which they described their leadership roles were common to all the leadership styles identified. The three styles were distinguished by differences between the leaders studied in these three components or elements of the styles.

This conclusion was reached through analysis of a pattern discerned in the dialogue which had been extracted and collated from the interviews. In this pattern the statements that they made regarding their values and beliefs about nursing and nursing education were usually followed by an example from their own experience. It was in this section of the dialogue that they most often depicted this aspect of their work through 'plays'. They enacted scenarios and described conversations that they had with other players in the 'drama', or recalled actual dialogue or actions that they and/or others took. This component is described as the 'behaving, acting, doing' component and was most frequently identified in relation to tensions, concerns and issues of the day related to nursing management.

Four major approaches were derived from the sixteen core leadership concepts and these describe the ways in which the leaders studied behaved or acted in their roles. These approaches are described as, the 'battler'; the 'enthusiast'; the 'opportunist'; and the 'dedicated'. The 'battler' approach was discerned during the early part of the study as it was noticeable that martial language was common. Some spoke of battles they had fought and struggles to achieve something. The fighting which went on between the different segments of the profession was a feature as were the descriptions of battles between nurses and administrators and nurses and doctors. 'Enthusiasts' were more likely to describe how these behaviours helped them to influence others within the work setting, usually those in subordinate or learning positions, although peers also often found their enthusiasm infectious. The 'opportunist' aspect of the behavioural component was most often linked to the openings presented to them for personal or professional career development. This aspect of an individual's behaviour can be linked to both environmental influences and the role of significant others. Whilst some thought that the 'luck' of being in

the 'right place at the right time' or 'working with the right people' were what had helped them others put this down to 'dedication, commitment or sheer hard work'. Their descriptions of their involvement in their work could lead to more and more opportunities until work and work related activities took over their lives. These four approaches to the 'behaving, acting or doing' component of the styles were most usually related to an aspect of the environment in which they worked or an encounter with a 'significant' other, occasionally both aspects were in evidence.

These three components of the styles, 'thinking'; 'feeling' and 'doing', are further described illustrated with extracts from the interviews in the next Chapter. A supplementary common facet discerned from the interviews, which will also be described in more detail in Chapter 4, was their motivation to 'survive'. This motivation, which appeared to sustain them throughout their careers, was sometimes related to personal 'survival' and at others to the survival of the profession. Most also recognised the alternative to survival, that of becoming a 'victim or casualty'.

Once the three elements or components of the individual approaches to management and the leadership styles had been constructed and paradigm cases used to identify examples of these approaches and styles each of the leaders interviewed was assigned to a style or styles. This was achieved through building up a matrix of all factors. From the file cards which had been used to record instances of examples of the styles and from the collated extracts of illustrations of the components from their interviews the numbers of cases were recorded for each leader. In all but four instances it was possible to assign a single dominant style, although elements of a subordinate style or styles were also present in many cases. An overarching approach to the ways in which they described how they had carried out their roles as nurse leaders was also discernible using this process. In the four cases where this was not possible two of those interviewed were considered to have demonstrated the existence of two equally dominant styles, the other two interviews had been terminated prematurely so there were insufficient examples from which to draw conclusions. The final matrices which show each leader assigned to a dominant style and a subordinate style and their chief area of work appear in chapter 7. It was in developing these final matrices that the realisation that leaders from different segments of the profession appear to have adopted or developed different styles

became apparent. This realisation posed a further question was the style developed in response to the tensions identified or the cause of the tensions?

3.14. Summary of the Research Design and Research Process Considerations.

This research study set out to analyse the effects of changes in the organisation and structure of nursing and nursing education within the NHS in the late 20th century on the leadership and management of nursing. The focus for this analysis is the tensions between nursing leaders during the period studied. In particular it was intended that the factors which affected the ways in which nurse leaders carried out their roles should be identified so that recommendations concerning the selection and preparation of nurses, especially those destined for future leadership and management roles, based on the findings of the study, might be made.

Through in-depth discursive interviews with 51 ex-leaders in the nursing profession these factors were considered to have been related to the characteristics of the individuals studied; the relationships that they had with 'significant others' and the situation or environment in which they worked. Through analysis of the data produced from transcriptions of the interviews and through use of reflective diaries it was found that during the course of their careers these influences combined so as to produce a distinctive way of coping with their leadership roles. These ways of coping have been categorised as three different leadership styles, powerful, pioneer and enabler. In the next chapter profiles of their careers and their individual characteristics are presented. In subsequent Chapters the influence of significant others (Chapter 5) and of the situation or environment (Chapter 6) on the development of these styles is assessed. In Chapter 7 the leaders ways of coping with the changes and the tensions between nursing leaders through the leadership styles developed are described. Finally, in Chapter 8, a summary of the findings of this study is made before going on to suggest ways in which the tensions and conflicts within and surrounding nursing leadership, particularly that of nursing education leadership might be lessened.

CHAPTER FOUR.

A PROFILE OF THE CAREERS OF THOSE INTERVIEWED

- THEIR INDIVIDUAL CHARACTERISTICS - SIMILARITIES AND DIFFERENCES.

Introduction.

This Chapter begins with a description of the professional achievements of those interviewed and establishes the claim that they were influential in the development of nursing during the period studied in order that the research aims might be achieved. Their career pathways are examined and, through their descriptions of their conceptions of nursing; the role of the nurse; and nursing education, the similarities and differences between them are analysed. Their approaches to their practice as nurse managers in their own leadership roles is then described, chiefly through their descriptions of their actions and motivations in the relationships between themselves and significant others. Thus this chapter, the first in which data from the interviews are presented, begins to deal with the overarching aims of the research, firstly: 'what was the impact of successive organisational changes within the N.H.S., and secondly; 'the way other environmental factors affected how these managers perceived their roles'. The Chapter also begins to explore 'in what ways their relationships with significant others affected them as individuals, especially with regard to their preparation for and response to these changes'. In addition the first of the four research questions is confronted: 'what were the effects of changes in health care delivery occurring in the late 20th century on the roles and relationships of leaders of nursing?'

4.1. The interviewees.

The first interview, with Roy Elm, was carried out in August 1993. Following this initial 'pilot' interview changes were made to the interview process (as described in

section 3.11.1. and the remaining interviews took place over a two year period. Details of the interviews carried out with the respondents identified by fictional name, their age at interview and the date and venue of the interview appear as Table 4.1. on the next page.

Table 4.1. Interviews carried out during the study.

No.	Interviewee	Date	Age	Venue
1.	Roy Elm	16.8.93	66	His work
2.	Barbara Pearson	14.10.93	67	Hired room
3.	Elizabeth Hamkin	29.10.93	89	Her home
4.	Walter Mant	29.10.93	77	His home
5.	Betty Deerman	2.11.93	78	Her home
6.	Sylvia Pole	12.11.93	72	Her home
7.	Ether Hurst	12.11.93	62	Friends home
8.	Heidi Mann	12.11.93	71	Her home
9.	Martha Larnet	26.11.93	64	Her home
10.	Carol Bury	26.11.93	70	Friends home
11.	Carmel Arter	26.11.93	66	Her home
12.	Janet Ightson	26.11.93	68	Her home
13.	Julia Menton	27.11.93	54	Hotel room
14.	Sebastian Reason	21.12.93	65	Hired room
15.	Elvira Smith	11.1.94	89	Her home
16.	Georgina Shaw	18.1.94	70	Her home
17.	Althea Turner	1.3.94	75	Her home
18.	Marcia Hughes	1.3.94	61	Her home
19.	Melba Rayner	1.3.94	69	Friends home
20.	Agnes Long	1.3.94	64	Friends home
21.	Lilian Johnson	2.3.94	75	Her home
22.	Elaeph Wright	15.3.94	78	My work
23.	Julian Burns	17.3.94	59	Hired room
24.	Vivian Stevens	21.3.94	63	My work
25.	Andrea Davies	22.3.94	59	Hired room
26.	Sylvia Thomas	23.3.94	63	Hotel room
27.	April Walabe	29.3.94	59	Her home
28.	Emma Bryant	19.4.94	59	Her home
29.	Ruby Porter	19.4.94	70	My work
30.	Pearl Trent	21.4.94	77	Hired room
31.	Margaret Norman	16.5.95	62	Her home
32.	Jean Bentoo	16.5.95	61	Her home
33.	Janice Williams	2.6.95	58	Her work
34.	Mimi Gold	5.6.95	80	Her home
35.	James Ray	12.6.95	79	Hired room
36.	Jacqueline Adams	13.6.95	80	Her home
37.	Wanda Hale	13.6.95	65	Her home
38.	Millicent Wood	22.6.95	71	Her home
39.	Charlotte Holmes	11.7.95	58	Her work
40.	Serena Crooks	9.8.95	74	Her home
41.	Marlene Adnam	24.8.95	71	Her home
42.	Mary Shilton	25.8.95	63	Her work
43.	Charlotte Calman	25.8.95	62	Her work
44.	Carol Nyman	29.8.95	73	Her home
45.	Hilary Miles	30.8.95	59	Her work
46.	Maude Oliver	30.8.95	68	Her work
47.	Maria Palmer	31.8.95	65	Her home
48.	Richard Crapton	20.9.95	63	Hired room
49.	Phillipa Simmons	26.9.95	73	Her home
50.	Nan March	3.10.95	76	Her home
51.	Jennifer Westley	23.10.95	69	Her work

At the beginning of the interview each individual was asked to briefly outline their career biography, using a standard format (Appendix 1), and these biographies, along with the data obtained via their interview transcripts, were used to develop the career pathway diagrams (Appendix 2). Along the vertical axis of these diagrams their roles are portrayed through the levels at which they worked during their careers. Their achievements in relation to levels of management is depicted as being at one of 5 levels at given points in their careers. These levels, considered by some writers (Jaques, 1978; Billis, 1984; Rowbottom and Billis, 1977; Owens and Glennerster, 1990) to identify broad levels of work common to many organisational settings, were considered preferable to trying to describe the many and varied posts which those interviewed had occupied throughout their careers. It was important to find a tool which would also allow for the level of work of those who left the N.H.S. to work in higher education, the statutory bodies, the civil service, professional organisations or to become journalists to be equated to, and/or compared and contrasted with those who remained in N.H.S. employ. This would have been extremely difficult given the range of re-organisations, re-structuring, and reform of the service which have taken place since the inception of the N.H.S. In addition to have identified the posts by title would have, in some cases, helped to identify the individual and therefore jeopardise confidentiality of the information obtained.

What is considered important in this study is a general level of achievement and possible influence rather than the specific post or posts held. However it is recognised that the choice of the 'levels of work' categories is not uncontroversial, particularly as it could be taken to assume that career pathways and career success are defined through moving up through a hierarchy. This is a masculine defined concept, some of the implications of which will be explored in a later Chapter. In reality though, for the majority of those who took part in the study, their careers would have been defined in this way and as they moved through the hierarchy and were rewarded by promotion, increased pay and status, most of them accepted this as the norm. The 'levels of work' categories chosen also have the benefit that they describe a manager's work in relation to the situations in which that work is carried out which fits well with the way in which it has been decided to analyse and present

the data in this study. When allocating the experiences of those interviewed into these five levels of work periods of full-time study whether for an initial qualification or for subsequent clinical, teaching or managerial qualifications are shown as level zero, even though there may have been some level of work included in the course. Part-time study has not been separately identified and the person has continued to be allocated at the appropriate level of work. The horizontal axis denotes the years spent in each of the positions that they held.

For the purposes of this study Level 1, or prescribed output, work, that is 'carrying out concrete tasks whose objectives are completely specifiable beforehand so far as is significant' (Owens and Glennerster, 1990), is considered to represent the level of work of a newly qualified nurse, staff nurse or its equivalent. Level 1 is considered to be the first in which a management role of any significance is undertaken. Ward Sister / Charge Nurse, Nursing Officer, or the midwifery or community nursing equivalents, and Nurse Tutor roles, are included in the definition of level two, or 'situational response', work in which the person 'carries out concrete tasks whose precise objectives have to be judged according to each situation encountered' (Owens and Glennester, 1990). In level 2 the manager is expected to be in charge of a ward or group of wards, for example over a span of night duty, as a ward sister or night sister or to be responsible for his or her own case load of patients, such as in the case of a District Nurse, Health Visitor or District Midwife. The level 2 manager may also be responsible for the education of a group of student nurses or midwives as a Nursing or Midwifery Tutor.

Level three work, where there is 'systematic provision according to the needs of a flow of open-ended situations' (Owens and Glennester, 1990) is assigned to the work of Senior Nursing Officers; Senior Tutors; Principal Nursing Officers; Deputy Matrons; Matrons of small hospitals and their midwifery or community equivalents, also included here are officers of the statutory body and civil servants at Nursing Officer levels. In hospitals a level 3 manager will have been responsible for co-ordinating the work of more than one ward, as a Nursing Officer or Senior Nursing Officer or overseeing a functional area of responsibility in a hospital, such as an administrative sister, assistant or deputy matron. Also included here is reporting to another nurse on the functions of a hospital or school of nursing, for example

Principal Tutor or Principal Nursing Officer (Service or Education). Nurses who were working in the community where they were responsible for organising the provision of nursing services within a specific geographical area and for those who had moved into higher education or research work, in Principal Lecturer roles, is denoted at level 3, as is Senior Research Fellow. Journalists at the assistant editor level were also assigned to this category.

Level four, 'providing a complete range of products or services throughout a whole territorial or organisational society, that is comprehensive provision' (Owens and Glennester, 1990) is adjudged appropriate to the level of a Group of hospitals, and a District or Area Health Authority, as well as 'second in line' nurses or midwives of national organisations. The level four manager is considered to have fulfilled a nursing management responsibility for a major hospital or group of hospitals or for a District or Area School or College of Nursing. The manager of community nursing services of a major city or a county council is included here. Within higher education Head of Department and/or Professor are designated as Level 4 management roles. Journalists at editor level were assigned here as well. Level 5 management, 'field coverage' which encompasses those 'covering a general field of need throughout society' (Owens and Glennester, 1990) is reserved for those with responsibility for services within a large part of the country or those with a national or international role such as Regional Nursing Officer, Chief Nursing Officer (Department of Health), Chief Executive of a Statutory Body or Professional Organisation.

From the career pathway diagrams it can be ascertained that all of the 51 people interviewed had achieved at least a level 3 post, four remained at this level whilst the rest went on to level four (36) and level 5 (11). From the career pathway diagrams the extent of each individual's possible level of influence was deduced. Table 4.2. shows each individual's most influential post as discerned from the level of management reached. Their 'paid' employment appears in the first column, most (43) had also been influential in more than one role, usually the second role was one held in an 'unpaid' capacity, expenses and a small retainer may have been paid but it was not a role from which they earned their main living. These additional influential roles appear in the second column. Of those interviewed eleven were

most influential in the field of nursing, midwifery or community service management positions within the NHS and seventeen in nursing or midwifery education in NHS schools of nursing and/or midwifery. In nine cases it was considered that their work in nursing/midwifery or community education within higher education was where they had most influence. Three were employed in influential positions in statutory bodies, six were in powerful positions in the civil service and four in professional organisations. The remaining one was a journalist. The most significant of the additional work activities were professionally related, thirty had achieved positions of significance within the professional domain, for instance Chairmanship or Presidency or deputy positions, in either or both of their professional organisations and statutory bodies. Thirteen of the respondents were considered influential through scholarly activity, of these three were influential in the research field and twelve contributed through publications and speaking at conferences.

Recognition had been the consequence of their activities (Table 4.3.), thirty-three had been awarded State honours, for instance O.B.E., M.B.E., C.B.E., D.B.E. or a life peerage. Forty-seven had been recognised for their contribution to the profession either by award of Fellow of the Royal College of Nursing, a similar level of recognition by other professional organisations or election by their peers to office of their professional organisation or statutory body. Academic honour, such as honorary doctorate, professorship or scholarships had been awarded to a further twenty-seven. Twenty three had their contribution recognised by all three methods.

Table 4.2. Most Influential Posts.

No.	Interviewee	Field	Additional
1.	Roy Elm	NHS Education (Nurse)	Publication
2.	Barbara Pearson	NHS Education (Nurse)	Statutory Body
3.	Elizabeth Hamkin	NHS Education (Nurse)	Professional Org.
4.	Walter Mant	NHS Service	None
5.	Betty Deerman	Statutory Body	None
6.	Sylvia Pole	NHS Education (Nurse)	Professional Org.
7.	Esther Hurst	NHS Education (Nurse)	Statutory Body
8.	Heidi Mann	NHS Education (Nurse)	None
9.	Martha Larnet	Professional Org.	Statutory Body
10.	Carol Bury	Professional Org.	Statutory Body
11.	Carmel Arter	Higher Educ. (Nurs)	Prof. Org./Publ.
12.	Janet Ightson	Civil Service	None
13.	Julia Menton	NHS Education (Nurse)	Statutory Body
14.	Sebastian Reason	NHS Education (Nurse)	Prof. Org./Stat.Body
15.	Elvira Smith	NHS Education (Nurse)	Professional Org.
16.	Georgina Shaw	Higher Educ. (Comm)	Publication
17.	Althea Turner	Higher Educ. (Nurs)	Publication
18.	Marcia Hughes	Civil Service	Publication
19.	Melba Rayner	Statutory Body	Publication
20.	Agnes Long	NHS Education (Nurse)	Stat. Body/Publication
21.	Lilian Johnson	Higher Educ. (Comm)	Public/Research
22.	Elspeth Wright	NHS Service	Professional Org.
23.	Julian Burns	NHS Service	Publication
24.	Vivian Stevens	NHS Education (Midwife)	Professional Org.
25.	Andrea Davies	NHS Service	Statutory Body
26.	Sylvia Thomas	Higher Educ. (Comm)	Statutory Body
27.	April Walshe	Civil Service	None
28.	Emma Bryant	Statutory Body	Professional Org.
29.	Ruby Porter	NHS Education (Nurse)	Professional Org.
30.	Pearl Trent	Journalism	Publication
31.	Margaret Norman	NHS Education (Midwife)	Stat. Body/Prof.Org.
32.	Jean Benton	Civil Service	None
33.	Janice Williams	NHS Education (Nurse)	Statutory Body
34.	Mimi Gold	Professional Org.	Publication
35.	James Ray	NHS Service	Professional Org.
36.	Jacqueline Adams	Professional Org.	None
37.	Wanda Hale	NHS Education (Nurse)	Professional Org.
38.	Millicent Wood	NHS Service	Professional Org.
39.	Charlotte Holmes	Higher Educ. (Nurse)	Publication
40.	Serena Crooks	NHS Service	Professional Org.
41.	Mariene Adnam	NHS Service	Statutory Body
42.	Mary Shilton	Higher Educ. (Nurse)	Research
43.	Charlotte Calman	NHS Education (Nurse)	Statutory Body
44.	Carol Nyman	Higher Educ. (Comm)	Publication
45.	Hilary Miles	NHS Service	Professional Org.
46.	Maudie Oliver	NHS Service	Professional Org.
47.	Maria Palmer	NHS Service	Statutory Body
48.	Richard Crapton	NHS Education (Nurse)	None
49.	Phillipa Simmons	Civil Service	Professional Org.
50.	Nan March	Civil Service	Professional Org.
51.	Jennifer Westley	Higher Educ. (Comm)	Research

Table 4.3. Recognition of their contribution to nursing.

Interviewee	State Honour	Prof. Honour	Ac. Honour
Elm	Yes	No	No
Pearson	Yes	Yes	Yes
Hamkin	No	Yes	No
Mant	No	Yes	No
Deerman	Yes	Yes	Yes
Pole	Yes	Yes	Yes
Hurst	Yes	Yes	Yes
Mann	No	No	Yes
Larnet	Yes	Yes	Yes
Bury	Yes	Yes	Yes
Arter	Yes	Yes	Yes
Ightson	No	Yes	No
Menton	No	Yes	No
Reason	Yes	Yes	No
Smith	No	No	Yes
Shaw	No	Yes	Yes
Turner	Yes	Yes	Yes
Hughes	Yes	Yes	Yes
Rayner	No	Yes	No
Long	No	Yes	No
Johnson	Yes	Yes	Yes
Wright	Yes	Yes	No
Burns	Yes	Yes	Yes
Stevens	No	Yes	No
Davies	Yes	Yes	Yes
Thomas	No	Yes	Yes
Walshc	Yes	Yes	Yes
Bryant	No	Yes	No
Porter	No	Yes	No
Trent	Yes	Yes	Yes
Norman	No	Yes	No
Benton	Yes	No	Yes
Williams	Yes	Yes	Yes
Gold	Yes	Yes	No
Ray	Yes	Yes	No
Adams	Yes	Yes	No
Hale	No	Yes	No
Wood	Yes	Yes	No
Holmes	Yes	Yes	Yes
Crooks	Yes	Yes	Yes
Adnam	Yes	Yes	No
Shilton	Yes	Yes	Yes
Calman	Yes	Yes	No
Nyman	Yes	Yes	Yes
Miles	Yes	Yes	No
Oliver	No	Yes	No
Palmer	Yes	Yes	Yes
Craption	No	Yes	No
Simmons	Yes	Yes	Yes
March	No	Yes	No
Westley	Yes	Yes	Yes

Thus it is considered that those interviewed meet the requirements of the sample for this study. All had reached a position from which they were able to influence nursing education, either at hospital, district, regional, national or international levels and all had their contribution for this recognised in some way. The profile of those interviewed now moves on to examine their careers and some of the factors which influenced them as leaders and managers of nursing.

Their professional nursing careers spanned the years between 1927 and 1995 (Table 4.4.), as the research had set out to interview those who had been in nursing leadership positions from 1948 to 1995 it was inevitable that some of those who were in positions of authority at the inception of the N.H.S. would have entered training for the profession many years before. One entered nursing in the 1920's (Elvira Smith who began nursing in 1927), eight entered nursing in the 1930's, 22 in the 1940's, and the remaining 20 entered in the 1950's. The years in which they completed their professional nursing careers shows a broadly similar spread, the earliest one to retire had done so in 1964 (Elizabeth Hamkin), only one other had retired in the 1960's (Elvira Smith in 1967). Six retired in the 1970's, twenty-eight in the 1980's and fifteen in the 1990's. The timing of the decision to retire was also significant in some cases. In the 1970's the most frequently chosen year for retirement was 1974, and in the nineteen eighties 1983 was the most often chosen for retirement, the significance of these data will be explored in Chapter 6. Although their professional nursing careers ended in the years noted in the career pathway diagrams all had continued to work in some capacity after retirement. At the time of interview only 5 (interviewees 3,4,5,15, and 36) were no longer actively employed in work of some sort. Most worked for a considerable time in their chosen profession (Table 4.5), the length of their careers ranging from 22 to 50 years. The descriptions of careers in nursing that follow cover seven decades of nursing within England and Scotland during the twentieth century.

Table 4.4. Career spans of the interviewees

Year Entered	Numbers Entering	Year Finished	Numbers Finishing
1927	1	1964	1
1933	1	1967	1
1934	2	1974	2
1935	2	1975	1
1937	11	1976	1
1939	2	1977	1
1940	2	1978	1
1941	2	1980	2
1942	5	1981	2
1943	1	1982	3
1944	3	1983	6
1945	1	1984	2
1946	2	1985	3
1947	3	1987	3
1948	3	1988	4
1950	3	1989	3
1951	6	1990	3
1952	5	1991	3
1953	1	1992	4
1954	2	1993	2
1955	2	1994	1
1958	1	1995	2

Table 4.5.

Length of careers in years.

Years	Numbers
22	1
27	1
30	1
31	2
35	1
36	1
37	4
38	5

Years	Numbers
39	6
40	4
41	9
42	6
43	5
44	3
45	1
50	1

Their careers can be divided into four main sections, a period of initial training; the early career in levels one and two work; the early middle career, usually the period of level three work; and finally the late middle and final stages of the career, normally level four and/or five work although there are some exceptions to this pattern. The following analysis concentrates mainly on the last three of these phases as the most germane to this study.

4.2. The early career.

Following entry to nursing most spent three or four years in initial preparation and then worked for a short period as a staff nurse before going on to take midwifery training. The early years in the profession were spent in gaining initial qualification in their chosen area of nursing. For the majority this was a general nursing course at the end of which the qualification S.R.N.(State Registered Nurse) or Registered General Nurse (R.G.N.), in Scotland, was awarded. James Ray and Walter Mant began their nursing careers studying psychiatric nursing and nursing the mentally handicapped respectively and Ruby Porter began with midwifery training. Some, usually those who trained in Teaching Hospitals, were expected to complete a further year after which they would be awarded their hospital badge. Table 4.6. shows professional qualifications obtained in the initial training and early career periods.

Table 4.6.

Professional qualifications obtained in the initial training and early career periods.

QUALIFICATION	NUMBER OBTAINING THE QUALIFICATION
S.R.N./R.G.N.	51
S.C.M./C.M.B.	31
MIDWIFERY Part 1	9
R.M.N.	3
R.S.C.N.	1
R.N.M.S.	1

Following initial training most went on almost immediately to further training. The time spent in level one work was very short for almost all of those studied. For most of the women in the study the staff nurse position served as an interim post between qualification as a State Registered Nurse (Registered General Nurse in Scotland) and undertaking further training, usually as a midwife. Midwifery training at this time was divided into two parts, an initial six months in hospital and a further six months in the community. Some (9) chose only to do the first part of midwifery training prior to making further career moves. For most of the women, having completed midwifery training, they were quickly promoted to sister. Thus having practised as a nurse for a minimal period after initial qualification they assume a position in which they are responsible for managing both nursing and nurses with little or no preparation at all for the role. This finding alone seems to have significance for their future careers and on the way in which they carried out their subsequent management and leadership roles.

The small number of men in the sample had somewhat different early career experiences. For those who entered general nursing, two did not undertake a second qualification, (Sebastian Reason and Roy Elm) as it was not possible in those days for men to do midwifery training. Both of the others took short post-registration courses in a specialist area of nursing, Richard Crapton in Genito-Urinary nursing and Julian Burns in nursing patients with Tuberculosis (B.T.A.). Of the two who did not enter via the general nursing route (James Ray and Walter Mant) both undertook shortened S.R.N. courses following initial R.M.N. and R.N.M.H. qualifications. The men spent slightly longer in the staff nurse position than the women as there were less opportunities for them to undertake further professional qualifications.

In the majority of cases the career pathway diagrams show a common pattern with a number of years being spent at first line management, or level 2, before a move is made to middle management, levels 3 and/or 4. The length of time, including initial training and any subsequent further training, between entering nursing and being promoted to Ward Sister or Charge Nurse ranged from four to thirteen years (Table 4.7) with the average length of time between entering the profession and

becoming a Sister or Charge Nurse being seven years. Two of those studied skipped level 2 (Walter Mant, interviewee 4 and James Ray, interviewee 35). In Walter Mant's case the move was from staff nurse to Night Superintendent and James Ray's promotion was from staff nurse to Assistant Chief Male Nurse. Both of those who were promoted in this way were men, one working in psychiatric nursing and one in nursing care of the mentally handicapped. By the time of the promotion in which they 'skipped a rank' both would have been older than their female counterparts having served in the Second World War.

From the data presented in Table 4.8. the majority then spent a long period of time in level 2 work before entering level three. The range of time spent at level 2 was from one year to twenty-five years with thirty nine of those interviewed spending eight years or more at this level. Three of those interviewed skipped level three moving from level 2 positions to level four posts (interviewee 11, Carmel Arter went from Lecturer to Head of Department, interviewee 47, Maria Palmer, from lecturer to Assistant Regional Nursing Officer, and interviewee 51, Jennifer Westley, from tutor to Director of Education). By the time the remainder were promoted to level 3 they had spent between seven and thirty-two years in the profession, including initial training, with one-sixth of the sample who achieved this level (eight out of forty-eight) having spent fifteen years in the profession.

Table 4.7.

The length of time, including initial training and any subsequent further training between entering nursing and being promoted to Ward Sister or Charge Nurse.

NUMBER OF YEARS	INTERVIEWEE NUMBER				TOTAL
4	2	11	14	23	6
	36	47			
5	3	13	25	38	9
	40	43	45	49	
	50				
6	8	10	12	18	8
	27	30	34	51	
7	6	7	15	17	14
	20	22	26	28	
	32	33	37	44	
	46	48			
8	1	5			2
9	16	21			2
10	19	31	42		3
11	9	41			2
12	19	39			2
13	24				1
Skipped level 2	4	35			2
					31

Table 4.8.

Period of time in level 2 work before entering level three or four work.

YEARS IN LEVEL 2	INTERVIEWEE NUMBER	TOTAL												
Skipped	4 35	2												
1	39	1												
2	30 50	2												
4	10	1												
5	15 31	2												
6	5 21	2												
7	3 20	2												
8	<table border="1"> <tr> <td>1</td> <td>11</td> <td>19</td> <td>24</td> </tr> <tr> <td>29</td> <td>32</td> <td>34</td> <td>40</td> </tr> <tr> <td>41</td> <td>46</td> <td>48</td> <td>49</td> </tr> </table>	1	11	19	24	29	32	34	40	41	46	48	49	12
1	11	19	24											
29	32	34	40											
41	46	48	49											
9	<table border="1"> <tr> <td>12</td> <td>17</td> <td>27</td> <td>38</td> </tr> <tr> <td>45</td> <td></td> <td></td> <td></td> </tr> </table>	12	17	27	38	45				5				
12	17	27	38											
45														
10	<table border="1"> <tr> <td>13</td> <td>14</td> <td>25</td> <td>51</td> </tr> </table>	13	14	25	51	4								
13	14	25	51											
11	<table border="1"> <tr> <td>6</td> <td>7</td> <td>18</td> <td>33</td> </tr> </table>	6	7	18	33	4								
6	7	18	33											
12	<table border="1"> <tr> <td>22</td> <td>43</td> </tr> </table>	22	43	2										
22	43													
13	<table border="1"> <tr> <td>9</td> <td>28</td> </tr> </table>	9	28	2										
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14	<table border="1"> <tr> <td>2</td> <td>23</td> <td>26</td> <td>37</td> </tr> </table>	2	23	26	37	4								
2	23	26	37											
15	<table border="1"> <tr> <td>8</td> </tr> </table>	8	1											
8														
18	<table border="1"> <tr> <td>16</td> <td>36</td> <td>42</td> </tr> </table>	16	36	42	3									
16	36	42												
25	<table border="1"> <tr> <td>44</td> </tr> </table>	44	1											
44														
		51												

Thus for the majority it could be said that they had learned to practice their profession in the time spent in level two work. However this statement masks the variety of activities that they pursued during the intervening years. A key factor to consider when later data is analysed and when recommendations are made for the future preparation of nurses and their leaders is the way in which they viewed their profession. As was described previously most had been promoted to the level two post of Ward Sister or Night Sister very soon after their initial and subsequent training. Most spent only two years in this position before going on to do other things, at this point a few left nursing altogether for a short period. Some combined nursing with other activities, two pursued full time employment related to the church (interviewees 24 and 28). Many travelled and worked abroad. The majority (48) undertook further education, most usually a one or two year full time teaching course (Table 4.9) some took courses in District Nursing and/or Health Visiting.

Table 4.9.

Educational and professional qualification gained following nurse training.

POST ENTRY EDUCATIONAL QUALIFICATIONS

	INTERVIEWEE NUMBER				TOTAL
H.V.	21	26	27	34	7
	45	50	51		
Q.I.D.N.	16	21	26		3
R.N.T.	1	2	3	5	29
	6	7	8	9	
	11	12	13	14	
	15	16	17	19	
	20	21	25	29	
	33	36	37	40	
	42	43	47	48	
	49				
M.T.D.	24	28	29	31	5
	32				
R.C.N.T.	47				1
H.V. TUTOR	16	26	50	51	5
	21				
D.N. TUTOR	44				1
OTHER e.g. E.N.T./ORTHO/FEVER CANCER/B.T.A./FLIGHT GENITO-URINARY	1	9	13	19	10
	23	27	34	45	
	48	21			

Table 4.9. continued

	Total
Diploma	
Diploma in Nursing	4
Diploma in Education	3
Diploma in Management	1
First Degree	
BSc (Hons) Sociology	8
BA (Hons) Open	7
BSc	2
BA (Hons)	2
BA (Hons) Psychology	1
BA (Hons) Soc. Sci. & Admin.	1
BA Soc. Ed.	1
BSc Soc	1
BSc Econ.	1
Masters Degree	
MPhil	5
MSc	3
MSc Educ. Studies	2
MA Educ. Admin.	1
MSc Econ.	1
MA (Hons) Phil.	1
MSc Soc Research	1
MA (Ed)	1
MA	1
Doctorate	
By Research	3
Hon DSc	1
Hon PhD	1

MANAGEMENT COURSES AND/OR QUALIFICATIONS

Top Management	13
Hospital Admin. Cert.	6
Kings Fund Senior Management	3
Senior Man. Dev.	2
Certificate Nursing Management	1
Nursing Admin. Course	1
Ward Sister Development	1
Middle Management	1
Housekeeping Course	1

The data previously presented and Table 4.9. shows that the length of time in level two work, 'learning the trade', may in fact have been split into two or three different activities, some of which included further training for a different post at the same level. These varied activities and experiences helped to develop their knowledge and values relating to their profession as will be seen when their differing conceptions of nursing and the role of the nurse are explored later in this Chapter.

Whilst some of those whose careers were investigated in this study demonstrate the 'lateral move syndrome' (Hardy, 1983) from the interview data analysed some of the reasons given for not wanting to move too quickly, if at all, into the more senior management positions (level three and above) are revealing. Many described their great satisfaction with clinical nursing and a reluctance to leave the 'hands on' care setting. The early career period can be seen as a vital and important preparation for what is to follow. The career pathway diagrams demonstrate that in the early years of their nursing careers the majority of the sample explored a range of options regarding their possible future as well as gaining experience in other countries and of other cultures. Sometimes these explorations were decided for them by factors outside their personal control, as with the Second World War; sometimes they appear to have been purposeful decisions made with a specific career goal in mind; and on occasions they seem to have been made with hedonistic motivations.

At face value these data could be taken to indicate that the first fifteen years of the careers of the majority were spent in fairly purposeless and undirected activity, and indeed this is how it has been interpreted in the past (Pape,1978; Dingwall and McIntosh,1978; Hardy, 1983). However the important nature of this time in forming their subsequent approaches to their leadership and management careers is demonstrated in this thesis. As well as gaining further experience in nursing, and of life in general, many of this sample also seemed to use their early experiences in nursing to 'cast around' for the type of work which best suited them. Whilst it can be argued that 'casting around' at the beginning of a professional career is wasteful of resources and that taking several different preparatory courses is repetitious and avoiding of commitment (Dingwall and McIntosh, 1978) in a more

positive light it can lead, as some of this sample have demonstrated, to people who eventually became leaders in their chosen area. If denied the opportunity to find their niche they might have carried on in an area of work with which they became bored and having become bored perhaps lost motivation and commitment or alternatively they might have left the profession altogether.

It must be emphasised that 'casting around' was not a phenomenon displayed by all of the respondents in this study. Some seemed to know very clearly where it was that they saw their future careers from an early stage and some others seem to have had the decision 'made' for them by the Matron, as will be demonstrated in Chapters Five and Six. The conclusion reached from the analysis of the early career experiences of this sample was that at the end of an exploration phase there was a time at which they decided to settle in an area of nursing. Having explored the options and gained a range of experiences, each of them found what they were looking for in career terms, and having found it, made a statement of commitment, as will be further explored later in this Chapter and in Chapters Six and Seven.

The interview excerpts in these Chapters will indicate that a significant number (43) of those in this study who initially entered general, psychiatric or mental handicap hospital nursing found that this type of work in the profession was not a career that they wished to stay in. Some (5) found their niche in midwifery. Others undertook midwifery training purely because it was the expected thing to do if one wanted to be promoted to Sister in a hospital, so having completed the course, or part of the course, they returned to hospital nursing. For nine of those who still were not satisfied that they had found the segment of the profession in which they wished to make their career they carried on the search and 'chanced upon' or 'drifted' into community nursing, often taking a district nursing course first and then moving on to health visiting. Twenty seven others soon made the decision that their future careers lay in teaching nursing and, after the required minimum amount of ward management experience, undertook a teaching course in preparation for this role. One went into full time journalism and one into higher education. Data analysed to develop these findings regarding their early careers revealed some tensions between segments of the profession and also between the 'dominant' general hospital nurses (especially those from Teaching Hospitals) and community, children's, and

psychiatric nurses. Also strains between 'service' and 'education' began to be apparent and tensions between male and female nurses, especially nurse managers, were noted. Each of these factors will be addressed in more detail in later Chapters.

4.3. The early middle career.

By the time they entered level three work many (twenty-nine) were embarked on careers in teaching. Thirteen entered a nursing or midwifery service manager post, the most frequent being Assistant Matron, or its later equivalent. Two became Night Superintendents, three who had commenced on clinical nursing careers in community nursing became managers and two of the midwives had hybrid education/service roles. One became a journalist, and, as indicated earlier, the remaining three were promoted directly from level two to level four. The middle part of their careers seems to have been critical in shaping their subsequent approaches to senior management. The experiences that they had, the knowledge and skills that they gained, the values and beliefs that they formed about what was important to them in their segment of the profession were all to shape the sort of manager they became. The contacts that they made during this period and the impression that they made on others was likely to sway the opportunities that they had for further work and to extend their chances to influence others. As they progressed through this phase they were often assisted in the decisions that they were making by family, friends, or more senior colleagues. Being assisted by more senior colleagues through role modelling or mentorship will be described in Chapter Five. From the data analysed in this section the importance of relationships in shaping the sort of managers they were to become, the kinds of roles they undertook, and their responses to their roles and the changes occurring in the health and in nursing education became very apparent.

Once they reached this level their career patterns became much more stable than previously was the case. There were fewer job moves although, as the data presented later in this thesis shows, many of the posts which they occupied changed considerably as a result of the re-organisation and restructuring of the N.H.S. For some the changes in organisational structure gave further opportunities for promotion, sometimes fairly quickly after they reached level 3. The ways in which moves

up the nursing hierarchy affected their careers and their approaches to their leadership and management roles will be examined in greater detail in Chapter 6. The situational and environmental factors deduced from their interview transcripts point to increasing tensions for nursing service leaders as they made the transition from administration to management and some of them describe the ways in which they changed their approaches to their roles and to their 'bosses' in the nursing hierarchy. Others describe the effects of the increasing constraints on their roles of finances and 'manpower' controls. Yet others recall the difficulties that they had adapting to the introduction of general management and the 'business' culture which were seen by some to be contrary to their professional nursing values. Conversely, as will be explored in subsequent Chapters, the careers of nurse education leaders who remained within the N.H.S. did not seem to be affected to such a great extent by organisational restructuring. Indeed many reported that the changes to the nursing service managers roles had given them opportunities for freedom to assume greater autonomy in the management of nursing education. Ultimately though this seems to have increased the likelihood of greater tension between the two groups. The nurse education leaders who had moved into higher education found that the environment that they had moved into allowed greater opportunities for experimentation with new approaches to nursing practice and education but posed similar constraints on finance to their N.H.S. counterparts. They also had to cope with the challenge of establishing nursing as an academic discipline whilst coping with their isolation from the remainder of the nursing profession. Again this was to prove a source of tension between different segments of nursing leadership.

4.4. The late middle and final career stages.

Forty-four of those surveyed went on to reach level four work, and one, interviewee 10, Carol Bury went directly from level three to level five. All but 11 had reached the peak of their paid careers at this level. As was indicated earlier some could be judged to have had the level of influence attributed to level 5 in work which was not their main employment, for instance as Chairman of a statutory body, as President of a national or international professional organisation, or as a Peer of the realm. Some ended their careers at a lower level than this either because their post was 'downgraded' in a re-organisation, restructuring or reform of the service, or because

they chose to take a downwards move, or because they became a 'victim or casualty' of the system.

The length of time spent in level 4 work ranged from 2 years to 29 years. 25 of those surveyed spent between 10 and 20 years at level 4. Similar to the findings regarding level 3 once promoted to these posts there was little movement between jobs, although the work often changed significantly as a result of the changes in the institution in which they were working. As previously indicated 11 went on to work in level 5 positions. The length of time varied greatly in these posts, the shortest being interviewee 2, Barbara Pearson, who spent 2 years and the longest, Carol Bury, spent 26 years in post.

In this section of their careers what became apparent was that as they assumed a higher national, and sometimes international profile, they became more exposed to situational and environmental influences outside of the profession. They described more interface between themselves and managers and politicians, they therefore appeared to have greater awareness of the politics and political influence. Many were also more aware of their own role and capabilities in influencing others and events. They described ways in which they shaped nursing and nursing education, through the direct influence of their roles in achieving higher standards of nursing care, or attempting to change standards. For some their role in shaping nursing education was through establishing nursing within higher education, others described their role in developing nursing research, whilst curriculum change, especially changes in pre-registration education was the focus of the careers of some.

The high profile within the profession which these activities brought to many of them was, sadly, not always supported by the rank and file, nor sometimes by their counterparts in other segments of nursing leadership. One of the ways in which they coped with the tension and conflict which arose was to use their networks of colleagues in similar positions. These networks were often, but not exclusively, based on their membership of a professional organisation and their work with a statutory body. Thus their work on the committees of these bodies served as a vehicle for increasing their influence within the profession as well as providing a support group to help them cope with the pressures and stresses associated with their

work. Ironically though this sometimes served to increase their separation from other groups of nurses and brought them into greater conflict with health service managers and politicians. Subsequent Chapters of this thesis will describe and analyse these issues in greater detail.

4.5. Discussion of findings from the analysis of the Career Pathways of those interviewed.

Their early careers, especially post-registration education and training for specialised segments of the profession, made their mark in that it was often during these experiences that the decision to remain in a particular segment of the profession was made. It was whilst analysing their statements of commitment to a particular segment of nursing, midwifery or health visiting that the ultimate focus of this study began to evolve. The majority had entered the profession because they wanted to be of service, had a sense of vocation, or wanted a satisfying career. Once in nursing the initial training period and some subsequent experiences did not seem to give some of them what they needed. Even for those who entered for less altruistic reasons there were experiences which were less than satisfying. It is suggested that this may have contributed in part to the phenomenon of 'casting about' in a search for a segment of the profession which would satisfy their motives. However through choosing another segment of the profession the division and subsequent tensions between nursing leaders began to emerge as significant.

Despite the commonality of initial training and their early career experiences once they began to choose different segments of the profession in which to make their career the differences between them become more starkly apparent and some of the issues which were to become tensions later begin to surface. What they considered nursing to be and what was important to them as nurses gave important clues to the area of nursing in which they attained a leadership position and the style of management they developed or adopted. The interviewees most frequently expressed their knowledge and beliefs about their segment of the profession when they were asked about the goals or vision that had motivated them throughout their careers. The descriptions of what they believed nursing is or should be are also laden with value statements.

The statements that they made when they found the area of nursing in which they wanted to settle signified an emphasis on care and caring, and on dedication to these ideals. This was an unanticipated reaction, comparison of the anticipated 'original' codes (Appendix 1) and the codes which emerged from the data (Appendix 1) shows that there was an expectation that their emphasis would have been much more on managerial issues and management 'speak'. As will be elaborated upon in subsequent Chapters the assumptions made in drawing up the list of original codes were based on current, and largely masculine biased, definitions of leadership and management. The fact that many of the nurse leaders had retained some essentially feminine concerns and characteristics led to the in-depth analysis of the styles or approaches they had developed or adopted in leadership of a caring profession.

Once the commitment to a particular segment of nursing had been made most of the sample then embarked on a period of relative stability in their careers. This mid-career period was described by many as a very satisfying period. Most describe ways in which they gained skills in their chosen area of work and whilst doing so extended their knowledge of nursing, sometimes through further formal courses, such as a post-registration clinical qualification or the Diploma in Nursing. Others describe learning through experience and reflection on that experience, often helped by a mentor. In these descriptions it became apparent that this period was accompanied by a further strengthening and development of their values and beliefs regarding nursing. As their careers progressed they became increasingly involved in their profession and built up a range of networks. As they described the middle and later stages of their careers the influences which are considered to have shaped their subsequent leadership styles became more evident.

So far this Chapter has outlined the career pathways of those interviewed and has signalled some of the factors which proved significant in the ways in which they carried out their roles in the leadership and management of nursing. The framework devised for carrying out this research and analysing data which was developed from the literature review and the description of the research process in Chapter 3 suggests that their individual characteristics would be a significant feature of the way in which they described how they carried out their roles (Figure 1).

Each individual, through the accounts given of their roles and how they performed them was considered to have demonstrated a 'world view' which had cognitive or epistemological elements, emotional, feeling or affective facets, and value aspects, particularly of an ontological nature. Each of the 'world view' components affected the way in which they described their actions and behaviour in carrying out their work. A similar world view is described by Thomas and Bennis (1972) who refer to McGregor's (1967) concept of managerial 'cosmology', the manager's view of reality, and to assumptions which are neither good nor bad, hard or soft, nor even distinct styles of supervision. A similar approach is taken here in describing the similarities and differences between the individual nurse leaders.

From the thematic analysis of codes and categories, as described in Chapter 3, it became apparent that the interview tapes and the transcripts were rich in presentational knowledge (Heron, 1992; Reason, 1994). The interviewees often 'acted' out a drama, playing all parts, as they told a story about their experiences. In these cases their non-verbal actions were as important, if not more so, as the words spoken. It was often obvious that the story was one which they had told before to illustrate the point being made and in some instances the accounts given were augmented by things they had written, by photographs or by other keepsakes. The analysis of the similarities and differences between them focused on their 'ways of knowing', their 'values and beliefs' and their 'ways of acting, doing, or behaving'. These three approaches or components were outlined in Chapter 3, especially the four modes of behaving, the 'battler', 'opportunist', 'dedicated or committed' and 'enthusiast'. These four approaches to the 'behaving, acting or doing' component of their roles were most usually related to an encounter with a 'significant other' or an aspect of the environment in which they worked, occasionally both aspects were in evidence. Analysis of these data, in the form of extracts from the interview transcripts, forms the remainder of this Chapter.

The interview texts themselves were also a fertile source of the third component of the styles, that of value statements. In some cases these values stemmed back to the reasons that they had made their original choice of nursing as a career. In exploring notions of service, and a vocation or calling to care there was often reference to the influence of school and/or parents in the development of these values. Some of these

values were developed through early training experiences and others were formed during the early career phases. As was described in Chapter 1 the vignettes selected to illustrate a point, or points, being made were chosen as those which best, or most succinctly describe the phenomenon under analysis. It will be recalled from Chapter 3 that during the process of data analysis paradigm cases and exemplars were isolated, the extracts used are drawn from these sources.⁵

In the following section (4.6) their knowledge and ways of knowing are presented through an analysis of their statements about nursing. The values underpinning these views are presented in section 4.7. and the ways of acting or behaving in section 4.8. In these sections the data is presented via extracts from the interview transcripts.

4.6. The leader's definitions of nursing.

Some of those interviewed believed that nursing was essentially a simple concept. Barbara Pearson thought that nursing consisted of 'looking after people', she also acknowledges that there are different conceptions of nursing:

when I came along it was so simplistic.[...] I think ah yes that's nursing [...] at the end of the day the only thing that matters [...] to me it's always been about preparing people to do a job and our job is looking after people, other bits of that⁶ are so high flown you don't recognise nursing and yet we're all seeing it differently. (2.10).⁷

Barbara makes an important point here with respect to the main focus of this study, the tendency for groups of nurse leaders to 'see nursing differently'. April Walshe expresses her belief in the 'named nurse' concept, and once again stresses the need

⁵ In the reporting of extracts words are sometimes omitted to enhance the focus of the point being illustrated, where this occurs the following format is used [...]. During conversation there were instances where special emphasis was placed on a word or phrase, in these cases the words are emboldened in the text. Laughter, pauses, silences are also denoted in brackets at the appropriate juncture.

⁶ A document which she had given me. Power Bases for Nursing - Report of a Fellows Seminar, Royal College of Nursing.

⁷ Where an extract from the interviews is used to illustrate a point being made the interviewee number and the page number from which the extract is taken appear in brackets after the quotation.

for simplicity:

I wanted to have every patient looked after by a named nurse [...] my reasoning behind that was that I felt very, very strongly, and still very strongly, that if I am a patient that I want to know who I can ask about my care, nursing care, who will give me an answer that is the same every time, is continuous. That if I am a Nurse Manager I want to know who I can call to account for that care, and that if I'm a relative I want to know who I can ask. They were very simple [.....] I always worked on the philosophy that messages should be, and concepts should be, simple. That to me of having a named nurse, and particularly when I describe it to you as it is, is a very simple concept and is understandable, I believe by anybody - Doctor, nurse, layman, member of the lay public, and I think that in management the simplest concepts are the best and that's why I am horrified with a lot of the jargon and pseudoscientific stuff that I see coming across in the journals now because they are not simple concepts. (27.8).

Again April highlights the tensions between the ways in which nurse leaders present nursing. Both of the previous extracts seem somewhat dismissive of the attempts by other nurse leaders to conceptualise nursing in complicated ways. Barbara Pearson's reference to 'highflown' writing and April Walshe's concerns about 'jargon' and 'pseudoscientific stuff' show how the divisions between nursing leaders were illustrated or created. These differences in the language used are examples of the divisions and tensions amongst nursing leaders. In direct contrast to the previous two leaders Mary Shilton believes that nursing is a more complex activity:

the main thing is that nursing really is complex, far more complex than many people realise who are not nurses. (42.24).

Alongside the different definitions of nursing there were divergent views of what constituted nursing care. The division of nursing into basic and technical tasks was considered by Pearl Trent to have adversely affected the way in which nursing is viewed by politicians and the general public:

I think Goddard ⁸ did an enormous amount of damage by his division of nursing into basic nursing and technical nursing. [...] Mr. Major's ⁹ walked right into this trap hasn't he? You see what is basic? Does basic mean fundamental, or does it mean lowly. Now we of course are not blameless in this respect, because if you remember, it was the junior probationer that gave

⁸ Goddard (The Work of Nurses in Hospital Wards, 1953)
⁹ Prime Minister at the time of the interview

out the bedpans and spent time in the sluice. Now the best ward sister I ever worked for in this establishment, always did a bedpan round herself once a day. And not only did she do it, and was therefore an example, but she showed people how it could be done and that the task was not too lowly to be undertaken. (30.17).

White (1985) considered that Goddard (1953) is widely understood to have proposed that nursing work should be divided into three groups: technical tasks, basic nursing and non-nursing duties. However White theorises that the report was the most widely misquoted and misunderstood in the period she studied (1948-1961). In an extensive description of the report and its repercussions she concludes that the Royal College of Nursing 'failed to respond to Goddard's thesis of the unity of nursing because they, like many nurses, considered that basic care of patients was at the root of the loss of nursing's prestige. This was seen as having been de-skilled by modern medical science. In an age of specialisation, general nursing was falling in value. This could partly be redressed by giving greater emphasis to the skills required by technical tasks..Trained nurses should therefore be managers and technicians' (1985:213). If this theory is accepted then Pearl seems to have ended up arguing that Goddard was right in his belief about the unity of nursing and the need for care to be delivered by registered nurses. One of the causes of current tensions can be seen to stem from the 'elite professional' view of nursing in which certain of the 'tasks' associated with nursing care were seen as too lowly for the registered nurse. A view which Roy Elm put forward:

I maintain and always will maintain that the whole gambit of nursing care from bedpans up to technical nursing should only be given by a fully qualified nurse. Once you start hiving it off you begin to say that's not nursing, that is , and once you start doing that you are moving further and further away from what nursing is supposed to be. (1.14).

Maude Palmer held a similar view of nursing she talked of how she helped students to learn to recognise patients' needs for care:

I remember a nurse once saying at the report "look, why is it that nurses as soon as something dramatic happens have to hand over to a doctor?". I said "it all depends what you mean nursing is"

RJR: That's right

Maude: Look at that patient down there. I can see a lot of nursing care that would help that man feel more comfortable and improve. Look at him. What can you tell me?" And she said "his pillows". I said "well, exactly, that's a man with about one pillow in his bed". (46.8).

Richard Crapton had a similar view of the components of nursing care and considered that he had acquired the necessary skills by the end of his training period:

I mean I think I could say that at the end of my training I knew, looking at people, whether they were comfortable or whether they weren't. I knew ways of making them more comfortable. We could take an overview of people and see who needed something now, who could wait. (48.33).

Both Maude and Richard appear to be referring to what on first analysis might be seen as 'intuitive' insights. The divergence in opinion here seems to be around when and how these skills are learnt. Benner (1984) suggests that nurses move through five stages from 'novice' to 'expert' and that the application of intuition in decision-making differentiates the 'old hand' from the apprentice in nursing skills and competence. Maude Palmer thinks this takes time and experience whereas Richard Crapton thinks that he had acquired these skills at the end of three years training. Heidi Mann referred to these seemingly 'intuitive' skills in her description of caring, she implies that the modern day recruit does not have these skills or that the current climate discourages this:

so caring is, I don't know, but we used to teach that you shouldn't have to go and ask a patient how they were. You should be able to go in and be able to tell by looking that someone has a headache or a pain or whatever, or you should be able to anticipate that they might have it and therefore, but I don't think sadly that the children¹⁰ that come in have still got the same ideals, or it's what we do to them that drives it out of them, loses it on its way or something. We don't somehow teach them how to make use of it or something. (8.7)

So whilst Heidi, Maude and Richard thought that intuitive skills in nursing were learnt during their training and subsequent experience, Jennifer Westley talked about the difference that the nursing process made to the way in which students learned

¹⁰ The nurse recruit today!

to care:

up until then, the practice of nursing had been very much rote. You know, you learnt the procedures and you did the procedures without any thinking about whether they were required or not. So there was, it was quite a revolution. (51.10).

Similarly Esther Hurst compares task allocation with patient allocation and starts to explore the implications for teaching and learning to care:

when I started off, probably before your time Bobbi, it was task allocation, for example, but in fact patients were cared for very well. Having said that I do sometimes think that as students, and sometimes as staff nurses, one avoided the emotional rapport. I certainly think going to individual patient care, with or without the nursing process, was a good move, because I certainly think there was more emphasis, and of course along the lines we were changing from the medical model to the nursing model, very much homing in on the emotional and psychological state of patients and how one copes with that. (7.11/12).

Esther's reference to the way in which students and others learn to cope with the 'emotional labour of nursing' (Smith, 1992), the foregoing examples highlight the different conceptions of nursing which were present during the period studied. Some of the implications of which were explored in the literature reviewed in chapter 2 (section 2.2.). The tensions between nursing leaders who espoused different conceptions of nursing are highlighted in these next extracts.

Georgina Shaw believes that nurses work through the emotional aspects of care with patients:

it's about nursing care¹¹, but the same theme runs through that we're a partnership, we're working with, alongside. We're going through grief with the patient; we're going through devastation; we're going through trauma; we're helping them to retain their dignity as a person. (16.10).

¹¹ A book she and a colleague were writing.

Georgina's view of nursing care as an adaptable activity with a strong affective component is one which seems unlikely to lend itself to rigid pre-definition, whereas a rational approach to planning nursing care attracted Jennifer Westley:

I think the nursing process thing was again this appeal to the very strong, rational principle that if you're going to plan nursing care, you've got to know what nursing care is needed, so you've got to assess and identify the problems and plan to meet those problems, and then evaluate it. And that seemed to be such a rational decision making process [.....] applied to nursing. (51.10).

Marcia Hughes believed that a patient's needs for nursing care could be measured and used to decide how many nurses were required:

calculating nursing establishments¹². It was looking at classification of patients or patients/clients, whatever they are, by disease classifications, by their needs in fact, needs for care. Breaking it down into you know their physical needs and their educational needs and their social needs and then by dint of an enormous amount of continuous observation and so on trying to find out how much time. This was done in a midwifery hospital but it could have been transposed to a nursing one. (18.4).

Marcia's analysis seems to be based on the medical model, with its reliance on a patient's disease classification and a prescription to cure, rather than on a more holistic nursing model. The approach might also be criticised on the basis that in the analysis of time needed to deliver care the 'emotional' and therefore largely 'invisible' aspects of care are likely to be neglected. Mimi Gold stresses the difference between the medical curative approach and nursing care:

Well, you know, this was my argument almost 20 years ago that we'd lost an empire, and this was the role we are going to find. I know this is not my own quote, it's Professor Alwyn Smith, who said to me once, I think it was apropos of a conference I was running. "We have cured what we can cure and we have prevented everything that's reasonable and what is left is care". And you see, nursing in fact really came into its own in pre-war days, when I first trained, when in fact medicine, before antibiotics came to being, when it came to pneumonias and typhoids everything depends on the nurse. Over to you nurse, everything depends on the nurse. That made you feel great. That went, that went, but we now, as Alwyn Smith said, cured what we can cure, prevented what we can prevent and

RJR: and almost the pendulum swinging back

Mimi: care and this is the place where the doctor can do little. When we

¹² She is describing some research that she carried out.

come to the Alzheimer's, the strokes. This is where nurses come into their own, and you know, I am very hopeful because I mean I have seen beautiful nursing care recently (34.19).

Mimi raises some important issues here with regard to some of the situational and environmental factors which have influenced the role of the nurse over the period studied. Carol Nyman also referred to the re-emergence of the caring role for nurses, although she was less optimistic than Mimi about the future:

I think nursing is a lost cause actually. I really do. I can see no future in it. I think it's going to be a paramedical support group and the people who do real nursing, as I have seen it, which was people looking after the elderly; people looking after the long term sick, where really nursing could have its independent role, are just being devalued all the time. So, no, I'm glad I'm out of it, I really am. (44.25).

Carol's view of the role of the registered nurse seems very much based on the view of the profession of nursing as synonymous with other professions such as medicine. Thus the nurse is seen to have an independent and autonomous role, a view which was challenged (Esland, 1980; Melia, 1987; Malinski, 1988; Jolley, 1989; Davies, 1995) in the review of nursing literature in Chapter 2. The notion of the nurse's role as a caring 'trade' practitioner working in partnership with her clients or patients and working collaboratively with other members of the health care team was one which was introduced in Chapter 2 and this is a concept which will be expanded upon in the final Chapter. It is interesting to note that both Mimi and Carol refer to the 'incurable' client groups; such as the elderly, the Alzheimer's and the strokes, as those in which the nurse's caring role can be best demonstrated. Sebastian Reason looked to the future and attempted to define the concept of care:

The nature of nursing practice is going to change. Inevitably nurses are going to take a much more, much greater initiatives; a much more central role in determining care and implementing it, and they're going to take over a lot of things which now doctors do.[...] that's part of the change and evolution so we mustn't be afraid of that, we must grasp it, and I think if we keep the nature of nursing in our minds that it's about caring. And I don't mean 'to care' - anybody can give care, but caring has a much more dynamic approach and needs to be understood. (14.32).

Sebastian was the only one of those interviewed who started to try to define nursing in caring terms, though even his attempt struggled to find a real definition. Each of these last three extracts have described ways in which the nurse's role has changed over the period studied. What became increasingly clear as the research continued was that most of these nurses, like so many others, found it difficult to define nursing and the work of nurses. Indeed in the following extract Betty Deerman and I share our frustration that others define nursing and nursing work for us:

Betty: how can anyone who is not a nurse say what nursing is?

RJR: Well they'll all have a go.

Betty: Well we don't know what nursing is do we?

[Laughter](5.10).

Betty seems to have articulated one of the underlying problems with the way nursing and nursing education developed in the period studied. Her reference to the lack of a clear and agreed definition of nursing led to a dichotomy between the two main segments, the nurse managers and the nurse educationists and is one explanation of the discernible tensions which is the focus of this study. Difficult as it was to find clarity in their definitions of nursing, nursing care and caring, the fact that their conceptions were very different was noticeable. These distinctions spread to encompass their views of the role of the nurse. What these data seem to highlight are the need for further development of the nurse's role in relation to other health care workers, especially doctors. The fluidity of the boundaries between the work of different health care professionals and the need for nurses to be able to work in partnership with other groups appears paramount. Each of these issues will be explored in the following section.

4.7. The leader's conceptions of the role of the nurse.

Marcia Hughes discussed her view of the role vis-a-vis that of the doctor:

*I believed that nursing had its place in the world complementary to medicine, not in any way subservient to it and I believe that **nursing, nurses**, would I*

thought grow in stature into a time when they would be making decisions about the appropriateness of care. That they would work as partners alongside the others rather than as subservient team members if you like and this is not in any way to denigrate the marvellous nursing that's gone on in the past.(18.14).

Marcia then went on to describe the role of the registered nurse as directing the work of 'helpers' but at the same time as being involved in giving basic care:

I think you need helpers to help professions, but it is when they become almost interchangeable with what is the professional's work that this becomes more of a concern. I am concerned when nurses are unable to articulate what is important about professional nursing, and it means that you have people saying, bathing and all basic care, "you don't need professional nurses to do this". You've heard the arguments a thousand times its what is going on during those activities and the sort of decision making that is going on in terms of appropriateness [...] Until we can explain this to people so that they begin to understand and that this person works under the jurisdiction of a professional nurse at all times and never is in charge.(18.15).

Lilian Johnson talked of what she believed about community nursing and nursing in general:

I just want nurses to be 'whole people' nurses.[...] I believe nursing and medicine are complementary and partly, I think, the nurse fills in, or should fill in, the whole patient aspect. Look at the patient as a person, whereas a consultant looks at the patient as, you know, an orthopaedic problem or whatever. So the thing that Florence Nightingale said about "nurse the sick and not the sickness, that's what I hope nurses will do (21.17).

Lilian seems here to be referring to nursing in terms of a mix of the 'ecological' and 'biographical' models described in the literature review. Nurses who adopted the 'biopathological or biotechnological model', with its focus on 'mechanical defects in the individual human being which sets out to rectify these in the light of biomedical sciences and technologies' (Beattie, 1995:19) worried her as she discussed later in the interview:

I am frightened of them [.....] it gives them a feeling of power and prestige to be doing complex clinical, technical procedures with lots of machinery, gives them the feeling of power too, and they forget they have hands and they have a heart and they have a head and, you know, I may be old fashioned but I can't help that. I really believe that nurses are losing their strength of really looking after their patient as a person.(21.18).

Both Marcia and Lilian have a view of nursing as a separate profession, with well educated, research active nurses playing a role in partnership with and equal to both doctors and administrators within the health care policy making and delivery arenas. Their conceptions of the role of the registered nurse though do seem different. Davies (1995) describes the 'fleeting encounter' model of professionalism as practised by hospital consultants which Marcia Hughes seems to be envisioning for nurses. Lilian Johnson's depiction seems to be of an alternative view of profession, that of 'sustained encounter' (Davies, 1995). These differing views were examined by others who saw nurses as 'consultants'. Janice Williams discussed the development of the nurse 'consultant' role following initial registration as an important future improvement:

So the vision for nursing in the future could, could be very strong. If in fact we can develop the model of the medical consultant, which a specialist nurse practitioner model is supposed to be all about, and our best nurses stay in nursing but also teach and so on.(33.27).

As the literature review showed the changes in nursing heralded by the introduction of the nursing process was seen as a way of professionalising nursing through the introduction of a rational and logical way of planning for and delivering nursing care. This development was based very much on the medical approach to diagnosis and treatment of patients, as Sebastian Reason discussed:

Nurses have got to come to grips with the fact that there is a, I think, a generic, underlying generic role. However that might be circumscribed and that increasingly, advanced work and of a specialist nature is going to be demanded of those who have been educated to apply it. And you can't actually sit back on your laurels and feel that, you know "I've done my bit and I'm what is called a nurse, therefore I'm all things to all men and women", you know. That's not true and never has been true, and we found it difficult to recognise that, and that the specialist role [...] which embraces the development of a consultancy post (14.32/33).

Whilst Sebastian was adamant that the nurse has a generic underlying role Althea Turner was vehemently opposed to this notion:

She ¹³ wrote "we all" that was her wording "we all want a generic

¹³ The then Registrar of the General, the English General Nursing Council, Miss Henry.

training". And I wrote and said, I don't know who she thinks 'we all', but I don't.[...] I think if I had any influence, it was that making it clear that a psychiatric, to my way of thinking, psychiatric nursing should be separate.[.....] I think we had an influence in setting up some kind of a committee to look at how psychiatric nurses should be taught, and having separate psychiatric courses.(17.11).

Thus whilst there were those who saw nursing very much as a specialist role others rejected the notion of nurses as specialists. Additionally some gave consideration to the possible demise of nursing. Charlotte Calman saw that there was more likely to be a generic, flexible, multi-skilled health care worker:

There will of course be the challenge of the boundaries and whether the nursing stays as nursing [...] in the future there could be amalgamation, and other kinds of preparation

RJR: A generic health care

Charlotte: health care workers, yes. I think that might happen too. (43.18).

Carol Bury also talked of the role of the nurse in relation to the boundaries between the health care professions, in the light of the focus of this study it is interesting to note in this passage that we hold different conceptions of the notion of 'professional boundaries':

RJR: I am certain that you've hit on one of the crucial areas and that is the professional boundaries and both the erosion of professional boundaries but the erosion of professions as well. You know and these issues of the various other workers that

Carol: You think [voices merged] an interesting distinction you talk about the erosion of professional boundaries that is something which is coming in from outside. I talk about flexibility which I think is something where we've got to make sound judgements as to how far we can move our boundaries and that's the one thing, it's something from outside, the other is something which is from inside and therefore you can hopefully control and I think if we are now in erosion we are on a very slippery path but if we say we know that in order to respond to change and so on we have got to be more flexible and these are the ways in which we can be more flexible, then I think you are still in control.(10.12).

Thus tensions were associated with control of nursing activities, especially in the debate about 'generalist' versus 'specialist' nurses. Roy Elm considered the generic health care worker in a positive light, he was concerned that nursing would become

too specialised and disappear:

RJR: What about the view held by some people about the development in the future of a generic health worker. Without divisions say between say nurses, physiotherapists or others

Roy: Well that has a lot of potential [...] I can't see anything wrong with it. [...] I can't see anything but good in it, it will break down the divisions. [...] I would guess in say 20 years time we probably won't have nurse training. We'll have all sorts of 'ists, 'stomatherapists', "I'm not a nurse I'm a diabetic specialist". So nursing as such will be clearly not, there'll be all these 'ists' all over the place who will want to have their own little enclave. It started did it not with the midwives saying, "I'm not a nurse I'm a midwife", health visitors, "I'm not a nurse, I don't do nursing". And so it goes on and on and on, and I think that will continue, because these youngsters coming up now who will be trained in 3 to 5 years time are going to look at nursing and say, "now hang on this is beneath me", and it shouldn't be, "this is something for these lesser people to do, so I'm going to go off and do something else". (1.14/15).

As examined in the literature review the boundaries between the nurse and other health care professionals were being redrawn during the period studied, whilst 'internal' closure between segments and subgroups of the profession, such as general, community, children's and psychiatric nurses, and between registered nurses, enrolled nurse and nursing assistants or auxiliaries was also occurring. Those interviewed expressed concerns about the role of the registered nurse particularly in view of the skill mix changes and new grades of carers being introduced. Many voiced the fear that having done away with the second grade of nurse, the enrolled nurse, the development of National Vocational Qualifications and of the Health Care Assistant role seemed to be starting the cycle all over again. The underlying tension appears to be between the caring role of the nurse and the academic level and content of courses to prepare nurses for their role, as Janice Williams discusses:

Maria Palmer¹⁴ and I once shared a platform [...] she said her vision for the year 2000 was that we would have an elitist nursing profession of technocrats at the high dependency intensive care end, well paid. Working alongside, almost in partnership with, doctors but at a very highly technical end of care and the majority of other care would sit with what she hoped would be the continuance of the enrolled nurse, 'cause she actually said we actually need these people. (33.28).

¹⁴ Another of the nurse leaders interviewed in this study.

Hilary Miles was quite clear that a registered nurse should be involved in all aspects of care:

but the big danger is if they set up a basic trained nurse to work 'up here', and that's the old enrolled nurse and registered nurse debate isn't it. And that must be stopped from happening, and those people who get up there must still be involved in care, so that they don't forget those skills and just put on their white coats and their stethoscopes and we have the treatment rather than the caring bit, 'cause that has got to be maintained if it's going to be a nursing role. [...]. Then the people who've been our enrolled nurses in the past can be our care assistants, nursing auxiliaries and what have you, with all their lovely skills and everything else but not so that all the registered nurses leave the bedside, because that's so important and the people who are going to be in hospital now are going to be so much sicker and they do need nursing at a prime level of care. (45.22).

Barbara Pearson echoed the importance of the caring role of the nurse:

There will always be a need for care, of a different sort, whether it is carried out by people called nurses, I couldn't answer that [...].] when the economic conditions improve, I would like to see, I hate the word clients, patients looked after by qualified nurses, you know and that qualified nurses see as their role, looking after people, wherever it is. Whether its in a counselling role or technical role or whatever I would like to see that carried out by qualified nurses, whether that will ever happen is debatable. (2.18/19).

In direct contrast to these views Carmel Arter saw a role for the health care assistant in performing the more menial and mundane aspects of care:

Well. I mean in principle I think there is a reasonable argument for a Health Care Assistant I am sure I know there are a number of activities which do not require a skilled nurse which any good natured, kind hearted and moderately handy person can do. I'm just still concerned that we are going to reinvent the enrolled nurse. (11.13).

Andrea Davies also considered that all nursing care would not be delivered by registered nurses:

I think that it's probably cost-effective to have a solid base of qualified nurses, supported by a well trained assistant force. I think we're moving into the days of multi-skilling, and I think that there's no doubt that the nurse will retain the responsibility for direct patient care, but will oversee things which need not be done by a qualified nurse, but the knowledge base of the nurse that task that's been performed by a non-qualified, non-registered nurse, needs to be fitted into the total picture of the care plan. (25.10).

Mary Shilton thought that there would be fewer numbers of registered nurses and that all pre-registration preparation would be at first degree level:

I think as nurses get more education about nursing and as more research is done to inform nursing then I think we will be OK because um we'll not be afraid to discuss with anyone else, we will be on a par with everyone in the health care field and will be committed to our own discipline. So I think the future, it will be smaller numbers but it should be smaller numbers of, of highly professional people who have a degree education and gradually as, PREP will be helpful, some Masters and, and more people at eh PhD, MPhil/PhD level. (42.25).

Carol Nyman held a similar opinion:

I'm one of the people who fought for two 'A' level entry for, you know, education and who really would like a graduate profession [.....] It is difficult, because of course you are talking of greater numbers. (44.24).

Hilary Miles was clear that all levels and types of nursing education would take place in establishments of higher education and that this would help to break the mould of nursing's insularity:

Because the monotechnic does not broaden, it narrows not only the students but the teachers themselves, and the whole idea of getting them based in good places of higher education would be to give them a much more general look on the world, much greater influences from better students, better teachers, um academically stretched and just all the influences that being in higher education brings you and so that you could stop the very inward looking thing. (45.23).

Janet Ightson believed that learning should not be in a rote fashion and that above all nurses should be able to think:

there's always the problem of what nurses ought to do, not just what they do, and I don't mean that they should be taught the army 22 procedure system. That they should be taught automatically to do, [...] I don't have any doubt in my mind that the only way to do that is to produce thinking nurses by educating them to think. (12.19).

Sebastian Reason agreed that it was important for nurses to learn how to reason

rather than to learn facts:

I think we don't have to worry about the knowledge, because how and why we do things are as, is important. (14.32).

However Millicent Wood was concerned that in learning how to become more questioning nurses were losing their caring values:

They seem to be quite obsessed - maybe rightly so - with doing nothing that hasn't got a research base to it. "Research has shown" they kept on saying "research has shown". I said I don't care about research, I want you to have some milk of human kindness and make me comfortable please and care for me. (38.13).

Heidi Mann was concerned that preparing nurses in higher education would lead to a diminution of what she saw as the essence of nursing, caring for patients:

nursing to me is the hands on stuff, it is not academia and so for that reason while I see that perhaps we must, though why we must, go towards the academic side I don't know, [.....]

RJR: You seem to be thinking about nursing as actually caring and looking after people

Heidi: People, yes

RJR: and the worry that almost we will get too cerebral to actually do that, too many people thinking about it but not doing a lot

Heidi: Yes, yes, not doing it you see [...] I do believe the spiritual side, the social side the whole lot are the important bits. (8.5/6).

Lilian Johnson was also worried that the move to higher education would further fracture the link between service and education and that graduate level education would not be translated into benefits for hands on care delivery:

I think the danger, the danger is ivory toweredness. On the other hand P2000 is supposed to make that link between clinical practice and also integrating community, health into the basic education. [Pause]... I'm just worried that, you know, we will educate nurses to a very high level but they won't be doing the nursing. Other people will be doing the nursing. [...] the basic, you know, every day nursing, won't be done by these highly educated nurses and I'm just wondering, in my most cynical moments, whether we are

educating nurses for a job they're never going to do.(21.14).

Whilst Heidi questioned the role of education in preparing a caring nurse and Lilian was sceptical about the level of preparation needed for every day nursing the main issues for some nurse managers and educationists were the separation of theory from practice, the levels of knowledge to do the job and the concern that 'academic' nurses would lose, or be incapable of maintaining, caring values. Lilian Johnson was also concerned to get the balance between teaching and learning right:

They're taught too much. They have to absorb too much information. Well giving people information isn't really teaching them. Teaching is helping people to learn, not giving them information, and some of the things that we spend hours teaching, standing there with our lecture notes and updating them and all the rest of it. To me those things are totally redundant [...] their reading is neglected and they are kind of stuffing people with information.(21.14).

As this section has shown there were a range of divergent views expressed by those interviewed. The points of polarisation in views were concerned with the nature of nursing and the role and preparation of the registered nurse. These ranged from nurses as highly trained and educated specialists to minimally prepared care workers and from a generic nurse to a specialist nurse to a generic health care worker with a range of flexible and interchangeable skills. Given the developments that were occurring in nursing, medicine and other professions supplementary to medicine during the period studied it is not surprising that their focus was on the demarcation lines between the work of the nurse and of other health care workers. There have been a range of theories about the nature of the boundaries between medicine and other health care workers and about internal divisions of labour in the caring professions. Etzioni (1969) and Toren (1975) used the term 'semi-professional' to describe the work of 'para-medical' groups, including nurses. They argue that nursing lacked some of the traits of a profession, notably a distinct knowledge base and autonomy in practice. Underlying these debates were issues of power and control, as Hugman (1991) points out:

the concern over professional status is about who controls which occupation. It is in the interests of a group to assert its professionalism as a means of exerting self-control, and it is in the interests of other groups to deny

professionalism to the extent that they wish to exert control themselves over the occupation.

(Hugman, 1991:79)

During the period of this present study the focus of those who were trying to establish nursing as a profession was to determine a scientific knowledge base (Chapman, 1976; Mcfarlane, 1977; Larkin, 1983; Jolley, 1989; Hugman, 1991). Thus the rational and seemingly logical approach to nursing care which the nursing process seemed to offer and the measurable outcomes of work study and some of the patient dependency studies were seen as offering nursing a new professional persona. The application of biological and social sciences to the practice of nursing was hailed as one way of giving nursing academic respectability. Alongside these moves were the economic pressures and the pragmatic view of those who considered that nursing care would never be delivered by an all registered workforce. It is to be expected that the concerns of this sample, many of whom were at the forefront of debates about the nature of nursing, should have centred on what sort of nurse and what kind of preparation he or she would need. Thus hand in hand with the differences in opinion as to who should deliver nursing care and the question of different levels or grades of nurse there were questions as to the numbers of registered nurses required and the inevitable corollary of the level and type of education needed.

In order to increase the status of nursing some considered that 'basic' and 'menial' tasks should be discarded to other health care workers or delegated to supervised assistants to the nurse. However there were equally strongly felt views that there was a loss of caring values in current nursing. This was especially true of present pre-registration education courses, particularly those which had moved into higher education establishments.

Thematic analysis of the statements that they made led to the discovery that in the expression of their knowledge about nursing experiential, practical, affective, spiritual and intuitive knowledge (Reason, 1994) were much more likely to be used as descriptors than propositional knowledge. From the epistemological perspective it was possible to elucidate several different types of knowledge about nursing and

about leadership and management. Examples of four main categories of knowledge; propositional, experiential, practical and presentational (Heron, 1992) were demonstrated in the interview analysis, although there was also evidence of intuitive, affective, and spiritual knowledge (Reason, 1994). What was evident from the interview texts analysed was that experiential, practical and presentational knowledge were very much in evidence but that few had made the link into propositional knowledge. This was particularly evident in the ways in which they expressed their beliefs about nursing and caring, as the interview texts revealed our struggles to define both concepts. As examined in the literature review tensions between the theory: practice divide existed which has important implications for the content of the nursing curriculum and for the ways in which it is taught which will be explored in Chapter 8. This chapter continues with an analysis of the second of the three components which are being used to illustrate similarities and differences in the individual leaders studied, that of their values base.

4.8. The values underpinning the leader's beliefs about nursing.

The origins of this component of the individual leader's approach to their role was evident in some of the descriptions already given. Vivian Stevens synthesises experiential, practical, affective, spiritual and intuitive knowledge when asked about the origins of her beliefs.

RJR: And where do you think those beliefs came from? If you can, you might not be able to identify specifically

Vivian: Believing that individuals matter, I suppose comes from my Christian faith, but I know it's in other faiths as well. Belief that midwifery is a separate profession, I didn't start out with. When I trained as a midwife I thought this was a branch of nursing too. That evolved somewhere along the line when I got to be asking that these were not patients, they were not ill. I think that just evolved, I don't think it came from anywhere [.....] The reason I stayed in midwifery, I think, particularly at the time I stayed in it, was because midwives had more autonomy than nurses did and responsibility for their own practice. And midwives could, even at that point, work in hospital or out of it. (24.13/14).

Vivian's description of the need for a degree of autonomy in her work was echoed by others. A similar need had determined which segment of the profession they had gone into and had shaped their future careers, as Sylvia Thomas describes:

I didn't realise it for many years but I realise looking back that all the things that always I had tried to find a position in which I could get as much autonomy as possible, I didn't want power over other people. What I wanted was power over me and given that one is an employee, to a certain extent you can have power, you can have autonomy rather, as a District Nurse, well you could in those days and as a Health Visitor in those days and then I realise that in my career in the Polytechnic I'd always made sure that I carved out an area that I was the expert in and therefore had an expert's autonomy. So that was the one single guiding principle that operated. (26.14).

Sylvia's decision to choose community nursing and then a career in higher education had its origin in a personal desire for autonomy. Using her own words this was not something that she recognised early in her career. It had been anticipated that the individual's value systems would be an important factor to take into consideration when analysing the determinants of leadership styles and this was confirmed in subsequent initial analysis.

As the earlier part of this Chapter shows the most significant period in the formation of their value systems about nursing were in the early years of their careers, especially in the periods of exploration and making a commitment. As well as these discussions about the role of the nurse the pivotal role of the ward sister was recognised. One of the problems associated with nursing in the past was the lack of career advancement for those in clinical grades. In order to progress within the profession it was necessary to leave clinical practice and become a manager or a teacher. This point of divergence in the career pathways often seemed to herald the start of the perceived tensions between segments of the profession's leaders. Serena Crooks highlights the ward sister's responsibility for the standards of care and the clinical focus of the area:

my belief that the key to nursing was the clinical role.[.....] I became so sure of this sort of vital role and the fact that until then we hadn't been using it properly. We got flashes of it - like Sue Pembrey¹⁵ coming up, you know, with the ward sister, but on the whole it was seen as a very subservient role to that of management, or teaching, and I was extremely keen on getting the nurses' specific role, which is clinical, you know, back into the picture and I believed that if we came out at the other end of all the problems, it would probably be the clinical nurse that would be important and that we needed to make sure that it was the clinical nurse that was into roles of influence, and had a say through in the various situations. And I think to a large extent this

¹⁵ Pembrey (1980) *The Ward Sister- Key to Nursing*.

is happening now - it's emerging. (40.18).

Hilary Miles considered that the ward sister, and her community nursing equivalent, has the focal role for all workers in the health care field:

Well to me it's a natural, it's the main contact with the patient, or whatever we might want to call them these days. It is the thing that has probably the biggest impact on the patient, whether they're well cared for or not and they can know whether it's good or not. Um, because they, they can judge, they can judge that and if you've got your nursing care right, you will get influences with the domestic staff, with the ward clerks, with everything else, because they will use the nurse as the role model as to how they should treat patients. So if you've got well prepared nurses, um who are running a super team, or whatever, in the community, others will follow. Junior doctors will follow um so to me it's, it's the whole pivot of where the patient is, um obviously. (45.20).

Hilary's point of focus for the ward sister and for the primacy of nursing was on the patient and his or her needs. Andrea Davies saw the need for some of the previously discarded aspects of the ward sister's responsibilities to be reinstated in order to improve standards of care:

I went ¹⁶ to look at patient focused care. I went to a hospital and if I'd turned the clock back to 1970 to Salmon, pre-Salmon 1969, pre-Salmon, and seen the ward sister in charge of the environment, and the ward sister in charge of catering, and the ward sister in charge of the linen - I don't mean, you know, mending the linen, or washing the linen, but actually being responsible for what went on in her ward. That was what they describe as 'patient focused care' and I think if we could go down that road, we will see the autonomy of the ward sister coming back, that we will see, from that point of view, patient care improved.[...] one of the wards I went into the hospital in the States, they had got the ward divided into four patient bays and they had a registered nurse and a team of assistants. And it worked extremely well, but they were responsible for catering. The food came up and was actually cooked on the ward, pre-prepared, but cooked on the ward. The nurses didn't do it, but the nurse was responsible for seeing the patient had it, ate it and if they didn't, have a replacement. Now you see that can happen. (25.10).

Millicent Wood recognised the difficulties that ward sisters are facing currently:

people I know who go in as patients, unless they are in Intensive Care Units, specialised units they get wonderful care, but in the general wards, they

¹⁶ She is referring to a study tour she had recently undertaken in the U.S.A.

practically don't see a ward sister, because she's looking at reams and reams of paper on her costings and management and so forth. (38.12/13).

The different approaches to defining nursing, nursing care and the role of the nurse, and the recognition of the demands now being made on the role of the ward sister had also led some of those interviewed to consider the most appropriate venue and processes for the pre-registration preparation of nurses. Andrea Davies describes the motivating principle behind her endeavours and highlights some of the difficulties which have faced nurse leaders in the period studied:

I suppose there was an inner drive to achieve the highest possible for nursing, and to ensure, I mean I thought that once we saw the nursing reforms with Salmon and then with the statutory body changes, reforms, that we were actually beginning to see a much more cohesive whole for nursing. I think, as we've just said, the difficulty in terms of organisational management has been a dilemma, and remains a dilemma, but I think it will go full circle. But I think one of the things that's driven me on is that at the end of the day, one wants to see the best possible patient care and how best that can be delivered by the preparation of the nurse and the facilitating of the nurse to actually perform that. (25.9).

Andrea points to a need for unity in the profession and for organisational structures which facilitate the delivery of high standards of nursing care. Serena Crooks was also motivated by the need to care, she recognises the current imperatives of value for money and the role of nurse leaders in achieving this. She stresses the value she holds for a focus on primary care:

It isn't all bad, the way the stress on money and efficiency, because we just use money and you know what it was like

RJR: I think that what we were saying earlier. I certainly think now that, you know, that a lot of paring has gone on and there hasn't been a great deal of detriment. I think there are probably some examples where there has

Serena: Oh, yes there have I think. But where it's going well, it really, and where the nurses are really able to contribute in the right place, the right area, it's going very well. I think the other thing which is beginning to come through now at long last, is struggle to get primary health care into the right situation, but it's really moving now at last. (40.18).

Serena was optimistic about some aspects of current and future care. Georgina Shaw outlined the value system which she thought important, and considers that these

would not be appropriate in the current scenario:

I wouldn't have survived today probably, because I wasn't, the qualities that I had were not necessarily the qualities that fit to-day's society. It fitted for the time and I think that's something. But I think nursing has got to prepare people to fit for the time in which they are, and I think the old qualities of high quality care, preparing yourself academically and practically and integrity, honesty in leadership - all those things, 'back to basics', it's forward to basics really. (16.30/31).

The values which emerged most strongly from the data analysis process were those related to an ethos of care and caring, of duty and service, of commitment and dedication, of faith, and of the need to set and maintain high personal and professional standards. The centrality and primacy of clinical practice vis-a-vis theory and research was a constant theme, as was the need for nursing scholarship, research and innovation to be related to practice. The importance of the development and maintenance of nurturing skills were also strongly held values.

Thus from the analysis so far it is clear that the nurse leaders of the past recognised and had to work with the constraints on their roles posed by the changing organisational structures of the N.H.S. and the increasing importance of economic restraint and increased efficiency. They also acknowledged that these mandates sometimes clashed with their own values. Thus the tensions for nursing leadership were not only within the ranks of their own profession but also extended to their relationships with other health care professionals and managers.

What became clear as the tapes were transcribed and then analysed was a sequence or pattern in the discourse. Very often an assertion of a belief or a statement of values was usually followed by an example of how they had acted in a similar circumstance, how they had dealt with a situation, how they did or might have behaved in a certain set of occurrences. This tendency to describe a way of behaving, acting or doing is the third of the components of the styles.

4.9. The leaders 'behaving', 'doing' or 'acting' approach to their leadership roles.

The use of paradigm cases and thematic analysis to tease out epistemological and ontological determinants of the individual similarities and differences between the leaders studied led to an investigation of the ways in which they described the actions they took in order to achieve their goals. As previously indicated it was in this section that they most often depicted this aspect of their work through 'plays'. They enacted scenarios and described conversations that they had with other players in the 'drama', or recalled actual dialogue or actions that they and/or others took. The statements that they made regarding their values and beliefs about nursing and nursing education were usually followed by an example from their own experience. This component is described as the 'behaving, acting, doing' component. Four major approaches were isolated from the texts, the 'battler', the 'enthusiast', the 'opportunist', and the 'dedicated'. The motivation which sustained them was that of 'survival', either personal or professional. Most recognised the alternative to survival, that of becoming a 'victim or casualty', however this end to a career was attributed to only one, Walter Mant. Chapter 3 describes how these aspects of the styles were isolated and analysed. Each of these components will be examined in turn and a synthesis of the beginnings or possible origins of these approaches will be made.

4.9.1. Battlers

Within the environment in which they worked there were 'battles' between the different segments of the profession as Vivian Stevens describes:

I think the professional support networks were close because the teams were small, and we were committed to one another and we, I think we felt we had to unite because we were always a minority

RJR: Almost this battle to get our voice heard above these other bigger groups that could eat us up if we don't stand up for ourselves

Vivian: Yes. We were very conscious of that. (24.16).

Carmel Arter recalled her contest with the statutory body:

I have always had to have a certain fight perhaps to persuade them that because we didn't do X number of hours at something we nevertheless were not disadvantaging the student in terms of their ultimate performance. So they have never stopped me, I wouldn't say that but I have never actually found

them that helpful in getting it off the ground. I had to persuade them. (11.17).

Sylvia Pole describes the struggle to acquire resources. As highlighted in the literature review and in the previous section, finance, or the lack of it, was a common theme:

You had to fight for every penny, and every staff nurse you wanted to supervise. (6.10).

Andrea Davies told of a present day struggle to try to get nursing representation at a policy and decision making level within the current N.H.S. structure:

the fight I've had to get a nurse onto the project team for a new seventy-five million pound development. You would not believe! [...] So I mean it's fight all the way and I thought those days had gone. (25.15).

Jennifer Westley describes conflict in the introduction of nursing education into higher education:

Had to 'fight the corner'. Had to be able to show what the academic underpinnings of nursing were; how nurses used them, that they weren't trying to be young doctors. (51.9).

From the 'significant other' perspective Hilary Miles described an encounter with her boss, which could demonstrate a nurse/administrator or a male/female contest:

Um and I to fight my RGM¹⁷ at that time because he was so condescending, you know, he was so chauvinistic, it's unbelievable, but I fought my corner successfully so no problem. (45.8).

As well as talking about the battles that they fought and the reasons why they considered it necessary to fight some described other aspects of this approach. Jean Benton discussed when not to fight:

the other thing is to learn what battles are worth fighting and you know, not to bang your head against the wall, against something that you are never going to change. (32.13).

Betty Deerman did not consider battling an appropriate technique, she believed in an equally tough but perhaps more subtle approach:

¹⁷ Regional General Manager

you must have goals, you must know what you want, but you must 'nt be so rigid that you can't change. You've got to be flexible, and I mean, some of the people are downright rude to you. [...] it's the people who want to fight that don't get anywhere. [...] I think you have to have a real love of people, and I think you have to be very firm, my friends always said I had an 'iron hand in a velvet glove', you must have the velvet glove touch, because without it you're not acceptable. You've got to be accepted first by administrators, other groups, all sorts of different people, and then you can't give in on what you believe and I think that's very important. (5.15).

April Walshe had also learned other strategies:

RJR: I mean fighting is something that has come out in some of the other interviews I've done. Not fighting in terms of fisticuffs obviously but battling for a belief, particularly about the profession. You've mentioned that you don't lose your temper often what other skills though do you feel are in the fighting repertoire as it were?.

April: Being a diplomat you've got to know when to say your piece and how to say it and that is key. (27.6/7).

Maria Palmer recalls how she advised others:

Yes I think one of the, in speaking on Ward Sisters, Management Course and so on throughout the years, one of the things I have said is that "If you meet a brick wall, follow that wall round 'til you get to a gate, and open it and go through". (47.16).

In the recognition of the fact that battling was not always an appropriate approach to dealing with issues in their relationships with others and in the environment in which they worked they also described some of the other ways in which they behaved. They also recognised their own leadership function as role models and described other approaches to aspects of their work. One way in which they shared their vision was considered to be through enthusiasm for what they were doing.

4.9.2. Enthusiasts.

Vivian Stevens describes her use of this strategy as opposed to the more warlike techniques of the battler:

Yes, as a clinical teacher, definitely. As a motivator, particularly with the ENB 997, I found that a most wonderful outlet for spreading enthusiasm and skills in clinical teaching. [...] and inspiring people to keep up to date [pause] In being, I don't like to use the word 'militant' of myself, because

I don't really think I was very militant, often not militant enough, but to champion the cause of midwifery. (24.18).

Carol Bury also recognised that it was necessary to curb the excesses of warfare in order to influence others:

you've got to have a capacity to [...] have 'fire in your belly'. In other words you have got to be able to enthuse others and you've got to be able to burn up with enthusiasm, with, it's a reaction to situations but always it's got to be under control. It's no good, you know, reacting and going off at a tangent with all the enthusiasm. [...] but you've got to have the zeal and the capacity [...] which carries you forward, but it's always got to be controlled, because if you're not controlled you lose control of others. (10.10).

Carol gave a hint here about the way in which she viewed leadership and the style which she adopted towards those whom she led. Andrea Davies described her own enthusiastic style as something which had been with her before she entered nursing:

I would describe myself as being someone who was enthusiastic and a bit charismatic and I've always been, well from school days, I suppose, someone who was in, it goes back to my St. John Ambulance days in Cadets, in that I was pulled out to lead the teams. And I've had leadership training right from the beginning of being a cadet from eleven to eighteen. I used to do leadership of the youth group. So I suppose it goes back to there. (25.3).

Jennifer Westley recounted how the enthusiastic approach provided motivation and stimulation for her own career, but how this approach alone was not enough to sustain the leader-follower relationship:

I suppose enthusiasm is the thing. I think ideas excite me, and there's a sense [chuckle] - I was going to say something about myself, which, I was going to say that there's a sense in which I would prefer to be doing the thing myself and getting the vision myself. Taking people with me is sometimes more difficult. And, you know, endless staff meetings where you can see where you want to go. It, I think, for a leader to take people with her is a difficult task. (51.23).

Barbara Pearson described this approach to her work and reflected on the fact that it had proved a useful motivating force later in her career but that it was not an attribute which was welcomed earlier in her professional life:

it's a job to get people sometimes to accept things that you believe in passionately. [...]

RJR: What is it do you think that triggered you in those , I mean they are

almost passions aren't they

Barbara: They are with me because I think I always saw, I mean I'm anxious to learn myself, I always want to know why and how and in those days it wasn't a useful attribute, never mind.....(2.5).

Julian Burns realised that whilst enthusiasm might sustain one through difficult periods in one's career it was not sufficient to rely on this technique alone:

but, you know, I think if you're enthusiastic, and I was so committed to nursing. I mean I've been very fortunate. Everything I've done in my professional life I've enjoyed and even though most of it has been unplanned.(23.3).

RJR: The other thing that comes across very strongly is enthusiasm.

Julian: Oh yes. That's never, never been diluted. I, there again, the enthusiasm it makes you do the job better but it also helps you to enjoy it, and I think if you are enthusiastic it also helps you to realise that if you haven't got it right on this occasion so what.(23.19).

Whilst 'battling' and 'enthusiasm' served as the driving force for some, others considered that dedication, commitment and sheer hard work were what was necessary. Others attributed success to luck or 'being in the right place at the right time', this idea of happenstance, or that things in their careers happened 'by accident' is what is described here as 'opportunism'. Opportunists were able to see advantages accruing from situations they were in and were able to capitalise on their relationships with others.

4.9.3. Opportunists.

Mary Shilton discussed the influence of another leader who created an opportunity for her career to develop:

but to have the opportunity to be actually, you know, the job was created for me to, to stimulate research in both practice and in the School. It was a good opportunity.(42.8).

Julia Menton talked of the organisation in which she worked as one which provided the chance for learning, even though it was not, in her eyes, a particularly innovative environment:

But, it was quite difficult to make change at Tor's, but it's a superb organisation for opportunities. (13.5).

The ethos was about encouraging people to reach their full potential; giving them enough rope to hang themselves; supported them if they hanged themselves once, but letting them hang if they did it twice. (13.10).

Carmel Arter talked of the influence that others could have in creating an environment in which opportunities and risks could be taken:

I learnt from other people of being prepared to give people their head. I really do think you have to do that. That means you have really got to not be a hierarchical sort of person but be able to have your staff, talk with them, have their ideas and, by and large, give them an opportunity to try them. I'm not saying I never said no - of course I did, but by and large give your people the chance. (11.7).

The propensity for some to seize and exploit every opportunity led to involvement in an ever expanding range of activities, this involvement could then lead to more and more opportunities until work and work related activities took over their lives. There was a recognition of the effects that this approach could have on their relationships within and outside work.

4.9.4. Dedication/commitment.

Marlene Adnam recognised the difficulties associated with this approach and also having a life outside of work:

I don't think there is any doubt that when I was planning Nonsuch and running Douglas', and I got all these extras, you know, the College of Nursing and the GNC and whatever, I could not have done it if I had home commitments. [.....] it really was very, very time consuming. No regrets, but it was very, very time consuming. [.....] and I don't think I could have done it if I'd got a husband and two or three children

RJR: Work was life almost

Marlene: That's right, that's right. (41.14).

Betty Deerman also found that her work life was all consuming:

I think you have to have a real interest and I suppose dedication, because, I mean my life at the [..place of work.....] started at 4 in the morning and usually finished at midnight, because I was paid to do a job, which I did to

the best of my ability. (5.6).

I could never have done the work I have done since I was in charge at Mumford, '46, if I'd had other responsibilities, because I gave everything. (5.17).

Georgina Shaw coined the original label for this approach, 'the dedicated spinster':

there were still a few of us who were dedicated spinsters around, which there aren't these days, you have to face it. I couldn't expect from the majority of my team, what I gave, and what Sylvia Thomas¹⁸ gave. Sylvia was another. The rest of them you had to accept their marriages and their children and their pregnancies, and that was quite hard for me, as it was my generation. So there was commitment, was one thing, and I don't think you can expect it today. (16.15).

Georgina seems regretful of some of the opportunities she missed through her dedicated approach. Carol Bury recognised the exhilaration and the potential toll of the sustained pace of a life of commitment, dedication and sheer hard work:

It was a tremendously exciting thing. It was an exhausting job, it was killing, I mean it wasn't a job, it was a way of life, because increasingly as the whole thing became bigger and bigger and bigger. And in my days we were jolly short of money so we couldn't staff at the rate required really to keep up with developments which meant I took on more and more and so did other key people, not just me, but I took on more and more. My social life suffered tremendously in latter years. (10.13).

Janice Williams described her approach in similar words:

looking back, I worked so hard that I never really did anything but work. [...] it did put enormous pressure on me, the sort of thing would happen for example, I'd have a late meeting in London, we did a lot of our meetings in the evenings, so I could leave work for half past four, be in London by six, we worked right the way through, I would, um I was in a, I had club membership in London, I would stay in London overnight, I would get up at the crack of dawn the next day and get the first train out. I would be at my desk at half-past eight, along with everybody else. Apart from the fact I had done it in that way, so the staff barely knew, but it was, I enjoyed it, I mean almost, it, my adrenalin was never, never dropped. Um, and I worked very hard indeed. [...] it was eh enormously satisfying 'cause the school was bubbling, but it was actually quite killing. (33.19).

The two previous extracts reveal that many of those interviewed recognised that

¹⁸ Sylvia was a senior work colleague

personal survival was jeopardised by the amount and pace of work. Many of those interviewed considered that nurses of the future need to develop their roles in flexible ways to enhance their chances of survival and that failure to do so might lead to the alternative, becoming a 'victim or casualty'. Many of those interviewed identified this as a possibility but only one was considered to have demonstrated this. Both the situation they were in or their relationships with others could precipitate the 'victim or casualty' mode.

4.9.5. Victims/casualties.

Walter Mant had been involved with one of the hospital inquiries in the early 1970's and decided at the 1974 reorganisation that he no longer wished to carry on in his nursing management post, even twenty years later he found it difficult to recall the end of his career:

I was asked to put in for a number 10¹⁹ at Sibdon, the Group, and I'd smelt a rat in this [.....] I knew this was a gag you know, so I didn't put in first time. I put in afterwards just to, because the Chairman asked me to, but I didn't play to get the job [.....]

RJR: Right so it was at that time that you'd decided

Walter: I'd had enough, yes, I could see already, before that, I was doing more paper work than actual work you know. Before that I used to go round the hospital twice a day, all 22 wards, then go down to round the other places, I worked damned hard too, on these excursions, getting to know that the job was doing right. Oh yes, I was well into management, I'll have to leave it now I'm getting a bit mentally exhausted, sorry

RJR: You want to stop,

Walter: Yes

RJR: O.k., I'm sorry about that.(4.10/11).

Walter's decision to leave nursing management may not have been entirely due to the 1974 reorganisation, he seems to display some awareness of the 'political' activity going on behind the scenes regarding the appointment of senior nurses at this time. It is true that there were casualties of the system in a way and on a scale

¹⁹ Chief Nursing Officer

not previously experienced in the health service (Watkin, 1982). Roy Elm was one who decided to take early retirement from the N.H.S. when the Griffiths report was implemented, although he subsequently continued to play an active part in a range of influential positions:

I had applied for my own job from 1974 to then about four or five times and I thought I'm not having this, who needs it?(1.10).

It may be that this was not the only reason for Roy's decision as he went on to describe how he felt that he had been held back professionally by his nursing service manager:

RJR: How personally influential do you think you were?

Roy: Within the profession not at all, outside the profession since I retired, very much

RJR: Why do you think that is?

Roy: Within the profession, certainly when I was at Mumford's, there was somebody up there trying to carve her own niche ²⁰ as it were. And so you were stultified, when I retired I didn't have anybody like that [.....] indeed I got the M.B.E. for what I'd done since I retired, I didn't get it for what I'd done before, its funny really (1.11)

Thus Roy's decision may well have been made because of tensions between education and service managers, male and female nurse managers, or between two nurse leaders with different personalities and leadership styles. Recognising the constraints of his working circumstances he may well have used the organisational restructuring as a way out of the situation. As well as casualties of re-organisation there were other occasions when individuals decided they could no longer remain in the situation. Sebastian Reason who, as Principal Tutor, had enjoyed a productive relationship with the matron found that he was not able to work with her successor and chose to leave.

Now Miss Wright ²¹ left and was replaced by another lady, who didn't see the set up in the same way. And the next Matron was very pleasant to me, didn't

²⁰ His nursing service manager

²¹ The matron with whom he enjoyed a good relationship, another of the respondents in this study.

interfere or anything, but wanted to control the clinical areas very much herself. And because, inevitably, I would turn up things in the clinical area because I was there, which would cause problems which I would ask her to deal with, or something like that, she said to me on occasion, I remember the words saying "listen, you go, you stay in your classroom" she said "and do your thing, leave the wards to me". And I said "I can't it's like a sausage machine".

RJR: Yes, that's right

Sebastian: "I'm not going to do that". And that's where we parted company. And I then decided that this was too uncomfortable, I couldn't be closeted in the school without any clinical attachment, and I wasn't going to get anywhere with her because she had a powerful personality, knew her own mind, what she wanted, and I looked around to see what else I could do then. Otherwise I wouldn't have left there because it was such an enjoyable experience and I think it was the most enjoyable experience that I've ever had.(14.9).

Sebastian decided that he could not work under the new regime, where he was to be excluded from any responsibility and decision making regarding the clinical areas in the hospital. As was explored in the literature review one of the over-riding tensions for many nurse education managers was their responsibility for the clinical learning environment for student nurses without the accompanying accountability (Boylan, 1984; Rider, 1984; Miles et al, 1988). Often the nursing service manager and the nursing education leaders were able to work together to ensure that appropriate standards for student nurse's learning and patient care were maintained, as Sebastian and Miss Wright were able to, there were however frequent instances where this was not the case. The tensions that this caused for the nurse leaders interviewed will be examined in Chapter 7 (Section 7.5.1.) where the relationship between nursing service managers and nurse education managers is explored. As this extract has shown Sebastian obviously found this situation unworkable and there were others who recognised that they were in a position which they found untenable and opted out as will be further demonstrated in the next two chapters.

4.10. Summary.

This Chapter has outlined some of the significant relationships and environmental and situational factors which affected the careers of nursing leaders. Their individual career pathways and the influence of significant others on their careers, especially

Matrons, doctors and administrators, was outlined. As well as having the potential to alter the direction of their careers the relationships provided important learning opportunities and provided points of comparison in their discussions about their conceptions of the role of the nurse in the health care team. Thus the overarching research aims have begun to be addressed.

For some the re-organisation, restructuring and/or reform of the N.H.S. had resulted in promotion within the nursing management hierarchy, for others these changes had stimulated change in career direction or had precipitated early retirement. Others found that changes in their 'boss' could have a similar effect on their own career. The influence of the situation on their own performance of their role was also a factor which emerged strongly in their descriptions of their actions as leaders. The environment in which they worked was described by some as facilitating and encouraging, especially where opportunities were created to support innovation and to allow experimentation and risk taking. For others the environment was seen to have been repressive, this was especially so when they described their own initial training, as the next Chapter will show in greater detail.

Tensions in nursing leadership began to be explored through an examination of their different conceptions of nursing. The creation of learning environments which encourage student nurses to learn to care for patients in a thinking way was seen as crucial to some but there were major differences in their conceptions of care and the role of the registered nurse in care delivery. The crucial role of the Ward Sister in creating this environment, for patients, nurses and others was demonstrated.

The ways in which they described their individual approaches to their work and a range of factors which influenced the development of their distinctive leadership styles have been identified. The ways in which they described their own approaches to leadership were revealing, especially in their descriptions of the 'battles' and 'fights' between segments of the profession and with other health care professionals, which highlight some of the tensions between different groups. Their vision of the purpose of the profession to care for patients was translated into enthusiasm for and commitment to the job and the ways in which this could be transmitted to those they were leading. Their recognition of themselves as mentors and role models began to

emerge. Major differences were discerned in the views that were held regarding the role and preparation of the registered nurse, the balance of the clinical and academic focus and the place of higher education.

This Chapter has delineated similarities and differences in the individual leaders knowledge, values and behaviour components in a general way. Some of the important differences between the segments of nursing represented by those interviewed have begun to be explored through the examination of what they considered important about nursing, there were very different views about the nature of the work and who should perform it. Inevitably there were also differences about the best form of preparation for nursing and where that preparation should take place. Many of the values that they held seemed very similar, with an emphasis on care and caring, what was striking was the different ways in which they had pursued achievement of their goals. At the crux of the argument is the conception of the nature of nursing in the future. A common theme was the need to 'achieve the best possible for the patient' and to do this they had set out to achieve a position from which they 'could make a difference'. This inevitably meant that they had to attain a position of power and influence. The majority of those interviewed believed that the road to future power, and hence survival, for the profession lay in better education for nurses. Many of those interviewed indicated that educating nurses within higher education should enable them to gain these skills and this is where they see the future survival of nursing. The arguments put forward seem to revolve around the need for nurses to be adequately prepared to take their place alongside other health care professionals in determining future policies for health care delivery. However there was a recognition that merely being 'educated' was not going to be enough. In order to achieve influence in the future nurses would need to reaffirm their area of expertise. All segments of the profession represented in the interview programme indicated that this must be in the clarification and development of a nurse's caring role in the clinical situation. Nursing theory and research should, in the view of those interviewed who expressed an opinion, be related to the clinical role. Nursing education and management should be in a supportive relationship to clinical practice.

The combination of caring on the one hand and power on the other are twin themes

which run like warp and weft threads through the following chapters. Sometimes the emphasis on care and caring will suppress issues relating to power and at other times power and influence will almost submerged the caring elements. The two concepts seem to be uneasy but essentially intertwined associates. What seems certain is that nurse leaders of the future will have to reach their own ways of reconciling the two in order to achieve nursing, as caring, goals and thus, to extend the weaving analogy further, to ensure that the fabric of nursing is strong and able to survive.

The ways in which this sample set about tackling similar dilemmas in their own working lives will be revealed in the three styles isolated in this study. This chapter has begun to examine the different leadership styles deduced from the transcripts of the nurses interviewed through an analysis of their individual careers and similarities and differences between them. The three styles 'powerful', 'pioneer' and 'enabler' are distinguished by distinct ways of contemplating nursing and nursing education. The ways in which these leaders appraised their work and the work of other nurses and some of the techniques of leadership and management have been identified.

In the chapters which follow some of the significant factors which affected their careers and roles which have been outlined in this Chapter will be illustrated and analysed in greater detail. Chapter 5 describes relationships and the influence of significant others. Chapter 6 analyses situational and environmental influences and Chapter 7 will describe the ways in which their leadership and management styles were demonstrated, especially in the later stages of their careers.

CHAPTER FIVE.

THE INFLUENCE OF RELATIONSHIPS WITH SIGNIFICANT OTHERS ON THE ROLES OF NURSING LEADERS.

5.1. Introduction

In this chapter the ways in which those individuals or groups with whom the past nursing leaders interacted during their lives, particularly their working lives, affected their management practices and the direction of their careers will be analysed. In relation to the research questions under examination this chapter is mainly concerned with analysing the ways in which the leader's work relationships with significant others affected them as individuals, especially with regard to their preparation for and response to changes in organisational structures. Some of the effects of changes in health care delivery occurring in the mid to late twentieth century on the roles and relationships between different leaders and different segments of the nursing profession, and different leaders within it, especially those with responsibility for nursing education are examined. The ways in which the past leaders of nursing responded to and coped with changes in the organisations in which they worked are identified, especially the effects of altered relationships between work colleagues, both within and outside the nursing profession, on the way in which they perceived and carried out their roles.

Thus this chapter considers research questions associated with how the leader's work relationships with significant others affected them as individuals, especially with regard to their preparation for and response to changes during the period studied. The relationships between different leaders and different segments of the nursing profession, and different leaders within it are focused on, and how past leaders of nursing responded to and coped with changes in the organisations in which they worked. Additionally the effects of altered relationships between work colleagues, both within and outside the nursing profession, on the way in which they perceived and carried out their roles, are examined.

Arising from the data analysed in Chapter Four when the past nursing leaders

entered nursing their peers in training were a source of help and support and they were also exposed to the socialising forces of those senior to them in the profession. They started to learn to nurse from those who acted as role models and mentors, for example ward sisters and tutors. One of the most profound influences on the direction of their careers and of their views about nursing was through the role and position of matron. The matron served as a significant role model, and sometimes mentor, for most of those studied. Also the position of matron was one to which many aspired, some were successful in this aspiration, whilst others were determined to leave the hierarchical hospital setting as quickly as possible. Many of those studied also remembered specific instances where their progress had been blocked or assisted by matrons. In this chapter the effects of their relationships with a matron or matrons is examined, in the next chapter the organisational role of the matron is examined.

5.2. Effects of the role of matron on the careers of those studied - a relational viewpoint.

Althea Turner recollected the way in which the matron helped determine her career path:

And from the way I became a tutor is purely accidental. I was Ward Sister on the children's ward. On a February day, when the crocuses were out, and the children went out and picked them, and the whole hospital was on at me about how "dare I let the children pick them" - crocuses. I said I hadn't let them, but they'd done it any way. And at about 9 o'clock in the evening the Matron turned up and said "Sister, have you ever thought of what you were going to do". I said "No, but if you think the crocuses are that serious, you can have my resignation now". And she hadn't known about crocuses. She must have been the only person who didn't [laughter]. So she said, would I go and relieve in the school because there were no tutors around. (17.12).

Ruby Porter told a similar story when describing the length of her initial training course:

it was supposed to be 4 years, but, by accident, and it really was an accident, I was doing a ward round with one of the Assistant Matrons, I'd finished my third year, who was saying they were terribly short of midwives, would I help them out. And I thought she was meaning, when I'd finished my fourth year. And I said "yes, I'd be delighted to" and the next day I was transferred to the Midwifery Department. (29.2).

Jean Benton narrated how her progress to becoming a tutor was speeded up:

the first person I think that really did have a big influence on me, was the matron [...] her successor actually also influenced me into doing the M.T.D.²². You know, I was pointed and sent and taught before I went to do this, and she gave me a lot of extra theoretical time, but she demanded a great deal. She demanded, you know, quite a lot of my time off every week. And so I look back on her as really being a very strong influence on my life. (32.15).

It seems that matron took a somewhat controlling stance in relation to the speed and direction of some of their careers, even when they were themselves in fairly senior positions. Betty Deerman describes a directive approach by a matron which led her to make a career transition:

I wouldn't have gone to the [national organisation] when I did because I was very happy in charge of the school at Mumford, I loved that, but Miss Mileham, the administrator²³ at that time, said, "oh well that's where you're going, you know". I didn't think I wanted to do that. (5.16).

Whereas Andrea Davies describes how a mentor/mentee relationship developed between herself and the matron in what appears to be a non-directive way:

she²⁴ was, again, someone who was perhaps very 'visionary' and light years before her time [...] she was a very great influence and taught me a tremendous amount, both from when I was a student, although you were very removed from the Matron, her influence was there, very, very much felt. And then when I went back as a tutor, [...] because I was very much involved in the 2 plus 1²⁵ that I was very much involved with her, and so much so that after she left and went to Speldhurst, I used to meet her quite a bit when I did a lot of assessing up in Speldhurst. I used to meet her quite a bit and, you know, she used to follow me through, so I think she was one person. (25.13).

Sebastian Reason was less than positive about the influence that the matron had on his career aspirations. He told how he had been appointed as a Charge Nurse:

the surgeons felt that I ran the ward better than she²⁶ did, so they petitioned

²² Midwifery Teacher Diploma

²³ Betty refers here to the matron as an administrator. There was often a reluctance on the part of some of those interviewed to consider that nurses in these positions were managers. This will be discussed in the next chapter.

²⁴ The matron of the hospital where she undertook her initial training.

²⁵ This was an experimental course of study in which the student nurses were supernumerary for the first two years after which they gained State Registration and worked for a further year as a staff nurse under supervision. Pomerantz (1973) describes this course.

²⁶ The ward sister who was off sick

the Matron [...] for me to be made up as the charge nurse. Now there was no such thing as a charge nurse [...] a man in charge of a ward at that time, not even on the genito-urinary ward. So they took over in a way, and I was interviewed by the Matron, who said that she'd had this request and said she would "try me out" as it were. And so I was allowed to remain in charge, but didn't get the appointment. After about a year, as the staff nurse in charge, I was prompted by my colleagues to go and ask for extra pay. At which point she said if I "continued down that road", she'd "simply take me off the ward" [laughter] So she left it another three months and then upgraded me as a charge nurse. (14.2).

Later on in the interview he recounted his difficulties in getting the Matron to agree to release him to undertake a tutor course.

So I went to the Matron to say "I'd like to do that" and she wasn't very keen, and so she said if I was going to do that, she'd take my ward away from me, which she did, and put me on night duty. So I did a year's night duty before I went to teaching [.....] and when I went to the Matron and told her that I'd got this place²⁷, again, I hadn't asked her permission before I went out and got it [...] So she wouldn't release me and I wasn't seconded, I had to wait another year before I could get seconded. You were really controlled to a very great extent, and what you did was determined by the Matron in those days, very much so

RJR: Talk about power

Sebastian: Oh absolutely. Yes, I mean, there was absolute power. (14.4/5).

Others reported ways in which the power to which Sebastian referred was demonstrated. Maria Palmer cited a head on encounter with a Matron:

halfway through that sort of period the Matron and I really didn't see eye to eye [.....] We both of us came to a crunch situation and I therefore gave up the opportunity of further Midwifery training because I had to find a job quite quickly, having told her I'll bring my resignation. (47.4).

In a similar way when she was seeking to develop her career by moving from teaching to management she found that opportunities were denied her:

But there was an urge in me, not just to be a Principal Tutor, or a Tutor in management, but I really did want to go into management, and I spoke to the Matron and they obviously didn't want to get rid of another tutor [.....]

²⁷ A place on a tutor course

So she blocked me at every turn on trying to get into an administration role, and I'd asked her if I could be given an experience perhaps in her office and there was nothing of this nature. And her whole attitude towards me actually changed. I don't know whether she felt I was a threat, or what. (47.3/4).

Thus the role of matron had a profound influence on their careers, and the matron was often the most significant person in shaping the way in which they carried out their future roles. Matrons controlled their careers and also tried, and often succeeded, in controlling their practices in the clinical areas. As the previous section showed there were instances in the careers of the individuals interviewed in this study where the Matron had blocked their attempts at change. However as this sample of past nursing leaders show they started to challenge the power and authority of the matron as they moved up the hierarchy, in the following extracts there are examples of Ward Sisters/Charge Nurses exerting their own authority. There are further examples of intra-professional tensions as the influence of matron and the nurses in her 'office' was sometimes considered to have interfered with the relative autonomy of charge nurses or ward sisters, as Richard Crapton indicates:

I had a ward that I was allowed to do pretty much that I liked with. [...] The matron had difficulties with the ward before and she was not happy about me being there to start with [...] but he'd ²⁸ wanted me [...] She then discovered that I ran it to her satisfaction and became even more "pro" so I could do exactly what I liked with her

RJR: Right [...] it seems to me that if a ward sister or a charge nurse got on well and worked well together, with the Consultant or Consultants, they actually formed quite a powerful alliance

Richard: They did indeed

RJR: sometimes against the Matron

Richard: Indeed, indeed, indeed. (48.26/27).

Richard describes a strong role as a charge nurse, one in which the alliance with consultants gave him power, sometimes to challenge the matron. Rowden suggests that 'control of nursing practice rested very much in the hands of the doctor who implemented his wishes via the sister who usually ruled her domain in an autocratic fashion' (Rowden, 1984:3). Maude Palmer recalled her own practice as a ward

sister:

I know my successor, I was amazed to hear that if she had problems with centre beds²⁹ she would ring the Matron's office. I didn't, I rang the doctor. The doctor rang me and said "would you take another patient on the ward?". And there was a theory that went round that Sister George³⁰ would never have middle beds. She would but not for more than one night. If somebody urgently needed to come in I could ask someone who was going out, I could say to the doctor "oh, what about Mr so and so, how much longer are you keeping him in? If he can go out tomorrow, then I can take this patient". And I could then say to the man "do you mind being in overnight?", but I wouldn't have more than one centre bed.

RJR: Mm. So you did your own

Maude: And I did my negotiations with the doctor

RJR: negotiations

Maude: because the doctor was the one that could say when they could be discharged. Not Matron's office. (46.10/11).

The growing independence of a ward sister like Maude or a charge nurse like Richard must surely have threatened the position of the matron and her deputy and assistants. If the sister could and did make decisions about which patients should be admitted in negotiation with the doctor, then presumably she could order supplies and arrange a duty rota without needing to be supervised by another person. There was some evidence from the interviewees that the deputy and assistant matrons posts were somewhat despised. Richard Crapton had been invited to take a post in Matron's office, but had declined:

RJR: Why didn't you want to go to matron's office. What was it about that scenario that put you off?

Richard: She was, she'd been appointed over a deputy matron who was still there, and there was a lot of sniping going on. It was at the time, pre-Salmon, when you had to count³¹ the spoons [...] from having responsibility of a ward were they were quite happy. You were then taken away from that.

²⁹ 'Centre beds' refers to the practice of erecting extra beds in the middle of a 'Nightingale' ward so that in an emergency acutely ill patients could be admitted and given care. This practice was deprecated as it had the potential to detrimentally affect patient care. Sometimes, for instance in a severe winter and during the smogs in London in the early 1960's I recall as many as four or five centre beds being put up. There were no extra resources nor additional nurses deployed for this.

³⁰ It was the custom in some hospitals to refer to the sister by the name of the ward. An example of the way in which nurses were depersonalised.

³¹ An 'outsider' perhaps would not understand Richard's reference to 'counting the spoons'. This was the common practice that a junior nurse had to check that all the cutlery was present following meals.

You didn't have any autonomy and you were just under somebody else. (48.8).

Some of those who had occupied posts in the Matron's office found that these jobs often turned out to be purely administrative and therefore somewhat demotivating of the nurses who filled them. In the following extract Hilary Miles describes her frustration with the post and how she coped with this frustration in her relationship with the matron:

Hilary: Well it was called an Administrative Sister in those days [...] and it was really the dogsbody in Matron's office to begin with. [...] I mean the Admin Sister was really just that

RJR: How do you differentiate between the two, you, you clearly see them as different things, what, what would your definition.

Hilary: I was sitting there writing in little books and transcribing things and doing things which a clerk could do. The only thing I achieved in that post is I reduced the paperwork. By the means of not doing it for six months and then going into Miss Simmons³² and saying, "I haven't done this for six months, have you missed it?" She said, "no", so I said, "I don't think we'll do it any more then, do you?", but I'd literally do it on that sort of level.[.....] I was allowed to do a few ward rounds [laughter]. If I reported back very carefully what I had found [laughter].....Um, but with the coming of Salmon of course, that really began to open out those things and I'd been determined to get rid of a whole lot of, of the dross that this poor person did. (45.3 and 45.12).

Both Richard and Hilary make reference to the small ways in which the matron's control was established and maintained. Routine, ritual and tradition were used to validate the matron's position and to keep junior nurses in their place. Julian Burns found that even on night duty the matron he worked for expected to be involved when major incidents happened:

I remember when I went over the next morning to give the Matron the report you know she nearly fell out of her hat, you know, I said "oh, we admitted the Night Superintendent"³³. "Oh, you didn't call me". You know I remember her saying that. (23.15).

Hilary Miles also commented on the practice of referring all decisions centrally:

³² The Matron, also a respondent in this study.

³³ The night superintendent had been taken ill in the night and admitted to the hospital for treatment.

If you were Langton, very few decision making, eh decisions were made at the lower end.[....] They sort of went up, I mean the, really before they rang for a workman to re, you know, replace a light bulb, you know, unbelievable in those days, um which I found totally amazing.(45.4).

A significant factor which many of those who were interviewed remarked upon was the influence that matron's had on their own management style. Margaret Norman, for instance, refers to her earlier approaches to management:

RJR: In terms of the things we have been talking about, what would you say your own leadership or management, leadership and/or management style was? Or perhaps is even, doing these other things

Margaret: I think it's changed because when I came into nursing it was very much so, almost a dogmatic management style. Because in the days when I was in training "you'll do that nurse, or else". And I think in my first job it was quite dogmatic.(31.18).

Margaret makes an important point here. The style of management to which most of them would have been exposed during their own formative years was most likely to have been authoritarian and, as was highlighted in the literature review, their early training experiences were often of being denied the opportunity to question what they were doing and why. Carol Nyman was scathing about the effects that this training in obedience and deference to hierarchy had on nurse managers when they took up leadership positions:

Having said that I'd been a manager all my life, I've never, I mean I've never had any time for managers. I don't think I ever was a manager like that.[...]

RJR: What is it about managers that you [laughter] I'm not sure if despise, or dislike, or whatever

Carol: Ooh, I think, I think managers are the dregs [....] I think, well nurse managers, they have been brought up to be obedient and as soon as they become a manager they try to do as they're told, to be a good manager, and they forget what they're there for, which is to represent nursing. They might as well never have heard of nursing. All they're interested in is management. They sell nursing down the river every single time. I think, you know, I have never yet found a manager. I mean, all they are, they've spent their lives making do. As soon as they get in a management position they say "Oh yes, we can do with less nurses".[....] that's why you need a nurse, they don't need a nurse to say I can make do with less nurses, anybody can say that. So that's why I'm anti-management.

RJR: Right

Carol: I think they are, they sell the profession down the river.(44.20).

Carol refers here to the skill mix and resource constraints which began to assume increasing importance in the N.H.S. The effects of these controls in terms of inter-professional tensions on the roles of nurse leaders will be described more fully in the next Chapter. They obviously caused intra-professional stresses as well. Carol blames the nurse managers for many of the ills in the profession and, as will be explored in the next Chapter, some of those interviewed tended to blame their colleagues for the ways in which the Salmon report and other organisational changes had affected nursing. This extract from Carol's interview seems to demonstrate in practice Davies' (1992) theoretical exposition regarding the 'coping' management style of nurse leaders. One of the symptoms of which is the development and maintenance of a blaming culture. Mackay (1989) refers to the tendency of nurses to 'bitch' about one another and Marcia Hughes mentioned the phenomenon described by Faugier (1992a) as 'tall poppy syndrome', see Chapter 2 (Section 2.4.):

I also am concerned about nursing in some extent, in that insisting on what they call the 'tall poppy syndrome' which is a strange thing, you know, as soon as anybody shows any initiative, somebody comes along to 'chop em down' and you do see quite a lot of that. You know I read it in the press. Anybody who is showing some innovation or you know the others are quick to set themselves

RJR: set themselves up to as

Marcia: Absolutely, yes, so I think that, you know, I am amazed [...] how nursing and midwifery [...] they're so easy to expose their problems to everybody else and you never hear doctors or other professions are doing the same. They will do it behind closed doors and sort themselves out but they don't do it so publicly and so hurtfully as nurses, I do think and it's as if they, I don't know, they are sort of jealous of each other in some way

RJR: They are so critical I think

Marcia: Yes indeed. There is not a generosity of spirit in terms of, you know, really praising those who are working away on their behalf and are really the leaders in terms of the innovators and the people who are really taking nursing forward, and they have not been supported enough I think, by their own profession.

RJR: Do you find that strange for a caring profession?

Marcia: I do. I mean they don't seem to care for each other very much. It's, I think, that something that somehow we must imbibe in them. (18.16).

In the foregoing discussion Marcia Hughes points to the paradoxical nature of a profession that purports to care yet does not seem to care about its members. Thus the role of matron, and the subsequent nursing service management posts up to the time of Griffiths, were significant to nursing in general and to this sample specifically. Matrons could affect the decision to start nursing and the early training experiences were often determined by the individual approach to the management of nursing and nurses adopted by the matron.

As was seen in the earlier section regarding the role of the matron, and from some of the extracts relating to the way in which some matrons affected their career, this was often in a more directive mode than would be expected. The way in which some mentors act as 'invisible godparents' has been commented on, Hardy (1983), for instance, indicates that 'silent mentoring' was common and that the Matron was a powerful figure in the careers of her sample. Once the potential for leadership was identified in a young nurse then opportunities were created for her to move more swiftly than was usual through the hierarchy. As Hardy points out 'this was not a relationship which incorporated mutuality, rather it was a directive situation where the Matron planned and one went along' (Hardy, 1983:266).

As well as 'directing' individual's careers the matrons were also quite influential in determining the fate of suggested developments in nursing and nursing education. There were examples of practice at the ward level being blocked or facilitated by individual matrons. Through membership of their own Association and through their work on the G.N.C. and R.C.N. they were also able to influence the progress of the profession and the relationships between different segments of the profession were often evidenced through the interface between these bodies. This will be further described in Section 5.4.

Thus the relationship with the matron could be a supportive one which helped the nurse learn to assume a future leadership role and deal with the tensions associated with this or, on the other hand, the relationship between some of those sampled and

a matron or matrons was a cause of tension in itself. The nurses interviewed also mentioned other role models and mentors as having been influential in their careers.

5.3. The relationships between nurses and others as role models/mentors and the careers and roles of those interviewed.

In contrast to Hardy's (1983) findings that role modelling and mentoring was not the most significant factor in developing the leadership careers of her sample the evidence in this study is that they played an important part in the careers of those studied. Ruby Porter was able to identify the positive influence of role models in her early career:

I think you saw more the mentor and role model a step or two back. I can remember the person that saw as a great role model was my midwifery tutor when I was a midwife.

RJR: So fairly early in your career

Ruby: And similarly the Principal Tutor when I was a student nurse. They were great role models. (29.16).

Charlotte Calman indicates that she learnt from role models throughout her career:

I think that one looked to senior people, um, and as well as taking the positive, you know, you looked at the positives and the negatives. So obviously you assimilate the things that you want to assimilate [.....] I think too that when you're a ward sister that you look to people as mentors. [...] and in my, in education I think probably the first Director of Nursing [...] Miss Wells. She was a good manager (43.8).

Esther Hurst also recalled the influence of this type of learning:

I'm a great believer in role models and I [...] always try to act like a role model. (7.5).

The previous extracts have referred to the individuals quoted as having learnt from the role model, usually in a positive sense, in that the role model exhibited behaviours and standards which they wanted to emulate. Barbara Pearson describes patronage by a more senior colleague:

you were talking about role models, I had been impressed with the Principal Tutor in Alfreton, and she had moved.[....] when I finished the tutor course I went up to Somersham for three years, because she was there. The Principal Tutor at that time was Jillian Porter who was the leader of her day in nurse education, and she was on the G.N.C. for that matter. She said, "if you promise to stay three years I will promise you that I will prepare you for a senior post", and she did, to the best of her ability.(2.2/3).

Some recalled in specific detail the kind of support they received when starting new posts. Emma Bryant says:

I was very much in a learning role because the senior teacher, who started the same day as I did, was Lavender Baker, who I later followed to the [national organisation], and she was fitting into a new senior teacher role and I was just qualified and we got on very well [....] and she was very good at giving you time to learn what to do; giving you time to prepare lectures; sorting you out, and sort of really getting my feet under the desk so to speak, at being a teacher and what it was really all about

RJR: Yes.

Emma: And so that was a very good learning situation with her.[.....]. When I was appointed as a member of the [national organisation], I had Lavender Baker to teach me again.

RJR: Right

Emma: I had a month with her, she is a brilliant teacher of how to do your job, and I, for the first few years, I used to refer to reports she wrote to learn how to write reports and what to do. And I did visits with her and saw the way she worked.

RJR: So we've got this sort of range of networks to do with the professional life etc. Some indication through some of the people of role modelling or mentorship and, did you ever experience what's now called 'formal' mentorship?

Emma: The word was never used [laughter]. I would have thought that my two roles, periods with Lavender Baker, very much so. But, no, the word was never used, but I'm sure that is how it would be described today.(28.6, 28.9, 28.17).

Hilary Miles recalled the relationship with other mentors who helped by making her think afresh about the direction her career was taking:

And because I wasn't actually ambitious in any way, the two people who've made me apply for jobs, have actually developed me, because I wouldn't have

developed if I hadn't in that sort of way. (45.14).

As well as relationships which provided career guidance there were instances when individuals recognised that they had learnt specific management skills from other nurses in influential positions and from general managers, as Andrea Davies describes:

The other person who taught me a lot about general management, was the Group Secretary here, when I was Chief [.....] I said to him "I'm not going home until we have found somewhere for nurse education, and I'm not going home until we've found somewhere for nursing management". So he said "right". So we stayed here ³⁴ until 7.00 o'clock at night and we decided to put these four huts together and put it as an education centre. We had tremendous opposition, but he believed in education and knew that.[....] so I learnt a lot from him.[....] I suppose in a way I learnt a lot from the early days at Region with Nigel Lincoln, who was the Regional Administrator, who was absolutely opposed to consensus management. My predecessor had to make an appointment whenever she wanted to see him, and I thought "I'm not having any of this" you know, so I started off from where I meant to go on, you know. And I learnt a lot from him in turn as well. I mean as well as me teaching him possibly a bit about nursing and what have you. It was a two way process and so I learnt from him.

I think I learnt a lot from Carol Bury ³⁵, from the way, both from her national perspective and also when I took over from her at the [name of national organisation]. I learnt a lot from her role model, and I suppose a lot from colleagues I've worked with, people from the statutory bodies and from the Region. I mean you learn a lot from your staff, and you learn a lot from, well you know. But those are the particular people. (25.13/14).

The previous extracts have described relationships which helped develop individual's careers, which assisted them to achieve the objectives of their role and which enabled them to deal better with conflict and tensions. April Walshe recalled the mentorship of a consultant during her career:

I had a couple of bits of advice given to me which have stood me in tremendous stead. One was, "Get hostility out into the open", if you encounter what you feel as an individual that there is hostility around you - get it out, lance it like a boil, and the other is "if people are being antagonistic to you, try to determine whether they are being antagonistic to you as an individual, to me as April Walshe, or what you represent". If it's the position, then you can deal with it, if it's personal then you deal with it

³⁴ I was carrying out the interview in the hospital where she had previously worked as Chief Nursing Officer.

³⁵ Carol was another of the respondents in this study with whom Andrea had a working relationship during her career.

in a different way.

RJR: Was it the same person who gave you those two pieces of advice.

April: Yes, yes and that was a Psychiatrist. (27.9).

Both Andrea and April spoke of specific ways in which they learned to work with others, particularly administrators and doctors, these skills were seen as important to their leadership and management roles. Andrea also refers to learning political skills from one of her role models:

And I learnt a lot from him on how to manage the HMC to get decisions, and political skills really, and general management skills, political with a small 'p'. (25.13).

In these examples of inter-professional relationships of significance to these nurse leaders there is reference to them having learned management skills, especially what they refer to as political skills and Section 5.5. expands on the role and relationship of politics and political affiliation in regard to nursing leadership. Increasingly in the period studied nursing issues, such as shortages of staff and wastage rates, were in the public view. Often the nursing leadership response to these issues was mediated through the profession's statutory body and, as the following section will show, this was frequently the cause of further tension between nursing leaders.

5.4. The role and relationship of the statutory bodies with regard to nursing leadership.

The statutory bodies most frequently referred to by those who had been in senior positions up to 1983 were the Central Midwives Board (C.M.B.) and the General Nursing Councils of England and Scotland (G.N.C.). The General Nursing Councils were not noted for their innovative approaches, the Council for England in particular had been heavily dominated by nursing service managers and doctors and was considered by Betty Deerman to be particularly repressive:

Now what was very rigid at the G.N.C. was that you must have X number of lectures in this, and X in that, and you had to break this down, that there wasn't need for that. (5.11).

Georgina Shaw spoke of the constraints that the G.N.C. had posed on development:

we had to push, shove and bang the GNC and all these other people to accept us, because they thought we were way out beyond. (16.9).

Whilst Ruby Porter recalled that the C.M.B. was also a block on innovation:

then in about '62 they wanted to introduce the midwifery option, and I, with a midwifery colleague, set this up. I was to be the tutor, and do general and midwifery teaching. The CMB clamped down and said "no way, you've got to go back to being a midwife teacher". (29.3).

These somewhat negative perceptions are countered by some positive comments. Julian Burns remembered having active support from the GNC in the development and approval of a new course:

we devised a very what I think, for just an ordinary idea of SRN student, courses which were college based, we increased the numbers of weeks that they had in block³⁶ and offered them courses in sociology, psychology, body dynamics, liberal studies, as part, and in fact the GNC approved this. (23.9).

Janice Williams recalled her own involvement in an innovative course which was supported by the G.N.C.:

So my, my first job was to set up and run the Mature Women's Course,[...] the model which had been researched in Canada and they actually picked it up from there, and it received support from the General Nursing Council as it was as an experimental approach to bringing in older women. (33.4).

Some of those interviewed had first hand experience of attempting to overcome the problems associated with the legislative aspects of the various bodies. Some of them were innovators and pioneered developments in this area, particularly following the legislation which brought into effect the major change in the organisational structure as recommended by the Briggs Report (1972). The legislation was passed in 1979 (The Nurses, Midwives and Health Visitors Act, 1979) and shortly following this a shadow structure was set up in order to prepare for the new United Kingdom wide Council and the four National Boards. The structures which these bodies were set up to replace had constituted nine separate bodies. Those who were in influential positions in the period up to 1979, when the Nurses, Midwives and Health Visitors

³⁶ Block release from clinical service work for study.

Act was passed, referred to the way in which this legislation was fiercely contested by some sections of the profession. Some of those interviewed had been at the forefront of the opposition to aspects of the Bill, particularly where it was considered that the mandate did not give adequate representation. Nan March was involved in the community nurses struggle for recognition on the new bodies:

this was what we were trying to impress throughout the Briggs legislation, you must give the people that are expert in a subject, the chance to influence what is happening in the courses [...] we were not against the idea of Briggs but there must be a, must be statutory provision. Now the midwives got this, eh, and we thought we were going in to get exactly the same thing, and when we got there we weren't give the same thing [...] We weren't given statutory powers, we were given a committee for the Health Visitors but not the statutory powers and that was a very great disappointment. (50.18/19).

Carol Nyman had also been involved in the 'fight':

it was when the Bill was going through Parliament [.....] they had said all the time "it's not worthwhile doing new legislation" [...] And we kept that pressure up. I was a member of the College ³⁷, you know, and we kept on getting the College, keeping the College involved, and we just had pressure, pressure, pressure until eventually we got, not quite what we wanted, but more or less what we wanted, in, you know, in the legislation. (44.18).

Andrea Davies, a general nurse, was scathing about the actions of her 'community' nursing peers:

and then whilst I was RNO, because I was RNO during this time, I went on to the Coordinating Committee for Briggs

RJR: Right

Andrea: to, as the RNO observer. So I was very involved with all the working parties that went towards the reforms and to the Bill going through. I mean I can think how we were sitting on the edges of our chairs with the District Nurses and what have you [.....] That taught me a lot about the political arena, because, although being an RNO, I'd been involved, you know, but considering the amount of the political arena, this taught me more [.....] it was quite a high powered committee and that was quite an interesting, you just wished you weren't a nurse when you saw how some of them behaved, you know, it was dreadful. (25.6).

Janet Ightson made similar comments:

the other thing was the Nurses, Midwives and Health Visitors' Act in 1979, which made some changes. Some of them were good and some of them were not good because, mainly because of arguments in the nursing profession. You know, the Health Visitors decided they weren't nurses [...] I think it worked quite well in a way, but, that Act, there were so many things that could have been done at the time had there not been this disagreement in the nursing profession. (12.8).

The tensions between segments of nursing leadership were obvious as Andrea and Janet have shown in their references to the way in which they considered that different segments of the profession were seen to have jeopardised the passing of the 1979 Act. Clay (1987) refers to this time as one marked by 'the profession's public disarray' characterised as a period when outsiders watched on while 'nursing's leaders display their political ineptness', he concludes:

The profession survived that catharsis - just. But I don't think we can in future afford to put our professional destiny quite so naively in the hands of the politicians.

(Clay, 1987:74)

Clay (1987), like White (1985), considers that, once again, nursing's leaders were seen to have acted naively in the political arena, and were considered culpable regarding the way in which nursing leadership was subsequently viewed. However the 1979 Act was passed and the U.K.C.C. and four National Boards came into being. The U.K.C.C. began work on revising legislation and at the same time undertaking detailed planning for the future education and training of nurses, midwives and health visitors, in keeping with the terms of the legislation. The views of the nurse leaders interviewed of some of these changes, many of whom had been instrumental in advocating and supporting the modifications, especially Project 2000 (U.K.C.C., 1986) will be examined in the next chapter (section 6.7).

Many referred to the way in which the new statutory structure, which came into effect fully in 1983, affected approaches to innovation. Earlier in this chapter we saw how community nurses approached the achievement of their goals with regard to the setting up of the U.K.C.C., and how these were viewed by other nurses. These differences in individual approaches were examined in the previous chapter and will be expanded on more fully when their leadership styles are examined in

As was shown earlier the role of the nurse manager was increasingly influenced by the need to be politically aware and the need to learn political skills in their relationships with others, within the health service; within the civil service; and in the move into higher education, became of paramount importance. As those interviewed began to progress through their careers their networks expanded and they referred to other nurses and others who worked within the N.H.S. who influenced the ways in which their leadership styles developed. Many described how they viewed the need to develop political skills, how they used their networks for these purposes, and how their relationships with others were affected by political considerations. The following section more fully describes some aspects of this.

5.5. The role and relationship of politics and political affiliation with regard to nursing leadership.

Rafferty (1993b) refers to the fact that some of the leaders interviewed in her sample attributed their views of leadership to their political affiliation. This did not come across significantly in this study. However what was notable was the ability to recognise and use political skills and influence in their work. Richard Crapton referred to his dislike of the political aspects of the job:

I could have had a greater influence outside if I'd played the game. But I couldn't play the game - I tried. It takes too much of your time, and I just couldn't relate to some that were in, in the game

RJR: Right, this is the, this is the sort of politics, the networking and

Richard: That's right, that's right. And I didn't, I don't think I've suffered fools gladly and I didn't have ways of covering up what I was feeling - it showed. And I tended to [pause] be destructive rather than constructive. (48.34/35).

Richard recognises that he had difficulties in his relationships with the 'game players', and that his own style could exacerbate tensions and conflicts. Hilary Miles disliked what she considered to be the unprincipled nature of the political aspects of the role:

but of course once you get to Region, you are a long way from the clinical areas and the operation areas and you are very close to politics. Obviously there's a big 'P' in District level but nothing like you get the pressures from politicians at Regional level and sometimes you felt sure integrity was impugned a bit really, wasn't actually a lie but it wasn't really the truth and um that was the most difficult part of the Regional job. (45.8).

I was pretty influential at Region [...] I would have liked more time in that post I think, it was, it was just the overwhelming demands of paper and politics and meetings, um which I think if I could have sat back and thought that one through better, I would have been happier. I would have said that was one, I wasn't unhappy, but I was the least happy with because of this 'not quite the truth' business. (45.16).

Vivian Stevens also disliked the political requirements of the role, but recognised that she needed to learn. She describes how she used a role model to do this:

and the Griffiths time, which all happened about the same period, was the beginning of politicisation, for which I felt totally inadequate, I hate things political [.....] It was very hard work and time consuming - not my forte, I think, but it had to be done. (24.10).

I was very impressed with Martina Trump³⁸ when I first met her. It was a time of big change for us, and for a short time when I needed to stand on my own professional feet, without a divisional head or without a - at any level this was - and report straight to the Area Nurse like she did, she was certainly a role model for that time.

RJR: She was very good politically wasn't she?

Vivian: Yes she was, and that was a time when we were having to face the politicisation. (24.18).

Vivian also described her involvement with her professional organisation, the Royal College of Midwives (R.C.M.), a role which she considered non-political!:

Mutual support. Yes that's right, sharing ideas there and trying to get things into the CMB Midwifery Officers' heads

RJR: Right, was that seen to be a political influence with a small 'p' ?

Vivian: No

RJR: the RCM or was it?

³⁸ The District Nursing Officer.

Vivian: No, I don't think it was at all, it was a professional influence

RJR: Right

Vivian: There was very little political about it in those days. (24.6/7).

Another of those interviewed, Elspeth Wright, reacted in almost the same way as Vivian when it was suggested that the professional organisation to which she belonged, the R.C.N., had acted politically. It was as if being 'professional' and being 'political' were inimical:

RJR: So really it was a way of extending that

Elsbeth: extending, yes, that's right

RJR: work. Was it political?

Elsbeth: No

RJR: with a small p?

Elsbeth: Not really, no, no. I think it's more political now than it used to be then

RJR: Yes

Elsbeth: No, it was very professional, even with the boys³⁹ there. (22.14).

These extracts demonstrate a view which has been referred to as the R.C.N.'s apolitical stance evidenced by such statements as 'nursing is a scientific and philanthropic profession: in which politics have no place, any more than colour, creed or class' (R.C.N., 1937 cited in Rafferty, 1992a:346). Senior nurses of the time seem to have an anathema to politics which perhaps did not stand them in good stead in their representations on behalf of themselves, other nurses, and patients, to the 'powers that be'.

³⁹ Elspeth's comment about the 'boys' is interesting. Firstly that she should refer to male nurses in this way and secondly an implication that male nurses were somehow more political and hence less professional than the female nurses. Later in this section some of the sex and gender aspects of the nurse leader's role and relationships are examined.

Elvira Smith describes her reaction to the influence of politics and politicians on the service:

When I came back⁴⁰ - ough Enoch Powell had been at things and I can't remember the fearfulness. All sorts of new ideas were being tried out.[...] Enoch Powell decided to shelve all that and put his ideas in. And what his ideas were I can't remember, but it was the beginning of the break up

RJR: I think it was that at the time when the political influences started to be very strong didn't they,

Elvira: That's right. And it never should be. Neither medicine nor nursing should be in the hands of a Government. And that's what's still happening now.(15.17).

Wanda Hale described how she learnt the importance of politics within higher education:

I'd some inkling about higher education,[...] the different ethos of that kind of establishment, which I must say worried me [...] I learnt to live with it and I learnt to um, you know, enjoy it and eventually to use it. But it was very hard work to start with and very good for me [...] made me politically aware, and that was an enormously valuable experience.(37.13).

As inchoate political activities began within nursing Phillipa Simmons, a nursing civil servant, was admonished for advising nurses to become more political:

I remember standing on a platform at the College⁴¹ and saying "nurses must become politically aware, because if you don't know what the present Government is aiming to do, you'll never be able to influence them, or couch your advice in a way that they'll accept it". I got ticked off for being too political

RJR: Mm !

Phillipa: I think I've learnt my lesson since then, but in those days it was rather a new concept I think.(49.23).

It seems that the nurse leader's political naivety or abhorrence of things political, on the one hand, was coupled with a desire by those in power to suppress the political awakening of nurses. Not surprising as, if nurses were to unite and exert

⁴⁰ After her 'retirement' she went abroad to set up a nurse training system.
⁴¹ Royal College of Nursing

political influence, they have the potential to disrupt the plans of politicians. There was some evidence that the nurse leaders became more politically aware and astute in the later stages of the period studied. Sylvia Thomas referred to her interest in politics:

I've always been a very political animal. I've always been interested in politics in general terms. (26.5).

Whilst Barbara Pearson spoke of her approach to dealings with politicians in general, and the then Minister of Health in particular:

I used to go to a lot of meetings at the Department of Health, and they used to be with the Ministers or Secretary of State, whoever it was, and the one I respect most, I don't say I necessarily agree with him, the man I respect most as a superb politician because he was always so well prepared, and heaven help you if you went on a deputation and you weren't, and that was Kenneth Clarke. Now he did not suffer fools gladly and some people had harrowing times at the Department, I never did because I jolly well knew what I wanted from the meeting, so did he. (2.17).

Julian Burns was very aware of the need for current and future nurse leaders to develop political skills:

There's no necessary correlation between change and progress. We've got to make sure that it is progressive and I think within all that we have to be very politically astute to work through the political systems and particularly people at the high levels when they're giving advice must never be unethical or hypercritical, but always give this advice so that everybody on that committee, whether they're Conservative or Labour or Liberal Democrat that it warms their heart and I think that's political astuteness. Certainly the former Directors of Nursing Service in the community were particularly politically astute because all their lives they have had to work in that kind of environment. (23.22).

Again it is interesting that Julian considers that community nurses were more able in respect of the political aspects of the job by virtue of their training and experience. Presumably these experiences gave them a wider outlook and more opportunities to demonstrate the skills of working with people.

With respect to the influence of significant others other factors such as gender and domestic responsibilities, faith and religious affiliation, class and race were isolated from the data. During the data analysis process, when specific instances of these

factors were extracted from each of the interview transcripts and then collated, it was considered that gender, faith and religious affiliation emerged as the most significant of the relationships which affected their later style. This judgement was based on the frequency of instances referred to by those interviewed and the number of situations described where these factors were considered significant. Extracts from the interviews are used to illustrate this in subsequent sections of this thesis (5.6 and 5.7).

This section has demonstrated some of the tensions in nursing leadership associated with politics. There were some who didn't like or didn't want to play the political game, others knew that they had to learn the rules, and yet others who positively relished this aspect of their role. The views of some of those in professional organisations regarding politics has been examined, in particular the differences between segments of the profession which came to a head in relation to the passing of the 1979 Act. Another tension which has been signalled was that between men and women and this forms the focus for the next section of this Chapter.

5.6. The role and relationship of gender with regard to nursing leadership.

Sebastian Reason reflected on the effects of being a man in a female dominated profession and of drive and motivation factors which he attributes to occurrences in his childhood, adolescence and when he first entered nursing:

I felt that unless I had credibility within the hospital, I wouldn't really, it wouldn't work. And being a man was going to be more difficult.(14.17).

He struggled to survive the discrimination against men in the profession. He found himself isolated and, as he perceived it, having to prove that he was better than a woman at the job:

it was really like being in a goldfish bowl all the time. I was the only man there, she⁴² expected higher standards from me than from other wards and it was very difficult. The interesting thing was that you were seen to be as somebody "different". I wasn't allowed to go and use the sisters' dining room, or the sisters' sitting room. In fact I had to use what was called the

42 The matron

Night Nurses Room and I had my meals brought to me. I was isolated from everybody else

RJR: Yes, gosh

Sebastian: I was a peculiar entity. And it was, oh, I think four years later before the men who were appointed in charge of wards could mix. Would be allowed to mix with the women. (14.2).

Sebastian's experience of being 'isolated' from his female colleagues was reflected by similar arrangements within the profession more generally. The inclusion of men into the main stream of professional nursing is fairly recent. Men were not included on the General Nursing Council's Register of Nurses until the early 1950's nor in membership of the Royal College of Nursing until 1960. During the 1950's the male nurses mounted a campaign for their integration into a profession which was more female dominated at the inception of the NHS than it is now, as Carol Bury recalled:

the College⁴³ was a professional organisation of the essence. Very high standards, high ideals and so on, but very elitist because we only admitted into membership the general trained woman nurse. And things had been moving externally which really made that rather an irrelevance. [...] there were a lot of die hards, the real traditionalists, who thought that the College would never be the same College again if we moved away from that position. However, there was also a lot of pressure coming up for the College to extend its membership and that came particularly from the men. [...] so we had a lot of pressure coming from the men. (10.4).

Sebastian Reason recalled the pressure that the men were exerting from a male perspective:

there was the Society of Male Nurses and I was part of that, because there was no opportunity [...] for men to join the College until 1960. [...] Jack Simmonds, was a leading light in nursing for male nurses at that time. I mean he was a pioneer [...] he was seen as the legitimate type of man, with a, married with a family and looked solid and sensible, and quietly competent never ruffled any feathers

RJR: Right

Sebastian: Now that was what was required at that time. The rest of us coming along were little rebels and started to make waves. (14.10).

⁴³ Royal College of Nursing

Sebastian's analysis of the men's different approaches to gaining acceptance within the profession is illuminating, the tactics ranging from 'not ruffling feathers' to being 'rebels'. In an earlier extract Elspeth Wright recalled that even 'the boys' had behaved professionally, she now talks of their approaches to gaining power:

Elspeth: it was in the mid '60's that we opened the doors of the College to the male nurses[.....] I was the Chairman. Occasionally one of them would be facetious, particularly Jim Allsop. He tried to be facetious and take a rise, or you know, if he thought he was going to throw me on a point of order. Oh, it was a great thing in those days with the male nurses, a point of order. "A point of order madam Chairman" - always be polite you see. "Point of order madam Chairman". It was gamesmanship when the male nurses first came in, that was mid '60's.(22.14).

Elspeth appears to recognise, and be comfortable with the politics of the 'game'. In a guide to 'corporate gamesmanship for women' Harragan points out that: 'once you know the rules, it's easy to predict opponents' moves, at least easier than when you don't even know you're in a game where explicit rules govern play' (1977:35). It is interesting here to recall Richard Crapton's reaction to the 'political games' which he saw being played within nursing. Pearl Trent was sceptical about 'letting the men in' to leadership positions within nursing, and speculates why, having overcome their marginalisation from the mainstream of the nursing, they quickly gained power within the profession:

Salmon was very influential. Well, indeed, we know he was very influential, because places that were running perfectly well were forced to Salmonise. Now this was the great gate which let the gentlemen in. They just swept through that green baize door and took over nearly everything, on the strength of one RMN, not an RGN at all. Now the thing that really fascinates me is, is this because they're men. Or is it because men have to work all their lives to support their wives and children, whereas women could regard it as a stopgap.(30.14).

This extract highlights some of the other tensions between the segments of the profession, especially the way in which the psychiatric nurses qualification was viewed. The male nurses obviously felt very strongly about their inclusion in nursing activities and some of the women were suspicious of their motivation. Elspeth Wright clearly thought that 'the boys' were playing games, Harragan (1977) writes of the problems that women leaders face when they do not know the rules of the game they are playing. For men in nursing leadership the 'shoe may have been

on the other foot' in the early days. The men, as well as the women, in this sample appear to have adapted their management perspective in order to succeed, as James Ray recounts:

I had some amusing incidents. There were some rather hard people (chuckle) Somewhat difficult, I think, they being difficult in the ordinary way, but I coped with them, I coped with them (35.9) [...] the Chief, the Chairman of the [...] Hospital Management Committee was the wife of one of the surgeons. She was also a member of the Regional Health Authority, and she was a former nurse, and she was a marvellous woman for getting things done, but she had a finger in every pie. She found it very difficult really, but she needed careful handling, do you know what I mean, otherwise it would have been very easy to fall out and say to her, you know, "this is my job and you mustn't interfere", but on the other hand, it was a tremendous help to have her backing at the same time. I got on well with her then

RJR: You sounded as if you made sure that you got on well with her

James: Yes

RJR: You seemed to have analyzed the pitfalls of not doing

James: Oh yes, yes

RJR: It sounds to me as if there are sort of political skills in there with a small 'p'

James: I haven't been a psychiatric nurse for nothing (35.13)

Although the R.M.N. qualification was somewhat derided within the profession James is very clear about the skills he considered this training had given him. Sebastian Reason spoke about his efforts to demonstrate that a man could hold values about care and caring as strongly as women stereotypically are supposed to:

I think their expectations were. First of all you were expected to take control of things. You were expected to demonstrate ability more overtly than some of the women were

RJR: Yes, yes

Sebastian: and yet at the same time you had to be careful that you demonstrated the caring role as overtly, otherwise people thought it was peculiar. I mean, I'll give an example; I was convinced that I needed to have in the ward things like flowers, and so on, which made the ward look nice and was pleasant. Many of the men that came into the ward were in

fact gardeners any way and they liked flowers and so on

RJR: Yes, so you could

Sebastian: but people didn't take men flowers you see, and there were no vases on the ward, so I started a collection of vases. And when visitors came I had a little request board, you know, for vases and so on. So the ward was in the end, had as many flowers as the women's ward

RJR: As the women's ward, yes

Sebastian: and it changed the whole culture. It wasn't so, so clinical in that sense. So there were one or two things that I tried to institute which I felt would improve the climate in which we were working. (14.2/3).

Whilst men like Sebastian were using their skills to try to break into the all female bastion of nursing, the women were using their own tactics to either keep them out or accept them on their own terms, as exemplified earlier by Elspeth and Pearl. Richard Crapton recalls his experiences of working for a woman boss who took a different approach:

Richard: Because I went into a very old fashioned school

RJR: Right, yes

Richard: With a Principal Tutor who never ever referred to me as a man, all the time I was there. She didn't like men very much

RJR: Right

Richard: She wouldn't see a doctor in her office without somebody else present

RJR: Oh !(48.8).

Richard: It was a nice atmosphere there, but I had no idea how you made up timetables; I had no idea what you did; I didn't know anything about forms, knew nothing, because she did it all herself

RJR: Right

Richard: And she did that to the day she retired [...] you had no autonomy. You were told what to teach, and you were told how to teach it [.....] But she ran it, and didn't help anybody else to do anything, from that point of view, but it wasn't through maliciousness or nastiness or anything it was the way she worked...And so I found that frustrating

RJR: Controlling?

Richard: Very

RJR: from that point of view

Richard: very, very. I mean even controlling your life to some extent outside

RJR: Outside, yes?

Richard: Because she liked to go into the bluebell woods at bluebell time and she had all these people around her and you had to walk, or escort to the lift with her at night. And she said "goodnight ladies" and went

RJR: Even though you were then

Richard: But she said "goodnight ladies" even when I was there, I mean they were all stunned that she took me into school at all

RJR: Knowing what she felt, yes, yes

Richard: But she quite liked me, so

RJR: Right

Richard: her liking I think was to exclude the fact that I was male and just count me in as one of the

RJR: One of the girls [laughter].(48.10).

In Richard's case the 'discrimination' seems to have taken the form of a lack of acknowledgement of the gender difference, so he was included in the life and work of the school in exactly the same way as any of the other, female, tutors. In this case it appears that Richard may have been experiencing what many women experience, the anonymity of their sex. In wider society men are more usually the norm and women the 'other'. Richard seems to have reacted to his treatment by this senior nurse with resigned bemusement, whereas Sebastian Reason reacted to his marginalisation by female nurses by setting out to prove that he was as good as, if not better than, the women:

when I first went into nursing in 1947, there were chaps that had arrived before me from the army, you see, and I had a note on my locker - pinned to my locker -the first day I arrived, from a group of male nurses, which said that men always come top of the class, now it's your turn [laughter]. And I was the only man in the class, so I knew that my colleagues were challenging me "Don't you let the men down".

RJR: Expectation

Sebastian: That's right, so I think to a certain extent you know, minority groups - any minority group - has to be a little bit more conscious of the need to excel, if they're going to make any mark at all. I mean women find it in men's occupations

RJR: Yes, that's right, well

Sebastian: And men find it in women's occupations, unless, you've got to say "what's the nature of this, what's the profile, and how do I fit into it". And say "well, if that's what's seen to be important, you've got to do it. (14.20/21/22).

Sebastian's analysis of the ways in which those in the minority in gendered occupations cope seems borne out by the following extracts from the interviews of some of the women who considered that the relationships between them and their colleagues had been affected by their gender, particularly those who moved out of the N.H.S. into the higher education sector or the civil service. Of the women interviewed there were some who referred to the lack of women in powerful positions and to the ways in which the men with whom they worked treated them. Some had also experienced gender bias, Janice Williams recalled her recent experience:

one of the most interesting things, of course, was the lack of women in the positions of authority and I mean that was quite critical and when they appointed me professor, I was the first woman professor [.....] I was interviewed on the local radio. Not because of me as Professor of Nursing but

RJR: Because you were a woman.

Janice: Woman professor. (33.30).

Marshall (1984) describes a very similar reaction by taxi drivers waiting to pick a 'doctor' up from the station. Andrea Davies describes how she was stereotyped during the top management course that she attended:

I was the only female on the course, out of 65 men, and they said "right, you chair the group". So I chaired the group, and we had so much money to buy in consultancy, so I said "come on let's buy in the expertise". So we bought in the expertise. And the critical thinkers, within - the game lasted a week - within 24 hours the critical thinkers had gone bankrupt and they'd got out of the game, because they were all arguing amongst themselves

RJR: Right

Andrea: and we won. And he “ couldn’t get over this. Because (a) they’d never had a female leading the group who’d won and (b) they never thought that this particular group could win you see. (25.6).

April Walshe talked of the difficulty of breaking in to a male dominated sphere of work:

RJR: Has it helped being a woman? Probably a strange question at this stage of the interview.

April: No, it hasn’t, it hasn’t, it’s been, I’ve had a lot of difficulties to overcome being a woman. When I went into the [...place of work...] ..there was tremendous clubability amongst the men which was very difficult to break into and still exists to some degree.

RJR: Yes, certainly in higher education it’s a factor. (27.16).

Jennifer Westley describes how she worked in a male dominated establishment:

When I went there I was the only woman in the Faculty of Medicine, although I never felt that I was working as a woman. I felt I was working as one of them using the same...I mean I would never use feminine wiles to get what I wanted out of the Medical School, but I would use their techniques and present a case and expect to be heard on the case. I mean, from the feedback that I’ve had subsequently I think worked. And they respected the fact that I tackled them on their terms. (51.8).

Some women would have reacted by advocating a woman’s right to be heard on her own terms. April mentioned her views of the feminist movement:

and in the international scene, there haven’t been a lot of women in senior posts and so one has had to handle it very carefully, and very sensitively, to never demonstrate any sort of feminist, not that I am a feminist, but you know any views which could cause offence. (27.16).

It is interesting that April considered that feminism might give offence! Jennifer Westley also found feminism bothersome:

RJR: Throughout, I suppose, that middle part of your career, the feminist movement was growing

Jennifer: Yes growing

RJR: Did that influence you at all do you think?

Jennifer: I think if anything it irritated me, and I expect that's naughty.[.....] So, you know, the fact that people were being so aggressive about it irritated me to death. And also latterly I felt that they were their own worst enemies because they were making enemies by being so assertive [...] when some of the feminists started throwing their weight around.... You can imagine the men in the Medical School exploding

RJR: Yes, yes, they would have known about

Jennifer: A load of fools. And it was that kind of extremism that really irritated me. And part of the irritation was that I knew that this was going to cause nursing to be held in less regard than I wanted it to be held. Some people say "you shouldn't play their game". And I'm a firm believer that if you are a woman you are a woman and you act as a woman. But I think, you know, in committees and things like that, you have business to get through and the fact that you're a man or a woman is a bit irrelevant. And I suppose we think in different ways very often. But, and we bring another dimension to the thinking- and that's good. But I don't want to go around flaunting the fact, and also playing down men, so that I feel sorry for men at times now. I feel they're the oppressed.(51.18/19).

Jennifer raises important points about women managers having to 'play the game' on men's terms, she also comments that women's thinking and approaches to leadership and management is different from those of men. Some authorities claim that women in leadership positions have had to assume a masculine style in order to succeed (Gallos, 1989; Marshall, 1984, 1989) and that this has detached them from feminist concerns. It is interesting that both April and Jennifer deny any attachment to the feminist movement. Hardy (1983) commented on the difficulty that her sample had in allying themselves with feminist ideals and Hancock (1989) observes that some women RCN members have reservations about the whole notion of women's issues and find the language of feminism threatening rather than liberating. She says she 'had problems with the concept of women's issues myself until I moved into general management and found that I was not getting jobs because I was a woman, or maybe because I was a nurse' (1989:18). Simmons and Rosenthal (1981) comment on the lack of involvement of nurses in women's issues and Smith (1992) also observes the:

curious lack of feminist perspectives brought to bear on the position of nurses by its leaders. Issues such as the stereotyping of care as women's 'natural work' and the gender division of labour within the health service and the patriarchal power relations between doctors.... and nurses...were not addressed in these official versions of nursing.

(Smith, 1992:10).

Recently the nurse leader's failure to be involved in feminist activity has come under some scrutiny. White (1986) offers a partial explanation to the phenomenon of the early nurse leader's neglect of the feminist viewpoint through examples of the 'Queen Bee' syndrome at work in nursing. Which is said to have 'evolved in the feminist movement to describe anti-feminist behaviour in women who have careers in leadership positions'. The 'bitching' and 'blaming' culture and the 'tall poppy syndrome' referred to earlier may well be examples of this. Arguably the 'Queen Bee' nurse leader will identify with male colleagues, for example doctors or managers, in order to gain a support system and in so doing they may create a 'credibility gap' between themselves and their staff, who will then carry out plans and innovations half heartedly, suspicious of her motives (Halsey, 1978). Male role models were cited by both Andrea Davies and April Walshe and whilst it would not be appropriate to attribute the 'Queen Bee' syndrome to Andrea, April or Jennifer on the basis of the examples given or from their remarks regarding feminism and feminists, some of the exemplars in the foregoing section describe women acting in this way, particularly the extract from Richard Crapton's interview describing the tutor in charge of the school of nursing. Thus there have been tensions between male and female nursing leaders and also tensions within the nursing profession regarding the position of nursing leaders relative to male doctors and managers.

Sex role socialisation and gender differences are obvious factors which need to be taken into account in an examination of the origins of different styles of leadership in nursing. Unfortunately the sample of men in this study was small but the data revealed some interesting, and somewhat unexpected findings regarding their careers and perceptions of nursing and care. The implications of the preponderance of men in leadership in a caring profession, such as nursing, needs to be explored further. As the extract from Sebastian Reason showed he deliberately set out to prove that he was as caring as a female nurse by ensuring that there were flowers on the male ward. Whether or not this action is one which exemplifies caring is open to question. It certainly could be adjudged to demonstrate 'caring about' (Hugman, 1991) and might well illustrate what Smith refers to as the 'little things' or 'gestures of caring' (1992:1). Almost certainly Sebastian's example would have 'set the tone

for the caring climate' on his ward (Smith, 1992:8). Some of the other men interviewed overtly display a regard for caring values though the number interviewed was small.

Other authorities are concerned that masculine conceptions of nursing create a paradox between the caring nature of nursing and the prevalent style of management:

the emphasis on nursing as a series of scientific, technical and sub-medical tasks indicates a belief in masculine rather than feminine values (science being mistakenly thought of as masculine, rational and value free). This is echoed in the pseudo-industrial style of nursing management, with its emphasis on manpower (sic) planning, cost-effectiveness, problem-solving and decision making.

(Salvage, 1985:9).

As was discussed in the last Chapter the emphasis on the scientific, measurable approaches to defining quality care may have been detrimental to the development of nursing. It is obviously important to take gender differences into account when considering leadership styles and strategies in nursing. Thus leadership and management style is influenced by a range of factors of which gender is one. The approach to their work by some was also affected by their faith and religious affiliations and they described how this affected their roles and relationships.

5.7. The role and relationship of religious affiliation and faith with regard to nursing leadership.

Information regarding religious affiliation was not specifically sought in the interviews. One person mentioned during the interview that there had been an element of religious discrimination during her career but when she returned her transcript she particularly requested that this not be quoted. What did come across quite strongly was that faith undoubtedly played a part in the styles of some of those interviewed. Many alluded to the role that their faith had played in their motivation to nurse and in decisions that they subsequently made in their careers. The notion of being of service and of being called to a vocation were factors linked with faith

which were isolated from the analysis of the interview tapes. Marlene Adnam thought these values had been with her since childhood:

My parents I suppose, I was always brought up to be of service to somebody. I was sort of given the impression that, you know, one had to give something and not necessarily to take all the time, and I suppose that might have influenced me for nursing and a career. (41.14).

Jennifer Westley was called to nursing having started a degree course:

Well, it was a vocational experience.....I knew I wanted to do something different, but I didn't know what, and it was waiting and, you know, really finding that this was something I felt called to. And that's unusual nowadays.....this thing of, you know, not wanting to go on working with test tubes came upon me. And I, at that point, I have to confess I thought that nursing was beneath me, and it was a big struggle to me to accept that I was meant to be a nurse. (51.2 and 17).

Vivian Stevens describes a similar experience:

I certainly thought I had a vocation to be a nurse. I have to confess I didn't feel I had a vocation to be a midwife, the only reason I went into it was because I wanted to specialise in paediatrics, and it was actually during my midwifery training that I became a Christian, which rather changed the progress of my career after that. (24.16).

Carol Bury refers to the role that her faith had in sustaining her in her career:

in your own job you might be lonely but you're not lonely you're not alone and I've got a very very strong Christian faith which has always been a great help to me (10.13).

Vivian Stevens also referred to the fact that the strength of her faith had helped her during some of the difficult times in her career:

My other support networks are probably right outside work, were my church and my Christian friends, and certainly my Christian faith was what kept me going through some of the really bad bits, particularly the validation bits. (24.16).

As Vivian indicated faith gave her support in times of difficulty, it is interesting to note that the transition into higher education and the requirements of validation were

seen by her as particular sources of tension. Emma Bryant recounted how her faith fitted into her personal support and learning network:

RJR: We've talked a little bit about the networks and support mechanisms, and I think that the Nurses Christian Fellowship probably is part of that wider

Emma: That's right it is. Yes, I mean I joined as a member when I started as a student nurse back in '52 and have been involved actively wherever I've been. (28.16).

Jennifer Westley talked more generally of the range of influences which motivated and sustained her, but where her faith was an important aspect of her work:

And so home influences were important. I think also, what I would say is, has always been one of the most important influences in life has been my faith. That has been a tremendous driving force - not an obvious driving - but a motivating force in everything I've done and I suppose that is a very strong [.....] a strong motivator.(51.17).

Georgina Shaw recalled being involved in a previous study in which faith had played a significant part:

some years back I was part of a guinea pig for a research somebody was doing on 25 nurse leaders and they had Jennifer Westley, Carmel Arter- all our contemporaries there..... And they came out with the fact that we were all single women with a very, very strong religious component.

RJR: Yes, yes

Georgina: We were either Jewesses, or Muslims or Christians or whatever, right across the board, it didn't matter what, but there was this strong allegiance. There was even an atheist among us, which was a very strong commitment, which interested me. And we'd all had somewhat adverse childhoods, there were problems somewhere which had made us survive, which I thought was very interesting, but I don't know if those are qualities which produce leaders.(16.31).

Julian Burns described the twin influences of faith and political belief in his career:

I know it's rather old fashioned but I came into nursing with a sense of vocation. I really did, and I still feel that very strongly. [.....].... I come from a Catholic background where the idea of vocation was always first. And I really did. I came into it after praying very hard and so that this commitment. I mean obviously the priority I have to say was to sick people.[...] I feel very strongly that it's a part of this calling to give service and that's something that's

RJR: Still there

Julian: I think actually it's never, you know, it helps you to see a problem. Analyses an act, with another dimension, and makes you very..... You have very strong feelings about social justice and equity. (23.18).

Hardy (1983) comments on the strong faith of many of her sample and other researchers have identified this. For instance Smith et al (1985) use phrases such as 'true believer', 'crusaders', 'pursuit of the holy grail', and 'testimonials', to describe the careers and life experiences of their sample, a group of educational innovators. These teachers and managers had first been studied during the introductory year of 'the new elementary education of the 1960's to a middle class suburban elementary school' (Smith et al., 1985). The follow up study, using the life history technique, took place fifteen years later. In their later description of these innovators Smith et. al. comment on the 'strange career of creativity' from which they imply an 'interpretive metatheory or paradigm' regarding the 'natural history of belief systems'(1985: 184-186). They conclude that:

the hypothesis that emerged involved the conversion of religious motivation, ideals and actions into the world of educational reform. In effect, our general claim is that 'educational reform is secularised religion'.

(Smith et al 1985:186)

As will be seen later in the description of the styles of leadership that are identified in this study of nursing leaders it is remarkable that so many of those who referred to the significance of their faith are seen to fall into the 'pioneer' category. The linked concepts of vocation and religion are important when one considers the role of faith and religion in respect of a career in nursing. Vocation is defined as 'the divine call to a religious career, calling, profession or occupation (Collins English Dictionary). As has been shown religion and faith played an important part in the careers of some of those interviewed. Some authorities consider that there is a 'tension' between the view of nursing as a truly caring 'vocation', and notions of professionalism (Francis et al,1992) and Salvage judges that the 'current preoccupation with the professional status of nursing has largely ousted the idea of nursing as a vocation'. She goes on to argue that 'religious commitment is still an important motive for many entering nursing' (Salvage, 1985:90). Reverby (1987)

highlights concern in this area in the 'dichotomy between the duty and desire to care for others and the right to control and define this activity'. These concerns are echoed in recent research by Francis et al (1992) who found that nurses who fell into the 'vocation' category were less likely than their peers to see problems with nursing and that they are the nurses who are least likely to leave nursing. They conclude:

it seems little will deter them from continuing in nursing, and, further they make few new demands upon the system. compared with other nurses they do not bemoan the pay, poor promotion possibilities, lack of training opportunities etc. Quite simply nursing is their life whatever the trials and tribulations.

(Francis et al, 1992:65-66).

This is a somewhat worrying conclusion for whilst faith, religion and a calling to nurse are important motivators to enter and remain in nursing they appear to detract from the nurse's ability to perceive concerns with their work and to lobby for changes. From the data analysed in this study the past leaders who were motivated and sustained by their faith and religious affiliation do not appear to have been held back from attempting to make changes to the status quo. The effects of this factor is one which would need further research and analysis before more firm conclusions could be reached.

5.8. Summary.

This chapter has focused on the significant relationships in the professional lives, and sometimes the private lives, of those interviewed. The significance of early role models and mentors has been highlighted, in particular the role that matrons played within their own careers and on the nursing profession more generally. From the data presented here it is evident that matrons had a well developed network system long before this became a fashionable management concept and that networking was used by all those sampled to achieve a variety of purposes. The fact that some of those interviewed had other role models and mentors was significant, especially when those role models were from outside the nursing profession and were of a

different sex. It was argued that this might have a significant effect on their style of management and on their subsequent relationships with their peers, colleagues and subordinates. This is especially so where different values might bring them into conflict with those who worked for them and is a potential source of tension within and about nursing leadership.

Those interviewed reflected on a range of interpersonal relationships which had posed conflicts and struggles for them. Especially highlighted were the relationships between nurse educators and nurse managers and in gender relationships. A significant factor is that whatever the difficulties they experienced they persevered in their attempts to achieve their personal goals related to nursing. These goals were expressed as a desire to care and to improve care. What is important to remember is that their role model for managing care was the matron, they had little personal experience of care delivery as a registered nurse, thus for many their conception of managing care is that of directing others to give care. They also gave examples of having been treated with a lack of care and consideration, particularly by other members of the profession.

What has emerged so far from the analysis of the interviews with these ex-leaders is a complex of characteristics affecting the way in which their careers and leadership styles developed. The time and the situation that they were in and their relationships with their own managers and significant others helped shape their responses. Work experiences and their education and training during their careers were important and their approaches to leadership and management were also shaped by role models, mentors and networks. All of this was closely associated with the 'climate', 'culture' or 'environment' in which they were working. Faith and religious affiliation was also identified for some as a significant factor. Thus the effects of the environments in which they worked and the influence of significant others helped to shape the ways in which these individuals carried out their leadership roles.

In relation to the research questions being studied this Chapter has highlighted some of the sources of tensions in the working relationships for those in nursing leadership in the period studied. This was demonstrated particularly in the

relationships between them as they rose in the nursing hierarchy and the nurse leaders of the previous generation who were their 'bosses' and role models. There was evidence that these relationships could be extremely supportive but they could also be conflictual, especially where the 'boss', usually the Matron, wanted a different career direction than the nurse studied. If he or she obeyed the Matron then relationships seemed to remain harmonious but if the nurse did not comply then penalties were applied. Also highlighted in this chapter were growing differences of opinion and approaches between nursing service managers and nurse educators. Nursing service managers were increasingly faced with influence from their general management counterparts and from the consultants with whom they needed to work in order to supply an efficient and effective nursing work force. As was seen in the previous chapter the pressures on them from these two groups were most often related to the need for budgetary and manpower controls. This ultimately brought them into conflict with nurses below them in the hierarchy, many of whom considered that the reductions in the numbers of trained nurses which were the consequence of the dependency studies and skill mix measures were detrimental to patient care. This theme is one which arises again in the next chapter when the influence of situational and environmental factors on their roles is analysed. The ways in which they coped with the demands from their managerial counterparts and their consultant colleagues whilst managing clinical and educational nurses is examined further in chapter 7.

There was also some evidence of clashes between different segments of the profession. Groups which had been dominated by general nurses for most of the twentieth century began to become more aware of their own skills and the needs of their client groups. In particular midwives, and community and psychiatric nurses began to assert their independence from matrons, general nurses and hospitals. The general nurses link with ill health which could be cured by a stay in hospital with treatment prescribed by a doctor and carried out by a nurse began to be challenged by midwives who were more interested in well women, and their families, who were involved in a perfectly natural phenomenon. Community nurses were more focused on well being and the effects of social provision, such as employment, housing, sanitation, and education on health or ill-health. Psychiatric nurses and nurses who cared for the mentally disabled began to reject the general nursing

model as inappropriate for the care of their client groups.

Linked to this were tensions between male and female nurses. Many male nurses who became leaders and managers within the profession following the Second World War (1939-45), the introduction of the National Health Service (1948), their incorporation into the R.C.N. in the 1960's and the recommendations of the Salmon Report (1966) began to challenge the authority of the female nurse leaders (usually the Matron) in ways which had not been previously experienced. Gender differences and the tensions which they caused were also commented on by the female nurses in senior positions within the managerial hierarchy of the N.H.S. and within the new environment of Higher Education. Thus a significant factor to emerge so far from this survey of the influences on nurse leader's roles is that of relationships. Their relationships with other nurses at whichever stage of their career could be supportive or destructive, this sometimes, but not always, was dependent on their position in the hierarchy. The social relationships between men and women was an increasingly important issue, both within and outside nursing. Within these relationships issues of power and influence were especially germane, principally in respect of their ability to achieve their goals of ensuring high standards of patient care. All of these relational factors were associated with the situations and environments in which they worked and this forms the focus of the next chapter.