

**A Grounded Theory of the Role of the Directors of Nursing in Band
One Teaching Hospitals in Ireland**

Jennifer Margaret Hogan B.A. (Hons), RGN.

**A thesis submitted to Dublin City University for the degree of
Master of Science (Research)**

Supervisors: Professor Anne Scott & Dr. Imelda Coyne

Date: July 10th 2006

I hereby certify that this material, which I now submit for assessment on the programme of study leading to the award of Master of Science (Research), is entirely my own work and has not been taken from the work of others save and to the extent that such work has been cited and acknowledged within the text of my work

Signed:

A handwritten signature in black ink, consisting of a large loop followed by a horizontal line and a small flourish.

ID no: 52178790

Date: July 10th 2006

Acknowledgements

I would like to take this opportunity to acknowledge the following people who contributed to this thesis in many different ways:

My supervisors Prof. Anne Scott and Dr. Imelda Coyne for their supervision and academic guidance.

The Director of Nursing who willingly participated in the study.

Declaration and Copyright

Acknowledgements

List of Contents

Abstract

1	Chapter One – Background to the Study	9
1.1	Introduction	9
1.2	Justification for the study	10
1.3	Research aims	13
1.4	Research objectives	14
2	Chapter Two - Review of Related Research	16
2.1	Introduction	16
2.1.1	Organisational Behaviour	20
2.1.2	Organisational Culture	22
2.1.3	Oppressed Group Behaviour	25
2.1.4	The Glass Ceiling	28
2.1.5	Exploring Power	31
2.1.6	Exploring Powerlessness	37
2.1.7	Exploring Responsibility	39
2.1.8	Conclusion	41
3	Chapter Three – Methodological Issues	43
3.1	Introduction	43
3.2	Grounded Theory	46
3.3	Grounded theory – From a Philosophical Perspective	47
3.4	Glaser and Strauss	49
3.5	Data analysis	51
3.5.1	The Three Central Tenets of Grounded Theory	51
3.5.2	Constant comparison	52
3.5.3	Theoretical sampling	52

3.5.4	Theoretical saturation	54
3.5.5	Coding and Categorisation	55
3.6	Theory/Concept Development	57
3.7	Memo Writing	57
3.8	Data Management	58
3.9	The Researcher	60
3.10	Rigour	61
3.11	Ethical Considerations	63
3.12	Anonymity and Confidentiality	64
3.13	Demographics of the Directors of Nursing	64
3.14	Limitations of the study	65
4	Chapter Four-Findings	66
4.1	Introduction: Powerless Responsibility	66
4.2	Core Concept: Being a Nurse	69
4.2.1.	Introduction	69
4.2.2	Core Category: Professional Socialisation	69
4.2.3	Core Category: Being a Woman Nurse	77
4.2.4	Core Category: Lack of Collegiality	81
4.2.5	Summary	85
4.3	Core Concept: Circumnavigating the System	87
4.3.1	Introduction	87
4.3.2	Core Category: Institutional Arbitrariness	87
4.3.3	Core Category: Not Being Heard	96
4.3.4	Core Category: Relationing	100
4.3.5	Core Category: Politicking	104
4.3.6	Summary	110
4.4	Core Concept: Plugging the Holes	112
4.4.1	Introduction	112

4.4.2	Core Category: Feeling Responsible for Everything	112
4.4.3	Core Category: Defining Role Boundaries	121
4.4.4	Summary	128
4.5	Core Concept: Playing by the Rules	129
4.5.1	Introduction	129
4.5.2	Core Category: Preserving the Status Quo	130
4.5.3	Core Category: Avoiding Overt Conflict	135
4.5.4	Core Category: Unionising	138
4.5.5	Summary	142
5	Chapter Five –Conclusions and Recommendations	143
5.1	Conclusion	143
5.2	Recommendations	151
5.2.1	Recommendations for Nursing	151
5.2.2	Recommendations for Nursing Education	151
5.2.3	Recommendations for Future Research in the Substantive Area	152
5.2.4	General Theoretical Implications of the Theory	152
	References	154

Appendices

Appendix 1 – Examples of Coding and Development of Categories

Appendix 2 - Examples of Theoretical Memos and Field Notes

Appendix 3 – Letter of Invitation to Participants

Tables

Table 1.1 - Gender breakdown for registered Nurses and Midwives (ABA 2005)

Table 1.2 - Visual representation of Powerless Responsibility

Abstract

It is commonly believed that concepts of power, authority and influence are synonymous. Luthans (1992) suggests that power and authority are separate but related concepts. He identifies power as the ability to get an individual or group to do something, while authority gives the person attempting to wield the power legitimacy and is actually a source of power. Unlike authority, power is not always nor does it need to be legitimate. Theories of power will be discussed and integrated into the final theory.

A grounded theory methodology was used to explore the role of a sample of the Directors of Nursing in the Band One Teaching Hospitals in Ireland. In-depth interviews were held with eleven Directors of Nursing.

A grounded theory of 'Powerless Responsibility' was identified. The level of responsibility for keeping the hospital functioning is not commensurate with the level of influence and/or power that Directors of Nursing exert. Directors of Nursing in Band One Hospitals in Ireland have responsibility for patient welfare and for keeping the hospital functioning safely, but have very few opportunities to influence the strategic direction of the hospital or the wider health care system. All of this occurs against a backdrop of working within a health service that is undergoing major structural reforms (Health Service Reform Programme 2004) and which has been identified as being 'systemically maladministered' (Travers 2005).

The study contributes to the body of knowledge about the role of the Directors of Nursing in Ireland in Band One hospitals, by helping to identify their position of Powerless Responsibility. The substantive theory indicates that Directors of Nursing need to understand power dynamics before they can successfully challenge the status quo. If nursing is to overcome its fixation with repressive power and begin to deconstruct nursing as an apolitical and powerless profession, self awareness of the history of the nursing profession within a feminist and sociological context must occur.

1 Chapter one – Background to the Study

1.1 Introduction

The role of the Director of Nursing internationally has evolved from that of 'Matron', responsible for ensuring that her nurses were well behaved, smartly turned out and deferential, to that of the corporate nurse executive with responsibility for strategic planning and policy (Hennessy et al 1993, Hewison 1996, Fedoruk and Pincombe 2000, Hills and Gulliver 2000, Lindholm et al 2000, Mintzberg 2002). This evolution has generally been perceived to be a positive change for the nursing profession, for improving the quality of patient care and for the contribution that the Director of Nursing makes to the wider health care system (Antrobus and Kitson 1999, Filkins 2003, Davies 2004).

This thesis demonstrates how the Directors of Nursing¹ in band one teaching hospitals in Ireland are in a position of 'powerless responsibility'. This powerless responsibility occurs within the context of a health care system that appears to function persistently in a systematically maladministered fashion (Travers 2005), which helps re-enforce the powerlessness. The theory of powerless responsibility is derived from the core concepts that emerged from the data. These are: 'Being a Nurse', 'Playing by the Rules', 'Plugging the Holes' and 'Circumnavigating the System'. All four core categories represent the causes of being in a state of powerless responsibility, but 'Playing by the Rules' is a cause *and* a consequence of being powerlessly responsible. 'Plugging the Holes' and 'Circumnavigating the System' are strategies the Director of Nursing adopt in order to function in their role.

Grounded theory aims to investigate the social processes that occur as a natural outcome of the interactions that humans are continually exposed to. The predication upon which grounded theory is built is that the social organization of life is always in the process of resolving relevant problems for participants. It is not interpretivist or

¹ Eleven out of twelve of the Directors of Nursing are female. For the purpose of this study the Director of Nursing, where appropriate, will be referred to in the female gender.

descriptive in nature, its product is conceptual and not accurate description (Glaser 2002).

Grounded theory has been used extensively as a research method in the discipline of sociology, which uses a systematic set of data collection and analysis procedures to develop an inductively derived theory. According to Hutchinson, (1993) grounded theorists base their research on the assumption that a group (sic) shares a specific social psychological problem that is not necessarily articulated.

The literature is replete with references to choosing the research methodology that suits the research question. (Lo-Biondo-Wood and Haber 2002). When choosing the right methodology, it is vital to consider the purpose of the research, whether it is to validate existing theories or to discover new concepts and/or relationships. As no theory about the role of the Directors of Nursing in Ireland existed at the time of data collection, the researcher used grounded theory as a means to identify patterns of behaviour of the participants, with the aim of developing a theory. The grounded theory methodology is both a way to conduct research and a way in which to create an inductive theory (Backman & Kyngas 1999). In chapter three of this thesis, grounded theory will be discussed in full.

1.2 Justification for the study

There is little published work relating to the role of the Directors of Nursing in Ireland (Carney 2004). The Report of the Commission on Nursing suggested that senior nursing and midwifery management in Ireland operated on the basis of command and control rather than consultation and the delegation of responsibility (Government of Ireland 1998).

The Report of the Commission on Nursing (Government of Ireland 1998) recommended that in recognition of the increased focus of senior nursing management on the strategic planning of nursing and midwifery services, all matrons in large acute hospitals should be called Directors of Nursing. The rationale for this

recommendation stemmed from a perception that senior nursing and midwifery management tended to concentrate on the individual day to day micro management of nurses and midwives, rather than concentrating on the overall management of those same nurses and midwives. The Commission recognised that senior nursing and midwifery management were apt to focus their work towards the rostering of staff, sick leave and annual leave rather than on the development of practice and policies. This management style undermined other nurse/midwifery managers; these middle managers were merely acting as gatekeepers or messengers for the senior managers.

Thus, The Report of The Commission on Nursing (Government of Ireland 1998) recommended that the responsibilities of senior nursing and midwifery management should include the following:

'Providing strategic and clinical leadership and direction for nursing and midwifery and related services, which results in the delivery of effective, efficient, quality assured and patient centered nursing and midwifery care

Developing a shared sense of commitment and participation amongst staff in the management of change, the development of nursing and midwifery services and in responding to the changing health needs of patients

Developing the concept of care planning in collaboration with other professionals

Participating in the overall financial planning of the health service provided, including the assessment of priorities in pay and non- pay expenditure

Ensuring that appropriate in-service education programmes and on-going learning needs are met for all assigned staff; and

Ensuring that modern standards of clinical nursing and midwifery care are in operation and that regular monitoring of nursing and midwifery care is undertaken.' (p.128-129)

Since these recommendations by The Report of The Commission on Nursing (1998), no follow up study has been undertaken to establish how effective these recommendations have been, and what they actually mean to the Directors. There may be unknown constraints, within the health system, that make the recommendations unachievable, unrealistic or irrelevant to the Directors. Alternatively, they may have been enabled to fully embrace the philosophy espoused by The Commission. No study has examined whether the recommendations were supported by the Directors of Nursing and the other relevant stake holders within the health care system such as the Chief Executive Officers (CEOs) or the medical consultants. A change in name does not necessarily equate to an adoption of the principles espoused, nor do recommendations necessarily always become implemented.

Of equal importance, no study has examined the educational needs that Directors of Nursing require to equip them for the role. In an action research study in one university in Ireland, Joyce (2005) has begun to examine the development of a nursing management degree programme, designed to meet the needs of Irish nurse managers. Although the study is primarily aimed at clinical nurse managers at grade two and three², some of these nurse managers may become the Directors of Nursing of the future. To date the study has demonstrated the need for educators to constantly update and change the curriculum to meet service needs. It concludes that a strategy for education and development of nurse managers at all levels should be supported in the face of what Joyce terms a 'turbulent and uncertain future' for nurses (Joyce 2005).

² Grade two and three is the equivalent to ward sister or 'G' grade in the United Kingdom and grade 3 is equivalent to 'H' grade. These grades are still in use in some areas, but it is acknowledged that Agenda for Change will change the grading system.

A grounded theory methodology is suited to this exploration of the role within the context of The Report of the Commission on Nursing (1998). Grounded theory is an extensively applied process which makes ground breaking contributions to the already large body of knowledge surrounding the development of nursing (Speziale & Carpenter 2003). Most of the development of categories in grounded theory are generated *from* the data, not the reverse. Grounded theory allows the research to transcend, or 'rise above' the data by continually conceptualising it. It does not set out to confront other theories which may not fit, nor does it, at the outset, validate theories that may appear to fit, this is known as 'conceptual transcending' (Glaser 1978 p. 6-7). The goal of grounded theory is to produce an explanatory theory for a given area of social research. Stern (1980) asserts that grounded theory is best used in investigations of relatively uncharted waters or to gain a fresh perspective in a familiar situation.

In the Irish context this would appear to be a suitable methodology as no theory, (at the time of writing) exists in Ireland about the role of the Director of Nursing, although there are ample international studies available (Antrobus and Kitson 1999, Cameron and Masterson 2000, Fedoruk and Pincombe 2000, Chiarella 2001 and Davies 2004). Therefore, as no theory about the role of Directors of Nursing in band one hospitals in Ireland exists, within or without the context of the Report of The Commission on Nursing (1998), it would seem appropriate to adopt a grounded theory methodology. Equally, there is a deficit of research in Ireland on how the Directors of Nursing view their role and how the recommendations of The Report of The Commission on Nursing (1998) have been adopted by them.

1.3 Research Aims

The research aim is to gain an understanding of the social processes and structures involved in being a Director of Nursing and to give the role, and its associated functions, meaning through dialogue

1.4 Research Objectives

- To explore if there are disparities in the way that Directors of Nursing perceive their job
- To explore what these disparities are, if they exist
- To explore why these disparities may occur³
- To explore the Directors of Nursing perception of their relationship with the corporate team
- To examine the factors perceived by Directors of Nursing that enable them to function in their role effectively and
- To examine the factors perceived by Directors of Nursing that inhibit them from fulfilling their role effectively.

The nature of grounded theory means that the researcher will refine and develop the research question as new data is collated and analysed. As the study progresses and evolves so too will the research aims and objectives. Glaser & Strauss (1967) stress that researchers require flexibility and freedom to explore a phenomenon in depth and therefore the researcher will be guided by the aims and objectives but will not strictly adhere to them. According to Glaser (1998), it is impossible to ask a truly accurate research question before the study has begun and consequently:

'The first step in gaining theoretical sensitivity is to enter the research setting with as few predetermined ideas as possible –especially logically deduced, a prior hypotheses... His mandate is to remain open to what is actually happening' (p.3)

Fundamental to grounded theory is the assumption that core concepts have not yet been articulated and identified. In a grounded theory study, no hypothesis is being tested, therefore one is not presented. Stern (1985a) agrees that problem identification cannot take place prior to the study. As such it follows that a problem statement is

³ Any evidence of disparity that may emerge will help develop high level conceptualisation by accounting for differences.

also impossible and that therefore a truly accurate research question is equally not possible. However, Stern (1985a) argues that a scientist needs some focus, thus the aims and objectives stated above are provided to help focus the researcher. Stern (1985b) also argues that the final refined research question will come at the end of the study when the researcher has identified the factors with which the problem is involved.

The next chapter discusses the issues relevant to grounded theory regarding the use of literature. It also examines some of the literature that the researcher felt was relevant to the study.

2 Chapter Two – Review of Related Research

2.1 Introduction

Stern (1985b) suggests that to conduct a literature search before the study commences would create three problems. A search may induce what she terms 'prejudgment', which may lead the researcher to 'premature closure'. In other words, the researcher will have made assumptions based on her review of the literature, and may cease asking questions and jump to inaccurate conclusions. As the theory evolves, the research focus may change. If the researcher has pre-determined notions of the direction of the study, based on the literature, then the study will be inaccurate. Finally, the literature that is available may not be an accurate representation of how things really are in a social psychological context.

The researcher must approach the literature with a cautious mind, the aim of a literature search being to inform and not to influence the researcher. Yet Glaser (1992) suggests that a literature *search*, as opposed to a full literature *review* is indicated as a pre-requisite to a grounded theory study in order to inform the approach the researcher may take.

Hickey (1997) highlighted that when he undertook a literature review prior to his study, he discovered that it derailed him into pre-conceived ideas about the nature of the problem he was going to study. Accordingly, he changed his conventional approach to the literature review and stuck rigidly to the approach outlined by Glaser (2001, 2003). This, Hickey claims, enabled the issues to emerge rather than rely on the '*assumptions of the researcher or what the literature seemed to reveal*' (p.373). The problem for Hickey was simply that he read the literature, identified what he felt were the gaps, and then proceeded to structure his interview questions around a subject he thought was relevant for his participants. It became evident to Hickey that his 'pre-conceived' ideas had derailed his study, thus he re-focused his interview schedule to be more open rather than pre-conceived.

In a review of Hickey's article in the same journal, Vaughan (1997) raises a note of caution, claiming that to a large extent, we are all influenced by our personal socio-historic surroundings and that the bracketing of our own perspectives is not possible. She argues that there is a case for extending our reading at the beginning of a study to get a wider view of other work and thereby shift from our own narrow perspective.

It is important to highlight that this literature search took place before the interviews and data analysis began and thus may, or may not, have a bearing on the final analysis. However, for purposes of laying the thesis out in a standard presentation I have re-integrated the relevant literature which was read *after* the data analysis into the review in order to make the theory more coherent. As Glaser outlines in his concept of 'theoretical sampling', the literature therefore becomes part of the data and forms part of the theory. Glaser (1998) states:

'do not do a literature review in the substantive area and related areas where the research is to be done, and when the grounded theory is nearly completed during sorting and writing up, then the literature search in the substantive area can be accomplished and woven into the theory as more data for constant comparison' (p.67)

The main aim in not reading the literature extensively beforehand, as in most other research methodologies, is to avoid 'preconceiving' and to avoid getting 'grabbed' by received concepts that do not fit or are not relevant. Finally, Glaser (1998) suggests that the researcher will become filled with speculation and make connections that will not fit or work. Glaser (1998) states:

'Grounded theory provides its own emergent interpretations as part of it. There is no need for speculation' (p.67).

The researcher should approach the study with an open mind. Glaser (1978) instructs:

'When the theory seems sufficiently grounded and developed, then we review the literature in the field and relate the theory to it through integration of ideas' (p.31).

As discussed above, there is almost a complete lack of published literature pertaining to the specific role of the Directors of Nursing in Ireland; this is disconcerting to say the least. This can be partly accounted for by the lack of a research culture and a lack of Irish nursing research journals. However, Carney (2004) identifies how organisational structure impacts on the role of the Director of Nursing in Ireland. Carney's study set out to examine if there was a link between organisational structure and strategic management, and in the process, to identify how the organisational structure impacts on the strategic management role of Directors of Nursing working in acute care hospitals in Ireland. Twenty-five semi-structured interviews were held with Directors of Nursing. Five 'core trees' were identified

1. Organisational structure,
2. Organisational power coalitions,
3. Conflict,
4. Strategic involvement and
5. Strategic consensus.

The principle argument espoused by Carney is that organisational members will exercise a higher level of strategic consensus if they have been initially involved in the development of strategy. One of the key findings of Carney's work is that exclusion of the Director of Nursing from strategic development is evident. The conclusion recommends that a role reappraisal of the Director of Nursing is required, which includes shedding the non-strategic elements of the role and the empowering of clinical nurse managers to provide tactical and operational management through the delegation process. However, the study fails to address what type of education and experience is required to enable this level of nursing management to achieve this tactical and operational management.

The relatively poor volume of literature must be contextualised within the lifespan of the Report of the Commission on Nursing (Government of Ireland 1998), as many of its recommendations have been implemented. Some of the recommendations have had implications for the Directors of Nursing. These include the establishment of the Nursing Policy Division in the Department of Health and Children, the establishment of the Nursing and Midwifery Planning and Development Units and the establishment of the National Council for the Professional Development of Nursing and Midwifery. And perhaps most importantly, for the future development of the profession, the establishment of the degree programme for undergraduate nursing. It must also be noted that The Commission on Nursing was set up initially following a labour court recommendation to address industrial unrest within nursing (Hyde et al 2004). Thus, nursing in Ireland must be viewed in the context of The Commission on Nursing, as it provided the framework for many of the developments that have occurred.

The following section attempts to critically analyse the literature and takes into account the concepts of organisational behaviour and organisational culture. The researcher read around these topics because the Directors of Nursing work in large, complex and constantly changing organisations. Morley et al (1998) argue that the experience of most social scientists would suggest that there is a multiplicity of factors which form and determine the behaviour of people at work and thus any inquest into the study of behaviour in the workplace necessitates a broad overview of that area.

Nursing has been well documented as an oppressed group (Roberts 1983, Kuokkanen & Leino-Kilpi 2000 and Begley 2002). The literature pertaining to this was examined to help illuminate my understanding of the concept. Thus, if data pertaining to oppression were collected during the interviews, I would be equipped to recognise it. Prior to the interviews I read around the concept of the glass ceiling to help me understand the barriers that women in general, in the workforce, might face when

wanting to move up the corporate ladder or indeed to gain equal status within an organisation or corporation.

2.1.1 Organisational Behaviour

Organisational theory examines the way in which structures and hierarchies within systems affect the working practices and functions of the people that work within them (Norman and Cowley 1999). Organisational behaviour as a theoretical framework is a relatively new field that has emerged from the older disciplines of psychology, sociology and political science (Morley et al 1998). Sociologists and political scientists have traditionally focused their research on the issues of group dynamics, conflict, culture, power and communication. Psychologists have focused on learning/behaviour modifications, personality, perception, attitudes and stress (Morley et al 1998). All of these strands of organisational behaviour are relevant to understanding the power dynamic of the Director of Nursing and her relationship, status and efficacy within the corporate team.

Organisational behaviour can be defined as 'the study of individual group and organisational processes as a means of explaining and predicting behaviour in the workplace' (Morley et al 1998 p.2). Morley et al suggest that the study of organisational behaviour must be contextualised within the workplace setting. An organisation is a collection of people working within a specific architectural paradigm, which has a number of goals or objectives. In the hospital context this translates into very differing groups of people, e.g., nurses, doctors, management, physiotherapists, pharmacists and social workers, all working to achieve the same end, that is, the delivery of quality patient care. Storch et al (2004) suggest that culture operates in health care at all levels. This can range from the individual's values, beliefs and meanings to group norms and practices, to organisational patterns and the ideology of society. The point Storch et al (2004) are arguing is that as individuals, we behave in different ways, depending on the social setting and the social standing of the members of the group. In other words, we behave according to our own perceptions of where we stand within or without that group.

Taft (1992) argues that one of the obstacles to organisational change in hospitals has been the proliferation of multi-professional groups. She suggests that this diversity inhibits flexibility to move in the same direction. Individuals can have allegiances to organised groups, such groups influencing their beliefs, values and assumptions, e.g. trade union membership (Johnson & Scholes 1993). Hunter (2001) talks about perceived power differences between organisations as well as between the individuals within them. He suggests that 'professional tribalism' has hindered collaborative working for years. Directors of Nursing, General Managers, Chief Executive Officers, Medical Consultants, Superintendents of Physiotherapy and Financial Directors may perceive themselves to be in a permanent state of conflict with other members of the corporate team. This may be simply because each member of the team has their own agenda and is concerned with their own issues. This is consequently detrimental to the collaborative agenda, which in the healthcare setting is patient outcome.

Another way of trying to understand how organisations work is proffered by Giddens (1984) in his theory of structuration outlined in *The Constitution of Society*. Giddens theory argues that structure and agency interact, and it is only through the action of agents that structures are socially reproduced. What this means is that it is we, as actors within the structure of the organisation, who reproduce the very structures that maintain the structure and the systems within that, in which we exist. This structuration, according to Giddens, is achieved by relying on the routine of day to day activity, which reduces unconscious anxiety. Giddens theory challenges the predisposition to blame the system, rather than to recognize one's role in contributing to evolution of that system.

The way in which an individual perceives his or her working environment is a fundamentally important consideration when examining behaviour. Bamford and Porter-O'Grady (2000) found that the concept of the Shared Governance Organisational Model can enable nurses to influence key decisions within the

organisation. Shared Governance means that an organisational structure is founded on the principles of partnership, equity, accountability and ownership. According to Porter-O'Grady, the attraction of this model for the health care professional is the demand for self-direction, clinical leadership, effective decision-making and strong involvement in the activities of the organisation at every level. The shared governance model, as described by Bamford and Porter-O'Grady, essentially changed the culture within one hospital organisation. Organisational culture as a concept is now discussed.

2.1.2 Organisational Culture

Attempts to define organisational culture have proved difficult and complex; there are as many different definitions as there are authors on the subject. Morley et al (1998) claim that organisational culture can be defined as:

'the philosophies, ideologies, values, beliefs, assumptions, expectations, attitudes and norms shared by the members of the organisation' (p.201).

Organisational culture, they argue, does not exist in a vacuum but is connected to the larger cultural processes within the organisation's environment. There are many layers of culture, as individuals bring their own personal experiences with them into an organisation, which in turn has an effect on the overall larger culture. Culture is expressed as rites, ceremonies, legends, stories, symbols, language, physical settings and artifacts (Morely et al 1998).

Schein (1984) describes organisational culture as:

'the pattern of basic assumptions that a given group has invented, discovered, or developed in learning to cope with its problems of external adaptation and internal integration, and that have worked well enough to be considered valid, and, therefore, to be taught to new members as the correct way to perceive, think, and feel in relation to those problems' (p.4)

Rather than trying to bring all the sub cultures of one vast organisation together, Hewison (1996) suggests that it may be more beneficial to conceptualise organisations as a collection of sub-cultures. To attempt to manage a single culture is to conceptualise something that cannot ever really exist (Hewison 1996).

The diversity of awareness of cultural differences can then have an effect on how members of the organisation might perceive each other. These perceptions therefore have the potential to be modified and the literature demonstrates that the most successful way to achieve this is by education (Freshwater 2000).

In their book 'Exploring Corporate Strategy' Johnson and Scholes (1993) suggest that the public service is often dominated by a high percentage of professionals who have a strong view (professional) of their role that may conflict with the managerial view of how the professionals can be used as a 'resource'. This concurs with Taft's (1992) notion about multi-cultural staff. The professional culture of nurses differs from that of doctors, administrators or social workers. Taft suggests that the notion that 'we're all here for patient care' is too simple, arguing that professional groups may have different opinions on the best way to achieve goals toward patient care. One of the most important of Taft's findings is that members of professional groups actively seek to advance the interests of their own disciplines, in addition to working together toward, what she terms, 'common super ordinate' goals (p.44).

O'Shea (1995) describes the predominant culture in one large teaching hospital in Dublin, as what she terms the 'Apollo'⁴ mode. Predictability and stability are treasured and encouraged and the organisational form is bureaucratic. Perhaps more importantly she discovered a sub culture which she refers to as 'Dionysian'; the consultants and doctors are masters, experts and stars in their own fields, who superficially consent to the introduction of a directorate model of health care management but berate its importance. O'Shea highlights her concern for the

⁴ (Handy 1991) uses Greek Gods to help illustrate cultural management styles.

emerging dominance of the doctors and consultants over the managers within the clinical directorate model where the doctor takes the lead. The superficial consent to new ways of management, juxtaposed with undermining the structure, creates what O'Shea refers to as an uneasy culture.

Hewison (1996) suggests that nurse managers need to have an acute cognizance of the concept of culture within their hospitals. When culture is clearly defined and appropriately applied, it increases the nurse managers' understanding of their organisation and can subsequently add to their contribution of the effective management of the organisation. This concurs with McCarthy (1997) who suggests that in the Irish context, the Director of Nursing must understand how all parts of the organisation interact and are affected by internal or external changes.

McCarthy (1997) goes on to suggest that many nurses who work in an Irish hospital setting have been indoctrinated into what she terms 'collective responsibility'. By this she means that nurses prefer to work in traditional task-orientated roles rather than moving into primary nursing which accentuates holism and accountability. Nurses who are willing and able to expand their roles and responsibilities are often hindered by health service managers and other health care professionals (non-specific) who want nurses to remain subservient.

Cameron and Masterson (2000) note that organisational structures are rarely entirely rational. Personal preferences of the organisation's leaders and the compromises that have to be made as power struggles ensue, contribute to this irrationality. Cameron and Masterson (2000) conclude that organisational characteristics militate against the Nurse Executive⁵ being able to plan and be strategic. Johnson (1990), when discussing what makes organisations work, suggests that the Nurse Executive role is central to the management of the nursing culture and collective values of nursing staff. The success of the Nurse Executive depends on personal relationships within

⁵ The Nurse Executive role referred to here is equivalent to the Director of Nursing role. The term Nurse Executive is American.

the organisation and the commitment of the CEO to professional leadership. The next section examines the concept of oppressed group behaviour.

2.1.3 Oppressed Group Behaviour

Oppressed groups have traditionally been controlled by forces outside themselves. These outside forces have higher prestige, power and status and have usually exploited the less powerful group (Roberts 1983). In order to maintain the status quo, the dominant group is prone to reinforcing the subordination of the oppressed group. Nursing may be viewed as exhibiting some of the traits associated with oppressed group behaviour, such as horizontal violence and nurse-on-nurse aggression. The medical profession has dominated it, and the status quo of nurses has been maintained historically by male physicians and latterly by hospital executives (Adamson et al 1995 and Riska and Wegar 1993).

Freire (1971) based his theory of the oppressed on the experiences of colonised Brazilians. He found that members of the suppressed group learn to hate themselves, their culture and own lifestyle. This hatred can be manifest in skin colour, clothing, food or even language. The dominant group norms become firmly rooted as part of the culture.

Roberts (1983) claims, that in relation to nurse leaders in the United States of America, nursing had been populated with a group of people who have suffered from low self-esteem, lack of assertiveness and poor initiative. Members of oppressed groups, it is argued, have found it natural to think of themselves as second-class citizens. The 'soft' character traits in nursing, such as warmth, sensitivity, mothering and caring have come to be perceived as negative qualities. This low self esteem etc. is endorsed when compared with those of the dominant culture, assertiveness, coldness and intellectual capability.

Tracey (2004) proposes that if we accept that Irish nurses are an oppressed group, then nursing membership of the Irish Nurses Organisation (INO) can be understood

in terms of power and affiliation. By this she means that the lack of power that nurses possess can be addressed by joining a trade union. Equally she suggests that because of the ambiguity of the role of the Director of Nursing and the lack of a sense of a belonging to a strong profession, nurses have sought refuge for their affiliation needs in the union.

Freshwater (2000), in an article arguing that the educational system in nursing may have contributed to the oppressed group behaviour of nurses, demonstrates how the system of nurse education has contributed to the cultural narrative of oppression by colluding with it. She suggests that the traditional educational approach of 'filling an empty vessel' suppresses the imagination of the student and the student loses the ability to be an autonomous learner. Freshwater (2000) further suggests that non-overt conflict manifests itself as internalised self-depreciation, self-harm and horizontal violence with self-love and self-regard being the less acceptable faces of nursing. In a rather weak attempt to address the problems she outlines, Freshwater suggests the solution to oppression is for the interactions between students and teachers to be seen as 'caring occasions' that celebrate what she terms the 'ethical self', thus paralleling the nursing process as a caring activity. This might be too simplistic a solution as the root of the problem may lie in first acknowledging the occupational socialisation of nurses and nursing within the context of gender and socio-economic politics (Farrell 1997).

Farrell (1997) describes horizontal violence as 'nurse on nurse aggression'. This aggression can range from overt and covert non-physical hostility such as criticism, sabotage, undermining, infighting and bickering to non-verbal innuendo and actual physical assault. Farrell concludes his discussion by commenting that nurses have not shaken off their subservience to medicine and that changes in role title such as 'nurse consultant' and 'nurse lecturer' are merely semantic changes rather than manifestations of any actual change in behaviour or relationships with their oppressors. Whist Farrell (1997) may have happened upon an extreme case of nurse-on-nurse aggression, which included potentially fatal occurrences, the question must

be asked whether this is 'normal' office politics or whether it is accentuated in nursing because of the gender imbalance and the occupational socialisation alluded to above. In a follow up article Farrell (2001) suggests that it is nurses themselves who in their everyday work and interpersonal interactions act as insidious gatekeepers to the status quo of oppression.

The value of medicine and the medical model are the dominant forces within the health care model (Mitchell 1998, Adamson et al 1995 and Riska and Wegar 1993). Lack of self-esteem and passive aggressive behaviour have been cited as personality characteristics commonly displayed by nurses (Roberts 1983). The only way to escape the oppressed group is to become like the oppressor, hence as Farrell (1997) has suggested attempts to introduce titles such as 'nurse consultant' could be argued, are exactly that. However, the dominance of the medical profession may be waning.

In an article discussing 'The End of the Golden Age of Doctoring', McKinlay and Marceau (2002) argue that the power of the medical profession is in decline. One of the reasons for this decline is the emerging competitive threat from other health care workers who provide an opportunity for profit-driven owners to replace doctors with appropriately trained workers at cheaper labour rates. However, it has conversely been argued that due to the complexity and ambiguity of clinical work, the dominance of the medical profession will not be totally stripped away, by either the advent of more managerial measures, or the increase in clinical autonomy of other professions (Flynn 1992). Conversely, Mitchell (1998) argues that the introduction of evidence-based clinical guidelines in the United States could be perceived as a way of removing the necessity of working under the direction of the medical profession and could be seen as a direct challenge to the traditional division of labour (Durkheim 1984, Allen 2001 and Allen and Hughes 2002). The same could be argued in the United Kingdom with the introduction of the National Institute for Health and Clinical Excellence in April 2005 when the National Institute for Clinical Excellence (NICE) took on the functions of the Health Development Agency to create a single

excellence-in-practice organisation for providing national guidance on the promotion of good health and the prevention and treatment of ill health (NICE 2005).

Roberts (2000) argues that the development of a positive professional identity will move nursing out of its oppression and into a more cohesive, effective and powerful force in the health care system. The model she endorses is based on models developed for other oppressed groups such as African-American women, for example 'Black is Beautiful'. Advertising campaigns such as 'Are you good enough to be a nurse'? (Western Australian Department of Health, 2002) help re-enforce this positive theory and add weight to Roberts's hypothesis. However, in order for nursing to move out of its oppressed state, it also has to acknowledge that as a predominantly female profession, it has to contend with what is known as the glass ceiling (Crawford 1993).

2.1.4 The Glass Ceiling

The Glass Ceiling is an extremely powerful analogy used to describe the limit beyond which women cannot advance in the corporate world. (Andrica 1997, Meyerson & Fletcher 2000). The glass ceiling theory has even greater resonance in the nursing world as nursing has traditionally functioned within the confines of a patriarchal hierarchical system that protects its own vested interest (money and power) and suppresses the advancement of any potential competition (Parkyn 1991, Lovell 1981). Nursing in Ireland is a largely female profession. In 2001 ninety two per cent of nursing graduates were female (Department of Health and Children, Interim report on the Nursing & Midwifery Resource 2002 p. 58).

Table1.1 Gender breakdown for registered Nurses and Midwives (ABA 2005)

Year	1996	1997	1998	1999	2000	2001	2004
Male	3,686	3,871	4,101	4,245	4,495	5,204	5,814
Female	49,955	52,284	54,909	56,203	58,979	63,459	70,231
Total	53,641	56,155	59,010	60,448	63,474	68,663	76,045

Crawford (1993) suggests that the foundation of the glass ceiling is determined by the power structure of a male dominated culture, in which women find it difficult to ascend. Crawford (1993) argues that evidence for the glass ceiling can be demonstrated when examining the statistics. Less than 5% of women in health care are CEOs of their institution. Arguably this statistic is now twelve years old, and thus may be out of date. In a healthcare environment, women experience hidden obstacles to promotional posts and these barriers are described as 'the glass ceiling'. In spite of Crawford's work being thirteen years old it would appear that the glass ceiling is still a very real issue for women working in health administration. According to the International Labour Office in Geneva⁶ (ILO 2004):

'in spite of the slow but steady increase being seen in the share of professional women in the workplace, the nature of women's career path continues to block them from making progress in the organisational hierarchies in which they work... They find themselves in what are considered 'non-strategic' jobs, rather than in line and management jobs leading to higher positions. Thus, they effectively become support staff for their strategically positioned male colleagues' (p.8 ILO 2004)

As far as women's share of managerial positions is concerned, according to the ILO, the rate of progress internationally is slow and uneven.

Within the healthcare context, nursing and midwifery accounts for up to 36% of the entire workforce but to date in Ireland only one CEO of a health board is a nurse. The question this must raise is, why is nursing and midwifery (or indeed other healthcare professional such as physiotherapists and pharmacists) not represented at higher executive levels in spite of all the recent educational opportunities available such as MBA in health services management and the Office for Health Management competency development for top level managers (OHM 2004). What is not clear in the Irish context is whether the lack of nurses at senior level is a gender issue or a

⁶ The ILO compared data from 63 countries.

'nursing' issue. It may be the case that being a woman *and* a being a female nurse acts as a double barrier to promotion.

The National Women's Council of Ireland (NWC 2004) in a press release of July 2004 highlighted that despite the fact that Ireland is placed tenth in the United Nations 'Human Development Index', which measures quality of life, Ireland remains one of the most unequal societies of all western nations. The 'Gender Related Index', which compares men and women, in a number of key areas, including 'Estimated Earned Income', places Ireland fourteenth (the UK is ninth). The report highlights that women are earning 40% less than men in Ireland. The NWC also identifies that the 'Gender Empowerment Measure' a measure that relates to women's representation and women in decision-making positions, in comparison to men ranks Ireland sixteenth.

Joyce (2005) in an action research study that explored nurses' expectations of the content and delivery of a nursing management degree programme finds that nurse managers may not know what they need to know in light of the changes taking place in the Irish health system. These managers had not taken on board the implications of the Report of The Commission on Nursing and as a consequence were not aware of their education and training needs. Parkyn (1991), on the other hand, writing two years earlier from the UK perspective as opposed to Crawford (1993) who was writing from that of USA, argues that the Glass Ceiling is effectively being lowered. She refers in her article to Maureen Dixon, the former director of the Institute of Health Services Management, who commented that the glass ceiling, above which few women rise, is actually being lowered. In other words it is becoming *increasingly* difficult for women to get above it. This, Parkyn argues, can be attributed to general managers replacing traditional uni-professional management in which women were relatively well represented as nurse and therapy managers. Parkyn (1991) claims that only 4% of women hold general management positions in the National Health Service (UK).

The following section is a discussion of the terms 'power', 'powerlessness' and 'responsibility'. It is important to note that this section was completed *after* the discovery of the theory of powerless responsibility. Undertaking an exploration of power and responsibility helped contribute to the development of the theory.

2.1.5 Exploring Power

In order to understand the concept of powerless responsibility, it is first important to understand the concept of power, powerlessness and responsibility. Each of these concepts can mean different things to different people. Weber (1947) defined power as:

'the probability that one actor within a social relationship will be in a position to carry out his own will despite resistance' (p.152).

It is commonly believed that definitions of power are synonymous with the concepts of authority and influence. Luthans (1992) suggests that power and authority are separate but related concepts. As with Weber, Luthans identifies power as the ability to get an individual or group to do something, but authority gives the person attempting to wield the power legitimacy and is actually a source of power. Power is not always, nor does it need to be (unlike authority) legitimate. On the other hand, the concept of influence is broader than power and requires the individual to have the ability to change people in a more general way.

The study of power in an organisational context depends on the assumption of the existence of conflicting and competing interests (Gilbert 1995). If there was an absence of conflict and no competing interests then, one could argue, there would be no power struggle within any organisations. In the Irish healthcare context, these competing interests could be said to be manifest by the power and authority given to, and taken by, the medical consultants and the authority vested in the CEO who has responsibility for the service. And, to a much lesser extent the other health care

professionals such as nursing, the allied health professionals, and the administrative grades.

The provision of a free comprehensive health service outlined by the proposed 1947 Health Bill (Hyde et al 2004) is an example of how power is legitimately achieved by medical consultants. The Irish Medical Association vetoed the Bill which included the provision of a free comprehensive health service. Hyde et al (2004) argue that the Bill posed a threat to the vested interests of private practice and to the complete professional autonomy that the medical profession enjoyed. The theme of resisting free medical care continued throughout the history of the State. Three years later, when Minister for Health, Dr. Noel Browne, attempted to introduce free health care for mothers and their children, this time, the Catholic Church and the Irish Medical Association opposed it and the proposal floundered (Barrington 1987). The 1970 Health Act ensured that general practitioners would become private practitioners and the right to private practice for consultants was protected in voluntary hospitals. Thus, the power the consultants in Ireland exert over the health service is enshrined in legislation (Hyde et al 2004). The recent Health Act⁷ (2004) does not in any way alter or temper this enshrinement, as it is mostly concerned with the dissolution of the Health Boards.

There are, depending on which organisational behaviourist you read, many different ways on which power can be conceptualised, and there are many different theoretical perspectives on power. Some distinctions drawn in the literature are the following: 'reward power', 'coercive power', 'legitimate power', 'referent power' and 'expert power' (Morley et al 1998).

Reward power is determined by the ability of the person who has the power (or thinks they have the power) to reward their staff. The value of the reward is dependant on the resources that the person in power has available to them, and the value that the staff place on the reward. If, for example, a Director of Nursing gives a member of

⁷ The Health Act (2004) legislated for the dissolution of the eleven Health Boards.

staff a day off, this is within her power and authority to do so. However, if the staff member believes this day off is due to them anyway, he or she will give it a low value ranking, thereby delimiting the power that the Director of Nursing perceives him or herself to have.

Sankowsky (1995) however, suggests that the source of *reward power* lies in the leader's access to physical and financial resources, the control of which, is down to the leader. Sankowsky (1995) suggests that leaders can hide behind seemingly liberating concepts, such as empowerment, to enact subtle abuses. He refers to a psychological phenomenon which he labels 'symbolic power', or the tendency for followers to regard (tacitly) leaders as parent figures. Sankowsky goes on to say that types of power may be defined in terms of the source of the power, area of control, related managerial function and responsibility to the followers, or more subtly by controlling information about a follower.

Coercive power refers to the power that an individual demonstrates when threatening or punishing in order to coerce staff. A person who uses coercive power often relies on fear. Morley et al (1998) suggest that some psychologists believe that much organisational behaviour can be explained in terms of coercive power as opposed to reward power. Whilst coercive power as a concept is barely mentioned in the nursing literature, it could be argued that this type of power manifests itself in nursing as bullying and harassment (Government of Ireland 1998), or perhaps more subtly, in the knowledge that a superior can control information about an individual.

Legitimate power is simply having the authority legitimately vested in the job by virtue of the position and with the rules and authority of the organisation. The CEO has the legitimate power invested in him by the Health (Amendment) Act 1996, in what is known as 'Accountability Legislation'. Hien (1998) defines power as the ability to influence and change the behaviour of others in order to achieve a specific end, qualifying legitimate power as;

'a position of power granted and delegated by the organisation. It is the position itself that has power, not the person in that position' (p.299).

The questions that must be asked in the context of the Directors of Nursing are: how much legitimate power is given to them by the organisation? How does this legitimate power equate to the perception of the level of power that the Directors of Nursing think they have? In other words, how much actual legitimate power does the Director of Nursing have within the hospital and in what terms can this power be measured?

Referent power is conditional upon the magnetism, appeal, inter-personal skills and the personal attraction of a person. Referent power is given by staff to the person because of their attractive personal characteristics, such as charm, charisma and good looks.

Expert power is derived from the expertise or know-how which distinguishes the individual. The power holder has to be convincing, trustworthy and honest. The extent of the power vested in this person is contingent upon the value that others give to the knowledge and expertise. The medical profession have exerted this type of power. It is fair to say that as technology and access to information has altered radically over the last decade, this monopoly over expert knowledge is beginning to weaken. Mckinlay and Marceau (2002) argue that the power of the medical profession is in decline. The expert power it exerted becomes diluted, as other health care professionals take ownership of the knowledge that was the basis of the expert power base.

A different framework for looking at the concept of power is identified by Lukes (2004). Instead of looking at power as either rewarding or legitimate, he refers to a framework for power which he describes as the 'three dimensional' view. This three dimensional view is Lukes attempt to sketch three conceptual maps of power. These

three maps will reveal what he terms 'the distinguishing features of three views of power.

The one dimensional view is that expressed by the pluralists, such as Dahl, Polsby and Wolfinger. The exercise of power and the outcomes of decision making are central to the pluralist view of power. This view of power involves a focus on behaviour in the making of decisions on issues over which there is an observable conflict of interests. Those successful in the conflict are considered to have power (Lukes 2004).

The two dimensional view of power is that of the pluralists critics. This two dimensional view involves a *qualified critique* of the *behavioural focus* of the first dimension (Lukes 2004 p.24). Lukes uses the terms *qualified*, because he considers non-decision making to be a form of decision-making. This view allows for deliberation of the manner in which decisions are prevented from being taken on issues over which there may be conflict of interests.

The final third dimension or view of power is based on the premise that the first two are inadequate (Lukes 2004). This radical view of power relates to the way power is manipulated to prevent conflict from occurring at the outset. According to Gilbert (1995):

'Power is viewed as operating to produce and shape the perceptions, cognitions and preferences of people in such a way that they accept social practices, and their role, as the natural way and therefore beyond questions. Conflict, in this view, does not arise because people fail to consider alternatives to the present order of things' (p.868).

Lukes (2004) argues that preventing conflict from arising in the first place is the most effective and insidious use of power. He suggests that what may be occurring in his third dimension is '*latent conflict*'. Latent conflict is a contradiction between the

interests of those exercising power and the real interests of those that the powerful exclude. This, Foucault (1980) would argue is because the power is what he terms 'non-productive power'. Foucault (1980) sees power as a positive thing, he described it as capillary like, all pervasive and constantly circulating. Power for Foucault is a productive network which runs through the whole social body. Foucault (1980) claimed that, '*we move in a world of strategic relations*'. In other words, individuals take up transitory positions within diverse sets of power relationships at different times. The Director of Nursing, if we apply this theory of power, will therefore adjust her behaviour/actions/inactions depending to whom, and on what subject she is negotiating.

In Foucault's (1980) analysis, power and knowledge are intimately connected and expressed as one (Manias and Street 2000). Knowledge thus, is an important technique of power and it reinforces and supports already established domains of truth. Foucault however, did not see power in terms of overcoming resistance, this is simply because he claims that resistance exists everywhere in the power system and as a consequence should have relevance for every individual. Foucault states:

'where there is power, there is resistance, and yet, or rather consequently, this resistance is never in a position of exteriority in relation to power' (Foucault 1990 p.95)

What Foucault is arguing, I think, is not that different theories of power are wrong, or right, but that we need to analyse power in a different way. Foucault sees power as both positive and negative, in other words, there is everything to play for. Foucault would ask what is the main danger facing us today? The fact that nobody actually really knows what is going on is the major problem for Foucault. Power thus, should be analysed at the micro-level of everyday life, he called this the microphysics of power (Smart 1985). In other words, power and its ramifications are omnipresent. The Directors of Nursing, it could be argued from a Foucauldian perspective, are

involved in the game power on a continuous basis at all levels, and with all their colleagues.

If power is the ability to get things done, to 'mobilize resources', (Kanter 1993 p166), to obtain and use whatever it is that an individual requires in order to achieve his or her goals, then it follows that only a few people can have access to or will have a monopoly on power. Not only do these powerful individuals have a monopoly on power, they (the powerful) prevent the majority of other people from being able to act effectively. So the total amount of power and the total system effectiveness is restricted. The effectiveness of the total system is restricted because the power of the organisation is vested in only a few extremely powerful and disempowering individuals. Kanter goes on to argue that if an organisation empowers people by generating autonomy, allowing more participation in the decision making processes and by giving more access to resources, the overall capacity for effective action increases. Lukes (2004) argues that we use the vocabulary of power in countless different ways and contexts and for different purposes. Thus, for the purposes of this study, power can be considered as a multifaceted concept that changes depending on the circumstances and on the individual's perception of their own power. Power, or the exertion or withholding of power is also determined by whom an individual is dealing with. In other words, how power manifests itself depends to a large degree on how much power and what relationship the Director of Nursing has with the individual she is dealing with. Powerlessness within this context is now discussed

2.1.6 Exploring Powerlessness

In order to understand the concept of power, it is equally important to understand the concept of powerlessness. However, the concept of powerlessness is not as well discussed in the literature as power. This may be due to the fact that powerlessness is often discussed in terms of oppression of the non-powerful by the powerful, more dominant group (Gilbert 1995, Roberts 2000, Daiski, 2004). Kanter (1993) however discusses behavioural responses to powerlessness that have resonance with the nursing profession.

Kanter (1993) claims that people who have authority without what she terms 'system power', are powerless. Kanter (1993) suggests that the powerless person inside an authority structure becomes what she terms 'rules minded', in response to the lack of opportunity for power in the work situation. As Kanter (1993) puts it:

'Getting everything right is the response of those who lack other ways to impress those above them or to secure their position; and in turn they demand this kind of ritualistic conformity from subordinates' (p.192).

The rules become the power tool and the rules are made in order to control what Kanter (1993) terms the 'uncontrollable'. The rules ensure that the person in the position of power has a legitimate basis for her authority. Nursing could be considered to be a rules minded profession, with an emphasis on planned career pathways (Commission on Nursing 1998). According to Kanter, the provision of planned, graded, incremental promotions and salary increases is an incentive for adhering to the rules of the organisation and conformity to official regulations. Powerlessness which is mingled with accountability and responsibility for getting results, will necessarily aggravate a cautious, low-risk, play it safe attitude. The powerless, it is concluded, hang on to rules. Kanter (1993) makes the important distinction that those individuals who have little organisational power but who need to lead or influence others, use the 'rules' for their personal discretion. In other words they can bend the rules for favours or for their favourites.

Finally Kanter (1993) suggests that in response to powerlessness the individual becomes bureaucratic and bossy. She argues that the provision of a graded career structure where incremental advances are small and all must wait their turn for promotion fosters a dependency on the organisation. That the most senior nurse becomes the one 'due' for promotion is a common mantra (Foster 2000).

An alternative view of powerlessness proffered by Morriss (cited in Lukes 2005) is that it is a mistake to *assume* that that powerlessness results from domination. When individuals lack power, Morriss argues it is not because of the intrigues of the powerful. To assume that powerlessness is an outcome of domination is to ignore the broader view of power and powerlessness. Lukes (2005) agrees with Morriss's warning about assumptions but urges a note of caution about viewing power too narrowly. What Lukes (2005) suggests is that power (and thus powerlessness) should:

'not be conceived narrowly as requiring intention, actual foresight and positive actions (as opposed to failing to act): the power of the powerful consists of their being capable of and responsible for affecting (negatively or positively) the (subjective and/or objective) interests of others' (p.68 Lukes 2005)

In other words the issues of powerlessness and of domination should not be viewed separately but rather, they should be viewed as being complex intertwining concepts that relate to each other. Morriss would also argue that by demonstrating a lack of power an individual can deny all responsibility. Thus, responsibility and its relationship to power are now discussed.

2.1.7 Exploring Responsibility

In order to grasp the full understanding of the grounded theory of 'powerless responsibility', it is important to clarify the meaning of responsibility within the organisational context. Responsibility is essentially an obligation to perform in an organisation. When individuals are given rights, they assume a corresponding obligation to perform (Morley et al 1998). Lukes (2005) would argue that the powerful are those individuals who hold responsibility for significant outcomes.

However, perhaps before we begin to examine responsibility in relation to nursing it is necessary to understand where it sits in relation to accountability. This is because responsibility is often understood as a sub-set of accountability. Accountability is determined by three things, authority, choice (or the autonomy to decide *otherwise*)

and responsibility (Tilley and Watson 2004). Some philosophers would see accountability through its 'key component or its 'chief constituent', which is responsibility (Tilley and Watson 2004 p.99). Lanara (1982) defines responsibility as 'being dependent upon knowledge, discretion, judgement and the ability to make decisions about one's work (p.9)'. However, this may be too simple an explanation, as to be responsible implies being accountable to oneself and/or another for one's acts and perhaps more importantly one's omissions. French (1993) suggests that a person is morally responsible for his actions only if he could have done otherwise. This moral responsibility presumes two essential premises concerning the dialogue around responsibility. Firstly, that the moral agent is acting in good faith and with free will (uncoerced) and secondly that there is a known (or unknown) choice of actions available. Responsibility can also be viewed, according to French (1993) as a form of barter. French argues that we spend a considerable amount of time trying to avoid responsibility. This avoidance stems from the logical deduction that if an agent accepts responsibility then accountability for obligations and outcomes will be implied. French (1993) even goes so far as to suggest that avoidance of responsibility has become an art form, which has been learned and practiced fairly early in life and continues throughout.

Exploration of the notion of responsibility in the nursing literature is practically invisible. Chiarella (2002) mentions the difference between the exercise of power and the shouldering of responsibility in various legal cases where the nurse calls the doctor's attention to a patient who has deteriorated but the doctor ignores the nurse's concerns. This appears to the researcher as the crux of the argument of powerless responsibility. The nurse, (or the Director of Nursing) knows that a situation is deteriorating. The nurse (or the Director of Nursing) calls the attention of the person who can rectify the situation, but cannot alone alter the deteriorating situation nor change the outcome. Thus she has the responsibility to 'discover' the situation, but not the authority to redress it. It could be argued that the doctor resisted the nurse's expert power, but equally the nurse accepted the doctor's decision to do nothing, thus, renegeing on her responsibility to the patients safety. Tilley and Watson (2004) would

argue that nurses are accountable (responsibility being a sub set of accountability) 'for' rather than 'to' patients, however, who nurses are 'accountable-for-patients' to remains unclear. Watson (1995) acknowledges that the concept of accountability (and by inference responsibility) is complex, confused and contradictory.

2.1.8 Conclusion

In this chapter I have attempted to address some of the issues that were relevant to the Directors of Nursing. The rationale for the selection of organisational behaviour, organisational culture, oppressed group behaviour and the glass ceiling stemmed from two sources. The first, from my own need to understand these concepts, as my knowledge of them was limited. Secondly, and perhaps more importantly, when I began to read around the literature pertaining to the Director of Nursing role in different countries, common patterns emerge. These include how the profession of nursing has been changed to suit changing organisations (Lindholm et al 2000) and changing cultures (Cameron and Masterson 2000, Richman and Mercer 2004). The invisibility of nursing within the health care setting in relation to the Director of Nursing is repeatedly alluded to in numerous studies (Jasper 2002, Antrobus 2004, Davies 2004). It is evident that nursing is women's work and thus valued less than men's work, which led me to read around the subjects of oppressed group behaviour and the glass ceiling (Chan 2002, Davies 2004, Jasper 2005). It would seem that nurses are regarded as an oppressed group because they are mostly women and because they are nurses. This dual combination would appear to have a double negative impact on the profession (Wall 1994, Sofarelli and Brown 1998, Crossan 2003).

Finally, I have outlined the concepts of power, powerlessness and responsibility. It is evident from a cursory examination of the concept of power that it is complex and multi-faceted. For the purposes of this study I will be using the term power from the perspective of the Directors of Nursing's ability, or inability, to influence hospital policy and the wider health service policy. In other words, the amount of power that

the Director of Nursing can exert is measurable by how readily she is able to achieve her goals.

The next chapter will outline the methodological and philosophical underpinning of grounded theory. It will also deal with the philosophical perspectives and the central tenets of grounded theory. Rigour and validity will be discussed and the methods of data analysis, data management, coding and theory development will be addressed.

3 Chapter Three – Methodological issues

3.1 Introduction

Grounded theory (Glaser and Strauss 1967) emerged from the symbolic interpretive school first articulated by George Herbert Mead (1934). George Herbert Mead and John Dewey began to look at the study of human behaviour through a pragmatic naturalistic perspective (Robrecht 1995). Symbolic interactionism was a tradition that emerged out of the Chicago school of sociology between 1920 and 1950. Strauss was trained in the use of symbolic interactionism and Glaser in quantitative research methods. According to Blumer (1969), a student of Mead, the three tenets to George Mead's conception of social psychology are:

- Humans act toward things based on the meanings that the things have for them
- The meanings of such things is derived from the social interaction that the individual has with his fellows
- Meanings are handled in, and modified through an interpretive process and by the person dealing with the things they encounter

In other words, human beings behave and interact depending on how they interpret or give meaning to symbols in their lives. The difficulty with these early studies, which became known as 'field studies', was that the analysis of data had no theoretical underpinning (Glaser 1998). Thus, quantitative researchers in the scientific fraternity were extremely critical of this rather aesthetic/creative artistic methodology. Something needed to be done to address this problem. Anslem Strauss and Barney Glaser who were working together in the University of California in San Francisco, first articulated a solution, which came to be known as grounded theory. In other words, the discovery of grounded theory (Glaser and Strauss 1967) was a response to what Glaser and Strauss considered to be the dominance of quantitative research on one hand, and poorly conducted qualitative descriptive research, on the other.

Grounded theory aims to investigate the social processes that occur as a natural outcome of the interactions that we, as humans, are continually engaged in and exposed to. According to Hutchinson (1993), grounded theorists base their research on the assumption that a group (sic) shares a specific social psychological problem that is not necessarily articulated, as Glaser puts it:

'The GT product is simple. It is not a factual description, it is a set of carefully grounded concepts organised around a core category and integrated into hypotheses. The generated theory explains the preponderance of behaviour in a substantive area with the prime mover of this behaviour surfacing as the main concern of the primary participants'
(2004)

In order to understand what grounded theory is, it is necessary to clarify some common misconceptions. Grounded theory is neither a quantitative method of data analysis, nor is it a qualitative method of data analysis. It is a method of data analysis that stands on its own, outside the quantitative/qualitative paradigm (Glaser 1998, 2001, 2003). Both quantitative and qualitative data can be used when doing a grounded theory, however as mostly qualitative data has been used where grounded theory has been the methodology of choice, it has become mistakenly identified as only a qualitative method of data analysis (Brady & Hyde 2002, Byrne 2001). To make this mistake at the outset of a grounded theory study is to seriously undermine the concept and principles of grounded theory and to derail the researcher into undertaking a qualitative descriptive analysis and not to develop a grounded theory. Glaser states:

'Grounded theory is a general method to use on any kind or mix of data and is particularly useful with qualitative data' (Glaser 1998).

As researchers mostly use grounded theory to analyse qualitative data, it has thus understandably become common, if not accepted practice, for grounded theory to be thought of and used as a qualitative methodology. Glaser (1990) again re-iterates:

'grounded theory stands on its own as a theory of a method which yields techniques and stages that can be used on any type of data and combination thereof' (p.11).

Equally the literature is unclear about whether grounded theory is a method or a methodology (Polit et al 2001). If we consider grounded theory as a method, then it can be used in conjunction with other qualitative/quantitative methodologies. Conversely, if we consider it as a methodology then it should be used as Glaser and Strauss indicated. Glaser and Strauss (1967) initially considered grounded theory as a method, maybe explaining the confusion. However writing more recently Glaser (2001) is in no doubt that grounded theory is a methodology. Crotty (1998) defines a method as:

'the techniques or procedures used to gather and analyse data related to some research question or hypothesis' (p.3).

He defines a methodology as:

'the strategy, plan of action, process or design lying behind the choice and use of particular methods and linking the choice and use of methods to the desired outcomes' (p.3)

Numerous articles (Brady & Hyde 2002, Byrne 2001, Dey 2001, Turkel & Ray 2001, Audiss & Roth 1999, and Heath 1998.) have been published which clearly state that grounded theory is a qualitative methodology, ignoring the fact that it can be used with quantitative data also. Glaser warns against mixing qualitative data analysis (QDA) and grounded theory, as to do so 'downgrades and erodes the grounded theory goal of conceptual theory' (Glaser & Houlton 2004). The outcome of qualitative data

analysis is description, the outcome of grounded theory is a set of integrated conceptual hypotheses systematically generated to produce an inductive theory about a substantive area (Glaser & Houlton 2004). Glaser (1978) states that:

'The goal is to generate a conceptual theory that accounts for a pattern of behaviour which is relevant and problematic for those involved. The goal is not voluminous description, nor clever verification' (p.93).

This researcher would consider that grounded theory is a methodology but acknowledges that many other researchers can and do use it to suit their own research purposes. What is important is that if a researcher is using grounded theory as a methodology, then they should articulate this. However, if they legitimately choose to use some aspect of grounded theory then this must be articulated, as to do otherwise leads to confusion and might undermine grounded theory.

3.2 Grounded Theory

Glaser and Strauss were influenced by Lazarsfeld and Henry (Glaser 1998) in their belief of continually comparing incidents to incidents when coding data in order to generate concepts and the properties of concepts. This they termed constant comparison, and the concepts being built up from what they termed 'indicators'. Indicators can change and adapt as more data is collected. This is reflected in grounded theory in the idea that the generation of theory is modifiable, that any new data which generates a new concept is integrated into the existing theory which is then modified accordingly (Glaser 1998).

Glaser (1998) describes grounded theory as 'what is', not what should, could or ought to be. What Glaser means by this is that in the realms of business and health, for example, people want answers to problems that work. Grounded theory tells the researcher what is going on and how we can account for the participants' main concerns. It could be quite successfully argued that any research could achieve this, but Glaser insists that as no preconceived theories or 'pet' theories are permitted,

grounded theory allows for patterns that the participants may not know exist to be discovered. The philosophical perspectives of grounded theory are discussed in full in section 3.3.

3.3 Grounded theory – From a Philosophical Perspective

Strauss and Corbin (1994) describe grounded theory as a way of thinking about and conceptualising data. This conceptualisation is formed in social settings chosen for the study and theory is developed in an empirical manner. Stemming from the philosophy of symbolic interactionism, grounded theory has its roots in the interpretive tradition.

According to Annells (1996), the researcher is encouraged to take into account the philosophical and paradigmatic aspects of grounded theory before embarking upon their research study. The current debate is concerned with which paradigm in which grounded theory sits: Positivism, Postpositivism, Critical theory or Constructivism (Guba & Lincoln 1994 as cited in Annells 1996).

Guba & Lincoln (1994) argue that these four paradigms can be understood by asking questions such as: What is the form and nature of reality and what can we really know about reality? This is known as the ontological question. What is the nature of the relationship between the researcher (the knower) and the participant (the would be knower) and what can be known? This is known as epistemological question. And finally how should the researcher go about finding out whatever she believes can be known? This is known as the methodological question.

Annells (1996) somewhat pedantically suggests that logic would determine the answer of which approach to use, as the epistemological question is constrained by the response to the ontological question, and the answer to the methodological question is dependant on the answers to the preceding questions. The somewhat ambiguous conclusion reached by Annells is that as grounded theory becomes more

popular, it will become subject to change through evolution and thus the philosophical paradigm to which it belongs will change accordingly.

Charmaz (2000) holds that grounded theory can be linked to constructionism and that a constructionist grounded theory can be developed which will help erode what she interprets as the positivistic nature of the method. Grounded theory has been criticised for being positivist in nature and for being associated with interpretativism (Norton 1999). What is clear is that it cannot be both; this would indicate that there is confusion in the literature. Glaser (2002) states clearly that the constructionist positivistic perspective of Charmaz (2000) is irrelevant to grounded theory methodology and he suggests that she is trying to re-model it. Glaser (1998), perhaps too simplistically, also states categorically that attempts to mix and match methodologies only serve to dilute what is a simple inductive approach to data analysis.

Hall & Callery (2001) suggest that grounded theory was developed originally to provide a basis for predicting cause and effect relationships within a post positivist paradigm. They suggest that theoretical sensitivity and the criteria for rigor designed by Glaser (1992) and Strauss and Corbin (1990) are supported by the post positivist assumptions underpinning grounded theory.

The ontological assumption of grounded theory is that there is a shared social reality in relation to a problem. The shared social reality is defined by them (the participants) and is embedded in their accounts, not the researchers. The researcher using grounded theory attempts to develop a theory about shared social reality, (the participants may not be aware of their shared reality) this is because the reality cannot be absolutely precisely captured due to our own perceptual limitations. This, one could argue is therefore a strictly post-positivist position. The researcher's role is to attempt to raise these perspectives to an abstract level of conceptualisation (Glaser 2002).

Controversy surrounding the method of applying grounded theory has been well documented in the literature (Melia 1996, Glaser 1992). The next section will outline the issues involved. It is important when reporting a grounded theory study that the researcher identifies whether the grounded theory they have chosen to use follows Glaser or Strauss's framework, as there are fundamental differences between the two.

3.4 Glaser and Strauss

As discussed above, grounded theory brought a new fresh credibility to qualitative research that was conducted in naturalistic settings when Glaser & Strauss published their seminal work *The Discovery of Grounded Theory* (1967). However, attempts by Strauss to provide guidance and help simplify the processes succeeded in drawing interest away from the data toward procedural steps. These attempts caused Strauss to be accused of being overly complex (Robrecht 1995).

Strauss and Corbin (1990) were attempting to respond to users of grounded theory who had found it to be neither straightforward or indeed simple to use. Hence, the authors made earnest attempts to make doing grounded theory a step by step procedure, but according to Glaser (1992), all they succeeded in doing was to undermine and blur the use of grounded theory. Glaser responded to Strauss & Corbin by publishing 'The Basics of Grounded Theory Analysis' (1992). In this book, Glaser claimed that his long time friend and colleague had forgotten about the central principles of grounded theory and he went on to claim that Strauss quite clearly never really understood the principles of grounded theory.

In 'The Basics of Grounded Theory Analysis' (1992) Glaser offered a direct critique to Strauss & Corbin's 1990 'Basics of Qualitative Research: Grounded Theory Procedures and Techniques' (1990). The premise of Glaser's argument was that Strauss and Corbin had actually described an entirely new methodology, which he termed 'full conceptual elaboration'. Although the differences between the two approaches are difficult to pinpoint, an understanding of the essential differences is necessary for the researcher to make a choice between which author to adopt. Glaser

had always advocated that theory, which is a set of integrated conceptual hypotheses, should 'emerge' from the data; meaning should not be imputed into the data and that generating good ideas also requires the analyst to be a 'non-citizen' for the moment so he can come closer to objectivity and to letting the data speak for itself (Glaser 1978 p.8).

However, Strauss & Corbin refined and elaborated the processes in an attempt to clarify the theoretical sampling procedures originally devised by Glaser & Strauss in 1967 (Strauss & Corbin 1990). The fundamental premise explicated by Glaser & Strauss in 1967, that the theory emerges from the data, was being slowly stripped away. Glaser felt that to interrogate the data endlessly in order to arrive at a forced or 'full conceptual elaboration' was cumbersome and over self-conscious (Locke 2001).

For example, if a Director of Nursing states 'I do not have control of the education budget', Strauss & Corbin would ask what does the director mean by 'control', whereas Glaser would take its meaning in a conceptual manner: controlling or lack of control. Strauss & Corbin are accused of over analysing the data by Glaser. Glaser suggests that the data will speak for itself and that the researcher does not need to over interpret it. The research practices of grounded theory as extrapolated by Glaser stress the importance of simplicity and restraint when analysing and interpreting the data (Glaser 1978).

This researcher would suggest that to adopt Strauss & Corbin's new method would be contradictory to the notion of theoretical sensitivity. According to the tenets of theoretical sensitivity, the researcher should have the ability to recognise what is important in the data, and to give it meaning, not to put meaning onto it. Strauss & Corbin when looking at the data, focus on a word and would ask 'What if'? Glaser on the other hand would ask 'what do we have here'? Strauss looks for every conceivable contingency that could tenuously be said to relate to the data, whereby Glaser focuses his efforts on the data, allowing it to tell its own story.

This researcher will therefore adhere to Glaser's approach to grounded theory, and let the theory emerge from the data. She concurs with Robrecht (1995) that strict adherence to the new procedures would violate the original methodology.

3.5 Data analysis

Glaser & Strauss (1967) and Glaser (1978) recommend that as soon as the data is collected, the analysis begins and this in turn will direct the next interview and/or observation period.

By joint collection and analysis, the sociologist is tapping to the fullest extent the in vivo patterns of integration in the data itself; questions guide the collection of data to fill in gaps and to extend the theory (Glaser and Strauss 1967 p.109).

An astute researcher will begin his or her data collection actively searching for clues for the direction in which to focus his/her research. Effectiveness of the grounded theory method will depend on the researcher's ability to encapsulate all the relevant, and even seemingly irrelevant, topics of the data collection and collateral analysis. Grounded theory dictates that the researcher collects, codes and analyses the data from the beginning of the study (Glaser 1998). This continuous data analysis is sometimes described as 'circular', enabling the researcher to alter the focus and chase theories exposed by the ongoing data analysis.

3.5.1 The Three Central Tenets of Grounded Theory

The three central tenets of grounded theory are constant comparison, theoretical sampling and theoretical saturation. Constant comparison, theoretical sampling and theoretical saturation help ensure that concepts emerge from the data rather than being imposed by the researcher (Glaser 1998). Not imposing the researchers' preconceived ideas or theories on the data, or trying to influence the patterns as they emerge with preconceptions, is one of the guiding principles of grounded theory. Avoidance of bias, prejudice and conjecture are ensured by using theoretical sampling and constant comparison (Glaser 1967).

3.5.2 Constant Comparison

Constant comparative analysis requires every piece of datum to be compared with every other (piece of datum) (Stern 1985b). By utilising a constant comparison approach, the core category or core variable will emerge. The emphasis in grounded theory is on the experience of the participants in that the problem (or concern), is defined by them and not the researcher and on letting the data speak for itself. This 'emergence' is not meant in a realist ontological sense but in the sense of not imputing meaning to, or making inferences from, what the participants are saying. People deal with problems by engaging in behaviour that helps solve these problems. However, whilst they may be aware of their behaviour, Glaser is suggesting that they may not see a pattern to that behaviour. Grounded theory is looking for those patterns and the researcher must let the data emerge in its own right (Glaser 1998). As every piece of data is compared to every other (piece of data), the theory is developed. This cycle of data collection, analysis and theory production ensures that only concepts that are based on the data earn their way into the theory.

The core variable will act like an invisible thread throughout the theory, linking all the categories together. The core variable should only truly emerge towards the end of the study. This is because not until the researcher has compared every piece of data with every other (piece of data) will the pattern emerge.

3.5.3 Theoretical Sampling

Theoretical sampling is the process of data collection where the researcher collects, codes and analyses the data and then decides what data to collect next and where to go to find this data. This is to allow for development of the theory as it emerges. According to Streubert and Carpenter (1999) it is impossible to know how many participants will be involved in the study, the sample size being determined by the generation of the data, the emerging categories and the final theory.

The main data sources in a grounded theory study are in-depth interviews, but other sources can include observation, field notes and documentation such as job descriptions service plans and annual reports. Prior to the interview process, demographic data such as age, gender, educational qualifications, length of time in post may be collected.

Glaser (1978) states that:

'Theoretical sampling is the process of data collection for generating theory whereby the analyst jointly collects, codes and analyses his data and decides what data to collect next and where to find them, in order to develop his theory as it emerges' (p. 36).

In this study the sample had already been selected, as the research aim was to gain an understanding of the social processes and structures involved in being a Director of Nursing and to give the role, and its associated functions, meaning through dialogue. Coyne (1997) suggests that all sampling in qualitative research is purposeful and theoretical sampling means that the emerging theory will determine where the researcher next goes for his or her sample, hence the term theoretical sampling. However, in this study the next sample was always the next Director of Nursing. In order to develop a theory about the shared social reality in relation to a problem, it was felt necessary to limit the study to the Director of Nursing perspective only. This was because I wanted to understand the role of the Director of Nursing from their perspective.

Glaser (1978) argues that the researcher selects a sample where the phenomena of interest lies, and then proceeds to select more samples as the categories develop. This study began with the purposeful sample of Directors of Nursing in Band One Teaching Hospitals in Ireland. Once concepts began to emerge, the researcher then moved onto the next Director of Nursing and so on, until all of the Directors of Nursing were sampled. Once each interview was completed the researcher transcribed

and began coding the data. Each interview began by the researcher asking the Director to tell me about her job and any concerns or issues that she may have had. This was a deliberate open question and resulted in most Directors venting or talking at length about their job. As the interviews progressed and patterns of their social reality began to emerge, I introduced the concepts. I spent time elaborating on the issue and then waited for comments to confirm or dismiss the concept being discussed. On this basis the core concepts were continually built on or dismissed.

The research sample was based on the 12 Band One Hospitals in Ireland. These 12 hospitals represent the major academic teaching hospitals across a rural urban mix.

3.5.4 Theoretical Saturation

When a core category has been identified, coding for that category ceases. Coding thus becomes more efficient as the study progresses. Whilst collecting and interpreting data about a particular category, in time the researcher reaches a point of diminishing returns. Eventually the interviews add nothing to what is already known about a category, its properties, and its relationship to the core category. Thus, the core category is described as:

'A category which accounts for most of the variation in a pattern of behaviour and which helps to integrate other categories that have been discovered in the data',
(Speziale & Carpenter 2003 p.119)

According to Holloway & Wheeler (1995) the gathering of data does not stop until the end of the project because new ideas and questions are constantly arising and new concepts being developed. New data sources will appear throughout the data collection as the theory emerges or is worked through. Thus data collection continues until the data is saturated.

3.5.5 Coding and Categorising

Glaser (1978) states:

'The essential relationship between the data and theory is a conceptual code. The code conceptualises the underlying pattern of a set of empirical indicators within the data. Thus, in generating a theory by developing the hypothetical relationships between conceptual codes (categories and their properties) which have been generated from the data as indicators we 'discover' a grounded theory' (p.55).

Coding and categorisation continue constantly as data is collected. Codes can change and be re-named as the researcher becomes more and more immersed in the data. Coding and categorising only come to a halt if the researcher can find no more information from all the sources and if the links between the categories are established (Glaser 1978). Once categories emerge, the researcher searches the literature for development and centralising of the categories. The researcher attempts to establish if other studies have reached the same conclusions or not and if not why not. In this way, the literature becomes part of the data (Cutcliffe 2000, Hickey 1997). Close examination of the literature can help direct the researcher to the next theoretical sample in grounded theory as the literature is considered part of the data (Hickey 1997). An example of coding is outlined in appendix 1.

As discussed above the aim of grounded theory is to discover a core variable, which will ultimately account for a pattern of behaviour, which is relevant and may or may not cause difficulties for the Directors of Nursing. Basic Social Processes (BSP) are core variables that illustrate social processes as they perpetuate over time in spite of differing conditions (Glaser 1978). In order to arrive at the core variable the researcher codes the data from the outset of the data collection. Coding occurs at three levels:

Level 1 - The researcher examines the data line by line looking for processes within. According to Speziale & Carpenter (2003) it is critical to code every sentence and

every happening using as many codes as possible in order to ensure a complete microscopic examination of the data. Glaser (1987) suggests that this line by line approach forces the analyst to verify and saturate categories, minimising missing an important category, produces a dense rich theory and gives a feeling that nothing has been left out. It corrects for the forcing of 'pet' themes and ideas, unless they have 'emergent fit' (p.58)

This level of coding is also known as 'substantive coding', because a coding system is given to the substance of the data and the interviewee's own language is usually used. A substantive code legitimises or conceptualises the empirical substance of the area of research, in this case the transcribed interviews.

Level 2 – Essentially this is level one data that has been condensed into what becomes known as categorisation using the constant comparative method. The coded data are compared with each other and where there is an 'obvious fit' they are clustered (Stern 1980a). These clusters are now known as categories and at this stage the theory should be starting to emerge. This level is known as theoretical coding. The researcher is looking for consequences and should be conceptualising how the substantive codes relate to each other as hypotheses to be integrated into the theory. (Glaser 1987)

Level 3 – This level describes what has now become the Basic Social Processes, or the central themes that have been extracted from the data. Basic Social Processes are one type of core category that illustrate social processes in a dynamic fashion, without being cognizant of varying conditions. Basic Social Processes could include such concepts as 'cultivating', 'defaulting', 'centering', or 'becoming'. As Glaser (1987) puts it:

'A basic social process succeeds in giving the feeling of process, change and movement over time' (Glaser 1987)

The researcher must continually ask herself 'what is actually happening in the data' and 'what is the basic social psychological problem faced by the participants'? Whilst a core category must always be present in a grounded theory research study, a basic social process may not, this is because a basic social process may not be found. (Glaser 1967 p.42).

3.6 Theory/Concept Development

Three further steps ensure that the theory is expanded and defined. They are: reduction, selective sampling of the literature and finally selective sampling of the data. The core variable will be drawn from these three steps. As discussed above, a huge volume of codes will be identified, that should next be compared to broader categories. This reduction of categories is an essential part of the process of establishing a theory as the primary social processes or core variables that should run through the emergent 'plot' will become evident.

3.7 Memo writing

Glaser (1978) stresses that the core stage in the process of generating theory is the writing of theoretical memos. Glaser goes on to assert:

Memos are the theorising write-up of ideas about codes and their relationships as they strike the analyst while coding (p.83)

Memo writing and field notes are perhaps the most intellectually stimulating aspect of grounded theory. The researcher conducts a written dialogue in relation to ideas, theory generation, and issues for consideration or simply generates questions to ask the next participant. In doing this the researcher will ensure that instincts about the data, abstract thoughts, early analysis and emerging hypotheses will be preserved. Memos that have been coded and kept in some sort of order will lay the foundation for the research report. Glaser (1987) suggests that there are four goals when writing memos:

- Ideas should be theoretically developed
- There must be complete freedom to develop ideas
- A memo fund should be created
- The memo fund must be highly sortable (p83)

Fulfilling these goals is the key to the success of creating the theory and to writing the eventual report. The researcher kept theoretical memos written at the time of transcribing the interviews when coding the interviews. It is fair to say that only when the researcher began to write memos did the true principles of grounded theory emerge. Memo writing freed up the researcher's ability to think without prejudice.

3.8 Data management

The data were analysed as outlined above and explicated by Glaser (1998). The aim of line-by-line coding was to fracture the data and then to re-construct it by conceptualising, while constantly comparing. By doing this manually, the researcher was free from what Glaser (1998) terms the 'technological trap' to compare, contrast and repeatedly go over the data. While coding, the theoretical memos were organised in such a way as to integrate the memos into the coding, thereby establishing an easy reference system for reviewing and changing concepts and codes, and then adding to the memos.

All categories and codes were given a coding system. In grounded theory there appears to be disagreements about whether a computer software package or a manual method should be used. Upon reading the literature there appears to be confusion in regard to what a computer package can actually offer. Some authors suggest that the computer package can actually assist in *analysis* of the data (Weitzman 2002). Whilst others, more reasonably suggest that computer packages can help with data *management* (Tesch 1991). As the researcher was using a strictly Glaserian methodology, she chose to manually manage and analyse the data. Glaser argues that the time spent learning a computer package is better spent learning how to do

grounded theory (Glaser 2001). Learning how to do grounded theory can take upwards of two years, Glaser (1998) explicitly states:

'doing grounded theory requires an amazing flexibility and freedom in manoeuvring ideas as they occur and as they change. This takes skill and a skill development curve that will vary..., anything that simplifies or superficialises this conceptual, ideational production undermines it' (p.185)

The coding required a four step phase:

1. coding the same data separately – from each individual interview
2. coding the same data together – from all the interviews
3. merging the lists of codes -
4. forming categories – merging the codes formed in step three into categories

The interviews were taped and then transcribed verbatim. The researcher transcribed the interviews herself in order to achieve a close relationship with the data. A two inch margin for manual coding was left on the side of the transcribed sheets. All data were stored on two hard drives and backed up on memory device.

In order for the reader to understand my coding system and to give coherence to how the analysis was completed, I will briefly outline it. When transcribing, each page was numbered and when coding each code was given an identifying number. For example if the code 'the cat sat on the mat', came from interview number three, page eleven it was coded as D3P11, or Director of Nursing three, page eleven, thus ensuring there was a robust and simple data trail. When coding the theoretical memos, the same applied, but the nomenclature TM was given to indicate it was a theoretical memo. For example interview number eleven, page twenty-one theoretical memo would be given the code TMD11P21. Again the principle being that I could 'get back' to the source of the memo or the code.

To summarise, in this study, the researcher invented a data management system that enabled her to complete the analysis in a functional and logical manner. Each interview was thus transcribed and put into a word document labelled 'interview one' and so on. When coding commenced, each interview was assigned a word document under the folder heading 'interview one codes', and so on. Then when the coding from each interview was compared with the next and the prior interviews the folder was labelled 'interview one and two merged' etc. Finally, when the core categories began to be identified another folder was created, termed, 'development of core categories'. In this way, the researcher was able to manage the data analysis in a controllable and logical manner.

3.9 The Researcher

Barnes and Donelle (1996) go to great lengths to stress the importance of the familiarity of the researcher with the culture of the individuals about whom she is attempting to develop a theory. Glaser termed this familiarity which refers to the personal qualities of the researcher as theoretical sensitivity, (Strauss & Corbin 1990). Theoretical sensitivity implies that the researcher has an awareness of the underlying subtleties of the meaning of the data and has the ability to recognise what is important in the data and to give meaning to it.

Theoretical sensitivity has two sources: personal and professional experience and knowledge gleaned from what Strauss & Corbin (1990) term 'technical literature'. Technical literature refers to academic papers as opposed to non-technical which refers to biographies, diaries, manuscripts and catalogues. However, what the researcher must be able to do is to separate the objective from the subjective (Locke 2001).

Locke alludes to the three-fold tensions that can be created when the researcher is attempting to assign meaning to the data. Firstly, the researcher needs to become totally immersed in the data but yet get a perspective on her thinking. Secondly, the researcher must hold existing theory in abeyance but rely on and cultivate theoretical

sensitivity. Finally, the researcher needs to be able to create names that closely fit the data but that can be abstracted to generate a high level of generality. This could be neatly termed the subjective/objective paradox of grounded theory analysis. However, Hall and Callery (2001) argue for the concept of reflexivity to be addressed in grounded theory studies. They define reflexivity as critically examining one's effects as a researcher on the research process. Reflexivity could more simply be described as questioning the grounds of one's own assumptions. Hall and Callery (2001) suggest that identifying the effects of interactions among investigators and their participants more transparently adds credibility to the construction of the theory which, the authors claim, has been neglected in grounded theory. Rigour will be discussed in the following section. In order to address the issues discussed above, the researcher wrote field notes after each interview. These field notes attempted to address the effect that the researcher may have had on the interview and also how the interview itself unfolded. See appendix 2 for example of a field note.

3.10 Rigour

According to Glaser, the criteria for evaluating grounding theory analysis are: 'fit', 'work', 'relevance' and 'easy modifiability' (Glaser 2001). By 'fit', Glaser means that concepts and categories must 'fit' the data. In essence, this means that only the concepts that have been generated by the data are used in the generation of the theory. Fit is thus achieved by constant comparison as discussed earlier. 'Work' refers to the ability of the theory to explain the behaviour in the substantive area, in this case the Directors of Nursing's behaviour. Relevance refers to the significance the theory has for the participants. 'Easily modifiable' means that as other indicators of a concept emerge by ongoing reading and study, the theory can be modified to take account of this new data (Lomburg and Kirkevold 2003).

According to Chiovitti and Piran (2003), researchers need to sustain a dialogue on the methods of, and practical application to, rigour in qualitative research practice. Cutcliffe (2000) asserts that to avoid method slurring and to enhance rigour, the researcher should explain and describe any digression away from the chosen method.

Cutcliffe (2000) discusses how the interaction between the researcher and the participants affects the emerging theory. On the one hand he argues it is the reflexivity and the researcher's own creativity within this reflexivity that makes grounded theory a valuable methodology; on the other hand, if the researcher does not hold their own personal preconceptions, values and beliefs in check, the whole scientific enterprise collapses and a theory based on the social reality will not emerge. Cutcliffe (2000) concludes that there is a need for the grounded theory researcher to openly acknowledge his or her prior knowledge and to discuss how it may have affected the development of the theory. To fail to do this, the researcher would be left asking herself:

'does that thought originate from my knowledge, experience or beliefs or does it belong to the interviewees'? (p.1482).

Trustworthiness will be achieved, Cutcliffe (2000) argues, by further interviews that allow the researcher to explore the emerging categories and/or concepts. If the questioning has no meaning for the participants, the researcher has no choice but to disregard the original hunch.

Finally Glaser (1998) states that the proof of grounded theory is in its outcome. He asks:

'Does the theory work to explain relevant behaviour in the substantive area of research. Does it have relevance to the people in the substantive field? Does the theory fit the substantive area. Is it readily modifiable as new data emerge. If the theory holds up to these four criteria, and if the researcher has been sufficiently rigorous, then those who might use the research results or feel conceptually empowered by the theory, will see that in the outcome of use, as their perceptions of a substantive area change' (p.17)

This researcher has knowledge of the world of nursing and of health care but not of the substantive area under investigation, the world of the Director of Nursing. In order to achieve a balance between reflexivity and rigour the researcher conducted a 'member check' with interviewees at the beginning of each new interview (Polit et al 2001). This member checking consisted of informing the participants of the development of concepts to date. For example, I offered the concept of 'Director of Everything' to interviewees and on each occasion they agreed with the concept once it was explained. Thus, I was able to be certain that the development of concepts was rooted in the data and did not come from my own intuition or pet themes.

3.11 Ethical considerations

Ethics is a field of philosophy concerned with notions of right, wrong, good, bad, vice or virtue. Eby (1995) established a list of codes for the ethics of research, of which the following are most pertinent to this study.

- The research must be necessary and contribute to further knowledge
- Respondents must receive a full explanation and have the right to refuse to take part
- Participants must give their consent
- Confidentiality of participants must be assured
- Researchers must be qualified and have the appropriate research skills and
- Participants must be protected from harm, suffering and injury.

The voluntary nature of the interviews were stressed to all participants and no Director was coerced into participating in the study. Participants were sent a letter inviting them to participate in the study (Appendix 3). The letter outlined the aim, objectives and the rationale for the research. The researcher received letters of response from eleven out of the twelve directors consenting to be interviewed. The methodology was explained and reassurances that all information gathered would be held in strictest confidence. All interviews were taped, and the tapes were stored in a

locked filing cabinet in the research area. Each director was reassured of this at the commencement of each interview.

3.12 Anonymity and Confidentiality

Confidentiality means that the identity of the respondent will not be linked to the information provided (Dillman 2000). Anonymity means that the individual's identity cannot be established by the researcher or others (Cormac 1996). All data were coded and no names or identifying marks were stored. Oppenheim (1992) advises that all data be treated as confidential, and as the researcher also transcribed the interviews herself, the risk of loss of confidentiality was further reduced as no third parties were involved. Reassurances were given before the taping the interviews that taping could cease at any time upon the interviewee's request (Burns & Grove 1997).

3.13 Demographics of the Directors of Nursing

All of the directors were Registered General Nurses and three were also Registered Midwives. Of the eleven interviewed, the age ranged from 40 – 64, with four directors refusing (politely) to give their age. The length of time in their current post ranged from two months to a maximum of seven years. Of the eleven Directors of Nursing interviewed, six had a master's degree, one was studying for a PhD, and one for an MBA. All were educated to degree level.

As discussed in chapter two, data were collected from 11 out of the 12 band one Directors of Nursing. For logistical reasons it proved impossible to find a mutually agreeable time to interview the twelfth Director of Nursing. Every interview took place in the Director of Nursing's own hospital except for two, one which took place in the Director of Nursing's home and one in the researcher's home. On average, the interviews lasted for sixty minutes. However, this does not include any 'informal' discussion before or after the tape recorder was switched on or off. It is worth noting that the Directors tended to be more frank once the tape recorder was off. An example of this was when one Director of Nursing commented *after* the tape recorder was off, that '*you are right we are directors of everything*' (TM D5P20). These types of

comments and observations were captured in the researcher's field notes and theoretical memos. Each interview was taped and transcribed by the researcher and coding and categorisation occurred simultaneously.

3.14 Limitations of the study

The limitations of the study are as follows:

My current role as Professional Development Officer in the National Council for the Professional Development of Nursing and Midwifery may have influenced the Directors of Nursing. This influence could have manifested itself as 'proper lining' (Glaser 2003), where the Director of Nursing tells me what they think I want to hear. I attempted to overcome this by continually stressing that the interview was confidential, that only I would be transcribing it, that the tapes would be destroyed after the study was complete and that no identifying quotes would be used in the final thesis.

Finally, an extremely important limitation in this study is what I have termed 'SIS', or 'Small Island Syndrome'. Ireland has a population of just over four million, and the nursing and health care population is perhaps as little as 100,000. Within this figure there is an estimated 60,774 nurses registered on the live register of An Bord Altranais (ABA 2005)⁸. The Directors of Nursing count for as little as 272 of these figures. I found there was a lot of valuable data that could not be used because to use it would have identified the Director of Nursing. This should be taken into consideration when reading this study.

⁸ Although 60, 774 are registered, there are no exact figures for how many nurses are actually employed in the Irish health services.

4 Chapter Four – Findings

4.1 Introduction: Powerless Responsibility – A Grounded Theory

The study examined the Directors of Nursing experience of working in a complex organisational setting, using a grounded theory methodology. Grounded theory aims to investigate the social processes that occur as a natural outcome of the interactions that humans are continually exposed to. The predication upon which grounded theory is built is that the social organisation of life is always in the process of resolving relevant problems for participants.

The grounded theory of 'Powerless Responsibility' was identified, with the supporting core concepts of 'Being a Nurse', 'Playing by the Rules', 'Plugging the Holes' and 'Circumnavigating the System', building the case for the theory. This thesis demonstrates how the Directors of Nursing in band one teaching hospitals in Ireland are in a position of 'powerless responsibility'. This powerless responsibility occurs within the context of a health care system that appears to function persistently in a systematically maladministered fashion (Travers 2005), which helps re-enforce the powerlessness. Powerless responsibility means that the Director of Nursing is given responsibility for keeping the hospital functioning twenty four hours a day, seven days a week. However, this level of responsibility is not commensurate with her ability to influence key strategic decisions within the organisation and/or in the wider health care policy. The two core concepts of being a nurse and plugging the holes are either a cause of powerless responsibility or exist as a consequence of living in the state of powerless responsibility. The concepts of playing by the rules and circumnavigating the system are strategies for dealing with that powerlessness, but paradoxically they are also a cause of that same powerlessness.

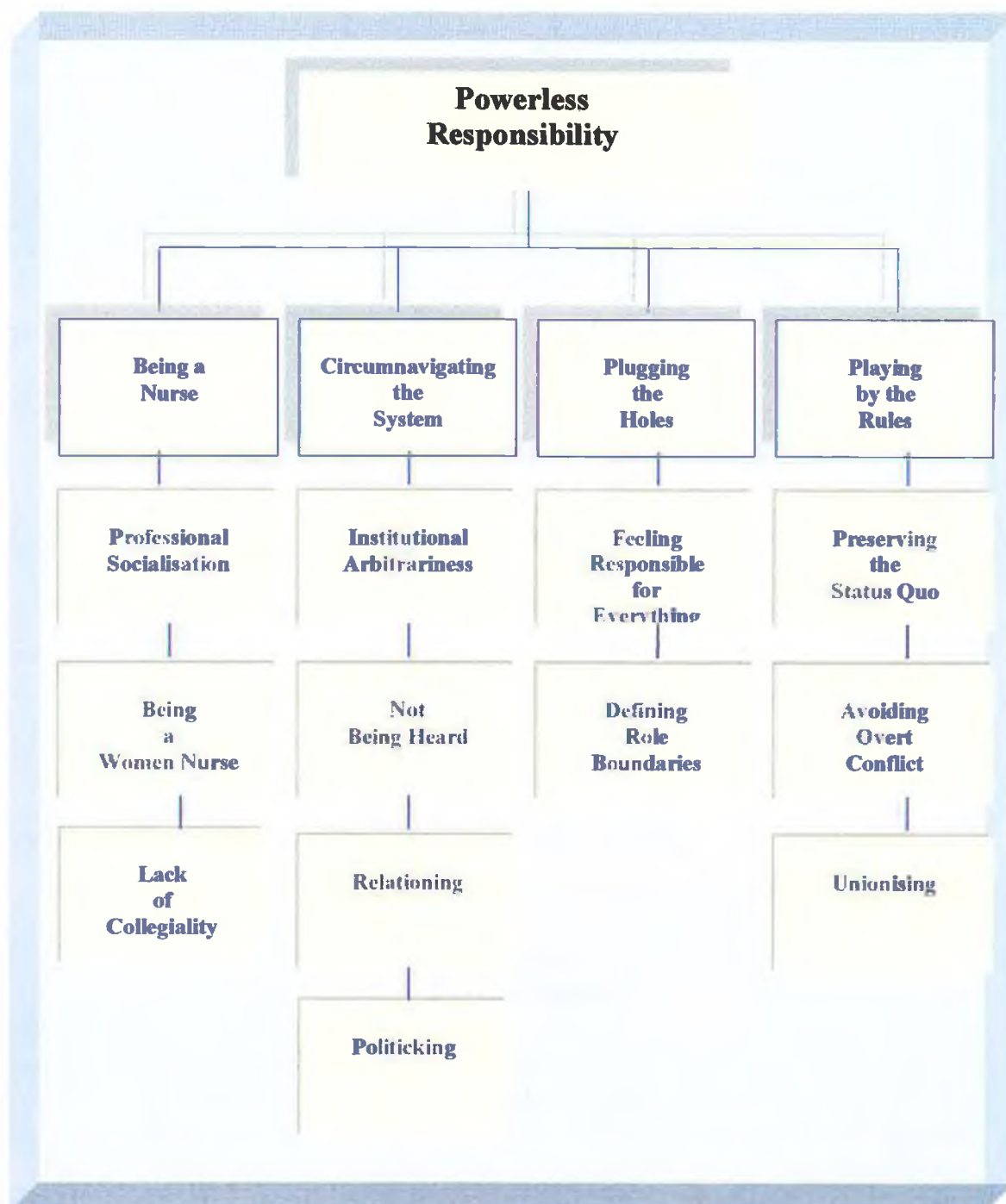
The Directors of Nursing are caught between being responsible for delivering quality patient care and becoming an equal member of the corporate team. Not only responsible for delivering quality *nursing* care, it appears that they are also

responsible for all aspects of patient care, yet they have no authority or control over other professionals who interact with those same patients.

The theory of powerless responsibility needs to be understood in terms of continuous movement, with aspects of each core concept influencing how the Director will behave within any given situation. The Director's behaviour is constantly adjusting depending on whom they need to influence and how they are going to achieve their aims. Ironically, and perhaps what the Directors may not realise is, that by their manoeuvring they are unwittingly accepting the lack of status associated with the post, within the organisation.

By examining each concept in detail and integrating it with relevant data, such as academic literature, government reports, non academic writings and the researcher's own experiences, I will demonstrate how I have built the case for the theory. The literature has been integrated and interspersed throughout this thesis in conjunction with the data, the categories and ultimately the conceptualization (Speziale & Carpenter 2003). Table 1.2 presents a visual representation of the grounded theory of powerless responsibility and the categories that underpin the core concepts:

Table 1.2 Visual representation of Powerless Responsibility



4.2 Core Concept: Being a nurse

4.2.1 Introduction

This section outlines the four core concepts as identified above; Being a Nurse, Circumnavigating the System, Plugging the Holes and Playing by the Rules. Each core concept is supported by core categories as demonstrated in table 1.2.

The core concept of 'Being a Nurse' resulted from the integration of three core categories which were 'professional socialisation', 'a lack of collegiality' and 'being a woman nurse'. Being a Nurse contributes to, and is a cause of, powerlessness. Professional socialisation, a lack of collegiality among nurses and being a woman nurse are now discussed.

4.2.2 Core Category: Professional Socialisation

As alluded to in chapter two, nurses could be considered to be an 'occupationally socialised' profession (Melia 1981, Begley 2002). Du Toit (1995) offers a definition of professional socialisation drawn from Cohen's work as:

'the complex process by which a person acquires the knowledge, skills and sense of occupational identity that are characteristic of a member of that profession. It involves the internalization of the values and norms of the group into the person's own behaviour and self-conception. In the process a person gives up the societal and media stereotypes prevalent in our culture and adopts those held by members of that profession'

Peplau (1988) makes the distinction between character structure and personality. Character structure is the governing foundation from which personality is derived, the decisions we make, based on our character structure, constitute our behaviour. For the purposes of this study I thought that as so much has been identified in the nursing literature about nursing stereotypes, the professional socialisation of nursing will impact on nurses' personality and behaviour (Kalisch and Kalisch 1987, Chiarella 2001, Hallam 2000, Savage 1987). Melia (1981), in a grounded theory study that

explored student nurses experience of their training, identified the concept of 'fitting in'. 'Fitting in' means that the student nurse had to fit into the work of the ward or risk becoming marginalised. In other words, if the student nurse did not accept the unwritten rules of the ward and asked awkward questions, she risked expulsion from the group. It could be argued that the occupational socialisation of the nurse begins at an early stage. Inherent in this socialisation, and indeed a factor contributing to this socialisation, is the concept of oppressed group behaviour (Begley 2002). Begley (2002) in a study that explored the views of Irish student midwives, concluded that there existed a subculture of nursing/midwifery subordination. The hierarchical nature of the midwifery profession is due to the fact that it is almost totally female-dominated. The female hierarchy exercises control over the female midwives within the context of a male-based power structure.

One of the factors that influenced the behaviour of the Directors of Nursing is the fact that they are nurses. By this I mean that the processes involved in becoming a 'nurse' has an effect on the individual that we call 'professional socialisation'. Professional socialisation is caused by many factors and will be discussed at length. A lack of agreement on what constitutes being a nurse and the culture in which 'becoming a nurse' contribute negatively to the professional socialisation will be discussed (Mitchell 2002). What I am arguing is that the Directors of Nursing represent a profession where even that profession cannot agree what exactly the definition of a nurse is⁹.

There is still an absence of consensus about a definition of nursing, or indeed if nursing is a profession or a semi-profession (Malin et al 2002). This in turn contributes to the Director of Nursing identity problems which I will attempt to argue causes an identity crisis (ICN 2002). This identity crisis is not related to the personal identity, only the professional one.

⁹ This is not to negate the importance of dialogue concerning the philosophy of nursing and the debate about what constitutes a profession. I am more concerned with the effects of the lack of surety this wavering instills in the Director of Nursing.

The nursing literature is replete with definitions of nursing, the changing nature of nursing, the notion of a theory of nursing, which epistemological framework best suits nursing, a philosophy of nursing and even a return to the concept of 'modern matron'. (Edwards & Liaschenko, ICN 2002, Edwards, 2001, 1997, Hewison 2001, Holmes & Warelrow 2000). To an outsider it would appear that nursing is not really sure what it is or what it does. Virginia Henderson (cited in Schober 1993) defines nursing as:

'The unique function of the nurse is to assist the individual sick or well in the performance of those activities contributing to health or its recovery (or a peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible.' (p.300-307).

Peplau (1988) summarises the concept of nursing as:

'Nursing is a significant, therapeutic, interpersonal process. It functions co-operatively with other human processes that make health possible for individuals in communities. In specific situations in which a professional health team offers health services, nurses participate in the organisation of conditions that facilitate natural ongoing tendencies in human organisms. Nursing is an educative instrument, a maturing force, that aims to promote forward movement of personality in the direction of creative, constructive, productive, personal and community living' (p.16)

Peplau (1988) acknowledges in the precursor to the definition that nursing is determined collaboratively and is occasionally defined by what others permit a nurse to view as the functions of nursing. Tracey and Hyde (2003) writing about an emergence of a disciplinary discourse in the Irish context offer:

'nursing is conceptualised as promoting and maintaining health and comfort as well as preventing ill health. The interpersonal aspect of nursing is central to the role in the delivery of care and nurses develop therapeutic relationships with patients (p.92).

Chiarella (2001) asks should we protect our name? Chiarella argues that other professions such as doctors, osteopaths and chiropractors have sections in their registration which identifies their 'lawful' work and in some cases actually forbid other people being able to do some of that work. She goes on to comment that there is little in most legislation to identify the lawful work of nurses. If we look at the definition of nursing in Ireland, it equates to being eligible to be entered onto the register:

'the word nurse shall have the meaning assigned to it in the Nurses Act 1985. The word 'nurse' means a person registered in the Live Register of Nurses as provided for in Section 27 of the Nurses Act 1985 and includes a midwife and nursing includes midwifery (ABA 2000).

Whilst this legislation is concerned with preventing non-nurses from using the title 'nurse', An Bord Altranais has not attempted to define what a nurse is other than by entry onto the nursing register. This is in contrast to the Royal College of Nursing (RCN) in the United Kingdom which has recently taken the step of publishing a document called 'Defining Nursing' (RCN April 2003). The document is written, it claims, for nurses and others to help them to describe what nursing is. It alludes to the fact that the United Kingdom Central Council (UKCC) reported in 1999 that it was sceptical about the usefulness of trying to arrive at a definition of nursing and concluded that *'a definition of nursing would be too restrictive for nursing'*. The RCN document acknowledges that definitions of nursing, like nursing itself, are dynamic and that nursing is constantly evolving to meet new needs and take account of new knowledge. The document, the authors suggest, is only a beginning. The definition they offer is expressed in the form of a core supported by six defining characteristics. The core states:

'The use of clinical judgement in the provision of care to enable people to improve, maintain, or recover health, to cope with health problems, and to achieve the best possible quality of life, whatever their disease or disability, until death' (p.3)

Whether one agrees or not with this attempt to articulate what it is nurses do, is not essential for the purposes of this study. The important issue is that as nursing strives to become universally accepted as a 'full' as opposed to a 'semi'- profession it can still not agree on what exactly it is nurses are, what it is nurses do and what their academic level of registration should be. As part of the work that informed the document, the RCN sent questionnaires to 123 countries asking whether the country had an official definition of nursing. Disregarding the poor response rate of just under 30% (34 countries), of the respondents 30 countries were identified as having either an official national definition of nursing, or a definition developed by the National Nurses Association or both. The lack of agreement and lack of clarity on what actually constitutes nursing has the potential to cause collective insecurity among nurses (Madison 2004). As a Director of Nursing progresses up the career ladder and further away from direct care delivery to patients, for which she has been trained, the more difficult it must be to be clear about the role of nurse. Nottingham and O'Neil (2000) have commented on the inadequate training that in the past has been provided for nurses who take on managerial roles.

If the nursing literature is so divided about the function of nursing, or if nursing has too many differing definitions, then a sense of uncertainty and a corresponding lack of confidence and assertiveness may be induced. One of the Directors commented:

'we are very poor at defining, we as in nurses, are very poor in defining what exactly they do in the delivery of nursing care' (D3P11)

The concept of nursing constantly changing and evolving to meet the needs of the patients and taking into account new knowledge is generally considered to be a

strength. However, has the nursing profession adapted to changes and evolved by its own volition or have its changes been enforced upon it? In other words, is the profession of nursing in control of its make up and future direction or are other more powerful forces at work?

Iley (2004) suggests that by accepting continued changes to the role of the nurse, the core function of nursing has become obscured and the profession is still viewed in terms of a role that is subordinate to, and dependent on, medicine. Iley (2004) suggests in her conclusion that nursing needs to discard the attainment of a professional status that is parallel to that of medicine and focus on what is needed to re-establish the role of nurses as care givers, rather than 'technicians responding to the needs of medicine and managers'. One Director of Nursing commented:

'I would fear for the role of the Director of Nursing for the future that Value For Money experts may see it as supplementary to requirements, albeit on average that I put in 70 hours a week in my working life' (D5P13)

The concern for the Director of Nursing is that if the profession that they represent has so many definitions and is always changing, others, outside the profession will interpret one to suit their own needs. If the profession is not in control of its own evolution, then it risks being manipulated to suit the needs of other health care professionals whose motives might be questioned. If there is no consensus, I would suggest that other (more powerful) professions will have their own interpretation of what nursing is and what nursing does. The following extract from interview number three helps to illustrate the point:

'standardise the direction we're going, so that nurses know where they are going, the general direction that nursing is going...nursing is floundering because there has been so much change so quickly' (D3P1)

However, using Dilenschneider's Evolution of Power table (see below) to demonstrate how nurse leaders have changed to adapt to the prevailing orthodoxy, Feldman (2001) suggests that having the ability to be flexible in the role is crucial if they are to survive in a constantly changing world. These changes have been in the form of a shift from administration to management to leadership. Feldman goes on to suggest that nurse leaders must be agile in reframing their responses if they are to survive in dynamic, changing organisations.

The 1950's and 1960's	The 1970's and 1980's	The 1990's
Power as administrator	Power as manager	Power as leadership
Conformist	Exception-driven	Visionary
Chain of command	Ad-hoc	Instant
Stable	Turbulent	Sustaining
Introspective	Market-driven	Positioning
Apprenticeship	Mentoring	Collegial

The Commission on Nursing identified that the Director of Nursing role needed to change, to become more strategic and less operational. The Directors of Nursing, in this study, would appear to be trapped between these two paradigms. They strive to be strategic and lead policy within the organisation, yet they are still operationalised and unable to avoid getting caught up in the day to day running of the hospital. I suggest that this situation has occurred whilst attempts to change the role of the Director of Nursing have been made from within nursing, but the perceptions of the role outside nursing have not. And, perhaps more importantly, the change of title and subsequent role may not have been welcomed by all within nursing, as the following extract from interview seven illustrates:

'The Director of Nursing at that time, they were seen by the commission people as being outdated and outmoded and not knowing where they were going and that was a mistake because they did very much know where they were going' (D7P11)

In a history of nurses as managers in Ireland in the late nineteenth and early twentieth centuries, Carney (2005) claims that women in nursing care were utilising many twenty-first century management principles and skills, but were not recognised for them and the managerial aspects of their work have stayed unrecognised. Carney is suggesting that the announcement in the UK to re-introduce the hospital matron is an indication that the place of the nurse manager has come full circle in the modern hospital structure. However, the modern matron in the UK does not resemble the 'old matron'. The modern matron has a defined set of responsibilities for the quality of care of three or four wards (Savage and Scott 2004). The matron of old, to whom Carney is alluding, effectively ran the whole hospital; there was no CEO or General Manager. Thus to compare them is rather futile. What is perhaps more noteworthy is the fact that the public in the UK perceived the decline in standards in hospitals with the decline of the role of matron and thus the role was re-introduced, albeit a watered down version (Hewison 2001). What I think is relevant for this study, is that Carney is probably right when she identifies that the skills and knowledge that matron had were not recognised and valued (Savage and Scott 2004). Since the introduction of the CEO and/or the General Manager, the role of the Director of Nursing has become something different. Whether this change is good for the health service and for nursing, although difficult to measure, remains to be seen.

In an editorial examining why nursing needs political leaders, Antrobus (2004) comments that nurses struggle to articulate nursing and to describe in a meaningful way the knowledge, skills and competence that are part of the daily practice of nursing. Landreneau (2002) states that he believes the profession of nursing and the professionalisation of nursing should and will continue to forge its own way through the continued use of philosophy, theory and knowledge. How true this statement is in the Irish context is discussed by Hyde et al (2004). When examining interprofessional relations in health care, Hyde et al (2004) suggest that a separate body of nursing theory continues to remain underdeveloped and they claim that this vacuum represents '*the single most difficult challenge for those aspiring to full professional status for nursing*' (p.246). Whether nursing does or does not yet have a separate body

of knowledge and whether it is a semi or full profession or not remains debatable. The relevance of this argument for the Irish Director's of Nursing is that in order to be aware of subtle changes to their role (which may or may not come from outside forces), they need to be entirely certain of the lawful work of nursing. This in turn will impact on what the lawful work of the Director of Nursing is. The alternative is that the Director of Nursing role will be eroded as they agree (knowingly or unknowingly) to take on more and more areas of responsibility outside of nursing's lawful work. Thus, in Ireland we may end up with no Director of Nursing as occurred in the United Kingdom in the 1990's.

4.2.3 Core Category: Being a woman nurse

Feminism has been adopted by nurse theorists as a method of highlighting how women are dominated and oppressed by the medical and more latterly the managerial patriarchy (Sigsworth 1995). Nursing care is delivered in a health care hierarchy that is bureaucratic and authoritarian in nature (Condell 1998, Sigsworth 1995). Much has been written about the fact that nursing is made up of mostly women and as such has become marginalised, oppressed and apolitical (Salvage 1985, Roberts 2000, Davies 1995). Hyde et al (2004) note that:

'..while efforts at formalising nurses' decision making seem to hinge on identifying a separate body of knowledge which is jurisdictionally nursing knowledge, the structural dimension of medical dominance remains a major obstacle to the articulation of such knowledge' (p.253)

According to Hyde et al (2004) the fundamental problem for nursing is a lack of formal recognition for its contribution, by medicine. The power that nurses exert over care, is *informal power*, which has been given to them by medicine, power that can be taken away at any stage should physicians wish to re-assert their authority. Power is 'extrapersonal', meaning that an increase in power has to be compensated by somebody else surrendering part or all of their power (Kuokkanen and Leino-Kilpi 2000).

Nursing is continually trying to shake of the stereotypical images of the nurse as the doctor's handmaiden, nurse as ministering angel, nurse as domestic worker, and nurse as subordinate professional (Chiarella 2002). One Director of Nursing commented:

'I think we have been the underdogs for so long, the hand maiden and I think there is an awful lot of the hand maiden culture thing and I see more and more of it, yes doctor, no doctor' (D9P13)

Brooks and Brown (2002) whilst examining the role of ritualistic ceremonial in removing barriers between subcultures in the NHS identified that a nursing sister needed the agreement of the consultants to stop the practice of waking patients at 6am. Although nurses are thought to organise the care environment, clearly they feel they can organise it only up to a certain indefinable point (Latimer 2000). Why the nursing sister felt the need to ask for the consultant's permission to stop the practice of waking the patients at 6am is not discussed by Brooks and Brown.

Davies (1995) discussed the image of the nurse as woman. Nursing and nurses appear to be secured in the public mind in the guise of the female sex. Not only this, but there is little sign of the male sex moving beyond the 8-10% of the qualified work force (ABA 2005). However, Davies goes on to claim that the 'cosy' image the public has of nursing as comforting, caring and nurturing is far from the truth, that most nurses love their work but hate their job is a common mantra. Davies (1995) contends that nurses will often report that they are not being allowed to get on with their job of nursing and that they are not gaining the respect they deserve. This concept of needing to be valued, respected and to be visible was omnipresent throughout the interviews. Only one or two Directors of Nursing, however, linked these concepts to the concept of oppression, either as a cause or as a consequence of their position. One Director of Nursing commented when discussing why nursing is not valued:

'sometimes people would say that maybe its because of our history, we are always seen as a subservient profession' (D6P16)

Another commented when discussing the lack of recognition from general management:

'maybe it's because it's a feminine profession predominantly, em, and we tend to under recognise our own achievements' (D7P1)

Hicks (1996), in a now somewhat dated but nevertheless relevant article, warns that good male nurse researchers may not be viewed with the same negativity as good female nurse researchers. Hicks suggests this is because male nurses are seen as marginal or atypical of the profession so the impact of their activities is limited and thus they do not become unpopular with their colleagues. The consequence of this prediction, Hicks claims, is that female researchers will be consigned to lower kudos activities, thus confirming them as subordinates. Hicks (1996), concludes that the progress of nursing as a research based profession will be left in the hands of the male minority. Whilst the impact of Hick's study is not directly relevant to this study, I think an important parallel can be made with female nurse managers. The proportion of managers who are men compared to the proportion of male nurses is disproportionate¹⁰ to the number of female nurses who are managers. Thus the progress of nurse management could be left in the hands of the male minority.

Kanter (1993) identifies four stereotypical roles that women have to compete against in the workplace in order for them to be seen as equal workers alongside their male counterparts. The 'mother earth' role depicts women as nurturing and caring, whereas the 'seductress' role casts women as sex objects whose function is to titillate men; this stereotype can lead to women becoming victims of sexual harassment. The 'pet' role stereotype views women as mere decoration rather than equal partners and

¹⁰ Three out of eight of the Directors of Nursing of the Nursing & Midwifery Planning & Development Units in Ireland are male. However, males account for less than 8% of nurses entering the register.

finally if any woman rejects the first three stereotypes and tries to assert herself she will be cast into the 'iron maiden' role, and be labelled as tough, dangerous and even unfeminine (p.233-237). Kanter (1993) suggests it was often easier for women to accept the stereotyped roles rather than fight them, even if doing so meant limiting the range of expression or demonstration of task competence, because accepting them offered a comfortable and secure position, as one Director of Nursing commented:

'it's the gender thing, and the traditional place of....,I don't want to get into a feminist debate. There is a place for women in Irish society and that is slow to change and yes you're a nurse, a good little girl kind of thing' (D7P10)

This comment would suggest that this particular Director of Nursing has insight into the gender issue, but yet did not want to get into a feminist debate. She realises that there is place in Irish society for women and that this is replicated in nursing. She makes the point that you have to be a 'good little girl'. Good girls don't threaten the status quo nor ask awkward questions. This quote from Kim Walker's unpublished PhD thesis, although rather long, I think demonstrates the point:

'The pre-eminent value inherent in the technique of sensibility I call 'being nice' is one that insists that overt conflict must be avoided wherever and whenever possible. This sensibility is sanctified in our culture that a good woman does not contradict. A nice woman does what she is told...by extension then, a good nurse takes what she finds (or is given) and does not question. A nice nurse must therefore be a good nurse. The behaviour this technique initiates in one of backing off, assuming a passive posture, or silencing oneself. It is a technique or sensibility which shapes (us) in pervasive and powerful ways. The reciprocal behaviour such a technique of sensibility elicits is one that is generally tacit, it does not usually ever come to expression. The combination of value, behaviour and response leads to a form of silent but mutual agreement between the individuals engaged in the conflict situation...it gently insists that no further dialogue is needed to resolve the situation. (Walker, 1993, p.145)

4.2.4 Core Category: Lack of Collegiality

Collegiality is an integral part of a professional culture (Chaboyer et al 2001). There is relatively little written about collegiality and cohesiveness among nurses. To date the focus of the literature has been on horizontal violence and aggression. As discussed in chapter two, Farrell (1997) describes horizontal violence as nurse on nurse aggression. This aggression can range from overt and covert non-physical hostility such as criticism, to sabotage, undermining, infighting, and bickering to non-verbal innuendo and actual physical assault. All of the Directors of Nursing exhibited some of the traits of horizontal violence. Although I think that 'violence' is too strong a word, it was more like 'mud slinging', ranging from direct name calling criticism, usually about more senior nurses or nurses in other jurisdictions to overt attempts at sabotage. The divisions and hostility between the Dublin Academic Teaching Hospitals (DATHs) and the non-Dublin based hospitals was perhaps the most evident. Superficially, the DATHs appear to be united and working towards common goals, however they are not successful in influencing national policy. One Director of Nursing commented:

'I suppose from a professional point of view unless, and I know I am saying this, and yet I am not willing to do it myself, unless we speak up as a group we haven't a hope in hell' (D7P20)

Another Director of Nursing outside the Dublin area (TMD4) commented that the DATH's only recently invited the other Directors of Nursing from the Band One Hospitals to their meetings, and they do not go to all of them, only the ones where there is an agenda of mutual interest. Another Director of Nursing hinted, very hesitantly, that the Directors of Nursing nationally are not united and are not singing from the same hymn sheet. The impression from the non-Dublin Directors of Nursing is that the DATH's seem to dominate and this domination, they argue is re-enforced by the Chief Nursing Officer who has not met with the Directors of Nursing nationally (TMD5P13). When referring to the invisibility of the Chief Nursing Office outside the ERHA, one Director of Nursing commented:

'No she doesn't, and that is known out in the wider world, they go in to meet her in the DoHC,¹¹we are different here, we are different in Dublin, that attitude has to change, it pisses the other don's off, together we will conquer but divided we will defiantly fall' (D11P2).

Davies (1995) observes that nurses are hard to help; in general they seem to be defensive and difficult. Davies argues that the problem with nurses is that they do not seem to know what they want, further claiming that they will agree with this assessment. It is the deep divisions within their own ranks that are the cause and the lack of nurses who are willing to engage in overt political action is at the heart of the problem. One director commented:

'if there is a nurse on the spit, there will a nurse turning it' (D7P9)

The following comments again demonstrates how frustrated the Directors of Nursing outside Dublin feel about the lack of cohesion among them as a group.

'Quite honestly I mean the band one hospitals in Dublin got their act together with the DATH's hospitals. We tried to become involved in that as Directors of Nursing in the other Band One hospitals out the country and we are invited to 2 or 3 meetings a year. Now I have attended one or two of those meetings but I haven't been as proactive as I should be because I you know, it's very hard to become ...,now its difficult, they have developed their own policies, protocols in relation to the issues they have and they,.. maybe,...have different to the issues we have. But certainly they have developed a whole em report on the whole recruitment issues, they will have other issues, now I mean I do think as a small island we need to be very very united, we need to be cohesive, we need to be bound together on all of these things if we want to be counted, now ok, em, the medical professional will stick together like glue, they

¹¹ Some text has been deleted for confidential reasons. *Defiantly* is the correct word here, although it sounds not quite correct.

will no matter, they are like spiders at a funeral, I mean they will no matter where the problem is they may not agree at all but they will certainly support one another, we are bad at that' (D5P14)

The concept of division appears in different guises. The Directors of Nursing are not one collective voice, and they cannot seem to get their message across. Whether it is influencing the Department of Health and Children on student ratio numbers, inequalities in salaries or getting together to address the agency nurse pay bill. Despite this the Directors felt that they had a good networking system. However, the effectiveness of this networking at achieving common goals was evident in the demonstration of frustration at not being heard at national level. If power is understood in terms of attaining selected goals (Sieloff 2004), it can be asserted that the Directors of Nursing have little collective power as they cannot seem to achieve their collective goals.

Gavin (1995), examining the introduction of the grading system in the UK in the late 1980's, points out that nursing lacks control over its practice, is fragmented in its representation and that its semi-professional status is reflected in its lack of occupational control. In his UK study, Gavin surmises that nursing as a pressure group is fragmented in comparison with the relative unity of the British Medical Union. It would appear that the Directors of Nursing, especially outside the Dublin area, feel powerless to work together as a group; they realise the potential of their united voice but seem helpless to make it happen.

Farrell (2001) attempts to offer an explanation for staff conflict beyond that of the oppressed group behaviour and feminist perspectives. In a review of the literature, he suggests that there are three levels of explanation: a macro level, which highlights nurses' relationships with dominant groups, a meso level analysis which looks at organisational structures, including workplace practices, many of which are controlled by nurses and finally a micro level analysis, which focuses on the interactional nature of interpersonal conflict. Farrell concludes that it is not just

oppression that restrains and inhibits nurses but nurses themselves who in their day to day work and interpersonal interactions act as *'insidious gatekeepers to an iniquitous status quo'* (p.2).

This extract from interview two demonstrates how a Director of Nursing, who wanted to introduce a new nursing role, received resistance from the Dublin Academic Teaching Hospital's Directors of Nursing not to introduce the role:

'a lot of resistance from Band One hospitals, themselves the directors and the Chief Nursing Officer, but I held my own, I said we are going to pilot this and see how it works. Yes, and can I make one final comment, this might sound a bit bizarre, but I think Directors of Nursing have to loosen up a bit, what I mean is that you know that collectively we could be a very influential group of people and we need to loosen up our thoughts, to respect each other, get together and drive change together. And sadly I don't think that happens, it shouldn't be a competition, is your hospital doing better than mine or are you doing this' (D2P21)

This Director of Nursing commented in relation to the Nursing and Midwifery Planning and Development Units:

'To be quite frankly honest I don't see them of any benefit at all, that's quite direct' (D2P11)

The Director of Nursing in this instance was arguing that the introduction of the NMPDU in her area was a waste of time. For her, they became one more bureaucratic layer to get through. Instead of seeing them as useful allies she preferred not to engage with the NMPDUs. Davies (1995) makes the point that due to the diversity and sheer size of nursing, it will always be very difficult to gain consensus. Dargon (as cited in Farrell 2001) suggests that horizontal violence proliferates in nursing because it re-enforces the hierarchical structures and preserves the status quo. This

director was disgusted that her colleagues in the Band Two hospitals might have been paid the same as those in the Band One hospitals¹²:

'within nursing in the country in band 2 hospitals, in hospitals with less responsibility or accountability than a band one, there are deals done, and I can tell you that many of the band two hospitals are earning the same salary as us. And there ARE specials deals done, they are getting allowances for this and that, so there isn't equity across all Directors of Nursing and that does annoy me, I could work in a band two hospital with less responsibility and less autonomy than I have here and earn the same salary' (D3P15)

The overt anger that this director was expressing at her colleagues who had (or had not, as she had no real evidence) negotiated a better deal for themselves is evident. Why this Director of Nursing should be concerned about another colleagues' salary is not evident. Perhaps more interestingly, another Director of Nursing who had been a Director of Nursing in a Band Two (quite a few had taken this route), commented that being a Director of Nursing in a band one was actually easier because the structure of the organisation was more established. For example she commented that the human resource function in band two hospitals lay with the Director of Nursing, but in the band one hospital a Human Resource department took over the function.

4.2.5 Summary

This section has identified how the Directors of Nursing are socialised into a certain pattern of behaviour. The lack of collegiality among them as a group has been well documented in the literature and the finding of this study would support the literature. The gender implications for the Directors of Nursing have also impacted on their powerlessness, as women have traditionally been oppressed and marginalised from society. Leahy and Wiley (1998) writing about the Irish health system in the 21st century are surprised to be told by representatives of the nursing profession that they

¹² Each of the Five Bands of hospital have a different pay structure. Band One being the highest salary, Band two the next highest and so on.

feel undervalued and have low self esteem. They concur that the role of the profession is ill-defined and poorly understood within the health services. The wider societal equality gained by women has not yet filtered through to the hospital setting. This, they argue, is due to the predominantly female nursing profession and the mainly male consultants. How the Director of Nursing works within this unequal system is now discussed in 'circumnavigating the system'.

4.3 Core Concept: Circumnavigating the System

4.3.1 Introduction

The core concept of Circumnavigating the System refers to how the Directors of Nursing have to navigate their way through the health service in order to have a voice, to be listened to and to overcome the difficulties associated with having to balance the operational and strategic role with the political issues that prevail. The core categories of 'institutional arbitrariness' 'not being heard' 'politicking' and 'relationing' build the case for the core concept of circumnavigating the system.

It ought to be stressed at this point in the discussion that the organisational structure within each hospital varies slightly. Some hospitals have boards of hospital management, hospital executives, and boards of governors that all have varying levels of influence on hospital decisions and funding allocations. Whatever the structure, the Director of Nursing is currently caught between the two wings of operationalism and the strategic role function (Fradd 2004). It is within this context that the Directors of Nursing have to negotiate their way for finite resources and for recognition of the value of nursing. They also appear to be constantly struggling to raise the profile or visibility of nursing. Consequently, in order to function effectively within what appears to be an arbitrary system, they are forced to circumnavigate the system itself.

4.3.2 Core Category: Institutional Arbitrariness

Institutional arbitrariness refers to the manner in which the organisation of the hospital is managed and more importantly how the manner in which it is managed is accepted by the Directors. In spite of the service planning process and the formal structures of legislative powers invested in the CEO, much of what appears to happen within the organisation is dependent on the ability of the individual (not necessarily just the Director of Nursing) to be able to influence. This influence is dependent on what I have termed 'relationing' and 'politicking'. Without the skills inherent in these

concepts, the Director of Nursing risks being marginalised and ineffective in her post. As one director commented:

'you have to be very Machiavellian in a hospital, you have to get very good at playing politics, sewing the seeds, pre-meeting meetings' (D10P5)

Another example of the arbitrary nature of the hospital was expressed by the same Director of Nursing when I was asking about the best way to manage such a complex system as the hospital:

'waste of time and effort and resources so frustrating, and you are right people don't feel valued because there is such fighting having to go on, a lot of that stuff, its all funding related..., this thing is farcical' (D10P6)

And by another Director:

'in the organisation where I work there is a lot of people doing a lot of things but there is no collective approach, and standardisation of, even reporting, across all professionals' D2P16

The influence of parish pump politics¹³ is a contributing factor to this arbitrariness. Many Directors of Nursing talked about getting phone calls from local Teachta Daile (TD's) or senior people in the health board asking questions about service delivery. As one Director commented:

'I certainly wouldn't underestimate their influence particularly when you are talking about a health board, you could get a phone call from someone very senior in the health board to say well what's wrong with accident and emergency or why is x on a trolley or this, that and the other it takes up a lot of time and energy' (D2P15).

¹³ Parish pump politics refers to the influence that local TD's can have on national policy decisions. The parish as it were 'pumps' the wider political agenda. Local politics thus fights far above its weight.

These phone calls will have been made in response to a local constituent contacting their local representative and that representative then asking questions and demanding changes in service delivery. Thus the institutional arbitrariness is legitimised.

Another way in which the institutional arbitrariness is evident is the actual organisational structure of the individual hospitals. The Director of Nursing in a Health Board hospital will regularly, but not always, report directly to the assistant CEO of the Health Board, not the General Manager of the hospital. As one Director of Nursing commented:

'And you can see the conflict there for the General Manger because they (the Director of Nursing) don't report directly to the General Manager, it's a crazy system, so like to be fair to a General Manager he has very little clout, only operational to try and do something (D2P10).

Thus any decisions the General Manger of the Health Board hospital makes can be overridden by the Director of Nursing if he or she does not agree with it. In the Voluntary hospitals however, the Director of Nursing reports to the CEO of the hospital, thus allowing for a slightly less arbitrary organisational structure.

Another example of how arbitrary the organisation appears to be is summed up by this rather long but yet invaluable insight into how the process of appointment of a consultant can affect the Director of Nursing.

'Sometimes you may not always know what's in the pipeline, take for instance new consultants and new developments. The consultant comes and if you are lucky enough and you have your ear to the ground and you will know what's happening, so you will be saying look right this consultant is coming, what is the commitment of this consultant to this hospital for instance, because in recent years, the consultant is no longer appointed to one hospital, they would have sessions in other hospitals, which is fair enough, that has worked quite well here, it has been to our advantage but the

only thing is you may not know that this is a very important appointment at a very high level, at CEO level and if you don't know if this appointment is at an advanced stage, you wouldn't have had the opportunity of putting in your service plan, have something put in, it's hard because you don't have the person in place and every consultant has their own views on how their service should be running, but you could end up, a consultant was appointed and there was no nurses to go with him, and then there was war when that person actually came on site (D6P3).

The arbitrary nature of how hospitals function is not alluded to anywhere in the literature. The organisational literature abounds with discussion about the best way to manage and run a health care system (Leahy and Wiley 1998, Malin et al, 2002). But perhaps only Maeve Ann Wren has managed to capture the arbitrary nature of the Irish health system (Wren 2004). Wren articulates that the Irish health system appears to be in a state of permanent crisis. She goes on to suggest that the Irish health care system 'defies rational analysis'(p.16). However, more importantly for this study, Wren apologises to the nursing profession in the preface of her book for not exploring in detail the nursing profession's contribution to health care. Thus, I think Wren inadvertently and without malice, supports the theory that the Directors of Nursing are powerless in their impact on how health care is delivered in Ireland.

The debate about how the health services in Ireland should be managed and structured has lingered on for years. Doherty (Leahy & Wiley 1998 ed) asks:

'did we really need eight boards, given the amount of money we were spending on health care, why was the citizen not receiving a more comprehensive service?' (p257)

The Report of the Commission on Health Funding (Government of Ireland 1989) was extremely explicit in its condemnation of the structure of administration and management in the health service of the 1980's:

*'the representation of local, regional and national viewpoints in the planning of services and in reviewing their adequacy and quality is a **political** activity. The management of services in pursuit of objectives determined by the political process is an **executive** one. These functions are entirely different but in the present administrative structure they are intertwined, to the detriment of both' (p.151)*

Many of the comments in the Report still have a clear resonance today. For example:

'the Minister for Health is also expected to deal with...the most low level executive work, the department of health is very much involved in the day-to-day management of large areas of the service' (p.152).

This quote from one Director exemplifies this:

'I remember getting phone calls from the DoHC about operational issues' (D1P4

The Report of the Commission on Health Funding continues by asking 'who is in charge' (p.156). The Minister is responsible to the Oireachtas, yet the accountability of those providing the service is less clear.

The Report on Certain Issues of Management and Administration in the Department of Health and Children Associated with the Practice of Charges for Persons in Long-Stay Care in Health Board Institutions and Related Matters (Travers 2005), otherwise known as the 'Travers Report'¹⁴, concluded, that the fundamental reason for the illegal charging of residents in state-run nursing homes:

'lies in long term systemic corporate failure at the overall level of the Department of Health and Children' (p.76).

¹⁴ This report concerns the illegal charging of residents in nursing homes in Ireland. The nursing home fees should have been paid for by the local health boards but the residents were made to pay, this went on for a period of thirty years.

What the Travers report fails to do is point out where the responsibility and accountability for failure lies. Travers ambiguously *asks* where the accountability and responsibility lie for the thirty years of illegal charges:

'Where lies the balance of morality involved. Attempting to arrive at any such conclusion does not fall within the terms of reference of this report. Were it to do so, I certainly would not be equipped to provide an answer. Who exactly would be so equipped appears highly indeterminate' (p.77).

It would appear that the author of the report is unclear where the accountability for the health services lies, nor indeed where to look for it.

What is evident is that the Director of Nursing working in the Irish Health Service has accepted (willingly or unwillingly) the way in which the system is managed, even though it appears to be arbitrary.

The following theoretical memo helps illustrate this institutional arbitrariness:

It is as if the Director of Nursing can't change the way processes are adhered to I wondered had they ever tried? She even agrees with me that it is not a great way to run an organization, but she justifies by it saying that everyone has to fight their own corner (TMD5P4).

When reading the Directors of Nursing interviews over and over I could not understand how they thought they could influence policy via the Department of Health and Children. However, on consideration I realised that they were not attempting to influence policy but attempting to influence the allocation of monies from the Department. This would appear to be an accepted form of practice, thus re-enforcing the findings of the above reports: the Directors of Nursing legitimately 'play' the system in order to achieve their goal and they can do this because the system allows them to. However, what is not clear is how successful the Directors'

were at getting money from the Department of Health and Children. The fact that they bypass the organisational structure of their hospital and directly negotiate with the Department of Health indicated to me that they are creative but powerless, within the confines of their own organisation.

In 2003, an *Audit of Structures and Functions in the Health System* was commissioned by the Minister for Health and Children (Government of Ireland 2003b). The report is unequivocal in its criticism of the lack of accountability, unwieldy governance and lack of clarity of roles (p.9-10). The findings indicated that extensive reforms are required and suggested that the report itself addresses many of the underlying difficulties experienced by health professionals in carrying out their work. These reforms are currently being implemented.

When referring to the reform of the NHS in the UK, Bradshaw (2001) makes the point that the real locus of power is the consultants and that despite some 'cosmetic evidence', policy changes still allow for 'unbridled historic privilege' of their clinical autonomy. He makes the point that it is the medical profession that is the spending agent of the NHS and he suggests that the power and influence that comes with this will not be disturbed. The following quote from interview 11 helps to illustrate how some consultants feel about hospital administrators:

'I remember a few years ago we were walking across the yard after a meeting and there was a consultant caught in a lot of difficulties or whatever and he was walking behind us with another consultant and he said to the other consultant, why should I take advice or direction from that pipsqueak of an administrator when he is on such a pittance of a salary, so he was being judged on his salary' (D11P2)

The Directors of Nursing in this study perceive that they have significant spending power. I would argue that their spending clout is swallowed up in the pay budget. If a Director of Nursing has 800 Whole Time Equivalents (WTE) in her establishment, this amounts to a large pay bill. She can juggle posts and make a staff nurse post into

a clinical nurse specialist post, *as long* as there are no significant budget implications. In other words although 'her' staff may account for 30%-40% of the hospital budget, the money is already allocated and in order for her to increase her WTE's she must negotiate and bargain.

It became apparent that the manner in which the health services are managed has an effect on the behaviour of the Directors of Nursing. They constantly have to fight for resources, navigating and negotiating their way around their own governance structure. They have no alternative but to accept the way the system is managed because to fight against it would render them more powerless than they already are. Two of the Directors of Nursing were working in organisations (both health boards) where the hospital management committee had been dissolved because of internal difficulties. Other Directors of Nursing admitted that there must be a better way to run the system and one commented that there was a problem with the way the health system is run. The service planning processes were also identified as a totally inept way to manage the system. Even when the Directors of Nursing identified the nursing priorities and pressure points, nothing was done to relieve them. Again the concept of not being heard is evident. This quote from interview six illustrates the point, the discussion between the Director of Nursing and the researcher was around whether the service planning process was a good method:

'I think here, I must say, I don't have a problem with the method. It's actually getting results from what you have put forward, also here what we have done is from a nurse management point of view, we would actually have put down what we would see as priority areas ok? We did that last year- just on one page – what we see as the pressure points here for us and to date we have got nothing to actually relieve that.'

(D6P4)

Dawson (1999) asks if health is just another commodity, is it just a more complex collection of goods and services? She suggests there are five spheres that contribute to the complexity of the health care system:

- The public sphere with its infinite demand
- The political sphere with funding regulation and party politics
- The professional sphere with occupational diversity and professional dominance
- The scientific sphere with its infinite supply of scientific, knowledge and technological applications
- The industrial sphere of powerful global industrial investment (p.12).

Dawson comments that if we examine one sphere alone, it will expose a highly complex set of players, relationships, power, influence, change and uncertainty. Dawson goes onto to declare that in terms of comparison with other organisations, the challenges for management of health care are similar. However, because of the diversity and strength of the pressures on supply, demand and the political contribution, the challenges to health are amplified.

Dawson (1999) concludes that acknowledging and managing boundaries is a crucial part of sustaining a successful health care system, because an action in one part of the system can have far reaching consequences for others. I would suggest that it is nursing and nurses that are usually most affected by actions, or inactions, within the organisation and that the Directors of Nursing are continually striving to influence those actions or inactions. Their success depends to a large extent on their relationing, politicking and navigating skills.

The Directors of Nursing commented that without medical support, introducing new ways of working (e.g., Advanced Nurse Practitioners, nurse-led pre admission clinics, clinical nurse specialists, etc) would not succeed. As this Director commented:

'No I suppose the obvious one is the ANP roles where you have to negotiate with consultants because they are going to do something that hasn't been done before' (D1P12)

Over and over again, nursing development is perceived as only being allowed as long as the medical profession allows it to happen.

What is evident from this study is that the Directors of Nursing work in, at the very least, a poorly managed system, with unclear lines of demarcation for responsibility and accountability. The Directors of Nursing are central to keeping the hospital functioning twenty-four hours, seven days a week, three hundred and sixty-five days a year. However, because of their low value within the health care system (Daiski 2004), the fact that they are nurses and women (mostly) and because of the divisions within nursing itself (Sieloff 2004), they depend on and have to rely on good working relationships. Their omnipresence and ability to be flexible and change their roles to suit the prevailing orthodoxy weakens them as power brokers within the organisation. However, their paradox is, if they were to stand up and assert themselves individually, they think the tentative power they have could be taken away.

4.3.3 Core Category: Not Being Heard

The concept that no-one is listening is a constant theme throughout the interviews. Not being heard occurs at two levels: locally, within the hospital and nationally, within the Department of Health and Children. By repeatedly claiming that no-one is listening, the Directors of Nursing are unconsciously admitting their own inability to influence and thus re-enforcing the concept of powerless responsibility. This lack of influence is mostly referred to in the context of national policy, but also occurs at hospital level.

In a study of management in the Irish health services, Flynn (1998) found in 13 unpublished theses that hospital management structures were described as bureaucratic, centralised and controlling. Irish nurses were found to have a limited role in managing the health services at the highest level and this function was found increasingly to be conducted by general managers. The report goes on to say that:

'the role of matron was initially that of leader and manager in the health service, however this role has been refined to that of one specifically relating to nursing management' (P.132)

The Director of Nursing is responsible for nursing and nurses but traditionally held responsibility for running the whole hospital and keeping it functioning. That overarching role has been eroded (for various reasons). This leaves the current Directors of Nursing in a state of confusion about their function (Jasper 2004, Clancy and Delaney 2005).

Many of the directors commented on the volume of data collection with which they now had to comply. Some directors were extremely angry with what they perceived as the time wasting this involved. Again, this points to their sense of powerlessness. The Directors of Nursing are obliged to submit human resource data to the Nursing and Midwifery Planning and Development Unit, the Health Board and the Department of Health and Children. The Directors of Nursing commented that this information in most cases is the same. Their sense of futility and frustration stems from the fact that they see no improvements in the nursing situation and no improvements in the delivery of quality healthcare per se, in spite of the volume of data that is supplied. One director commenting on the figures that she sends into the health board stated:

'but these figures that are going out there, nobody is validating them, there is nobody comparing that data that has been collated, it is not being used for any purpose' (D3P5)

Pelletier and Diers (2004), Diers et al (2000) and Diers and Potter (1997) identify the necessity of effective information technology that should be used to deliver timely and accurate information for modern hospital nursing management, in order to allow for the effective use of resources to fit patient requirements. Pelletier and Diers

(2004) argue that in the Australian context, massive data collections are often not used effectively to generate meaningful information to help inform decision making.

The same director expressing her anger at the Department of Health and Children and the health board commented:

'they are not listening to people like us as Director of Nursing, when I say 'they' I mean maybe nursing in Ireland, maybe the health board and the Department of Health' (D3P5)

It would seem that data is a double edged sword. On the one hand the directors are trivializing the necessity of sending in data to the organisations already alluded to, but on the other, they say that when they have the relevant data to build a case, they are not listened to. One director highlighted this when discussing the need for a call bell system to be introduced. The following passage from interview 6 illustrates this:

'I suppose if I give you a simple example of about a year ago we noticed that we had quite a large percentage of patients falling out of bed, there was a nursing survey done and what was found was there was a problem with patient bells, so that was highlighted, we decided at a nursing management meeting that from a certain period that all issues to do with call bells and falls, was to be documented in a risk management form, so this went on for about a year before we could actually get a complete new system in the hospitals so since then the number of falls have reduced considerably, that's just one small example, yet that was causing nurses an awful lot of aggravation and for nurse managers, it shouldn't be, our word should have been accepted, that there is a problem here... that's a problem for nursing, the frustration I think particularly at senior nurse management level, at times, I mean this is only one small example, but I think you could use that as a parallel for other examples. (D6P3)

The issue in this example is not one of the Director resisting the request for evidence to demonstrate the need for a functioning call bell system, but the fact that their

expert opinion was not good enough. It would seem that such an important health and safety issue, as patients having access to a call bell would not require much evidence to demonstrate the importance.

Over and over again, all of the Directors talked about nursing needing to be valued, to be respected and to be listened to. I think it is fair to comment that if the Directors of Nursing felt they were being listened to then they would feel valued and respected. When I asked one of the directors why she felt it was necessary to comment that nursing *was* respected and valued in her organisation, she changed her argument by saying she thought that it wasn't respected in *other* hospitals. She became defensive and said maybe there was no need for her to say it but she felt that in other hospitals nursing was not respected.

Storch (eds) et al (2004) in an essay examining health care ethics identify that the ethics of organisations is not something that has been widely discussed to date. They claim that organisations have not necessarily always functioned in the best interests of the people they are meant to serve nor the people they employ. They cite examples of clinical disasters where it became evident that nobody listened to the nursing staff, and where even the nurses themselves felt threatened. One solution to these complex organisational ethical issues, is the use of professional guidelines or explicit statements of responsibilities for individuals at all levels of the organisation (Storch et al 2004). This, one assumes, is intended to help demarcate the responsibilities and roles and may redress the issue of not being listened to for nursing and the Director of Nursing.

Davies (2004), comments that nurses' voices are not sought and if they are offered, they are rarely heard. The following comment has a strong resonance in this study as one Director of Nursing commented when discussing how they are not listened to:

'you might as well not be here, from an external point of view (shouting) you MAY AS WELL NOT BE HERE!' (D3P16)

Davies (2004) is commenting on the lack of political leadership ability in nursing to influence national health policy. As a consequence of this deficit, the implications for health policy and organisational change for nursing are ignored. This concurs with the findings from this study - the Directors of Nursing find it difficult to influence at an organisational and national level. This statement from interview nine illustrates the helplessness that the Director of Nursing was feeling:

'We wrote to the Department of Health about the student nurses because of the rostered year, there was no one actually discussed it with us. We discussed it amongst ourselves but nobody from the Department of Health came out to discuss what we were going to do. Nobody at the university, they are completely at a loss as well, they didn't know what was going on, so people were deciding what was happening. There was also, and that's what got up the backs of the DATHS basically. They were deciding on how much these students were going to be paid and what the ratio was without talking to any of us' (D9P14)

This comment, I think, demonstrates the importance for the Director of Nursing to have a good relationship and a working knowledge of who's who within the Department of Health and Children. Not having a working relationship or a direct contact within the Department of Health and Children renders the Director of Nursing impotent when looking for extra funding or posts. The concept of relationing within the context of institutional arbitrariness is now discussed.

4.3.4 Core Category: Relationing

All of the directors spent a lot of time talking about their relationship with the CEO, the General Manager and/or the medical consultants. In situations where the director had a good working relationship, their job was perceived by themselves to be much easier. However the converse of this is that where the relationship was poor, the Directors of Nursing found it extremely difficult to function effectively and a constant state of tension was created. This tension became exacerbated in those

Directors of Nursing who worked in a health board hospital, simply because they did not report to the CEO (or general manager) of the hospital but to the deputy CEO of the health board.

'I am trying to identify when you mentioned things about my job that are important to me, organisational structure is really important, the second thing that is extremely important and is the reason probably why I will still be here longer than my last job, is the relationship with the CEO. And the recognition by the CEO or a willingness by the CEO to allow you to develop, both as an individual manager as a healthcare manager and not just keep you in the Director of Nursing box if you like (D1P2)

'so I think actually a core issue was poor relationships with the general manager'(D2P6)

If the relationship between the CEO, other key stakeholders and the Directors of Nursing was 'good', the Directors subsequently found it easier to be heard and to achieve their goals. However, where the relationship was 'bad', the Directors of Nursing found it increasingly difficult to be heard and to get things done. This relationing not only applied within the hospitals. It was evident that the directors thought if they had a working knowledge of, and some form of personal relationship with, relevant members of the Department of Health and Children, they would be able to influence the allocation of arbitrary funding.

The focus of this influence was usually (but not always) funding for new nursing posts. Often the necessity for these new posts was driven by the introduction of a new consultant or by an acute service need. This would suggest that when the Director of Nursing identified a problem but was powerless to effect any change, she used all of her navigating and relationing skills to redress the problem. This included going outside the organisation and into the Department of Health and Children to look for solutions.

Cameron and Masterson (2000) identified that the role, function and remit of the nurse executive varies across trusts (UK). Crucial to this functionality was the relationship between the nurse executive and the chief executive and the board. Cameron and Masterson (2000) also identified that the relationship with the medical profession was central to the successful development of new nursing roles. The development of these new nursing roles was dependent on the availability of money.

Perhaps most interestingly, the manner in which the money for new roles was allocated presented the Directors of Nursing with a paradoxical problem. Money was made available to the Directors of Nursing in an ad hoc fashion. Consequently, the Directors of Nursing had to have an opportunistic approach to service development which undermined the management of professional issues such as the educational needs of staff, accountability and risk management, titles and grading. In other words the development of the profession was only able to develop in an ad hoc arbitrary manner. This would concur with the findings of the National Councils' *Report into the Continuing Professional Development of Staff Nurses and Midwives* (National Council 2004a). In this Irish study staff nurses and midwives highlighted that their continuing professional development needs were addressed in an ad hoc manner.

Cameron and Masterson (2000) conclude that the obstacles facing nurse executives in exerting control over new role developments included:

- Organisational characteristics which diminish strategic planning
- A reliance on getting funding from any corner, even charity
- Short term government initiatives
- Power imbalance between medicine and nursing at individual, organisational and policy levels
- A lack of national policy and professional frameworks to help nurse executives lead health care development.

All of these obstacles thus force the nurse executive to 'muddle through' (Hewison 2003).

One of the core issues omnipresent throughout the interviews was how the Directors of Nursing were able to influence and the manner in which they influenced was seen as key to their effectiveness. The following extract from one interview highlights this point:

'as I say, talking about influence or whatever, and that form of structure, but you know, the informal sort of approach of going to talk to whoever it would be, the head of service or consultant or whatever, that's done all the time here' (D8P3)

It is thus evident that unless the Director of Nursing plays the system and builds effective working relationships with the key stakeholders she risks becoming marginalised (Tracey 2004) and consequently ineffective in her post. However, equally important is that when the Director of Nursing does have a good working relationship with the CEO, the consultants or the General Manager, the working life is made easier as the next extract demonstrates:

'I have to work and build up a relationship with the chairman of the medical board, and he likewise me, he is key to me. Because he is key to me, I will ask him who do I need to see...you have to try and work around it, when you come in the gate and have to work together, it doesn't matter what you think of each other outside the gate, you have to think what mechanisms or processes can you put in place so that professionally you can work together and that you can respect each other, it's hard bloody work' (D11P11)

The ability to have good working relationships would seem to be linked strongly with the Directors of Nursings' ability to play the system and to have political savoir-faire. Politicking is now discussed within this context.

4.3.5 Core Category: Politicking

The concept of the hospital as a political entity with differing levels of political implications was pervasive throughout the interviews. Some of the directors alluded to the fact that they had learnt to play by the rules. To not play by them, would lead to expulsion from the 'club'. This Director was talking about the CEO and the lip service that is paid to partnership in the health board:

'They would be continuously talking about valuing and partnership and all, they don't value their senior people, it's a boys' club' (D11P1)

Another Director of Nursing, when discussing how consultants accept admissions regardless of whether there are nurses available to care for the patient states:

'you have to flag these things up before you actually take acceptance (of the patient) but that's sometimes out of your control because clinicians will take acceptance and you have to try to deal with it, you just have to flag up the issues make sure that the GM is aware...you have no choice, you just have to keep at it, I mean you have to argue for everything that you get' (D5P4)

The issue is not about accepting the patient and having to employ agency staff, the issue is that the Director of Nursing is made to feel 'bad' if she goes over budget. The Director of Nursing has no choice but to employ extra staff to cope with increasing acuity, but has to argue for it every time.

It would appear that the biggest issue for the Director of Nursing is that the hospital is a huge political organisation, and if they (the Director of Nursing) have not built up networks and good working relationships with all the key players, then it is more difficult to 'get things done'. Notwithstanding what this implies for the health system as a whole, this has real implications for the Directors of Nursing and is linked to the 'relationing' concept. The Director of Nursing's relationship with all the relevant stakeholders will directly effect how effective she is at getting things done. Almost as

important as having political 'savvy', is being able to speak the same language as everyone else. Richman and Mercer (2004) discuss the new managerial language of modernisation, claiming that there is a fundamental contradiction between the ethic of caring and the expectations of Government. It may be the case that the Director of Nursing is caught between these two, not necessarily opposing, paradigms. On the one hand they understand the need to speak in the rhetoric of business language, but on the other they feel that their experience and centrality of the clinical area to their world deserves an automatic response from managers and medics alike. The dilemma for them is that their knowledge and expertise is not, as we have seen, always listened to or valued. Thus, they become frustrated and are forced to 'muddle through'.

Being able to influence is the essence of power, you are only 'good' or effective as a Director of Nursing if you are able to play the political game and influence the right people at the right time in the right place. As one director commented:

'I also think its about playing games and being wise enough and hopefully astute enough to keep your mouth shut when you need to but open it when you need to. And not just because if I am a don to have a big speel out of me mouth for the sake of it. Does that make sense'? (D2P22)

They have to play the game also because not playing would render them powerless altogether. If they were to step outside the unwritten rules of engagement, with the Department of Health and Children for example, they would risk being marginalised by the CEO and the Department of Health and Children. The Directors of Nursing perceive that if they have 'an ear' in the Department they will be able to influence things within their own organisation. However, when asked would they go directly to the Minister for Health and Children if they could, the Directors responded in the negative. This would be seen as going above people's head and could result in political expulsion from within the hospital. Thus, the Directors of Nursing feel it legitimate to try to influence funding/extra posts from the Department of Health and Children but only up to a certain level.

Kanter (1993) suggests that individuals who are given titles such as director, manager or supervisor, are considered leaders and, as such, have followers. Power is supposedly an automatic part of their functioning. However, Directors of Nursing are not necessarily perceived as leaders of the organisation, they are leaders within the profession of nursing. Kanter outlines that they are expected to aid the mobilization of others (nurses) towards the obtainment of objectives (hospital, medical and nursing objectives). The Director of Nursing has responsibility for results (quality patient care, safe patient care, staffing, retention, professional development etc.) and is accountable for such. Kanter contends that power does not necessarily come automatically with the designation of leader, but with the delegation of formal authority (Kanter 1993, p.165). According to Kanter, people sometimes have to get power from the hidden political processes and not from the official structure.

Within the context of relationing and politicking, the Directors of Nursing eventually acquiesce to the way the health system is managed (or mismanaged). This is central to their powerlessness, because whilst the power that they do possess within the organisation of the hospital will not necessarily be taken away from them, the threat is always there and they genuinely feel that their career prospects will be severely diminished. When discussing how the health boards operate and how nobody seems willing to say how badly the system is managed, the following exchange between the researcher and one director exemplifies the point:

Researcher

Do you think anyone will question and say how it is?

Director of Nursing

No

Researcher

Why not?

Director of Nursing

Because these people will shaft you, its very easy to shaft

Researcher

How? Is it really that easy?

Director of Nursing

It is they will put you in a dark corner, they alienate you, it's very easy

Researcher

Because they control who gets the senior posts?

Director of Nursing

For instance if I compare, I worked it and I got on and did my job, I made sure I was at meetings, I did my best

Researcher

So you played the game?

Director of Nursing

I played the game.... (D11P1)

This type of behaviour would suggest that they function on a very delicate tight rope, they have to keep relationing and politicking within an informal unwritten rule between going too far and being ostracised from the workings of the organisation and being able to function effectively as a Director. This tight rope appears to be so delicate that one Director of Nursing admitted that during board meetings, she adopts a strategy of not mentioning nursing per se. The strategy adopted by this Director of Nursing when attempting to achieve an increase in staffing levels or get new posts sanctioned was to focus the argument on the patient.

'Well having said that its still difficult to influence within that level (corporate), it can be, you have to be very wide about it. You have to know what you're shouting for and to go for it, just make the decision, you can't be yacking on all the time about the trivial issues, at the end of the day, you keep bringing it back, I don't talk nursing at that level, unless its specific nursing, you talk patient service of which nursing is a whole part, put the emphasis on that as opposed to saying oh we need more nurses, this is how its affecting nurses, try to reverse it around, what's the best way of

managing this? And then you draw it out..., instead of banging on about it (nursing) ' (D10P4.)

Whilst I initially thought that this strategy was clever and demonstrated that the Directors of Nursing were being political, I began to re-think this view, when I read Lukes (2005):

'power is tolerable only on condition that it mask a substantial part of itself. Its success is proportional to its ability to hide its own mechanisms (Foucault 1980, cited in Lukes p.90).

I initially thought that the Directors of Nursing were masking any *potential* power that they may or may not have had, by achieving their aims using the patient as the focus of their argument. However, what I think the Directors of Nursing are doing is avoiding any type of conflict and perhaps also inadvertently weakening the nursing argument. To avoid arguing for more nursing resources by arguing about quality of patient care, the Director of Nursing is making nursing invisible and undermining its importance to the organisation. Interestingly, the Directors of Nursing all talked about the invisibility of nursing within the organisation. The invisibility theme arose in the same context as nursing not being valued. It would appear that the Directors of Nursing contribute to the very thing about which they complain.

The challenge for the Directors of Nursing arguing for more nursing resources lies in them finding ways to transform the system to enhance the practice of their nurses for the benefit of patients. By emphasizing the quality of patient care, rather than sounding like an oppressed powerless individual the Director of Nursing is demonstrating the multiple and productive nature of power.

Therefore I asked myself, were the Directors of Nursing using a Foucauldian mechanism to achieve or influence what they want to achieve? If so, I do not think this is deliberate; they believe that if they assert their power (potential) then people

(management and the medics and other health care professionals) will marginalise them. This pattern of behaviour takes place within the overall context of the nursing profession and the culture of the organisation in which they work. What would really happen if they were to exert the full weight of their potential power? Sandra Bartky (in Lukes 2005) puts it in context when writing about what she terms 'the contemporary subjection of women':

'Women who practice this discipline on and against their own bodies... the woman who checks her make up half a dozen times a day to see if her foundation has cracked or her mascara has run, who worries that the wind or rain may spoil her hairdo, who looks frequently to see if her stockings have bagged at the ankle, or who, feeling fat, monitors everything she eats, has become, just as surely as the inmate of the panopticon, a self policing subject, a self committed to a relentless self-surveillance. This self-surveillance is a form of obedience to the patriarchy' (cited in Lukes p.99)

I am suggesting that is it the Directors of Nursing themselves who accept this obedience to the patriarchy, by not using 'nursing' to argue for their cause. They are consequently constantly affirming their state of powerlessness. Fradd (2004) would suggest that challenging the status quo and being brave enough to ask 'why' and 'what of' are essential elements of the role of the Directors of Nursing. What would really happen if a Director of Nursing spoke out and asked the awkward questions either locally in the hospital or publically in the media just what he or she thought?

The findings of this study would indicate that the Director of Nursing has to play the game (political) to negotiate and win a bigger share of the resources and to give nursing a louder and more visible voice, but without actually appearing to do so. The following quotes from interviews, five, seven and ten illustrate this point:

'eh..that politics is very important within an organisation as big as a hospital and that eh that it is important to build up those kinds of relationships, now a lot of them will, the more seasoned managers will have their own network, they can get things

done much quicker, by an informal route, rather than following the procedures' (D7P1)

'yea it is intimidating I suppose because there's a language a business language which we wouldn't be fluent with em..and that's probably an area that directors would benefit from, just an exposure to that language and to how to be political at that level, em most of the working I would see are done after the board meeting, not at the board meeting' (D7P3)

'I just think that it can become a political football and people can play games and you are left as a Director of Nursing trying to protect your nurses, trying to protect the fact that they are being maybe left in a situation' (D5P3)

Interestingly, none of the Directors of Nursing discussed their ability, or lack of it, to actually influence health policy on a macro level. Most of the politicking that they undertook was to help them achieve their own goals, be it funding for a Clinical Nurse Specialist or an Advanced Nurse Practitioner or other posts. They only mentioned their lack of ability to influence the Department of Health and Children on things that were pertinent to their own organisation. Davies (2004) suggests that nursing political leadership is inward-looking and individualising, it is immature as a profession and it (nursing leadership) stresses separation instead of alliance formation.

4.3.6 Summary

In this section I have discussed how the Directors of Nursing work in a health system that appears to function in an arbitrary manner and within an organisation that has informal and formal methods of getting the work done. The Directors of Nursing have to circumnavigate this arbitrary system in order to allow them to function effectively, or at least, they think they do. They have to balance getting the job done, using their political and relationing skills within the context of not being heard and

being invisible, without over stepping the authority of their role. The next section will discuss the third core concept of 'Plugging the Holes'.

4.4 Core Concept: Plugging the Holes

4.4.1 Introduction

The core categories for this concept include: 'feeling responsible for everything', and 'defining role boundaries'. The core concept of 'Plugging the Holes', refers to the concept that the Director of Nursing has responsibility for keeping the hospital functioning twenty-four hours a days, seven days a week and three hundred and sixty five days a year. She appears to be the person to whom everybody turns when a problem needs to be fixed. As the Director of Nursing, she has inherited, or indeed been part of the old system of 'matron', a nomenclature and its associated image that appears hard to shake off. In other words, she is still perceived (and perhaps perceives herself) as the person who is responsible for everything in the hospital, even though specific domains of responsibility, such as catering and portering have been stripped away. It follows that if you are the person who is made to feel responsible for everything (or you make yourself feel responsible for everything) then the limits of your role will be ever increasing. Thus the definition of the role of the Director of Nursing will constantly change.

4.4.2 Core Category: Feeling Responsible for Everything

It became apparent very quickly after coding the first few interviews that the Directors of Nursing were responsible, or maybe made to feel responsible for essentially keeping the hospital functioning on a twenty four hour, seven days a week, three hundred and sixty five days a year basis. With this omnipresence came the perceived responsibility for everything within the hospital. As one Director of Nursing commented:

'there is no area of the hospital that I am not involved in and that I am not asked my opinion' (D3P10)

Another commented:

'I think yes you're right, it's grand when everything is going well. It's when something goes wrong all of a sudden you're the person to be found responsible for what has gone wrong and I do find that its very important to be always fighting the cause of nursing, whatever meeting one is at or what ever opportunity one has, that you have to be fighting the corner all of the time' (D6P1)

When I asked this Director of Nursing how she managed to balance the workload, she responded:

'it's really crazy, I mean I feel at times hard done by, such as that, I mean if you are a general services manager you only have the general services to look at, or if you only have Human Resources, now I have a team of 1,000 nurses to look after, as well as all this, in another way it isn't really, because the nurse managers are accountable for each area, so if we were in directorates I wouldn't have anything to do with things, but needless to say we are still in an old fashioned system, where somebody has a little bed problem up the house and they ask me,...I would get a question if there was a cat out in the corridor' (D3P10)

Clearly this director is involved in every aspect of running the hospital. It also became apparent that every decision made at executive or corporate level in one way or another always eventually impacted on nursing and nurses. Whether the decision involved the appointment of a new consultant, the commissioning of a new unit, the introduction of accreditation or something as simple as re-engineering the supply system for CSSD, nursing and nurses were involved and affected. Whether this effect was as passive bystander or active participant depended to a large extent on the ability of the Director of Nursing to bring the proposed change to nursing and nurses to the attention of the CEO, GM or Consultants. As we have seen some Directors of

Nursing adopted differing mechanisms to achieve this. Some managed by not mentioning nursing or nurses per se but talked about quality of patient care, other mechanisms included going straight over the head of the general manager or doing deals outside of the boardroom. As one Director commented:

'I am embroiled, involved beyond nursing, if something happens and somebody senior has to basically deal with it or whatever, it could be a parliamentary question, it could be whatever, know what I mean?' (D4P8)

Some Directors of Nursing got deeply involved in the commissioning of new units, this they referred to as 'project management'. Project management was given an elevated sense of importance by those directors who took the lead in it. The following comment represents this point:

'at the moment I am chairing the HSSD project group, that's a project of about two million for basically upgrading the HSSD department, now it's a multidisciplinary group, I am also chairing the catering services project group, now that's basically a project looking at the expansion and upgrading of the catering service to actually meet the service needs of patients, staff and the public' (D4P8)

Scheff (cited in Hyde et al 2004) claims that the individual sense of self becomes intimately bound up with the stereotype of what they ought to be. Nurses are continually striving to prove themselves equal or in some case 'more equal' to their medical and para-medical colleagues in the hospital (Hyde et al 2004). It could be argued that for the Directors' of Nursing in this study, this manifests itself as taking on responsibility for things beyond their remit in order to prove themselves more equal.

The Directors of Nursing are spread so thinly and cover so many aspects of the hospital functionality that they become powerless. For example, the human resources manager has human resources to deal with, the finance manager has finance, and the

risk manager has risk management. By contrast, the Directors of Nursing have to manage their budget, they have responsibility for anything up to 1,000 staff, that responsibility includes ensuring developmental and professional practice are adhered to, they have responsibility for ensuring the practice environment is safe and effective, they have to produce a service plan, an annual report and write numerous business cases. In conjunction with these roles, they are expected to deal with the day to day crises that affect the hospital. These crises can range from a lack of ITU beds, to patients absconding, to handling complaints from patients and staff. The following theoretical memo helps to illustrate the concept of director of everything:

'Once the tape was turned off, she admitted that they were directors of everything and really that she was a facilitator' (TM D5P20).

In an article that still has resonance ten years later, Wells (1995) comments that there is policy confusion over who is responsible for what in the NHS when deciding who has responsibility for the long-term chronically ill. The argument here is that the chronically ill long-term patients have greater relevancy for nursing, yet the clinicians decide who is to receive this nursing care. In other words the medical professionals are designing the nursing workload. Nurses become the problem solvers and are reactive, not proactive and thus become inert political activists.

One Director of Nursing who had insight into her onerous areas of responsibility commented:

'I think maybe that's where we have been wrong, we have been trying to solve every one else's problems and that has been wrong for us, I think we do need to have a clearer vision what is our role and also say sorry – its not my area! (D6P16)

Worth (1998), talks about her role of as matron in an independent hospital, she concludes her chapter by stating that the matron's role encompasses a wide range of responsibilities, the most important of which is the quality of care given to all the

hospital's 'customers'. How matron can be responsible for the quality of ALL the care given to the customers is difficult to understand. This, one can only assume, means that she is responsible for all of the other health care professions interactions with patients as well as the nursing staff. Thus, the level of responsibility that this matron willingly appears to accept is not commensurate with her level of authority. She has no authority over other health care professionals, unless this has been explicitly given to her by the relevant body with the gift to do so.

Fradd (2004), writing about her inability to influence policy while working for the Commission on Health Improvement (CHI), comments that the CHI found that senior nursing roles are often very diverse and as a consequence of this they are unable to focus on key priorities. The following extract from one interview demonstrates this:

'I mean it's a portfolio that is vast It's far too big you are there looking at the student education and the education of the profession and how you are going to produce enough nurses to fit the service needs in 5 years time, you are looking at all the specialist area and the developments, technological and medical and nursing and how are you going to meet those needs and how are you going to develop people in order to serve those needs, you are looking at the patient population and what services are you going to need to suit that patient population, what services are you going to need in the community, how can you organise and sort that one out and you are looking at the professional education of your own staff, how are you going to grow them, how are you going to retain them especially here in Dublin you know and then just the day to day needs of the hospital and running it and making sure that it's efficient.' (D7P12)

When the researcher probed further and asked her did she actually run it, her response was:

You do, you do, of course (D7P12)

Fradd (2004) makes the point that many nurse directors' roles are unclear to others both within and outside the organisation. The role has changed and this change has not been communicated to staff and role specifications have not been adapted. Fradd (2004) asks why Directors of Nursing are not able to influence policy, surmising it is something to do with them being too willing to take on work, and then becoming overloaded with work. Fradd (2004) concludes that balancing the strategic role, leading nursing and being responsible for operational matters has left Directors of Nursing isolated and the target of blame. One director commented:

'we don't have the infrastructure to support good management decision making at middle management level, because they have to keep going to the top' D10P7

What is not certain is whether the Directors of Nursing willingly get sucked into everything. Chiarella (2002) refers to Kim Walker's (1993) 'tyranny of niceness'. This tyranny manifests itself as avoiding conflict and of the nurse taking a passive stance or silencing themselves. The inability to refuse work that is offered combined with the elevated sense of importance that the director feels when asked to 'project manage', helps re-inforce a sense of powerlessness as the role expands and the remit extends beyond 'nursing'.

The introduction of the concept of the Director of Nursing role becoming strategic and being involved in policy making is perhaps the cause of powerlessness because the changes in the role have emanated from within nursing and not from within the organisation. In other words, how did the Directors of Nursing orchestrate the changes in their role with the other member of the corporate team? When The Commission on Nursing (Government of Ireland 1998) recommended the change in title from Matron to Director what measures were put in place to ensure this transition happened corporately? What other effects did this change of role have upon the organisation?

The Directors of Nursing think that they cannot be strategic without being operational because they need to know what is happening 'on the floor'. This then presumably will inform her thinking when being strategic. Maybe this is the paradox of being a modern Director of Nursing; she has to know, or thinks she has to know and has to be in control, of what is happening on the floor in order to be strategic. However, in order to know what is happening at the coal face takes time and requires a good surveillance system. Once she has discovered what is going on at the coal face she inevitably becomes involved in the minor problems and caught up in the cycle of operationalism, thus the ability and time for strategising is lost and the scenario is repeated.

Filkins (2003) looked at the Directors of Nursing role from the United Kingdom, Germany, Finland, Belgium, Slovenia, Croatia, the Netherlands and France perspectives. In a SWOT analysis, the directors of these countries identified that the most striking phenomenon in terms of the strength of the Directors of Nursing post was the cross-departmental and cross-professional sphere of responsibility and having responsibility for such cross-departmental working. Having to take on responsibilities that are not linked to the function of the post and always having to justify what nurses do was also identified. One respondent in Filkins (2003) study stated that 'they' do not see who the main co-ordinator is. Interestingly, the respondents felt that the strengthening of nursing has put it on a collision course with other power bases, especially doctors.

The Office for Health Management in Ireland published The Senior Nursing Management Competency Development Pack (OHM 2002). The five specific competencies for top/senior level are:

- Strategic and systems thinking
- Establishing policy, systems and structures
- Leading on vision and values
- Working at corporate level

- Developmental approach to staff

Nowhere in the OHM competencies does it mention the operational aspect of the role. Nor does it offer the director a method for explaining to the CEO and the medical directors that they see their role in different terms (Fradd 2004). The OHM *strategic and systems thinking* competency identifies scanning the environment as a key behavioural trait that is required. However, as soon as the environment is scanned, the director necessarily becomes involved at operational level.

Mintzberg (2002) identifies that within nursing management there is a blending of managerial energy with clinical delivery, and that perhaps managing comes more naturally to nurses than to physicians and professional managers. He goes on to suggest that managing might be less natural for men than women and that nursing may be the appropriate model for managing healthcare and disease care. Maybe Mintzberg has identified and articulated something that many nurses anecdotally discuss, that losing the role of 'matron', has been detrimental to nursing's power base and ability to influence.

The increasing calls from the British public (not professional health care managers) for matron to return to the fold led to the introduction in the United Kingdom of the 'Modern Matron'. In spite of the criticism that the introduction of the role has received from a large section of the nursing profession, the embracing of old methods of running the hospital has been well received and evaluation studies have been positive (Savage and Scott 2004).

According to the Department of Health in the UK, the key attributes of the role of the modern matron include: visibility and accessibility, clinical credibility, setting standards and controlling resources and administrative support (Hewison 2001). The attributes of visibility and accessibility, controlling resources and 'sorting out' clinical problems were mentioned by every Director of Nursing in my study as important parts of their role.

In contrast, Fedoruk (2000) suggests that if nurses are to assume leadership positions within healthcare, they need to let go of traditional managerial practices and behaviours. Carney (2004) may well be correct when she positions Directors of Nursing at 'middle management' level within the organisation. Because Matron did actually run the hospital at all levels and the Director of Nursing has different responsibilities, it is nursing itself that has put an elevated sense of importance on the role. What needs to occur is an honest evaluation of what the CEO and the clinical directors' perspective of the role of the Director of Nursing actually is.

I think what is evident from this study is that the Directors of Nursing have lost areas of control, although whether this shedding has been voluntary or involuntary is not clear. For example, the advent of contract cleaning had a direct negative consequence for the hospital, as general ward hygiene deteriorated. This deterioration has had a direct effect on the increase of hospital borne infection (Savage and Scott 2004). The Director of Nursing used to manage this area, but didn't attribute any value to the knowledge, skills and information associated with housekeeping. This was probably because it was seen as 'lesser' work on the scale of becoming a profession as this type of work has a low social value. The Directors of Nursing reflected this themselves when they inadvertently suggested that the matron role was missed. This concurs with Carney's (2005) discussion of the lack of recognition of the complex managerial skills of 'Matron'. The following statement from one Director helps illustrate this point:

'the matrons were trying to deliver a service under difficult circumstances, they started to shed things because they had to because they couldn't keep their eye on the balls, in all of the corners, so you ended up with two opposing you know so their power became diluted, the CEOs then were very suspicious of the matrons if you like and very anxious to build up their own empire' (D7P11),

All of the Directors of Nursing admitted to working more than a 70 or 80 hour week, and all of them are involved in the day to day running of the hospital. They get called at night or at the week-end if there is a bed crisis and are expected to sort it out. One Director of Nursing, who was new in post, told me how her CEO told her he now sleeps at night because she has come on board and now takes the phone calls at three in the morning when there is a crisis.

'The example is the CEO he said to me, I am able to sleep at night time now (D11P6)

Storch et al (2004) claim that nurses in almost every arena of health care delivery are excessively over stretched, and that only by adopting a feminist perspective can we begin to understand the power relations that exist within the hospital. Hyde et al (2004) comment that the issues that continue to plague nursing are the frustrations of an occupational group who are subject to a high degree of control in the work environment, who have little promotional prospects, little recognition and meagre financial remuneration *relative* (my italics) to the degree of responsibility which they are expected to have.

4.4.3 Core Category: Defining Role Boundaries

As a consequence of the Director of Nursing feeling responsible for everything, it is not unrealistic to suggest that the role of Director is thus being constantly changed in response to being responsible for everything. It follows that this change will continue until the Director of Nursing stops feeling responsible for everything and has a defined role boundary. This is a particular problem for the Directors of Nursing as they are drawn into everything, become something to everyone and lose their own role definition. As Oakley (1993) argues in her seminal text, 'Essays on Women, Medicine & Health', if we accept that the boundaries between different health care professions are constantly shifting, then the important question is:

'Which occupation's definition of its role is the prime cause of changing occupational boundaries throughout the system' (p.43)

Oakely (1993) stresses that as with any social change, the driver for change in professions comes from the top, from those professionals with the highest status, highest pay and the most power, and perhaps most importantly the profession that has a direct link to the real power, the state.

Thus, the Director of Nursing role will change to suit the other higher status professionals: doctors, general managers and senior public servants. For example I recently noted that one Director of Nursing title in a band one hospital was 'Director of Nursing and Patients Complaints Manager. Nurses and nursing have historically changed to suit the prevailing orthodoxy (Chiarella 2002, Colyer 2004, Krejci 1999). When the porter, the domestic, the doctor and the manager go home at 5pm, although a skeleton representative may remain, it will be the nurse who has to adapt to the 5pm shutdown. One director apologetically commented:

'If you speak to any of the paramedics they are certainly very clear on what they see as their role and regardless of whether there is a patient or not. If they don't have the resources, they say sorry I can't treat that person. Whereas we would say right I don't have the resources but this person needs to be taken care of and no matter what, we will try and take in that person and do something for them, whereas in a way I admire the paramedics, they know, sorry' (D6P17)

So if a crisis occurs in the hospital, it will be the nurse manager on call who will be the person who has to deal with it. Is this why the nursing literature is continually discussing definitions of nursing? Nurses and nursing make up the constituent parts of the hospital and this directly affects how the Directors of Nursing are forced to function because nursing is omnipresent and because nurses are still the only healthcare professional to provide a continuous presence (Chiarella 2001). Chiarella (2001) goes on to explain:

'because of the nature and intimacy of nursing work, it is still the case that nurses will do whatever needs to be done to assist the patient at a particular point in time. If the focus of nursing care is to take care of a person who is ill, part of that may well be to take away their dirty dishes because this may ultimately have a beneficial effect on their well being' (p.39)

She concludes that maybe a better way to define nursing is by examining the intent behind the action, to ask whether the work was performed with a *mens nutricia*, or a 'nursing mind'. However, whilst it is indubitably important to keep nursing in mind, the following statement from a Director of Nursing when asked if she thought that they were 'directors of everything' exemplifies my argument:

'It is yea, that's what I am saying whose job is it? If you are going to be strategic you can't be a strategist and be so far away from the coal face that they don't know who you are, not in this game I don't think you can be, you know so we just need to be careful what we're trying to say, and what I am trying to say is badly, is when I am sitting at the board of directors table and I hear that there is an initiative going on between the medics and UCD to look at the whole education strategic for the medics and I am sitting there and I am thinking we need to be at that table as well, because we are actually now the biggest faculty in UCD and so I steel myself to say it, I say it and I know that it isn't been given the weight that it should be given because it's coming from the director of nursing' (D7P23)

Not only does this Director of Nursing not feel sure what the boundaries of her role are, she is certain that if she offers an opinion to the board, her comment will not receive any weight from her colleagues. Doherty (1998 cited in Leahy & Wiley) alludes to the fact that there is a widely held view that the role of the profession (nursing) is ill-defined and poorly understood within the health services. It would appear that the nurse is expected to be capable of taking care of whatever problems arise within the hospital, regardless of the area in which they occurred (Salvage 1985, Jolley 1994).

As the role of the nurse on the front line changes to suit the prevailing orthodoxy so too does the role of the Directors of Nursing. By this I mean that the nurses' work in the practice environment necessarily becomes the Director of Nursing's problem at the top. The Directors of Nursing are always taking on new roles and new tasks which have been 'given' to them by the managers or the medics. They take on more and more work, they consequently become overloaded and work on average 70-80 or more hours per week. This is calculated on a five day week, Monday to Friday, but some Directors admitted that they would often get called at home at week-ends and in the middle of the night. The nature of these calls often demanded that the Director go into the hospital to sort out the problem. One example given was when a patient went missing from a ward. Interestingly, although the consultant in theory 'owned' the patient he or she did not get called, it was a nursing issue. One Director of Nursing admitted that the health service was a bottomless pit and that she would regularly work a 12 hour day except maybe for Fridays.

The nursing literature is replete with references to how the world of health care is changing due to technological and communication advancements combined with changes in economic, political and demographic changes (Sofareli 1998). The nursing discourse would suggest that nursing has re-invented itself in order to 'keep up' with these changes. Coyler (2004) suggests that non-medical professions have taken the opportunity to assume key roles in care and treatment decisions, as the shift from the biomedical model to more holistic quality of life models take on more significance.

Abbott (1988) claims that most professions desire full jurisdiction, but suggest there are not enough jurisdictions to go around. Abbott argues that most professions do not try to control the work (to be done) by controlling technique, but by developing a body of abstract knowledge in which the specialist expertise is intrinsic. Abbott (1988) claims that the negotiation over the jurisdiction of work is done face to face in social interactions. This is where formalised job descriptions are translated into actual working relationships. This appears to happen over and over again in this study. The

Directors of Nursing are constantly navigating their work load and their work load is constantly changing. Forces outside the directors themselves, such as the introduction of the NMPDUs and the move to third level, have and will continue to affect how their job is operationalised (Chiarella 2002).

When an incident occurs, either a bed crisis in accident and emergency or lack of beds in intensive care, the Directors of Nursing are looked to for help. This help manifests itself in finding nurses to staff beds that have been closed or to open new beds. The crucial thing here is that in every case the Directors of Nursing had no say in closing these beds originally and have to 'get permission' from the CEO to open the beds. It really just becomes a search for replacement staff. So although the Directors of Nursing feel very involved in managing the bed crisis, they have little or no influence shaping the overall bed policy within the hospital. This quote from interview ten highlights this point:

'I let the expenditure go, the CEO says 'you don't have the authority, you're overspent', I reply 'what do you want, 40 patients in Accident & Emergency and no nurses', and when you talk to them, they back down, they know the reality' (D10P8)

The Director of Nursing is being admonished by the CEO, for overspending the nursing budget, but the reality is she had no choice because to not supply extra nurses would have effectively closed down Accident and Emergency. But by spending on agency nurses, the director 'gets into trouble'. It is a no win situation for her and everybody in fact appears to be powerless to do anything about the repeating cycle of crises in accident and emergency departments.

If we accept that the medical consultants have ultimate responsibility and accountability over the patients that they 'own', and that the hospital is managed by the CEO or the General Manager who have ultimate responsibility and accountability for the budget and for services, where does this leave the Director of Nursing? She is responsible for keeping the hospital running with competent, safe nursing staff, and

has responsibility for the delivery of quality patient care, but neither 'owns' the patient nor has accountability for the overall budget. All she can do is hope to influence the allocation of that budget.

The report of a panel that reviewed the death of a three year old Irish girl with a cardiac defect, (Ruddle Report, DoHC 2005), states:

'Given the centrality of the ICU to the operation of the hospital as a whole, the panel considers that the shortage of nurses to staff the unit does not appear to have been seen by hospital management at the time as a priority issue warranting significant management attention. From the evidence presented, it is clear to the panel that the problems relating to the recruitment and retention of specialist nursing staff were considered matters to be addressed solely by the Director of Nursing and her staff. Although aware of the problems, there is no evidence that hospital management or the Committee of Management gave any active support, other than the approval of financial resources, to helping the Director of Nursing with the problem solving initiatives that were clearly needed to address the recruitment issues for this highly critical area of the hospital's activities' (p.5)

This finding concurs with the findings from this study as alluded to in section 4.4.3, that no-one is listening to the Director of Nursing. However, I would suggest that this extract from the Ruddle Report (DoHC 2005) indicates that hospital management saw the nursing problem as just that, and not a hospital problem. It also suggests to me that nursing within the hospital has a low priority. It would appear that management did not realise that without nurses to staff, in this case the ICU, the hospital simply cannot function.

The Ruddle Report (DoHC 2005) offers a series of recommendations following its deliberations, one of which suggests strongly that the Director of Nursing is indeed in a state of powerless responsibility:

'The panel is aware that arrangements are in train to review the governance and management structure within Our Lady's Hospital. The panel recommends that, whatever management structure is put in place, it should facilitate arrangements whereby critical issues are brought to the attention of senior management and to the Committee of Management (or its successor) at the earliest possible date, so that any measures intended to resolve those issues can be monitored and evaluated at an appropriate level' (p.29)

This would appear to be stating that the Director of Nursing was not listened to at corporate level. Eight out of the thirteen recommendations are nursing related, but yet no reference is made to the fact that as Director of Nursing the person in that post is not expected to be part of the corporate team. If the Director of Nursing was a member of the corporate team, the '*critical issues*' would always be on the table. Maybe the Director of Nursing in this instance, (it is not clear), was a member of the corporate team, but as we have seen in this study, was simply not listened to. This could be considered at the very least a curious omission by Ruddle, or at the worst an unconscious assertion that the Director of Nursing is not considered a key strategic player within the health service. In interview six, the director admitted that her professional opinion is not accepted at corporate level, and how she has to *keep at* something all the time to get what ever it is she needs (TM D6P2).

Davies (2004), in an overview of the literature relating to nursing's lack of ability to influence politically, comments on how some authors explored the ways in which nurses experienced alterations to their work as a by-product of other changes. (Davies 1995, Humphreys 1996, Hennessy and Spurgeon 2000 and Buresh and Gordon 2000). Davies asks that if we assume that nursing does not lack leaders but operates in a position of both structural and cultural differences, then a different perspective will emerge. This cultural devaluation of nursing contributes to the lack of ability to influence. This devaluation occurs because nursing is seen as women's work and as a result:

1. Few resources are devoted to its reorganisation and further development
 2. The work remains under-analysed and poorly understood
 3. Changes arise as a by-product of other policy initiatives
 4. Nursing voices are accorded little legitimacy and respect in policy debates
- (p.238)

Davies concludes by suggesting that leaders at all levels need to acknowledge and understand the complex and ambiguous position that nursing continues to occupy in health care. Ewens (2003) suggests that nurses will respond to developments because of their ability to re-conceptualize work roles. Ewens cites Howkins (2002) who warns that in response to nursing reassessing its identity, the reassessment needs to be a re-conceptualisation and not a dissolving of professional role identity, as role confusion and demoralisation will follow.

4.4.4 Summary

The core concept of 'Plugging the Holes' refers to the Director of Nursing coping strategies in a system that appears to function in an arbitrary manner. The Directors of Nursing feel responsible, or are made to feel responsible for the day to day management of the hospital. The boundaries of their role seem to be ever increasing, thus delimiting the power that they can exert on local and national health policy.

4.5 Core Concept: Playing by the rules

4.5.1 Introduction

The core concept of 'Playing by the Rules' concerns the notion that the Director of Nursing has to continually accept how the organisation is managed and her role within it, without questioning how the system functions or being able to influence or change how it functions. She accepts how the hospital is managed because to challenge it, as discussed earlier, would lead to her expulsion or marginalisation. The hospital and the wider health system appear to function in an arbitrary and even maladministrated fashion (Travers 2005). Thus, the Director of Nursing is forced to accept the status quo of the hospital system and work within her own framework of responsibility and authority. The concept of 'playing by the rules' as a cause and a consequence of powerlessness is based upon the premise that the Directors of Nursing risk expulsion from the corporate structure, if they do not play by the unwritten rules. Expulsion is simply done by not including them in key decisions, for example the appointment of a new consultant. The basis for this acceptance appears to stem from three interlinked factors; preserving the status quo, avoiding overt conflict and unionising.

To threaten the status quo puts the Director of Nursing at risk of alienation from management in the guise of the CEO or the boards of management. As demonstrated earlier, a good working relationship with the CEO is imperative for getting things done. Secondly the doctor- nurse game of power relationships is well documented (Stein et al 1990). This describes how nurses in the clinical setting, give subtle suggestions to doctors about the best of course of treatment for a patient, while the nurse all the time maintains a show of deference to the doctor. The cardinal rule is to avoid open disagreement. The Directors of Nursing do this without realising that is what they are doing. Even though they are far removed from the clinical situation this behaviour is replicated. The Directors' of Nursing have become socialised into accepting the consultants' perspective at board level.

Finally, the Directors of Nursing appear to exist in a state of fear. This fear is represented by the unions and the threat of litigation. Throughout the interviews, the underlying fear of ending up in the courts, or worse exposure in the newspapers was evident. These three factors, 'Preserving the Status Quo', 'Avoiding Conflict' and 'Unionising' make up the core concept of 'Playing by the Rules' and are discussed in full now

4.5.2 Core Category: Preserving the Status Quo

This core category refers to how the Directors of Nursing appear to accept the manner in which the hospital is managed. They are aware that there is probably a better way to run a health service, but they can neither change the system, nor criticise how it is managed. In order to survive working in such an arbitrary organisation, the Director of Nursing has to accept this status quo because to do otherwise would risk marginalisation and risk losing what influencing ability she already has. The concept of preserving the status quo has been socialised into the Directors of Nursing since they began their nursing training. Holloway and Penson (1987) claim that nurse education is a process of social control which is imposed externally, by the curriculum and the hospital and usually internalised as acceptance of the status quo. Learning the competencies and skills of a profession is combined with learning the values and standards of that profession. Holloway and Penson (1987) suggest that the nurses who want to progress and be promoted may often find it safer to accept the status quo. One Director of Nursing commented when we were discussing how the DATH's were not being listened to by the universities or the Department of Health and Children:

'Well I suppose you know my reaction coming in from the outside would be why don't you explode this? Get out there and be listened to, but I mean its obvious why, because if you did that, then any little power that you might have, would certainly BE TAKEN AWAY'(her emphasis) (D7P8)

This Director of Nursing clearly feels that the power that she has can be easily taken away. When I asked her who would take the power away, she claimed that the board of management would not be happy if the DATH's Directors of Nursing were to come out and start shouting. Again she was discussing how she felt that the DATH's Directors of Nursing were being paralysed by the universities in relation to the student nurses being required to undertake a rostered year, for which the Directors of Nursing would be financially responsible.

An example of how the Directors of Nursing preserve the status quo is illustrated, I think, in the silence that abounds from the Directors of Nursing in relation to the ongoing Accident and Emergency crisis in Ireland (Irish Times September 28th 2005). For the last eighteen months, nurses in Accident and Emergency in Ireland have been working to rule in protest over working conditions and the large volume of patients

This Director of Nursing clearly feels that the power that she has can be easily taken away. When I asked her who would take the power away, she claimed that the board of management would not be happy if the DATH's Directors of Nursing were to come out and start shouting. Again she was discussing how she felt that the DATH's Directors of Nursing were being paralysed by the universities in relation to the student nurses being required to undertake a rostered year, for which the Directors of Nursing would be financially responsible.

An example of how the Directors of Nursing preserve the status quo is illustrated, I think, in the silence that abounds from the Directors of Nursing in relation to the ongoing Accident and Emergency crisis in Ireland (Irish Times September 28th 2005). For the last eighteen months, nurses in Accident and Emergency in Ireland have been working to rule in protest over working conditions and the large volume of patients lying on trolleys for days. To date, no Director of Nursing of any of the hospitals involved has given a statement to the press either in support of the nurses' protest or to comment on the working conditions of their staff. In a book entitled 'From Silence to Voice: What Nurses Know and Must Communicate to the Public', Buresh & Gordon (2000) comment that when they began examining the invisibility of the nursing voice in the media:

'underestimated the complexity of the cultural imperatives in the relationship between the nursing and the external world' (p.1).

They explain this by reasoning that, when they began to examine the relationship between nursing and public communication, they felt that the key to increasing the public visibility of nursing was in 'reversing the media's indifference to nursing'(p.1). However, they began to realise that the problem was not the media's indifference to nursing but nursing's indifference to the media. They argue that the overriding barrier to nurse visibility in the media is the reluctance of nurses to use communication skills. Buresh & Gordon examined 908 quotations in the media that related to health issues, of these only 1.1% could be attributed to nurses. This was

even more shocking, they claim, when nursing is the largest health care profession by far. The nursing voice was quite simply inaudible. Many journalists reported to Buresh & Gordon that nurses seemed terrified of expressing strong opinions and were overly concerned that they might offend someone. Wilmot (2000) discusses the complex ethical issues involved in whistle blowing. He suggests that if nurses are to blow the whistle, firm political and legal safeguards need to be in place to allow the nurse to make an informed, rational and ethical decision to do so. The INO in Ireland has recently called on the government to put such structures in place. To date there has been no response.

The Directors of Nursing are ultimately responsible for all things to do with nurses and nursing. As a consequence of this responsibility, the director has to always protect herself and to do this she has to first protect her nursing staff, as one Director of Nursing commented:

I just think that it can become a political football and people can play games and you are left as a Director of Nursing trying to protect your nurses, trying to protect the fact that they are being maybe left in a situation where they are being asked to deal with these babies and unless they have the competencies and the turnover on a frequent basis to be able to manage those competencies, it is unfair for us to do that, yet from a management, from a general management perspective you are trying to complete the circle and you are trying to em....make sure that you are maximising your efficiencies and that you have value for money (D5P3).

During a conversation where she was discussing the waste of time and resources that go into service planning, one Director commented when I asked her was there a better way to run a hospital:

'Mutli-annual budgeting for starters, this thing (service planning) is farcical' (D10P6)

This Director felt that the processes for allocation of monies were a farce, and, more importantly, extremely time consuming. However, she continues to preserve the status quo of service planning even though she thinks it is farcical. The Directors of Nursing have to accept how the system works and cannot influence its change, even though they have the knowledge, in this case suggesting multi-annual budgeting as a better alternative to annual service planning.

Another Director of Nursing, when asked if she thought the current model of running the service was good, instead of disagreeing, said that it's changing now:

'Well it's going to change, well it wasn't a bad model, I am not too sure that I do think that there was a certain amount of duplication, which is, it won't be a bad thing to do without' (D5P20)

She did go on then to say that the system needs to be streamlined, by less duplication and that patient information systems need to be introduced (TM D5P20).

Another prevailing reason for accepting the status quo is self preservation. The Directors of Nursing would appear to want to prevent anything adverse happening as this, they feel, would reflect badly on them, their nurses and the hospital. As one Director of Nursing commented:

'I think you are protecting yourself and the nurses, because you don't want anything to be exposed to be honest that would show you as the head of profession in a bad light, or that maybe sometimes systems fail within it, and this is where I see that maybe we should be reviewing the system and getting into that side of things, and em you know being more as a professional head' (D6P14).

This Director of Nursing is accepting that the system is flawed, but believing that protecting herself and her nursing staff is paramount. Yet she feels powerless to change the system. The Director of Nursing is so caught up in the operational day to

day running of the hospital that she cannot become strategic. And even if she managed to shake off the operational side of things, it is not certain, whether in fact, she would be listened to or whether her opinions would carry any weight. This is in part due to the fact that within the structure of the organisation, she has little power. A large part of the role is to pre-empt problems, as this extract from interview six exemplifies:

Director of Nursing

'very often you are diffusing situations, that never go to a higher level, they wouldn't even know a scintilla about, because if it goes into that arena it will become almost a tribunal and you don't want to be getting into that so you try to solve everything that you can at local level as far as possible, but to me, I think certainly we should be more involved at strategic and policy making level.

Researcher

Is that why you are so operational because you are trying to head off things at the pass, I'm just speculating?

Director of Nursing

That is part of it (D6P14)

Storch et al (2004) claim that health care delivery is operating under what they term, a pervasive *ideology of scarcity*. This ideology rewards those who solve problems quickly and who are efficient in processing patients through the system. As Farrell (2001) quoting from Dargon's unpublished masters' thesis from the University of Tasmania:

It is contended that it is not only the alleged 'misogyny' intrinsic to oppression theory that shackles and impedes nurses (but nurses themselves, who, in their everyday work and interpersonal interactions), act as insidious gatekeepers to an iniquitous status quo'.

Not wanting to allow problems to get to a 'higher' level leads onto the next sub category, avoiding overt conflict. It appears that the Directors of Nursing feel that a large part of the job is to keep 'minor' operational issues away from those at a higher level.

4.5.3 Core Category: Avoiding Overt Conflict

During the interviews, the researcher pressed the Directors of Nursing about why they don't challenge the medical profession on issues such as their refusal to implement the European Working Time Directive and the fact that the consultants have been working to rule for the previous nine months¹⁵. One Director of Nursing accused the medics of not playing the game and suggests they are responsible for holding back service developments, but when I pushed her about challenging the medics and taking them on, she changed her argument, blaming the government for not implementing reforms. When I suggested that the medics have had thirteen years to develop a revised model for education and training to comply with European Working Time Directive, she changed the subject.

Sieloff (2004) claims that members of oppressed groups are fearful of challenging the oppressor for fear of retaliation. I am suggesting that the Directors of Nursing are fearful of challenging the medical profession for fear of retaliation. The Directors of Nursing are dependent on the medical profession for developments within nursing. For example, if the Director of Nursing wants to introduce an Advanced Nurse Practitioner in the Emergency department, she is dependent on the support of the consultants. Without consultant support for the introduction of the new role, it will, quite simply, not happen (National Council 2005). So, in order to achieve their professional development (and others) objectives, the Directors of Nursing *perceive* that they have to keep the medics on their side and convince them of the need for change (Fradd 2004).

¹⁵ At the time of writing, the consultants were still working to rule.

In another hospital the Director of Nursing was leading out the hospital accreditation process. Seventeen committees had been established to address the various processes involved. After eight months of intensive work and hundreds of meetings, the accreditation process was stopped because the consultants refused to participate. This extract highlights the Director of Nursing's lack of anger at the consultants:

'..we were unfortunate ok that a number of consultants, which were in the minority, were very much involved I have to say that and were very helpful in the teams that they were participating in, but the majority did not want to know anything about accreditation and also due to their industrial action as well, so we were very disappointed from the view that we will not be getting a mark as a result of the visit because not every body was involved as part of the process but we did find it a very useful experience and I personally did, I think the nurses did too, but we are extremely disappointed and annoyed, we won't know what our mark is' (D6P5).

The Director of Nursing was not angry or even a little disappointed at the consultants' behaviour, she is more concerned about not knowing what mark they would have achieved. She has passively accepted the consultant's behaviour. I think it is fair to suggest that this Director of Nursing does not value her own time; she told me she spent weeks and weeks on the project and it came to nothing. Lovell (1981) and Mackay (1993) suggest that nurses ensure the dominance of the medical profession by their silence. When discussing the lack of involvement of doctors in the introduction of clinical governance in the NHS, Hewison (2003) asks how valuable is the process to the overall management of quality in the trusts if the medics are missing from the process?

One Director of Nursing admitted that consultants had to be 'worked', this fits with the concept of relationing and politicking as discussed in section 4.3.4 and 4.3.5. As one Director of Nursing commented:

'very political, egos have to be massaged, consultants obstructing power playing, Consultants not participating. I think, am I losing the power base it's such a vast organisation?' (D10P11)

Another Director of Nursing referred to her perception that no-one in the Health Services Employers Agency (HSEA) was listening to the Directors of Nursing. When I asked why she didn't submit her position paper (in this case the issue was in relation to the centres of nurse education) to the Minister for Health and Children, she commented:

'well, ...I mean (long long pause), I don't want to go above anybody's head and say does the Minister realise these things are happening?' (D3P16)

Finally, another Director of Nursing when discussing the triumvirate of medicine, nursing and management as being the decision makers commented:

'One of the things that struck me, was the way the institution, that is the hospital is run, and maybe I am wrong, it is only the very early stages, I haven't read around it from an organisational behaviour point of view yet enough. There is your nursing staff, as you say, 40%, there is the medical staff, there is the allied healthcare professionals, there is the non professional and then there is administration and management and I suppose you could argue, between medicine, nursing and management you have the three kind of people who make the decisions. But the difference here, between here and I think even in the NHS, God is still answerable to the consultants.

Researcher

God is?

Director of Nursing

He is answerable to the consultants and what they say holds (D9P2)

It is clear that the consultants hold the power base within the hospital and the Director of Nursing has to avoid conflict with them in order to achieve what she can for nurses and nursing. Hyde et al (2004), in an examination of the literature based on the relations between nursing and medicine, suggest that contemporary nurses display varying degrees of assertiveness in their dealings with physicians depending to a large extent on the seniority of the physician, even senior nurses, they suggest accept the authority of consultants. I think Hyde et al (2004) make an extremely important point which has resonance for this study. They argue that the status of nurses' decision-making capacity would seem to be highly brittle and subject to disintegration in the face of medical dominance. This is because the 'nursing' constituent of patient care, over which nurses may have legitimate control, is not always clearly demarcated from the medical aspects of care. It would not seem possible to delineate all aspects of patient care among all the different health care professionals, assuming that somebody needs to be responsible for the patient's ongoing care. After the individual health care professional has completed an episode of care, nursing remains the one constant for the patient. Thus, as health care has become fragmented and each profession has become more specialised the Director of Nursing feels responsibility for all aspects of patient care, which may help explain why the role is becoming more complex.

Finally, it is worth noting that it is not just nursing and nurses who are 'victims' of medical dominance. Minor (1998) acknowledges that due to the power that doctors possess, it can be extremely difficult to challenge their authority. Minor claims (albeit anecdotally) that challenging the medical profession can be tantamount to professional suicide and he wonders how many chief executives and senior nurse managers have 'moved on' after challenging the medical profession.

4.5.4 Core Category: Unionising

As discussed in section 4.6.2 the impact that the union, the Irish Nurses Organisation (INO), has on the Directors of Nursing would seem to be ambiguous. On the one

hand the union have to be pacified, as this comment about bed managers and night superintendents' salaries from one director would indicate:

'..nobody wants to know, they keep the unions happy as such, but the impact it's having on the ground, why would anybody stay in nursing, I mean you have DoN posts vacant in Dublin at the moment, nobody wants to go for them?' (D3P17).

In this case, 'they' is referring to the Department of Health and Children, the perception being that the Department of Health and Children will do anything to pacify the unions. And on the other hand, the Directors of Nursing sometimes need to use them to suit their own purposes, as this comment would indicate:

'I have different views about unions, but I do feel when you need to use them, use them. I got the unions to send memos to the Chief Executive Officer and Assistant Chief Executive Officer and General Manager that I believe there were rumblings for cuts of staff, our unions won't tolerate it, so that was very helpful' (D2P12),

Another Director of Nursing reflecting on how the INO has evolved from an organisation into a union stated:

'I mean, (hesitating) back in 1999 when the INO changed from being an organisation to being a union em, I suppose in one sense some of us would have had hoped that that would change but unfortunately the INO has become a union in the true sense and its focus is not the good of the profession, its focus is money and that is unfortunate we lost I think an opportunity at that point' (D7P9)

Unlike the Royal College of Nursing in the United Kingdom, the Irish nursing union would appear to be just that as opposed to a professional organisation. Commenting on how time consuming and frustrating the union issues can be, another Director of Nursing stated:

'It's annoying stuff, that could take up half your day, stupid, it's really frustrating'
(D10P10)

This Director of Nursing articulates that nursing has literally 'lost the plot', by allowing the unions to be the voice of nursing. She thinks because the biggest percentage of union membership are staff nurses, and the unions keep securing more money for them (they also secured pay rises for Directors of Nursing, but that is not discussed) staff nurses will remain loyal to the union.

'Well I mean I think we have definitely lost the plot and I think part of that is empowering the unions to have the voice that it has it will be almost, I have thought about it, how to turn that around and I really can't see a way out of it because the majority are staff nurses eh and the unions keeps getting them more money and for as long as you keep giving people more money they are going to keep buying into it'
(D7P17)

This Director of Nursing probably articulated what all of the Directors of Nursing were saying, that the unions are a barrier to organisational change and practice development and cause her a huge amount of stress:

'The thing that stresses me out the most at the moment is the energetic or eh interventionist unionist approach , and I am talking about our own professional union, if you were to ask me what gets my back up or if I'm upset on a Friday evening, what would it be that would upset me?, it would be the intervention of the union, ..., but just for me it's a barrier to change....to me it's a barrier to developing the profession and to develop practice, the concept of engendering that notion that you can demarcate your job and say it's a non nursing duty, feeding a patient is a non nursing duty gets my back up, if you want me to be stressed or if you want me to be annoyed that's the button, that's the one to press that really gets me going. I think it's actually the biggest barrier that I have I would perceive to developing'
(D1P11)

It would appear then that the Directors of Nursing are rendered powerless when they want to introduce practice development initiatives or changes in working practices, which one could argue is the essence of their job as leaders of the profession. The time that the Directors of Nursing appear to spend on union matters would also appear to have an impact on their ability to become more strategic. For example one Director of Nursing commented:

'then Thursday came I had the unions for breakfast, lunch and evening at meetings, why are you doing this, what are you doing about that, now a lot of it was medical issues' (D3P16)

This final comment from another Director of Nursing illustrates the ambiguous relationship that the Directors of Nursing appear to have with the unions. The unions, it would appear, are a double edged sword.

'when I say I have no difficulty with regard to the, I like the staff to be unionised in the sense that I think it is important from the point of view of indemnity and security and all that goes with that sort of thing and in term of if somebody has a spot of trouble at least they have someone who will come in and support them and advocate for them. Fine by me no difficulty, my difficulty really is basically where the unions are obstructive to their progress and development of the nursing and the nursing agenda' (D4P13)

Every Director of Nursing informed me that they had a gagging clause in their contract. In other words they were prevented from whistle blowing or speaking to the media. Maybe this explains the total absence of a nursing voice, other than the Irish Nurses Organisation (INO) in the Irish Media, an observation that concurs with Buresh and Gordon (2000). Whilst this gagging clause maybe accepted practice, the Directors of Nursing seems to interpret it as never being allowed to speak to the media, even when something positive occurs.

Assuming that the medical staff also have a gagging clause in their contracts, they appear not to worry about the implications of speaking out about poor services. It would seem that this passive acceptance of an 'unwritten rule' is peculiar to nursing (Minor 1998). The power of the media in the 21st century is undeniable, I would suggest that being able to utilise it effectively to suit one's own purposes is also a symbol of power and strength. The researcher examined the Irish Times daily for nearly eighteen months and other than a weekly health section piece where some members of the nursing profession are profiled in their jobs, there was no political comment from any Director of Nursing or nurse, other than the Irish Nurses Organisation¹⁶. The INO it would appear is the mouth piece of Irish nursing. It is this 'union factor' which often hinders the Director of Nursing's ability to professionally develop nursing. The Directors of Nursing, it would appear, are happy to accept the unions as their voice. This is clearly an ambiguous, but nevertheless pragmatic situation.

4.5.5 Summary

The core category of 'playing by the rules' is a strategy that the Directors of Nursing are forced to adopt in order to achieve their objectives. They are forced into preserving the status quo, avoiding overt conflict and are effectively paralysed by the unions. It would appear that the Directors of Nursing do not want to lose the protection of the union, in case they ever need to rely on them, so they are forced to 'play by the rules'. Accepting the status quo ensures the dominance of the medical profession. Those directors that accept the status quo by avoiding overt conflict would appear to be 'rewarded' by being given a more corporate role within the organisation, such as project management.

¹⁶ One Director of Nursing did comment on the appointment of the new CEO of the Health Service Executive in April, as she had worked with him (Irish Times April 15th 2005)

5 Chapter Five – Conclusions and Recommendations

5.1 Conclusion

The substantive theory of Powerless Responsibility explains the patterns of behaviour of the Directors of Nursing in eleven out of the twelve Band One teaching hospitals in Ireland. The Directors of Nursing have learnt to deal with being a nurse, they have learnt how to play by the rules and how to plug the holes in order to achieve their goals. The Directors of Nursing have adopted strategies to enable them to function within an arbitrary, if (not) maladministered system (Travers 2005).

The theory of Powerless Responsibility is built upon the four core concepts of 'Being a Nurse', 'Circumnavigating the System', 'Plugging the Holes' and 'Playing by the Rules'. At the outset, before one even begins to examine the role of the Director of Nursing, the condition of 'Being a Nurse' puts them at a disadvantage within the organisation. The lack of collegiality between the Directors of Nursing, being mostly women, and the professional socialisation of nursing contribute to and are a cause of powerlessness.

In order to overcome the arbitrary nature of the health system and the condition of 'being a nurse', the Directors of Nursing are forced to adopt various strategies to achieve their objectives. They have learnt to 'Circumnavigate the System' within which they work. Not circumnavigating the system would bring them into direct conflict with it. By this I mean, that the Directors of Nursing have adopted strategies to achieve their goals. These strategies include learning how to develop effective relationships with the key stakeholders within the organisation and learning how to be politically effective. These strategies are undertaken against a backdrop of institutional arbitrariness and not being heard. In other words, the Directors of Nursing have learned strategies that enable them to be heard in a system that is arbitrarily managed. These strategies actually contribute to their powerlessness,

because by adopting them, they are reinforcing the arbitrary nature of the system, rather than challenging it.

If the Directors of Nursing challenge the system, they risk becoming marginalised by it. Therefore, in order to function and achieve their goals they 'Play by the Rules' by avoiding overt conflict with the medics, management and the unions. Thus, playing by the rules renders them powerless. It is not clear from this study what would, in reality, happen to the Directors of Nursing if they refused to play by the rules, but, the perception among the Directors is that not to play by the rules risks expulsion from the 'club'.

Contributing to their powerlessness is the fact that they are made to feel responsible for keeping the hospital functioning at all times, and more importantly perhaps, they accept this responsibility without question. They have responsibility for the quality of patient care, which they appear to accept willingly. The question must be asked how can one healthcare professional and one profession be held responsible for the quality of patient care, when there are so many other professionals and non-professions contributing to that care? This, I am suggesting, is the nursing paradox. By being necessarily involved in all aspects of running the hospital, the Directors of Nursing are rendered powerless because their sphere of responsibility is so wide and their roles so diverse.

However, it became apparent to me that there was a contradiction in the core concept of feeling responsible for everything. This contradiction was that the Directors of Nursing of old (aka 'matron') were responsible for managing the hospital and all that that entailed. Yet I am arguing that the Director of Nursing today is still responsible for managing the hospital, and that this level of responsibility has contributed to the position of powerlessness. What is crucial to emphasise in this argument is that Matron ran the hospital, and had a lot of power to do so (Carney 2005). But the hospital that Matron managed and the hospital that today's Director of Nursing helps manage are two vastly different places. The advent of new technologies, the size of

the hospital, the increasing acuity of the patient, and the ever increasing number of professions have made the modern hospital a much more complex organisation than the one that Matron once managed. Thus, it is evident that the role of the modern Director of Nursing has evolved from that of Matron with power and authority for managing the hospital into that of the modern Director of Nursing with too much responsibility and not enough power. The latter's role has become ambiguous and ill defined because of the complexity of the system and because the authority she once held has been stripped away.

This study attempted to examine the role of the Directors of Nursing following the recommendations of The Report on the Commission of Nursing (Government of Ireland 1998). However, what became apparent is that the Commission on Nursing may have inadvertently contributed to the demise of the authority of the role of the Director of Nursing in Ireland. The tension created between the demands of corporate responsibility and the demands of operationalism appear intractable. The Director of Nursing cannot help but be operational because, (and this is the paradox) to be strategic, she needs to know what is happening on the ground. However, by knowing what is happening operationally, she becomes involved at operational level, or she perceives that she does. Thus, the strategic element of the role is diminished.

Nursing, as a female profession, is at the lower end of the health care hierarchy and it would appear that as the divisions in nursing continue, the potential for exploiting the collective power will not be realised (Davies 2004). The lack of collegiality among the Directors of Nursing and the inability to use their potential collective power to achieve their objectives were evident in this study.

Perry (1993) refers to the 'hidden agenda' in nursing. Nurses are charged with the responsibility of carrying out the orders of others without the authority to affect major structural decisions concerning modes of practice. Perry argues that this hidden agenda is not a random side effect of, for example, nursing education but an integral

part of nursing's long history of subservience to hospital medicine and hospital administration. Perry concludes:

'the old problem of powerlessness in nursing cannot be cured by assertiveness training, quality management styles or even academic training. 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, p.47).

The Directors of Nursing are striving for nursing to be treated equally not just at the board table, but on a wider scale, to influence national health policy. They are forced to negotiate their way around the corporate table, not wanting to offend anyone or to challenge the status quo and they appear powerless to act in a collegiate manner to influence health policy. The silence that abounds from not mentioning the words 'nurse' or 'nursing' as an accepted strategy at the corporate table to the silence in the media from the directors, is perpetuated by the directors themselves (Lovell 1981). Carter (1994) identified this phenomenon and described it as such:

'Firstly, consider their responsibility for maintaining the oppressive working climate in which they find themselves and secondly evaluate their hesitation to challenge the status quo' (p.368)

In other words, the Directors of Nursing themselves perpetuate the condition of powerless responsibility by not asserting nursing's place at the corporate table and not engaging with the media.

The Directors of Nursing are forced to adapt a pragmatic approach to practice development opportunities that may (or may not) arise. A large proportion of their success in introducing new roles and for achieving professional development changes relies on their ability to develop robust personal relationships within the organisation and a commitment from the CEO to encourage nursing developments (Cameron and Masterson 2000). Without good relationships and support for nursing from the CEO,

the Directors of Nursing can find themselves with no control over financing nursing services or the wider professional agenda.

The lack of willingness of some powerful consultants to reform the health service has been demonstrated from the early 1950's with the rejection of the Mother and Child Scheme. This continues today, where areas of the Health Service Reform Programme are dependent on re-negotiating the Common Contract with consultants. These same consultants have been working to rule for eighteen months and have been refusing to enter into negotiation with the Department of Health and Children (Irish Times February 15th 2005).

A discussion about the role of the Directors of Nursing will inevitably veer towards a discussion about how the health care system in Ireland is managed. This is because as a Director of Nursing, she represents nursing and nurses, and as such, is responsible for the practice working environment where most of the division of labour arguments occur (Allen and Hughes 2002). Thus, the Director of Nursing can challenge the status quo, on behalf of nursing and nurses but only to the extent that is accepted by the medical and managerial staff. Her success is directly proportional to the amount of power, for example, clinical autonomy, that the medics are willing to relinquish, and the volume of work allocated to the Director of Nursing by the CEO, for example project work. This argument is dependent on the Directors of Nursing's willingness to accept the work that is allocated to them without question, which I am arguing they appear to do. Thus, they become overloaded with work and lose their role definition. Equally importantly, nurses have reported that they felt powerless to change either the daily breakdowns or problems within their practice environment or the hospital policies that contributed to them (Weinberg 2003). Thus, the influence the Director of Nursing has on key strategic decisions within the hospital directly affects the nurses for whom she has responsibility.

Nurses and nursing keep the hospital running under all circumstances (Holmes and Gastaldo 2002). By doing this invisibly, they experience nonegalitarian, non-

privileged positions within society, the health care system and even within nursing itself. Holmes and Gastaldo (2002) argue that it is nurses themselves who constitute and make up the institution and organisations that nurses believe are the source of oppression. Using a Foucauldian framework, they further argue that nursing needs to overcome the 'obsession' with repressive power and adopt what they term a 'governmentality' approach to deconstructing nursing as an apolitical and powerless profession.

Farrell (1997), by contrast, concludes that the oppression theory debate is futile without dismantling the prevailing hegemony of the oppressors, something that is unlikely to succeed, and *he* suggests that instead, nurses need to focus on the *practice* of nursing, and by doing so will become full partners in what he terms the 'workplace redesign' (p.12). To not focus on the practice of nursing will lead to nursing's continued marginalisation and a lost opportunity to control change. Oakley (1993) concurs with what Drummond (2005) terms a 'return to the Avant Garde'. The fact that nurses are not yet (sic) members of a professional power elite means that their authority is not being challenged, as they have little. This, Oakley (1993) argues, gives nurses a unique opportunity to reshape their own place in health care. However, when reshaping this time, nurses need to ally themselves more closely with the needs of the patient, rather than with the needs of the medical profession. Oakley argues that the shift in health care consumerism away from the needs of the healthcare professional to the needs of the patient, something that the history and ideology of nursing has always espoused (Millicent Ashdown 1927), is central to this reshaping. Nursing, therefore need not re-invent itself, or allow itself to be re-invented, all nurses need to do is to 'recover their past' (Oakley 1993 p.46).

Durkheim (1984) claims that the more specialised the functions of the organism, the greater its development, which in turn can lead to what he refers to as 'mutual obligation'. In this case, nurses and doctors work together in a symbiotic relationship; one cannot exist without the other. The increasing specialisation of professions actually causes more cohesion (not less) because accentuated differences increase

interdependence and the need for full co-operation. Durkheim talks about the web of mutual interdependence and he suggests that occupational competition would actually accelerate the process. In the struggle for survival (Darwinian) some (professions) would either have to disappear altogether or transform. According to Durkheim, some of these transformations have at times led to new specialisms. Arguably, the introduction of the clinical nurse/midwife specialist and more recently, the development and accreditation of increasing numbers of Advanced Nurse Practitioners¹⁷, suggests that this is what is happening in Ireland at present.

All health care professionals (HCPs) (except medics) stand in ambiguous relationship with medicine. On one hand, they pose a threat (Mckinlay and Marceau 2002, Tormey 2003) because of the potential to take over and/or compete equally with the medics and on the other hand medicine needs the services provided by HCPs, as medicine has and will continue to relinquish low status or routine work. The medics then focus on specialist services, and sub specialisms.

In a UK study that explored new roles in practice, Read (2001) identified significant obstacles for the Nurse Executive Directors who wanted to exert greater control over developments within their Healthcare Trust. The factors identified included the configuration of the organisation, which militates against central planning and strategic development; a lack of funding for service developments which generates a culture of reliance on charity; the need to respond to government initiatives and finally the imbalance of power between medicine and nursing at individual, organisational and policy levels. It would appear that the Directors of Nursing in the United Kingdom share some of the issues identified in this study.

The Director of Nursing is not only responsible for delivering quality nursing care, she is also responsible for all aspects of patient care, yet has no authority to control other professions who interact with those same patients. In the United Kingdom, the

¹⁷ At the time of writing there were 30 accredited ANPs posts in Ireland, compared to only one four years ago. 1702 CNS are now approved, compared to 1353 in 2000.

introduction of the Modern Matron role could be viewed as an attempt to address this unbalance. 'Matron' historically managed the hospital with full authority and responsibility. The skills and knowledge that she brought to the role were not articulated or valued (Carney 2005). Modern management was introduced and the Director of Nursing role has been eroded and changed as a consequence (Jasper 2002). The introduction of the modern matron is an attempt to redress the balance between the clinical practice environment and the 'out of touch' corporate agenda. Savage and Scott (2004) argue that a tension between the corporate and the clinical models arose with the introduction of the modern matron because it was not clear whether 'matron' should be focusing primarily on the responsibilities of corporate management or on providing credible professional leadership, through some level of clinical involvement. I would argue that in Ireland, this tension is very real for the Directors of Nursing, as they are trapped between the necessary dual responsibilities of operationalism and strategic involvement.

Before beginning this study, I had always thought that the demise of 'matron', was a good thing for nurses and nursing. My rationale for this was based on the concept that if nurses and nursing were represented at corporate level, it followed that key strategic decisions for the management of the hospital would be made with nursing involvement. I now think that merely sitting at the corporate table does not guarantee nursing a voice. The vested interests of the medical profession and party politics play a very real role in key decisions locally at hospital level and also on a wider national policy level. Carney (2005) is perhaps correct when she identifies that women in nursing in the nineteenth and early twentieth centuries were utilising many of the twenty-first century management principles and skills but were not recognised for them and the managerial aspects of their work have stayed unrecognised. Carney (2005) is suggesting that the announcement in the U.K. to re-introduce the hospital matron is an indication that the place of the nurse manager has come full circle in the modern hospital structure. What I think Carney means by this is that the erosion of the role of matron has been bad for the hospital. Traditionally, Matron had responsibility for 'household arrangements, including cooking, laundry and hospital

sanitation' (Carney p.190). These areas of responsibility have gradually been taken over by other professions, each area even requiring its own departmental head (Carney 2005). What Carney is suggesting is that as Matron lost these areas of responsibility, hospital conditions deteriorated (Health Services Executive 2005) and now the emphasis is to re-instate a modern version of Matron who will have responsibility, with some authority, for the quality of patient care in the clinical area.

5.2 Recommendations

I have broken down the recommendations from this study into three areas: the recommendations for nursing and nursing education, the implications for future research in the substantive area and finally I discuss the general theoretical implications of the theory.

5.2.1 Recommendations for Nursing

Nurses must continue to engage with the patient and form an alliance with patient groups. Oakley (1993) suggests nurses simply need to recover their past. Patient centeredness is becoming the focal point of health care (DoHC 2001) and as nurses have always been at the centre of patient care, they need to ensure that this continues to be the focus of their work. However, I would suggest that this may be too simplistic a solution in modern healthcare and I would add the caveat that nursing needs to recover its past, but do so within a framework of modern technology and new ways of delivering health care. Oakley's seminal text is now sixteen years old and health care delivery has changed more dramatically in those years than perhaps in any other period. Thus, new technologies and new ways of delivering health care must continue to be embraced with the patient at the forefront.

5.2.2 Recommendations for Nursing Education

It is too early to evaluate the impact on professional socialisation of nurses in Ireland by the transfer of undergraduate nurse education to the third level institutions. However, the opportunity should not be lost for baseline data to be collected on how nursing students engage with other third level students. The purpose of this baseline

data is to be able to establish in ten or twenty years time if professional socialisation traits have been changed, or influenced, by the move to the academy. It could be argued that cross disciplinary education, shared core modules and new ways of learning may have an impact on nurses' professional socialisation. Politics and philosophy should, as a matter of course, become part of the undergraduate curriculum (where it has already not become so). Sociology and the history of nursing as an oppressed group should also be mandatory, if, as Holmes and Gastaldo (2002) suggest, nursing is to overcome its 'obsession' with repressive power and begin to deconstruct nursing as an apolitical and powerless profession. This can only happen when self awareness of the history of the nursing profession within a feminist and sociological context occurs.

5.2.3 Recommendations for Future Research in the Substantive Area

The Nursing Policy Division in the Department of Health and Children should commission a national study to examine the impact that the Report of the Commission on Nursing had on the role of the Directors of Nursing. A further study to examine the perception of CEOs and medical staff of the role of the Directors of Nursing should also be undertaken. The purpose of these would be to examine the perceptions of the CEO and the medical profession of the contribution made by nursing to healthcare.

5.2.4. General Theoretical Implications of the Theory

This study makes a unique theoretical contribution to the understanding of the role of the Director of Nursing in band one teaching hospitals in Ireland. The existence of the Directors of Nursing in a state of powerless responsibility has not been identified previously in an Irish context. The grounded theory of 'positional marginalisation' of fifty or so Directors of Nursing discovered by Tracey (2004) is, I would suggest, one of the indicators for the grounded theory of 'powerless responsibility'. In other words, by becoming marginalised, the marginalised become less powerful. What Tracey identified in her study supports the theory of powerless responsibility.

The practical implications of the grounded theory of Powerless Responsibility mean that the theory can be used by Directors of Nursing to help them develop strategies that will ensure they become more influential within the hospital and the wider health care system. By understanding the patterns in their own behaviour, and in the behaviour of others, the Directors of Nursing can only then begin to unravel these patterns of behaviour. Only then can the Directors of Nursing seek greater acceptance of what the role involves and how it needs to be supported and resourced.

REFERENCES

Abbott, A. (1988) *The System of Professions. An Essay on the Division of Expert Labor.* The University of Chicago Press, Chicago.

Adamson, B., Kenny, D., Wilson- Barnett, J. (1995) The impact of perceived medical dominance on the workplace satisfaction of Australian and British nurses. *Journal of Advanced Nursing.* Vol. 21 p.172-183

An Bord Altranais (2005) Nurse Registration Statistics. www.aba.ie accessed July 27th 2005

An Bord Altranais (2000) *The Code of Professional Conduct for Each Nurse and Midwife.* www.aba.ie accessed July 2005

Allen, D., Hughes, D. (2002) *Nursing and the Division of Labour in Healthcare.* Palgrave, Macmillan

Allen, D. (2001) *The Changing Shape of Nursing Practice.* Routledge, London

Anells, M. (1996) Grounded theory method: Philosophical perspectives, paradigm of inquiry and postmodernism. *Qualitative Health Research;* Thousand Oaks; August. Vol. 6, issue 3.

Andrica, D. (1997) The Glass Ceiling: Are you Affected? *Nursing Economics.* Vol 15 (3). P.162

Antrobus, S. (2004) Editorial: why does nursing need political leaders? *Journal of Nursing Management.* Vol. 12 (4) p.227-229

Antrobus, S., Kitson, A. (1999) Nursing Leadership: influence and shaping health policy and nursing practice. *Journal of Advanced Nursing*, 29 (3) p.746-753

Audiss, D., Roth, T. (1999) Application of grounded theory to content definition: A case study. *Topics in Health Information Management* February Vol.19, Iss.3.

Backmanm, K., Kyngas, K., A. (1999) Challenges of the grounded theory approach to a novice researcher. *Nursing and Health Sciences*. 1, 147-153

Bamford, A., Porter-O'Grady, T (2000) Shared Governance within the market-orientated health care system of New Zealand. *International Council of Nurses, International Nursing Review*, 47, p.83-88

Barnes, P., Donelle M. (1996) An analysis of the grounded theory method and the concept of culture. *Qualitative Health Research*, Vol.6 issue 3 p429.

Barrington, R. (1987) *Health, Medicine & Politics in Ireland 1900-1970*. Institute of Public Administration, Dublin

Begley (2002) 'Great fleas have little fleas'? Irish Student midwives' views of the hierarchy in midwifery. *Journal of Advanced Nursing*, 38 (3) p.310-317

Blumer, H. (1969) *Symbolic interactionism: Perspective and method*. Englewood Cliffs, NJ: Prentice -Hall

Bradshaw, P. (2001) Politics, power and control in the British National Health Service – will anything really change? *Journal of Nursing Management*. Vol. 9 p.311-313 An editorial.

Brady, D., Hyde, A. (2002) Certificate-trained staff nurses' perceptions of the changes in nursing education in Ireland from certificate to diploma level. *Journal of Continuing Education in Nursing*. Vol. 33 (5) p.231-237

Bristol Royal Infirmary Inquiry (2001) The Report of the Public Inquiry into Children's' Heart Surgery at the Bristol Royal Infirmary 1984-1995. Stationery Office, London

Brooks, I., Brown, R. (2002) The role of ritualistic ceremonial in removing barriers between subcultures in the National Health Service. *Journal of Advanced Nursing*. Vol. 38 (4). P.341-352f

Buresh, B. Gordon, S. (2000) From Silence to Voice: What Nurses Know and Should Communicate to the Public. Canadian Nurses Association. Come,, University Press.

Burns, N., Grove, S. (1997) The Practice of Nursing Research: Conduct,Critque and Utilisation. 3rd ed., Philadelphia, WB Saunders Company

Byrne, M. (2001). Grounded theory as a qualitative research methodology. *Association of Operating Room Nurses*. Vol. 73 (6). p. 1155-1156

Cameron, A., Masterson, A. (2000) Managing the unmanageable? Nurse Executive Directors and new role developments in nursing. *Journal of Advanced Nursing*. Vol. 31 (5). Pp.1081-1088

Carney, M. (2004) Middle manager involvement in strategy development in not-for profit organisations: the Director of Nursing perspective-how organisational structure impacts on role. *Journal of Nursing Management*. Vol.12, p.13-21

Carney, M. (2005) in *Care to Remember: Nursing and Midwifery in Ireland*. Edited by Gerard Fealy. Mercier Press, Cork

Carter, H. (1994) Confronting Patriarchal Attitudes in the Fight for Professional Recognition. *Journal of Advanced Nursing* Vol. 19

Chaboyer, W., Najman, J., Dunn, S. (2001) Cohesion among nurses: a comparison of bedside vs. charge nurses' perceptions in Australian hospitals. *Journal of Advanced Nursing*. Vol. 35(4) p.526-532

Chan, S. (2002) Factors influencing nursing leadership effectiveness in Hong Kong. *Journal of Advanced Nursing*. Vol. 38 96) p.615-623

Charmaz, K. (2000) Grounded Theory objectivist and constructivist method. In: Denzin, and Lincoln, Y. (eds) *Handbook of Qualitative Research*. Sage Publications, Thousand Oaks, p.509-535

Chiarella, M. (2002) *The Legal and Professional Status of Nursing*, Churchill Livingstone

Chiarella, M. (2001) What's in a name? *Australian Nursing Journal*: Dec 2000/Jan 2001; Vol. 8, No.6

Chiovitti, R., Piran, N. (2003) Rigour and grounded theory research. *Journal of Advanced Nursing*. Vol. 44 (4) P.427-435

Clancy, T., Delaney, C. (2005) Complex nursing systems. *Journal of Advanced Nursing*. Vol 13 (3) p.192-201

Corbin, J. & Strauss A. (1990) *Grounded Theory Research: Procedures, Canons, and Evaluation Criteria*. *Qualitative Sociology*, Vol. 13, No.1

Condell, S. (1998) Changes in the Professional Role of Nurses in Ireland:1980-1997. A report prepared for the Commission on Nursing. Dublin, Stationery Office.

Cormac, D.F.S. (1996) The Research Process in Nursing. 3rd edition. Oxford, Blackwell Science, pp.135-143

Colyer, H. (2004) The Contruction and development of Health Professions: where will it end? Journal of Advanced Nursing. Vol.48 (4) p.406-412

Coyne, I.T., (1997) Sampling in qualitative research. Purposeful and theoretical sampling; merging or clear boundaries? Journal of Advanced Nursing. Vol. 26(3), September pp.623-630

Crawford, D., I. (1993) The Glass Ceiling in Nursing Management. Nursing Economics. Vol.11 (6) p.335-341

Crossan, F. (2003) Strategic management and nurses: building foundations. Journal of Nursing Management. Vol. 11 (5) p.331-335

Cutcliffe, J. (2000) Methodological issues in grounded theory. Journal of Advanced Nursing. Vol. 31 (6) P.1476-1484

Crotty, M (1998) The Foundations of Social Research. Meaning and perspective in the Research Process. Sage Publications, London.

Daiski, I. (2004) Changing nurses' dis-empowering relationship patterns. Journal of Advanced Nursing., Vol.48(1), P.43-45

Dawson, S. (1999) Chapter 2, p.7-28 in Organisational Behaviour in Health Care: The Research Agenda. Eds Mark, A.,L. and Dopson, S. Palgrave Macmillan, New York.

Davies, C. (2004) Political Leadership and the politics of nursing. *Journal of Nursing Management* . Vol. 12 (4). Pp. 235-241

Davies, C. (1995) *Gender and the Professional Predicament in Nursing*. Open University Press, Buckingham Philadelphia

Department of Health and Children (2005) Report of the panel reviewing the events surrounding the death of Roisin Ruddle. February. Accessed 14/02/05 www.doh.ie

Department of Health and Children (2002) *The Nursing and Midwifery Resource: Final Report of the Steering Group. Towards Workforce Planning*. Stationery Office, Dublin

Department of Health and Children (2001) *Quality and Fairness: A Health System for You*. Stationery Office, Dublin

Diers, D., Torre, C., Heard, D., Bozzo, J., O'Brien, W. (2000) Bringing decision support to nurse managers. 18 (3) p.137-146

Diers, D., Potter, J. (1997) Understanding the unmanageable nursing unit with casemix data: A case study 27 (11) p.27-32.

Dillman, D.A. (2000) *Mail and Internet Surveys: The Tailored Design Method*. New York, 2nd edition, John Wiley & Sons, Inc.

Drummond, J. (2005) 'A Return to the Avant Garde' Paper delivered at the Royal College of Surgeons Annual Research Conference. February 2005.

Durkheim, E. (1984 ed) *The Division of Labour in Society* . The Free Press New York

du Tiot, D. (1995) A sociological analysis of the extent and influence of professional socialisation on the development of a nursing identity among nursing students at two universities in Brisbane, Australia. *Journal of Advanced Nursing*. Vol 21(1) p. 164-171

Eby, M. (1995) Ethical Issues in Nursing Research: the wider picture. *Nurse Researcher*. Vol. 3 No. 1 pp. 5-13

Edwards, S. (1997) What is Philosophy of Nursing? *Journal of Advanced Nursing*, Vol 25 (5) pp.1089-1093

Edwards, S., D. (2001) *Philosophy of Nursing: An Introduction*. Palgrave Macmillan, Hampshire.

Edwards, S. Liaschenko, J. (2003) On the quest for a theory of Nursing. *Editorial Nursing Philosophy*, 4, pp.1-3

Ewens, A. (2003) Changes in nursing identities: supporting a successful transition. *Journal of Nursing Management*. Vol. 11 (4) p.224-228

Farrell, G., A. (1997) Aggression in clinical settings: nurse's views. *Journal of Advanced Nursing*. Vol 25 p.501-508

Farrell, G. (2001) From tall poppies to squashed weeds: why nurses don't pull together more? *Journal of Advanced Nursing*. Vol.35 (1) p.26-33

Fedoruk M., Pincombe J. (2000) The Nurse Executive: Challenges for the 21st Century. *Journal of Nursing Management* 2000, 8 13-20

Feldman, H., R. (ed) (2001) *Strategies for Nursing Leadership*. Springer Publishing Company Inc, New York.

Filkins, J. (2003) Nurse Directors' jobs – a European perspective. *Journal of Nursing Management*. Vol 11 (1) p44-47

Fradd, L. (2004) Political leadership in action. *Journal of Nursing Management*. Vol. 12 (4) p.242-245

Freire, P. (1971) *Pedagogy of the Oppressed*. Herder and Herder, New York.

French, P. (1993) *Responsibility Matters*. Kansas University press.

Freshwater, D. (2000) Crosscurrents: against cultural narration in nursing. *Journal of Advanced Nursing*. Vol. 32 issue 2, p.481-489

Flynn, M. (1998) *Management in the Health Services – The Role of the Nurse*. A report prepared for the Commission on Nursing. The Stationery Office, Dublin.

Flynn, R. (1992) *Structures of Control in Health Management*. Routledge, London

Foster, D. (2000) The development of nurses as managers: the prevalence of the self-development route. *Journal of Nursing Management*. Vol. 2 p.193-199

Foucault, M. (1980) *Power/Knowledge: Selected interviews and other writings, 1972-1977*. Brighton, England. Harvester Press.

Foucault (1990) *The history of sexuality. Volume one: An introduction*. London, Penguin Books.

Gavin, J., N. (1995) The Politics of Nursing: a case study-clinical grading. Journal of Nursing Management. Vol. 22 (2) PP.379-385

Gilbert, T. (1995) Nursing: empowerment and the problem of power. Journal of Advanced Nursing. Vol.21 (5) p.865-871

Glaser, B., Holton, J. (2004) Remodeling Grounded Theory. Forum qualitative Sozialforschung/Forum: Qualitative Social Research. Vol. 5, No.2

Glaser, B. (2003) The Grounded Theory Perspective II: Description's Remodeling of Grounded Theory Methodology, Sociology Press, Mill Valley, California.

Glaser, B. (2002) Forum qualitative Sozialforschung/Forum: Qualitative Social Research 3 (3) <http://qualitative-research.net/fqs-eng.htm>. Accessed 4/07/04

Glaser, B. (2001) The Grounded Theory Perspective: Conceptualisation Contrasted with Description, Sociology Press, Mill Valley, California.

Glaser B. (1990) The Future of grounded theory. Qualitative Health Research; Thousand Oaks. Vol. 9 (6)

Glaser, B. (1998) Doing Grounded Theory: Issues and Discussion, Sociology Press, Mill Valley, California.

Glaser B. (1992) Basics of Grounded Theory Analysis. Sociology Press, Mill Valley, California.

Glaser, B. (1978) Theoretical Sensitivity: Advances in the Methodology of Grounded Theory. University of California, San Francisco. Sociology Press, Mill Valley, California

Glaser B., Strauss A., L. (1967) *The Discovery of Grounded Theory: Strategies for qualitative research*. Aldine de Gruyter, Hawthorne, New York

Government of Ireland (1989). *Report of the Commission on Health Funding*
Published by the Stationery Office, Dublin

Government of Ireland (1998) *Report of The Commission on Nursing: A Blueprint for the Future*. The Stationery Office, Dublin 2.

Government of Ireland (2003a) *Commission on Financial Management and Control Systems in the Health Service*. The Stationery Office, Dublin 2.

Government of Ireland (2003b) *Audit of Structures and Functions in the Health System*. The Stationery Office, Dublin 2.

Guba E., Lincoln Y. (1994). *Competing paradigms in qualitative research*. As cited in
Annells, M. (1996) *Grounded Theory method Part 2: options for users of the method*.
Nursing inquiry 4 (3), p.176-180

Hall W.A. & Callery P. (2001) *Enhancing the Rigor of grounded theory: Incorporating reflexivity and relationality*. *Qualitative Health Research*; March Vol 11, Issue 2. p.257-272

Hallam, J. (2000) *Nursing The Image: Media, Culture and Professional Identity*.
Routledge, London

Handy, C. (1991) *The Gods of Management*. 3rd edn. London: Arrow

Health Service Executive (2005) *Report on a National Acute Hospitals Hygiene Audit undertaken on behalf of the National Hospitals Office, Health Service*

Executive. Desford Consultancy Limited. October. Accessed via www.hse.ie. November 13, 2005.

Health Services Reform Programme (2004) www.healthreform.ie accessed August 2005

Hein, E. (1998) 'Sizing Up' the System, in Hein, E. (editor) Contemporary leadership behaviour: selected readings (5th ed), pp.295-306

Hennessy, D. Spurgeon, P. (2000) Health Policy and Nursing: Influence, Development and Impact. Macmillan, London.

Hennessy D., Rowland H., and Buckton K. (1993) The corporate role of the nursing director. Journal of Nursing Management, 1993,1,161-169.

Hewison, A. (1996) Organizational culture: a useful concept for nurse managers? Journal of Nursing Management, Vol. 4,3-9.

Hewison, A. (2001) The Modern Matron: Reborn or Recycled? Journal of Nursing Management, July, Vol.9 Issue 4, p.187

Hewison, A. (2003) Modernizing the British National Health Service (NHS)- some ideological and policy considerations: a commentary and application. Journal of Nursing Management. Vol. 11(2) p.91-97

Hicks, C. (1996) The potential impact of gender stereotypes for nursing research. Journal of Advanced Nursing Vol. 24 (5) pp1006-1013

Hickey, G. (1997) The use of literature in grounded theory. NTRResearch Vol. 2, no. 3 p371-378

Hills, B., Gulliver, P. (2000) A comparison of senior nurses and managers views on the development of mental health services in NHS trusts in London. *Journal of Nursing Management*. Vol. 8. p.291-296

Health Act (2004) Number 42 of 2004. Published by the Stationery Office, Government Publications sales Office, Molesworth Street, Dublin 2.

Holloway, I., Penson, J. (1987) Nurse education as social control. *Nurse Education Today*. Vol.7 p.235-241

Holloway, I., Wheeler, S (1995) Ethical issues in Qualitative Nursing Research. *Nursing Ethics*. Vol 2, pp. 219-225

Holmes, C., Warelw, P. (2000) Nursing as Normative Praxis. *Nursing Inquiry*. 7:175-181

Holmes, D., Gastaldo, D. (2002) Nursing as a means of governmentality. *Journal of Advanced Nursing*. Vol. 38 (6). P. 557-565

Howkins, E. (2002) Accepting the surfing challenge: making sense of collaboration. In *Managing and Leading Innovation in Health Care*. (E. Howkins & C. Thompson eds), pp.126-149. Bailliere Tindall, Edinburgh.

Humphreys, J. (1996) English Nurse Education and the Reform of the NHS. *Journal of Education Policy* 11 (6), pp.655-679

Hutchinson S.A. (1993). Grounded theory: The Method. In P. L. Munhall & C.O. Boyd (eds), *Nursing Research: A qualitative perspective* New York: National League for Nursing Press (pp.180-212).

Hunter, D., J. (2001) 'Mind the gap!' managing across boundaries. *British Journal of Health Care management*. Vol. 7 (12) p.482-485

Hyde, A., Lohan, M., McDonnell, O. (2004) *Sociology for Health Professionals in Ireland*. Institute of Public Administration, Dublin

ICN (2002) A new Definition of Nursing [WWW.icn.com](http://www.icn.com) accessed 27/8/2004

International Labour Office (2004) *Breaking Through the Glass Ceiling: Women in Management*. www.ILO.com accessed 29/06/06

Iley, K. (2004) Occupational changes in nursing: the situation of enrolled nurses. *Journal of Advanced Nursing*. Vol. 45 (4). P. 360-370

Irish Medical Organisation (2005) *Position paper on Health Service Funding*. Dublin

Jasper, M. (2002) Editorial: Nursing roles and nursing leadership in the New NHS – changing hats, same heads. *Journal of Nursing Management*. Vol. 10, p.63-64

Jasper, M. (2004) Editorial: The realities of nursing management. *Journal of Nursing Management*. Vol. 12 (5) p.287-289

Jasper, M. (2005) Editorial: New nursing roles – implications for nursing management. *Journal of Nursing Management*. Vol. 13 (2) p.93-96

Johnson, J. (1990) Strategic management: a new dimension of the nurse executives role. *Journal of Nursing Administration* 20 p.7-20

Johnson, G., Scholes, K. (1989) *Exploring Corporate Strategy: Text and Cases*, 3rd ed. Prentice Hall International UK.

Jolley, M. G. (1994) Out of the past. In: Jolley, M & Brykczynska, G. (eds) Nursing: Its Hidden Agendas. London: Edward Arnold

Joyce, P (2005) Developing a nursing management degree programme to meet the needs of Irish nurse managers. *Journal of Nursing Management*. Vol. 13 (1) pp.74-82

Kalisch, B., Kalisch, P. (1987) *The Changing Image of the Nurse*, California: Addison-Wesley

Kanter, R., M. (1993) *Men and Women of the Corporation*. Basic Books, New York

Krejci, J., W. (1999) Changing roles in Nursing: Perceptions of Nurse Administrators. *Journal of Nursing Administration*. Vol. 29 (3) p.21-29

Kuokkanen, L., Leino-Kilpi, H. (2000) Power and empowerment in nursing: three theoretical approaches. *Journal of Advanced Nursing*. Vol. 31 (1) pp235-241

Lanara, V. (1982) Responsibility in Nursing. *International Nursing Review*, 29, p.7-10

Landreneau, K. (2002) Response to: 'The nature of philosophy of science, theory and knowledge relating to nursing and professionalism. *Journal of Advanced Nursing* Vol. 38 (3) pp.283-285

Latimer, J. (2000) *The Conduct of Care: Understanding Nursing Practice*. Blackwell Science.

Leahy, A. L. Wiley, M.M. (1998) *The Irish Health System in the 21st Century*. Oak Tree Press, Dublin

Lindholm M., Sivberg G., Uden G. (2000) Leadership styles among nurse managers in changing organisations. *Journal of Nursing Management*, 8, 327-335.

Locke, K. (2001) *Grounded Theory in Management Research*. Sage publications, London.

Lovell, M (1981) Silent but Perfect Partners. *Advances in Nursing Science* 3 (2) pp.25-40

LoBiondo-Wood, G., Haber, F. (2002) *Journal of Nursing Research: Methods, Critical Appraisal and utilization*. Mosby inc., Missouri 5th edition.

Lomburg, K., Kirkevold, M. (2003) Truth and validity in grounded theory – a reconsidered realist interpretation of the criteria: fit, work, relevance and modifiability. *Nursing Philosophy*, 4, p.189-200

Lukes, S. (2004) *Power: A Radical View*. 2nd ed. Palgrave Macmillan, Hampshire, UK.

Luthans, F. (1992) *Organisational Behaviour*, 6th ed, New York: McGraw-Hill

Mackay, L. (1993) *Conflicts in Care*. London, Chapman and Hall

Madison, J. (2004) Positive and Negative Socialisation in Nursing. Paper presented at Sigma Theta Tau conference Dublin July 2004. Accessed 20/7/04. http://stti.confex.com/stti/inrc15/techprogram/paper_17833.htm

Malin, N., Wilmot, S., Manthorpe, J. (2002) *Key Concepts and Debates in Health and Social Policy*, Open University Press, Maidenhead, Philadelphia

Manias, E., Street, A. (2000) Possibilities for critical social theory and Foucault's work: a toolbox approach. *Nursing Inquiry* 7 (1) p.50-60.

McCarthy G (1997) Nursing and the Health Services in: Robins, J. *Reflections on Health* Dublin IPA.

McKinlay, J.,B. Marceau, L.,D. (2002) The End of the Golden Era of Doctoring. *International Journal of Health Services*. Vol. 32 (2) p.379-416

Mead, G., H., M. (1934) *Mind, Self, & Society: from a standpoint of a Social Behaviourist*. The University of Chicago Press. Chicago and London

Melia, K. (1996) Rediscovering Glaser. *Qualitative Health Research* 6 (3), p.368-378

Melia, K. (1981) 'Student nurses' Accounts of their work and training: A qualitative analysis, unpublished PhD thesis, University of Edinburgh.

Meyerson, D., E, Fletcher, J., K. (2000) A Modest Manifesto for Shattering the Glass Ceiling. *Harvard Business Review*. January-February, p.127-136

Millicent Ashdown, A. (1927) *A Complete System of Nursing*. Waverley Book Company Ltd. London.

Minor, J. (1998) Can we really blow the whistle? *Nursing Management*. Vol 5(3) p.11-14

Mintzberg H. (2002) Managing care and cure – up and down, in and out. *Health Services Management Research* 15, 193-206.

Mitchell, D. (1998) Power, professions and evidence-based guidelines: lessons from an organisational case study. *Journal of Nursing Management*. Vol. 6 (5) p.275-280

Mitchell, T. (2002) *Becoming a Nurse*. Ashgate, Aldershot.

Morley, M., Moore, S., Heraty, N., Gunnigle, P. (1998) *Principles of Organisational Behaviour – An Irish Text* Gill & Macmillan, Dublin 12

National Council for the Professional Development of Nursing and Midwifery (2005) *An Evaluation of The Extent and Nature of Nurse-led/Midwife-Led Services in Ireland*. Dublin

National Council for the Professional Development of Nursing and Midwifery (2004) *Report on the Continuing Professional Development Needs of Staff Nurses and Staff Midwives*. Dublin

National Women's Council of Ireland. Press Release July 2004. Accessed July 2005 via www.nwci.ie

NICE - The National Institute for Health and Clinical Excellence (2005). www.nice.org.uk/page.aspx?o=whoweare accessed 03/11/2005

Norman, I., Cowley, S. (eds) (1999) *The Changing Nature of Nursing in a Managerial Age*. Blackwell Science, London

Norton, L. (1999) The Philosophical bases of grounded theory and their implications for research. *Nurse Researcher* 7 (1), p.31-34

Nottingham, C., O'Neil, F. (2000) Out of the Church and into Kwik Fit: the nursing profession and the secularization of health care. In: *Analysing Health Policy*. (ed. Hann, A) 1st edition. P.183-195, Ashgate, Aldershot

Oakley, A. (1993) *Essays on Women, Medicine & Health*. Edinburgh University Press.

O'Shea, Y. (1995) *Resource Management and the Clinical Directorate Model- Implications for St. James's Hospital Dublin*, unpublished MSc (Econ) (policy studies) Thesis, University of Dublin, Trinity College.

Office for Health Management (2002) *Senior Nursing Management Competency Development Pack: Top Level Managers*. Published by the OHM, Dublin.

Office for Health Management (2004) *Management Competency User Pack for Nurses and Midwives*. Published by the OHM, Dublin.

Oppenheim, B. (1992) *Questionnaire Design, Interviewing and Attitude Measurement*. 2nd ed London. Pinter Publishing

Parkyn, A. (1991) *Operating Equal Opportunities in the Health Service*. Personnel Management, August.

Pelletier, D., Diers, D. (2004) *Developing Data for Practice Management: An Australian Educational Initiative*. Computers, Informatics, Nursing. 22 (4) p.197-202.

Peplau, H. (1988) *Interpersonal Relations in Nursing*. Palgrave Macmillian

Perry, A. (1993). *A sociologist's view: the handmaidens theory*. In Jolley, Moya and Bryczynska Gosia (eds). *Nursing – its hidden agendas* (pp.43-79. London, Edward Arnold

Pervin, L.A. (1990) *Personality: Theory and Research*, 6th edition, New York, Wiley

Polit, F., Beck, C., Hungler, B. (2001) *Essentials of Nursing Research; Methods, Appraisal and Utilisation*. Lippincott 5th ed, UK.

Read, S. (2001) *Exploring New Roles in Practice Final Report*. University of Sheffield.

Richman, J., Mercer, D. (2004) 'Modern Language' or 'spin'? Nursing, 'newspeak' and organisational culture: new health scriptures. *Journal of Nursing Management*. Vol. 12(5) p.290-298

Riska, E., Wagar, K. (eds.) (1993) *Gender, Work and Medicine. Women and the medical division of labour*. Sage Publications, London

Roberts, S., J. (1983) Oppressed group behavior: implications for nursing. *Advances in Nursing Science*, 5(3), p.21-30.

Roberts, S., J. (2000) Development of a Positive Professional Identity: Liberating Oneself from the Oppressor Within. *Advances in Nursing Science*. 22 (4) p.71-82

Robrecht, L.C. (1995) Grounded Theory: Evolving Methods. *Qualitative Health Research*, Vol.5 No.2, May 1996 169-177

Royal College of Nursing (2003) *Defining Nursing*. www.rcn.org.uk accessed march 2005.

Salvage, J. (1985) *The Politics of Nursing*, London, Heinemann

Sankowsky, D. (1995) The Charismatic leader as Narcissist: Understanding the Abuse of Power. *Organisational Dynamics*, 23 (4), pp.57-71

Savage, J. (1987) *Nurses, Gender and Sexuality*. Heinemann, London

Savage, J., Scott, C. (2004) The modern matron: a hybrid management role with implications for continuous quality improvement. *Journal of Nursing Management*. Vol. 12 (6) p.419-426

Schein, E. (1984) Coming to a new awareness of organisational culture. *Sloan Management Review*. Vol. 3-6

Schober, J. (1993) Frameworks for nursing practice. In: Hinchcliff, S.M., Norman, S.E., Schober, J.E. (Eds), *Nursing practice and health Care*. Edward Arnold, London

Sieloff, C.L. (2004) Leadership behaviours that foster nursing group power. *Journal of Nursing Management*. Vol. 12(4) p.246-251

Sigsworth, J. (1995) Feminist research: its relevance to nursing. *Journal of Advanced Nursing* Vol. 22 (5) p.896-899

Smart, B (1985) *Michael Foucault*, London Routledge

Stern P.N. (1985a) *Qualitative Research Methods in Nursing*. Leininger M.M. (ed) Grune & Stratton, Inc. Orlando.

Stern, P.N. (1985b) *Using Grounded Theory Method in Nursing Research*. *Qualitative Research Methods in Nursing*. Ed. M.M. Leininger. Orlando. Grune & Stratton Inc.

Stern, P.N. (1980) *Grounded Theory Methodology: Its Uses and Processes*. Image 12 (1)

Stein, L. Watts, D. Howell, T. (1990) The doctor-nurse game revisited. *New England Journal of Medicine* 332 (8) pp.546-549

Strauss A. Corbin J. (1990) *Basics of Qualitative Research: Grounded Theory Procedures and Techniques*. Sage, Newbury Park, California.

Strauss A. & Corbin J. (1994) *Grounded Theory Methodology-An overview*. In N. Denzin & Y Lincoln (eds), *Handbook of qualitative research* (pp.273-285). Thousand Oaks, CA: Sage.

Speziale, H.J & Carpenter, D.R (2003) *Qualitative Research in Nursing: Advancing the Humanistic Imperative*. 3rd ed. Lippincott Williams & Wilkins

Streubert H.J. & Carpenter D.R.(1999) *Qualitative Research in Nursing; Advancing the Humanistic Imperative*. 2nd ed. Lipponcott

Storch, J.L., Rodney, P., Starzomski, R. (eds) (2004) *Toward a moral horizon. Nursing Ethics for Leadership and Practice*. Pearson, Prentice Hall, Toronto

Sofarelli, D., Brown, D (1998) *The need for nursing leadership in uncertain times*. *Journal of Nursing Management*. Vol 6 (4), pp.201-207

Taft, S.,H., Jones, P., Minch, E. (1992) *Strengthening Hospital Nursing, Part III. Differences Among Professional Groups in the Hospital Planning Process*. *Journal of Nursing Administration*. Vol. 22 (7/8) p.41-50

Tesch, R. (1991) *Computer programmes that assist in the analysis of qualitative data: an overview*. *Qualitative Health Research*. Vol. 1 p.309-325

The Irish Times, (2005) September 28th

The Irish Times, (2005), April 15th

The Irish Times, (2005), February 15th

Tilley, S., Watson R. (eds) (2004) Accountability in Nursing and Midwifery. (2nd edition) Blackwell Publishing, Oxford.

Tormey, B. (2003) A Cure for the Crisis: Irish Healthcare in Context. Blackwater Press, Dublin

Tracey, M., Hyde, A. (2003) Developments in Nursing in Ireland: the Emergence of a Disciplinary Discourse. Journal of Professional Nursing. Vol. 19, No. 2 p.91-98

Tracey, C. (2004) Positional Marginalisation: a grounded theory of directors of nursing in Ireland. Trinity College Dublin, 2004

Travers, J. (2005) Report on Certain Issues of Management and Administration in the Department of Health and Children Associated with the practice of Charges for Persons in Long-Stay care in Health Board Institutions and Related matters. Government of Ireland, Dublin

Turkel, M., C. & Ray, M., A. (2001) Relational complexity: From grounded theory to instrument development and theoretical testing. Nursing Science Quarterly; Oct Vol.14, Iss. 4

Vaughan, B. (1997) Review: The use of literature in grounded theory. NTRResearch Vol. 2, no. 3 p.379

Walker K. (1993) On what it might be to be a nurse: a discursive ethnography. Unpublished PhD thesis. La Trobe University

Wall, A. (1994) Role out of control. Nursing Management Vol. 1 (7) p.17

Weber, M. (1947) *The Theory of Social and Economic Organisation*, New York: Free Press.

Weinberg, D., B. (2003) *Code Green: Money-Driven Hospitals and the Dismantling of Nursing*. Cornell University Press

Weitzman, E. (2002) Software and qualitative research. In *Handbook of qualitative research*. (Denzin, N., Lincoln, Y. eds). Sage, London, p.803-820

Wells, J. (1995) Health care rationing; nursing perspectives. *Journal of Advanced Nursing*. Vol. 22(4). P.738-744

Western Australian Department of Health (2002). www.nursing.health.wa.gov.au. Accessed June 2004

Wilmot, S. (2000) Nurses and whistle blowing: the ethical issues. *Journal of Advanced Nursing*. Vol. 32 (5) pp1051-1057

Worth, H. (1998) Castledine ,G., McGee., P. eds. *Advanced & Specialist Practice*. Blackwell Science, Oxford.

Wren, MA. (2003) *Unhealthy State. Anatomy of a Sick Society*. New Island, Dublin

Appendices

Appendix 1 – Example of Coding and Development of Categories

Code	Category
<p>Being in charge d1p10</p> <p>God I'm actually in charge d1p16</p> <p>Really feel that responsibility d1p16</p> <p>Really feeling the responsibility d1p16</p> <p>Having a large brief d1p1</p> <p>Making you conscious of responsibility for nursing practice d1p17</p> <p>Making you feel really in charge d1p16</p> <p>Recognizing own developmental needs d1p3</p>	Being responsible
<p>Having good collaborative relationship d1p12</p> <p>Having good relationships d1p17</p> <p>Being widely accepted d1p10</p> <p>Managers having good relationships d1p17</p> <p>Isolating yourself d1p8</p> <p>Relationship with middle managers d1p8</p> <p>Consultant reporting directly to H/B CEO d2p16</p> <p>Consultants are very open d2p9</p> <p>Consultants being difficult d2p9</p> <p>Consultants being respectful of the DoN d2p6</p> <p>Consultants being rude to staff d2p9</p> <p>Consultants deciding d2p6</p> <p>Consultants talking to the DoN d2p6</p> <p>Dealing with consultants on behalf of</p>	Having good relationships

<p>nursing staff d2p2</p> <p>Challenging the medics d2p20</p> <p>Having lots of resistance from band ones d2p21</p> <p>Having lots to say d2p13</p>	
<p>Collaborating with the complaints manager d1p8</p> <p>Collaborating with the risk manager d1p8</p> <p>Coming to me d1p17</p> <p>Communicating the message d1p7</p> <p>Communicating to their own units d1p14</p> <p>Computerised care plans d1p13</p> <p>Conduit for information to come up d1p8</p> <p>Discussion taking place at their own operational meeting d1p15</p> <p>Discussion taking place d1p15</p> <p>Everything comes up d1p7</p> <p>Everything goes down d1p7</p> <p>Everything not coming to me d1p17</p> <p>Finding out how many patients are crawling the walls d1p14</p> <p>Finding out what's happened overnight d1p14</p> <p>Getting feedback d1p7</p> <p>Getting around once a fortnight d1p14</p> <p>Getting information from people d1p3</p> <p>Getting information presented to me so well d1p16</p> <p>Getting information so efficiently d1p16</p> <p>Getting informed d1p16</p>	<p>communication</p>

<p>Going around wards d1p11</p> <p>Going out to meetings d1p15</p> <p>Having a briefing meeting d1p14</p> <p>Having a briefing session d1p14</p> <p>We are communicating d1p15</p> <p>Walking the wards d1p14</p> <p>Trying to source information d1p13</p> <p>Thinking not enough meeting time d1p6</p> <p>Seeing staff every day d1p17</p> <p>Seeing the NMT every morning d1p14</p> <p>Ability to have open discussion d1p16</p> <p>Imparting information d1p15</p> <p>NMT having to take the information back d1p14</p> <p>Having private meetings d2p7</p> <p>Having direct access to ACEO of HB d2p7</p> <p>Having health board meetings d2p12</p> <p>Calling a meeting d2p9</p> <p>Communication</p> <p>Difficult o meet d2p13</p> <p>Having to meet with people d2p18</p> <p>Having twice yearly meetings d2p4</p> <p>Getting the message out d2p9</p> <p>Meeting people d2p18</p> <p>Recommend all band ones meet quarterly d2p13</p> <p>Role of OHM in communication between bands d2p13</p>	
--	--

<p>Setting up a group d2p8</p> <p>CNO needs to communicate her views d2p14</p> <p>CNO not communicating d2p14</p> <p>CNO not meeting us d2p14</p>	
<p>The idea that it's not my job d1p12</p> <p>Same level as everyone else d1p5</p> <p>Saying I 'm not going to do that d1p12</p> <p>Saying to people its ok d1p8</p> <p>Set ideas about the role d1p2</p> <p>Being a non-nursing duty d1p12</p> <p>Outside the remit d1p17</p> <p>Nurses not taking blood d1p11</p> <p>Nurses refusing to clean a scope d1p12</p> <p>Not nursing d1p1</p> <p>Not just nursing, be multi-disciplinary d1p8</p> <p>Non-nursing duties d1p11</p> <p>Non-nursing duties d1p11</p> <p>Non-nursing project management d1p1</p> <p>Needing to be careful not to lose nursing focus d1p2</p> <p>Needing to be clear about own role d1p2</p> <p>Making sure people are aware of their scope d1p12</p> <p>Creating boundariesd1p12</p> <p>Determining own role d1p2</p> <p>The unions will get us somehow d1p12</p> <p>No conflict where clarity of roles exist d2p3</p>	<p>Creating boundaries</p>

<p>Personality causing conflict d2p3</p> <p>Conflict between DoN & GM d2p6</p> <p>Consensus not being reached d2p13</p> <p>Consultant being like a dog with a bone</p> <p>Lots of fighting d2p5</p> <p>Coming into a hostile situation d2p8</p>	
<p>A hierarchal mindset d1p10</p> <p>Attitudinal thinking d1p1</p> <p>Bureaucracy within the NMPDU d1p13</p> <p>Centralist management structure d1p1</p> <p>Centralist organisational structure d1p7</p> <p>Persistent centralist management structure d1p1</p> <p>Centralist way of managing not right d1p7</p> <p>Operational management d1p1</p> <p>Organisational structure d1p1</p> <p>Organisational structure very important d1p1</p> <p>Organisational structure very important d1p1</p> <p>Very centralist Structure d1p8</p> <p>Unhealthy work behaviours d1p3</p> <p>Union intervention d1p11</p> <p>Unions as a barrier to change d1p11</p> <p>Unmanageable organisation d1p7</p> <p>Unnecessary regional interest d1p4</p> <p>Upward management d1p2</p> <p>Strong HR d1p8</p>	<p>Organisational structure</p>

<p>Struck by organisational structure d1p1</p> <p>Structure to merge the hospitals d1p7</p> <p>Structure worked during the merge d1p7</p> <p>Size of organisation not the issue d1p10</p> <p>Small executive management group d1p7</p> <p>Small team d1p7</p> <p>Clinicians in management d1p7</p> <p>Decentralising down to ADoN d1p15</p> <p>Dividing into sub-functional units d1p7</p> <p>Now organisation too big d1p7</p> <p>Not calling them directorates d1p7</p> <p>Having a deputy DoN d1p15</p> <p>Hospital too big to get around in one go d1p14</p> <p>Having a governance council d1p8</p> <p>Moving away from operational level management d1p3</p> <p>How the organisation looks d2p20</p> <p>Having no consultation d2p14</p> <p>Having no hospital executive d2p6</p> <p>Having no standard approach to reporting d2p15</p> <p>Hospital executive not functioning d2p5</p> <p>Hospital Executive Team not working d2p6</p> <p>How other systems work d2p22</p> <p>Not being accountable to GM d2p7</p> <p>Bureaucracy is frustrating d2p17</p> <p>Having strategic collective agreement d2p6</p>	
--	--

<p>Having a good structures d2p12</p> <p>Having a joined up service d2p21</p> <p>Having divisional management structures d2p5</p> <p>Having a professional bureaucracy d2p7</p> <p>Having devolved management d2p3</p> <p>Flattening the Nursing organisational structure d2p5 Nursing organisational structure</p> <p>Focusing on operational issues d2p6</p> <p>Nursing structures are excellent d2p17</p> <p>Teamwork within nursing management d2p4</p> <p>Nursing managing nursing well d2p2</p> <p>Reshaping the management structure of the hospital d2p6</p> <p>Restructuring d2p3</p> <p>Evolving role of nursing d2p1</p>	
--	--

Appendix 2 - Examples of Theoretical Memos and Field Notes

Initially the interviewer felt slightly embarrassed because the interview had no structure as she was adhering to the Glaserian ideology of not knowing what the essential matters are. According to Backman (1999) during the first interviews the researcher may wonder whether the essential matters are discussed or not.

In this sense before the interview the researcher was glad to have read around the grounded theory approach so that she could explain why she had no structured questions to the interviewee. This had the potential to be extremely embarrassing and the potential for the director to feel that she was dealing with a naive and somewhat sloppy researcher might have inclined her not to put the effort and thought into the interview. This is important to remember for future interviews. The tempo of the interview was overall very good, I was rather nervous more so because I had no set questions. I had sent all the directors a letter stating the aims and objectives of the research. However I think the director felt slightly odd initially just talking about the job. But saying that they soon got into the flow, they listed things or issues that they felt were pertinent to what I wanted to hear. It was mostly operational issues, the main thing that struck me was the relationship concept.

Appendix 3–Letter to Participants

78 St. Columbanus Rd.
Milltown,
Dublin 14

Dear,

I am embarking upon a masters degree through research under the supervision of Professor Anne Scott in Dublin City University.

The aim of the research is to explore the role of the Directors of Nursing in Band One Teaching Hospitals in Ireland using a grounded theory approach. The objectives are as follows:

- To explore if there are disparities in the way that Directors of Nursing experience their job
- To explore what these disparities are, if they exist
- To explore why these disparities occur
- To explore the Directors of Nursing relationship with the corporate team
- To examine the factors that enable the Directors of Nursing to function in their role effectively and
- To examine the factors that inhibit the Directors of Nursing from fulfilling their role effectively.

The method of data collection is a semi-structured taped one-to-one interview lasting approximately one hour.

I realise that time is your most precious commodity and I am asking for quite a lot of it. If you would like more information please don't hesitate to contact me prior to consenting.

Confidentiality and anonymity will of course be guaranteed.

If you would like to participate please email me at jhogan@ncnm.ie or phone me at 087 9678610 to arrange a suitable time and date at your convenience.

I look forward to hearing from you.

Yours sincerely,

Jenny Hogan

Tables

Table 1.1 Gender breakdown for registered Nurses and Midwives (ABA 2005)

Table 1.2 Visual representation of Powerless Responsibility