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

Thesis

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CHAPTER SIX

THE SITUATIONAL OR ENVIRONMENTAL FACTORS WHICH AFFECTED NURSING LEADERSHIP ROLES.

6.1. Introduction

This chapter deals with the impact of successive organisational changes within the N.H.S., and the way other environmental factors affected how the past nursing leaders and managers perceived their roles. In Chapters One and Two contemporary and historical tensions in nursing and nursing leadership were outlined. The literature which was reviewed in Chapter 2 suggests that a range of factors might have contributed to this position. The environmental aspects which appeared most significant were the organisational structure of the N.H.S. and in particular the position of nurse leaders within the organisation. Nurse leaders had largely lost their place at the top levels of management, especially in the new market environment, and this was considered detrimental to the delivery of high quality nursing care. Hierarchy and bureaucracy in both the organisation of the N.H.S. and in the way in which line management in nursing was structured were seen to have created, in some nurse managers, mind sets and ways of behaving which were not conducive to leadership. It was considered that the way pre-registration nursing education had been organised in the past had stifled nurse's creativity and autonomy and that lack of educational opportunities and preparation for their managerial roles had served to induce repressive or reactive coping styles rather than proactive transformational approaches. In this chapter aspects of the environment in which those interviewed in this study worked will be analysed for possible illumination or explanation of the veracity of these views. An analysis of the role of the matron in organisational terms is made, as was highlighted in the previous Chapter, this role was one which influenced the development of their own leadership and management practices and styles.

In the previous chapter the effect of the role of the matron on the careers of those studied was analysed from the relational viewpoint, in this chapter the role is

examined from an organisational perspective. This is followed by their recollections of the 'highs' and 'lows' in nursing leadership through the successive organisational changes in the N.H.S., especially the ways in which their own or other nurse managers careers were affected by the changes. Finally some of the specific changes in nursing education in the period studied are examined, in particular their current views of Project 2000 are explored. The integration of nursing education into higher education is discussed and the potential influence of higher education on nursing education is evaluated.

6.2. The role and influence of the Matron - an organisational perspective.

Prior to 1948 matron in a voluntary hospital was responsible to the Board of Governors for the control of nurses and nursing and for the resources they consumed. After 1948 the matron, who had direct access to the Board of Governors, found that she was only one among several matrons for which the hospital management committee had responsibility. Under this regime the hospital management committee might exclude all the matrons or a compromise would be reached by which one matron would represent the others on a rotating basis. Under this regime the matron, whilst powerful in her own sphere, was seen to be subservient to both the medical superintendent and the hospital secretary. Elizabeth Hamkin gave a graphic account of the management of a Voluntary Hospital in the North-West of England prior to its inclusion into the NHS:

the Royal Loughton Infirmary was supported, we had a lot of big industries in Loughton and they had the Work Peoples Committee and there were, must have been thousands of men and women worked, and they paid a penny a week out of their wages to the work peoples scheme, which meant that a certain big sum of money came to the Infirmary every year, and they had so many beds allocated which they could request their members to use. Otherwise people left sums of money and there was the Ladies Committee, they made all the linen which was needed for the Infirmary every year. At the end of the year along the bottom corridor was laid out, Matron used to estimate what she was likely to need, sheets, at that time there were many tailed bandages, T bandages, towels, and lots of things which are never used now. Operation stockings, baby things, nappies, everything, they either actually made or they bought, in the case of sheets. There was one man who was the Treasurer and the Hospital Committee with both Doctors and non professional people on it, who took a tremendous interest in the Infirmary, and as far as I can remember it was fairly well financed. I remember to my

horror when I started to do the tutor course we used to go on visits to other hospitals and I discovered there were some of the London hospitals still using old chipped enamel bowls for things, when we'd had stainless steel right from it coming in. So that they were, they really did keep abreast of things. (3.10)

It is interesting to note the different roles that were ascribed to men and women in the management of the Infirmary. Men and Doctors (almost certainly all male at that time) dealt with finance and managing the Hospital, Matron (almost certainly a woman) and the Ladies Committee being charged with responsibility for linen and domestic issues. This respondent has highlighted issues which have repeatedly recurred since the start of the NHS; power, status and role issues between the genders and between Doctors, Nurses and Administrators; status issues between Teaching and Non-teaching Hospitals and the North- South divide, in particular the differences between London and the rest of the country. All of which have the potential to have caused or exacerbated tensions within nursing leadership.

Several of the respondents in this study referred to the pivotal role that the matron held in the management of nurses and of nursing, particularly in relation to the setting and maintenance of standards. Many matrons took their role regarding this very seriously, perhaps too seriously, in some instances. In order to be seen to be in control they set up a range of ways in which they could monitor what was happening at ward level. The matron's involvement in most of the activities in the hospital inevitably led to severe demands on their time and skills. They expected to do a 'round' of all the wards, getting to know all their nurses and many of the patients as well. While this practice meant that they saw first hand what was happening in ward areas it would have made exacting requirements on their time as Elizabeth Hamkin remarks:

I think the other, and other people have agreed with me on this, the biggest change and mistake that was made was when there were no longer people called Matrons and when Matrons didn't do a daily round, because at one time if Matron didn't do two rounds a day she did one and one of the Assistants did the other. So people knew that they'd got to just keep their standard right because they never knew when Matron might come, and she would soon spot something not being done properly. So I think that made a difference. [.....] Yes, and although Matrons were derided and despised, they

were wonderful women, and they did keep up the standard. (3.17 and 3.32).

Thus the ways in which matrons performed their duties were seen by some as important in the setting and monitoring of standards of nursing practice as Elvira Smith shows:

Oh then from the standard at St. Tor's. [...] Cross infection was the thing that if we had it, well we never had it

RJR: No that's right it was, if you had it you were in trouble

Elvira: I remember once a patient developed [...] erysipelas and I remember that the sister in charge of the ward concerned had to go straight to matron's office because it was thought then this was a cross infection and she very nearly lost her job over that. It was nothing to do with her of course and matron knew it. She was a very fair woman but she had to make an account for it. But cross infection was unheard of and so were bed sores. (15.41).

These examples, which refer to matrons setting and maintaining standards of nursing care, reflect the early days of establishing professional nursing when the matron might well be the only registered nurse in a hospital. It would have been necessary for her to have methods of controlling the practices of the untrained nurses who were actually delivering care. The fact that some matrons continued to do these things long after the introduction of formalised training for all nurses perhaps gives some explanation why the role of matron fell into disrepute. It has been suggested that the way in which this control was exercised de-professionalised other nurses leading to an unquestioning, uncritical approach to nursing work on the wards (Beardshaw, 1981; Salvage, 1985; Sines, 1994).

Elvira Smith begins to identify how the somewhat restrictive and controlling ways in which the matron managed nursing began to cause problems as the nature of the service changed:

And the other thing was that she herself needed to know every nurse. Now I think that brings us onto another important point. The size of hospital then was about 700 beds and I think that's an ideal size for a hospital. Because matron was able to know all her nurses. She was able to visit the wards and get to know a good many of the patients in those days because they were a longer stay of course. (15.29).

Elvira picked up two important factors here which started to encroach on the matron's ability to fulfil the role that she had set for herself in respect of managing nursing. It is conceivable that some of the matrons thought that their own power would be diminished if they allowed others more control over their own sphere of responsibility. It is also possible that administrators and doctors realised that by keeping the matron busy with what was essentially trivial minutiae their own power was less threatened. Alternatively questions of this nature may never have even been considered. Because of the gendered nature of care and the role of the nurse as 'the wife' to the doctors 'husband' neither the matron nor the doctor or administrator would have considered it strange that she spent her time in this way. It is only in retrospect that it appears odd that the matrons of the day could be seen to be 'fiddling while Rome burned'. Thus matrons were influential within their own hospitals but their power to manage nursing and nurses could be judged somewhat limited.

With the advent of the N.H.S. whilst the matron had a range of responsibilities for a significant amount of the work of the hospital and although influential in a wide range of activities many nurse leaders of the time were disheartened by the roles which they were performing and by the way in which the doctors and administrators (usually men) presumed to speak for nursing at a management level. Carol Bury referred to this in general terms:

in the beginning, early '60's, it was apparent that the role of the nurse within the hospital management structure was a very unsatisfactory one. Some Matrons attended meetings of their Hospital Management Committee to deliver their nursing report and in other instances the Hospital Administrator gave the nursing report and we felt that well, didn't feel it was obvious, that increasingly nurses were not being attracted into nursing management, because it was altogether unsatisfactory. (10.7).

Maude Palmer referred to being invited to attend H.M.C. meetings to sit at the back in case she was asked her opinion on a nursing matter:

we sat at the back, you know, you weren't at the table.[.....] I don't know, since our seats were behind the Chairman that you could have put your hand

up to say anything, unless asked

RJR: Right, right

Maude: but the reason for you being there was so you were there if they needed to ask you anything really

RJR: Right, but not to volunteer information [chuckle] (46.26).

Marlene Adnam recalled a similar experience:

but when I started the Board meetings we used to be present and we, the Matrons, we used to sit round the side of the room. We didn't even sit in the 'body of the kirk', as it were, and I felt very strongly that nursing must have a voice at all levels in management. (41.5)

Thus the nurses in this sample who were Matrons commented on their lowly position in the managerial hierarchy, and those who were in nursing leadership positions outside the N.H.S., such as Carol Bury, remarked on the effect that this had on the profession in general. As was discussed in Chapter 2 the Bradbeer Report (1954) had done nothing to redress this position. With the Salmon Report (1966) the need for change was recognised. The Department of Health summarised the factors which were the source of tension:

Nursing is not always adequately represented at meetings of governing bodies as are medical and administrative staff;

Confusion arises from the way the term 'Matron' is used in various types and sizes of hospitals. This title does not show the responsibilities of individual posts;

Nursing administration is frequently authoritarian in its approach and as a result communication can be inadequate. Matrons are often overloaded with day to day detail, while those below, who have the ability and knowledge to make decisions within the established nursing policies, cannot do so. This causes frustration for the nurses concerned and may prevent decisions being made quickly and where they are most needed - near to the patient;

In general, nurses are not adequately prepared for the responsibilities of higher posts.

(D.H.S.S. 12/71. 4-5)

As the previous chapter and this section has demonstrated from the inception of the N.H.S. to the introduction of the Salmon Report the role of the matron raised strong emotions, both negative and positive, in the nurse leaders sampled. A variety of responsibilities was required of hospital matrons and in addition the attention to detail which most matrons seemed to emphasise were factors which in 1963 led to the setting up of the Salmon committee. The lowly position of the matron vis-a-vis medical and administrative colleagues and the lack of role clarity were, in the view of the Salmon report, coupled with a variety of failings on the part of Matrons. They were considered repressive and lacking in skills of communication and delegation, all of which resulted in a failure by the nurses below them in the hierarchy to take decisions. The solution to these ills was seen to lie in better preparation for their roles. The Salmon Committee was to advise on the senior nursing staff structure in the hospital service (ward sister and above); the administrative functions of the respective grades and the method of preparing staff to occupy them (Salmon, 1966). With the recommendations of the Salmon Committee the position of matron was removed but, as the following section will show the 'prescription' to 'cure' the ills of nursing leadership was to prove unpalatable to some nursing leaders and served to cause or increase the tensions within nursing leadership.

6.3. The Salmon Report (1966).

The structure for nursing recommended by the Salmon Committee (H.M.S.O., 1966) introduced a further hierarchical organisation into nursing leadership which ranged from the Chief Nursing Officer post (Number 10) at Hospital Group level to Ward Sister (Number 6). 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), both Number 9. 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). Thus one of the sources of tension between nursing leaders was to remain.

All of the respondents in this study were nursing at this time, many in senior positions. The Salmon Report affected only hospital nurses so, on the whole, only those who were working in hospitals in the N.H.S. were to find that their own careers were affected by the report. Those working in community settings were affected when parallel arrangements were introduced some two years afterwards following the Mayston report (1968). The Department of Health accepted the Salmon recommendations and set up 'pilot schemes' to evaluate the structure in operation. Before this evaluation was completed wholesale implementation was forced on the government through the recommendations of the Pay Review Body. Pearl Trent considered that the speed of this implementation was one of the reasons why the Salmon recommendations were not as successful as they could have been:

But if you remember, the Government at the time, said you've got to Salmonise the lot and they Salmonised the lot

RJR: PIB 60 “

Pearl: Exactly (30.13).

Carol Bury referred to the lack of understanding of the underlying principles expressed in the report as another factor which was considered to be important in the perceived 'failure' of the Salmon structure:

because the Salmon Management Structure was implemented in a way which showed no real imagination, no real appreciation of the basic principles. Which, if the principles had been accepted and they had been applied intelligently, related to different situations, then I think Salmon was a very good thing, but it was applied by people who didn't understand it, in a totally unintelligent way, and so you got massive structures, you know, management structures mushrooming all over the place, because people felt that every grade which was mentioned by Salmon had to be introduced into every situation. (10.8).

Janet Ightson also commented on the inclusion of grades and numbers in the titles of nurse managers:

I mean the Salmon report could have been implemented in quite a different way, but nurses in my view are obsessed with structure and numbers and

things like this and that quite honestly wrecked the Salmon implementation [.....] I don't know whether it was the Salmon report that, - well, no it wasn't the Salmon report I don't think you can blame the Salmon report but the way people interpreted the Salmon report somehow gave people the notion that you've got have this hierarchical management structure to get anything done. (12.32/33).

On the other hand Marlene Adnam was positive that the Salmon report had given nurse managers the opportunity to be heard at policy making levels:

And I saw the Salmon report as a structure where the nurses would have a voice. And in my experience it took time, but we did, we did have a voice. (41.10).

However Walter Mant considered that the structure had interfered with the effectiveness of the service he was able to give, and with his job satisfaction:

I many times worked 7 days and into the next week sort of thing 'cause it was enjoyable, the job was enjoyable, before Salmon. Before it was over organised. (4.11).

On the one hand many of the respondents indicated that the Salmon report had provided both personal and professional opportunities for advancement for them and for nursing as a whole. One of the major benefits was seen to stem from the report's recommendation that nurses should be provided the opportunities for management preparation at all levels. Whilst on the other hand Pearl Trent was somewhat sceptical about and cynical of the benefits of these management courses:

I think they were managing by the seat of their pants, and many of them doing it quite well [...] Just imposed upon by a lot of jumped up people that were doing very nicely out of running management courses. (30.16).

Millicent Wood seemed to share Pearl's cynicism and declined to undertake management training, she was very clear about the detrimental effect that the report had on the nursing profession:

I didn't do a course, because I felt, and this may be considered quite arrogant, but there were aspects of the Salmon report that I strongly opposed.

I thought that this was the beginning of the end of the profession. I saw it as the beginning of the end of our really supreme position, and I thought that the interpretation of Salmon was very unfortunate. There was nothing wrong with Salmon, his principles were extremely sound, but the way many in the top of the nursing profession interpreted it was. (38.11).

It is interesting to note that the concerns about the position of the Matron which were referred to at the beginning of this Chapter do not appear to have been shared by all. Millicent obviously considered the role of Matron as much more satisfying than some of the other respondents. She was Matron of a Teaching Hospital for 20 years which perhaps helps to explain her satisfaction with the role. Carpenter (1977) claims that the Salmon report was implemented because of an unwritten assumption that women could not be 'real' managers. As a consequence of this view there was a rise in the number of male nurse managers 'drawn from psychiatric and mental handicap nursing' (Jones, 1994:471), as was shown in the previous chapter (Sections 5.6. and 5.8.) there were tensions arising regarding the qualifications of nurses from these segments of the profession. Pearl Trent commented on this phenomenon:

Then the green baize doors were opened and a lot of people, a lot of the gentlemen who were looking after the psychiatric side, and of course they couldn't get promotion there, went through the green baize doors and took over the lot

RJR: What's the green baize doors?

Pearl: The green baize door. The green baize door is the door that separates the male side from the female

RJR: Oh right, yes of course

Pearl: of the mental hospital. (30.25).

Although there was some cynicism about the structures implemented as part of the Salmon report it did give nurse managers a voice at every level of management within the NHS. The scepticism that some of the nurse leaders in this sample showed was directed at the speed of implementation; the 'numbers' attached to the nursing roles; the management courses introduced; and the advent of men into senior nursing positions in general hospitals. Concomitant with this change came a reduction in the influence of the Matron. Jones (1994) comments that the Salmon

report:

introduced a managerial model into nursing, and the power of the matron was broken. The all female hierarchy of the hospital was undermined by the incorporation of management structures drawn from industry and the definition of posts in functional terms.

(Jones, 1994:471)

This transition, from administration to management, was one which caused comment from some of the older of those sampled. The imposition of the tenets of managerialism were not universally welcomed by the respondents in this survey:

RJR: So the night sister post would you say that was your first management post?

Elizabeth Hamkin: Well I suppose so except that we never used such a word. (3.4).

Janet Ightson, unhappy with the term management, described administration as a very different activity:

she was the best administrator of a School of Nursing and I don't mean manager. It's a different kind of process. (12.7).

Jacqueline Adams refers to what she saw as the fundamental problem with the term management:

what we then called in an old fashioned way an administrative role.

RJR: Right. Did you see a difference between administration and management.

Jacqueline: We did, yes. Um, mind you in the early days management as a term had barely been heard, but we regarded administration as, as more important, in that it had also caring in its derivation as, as administration.

RJR: Right.

Jacqueline: Um it had also a, a caring, persuading role rather than a 'bossing about' role. (36.6).

Jacqueline seems to have captured the nub of the problem from the perspective of some of the nurse leaders of the time with regard to the environment in which nurse

leaders and managers were working. She refers to the etymology of the word administrator and its links with the concept of ministering. This she connects with the caring nature of nursing. As Chapter 4 showed some of the nurses interviewed held strong values regarding care and caring with which managerialism, with its connotations of a hard scientific approach, was at odds. There were other nurse leaders though who embraced 'scientific' nursing and 'scientific' management as ways of enhancing nursing's claims as a profession, this served to increase tensions between nursing leaders. It seems that the tensions between the values of some nurses and those of managers to which others have referred in earlier Chapters, for instance Georgina Shaw in Chapter 4, and the dichotomy between measurable outcomes and the 'invisible' acts of caring may in part be attributed to change in nursing leadership roles and structures consequent upon the Salmon report and not to some failing in nursing leaders themselves. From the evidence presented here what Rafferty (1993b) refers to as the 'inimical' values between the business culture and those of nurse leaders may well have been operating as early as the 1960's.

However it is interesting to note therefore that some of those interviewed laid the blame for the derision with which the Salmon report was viewed squarely on their colleagues in nursing administration. It seems that in the eyes of their colleagues their lack of understanding of the Salmon report rather than abhorrence of the underlying tenets of management on the part of some nurse leaders were to blame for the ills which beset the nursing profession following the implementation of the report. Many attributed the 'failure' of the system to nurses and particularly to nurse leaders. As the extracts have shown some referred to the leaders of the profession as 'unintelligent' and having 'no real imagination, no real appreciation of the basic principles'. Others commented that nurse leaders were 'obsessed with structure and numbers' and that 'massive management structures mushroomed' because the leaders of the time considered that 'every grade which was mentioned by Salmon had to be introduced into every situation'. This was attributed to the fact that nurses had 'the notion that you've got to have this hierarchical management structure to get anything done'. Millicent Wood, who was by then herself in a senior position, sums up the approbation of some of the leaders of the profession for their peers and colleagues:

they flung off their uniforms overnight, they disappeared overnight and they left a vacuum for leadership at the hospital level. And suddenly they were detached.(38.11).

Whilst critical of their colleagues some of the censure of the Salmon report was laid at the door of the then Labour government in an oblique way with the references to the abandonment of the pilot schemes following on from the report of the National Board for Prices and Incomes (1968). What seemed important to some was that somehow the caring aspect of the nurse leaders role was jeopardised. Several refused to accept that management was a term which could or should be applied to nursing leadership. The term administration was preferred as it was considered to have more caring and enabling connotations. Janet Ightson described it thus:

I am not into this management business, I'm into this administration business, which is an enabling process, it's a very old fashioned concept.(12.7)

Thus the Salmon report was derided by some of the then nurse leaders who were by their own admission 'managing by the seat of their pants' (Trent (interviewee 30), 1994). Carpenter sums up the rationale for and effects of Salmon on nursing leadership:

the desire of the elite elements to restore some of their lost influence and increase the status of nursing as an occupation, coincided with the state's desire for greater efficiency in the use of labour. It was necessary, however for the elite to engage in a thorough self-criticism of their traditions.....The Salmon report was an implicit critique of female authority and as such is sexist. Female nurses are viewed almost as inherently unable to exercise administrative skills.

(1977:176/180)

Thus the 'professionalising' aims of some of nursing's leaders was seen to have occurred at a time when government was pursuing its own aims with regard to the nursing labour force. Carpenter's argument that nursing issues only interested policy makers when the two agendas coincide is one which Rafferty (1992b) was to repeat:

Where changes deriving from an agenda set by nurses appears to have been successful this can usually be traced to a synchronisation with wider organisational and governmental concerns.

(Rafferty, 1992:82)

There are obvious tensions here for nurse leaders who, on the one hand, are trying to pursue objectives in keeping with their own values but on the other hand realising that in order to get the necessary mandate for change from the government and/or from managers and doctors that they will have to compromise those values. Carpenter's final point is also important and very much at odds with the opinions of later authorities who consider that much of the administration of the hospital, the organising, controlling and recording functions, had been carried out by matrons, almost in an unnoticed way (Davies and Rosser, 1986; Ackroyd, 1995). Loss of these functions led to a further source of tension for many nurse leaders for, as Ackroyd (1995) comments, as the administrative functions which nurses had carried out were transferred to administrators the co-ordinating and recording functions turned into a means of control, particularly financial control. Thus the management structures of the NHS which followed the implementation of the Salmon report continued to demand increased efficiency in controlling expenditure. Finance and budgetary control began to be increasingly referred to by the respondents in this study. With regard to financial aspects it was usually to talk about the lack of preparation they had for this role, as Vivian Stevens shows:

I think one of the things that emerged as a role some time at this time was budget holding, for which there was no preparation, I'm totally innumerate, as you know. (24.9)

Agnes Long confirmed the view that there was little preparation for this aspect of the role:

RJR: What about things like budgets? I mean that was one of the things I found that I hadn't been prepared for, and you needed to learn very quickly, on the job.

Agnes: Yes you did. It was never my forte (laughter). (20.9)

Serena Crooks recalled the effects of the implementation of the report on the matrons and some of the senior staff in the hospitals:

the problems we were having in those days of two hospitals. [.....] it was a question of we were about to start building, how do you bring two hospitals together, what kind of structures, you know, the thing that you're faced with. So I did have two died in the wood Matrons

RJR: Still in post?

Serena: Yes, they were but of course within six months of my being there I had to start moving into the new structure and we had all the trauma of the applying for interviews, etc. etc. Yes, one retired quite soon. The other one on the surface was with it and underneath wasn't. And that caused more difficulty I think. And we had some real deadwood among the so called Assistant Matrons and Departmental Sisters. I think Salmon may not have had such a bad reputation if it had really been able to choose and prepare the people properly. But there wasn't a hope, because you had these people and they had to be answerable, there was no way you could do anything else and, you know, they did take to their clipboards and wander round apparently not doing anything. [....] I suppose I didn't find it so peculiar myself because I wasn't used to being a Matron, but it took a lot of persuading of the Matrons to stop doing rounds, that sort of thing, for the Ward Sisters to relate to the Departmental Sisters

RJR: Yes, because it was seen to be a layer that was coming sort of between

Serena: Yes, and yet they'd always been there. They'd been there as Assistant Matrons with no authority. (40.25)

Serena highlights some of the problems for the nurse leaders at the time of the implementation of the Salmon report. The attitudes and practices of the matrons, and the senior nurses below them in the hierarchy were not in keeping with the structure and philosophies of the Salmon report and, because the report was implemented precipitately, there was little or no preparation for the nurse leaders to assume different roles and change their practices. Some of the matrons and their deputies and assistants chose to retire at this time or were 'weeded out' during the rounds of interviews which took place when the 1974 reorganisation was introduced⁴⁶. By the time of the next re-organisation, in 1974, forty-nine of the sample of nurse leaders interviewed were still working in nursing and a further two retired during that year. By now the majority were in the latter stages of their careers and all but three (Julia Menton, who entered nursing in 1958, and Charlotte Holmes and Janice Williams, who both started training in 1955) had been in the profession for

⁴⁶ It should be remembered that many hospitals did not introduce the Salmon structures until 1972 or 1973. Some of my respondents recalled instances of nursing structures in hospitals moving directly from the 1948 lines of authority to the 1974 structure.

over twenty years. The 1974 reorganisation was therefore to have a profound effect on the careers of the majority as the following extracts will show.

6.4. The 1974 re-organisation.

The 1974 re-organisation introduced new tiers of management, the Regional and Area Health Authorities, with responsibility for planning and development of services. At the point of delivery of the service larger groupings of hospital and community services formed into Health Districts. Thus there were three tiers of health service management below the Department of Health and Social Security (D.H.S.S.). When asked about the effects of the 1974 re-organisation on nursing most of those interviewed actually talked of the effects on nurses. In particular the way in which appointments were made to the new posts. The reorganisation of 1974 gave some of them opportunities for career enhancement with moves up the hierarchy. The structure following the implementation of the Salmon Report had prepared some nurses for the 1974 reorganisation but, as Carol Bury recalled, all those in senior management roles did not go on to higher positions:

of course that caused a great deal of turmoil again because it meant that people who thought they had got themselves established very nicely at Chief Nursing Officer level were applying for what they regarded as their jobs again and of course there were less jobs because of the new structure. (10.15).

For the less fortunate nursing leaders this reorganisation caused an unprecedented furore in the nursing and national press as senior people were passed over and saw their career prospects declining. Watkin asserts that the 1974 re-organisation was 'an upheaval that many senior officers, nurses, administrators and doctors had found the most painful of their professional careers' (1982:58), this led to further tensions between nurse leader colleagues, as Maria Palmer recalled:

the 1974 reorganisation [...] there were a lot of casualties along the way where those in senior appointments were encouraged to apply for five Areas and two Regions. [...] So I was appointed, and for the four years that I spent in that post I had my former boss as my subordinate [...] it was an uncomfortable period.[...] I became very aware of casualties because the Regional Nursing Officers that had been appointed were then used as assessors for all the Area posts throughout the country. And there were people that I saw at least nine times. People who had had important roles, and seemed to

me to have been doing them adequately, but were doing this round, rather like my subordinate. Nobody had told them that perhaps there were better people out there. (47.9/10).

Few of those interviewed had been casualties of the 1974 reorganisation but for many the issue of whether or not they should wear uniform appeared symbolic of the transition that they were making from one form of management to another. Julian Burns, who made the transition from nursing education to nursing service leadership with the introduction of the 1974 structure, considered that uniform was a symbol of the old hierarchical and authoritarian style of management from which he considered nursing education leaders had moved away. In the following extract he raises some of the tensions in nursing leadership between the different segments which were prevalent at the time of the 1974 reorganisation:

I had no preconceived idea about, you know, who the Head Nurse should be. I think as an educator de facto you tend to be less hierachial. I've always found this in education. It was very much a collegial relationship, and I think that was probably the best preparation, actually when I went to Bulstrood⁴⁷ I felt that it was because I wasn't a threat to anyone, the people were there, those Heads of the Nursing Services were thinking, oh well he's going to do us no harm because he hasn't a clue, you know. People in the community were particularly delighted because I wasn't a Hospital Manager going along (23.34)

He reflected on the effect that changes in the management structure of the NHS had on some senior nurses and uses the issue of wearing uniform to illustrate some of the ways in which nurses responded to and coped with these changes:

And you know there were a number of hospitals being brought in that had been part of other organisations and (pause) in fact there was one Senior Nursing Officer I think who had been taken over about three times. She was nearly at the end of her tether [.....] Now this woman was in her mid fifties, been taken over about three times and really when I went to see her she'd actually got out of her uniform, she said because she said "I've heard that the Cheriton Hospital⁴⁸ don't wear uniform" [...] she made it quite clear that she was just seeing this as a tide over to a pension. But when I was talking to her I realised she'd been in that hospital so many years that she had actually great qualities, of leadership and management skills [...] and a few years later when we had a farewell dinner for her she said to me, she

47 He had previously been a Principal Tutor and had been appointed as District Nursing Officer in the rounds of interviews which had taken place at the time of the introduction of the 1974 structures.

48 The hospital that he had been working in prior to his appointment.

said "do you know, when I saw you in 1974 I never dreamt I'd say this that the last few years have been the happiest of all my life" and you know as an educator you do tend to, well I don't know whether all Nursing Managers were hierarchy but I was always looking for, you know, what can we do to develop this person (23.34).

one of the first things I did in Bulstrood was to look at the Nursing Officer post, and the people in them, and of course there had been a lot of slotting in⁴⁹. They were all wearing navy blue Matron's uniforms with frilly hats, and so the system I devised was a system of Nursing Officers where they would be clinical [.....] so I devised areas that were clinical, and got them out of these navy blue matrons uniforms into clinical uniforms, and insisted that whoever appointed had the appropriate clinical background and experience. Again, getting them out of the uniform, sociology was useful there, because I always remembered Asylums. I don't know whether you know Goffman's Asylums, but the role stripping, when the monks go to the Benedictine Monastery and the clothes are taken off them. It's the same with the uniform there. Getting them out of these (23.34)

Another of those interviewed who had made the transition from working in nursing education and a professional organisation into nursing service management at the time of the 1974 reorganisation also reflected on the issue of whether or not a nurse manager should wear uniform. Again she contemplates the possible effects of her 'non traditional' preparation for management had on the way in which she perceived her Chief Nursing Officer role:

So I don't know that I was quite sure what to expect, except that I had absolutely no preconceived ideas as working as a Matron or administration at all. And my background in management of course at the RCN, certainly, you know, it wasn't anything that would have prepared me. And neither really was Henley. Yes, it gave me lot of principles of management, but it wasn't in any way like the sort of top management that the Kings Fund were running and which were very much into the Health Service [.....] it was Matrons only in those days, it was females only wasn't it. So I really don't know quite what to expect, and I can remember one of the first questions from the Group Secretary was, "what would I expect to wear on duty?". I remember looking at him as if I thought he was a bit mad, and I said "I presume a suit or suitable dress, why? You wouldn't expect me to walk round with an army veil would you?" (laughter) There were two very, very Senior Nurses on the interview panel [.....] I think they looked a little startled (40.23)

⁴⁹ The practice of fitting people who had been in senior positions in the previous structure into equivalent posts in the new structure.

This extract from Serena's interview shows that one of the ways in which leading nurses were prepared for their roles in consensus management was to encourage attendance at multi-disciplinary management courses. The matrons had previously been prepared for their roles, if any preparation was given, at establishments which ran uni-professional (and uni-sex) courses. From the nurse managers perspective 'team' or 'consensus' management was seen as a positive move. Watkin claims:

it is easy to see the proposals as an attempt to recreate the golden age in which the matron and the hospital secretary managed the hospital in partnership, and everyone knew where to turn for decisions (1982:59).

Baggott makes a further positive assertion for the 1974 structure which: 'enabled the management team to consider a wide range of perspectives before arriving at a decision. Also, as the importance of securing agreement was emphasised, it was widely believed that the decisions made stood a greater chance of being accepted and implemented by all the staff' (Baggott, 1994:123). Many of the respondents in this study who had been members of consensus management teams during the 1970's commented positively about them, as Julian Burns recalled:

I'd enjoyed my job so much⁵⁰, not only as a nurse but also as part of the management team where you could actually monitor, innovate, criticise other services, challenge proposals for medical development and I really loved that consensus situation. We rotated as Chairman every six months so we really were co-equals - extraordinary experience. (23.21).

Marlene Adnam saw the period as equally constructive:

And when we had consensus management in the group of four, in the, ultimately, in the Chief Area Nursing Officer, there our voice was equal to that of the Secretary, the Treasurer and the Medical Superintendent. Now, I know some people argued that consensus management wasn't the best scheme, and I can see that I think, but nursing did have a voice. (41.10).

Superficially the 1974 reorganisation could be seen to have promoted team work between nursing service managers, administrators and doctors, but, as in Animal Farm, all parties to consensus were not equal. The greatest power still lay with the consultant (Strong and Robinson, 1990). From the nursing service managers viewpoint the 1974 reorganisation was considered in a positive light if one had been

appointed to a new post within the structure but negatively if one had been a casualty of the rounds of interviews. Some nurse education managers viewed the changes positively as they gave them opportunities to begin to manage in their own sphere of responsibility. In creating the new schools of nursing based on a single District Health Authority, or based on and Area Health Authority, they were faced with inter-professional conflicts. Barbara Pearson recalled some of the problems that she confronted her:

but it was very difficult you see and at that time, it was all very well saying well we've got an Area Director of Nurse Education, but there were two Health Authorities, there were two District Nursing Officers, and again they were very different, and it was a fairly difficult situation, there were very few, when I came along, there were very few Area staff you see, and the Districts resented them bitterly. I think eventually things eased, and eventually, as far as nurse education was concerned the staff saw that the way things were going, and also I think and hope they saw that all we were trying to do at Area level was to improve the working environment for them. (2.7/8.)

Richard Crapton had similar experiences:

RJR: So you formed the area school. Who were you accountable to?

Richard: The Area Nursing Officer

RJR: Ok. And what sort of line accountability and management?

Richard: It was extremely difficult, because there were two District Management teams. There were two District Nursing Officers. There was an Area Nursing Officer and two Area, whatever they were called, in the Area. Um, the District Nursing Officers were chalk and cheese. The Districts were run differently. [...] So the difficulty I found was that the GNC, although they accept us being involved in setting us up, didn't recognise the Area schools existed

RJR: Oh, that's interesting. I hadn't realised that

Richard: They persisted in dealing with Districts

RJR: Oh, how interesting

Richard: So the examination results at first would go to the Districts [...] they didn't even go to the Area Nursing Officer to whom I was accountable. So there was a lot of correspondence with the GNC about that, and they couldn't understand what I was getting at. [...] The RNTC⁵¹ had some

difficulty in doing this too because they were giving it to Districts. So I had to get the budgets from the Districts put together, which was of an advantage, because you just collected whatever had been given to the Districts, and eventually I got them made out to an Area budget. [.....] There were two Finance Officers and I had a terrible job getting the finance away from the District. [.....] I had to manipulate and manoeuvre to get the money out of the others. So eventually I got the budgets taken away from the District

RJR: Right, this was the student salary budgets?

Richard: The student salary budgets [.....] and the non R.N.T.C. monies. So I got them put to the Area and that gave me flexibility in that I could get the money from the Area, rather than from District, and still get bits from the District, you know what I mean

RJR: Yes, yes. Creative accounting [chuckle]

Richard: That's right, fiddling. (48.14).

As well as being responsible for providing education over a larger and more diverse sphere these nurse education managers were accountable to more than one District Nursing Officer. The difficulties that this transition posed for nursing education leaders was graphically described by two respondents. Barbara Pearson talked of the problems which she encountered with the deposed Principal Tutors who had been the leaders of the six small schools of nursing which had been amalgamated into one Area school:

Barbara: Gables and Bowmans was the hardest job I had in my whole career [....]

RJR: Do you mind sharing with me why that was, some of the factors involved in that?

Barbara: Well the thing I suppose that I'd had 11 years at Chumleys which was a teaching hospital group, in a senior post working with people who saw the need for a nurse education, who saw the need for libraries, who saw the need for staff development, who saw the need for the right people in the right jobs in the right environment and creating a, we had a smashing time at Chumleys and I think we really did, all of us, achieve something [.....] Gables and Bowmans was almost a culture shock. Elspeth Wright ⁵² asked me to, they wanted an Area Director of Nurse Education, they had at that time about six Principal Tutors scattered in all these places [.....] Up to

⁵² Another of the respondents to this study.

a point a hostile staff at senior level, not entirely, I don't mean nursing administration, I'm talking about the colleagues with whom, most of whom hadn't got the job for which they had applied, which was the one that I'd got, and it was very, very difficult indeed. [...] Of course Elm⁵³ left to get a senior post, I think he'd gone by the time I came, the one at the Brigstock retired fairly soon, the one at Bowmans, we became eventually, very good friends and worked well together, I can't remember what happened in the other places but we did get over it, but it was a very difficult time. (3.6/7)

Barbara reflected here on difficulties experienced by other Area Directors of Nurse Education who had to bring together two or three schools and try to rationalise resources and services and to manage this through the deposed previous senior managers. Thus the tensions within nursing leadership were not confined to inter-segment difficulties, they also existed between colleagues within the same segment, in this case within nursing education itself. Richard Crapton talked of how he coped with the hostility from within the ranks of his senior staff as he attempted to form one school from the previous three:

Richard: So I had to bring it together

RJR: centralise that. Had any of the three applied for, had they been part of the unsuccessful....

Richard: Yes, they'd all applied

RJR: Right. And how did you find that situation?

Richard: I found it very difficult. Um, the one in psychiatry went soon afterwards. And he was pleasant enough. I mean he wouldn't just accept that that's what had happened.[...] The other one was a bit, not quite as good as she might have been. Realising she was out of her depth.[...] but was pretty nasty in the process. The third one had been there for a very long time and was quite well known and had a lot of loyalty throughout the place. And she was really nasty. I mean she was undermining you

RJR: Right. So, putting people against, up against you and things like that?

Richard: So the only thing I could do with her was, eventually I appointed her as the Assistant Director [...] and then made her come into my camp, so that she had to then be seen as part of the policy making. She couldn't be outside the post so she then had to come down, and she in fact retired after about three years. And I resolved the difficult situation by doing nothing. (48.15/16).

⁵³ Also one of those interviewed in this study.

So, whilst the 1974 re-organisation seems to have provided opportunities for nurses in both the service and education segments to consider their contribution to the management of the health service affirmatively the process proved conflictual and, as these previous examples have shown, intra-professional tension was rife. Inter-professional tensions also arose for although consensus management gave nursing service leaders a voice in decision making flaws in the 1974 service soon began to appear. The negative aspects of consensus were considered to be the absence of clear lines of management responsibility, with delays in decision making and the avoidance of making tough decisions and the blurring of responsibility (Baggott, 1994; Hancock, 1984). It has been suggested that the Salmon and 1974 changes in the NHS and the effects on nursing can be understood as:

the decisive steps from the viewpoint of nursing were taken in the 1960's. Instead of merely holding tight the purse strings, the state sought to evolve new structures of management and work organisation that could achieve economies in the use of resources.

(Bellaby and Oribabor, 1980:167).

These structures were to increase conflict and tension for, as well as the budgetary controls, ways of estimating and controlling manpower were becoming important, as this example from Serena Crooks shows:

the Ward Sisters made their rotas as they wanted them and then they had gaps here and there, and there was no suggestion of, you know, organising the day offs or the holidays in a reasonable rota, people had what they wanted, and there was no question if you were desperately short, you know, could somebody change. And they just themselves used to ring up the agencies and bring in nurses. It was the first thing that startled me, because the cost of it you could imagine. The second thing was, these two hospitals were three miles apart and, again, the Ward Sisters used to order taxis to take them back and forth and at night as well. And even, I remember we had someone that lived not very far from here and they used to take the record, it was a Kardex system box, it wasn't very big, and they used to have taxis to take themselves down [....]. And the amount of money; the waste of money on that sort of thing, you know, really quite startled me. (40.25)

And of course there was no incentive to do anything else because the nursing budget was put out at the beginning of the year according to your

establishment. Because you never met your establishment you, you know, money was lashing round and then at the end of the year everybody else used to use what was left [...] I do remember in the early days, the two Matrons⁵⁴ worrying about their establishments, and they would come up and say to me, "Now look, I've got another post, so will you put that into my establishment, it must go up from, you know, 609 to 610." I used to say "Well, it doesn't really matter, we're not working from establishment any more, you're working from a budget" (40.27).

Serena was critical of her predecessors and it certainly seems that whilst the new twin 'gods' of economy and efficiency took some nurse leaders by surprise others supported them, as Phillipa Simmons recalled:

they put in this thing called the Planning Cycle. Does that ring any bells with you?

RJR: Yes, mm. It came in with the '74 reorganisation didn't it

Phillipa: It did, yes, that's right [...] there was a 'figure of eight' and I have to tell you - perhaps it's nostalgia - but I thought it was excellent, if only it had been allowed to continue. It meant that [...] there'd be a group, and there would be administrator, doctor, nurse, social worker within that group, more than one, and administrative support. And from their expertise, or from their contacts with people in the field, they would decide which was the way that they thought that that service should go, taking in terms the projected population, you know things like that. Well, then they would produce a suggested policy document which would go out for consultation and the Regions would consult on it. And then there would be a presentation to the top of the office within, perhaps we'd include Ministers to say this is the way we think this particular service should go to meet the needs of the country in the next X number of years

RJR: Right

Phillipa: And then [...] if it was generally agreed and there would be a question, then it would be costed, and it would be decided whether the allocation would meet those things or not. And then it would go out as an edict. This was the policy for that group and that's the way the Health Service, the Regions and the Districts would try to do their planning. And then they would feed in their proposals and they'd be looked at in the light of these things, and modified. And that's the figure of eight thing, which I thought the concept was very good

RJR: Yes. I mean it's rational and logical

⁵⁴ Her Chief Nursing Officer post encompassed two hospitals which had retained their matrons and had not fully moved into the Salmon structure.

Phillipa: Well it is for a country of this size

RJR: I wonder if one of the major problems was that it had to go through so many layers. (50.37).

As was shown in the previous section some nurse leaders were 'pro' Salmon and were condemnatory of their nurse leader colleagues, blaming them for the subordinate position in which nursing leadership found itself. Others though were critical of the way in which nursing leaders interpreted the philosophies and structure of the Salmon report. The picture was similar with the 1974 reorganisation, again the 'new' nurse manager was critical of her predecessors lack of control of the resources. However the 'new' nurse manager was no more successful in controlling the escalating costs of the NHS and, as Baggott comments, 'by the late 1970's the situation was becoming so serious that even the considerable achievements of the N.H.S. appeared to be under threat' (1994:85). As the problem worsened the then Labour Government set up a Royal Commission in 1976 to 'consider the best use and management of financial and manpower resources of the N.H.S.' (Cmnd 7615, 1979:1). By the time the Commission reported the Labour government had been replaced by a Conservative government, under the leadership of Mrs. Margaret Thatcher. Some of the Report's recommendations, particularly the recommendation to abolish the Area Health Authorities, were accepted by the new government and in December 1979 the proposals for a restructured N.H.S. were published (Patients First, 1979). Whatever gains nurse leaders considered had been made through their inclusion in and involvement with corporate decision making since 1974 were to be short-lived in the subsequent reforms.

6.5. The 1982 restructuring and the Griffiths Report (1983).

The 1982 restructuring devolved decision making regarding the delivery of health care services to units of management with one unit administrator, one director of nursing services and one doctor as the core members of the management team. The development of units of management were seen as an opportunity to involve clinical nurses in decision making and thereby narrow the gap between the unit team and the medical staff (Hancock, 1984). There were therefore several Unit Management Teams reporting to a District Management Team, one of the core members of which

was the District Nursing Officer. Nurse education provision within the District was the responsibility of the Director of Nurse Education who reported directly to the District Nursing Officer.

The 1982 structure had the potential for conflict and tension between the layers of nurse leaders, the focus and loyalty of most Directors of Nursing Service was to their Unit rather than to the District as a whole. From personal experience there were frequent clashes with each other and with the District Nursing Officer over which part of the service should get the biggest slice of the budgetary cake. The focus of attention in these debates was often turned on the Director of Nurse Education whose budget for nurse learners was usually underspent, due to under recruitment and wastage of students, the Directors of Nursing Service saw this surplus as a convenient way to bail out their usually overspent nursing manpower budgets or as a way of funding developments in the service. Frequently the District Management Team, in the form of the District Nursing Officer, had other plans for the education 'pot of gold' (Moores, 1979; Bendall, 1984; Holder, 1984). Thus nurse education in a District was often the source of heated debate for what some would consider to be the wrong reasons. For those Directors of Nurse Education whose School spanned more than one District this could prove a source of increased difficulty in trying to reconcile differences between the two, alternatively it could be seen as a source of new independence from nursing service management control. As Richard Crapton had earlier explained the transition to the 1974 structure had enabled him to gain control of the school's finances and to created a structure which enabled him to move away from direct nursing service management control. When the Area Health Authorities were dis-established the Area Director of Nurse Education was left in a vacuum as far as direct accountability was concerned:

I had the budgets set. Money is power. And I had that there together. And because I had it there, I was left. So

RJR: Right. So they weren't too worried about interfering

Richard: They weren't worried at all. The person who was appointed as the

DNO⁵⁵ left me to do what I liked

RJR: Right

Richard: and didn't interfere at all. I mean I saw him occasionally but he wasn't really bothered about what went on. I could do what I liked really and I knew the people who were appointed to the other posts and I related very well to them. And then I had an education committee, which was chaired by a member of the Authority. So I had an 'in' to the Authority and that worked quite well. (48.19)

Although earlier Richard had indicated a lack of political acumen some of his examples of the ways in which he coped with his role show skills in this area. Before the 1982 restructuring came fully into place the Griffiths Inquiry was commissioned, in late 1981, to look at the management arrangements in the N.H.S. in England. Consensus management was replaced by general management following the recommendations of the Griffiths Report (1983) and the director of nursing's line management role in respect of nurses and nursing was removed. The development of nursing leadership in the years between the Second World War and the Griffiths Report were summarised by Mimi Gold:

Well, I think what is very interesting is the fact that in a way nurse leadership came into its own with the Second World War, because it had to, and also nurses were able to prove themselves in all sorts of ways. People going out into the sectors, people in the armed forces doing all sorts of things that they'd never done before. You know, no such thing as the extended role of the nurse. And after, then it was a sort of slow climb after the war. The peak came really with Salmon, you know, here at last you had got nurses and the voice of nursing through to all the corridors of power. After the war we got them into the Ministries, we got them into the Department and so forth, but they lost out in the management committees, because as you know

RJR: They didn't have to be there necessarily

Mimi: But at last, at last, we got nursing voices through all the corridors of power. (34.18).

The respondents in this study expressed a range of views about the successive reorganisations and restrukturings of the health service between 1948 and 1983. As has been shown there were both positive and negative reactions from past nursing

⁵⁵ When the Area Health Authority was disbanded it was usual practice for one of the District Nursing Officers which the Area School encompassed to be nominated to take the lead with regard to nursing education. As long as there was no conflict of interest between the Districts, nor between the District Nursing Officers, this system could work. However in practice it often led to one or more of the Districts, depending on the number of Districts covered by the school of nursing, being somewhat overshadowed by the dominant District. This posed further tensions and conflicts for nursing service and nursing education leaders at a local level.

leaders to the Salmon and 1974 reforms, however the implementation of the Griffiths report, which did away with consensus management and introduced the tenets of business management to the N.H.S., was generally greeted by them with dismay. Many, if they were still in employment (by the end of 1982 only fifteen of the sample had retired), decided to 'opt out' of the N.H.S., either through retirement or moving jobs, often out of the N.H.S. altogether, and six more retired during 1983. As the Griffiths report led to a diminution in the exercise of direct nursing management the R.C.N. and the Trades Union which represented health service workers, the nursing and national press lobby and pressure groups were enlisted to put the case that a representative of the profession with the most numerous employees in the service should have a say in strategic decision making. Serena Crooks indicated that the conflict was the precipitating factor in her decision to leave the NHS:

we had great confrontation with Griffiths, we really did

RJR: Yes

Serena: nonstop practically, and with the Department at the time, and it was at that point of time that I really felt it was getting quite untenable to be Chief Officer in authority and really having so much confrontation with the Department and so on. [...] So that was when I parted from the NHS. (40.29).

Marcia Hughes commented on the distraction from their purpose that this conflict posed for nursing leaders:

events overtook all of us in terms of the [...] Griffiths reviews [...] it was a great hold on the time that you would have liked to have spent on other things. That took up an inordinate amount of time in a way defending the nursing position [...] the changes I think in the system itself meant that the Chief Area Nursing Officers were being faced with so much other change, you know that they were defending positions and fighting so hard that there were an awful lot of lost opportunities I felt that we could have had (18.12/13)

Esther Hurst commented on the change from line management to advisory roles for nurse managers which was one of the effects of the Griffiths Report:

it was going from consensus wasn't it, going to executive, yes. I think one of

the changes we found, the tendency in the end for nursing to become more of an advisory role, rather than having nurses in executive positions. We were talking about the 'service side', I think that, in many ways, was a detriment to the nursing service. I'm not saying that nurses and nursing should only be managed by nurses, I don't necessarily mean that, or that the nurses should only manage that, I think that they should manage other things as well. But, in a funny sort of way, I think that the lack of influential nurses at executive level has certainly made a difference to how nursing is being viewed. (7.21).

Esther highlights some of the effects that the change from consensus management to general management had on nursing service managers. The previous Chief Nursing Officers at District level in England (Chief Area Nursing Officers in Scotland) lost their automatic place on the District Management Board as the new District General Managers created their own management structures. Some Districts retained nurses on the Board but with roles which combined one or more additional responsibilities, for example personnel, training, education, or quality (Baggott, 1994). Sylvia Pole was concerned at the loss of nursing input to the management of the service:

I think that's a sadness because the sad thing I think currently about many aspects of the Health Service is that a nursing voice at the top of, at the top levels is missing [...] I feel very strongly that we've lost out a lot really since the C.N.O. position went. It may have been necessary that it went, for good reason, but it hasn't been replaced somehow by a really effective professional nursing advisory machinery. (6.18).

Serena Crooks was one of the respondents who blamed the nursing profession itself for the position in which nursing management found itself:

The problems that we had with Roy Griffiths in person and Margaret Thatcher⁵⁶, and one or two more, we were trying to get the position of the nurse clear but I think that our own performance over the years before it didn't help, and indeed, in situations where the nurse had kept the position. If they didn't perform well, they started to go down rapidly, and I think of course it was from that point when general management came in that I think we began to lose out very badly. It was largely our own fault. (40.16).

There were other nurse leaders who supported the Griffiths reforms:

56 The Prime Minister at the time of the introduction of the Griffiths report.

April Walshe: The introduction of general management came, I supported Sir Roy Griffiths' philosophies, but unfortunately they were misinterpreted, because he wasn't looking to see the demise of the nursing hierarchy any more than the medical hierarchy. He wanted people called to account but he also wanted a slicker management but that was a functional management really, rather than the total management. (27.10).

Janet Ightson: I had some sympathy for Griffiths when he said - well if you go into a hospital and ask who is running things the Florence Nightingale phrase [Laughter], but I don't know. (12.34).

The response of many of these leading nurses to the demise of nursing leadership following the Griffiths report is thus similar to that following the Salmon report: they blamed one another. Nurses have been characterised as having a tendency to 'bitching' (Mackay, 1989) or 'whinging' (Rule cited in Wright, 1993) and Davies (1992) refers to their proclivity to be seen as 'their own worst enemies'. Some of the respondents in this study certainly demonstrate some of these tendencies, many of those interviewed could not, or would not, consider the possibility that factors other than their own performance or other motivations were at play in the demise of nursing leadership. The role of government in this, particularly through the mainly male, non-nurse, political appointees to general management posts, was rarely alluded to. Although Sylvia Pole considered that there was a general move by government to reduce the power of professions:

I don't agree with the current attitude of doing down the professions, I don't agree that you can teach students in a primary school how to become a teacher, I think it is a very expert thing to teach, they can't learn without being there, but it is like a nurse you can't do without the professional input, can you, but it isn't an ethos in which experts are awfully well received. (6.18).

Or as Mimi Gold said more pointedly:

But the other attitude was of course was an anti-professional attitude which came in with Thatcher and I lay most of the blame on the Thatcher era

RJR: Yes, there seems to be almost a war on the professions

Mimi: War on the professions, well

RJR: de-professionalising education or whatever

Mimi: the BBC, the church, the doctors, the nurses, the lot, you know. We all came in the arc of her handbag [chuckle]. (34.18).

As has been shown the Griffiths reforms were seen by many as heralding the demise of nursing leadership (Bowman, 1986; Strong and Robinson, 1990). Clay (1987) comments that 'nurses were deemed monumentally unimportant - barely mentioned in the report itself except for a whimsical reference to Florence Nightingale', he sums up the effects on nursing management and leadership:

The arrival of general management..has hit the nursing profession for six. Nursing has invested a great deal over the years in training its managers for leadership positions, and a cadre of potential leaders was being built up. The advent of general management has set this back at least two decades.

(Clay, 1987:102)

The subsequent publication of Working for Patients (1989) which, in a similar fashion, failed to recognise nursing is adjudged by Davies (1995) to further demonstrate its 'insignificance'. The fact that nursing leadership had been treated in such cavalier fashion in successive restructuring of the NHS led to conflict between senior nurses and the government. These tensions were to escalate with the introduction of the NHS and Community Care Act (1990).

6.6. Working for Patients (1989), the N.H.S. and Community Care Act (1990) and beyond.

Following the implementation of this report and Act clinical directorates were developed with clinical and business managers having devolved responsibility for all services in the directorate. Janet Ightson commented that the introduction of general management was accompanied by a change in the relationships between nurses and administrators:

I mean in the Health Service administrators used to consider that their role was enabling nurses, doctors, physiotherapists or whatever it was to do their thing for patients. (12.32/33).

These organisational changes are seen by some as causing nurses great problems in

delivering the standard and quality of care to patients and clients that they see as essential (Davies, 1995). There is a recognition by those interviewed that nursing leaders are leaving the profession and that nursing currently appears to lack a voice in policy and decision making. Andrea Davies considers that the nurse leader needs to re-emerge:

The one thing that I am concerned about is the organisation of nursing within the total context of the NHS. And I think it's important that we see the re-emergence of nurses at policy making level and purchaser level. Because they're not in there determining quality. So I think we've got to somehow influence the input of nursing as it is today, within the current reforms. And certainly, my experience as a non-executive director on a Trust has taught me a lot about what isn't happening as far as nursing is concerned. (25.15).

This section of the chapter set out to examine the environment in which the nurses interviewed carried out their roles and to identify the effects of subsequent re-organisations, restructurings and reforms of the organisational structure of the N.H.S. on the roles and relationships of nurse managers generally. In particular the power and influence of matrons and of subsequent nurse managers has been examined through the eyes of those who were in these positions and tensions within and about nursing leadership have been noted.

So far this thesis has considered the characteristics of the individual nurse leaders, their roles and significant relationships, and the structure and organisation of the N.H.S. as factors which could be considered as possible causes of the tensions within the nursing leadership. As the literature review and subsequent Chapters have revealed one factor which is seen to have limited the development of nursing leaders is their early training and the organisation, content and delivery of pre-registration nursing education. As the literature review showed during the period studied there were also numerous views of nursing, what the nurse's role should be and how nursing should be practised. These multiple views of nursing and the knowledge base which nurse educators were called upon to transmit served as a further source of conflict between the service and education segments of the profession. Coupled with the many forms of professional values and ideals this caused increased tensions between nurse leaders. Current tensions in nursing leadership have been attributed

to the numerous views that exist with regard to what nursing is and who should carry it out. This multiplicity of views has led to confusion as to the purpose of pre-registration nursing education which was coupled with the economic difficulty of extricating student nurses as workers from the clinical practice of nursing. This Chapter continues with an analysis of this aspect of the environment in which the leaders studied worked.

6.7. Pre-registration nursing education 1948 to Project 2000.

One aspect regarding the preparation of student nurses which has been seen as a problem throughout this century is the requirement that learning should take place in a ward or other clinical environment. It seems that the ward was not and still is not an ideal place to learn to care. For those interviewed there were also tensions surrounding trying to learn to care but feeling uncared for. The apprenticeship system was seen as a particular problem from an educational viewpoint. Betty Deerman was concerned that the system did not help nurses to learn to care:

I do believe that the old apprenticeship system was very good when it was 'one man, one dog', but when it became 'one man' and about 12 'puppies' the apprenticeship system really wasn't satisfactory [.....] We really, I believe, that we should always consider total patient care, now you can't give total patient care if you are being used as a 'pair of hands' and cheap labour, which is what was going on for years, and extremely difficult to change. (5.6).

Rather than learning to care for patients some of those interviewed seem to have learned obedience within the nursing hierarchy, a factor which Carol Nyman referred to scathingly in the previous Chapter. Hardy (1983) made the point that the nursing hierarchy stifled professional growth and, as we saw earlier, there was a 'pecking order' of seniority which nurses learnt early in their training period. Nurses had to learn to carry out the orders given to them by their seniors, even if those seniors had only joined the hospital a few days or weeks before them. Elizabeth Hamkin recalled how students who showed initiative were soon taught to curb this behaviour:

in my first days of training, we went on duty at half past 7 and if we were off in the evening we came off at 7 o'clock. The ward sister she would never send

her many tailed bandages⁵⁷ and that to the laundry, they always had to be washed on the ward, and there was an occasion when it was coming time for me to go off, but the junior nurse did this washing, and the next girl, next to me, said, "you go off I'll wash your bandages", and so I went. Of course we'd long sleeves and cuffs, and to begin with you didn't go to sister's office except you'd got your cuffs on, so I went and got my cuffs on, went to sister's office, and said could I go off duty, so she said had I done all my work, and of course the raw recruit said, "well all except washing the bandages, but nurse so-and-so's going to do them for me". Oh, "and who's going to do nurse so-and-so's work whilst she's washing your bandages, go and wash your bandages nurse, and then you can go off duty". [...] So by half past 7 or so I went off duty, but of course I learnt, you learnt to keep your mouth shut. (3.16).

Similarly Lilian Johnson learnt to restrain her questioning nature:

I was at Langton Hospital as a student nurse and I was interested to find that some patients had pressure sores and others didn't and what surprised me was, not that some people got sores, but that some people didn't, because the bed linen in those days was heavily starched and we used to build houses with it for fun. You know it stood up on its own and it's surprising that not everybody got pressure sores. And I remember going to one of the Ward Sisters to ask her if she could give me an explanation. And her answer was "it's not your business to ask questions, your business is to deal with the sores, and if we knew the cause we wouldn't have any". And I was so indignant about this answer that I decided that if ever I could finish my nursing education, if I weren't thrown out before I finished, I would never, never discourage people from asking questions, because I think questioning is the most important thing we can do. (21.5).

As well as stifling curiosity the training period was not very intellectually challenging, as Jennifer Westley recalled:

I think after being at university⁵⁸, I settled back and thoroughly enjoyed it but didn't work terribly hard, because I found that things that I'd done at school in zoology and chemistry, and things I'd done at university, carried me through. [...] I didn't need to learn much in nursing, but I thoroughly enjoyed the social contact with other nurses. So I was a lazy student I think. (51.2).

Whereas Jennifer appears to have enjoyed her training period Sylvia Thomas's recollections of the lack of academic challenge and the exploitation of the training

⁵⁷ Large bandages usually made of flannelette which were used to secure abdominal dressings.
⁵⁸ She had started to do a degree but following a vocational call to do nursing had left university to train as a nurse.

period were less positive:

the training, it was dreadful, in my view. [...] I think it was just that it was blatantly obvious that we could have learned what it we were supposed to have learned, both academically and practically in eighteen months and we were doing a three year training to be cheap labour. (26.14).

Being used as inexpensive drudges, almost as a commodity to use and then 'throw away', filtered into the perceptions of many of their training period. The initial training period, particularly the experience of being treated 'badly', the lack of care they were shown and the devaluing of their intellect and individuality, was obviously an important formative factor in regard to their later careers. Many were involved in educational experiments, the Two plus One Scheme was the most often quoted and most highly regarded as having the potential to overcome some of the problems of pre-registration nurse education. However, none of these developments could do any more than tinker with a basically flawed model until the advent of the pre-registration course for student nurses, popularly termed Project 2000 (UKCC, 1986).

A core recommendation of the U.K.C.C's 'A New Preparation for Practice' (1986) was the introduction of 'supernumerary status' for the whole of the course (U.K.C.C., 1986:54). This was later reduced to 80% of the course by the Conservative government and the first 'Project 2000' schemes when introduced in 1989 allowed for supernumerary status for students for the first 2 and a half years of preparation. The student is counted as giving 'rostered service' for 1000 hours of the three year programme and to make up for the loss of the student nurse from service provision a new grade of health care support worker (later referred to as a health care assistant) was introduced.

As was described in the previous Chapter during their mid career period and when they moved into more influential positions many of those interviewed were instrumental in fighting for or against the legislative changes during the mid and late 1970's which culminated in the setting up of the U.K.C.C. and 4 National Boards. When the first Project 2000 courses started in 1989 one could claim that their dreams had been realised. However when interviewed some years later many were

concerned that the course was not providing what the profession, the service, or more importantly, the patient needs. Some of those interviewed had first hand knowledge of the course from their own or their friends' experiences as patients. There were many who were concerned that student nurses are not being taught caring values. Elizabeth Hamkin was concerned that the focus for care is on technology:

I recently visited a friend who was up on the medical ward at the Mimes Hospital, and she was telling me that they'd had a young girl on the ward for a fortnight who was starting her training, her fiancee had done his training and was going to go on to do the tutor course, and she thought she would like to be a nurse. But she said, "I'm already disillusioned", she'd had to spend, I've forgotten how long, up at St. Monks College learning how to work computers, and she was on that ward with no hands on the patient. (3.15).

Jennifer Westley had similar worries:

I meet people who have come away from Project 2000 courses disillusioned, [...] I think somehow you've got to enthuse the people coming in to nursing with the whole idea of caring, which is an unpopular word now isn't it? [.....]

RJR: I've just been reading Kathleen Raven's talk (Raven, 1995)

Jennifer: Oh yes, yes

RJR: she very much is saying, you know that the things that got the care were the computers and sphygmomanometers and the clipboards and things

Jennifer: She's got something there. (51.12).

Millicent Wood commented that the caring ethos seemed to have been lost in modern nursing and in nursing education:

And I was admitted to Hunter's Hospital⁵⁹, and student nurses, well forget, it, I hardly ever saw one, and when I did, they didn't do any hands on nursing, at all. They would have been fascinated if I'd got a psychological problem for them to sort out. I'll give you an instance, a little student nurse came in one day and, "how are you?". And I said "oh, a bit tired, I didn't sleep very well". "Oh", she said "were you depressed?" [...] I said "no, the light was too bright in the corridor outside". I also went on, you know, and said I was mighty uncomfortable. I'd only got one pillow, you know, soft pillows, and rubber mattress, and crumbs in the bed, but never once, I didn't see them very often, did anyone ask me if I was comfortable, or seek to make

⁵⁹ The Teaching Hospital in which she had been matron for 20 years.

me comfortable. They just appeared to be always writing notes. Their own histories they called it. I said "what are you going to do with all that writing?". "What do you mean, what do we do with it all?" And she said "we write it all down". She obviously had been told "now look, you've got to write it down", but banal questions, useless. Oh, what's all this about.[.....] So you've got a different animal. They are more questioning, without doubt".(38.12/13).

Nan March's recent experience of hospital care also left her with a sense of loss of the caring aspect of the nursing role:

there's very much less in the way of comforting the sick these days, um it seems so much more eh, eh a mechanised job [.....] what my generation say is there is no nursing care any longer, and this was certainly my experience. I broke my leg and then just this year, I fell over and banged my nose, I was in hospital eight days, which was quite a long time in this day and age.[...] What I found was I always had to ask for everything.[...] they don't come and ask you how you are.[...] on the whole you had to ask for things. They always came and there was no disagreeable anything about it [...] one does get this impression nowadays, they've got their job to do and eh the mechanics are there [...] and of course you couldn't help, having been a nurse yourself [...] to see what happened to 50 years of tender loving care (50.21).

The worries that they had about the student's, and other nurses, abilities to deliver care as they defined it, 'caring about' as well as 'caring for' (Graham, 1983) and performing some of the 'little things' (Smith, 1992), seem related particularly to the skill mix of nurses on the wards, as demonstrated through the lack of visibility of nurses on the ward. They were also concerned that the somewhat mechanistic and academic approaches that they and their friends had perceived diminished the caring content of the course.

The compromise which was reached regarding supernumerary status and the introduction of the health care assistant when Project 2000 was finally accepted by the Conservative government seems not to have proved an overwhelming success from a variety of points of view. Various authorities have researched the opinions of and effects of this on students, teachers, registered nurses, service providers and service and education commissioners (Jowett et al, 1992; Jowett et al, 1994; Hallett et al, 1993; Hallett et al, 1995; Elkan and Robinson, 1995). This present study of past nursing leaders adds to this body of research by adding the views of patients, relatives and friends, an informed 'lay' view, to use their terminology. One of the

main problems with the current 'skill mix' seems to centre on the formula used by the Department of Health when calculating the student service replacement factor. When this was first applied there were concerns at the small numbers of replacement staff identified and the paucity of the funding model. There is now a growing body of evidence that demonstrates the detrimental effects that this has had on staffing levels and on the practice of nursing, with registered nurses having to adopt 'task allocation' in their own practice as there are insufficient qualified staff available to deliver care (Elkan and Robinson, 1995).

A further area of difficulty is that 'Project 2000' was implemented at the same time as the NHS Reforms which created NHS Trusts and GP fundholders and introduced Working Paper 10 and the concept of commissioning of educational services. A sceptical view of the government's acceptance of most of the Project 2000 proposals is that they did so only to appease nurses, especially the nurse leaders, knowing that the changes that they were about to introduce would create a philosophy and structure which would destroy the concepts of Project 2000. In addition, simultaneously, the former colleges of nursing were being integrated into higher education establishments. This has caused a somewhat chaotic tangle of identifying which students belong to whom for the purpose of service delivery and a maze of funding flows to sort out. Some service providers find it difficult to allow students to perform rostered practice because of the possible risks of litigation and of not meeting their own performance criteria standards. Others count the cost of providing clinical placements to supernumerary students, which has resulted in some of the tensions for current nursing leaders. Julia Menton outlined some of the problems with the course in the current N.H.S. scenario:

I think education will be influenced by the sort of purchaser-provider role which says we've got to cost every unit of the students time, which I think is very sad, against the Trust. Because the opportunities for community experience are tremendous

RJR: Yes, I certainly found that I think, when we were planning Project 2000, the issues of Working Paper 10 and the Trusts, we just hadn't envisaged and, as you say, what you could plan as an educationally led programme. (13.15).

Just as ward allocation methodology was criticised in 'traditional' nurse training programmes (Moores and Thompson, 1975) so student placements are a much

censured aspect of Project 2000. In addition the reduction in numbers of registered nurses in placements to act as practice facilitators, and to provide supervision and teaching for student nurses, has highlighted the need for nurse lecturers to play a larger role in this arena (Elkan and Robinson, 1995).

The introduction of Project 2000 has thrown into even sharper focus the failure of student nurses to integrate theory with practice. The original premise of the reform was that nurses should become 'knowledgeable doers' (UKCC, 1986). Problems of gaining practical skills in a shorter amount of clinical placement time than was previously the case, aggravated by the issues previously described of failures in practice supervision, seem to have exacerbated the gap between theory and practice and heightened tensions between nursing service and nursing education leaders. Elkan and Robinson (1995) point out that nursing is not alone in wrestling with this concern and that education and social work face similar quandaries. These tendencies in both professions has led to an increase in the practice-based, employer-led focus of the training, a trend which has occurred at a time when nursing is moving in the opposite direction. Some would argue that the emphasis in the political climate of the late 1980's and early 1990's was anti-professional and anti-academic (Elkan and Robinson, 1995) and Pritchard (1995) also comments that these approaches are common across the public sector as the government of the time 'dedicately pursued a campaign of deregulation of public utilities' (Pritchard, 1995:16). Project 2000, which was built on the professional desire for an 'education led' preparation for nurses, seems to fly in the face of current trends, and if this is the case, one could argue that it is likely to be shortlived.

Thus there are a range of continuing tensions for nursing leaders surrounding the arrangements for pre-registration nursing education. Coinciding with the move of much of nursing education into higher education the Department of Health issued a series of challenges to nurse education providers (1994b). One of these challenges is to 'search for better ways to combine the art and science of nursing, midwifery or health visiting and to place the student at the centre of the learning experience within a framework which is explicitly practice led, research based and employment focused'. The extreme difficulty, if not impossibility, of achieving this target was examined in the literature review and earlier in this chapter. The demands for

training to be practice-led and employment focused seem to preclude the organisation of learner centred, research based education. The compromise reached regarding a service providing element in the Project 2000 course and the advent of these courses coinciding, as they did, with the introduction of Working Paper 10 contracting arrangements have meant that Project 2000, whilst going part of the way to overcoming some of the problems associated with student nurse training, has been less successful than was hoped in the eyes of some of nursing's past leaders. There are also serious questions about the suitability of the course design requirements to meet the needs of students, service providers, educators and patients. Whilst recognising the requirement for employment focus Elkan and Robinson (1995) argue:

that in being employment focused nurse education must remain education-led, and not dominated by service requirements.

(Elkan and Robinson, 1995:389)

However the service domination of the curriculum through the current contracting mechanisms is now being recognised as the cause of tensions for nursing education leaders (Kershaw, 1996; Butterworth, 1997). In the past nursing education and nursing service leaders were all in the same employ so that there was a greater imperative on nurse education leaders to submit to the wishes of service. The move into higher education seems to have exacerbated some of the previously experienced tensions (Owen, 1988). The introduction of Project 2000 was also one of the factors which led to the integration of nurse education into higher education. This shift in the environment in which nurse education is based is seen to pose additional threats to the autonomy and power of the nursing profession, especially its leaders, to determine the content of the pre-registration curriculum, especially in respect of providing an appropriate venue in which to learn the caring elements of the course. During the period studied nursing education was established in some higher education institutions and some of those interviewed had experiences of this. They recalled some of the difficulties which a new subject area can encounter as its proponents struggle to survive in a new, and sometimes, alien environment.

6.8. The place and role of higher education in nursing education.

The respondents in this study viewed the integration of nursing education with higher education as both potentially beneficial and threatening. One of the chief benefits they anticipated was through the development of nursing degrees and nursing research. In their view nurses would then be seen as equal to their health care professional colleagues in terms of academic background and would be better equipped to argue for enhanced patient care and nursing practice in decision and policy making arenas.

6.8.1. The benefits of higher education for nurses and nursing.

Many of their own previous experiences of higher education had led those interviewed to consider that it was important for all nurses to be exposed to this sort of educational experience. From their personal experiences they saw a range of benefits accruing to the profession. Andrea Davies referred to the potential benefits to students and nurse teachers:

I was absolutely a hundred per cent for going into higher education, because I think nursing had been isolated too long, and certainly looking at the biological/social sciences, we needed to see that expansion. We also needed to see the students being part of a much bigger whole [...] and the tutors, particularly. I think they were too long isolated and needed to be [...] mixing in a faculty and a campus is very important. And so, I mean I've been very much pressing for moving into higher education for a long time. So I think it has a lot to offer, a lot to offer. (25.12).

April Walshe was equally positive:

I think it's absolutely right that the profession has a cadre of highly skilled academic research based nurses, but that is only one element within. Now I think that the involvement of higher education is tremendously enriching. (27.15).

Hilary Miles, whilst positive about the potential that graduate level courses have for nursing, was critical of the nurse educationist's abilities to deliver what is necessary for the future survival of the profession:

Having said that about degrees, because I do think it helps people to be more analytical and to get a wider view of the world. I have known an awful lot of people with degrees who, who couldn't manage a 'piss up in a brewery'. Um and just appointing people because they've got a degree is not good enough, they have got to have management experience and just popping you

up to the top because you've got a degree is a nonsense. (45.14).

A view shared by April Walshe:

the other thing is that I feel that a lot of educationists haven't come to terms with what management's all about and they don't know how to manage their organisations or their departments. (27.15)

Both previous extracts were from nursing service managers and seem to confirm White's (1983) claim of an anti-education bias in nursing. Whilst higher education may be seen as the answer to nursing's tensions the nurse education leader's abilities to deliver were still questioned. Charlotte Calman, a prominent nurse educationist, discussed the advantages and disadvantages for nursing and nursing education of integration with higher education. She also describes some of the ways in which nurse educators might demonstrate their commitment to practice and her fears that the focus of nursing is being lost through integration into higher education:

RJR: What about, um, I mean, often the fear that's expressed to me by people with a service rather than an education background, is that, you know, progressively we're moving away from a clinical focus, and that will be lost and, you know, when we go into higher education we'll be in these 'academic ivory towers'

Charlotte: Well, we see that nursing is a practice based profession and unless we have the theory supported by practice we shouldn't be in business. Now, the course leaders here are absolutely one hundred per cent agreed about the practice [...] about the teachers keeping links with the students when they're in practice. (43.12).

These extracts highlight fears about the roles of nurse teachers within higher education and their lack of preparation for these roles. In part the fears were associated with the failure of nurse educationists to remain clinically and theoretically up to date and to manage their own business. As the anticipated benefits of investment in degree level study did not materialise those interviewed began to reflect on the impact on the profession and on individuals of the degree courses that they had chosen, or that had been available, when they decided that this strategy was important. Jennifer Westley regretted the way in which some nurse teachers in higher education lost their nursing focus:

nurses who'd done degrees were quite rare, and they would come and say

"Well, I've got a degree in Sociology. I don't want to teach nursing, I want to teach sociology, it's so much more respectable". And I found that terribly difficult, because nursing was the thing that was tops [...] absolutely for me, so, you know, I insisted that unless they practised nursing and could teach nursing. If they could teach the application of sociology to nursing, fair enough. [...] part of the philosophy of the department came to be, you know, nursing is the priority and you have got to be proficient at the practice of nursing if you're going to teach. (51.9).

This philosophy was shared by Mary Shilton:

what I fear [...] is that they will come in feeling that their kudos lies in "I teach biological sciences" or "I'm the sociologist in our school", in which case nursing just goes down and down in value. (42.25).

For most nurse lecturers the need to acquire a degree has required time to be spent on their own professional development. Sadly, as these extracts have shown, this seems to have taken nurse educators away from a nursing and clinical focus at a time when it seems that they and the profession most need these aspects to be strengthened. Elkan and Robinson (1995) report that:

Teachers have been overwhelmed by the competing demands on their time of their clinical and 'classroom' responsibilities. These have been compounded by the demands on their own education to a higher level... Teachers have known they had to pursue academic credibility or be left behind, but at the same time there has been pressure to extend their practical skills.

(Elkan and Robinson, 1995:388)

This quotation highlights some of the recent tensions for nurse educators. What emerged noticeably from these data were ambivalent and polarised views of the relationship between nursing and the education of nurses. Most of those interviewed believed that an increase in the academic level of nursing was necessary for its future survival and for nurses to be able to achieve real power in health care policy making. On the other hand there is a fear that intellectualising nursing would lead to a diminution of the ability of nurses to care for patients. There was also a worry that nursing education would become dominated by yet another group, the managers of the institutions of higher education.

6.8.2. The disadvantages of higher education integration for nurses and nursing.

Some of those interviewed expressed concern that the 'new masters' failure to understand the specific needs of nurse education would further diminish the caring content of the courses. Mary Shilton was also concerned about the motives of the institutions of higher education:

the main thing is that nursing really is complex, far more complex than many people realise who are not nurses. [...] so there has to be tremendous astuteness on the part of nurses as they come in, especially if they come into a University that's not used to them and sees them as a pot of money. They've got to be able to convince people about the value of nursing and the cost of nursing, and nursing is more expensive than sociology or psychology. And it's, it's expensive in a different way from biological sciences, we don't need electronic scanning microscopes but we need staff who will continue to practice as well as to teach, and that is costly. And, so I guess the challenge is for the people who are going to join us, to say "my discipline's nursing" and, "this is what nursing means" and, "this is what research into nursing means". It doesn't mean a controlled trial, it may on occasion mean that, but it means qualitative work, which again is costly and needs to be funded. (42.23).

Mary points to the skills which nurse educators and their leaders will need in the higher education environment. The 'costs of the change to higher education' had been a recent topic of interest (Goodwin, 1986), so Julian Burns, among others, was worried that financial considerations might overshadow the academic and clinical requirements of nursing education and again reiterates the need for political astuteness in nursing's leaders:

It's the same with people in your posts in education. Again it's something we need to watch with care because higher education's welcomed us in now. But it's student numbers, political, money wise but given the system anybody could become a Dean and I think in some parts of the country, you know, there are already reorganisations. It seems to me that if we lose control of recruitment, control of developing our own curricula and the education of our own professionals then I think we've lost a lot (23.22).

Vivian Stevens expressed similar fears:

I think nursing and midwifery education are very vulnerable to higher

education political changes, and economic pressures. I fear that higher education might price nursing and midwifery out of the market. (24.16).

There was an underlying fear in these extracts that moving into higher education would mean that control of nursing education by nurses would be diminished or lost. There was also a fear that regulation of professional standards and professional management of curricula would be missing. In this respect Sebastian Reason reflected on the political and historical influences of the past, in particular regarding the regulations in respect of nurse education and the role of the statutory bodies in maintaining standards:

I don't think that there is, necessarily, a necessity for professional bodies to be engaged in education, but they must have some relationship with it if some integrity of the practice and the education is to be reassured otherwise it becomes fragmented different faculties, different disciplines. This is particularly true of medicine and nursing and social work where they depend on other disciplines. (14.32).

In the view of some the move into higher education will take nurses away from their clinical and practice focus and this threatens the future survival of nursing and hence nurses and provides a source of tension for nursing leadership. Some of those interviewed considered that the integration of nursing education into higher education would lead to nurses losing control of the education of students and that this would have detrimental effects on patient care. Whilst the environment of higher education was valued for its potential benefits for the education of nurses, there was a concern that the clinical elements and caring ethos of nursing programmes would be lost and that the consequence would be the nursing profession's demise. There were also fears about the roles of nurse teachers within higher education and their lack of preparation for these roles. Mainly the fear was associated with the failure of nurse educationists to remain clinically and theoretically up to date although the academic level, and focus of the nurse educator's qualifications, was also a worry. A further significant fear was regarding the lack of managerial and political skills of the leaders of nursing education.

6.9. Discussion and Summary.

This chapter has examined a range of environmental influences on the careers of those studied and has highlighted some of the factors which have contributed to the tensions within nursing leadership. The roles of nurse leaders and managers throughout the successive re-organisations of the NHS have been surveyed through the perceptions of those who were in leadership positions during the first five decades of the service. One of the factors which caused subsequent concern to those interviewed was that they learnt to nurse in an environment which sought obedience to hierarchy. They were instructed not to ask questions and to follow orders to the letter. There was always someone further up the hierarchy to whom they could pass on the need to make a decision. Those further up the hierarchy often became 'bogged down' in the minutiae of administration, which one of those interviewed described as nursing's need to 'dot every I and cross every T' (Maria Palmer, Interviewee 47).

From the nursing management perspective there is evidence that there was widespread dissatisfaction with the way in which the role of matron had been translated into the structures of the new NHS and that in order for nurses to be more involved in policy making decisions the Salmon report had been commissioned. The recommendations of the Salmon report were considered an overt criticism of the management and leadership styles of the matrons, deemed fussy and feminine, a view with which they colluded in order to gain what they saw as status and hence power (Carpenter, 1977; Lorentzon, 1990). The Salmon report introduced a further hierarchy of nursing management posts, accompanied by quasi-military and masculinized version of nursing titles. The male nurses, usually from psychiatric or mental handicap hospitals, who had gained admission to the full nursing register and to membership of the professional organisation earlier in the decade were now poised to exert their influence in nursing management. The power relations between nurse managers and senior colleagues enjoyed a brief period of seeming equality with the introduction of the Salmon report and the consensus management of the 1974 re-organisation. Strong and Robinson (1990) comment on nursing management in this era:

Long the handmaiden of medicine and totally subordinate to it, nursing was now undergoing a major upheaval. Though wholly different in size, recruitment, education and organisation, nursing reformers took doctors as a

model. The nurse of the future would be scientifically trained and use independent clinical judgement. A new profession would arise to stand alongside - and equal to - medicine; a new syndicalist craft would be born. 1974, therefore, marked a massive extension of nursing power within the service.....At long last, nursing sat at the top table. Nursing, too, was part of the consensus.

(Strong and Robinson, 1990:19)

Arguably the 1974 re-organisation was the 'high point' this century in terms of nurse managers participation in consensus management, however this was to be short lived as the Griffiths report removed managerial responsibility from most nurses above the level of ward sister. Prior to 1982 it was generally recognised that the dominant group within the clinical-professional hierarchy was the doctor (Abel-Smith, 1960; Ackroyd, 1995; Harrison and Pollitt, 1994). The manager, or administrator, was seen as having little authority (Ackroyd, 1995), a 'diplomat' who 'helped to provide and organise the facilities and resources for professionals to get on with their work, and helped to mediate conflicts within the organisation' (Harrison and Pollitt, 1995:36). The role of the nurse manager of the time was seen as the 'junior partner' to the 'senior partner' of the doctor in a 'cooperative division of labour' (Gamarnikow, 1978). Whilst Ackroyd (1995) argues that the practical activity of the nurse in maintaining the smooth running of the service should be acknowledged more fully.

In the previous two Chapters the nurse leaders tensions regarding their position has been revealed, ranging from Millicent Wood's view of her 'supreme position' as matron to Marlene Adnam's frustration at not being allowed to 'sit in the body of the kirk' (Interviewee 41). Many respondents wanted nursing leadership to 'have a voice' in policy making but it must be remembered that it was only nursing service managers who were gaining 'a voice', nursing education leaders were rarely included in this. As a Director of Nursing Education for seven years I was only once invited to address the D.M.T. and D.H.A., when the manpower and financial implications of Project 2000 were being considered.

As was demonstrated in the excerpts from the interviews the implementation of the Griffiths report resulted in the loss of nursing management careers (Harrison and Pollitt, 1994) with relatively low numbers of nurses appointed to general

management posts (Allsop, 1984; Harrison and Pollitt, 1994). Career opportunities for nurses were diverted through incorporating other responsibilities, usually with an emphasis on quality issues, into the most senior nurse posts. At the same time greater non-nursing management controls over nurse staffing numbers, activity levels and performance measures were introduced through workload and skill mix measuring systems and standard setting and quality measures. Nurse managers willingly opened up professional practices to external scrutiny themselves in the name of professional and scientific advancement, whereas doctors held out against these controls for some time. In retrospect the work study, nursing manpower models and economic controls that leaders like Marcia Hughes and Serena Crooks referred to seem to have played into the hands of the policy makers in that none of these measures were able to capture the value of 'invisible' or 'intuitive' aspects of care which registered nurses give. Thus the cost controls which were introduced were aimed at minimising the amount of time that the most skilled, and most costly nurses, spent in these activities. The Audit Commission reported in 1991 that the NHS Reforms 'increase the pressure to find outcome measures for nursing that will enable purchasers and providers to specify relationships between ward resources, the organisation of nursing care and quality' (Audit Commission, 1991:4). However whilst quality outcomes are specified in measurable terms by purchasers and providers it seems unlikely that the 'little things' (Smith, 1992) that patients prize will be part of the equation. Other leaders therefore argued for greater numbers of nurses to ensure the inclusion of these aspects of care and yet others called for a return of control over the so called 'non-nursing' duties.

In summary the environment in which nursing service managers worked was characterised by a period, between the implementation of the Salmon report and the passing of the Griffiths report, when they 'had a voice in policy making' and were 'treated as an equal' in decision making. Even this halcyon period was marked by tensions between the 'old' style of nursing management, the matrons and their assistants who, whilst operating systems of close control over the nursing staff of the hospitals, were seen to have been controlling the wrong things by their successors. These 'new' nurse managers were dismissive of the matrons need to centralise decision making, to 'count spoons' and keep record books, they preferred a style of 'scientific' management in keeping with the budgetary and manpower

controls which were being introduced. Yet others were advocating collegial-democratic styles based on staff development and empowerment. In the event though they also were found wanting, those who were hospital matrons were considered incapable of managing, and their successors were criticised by doctors and administrators (Strong and Robinson, 1990), and by their own colleagues.

Thus it seems that the successive organisational structures of the NHS was one of the significant factors which contributed to tensions within and about nursing leadership during the period studied. As has been demonstrated in this Chapter and in the previous Chapter the nurses interviewed held strong values regarding care and caring with which managerialism, with its connotations of a hard scientific approach, was at odds. It is suggested that the current tensions within nursing leadership and the demise of the nursing leader might, in part, be due to the introduction of a style of health care management which represents a 'cultural transformation inimical to many nurse's values' (Rafferty, 1993b).

Nurse educators, on the other hand, worked in an environment where the needs of service took precedence over the needs of students, they learned to survive dominance by service colleagues and to tinker with the flawed system of nursing education in the guise of curriculum innovation. Even the much heralded triumph of Project 2000 was compromised in such a way that the changes of the 1990's have almost destroyed its potential to overcome the problems of the past. Throughout the history of nursing education those responsible for the preparation and development of practitioners have never been able to lay claim to controlling their own sphere of work. In the early days the control of the content of the curriculum lay with doctors and the control of the methods and timing of teaching lay with nursing service managers. This control continued up to and including the reforms of Working for Patients (1989). Current developments in the contracting mechanisms for nursing education allied to the integration of nursing education into higher education have shifted control into other arenas, but it could be argued that the leader of nursing education is still not 'headmistress in her own school' to use the phrase that Maria Palmer used to describe one of the reasons why she left nursing education.

Most of the respondents in this study seemed convinced that nursing education must take place alongside the education of other health care professionals in order to enable nurses to take part in the debates and decision making regarding future services, and thence to ensure the continued survival of nursing and nurses. On the other hand there was the fear that nursing education would be subsumed within a system which did not understand the particular needs of the service. Forced to comply with the demands of the higher education establishment the practice or clinical element of education and hence the caring focus of nursing would be lost. There was a healthy scepticism about the motives of the higher education establishments, in particular that nursing education was not being welcomed by higher education for philanthropic reasons, but rather for the funds that the work brought to institutions at a time when their own resource base was being squeezed.

What emerged as important to this sample was the possible or actual subordination of nursing to new powerful groups outside the sphere of the previous experience of most nurses. It appears that those interviewed recognised that nursing education could be subordinated to higher education in much the same way that it had been subordinated to doctors and nursing service managers in previous decades. Coupled with the current alleged dearth of nursing leaders (Ackroyd, 1995; Rafferty, 1993b) they recognised that the survival of nursing is once again under threat. There are concerns that nursing management and leadership has been diminished as a result of the changes described so far.

A theme throughout the whole of the last two Chapters has been the emphasis by the past nursing leaders of the centrality of care and caring to the role of the nurse. As well as expressing concerns that nurse leaders and managers were losing or had lost their voice in policy making because these values are inimical with managerialism they also considered that current student nurses were not being taught to care in Project 2000 courses. Whilst the move of nursing education into higher education was seen to have potential benefits their fears regarding the possible loss of a clinical and caring focus for nursing education was strongly argued.

The current tensions within nursing leadership appear to have stemmed from a combination of multi-factorial influences. As the previous three Chapters have

shown individual differences in their careers, views of nursing and approaches to their roles added to the relationships which they had with significant others and the situational and environmental factors have created multi-faceted demands on nursing leadership. The ways in which they responded to and coped with these demands through the leadership style they developed or adopted is recounted in the next Chapter.

CHAPTER SEVEN

LEADERSHIP STYLES IN NURSING

7.1. Introduction.

This chapter deals with the third of the research questions which were set out in Chapter One. From the data analysed in the previous three chapters it was possible to deduce that the ways in which nursing leaders responded to and coped with changes in the organisations in which they worked, and the effects of altered relationships between work colleagues, both within and outside the nursing profession, was to develop a leadership style which was distinctive to each individual but from which it was possible to conclude that there were common factors. These collective features are what have been typified here as 'styles', three of which were isolated and named 'powerful', 'pioneer' and 'enabler'. In this chapter details of the three styles are examined.

Through the processes described in chapter 3 each of those interviewed were assigned to a style or styles. As indicated in previous chapters it became increasingly apparent that their styles were greatly influenced by their motivation to be of service and their conceptions of care and caring. They considered that in order to be able to achieve their altruistic goals they had to attain positions from which they could influence others to achieve these goals. The ways in which they went about translating these aims into their practice of management resulted in the isolation of three major approaches to leadership.

Apart from interviewees 4 and 8 (Walter Mant and Heidi Mann) all other individuals demonstrated at least one dominant style, in most cases there were also elements of one or more subordinate styles. Problems encountered during the interview are considered the chief reason why it proved difficult to assign a dominant style to the two named individuals. Two other individuals, Sebastian Reason and Mary Shilton, are considered to have demonstrated shared dominant styles. **Figures 2, 3 and 4 (Leadership Styles in Nursing)** show each of the

individuals interviewed assigned to a style or styles according to the thematic analysis of their interview tapes. The styles describe how those individuals studied viewed their own careers and the careers of others in ways which linked them into the situation and environment in which they worked, and with those co-workers and other people who were significant to them. The leadership styles developed encompass the effect on the individual of the role; relationships; situation and environment as well as the effect of the individual on other people and the environment or situation. Thus in relation to the observable tensions within nursing leadership the overarching research questions; what was 'the impact of successive organisational changes within the N.H.S., and the way other environmental factors affected how these managers perceived their roles', and '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 these changes', can best be answered by an analysis of the ways in which the past nursing leaders responded to and coped with these changes by developing distinctive styles of leadership. The fact that these styles differed according to the segment of the profession in which their leadership role was played may, in part, have caused or contributed to the tensions between them or may have been as a response to the tensions. The following descriptions of the styles examines these aspects more specifically, especially the differences between nursing service leaders and nursing education leaders. As the following data show the majority of nursing service leaders were attributed to the 'powerful' style whilst the nursing education leaders mainly adopted the 'pioneer' and 'enabler' styles.

7.2. The Powerful Style.

This was the most often identified style (Figure 2). Twenty-three of those interviewed were considered to have demonstrated this as a single dominant style and one further individual was categorised as illustrating shared dominant styles of 'powerful' and 'pioneer'. Six of the twenty-three exhibited subordinate styles, the most frequently occurring was 'pioneer', demonstrated by 5 individuals, the 'enabler' style was evident in two cases.

FIGURE 2.**POWERFUL LEADERSHIP STYLES IN NURSING****Powerful Dominant Style**

NAME	MOST INFLUENTIAL AREAS OF WORK	SUBORDINATE STYLE
Hughes	Civil Service./ Publication	Enabler
Calman	NHS Education./ Statutory Body	None
March	Civil Service./ Professional Org.	None
Davies	NHS Service./ Statutory Body	Pioneer
Simmons	Civil Service./ Professional Org.	Pioneer
Deerman	Statutory Body.	Pioneer
Bury	Professional Org./ Statutory Body	None
Larnet	Professional Org./ Statutory Body	None
Benton	Civil Service.	None
Wood	NHS Service./ Professional Org.	None
Adnam	NHS Service./Statutory Body.	None
Thomas	Higher Educ.(Comm)./ Stat. Body	None
Oliver	NHS Service./ Professional Org.	None
Trent	Journalism	None
Walshe	Civil Service.	None
Crooks	NHS Service./ Professional Org.	None
Wright	NHS Service./ Professional Org.	None
Adams	Professional Org.	None
Pearson	NHS Education./Statutory Body	Pion./Enabler
Palmer	NHS Service./Statutory Body	None
Burns	NHS Service./ Publication	Pioneer
Rayner	Statutory Body/ Publication	None
Ightson	Civil Service	None

Shared Dominant Power/Pioneer

Reason	NHS Education./Prof. Org./ Stat.Body.	Enabler
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In Figure 2 their most influential 'paid' work appear first, in column 2, followed by their most influential 'additional' work. The process of arriving at the decision as to which were their most influential roles was described in chapter three and in Table 4.2. Eight of the 'powerful', were considered to have been most influential in NHS nursing service roles (Figure 2) and six were influential in their roles as nursing civil servants. Three were officers of a professional organisation, two were employed in NHS nursing education and two were officers of the statutory body. One was a journalist and one worked in higher education. The individual who was assigned to shared powerful and pioneer styles worked in NHS nursing education and held roles within both the statutory body and a professional organisation. Of their secondary influential roles 8 were members of statutory bodies, 6 held senior posts in their professional organisation and 3 were influential through their publication and public speaking activities. All of the nursing service managers had achieved the highest levels of work (levels 4 or 5) - see career pathway diagrams Appendix 2 - either in their paid employment or in their additional influential role. Of the educationists all had been influential at a national level, as members of the professional organisation and/or statutory body, fourteen of the 'powerful' had their contribution recognised by the State and/or by the profession. Two of the twenty-four were men. Power was also the most significant of the subordinate styles of the 'pioneers', and it featured for two of the 'enablers' (Figures 3 and 4).

7.3. Characteristics of the powerful style.

These characteristics are extracted from the matrices of the three elements or components of the individual approaches to management and leadership styles and from the paradigm cases used to identify examples of these approaches and styles. The file cards which had been used to record instances of examples of the styles and the collated extracts of illustrations of the components from their interviews were analysed and the characteristics extracted and grouped. See Chapter 3, section 3.13, for a full description of this process.

Typically those exhibiting this style did so through acknowledging their desire to achieve a position from which they could 'make a difference' to the standards of

nursing care; to nurses conditions of work; and to the education of nursing students. The positions most often mentioned were matron, or its latter equivalents; nursing officer at the Department of Health; and becoming an officer or member of the statutory body. Interestingly, as was discerned from the career pathways diagrams, six of those who rose to significantly influential positions as service managers had originally embarked on careers in nurse education, but had perceived that in order to achieve the power they needed to realise their goals had switched to service management. Additionally six had careers in NHS nursing or midwifery education prior to their moves into the civil service, professional organisation or statutory body.

From the data presented in previous chapters and from the analyses which resulted in their 'allocation' to this styles, through the processes described in Chapter 3, it was deduced that they also recognised power in other individuals, for instance their 'boss' and powerful role models and mentors that they had encountered during their careers. Additionally certain groups, such as statutory bodies, Doctors, Health Service Administrators, politicians and the government were seen as powerful. Many of the extracts from the interviews which illustrate the powerful style relate to actual or perceived status and power between nurses and other groups. This was especially noticeable in relation to the more lowly position of nurses vis-a-vis medical and administrative colleagues in similar positions within management boards. Most common in this respect is the power differential between nursing service and nursing education and most specifically the role of principal nursing officer (education) or director of nurse education vis-a-vis their nursing service manager.

The 'powerful' considered that the attributes of power were knowledge (or credibility) and expertise, particularly nursing expertise. Equally the acquisition and management of money and other resources was considered an important facet of the application of power. For some the management of human resources, through 'hiring' and 'firing' and all the management processes in between, such as performance review and staff development, was a major consideration. For others autonomy to determine the way in which they carried out their work and freedom to act, speak, and write independently were regarded as essential. It was largely

recognised that autonomy and freedom were relative in all situations and that a higher power or powers existed.

Power was exercised through acquiring skills such as self-confidence, particularly in public speaking, and the ability to influence others through securing the authority and position to do so. Credibility with peers was seen as important and the ability to negotiate with other powerful individuals or groups on behalf of professional colleagues was a significant element of this style. Forming, chairing and working on committees was considered to be one of the most important methods through which the process worked. Often the achievement of these skills was referred to as learning political skills. Some gave descriptions of 'doing their homework' prior to meetings to ensure the outcome they desired, especially this was evident in the description Barbara Pearson gave of her meetings at the Department of Health, with the then Minister, as was described in Chapter 6. In particular it was considered essential that the powerful nurse leader should be able to gain the support of powerful allies, often through using their extensive networks, and be capable of negotiating their way through bureaucratic processes in order to achieve necessary change. Whilst recognising the need to find a way through due processes some did acknowledge that on occasion when 'red tape' or rules got in the way they used other means to achieve their ends. In the main they indicated that an awareness of the politics of power were important and that in order to succeed one needed to 'know the rules of the game' and be 'willing to play the game'. As discussed in Chapter 6 some of those who did not fall into this category recognised that politics were an important facet of this style but either refused to play or opted out.

Other aspects of this style which caused some concern to those who experienced it were discrimination of varying kinds. Intra-professional bias between service and education personnel was the most frequently mentioned; different segments of the profession considered that other segments were prejudiced against them, the most often cited being general nurses 'against' community nurses or midwives. Other forms of discrimination referred to were on the grounds of race, gender and religion. Nurses also felt that they were less favourably treated than general managers, administrators and doctors. The ways in which discrimination was considered to have been enacted was through less favourable terms and conditions

of service; job or study opportunities being blocked; and being marginalised or denied access to information or decision making fora. Those interviewed indicated that they had gained the necessary knowledge and skills to fulfil their roles in the ways mentioned through a variety of methods, both formal and informal. Some of those interviewed also perceived the need to use their own position and skills in this area to recruit, select, train and develop their own staff and possible leaders of the future.

As indicated in Chapter 4 the behavioural approaches used by the powerful leaders were mainly a combination of 'opportunism' and 'battler', for instance when they recognised an occasion when they could influence change to achieve the aims identified above they were prepared to 'fight' to achieve their goals. Sylvia Thomas exemplifies such an approach to this style:

I had always realised that a lot of things get done, not because the people concerned have enormous power bases but because they've got particular personalities and can influence other people. And that's that, because I didn't have an enormous power base, anyway in a small department of women in a large Polytechnic of men that was the obvious way to go about things. And one saw who also had influence, and cultivated them in a way. That sounds terrible [...] you know it was the thing to do. I think the other point was that we realised very early on, all of us I think, it was no good being on the sidelines. You had to get 'in there'. So for instance we joined the Union, NATFE⁶⁰, as it then was. [...] And again, people who had influence tended to belong to that as well. [...] the fact that you happened to be a PL⁶¹ didn't necessarily mean that you had any influence or authority, it was very much a community of equals. And if you didn't, you had to persuade everybody else, you know [...] I think, you know, you're going to have a job laying this against the normal management criteria. (26.5).

I didn't take a lot of interest in nursing politics quite honestly...That was in my past, not in my present, until I read the Briggs report and read the sentence that said something like "those courses that are now in Higher Education will have to come back into the Briggs colleges". Now I'm not quoting it exactly. When I read that, that got me into nursing politics straight away. So it was that single thing, because I felt that, not that, not that Higher Education is so marvellous to be in, as you know, it's got all sorts of hassles and problems, but that to me [...] To suggest that little piece should then be whipped out into what I regarded as monotechnics, which did not turn out educated people, you know. [...] So that set me off. I mean that really fired me. (26.7).

Sylvia shows here that she had been content to use her knowledge and skills in regard to influence mainly in her work place until the recommendations of the Briggs Report (1972). Sylvia's opposition to the report in particular centred on the educational aspects, she had a vision of all nursing education needing to be in higher education. She reflects herself that her own approach to the acquisition and use of power is that of expert power, which is established when those influenced believe that the other person has some special knowledge or expertise. She also described the ways in which she and her colleagues (all female) set about acquiring a power base within a male dominated institution of higher education and how power and influence could be exercised in a collegial rather than hierarchical environment. Sylvia considered that it would be difficult to match her tactics with regard to power with those to be found generally in relation to management or leadership in nursing. She was the only one of the leaders interviewed assigned to this category who had furthered her career in higher education.

Some of those interviewed admitted to a more traditional, authoritarian approach to the use of power than that described by Sylvia Thomas, or they reflected on the autocratic style of nurse managers whom they had encountered in their careers. Many of these examples of power in relationship to their work are based on the interface between nursing service and nursing education managers. As shown earlier the majority of those who were assigned to the 'powerful' style were nursing service managers, who were among the most influential nurse leaders of the time.

As discussed in Chapter 5 relationships between the leaders studied and other nurses, both individual and groups as well as relationships with other health care workers were significant features of their descriptions of their roles. Those interviewed reflected on a range of interpersonal relationships which had posed conflicts and struggles for them. These were especially highlighted in their descriptions of the relationships between nurse educators and nurse managers and in the gender relationships described in Chapter 5. In the next section the relationships between nursing service managers and nursing education managers are explored to illustrate aspects of the powerful style in action and to give a historical background to some of the current tensions in nursing leadership.

7.4. Nursing service managers vis-a-vis nursing education managers.

Barbara Pearson commented on nurse educationists subordinate position in the relationship with matron and the service:

we were very much the junior bit of the partnership and the Matron was all powerful, and it was a battle for nurse educationists to have any sort of say at all. (2.3).

Sylvia Pole describes her recollection of her position in the hierarchy and of how there was a noticeable difference after the 1974 re-organisation when her role changed from Principal Tutor to D.N.E.:

I enjoyed being a Principal Tutor, it was more irksome as I'm sure you're aware, than when you became a Director because there were responsibilities related to what the Matron wanted and that was not always what one wanted, but there again that was leadership

RJR: How did you deal with the relationship as it was at that time between the Matron and the Principal

Sylvia: [.....] you know that I think is the right sort of tension, not loggerheads but recognising that there is a different view, which you may or may not be able to agree with. I wouldn't say it wore me down but it was definitely a different role. (6.5).

Interestingly Sylvia saw the separation between service and education roles as potentially constructive. Roy Elm recalled the potential for the relationships between colleagues to be destructive:

you've got to remember in those days there was this dichotomy around, I'm management, you're service, you're education. Of those three education was looked at sideways all the time. Anybody thought that everybody, except nurse educators, could teach, and anybody, except nurse educators, were telling them how to teach. So we were a little bit out on a limb

RJR: Certainly we were seen as not quite part of what was going on

Roy: I'll always remember Carol Hurst⁶² telling me I didn't know how to nurse. I said to her, "right Carol, you tell me what you would do with a patient in acute cardiac failure in a Lear jet 30 thousand feet "⁶³ up"? She couldn't answer that, she never said it to me again

RJR: So you were seen because you were an educationist that you were divorced from nursing. (1.11/12).

The tensions and conflict surrounding the perception by nurse managers of nurse educators as divorced from practice was echoed by Sebastian Reason:

I mean, I have one hurt which I carry with me. There's a fairly well known person who was at one time Principal Nursing Officer at St Mells during the time we had those sorts of people, and I remember at a meeting when I was challenging something or other, and she said in a rather superior voice "of course" she said "you are right, but you see you deal with theory and you are theoretical and we have to deal with practice". And I was incensed - I don't know how I didn't actually lose my temper with her. Well I did internally. I suppressed it, but, and that stays with me that the thought that because we are in education, and because we are dealing with theory and the theoretical base, we've nothing to do with practice. The whole raison d'être of any education is to inform practice and for practice to develop education. I mean, it's a circular thing and if we don't understand that, I find it's so extraordinary. (14.29).

As previously claimed there was an 'anti-education' or 'anti-theory' bias amongst nursing service leaders which are re-confirmed in these extracts. In addition most nursing education leaders who remained within the NHS clearly saw themselves as dominated in their relationship with nursing service managers. Maria Palmer was one of the six nursing service managers who had embarked on a career in nursing education then moved back to service in order to gain promotion. Her rationale for doing so reveals several of the tensions which have already been highlighted:

But there was still this urge really to get into management

RJR: What was it? I mean I was going to ask earlier on and didn't want to, didn't want to interrupt

Maria: I think, I've always explained it, and whether I'm sort of deluding myself or not, I don't think I am. Right from the beginning I've always looked

⁶² His nursing service manager

⁶³ He was involved with an organisation which flew 111 people from overseas to England and vice versa.

at a post beyond, that could exert more influence upon the nursing situation and upon students. And, as a Ward Sister, I enjoyed my Ward Sister's role that I had to undertake in order to do the Tutors Course, but nevertheless, I could see that I could influence two or three students at a time on the ward, but I thought now, if I was a Tutor I could in fact influence thirty odd at a time and therefore since every one of us thinks that we have nursing 'right there' and we know what we're doing, so it was that. I then began to realise that in the situation in which we were working of the managerial dichotomy and the need to staff the wards and so on

RJR: Mm, mm

Maria: the influence of the teacher in the totality of the situation was really quite limited. And therefore, you know, we weren't really Head Mistresses in our own school

RJR: Mm, mm

Maria: and I had one almighty sort of debate and bust-up with the Association of Hospital Matrons and Principal Tutors Group and kept saying "but are you saying that you would allow us to be Head Mistresses in our own school?" "Oh, no we must have the final rubber stamp."

RJR: Yes

Maria: So that management was something that I felt, well, if I'm to influence nursing in its entirety, I've got to get on to that sort of sphere. (47.8).

Maria demonstrates the fact that in order to progress up the career ladder there was a need to move from clinical practice, she also recognises that each individual considered her own version of 'nursing' to be the 'right' one. The fact that the need for students to staff wards took precedence over their educational needs and that nursing education leaders had a more lowly position in the nursing hierarchy than nursing service leaders is also demonstrated. Others who were considered to have illustrated the powerful style had been teachers at some stage in their careers, but had decided that this was not where their longer term career lay. Marcia Hughes preferred working on the wards:

I did my Midwife Teacher's Diploma at [..institution..], was where we used to do it, as a residential course of 6-7 months, and came back. I taught for a short time but in fact I didn't like the isolation of the classroom, I preferred being on the wards itself. (18.2).

Carol Bury was influenced to start a teaching career but she always saw this only

as a way to enhance the skills she would need for an administrative post:

at one time I had thought that I might take the Tutors Course but I had not seen teaching as a continuing role. If I had taken the Tutors Course it would only have been as another way of moving eventually to nursing administration. (10.4).

Some of the nurse educationists who are allocated to this style who remained within the N.H.S. described how they deliberately set out to achieve control. Sebastian Reason was among those who consciously set out to acquire power in order to achieve change:

I was in a very advantageous position early on in my career, knowing what was happening and who the power people were. [...] So to that extent I was engaged with a lot of power struggles and I began to learn how that was. (14.10/11).

The sample reported a view of nurse educators as people who were not very committed to the ideals of the profession, they went into teaching either because they did not like, or could not do, nursing and/or they were not prepared to work hard. These negative perceptions also encompassed a view that nursing education leaders were not able to manage. Charlotte Calman, a prominent nurse educationist, pondered on the reasons for some service manager's desire to dominate nurse education:

The sad bit for me has been the Senior Nurses who wouldn't let go of education; who wanted to keep control of it. And I found that the biggest sadness in my professional career. And of course they've had to let it go now. And I think we might just have been in a better state if we'd been allowed to go a bit earlier.....

RJR: Yes. Why is it, do you think, that they wanted to hold on to nurse education?

Charlotte: Ah, well, [sigh] I suppose further back I think people got the idea that it might have been, it could have affected salaries, their salaries

RJR: Right, yes, because of the grading

Charlotte: Way, way back for the size of the C.A.N.O's,⁶⁴ or whatever the job. There's another point too. There's the question of power, and I think that was, it was, they felt it was powerful. But I think they thought that it would all 'go down the drain' if they weren't in charge

RJR: Right 'down the drain' in terms of our ability to manage?

Charlotte: Yes, well, you know, their ability. You see, I think sometimes they thought that they'd more power than they actually had

RJR: Mm, right

Charlotte: And I suppose in some ways they felt "Oh, well, it's our health, it's our area of our hospital, we want to have control about the nurses that they're prepared to go in. (43.12).

Charlotte suggests multiple motivations for 'holding on' to nurse education, mainly financial considerations and the service managers desire for power and control. Marlene Adnam implies that this control gradually diminished over the years as her own role expanded, but that the final step of 'letting go' meant relinquishing control of the nursing workforce and that this was not possible until the advent of supernumerary status for student nurses:

we were very reliant on the students in the ward situation and we had an Allocations Officer then. [...] it made me feel that I can't relinquish this entirely. That I've got to have a little bit of an input here, because of all these students. It's interesting

RJR: And the implications that would have for your own staffing

Marlene: That's right, that's right, for your own staffing. And then gradually over the years they were taken on more as students and not so much as pairs of hands. But it took a long time. (41.4).

As Marlene implies there was a gradual loosening of control of nurse education by service managers. Following the Griffiths Report, and in line with regional strategic plans for education, Colleges of Nursing (often joined with Midwifery Schools) were set up. This meant that the close link between a hospital or district and its own school of nursing and midwifery was severed and, with the formation of the college, the service domination of education was further diminished. Gradually the

change in the power relationships between service and education managers demanded different skills on both sides. In order to try to resolve the tensions between the two groups of nurse leaders Charlotte Calman talked of the ways in which she involved nursing service personnel in course development:

So I think service and education - we work very closely. In fact any programmes that we, new programmes, we always have service people on [...] it's all very well to have them involved and agree. They've moved on and one or two service people can't talk for five hundred ward sisters

RJR: No, no

Charlotte: But we've had different mechanisms I think, in the different colleges to help that, and I think that if you forge good relationships with the nursing manager of the service situation, you can take it forward together. (43.12).

Janice Williams indicated a similar approach through close working arrangements which included joint financial agreements:

in the '80s it was. I, mean our school grew so phenomenally we, I mean we grew to over 40 ENB courses. Strong, fully funded, courses and alongside that the staff. Now, obviously that was done in collaboration with my service colleagues because for every appointment we made for an ENB course, they paid half the staff, half the course. I paid for the other half, we raised our money. (33.10).

Sebastian Reason believed that nurse teachers could develop dual roles and that this might help to overcome the divisions between the two conceptions of nursing:

I wanted a nursing development unit. I offered the teachers; persuaded the teachers in the department that we could run a 15-bedded ward, because I wanted us to have our own research projects and so on

RJR: Yes, right

Sebastian: That was scuppered by the Principal Nursing Officer management at the time, because she couldn't see that, she was wanting accountability for those beds. And I said "No, you don't have it, it will come to me"

RJR: Yeh, yeh, through you

Sebastian: And she couldn't live with that. So again, you can run too fast. The sad thing was that three years later Oxford was developing nursing units

RJR: Yes, that's right

Sebastian: And everybody said "Oh we could have had that". I said "Yes, but you can't do it unless you've got the right people in the right places [...] at the right time". And I think this aspect of realism and visionary, it has to go along together, otherwise you don't accomplish anything. (14.22/23).

It is interesting that Sebastian's innovative approaches seem to have been welcomed and supported by his nursing service colleagues until he started to encroach on areas that they saw as their own domain. This example is considered a further illustration of the responsibility of nursing education leaders for the provision of appropriate clinical learning environments without the accountability for the nursing standards in these areas. The tension and conflict which this posed for nurse education managers was a focal point in the literature review and was outlined again in chapter 4 (section 4.10.5). In the previous extract Sebastian's solution was to lay claim to responsibility and accountability for both for nurse educators but this was not acceptable to his nursing service manager. However, the organisational changes outlined in Chapter Six gradually allowed nursing education managers to begin to gain some autonomy from nursing service managers. Some of the interviewees considered that this was achieved through gaining control of budgets and setting up education committees, through which the work of the school could be directed, as Richard Crapton shows:

So I had to get the budgets from the Districts put together, which was of an advantage, because you just collected in whatever had already been given to the Districts, and eventually I got them made in to an Area budget. The Area budget was then much larger than it would have been had it been a District budget. [...] you garnered in, so I did quite well financially [...] But trying to get people to see that an Area School of Nursing - trying to get people to understand that the Area School of Nursing, was no longer a hospital School of Nursing....And it was just an insurmountable barrier to get across to people [...] It was extremely difficult, extremely difficult. (48.16/17). I had terrible problems [...] of course the students' salaries should have gone to the District, but didn't, so they stayed there [...] I wanted the autonomy to manage my way, with the total budget [...] The Chairman of the Authority was the Chairman of my Education Committee. So I used the Chairman to solve my difficulties. (48.20/21).

Janice Williams describes her approach to working with nursing service managers following the Griffiths Report:

Now right from '82, I'd had to work to a 1% cost efficiency per year

because the Units did, now talking to Sheila Simmonds⁶⁵ that sort of language even now she finds hard but it was my world and I had to work to a £150,000 a year, that money not coming into the budget. And you could do it. Of course you can do it by having a cheap turnover. [...]I liked that type of business world because it was about close service education collaboration and we as professional nurses or midwives were shaping what we wanted. They would come to me and say we badly need X and we would work. We would go through the proper systems but we were controlling it. (33.21/22)

In these ways the nurse educators who remained within the N.H.S. culture sought greater autonomy through gaining control of the student manpower and the education and training finances. They were also pursuing personal and professional development mainly to try to bring the nursing curriculum out of the weight of tradition which was threatening to stifle it (Davies, 1980; Perry, 1987; Jolley, 1987). Other reasons for this were to try to dispel some of the negative perceptions and the anti-education bias within the profession (White, 1985). Their enhanced education and exposure to the culture of higher and further education led them to challenge the authority of nurse managers in an area where the nurse manager had little expertise, namely nursing education, but this seems to have heightened tensions between the two groups.

The majority of the nurse leaders designated as 'powerful' had responsibility for managing nursing education and the nurse educators, and many attempted to use their influence to make changes to the educational structures and systems. What arose from the literature review and was developed in later chapters was the control and domination of nurse education, nurse educators and the nursing curriculum by nursing 'service' managers. What seems clear in the analysis of the differences between this style and the other two ('pioneers' and 'enablers') are that views were most polarised between 'service' and 'education'.

Time and again the interviewees returned to the question of the education-service divide. It has also been suggested that nurse managers needed to hold onto control of nursing education as their powers in other areas were stripped away. In particular this occurred when matrons lost their powers following the Salmon report and when

⁶⁵ A current nursing education leader.

nurse manager's posts became advisory following the Griffiths report. Whilst some nurse educationists were included in the powerful category, it was more usual for them to be assigned to one of the other two categories. Most of the nurse educationists, especially those who went into higher education in the 1950s and 1960s, are considered to have demonstrated the 'pioneer' style of leadership.

7.5. The Pioneer style.

The previous section described some aspects of the relationship between the dominant nursing service manager and the techniques of those nurses, usually nurse educators, who were managed by them. Some nurse educators remained within the NHS education system and attempted to change the system from within. Others left the NHS for higher education and pioneered developments in nursing education within this culture.(Figure 3)

FIGURE 3**PIONEER LEADERSHIP STYLES IN NURSING****Pioneer Dominant Style**

NAME	MOST INFLUENTIAL AREAS OF WORK	SUBORD. STYLE
Turner	Higher Educ.(Nurse)./ Publication	None
Gold	Professional Org./ Publication	None
Stevens	NHS Education./ Professional Org.	Power/Enab.
Arter	Higher Educ. (Nurse)./ Prof. Org./ Publication	None
Long	NHS Education./ Stat. Body/ Publication	None
Menton	NHS Education./ Statutory Body	None
Crapton	NHS Education.	None
Johnson	Higher Educ. (Comm)./ Publication/ Research	Power/Enab.
Elm	NHS Education./ Publication	None
Williams	NHS Education./ Statutory Body	Power/Enab.
Nyman	Higher Educ.(Comm)./ Publication	Power
Westley	Higher Educ.(Comm.)/ Research Comm.	Power
Shaw	Higher Educ. (Comm.)/ Publication	Enabler
Bryant	Statutory Body./ Professional Org.	None
Hamkin	NHS Education./ Professional Org.	None
Norman	NHS Education./ Stat. Body/ Prof.Org.	Enabler

**Shared Dominant Styles
Powerful/Pioneer**

Reason	NHS Education./Prof. Org./ Stat.Body.	Enabler
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Enabler/Pioneer

Shilton	Higher Educ. (Nurse)/ Research	None
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7.6. Characteristics of the pioneering style.

As described for the powerful style these characteristics were deduced from the matrices of factors used to build up the styles. This style was identified as dominant in sixteen of those interviewed, in addition two of those interviewed were considered to have demonstrated mixed styles, one 'powerful' mixed with 'pioneer', and one 'pioneer' mixed with 'enabler'. Of the 18 so identified all but two had reached their most influential position primarily in the field of nursing education (Table 4.2 and Figure 3). Nine were from NHS nursing education and seven had worked in higher education (four were from community nursing backgrounds), of the other 2 one was influential in a professional organisation and one in a statutory body. Fifteen were female and three were male. Some of this group displayed a range of subordinate styles, nine had no significant alternative style and of these five became near casualties of the system at the end of their careers, all taking early retirement from an organisation with which they had become disenchanted. The subordinate styles of 'enabler' and 'powerful' were equally represented, five times each.

In the behavioural component of their work, as established in Chapter 4, this group showed a range of approaches to work, predominant amongst these was a 'opportunism/battler' combination. It appears that they had a clear view of where nursing education or midwifery should or could be going and they were prepared to fight to achieve their goals. The 'powerful' nurse leaders described in the previous section had also predominantly used the 'opportunistic/battler' combination and, perhaps not surprisingly, the 'powerful' and 'pioneer' nurse managers were sometimes locked in battle with one another. This may be one of the explanations for the nurse educationists having left the N.H.S. and certainly was a source of personal and professional tension, as some of the extracts in the previous section showed. The other significant combination of behaviours used by the 'pioneers' was that of 'dedicated/enthusiast', they were prepared to work long and hard at what they believed in and had the ability to share their convictions with others.

These nurse leaders of the past had a clear vision of what they wanted to achieve. Primarily their objectives were directed at ensuring the best quality of care for patients and, where necessary, improving patient care. The main route chosen to achieve this aim was through creating a role for nurses which, whilst complementing that of the doctor, was seen to have elements of independence from the practice of medicine. Many of those interviewed were among the leaders of the time who had pioneered the nursing process and had laid claim to nursing's status as a profession. In order for nurses to be able to practice this role the 'pioneers' developed nursing curricula which emphasised this independence. There was a shift away from traditional subjects, such as anatomy, physiology, hygiene, pathology and pharmacology and an increase in the study of nursing through the burgeoning nursing theories and models which were being developed. As the literature review showed the claim was made that nurses needed different skills (De la Cuesta, 1979; Hollingworth, 1985) particularly in dealing with the interpersonal aspects of care. The nursing syllabus at this time showed an increase in the amount of time given over to the study of psychology and sociology, which, it was believed, would enhance nurse's abilities in this field.

In their descriptions of their pioneering endeavours they identified a complex set of characteristics which enabled or constrained change. The most usual constraint on development was that posed by lack of resources but this did not stand in the way of the 'pioneers' for long. They gave accounts of a range of innovative ways in which these difficulties were overcome. The two most significant factors in holding back change seem to be the attitudes of their colleagues towards the new methods and the failure of government to support them. There is evidence that they effected a range of changes in the way in which nursing was practised and in the education and training of nurses in the decades examined. There was also some evidence from the data that they were concerned about the wholesale move of nursing education into higher education. Having been the pioneers for nursing education in higher education and having fought the battles for its recognition as an academic discipline they were concerned that some of the 'new' approaches, for example the non-medical education and training contracting mechanisms; the development of credit accumulation and transfer (CATS); and the mechanisms for accreditation of prior

learning (APL) and prior experiential learning (APEL) all had the potential to lead to a reduction in standards in nursing education. Ultimately they feared for nursing's future survival and linked this to care for patients in the next millennium.

The majority of those who identified strongly with the pioneer style expressed a vision of what nursing could or should be and had a clear orientation to the importance for nurses at all levels to be educated to achieve that vision. All but two had ended their careers in nursing education, those who left the NHS and went into institutions of higher education set about establishing nursing as an academic discipline and some of their pioneering work has already been described. Those who remained within the NHS depicted innovations in the curriculum which were aimed at overcoming some of the difficulties with nursing education, particularly the division between service and education. There was a strong belief from the 'pioneers' that they could make a difference to nursing education, in collaboration with their service colleagues, and that in this way they could begin to overcome the gap between theory and practice. They hoped that this might alleviate some of the tensions between the two groups. Mary Shilton in particular emphasised the need to strengthen the link between education and service in order to improve patient care:

I was becoming known I suppose in, in terms of a real commitment to nursing education and to this business of having practice reflected in education and in the curriculum, so that so the theory-practice area has always and still is my main interest. (42.15).

I suppose in a way I have been quite influential in terms, I think everybody knows that, that, that nursing is, is in a sense a passion and it has to come, education's about nothing if it's not about leading nursing to better care. (42.26).

Sebastian Reason had similar views:

I mean, it's embedded in nursing. The pity of it is that people don't realise, that people haven't understood, that practice is enhanced by improvement of

knowledge. They're not mutually exclusive one of the other. (14.25).

I think that it seems to me you can only buttress and reinforce and develop practice if you improve your knowledge base. (14.32).

Their beliefs and vision about their segment of the profession and the need for education to be strongly linked to practice in order for the profession to achieve its goals of client or patient care led them into pioneering roles. For many the environment in which they worked and the relationship which they had with others, especially the boss, were crucial factors in the establishment and maintenance of these roles.

7.6.1. The environment and relationships in connection with pioneering roles.

Janice Williams discussed the way in which her manager, a general manager, originated a new role for nursing in his structure which she was called on to play. This role created nursing education as a Unit of Management in its own right and combined the role of DNE with that of professional nursing advice to the DHA:

it was the massive change that brought in Chief Nursing Officers and Chief Executives, total change. And, and that in a way was very influential, that left us, um Clive Walker “, the chance to review what he wanted in terms of senior nurse structure in the district and he decided he would not have a Chief Nursing Officer [...] which meant that I was directly accountable to him. (33.7).

Janice went on to indicate that the R.C.N. became concerned enough about her boss' new structure to send their General Secretary to meet with him.

which, of course, caused [....], we had the General Secretary of the R.C.N. and everybody marching down to sort him out (33.7).

It should be remembered that the tensions and conflict surrounding the role and status of the nurse leader within a District Health Authority were such that the R.C.N. mounted a vigorous campaign against the Griffith's reforms. The fact that the DNE had been placed in the position of overall advisor regarding nursing was viewed by the RCN and others as inappropriate. As has been demonstrated previously changes in organisational structure gave some of the nurse education leaders opportunities to innovate. Similarly academic achievements gave opportunities to pioneer new roles. Mary Shilton describes how one DNE saw her Doctorate in nursing as a threat whilst a fellow visionary created a role for her on completion of her research:

So, when I went back to talk to the Principal, it was very interesting because she said, well you won't want to come to the School of Nursing with a PhD. And I was really quite taken aback by that because it hadn't occurred to me. [.....] before I finished a DNE from Ilham, Patricia Wemyss, who was the DNE up there who I didn't know at all but was a very avant garde DNE [....] she asked if I would consider coming up as a Senior Tutor and Research Adviser and listed, she sat there and listed all the things that she could offer me, including a first class library [.....] the nursing care and also the research advisory role was, she recognised that her staff, her teaching staff didn't have a background in research and of course none of the clinical staff had any background too, so I had, it gave me a very good eh clinical plus education role.

RJR: She sounds quite visionary actually.

Mary: Yes, she.....She was really a visionary. She stood apart from, from the other DNEs. (42.7).

Both Mary and Janice raise some important issues here regarding the way in which pioneers could be viewed by other members of the profession. Many of the pioneers interviewed in this study were leaders in the research field. As Lilian Johnson recalls, they were not always welcomed by the others in the profession who did not share their beliefs:

that⁶⁷ I think, sort of caused me to decide that my research dimension needs to be preserved I think it went on from then.

RJR: Did you find it difficult to preserve it through the almost the socialisation and conforming process?

Lilian: Oh, very difficult. But in those days I was, after, long after I finished training when the research discussion group began [.....]. we used to meet in each other's homes, and we used to support each other because everybody had the same problems and that helped me through it because I realised I wasn't fighting a solitary battle. Everybody was in the same boat. (21.6).

Lilian's feeling of loneliness in a pioneering role was echoed by Carmel Arter in her interview, both emphasise the importance of having a network of like minded colleagues at these times:

that⁶⁸ was a very fertile breeding ground and encouraging ground for those of us who were in new jobs, they were very exciting times [...] when we were all starting new. We really all needed support and, there were only three places where there were head nurses in Universities. We used to meet for weekends to give each other mutual support and encouragement.

RJR: Yes I mean that certainly is one of the areas that has come out from all of the talks that how people actually got support

Carmel: Yes from other [merged voices]

RJR: In things that they were doing at the time because many of you were you know sort of up in front of the field

Carmel: Well we were alone [...] There was a lack of understanding from colleagues - nursing colleagues, but of course you did also, perhaps I was lucky here you did begin to pick up collegiate relationships with others - medical staff because I was an [indistinct] of medical sociologists because I kept in contact with sociology in [name of university]. So you got other people beginning to, but no, nursing wise it was pretty lonely on that score. (11.10).

⁶⁷ A previous extract from her interview in which she described how her questioning nature had been curbed during initial training.
⁶⁸ The Association of Integrated Degree Courses in Nursing

Lilian Johnson had also experienced a lack of support from nursing colleagues, both within and without the university in which she was working:

people felt, I think, a bit threatened by research there weren't many members of staff, you know, had their PhD's or anything like that, it was all a very new concept. (21.7).

RJR: How did you feel that the profession in general viewed research and your activities?

Lilian: [Pause] All kinds of receptions. Interestingly enough we did an experiment with student nurses, and we had ten students, there were three Colleges of Nursing in the Dalton area.....Three Schools, and we had ten students from each school in for a study day. Went through clinical research with them from, you know, doing dressings and who says how it should be done and really just to help them to realise how knowledge is generated and we enjoyed it. Everybody seemed to enjoy it. And then we had their Directors of Education to get a feedback from their point of view and they said, "well yes, the students enjoyed it but we couldn't have it again because the students need to have black or white answers. They can't be given this grey area of, you know, this researcher says 'this' and the other says 'that'. They have to know what to do, when to do it, and have rules, and they can't really be encouraged to be doubters". So it's really back to the same thing that I met at Langton Hospital a long time ago. Don't ask questions. (21.8).

This extract reveals some of the tensions that there were between nurse educators in higher education and those in NHS nursing education. Thus those who were assigned to the 'pioneer' category demonstrate that there were intra-professional tensions which surrounded their trailblazing activities. They showed that they needed resilience and a supportive network in order to survive. Others described personal qualities such as determination, intelligence and the fact that they were capable of ignoring the rules in order to achieve change. Carol Nyman described a series of roles in which she was a pioneer and reflected on the reasons why she had been selected for these roles and the effects this had on her career. She also describes some of the personal characteristics that she considered important in a pioneer:

I don't think I ever realised the implications of everything I took on, and I don't know, I suppose one gives the impression of being reasonably bright.

It's like, you know, "why bother if she's fool enough" [chuckle]

RJR: But it seems to have, you know, come through the description that you made there that very often you had pioneering roles almost

Carol: Yes, yes. Well I think people nine times out of ten, you know, well certainly my generation didn't plan their career. [...] I suppose I haven't ever been cut out for being obedient, or, you know. I have always, I think, used my head. You know, which nurses aren't necessarily meant to do. (44.14).

Carol indicates that not 'being obedient' and 'using her head' were important attributes whilst Carmel Arter highlighted determination as an important factor in her success:

And, secondly, I suppose it's I don't know being determined I suppose and determined to know where you wanted to go and get there. I remember the first provost I worked with in the medical school in Holmsdale, with whom I did not get on, said to me once in exasperation - "if we'd known what a determined woman you were going to be you wouldn't have been appointed", [laugh] so that was it. (11.7).

Carmel describes that the pioneer nurse leader faced tensions from outside the nursing profession as well as from within. Betty Deerman recalled an instance where proposed educational change brought her into open conflict with some members of the medical profession:

you must have goals, you must know what you want, but you mustn't 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, I went one day to a medical committee and a Doctor met me at the station, he said have you come alone? and I said yes, he said well they're going to be very rude, they know they're not going to have this, any increase in education, and study, and I said , if they want to be rude I don't mind , but I shan't be rude, and I shan't rise' (5.29).

Many of the interviewees discussed the ways in which they set about achieving their goals and the goals of those with the vision to foresee a different future for nursing education. One of the ways round the difficulties of the education-service divide was seen to be in the creation of new roles which brought the two more closely together. Joint appointments, lecturer practitioners, clinically related roles for nurse teachers

and nurse researchers were all proposed as ways in which the schism might be bridged. They recalled experiments with joint appointments between service and education, or through nurse educators ensuring that their roles incorporated a clinical element. What is salutary though is that many of them had to move outside the 'traditional' nurse education structures and into higher education to find the freedom to innovate in this way. One of the main problems was seen to be the way in which the nurse teacher role had evolved separately from practice, as the interview with Roy Elm shows:

at that time the major issue was the division of management, service and education. No way could that division be broken, if I could have broken that down, or prevented it being set up in the first place, we'd be in a far better position than we are now. But because once you've delineated something like that then people become protectionist, that's my bit and that's yours, and I'm not going to let you come in. It's very, very wrong I find, being like that

RJR: I think the big mistake that we made was separating nurse education from service the way we did and divorced ourselves from practice in many instances. (1.13).

Charlotte Holmes agreed:

RJR: I think in some ways, one of the regrets that I think about our profession is that the nurse educationists very quickly became removed from practice. And I think midwifery educationists actually can teach us a lot about remaining clinically up-to-date and involved. I think that's something that we've really got to strive to get back

Charlotte: I couldn't agree more. I felt very strongly that, from my own experience there, I mean, there's no substitute in my view for what it's really like back in the clinical front line, carrying those responsibilities, and being with people who are very vulnerable and in pain. That's what it's all about. And I think the more distant Mrs Ramsammy, the more out of touch one gets with what it's all about. (39.11).

Jennifer Westley was advised by a colleague to emulate the example of medical educators to overcome this problem:

But I think the other thing I found, the day I was made a Professor, I met a Professor of Surgery in the corridor and he said "Well Jennifer, now you're a Professor just be careful that you don't lose touch with what nursing is really about." He said "If I didn't practice surgery, I could never teach the students how to operate, and you should be doing the same". And I think out of that sort of passing remark on a Medical School corridor, the whole idea of having joint appointments and keeping us very much in touch with the practice of nursing so, you know, I insisted that unless they practised nursing and could teach nursing.(51.9).

There is a clear theme running through all these different approaches to the role of nurse teacher that the educator needs to be credible clinically and that if innovation is to be successful the relationship between the nursing service and nurse education is vital. In considering the possible future for nursing the 'pioneers' felt that education was a key factor. They also saw the integration of nursing education into higher education as one of the ways in which nursing's future might be more secure, although they too were fearful of the potential for loss of clinical contact. Integration into higher education, for the 'pioneers', provided opportunities for nurse educators, in conjunction with service managers, to review the most appropriate role for the nurse of the future and to devise courses which would enable nurses to fulfil these roles. Others speculated that the requirements of the service and the opportunities that closer liaison with other students in higher education offered would bring about a more generic approach to education.

This section has examined the role of the nurse leaders interviewed in the management of innovation, especially in education and research. They were very aware of the demands upon themselves and those with whom they worked of the challenges of innovation and they gave detailed accounts of the skills necessary for the management of change. Thus far two of the three styles of leadership identified

in this study have been described. It appears that in responding to and coping with the changes in health care delivery, which is the overarching purpose of this research study, the primary style adopted by nurse leaders was that of acquiring and using power and influence. The nurse managers who used this style attempted to achieve improvements in patient care through their ability to influence others in health care policy making and through their control over other nurses, particularly nurse educators. Many of the leading nurse educators interviewed in this study left the NHS education system and pioneered the development of nursing education within the higher education system. In this new culture they faced similar challenges of funding and attitudinal constraints to their counterparts in nurse education who remained within the N.H.S. The final group, the 'enablers', also predominantly from an education background, functioned primarily in a way that facilitated the development and achievements of others.

7.7. The Enabler Style.

In all eight of those interviewed were considered to have exhibited this style and in addition one was jointly shared with the 'pioneer' style. This latter individual was one of the two identified in this group who had worked in higher education (Figure 4). Of the nine individuals who manifested this style five were from a nursing education background, two were from nursing service, one from a community background and one Registered Mental Nurse. It is interesting to note that two of the three people who held this qualification fell into this category, the remaining two were from higher education. All but three of those evincing this style combined the attributes of the style with those of at least one other style, four with 'pioneer' and two with 'powerful'.

FIGURE 4
ENABLER LEADERSHIP STYLES IN NURSING

Enabler Dominant Style

NAME	MOST INFLUENTIAL AREAS OF WORK	SUBORDINATE STYLE
Smith	NHS Education./ Professional Org.	Pioneer
Porter	NHS Education./ Professional Org.	None
Pole	NHS Education./ Professional Org.	Powerful
Holmes	Higher Educ.(Nurse)./Pub.	None
Ray	NHS Service./ Professional Org.	None
Hurst	NHS Education (Nurse)./Statutory Body.	Pioneer
Miles	NHS Service./ Professional Org.	Powerful/Pioneer
Hale	NHS Education (Nurse)/ Professional Org.	Pioneer

Shared Dominant Style
Enabler with Pioneer

Shilton	Higher Education (Nurse)./ Research.	None
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7.8. Characteristics of the enabler style.

Once again these characteristics were derived from the matrices, the development of which were described in Chapter 3. The style was demonstrated through their commitment to their work, through giving of themselves and their time they contributed to the achievement of their personal goals and the aims of the profession. The main approach to their work was through 'opportunism', they used all available occasions to help others to perform their work better and to develop their skills in preparation for the future, they used the same approach to their own development.

The members of this category also showed an extraordinary dedication to their work, although this characteristic was a feature of other styles, it was most noticeable and prevalent here. In this case they worked long hours and/or took on work related commitments in order to share their expertise or resources with others. In this way they considered that they enabled others to develop. In particular they believed that by helping others to perform their jobs better they were improving patient or client care. They worked through the formal structures of the system, mainly committees, to further their ideals and in their own work setting they tried to develop an enabling environment and devised enabling structures and processes to do so. They used career guidance, mentorship and role modelling to enable development in both their own staff and others. They also used their extensive networks to disseminate their activities outside their immediate locale. Through these methods they sought to help and support professional colleagues. A significant feature of the manner in which they described the way in which they worked was through education and training activities. They considered continuing education an important vehicle and they variously discussed the structure, content and style of teaching and learning activities as significant ways in which others could be enthused by nursing. Their reasons for trying to enable others were to improve relationships and through doing so to help them to work more effectively. Through developing their staff's abilities they sought to improve care. Thus their techniques were designed to share their vision of nursing and its future and they considered that through the methods they used they could best achieve innovation and change. Like

the pioneers they put a lot of effort into ways of overcoming the theory-practice gap in pre-registration nursing education. The enabler style was very 'person' oriented, those functioning in this way seemed very aware of themselves and the effects of their approach to work on others.

7.8.1. Democratic style of management.

This was most clearly expressed in their descriptions of their management style, which Esther Hurst depicted:

I think, it's a hackneyed phrase, but I think there's got to be true sharing of information, and you do this in all sorts of ways. I also think that people have got to know that they can have views which can be expressed which are sometimes against what they think you yourself believe, and it doesn't matter, it's got to be a pooling of ideas. I do think that's crucial, and I think the bigger places become the more difficult that form of sharing becomes. [...] That doesn't mean to say that you don't take decisions yourself, of course you do, I think that's important for that to be spelt out occasionally, yes I am the leader, and there are decisions, but if I have to make a decision without consultation, you'll always know the reason why, and then we can share. (7.6).

She talked of this style as the antithesis of the more authoritarian style of the past:

and then your, the structure, and whatever you are doing, reflects that style of thinking, which is true involvement as far as it goes, involving people. Because you attract people then, don't you, to that form of organisation, if people require a more authoritarian, structured environment, then they don't come to you. It seems to me, they are attracted elsewhere. (7.6).

Sylvia Pole described her style in a similar way, although her subsequent comment seems to belie her total commitment to democratic approaches:

Well I've always felt that it was no good being an autocratic leader. Now, if any of the people I have worked with were to hear me, they'd say, "Ho, ho", because ultimately the 'buck stops here', you have to say yes or no. (6.7).

Hilary Miles compares the 'autocratic' to the more 'facilitative' style of management:

Even when you've got line management you don't say to your DNO [District Nursing Officer] "you will do that", do you? [laughter]

RJR: No.

Hilary: I mean, you [laughter], I mean if there's a fire, you say

'out' but I mean for the normal course of things you're wanting their ideas just as much as they're wanting yours.

RJR: I was going to ask about style, you certainly sound as if facilitative and participative style rather than a

Hilary: And the sharing, 'cause I said that if I dropped dead that District should be able to carry on so that the only information I kept to myself were those which were confidential to individuals but the rest was shared. And that was part of their development. (45.19).

Charlotte Holmes also described her style in comparison to the 'authoritarian or autocratic' style:

I would like to think that it was not an autocratic management style. That I would have engaged colleagues and devolved responsibility in so far as it was possible to do so. [...] it's teamwork, partnership and devolving responsibility, so that people get the job satisfaction of their own ownership, if you like, of their own projects. (39.10).

James Ray recounts the way in which he went about achieving change:

I had always felt really that a great deal needed to be done, but it had to be done gently and when I had my first job as Assistant Chief Male Nurse, I was able to get at the younger staff and to quietly, surreptitiously, in a way, lead them on to wider thinking and to get them forward looking in the handling and the management of patients, and an interest in their work and their profession too. (35.6).

He considered that his greatest achievement was in breaking the mould of traditional nursing management:

I have been able really to introduce a style of management that was enabling, enabling management, but at the same time trying to see management also always including as far as possible, in elements of the, what do you call it, bedside nursing really. (35.16).

Many of the previous extracts have highlighted the importance of staff development. The 'enablers' described a range of activities designed to enable staff to share in the work of the team and to be prepared to take on more senior roles in the future. Delegation was described as an important way to assist the development and maintenance of the team.

7.8.2. Delegation and staff development.

Charlotte Holmes recognised the importance of delegation in developing her team:

I appointed project leaders to undertake the main projects, and they would carry responsibility but also the for recognition for writing up the projects and those projects became their projects, although I was actually involved in a few of the discussions, they were their projects and I didn't, as it were, keep very much in the centre, just farm out the work. Similarly, in the degree, the structure at the Polytechnic was very much a committee structure as it was in those days so there was a lot of devolution, so I thought we benefitted from the changing ethos of the context in which I worked. (39.10).

Sylvia Pole stressed delegation as an aspect of staff development:

it seems to me that, in fact I had observed amongst colleagues, either nobody wants to delegate anything, some people say, "well I'm, it's my responsibility, I must hold onto it," or else they say, "well they ought to get on with it", but there is that middle which is difficult, and that's where I think we fall short, bringing somebody up to feel responsible, with support, that's what helps. (6.7).

Esther Hurst expresses a similar view:

I think it's, I think as a leader first of all one has to delegate with responsibility, now I don't just mean those as words but what I really mean is to let people know that at the level they're operating what decisions they can make within their sphere, that's crucial. [...] I think they've got to know, this is their particular sphere [...] that is what they can do in that particular sphere, plus the fact that together, the D.N.E./the Principal, together with them act as a management group, and then your the structure, and whatever you are doing, reflects that style of thinking, which is true involvement as far as it goes, involving people. (7.6).

James Ray describes how he instituted selection procedures which would enable him to delegate responsibility:

Well, I made sure really that when I was selecting staff and so on that I had people whom, you know, I could leave to get on with their jobs. (35.12).

As well as emphasising the role of the leader in ensuring appropriate staff development Esther Hurst points to other ways in which staff were developed. She introduced systems within the workplace to spot and nurture the potential leader of the future:

what we tried to do of course was to identify, what we're talking about is something that I was against at one point actually, which is almost like a fast lane, in a way for people, but I think it's crucial these days, particularly, to

identify people who wish to develop further. Now we all want to develop further, I don't mean that, but I mean, if you like, to develop further in the hierarchy [...] So it's identifying those people who themselves say I wish to progress further, sometimes they can be tested out by enabling them to take over certain things in the college, and then identifying appropriate courses which they can go on. (7.7).

This emphasis on delegation to and development of staff was seen as empowering. James Ray explored how he set about creating an environment which would enable him to pass on his vision of nursing and what he had hoped to achieve throughout his career in management:

I read about a conference in London - conference in Mental Health actually it was, and I went and I was so impressed by all that I heard, that I felt really that I must take some of this back with me, and, as I said, I began then to, well I found really that the Chief Male Nurse and the Medical Superintendent weren't interested. So I, they were nice people, nice kind people, all well intentioned in every way but the world had passed them by. And I felt that I must take advantage of the opportunities that existed and I had seen what it was possible to do with the mentally ill, with my experience during the war, handling the most difficult patients; handling the most severely neurotic and nervous people with mild nervous breakdowns and so on and that all of these really were being confined to locked wards in mental hospitals, and that there was a better way of dealing with them. And so my mission, if I could call it that was to try and influence the student nurses who were amenable to learning and to influence them. (35.7).

James brings the question of management and leadership right back to one of the key themes of this thesis, that of nursing care. Others recalled the effects that working with visionaries had on their careers, which they felt had enabled change in nursing. Carmel Arter mentioned the effect of working with an enabler:

I suppose I should also mention one other person - Julia Davis was principal tutor in Smarden when I was there. She was a very facilitating woman. She didn't do much innovation herself but she facilitated other people and I think that was it. I think I have been fortunate. I have worked with people who have encouraged me. I have always had lots of ideas that goes back right to being a student nurse when I used to get into trouble for them. Later on [...] I was fortunate enough to work with people who encouraged them.

RJR: What if you were analysing, what it was that they did that facilitated that? Was there a style, were there certain skills?

Carmel: I think it was reasonableness. If you had an idea they would be

prepared to discuss it, listen to you, and then say O.K. go ahead, try it. Of course if it fails it is on your head and you will have to pick up the pieces. And it was that sort of reasonableness. Equally if they didn't think it was very good after a trial they would say O.K. you know it's not really any advantage stop it. I think it was that giving you your head. Not everything I tried worked. (11.5).

The link between innovation and the 'enabler' style has been demonstrated throughout these extracts. In these descriptions many referred to working for 'bosses' who were prepared to take risks and to facilitate development of others. In Chapter 2 the need for reflection on experience in order to develop propositional knowledge to help overcome the theory-practice gap was examined. The fact that some individuals practised this approach themselves, or that mentors encouraged this form of learning was exemplified by Hilary Miles:

One's always learning, um but mainly through bosses and colleagues and the mistakes and successes, yes.

RJR: So reflecting on experiences and adjusting.

Hilary: That's right. (45.14).

Hilary: And so it's not just courses, its experience which I think is also terribly important, um and then having some sort of mentor who'll help you to reflect back on what you've learnt and how that can be applied within any situation. (45.23).

As these extracts have shown the 'enabler' had a style of management which empowered others to develop and to innovate. The leaders of nursing who have emerged as 'enablers' demonstrated a style of management which helped others to reach their potential. They supported staff development through a range of individual and organisational means. Innovation and risk taking in a supportive environment was facilitated, so that if the risk backfired the mistake would be acknowledged and used as a vehicle for learning rather than for blame. James Ray describes how he saw his role as Chief Male Nurse contributing to the work of the team in the care of patients:

When I went to Mattersey I found a totally different atmosphere. There was a new Medical Superintendent, there were other people who had returned from the war, there the whole atmosphere, it was exciting, and I, when I went for the interview, I thought this is what I want. I want to be a part of this. And it was a most satisfying period of my professional life, because there was total

encouragement and total freedom to get on and do things, and bring about change

RJR: Right. So you're really describing two very contrasting cultures in terms of innovation and change

James: That's right, yes

RJR: What contribution were you able to make to that, do you feel, personally?

James: I suppose the biggest contribution really was in the selection of staff. In the selection, well the tutors, and the selection of student nurses, but also in the selection of the people who were to work as my deputy and my assistants, and by that time the name of the hospital had become pretty well known, and whenever a job was advertised we were overwhelmed with applicants, and we were determined we were going to find the very best. (35.8/9).

Throughout the description of the 'enabler' style one of the over-riding concerns has been with relationships between work colleagues. Many of the extracts have demonstrated that the 'enabler' believed that through improving relationships with nursing colleagues, and with other professional groups working within the service, many of the tensions between nursing leaders could be reduced. Yet again there was a focus on the relationship between nurse educators and their nursing service colleagues. Elvira Smith describes how she set about forging good relationships and encouraging her staff to do the same:

And indeed we developed very close relationships as you know⁶⁹, and each ward, each of the tutors. [...] eventually you see each tutor chose which ward she would like to link herself to. And you know they used to go on the wards as much as they could. (15.13).

Others considered the relationship between themselves and their staff to be a vital ingredient in the success of their organisation. They worked hard to develop and sustain the association. For this group of leaders the relationships between themselves and a range of colleagues was paramount, especially with co-workers in the health care professions. There was a suggestion that shared learning was one of the ways in which the previous divisions might be broken down.

⁶⁹ I trained at the hospital to which she is referring.

From the preceding extracts one of the overwhelming issues seems to be correlated with learning. The 'enabler' described their own approaches to learning throughout their careers, particularly from role models and through mentorship. Networks were another way in which they learned and encouraged the development of others. One of their main preoccupations was with staff development, for both their own staff and the nursing profession as a whole. They put in place in their own workplace systems and structures which would enable others to develop and to reach their potential within their careers. In today's jargon the environment that they created would be termed a 'learning organisation' (Senge, 1990) and the skills people develop as 'lifelong learners' (E.N.B., 1994), are seen to be empowering as is to 'give people at the most junior level the knowledge, information and permission to use their common sense... to encourage employees to work in a broad context' (Wille, 1992:8). Within the N.H.S. currently there is some recognition of the need for nurses to be 'enabled' and 'enabling', as both managers and as clinical nurses (Merrett and Holloway, 1991). Thus the 'enabling' style of leadership seems to have great potential for achieving change in the future.

7.9. Conclusions regarding the development and use of the leadership styles identified.

Previous chapters demonstrated there were a range of factors which influenced the styles of leadership which those interviewed adopted or developed in order to respond to or cope with the changes in health care delivery in the late 20th century. Some of these factors related to their individual attributes and some to their upbringing, schooling and early life and work experiences. When they entered nursing their early careers were important in developmental terms, especially when they made the choice of the segment of nursing in which to make their subsequent career. Relationships with a range of significant others have proved an important influence on the roles of leaders of nursing. In addition a range of situational and environmental factors affected the ways in which they perceived and carried out their roles. In particular the changes in the organisation and management of the National Health Service from its inception to the present have proved that it was difficult for some to maintain their ethos of care.

Tensions within and surrounding nursing leadership in the period studied appear to have manifest themselves through intra-professional conflict and inter-professional challenges regarding the definitions and practices of care obtaining at the time. As was suggested in Chapter 4 the combination of caring on the one hand and power on the other have appeared as twin themes running like warp and weft threads through their descriptions of their relationships throughout the changes which have occurred in health care delivery. Sometimes the emphasis on care and caring has seemed to suppress issues relating to power and at other times power and influence has almost submerged the caring elements. The two concepts seem to be uneasy but essentially intertwined associates for nursing leaders, for as Reverby argues:

Within the limits of their circumstances and understandings, many pressed in different ways for increasing autonomy and power. Ironically, the demand for autonomy based on the duty to care could not provide them with the ideological formulation needed. Such a demand appeared as an inherent contradiction and the essence of abandonment of obligation. Thus efforts by those in leadership to gain greater freedom and power for nursing through efficiency techniques, increased division of labour, and educational reform merely escalated conflict. [...] The language and strategies of change that had seemed to work so successfully for predominately male groups had differing consequences for this female work force. The social and ideological experience of gender and class continually thwarted nursing's efforts to lay claim to social power in this way.

(Reverby, 1987:20)

Although Reverby's study, and hence her conclusions, are based on nursing within the U.S.A. the similarities between her findings and some of those in this study are striking. From a nursing leadership perspective one of the most often repeated phrases in the description of leadership styles was that nurses should not be 'subservient'. It has been suggested that one of the major problems currently associated with nursing leadership is the lack of representation at policy making levels (Rafferty, 1993b; Davies, 1995). In part this is attributed to the organisational hierarchy which existed within nursing until recently. The 'culture of conformity' this engendered is seen to have 'thwarted the launching of nursing leaders willing to challenge the status quo' (Rafferty, 1993b:5). The evidence from this current study is that all there were individuals from within all three groups of past nursing leaders who were prepared and willing to confront others in their attempts to

achieve the best for nursing, for patient care, and for the education and training of students. The three leadership styles depicted here show the different ways in which they attempted to cope with the tensions and conflicts they faced and to bring about change. The 'powerful' achieved positions of authority in which they attempted to influence other policy makers. The pioneers innovated changes in nursing practice and education, often taking on new challenges themselves, the enablers worked on developing others through the creation of environments in which learning and harmonious relationships could be fostered. It seems that the causes of the current tensions in nursing leadership cannot solely be laid at the door of the past nursing leaders.

Some of the leaders in this present study recognised that, in part, the solution to the dilemma lay in developing the leaders of the future. By concentrating on spotting the potential leaders of the future and then developing in them a different approach to nursing management than had hitherto been the case they hoped that the future for nursing might be brighter than the past. However there are current nurse leaders who wish for a return to the past ways of nursing leadership (Jennings, 1991). Some of the past leaders interviewed considered that education and training alongside their co-workers, either through basic and specialist courses in universities or in multi-disciplinary management training, would help to break down the perception by the others of nurses and nursing as 'second class' and help to instil in nurses a better sense of their own worth and that of their profession. This may, however, be a pipe dream. Davies (1995) considers that for nursing leaders to make the transition from a 'traditional' style of management to a 'progressive' one will not come about by:

exhorting nurses alone to change - it is part and parcel of the dilemma of devaluation of their work as 'women's work'- something we are not used to seeing as in need of management

(Davies, 1995:165)

This chapter has considered in some detail the changes which past nursing leaders have coped with and responded to during the latter half of the twentieth century. The research questions which have been examined in successive chapters of this thesis have shown that the effects of changes in health care delivery occurring in the late 20th century have increased tensions in the roles of nurse leaders and have

brought different leaders and different segments of the nursing profession into conflict. Some of the situational or environmental factors which affected the ways in which those in leadership and management positions within the different segments of nursing perceived and carried out their roles have been identified. In particular the effects that changes in the organisation and management of the National Health Service, from inception to the present, had on the roles of nursing service leaders and working relationships between them and their managerial counterparts have been described. The ways in which these changes, coupled with the effects of the strengthening links and subsequent movement of nursing education into higher education, affected the roles and working relationships of nursing education leaders, especially vis-a-vis their nursing service colleagues have been examined. Finally the ways in which past leaders of nursing responded to and coped with changes in the organisations in which they worked, and 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 have been identified through three leadership styles, 'powerful', 'pioneer' and 'enabler'. The cognitive, attitudinal and behavioural component parts of the styles have been examined. In the next Chapter a synthesis of these findings is made and then the fourth research question, '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?', is dealt with.

CHAPTER EIGHT

LEADERSHIP STYLES IN NURSING - A NEW PARADIGM

8.1. Introduction.

This thesis has been 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 has formed the focus of the investigation. The study has shown that 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, nevertheless conflict between the two has been a consistent feature of the profession for most of this century. These tensions have been explored through qualitative data collected via in depth interviews with 51 people who held leadership positions in nursing.

The study has examined some of the factors which have led up to this situation, in particular the part which leaders of nursing education from the inception of the National Health Service (N.H.S.) to the present time, have played. The research questions investigated have been the impact of successive organisational changes within the N.H.S., and which other environmental factors affected the way in which these managers perceived their roles. Also significant were the ways that their relationships with significant others affected them as individuals, especially with regard to their preparation for and response to the changes isolated. The investigation has revealed that these nurse managers responded to and coped with the changes by developing distinctive leadership styles.

In previous chapters three of the four questions which stemmed from the aim of the research have been considered in depth. In Chapters 3, 4 and 5 the first research question was addressed, namely:

1. **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?

Chapter 6 dealt with the second research question:

2. What situational or environmental factors affected the ways in which those in nursing leadership and management 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?

Chapter 7 concluded with a synthesis of the preceding Chapters and specifically focused on the third question:

3. How did past leaders of nursing respond to and cope with changes in the organisation in which they worked and what were the effects that changing relationships had on the way in which they perceived their roles?

This question was chiefly answered through the description of three leadership styles, 'powerful', 'pioneer' and 'enabler', the findings from which are set out in Section 8.2.1. In this final chapter the findings from the previous Chapters are drawn out and then the fourth question is answered:

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?

8.2. Summary of findings from the study.

In this part of the Chapter the findings pertaining to the three leadership styles are examined first, this is followed by an analysis of the factors which contributed to the development of the styles.

8.2.1. Findings concerning the three leadership styles.

This thesis set out to examine the origins and manifestations of tensions within and about nursing leadership. Historically and contemporarily tensions appear to stem from differences between the segments of the profession to which nurse leaders belonged and this seems to have emanated from different leadership styles evinced by these nurse leaders. Whether the leadership styles which they adopted or developed were as a result of the tensions or were the cause of tensions remains a moot point.

In Chapter 7 the leadership styles which are considered to have developed from the a mix of the factors which affected them during their careers are explored. The ways in which the leaders interviewed had approached their roles as nurse managers was explored through a synthesis of three leadership styles. The most often occurring style was that of the 'powerful'. Their overriding motivation seemed to be that they should reach a position from which they could make a difference on behalf of their 'constituency', however this was viewed. This often brought them into conflict with other groups, necessitating the development of a range of political skills. The most frequently reported area of conflict was that of control of nursing education, especially in respect of the student nurse manpower and the pre-registration curriculum. The second group, the 'pioneers' were most likely to have considered that the future power of the profession lay in the development of degree level pre-registration courses and education and research which is linked to clinical practice. The third, and smallest, group the 'enablers' saw that the future for nursing lay in a 'democratic' style of management which emphasised the empowerment of others, mainly through educational techniques.

As was seen in Chapter 4 it was in the ways in which they described the practice of caring and in the ways that they had gone about their leadership and management roles to facilitate nursing's caring work that they differed most widely. As Figure 2 (Chapter 7) showed the powerful style was the most often identified. Twenty-three of those interviewed were considered to have demonstrated this as a single dominant style and one further individual was categorised as illustrating shared dominant styles of 'powerful' and 'pioneer'. One of the chief characteristics of those exhibiting this style was to attain prominence in the nursing profession and also to be recognised outside the profession so that they could influence standards of

nursing care; nurse's conditions of work; and the education of nursing students. The posts considered most influential in achieving these goals were the highest nursing 'service' management positions and 'officer' level posts in the Department of Health or the appropriate statutory body. Becoming an influential member of the statutory body, usually through election or selection by one's peers was also seen as achieving the 'kudos' from which to exert power. Education posts, either in the NHS or higher education, were not seen as carrying the same ability to influence in the ways desired and six of the twenty three designated as powerful who had embarked on nursing education careers changed the direction of their careers back to service management or to civil service or statutory body posts to realise their goals.

The powerful nurse leaders also recognised power in other individuals, for instance their immediate superiors and influential role models and mentors that they had met throughout their lives and careers. Other individuals and organisations, for example statutory bodies, Doctors, Health Service Administrators, politicians and the government were seen as powerful. A repeated theme in the interview excerpts used to depict the powerful style is the relationship in actual or perceived status and power terms between nurses and other groups, particularly associated with the less commanding position of nurses vis-a-vis medical and administrative colleagues in comparable posts on management boards. They described ways in which they considered they had been less favourably treated than general managers, administrators and doctors, such as less advantageous terms and conditions of service; job or study opportunities being blocked; and being marginalised or denied access to information or decision making fora.

Another frequent theme in power differential terms was the relationship between nursing service and nursing education managers, specifically the more dominant role of the service nurse manager over the principal nursing officer (education) or director of nurse education. Other aspects of this style which caused some concern to those who experienced it were discrimination of varying kinds. Although intra-professional bias between service and education personnel was the most frequently mentioned different segments of the profession also considered that other segments were prejudiced against them, the most often cited being general nurses 'against'

community nurses or midwives. Other forms of discrimination referred to were on the grounds of race, gender and religion.

In recounting the differences between nurse leaders and in contrasting the ways in which they set out to achieve their goals it must be recognised that until the mid 1980's, after the Griffiths Report, the leaders of nursing education within the NHS had been responsible and accountable to the leading nursing service manager. Some of these nurse educators described how they had attempted to have influence which was wider than the syllabus or curriculum but had been put down, or rebuffed, by their service 'colleagues'. Of the three nurse educators who were assigned to the 'powerful' style two had remained in the NHS and one worked within higher education. In addition all three held powerful positions within their statutory body and attempted to exert their influence on nursing through this means.

The nurse leaders in this study regarded that the characteristics of power were knowledge (or credibility) and expertise, particularly nursing expertise. Equally the possession and management of budgets and other resources was considered an important facet of the application of power. Managing people was seen as an important part of the powerful nurse leaders role, the processes considered most significant were the possession of authority to employ and dismiss staff. In addition the potential for performance review and staff development procedures to influence others was seen as significant.

The powerful nurse leaders believed that through their own mastery of and proficiency of management skills they gained credibility with their management colleagues from other professions. This was considered a notable feature of the style and gave them the opportunity to negotiate with other powerful individuals or groups on behalf of nursing colleagues. Committee work was appraised as one of the most important means through which the powerful nurse leaders could achieve their goals. The achievement of the necessary management skills was frequently referred to as learning political skills. In the extracts used to illustrate this there were descriptions of 'doing their homework' prior to meetings to ensure the outcome they desired, this was especially evident in the description Barbara Pearson gave of her meetings at the Department of Health, with the then Minister, as was

described in Chapter 6. The powerful nurse leaders considered that the ability to gain the support of powerful allies, often through using their extensive networks, and capability in negotiating their way through bureaucratic processes in order to achieve necessary change were paramount. Notwithstanding the need to find a way through proper channels some did concede that on occasion when 'red tape' or rules got in the way they used other means to achieve their ends.

Whilst the powerful nurse leaders relished the political aspects of their roles other nurse leaders, the 'pioneers' or 'enablers' in this study, either did not recognise the need to acquire political skills, or refused to 'play political games' or deliberately opted out of this aspect of their role. There were instances in the interview extracts where these differences had been a source of tension between individuals and groups. Especially when the behavioural aspects of the different styles were similar. As indicated in Chapter 4 the behavioural approaches used by the powerful leaders were mainly a combination of 'opportunism' and 'battler', for instance when they recognised an occasion when they could influence change to achieve the aims identified above they were prepared to 'fight' to achieve their goals. The leaders in this study who were designated as 'pioneers' also used similar techniques, it seems that they too had a clear view of where nursing education or midwifery should or could be going and they were ready to enter combat to accomplish their aspirations. It was noted that sometimes the 'powerful' and 'pioneer' nurse managers were in contention with one another. This may be one of the reasons for some of the nurse educators having left the N.H.S., it certainly was a basis for both specific individual and general professional tension as some of the extracts in the previous section showed.

Figure 3 (Chapter 7) showed that the 'pioneer' style was catalogued as dominant in sixteen of those interviewed, in addition two of those interviewed were considered to have demonstrated mixed styles, one 'powerful' mixed with 'pioneer', and one 'pioneer' mixed with 'enabler'. Of the 18 so identified all but two had reached their most influential position primarily in the field of nursing education (Table 4.2 and Figure 3). Nine were from NHS nursing education and seven had worked in higher education (four were from community nursing backgrounds), of the other 2 one was influential in a professional organisation and one in a statutory body. Fifteen were

female and three were male. A variety of subordinate styles was deduced for this cluster, nine had no significant alternative style and of these five became near casualties of the organisation at the conclusion of their careers, all taking early retirement from a structure with which they had become disenchanted.

The other significant combination of behaviours used by the 'pioneers' was that of 'committed/champion' for the cause of nursing. They were prepared to work long and hard at what they deemed important and they had the talents to share their fervour with others. These pioneering nurse leaders of the past had a lucid image of what it was they wanted to secure for nursing. Primarily their ambitions were focused on securing the best quality of care for patients and where necessary improving patient care. The chief direction chosen to achieve this goal was to establish a role for nurses which, whilst complementing that of the doctor, was seen to have component parts which were separate from the practice of medicine.

As they described their pioneering ventures they catalogued a range of factors which had facilitated or held back the innovations which they wished to achieve. Chief amongst the constraining factors was lack of resources, especially finance, they showed that they were able to overcome the difficulties that this posed through a variety of ingenious means. In their view two pivotal considerations impeded change; the negative attitudes of some of their contemporaries towards the innovations and insufficient backing from the government. They described ways in which the state generally and the hierarchy in nursing specifically had held back development. Despite these difficulties and constraints they illustrated that they brought about modifications delivery of nursing care and in the management and education and training of nurses in the decades examined. Some of the data examined showed apprehension about the wholesale move of nursing education into higher education. Whilst recognising the benefits of the location of nursing education in higher education for which they had fought so hard, the system which they had pioneered was selective, and it could be claimed elitist. They were worried that some of the current techniques, for example the non-medical education and training contracting mechanisms; the development of credit accumulation and transfer (CATS); and the procedures for accreditation of prior learning (APL) and prior experiential learning (APEL) all have the capacity to decrease standards in nursing education.

The majority of those classified as having the 'pioneer' style of leadership discerned a more independent future for the nursing profession and had a clear orientation to the importance for nurses at all levels to be educated to achieve that vision. Many of leaders studied were among the pioneers of the nursing process in the United Kingdom and they had asserted nursing's status as a profession. To enable nurses to practice autonomously the 'pioneers' evolved nursing curricula which stressed this independence. Traditional subjects, such as anatomy, physiology, hygiene, pathology and pharmacology were considered to reflect a 'medical model' and the time spent on them was decreased in favour of the study of nursing through the developing nursing theories and models of the time. Nurses were considered to require different skills as well (De la Cuesta, 1979; Hollingworth, 1985), specifically in handling the interpersonal facets of care, so the nursing syllabus at this time showed an increase in the amount of time given over to the study of psychology; sociology; and communication skills.

All but two had ended their careers in nursing education, those who left the NHS and went into institutions of higher education founded nursing as an academic discipline, in doing so they recounted feelings of loneliness and ostracism from the profession. Those who remained within the NHS described syllabus and curriculum changes directed at reducing some of the problems with nursing education, particularly the separation between service and education. The 'pioneers' considered that they could alter nursing education for the better and, with cooperation from their clinical colleagues, the hiatus between theory and practice could be reduced. In this way they believed that some of the tensions between the two groups could be lessened. However it appears from the data presented that the pioneer leaders from both areas of nursing education, NHS and higher education, were not valued by their professional colleagues.

These 'academic professionalisers' (Melia, 1987) or 'pioneers' were judged by their peers as detached from the reality of everyday nursing, especially those who pioneered courses and research in higher education. In their 'ivory towers' they were dismissed by their 'service' colleagues. The references in Chapter 6, by April Walshe and Hilary Miles to their education counterparts as incapable of managing, and the reports by Lilian Johnson and Carmel Arter of their 'isolation' from the

majority of their nursing contemporaries in their positions in higher education accented the tensions between nursing service and nursing education managers. The subjugated manner in which Sylvia Pole, Roy Elm and Sebastian Reason illustrated their relationships with their nursing service colleagues and the ways in which some of the attempts by nurse educationists to innovate in nursing practice were rejected by their service colleagues led to the conclusion that there was an 'anti education' and 'anti theory' bias within the nursing profession, which appears to relate to similar arguments put forward by White (1985) and Rafferty (1997a). The pioneering nurse educationists seem to have been seeking to champion the cause of nurses and nursing as a profession rather than nursing as caring work. As argued in Chapter 2, and as illustrated in the different definitions of nursing and the work of nurses held by the leaders studied (Chapter 4), the essence of the tensions between the 'powerful' and the 'pioneers' arises in the aspiration of some leaders to alter the perception of the work of nurses in order to raise its status. Thus those seeking to reach professional status by means of occupational mobility and occupational closure were seen by some of their counterparts as having squandered or handed over to other workers some important aspects of their work. These arguments were most strongly advanced by Andrea Davies and Serena Crooks, both of whom had reached the highest levels of work and were designated within the 'powerful' category.

The 'enablers' on the other hand appear to have remained closest to an ideal of nursing as caring work and, whether service or education managers, to have maintained the essence of nursing as caring in their guiding values. The small number of 'enabler' nurse leaders (8) were chiefly from an education background and their fundamental mode of operation was through encouraging the development and achievements of others. The 'enablers' believed that by helping others to perform their jobs better they were improving patient or client care. Like the powerful the enablers worked through the formal structures of the system, mainly committees, to advance their ideals and to introduce empowering conditions and facilitative organisations and procedures in work settings. They used career guidance, mentorship and role modelling to enable growth in both their own staff and others. They also used their far-reaching networks to disseminate their activities outside their immediate locality.

This style was aimed at providing help and support to professional colleagues. An important emphasis of the way in which they worked was through education and training, they considered continuing education a significant way through which change in the profession might be achieved and they variously discussed the structure, content and style of teaching and learning activities as significant ways in which others could be enthused by nursing. Their reasons for trying to enable others were to improve relationships and through doing so to help them to work more effectively. Through developing their staff's abilities they sought to improve care. Thus their techniques were designed to share their vision of nursing and its future and they considered that through the methods they used they could best achieve innovation and change. Like the pioneers they put a lot of effort into ways of overcoming the theory-practice gap in pre-registration nursing education. The enabler style was very 'person' oriented, those functioning in this way seemed very aware of themselves and the effects of their approach to work on others.

The values which underpinned the beliefs which they put forward about nursing which were described in the previous paragraph were those which emphasised care, caring and the importance of retaining the focus of clinical practice as at the heart of nursing. Arguably this was the finding which was most surprising, it had been assumed that as they had become nurse managers their emphasis would have changed to that of the managerial imperatives of budgetary and manpower controls, which have been stereotyped as the three 'e's' of efficiency, effectiveness and economy. There was a recognition that their orientation was not what other managers, nor even society at large, found fashionable. They described how their careers had developed and been influenced by these factors, how they had fought for what they believed in and how their lives had been dedicated to achieving what they considered the best for their patients, their students and their profession. There was also a view that some of them had compromised these values, whilst others admitted that their own careers had been cut short or that they had deliberately opted out of systems and environments which they found incompatible with their values. When they contemplated the current and future position of nursing they were keen that these values should regain or retain pre-eminence. In the second section of this Chapter it is suggested that the concept of caring has the potential to become

a unifying theme. The following sections of this final chapter examine the findings from the study which are considered to be factors which contributed to the development of the three leadership styles described.

8.2.2. Findings related to career experiences.

The observable tensions between those in leadership positions in nursing studied here appear to stem directly from the experiences that some of them had of general hospital nursing in the middle decades of this century. The analysis of their career pathways in Chapter 4 (Career Pathway diagrams appear in Appendix 2) showed that a significant number did not like hospital nursing, general nursing in particular. In the main the reasons given for this were related to their experiences as student nurses being used as 'disposal, cheap labour', and some actively sought to leave general nursing at the earliest opportunity. After a period of what has been termed 'casting about' most of these discovered midwifery or community nursing, although there were a small number who chose mental illness or mental handicap nursing, and settled into a segment of the profession which was more in keeping with their values. Others left nursing practice and became nurse teachers after a relatively short period of time. As was described in Chapter 4 the settling into a segment of the profession which matched their beliefs and values was usually accompanied by a statement of commitment. However the division into segments seems both a cause and an effect of the profession's disunity, and has resulted in some of the tensions within and about nursing leadership which are the focus of this study.

Another important finding from the analysis of their career pathways was that many spent a very short period of time actually practising nursing before promotion to a managerial position. Most commented that they had little or no preparation for management, learning was very much 'on the job' and 'coping' or 'muddling through' were the outcomes for some. The importance of learning from role models was highlighted and this was described in more detail through subsequent Chapters of the thesis. The significance of developing the abilities necessary to learn from experience, especially those of being able to stand back from a situation and reflect on it was also identified in Chapter 4, again this was explored in more detail in Chapters 5, 6 and 7.

The analysis of their individual similarities and differences and the experiences encountered during their training and early careers, coupled with the wider background in which nursing and its management was practised, came together to form their own approaches to nursing when they were promoted to positions of authority. This was explored through an analysis of the knowledge and ways of knowing; the ways of behaving; and values and commitments which they evinced.

The statements that they made about nursing were analysed and this led to the discovery that 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 several different types of knowledge about nursing and about leadership and management were isolated. 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). Experiential, practical and presentational knowledge were very much in evidence but it was considered 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. With regard to ways of knowing, presentational knowledge (Heron, 1992; Reason, 1994) came across as the most vivid.

There are implications based on these findings for the ways in which nurses of the future learn both to care and to lead in a caring profession. As previous chapters have shown the situational and environmental factors which the leaders of the past encountered contributed to their views of nursing and their styles of leadership. The findings concerning these factors will be examined in the following section.

8.2.3. Findings regarding situational and environmental factors.

The organisations in which they worked and the status and position of nurse leaders within that organisation had profound effects on their subsequent leadership styles. In Chapter 5 the significance of their relationships with others drew out the importance for all of them of the post and role of the Matron. A matron or matrons

had influenced them, their career or the profession at large, at the risk of speculating unnecessarily one wonders if the same could be said of the senior nursing service positions today. The loss of the position of matron was followed by a series of re-organisation, re-structuring, and reform of the National Health Service the dual effects of which were seen as heralding a 'male takeover' and the loss of the 'nursing voice' in decision and policy making at levels which could make a difference to patient care. The tenets of managerialism were considered incompatible with the caring values of nursing and coupled with the advisory nature of senior nursing service managers positions nursing leadership was considered to be missing. Many laid the blame for this squarely on the shoulders of their colleagues although there were those who acknowledged the role of politicians and the growing economic stringency as factors.

The respondents in this study were fearful of the future with regard to the organisation and management of the N.H.S. Their own increasing age and infirmity and that of their friends and relatives led them to wonder who would care for them. As Chapter 4 showed many were worried that they would not be cared for by registered nurses and that the needs of minority patient groups, such as the elderly, the mentally ill and the mentally handicapped, would not be acknowledged by health service managers. They drew on their experience as 'co-equals' with others on the management team following the Salmon Report (1966) and the 1974 N.H.S. structure to advocate for change in this area.

During the period studied views of nursing changed from those of the 'wife' to the doctor, trained in housewifely arts, through periods when the nurse would act as the doctor's assistant, then, with a scientific training as an autonomous professional. In partnership with medicine and with the nurse's caring skills matching those of the doctor's curative role, a new 'syndicalist craft' (Strong and Robinson, 1990) was envisaged. The effects of these views and the wider environmental changes on pre-registration nursing education were explored with the respondents, and findings were reported mainly in Chapters 5 and 6. In considering factors which had enabled or constrained educational change they variously described nursing's statutory bodies as repressive and bureaucratic or facilitative and enabling, although on balance the former view was the most likely to be expressed. In the early part of the period

studied the problems associated with the 'apprenticeship' system and the didactic and repressive nature of their own early training experiences had led many to become leading advocates of changes in pre-registration nursing education. The culmination of which was seen as the introduction of Project 2000. From personal experience as patients, the experiences of friends or relatives and from their current positions within the Health Service they expressed their views about this course of preparation. They were especially vehement in the view that today's student nurses were not being taught to care for patients. They considered that some of the organisational and process aspects of the course, such as the reduction in 'hands on' care; the emphasis on the 'academic' rather than the practical; and the lack of early specialisation had all served to increase the 'theory-practice' gap. This was exacerbated by the introduction of the health care assistant grade and a diminution of the numbers of registered nurses on the wards, all of which meant that the problems of supervising students in clinical placement areas were as severe, if not more so, as when student nurses were 'apprentices' rather than supernumerary. Finally the introduction of the 'internal market', especially as it has been applied to nursing education in the form of Working Paper 10, and its successors, was seen as detrimental to the ability of nursing education managers to achieve an 'education led' programme.

The other environmental factor which proved of significance in the time period studied was that of the move of nursing education into higher education. The past nursing leaders interviewed viewed the integration of nursing education with higher education as both potentially beneficial and threatening. One of the chief benefits they anticipated was through the development of nursing degrees and nursing research. In their view nurses would then be seen as equal to their health care professional colleagues in terms of academic background and would be better equipped to argue for enhanced patient care and nursing practice in decision and policy making arenas.

Extracts in preceding chapters highlight fears about the roles of nurse teachers within higher education and their lack of preparation for these roles. In part the fears were associated with the failure of nurse educationists to remain clinically and theoretically up to date and to manage their own business. Some of the leaders

studied also worried that intellectualising nursing would lead to a diminution of the ability of nurses to care for patients. There was also an uneasiness that nursing education would become dominated by yet another group, the managers of the institutions of higher education. They expressed concern that the 'new masters' failure to understand the specific needs of nurse education would further diminish the caring content of the courses and that financial considerations might overshadow the academic and clinical requirements of nursing education. Alongside these concerns about funding and control issues in respect of the higher education influence on nursing education the move was seen as having the potential to take nurses away from their clinical and practice focus thus jeopardising the future survival of nursing and hence nurses. Some of those interviewed considered that the integration of nursing education into higher education would lead to nurses losing control of the education of students and that this would have detrimental effects on patient care. There was thus a view that whilst they welcomed the potential benefits for nursing education of its presence in establishments of higher education there was a need for political astuteness on the part of the nursing leaders in this environment so that the control of nursing education, especially the clinical and caring aspects of its curricula and the funds allocated for teaching and research, should not be lost. The need for nurse managers, especially the leaders of nursing education to retain a philosophic orientation to care and caring in the face of powerful others was further explored in Chapter 6. Relationships with others was considered to be a significant factor which had contributed to the leadership styles developed in this thesis.

8.2.4. Findings with regard to relationships with others.

As was seen in Chapter 5 senior nurses, especially matrons, had a profound effect on their careers. This was analysed in greater depth in Chapter 6, especially the ways in which their future approaches to their own management and leadership style developed through these influences. The fact that many of those who furthered their careers in hospital nursing had actually practised nursing for a very short period of time before being promoted to a position in which they were managing nursing and nurses emerged as significant. Therefore they had very little experience of caring for patients as registered nurses, the majority of the time that they would have spent in direct, hands on care would probably have been as second and third year student nurses. They were more used to being in a position where most nursing care was delivered by untrained personnel. When they were promoted to ward sister they learned many of the skills of management, not the skills of nursing. Thus their own style of management, when it began to develop, was based on directing others to give care. This is not so true of those who moved into community nursing practice or to a certain extent of those who remained in midwifery practice. They were much more likely to have had a period of time managing their own case load of patient or client care, and, as the literature review showed, they were amongst the arch proponents of the move to professionalising nursing or of asserting the autonomous role of the midwife.

As well as highlighting the role of mentoring and role modelling in developing future leaders in the nursing profession Chapter 6 went on to explore some of the other significant factors associated with the relationships that these nurse leaders had during their careers. Some described learning management from administrators and doctors, especially when it came to developing their appreciation of the need for political skills in the performance of their roles. The fact that some of those interviewed did not relish this aspect of their roles was evident, although most spoke of recognising the need and setting out to acquire the competencies required, again through both formal and informal means of learning. Their preparation for management had been patchy and usually post promotion to their managerial positions. The Salmon report had recommended that nurse managers receive

management preparation and courses had mushroomed, some of those interviewed were somewhat sceptical of the benefits of the courses that they had attended, stressing the need for real-life learning, preferably under the tutelage of a mentor. Whilst formal courses might not always provide what they saw as necessary many stressed the importance of time out from the demands of the workplace and the opportunity that this provided for reflection. There were thus important findings in this chapter, which expanded on some of the evidence presented in other chapters, about the ways in which the sample studied learned their management role. These findings have important lessons for the preparation of future nurse leaders which will be expanded on in the second part of this chapter.

Two other factors emerged from the analysis regarding their relationships with significant others, the role of gender and faith in the formation and maintenance of their own style of managing. The gender of nurse managers and the effects of gender on their careers and approaches to leadership has been scrutinised during the period studied. The emergence of male leaders in nursing was viewed with scepticism and distaste by some of those studied and was positively welcomed and campaigned for by others, usually but not always, men. Female nurse leaders during the period studied have been caricatured as bitchy and bossy. These 'Queen Bees' were considered by some to have been over controlling, to the extent that decision making by others, lower down the hierarchy, was not encouraged. This domination was accompanied by an over emphasis on trivia, described by Richard Crapton as a 'counting the spoons' mentality and by Maria Palmer as nurse's need to 'dot every I and cross every T'. Janet Ightson attributes these traits in nurse leaders to the rote learning which was rote, which was fostered during the majority of the period studied, whilst Lilian Johnson and Charlotte Holmes described how they were discouraged from asking questions. The net result was nurse leaders who were considered repressive to juniors and subservient to seniors, most scathingly referred to by Carol Nyman as 'the dregs', who, when promoted to the most senior positions, lost their nursing focus.

Following World War 2, the introduction of the NHS and changes within the nursing profession which admitted men to the Professional Register and to the RCN, these views of female nurse leaders led to the increase in male leaders previously

described. Like many of the factors isolated and explored in this study the rationale for these different approaches were multi-faceted. It has been claimed that the masculine influence on nursing has taken it away from its caring values and from its clinical emphasis. If this is true it is too simplistic to say that it is only men who are culpable and if the argument is accepted that nursing needs to return to, or achieve a new ethos of caring then to claim that it is only women who can realise the changes needed is pure arrogance. It is considered that the findings of this section of the study are that in respect of gender a balance of the masculine and feminine approaches needs to be found. The implications of this conclusion will be further explored in the second part of this chapter.

With regard to the last of the factors which were isolated and analysed in Chapter 6 those of faith and religious affiliation were significant and the link was made with the motivation to enter nursing and the forces which sustained the careers of some of those interviewed. The desire to be of service and the duty to care which many of them expressed was linked with tensions between a view of nursing as a truly caring 'vocation', and notions of professionalism (Francis et al,1992). There is a view that the obligation of nurses to care for their patients is at odds with their own welfare which Reverby (1987) highlights as the 'dichotomy between the duty and desire to care for others and the right to control and define this activity'.

8.2.5. Conclusions with regard to the findings of this study.

The key features associated with the three leadership styles identified is the emphasis on the centrality of clinical practice as the essence of nursing and the importance for nurses to retain an ethos of care and caring. What was clear though, from the evidence presented, was their differing conceptions of the meaning of care and caring and this led to tensions, and sometimes conflict, between nursing leaders. From the literature reviewed regarding nursing leadership it appears that there is a dichotomy between the rhetoric of the values of care and the reality of managing care.

It should be noted that our efforts to explore the concept revealed the inchoate nature of our understanding of it. Smith found that the students in her sample had

little guidance and personal support throughout their training from either teachers or ward sisters, and she concluded that:

Nursing leaders exhort nurses to care, but their definitions are limited because they fail to take into account the emotional complexity of caring. Neither do they consider the way in which care is stereotyped as women's 'natural' work nor the gender division of labour and power relations between doctors (predominantly men) and nurses (predominantly women) within the health service which marginalise care to 'the little things'

(Smith, 1992:135)

Smith's comments about the failure of nurse leaders to define care certainly seem borne out by this study. There were few attempts to define what they meant by nursing, nursing care and caring or to explore the implications of their stated beliefs and values regarding care for the nursing profession or for the work of nurses. It is perhaps unfair to judge the past leaders too harshly when the concept has only recently become fashionable and when nurse academics themselves have only begun to explore what the concept entails. The leaders studied here believed passionately in the centrality of caring as the philosophic basis of nursing, what was different was their definitions of caring. The different conceptions of caring demonstrated in the descriptions of the leadership styles in previous chapters was obvious. All the leaders interviewed clearly showed their commitment to nursing, a profession that they had worked in for between 22 and 50 years and many espoused caring values. The different leadership styles seemed to stem from disparate views of what constituted nursing care, who should deliver that care and the education and training needed in order to best prepare the different grades of carers. It seems that there was a lack of agreement between the different segments of the profession and that the nurse leader's energies at times appear to have been turned inwards to argue their case against each other, or against the claims of another segment of the profession, than to have been directed outwards to face the other causes of tension in nursing leadership. These disagreements were most vivid between the nursing service managers and the nursing education managers, although there was also evidence of disagreement between hospital nurses and community nurses and health visitors, between nurses and midwives, and between general nurses, children's nurses and nurses of the mentally ill and mentally handicapped. The message derived from these conclusions is that in order to harness the political power which

could be theirs nurses need to find a unity which has heretofore not been evident. However there was evidence from the data presented that some of the situational and environmental factors which the leaders studied had encountered during their careers which had contributed to the relatively low profile which nurses gave to political issues.

In the next section of this Chapter some of the implications for policy makers and for nurse leaders of a shift from past ways of managing nursing to one which has caring at its heart will be explored. From the nursing leadership styles developed in previous chapters the strengths of each of the three styles will be harnessed to suggest an alternative future. In particular their emphasis on care and the need to preserve the caring elements of nursing will provide the focus for the future structure, organisation and education of the nurse and help to decrease the tensions which form the basis of this study.

8.3. Future leadership of nursing based on the concept of caring - a new paradigm.

It is widely claimed that the essence of nursing is caring (Briggs, 1972; Leininger, 1985). Radsma (1994) argues that the claims have yet to be substantiated, she contends that nurses have failed to demonstrate that they do care, and cites examples of lack of care for patients and for colleagues. From the literature reviewed in Chapter 2 it was ascertained that power relationships; nurse-nurse; nurse-patient; and especially nurse-doctor; appear to be at the heart of the dichotomy between care and cure models of health. The work associated with 'illness' has been redefined over the period in question. Medicine and cure can no longer be seen as the only or the most important answer to such problems as Acquired Immune Deficiency Syndrome, old age and dementia, long term and chronic mental and physical disabilities. Acute and life threatening episodes are relatively rare, and for most patients are over fairly quickly, what is left is long term care. Thus the divisions and boundaries within 'medical' work need to be redrawn. Whilst a new paradigm for nursing leadership is proposed, nurse leaders, alone or collectively, no matter what approach to management or leadership they use, cannot put this situation to rights. Society, government, health care policy makers, and all health care workers

will need to face up to a range of issues that contribute to the current tensions in nursing leadership. Present and future generations of nurses will need to challenge current social and health care policy in ways which differ from their predecessors. What should be recognised is that achieving unity is going to be as difficult, if not more so, today as it was in the years in which the sample studied here practised. Even if the concept of caring is accepted as a unifying theme, as Brykczynska (1997) points out, nurse theorists do not agree with each other and there is the danger that it might become another 'academic fad' to be 'discarded'. What nurse managers and leaders will need to do is to ensure that they overcome their current disunity, unimportance, insignificance and invisibility, and draw the issues associated with lack of care, failure to care, or poor standards of care, and the effects of this on the economy and health of the nation, to the attention of all groups.

8.4. Implications for the Future.

A re-orientation of nursing to the tenets of caring is proposed as fundamental to what would be a revolutionary approach. The pre-registration curriculum and arrangements made for students to learn nursing in both the classroom and clinical areas appears as one of the most crucial areas to which nursing leaders need to give their attention. Alongside this review of the curriculum there is a need to re-evaluate the organisation and delivery of nursing work. All of which will have important effects on future careers in nursing for those who practice, teach, manage and conduct research in the profession. The identification of and preparation given to the nursing leaders of the future is a vital component of this analysis.

8.4.1. Recruitment and selection.

The focus for selection of potential recruits to nursing needs to be on the attributes which are capable of translation into thoughtful carers. In the past nursing attracted a wide range of men and women with a variety of skills and attributes. The diversity of educational, social and cultural backgrounds which can be deduced from the information presented here and the richness of experience that previous nursing leaders brought with them into nursing may have important significance for the

future. Whilst not wishing to denigrate the work that they did and the achievements that they made for the profession, it is suggested that selection should be much more rigorous and objective than in the past. The focus should be more on the attributes needed for care and caring than has previously been the case. There is obviously a need to attract and select people who are willing and able to learn nursing, but what is also needed is to attract and select people who can nurse and who can lead and teach nurses.

The starting point for any assessment of what is needed for the future must be with ensuring that an accurate picture of the new approach to nursing is portrayed in advertising campaigns. Potential recruits should have as realistic a picture as possible of the reality of health care delivery and of nursing's role within it. All attempts should be made by policy makers and by those responsible for recruitment at a local level to assist potential recruits to base their decision to enter nursing on sound knowledge and facts not on some starry eyed or idealistic notion. The range of possible nursing careers and the varied groups of people who have found satisfying work within nursing should also be portrayed.

Some kind of a 'pre-nursing' experience might also be offered, perhaps a short course of work experience for school leavers could be devised. Those attracted to nursing who have already left school, and maybe have had other careers, might be encouraged to undertake voluntary work in their preferred field of nursing. Alternatively they could work as health care assistants for a period of time. Whilst acknowledging that this strategy might result in prior learning of current approaches, which nursing will be seeking to change, the experiences will form a basis for exploration and reflection on experience once the individual begins the course. The benefits should be that the recruit has a better understanding of the work which they are choosing to enter and so hopefully will make a more informed decision.

There is obviously a need for selection methods to be devised which will ensure, as far as possible, that the decision that the institution makes is based on objective criteria. If the level of all pre-registration nursing education is raised to that of a first degree then there will be a need for the candidates to display the intellectual capacity to undertake a course of this nature. However it is important to recognise

that some of the current criteria used for entrance to higher education may discriminate against the kind of people who could be successful in nursing. Selection tests should be used which are capable of assessing different kinds of intelligence. Handy (1994) lists nine: factual; analytical; linguistic; spatial; musical; practical; physical; intuitive; and inter-personal. At face value some of these forms of intelligence appear to have more relevance to nursing than others, however to some extent this depends on the area of nursing which attracts the recruit.

Linguistic (interpreted as the ability to learn other languages) and musical aptitude are perhaps those areas of intelligence which are the least likely to be crucial to the ability to nurse successfully. Spatial, practical and physical competence will be required more in certain areas of nursing, such as high technology care, than others. It is possible though for psycho-motor coordination and the connections between patterns of data to be learned during the course if this is a requirement. If these skills are considered to be a necessary pre-requisite for selection it is feasible to test for them. Factual intelligence, defined as the possession of a good memory, is considered important for all segments of the profession. Handy (1994) suggests that analytical intelligence, reducing complex data to more simple formulations, is a strong feature of academic work, he does not say whether he is basing this assumption on empirical evidence, nor whether he is referring to male or female academics. There is some evidence to suggest that institutions of higher education have been as gender biased as the Health Service and that until recently women's ways of knowing have been neglected. Belenky et al (1986) review the extensive evidence for this claim and conclude:

It is likely that the commonly accepted stereotype of women's thinking as emotional, intuitive, and personalised has contributed to the devaluation of women's minds and contributions.

(Belenky et al, 1986:6)

There were clear areas of difference regarding this issue in the data presented from the nursing leaders interviewed. Jennifer Westley obviously prized what she referred to several times in the interview as a 'strong, logical, rational, line of thinking', while Andrea Davies referred to herself as 'not academic' yet able to lead groups in problem solving as well as, if not better than, men. Elspeth Wright was clear that

she used intuitive knowledge as part of her work as a leader and others expressed the implications of intuitive applications to nursing work. Handy (1994) suggests that intuitive intelligence, seeing things which others do not and the inability to explain why's and wherefore's, is an attribute which women have to a greater degree than men. He also suggests that interpersonal intelligence (the wit and the ability to get things done with and through other people) is needed to be a leader but that it does not often go with factual and analytical intelligence. Interpersonal intelligence appears a requisite for nursing and recent work by Goleman (1995) could be used to devise ways of assessing whether or not the potential recruit has the knowledge and abilities which are encompassed by this kind of intelligence. Goleman suggests that these are:

Knowing one's emotions, this self-awareness, of recognising a feeling as it happens, is the keystone of emotional intelligence;

Managing emotions, this basic emotional skill allows those who have it to handle anxiety, gloom and irritability, whilst those without it are 'constantly battling feelings of distress';

Motivating oneself, the ability to marshal emotions to achieve a goal is fundamental to concentration, self-motivation, mastery and creativity. It is claimed that those with this ability are more highly productive and effective in whatever they undertake;

Recognising emotions in others, i.e. empathy, is the fundamental 'people skill' and that those who are 'empathic are more attuned to the subtle social signals that indicate what others need or want....this makes them better at callings such as the caring professions';

Handling relationships, skill in managing emotions in others, or social competence, are the abilities which 'undergird' popularity, leadership, and interpersonal effectiveness.

(Goleman, 1995:43)

What seems clear from the extensive empirical evidence that Goleman reviews to substantiate his claims is that possession of these abilities are crucial to nursing and other caring professions. For as he claims:

medical care that neglects how people feel as they battle a chronic or severe disease is no longer adequate. It is time for medicine to take more methodological advantage of the link between emotion and health..so that a more caring medicine is available to us all...compassion is not mere hand

holding. It is good medicine.

(Goleman, 1995:185)

In this section of the chapter arguments have been advanced for a fundamental review of selection and selection criteria which match the skills and attributes of caring which have been isolated. Additionally recruitment should be aimed at attracting people from as wide a range of people in the community as possible. Issues of class, race, age and gender equality should figure highly in recruitment campaigns. It is important that people who have been ill are not excluded from this as they often have first hand experience of the 'little things' (Smith, 1992) which make the difference between a nurse who is 'caring' and one who is not.

Selection techniques should be devised which are capable of assessing the possession of the attributes required. As was discussed earlier the reliance on intelligence as demonstrated through G.C.S.E. and other examinations should be augmented by ways of measuring 'emotional intelligence'. Goleman (1995) identifies that there are no paper and pencil tests as yet that can do this but that there are many which can test its components. This he suggests is best done through testing people's actual ability at the task. For instance experiments have been carried out to test empathy using video tapes and asking viewers to read a person's feelings. Other techniques which might be useful are simulations and ethical discussions. For example a group of potential nursing students might be posed a question on a topical issue regarding health care, such as health care rationing, euthanasia, genetic experiments or similar topics. The interviewer should be able to assess their levels of reasoning as well as their interpersonal skills in the ensuing debate and discussion.

8.4.2. Implications for the pre-registration curriculum.

The curriculum will need to ensure that nursing students are equipped with the abilities to care about and to care for their patients. As argued in the previous section this will involve emotional, intellectual, interpersonal and practical expertise. Currently there is confusion in the minds of the various factions within nursing as to the focus of the curriculum. As was concluded in the literature review the implications of shifting the nursing curriculum from the medical model of curing to

the nursing model of caring have yet to be realised. Thus both approaches are evident in nursing practice and education and this has led to confusion for nursing students and internal strife between different segments of the profession. The inference which has been reached from the data presented in this thesis is that the root cause of the confusion and dissent is the failure of nursing and nurses to fully espouse the tenets of caring. To follow these convictions to their ultimate conclusion would, it is suggested, bring nurses into conflict with doctors, managers, policy makers and possibly society. Student nurses need also therefore to be prepared to assert nursing's role, and to be equipped with the skills to do so.

This is not a new suggestion the U.K.C.C. (1986) advises that the way forward for curriculum planners is to strengthen the emphasis on caring. The fact that the need to reinforce this message is occurring almost a decade later seems to point to missed opportunities for nursing. Drawing on the components of leadership which were identified from the interviews with past nurse leaders it is possible to construct an analysis of the content and structure of a caring curriculum and to suggest ways in which caring might be taught and learned. A sketch of some of the fundamental elements rather than a detailed blueprint is offered and some of the implications for change that adopting this curriculum might entail are pointed out.

Ways of knowing.

From the epistemological perspective examined in earlier chapters 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. This has important implications for the content of the nursing curriculum and for the ways in which it is taught.

Whilst many of those interviewed seemed to have translated their abundant experience and practice into stories and their use of metaphor was sometimes vivid, translation of the images produced into propositional knowledge was infrequently evident. Dale (1994) suggests that practitioners need to increase their propositional knowledge of theory which underpins nursing practice, for example models of nursing or nursing theory, and that nurse lecturers need to refocus their practice knowledge through a return to clinical practice and through developing their skills in enabling students to gain experiential knowledge.

Dale (1994) seems to be suggesting that the missing link for many nurses is experiential learning, that is: 'experience followed by reflection, discussion, analysis and evaluation leads to insight, discovery and understanding, which is then conceptualised, synthesised and integrated into the individual's system of constructs which (s)he imposes on the world' (Wight in Boydell, 1976). In earlier publications by the author of this current study it was suggested that student nurse's learning was often left to chance because the experiential learning cycle is not completed (Miles, 1981 and 1987). It seems that the respondents in this present study, like so many nurses before and after them, had little time for reflection and were not taught to use the time they did have to best effect. Thus a vital chain in the learning link was lost. A critical aspect of the pre-registration curriculum which is proposed here is that student nurses, nurse practitioners and nurse lecturers learn to make the link between practical and propositional knowledge. Some nursing scholars wish to distance themselves from what is considered to be the almost inevitable link between theory and practice when considering the present status of nursing as an academic discipline. Packard & Polifroni (1991) suggest that this route 'seals the fate of nursing as only (author's emphasis) an applied science'. They go on to suggest that:

There is, however, the possibility that nursing could and should evolve as a pure science; that is a science for its own sake, for the purpose of knowing as detached from the sole purpose of immediate application.

(Packard and Polifroni, 1991)

One of the particularly worrying aspects of using caring as the central concept to guide nursing, nursing education, nursing leadership and management and nursing research is the tendency for nurses to 'obsessive self-scrutiny' (Parsons, 1986;

Jolley, 1989). Morse et al (1992) analysed nursing research and theorising about caring and devise five conceptual categories into which these studies fall. These categories are: caring as a human trait; caring as a moral imperative; caring as an affect; caring as an interpersonal interaction and caring as therapeutic intervention. They suggest:

Presently the concept is poorly developed....There remains a loose link between many definitions of caring and patient outcomes....If the relevance of caring to practice and to the patient cannot be clearly explicated, or if it is claimed that caring cannot be reduced to behavioural tasks, and if caring is the essence of nursing, then nursing no longer will be a practice discipline.

(Morse et al, 1992:87).

This is clearly nonsense, nursing is self-evidently a practice discipline and one which most, if not all, of its practitioners would claim is based on notions of care and caring, however unsophisticated their conceptualisation. It is obviously important for nurse leaders, especially academic leaders, to stop expending too much ink on theorising and spend more time helping practitioners to develop and improve practice, especially through assisting them to develop propositional knowledge.

Whilst the sentiments expressed by the above authors is understandable in light of the way in which nursing is viewed in some establishments of higher education, this approach is not advocated here because of a belief that separating nursing knowledge, or theory, from the practice of nursing would herald the end for an emerging craft based occupation. Alternative views of the role and place of nursing as an academic discipline are suggested by Rafferty (1993a) and Glen (1995) and it is proposed that future research should be directed to an examination of this question.

The alternative to the separation of nursing theory and nursing practice which is suggested here is that from the beginning of the pre-registration programme nursing students should begin to explore the meaning of the term caring and its application to nursing as caring work. This will entail an exploration of the knowledge necessary to achieve the 'enabling of the other person or the idea to grow, develop

and achieve the maximum possible of her, his or its potential' (Mayerhoff, 1972). This implies a well founded knowledge of epistemology and ontology and an in depth study of people as individuals and in groups. What should not be forgotten is that many of the students will already have their own knowledge and theories of caring, and some of them may well have practical experience of care giving. The analysis of caring carried out throughout their course should enable them to build on their current level of expertise in a way which respects them as learners (Belenky et al, 1986).

Nursing as caring implies the 'therapeutic use of self' and this is not possible without an understanding of oneself as well as others. Students will need to examine the personal traits of caring; patience and humility, constancy and guilt (Mayerhoff, 1972) and apply this knowledge to themselves and to their work as nurses. It is anticipated that recruits to the profession will already have a good understanding of self as it is hoped that acquisition of this knowledge will have started in school. Improvements in social and emotional awareness in school children are reported (Goleman, 1995) and it would seem possible to develop similar courses in this country. There are already proposals to introduce community service into the curriculum and to encourage schools to develop in students values relating to self, relationships, society and the environment (National Forum for Values in Education and the Community, 1996).

The nursing curriculum should build on these areas of learning, perhaps by using some similar methods. It is important to recognise that many of the students of nursing will continue to be women. If women's abilities in respect of learning to learn and learning to assert an autonomous role are to be altered the teacher's role needs to change to that of facilitator of learning or to the teacher as 'midwife': 'they assist the students giving birth to their own ideas, in making their own tacit knowledge explicit and elaborating it' (Belenky et al, 1986:217). Adopting this approach to teaching will ensure that the values which teachers demonstrate in their relationships with students mirror those that are necessary in a caring association with patients.

Values.

Watson claims caring as the 'moral ideal that guides the nurse through the caregiving process, and knowledgeable caring, that is professional nursing, is the highest form of commitment, an end in and of itself'. She develops ten 'carative factors' as a caring basis for all nurses. These factors are 'a humanistic, altruistic value system; the installation of hope and faith; empathy; a helping-trust relationship; interpersonal teaching; and the provision of a supportive/protective physical and/or mental environment (Watson, 1988:423). Roach (1982) devised a unified caring model which unites health and human needs, the components of this model are compassion, competence, confidence, conscience and commitment. Miles (1987, 1988) considers the relevance of these concepts in curriculum development for nurses. What seems increasingly clear is that some of these values, particularly those related to altruism, seem incompatible with assertiveness and autonomy (Reverby, 1987). Not until nurses are able to understand and work through the dilemmas posed by the contiguity of power and caring on their work for themselves will it be possible to change the curriculum in the ways suggested.

In order to learn caring the core value in the relationship between the teachers of nursing and their students must be that of care (Watson, 1988; Bevis, 1989; Diekelmann, 1990; Tanner, 1990; Paterson and Crawford, 1994). This has implications for teaching and learning methodologies (Bevis and Murray, 1990; Hughes, 1992) and assessment techniques (Diekelmann, 1990, Tanner, 1990) which are well documented in the literature. Perhaps the most significant message though is that nursing students find it difficult to learn caring in environments which do not demonstrate caring (Hegyvary, 1990). Current leaders in nursing, both in practice and educational settings, will need to face up to and take action to remedy the situation in which:

nursing students enter a profession with caring ideals but face negativism about nursing and nursing education by practising nurses in the clinical area.

(Paterson and Crawford, 1994:169)

In the literature review and in the leaders subsequent descriptions of their own training there was ample evidence of students being exposed to uncaring clinical environments during their initial occupational socialisation. In addition there was

evidence of teachers behaving in ways unconducive to learning to care. Recent and current research shows that teachers find it difficult to find the time to behave in a caring way to their students and also that some current organisational arrangements in education establishments are not conducive to learning caring. Arguably the emphasis on training and preparing students to be 'institutional employees' (Watson, 1988:423) has taught the skills of survival within the institution, rather than educating for caring. A former Project 2000 student, sums up the past and the needs for the future:

In unsafe environments 'survival skills' appear to be more necessary than 'growth inducing' ones. Nursing has been subject to many reappraisals and so much oddly shaped new packaging, but its core has been little touched. If we fail to care for care givers, or to counsel and develop, where will anybody find a role model of caring from which to learn?

(Brownrigg, 1992:52)

A curriculum revolution is needed accompanied by a revolution in the practice of teachers and clinical nurses (Spence, 1994). Thus in both the clinical and classroom learning environments students need to be exposed to teachers who demonstrate caring attitudes to patients and to staff. The organisations in which staff work will need also to show that it values them and the work they do.

Organisation and structure of the pre-registration course.

A key question is whether initial programmes should prepare nurses for a generic or specialist role. The author's preference would be for specialist courses that recognise the skilled nature of the different segments of nursing. This does not mean though that courses for separate parts of the Professional Register should be pursued entirely apart. Shared learning should be encouraged so that each segment of nursing grows in awareness of and respect for one another's unique contribution. For similar reasons joint and shared learning between other students on pre-registration courses leading to a health care professional qualification should also be encouraged. The emphasis on care and caring which forms the focal point of the nursing curriculum lends itself to sharing with other neophyte members of the health care team. The fact that each of the students is undertaking a degree level programme should also enhance integration. For instance, student nurses, doctors, physiotherapists, might

learn to understand their respective roles and relationships and to explore the issues surrounding the distribution of power in the divisions of health care labour, particularly emotional labour, in joint experiential sessions. The problems and successes associated with this kind of learning have been documented since their introduction in 1986 in Sweden (Areskog, 1995) and the experience of student nurses and medical students successfully undertaking a shared community module is reported by Frederickson et al (1993).

There is a need to offer a range of well supported clinical experiences in the early part of the programme. The current reliance on registered nurses in clinical areas to give care to patients, supervise students and the unregistered members of the care giving team needs to be rethought. Similarly the exposure of patients, particularly those who are receiving care in the community, to large numbers of student nurses, as well as students on other courses, needs to be reconsidered. More of the course might consist of simulated practice in an environment where patients are not also being cared for, for example a clinical skills laboratory, followed by periods of practice under the supervision and guidance of nurse lecturers or lecturer practitioners. It must be recognised that this sort of preparation will not produce nurses who can practice with complete confidence and competence immediately upon qualification. A period of continued support needs to be offered following registration, what the U.K.C.C. refers to as 'preceptorship'. This is currently not offered by all employers, usually on the grounds of costs. In the long run the benefits, especially to improved standards of patient care and nurses' morale and competence, are likely to outweigh the costs to those Trusts and other managers adopting this short sighted policy. Thus the course structure proposed is along the lines of a new kind of Two plus One scheme, perhaps a Three plus One, with a period of supervised practice after initial registration.

Learning to nurse.

As suggested earlier systems of pre-registration education that rely less on learning facts and how to carry out procedures and more on learning to learn and to reflect on experience, need to be more widely adopted. Numerous schemes using experiential and problem solving approaches to nursing curricula have been

described (Miles, 1987). The Griffith University programme (Anderson, 1993) in the preparation of nursing students is well documented and there are arguments for the adoption of problem based learning in nursing higher education as an approach in which 'clinical nursing is not seen as the end product of a theoretical programme but as part of the learning experience' (Glen, 1995:94). Currently the emphasis in this country is on teaching rather than learning in many nursing courses. Gibbs (1996) proposes a paradigm shift from teaching to learning which has currency for nurse educators.

In these experiential or problem solving sessions the nursing student will need to examine and explore the implications for nursing work of the analysis of caring which has been suggested. The distinction between caring about (the emotional and intellectual activities of caring) and caring for (the practical activities associated with tending for the ill and disabled, nurturing patients to encourage independence, teaching patients or their relatives about their illness, how to self care or care for others, how to avoid illness) will need to be made. Nurses will need to understand that in this context no aspect of care is beneath them, no task so menial that it can be discarded to other health care workers; in short nursing students will need to learn and be enabled to practice nursing. This is the most fundamental and radical of these proposals so far as it implies re-ordering the way in which nursing is viewed and practised currently.

8.4.3. The organisation and delivery of nursing.

Strong and Robinson (1990) have referred to the possibility of nursing being re-born as a 'syndicalist craft' and Melia (1987) suggests that nursing should be developed along the lines of a craft rather than a profession. These notions are developed here as they seem to offer ways in which nursing might develop along caring lines. By recognising that nursing is skilled work, that nursing is a trade and that nurses are 'journeywomen', a more accurate assessment of their worth should be possible. Radsma (1994) claims that 'little recognition is afforded to the actual work involved in care. Nurses struggle with the responsibility of care, but are given little autonomy in determining what constitutes care, or how care should be given' (1994:444).

Work study surveys of the 1950's (Goddard, 1953), dependency measures of the 1960's and 1970's, the 'extended' and 'expanded' role debates, clinical grading and the skill mix reviews of the 1980's and 1990's, have tended to split and polarise nursing work. The higher status, usually technically oriented, often discarded medical tasks have been seen as the preserve of the registered nurse. In addition the increasing amount of administrative and managerial duties associated with the accountability movement of the 1980's, for instance performance indicators, Korner returns and Rayner scrutinies and the demands of the current reforms, have taken the qualified nurse further away from the notion of delivering holistic care. Care delivery therefore continues to be the preserve of the untrained and part-trained, a situation which seems to have worsened since the introduction of 'Project 2000'. In addition along the way many activities which nurses should be carrying out have been 'hived off' to other health care workers. Hence, responsibility for safeguarding patients so that they are cared for in clean environments which are conducive to recovery and the responsibility for ensuring that patients have eaten an adequate and appropriate diet have all been deemed non-nursing duties. Clay (1987) comments that nursing should reconsider its role and reclaim some of the 'non-nursing duties' which nurses in the past were too ready to give away' (Clay, 1987:89).

The 'think tank' of nursing leaders which is spearheading developments to determine the appropriate role of the registered nurse needs to consider the extent to which so called 'non-nursing duties' should be redesignated in the interests of better patient care. The example given by Andrea Davies of examining some of the patient-focused hospitals in the U.S.A. seems to hold out some interesting possibilities in this respect. It is encouraging to note that at a meeting in 1996 national nursing leaders concluded 'there is a need to ensure strategic coherence in the development of nursing and health visiting roles in clinical practice' (Department of Health, PL/CNO (96)3, 1996). However, without appearing too cynical, it is important that the gathering of nursing's 'great and good' which was called together to agree these laudable aims should take the opportunity to challenge some of the current practices rather than accepting the status quo. It is hard to see that challenge forthcoming as all but two of the six signatories to the Department of Health letter are employees of government.

Government will need to examine the effects that current funding mechanisms are having on the education of nurses, particularly at pre-registration level. The divisive nature of this process increases tensions within nursing leadership and despite the fact that the advent of Working Paper 10 in 1991 was supposed to herald rational commissioning of sufficient nursing students to replace trained staff wastage, there is now an acute shortage of nurses in many specialties (RCN, 1997). Manpower planning systems, which were to become so much more sophisticated with the advent of the purchaser - provider split between service and education, seem as bad, if not worse, than previously was the case. There is evidence that the current mechanisms are not successfully meeting workforce planning needs and that student nurses are being used as stop gaps to meet short term crises in the care delivery system (Kershaw, 1996). Demands for nurses to meet current 'fitness for purpose' criteria is having a deleterious effect on their educational needs and is not enhancing the nurses' abilities to develop the critical analytical skills necessary to enable changes to be made in the future delivery of their service. Contracting mechanisms and the 'macho' style adopted by some Consortia and Trust staff are adversely affecting the ability of service and education managers to work together to plan for the future (Butterworth, 1997). Thus strong consideration should be given to removing all pre-registration nursing and midwifery education, and some areas of post-registration education, from the strait jacket of local contracting. Government should also consider the funding arrangements for the education of other health care professionals who fall into these categories. The simple alternative would be to fund nursing, and other areas of health care education, through the H.E.F.C.E. processes. Considerable savings could be made in this way by dismantling the bureaucratic structures which have been built up to service this divisive and inexact process.

Under an H.E.F.C.E. funding model universities with established Departments of Health Care Studies (or whatever title) would be given a target of student numbers within their maximum aggregate student numbers and student recruitment, wastage and success rates could be monitored in exactly the same way as all others are within the University. This process could also be linked in to the National Board's data bases and savings could thus be made by freeing up staff from double and sometimes triple counting of students. It is possible that this proposal would be

considered too radical, and that the Department of Health might not wish to part with the substantial sums of money involved. If this is the case then a separate system, along the lines of the Teacher Training Agency, might be devised.

Nurse leaders at national level would need to unite to put this proposal together. This would mean that the present policy of the Chief Nurse at the Department of Health of keeping Executive Nurses and 'Deans' of Nursing, in England, apart would need to be reversed. This policy is not helping to maintain the communications between the two groups and means that nursing policy at a national level is not coordinated. At the same time as examining policy issues regarding the funding of nursing education this grouping of nursing leaders, perhaps on a regional basis, should consider the nature of the programme for pre-registration education. There is sufficient evidence to suggest that the structure of 'Project 2000' is not meeting the needs of today's service and that the placement requirements are putting a great deal of strain on certain areas, particularly in the community. Leaders of the U.K.C.C. and National Boards (if they continue after the quinquennial review which begins in 1997) should be invited to these meetings. As well as giving consideration to the structure of the programme nursing leaders should determine the level at which the course should be offered.

The anomaly of running a three year Diploma should be abandoned. In order for nurses to achieve the changes, which the remainder of this chapter will outline, nursing needs to be an all graduate profession. Patient care should be planned and evaluated by registered nurses and much of it should be also be delivered by registered nurses. McFarlane (1987) argues for an all graduate nursing profession by the year 2000. She considers that nurse graduates should fulfil a major policy making role as well as developing the knowledge base of nursing action. She claims that the key function for nurse graduates is the clinical role, as primary nurse, as clinical nurse specialist and as nurse practitioner. It is also important that the role and function of registered nurses is debated and agreed at national levels and that nursing's leaders should take the lead in this debate. The evidence for improved standards of patient care when delivered by registered nurses needs to be understood by all parties and the costs and longer term benefits of care delivered in this way should be explored. Clay argues along similar lines:

How will it be possible to win the argument for a wholly qualified nursing workforce?....a strong case can be made on the grounds both of quality of care and of economics"

(Clay, 1987:103)

Alternative scenarios should also be examined, particularly the outcomes of care being delivered as it is now, largely by unregistered health care assistants loosely supervised (if supervised at all) by a dwindling number of hard pressed nurses. Recently doctor's assistants, similar to the physicians assistants introduced in the 1960's in the U.S.A., have been employed. This has raised concerns about conflict and confusion between the roles of these workers and nurses (Castledine, 1996; Peysner, 1996). There are also worries about patient safety, protection and quality of care (Castledine, 1996) and the implications for nurses of a more extended role (Peysner, 1996). The ramifications of the other recently proposed 'multi-skilled care worker' should also be explored. Rank and file nurses will need to conquer their seeming aversion to political activity and unite in a way that they have not done previously to back their leaders in this endeavour. They must all be aware of the potential personal consequences of collective whistleblowing in this way and be prepared to take the risks entailed. Only then will nurses be able to lay claim to care and caring as the essence of their work.

However, the Department of Health (1989b) does endorse adoption of 'new nursing' or primary nursing, which seems to offer nurses most in terms of recapturing the caring aspects of nursing. Merrett and Holloway (1991) describe how primary nursing was introduced into a private hospital as the most appropriate response to the 'changing needs of patients'. However even this approach is seen to have potential for further divisiveness in nursing's ranks. Robinson argues that:

primary nurses will be the elite core of nurses; trained to a high level both academically and in terms of key skills such as assertiveness, they will expect to be participating as equals in innovative schemes, research work and further development work...there will be little left over for full-time associate nurses and even less for part-time and bank staff.

(Robinson, 1992:34)

Kate Robinson goes on to argue that these policies are likely to discriminate against married women with children and black nurses, particularly black women. Clearly

for a nursing workforce which is espousing the ideals of caring this would be an anomalous situation. Organising nursing in a way which discriminates against some members of the profession would not demonstrate values of equality and would deny black patients the opportunity to be cared for by nurses with intimate knowledge and understanding of their culture. Discrimination of this kind will also deny married nurses with children and black nurses the career and development opportunities which will enable them to become the leaders of the future. Furthermore it is a system which will fail to provide student nurses and the recently registered nurse with the opportunity for role models and mentors. It is therefore important for current nurse leaders to pay careful attention to the career structure and continuing professional development of all sectors of the profession.

An alternative, and much more radical approach to the future structure of nursing, is for practitioners to contract out their services. Kanter suggests that one of the ways for individuals to creatively overcome the effects of uncertainty and instability caused through restructuring is to set up in business for themselves, and she comments that temporary business is 'booming' for the medical professions (1989:305). In the future individual nurses, or groups of nurses, could set up independently and contract their services back to N.H.S. Trusts or G.P. fundholders. They might also set up private companies and health care purchasers could contract directly with them, rather than with Trusts or G.P.s for the nursing service they require. The effects of this could prove revolutionary in the way in which nurses and the services they are able to provide are viewed. The individual nurses or the nursing service companies would be responsible for ensuring that they are competent to practice and that their educational requirements have been met. N.H.S. Trusts or G.P. fundholders would be freed from the need to spend time and money on meeting the personnel requirements of a large, static workforce. They would only need to 'employ' nurses at times when they had to provide care for patients, they would not have to pay for holidays, or sickness, nor to release staff for education and training. They could satisfy themselves that the nurses they employed were capable of providing the kind of service they required. Similarly the nurses who went to work for the Trust or GP could ensure that the philosophy and approaches to care in operation in the workplace were in keeping with the tenets of caring, and, if not, they would have no obligation to work for an employer who did not provide

optimum facilities and resources to ensure high standards of patient care. In short only the best nurses would be employed and only the best organisations would be able to attract those who would want to work with them. Poor calibre nurses would need to change or become unemployed, poor quality Trusts or GP's would go out of business. Whether nurses remain in fulltime employment with health care providers in future structures or whether individuals or groups contract out from the service there are important implications for future careers in nursing.

8.4.4. Future Careers.

The data presented in this thesis indicates that past leaders used the early parts of their careers to 'cast around' for a segment of the profession which fulfilled their particular individual needs. This finding may help to further illuminate some of the factors causing lowered morale amongst the registered nurses of today. Opportunities to 'cast about' have been significantly reduced in the last five years. Few nurse education establishments offer post-registration opportunities in a second registerable qualification, apart from midwifery. The 'controls' imposed by Working Paper 10 contracting methodologies further reduce an individual's opportunities to try out another nursing speciality unless they are prepared to fund it themselves. The current employment and economic climate within the country are also factors which inhibit career mobility. It appears not inconceivable that there are some registered nurses having to work in a specialty area in which they are less than fulfilled and who are denied the opportunities offered in an earlier age to 'cast around' until they find their niche. The reduced opportunities for people to find an aspect of nursing which suits them is another factor which might ultimately reduce the opportunity to attract potential candidates who could enrich the profession.

In the past there have been criticisms regarding the lack of a clinical career structure (Glen, 1983) and the evidence from some of the leaders interviewed was that they did not wish to leave the profoundly satisfying position of ward sister. Focusing nursing on caring and better targeted recruitment and selection criteria should obviate the need for so many nurses to 'cast around' in the future. It is also envisioned that increased emphasis on careers which have at their core the clinical role of the nurse will be more satisfying.

Nursing must revamp its work both on the clinical career structure and on raising standards of care. Equally important, the close interrelationship between the two must be recognised and reinforced.

(Clay, 1987:60)

The implications of this statement are that a much flatter career structure than has here-to-fore been the case must be devised. If promotion, status and power, and the material benefits associated with this, continue to reside with management and teaching then it is almost inevitable that ambitious nurses will be forced to leave the clinical area. Rafferty, writing about the current emphasis by the D.O.H. on Opportunity 2000, comments that the:

emphasis on management may limit the scope for developing creative careers in nursing,....paradoxically this may stymie rather than stimulate innovation. It remains to be seen to what extent such changes redistribute the resources and educational opportunities for leadership posts in the NHS in a manner which is sensitive to the politics of women's career patterns and aspirations.

(Rafferty, 1993b:13)

There will thus be a need to focus on the opportunities that nursing does offer for a worthwhile career and to enhance the development of nurses who wish to remain clinically focused. It seems vital that current nurse leaders encourage the organisations in which they work to provide careers advice to qualified nurses. Numerous studies into the careers and professional development needs of nurses have found that this aspect of employment was inadequate. Shepherd (1995) found that 69% of respondents had never experienced performance review at any time during their careers and that nearly 50% had not received adequate or appropriate careers advice. Currently there are over half a million registered nurses within the United Kingdom so it seems that there is the potential for a great deal of saving of time and morale if greater emphasis were placed on providing proper careers advice across the country.

Hardy comments that 'how nurses come to value bedside nursing to the detriment of the development and promotion of self needs to be explored in some depth' (Hardy, 1983:310). Recent emphasis on continued professional development and the enhancement of clinical skills through clinical supervision (Butterworth and Faugier,

1992; Faugier, 1992b; Faugier and Butterworth, 1994; Department of Health, 1994c) offers opportunities for practitioners and skilled supervisors to reflect together on practice, to identify problems and to agree improvements in practice and greater understanding of professional issues. Role and career enhancement is also offered by the 'Scope of Professional Practice', which demonstrates the ways in which nurses, midwives and health visitors can lead flexible, creative and innovative initiatives relating to the changing needs of patients and clients and so improve the quality of care (U.K.C.C., 1996). The requirement for each nurse who wishes to continue to practice to compile a personal professional profile encourages individual practitioners to assess their current standards of practice, develop reflective and analytical skills, review and evaluate past experience and learning, plan continuing education and career development and provide evidence which may be credit worthy through A.P.E.L. and C.A.T.S. systems. All of which should enhance the status and quality of bedside nursing.

As well as enhancing clinical career possibilities there is a need to ensure that those nurses who do become managers or teachers are encouraged and given opportunities to remain clinically involved and up to date. Clay argues that:

Nurse managers ...will have to return to the clinical area if they are to contribute to leading a service where nurses act more independently and to a higher level of competence.

(Clay, 1987:94)

More recently nurse managers themselves are demonstrating ways in which they are achieving this. Batehup (1992) writes of her role as clinical nurse manager and MacPherson (1994) argues that executive directors of nursing can, and should, maintain a clinical aspect to their roles. Edwards considers that nurse leaders should be 'firmly located at the provider end' of the internal market and that the nursing profession should not look to the district, regional and national officers for its leaders as 'that is the old world. It is time that we moved the leadership focus back to the place where the nurses are' (1990:1465).

If, as Kanter claims, professional career structures in future will be defined by craft

or skill and possession of valued knowledge will be the key determinant of occupational status, and reputation will be the key resource for the individual (1989:309/310) then the careers of nurse teachers or nurse managers who move away from their craft and who fail to make a name for themselves will be endangered. Thus future career patterns in nursing are more likely than ever to show horizontal job moves, to gain experience and to refresh clinical skills. This pattern will be in direct contrast to that of most male dominated occupations and professions where the career pattern of the potential leader follows an 'arrow like' trajectory (Marshall, 1989), travelling straight to the target. The fact that arrows can fall to the ground if they fail to reach or miss the target is an alternative explanation for the 'derailed' career (Fritchie, 1995) or what was referred to in this thesis as the 'victim' or 'casualty'. The potentially destructive notions which this analogy conjures up might be offset by what feminist writers, such as Gallos (1989) and Marshall (1989) call the 'female spiral' career, which could be beneficial to both men and women:

The linear career view is shifting toward a scheme of sequential stages. Development is largely cumulative, each phase building on the achievements or conflict resolution of its predecessor in continual improvement. Development is acquisitive; once something has been gained, it should be retained. 'Backward' as a direction has negative connotations. Theoretically a range of career possibilities are being recognised, but many are depicted as 'failure'....Female values offer career theory a more cyclical interpretation of phases, based on notions of ebb and flow, of shedding and renewal...They involve giving something up, letting achievements go, in order to create anew and differently....It is part of a more cyclical view of development sometimes to go backward, to recapitulate steps made before, although they will be different each time and offer new learning because of their different place in the life pattern.

(Marshall, 1989: 285)

Thus it seems that career patterns of the future need to be very different to those of the past. The preparation for future nurse leaders will need to reflect these changes.

8.4.5. Preparation of the leaders of the future.

To change the practice of nursing and place caring as its nucleus has profound implications for the education of nurses and also for the leadership and management

of nursing and nurses. To alter the focus in this way challenges the culture of the health care delivery system and the society in which and for which health care and nursing are provided. The way society views nurses appears somewhat ambiguous. Reverby (1987) argues that 'nurses are ordered to care in a society which does not value caring', however, the public's conception of what nurses are and what they do are multifarious and sometimes confused. Salvage identifies that in general the images that the public have of female nurses fall into three categories, 'angels', 'battleaxes' and 'sex symbols' and men in nursing are considered somewhat 'funny and effeminate' Salvage (1985:23). The role of the media in presenting stereotyped images of nurses led Kalisch and Kalisch (1987) to conclude that the negative effects that this had on the way in which society envisions nurses could lead to an inability of the public and policy makers to enter into an unbiased assessment of the position and worth of the nurse to the nation's health care.

Clay argues that nurses need to ascertain whether or not society is in accord with nurses in their political endeavours.

Nurses have demonstrated in recent years...that instead of being the product of social policy, they wish to influence and even create policy. We need to know therefore if the public views us as acting legitimately when we act in this matter, as we increasingly have done. The future direction of nursing must be one that is in harmony with the needs of society and with our professional aspirations.

(Clay, 1987:35)

This poses a major challenge to nurses and their leaders whose voices are not judged to be particularly evident and prominent in health care delivery or health care policy making. Recently nursing's invisibility has been descriptively expressed as 'a black hole' (Robinson, 1992). Davies (1995) depicts nursing practice as the 'polo mint' problem: that is 'qualified nurses find themselves in the main supervising and managing others who do most of the care delivery....the practice of nursing...drops through the vacuum in the middle' (Pembrey, 1985; Davies, 1995:90). Perry suggests that 'the mentality of caring' is submerged within medicine's empirical science and that 'despite the nursing theory of holistic caring it is apparent that real barriers to this approach exist in health organisation' (1993:48). Nursing's lack of visibility and influence may in part be responsible for failure to attract potential

leaders. Rafferty suggests that this weak competitive position in the labour market may be due to 'nursing's image as facilitative, caring and nurturing' (1993:10). Perry (1993) claims that the consequence of nursing's long history of subservience to hospital medicine and hospital administration is:

an inferior status in their institutional roles compared to that of their professional or idealised nursing model. The old problem of powerlessness in nursing cannot be cured by assertiveness training, quality management styles or even an academic education. Nurses' lack of authority is not the fault of passive individuals but a system of health care which undervalues caring as non-scientific work.

(Perry, 1993:47)

If the changes proposed here are to be achieved then the way in which nursing is portrayed must be addressed so that prospective recruits are aware of the reality of nursing and see it as a worthwhile career for intelligent, thoughtful, articulate and empathic people.

It is one thing for nurses to be faced with re-educating the general public with regard to their proper role and function, what is more worrying is that it appears that policy makers share the stereotypes held by the media and the general public. Smith (1992) reviewed the recruitment advertisements for nursing published by the Department of Health and its predecessor the Department of Health and Social Security. She concludes that the posters and literature 'convey the predominate image of nurses, usually women, as carers....caring is portrayed as intuitive, instinctive, as something you're born with by virtue of your gender' (1992:2).

Nurses will need to unify in order to achieve the changes advocated. Robinson argues that the 'competing groups within nursing which fail to set the occupational issues within the wider socio-economic context of health care' and to recognise that the 'internal divisions' maintain nursing's subordination (1992:8). She believes that the future for nursing is through the role model of the few highly educated nursing leaders that she and her co-researcher observed 'taking their seat at the policy-making top tables and asserting their right to be heard, not just for nursing but across the whole spectrum of health care issues' (1992:8). Education is considered

to be the central and crucial way forward in order to equip leaders of the future with the necessary skills. Bennis (1972) puts forward an argument for leadership preparation which is seen to have special relevance to the education of future nurse leaders.

We must educate our leaders in at least two competencies: (a) to cope efficiently, imaginatively, and perceptively with information overload.....(b) We must educate for empathy, compassion, trust, nonexploitiveness, nonmanipulativeness, for self-growth and self-esteem, for tolerance of ambiguity, for acknowledgement of error, for patience, for suffering. Without effective competence, and the strength that comes with it, it is difficult to see how the leader can confront the important ethical and political decisions without succumbing to compromise or to 'petite Eichmannism'.

(Bennis, 1972:117-118)

Bennis' proposals seem to be advocating a shift to more creative and expressive leadership styles for all managers. Arguably the 'feminine leadership styles', based on notions of nurturant or therapeutic power (Lorentzon, 1990), will be what are needed by managers of both sexes in the future. It would seem that nurses, with a strong ethic towards nurturance will be natural candidates for management posts in the health services of the future. If this is the case then there will be a need to establish mechanisms for spotting nurses with the potential for leadership early in their careers. Opportunities should be included in pre-registration degree programmes to build on the lifelong learning skills introduced, hopefully, in general education.

Currently specific skills based management training is the responsibility of N.H.S.Trusts, with support and possibly some accreditation from Universities. At the Trust level it is important that current nurse leaders use the opportunity to ensure that nurses within the organisation are equipped with the leadership and management skills necessary to do the job of the future in creative ways. It seems vital for the success of the proposals put forward here that future talent spotting is not left to the methods of the past otherwise nurses will be passed over because their caring values are not prized or nurses may be forced to conform with the prevailing ethos. Contemporary management theorists, such as Marshall, argue for a more balanced approach to leadership than that which obtained previously. An approach

which neither 'glorifies or devalues the female or male' (1989:167) but which enables men and women to develop the management skills of the future:

ways to enquire together, learning - above all- to listen with respect to others, especially when they seem different to us, allowing the tentative to be tentative, the passion to be expressed, learning to sit with what emerges and not hold on too tightly as we let our appreciation of the world change.

(Marshall, 1989:169)

In this new approach, transformational leadership, leaders have been described as self aware and mature, able to handle confrontation, conflict, stress, both personal and within the organisation. They have clear personal values and goals and the ability to articulate these to their staff in a consistent fashion (Leigh, 1988; Wille, 1991). Later in the analysis of the nurse leaders styles there is some evidence that nurse managers and leaders, male or female, already possess some of these qualities, particularly those in the 'enabler' style category.

More recently feminist writers have suggested that the definitions of success in careers are gender biased (Gallos, 1989; Marshall, 1989), and that there should be a recognition and valuing of the less 'arrow like' career pattern for both men and women. Auld (1992) argues for an appraisal system for nurses designed to identify those nurses with the ability for 'innovative thought and action'. She claims that an accelerated career pathway should be encouraged for those nurses with 'exceptional potential', but recognises that the nursing profession finds this concept difficult because 'we have had to climb every rung on the ladder..our successors must do the same' (Auld, 1992:29). There are concerns that the new structures do not provide opportunities for nurses to gain the experience necessary to become directors of nursing or general managers (Markham, 1991; MacPherson, 1994). Trusts are urged to develop the role of the nursing director and nurses and nursing are exhorted to seize the opportunities that the new culture offers.

There are some examples that the need for change is recognised. Savage argues that nurses need to develop better people managing leadership styles as the 'highest quality of care is supplied by nurses who exhibit contingency model styles of leadership' (1990:8). Merrett and Holloway (1991) describe a Senior Sister

Development Programme designed to 'transfer values and develop skills as a means of unification and establishment of an organisational climate where only the highest quality of nursing service would be acceptable'. The programme was designed and implemented within a private hospital with support, in the form of a jointly appointed nurse teacher, from the local college of nursing. This kind of innovation may well be the model for the future as the role of nurse lecturers will also need to change in light of the findings of this study and the ways in which it is proposed that nursing and nursing education should be transformed in the future. The R.C.N. identifies that nurse teachers are 'teaching in a different world' and offers a radical scenario for the future of the teacher as 'first and foremost a practitioner'. It is envisioned that nurse teachers will have abilities and skills:

They will be teamplayers and networkers, 'wholesome entrepreneurs', creative and assertive, financially aware, politically astute, and professionally responsible. They will be accustomed to a concept of 'flexi-careers', and will be skilled in managing change at both the personal and the organisational level.

(R.C.N., 1993:13)

The individual that the R.C.N. envisages as the lecturer of the future was found in some of those interviewed but what is needed for the future are nurse leaders who can encompass the skills and abilities of all three of the leadership styles isolated in this research. In many instances the future relationship between nurse 'education' and 'service' will need to be rebuilt so that there are opportunities to talent spot and nurture potential leaders who emphasise caring values. Merrett and Holloway describe how they developed a 'collegial' relationship to 'unlearn stereotypical attitudes of lack of understanding, conflict and mistrust' between service and education nurses (1991:34). Joint structures to allow more flexibility and interchangeability between the two organisations, for example, in clinical practice, in management, in research and in teaching at a range of levels will need to be developed. There is some evidence that developments of this kind are already underway (Allan, 1995; Bernhauser; 1995). In the future it seems not impossible to have a Professor of Nursing who is also an executive nurse of an N.H.S. Trust or Independent hospital.

The ways in which nurse leaders of the future learn should also be enhanced. In the

final stages of the data analysis process in this study a potential core category was identified:

that each manager's life and work, 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

(*Reflective Diary, 1996*)

Robinson believes that 'finding a common voice in nursing will only be achieved by nurses adopting a reflective stance which demands a critical evaluation of values just as much in day to day practice as in the qualitative research enterprise' (1992:8). Handy claims:

We need to be able to recognise and identify problems and opportunities. We need to be able to organise ourselves and other people to do something about them, and we need to be able to sit back and reflect on what has happened in order that we can do it all better the next time round. It is the cycle of discovery at work. The skills involved are conceptualising, co-ordinating and consolidating - the three c's. They are the 'verbs' of education as opposed to the 'nouns', the 'doing' words not the facts. We don't learn to use these verbs by sitting in rows in a classroom, but by practice.

(Handy, 1994:207)

Thus it is considered essential that nurse leaders are all able to reflect and learn from practice and that they have the skills to recognise when they, others and/or systems need to change, and that they have the skills to effect these changes. Like the student nurses they need to be able to analyse self, others and organisations and have the will and ability to argue for modifications to, and transformations of, systems which do not accord with the ideology of caring.

8.4.6. Future organisation and management of the health service.

It is important to recognise that the changes suggested in the structure, organisation,

leadership and management of nursing will not and cannot take place in a vacuum. The organisation and management of the health service will need to change as well if the tenets of care are to be embraced. There are some signs that there are shifts in the way the service is managed (Dix, 1996), but each analyst reads the signs differently. The Health Service Journal in June 1996 speculates that the handling of the 'Yorkshiregate' affair by the Government 'marks the strange symbolic death of NHS managerialism'. The ex-regional general manager considers that there is the danger of moving to an administered rather than managed system, with 'unimaginative, cautious, non-inspirational management' (McLean, 1996). However he had just become a casualty of the system so perhaps too much should not be read into these prognostications. There is, however, recent evidence that general managers are demoralised by 'manager bashing, the long hours culture and hampered in their leadership role by central bureaucracy'. Managers in the survey, carried out by the Health Service Journal, also comment on the 'culture of fear in the NHS' the 'increasingly unreasonable pressure' and the 'macho culture' (Carlisle, 1996; Dix, 1996).

If the tenets of caring are to become widespread within the service then the macho management style must be replaced. Hancock (1989) comments that senior management within the NHS is exclusively male and the atmosphere, imagery and language serves to reinforce an expectation that senior staff will be male. For financial and social reasons the gendered culture of the NHS must be combatted. Better gender balanced management teams and an open management style are suggested ways of achieving this (Maddock, 1995). Openness, responsiveness, accountability and fair play as manager's core values would help to improve patient care and quality management (Maddock, 1995). Nurse leaders of the future need to be 'well educated, articulate and assertive practitioners, who are both research-minded and intuitive, who practice ethically, who possess professional maturity, who espouse social justice and equity, and who demonstrate personal commitment and political astuteness' (Smith, 1995b:816). These qualities seem necessary for managers and leaders of the service as a whole.

The environment in which nurses and others who deliver health care work needs to become one in which the health and welfare of the workforce is acknowledged in

tangible ways. The then Director of Human Resources in the NHS Executive refers to the need for some aspects of the employment environment to adopt 'family friendly' practices (Jarrold, 1996). Another initiative which appears to demonstrate the importance of staff and their contribution to the organisation is the Investors in People enterprise. Other developments which focus on the health of staff, for example employers who provide leisure facilities, which can help improve fitness and well being, or the provision of counselling and support services to counter the effects of stress in the workplace are important. Nurse leaders have a part to play, alongside other managers, in supporting developments which help to humanise the workplace for staff. Managers of the future service will also need to recognise the need for nurses, and other caring professionals, to receive financial rewards commensurate with the work they do. This will mean acknowledging the loving and emotional components of nursing work and the stress and anxiety that working with people in this way engenders.

Hugman (1991) suggests that society, and especially individuals and groups, can help to gain the changes necessary by being involved through partnership and participation. These partnerships need to be real though and not mere lip service to including token 'service users'. He gives examples of ways in which members of the public have been involved in service delivery and policy making fora. He also advocates that professional organisations and statutory bodies should find ways of including service users and informal carers views. Doyal (1983) gives examples of the ways in which the women's movement has strengthened the links in some areas between women as providers and women as users of health care, including setting up G.P. practices organised along feminist lines within the health service with 'non-hierarchical working relationships and the active involvement of users in the running of the organisation' (Doyal, 1983:24).

Interestingly there are also some examples of the ways in which partnerships are being developed between NHS purchasers. A range of emerging models of health care commissioning has been surveyed which shows 'cultural change sweeping into the NHS....with 'win-win' power sharing rather than which group was seen to be leading....and opportunities for innovation and imagination in the commissioning of health services' (Health Services Management Centre, NAHAT, August 1996:5).

Nurses need to learn to acquire and use power in ways which differ from those of the past in order to achieve significant change in the services they provide.

8.5. Conclusion - The future for nurses and nurse leaders.

The major common feature of all the leaders studied was that of a vision. The ability to project the future, convince others of the need to change and support and sustain them through the changes is a widely accepted skill of a leader. While many of them said the words, in that they stressed the centrality and importance of caring, the actions they took were piecemeal and the divisions in the profession meant that there were never enough nurses saying the same thing and working towards the same goal. Clay (1987), who died before it was possible to include him in this study, reminds nurses that they constitute 5 percent of the working population. He sums up the challenge to all nurses for the future.

If those nurses become involved in and participate in political decision makingI believe they will be an unstoppable force for change....We must look beyond the immediate frustration of not being able to give all that we would wish for today's patients but resolve as individuals, as I believe is our duty, to do everything reasonable within our power...to make sure that tomorrow's people get the nurse and the nursing they deserve. I am confident that together we can be a powerhouse for change.

(Clay, 1987:151)

There are those who will scoff at the ideas proposed in this chapter, there will be those who question the necessity for such a radical change in emphasis, changes which strike at the heart of fundamental relations between men and women and at some of the long standing institutions in society, education and health care in particular. Others will say it cannot be done, and perhaps they are right. The changes will involve shifting the ingrained attitudes and deeply held beliefs of hundreds of thousands of people. The changes, if adopted, will take many years to achieve. Those who adopt them must be prepared to face adversity, but as the interviewees in this study have shown they, along with many nurses are determined, dogged, persistent, enduring survivors, who care deeply about their patients and the care that they give. What society cannot do without is the caring work of registered nurses. In order to provide this the current leaders of the profession, be they in

nursing service or education, working for statutory bodies, professional organisations or in the civil service need to take notice of the findings of this study.

Nurses at ward manager level or the equivalent level in the community should consider the ways in which they currently organise care and ask themselves two questions. Do these arrangements meet the needs of my patients or clients? Am I providing the best quality of care that I can? If the answer is yes - how do I know? If not - how might I change them? Those higher up in nursing service positions need to ask themselves the same questions, and be prepared to support their more clinically focused colleagues to challenge any arrangements which might not be in patients' best interests. Nurse educators need to question whether or not the preparation they give to pre- and post-registration nurses provides students with the skills to ask these questions, to know when and how to ask them, to have the ability to collect the evidence needed to answer the questions, and to present their case for change in ways which will influence decision makers. Nurses who have made the transition into general management, those who assume positions as Chairmen or Non-executive members of Trusts or Health Authorities, should be prepared to take the same stance. To this end current nurses and nurse leaders might consider harnessing the skills and experience of our colleagues who are in the third age of their careers (Handy, 1994). As this study has shown there are a number of them still involved in a range of activities related to health and health care. Many of them are very concerned about the present position of nursing leadership and about the future care that they will receive as they get older and more infirm. Many would like to help nurses to achieve the changes proposed in this chapter.

The concluding remark is left to another leading nurse of the past who was not able to be included in the study, due to her pressure of work:

Through all this 'chaos'...nursing will find its way - perhaps lead the way. You will go forward with hope. Something of the art and much of the vocation remains to illumine the path which leads to the future. In 100 years hence, or even 50 years, how will our age - your age - of nursing appear? Perhaps like this:

In an age when giving was out of fashion, because the prevailing mode of thought was that people should have all they wanted by right, you gave something that could not have been controlled or

rationed or adequately paid for in money - You gave something that the world cannot do without.

(Raven, 1995:74)

This thesis set out to examine the causes of observable tensions within the leadership of the nursing profession through analysis of qualitative data from fifty-one past leaders of the nursing profession. Specifically the tension between the leaders of nursing service and of nursing education has been the focus of the investigation. Although, as was shown in Chapter 4, both groups within the profession have a shared and overlapping 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.

The background to this study was shown to be both current and steeped in tradition. Contemporarily those nurses responsible for nursing service leadership face more demanding patient care needs at a time when financial prudence is preeminent (Hunt, 1992; Department of Health, 1995). Nurse educators on the other hand, recently removed from National Health Service employment into that of Higher Education, are faced with educating nurses to confront and contend with the demands of the current situation whilst simultaneously equipping the nurse of the future with the problem solving skills to adapt to expected changes and play their part in determining future health care policy (Department of Health, 1995).

Historically the conflicts between these two major segments in nursing has been rehearsed throughout this century. Consecutive inquiries into difficulties with nursing and the training and education of nursing students have suggested the need to detach the management of nursing 'service' and 'education' (Lancet Commission, 1932; Horder, 1943; Wood, 1947; Platt, 1964; Briggs, 1972; R.C.N., 1985). The crux of friction between these two groups of leaders seems to arise mainly from the situation of the student nurse as worker rather than learner and from the inferior status of the nurse education leader vis-a-vis the nursing service leader.

This thesis has examined the relationships between these two groups of leading

nurses and has also identified other factors which have produced tensions within and about nursing leadership. A key factor which has been suggested as contributing to the strain under which nurse leaders have worked throughout the latter part of this century has been that of the increasing shift of the NHS away from caring values and towards a greater business-like orientation. The demands for nursing service leaders to become more effective in the delivery of nursing care were at odds with the reasons why they entered nursing. Hingley and Cooper (1986) point out that:

a need to help others is a powerful reason why nurses enter the profession... the quest for competence and efficacy is especially crucial for those engaged in human service work....any factor that thwarts the worker's efforts to perform effectively or to feel effective will be a major source of job stress, strain and burnout...one of the inherent difficulties of all the caring professions revolves around the problem of judging personal efficacy and individual levels of professional competence' (Hingley and Cooper, 1986:41).

This thesis has suggested that these tensions did exist for the nurse leaders interviewed and that they responded to and coped with the role stress in a variety of ways according to the major segment of the profession in which they had chosen to make their careers. Some adopted the characteristics and values of the dominant group, the managers of the health service, and went along with the increasing stringency in finance and the measurement of nursing effectiveness through objective means. In doing so they were critical of their predecessors, especially those of the matrons, styles and approaches to management. However most of these nurse leaders found the changes in the health service in 1983 and 1989 difficult to accept and chose these years, or shortly after, to escape through early retirement, or to leave the N.H.S. Increasingly the leaders of nursing education sought to escape dominance from nursing service leaders through enhancing their own academic background; through pre-registration curriculum change, especially aimed at freeing the student nurse from their worker role; and through incorporation into higher education. These moves brought them into even greater conflict with their nursing service counterparts as they were seen to be increasingly detached from the reality of service provision.

The late 1980's and early 1990's were marked by a series of momentous changes

for nursing, and both nursing service and nursing education leaders were found wanting as the successive impacts of the introduction of Project 2000, the NHS and Community Care Act (1990) and incorporation into higher education were felt. By the mid 1990's the situation for nursing leaders was adjudged so bad that nursing leadership was seen to be at an all time low (Rafferty, 1993; Robinson, 1993; Davies, 1995; Williams, 1995). However, as this thesis has shown, every major change in the organisation of the NHS appears to have been accompanied by the denigration of the previous nursing leaders followed by a 'clear out' of their ranks and a new breed of nurse leader follows on, only to find that in five or ten years time they will be found wanting in the next round of changes. The country and the nursing profession surely cannot afford the waste of skills which this represents. This thesis concludes with recommendations which if adopted should go some way to ensuring that the nurse leaders of the future, whether they remain in nursing service management or take up nursing education leadership roles, are better able to cope with the challenges of the changes of the future.

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APPENDIX ONE

The Interview Schedule

Schedules for semi structured interviews with previous leaders of nursing and midwifery professions, particularly with those who had a significant impact on nursing/midwifery education.

Introduction

The purpose of the interviews is to identify the leadership and management roles and responsibilities of those interviewed and the key factors influencing how they undertook these roles.

The interviewer will also explore with the interviewees their perceptions of the overall management ethos of the N.H.S. at the time in which they were most influential, and what effect they consider they had on wider management and leadership of the professions of nursing and midwifery and more widely e.g. of the N.H.S. as a whole, regional or local influence particularly related to health and health care.

Lastly their views as to the past, current and possible future of nursing and midwifery education, and what they see as the major challenges will be ascertained.

Section 1

Leadership and management roles.

When did you first enter a management role and what was that role?

What subsequent management roles did you hold up to leaving the service.

What was the most influential of these roles?

What were the KEY RESPONSIBILITIES of that position?

Note: It will be up to the interviewer to focus here on the most influential role or roles, particularly if individuals have had a wide range of roles.

What factors determined how they undertook Management roles?

Note: If prompts are needed, for instance, their own leadership style, the leadership style of those around them, the requirements of the job, the skills and experience of subordinates.

Section 2

The delivery and management of Health care at the time that they were in influential positions.

Were you working in the N.H.S. during the time at which you were in these roles?

- if yes when was it and what were the key issues nationally and locally

- if no then where were they working , and again what were the key national and local issues

Note: If prompts are needed then:

give some background knowledge of the time and refer say to the politics and government, significant reports or events in nursing/midwifery history at that time, technological or social changes occurring etc.

How influential do you think you were personally?

Note: with each individual the interviewer will have prepared so that the question can be phrased to refer to something they published, something that they were working on, e.g. an enquiry, government working party, a piece of research etc. and ask them about that and then carry on into the question of influence.

Who or what were the other influential individuals or groups of the time?

How did the 'influence' network work e.g. through informal contacts, statutory bodies, professional groups etc.

Section 3

Nursing and Midwifery Education.

What were the key features of the provision of nursing/midwifery education at the time?

Note: Prompts here might relate to the G.N.C. syllabus current at the time, if there was one, if not what regulation was in place, whether it was before or after 1974 reorganisation, or after the formation of Area Colleges and the creation of the D.N.E. post.

What reports or investigations were current e.g. Platt, Briggs etc.

What are your views of the current issues in nurse/ midwifery/ health care education?

Note: Prompts here re: market forces, Project 2K, Higher Education 'links' or incorporation, N.V.Q.'s./ health care assistants

What do you think that the future might hold and what do you consider will be the challenges for the future leaders/ managers of nursing/midwifery/ health care education.

Letter sent to the sample selected in the first round of interviews Date 1992/3

Dear

I am currently employed as Dean of the Faculty of Health, University of Greenwich, prior to the 1st of January this year I was Principal of Thames College of Health Care Studies, which encompassed the previous schools of nursing and midwifery of Dartford and Gravesham and Greenwich and Bexley Health Authorities. The College was incorporated as a Faculty of the University of Greenwich at the beginning of this year.

I am carrying out a study to investigate the roles of the leaders and managers of nursing and midwifery, with particular emphasis on nursing/midwifery/and health care education, in the latter part of this century, i.e. since the inception of the N.H.S., and wondered if you would be willing to take part in my research? In the first stage of my investigation I would like to interview people who have held influential positions as leaders/managers in these fields during the period of time indicated. The areas that I am interested in exploring with you are your perceptions, and the key responsibilities of, the leadership role/s you held; the major factors influencing nursing and nursing education during your professional career, in particular in the period spent as a leader and manager of nursing education; the preparation undertaken for your leadership role/s and finally your views of current and future trends in health care and education for health care professionals.

The purposes of my study are to analyse management changes within the N.H.S. in the period mentioned and to identify the effects of these changes on the nursing profession. I then intend to make recommendations to policy makers regarding the most appropriate organisational and management structures and systems for the delivery of health care education in the 21st century; and on the preparation, development, recruitment and selection of the future leaders and managers of health care education.

If you are willing to take part in an interview I would be delighted to hear from you, any information that you give me will, of course be treated in strictest confidence, if you know of a previous colleague or friend who held a similar position to yourself and who might also be willing to participate I would be grateful for permission to write to them.

I do hope that you will be able to help, I would aim to carry out the interviews between August and December this year and to carry them out where ever is most convenient for you. I would like to use a tape recorder during the interview and would send you a full transcript soon afterwards so that you could correct the data prior to me using it for the purposes of my research.

I enclose a stamped, addressed envelope and look forward to hearing from you.

Biographical data collected from the interviewees.

RESEARCH INTERVIEWS

Biographical Details.

Name

Name for the purposes of the research.

Date of Birth.

First Training dates ... /... /..... Qualification.

Subsequent Training dates ... /... /..... Qualification.

Employment history

Educational qualifications

O levels or equivalent

Degree, first-

higher-

When taken ... /... /.....

Management or leadership training undertaken

Any other training

Leadership and management roles

Other professional interests/commitments.(Past and Current)

Original Codes

These were the categories and concepts which I had thought would prove important aspects to look out for when analysing their interview tapes.

ORIGINAL CODES.

- A.1.** Accountability
- A.2.** Ambiguity
- B.1.** Business
- B.2.** Boss
- C.1.** Change Management
- C.2.** Chaos
- C.3.** Curriculum
 - C.3.1.** Change
 - C.3.2.** Customisation
- C.4.** Culture
- E.1.** Ethics
- E.2.** Ethnic Issues
- E.3.** Education
 - E.3.1.** General
 - E.3.2.** Higher
 - E.3.3.** Nurse
 - E.3.4.** 'Links'
 - E.3.5.** Midwifery
 - E.3.6.** Management
 - E.3.7.** Mass
- G.1.** Government
- H.1.** History
- I.1.** Influence
 - I.1.1.** Personal
 - I.1.2.** Other
- J.1.** Job
- L.1.** Leadership
 - L.1.1.** Theories
 - L.1.2.** Qualities
 - L.1.3.** Preparation for
- M.1.** Management
 - M.1.1.** Style
 - M.1.2.** Roles
 - M.1.3.** Ethos
 - M.1.4.** Responsibilities
- M.2.** Market forces.
- N.1.** Networks
- N.2.** N.H.S.

- N.2.1. Reorganisation**
 - N.2.2. Reform**
- O.1.** Organisational Structure
- P.1.** Policy
- P.2.** Professional Groups
- P.3.** Project 2000
- P.4.** PREPP
- Q.1.** Quality
 - Q.1.1. Standards**
 - Q.1.2. Performance Indicators.**
- R.1.** Reflective practitioner
- R.2.** Role Model
- R.3.** Research
- S.1.** Self actualisation
- S.2.** Stress
- S.3.** Social change
- S.4.** Statutory bodies
- T.1.** Technology
- V.1.** Value systems

Emergent Codes. As well as the above original codes these categories emerged as important issues or concepts during the interview tape analysis. As described in Chapter 3.

Battling - as a way of achieving their goals.

Care/Caring - as central to their value system. An orientation towards care was often what motivated their decision to enter nursing, what sustained them when times were hard, and what was the driving force for what they did.

Careers - the differences in the way in which they viewed the work that they had done. For some their career had been planned (by them) from an early stage, for others it had been 'directed' by others in more senior positions, others seemed to have largely unplanned careers in which they took opportunities as they arose.

Clinical practice - the importance of retaining clinical practice as central to nursing management, nursing education and nursing research.

Curriculum content

medical model vs. nursing model

biological sciences vs. behavioural sciences

professional vs. academic

Commitment and dedication - as a way of achieving their goals, - those who talked of this saw it as an 'old fashioned' concept, some felt that they had given of themselves to their nursing careers to the exclusion of other aspects of life, for instance marriage and having children. They did not think that nurses today possessed a dedicated attitude to their work in quite the same way.

Enthusiasm - linked to commitment and dedication some saw enthusiasm as a way of motivating other nurses and a characteristic which had sustained them throughout their careers.

Entrepreneurship - as a way of helping to overcome the financial constraints of the NHS and HE.

Emergent Codes continued.

Europe - as a growing influence on what they did, particularly immediately before and after the signing of the EEC directives in 1977.

Innovation - the introduction of new approaches to nursing care and nursing education was a key element of some interviews.

International - the influence on them of opportunities to travel, either to work as nurses or to study nursing and issues related to nursing in a different country or countries. Also the influence of nursing scholars from other countries, especially the U.S.A. For some of them their own growing influence in an international arena was an important feature of their careers.

Matron the profound influence that the role as a whole and individual matrons had on their careers.

Mentorship - the role that mentors had played in their careers and their own role as mentors as they assumed more senior and influential positions.

Modesty - the reluctance of many of them to admit to having been influential within the profession or influential to the careers of other nurses. In discussion with some of them about this we speculated whether it was a typically British trait, and/or something related to the way in which nurses and women reacted to recognition of their work.

Opportunism - linked to their careers (see above), the propensity for some to see and seize on opportunities for personal advancement or openings for nurses or nursing more generally.

Power - their own power and influence throughout their careers. This was an interesting area, especially when linked to modesty (see above). If some of these nurse leaders found it difficult to accept that they had been influential then they may have missed opportunities to use the power of their position to further the cause of nursing on behalf of patient care. Others were much more tuned in to issues of power and control, especially the relative powerlessness of nurses vis-a-vis medical and management colleagues. Nursing's potential power was recognised.

Emergent Codes continued.

Risk Taking - this was closely linked with opportunism, innovation and power (see above). Taking opportunities and introducing innovation were seen as a challenge to the status quo and hierarchy in nursing and thus posed risks for the individual's future career.

Scholarship - for some the need for nurses to become more scholarly was linked to their own excursions into higher education. Those who had pioneered in this area were aware that many of their nursing colleagues viewed their activities with suspicion.

Students/Role and Status of - especially related to the tension and conflict between nursing service managers and nurse education managers.

Survival - this emerged as an important aspect both personally and professionally.

Teaching/Learning Strategies - innovations in this area were especially talked about by nurse educators. The need to move away from 'chalk and talk' and didactic methods in order to produce 'thinking' nurses who would be able to problem solve rather than relying on following laid down procedures. This was closely related to the role and status of nursing students and the survival of the profession (see above) and the theory-practice divide (see below).

Tension - this assumed greater importance as the research progressed and became the central theme of the thesis. I was aware of a growing personal tension about the move from NHS to HE and the gulf that Working Paper 10 and the contracting mechanisms for nursing education seemed to be causing between nursing service managers and nurse education managers. As the interview transcripts were analysed the fact that there had been similar tensions for the nursing leaders who preceded us became apparent. This was closely linked with power, the role and status of nursing students and the theory-practice divide (see above and below).

Theory/Practice divide - the division between the two segments of nurse leaders (service and education) which caused tension and conflict between the two groups in the period studied. This was especially related to issues of power.

Emergent Codes continued

Travel - the opportunity to travel and work, study and meet nurses from other countries was a feature for those who reached senior positions in the late 1950's and early 1960's. See Europe and International above.

Victims - this became especially apparent following two of the early interviews. Roy Elm (interviewee 1) considered that his career as a senior nurse educator had been cut short by the successive re-organisations of the NHS and by his boss, who questioned his ability as a nurse and who was carving out a name for herself and thus 'putting down' the achievements of other senior nurses. Walter Mant (interviewee 4) considered that a hospital inquiry into neglect of patients and the 1974 reorganisation had prematurely ended his career as a nursing service manager.

Vision - the importance for many of them of a clear picture of what nursing should and could be, which had motivated them throughout their careers and which they considered vital for the future of nursing. Closely linked with care and caring, clinical practice and survival (see above).

Vocation - a motivating force for some to enter nursing. Linked to commitment and dedication (see above).

Statement of Personal Values and Beliefs.

Read (1989) and Strong and Robinson (1990) follow Weberian tradition in highlighting the importance of recognising how the experience and values of the researcher may influence and contribute to the research study. Thus it was decided that the main characteristics of the research design should reflect my experience, current position and values. It is therefore considered appropriate to narrate some of my experience and how this influenced some of the decisions and choices which were made in designing and carrying out this study.

The impetus for the study was formed when I was first appointed as Director of Nurse Education in 1982 at a time when the N.H.S. was undergoing a re-organisation consequent upon the recommendations of Patients First (1979). My first experience of the effects of a similar activity had been as a newly appointed Nursing Officer (No.7) in large, traditional, psychiatric hospital following the introduction of the Salmon Report (1966). During this experience I was aware that few of my senior colleagues had much idea of what was expected of this new 'clinical' grade of nurse manager. Without any specific preparation for the role I was expected to 'get on with it'. Sometimes I was expected to provide some form of clinical nursing leadership to my group of wards, however the ward sisters (mostly much older and greatly more experienced in terms of years served than me) were not easy to influence to develop new practices. Often they had the covert, and sometimes overt, support of the Consultants in their resistance. At other times I would be the only Nursing Officer on duty for the whole hospital. This necessitated visiting the 'male side' of the hospital as well as the 'female side'. What a nuisance I was as I had to be accompanied by a male nurse throughout the visit as 'they had never had a woman on the male side before'. At other times I was the 'gofer' filling in interminable record books and carrying messages. Tensions and conflicts associated with this role were the lack of role clarity; lack of preparation for the role; hostile senior nursing staff; and the opposition of the medical profession to nursing developments. In addition having to follow the rituals and tradition expected; the mundane administrative rather than managerial aspects of the job and the gender issues associated with the work all led to disillusionment and frustration. Little wonder that this experience of 'nursing management' provided little job satisfaction and I left the hospital, and the N.H.S., after only eighteen months.

I returned to the N.H.S. in time to observe, and participate in the 1974 re-organisation of the Health Service. The 1974 re-organisation of the N.H.S. had been followed by the formation of Area Schools of Nursing and by role transition for the leaders and managers of these schools from Principal Nursing Officer Education, (P.N.O.Ed.) to Director of Nurse Education, (D.N.E.). Some of the people making this transition had been Principal Tutors in the pre-Salmon era and they were obviously finding the changes difficult and often did not appear to have

the knowledge and skills required to undertake these new roles. What I saw concerned me, there was obvious distress within the 'higher' ranks of both service and education leaders and managers. Some were disaffected by being 'passed over' for appointment to the more senior positions which the creation of Area Health Authorities and Area Schools of Nursing had generated, they had been big fish in little ponds and were now little fish in big ponds and they were obviously finding the loss of autonomy hard. Others had opted out of the system altogether through early retirement. Some of those who had been successful in appointment were struggling with their new responsibilities. It seemed to me, and to many others at the time, that for a so called caring service, and nursing in particular as one of the major caring professions, little was being done to alleviate the distress of our senior colleagues. I considered that the costs to the service through lack of preparation of those promoted to more senior positions and through poor management of the change to the new management structure were not outweighed by any savings or other benefits gained through the introduction of the new system. Again tensions between senior nursing colleagues was noted as these new systems were introduced. In particular I noted the anti-education bias of the profession in the move from nursing service to nursing education.

After a period of work as a tutor and senior tutor in N.H.S. schools of nursing I was appointed to the Royal College of Nursing, Institute of Advanced Nursing Education, to teach on the teacher preparation courses. Whilst there I also ran and taught on workshops for Directors of Nurse Education and then, as a joint appointee with the Institute of Education, University of London, on the Diploma and Masters in Education. All of these experiences served to broaden my horizons and increase my personal network of professional colleagues and expose me to the difficulties and tensions within nursing education, I also became increasingly frustrated at teaching the theory of educational change but not being able to put it into practice. In 1982, two years after joining the R.C.N., I was appointed as Director of Nurse Education.

Preparation (or the lack of it) for leadership and management posts in nursing and in particular in nursing education was therefore identified as an important area for consideration in this research study. My own experiences of entering management and preparation for the management role was that it was extremely haphazard. I was appointed to a Nursing Officer position in a large psychiatric hospital in the late 1960's, management preparation having been confined to that which was included in my S.R.N. and R.M.N. education programmes plus what I had learned 'on the job' in the previous 2 years as a ward sister and unqualified tutor. This first 'management' post was just after the implementation of the Salmon report, which introduced the concept of specific preparation for management at different levels in the organisation, for instance 'first line management' for ward sisters, 'middle management' for nursing officers and senior nursing officers and 'top management' for Principal and Chief Nursing officers. I therefore never undertook 'first line management' preparation but learnt a range of management skills from successive

positions in health and social services. I finally was released to undertake a 'middle management course' in 1979 one year after having been appointed as Senior Tutor. This was my first introduction to management theory and to multi-disciplinary courses of this nature. I discovered as my career in nurse education progressed that this pattern was typical of many nurses, and was repeated in many of the other health care professions, that is we were promoted into a position of responsibility with preparation for the post following some years afterwards, if at all.

As previously indicated I became a Director of Nurse Education in 1982 and in 1983/4 undertook a Senior Management Development Programme, the new name for the 'top management' course. Soon after this I was involved, as an adviser and facilitator, with the National Staff Committee for Nurses, Midwives and Health Visitors, in the development and implementation of a course designed to prepare prospective Directors of Nurse Education. This programme had been specifically set up to address what was seen as a worrying dearth of suitably prepared candidates for what had become an increasingly important and responsible post (N.S.C.N.M., 1984).

These experiences, particularly the latter ones, were what triggered this current research study, it appeared to me that the leadership and management of nursing education were too important to leave to chance and that the cost of appointing ill prepared leaders was one which the profession could not afford. Shortly after my appointment as DNE the NHS was subjected to further re-organisation following the Griffiths (1983) report and Working for Patients (1989) was introduced just as I took up post as Principal of a College of Health Care Studies. At the time of starting the study I was still Principal of this College which had been formed some two years previously from four Schools of Nursing and Midwifery. The College of Health Care Studies served the education and training needs of three District Health Authorities and the College was managed by a Board of Governors with representatives from these District Health Authorities and the local Polytechnic, with which a Memorandum of Cooperation to devise and deliver courses had recently been signed. My main focus since appointment early in 1990 had primarily been to manage a considerable amount of organisational change, at this time both the N.H.S. and Higher Education were also in the throes of major change. It became increasingly clear that further change in the organisation and management of nursing education generally, and my College specifically would be necessary, and that I would need to spearhead this change on behalf of the College. I would therefore be immersed in the very systems and cultures which I was intending to research and these factors needed to be taken into account in designing the research.

As will be obvious from the preceding description of my professional career in senior and management positions in nursing service, social services and nursing education is that many of these experiences had shaped the research questions to be asked and the values and beliefs that I brought with me and which would therefore be important considerations in designing and carrying out the research. As the

extracts from the reflective journals will show these factors continued to influence the study up to and including the writing of the final thesis.

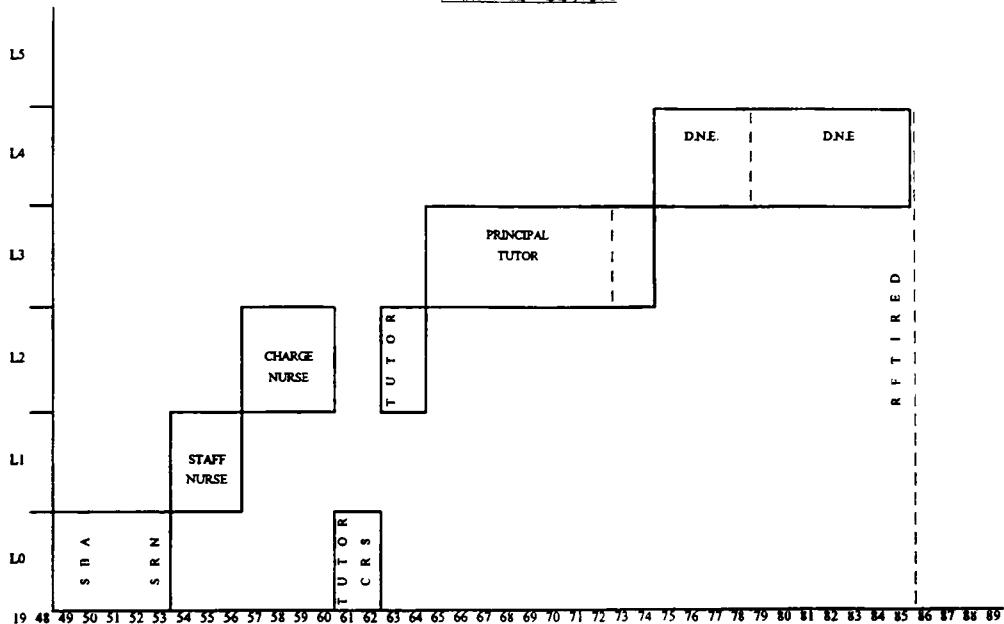
It is important to recognise that my personal beliefs and values were also extremely influential during the process of the research study. Most of this personal statement was written early in the research study, during 1992 and early 1993, and is presented virtually unchanged. I believe that it is important to state near the end of the study (summer 1997) that while my fundamental beliefs and values are largely unchanged my approaches to the analysis and criticism of some issues which I previously would have left unchallenged have altered significantly. The process of this study has therefore been a personal journey of development and discovery not only about the leaders studied but also about myself.

APPENDIX TWO

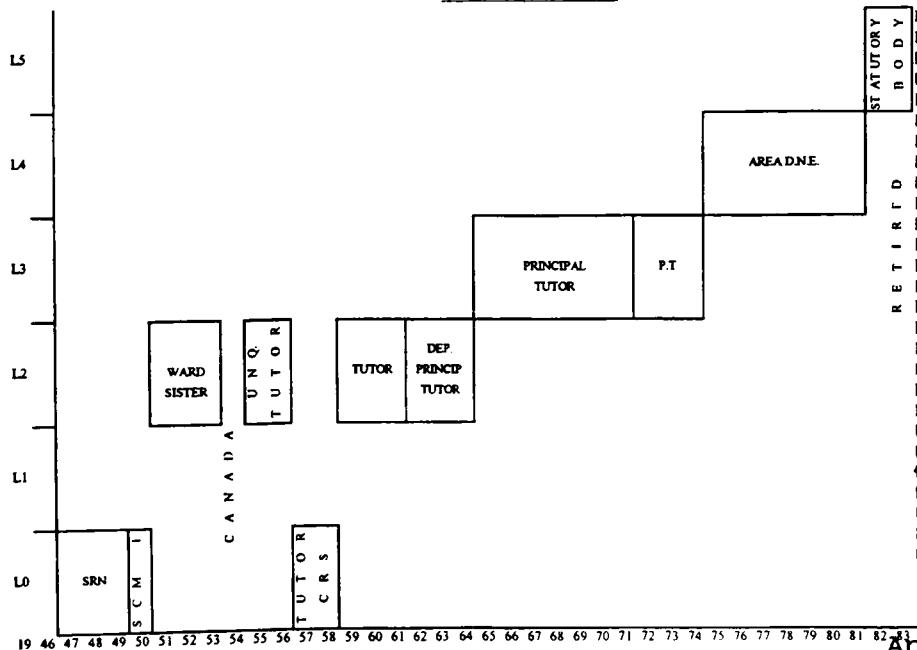
THE CAREER PATHWAY DIAGRAMS OF THE FIFTY ONE LEADERS STUDIED

Career Pathway Diagrams 1 and 2

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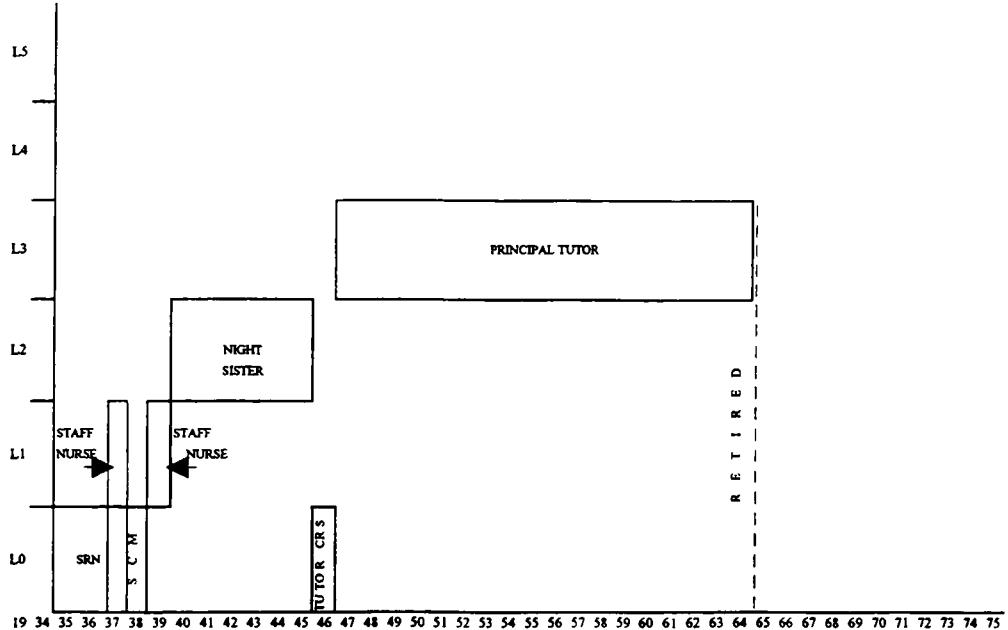


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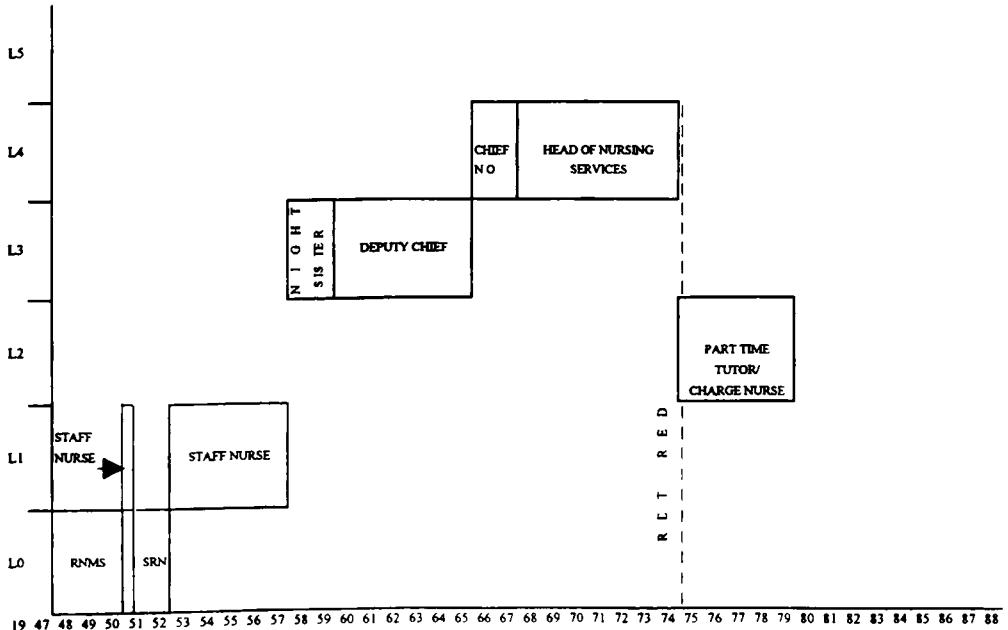


Career Pathway Diagrams 3 and 4

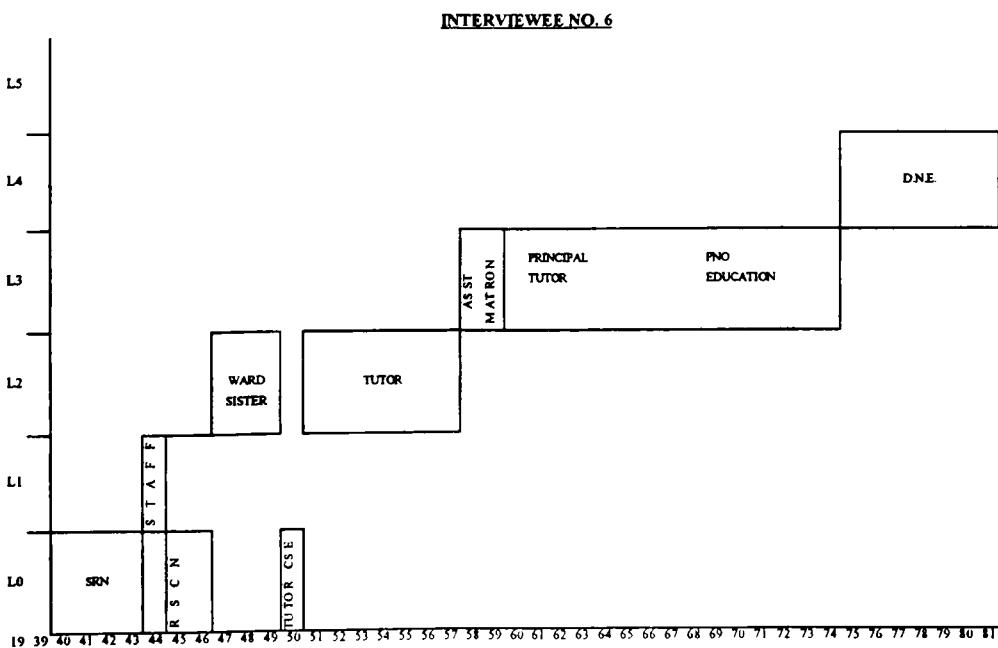
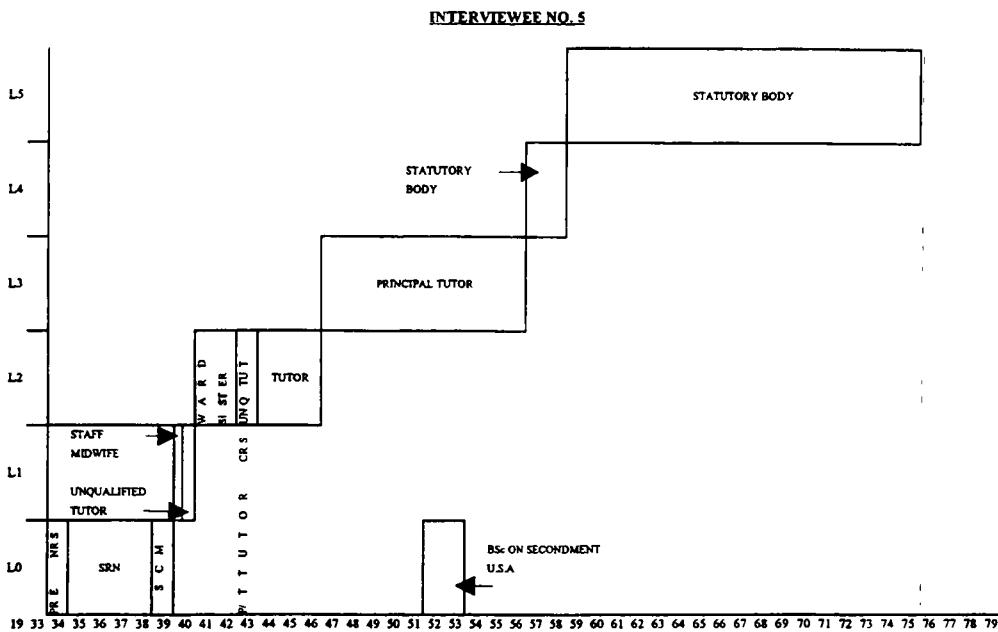
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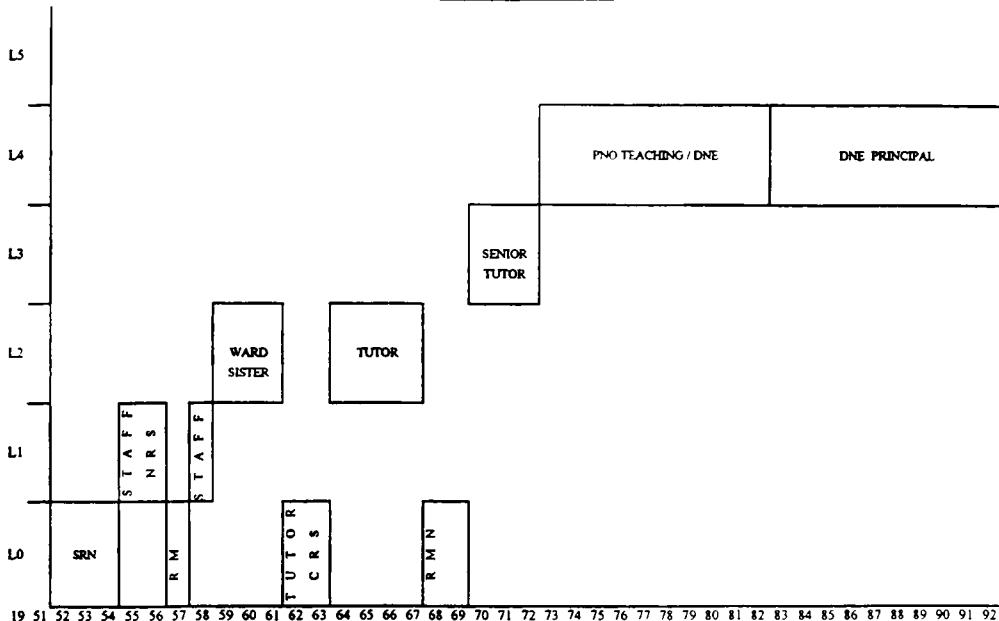


Career Pathway Diagrams 5 and 6

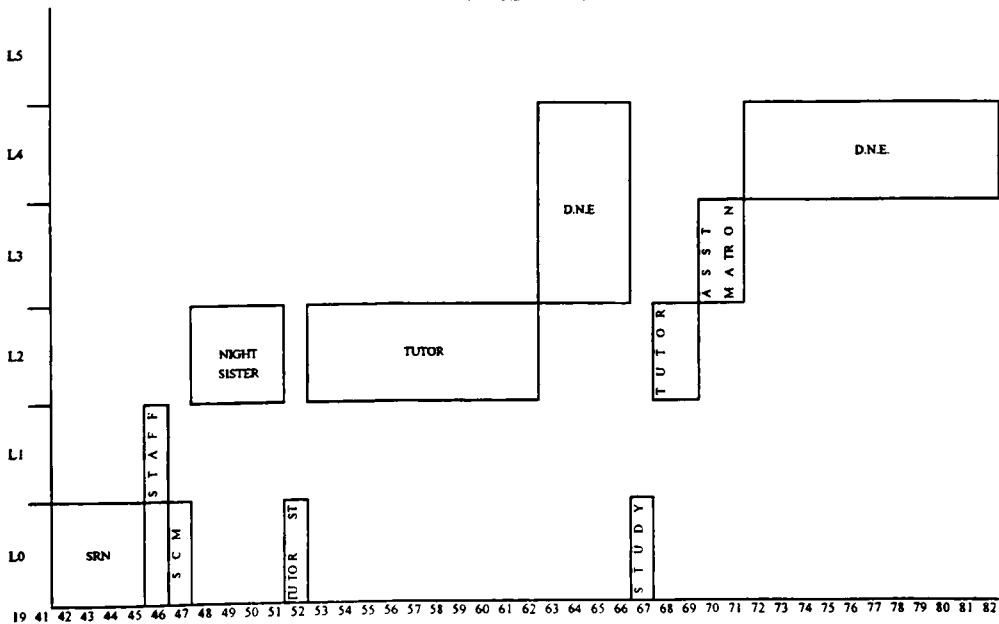


Career Pathway Diagrams 7 and 8

INTERVIEWEE NO. 7

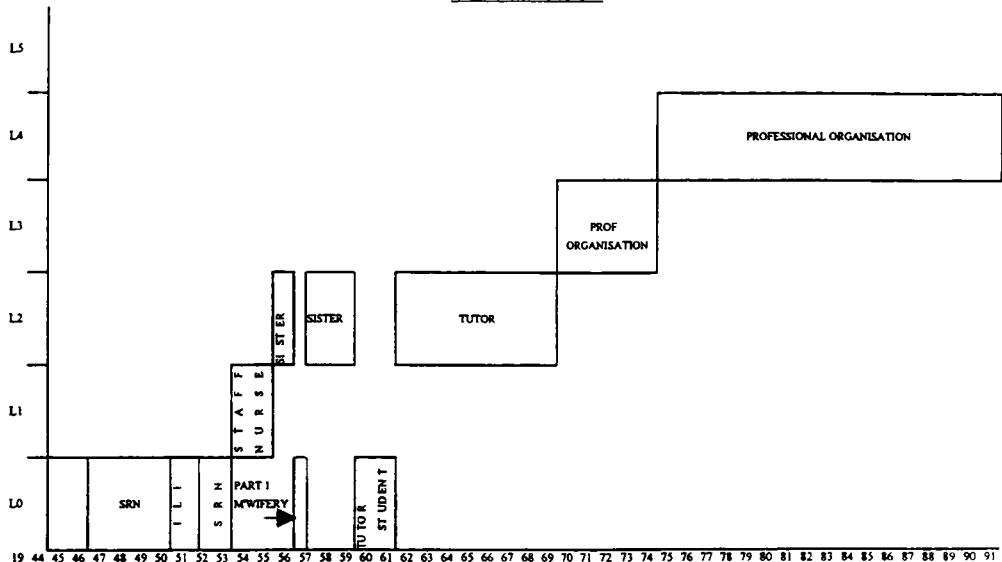


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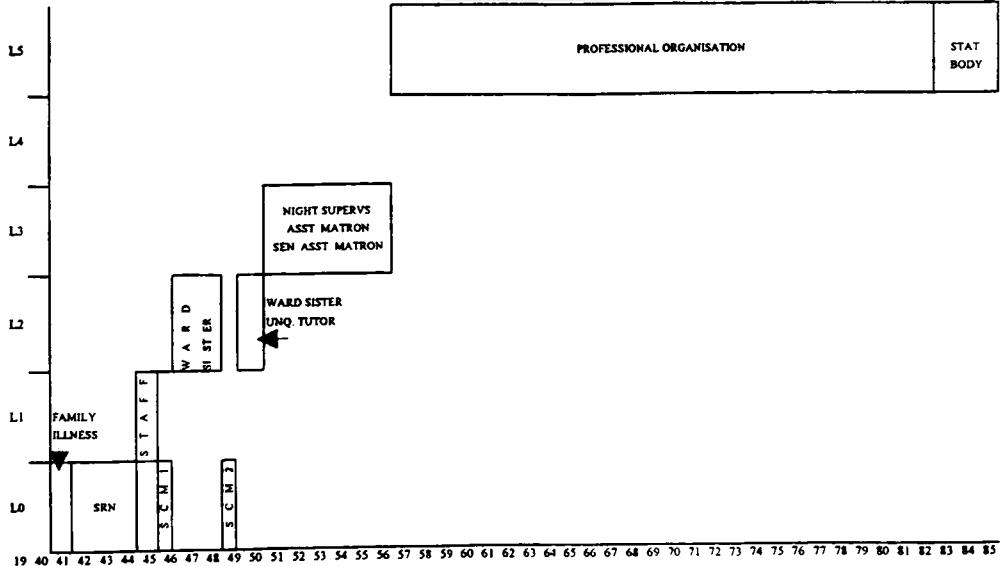


Career Pathway Diagrams 9 and 10

INTERVIEWEE NO. 9

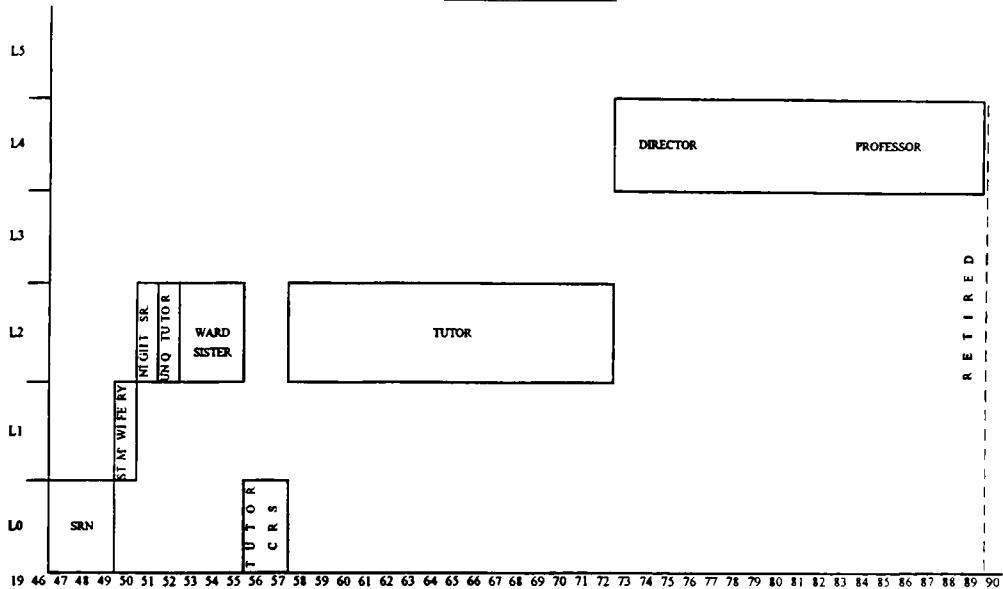


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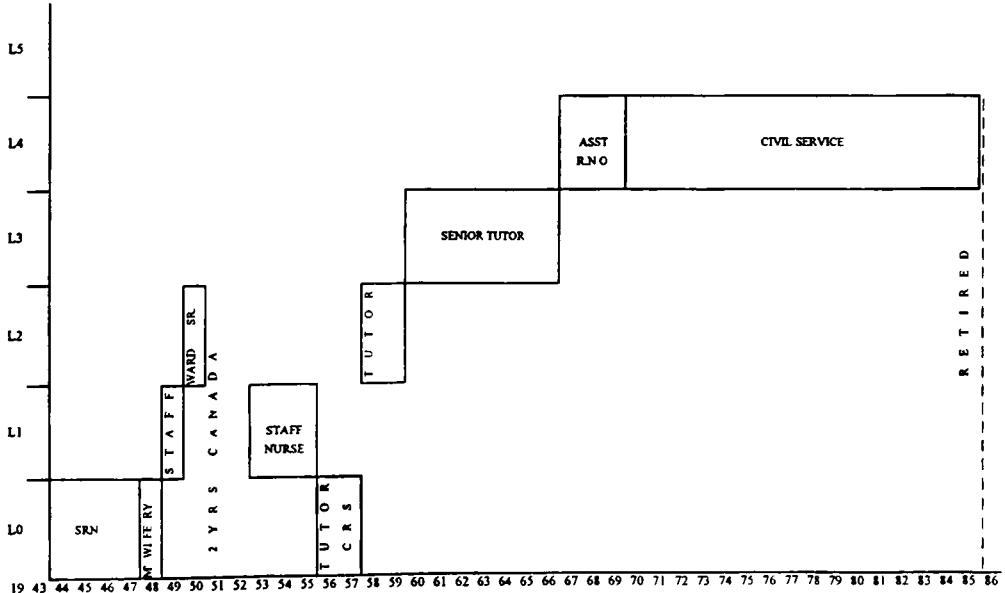


Career Pathway Diagrams 11 and 12

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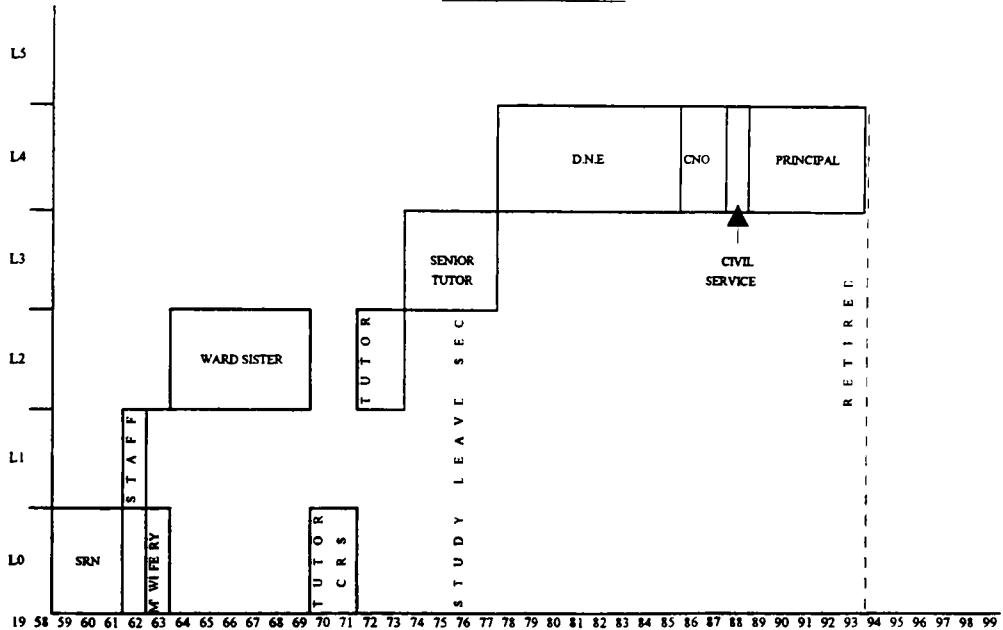


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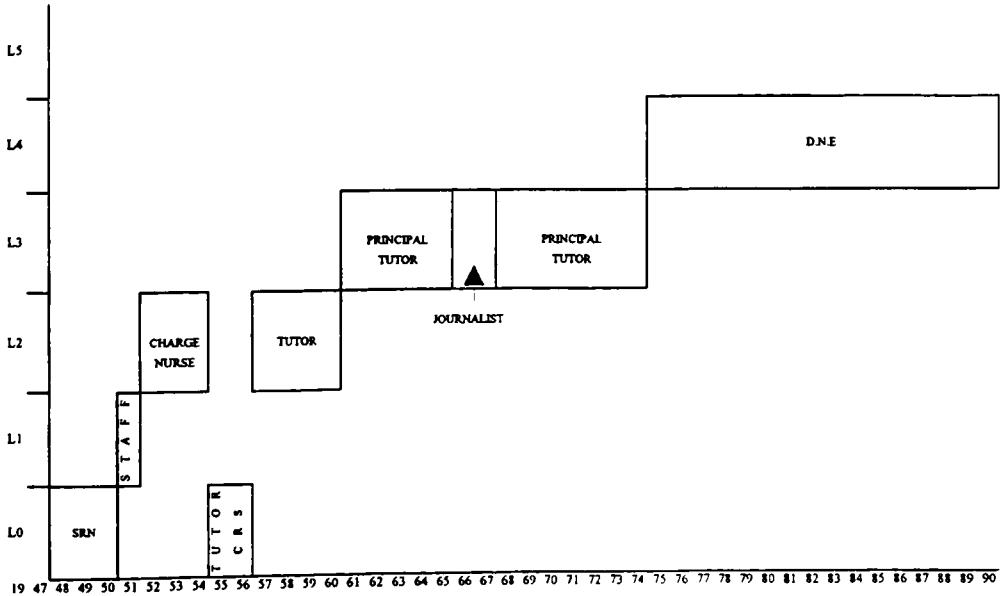


Career Pathway Diagrams 13 and 14

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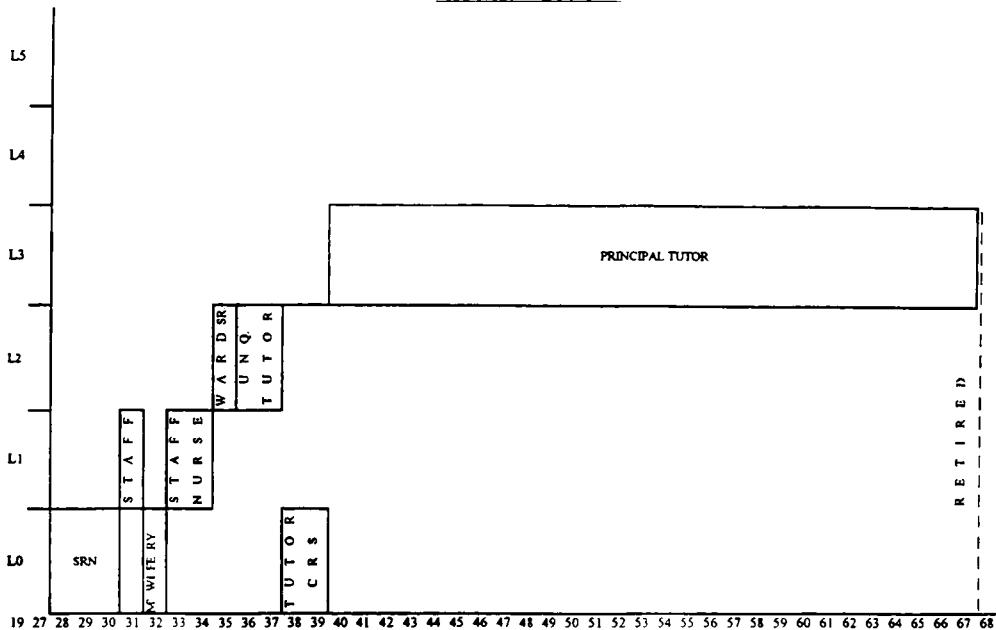


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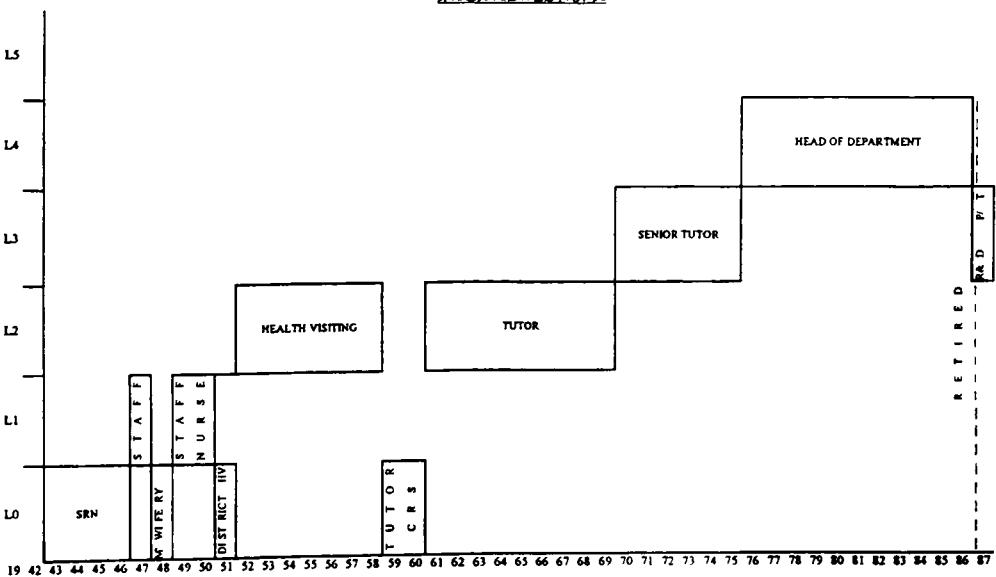


Career Pathway Diagrams 15 and 16

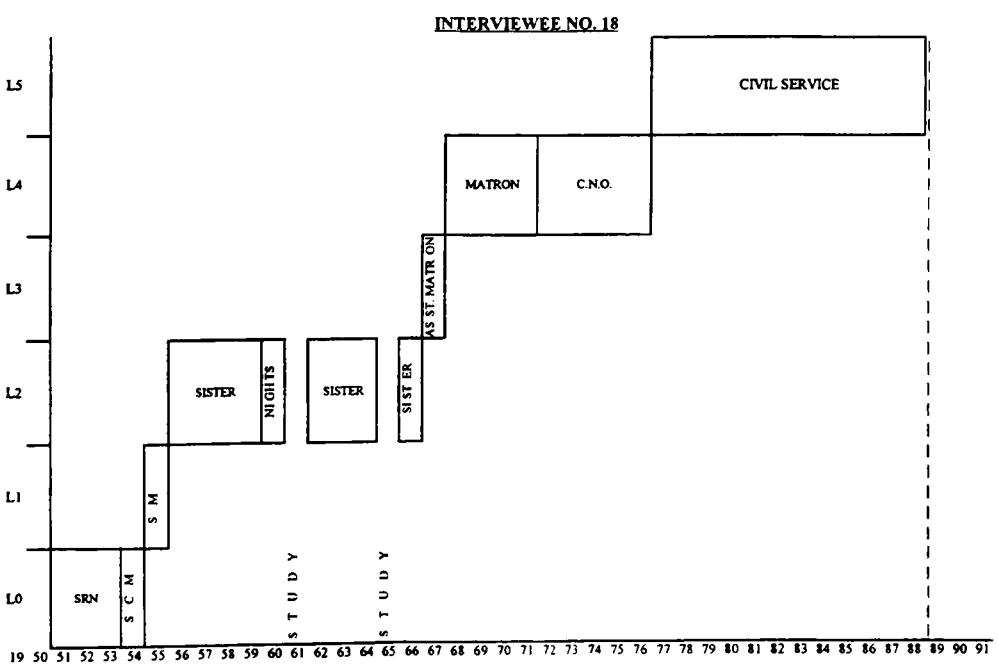
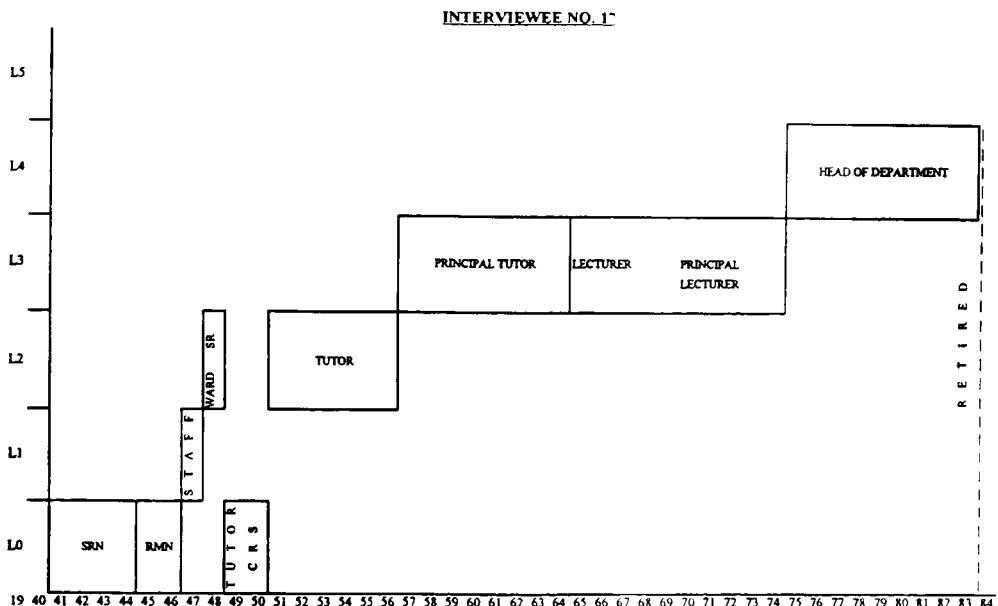
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INTERVIEWEE NO. 16

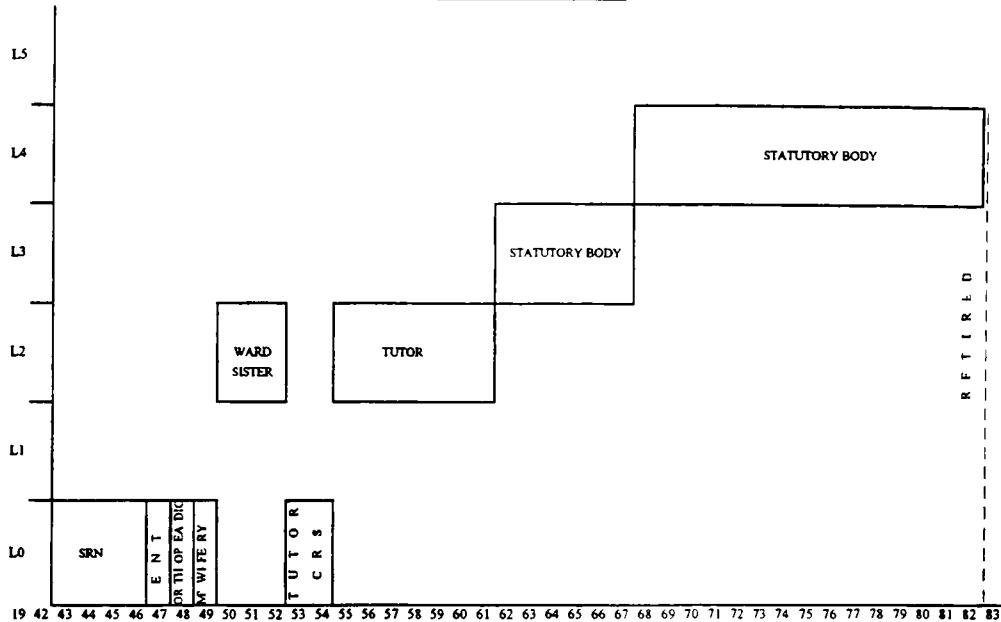


Career Pathway Diagrams 17 and 18

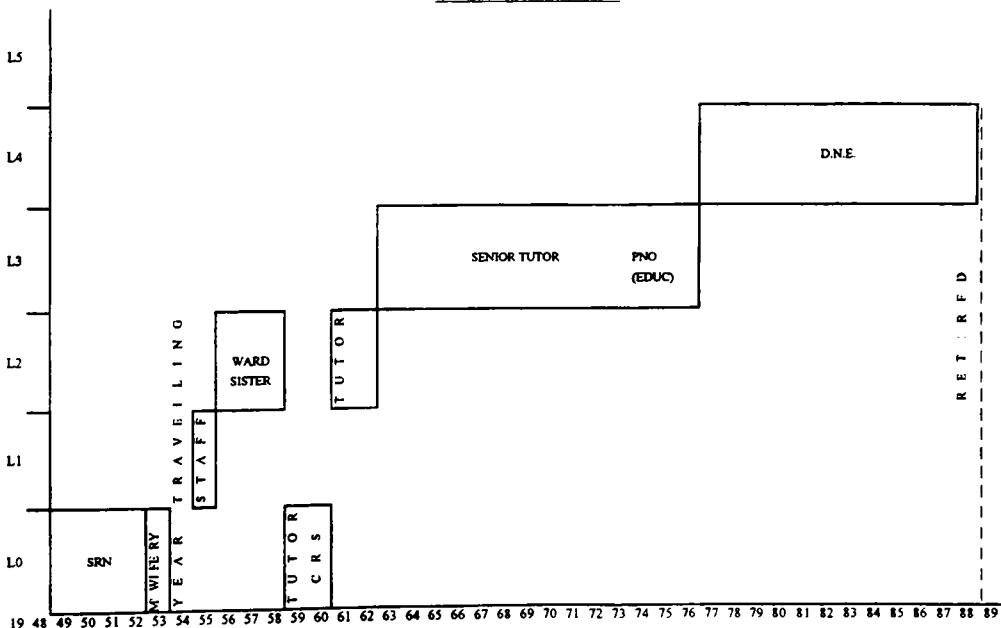


Career Pathway Diagrams 19 and 20

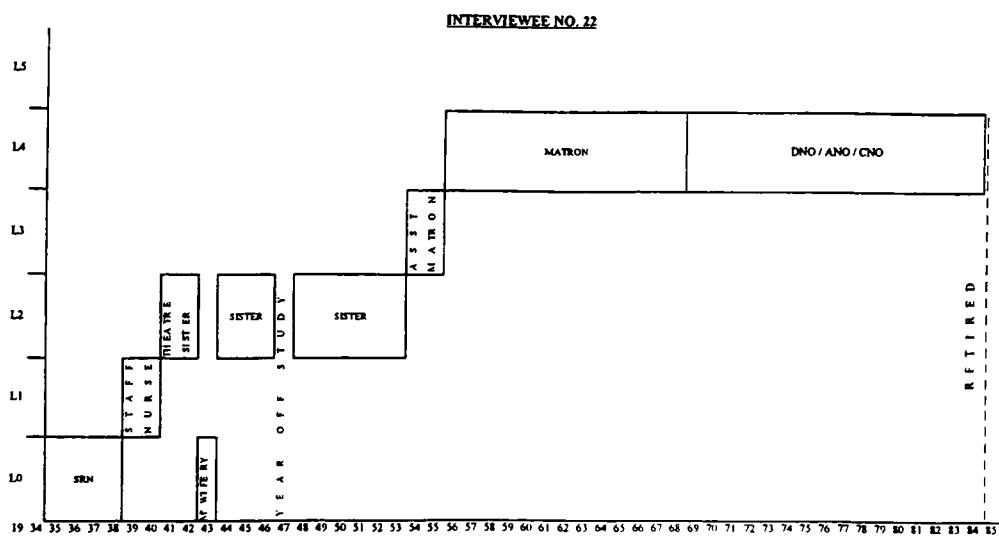
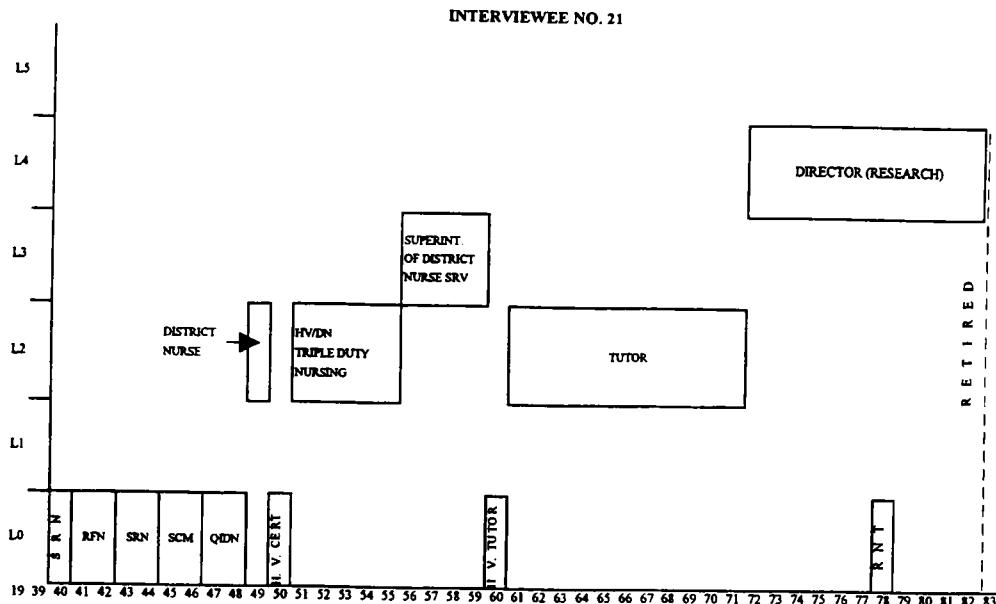
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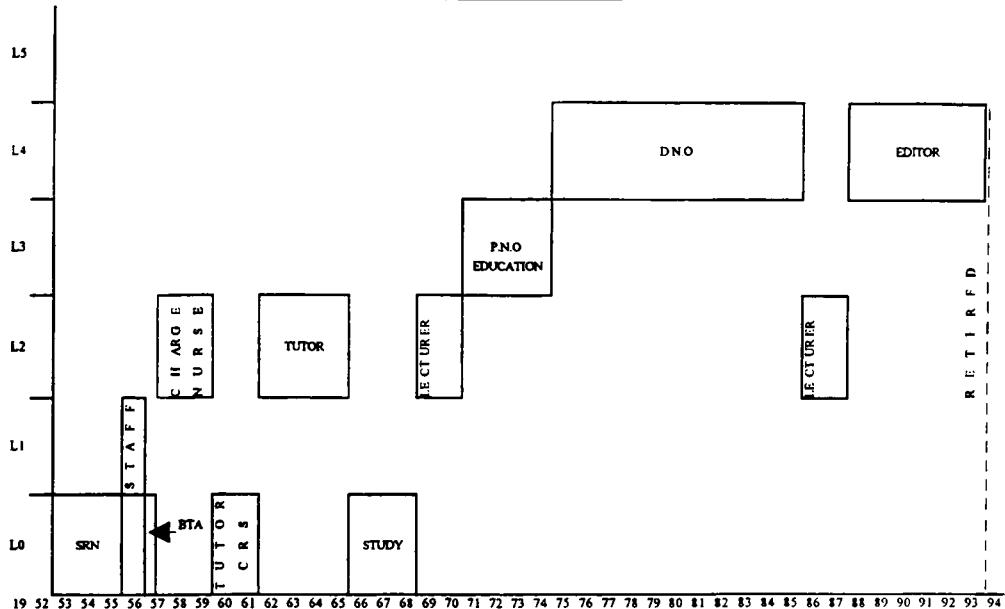


Career Pathway Diagrams 21 and 22

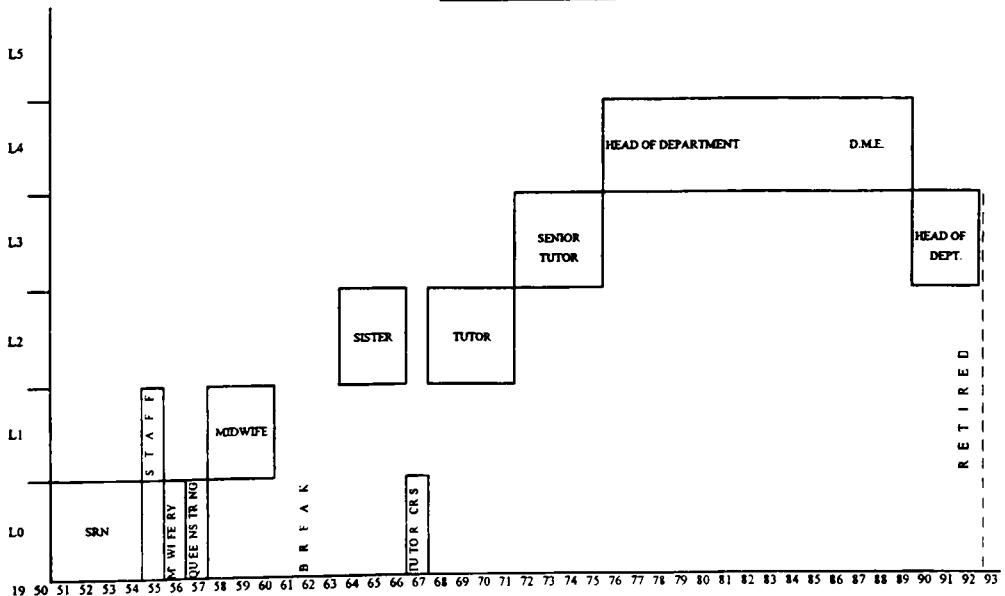


Career Pathway Diagrams 23 and 24

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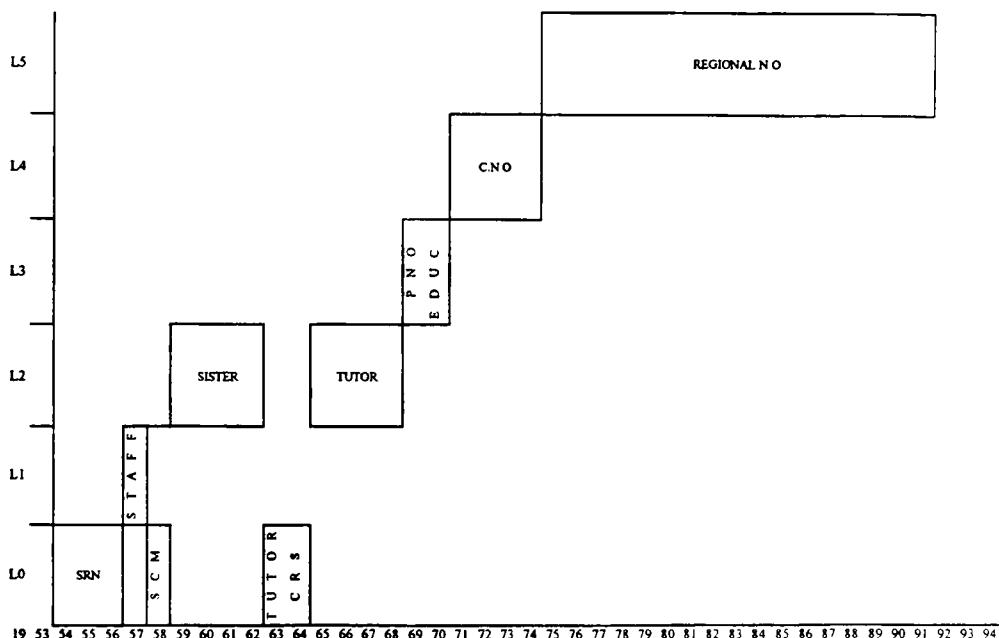


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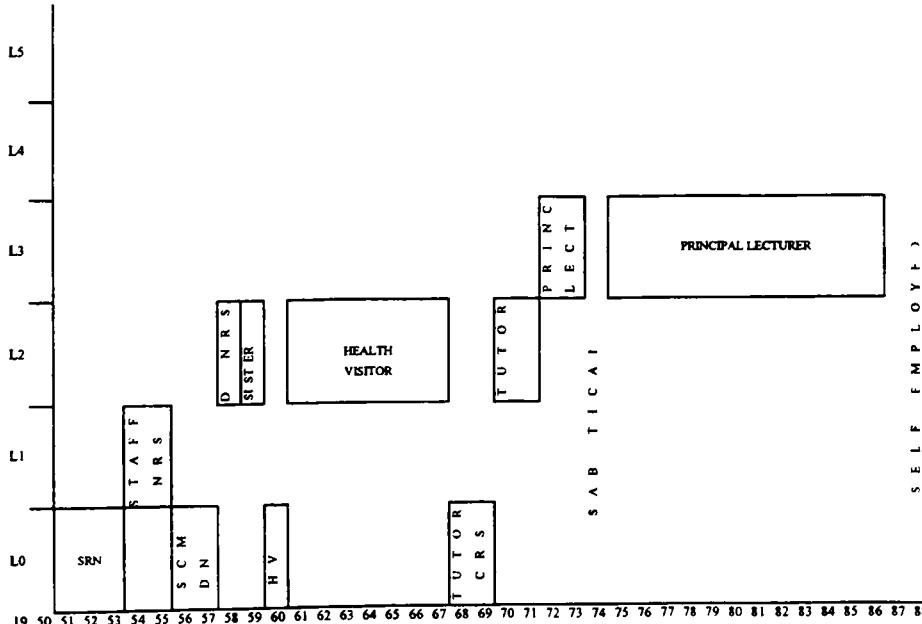


Career Pathway Diagrams 25 and 26

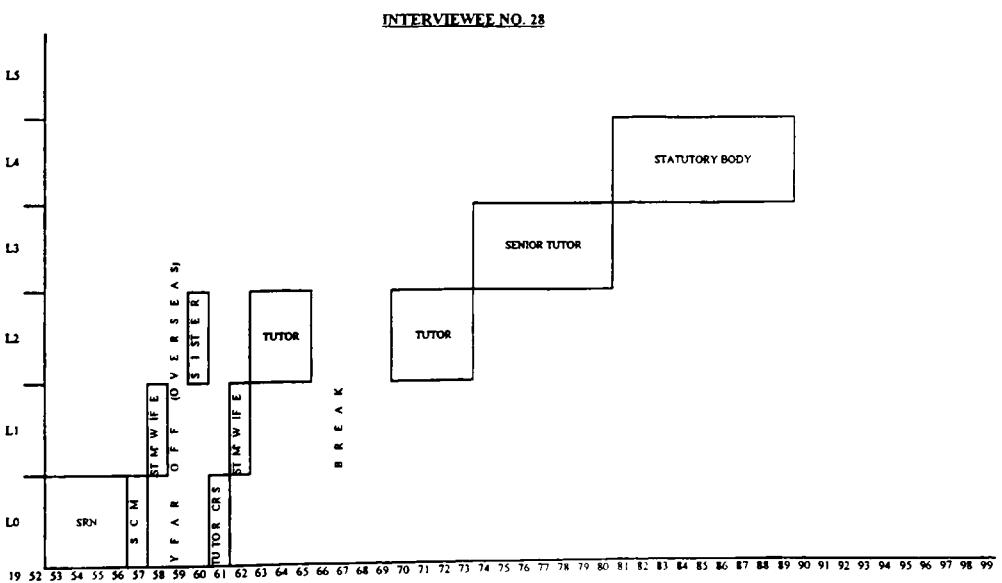
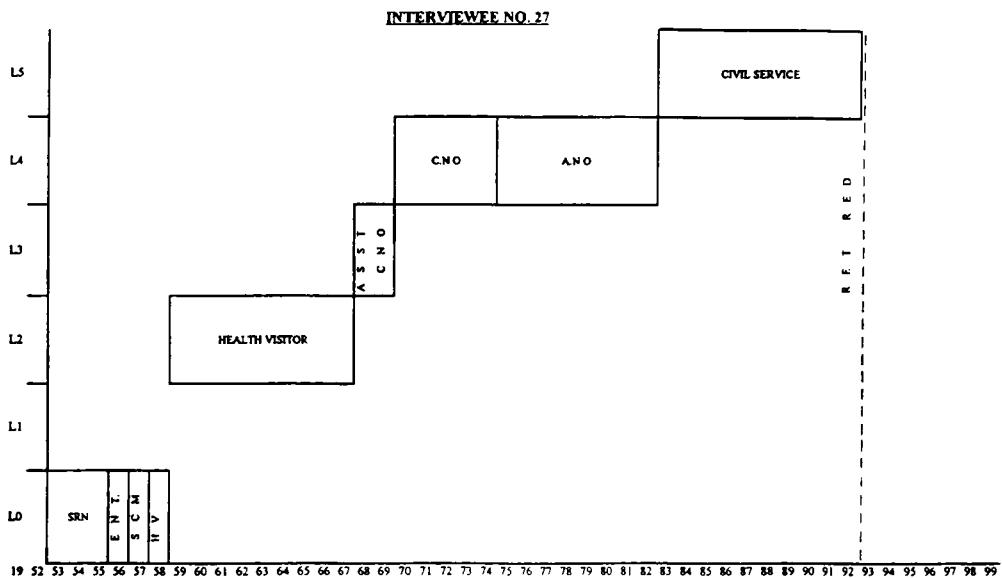
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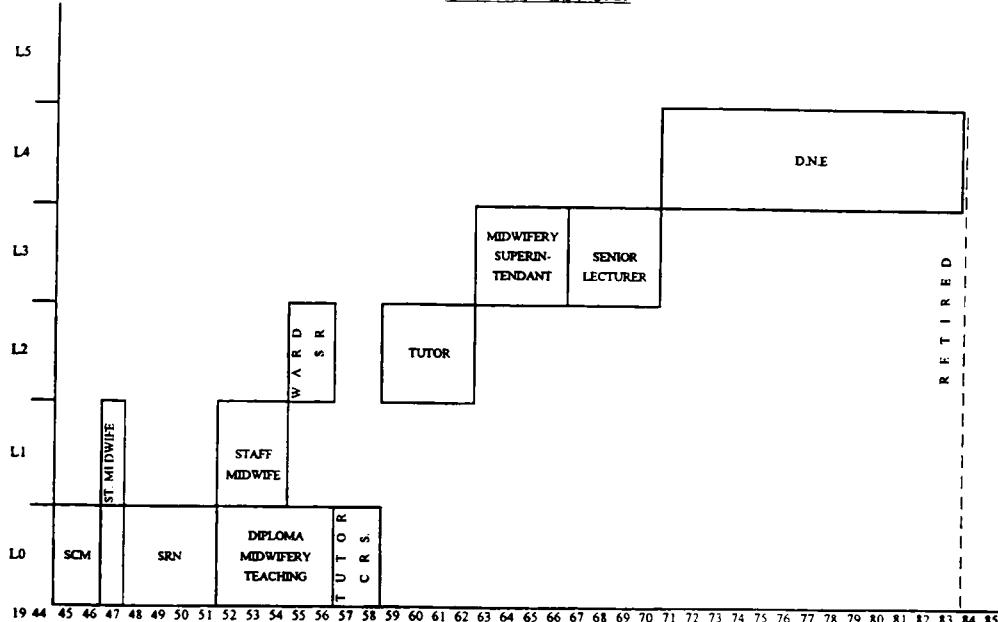


Career Pathway Diagrams 27 and 28

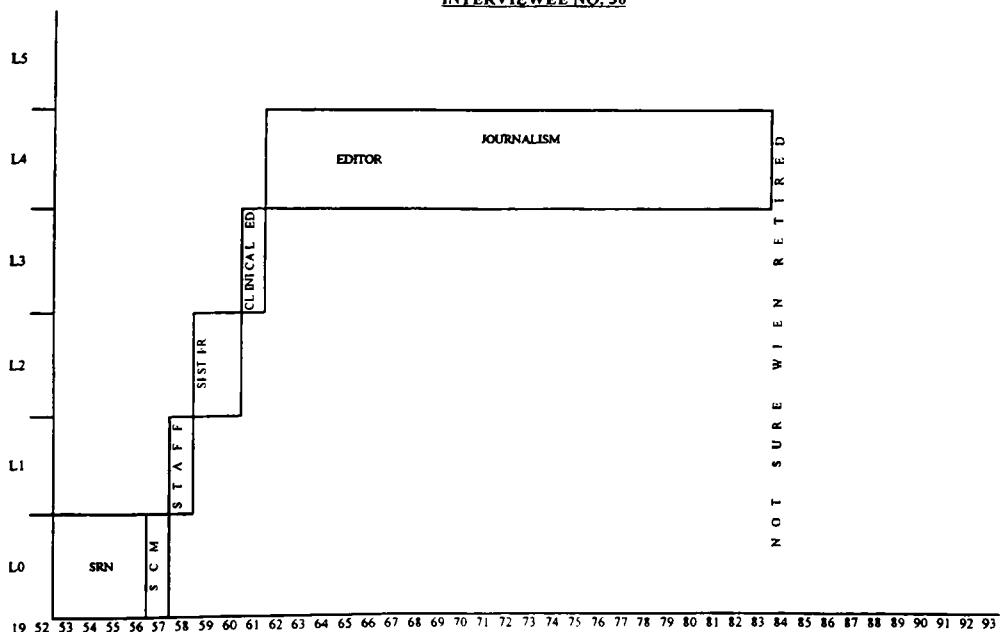


Career Pathway Diagrams 29 and 30

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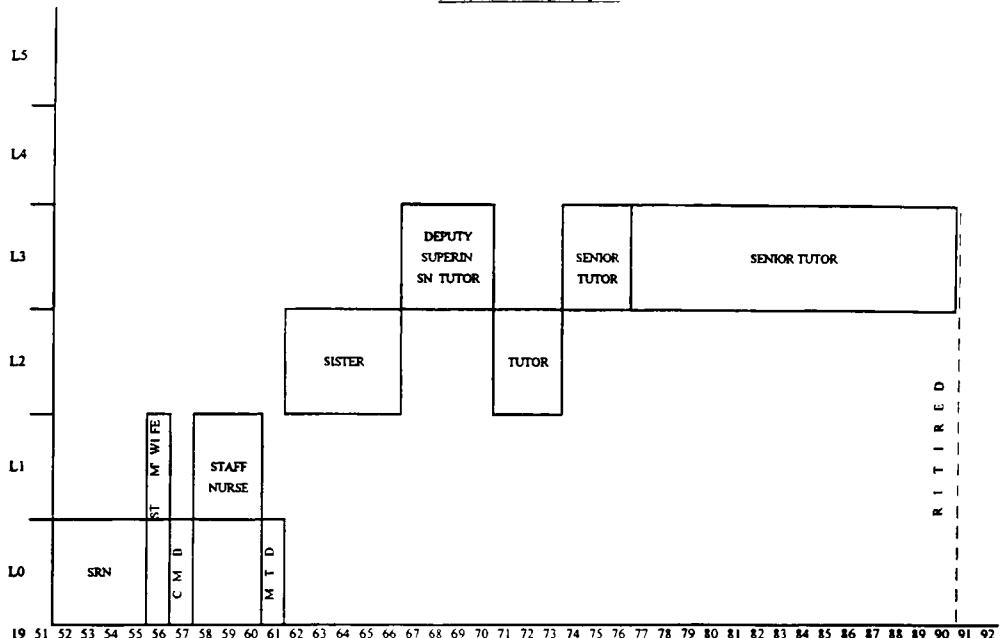


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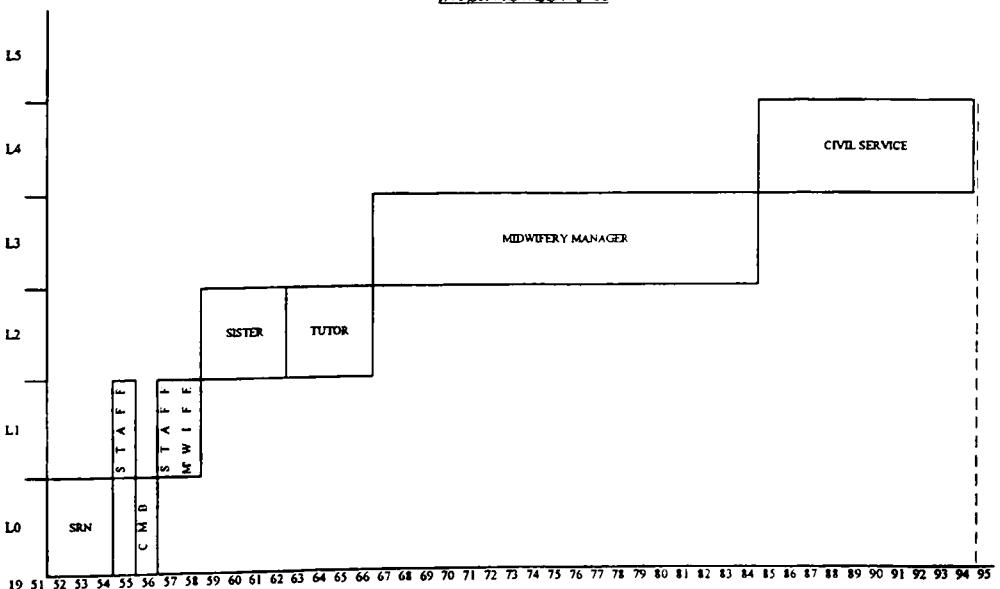


Career Pathway Diagrams 31 and 32

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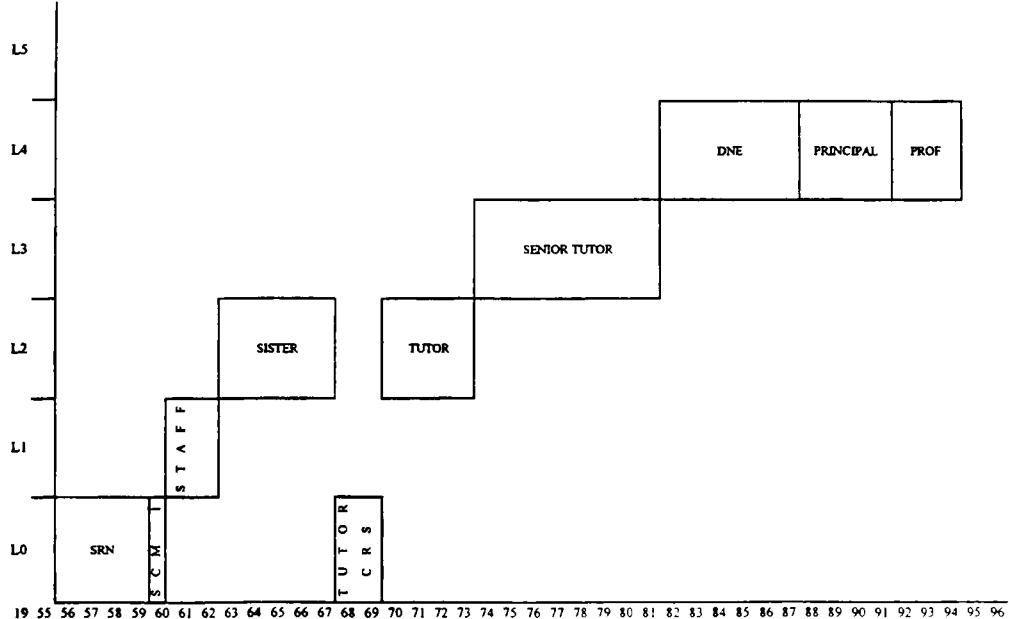


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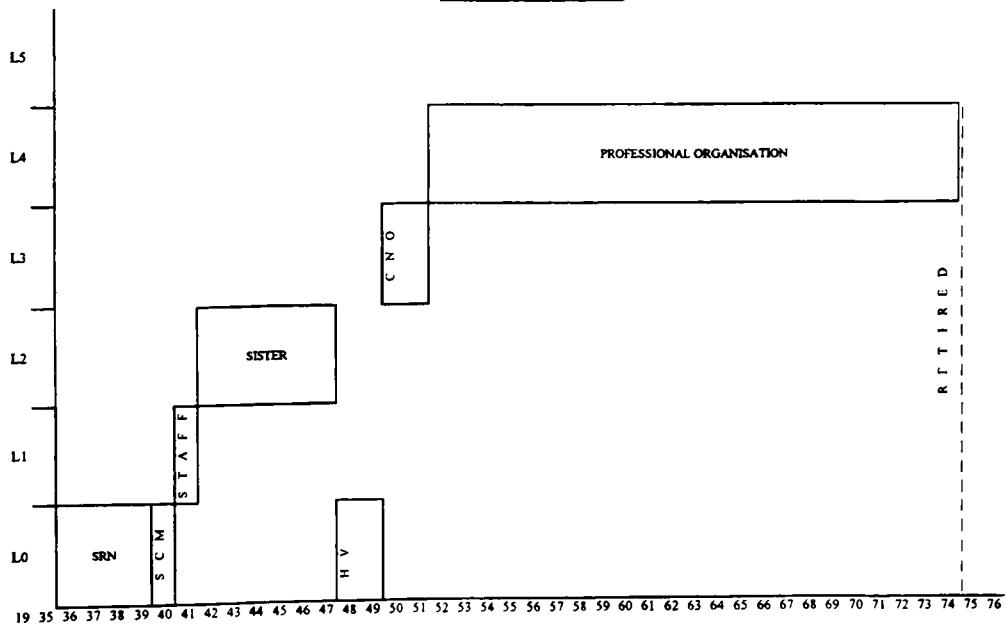


Career Pathway Diagrams 33 and 34

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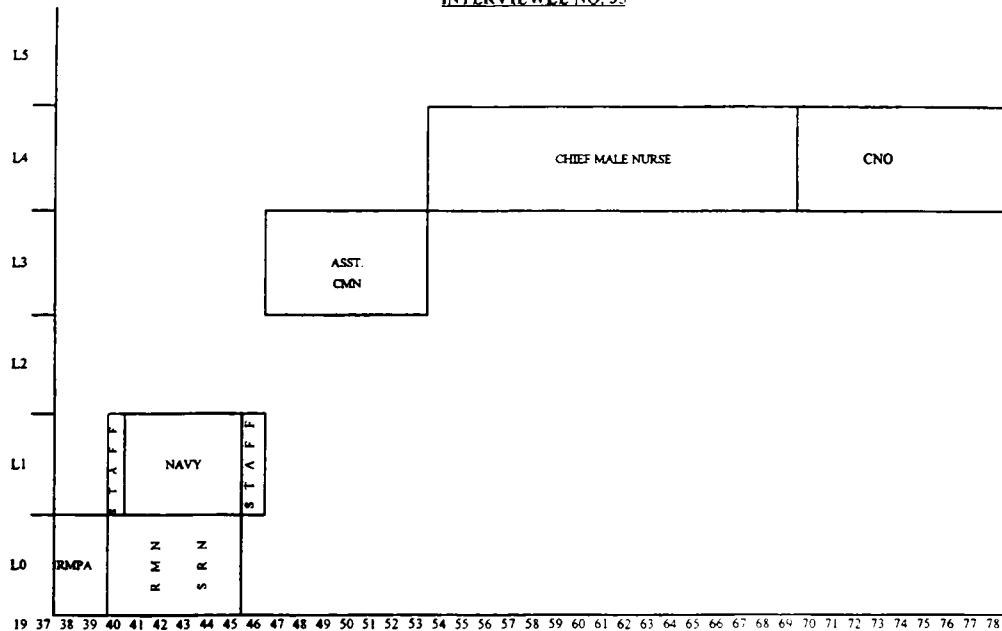


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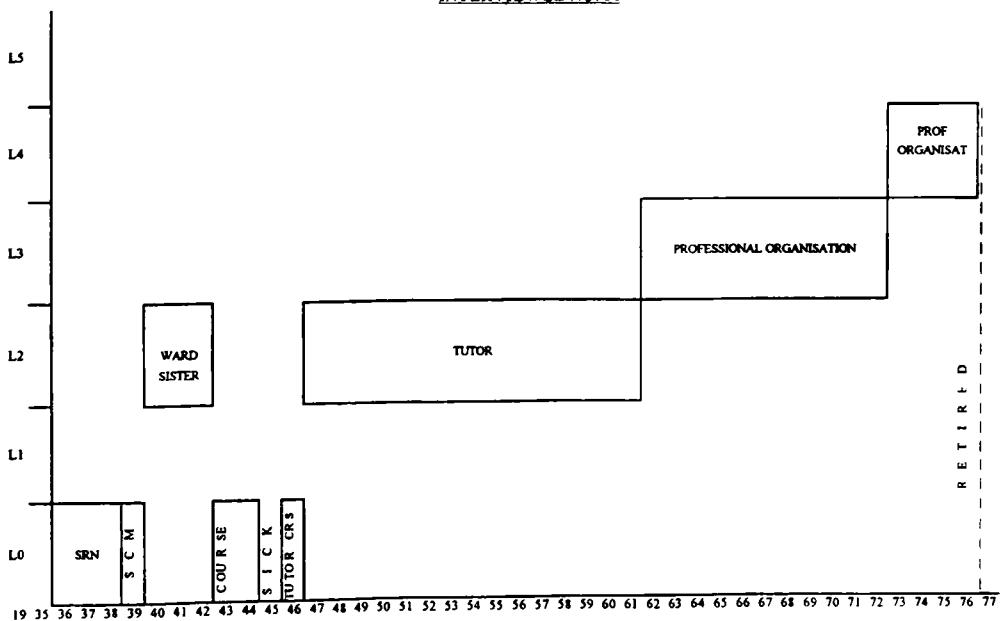


Career Pathway Diagrams 35 and 36

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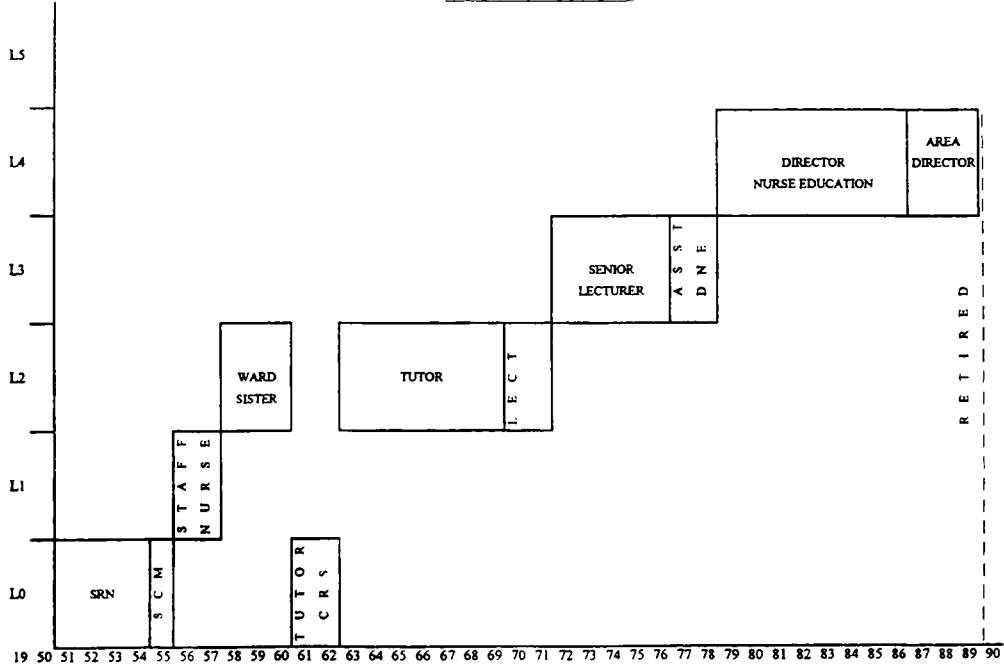


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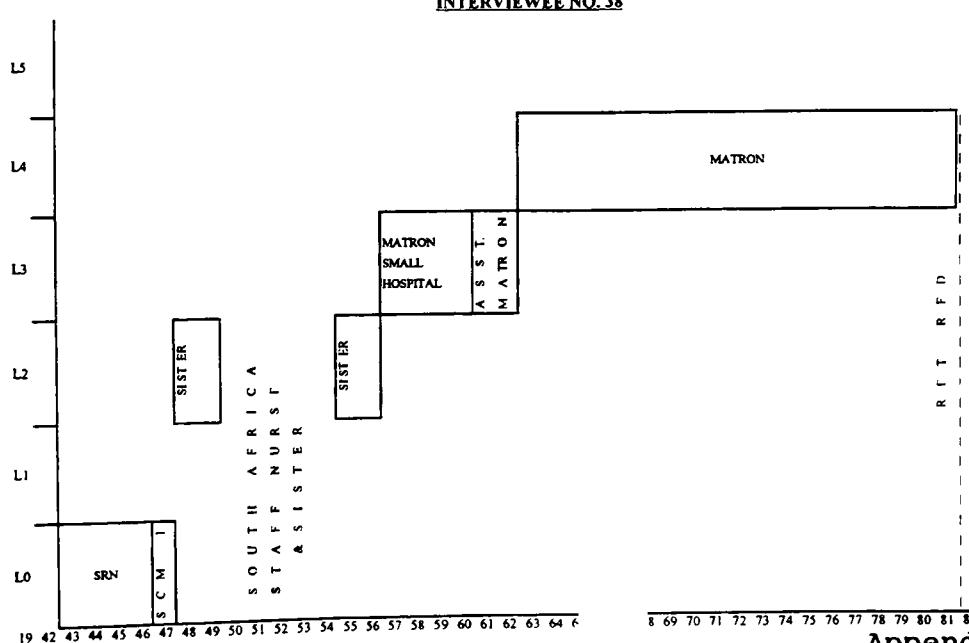


Career Pathway Diagrams 37 and 38

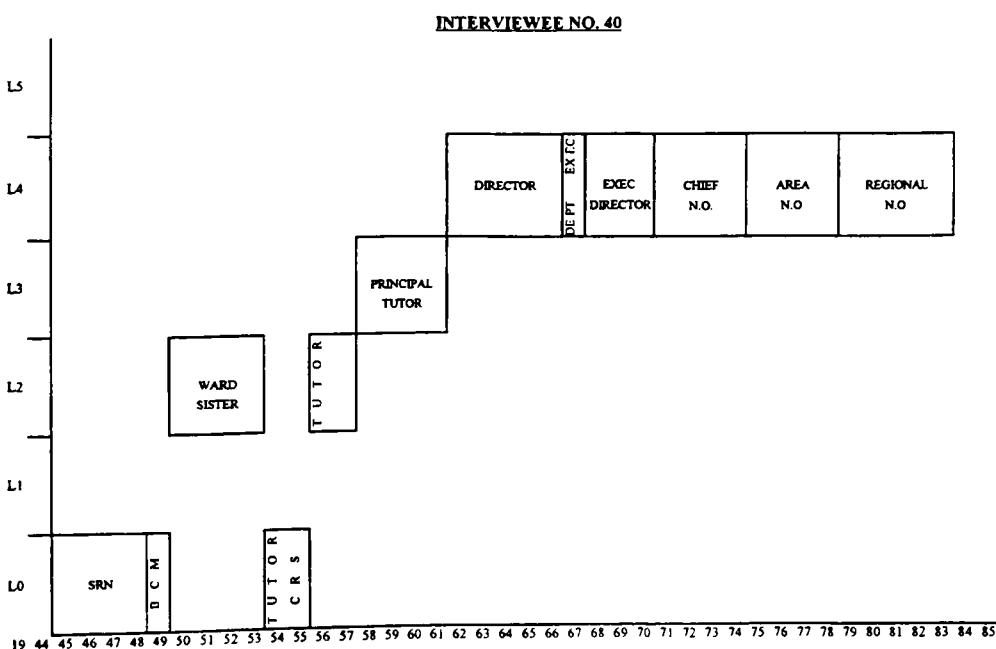
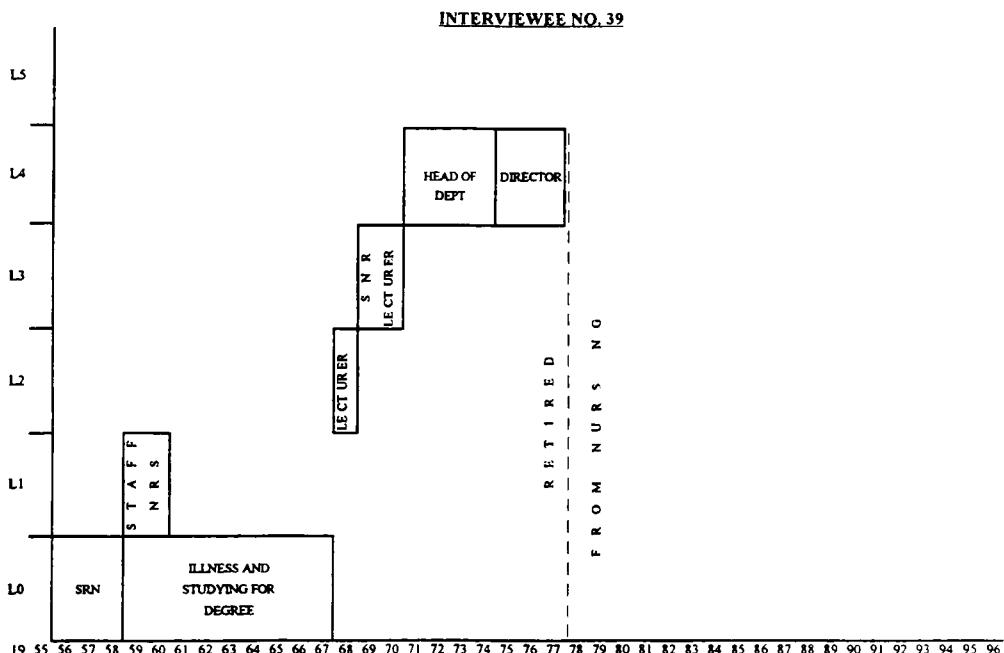
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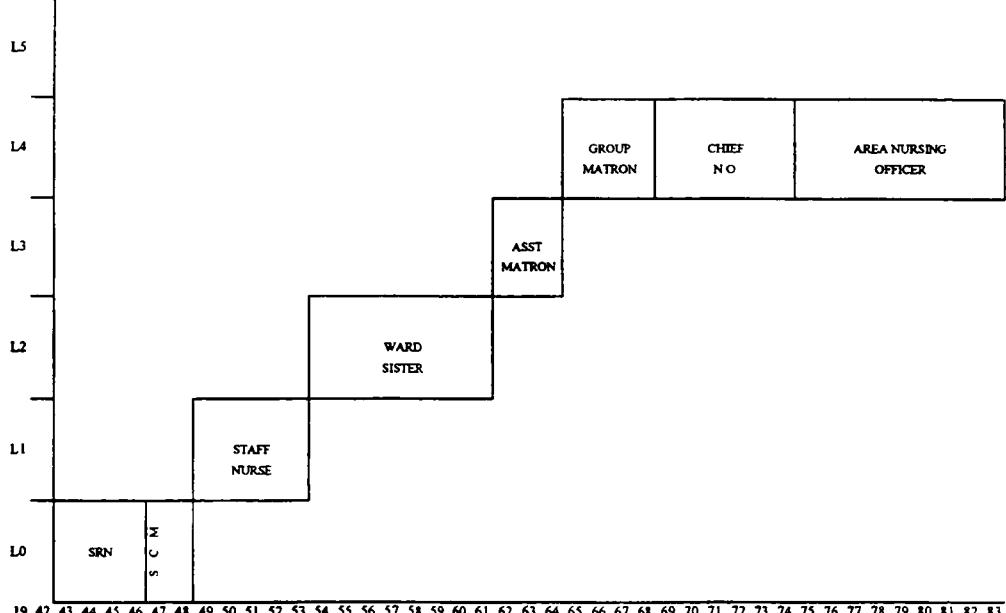


Career Pathway Diagrams 39 and 40

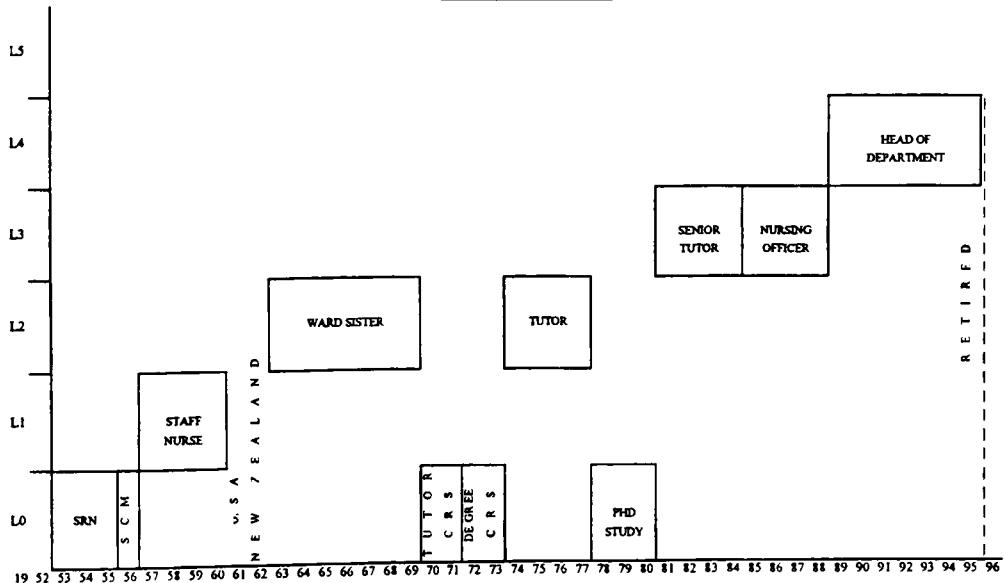


Career Pathway Diagrams 41 and 42

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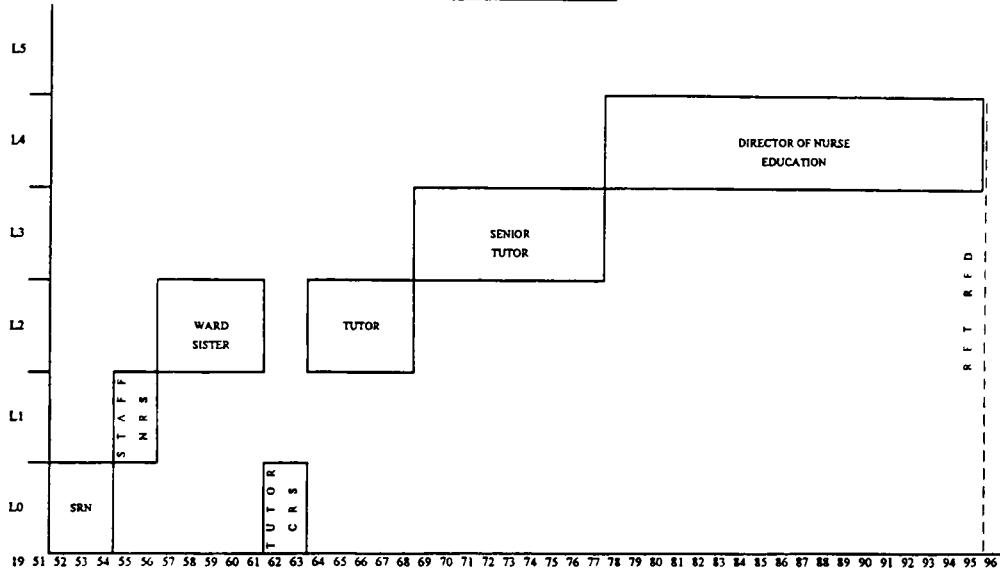


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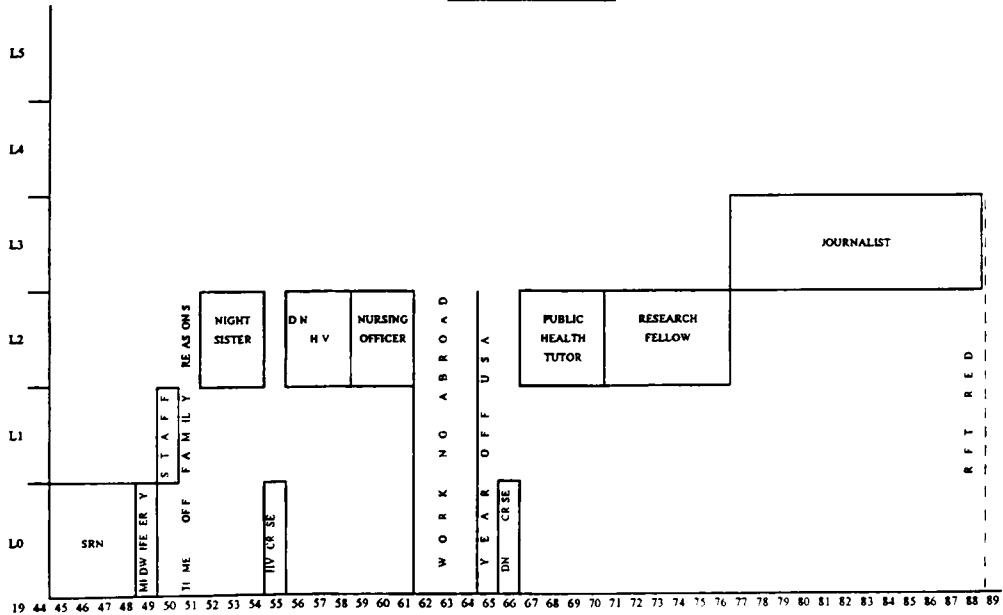


Career Pathway Diagrams 43 and 44

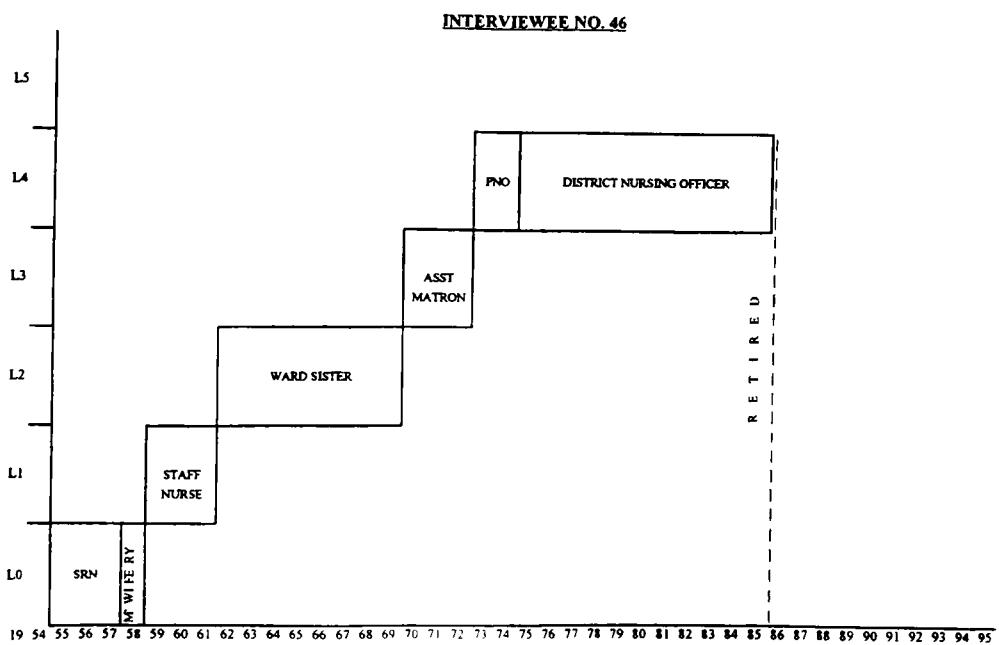
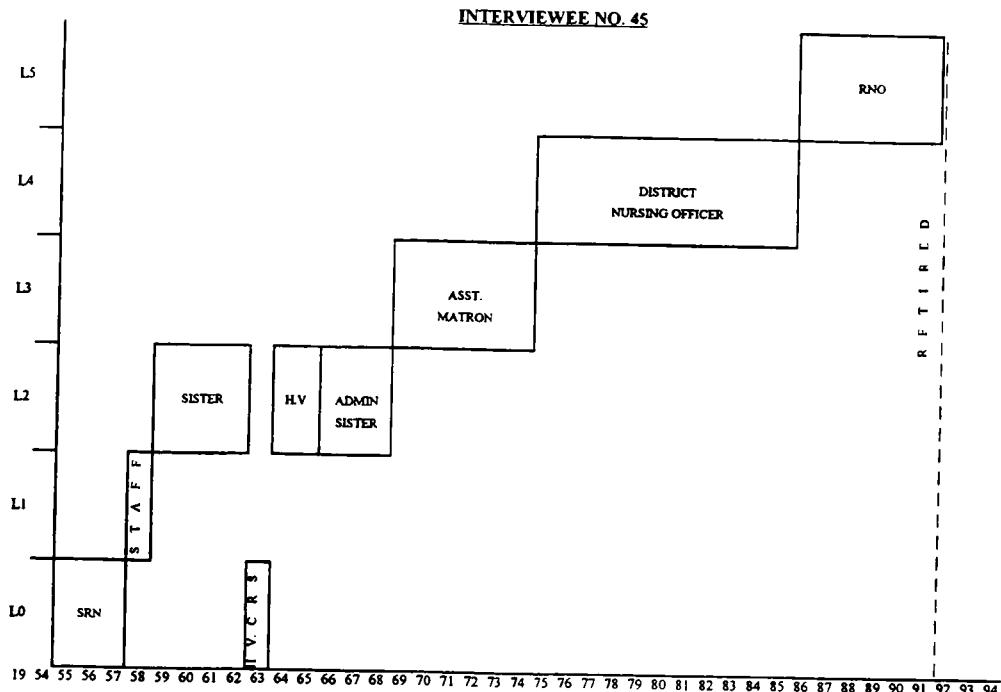
INTERVIEWEE NO. 43



INTERVIEWEE NO. 44

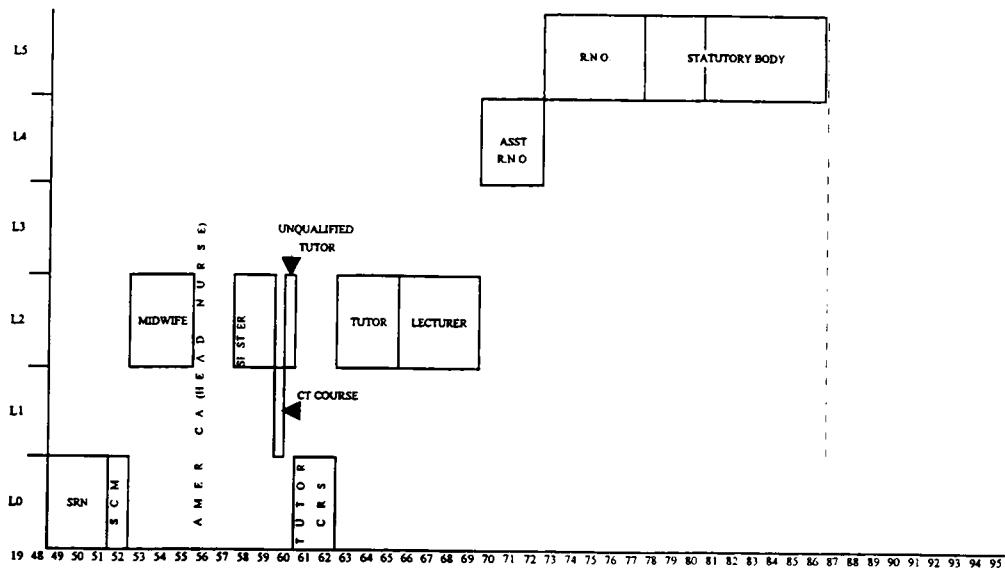


Career Pathway Diagrams 45 and 46

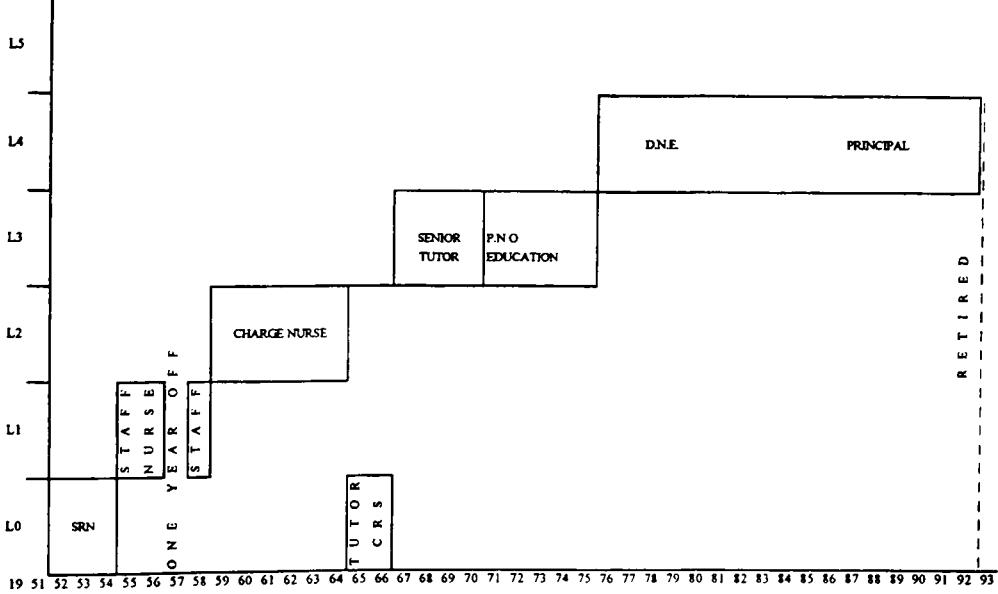


Career Pathway Diagrams 47 and 48

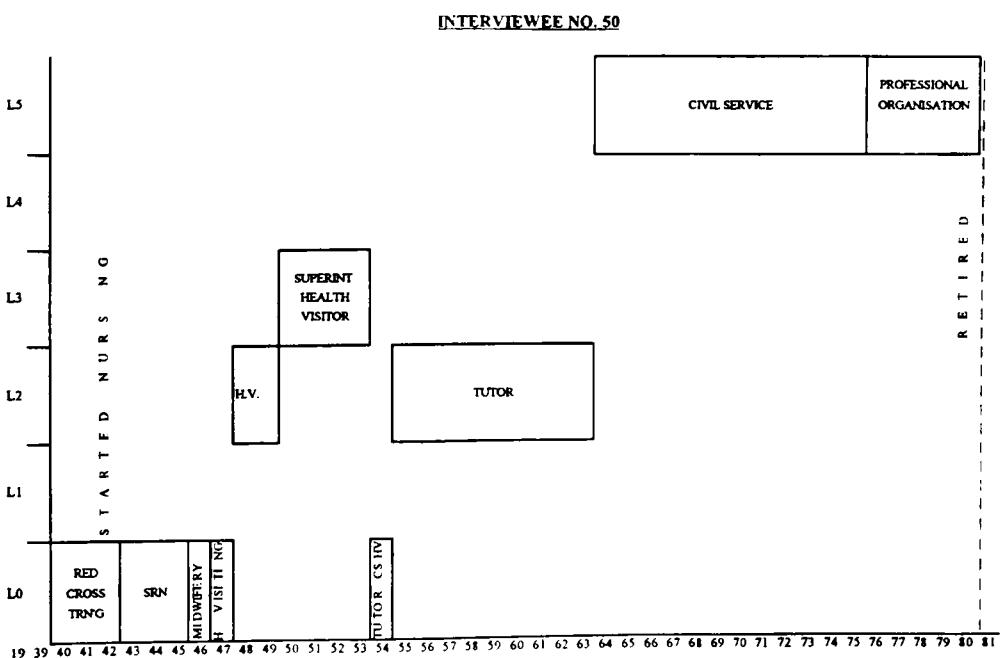
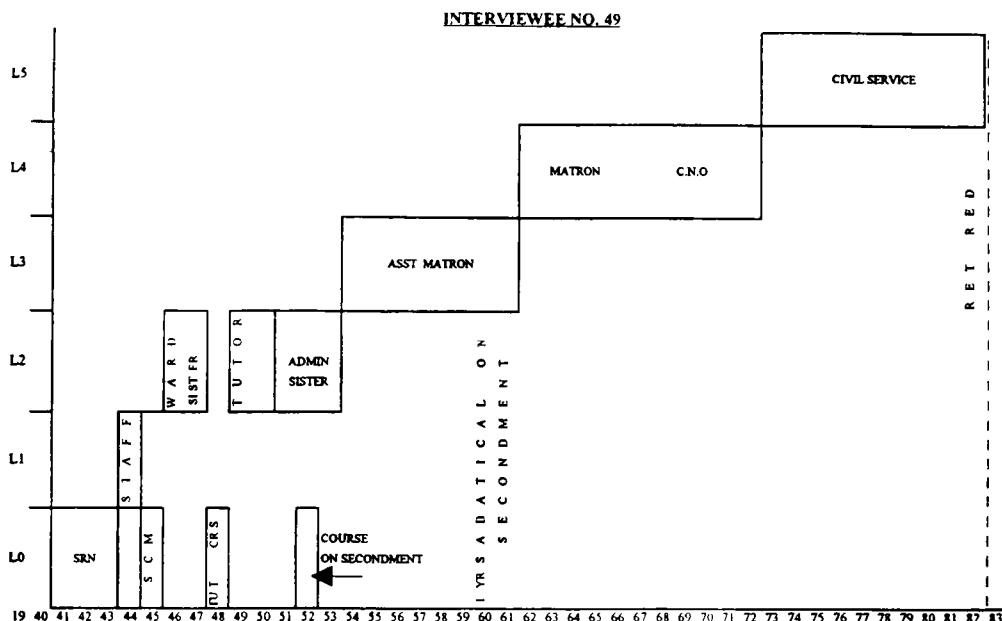
INTERVIEWEE NO. 47



INTERVIEWEE NO. 48



Career Pathway Diagrams 49 and 50



Career Pathway Diagram 51

