Context and the leadership experiences and perceptions of professionals: a review of the nursing profession

Introduction

Workforce ageing and employment retention of the nursing workforce are key issues of ongoing concern in developed western economics (Preston, 2005, WHO, 2002). These issues have been linked with predicted skill shortages in nursing as ageing populations will lead to increased demand for the many roles fulfilled by nurses. While increases in the number of nurses trained provides one response to this, retention of trained nurses is also critical. The experience of leadership has been identified as one of the important issues for nurse retention (Rebelin, 2003, Ashbaugh, 2003).

This paper forms part of work undertaken for a large research project commissioned to explore new models of leadership for nursing and midwifery in the Western Australian public health system. The starting point for this research was to review current practice and knowledge in the area of leadership, nursing and midwifery. This article draws specifically on literature which details and seeks to understand key factors in the current environment that shape the practice and experience of leadership by nurses. Our focus was guided by reports and research articles on nursing structure and leadership, published in Australia, New Zealand, UK and North America, mainly since 2000.

Two decades ago, a review of the career structure of nurses in the Australian Capital Territory (Perrett and Monck, 1990) identified a fragmented approach to leadership and management and a lack of role clarity. Twenty years later reports and research continue to emphasise lack of role clarity and tensions with leadership and management which impact on the nursing profession. Fulop and Day (2010, p.347) note that much of the recent research on health leadership has been used 'to create a categorisation, labelling and sorting approach

to leadership studies' that, while important, 'rarely admits of other approaches that could more closely resonate with the lived experiences of clinician managers'. Our review of reports into nursing leadership and our exploratory qualitative research led us to the conclusion that, to understand the continuing issues interacting with and shaping how nursing leadership is practiced and perceived by nurses, that is the lived experiences of nurses, it would be important to consider nursing leadership in context. Our goal was to gain insights into the contributory factors that explain how and why experiences of leadership by nurses and by nurse leaders and leadership behaviours of nurse leaders are observed, rather than further description of nursing leadership (Jepson, 2009a, p39).

We adopted the contextual dynamics approach pioneered by Jepson (2009a). This was consistent with our objective of understanding the issues interacting with and shaping how nursing leadership is structured, practiced and how it is perceived by nurses. The focus of this review is on whether viewing leadership in nursing in context (Jepson's (2009a) social, cultural and institutional contexts) provides a way of understanding the practice and perceptions of nurses and nursing leaders and tensions within nursing leadership which the many government reports and reviews (New South Wales Health, 2009, Perrett and Monck, 1990, Queensland Health, 2008, Scottish Government, 2008, Royal College of Nursing Institute, 2004) have identified.

Jepson's research considered how characteristics of the immediate social context of the workplace interact dynamically with broader contextual factors (Jepson, 2009a; Edwards, 2011, p.304). Jepson (2009a, p.38) argues that to understand how individuals construct their own understanding of leadership we need to consider the dynamic interaction of contextual types, identified as the immediate social context (e.g. industry, department, technology), the institutional context (history, regulation, education, government policy) and the general social context (national and organisational culture) (see fig 1 below). Jepson's concept of the

dynamic interaction of contextual factors was used as a framework for this review on insights into how leadership is practiced and perceived within one professional group – nurses. We take the concept of contextual dynamics and use it to analyse how those dynamics influence and shape or impede the enactment of leadership and also how that shapes the perceptions of 'followers' about whether leadership is being provided, by whom, and how that is being done. .

Figure 1 here

The Review Approach

Previous policy reviews of nursing leadership (noted above) and a preliminary set of semi-structured qualitative interviews with the senior nurse manager group of the and Western Australian public health system focus groups allowed us to identify three specific interrelated and potentially dynamic contextual factors relevant to nursing leadership experiences. These included: dissonance between professionalism and managerialism; leadership within hierarchical systems; and knowledge work. Our goal in this review is to document and explore the relationship between these factors as they are discussed in the nursing and related literature.

The methodological approach taken in the review is based on Denyer and Tranfield's (2009, p. 672) argument for 'fit for purpose methodology, which can cope with the variety and richness of research designs, purposes and potential end uses'. While the Denyer and Tranfield were referring to systematic discipline-focussed reviews, we believe that their suggestion is also pertinent to the critical, exploratory, transdisciplinary review we have undertaken.

Having established the boundaries of our review as involving the dynamic contextual factors noted above, we identified keywords to use in the interrogation of data sources. These included nurs* + autonomy/professionalism/knowledge work/managerialism/hierarch*; knowledge work; professionalism and managerialism; hospital + hierarch*; medical model + nurs*; medical hegemony; medical homophily. Using these keywords, we conducted searches of specialist health databases, such as Medline and CINAHL, specialist business databases such as EBSCO Business Source Complete, and the general databases Proquest Central, Web of Knowledge, and Informit. The online searches were restricted to scholarly material written in English, published predominantly post 1999. The review's emphasis on recent literature recognises the changing landscape of health care and we have sought to identify current issues and debates rather than visit historical material. As relevant articles were found, further literature was sourced by tracing cited articles through the Scopus database. 'Grey literature' such as reports which are not always covered in indexing databases were also sourced where possible. Our emphasis was on material published primarily, though not exclusively, in Australia, New Zealand, the United Kingdom and North America. The review is not intended to be exhaustive but rather to identify key issues and stimulate further investigation.

In their description of question formulation in the development of systematic reviews, Denyer and Tranfield (2009, p. 683) suggest the need for flexibility and modification of questions as the reviewer's understanding of the problem progresses. While wishing to ensure the rigour of our review process by using identified keywords to search specific databases, we enhanced this process by adopting a flexible approach to the range of literature we investigated and search terms used and allowed ourselves to be guided by the contents of this literature as the process unfolded.

In what follows, we consider the evidence from the literature for the interaction with, and impact on, leadership in nursing of the contextual dynamics resulting from managerialist reforms in healthcare, evolution of hierarchical models of leadership in healthcare and the growing pressures from an environment of knowledge work and a knowledge based health workforce. Consistent with Jepson's (2009a) model these three forces are analysed in their interaction with the other social, organisational and institutional contexts which are relevant to nursing work and nursing leadership.

Managerialist Reform in Healthcare as a context for Nursing Leadership

Nurse Leaders and managers: Role confusion

Two decades after a review of the career structure of nurses (Perrett and Monck 1990) had identified a fragmented approach to leadership and despite numerous efforts to provide leadership training (O'Neil *et al.,* 2008), the latest reports and research into nursing leadership continue to raise similar issues (Queensland Health, 2008; Scottish Government, 2008; New South Wales Health, 2009; Prime Minister's Commission on the Future of Nursing and Midwifery in England, 2010; Tarrant and Sabo, 2010; Hughes and Carryer, 2011). The literature reviewed consistently indicates that there is conflict between the leadership of professionals by professionals and the pressure of managerialism. Brought on by public sector management restructuring in countries such as Australia, we have identified interaction between institutional culture in the form of managerialism and social culture in the form of professionalism as important to an understanding of the perceptions of nurses relating to leadership and the experience of nurse leaders. *Dissonance between professionalism and managerialism*

In their 2002 study of Western Australian nurses, Nowak and Bickley (2005, p.422) identified 'an ideological dissonance with their environment', 'a clash between the

commercial and clinical cultures in the WA health system'. They argued that the requisites of the public administration reform (or New Public Management, NPM), implemented in the 1980s, are not compatible with the professionalism that underpins the delivery of health care. Their findings resonate with similar studies in 'caring professions' such as social work (eg Lymbery, 2000; May and Buck, 2000; Harris, 2003) and other allied health professions (Germov, 2005). The dissonance identified also relates to what Tummers *et al.* (2009) define as 'policy alienation', or psychological disconnect from the policies being implemented. While there is some suggestion in the literature that cracks have appeared more recently in NPM (O'Flynn, 2007) and that we are now in the 'post-NPM' era (Doessel *et al.,* 2009), the legacy of NPM remains apparent in the health sector and this was borne out by the literature.

New Public Management and Health Care

The implementation of managerialist health reforms in the 1980-90s has been well-documented, e.g. New Zealand (Bamford and Porter-O'Grady, 2000; Bryson, 2003; McCloskey and Diers, 2005; Brophy, 2008; Carryer *et al.,* 2010), Australia (Germov, 2005; Doessel *et al.,* 2009); the UK (Harris, 2003; O'Reilly and Reed, 2011); Singapore (Wong, 2004). Bamford and Porter-O'Grady, (2000, p.84) note that these reforms were based on belief in the superiority of markets, competition and self-reliance, underpinned by the ideologies of economic rationalism and managerialism (Brophy, 2008)

Underpinning the managerialist philosophy in the public system was a view that the technical rationality of managerialism is superior to professionally dominated decision making (Lymbery, 2000, p.128). The introduction of managerialism was accompanied by a new vocabulary of 'performance indicators', 'deliverables', 'targets', 'devolved budgets', 'organisational development teams', 'objectives' and 'evaluation schemes' (May and Buck, 2000, p.142). Its aim was to make public sector organisations and their employees more

business-like, oriented towards performance, cost, efficiency and audit (Diefenbach, 2009, p.893).

The significant change process and the resulting new structures and organisational drivers affected health professionals, including nurses. From the literature it is apparent that Tthis change engendered considerable disruption of professional power and conflict with professional values and discourses, impacting on leadership of the professions in services such as health. The implementation of the change necessitated 'the removal of structural obstacles and the eradication of cultural and ideological barriers that stood in the way of progressive modernization' (O'Reilly and Reed, 2011, p.1088).

 Professionalism has traditionally been characterised by 'autonomous decision-making, access to a unique body of knowledge and an ethical obligation to the client' (Traynor *et al.,* 2010, p.1511). Professionals began to find their autonomy curtailed by performance management systems, output controls and increasing pressure to produce results (Tummers *et al.,* 2009). They experienced role conflict through a trade-off in values (Tummers *et al*., 2009), where judgement based on professional standards has been replaced by the key values of transparency and accountability (Reinders, 2008; Harris, 2003, p.15). Quality of service is still emphasised, but is only measured in terms that are quantifiable and can be documented. Reinders (2008, p.568) suggests that the increasing involvement of professionals with management responsibilities has eliminated the separation of professional from non-professional activity. He refers to a process of hybridisation when professionals take on managerial responsibilities. Diefenbach (2009, p.903) argues that professionals in management have taken on managerial attitudes, rhetoric and ideology, setting aside their professional worldviews and values. Fulop (2012), however, notes there are tensions and conflicts inherent in leadership as part of professional   practice. She considers hybridity provides a complementary way of looking at leadership in healthcare but notes there is no

hybrid leadership theory per se. Instead she proposes leadership issues call for domain specific research and proposes the need to explore an approach in which context is made more explicit in leadership research in healthcare.

In her discussion of contextual dynamics Jepson (2009a, p41) considered the issue of how leadership is legitimated. One effect of co-opting professional leaders into management can be that such leaders become an 'out group', differentiated from the 'in-group' of professionals by attitudes and behaviours that don't accord with the values of the profession. This perspective is supported by the social identity theory (Tajfel, 1978) of leadership. Hogg (2001, p.186) suggests social cognitive processes associated with group membership may significantly affect leadership dynamics. These processes include self-categorisation (assimilating attitudes, feelings and behaviours consistent to the 'in-group') and depersonalisation (whereby context specific prototypes define and prescribe attitudes, feelings and behaviours that distinguish from other groups). 'Leaders and followers are interdependent roles embedded within a social system bounded by common group or category membership' (Hogg, 2001, p.186). This relationship may break down when the leader is not accorded 'in-group' status by those they are expected to lead. This recognisable reaction is supported from within the literature on nursing considered below.

New Public Management as Context for Nursing Leadership Practice

In the following section we draw on research into the practice of leadership by nurses and nurses' perceptions of that practice. The research reports continuing confusion, role ambiguity, dissonance between the perceived values of nursing leaders and nurses, and discomfort with nursing leadership or a perceived lack of leadership resulting from co-option of leaders and leadership roles to management. This is consistent with the analysis above of

how the dynamic interaction of the professional culture and the managerialist culture would become manifest the in perceptions and experience of leadership by the professional group.

The roles and responsibilities of nurse executives have changed from a focus on nursing to active participation in broader hospital leadership functions resulting in role ambiguity (Tarrant and Sabo, 2010, Carvalho, 2012). Where nursing leaders have moved to acceptance of the corporate values of managerialism the way has been opened for dismantling operational responsibilities in nursing administration (Brophy, 2008, p.23; Bamford and Porter-O'Grady, 2000). Change has occurred from a profession that was previously self-managed, to one which includes generic managers (Nowak and Bickley, 2005) whose aim is to increase efficiency and save money (Carryer *et al.,* 2010). For example, New Zealand adopted generic management structures and nurse management positions were replaced with non-nurse business/service/operations managers (McCloskey and Diers, 2005).

Tension and ambiguity is created for nurse leaders in situations where they report to a service manager for operational matters but also report to senior nurses for professional accountability (Nowak and Bickley, 2005). The situation is exacerbated when generic service managers do not have professional accountability to senior nurses (Nowak and Bickley, 2005, Carryer et al., 2010). Those balancing dual roles of specialist and manager may also experience conflict because, while they may be trained in their profession, they may not be trained in management. In their frustration in dealing with their management responsibilities they may see their 'real work' as their technical specialty and neglect their managerial tasks (McConnell, 2002). Role conflict is evidenced around the need to demarcate artificial "professional" accountability from "operational" accountability (Hughes and Carryer, 2011, p.43). Hughes and Carryer (2011) believe that this raises questions around professionalism, scope of practice and the definition of clinical practice. Tensions have been identified between the professional ideals of nurses and the realities of nursing work,

particularly due to managers' expectations of compliance with efficiency imperatives (Brophy, 2008, Nowak and Bickley 2005). Professional practice is more than the mastery and performance of a set of tasks, there must be a certain 'something else' to it, and it is the difficulty in defining this 'something else' that conflicts with empiricist categorisation implicit in managerial approaches to accountability (Sellman, 2011).

Values seen as core to the profession have been identified within nursing. 'Truly compassionate care is skilled, competent, value-based care (Prime Minister's Commission 2010, p.3) and there are 'core values of wanting to make a difference to patient care' (Queensland Health, 2008, p.4). The International Council of Nurses (Royal Australian College of Nursing, 2011) is guided by five core values – visionary leadership, inclusiveness, flexibility, partnership and achievement, while the core values espoused by the American Association of Colleges of Nursing are human dignity, integrity, altruism, autonomy, and social justice (Shaw and Degazon, 2008). These statements, with their focus on 'value based care', underline the nature of the disconnect, where the discourse of the nursing profession does not identify with that of the managerial imperatives.   Significantly, Pannowitz *et al.* (2009, p.111) found that 'the discourse of *values attributed to nursing* was empowering to each, whereas, the discourses of *bureaucratic managerialism* and the traditionally gender-biased *discourse of medical science* were found to be generally disempowering'.

Sellman (2011) suggests that nursing's voice is further marginalised through decisions of managers that discourage rather than encourage practitioner values.Wong (2004, p.10) suggests that a fiction of upholding practitioner values may be transmitted to nurses such as ward managers who attempt to portray themselves as working in an egalitarian, caring, holistic way while at the same time trying to reach managerial objectives. Wong argues the managerial standards actually seek to control the work of healthcare givers through securing

their active consent, rather than through direct intervention,. by ensuring nurses self-monitor their performance as cost-efficient employees (Wong, 2004).

One crucial aspect of professionalism discussed in the nursing literature is autonomy (Salhani and Coulter, 2009; Skår, 2009; Traynor *et al.*, 2010). Kimpson and Purkis (2011) suggest that the issue of autonomy is a major influence on nurse retention. A study by Skår (2009, p.2229) found that 'being knowledgeable and confident is the coherent meaning of autonomy in nursing practice'. This supports earlier findings by Mantzoukas and Watkinson (2007, quoted in Skår, 2009, p.2232) that the use of knowledge by nurses is important to gain professional autonomy. We will explore the linkage with 'knowledge' further in the paper.

Without autonomy nurses are not able to control their work and self-direct their practice and their subordinate position in relation to doctors is reinforced (Apesoa-Varano, 2007, p. 270). Brophy (2008, p.24) observed that control mechanisms such as increased audit and monitoring, pressure to redefine nursing roles to match management agendas and values, and dismantling of operational responsibilities in nursing administration' systematically undermines autonomy and professional status. This observation contrasts with a study by Germov (2005, p.753), who found that nursing and allied health professionals exercise their agency to produce a "re-negotiated order" that incorporates managerial strategies.

In Australia, Paliadelis (2005) found there was unwillingness amongst Nurse Unit Managers (NUMs) to identify with the role of 'manager'. 'The NUMs tended to devalue and discount the administrative and managerial aspects of their job, preferring to talk about their nursing role' (Paliadelis, 2005, p.5) suggesting that they saw leadership as exercised through membership of the 'group' (Tajfel 1978, Hogg 2001)

Nurses do not see managers as leaders because they are away from the professional decision making role and lack professional clinical practitioner autonomy. This can lead to the

evolution of a shadow leadership structure. An evaluation of the role of matrons in UK

National Health Service Trusts, found they failed to match the idealised expectations of the

matron role and this was a source of anxiety (Royal College of Nursing Institute, 2004,).

Sixty per cent of the participants reported either they were unclear about the role themselves

or there were misunderstandings about their role by other staff, which undermined their

effectiveness. Ward sisters felt that the priority given by matrons to

organisational/managerial concerns 'diluted their clinical role' and that matrons were too far

removed from patient care (Royal College of Nursing Institute, 2004, p.115). The Prime

Minister's Commission on the Future of Nursing and Midwifery in England (2010) also

identified the lack of recent clinical experience of some nurse leaders and that this 'could

result in a lack of clinical credibility and awareness and hinder them from taking a lead role

in clinical governance' (p.86).

The tension between nurse leaders and clinical nurses has been described by Bolton (2004) as

the "we/they" dichotomy. The literature reviewed suggests this to be the outcome of

contextual dynamics resulting from the institutional and organisational changes wrought by

NPM philosophies working against a professional nursing culture reinforced by a shared

professional discourse and educational experience. Clinical nurses may believe leaders make

decisions based on financial or political expediency rather than concern for patients or staff;

that is, leaders do not display the prototypical behaviour which would place them in the 'in-

group' to provide legitimacy in the exercise of the power of leadership (Jepson 2009a ; Hogg,

2001; Cicero *et al.,* 2010). Leaders are seen as those who have some form of authority, power

or control that they can draw upon to influence others, hence creating 'followership'

(Northouse, 2004; Sinclair, 2007; Grint and Holt, 2011). 'Without influence leadership does

not exist' (Northouse, 2004, p.3). 'In-Group' legitimacy provides the lubrication for the

wielding of influence and hence leadership. Bolton, (2004) argues that the negative view of

leadership resulting from lack of legitimacy from the perspective of nurses deters capable nurses from taking leadership positions, interferes with succession planning, isolates leaders from those they lead, perpetuates a culture of blame and conflict, spurs leader burnout, creates unsafe environments for staff and patients, and prevents individuals and organizations from achieving their full potential.

Analysis of the dynamic interaction between nurses, nursing leadership and NPM philosophies and attendant managerialism is critical to an appreciation of how nursing leadership has been perceived and practiced over the past 20 years. This interaction took place within a system which was increasingly constrained for resources. This dynamic is integral to the understanding of role ambiguity and confusion by nurses and their leaders, perceptions by nurses of values conflicts with leadership, tensions between clinical and managerial roles of nursing leaders and perceptions of loss of professional status and autonomy by nurses and their leadership. The introduction of NPM-based structures and accountabilities may be characterised as an example of the dynamic interaction of Jepson's Cultural (in this case professional culture), Institutional (in this case government regulation and policy, education and socialisation) and Immediate Social (industry, department, and job) contexts affecting the perceptions of and practice of nursing leadership.

Leadership within hierarchical systems

One of the continuing contextual dynamics of the nursing job is the interprofessional context in which nurses work; using the Jepson framework this involves the immediate social context and elements of institutional context such as education and generational differences. Nurses work in multidisciplinary teams and nursing leaders work within hierarchical structures and a 'hierarchy of occupations' (Nancarrow and Borthwick, 2005, p.904). Nursing leadership and how nurses perceive that leadership is impacted by the other health professions, particularly

the medical profession, which has been so influential in shaping the development of modern healthcare delivery. We find evidence from the literature that the medical model, which dominates the models of care in hospitals, causes conflict as young university-educated nurses expect more professional autonomy from their leaders and a greater professional role for nurses than medical doctors may be willing to concede.

Despite considerable change in recent decades medical homophily continues to exist (Lewis, 2006, p.2134). Bourgeault and Mulvale (2006) suggest this is structurally embedded while Tousijn (2006) suggests that the power exercised by the profession is not replicated in other professional fields. In a study of senior nurse executives and medical leaders in the UK, West and Barron (2005, p.139) found that professional homophily was more marked among doctors than nurses, and that doctors comprise a powerful block within hospitals.

The hierarchical 'doctor-nurse game' fosters arrogance, condescension, and inequality and limits the potential of nursing staff (DiPalma, 2004) while nurses feel they have to prove their competence in every interaction (Fagin and Garelick, 2004). This professional hegemony of the medical profession pre-dated the NPM reforms and, though challenged, has been largely maintained, adding further complexity to the context of nursing leaders. At the same time the medical profession itself has reacted to management change by acting defensively and looking inward (Ackroyd, 1996).

A study by Atsalos (2004, quoted in Surakka, 2008, p.527) found that the hierarchical relationships between the different health professionals are a problem for nurse managers in Australia. Nurses may have to 're-negotiate their nursing knowledge and practice expertise' with doctors new to their ward or unit (Pannowitz *et al.,* 2009). Daiski (2004, p.45) describes the problematic relationship of nurses and physicians and notes that some nurses viewed the unequal relationships as normal.. The gendered division of labour within health care may

also exacerbate the subordinate position of nurses (Churchman and Doherty, 2010). Nursing traditions have emphasised hierarchical rule-following, with nurses working "around" others (Davies, 2000) to avoid conflict and stress. Churchman and Doherty (2010, p.46) suggest that nurses themselves, particularly some senior nurses, are complicit in this subordinate role through their deference to the medical profession. Comments by participants in studies by both Daiski (2004) and Nowak and Thomas (2009) that 'nurses eat their young', are indicative of a hierarchical structure which is potentially hostile. Pannowitz *et al.* (2009, p.112) found there was disempowerment of nurses within a cultural context 'of oppression by nurses upon nurses'. Radcliffe (2000, p.1085) suggests that nursing, in developing postgraduate education, evidence-based practice and expanded roles, mimicks the medical career structure as a means to affirm professional worth. What are the implications of these hierarchical relationships for nursing leadership? Senior nurse leaders are disadvantaged in the level of peer support available to them. West and Barron (2005) found in their study that while peer groups appeared to be available for Clinical Directors of Medicine, this was not the case for roles such as Directors of Nursing. Cott (1997) suggests that as groups which are subordinate to medicine have sought and achieved greater autonomy and control over the conditions of their work, teamwork has evolved as a more egalitarian, independent model of working. However, her research has found that the interaction of nursing with other professions that does occur is mainly with senior or higher status nurses. There is clear differentiation of power and influence between senior nurses and nursing 'sub-teams', whose teamwork consists of assisting each other with work tasks.

Within the nursing profession there is also discord around the hierarchical model of nurse leadership. In this sense 'hierarchical' also relates to age/generational differences in addition to formal reporting structures. Duchscher and Cowin (2004) believe that the micromanagement style of older nursing leaders clashes with the needs of younger nurses

who want to work in a culture of independence and collaboration, consistent with the desire for autonomy of practice noted earlier. While responding to positive mentoring, they will resist what they perceive as prescriptive or autocratic leadership styles. In a study of middle-level women nurses by Pannowitz *et al* (2009, p.110) one commented that 'the graduates are educated in university to be autonomous practitioners and to be creative, but, when they come out, the nurses in the wards are hospital trained, and they tell them how to do their job... That's the traditional mindset... it's all centred around the doctor... That's why a lot of junior nurses get really disillusioned'. Hunter (2005) found that hospital-based midwifery was strongly hierarchical, junior midwives had little overt power (Hunter, 2005). Chadwick (2010,) supports the view that nurse leaders face a challenge in bridging the generation gap between older nurses and physiciansand the younger nurses who expect everyone to be treated as equals. Because medical knowledge remains dominant, clinical decision-making is controlled by doctors with whom nurses have limited standing in clinical practice (Degeling and Carr, 2004,). This paradoxical situation means that nurses must manage the tensions arising from the role of self-disciplined assistant and professionally educated practitioner' (Coombs and Ersser, 2004).

Consideration of the hierarchical medical model elevates power relations within, and importantly, between professions as a contextual issue to be negotiated by nursing leadership. Changing patterns of education and generational transitions, along with the changing demands on health delivery processes implicit in managerialism, have created tensions for the historical conception of the hierarchical leadership model in nursing. Responses to the perception of many younger, university educated nurses that hierarchical leadership is not relevant or contributing effectively to their workplace practice require an understanding of the contextual dynamics or forces which have created and are sustaining current nursing leadership practices and structures.

Knowledge work

The job of the nurse has increasingly involved the 'use of knowledge' and the preparation for nursing through tertiary education has fed into expectations of new nurses to be able to operate as autonomous professionals. The contextual dynamics around the conflict involved in facilitating an environment for knowledge work, within an organisational context where managerialism is the dominant paradigm and hierarchical leadership models hold sway, provide further understanding of the issues for nursing leadership. These issues may increase in importance for future nursing leaders.

It has been suggested that the most valuable asset of a 21st century institution will be its knowledge workers and their productivity (Drucker, 1999, p.79). Factors which determine knowledge-worker productivity resonate with the themes we have already identified – 'Knowledge workers have to manage themselves. They have to have autonomy'; they must be 'seen and treated as an "asset" rather than a "cost" (Drucker, 1999).

Hamilton (2010, p.10), who noted the rise of 'knowledge workers' such as the new nursing graduates, commented that 'Models of leadership and organization that worked to keep systems stable and constant are not compatible with the concept of knowledge workers. Knowledge workers need scope to function in the work place in accordance with the principles by which they are prepared, to reflect, question and evaluate practice. What was needed was flexibility and adaptability, to allow for innovation and creativity in the continuing search to improve ... outcomes and the removal of constraints deemed counterproductive to the work effort' Valentine, (2002) argues that early autonomy for those at the first line of decision-making, creates the building blocks of leadership).

Kerfoot (2007, p.108) notes that many nurses leave the profession 'because they are not treated as knowledge workers who can design and experiment with process and innovations...

the productivity targets leave them with no time to consider, experiment, and grow'. . If, as Karseth and Nerland (2007, p.352) suggest, knowledge is "the foundation of professionalism", then these are professional values that conflict with managerialist philosophy and systems and hierarchical leadership models. There is therefore a tension between the bureaucratic demands of the health system and what it requires of nurse 'leaders' and nurses who want to work in a professional environment in which they can be innovative and grow.

The Registered Nurses' Association of Ontario, (2006) considered a core competency for creating an environment that supports knowledge development and integration would be nurse leaders who foster norms and practices supportive of broad participation in knowledge development, sharing, and dissemination.. Snyder-Halpern et al., (2001) find traditional clinical practice environments control information flow and discourage independent action. Effectively supporting the knowledge work of nurses, empowering their decision making and enabling them to provide better patient care requires change to this environment (Snyder-Halpern et al., 2001). The ideal of knowledge workers and learning organisations is related to the professionalism and autonomy sought by many nurses. 'To practice autonomously, a nurse must know, must have up-to-date knowledge backed by research and evidence' (Kramer and Schmalenberg, 2008, p.69).

The knowledge worker model holds implications for the practice of leadership. Šajeva, (2007, p.650) proposes that facilitation of the effective use of knowledge requires smart leadership. Leaders must 'promote positive relationships through disclosures, including openness in terms of information sharing, accountability, and honesty…and objectively analyse relevant information and solicit view from others – including those they lead – before making decisions' (Walumbwa et al., 2011). Weaver and Sorrells-Jones (1999)propose that to develop the knowledge assets of professionals requires the leader to support, rather than

direct efforts and the leader cannot rely on hierarchical or position power to achieve this.

Thus leadership of knowledge workers would be dependent upon 'influencing' activity

(Northouse, 2004, p.3), or as Grint (1997, p.9) argues 'essentially interwoven . . . acts of

persuasion'. As previously discussed, (Duchscher and Cowin 2004, Pannowitz et al 2009,

Chadwick 2010), the context is one where many in nursing leadership retain a hierarchical

leadership world view while younger nurses, usually those to be 'led', seek more autonomy

in practice and see themselves as skilled professionals. This may contribute the development

of the 'informal' leadership observed in nursing. There is support for the position that it is

the knowledge workers themselves, those with important tacit knowledge, who will act as

leaders in communicating knowledge and adapting and driving new and evolving healthcare

system technologies (Brooks and Scott 2006, Conrad and Sherrod, 2011). The literature on

nurses as knowledge workers is sparse. Even less is written about the implications of

knowledge workers for nursing leadership. We have identified this as an aspect of nursing

leadership where contextual dynamics will have a significant impact on the way forward

and one which should be explored further.

Discussion

Our goal was to explain 'the why and how' of the contemporary experiences of leadership by

nurses and nurse leaders and perceived leadership behaviours of nurse leaders. Our review of

the literature suggests that insights into why and how contemporary nurses constructed their

understanding of nursing leadership requires consideration of the contextual dynamics of the

environment within which the nursing profession is practiced.

Using Jepson's (2009a) framework we found that of particular significance in developing an

understanding of leadership experience in nursing has been the change in context to a

managerialist approach to organisational structures, objectives and operations within health

institutions. This has impacted on leadership in nursing through the interaction of managerialism and the professional culture and values of nursing. This interaction has created tensions and ambiguities for nurses and critical conflict for those in senior nursing roles because, in many environments, the managerial imperative at the organisational level is seen by both nurses and those designated as nurse leaders to co-opt the nursing leadership into organisational management. This results in perceptions by nurses of lack of nursing leadership while those in leadership roles experience role ambiguity, confusion and disconnection from nursing.

We considered the question of why this changing organisational and philosophical context has created the issues identified in the literature for nurses and nurse leaders. We found that questions of professional identity and the role that plays in conferring or withholding legitimacy on the leader are important. Professional culture and discourse, reinforced by common educational experiences and a community of practice, underpins these perceptions of professional identity and thus governs the bestowal or withholding of influence and legitimacy on leaders. This is an area for further research.

We identified the changing dynamic of the interaction of nurses and nurse leaders with the hierarchical medical model and the power structure inherent in that model within health systems as important organisational contextual issues. Our review indicates this affects nurses and nursing leadership in two ways. Firstly, the inherent power structure of the medical model, has continued to muffle the voice of the nursing leadership within health organisations. Secondly, it informs the actions of some in nursing leadership and the structure of nursing leadership itself and creates generational tensions between younger, university-educated nurses and older, hospital-trained nurses.

A further developing contextual dynamic is contributed by the concept of the knowledge worker. This picks up a range of dynamics within the immediate Social context relating to the interaction of the developing knowledge industry characteristics of the health industry, the changing educational requirements for nurses and the dynamics of generational change. It challenges both the power dynamic inherent in hierarchical medical leadership models and the diminution of autonomy inherent in the managerialist approach. The literature relating to this contextual issue is focussed on the health industry as a whole, with only limited discussion in nursing literature. However, what is clear is the importance of knowledge work and the need both to recognise it as a contextual issue for nursing leadership and to understand that new structures and new ways of enacting leadership are a potential response.

Jepson's (2009a) framework provides a coherent approach for considering how dynamic elements within the context of the leadership environment have an impact on the constructs, experience and perceptions about nurse leadership. We argue that to understand the contemporary issues for nursing leadership and its practice we must explore the dynamic interaction of managerialism, the hierarchical medical model and the social context of change including knowledge industry characteristics, with nursing work and the professional culture and values of nursing as a profession.

The insights generated here could also potentially be seen as one element of 'situated agency', in which context and leadership are inextricably linked (Choi 2006). That is, a review of the contextual framework in which nursing occurs demonstrates the ways in which nursing leadership both informs and is shaped by the individual agency of those practicing nursing leadership. There are different levels of context, such as national, organisations, hierarchical and department and that these different levels are important for agency that individuals perceive, understand and practice leadership (Jepson 2009a, b). The literature in this review suggests that a focus on industry, organisational and departmental contexts can

thus also provide a focus on how leadership practice in a specific profession such as nursing, might reinforce or challenge the social, cultural and institutional context in which it takes place. We were unable to find any existing literature which specifically integrates the concept of 'situated agency' within organisational explorations of nursing leadership, although there are some examples in the broader organisational and leadership literature (Koene, 2006; Sullivan *et al*, 2012). However, an understanding of the changing contexts of nursing leadership might be considered one contribution to the development of such an understanding.

The Jepson model

In this paper our objective was to consider whether going outside the nursing leadership literature and reviewing the nursing literature relating to context and the dynamics of contextual interactions would provide valuable insights for understanding the issues and problems in nursing leadership that had previously been identified. This approach has provided valuable insights, reinforcing and extending Jepson's argument that the context of leadership shapes its practice and identifying the value of contextual literature in the study of particular leadership issues. We note that the way in which leadership practice potentially reproduces or alters the social context in which it occurs remains relatively neglected in this framework and is an area for future research.

In her own work Jepson (2009a) focussed on the impact of contextual dynamics on the 'how and why' of leaders 'doing' leadership. Our review finds that this is an important dimension, where context assists understanding of how leadership is done. However, we have also considered the explanatory power of identified contextual dynamics in the contemporary experience and perceptions of nurses of their leadership. We find that contextual dynamics

can also contribute valuable understanding about how nurses perceive the leadership of those in leadership roles.

We propose that the Jepson contextual model itself would gain from the explicit inclusion of some of the dimensions discussed in this review. The addition of professional identity and values is an important context for inclusion in Jepson's Cultural contextual dimension, given the importance of identity for many professional groups. The addition of management orthodoxy (or ideology) to the Institutional dimension of Jepson's model we also consider would add value; the ebb and flow of ideas and fashions in management can be seen as part of the context within which leadership is enacted. In our review this is demonstrated by the contextual interaction of managerialism in the health sector and professional cultures.

Implications for Nursing Leadership

Recognition of these contextual issues must inform new ways of structuring and communicating about nursing leadership. From the literature we have reviewed there emerges a picture of contemporary nursing leadership where role ambiguity, fragmentation and loss, in the eyes of some nurses, of the legitimacy to lead by substantive leaders have become an issue of concern. Given continued concern, noted earlier, around workforce shortages and nurse retention in the health system, the insights from this review provide an important analysis of the contextual issues to be addressed in a process of reform. We have identified that, in the context of managerialism, nurses in management and leadership roles can face a perceived loss of legitimacy as leaders. Through their role in espousing the objectives and targets of management, such leaders can be perceived as an 'out-group', no longer prototypical of the profession and thus having lost their legitimacy to lead nurses. This has given rise, in some cases, to a shadow leadership system. Managing and turning around this perception is a challenge not only for the profession's leaders, but also for the health system

itself. Closer identification of nurse leaders as being those facilitating and informing nursing clinical practice will be a critical element in this.

Our analysis also shows that the historical hierarchical model of nursing leadership is already under considerable pressure and, as a result of changing contexts arising from educational changes for nurses and generational change, seems unlikely to represent a way forward. The developing conception of the role of the knowledge worker in health, and the implications of that for the structures and organisation of the delivery of health services, poses a further challenge for leadership of nurses. However, efforts to increase the legitimacy of nurse leaders though closer identification with and involvement in clinical practice may also facilitate effective transition to an environment of flexibility and adaptability, one which allows for innovation and the creativity of the knowledge worker. **References**

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Figure 1   Jepson's (2009) dynamic interaction of different levels and types of context.

Source: Jepson, D. (2009), "Leadership in context: the importance of departments", *Leadership & Organization Development Journal*, Vol. 30

No. 1

Immediate Social

Organisation
Technology
Department
Group
Job   Hierarchy   Industry

History

Specific context

National culture

Education

Organisational culture

Regulation

Socialisation

Cultural

Institutional