Chapter Three
THEORETICAL FRAMEWORK: Kanter's theory of organizational power

3 Introduction

The previous chapter reviewed the literature that considered the NUM's role from both an Australian and international perspective. This chapter introduces and discusses the theoretical framework that underpins the study, and provides a rationale for its utilisation. As the purpose of this feminist study was to explore the construct of power within the working world of nursing unit managers, a theoretical framework of power in the workplace was required to support it. Kanter's (1977) theory of organizational power was chosen because it could provide a means of uncovering and understanding power issues faced by nurses who are managers. The concept of organizational culture is also presented and discussed, as it further explicates the importance to this study of the theoretical framework. An overview of the literature that explores the social and political nature of healthcare organizations is presented, as it further contextualises the importance of this framework to this feminist study.

In addition, this chapter reviews literature regarding the public and professional image of nurses, which further links the theoretical framework to the topic of interest. This is important because it will be shown that both the traditional gendered images of nurses and the patriarchal hierarchy of healthcare organizations work to oppress nurses by limiting their access to organizational power. Further, a discussion of the values embedded within the nursing role is included to demonstrate the dichotomy between the caring role of nurses and the organizational expectations of managers.

3.1 Justification for the theoretical framework

The focus of this study is the construct of power within the working world of NUMs. In order to explore this topic a framework that explains the nature of power within organizations was considered vital. In addition, as feminist studies are based on political perspectives that strive to uncover issues of oppression and powerlessness (Speedy 2000), a theoretical framework of organizational power that relates to women's working lives, such as Kanter's (1977) was needed to underpin it. Kanter's (1977) theory of organizational power was developed more than two decades ago, at a time when women were challenging their traditional roles and seeking to be accepted as equal players in working environments.

While working women have overcome many of the challenges of the 1970s, Kanter's (1977) theory is still considered robust in explaining some of the current issues that face women as managers. For example, Kanter's (1977) theory of power has been widely assimilated into organizational literature as a framework for exploring women's work roles (Acker 2003; Kanter 1979; Kanter 2003; Spence Laschinger 1996). In this study, Kanter's (1977) theory is used to explore the power inequalities experienced by NUMs in healthcare workplaces. The literature indicates that in traditional patriarchal healthcare workplaces, nurses are disempowered and marginalised (Daly, Speedy & Jackson 2006), so a theory of organizational power was considered vital in understanding how this lack of power might impact on NUMs' working lives. Furthermore, this framework is appropriate because it explains why access to organizational power is difficult for women, and for first-line managers of both genders (Acker 2003:52). Thus, in this study that seeks to explore the working world of NUMs, who are predominantly women, this framework is congruent with the study aims and a feminist research methodology.

Within the nursing literature, Kanter's (1977) theory has been used before to explore nurses' professional roles in the context of healthcare settings (Finegan & Spence Laschinger 2001; Sarmiento, Spence Laschinger & Iwasiw 2004; Spence Laschinger et al. 1999; Spence Laschinger, Almost & Tuer-Hodes 2003; Upenieks 2003), but no literature was found that used Kanter's (1977)

theory to understand the power dynamics experienced by nurses who are managers.

As discussed in Chapter One, while there are other theories of power, Kanter's (1977) theory was considered the most appropriate for this study because it specifically identifies organizational role constructs, rather than individual characteristics, as key factors in influencing managers' access to organizational power. In this way, Kanter's (1977) framework can explicate aspects of the NUM role that may remain hidden using other theories. Furthermore, Kanter's (1977) theory offers a means of understanding the role of first-line female managers in a way that links power inequality to more than just gender bias. According to Acker (2003:49), 'the problems that women have in organizations are the consequences of their structural placement, where they are crowded in dead-end jobs at the bottom, or as tokens at the top'. In between these two positions is the role of the first-line manager.

A significant feature of Kanter's (1977) theory is that one particular group of workers has been identified as prone to powerlessness. This group is first-line managers. Based on a number of studies described in Kanter's (1977:186) book, *Men and Women of the Corporation*, first-line managers of both genders are described as functionally powerless because they are frequently responsible for results without 'the resources to get them'. According to Kanter (1977), first-line managers often have limited access to organizational power, which means that their positions are organizationally invisible and generally unrewarded. Kanter (1977) contends that as women workers commonly only reach this first level of management, these issues are particularly relevant to female first-line managers, and this is still true today. As discussed previously, NUMs are predominantly female, and they work in hierarchical organizations as first-line managers, making Kanter's (1977) theory well suited to exploring the construct of power within their role.

Kanter's (1977) theory will also aid in understanding the relationship between gender, role and power within the organizational culture of healthcare. Acker (2003:51) sums up the role of gender in organizations by saying that 'gender is a primary way of signifying relationships of power'. Kanter's (1977)

understanding of power is not power in a negative sense, which is power used to control, intimidate or subjugate others. Rather, this author describes power as a positive force. According to Kanter (1977), having organizational power causes workers to feel they are valued, contributing members of an organization. Managers who are empowered in this way are also able to empower their staff, which as mentioned in the preceding chapter is one of the responsibilities of NUMs (Jones & Cheek 2003; Kramer & Schmalenberg 2003). Thus, Kanter's (1977) concept of power is congruent with the principles of feminist research, which seeks to expose the controlling and oppressive use of power and facilitate changes that can encourage empowerment for those suffering oppression.

Thus, in applying this framework to a study of NUMs, my aim is not only discover how they experience oppression and powerlessness within their role, but also, in accordance with the goals of a feminist study, to suggest how the findings could guide practical change. This will be discussed in the final chapter of the thesis.

3.2 Kanter's theory of organizational power

Power, according to Kanter (1977:166), is 'the ability to get things done', and in Kanter's view, power is to be found in a worker's ability to mobilize whatever resources are necessary to achieve a goal. Power consists of both formal and informal components. Formal power refers to the power conferred on a particular job role by the organization, as well as the visibly competent performance of that role. Thus, holding a position deemed powerful by the organization does not necessarily confer power, unless the incumbent is credible, recognizable and valued within that role (Kanter 1977).

According to Kanter (1977), informal power is a more nebulous concept, as it is based on having social and political savvy, plus access to organizational resources and relationships that can confer power. Having access to support from powerful people within the organization can assist one to become more powerful, as can being considered powerful by peers and subordinates (Kanter 1977).

Kanter (1977:245) theorises that elements of both formal and informal power are to be found in the 'structural determinants' that underpin the notion of power. According to Kanter (1977:275), the structural determinants that influence a worker's access to organizational power are: opportunity, information, support, and resources. Opportunity refers to 'the individual's prospects relative to others of his/her age or seniority' (Kanter 1977:246). Kanter suggests that people low in opportunity have limited aspirations, low self-esteem, and limited upward influence. In addition, such people are less likely to seek or accept change (Kanter 1977:247).

The next structural determinant of organizational power is access to information. For Kanter (1977:278), this involves having access to open channels of communication, or 'system knowledge'. For example, in order to function effectively, workers need access to information about budgets, salaries, routines and operating data. This information is vital if workers are to participate effectively in the operation of the organization (Kanter 1977).

Support or 'sponsorship', according to Kanter (1977:279), is another structural determinant of power and this refers to both formal and informal mechanisms that develop competence and confidence in workers. Kanter (1979:66) explains that support refers to both the formal job description that defines and supports a manager's decision-making powers as well as more informal support alliances. For example, the support gained through mentorship and informal networking opportunities can provide workers with links to those who are more powerful within the organization.

Access to resources, the last structural determinant of power, refers to the individual's ability to mobilise the things that are needed to get the job done (Kanter 1977:166). For example, money, staff, time, space, equipment and supplies all fall into this category. Kanter (1979:66) suggests that managers with organizational power can also gain access to resources as a demonstration of their prestige and to distribute to workers as rewards.

Kanter (1979) proposes that if managers are denied access to organizational opportunities and reliable lines of supply, information and support they are insecure and inefficient in their job. This in turn can cause them to blame, oppress and hold back their subordinates. This situation occurs when first-

line managers have no upward influence and do not feel valued, recognized or important to the organization. In other words, according to Kanter (1979:65), they have no 'clout'. Managers in these types of positions often display the classic symptoms of powerlessness, in that they develop rule-mindedness, even pettiness, they are bossy and closely supervise the work of subordinates, they lack creativity and do not display innovative practice. They also have a tendency to do the job themselves rather than delegate tasks, and they show a reluctance to train, groom or support subordinates to take over their role (Kanter 1979).

Kanter's (1977) image of a powerless worker bears a striking similarity to nursing relationship patterns labelled 'oppressed group behaviours' first discussed by Roberts (1983), in a study which highlighted the destructive effects of oppression. Daiski (2004:44) notes that nurses' frustration with their powerless positions leads to 'internal divisiveness' and a 'bullying culture'. Speedy (2004:8) also discusses the power and politics of organizations, suggesting that 'powerless managers tend to be bossy and abusive, indicating the important role that power structures and roles have in organizations'. Kanter (1977:203) explains that managers within occupational groups that have 'tightly supervised and rules-conscious hierarchies' are often powerless, because they do not have positive relationships with those in positions of power. From the review of the literature plus anecdotal evidence, this explanation seems to fit the NUM's role.

Conversely, Kanter (1977) found that empowered managers feel satisfaction, and because they are informed and valued, they provide subordinates with information, they delegate readily, and they encourage, support and reward subordinates' achievements. Kanter (1979:73) argued that if powerless first-line managers had formal and informal power to share with their staff, then both manager and subordinates would become empowered. According to Kanter (1979), empowered workers benefit both the organization and themselves.

One very important feature of Kanter's (1977) theory is the belief that organizational structures create roles and work behaviours, meaning that powerlessness is a feature of a role construct rather than being gender based

or dependant on personal characteristics. Kanter (2003:34) contends that powerless behaviours are 'a universal human response to blocked opportunities'. Brightman and Moran (2001) also discuss the importance of focusing on role construction in healthcare. These authors suggest that in order to understand the requirements of a management role, one should explore not who the manager is, but what the manager does.

Figure 3.1 below is a diagrammatic representation of my conceptualisation of Kanter's (1977) theory of organizational power as it informs this study. To develop this concept map I considered Kanter's (1979) descriptions of the nature of formal and informal power, and linked these to the four structural determinants needed to gain access to power, namely: resources, information, support and opportunity. This concept map is based on the image of a power pole energising a light bulb, and it depicts power as a flow of energy that achieves benefits for both the workers and the organization. This representation is included to show my understanding of the positive effects of having access to both formal and informal power. Obviously, if access to the structural determinants is lacking, then both the organization and the individual worker will not reap the benefits identified, but will instead be more likely to suffer from inefficiency, low morale, burnout and stress, which in turn will impact on the effectiveness of the organization as a whole.

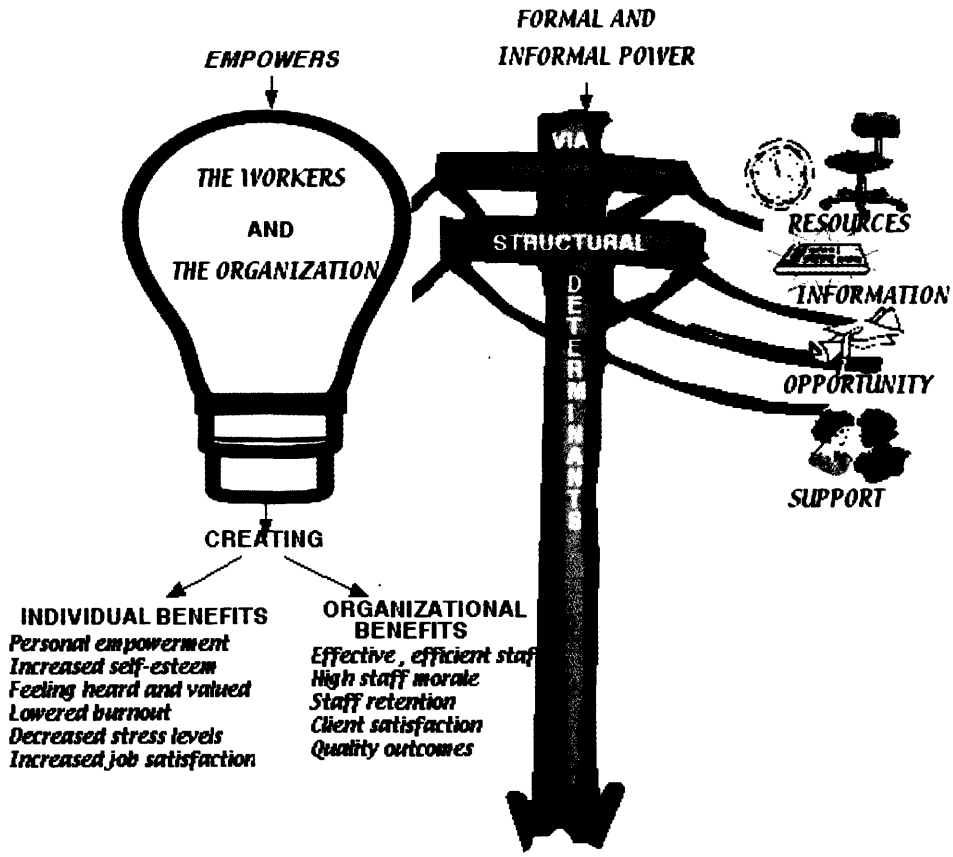

Figure 3.1 The determinants and benefits of organizational power
(Paliadelis 2004)

When considering the applicability of Kanter's (1977) theory of organizational power to this study, I was immediately struck by the significance of the relationships between gender, role construction and organizational structures used by Kanter (1977) to understand power issues. As discussed below, nursing is a profession that is strongly gender specific, and during my nursing career I have observed the subservient role that nurses are expected to play in healthcare organizations. This led me to consider how these factors might impact on nurses who are promoted to managerial positions.

Kanter's (1977) theory of organizational power provides an alternative way of considering the power issues that goes beyond just the impact of gender and the personal characteristics of powerless people to conceptualise power as embedded in the structures, interactions and relationships of members and groups within organizations. Kanter (1977) theorises that an exploration of the formal and informal organizational constructs of power can explain why some managers are in powerful roles while others are not. I suspected that the

role of a NUM would be influenced by an organizational culture that does not sanction power and authority for nurses.

Kanter (1977) does not refer specifically to organizational culture when discussing power, so the next section presents an overview of the concept of organizational culture, which has assisted in my understanding of how the construct of power is created and maintained within an organization.

3.3 Organizational culture

Studies that explore the roles of healthcare professionals often include a discussion of the organizational culture in which they work, because workers are the foundations of organizations, and organizations do not exist in a vacuum (Ashburner 2001; Helms & Stern 2001). Rather, organizations are social systems, which both create and dictate workers' job performance, job attitudes, values and roles (Alvesson 2002; Burnes 2000; Schein 1996a). Organizational culture is both formed and influenced by broader cultural contexts such as national, political, social, ethnic and occupational group memberships (Fulop & Linstead 2004; Willcoxson & Millett 2000). Daly, Speedy and Jackson (2006:4) offer the following comment about how culture contributes to nurses' vulnerability:

> It is important to recognise that the concept of nurse is socially constructed and that nurses may want to believe in their power and control but the wider societal context situates nurses in a much more fragile position.

Trice and Beyer (1993) suggest that organizational culture forms over a period of time and is created and maintained in a symbiotic manner by the assumptions, beliefs and behaviours of organization members. This reinforces similar comments made by Kanter more than a decade earlier:

> We have seen that organizational roles carry characteristic images of the kinds of people that should occupy them, thus encouraging incumbents to turn into those kind of people. Positions carry a particular structure of rewards. These rewards may or may not be related to formal tasks in the

> narrower sense, but they emerge because of the human issues with which people must grapple as they live in large organizations (Kanter 1977:250).

Therefore, in this study that seeks to explore the construct of power within the working world of nursing unit managers, it is appropriate to consider the impact of the organizational and professional nursing culture on the NUM's role.

Within any organization, it is the culture that provides a web of interconnected elements that link it to the experiences of members (Green & Cassell 1996; Osborne & Gardner 2005). This web can be seen in the organizational structures, such as the hierarchies, the power structures, the rituals, the routines, and the stories that form the day-to-day working environment of an organization (Johnson 1988). While a comprehensive discussion of organizational culture is beyond the scope of this thesis, one author in particular, Schein (1992), has been influential in developing and studying the concept of organizational culture. It is Schein's definition of organizational culture that has helped to augment my understanding of Kanter's (1977) theory of organizational power. According to Schein (1992:373-374) organizational culture is:

> A pattern of shared basic assumptions that the group learned as it solved its problems of external adaptation and internal integration, that has 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.

Schein (1996a; 1996b) contends that studies of organizational culture can shed light on both the experiences of people in their work roles and the success of organizations as a whole, by exposing the complex web of interactions and conflicting views held by group members who make up the organization. Organizational culture, according to Schein (1992:9), exists on three levels. The third and deepest level is assumptions, the second, values and beliefs, and the first, artefacts. Assumptions are taken-for-granted understandings of reality that give rise to values and beliefs, which consist of principles and

standards that have value to organization members. Schein (1992:56) describes artefacts as the visible or audible indications of values and beliefs. For example, artefacts can be seen in the physical work environment, the behaviour of workers, social rituals of the workplace and the status symbols of workers. In Schein's (1992) view, organizational culture arises from interactions between these three levels of the collective unconscious. Assumptions are rarely debated or even confronted by members of the organization because they are such powerful feelings and perceptions about reality. According to Schein (1992), organizational culture is invisible, yet pervasive, as it creates and maintains our thoughts and behaviours about what is normal and 'right'. According to Schein, the following metaphor explains how assumptions underpin organizational culture:

> Culture at this deeper level can be thought of as the shared mental models that members of an organization hold and take for granted. They cannot readily tell you what their culture is, any more than fish, if they could talk, could tell you what water is (Schein 1992:21).

Schein's (1992) understanding of organizational culture illuminates how artefacts and values reveal underlying assumptions. Schein's conceptualisation of organizational culture provides a pathway for members of an organization to bring to consciousness their own cultural assumptions, which can aid in understanding the construction of their role. Furthermore, Schein (1992) explains that the espoused and hidden values of an organization are reflected in the roles of its members. Thus, Schein (1992) provides a way of teasing out how Kanter's (1977) theory of organizational power explains the distribution of power and status of certain workers within an organization. Furthermore, Schein's (1992) definition of artefacts and values reinforces Kanter's (1977) belief that organizational roles are constructed in such a way that power or lack of it can be seen in the opportunities, support, information and resources made available to the incumbent.

3.4 Organizational power within the context of healthcare

In this section, literature is reviewed that explores the construct of organizational power within the context of healthcare. As discussed

previously, a consideration of organizational culture is common in studies that seek to explore the impact of the healthcare context on the roles of healthcare professionals. A number of authors suggest that healthcare organizations have a distinctive culture. For example, in a description of the concepts and practices of managing healthcare organizations Mickan and Boyce (2002:52) contend that healthcare organizations 'have unique issues of management' as the nature of the work is highly variable, complex and usually urgent. As well, these authors explain that healthcare is carried out by a diverse range of professionals, who are required to deliver care founded on humanistic values, within a political landscape in which professional rivalry and cost containment are the driving forces (Mickan & Boyce 2002).

Some authors suggest that the complex organizational culture of healthcare is based on competing assumptions, beliefs and values of the various professional groups (Brooks & MacDonald 2001; Courtney, Yacopetti & Rickard 2001; Willcoxson & Millett 2000). For example, Bloor (1999) and Bloor and Dawson (1994) explain that healthcare workplaces contain various subcultures, some of which are based on professional identity, such as medicine or nursing, while others may develop because of workgroup allegiances, such as loyalty to a surgical team, or the allegiance of staff members to a particular ward. Some of these subcultures are more powerful than others, and in healthcare the medical profession has always been the dominant subculture (Bloor 1999; Daly, Speedy & Jackson 2006). According to Beil-Hildebrand (2002), conflicts generally occur because medical personnel expect to be in a leadership role in multidisciplinary healthcare teams, leaving nurses in dependent, less powerful positions. The reasons for the unequal power relations are to be found in the traditional gendered roles of nurses and doctors (Speedy 2000). Cronenwett (2001) agrees that some workers in healthcare settings, such as medical doctors and senior administrators do not embrace nursing as a full partner in healthcare decision-making, policy and delivery. Similarly, as Clare, Jackson and Walker (2001:171) state:

> nurses are the backbone of the hospital structure since patients enter hospital to receive nursing care...Yet nurses are placed at the bottom of the hierarchical management system.

It seems that despite their greater numbers, nurses do not have organizational power. Daly, Speedy and Jackson (2006:5) offer further insights into the reasons why nurses lack power, stating that 'nurses collude with their oppressors by uncritically accepting outsiders' social construction of nurses and nursing'.

In the Australian public healthcare system, the literature indicates that nursing unit managers operate in a cultural context where they are professionally overshadowed by the dominant organizational subculture, which is medicine, and restricted by financial constraints imposed by governments and controlled by bureaucrats (Duffy & Chan 2001; Van Eyk, Baum & Houghton 2001; Lewis 2004a). In addition, a number of the studies discussed earlier indicate that NUMs frequently do not have any input into decisions concerning their ward's budget allocation, yet they are expected to be responsible for the financial management of the ward (Bolton 2003; Brewer & Lok 1995; Crossan 2003; Duffield, Donoghue & Pelletier 1996). Thus, it is easy to understand why NUMs might experience tensions between the demands of their professional role and the expectations of the organization that employs them. However, whether the tensions NUMs experience are caused by powerlessness remains to be seen. What is clear from the literature is that the effect of powerlessness on nurses leads to burnout and job dissatisfaction (Chandler 1991; Finegan & Spence Laschinger 2001; Sarmiento, Spence Laschinger & Iwasiw 2004; Spence Laschinger 1996; Spence Laschinger, Almost & Tuer-Hodes 2003; Upenieks 2003; Wilson & Spence Laschinger 1994).

An alternate view of the power issues in healthcare is offered by Calpin-Davies (2000:17), who suggests that NUMs who blame the organization, the environment, colleagues or the changes to the healthcare system for the challenges they face are really just ineffective managers. This suggestion is countered by Reedy and Learmonth (2000) who argue that the challenges that NUMs face are not the result of personal inefficiency, but rather are grounded in the conflicting values and role expectations they face as both nurses and managers. Bolton (2003:122) agrees, stating that the 'role of ward and clinical nurse managers are full of conflict and contradiction', because the managerial responsibilities of the role are clearly at odds with a NUM's identity as a

nurse. In the following section, nursing identity and the influence of gender and image on nurses' roles is discussed.

3.5 Organizational power, gender issues and the image of nursing

As previously mentioned, in this study Kanter's (1977) theory of organizational power provides a way of understanding how the traditional gendered image of nursing is linked to the construct of power within nurses' working world. An awareness of this relationship between image and power is vital if this study is to lead to insights into how nurses' powerlessness impacts on the role of NUMs.

To be a nurse is to have a strong and particularly enduring public image (Buresh & Gordon 2000; Sullivan 2004). This image interacts with nurses' organizational roles to create and maintain certain assumptions and beliefs about the scope of nursing within healthcare organizations (Glass 1997). So, for the purpose of this feminist study a consideration of gender and image is necessary to explain the interactions between nurses' roles in healthcare organizations and the construct of organizational power. It is important to note that this discussion of gender and image does not refer to the gender of individual nurses, nor is gender considered the only reason for nurses' powerlessness. Rather, as described by Kanter (2003), gendered assumptions about certain work roles often underlie powerless positions in organizations. Therefore, a consideration of gender issues as they relate to the image and professional culture of nurses is appropriate, as it provides a lens through which to view the findings of this feminist study into the working world of NUMs.

It is common knowledge that modern nursing began with Nightingale during the Crimean War. Prior to that, care of the sick was mainly provided by members of religious orders, such as monks and nuns (Buckenham & McGrath 1983; Jacobs 2001; Matthews 2001). Since the Nightingale era, nurses have been predominantly female, and have been described in a variety of ways, including angels of mercy, doctors' helpers, battle-axes, heroines, tarts, and the housewives of healthcare (Darbyshire 2000; Duffett-Leger 1996; Freda

2001). Unfortunately, remnants of these early images of nurses continue to influence today's perceptions of nursing (Fealy 2004). Nurses are often portrayed as bimbos or battle-axes. They are often trivialised and ridiculed in popular media by being shown in tight white uniforms, or as grumpy matrons (Center for Nursing Advocacy 2003). Nurses of today are burdened with the historical baggage that comes with these common images (Girvin 1998:67). However, some authors have tried to raise awareness of the serious implications to the profession of these negative images (Bloomfield 1998, Daiski 2004; Freda 2004).

For example, a website for the *Center for Nursing Advocacy* (2003) has an on-line database that seeks to promote the image of nursing. The web site posts a yearly list of misrepresentations of nurses in the media, which aims to correct negative stereotypic images of nursing. The Board of Directors of the Center is committed to correcting erroneous public perceptions of nursing and to raising the profile and visibility of nurses in popular media. The website lists the ten best and ten worst portrayals of nursing each year, and comments on why each was selected. For example, in 2003 many of the worst portrayals of nurses came from TV and film representations where nurses were identified as brainless physicians' helpers. The site also features a Canadian newspaper article in which a journalist (Blatchford 2003:1) attacked nurses because nursing has become a profession rather than a 'calling'. According to the author, this means that people are choosing to become nurses for the pay and benefits rather than to 'help the ill' (Blatchford 2003:2). Commentary such as this reinforces the public perception that nurses should be self-sacrificing (Center for Nursing Advocacy 2003; Roberts 2000).

Another negative example of the way nurses are portrayed is evident in an editorial in a recent volume of the *British Medical Journal* (2000), which states:

> Nurses and doctors are divided by gender, background, philosophy, training, regulation, money, status, power, and – dare I say it? – intelligence! (doctors are usually at the top of the class, nurses in the middle).

According to Sheridan and O'Sullivan (2003), there is a growing understanding of the role that public and media images play in both

reflecting and affecting the attitudes and beliefs of the public regarding cultural norms. Indeed, there is evidence that the negative stereotypes of nurses are mediated by the historical and cultural beliefs that nursing is women's work, it is dirty, and it requires no special skills other than those that are traditionally seen as feminine, such as caring, nurturing and having a compassionate nature (Ceci 2004; Davies 2004; Diers 2004). Of course, the problem with this view is that these enduring stereotypes are compounded by a lack of alternative media coverage that challenges these gendered images. Several authors describe how the image is both created and maintained by the socially constructed nature of public perceptions about the identity and power of certain roles. Diers (2004) and Sullivan (2004) both describe the public image of nurses as one-dimensional and inaccurate, suggesting that the popular image of nurses both reflects and reinforces public perceptions that nursing is a low status job with limited power and influence. Darbyshire (2000:41) states that:

> The major stereotypes [of nursing] can be so unrelentingly negative in their connotations and so wholly untenable in their relationship to any notion of a reality of nursing.

This author adds that we live in a world where image and marketing are increasingly important, and that nursing's image needs to move away from the traditional stereotypes if we seek to attract committed, intelligent people into the profession. One recent development aimed at achieving a more positive nursing image in Australia is being undertaken by the National Nursing and Nursing Education Taskforce (2005). To explore how a more positive image can be promoted, forums are currently being organized in each State and Territory to examine the image of nursing and identify strategies that will portray a more contemporary image of nurses at all levels. Despite initiatives such as this, and unless a great deal of time and money is poured into such campaigns, I suspect that the image of nursing will be slow to change.

Interestingly, the pervasive nature of the nurse's image can be identified in a popular Australian television 'soap opera' called *All Saints* (2004), which actually attempts to show both nurses and doctors as skilled professionals.

However, even with the best intentions, there are still hints of the lower status and power accorded to nurses. For example, in the show, the medical director and the nursing unit manager of an emergency department share an office. In the office there is a large desk that dominates the room, as well as a narrow wall-mounted desk with a much smaller chair that is in an awkward position just inside the door. In every episode the NUM is relegated to using the small wall-mounted desk, while the medical director uses the large desk, and sometimes the medical director even orders the NUM out of the office, despite it being a shared workspace.

I use this example to demonstrate that even when the media attempts to portray a more positive image of nurses as skilled professionals, enduring assumptions about the power and status differentials of nursing and medicine are still evident. The important point in relation to the impact of the public image of nurses on NUMs is that the image is created, maintained and reflected in media and public perceptions of work roles (Sheridan & O'Sullivan 2003; Sullivan 2004). For example, the literature indicates that nurses are still seen more as the 'housewives' of healthcare, because they are the doctors' helpers, rather than skilled professionals in their own right (Roberts 2000:77). Thus, the public image of nurses as subservient is maintained and reinforced by media images and mediated by the powerlessness of nurses' roles within healthcare organizations (Sieber et al. 1998). Darbyshire (2000:43) suggests that medical doctors often fail to recognise the contribution nurses make to healthcare.

Buresh and Gordon (2000:16) also raise concerns about nurses' lack of power, stating that 'the public has a limited concept of professional nursing'. This may well be linked to the frivolous images of nurses that abound in books, movies and even on greetings cards (Bradley 2001). The difficulty in giving the public a true picture of nursing seems to stem from the fact that much of what nurses actually do is invisible (Russell 2000). Russell (2000:195) goes on to say that because effective nursing care is difficult to define or quantify, nursing is viewed as a cost factor in healthcare delivery, rather than as a key contributor to positive health outcomes. Chang (2005:123) also comments on the lack of visibility of nursing in healthcare contexts, suggesting that more research is needed to identify outcome measures for nursing care. Kanter

(1977:251) talks about the need to be seen, heard and valued if one is to have organizational power, adding that for many powerful people 'public appearance is more important than substance'. If this is the case then I suspect that the lack of visibility of nurses adds to their powerless.

On a more positive note, paradoxically, alongside the image of nurses as bimbos or battleaxes, there is also a pervasive cultural belief that nurses are noble and moral, based on book and media characterisations of caring, compassionate and selfless individuals. The impact of this image is reflected in numerous polls, in which nurses are rated very highly for honesty and ethical behaviour (Beaumont 2004; Ulmer 2000). In Australia, for example, an annual national poll to determine which professional group the public trusts the most has found that since 1994 nurses have topped the poll, with 94% of people considering nursing as the most honest and ethical profession (Beaumont 2004). A similar poll in the US rates nurses highest out of a field of 23 professions, because they are perceived as having 'the patients' best interests at heart, with no other agenda' (Formella & Rovin 2004:268). If this is the case, then this prescriptive belief seems to dictate what nurses should be doing. Thus, even this seemingly positive image of nurses further limits their access to power because it carries the assumption that nurses should only concern themselves with caring for others.

As previously discussed, feminine images of nurses in all forms of media range from nurses as motherly, virginal and heroic, or as high-heeled sexy sirens, while of course the reality of nursing is never reflected in any of these extremes (Diers 2004). Roberts (2000) and Sullivan (2004) both believe that the value of nursing is rarely publicly recognised because medicine dominates public thinking about healthcare. Nurses are often described by the public as kind and caring, because they are seen to fluff pillows, empty bed-pans and make beds, while doctors are perceived as clever and academic because they investigate symptoms and cure disease. This equates to stereotypic images of doctors as thinkers and nurses as doers (Bloor 1999; Speedy 2000). Similarly, even within nursing an academically clever nurse is often considered unlikely to be adept at the practical aspects of the job (Daly, Speedy & Jackson 2006). Kuhse (1997) in a text that explores the caring aspect of nursing, suggests that it is impossible to see the relationship between nursing and medicine as

anything other than an enduring expression of sexism, fed by the traditional image of nurses as merely doctors' helpers. For example, in an editorial in the British Medical Journal (2000) it was suggested that medical staff allocate to nurses those tasks that are time consuming and boring for doctors. Further, the editor concluded that 'What feminism had done for nursing is to make more young women choose to be doctors' (British Medical Journal 2000). Such comments reinforce the low status of nursing in healthcare contexts.

On the other hand, Parker (1997:16) suggests that nurses are privileged to care for patients in ways that doctors cannot. In order to better understand the influence of traditional nurses' roles on the organizational power available to them, several studies that have explored the relationship between the nursing and medical professions exemplify the less powerful role of nurses. Speedy (2000:139) explains that nurses receive little recognition for their expertise, because the concept of caring is seen as a feminine concern, requiring little knowledge or skill. Thus, nursing work is devalued as a feminine pursuit and medicine continues to hold the power and status in healthcare contexts.

Two studies were found that explored the working relationships between doctors and nurses in Australia. In one study by Manias and Street (2001), the authors described the participation of nurses in ward rounds in a critical care setting. Using a critical ethnographic approach, the data collection methods for this study consisted of observation and participant journaling. The study found that the six critical care nurses who participated developed an awareness of the way in which the medical staff defined and limited their participation in clinical care, their workspace and their power. In another study by Blue and Fitzgerald (2002), the relationship that exists between nurses and doctors in rural Australia was explored. These authors used observation and in-depth interviews to illuminate how these relationships are constructed in rural healthcare organizations. The findings suggested that medical doctors control the scope of their working relationships with nurses. While there are some variations to the structure of these relationships in rural areas, the results of Blue and Fitzgerald's (2002) study reinforce the finding of the study by Manias and Street (2001) that medical staff are members of a dominant and powerful subculture in healthcare, while nurses are cast into supportive and subservient roles.

The decision to consider gender and image in relation to this study was also based on the premise that society, work, and organizational cultures are never gender-neutral (Brewis & Linstead 2004; West & Zimmerman 2003). The literature identifies how deeply embedded assumptions about work roles render many aspects of organizational gender inequity invisible to workers (Acker 2003:51). For example, the gendered nature of healthcare organizations was evident in a study by Halford and Leonard (2003), which explored one aspect of healthcare workspace in the UK, investigated how nursing and medical staff use workspaces. These authors observed hospital staff and interviewed more than 50 nurses and medical staff in an effort to explore how they utilize the workspaces within their organization. While workspaces are often perceived by staff as nothing more than a passive backdrop to hospital life, such spaces actually reflect enduring assumptions about gender, work roles, boundaries, power and status (Dendaas 2004; Halford & Leonard 2003). In Halford and Leonard's (2003) study, it was found that there were unspoken rules about who goes where in a hospital, and these rules were clearly linked to gender and power. The findings indicated that nurses had access to the least amount of space, as they were mainly confined to their ward or unit area, while doctors had the power and freedom to use all workspaces freely and could roam all over the hospital.

Other studies support the belief that nurses, as predominantly women, lack the freedom of movement available to other healthcare professionals because they are constrained within rigid role boundaries both physically and metaphorically. For example, and as previously discussed, Pearson (2003), Manias and Street (2001) and Sullivan (2004) contend that the rigid hierarchical nature of healthcare organizations and the outdated pretensions of the system create a work environment that is oppressive and limiting for nurses as women workers. Helgesen (2003:28) suggests that workspaces reflect 'bureaucratic divisions and hierarchical rankings', which communicate the power and status of a role. In my own experience of working in a large teaching hospital, doctors' and nurses' had separate staff rooms. Medical staff were at liberty to sit in the nurses' staff room if they wished, but nurses were forbidden from entering the doctors' staff room.

As Kanter (1977:250) contends, analysis of a work role is incomplete without considering the influences of contemporary society on the distribution of power and opportunities available to certain groups of workers, mediated by those in power within an organization. According to Kolb et al. (2003:13), most large public organizations were created by and for men, and if women are involved in the organization, they tend to fill the less powerful positions. Australia has one of the most gender-segregated workforces in the world, with women relegated to the lower paid, lower status jobs, with little representation in positions of senior management in the majority of organizations, including healthcare (Barrett & Hede 2003:114). Despite the recent small increases in the number of men choosing nursing as a career, the image of nursing as a women's role has not changed (Clare, Jackson & Walker 2001; Girvin 1998; Speedy 2006).

As stated earlier, Kanter's (1977) theory of organizational power goes beyond just blaming the powerlessness of women in management on traditional gender roles, by describing organizational constraints as the reason why so few women attain powerful positions. Kanter (1977) questions whether a preference for male bosses, by both superiors and subordinates, reflects any genuine differences in management style or merely reinforces the status quo, bearing in mind that in the 1970s male bosses were the norm. Following the advent of equal opportunity legislation in a number of countries, including Australia, the number of women in management roles has increased since the 1970s. Yet despite this, the debate on gender issues in the workforce continues, as does the dominance of males in management roles (Helgesen 2003).

Another example of how gender impacts on workplace environments is the way in which women at work are commonly subjected to comments and/or regulations regarding their dress, their hair, their makeup and their behaviour, while men do not generally suffer the same level of scrutiny (Speedy & Jackson 2004). This preoccupation with the way women look has always impacted on nurses. In most clinical settings nurses are required to wear uniforms, while medical personnel are not. Pearson et al. (2001) suggest that this may be because nurses are not trusted to choose appropriate clothing, while Houweling (2004) asserts that nurses are required to wear

uniforms as a symbol of their status, rather than for any practical reason. This inconsistency in dress requirements between nurses and medical doctors is one indication of the influence of gender on the nursing profession. This can be seen in situations where female nurses and doctors, working side-by-side as healthcare professionals, have different dress codes. In this example, the nurse is in uniform, and the doctor is in business style clothing, which reinforces the difference in their professional roles and status. It is in these seemingly small inconsistencies between the perceptions of appropriate dress, manner and behaviour expected of nurses and medical staff that the impact of gender issues on nursing's lack of power are manifested (Aroch 1996; Solomon 1986).

Of course, gender-based inequality is not unique to the healthcare context, and the literature abounds with examples of gender bias in many workplace settings. For example, Hayes, Allinson and Armstrong (2004) randomly surveyed over 1000 managers of both genders in the UK. The aim was to discover whether there were gender-based differences in management styles. Although only 22% of the 1000 respondents were women (itself an interesting finding), the authors found that the results supported the findings of other researchers, such as Kanter (1977), that men create and dominate organizational structures, processes and practices. This limits the freedom of women to manage in ways that might differ from the traditional male management style.

Little difference was found in the management styles of male and female participants in the study by Hayes, Allinson and Armstrong (2004). These authors explained that they attributed this to the fact that in order to be selected for a managerial position women have to display male characteristics, such as competitiveness and aggression. Similarly, Hale (1999), in a US study that explored how gender affected the workplace of twenty-three men and women who worked in government departments, universities and public sector roles, found that women had a difficult time having their opinions heard. Women in the study generally felt ignored within their organizations, and the author concluded that workers need a greater understanding of the development and maintenance of 'gender-based inequities in organizations' (Hale 1999:420).

Kanter (1977) links organizational role constructions to gender-based powerlessness by explaining that women in many occupations only ever reach first-line management positions. This is certainly the case in healthcare, where nurses make up the bulk of the workforce, yet they still generally only reach first-line management positions (Clinton 2004). The behaviours they display in their role are often attributed to their gender, but Kanter (1977:204) found a congruency between the image of a 'mean and bossy woman boss stereotype' and the behaviours of managers, of both genders, in powerless positions. Kanter (1977) concluded that powerless behaviours in female first-line managers were not merely the result of gender bias but evidence of the powerlessness embedded in the role. Kanter found that powerless males responded in exactly the same way when excluded from the structures of power:

> A careful look at comparisons between men and women in the same position shows that what looks like sex differences may really be power differences (Kanter 1977:202).

Furthermore, Kanter (1977:204) claims that when managers feel vulnerable and lack confidence in their abilities because of a lack of training, support or experience, they tend to adopt controlling, authoritarian leadership styles because they are using rules to guide their performance. Kanter (1979) explains that work performance is shaped more by assumptions about the scope of an individual's role within the organizational culture than by an individual's personal attributes and characteristics, meaning that power is located in the role, not in the person. Kanter (1977:202) concludes that 'powerlessness tends to produce those very characteristics attributed to women bosses'. Thus, the NUM's role is likely to be affected not only by the gendered image of nursing, but also by the limited power available to first line managers.

At this point, a discussion of the literature regarding males who choose nursing as a career will provide some balance to this discussion of gender in relation to the organizational power of nurses. Matthews (2001) suggests that the primary reason men choose nursing as a career is that nursing offers them the opportunity to care for others, something that is lacking in most

traditionally male occupations. In contrast, MacDougall (1997) believes that male nurses have a very different view of caring, one which focuses much more heavily on providing care based on technical excellence, rather than the more 'feminine' interpretations which include touching and emotional support.

Clare, Jackson and Walker (2001) suggest that nurses who are male are more likely to hold senior nursing positions, more likely to publish in nursing journals and are less prone to sexual harassment and violent assault in the workplace than their female counterparts. These authors contend that the gendered nature of nursing work does not really impact on male nurses. Similarly, Kleinman (2004b:80) argues that men who take up nursing as a career take their 'gender privilege' with them, which assists and propels them into senior nursing roles more rapidly than female nurses. However, a number of authors disagree. For example, Buresh and Gordon (2000:29) suggest that 'even though there are men in nursing, they are part of a "female" profession, and therefore they are tainted by the same gender images as female nurses'. The belief that nursing is a feminine career can also be heard in the opinions of men surveyed by the *Australian Nursing Journal* (2003:26), with one respondent commenting: 'blokes never became male nurses – it's a ladies job'. Thus, while a number of authors (Armstrong 2002; Buresh & Gordon 2000; Matthews 2001) indicate that controversy and debate still surround the impact of gender issues on the roles of men in nursing, to my mind the more pressing issue is the lack of organizational power experienced by all nurses. In this study, I have taken the stance that NUMs of both genders have a feminised nursing image and identity, and as a result, they may face the same issues of powerlessness.

According to Kanter (1977), it is very important that workers' efforts are seen and valued, as this confers organizational power, whereas invisibility, no matter how efficient the worker, leads to reduced power and career stagnation. Thus, nurses' organizational silence and invisibility limits their access to power. It has been suggested by some authors that the tendency for nurses to remain silent about nursing is grounded in the belief that if nurses call attention to their own acts of goodness, or the acts of goodness of other nurses, then they are in some way tainting the very nature of the act (Buresh

& Gordon 2000). Diers (2004:202) believes that it is this professional reticence about nursing that 'makes it look easy to the untrained eye'. The layperson may see a nurse feed a patient, help them to the toilet, or wash them, and may think: 'Why do nurses need a university degree to do those things?'. According to Sullivan (2004), what is missing is an understanding of the knowledge, the skills and the thinking that underpins the doing of these seemingly simple acts. In 'doing' nursing, nurses embed assessment of patients' physical, psychological, and cultural well being, using active listening skills, empathy and sometimes humour to provide holistic nursing care. Lawler (1997:43) contends that any suggestion that nurses just 'pass the time of day' when they talk to patients, is erroneous, as the conversations between patients and nurses are grounded in nursing skill and knowledge and are therapeutic for patients. If such conversations are conducted skilfully, the patient perceives only that the nurse is providing care and kindness, as the expert clinical knowledge is hidden from view (Buresh & Gordon 2000; Diers 2004).

Devaluation and marginalisation of the nursing profession permeates the organizational culture of healthcare (Speedy 2000), because although nurses make up the greatest numbers in the healthcare workforce their opinions are not often sought, respected or valued within healthcare organizations (Diers 2004; Halford & Leonard 2003; Manias & Street 2001; Sullivan 2004). Thus, the organizational powerlessness of nurses not only affects their working lives but also reinforces the low status image of nurses in the media (Diers 2004; Girvin 1998). When Buresh and Gordon (2000) and Sieber et al. (1998) studied media coverage of health issues, looking for nursing images and input, they found that nurses were virtually invisible on issues of healthcare delivery or health policy. Buresh and Gordon's (2000) study concluded that nurses' professional opinions are not sought when health issues are discussed on television news shows, in documentaries, in current affairs reports or even in women's magazines (Buresh & Gordon 2000). This is linked to the stereotypic view of nurses as silent, self-sacrificing, unassuming and unambitious. According to Schein (1996a:241,) such tacit, shared assumptions about how certain workers should behave are 'invisible yet powerful'. This helps to explain Kanter's (1977:250) statement that 'organizational roles carry

characteristic images of the kinds of people that should occupy them'. This leads me to believe that both the public image and organizational assumptions about nurses' roles might influence how much organizational power is available to NUMs.

Nursing professionals at all levels want to be acknowledged for their clinical knowledge and abilities and valued as caring health professionals (Girvin 1998:71). For example, a recently published textbook by Sullivan (2004:5-6) titled *Becoming Influential: A Guide for Nurses,* states that:

> The structure of the healthcare system has consistently been a barrier to nursing's influence...Nurses have little say in the decisions about what care is provided.

To this point in this discussion of the organizational power, gender and image of nurses, I have focused on the traditional gendered images and assumptions about nurses that are seen within healthcare organizations and society. I consider this information important to this feminist study because in order to understand what it is like to be NUM, the political, social and organizational context of nurses' roles within healthcare must be considered. The next section provides a discussion of the relationship between the values of nurses and their organizational power.

3.6 Organizational power and the values of the nursing profession

The following discussion of the connection between the values and beliefs that nurses hold dear and the organizational power available to them in healthcare settings will assist in understanding some of the challenges and conflicts faced by nurses that might impact on nurses who are managers. Kanter (1977) theorises that workers prefer to work under powerful bosses who have the ability to attain and retain power, so for NUMs, as first-line managers, their ability to attain and retain power is of vital importance if they are to perform their job effectively and empower nursing staff. As already discussed, nursing as a profession is not considered to be powerful or influential, and NUMs are therefore disadvantaged by their professional

status as nurses when they assume a management role (Bell & Nkomo 1992; Mills 1992; Sullivan 2004). Whether this disadvantage translates into a lack of organizational power remains to be seen.

Kanter (1977:186) states that first-line managers 'have little chance to gain power through their activities since their functions do not lend themselves to demonstrations of the extraordinary, nor do they generate high visibility'. Therefore, according to Kanter (1977), accessing organizational power is a challenge for all first-line managers, and I suspect that this is particularly true for NUMs, when there are such obvious conflicts between their professional values and organizational expectations of them as managers.

Nursing has strong professional values based on the principles of caring and connectedness (Bone 2002; Gilmartin 2001). Nurses internalise these values during their education and then embed them into their practice (Buckenham & McGrath 1983; Fagermoen 1997). In Australia, as in many other countries, nursing students must complete an accredited education course in order to gain registration as a nurse. Since the late 1980s, successful completion of a Bachelor degree is the only pathway to becoming a registered nurse in Australia (Anderson 1994). The abandonment of hospital-based nursing education in favour of a university degree and the adoption of national competency standards and guidelines for professional practice all reflected a desire to advance the professionalism of nursing in Australia (Paliadelis & Cruickshank 2003). Each Australian state and territory has a regulatory body that ensures only suitably qualified nurses are registered to practice and to use the title of nurse (NSW Nurses and Midwives Board 2005).

Nurses are also guided by codes of professional conduct and ethics. These codes are designed to inform not only professional nurses but also the general public about the values, beliefs and behaviours that underpin professional nursing practice. Similarly, in most developed countries codes of ethics articulate nurses' professional norms, values and behaviours and provide a framework for nursing practice (Australian Nursing & Midwifery Council 2003; Canadian Nurses' Association 2002; International Council of Nurses 2000; UK Central Council of Nursing and Midwifery 2002). In all the codes the elements of professional nursing practice are similar, in that nurses are

expected to provide care in a safe and competent manner to those in need of nursing, to respect patient diversity, dignity and confidentiality, and to be accountable for their practice (Australian Nursing & Midwifery Council 2003; Canadian Nurses Association 2002; International Council of Nurses 2000; UK Central Council for Nursing and Midwifery 2002). The value of caring, however, is not explicitly recognised or valued in the medically dominated context of healthcare, as 'caring itself is a gendered construct' (Speedy 2000:139), linked to nurturing and femininity, rather than knowledge and skill (Kuhse 1997).

Schank and Weis (2001) explain that professional codes of conduct and ethics prescribe standards of behaviour that are premised on the values and beliefs embedded in ethical nursing practice. These authors surveyed 599 nurses and nursing students in the US, using an instrument to measure professional nursing values derived from the Code of Ethics of the American Nurses Association (Weis & Schank 2000). The findings indicated that nursing values are introduced and integrated into the educational preparation of nurses, and they then become embedded in the practice of registered nurses. These authors concluded that the values of a profession teach, shape and inform professional education, behaviour and conduct in the workplace (Weis & Schank 2000). Nursing unit managers are responsible for ensuring that nursing staff behave in a professional manner, in accordance with the relevant standards and codes (Schank, Weis & Ancona 1996), while senior nurse executives are responsible for monitoring the professional performance of NUMs. Thus, nurses at all levels are expected to apply these standards and codes to their practice.

Previous studies show that the values and behaviours prescribed in nursing codes of ethics and conduct form the basis of a distinctive nursing identity. For example, in one Norwegian study the values underlying nurses' professional identity were investigated by surveying over 700 nurses (Fagermoen 1997). Ethical codes and statements of professional conduct were found to reflect what it means to be and act like a nurse, and as such they form the basis of a professional nursing identity (Fagermoen 1997). Other studies support these findings. For example, Kirpal (2004) reported on a comparative qualitative study into healthcare workers' professional identity

in five European countries. Interviews were conducted with 100 nurses, doctors, and other allied healthcare professionals in Estonia, France, Germany, Spain and the UK with the aim of exploring 'the manifestations and formation' of work identities (Kirpal 2004:279). The findings indicated that 'nurses' work identity is based on a strong identification with the ethics of their profession' (Kirpal 2004:287). The findings further reinforce the notion that a nurse's professional identity builds up and develops over time, until nurses integrate the values of the profession into their self-concept as a nurse. This is consistent with the findings of a study discussed earlier by Weis and Schank (2000) in which they suggested that nurses embed the values of their profession into their role identity.

Another study that lends weight to the argument that nurses share a core set of values examined the core values of 799 nurses working in the US, 30% of whom trained in other countries (Flynn & Aiken 2002). Using a survey, this study concluded that 'US and international nurses share a set of core nursing values' (Flynn & Aitken 2002:72). Thus, the literature supports the belief that nursing has emerged as a technical, practice-based profession with a strong occupational identity based on a common set of core values. It remains to be seen whether the NUMs in this study retain their nursing values.

3.7 The relationship between the construct of power and the nurse's role

Since the early 1990s a number of studies have used Kanter's (1977) theory of power as a framework for exploring nurses' professional roles (Chandler 1991; Finegan & Spence Laschinger 2001; Sarmiento, Spence Laschinger & Iwasiw 2004; Spence Laschinger 1996; Spence Laschinger et al. 1999; Spence Laschinger et al. 2003; Upenieks 2003; Wilson & Spence Laschinger 1994). One researcher in particular, Spence Laschinger, has been involved in a number of the quantitative studies that have used Kanter's (1977) theory to explain nurses' perceptions of their job satisfaction, job strain and level of empowerment. These studies have involved staff nurses, directors of nursing, nurse managers, nurse educators, and nursing students. However, all of them have focused on the role that senior nurses can potentially play in

empowering nursing staff. No studies were found that specifically focused on the construct of organizational power for NUMs.

In one study conducted by Wilson and Spence Laschinger (1994), 161 nurses were surveyed to explore their perceptions of their access to organizational power and how this influenced their work commitment. The findings suggested that the participants felt only moderately empowered because it was their belief that their managers had only limited access to power. In this study, nurses – not NUMs – were the participants, but based on the findings the authors concluded that nursing managers should structure the work environment in such a way as to allow nursing staff more access to power. Wilson and Spence Laschinger (1994) also suggested that more studies are needed to explore nurses' experiences of hospital working environments, because powerlessness breeds behaviours that are counterproductive and prevents effective role performance, leading to job dissatisfaction. However, as Kanter (1977) indicates, first-line managers often have difficulty gaining access to power structures themselves, and as powerless managers they are unable to pass on power to staff. In a more recent study by Spence Laschinger, Finegan and Shamian (2001), the empowerment of nursing staff at all levels was suggested as the solution to job strain. In this study, 400 Canadian nurses were surveyed to determine their level of job satisfaction, empowerment and job strain. The results provide further support for Kanter's (1977) theory of organizational power, by demonstrating a relationship between nurses' job strain and their lack of organizational power (Spence Laschinger, Finegan & Shamian 2001). These authors suggest that the results could be used to guide NUMs to create work environments that foster greater empowerment for nursing staff. However, there was no discussion of the existing power of the NUM's role.

In more recent literature, several other authors have also linked staff empowerment to job satisfaction, and although these articles are not research-based, they restate and reinforce the link between access to appropriate levels of power and job satisfaction. For example, in a review of literature concerning nurse empowerment, Kupperschmidt (2004) discusses the need for nurses to share in the responsibility for creating satisfying work environments. In an article that discusses nurse leadership, Kleinman (2004a)

calls for more research into whether NUMs should be held accountable for staff nurse job satisfaction. When this literature is considered using Kanter's (1977) theory, the question then arises: how can nursing unit managers empower their staff when it is unclear how much access they have to the structures of power? Thus, it would appear that the construct of organizational power within the NUMs role is an unexplored area of research. Kanter (1977:186) indicates that one of the reasons first-line managers experience powerlessness is that they are in roles where they have 'accountability without power'. As discussed in the previous chapter, in the rapidly changing, fiscally constrained context of healthcare, NUMs are expected to assume a growing number of responsibilities, and when I set out to undertake this research I suspected that NUMs lacked sufficient organizational power to get the job done effectively.

Further to this, the need to create a more empowered nursing workforce in Australia is evidenced by the following statement made by the Nurses Board of the Australian Capital Territory (ACT) in a submission to the National Review of Nursing Education (Department of Education, Science & Training (DEST) & The Department of Health & Ageing 2002:4):

> There is evidence to support that nurses commonly experience role difficulties around authority, autonomy and linkages to empowerment. When nurses lack the autonomy to practice, though legitimately authorised to perform their nursing role, they are in a position of responsibility without authority.

Kanter (1977) argues that powerlessness is an organizational construct that causes people to behave in certain ways, rather than an internal state. Chandler (1991:22) also supports this argument, suggesting that in the past 'power has been assumed to emanate from the individual', but that more recently powerlessness has been linked to narrowly designed job roles that do not provide workers with access to formal or informal power structures. Thus, in this study, which explores the construct of power for NUMs, it will be interesting to explore whether their role allows them adequate access to the

organizational determinants of power, which are information, support, resources and opportunity.

Kanter, Stein and Jick (1992) explain that power struggles within organizations are not necessarily bad. In fact, power struggles can be productive if they allow more voices to be heard. At the same time, the nursing literature abounds with evidence that nurses are not heard in the context of healthcare (Dingel-Stewart & LaCoste 2004; Buresh & Gordon 2000; Spence Laschinger & Finegan 2005). These authors indicate that there is an urgent need for nurses to develop a louder voice and this could be achieved by nurses' gaining greater access to the determinants of organizational power. However, unless nurses are valued and recognized for their competence, their access to formal power will remain limited (Stanton 2004). This powerlessness, according to Kanter (1977), causes workers to feel undervalued and dissatisfied. This in turn, leads to frustration and dissatisfaction, which impacts on staff morale and retention (Chang 2005; Lindholm et al. 2003; Spence Laschinger 1996; Wilson & Spence Laschinger 1994).

In recent times, much has been written about the fiscal constraints in healthcare and how these constraints have contributed to nurses' lack of time, equipment, staff and resources to perform their job effectively. As well as contributing to a lack of power, these constraints also impede nurses' ability to provide quality patient care (Bone 2002; Callaghan 2003: Courtney, Nash & Montgomery 2002; Jones & Cheek 2003; Pelletier & Duffield 2003). However, for nurses as managers a lack of adequate resources to perform their role also impacts on their ability to manage a ward. While no literature was found that explored this concept, according to Kanter (1977) a lack of appropriate office space, office equipment, time and support to perform management duties can contribute to a lack of power. Thus, while these resources are not mentioned in the nursing literature discussed in this chapter, according to the business and management literature, a working environment with appropriate resources is not only necessary for effective management, but it is also closely linked to corporate understandings of power (Denton 1991; Ettorre 1995; Fried et al. 2001; Hofstede 1994; Hymowitz 1999; Pristin 2004; Sproat 2001;Warshaw 1998).

The abovementioned authors all indicate that the status or power of a member of an organization is often evidenced by the size and standard of their office and the furnishings, equipment and clerical support provided to them, as these are the visible symbols of power. While Schein (1992) describes these as artefacts that demonstrate the underlying values, beliefs and assumptions of an organizational culture, Kanter (1977) refers to them as resources. Thus, the workspace, equipment, and support staff provided to a manager by the organization send a clear message to all workers about the level of formal power sanctioned by the organization and embedded in the position.

Sandberg (2003:1) states that in the corporate world 'a lousy desk location can threaten more than morale', for the unfortunate staff member. By using Kanter's (1977) theory to understand the significance of a 'lousy desk location', for NUMs links can be made between low morale, a lack of suitable resources and the construct of organizational power, both from the worker's perspective and the perspective of others. This is an unexplored area in nursing, and one that did not occur to me as a nurse, until I explored the business and management literature regarding the resources that are seen as symbols of power. I did find one reference to the link between such resources and organizational power in a nursing leadership text in which Speedy and Jackson (2004:59) offered the following statement:

> Other rituals or non-verbal messages of power in the workplace include placement of furniture, size of office space, displaying symbols of achievement or power (diplomas, awards etc.). Choice of clothing can also affect power and influence.

Dendaas (2004) also stresses the importance of considering work environments if researchers are to understand the impact of organizational culture on workers. Thus, when exploring the working world of NUMs, the presence or absence of power symbols, such as adequate office space, equipment and clerical staff, will reflect the NUMs' level of organizational power. Therefore, in this study of NUMs, as well as interviewing participants, I also draw on my observations of the NUMs' working environment recorded

in a journal. Interpretation of this data, along with the interview transcripts, will be underpinned by Kanter's (1977) theory of organizational power.

Brown (2002:15) suggests that healthcare organizations worldwide face their greatest challenge if they are to create the organizational structures needed for nurses to feel empowered, appreciated, valued and heard. Similarly, Girvin (1998:68) suggests that gaining access to appropriate levels of organizational power will remain a problem for nurses because unless strong nursing leaders emerge who are able to challenge the assumptions of the organization, nurses will remain powerless and divided. Paradoxically, as long as nurses remain powerless and divided, it will remain difficult for strong nurse leaders to emerge. To break this vicious cycle nurses need to gain a deeper understand of the political, cultural, historical and organizational factors that have led to their organizational powerlessness, so that they can identify how to address this power deficit (Girvin 1998:71).

Finally and as stated previously, empowerment, according to Kanter (1977) occurs when people have the ability to access both formal and informal structures of power to perform their role effectively. Women in traditional female roles, such as nurses, are often denied access to organizational power because 'that is the way it has always been' (Kanter 1977:198). Passivity in nursing reinforces subservience, and according to Moloney (1992:285), nurses need to become a political force in order to increase their power. Similarly, Marquis and Huston (1992:125) state that 'the ability to manipulate resources is the art of management and requires political astuteness'. Clare, Jackson and Walker (2001) and Girvin (1998) exhort nurses to understand the political, historical, social and organizational factors that have led to this situation and to stop playing the same games and move forward.

There are three central issues to consider when exploring the construct of power for nurses as managers, and in the preceding discussion, these have been linked to Kanter's (1977) theory of organizational power. First, the nursing role is culturally constructed as feminine. Thus all nurses, male and female, are tainted by this femininity that is so closely linked to the job of nursing (Davies 2004; Hunt 1998; Speedy 2000). Second, as the dominant culture in healthcare is medicine, nurses are relegated to powerless or

subservient roles (Clare, Jackson & Walker 2001). The third issue is that management roles are also perceived to be the domain of males. For example, the traits expected of successful managers such as competitiveness, aggressiveness, and hard-nosed analytical skills are commonly linked to the masculine stereotype (Hayes, Allinson & Armstrong 2004; Speedy 2004). If women display the same types of attributes, they may be considered domineering, or 'pushy' (Acker 2003). In the past nurses only had to contend with having a powerless role in the traditional doctor–nurse game, while today's nurses may find they are also losers in the health administrator–nurse game (Dendaas 2004). In order to gain an understanding of the organizational context in which NUMs work, it is important to consider the impact of these three issues on the role, the responsibilities, and the power of nursing unit managers. Clare and Hofmeyer (2004:349) note that 'many nurse leaders are caught between the need to support traditional hierarchical management styles expected in organizations and the need to demonstrate more current attitudes'.

In addition, none of the studies discussed in this section have used Kanter's (1977) theory to underpin a qualitative study of the construct of organizational power for NUMs. In fact, no studies were found that specifically focused on the organizational power of nurses who hold managerial positions. Evidence from the literature indicates that historically nurses have not been encouraged or supported to become powerful leaders, largely because healthcare organizations work from the assumption that leading is not something that nurses ought to do (Girvin 1998). Therefore, this feminist study aims to explore what it is like to be a NUM within the construct of organizational power.

Throughout this chapter, the literature regarding the role and power of nurses within healthcare organizations has been explored, by considering the traditional gendered image and context of nursing work. The scope of traditional nursing roles has been used to explain why contemporary nurses at all levels find themselves limited by their historical baggage. Some authors have suggested that nurses need to develop a stronger voice, both publicly and professionally, if they are to take their place as respected and empowered healthcare professionals (Buresh & Gordon 2000; Diers 2004; Sullivan 2004).

To achieve these goals nurses need to be heard and taken seriously. Only when nurses have developed a stronger voice will they be able to achieve greater organizational power.

3.8 Conclusion

This chapter has presented and discussed the theoretical framework used to underpin this study, which is Kanter's (1977) theory of organizational power. A justification for the use of this framework has been provided, and this was linked to the public image of nurses, and their professional and organizational roles within the culture of healthcare. A review of the literature illustrated the relationship between gender, image, values, role construction and organizational power for nurses. In order to locate the NUM's role within the context of healthcare, the chapter demonstrated the relationship that exists between the theoretical framework, the study aims and the existing literature discussed throughout Chapters Two and Three. In the next chapter, the methodology and procedures are described and it will be shown that the theoretical framework is congruent with the methodological choices made in this study.

Chapter Four
METHODOLOGY

4 Introduction

The preceding chapter introduced the theoretical framework that underpins this feminist study and provided an analysis of the literature that justified the use of the framework. This chapter presents and discusses the methodology chosen to investigate the construct of power within the working world of nursing unit managers. The chapter commences with a justification for the choice of the research paradigm used in this study, and provides a discussion of the feminist methodology utilised to explore the NUMs' experiences. As outlined in previous chapters, a feminist approach was considered vital in order to fully explore the experiences and contexts of participants who potentially lack voice and power.

The methods section of this chapter describes the procedures and techniques used in the study. First, the setting and sample of the study are discussed. Second, the pre-pilot and pilot studies are described, followed by an account of the data collection and analysis procedures. Issues of rigour and trustworthiness are addressed using strategies consistent with a feminist methodology.

The discussion of ethical considerations presented includes not only the process of gaining ethical approval from two human research ethics committees, but also the ethical concerns that were addressed throughout the project. Finally, I make explicit the methodological issues and assumptions that impacted on this study and include my reflections on the research process to demonstrate transparency regarding the decisions I made throughout the study. I believe that this chapter provides the reader with a clear and logical explanation of my intentions and decisions and demonstrates the integrity of the feminist methodology chosen to guide this study.

4.1 Justification for the research paradigm used in this study

Philosophical beliefs about reality and the development of knowledge, or ontology and epistemology, assist in choosing a research methodology to generate a particular form of knowledge (Andrews, Sullivan & Minichiello 2004). Koch and Harrington (1998) argue that in order to justify the methodology chosen for a research project, researchers must first explain their beliefs regarding ontology and epistemology. Ontology, the study of existence or the meaning of life, refers to the concepts and relationships that humans have with and about reality (Roberts & Taylor 2002). The ontology that underpins this study is based on the belief that I, as the researcher, do not have the truth in an absolute sense, but can only offer insights into the participants' lives that can be further interpreted by those who read this thesis. This assumption is premised on post-modern thought, as described by Rosenau (1992) and Fairbairn (2002), who both suggest that a research method that explores human stories should aim to provide a real look at life. The ontology on which this study is based can also be described as relational, which according to Doucet and Mauthner (1998), refers to a stance in which human beings are seen as interconnected parts of a complex web. This relational ontology has been developed within feminist theory to emphasise the importance of social structures and relationships to understandings of reality (Doucet & Mauthner 1998:4). The ontological assumption on which this study is based is that participants' stories about their lives are accepted and respected as a true reflection of their experiences (Acker 2001; Campbell & Wasco 2000; Dallimore 2000; Wicks & Whiteford 2003).

Epistemology is the theory of knowledge, which means it is concerned with the philosophical basis of knowledge creation (Gerber & Moyle 2004). It is broadly divided into two main paradigms: positivism and interpretivism (Borbasi, Jackson & Langford 2004). In an effort to make explicit the beliefs about the epistemology that underpin this study it is important to understand these two paradigms. Positivism is the belief that knowledge is external to the researcher and can be gained by observing and organizing data received via our sensory organs (Harris 2004:75). In the positivist view, knowledge is 'out there' waiting to be known, independent of the researcher or the context (DePoy & Gitlin 1998:26). The positivist perspective underpins quantitative

scientific research, such as randomised control trials, where the aim is to understand the value of one intervention over another, or over no intervention (Carson & Fairburn 2002). Positivists believe that data need to be analysed objectively using statistical means to arrive at a quantifiable outcome that can be verified by others (Grbich 2004). This paradigm may be appropriate for many scientific research studies. However, it is less suitable for studies that seek to understand human experiences and perceptions which cannot be analysed objectively or measured using numerical data (Denzin & Lincoln 2000). Furthermore, Brayton (1997) argues that a positivist epistemology represents only a white male viewpoint, which ignores alternative, feminine or minority group perspectives. It is therefore considered unsuitable as the basis for studies that seek to explore experiences of oppression, power or gender. In the past, nurses conducting research were encouraged to adopt the positivist approach as this has always been the dominant paradigm in healthcare. However, a positivist inquiry often is not appropriate to 'answer many of the questions nursing asks' (Speedy 2006:165). Thus, in this study, which explores the experiences of NUMs who are predominantly women, a positivist perspective was rejected as inappropriate and unlikely to achieve the study aims.

The alternate view is called interpretivism or constructivism, and studies using this paradigm are based on the belief that people construct knowledge as they interact with and attempt to understand their world (Cutler 2004; Fitzgerald & Field 2005; Shipton 2001). In his book *The Sensory Order*, Hayek (1952:6) defends constructivism by stating that 'much that we believe to know about the external world is, in fact, knowledge about ourselves'. Similarly, as nursing roles are constructed as feminine, knowledge about the participants in this study is more likely to be authentic and accurate using a constructivist feminist epistemology (Brayton 1997; Cook & Funow 1986). Feminist approaches to research are commonly grounded in the constructivist paradigm, as they seek to identify what counts as knowledge and who has the power to define it (Glass & Davis 2004; Jackson, Clare & Mannix 2003; Lincoln & Guba 2000). Feminism seeks to unpack taken-for-granted ideas about people within historic, social and cultural contexts, and presents new ideas that challenge traditional patriarchal views (Olesen 2000:215). A feminist

methodology can bring to awareness knowledge about power and oppression that may remain hidden using other qualitative approaches (Speedy 2006).

Other qualitative methodologies, such as phenomenology or grounded theory, were rejected for this study principally because they do not clearly recognise the centrality of women's experiences as a source of knowledge (Jackson, Clare & Mannix 2003:206). Nor do other qualitative methodologies focus on the social and cultural influences on people's lives, roles and power to the same degree as a feminist methodology (Way 1997). Rose (2001:3) identifies why social and cultural influences on participants' experiences are so important to feminist researchers:

> Many feminist scholars argue that it is their social responsibility not only to legitimize subjugated knowledge, make visible the invisible, but also to develop analyses that interpret and contextualize the experiences that shape people's horizons.

Similarly, according to Olesen (2000), feminist research can present new ideas about situations in which people lack power, while Blue and Fitzgerald (2002:314) indicate that a feminist perspective provides an appropriate way to understand the exploitative divisions of labour in healthcare.

Speedy (1987:21) defines feminist philosophy as 'based on the assumption that women are oppressed and that their position in society results from patriarchal dominance'. Feminist research studies are defined by their values and processes, rather than by any particular research method (Benhabib 1994; Brayton 1997; Campbell & Wasco 2000; Grbich 2004; Jackson, Clare & Mannix 2003). According to Jackson, Clare and Mannix (2003:209) the difference between a feminist research methodology and other research methodologies is that feminist research aims to 'facilitate women's ways of knowing and being visible, and thereby challenge dominant structures oppressive to women'. I believe this comment refers equally to nurses of both genders, who are oppressed because of the feminine image of nursing, and because they work in an environment dominated by traditionally masculine roles, namely medicine and business management. As I was interested in exploring the construct of power within the working world of NUMs, this study takes an

eclectic feminist approach, which means that while the guiding principles of feminism are reflected throughout this thesis, no single feminist perspective, such as feminist standpoint theory or contextual empiricism, has been used (Olesen 2000). The three key assumptions of feminism on which this study is based hold that:

1) traditional scientific, positivist research is founded on male constructs;

2) issues of oppression and power inequality are exposed by exploring the political, cultural and social world of women;

3) by raising awareness of oppression and power inequality, women can be empowered to address these issues (Speedy 2000).

According to Clare and Hamilton (2003:77), feminist studies allow participants to have 'voice and agency', which is described by these authors as a demystification of who is speaking within a research study. These authors suggest that traditional methodologies bury both the researchers' and the participants' voices under a cloak of objectivity, which masks their authentic voices. It follows that in recognizing the researcher as a part of the research process, the researcher must clearly identify her location within the social world inhabited by the participants (Brayton 1997; Olesen 2000). Therefore, in Chapter One of this thesis I provided a personal profile that situates me within the social landscape of healthcare, and describes my motivation for conducting this study. I will now discuss the three main reasons why a feminist methodology was considered the most appropriate way of exploring the working world of NUMs.

First, this methodology was selected because feminism is concerned with exposing issues of power and social inequality. Daly, Speedy and Jackson (2006:6) suggest that 'feminist theory can be used to examine power relations in nursing and healthcare', and is therefore well suited to considering these issues for NUMs of both genders. Second, feminist research is politically motivated, in that the aim is not only to present data, but also to challenge inequality by raising awareness of the reality and experiences of those who are oppressed or powerless (Brayton 1997; Cook & Funow 1986; Fitzpatrick &

Wallace 2006; Jackson, Clare & Mannix 2003). As the literature indicates, nurses need to counter oppression by developing political power and astuteness (Daly, Speedy & Jackson 2006; Marquis & Houston 1992). Third, it is hoped that such a stance will encourage the NUMs to seek change, because as described by Speedy (1997) awareness of oppression is needed to drive collective political action.

Thus, a feminist methodology was chosen for this study as it could assist in exploring the construct of power within the NUMs stories, by focusing on evidence of oppression and then fostering awareness of the need for change. According to Glass (1998), a feminist methodology allows for a critique of the power relations embedded in the social constructs of roles. Glass (1998:123) also adds that a feminist approach is ideal if the research aim is to understand 'the conditions which foster, constrain and erode empowerment'.

One of the major tenets of feminist research is to present data in a way that 'does not diminish the very thing it is seeking to expound' (Jackson, Clare & Mannix 2003:211). By utilising a feminist methodology, this study aims to give the participants an effective and authentic voice. Throughout this chapter the basic tenets and beliefs that underpin a feminist methodology are presented and discussed. The next section describes and justifies the method of data analysis chosen for this study.

4.2 Justification for adopting Gilligan's voice-centred relational approach to data analysis

In qualitative research, data can take many forms, for example, music, conversations, photographs, interview transcripts and field notes. Such data are analysed by examining, summarising and interpreting them, to produce results that aim to reflect the raw data (Browne 2004). The way that this is achieved varies according to different types of research design, such as grounded theory or phenomenology. However, according to Doucet and Mauthner (1998:1), 'detailed discussions of the nitty-gritty of [qualitative] data analysis and the actual step-by-step processes of analysing interview transcripts are rarely presented'. To analyse the data in this study I searched for a process that could satisfy four characteristics:

1) It was clearly explained.

2) It would assist in hearing the voices of the oppressed.

3) It would be consistent with a feminist methodology.

4) It would be congruent with the aims of this study.

Following extensive reading of the research literature I decided to adopt a method of data analysis that not only places the participants' voices at the centre of the study, but also links their experiences to their working relationships and context. I felt this to be of vital importance because, as discussed in Chapter Three, I suspected that the working world of nurses is fraught with contextual conflicts and challenges.

The method of data analysis chosen for this study is the **voice-centred relational approach** to data analysis. This method, developed by educational psychologists from the Harvard University Graduate School of Education (Gilligan 1982; Brown & Gilligan 1992; Taylor, Gilligan & Sullivan 1995), although extensively applied in feminist research to elicit women's values and attitudes, has not been widely used in healthcare research. However, I believe it to be an ideal method of hearing the NUMs' voices and exploring the construct of power in their working world, in a way that would not have been possible using other methods of qualitative data analysis.

The voice-centred relational method of data analysis was first developed and used by Gilligan (1982), and later more fully described by Brown and Gilligan (1992), in their influential book *Meeting at the Crossroads.* Gilligan (1982), Gilligan and Brown (1992) and Taylor, Gilligan and Sullivan (1995) used this method of data analysis in a number of studies aimed at hearing the different voice, which these authors describe as the voice of powerless participants, and the 'voices of women in a male-voiced world' (Brown & Gilligan 1992:20). In Gilligan's (1982) first book, *In a Different Voice,* three studies are presented which demonstrate the efficacy of this method of data analysis. The book argues that women's voices are often not heard in traditional research studies because they do not generally fit the mould of the traditional theories of human development. This is because, according to Gilligan (1982), women

define their lives as relational, while men see themselves as detached from others. This means that women gain strength and a sense of self within their relationships, while men see themselves as autonomous and view relationships as an expression of dependence. Based on this stance, Gilligan (1982) contends that the authentic voices of women are rarely heard in research because women's sense of self, defined by relationships, is seen as aberrant in a male-voiced world.

While Gilligan's (1982) early studies used this method of data analysis predominantly to explore the lives and moral development of women and girls, this approach has also been used by others in more recent studies to explore the lives of men and boys, where the aim was to understand the relational nature of experiences in a societal and cultural context (Tolman et al. 2003; Way 1997). A number of other recent studies have also used modified versions of the voice-centred relational method of data analysis to explore the relational aspects of a variety of human experiences (Letvak 2003; Mauthner & Doucet 1998; Mauthner 2002; Wilkinson 1996; Phan 2003; Tolman et al. 2003; Way 1997). Of these studies, only one was found that applied this method of data analysis to a study of nurses. In the study, Letvak (2003) adopted this method as a means of uncovering what it is like to be an older perioperative nurse. Letvak presents a powerful argument regarding the applicability of this method of data analysis to a feminist study of nurses, suggesting that to gain an understanding of the roles of nurses, their relationships and contexts must be explored. Letvak (2003:637) adds that 'the premise of a relational framework is that women's development endows them with relational and expressive skills'. This author goes on to say that 'this method of data analysis allows narratives to be explained in terms of their relationships and the broader social and cultural contexts in which they live' (Letvak 2003:638).

It needs to be noted that the way in which I have applied this method to the experiences of the participants in this study is my interpretation of Gilligan's (1982) method. According to Doucet and Mauthner (1998:5), Gilligan and Brown's (1992) original method was designed to be adaptable to 'individual interpretations, adaptations, and versions of it'. As such, this method can be adapted to suit a variety of disciplinary backgrounds. Thus, my interpretation

of this method reflects my research topic. For example, I have placed more emphasis on the participants' roles within an organizational context than Brown and Gilligan (1992) did in their original description of this method.

To further explain how this method of data analysis aligns with the reasons for using it, I will first discuss how this method can assist in hearing the voices of those who might be oppressed. Brown and Gilligan (1992:20) suggest that this method allows the researcher to become attuned to the 'relational struggles that plague many women'. Such relational struggles tend to rob women of a voice in a male-voiced world, in which a higher value is placed on objectivity and detachment, rather than connectedness and caring (Gilligan 1982). Gilligan's (1982) focus on caring as a core function of women makes this method an ideal choice for a study of NUMs.

In addition, the voice-centred relational method of data analysis is closely aligned with feminist methodology, particularly because one of the aims of feminist research is to address issues of inequality. Furthermore, because this study seeks to give participants a voice of agency, this data analysis method assists in keeping the NUMs' voices central and yet also allows the researcher's voice to be heard as a part of the research process, which is another important principle of feminist research (Jackson, Clare & Mannix 2003; Lincoln & Guba 2000:183).

Gilligan (1982) argues that a relational view of women's experiences acknowledges the importance of social interactions, relationships and contexts that connect individuals to each other. In particular, this method provides a pathway into the experiences of those who are usually ignored, oppressed or unheard, such as women or minority groups, so it was considered an appropriate choice to achieve the aims of this study.

The relational aspect of this method of data analysis forms the core of Gilligan's (1982) method, by focusing on the interconnectedness of human experiences. Such an approach was considered vital for this study of NUMs, because, as discussed in Chapter Three, nurses' identities are underpinned by their sense of connectedness to others. For example, nurses define themselves in relation to their patients, their nursing colleagues, and other healthcare professionals (Kirpal 2004). Gilligan (1982:17) suggests that 'women not only

define themselves in a context of human relationships but also judge themselves in terms of their ability to care'. Therefore, this focus was selected as an ideal way of exploring the working world of NUMs.

As discussed in Chapter Three, the core business of nursing is caring, and nurses value their connection to others. The relational method of data analysis was an essential part of being able to hear if the voices of the NUMs' came from within that traditional nursing role. Furthermore, this method was pivotal in understanding the participants' sense of self (Brown & Gilligan 1992:20), as it would be difficult to understand the construct of power within the NUMs' experiences of their working world without considering how they see themselves within it. Thus, Gilligan's (1982) data analysis approach was selected for this study because it allows for a depth of analysis that would not have been possible using alternate means of qualitative data analysis. A more in-depth description of how this method of data analysis is actually applied to the data is provided later in this chapter.

Finally, the relational method of data analysis is designed to increase awareness of the relational parts of people's lives and to focus attention on the different voices, the oppressed voices and the voices of those without power (Brown & Gilligan 1992). This focus was considered vital in uncovering the construct of power within the NUMs' working world.

4.3 Methods

4.3.1 Location of the study

When this study was conducted in 2003, the state of New South Wales (NSW) was divided into seventeen health areas, each responsible for providing integrated public health services to the population of the area. The location of this study was New England Area Health (NEAH), a regional health area in the far north of the State covering 98,000 square kilometres and servicing the health needs of 175,000 people (NSW Health Department 2004b). Within this region there are two cities: Tamworth with a population of approximately 50,000, and Armidale with 25,000 residents. There are also numerous smaller towns, such as Glen Innes, Guyra, Walcha, Inverell and others, ranging in populations from several hundred to 10,000. There are 21 public healthcare

facilities in the area (e.g. hospitals, community health centres, multipurpose centres), all of which provide healthcare services to the population. This area health service employs just over 3000 people, of whom 42 employees of both genders are NUMs. Figure 4.1 is a visual guide to the location of the New England area in relation to the other sixteen area health regions of NSW. Figure 4.2 is a map of the New England Area Health (NEAH) region with the 21 healthcare facilities marked.

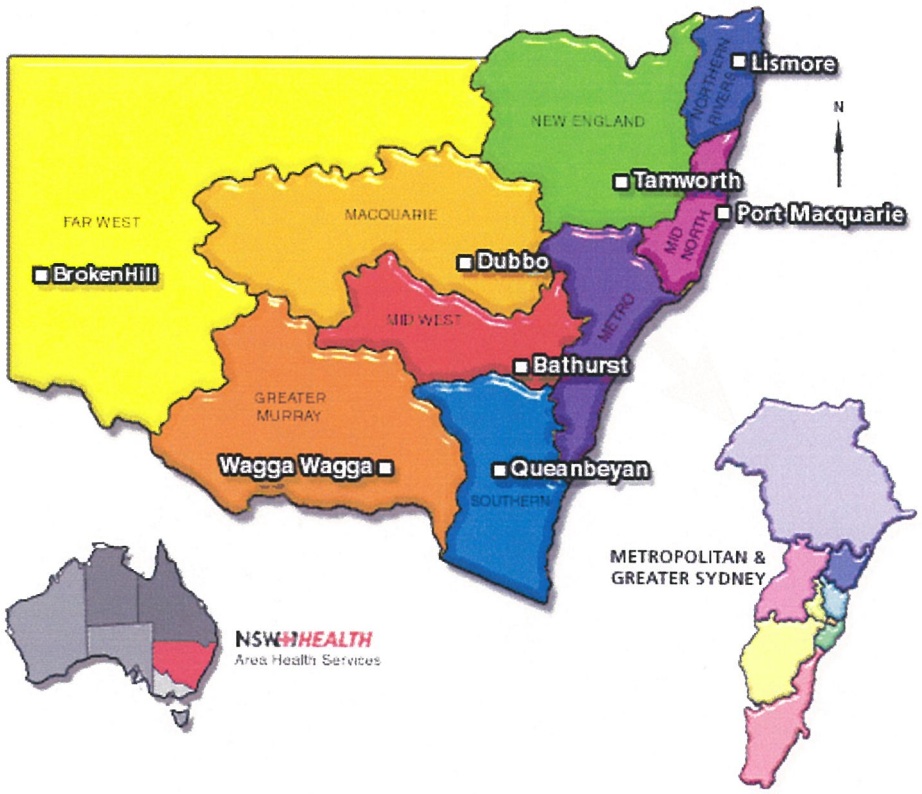

Figure 4.1 New South Wales Area Health regions
(NSW Health Department 2004b)

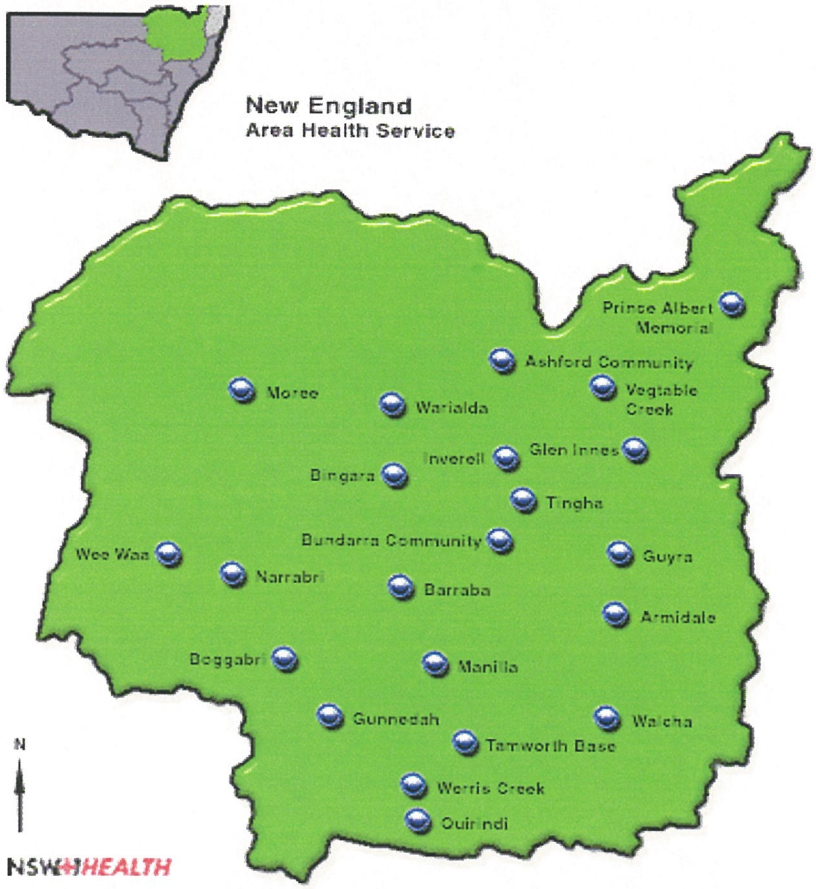

Figure 4.2 New England Area Health region
(NSW Health Department 2004b)

4.3.2 Recruitment of participants

After gaining ethical approval to commence the study from both the University of New England and the New England Area Health Human Research Ethics Committees, a convenience sample of all 42 NUMs employed by NEAH were invited to participate. The NEAH central nursing administration provided the names of all NUMs employed in the region, and granted me permission to contact them in writing at their workplace. Because the central aim of this study was to explore the construct of power within the nursing unit manager working lives, all 42 NUMs were invited to participate. The decision regarding whom to interview for this study was based simply on who was willing and available. There were no inclusion or exclusion criteria. I made no attempt to select certain participants over others, as I did not wish to place myself in a position of power to make such choices. In feminist research, the researcher must guard against assuming the more powerful position in the research process (Jackson, Clare & Mannix 2003:212). Ultimately, all NUMs who indicated a willingness to participate and who could be contacted, were interviewed.

This use of convenience sampling was considered appropriate for this study as a feminist perspective acknowledges that all potential participants have equally valuable information to impart about their experiences. According to Grbich (1999), in qualitative research the selection of participants is not driven by a need for representativeness, because the aim of the study is not to generalise the findings, but rather to connect with people who have experience of the activities, procedures or events of interest being studied.

An invitation to participate, along with an explanation of the research project (Appendix 1), was first sent to every NUM in January 2003, and those who responded positively were contacted to arrange a suitable interview time. This recruitment strategy is consistent with that described by Llewellyn, Sullivan and Minichiello (2004), in which the importance is stressed of providing all potential participants with sufficient information so they can make an informed choice about participation. Another copy of the same invitation letter was sent to all potential participants in June 2003, as I discovered that a number of NUMs had either left their positions, were on extended leave or had been seconded to other positions.

By October 2003, approximately seven months after data collection had commenced, a thank you letter containing a brief reminder that the study was underway and another invitation to participate was sent to all NUMs (Appendix 2). In total, 23 NUMs indicated a willingness to participate in the study. However, three NUMs left their employment before I could interview them, leaving a total of 20 NUMs who participated in the study. Data were collected throughout 2003, ceasing in late December 2003.

The biggest challenge I faced when organising interviews was the unpredictability of the NUMs' workloads, which caused difficulty for the participants in finding the time to be interviewed. This was the main reason that data collection spanned a ten-month period, as many of the interviews were scheduled, cancelled and rescheduled a number of times. During this time, I was very aware that the NUMs' participation should not be an added burden to their already heavy workload. Thus, after an arranged interview was cancelled I always telephoned the NUM to assure them that they were under no obligation to speak with me. This strategy is consistent with feminist

interview techniques as described by Lyons and Chipperfield (2000:33), who suggest that the feminist researcher should make every attempt to develop a 'non-hierarchical, non-manipulative' relationship with participants. I was grateful that all the participants who initially cancelled interviews were still willing to be part of this study.

4.3.3 Pre-pilot and pilot studies

Teijlingen and Hundley (2001) discuss the use of pilot studies and note that there is a common belief amongst many qualitative researchers that pilot studies are not necessary prior to commencing interviews, because interview questions often change over the course of the data collection period. However, Teijlingen and Hundley reject this belief, suggesting that pilot studies are potentially valuable in any type of research, as they contribute to improvements in the methods used, and therefore should be included as a vital part of the research process (Teijlingen & Hundley 2001). Byrne (2001:207) concurs, stating that many researchers 'view a pilot study as busy work or a time-wasting step, [but] in the long run it will expedite the actual implementation stage of a research study'. Teijlingen and Hundley (2001:5) contend that pilot studies are 'underdiscussed, underused and underreported' in most qualitative studies, noting that full descriptions of pilot studies are rare in any research literature. This description of the pre-pilot and pilot studies is consistent with the feminist principles on which this study is based and provides a clear documentation of this stage of the research process (Brayton 1997; Olesen 2000).

The actual process of pre-piloting the study commenced with a review of the existing literature related to the purpose and aims of this study. From the literature, I gained a sense of what was known and what needed to be known about the construct of power within the NUMs' working world, which led to some potential interview questions. In an effort to determine whether the questions would achieve the aims of the study and be easily understood, I asked nursing colleagues from both academic and clinical settings to consider the questions and provide feedback. Three colleagues gave me detailed responses following their review of the draft questions. This pre-pilot phase provided valuable feedback about the phrasing, clarity and meaning of the questions, which allowed me to address any ambiguity prior to the

commencement of data collection (de Vaus 1995). The feedback indicated that several of the questions were unintentionally biased. For example, two of the questions initially asked:

> How do you believe that you gained the skills needed to perform the role of NUM effectively?
>
> What sort of support would have been helpful?

The feedback I received from those who reviewed the questions indicated that I had made two assumptions when framing these questions. The first assumption was that the NUMs' performed their role effectively, while the second assumption was that any existing support available to them was not necessarily helpful. The reviewers also suggested that I make the focus of one of the other questions broader, as they thought it was too narrow. This question initially asked 'How do you cope with difficult or challenging work relationships?' One reviewer suggested that this be changed to 'Can you tell me about your work relationships?' This broader question gave the NUMs an opportunity to discuss any work relationship, not just the difficult or challenging ones. Thus, this pre-pilot stage allowed me further opportunities to reflect on the focus of questions needed to explore the construct of power. Furthermore, as researcher reflexivity is vital in feminist studies (Jackson, Clare & Mannix 2003) this pre-pilot study gave me the opportunity to reflect on my purpose in asking these questions.

Once the questions had been amended based on the feedback from the reviewers, I invited two clinical colleagues, who had both previously worked as NUMs, to participate in individual semi-structured interviews. During these two pilot interviews, I reflected on whether the questions allowed the participants sufficient flexibility to tell their stories in their own words, a core principle of feminist research (Brayton 1997). I also asked for feedback from the participants at the end of each interview to determine whether they thought the questions were consistent with the aims of the study. I audiotaped the pilot interviews, with the participants' permission, and left the tape running to capture their immediate reactions following the interview. I asked them whether the questions were clear, if they were biased, and

whether they thought the questions were broad enough to capture the reality of being a NUM. This was an important issue for me as I was mindful of not creating questions that would limit my access to the NUMs' working world. The early versions of the interview schedule are contained in Appendix 3 to show how the questions evolved in response to the pre-pilot and pilot studies, while the final version is provided later in this chapter. I believe that the processes I followed were an important part of the inquiry as they allowed me to reflect on whether the data collection procedure and the interview questions were suitable to achieve the purpose and aims of this study.

4.3.4 Data collection procedure

When willing NUMs were contacted to arrange an interview time, I encouraged them to ask any questions to further clarify the nature of the interview process. This strategy was based on the tenets of feminist research, which requires researchers to ensure that participants are well informed about the purpose and structure of the interviews (Lyons & Chipperfield 2000). To this end, I assured each NUM that they were under no obligation to participate, that the purpose of the interview was to hear about their experiences as a NUM, and that while I intended to ask them a few broad questions, the interview would be more like a conversation between nursing colleagues, rather than a question and answer session (Lyons & Chipperfield 2000).

I conducted all the interviews during the NUMs' working day. Of the 20 interviews, all but one was audiotaped. Two of the interviews were conducted in my office, fourteen were conducted in the NUMs' offices or other workspace used by the NUM, and four interviews were conducted by telephone. The telephone interviews were conducted either because of the difficulty with scheduling and rescheduling face-to-face interviews, or because the participant requested it. The decision to interview as many participants as possible in their workspace was based on my desire to make them feel at ease. My presence in their office or workspace gave them greater control over seating, the handling of interruptions and the duration of the interview, thereby reducing my power base, an important strategy in feminist research (Lyons & Chipperfield 2000). Furthermore, by interviewing the majority of the participants in their workplace, I was also able to observe their

working environment, which according to Marx (2001:131), is another useful source of data in feminist studies, because it exposes the 'social location of the respondent in the power structure of an organization'.

After contacting each willing NUM to arrange an interview time, I always telephoned on the day of the interview to reconfirm the arrangements. However, despite doing this, on several occasions I travelled by car for more than an hour only to find that because of unforseen circumstances the NUM was unable to participate, so re-scheduling was necessary. In all cases where this occurred, the participants involved were very apologetic, despite the fact that the situation was beyond their control. I assured them that I understood the difficulties they had in finding the time to participate, and made sure that I did not pressure them to reschedule another interview.

Each interview lasted between 40 and 90 minutes, but the duration depended very much on the NUM. Many of them were very busy, and during several of the interviews there were a number of interruptions which required the NUM to attend to issues immediately, before returning to complete the interview. These events were all recorded in my journal.

Prior to the commencement of each interview, I gave each NUM an information statement, which again explained the purpose of the study (Appendix 4), and a consent form (Appendix 5). I also reiterated that I was interested in their experiences and perceptions and I reassured the participants that the stories they shared with me would not be attributed to any particular individual or workplace in any report or publication, but would be identified only as stories from NUMs employed by NEAH. I also informed them that they could withdraw from the study at any time and elect to have their data destroyed. Llewellyn, Sullivan and Minichiello (2004) stress the importance of giving the participants uncomplicated information, making it clear that their participation is voluntary, and explaining how their privacy and confidentiality will be protected. Before commencing each interview I answered any questions and then I asked the participants to sign two copies of a consent form, one they retained for their records and one I stored in a locked filing cabinet. The consent form (Appendix 5) required the participant to consent to both the interview, and to the interview being audiotaped, so

that non-consent to audiotaping did not preclude a NUM from consenting to an interview.

Once consent was gained, the participants were given a demographic questionnaire to complete (Appendix 6) and they were then asked a number of broad open-ended questions. The opening question for each interview was: *'Thank you for agreeing to talk to me. Can I ask you first, why did you agree to participate in an interview?'* This conversational question allowed each NUM to discuss the reason for agreeing to be interviewed, as I was interested in discovering why such busy people would agree to be involved in the project. This initial question also allowed the focus of the interview to immediately shift from my motivations to those of the NUM. This is of particular importance in feminist studies, where the aim is to interact with the participant on equal terms and to foreground the participant's perspective (Olesen 2000). Crotty (1996) and Beanland et al. (1999) contend that a semi-structured interview is designed to introduce the topic of interest and then follow the participant's lead, rather than gain answers to specific questions. Using this approach, the second interview question was: *'Can you tell me what it is like to be a NUM?'* From this point, each interview progressed as a conversation, rather than a question and answer session. In addition, conducting the interviews as a conversation, led by the NUM, assisted in reducing any perceived power differential between the participant and myself (Brayton 1997). The remaining prompting questions contained in the interview schedule were only asked if the participant or I lost our train of thought or the conversation stalled.

At the conclusion of each interview, I asked participants whether they wished to make any further comments about being a NUM. Following this, I thanked them for their time and told them I would send them a brief, preliminary summary of the results of the study. This summary was sent in December 2004 (Appendix 7). Data collection ceased after twenty interviews as no other potential participants indicated a willingness to participate. However, as many of the issues raised by the NUMs were heard in all the narratives, I did not believe that any new data would emerge if I continued to try and recruit participants. Had the last few interviews yielded new data then I would have

made further efforts to continue the data collection (Llewellyn, Sullivan & Minichiello 2004).

4.3.5 Interview schedule

Below is a copy of the final interview schedule, however, as previously stated, not all questions were asked of every participant. Rather, they were used to explore the stories of the NUMs, by prompting them to discuss aspects of their working lives that addressed the study aims. Some interviews progressed with minimal prompts, while others included a number of the prompting questions to encourage the participant to continue with their story:

Opening question: Thank you for agreeing to talk to me. Can I ask you first, why did you agree to participate in an interview?

Focused question:

Can you tell me what it is like to be a NUM?

Prompting questions:

1. Can you tell me what it was like for you when you first became a NUM?
2. Why do you think you were successful in gaining the position of NUM?
3. How have you gained the skills needed in your role?
4. Can you tell me about the support and education available to you in your role as a NUM?
5. Do you think of yourself as primarily a manager or a nurse?
6. How do you integrate your nursing and managerial roles?
7. What part do you play in your organization?
8. Can you tell me about your work relationships?
9. Do you think your nursing values are reflected in the values of your organization?
10. Are your opinions heard in your organization?
11. How are your achievements rewarded?

Over the duration of the twenty interviews, some of the questions were re-worded slightly or were asked in a different order, but overall the questions were sufficiently broad to gain access into the construct of power within the

working world of the NUMs. Of particular note is the fact that while the overarching purpose was to explore the construct of organizational power for NUMs, none of the questions directly asked about power. This was a deliberate ploy to avoid introducing the concept of power into the interviews, as, according to Speedy and Jackson (2004:58), 'power may hold negative associations for women', because it may be associated with ideas of domination and control. Thus, the interview questions were designed to explore power indirectly, by asking the participants about their working lives, their organizational role, relationships, values and rewards. Kuokkanen and Leino-Kilpi (2000:236) suggest that 'the essence of power cannot be grasped simply by asking who has access to power'. The prompting questions therefore aimed to uncover information about the participants' access to the structural determinants of organizational power, as described by Kanter (1977).

4.3.6 The researcher's journal

As well as interviewing the participants, I also kept a journal throughout the study. In the journal I recorded my observations about the process of recruiting participants, the location of the interviews, my personal feelings about the interviews and any other notes or reminders related to my responses to, and impressions of, the data collection. The journal was also used to make notes when interviewing the participant who did not wish to be audiotaped. By recording my responses to the participants and their stories in a journal, I was able to reflect on the appropriateness of the questions and the order in which they were asked at each interview. According to Andrews, Sullivan and Minichiello (2004), my own experience as a nurse makes me an insider. A number of feminist researchers describe an insider as someone who is trained in and studies within the same field as the participants, and has knowledge of the social and cultural context in which the participant operates (Acker 2001; Dallimore 2000). Insider status is based on more than just having gender in common with research participants (Jackson, Clare & Mannix 2003). In this study, my insider status allowed me to identify with the participants, to understand their jargon, and to acknowledge common ground. I used my insider knowledge to establish a rapport with each NUM and to vary the timing and number of interview questions to suit each participant's story and

context. As a woman and a nurse, I believe that my insider knowledge allowed me to better understand the experiences of the participants of both genders.

Fontana and Frey (2000) suggest that traditional interviewing techniques are embedded in a masculine paradigm, which casts the respondent into a subordinate position with the interviewer controlling the interview. The end result is that the relationship between interviewee and interviewer is never made explicit. In an effort to reduce the power differential between the NUMs and myself I recorded in the journal my reflections about my role in the research process. In addition, as suggested by the voice-centred relational approach to data analysis (Brown & Gilligan 1992), I also recorded my reflections on, and reactions to, all the NUMs' stories. My journal thus became another valuable source of data that complemented the interview transcripts to create a pathway into the construct of power within the working world of the participants, based on the NUMs' relationships with others and their environment (Brown & Gilligan 1992).

4.3.7 Data analysis

As already discussed, in order to analyse the data in a way that was consistent with the aims of this study and a feminist methodology, I selected the voice-centred relational method of data analysis, developed by Gilligan (1982), to allow the voices of the NUMs' to be more clearly heard. Furthermore, by using this method, my voice is also heard, in my interpretations and in my reflections, as a different but linked part of the same research process. Thus, the voice-centred relational approach to data analysis provided a means of acknowledging not only who is speaking, but also who is listening (Brown & Gilligan 1992; Gilligan 1982). Data analysis commenced following the transcription of the first interview in June 2003 and concluded in June 2004.

The voice-centred relational method of data analysis is fundamentally different from other methods employed in qualitative studies. For example, thematic analysis seeks to identify themes that cut across individual stories (Browne 2004), and narrative analysis focuses on the structure and content of the language used (Herda 1999). The major difference with the voice-centred relational approach is that the researcher undertakes a detailed and time-

consuming analysis of each transcript that requires each story to be considered from a number of perspectives. Gilligan (1982) developed and used this method in the 1970s, and a more detailed account of how to apply it is provided in Brown and Gilligan's (1992) text *Meeting at the Crossroads.* In this text, the details of the method are found in a 'Listener's Guide' (Brown & Gilligan 1992:25).

This guide suggests four stages of data analysis, each consisting of reading and listening to interview data simultaneously (Brown & Gilligan 1992). With each stage of the data analysis the focus changes, so that with each reading the researcher attempts to identify:

> (1) Who is speaking?
>
> (2) In what body?
>
> (3) Telling what story about relationships?
>
> (4) In which societal and cultural frameworks? (Brown & Gilligan 1992:21).

Taylor, Gilligan and Sullivan (1995) contend that Brown and Gilligan's (1992) Listeners' Guide can be adapted to suit the focus of any qualitative research study, although it is ideally suited to feminist-based studies, particularly those that seek to hear the stories of those who are not generally heard in society. Taylor, Gilligan and Sullivan (1995) also explain that potentially any number of readings can be done, depending on how many dimensions of the participants' stories are to be explored. In addition, this process also allows each respondent's story to be heard as a whole at the forefront of the analysis and yet also allows for the researcher's role to be made explicit in the co-creation and analysis of the data, an important principle of feminist research (Brayton 1997; Jackson, Clare & Mannix 2003; Marx 2001). The following account describes how I applied this method of data analysis to the data in this study.

Once each interview was transcribed, I read the transcript while listening to each audiotape four times. With each listening, I focused on certain elements of the NUMs' stories. The first reading/listening of each interview was

uninterrupted, in that I listened to the entire interview while reading the transcript before considering each NUM's story. After each tape finished I reflected on the whole story, I thought about what the participant had told me about being a NUM, I thought about the story as a drama, and I considered the plot, the characters, the tensions and the consequences (Brown & Gilligan 1992).

According to Gilligan (1982), Gilligan and Brown (1992) and Doucet and Mauthner (1998), this first reading is common to many other methods of qualitative analysis used to interpret interview transcripts, in that plots, themes and events are considered.

However, the second stage of the first reading using a voice-centred relational approach differs from other methods as it requires the researcher to reflect on and record responses to the participants' stories in a journal (Brown & Gilligan 1992). So, immediately following the first reading of each transcript I made notes in my journal about my reactions to the speaker and the story. I asked myself what I thought of each speaker, how I reacted to each story and whether I identified with the participants. I also considered the emotions elicited by each of the stories. I completed the first reading of each interview and made copious notes in my journal before moving on to the second reading.

The second reading focused on the way that each NUM spoke about themselves. Brown and Gilligan (1992:21) explain that in this reading the researcher listens for indications of the participant's sense of self, to gain a feel for 'the heart and mind of another body'. I listened for sentences containing the words 'I', 'me' and 'my' in order to gain insight into the identity of the NUM from their perspective. An exploration of how the NUMs perceive themselves assists in exposing the construct of power embedded in their work roles. Mauthner (2002:214) used this method to explore the experiences of mothers suffering post-natal depression, and concluded that this reading allows a researcher to hear when the speaker shifts the focus from 'I' to 'you'. This shift is significant as it indicates not only how a participant perceives themselves but how they think others perceive them, information that I thought would be vital in locating the NUMs within the context of healthcare.

According to Brown and Gilligan (1992) the second reading not only helps researchers to identify the voices of participants, but also allows participants to speak of themselves in their own body and space, before we, as researchers, speak of them. This perspective is particularly appropriate for feminist studies where the aim is to understand another person's reality. I used a highlighter pen during this reading to mark the sentences in each transcript that contained first person descriptions of the NUMs' working life.

Brown and Gilligan (1992) explain that the third and fourth readings both focus on relationships, with the third reading centred on relationships with others, and the fourth reading focuses on the relationship between the participant and their socio-cultural context. These last two readings allow the researcher to identify how speakers 'experiences themselves in the relational landscape of human life' (Brown & Gilligan 1992:29). During the third reading, I listened for information about the working relationships of the NUMs, in order to hear how they described their interactions with others, as one of the aims of the study is to understand what it is like to be a NUM in the context of the healthcare system. The purpose of this reading is to uncover the basis of the NUMs' work interactions, to discover who has the power and who has the voice. This reading assists in uncovering experiences of oppression and helps to identify the power dynamics at play (Brown & Gilligan 1992). Again, I used a highlighter pen in a different colour to mark the passages in which the NUMs described their work relationships.

In the fourth and final reading, I focused on the context of the NUMs' stories, by looking for examples of the NUMs' relationships with the political, societal, cultural and organisational aspects of their lives. In adopting this focus, I also drew on Mauthner and Doucet's (1998:132) explanation of this reading, in which they stress that this reading is focused on 'placing people within cultural contexts and social structures', a vital step in feminist studies (Brayton 1997; Campbell & Wasco 2000). Thus, it was during this reading that I particularly listened for the NUMs' experiences that spoke of access, or lack of it, to the structures of organizational power, as described by Kanter (1977). This reading helped me to understand how the construct of organizational power is embedded in the context of healthcare as well as the relationships and professional identity of each NUM. I made notes during this reading, as

much of what was said about the context and organizational culture of healthcare was embedded in each story and could not be easily captured by just highlighting sentences.

Once all readings were completed, I revisited each transcript and reread the notes I had made in my journal relating to the content of the interviews. In addition, I read my reflections, also recorded in my journal, and considered them in light of the participants' stories and demographic data to gain an integrated picture of each NUM. I found that there were some commonalities in the experiences of the NUMs. By that I mean that some aspects of their stories I heard in a collective voice, while other aspects were common to a few or were even unique. I reflected on my responses to their stories, their relationships and their contexts, and during this time, I decided how best to present their stories to be consistent with the aims of feminist research. Therefore, in accordance with feminist thought, the data analysis chapters of this thesis are organized in such a way that the NUMs' stories are foremost, interwoven with my interpretation as another, but not more powerful, voice (Olesen 2000).

I found the data analysis process very absorbing as it allowed me to shift the focus of the analysis from the story as a whole to the relationships and context of each storyteller, in order to expose how the construct of power is embedded in the NUMs' working lives. In addition, it allowed my role in this study to be made explicit (Brown & Gilligan 1992). I believe that this method of data analysis has afforded the participants a 'voice of agency' (Buresh & Gordon 2000:34) and has uncovered the knowledge embedded in the NUMs' reality, particularly in relation to organizational power and voice.

4.4 Rigour and trustworthiness of the study

Rigour is about ensuring that a research study demonstrates methodological accuracy and truthfulness (Roberts & Taylor 2002:377), while trustworthiness is the coherence between intention and outcome (Grbich 1999). In much of the literature that describes research methods, it is suggested that rigour can be achieved by demonstrating validity and reliability (Depoy & Gitlin 1998; Greenwood 2004; Roberts & Taylor 2002). However, qualitative research

studies do not generally use the same methods of ensuring validity and reliability as quantitative studies. For example, Stenbacka (2001) suggests that a quantitative understanding of validity and reliability are not appropriate for qualitative studies if the traditional meanings of these terms are used. This is because validity refers to whether the intended object of measurement is actually measured, while reliability refers to the replicability of the measurement results, given the same conditions (DePoy & Gitlin 1998). These concepts are clearly not applicable to many qualitative designs that seek to understand the dynamic, subjective meaning of peoples' experiences. Furthermore, a number of authors indicate that in the search for validity and reliability, feminist qualitative researchers are faced with additional dilemmas (Brayton 1997; Dallimore 2000; Lincoln & Guba 2000; Olesen 2003). For example, Dallimore (2000:157) argues that while critics claim that validity in feminist studies is weak, this weakness can be overcome by 'reconceptualizing issues of validity as they relate to feminist goals and methodologies'.

As one feminist researcher suggests, 'there are ways of achieving validity that reflect the nature of qualitative work' (Olesen 2000:230). Similarly, Jackson, Clare and Mannix (2003:212) stress the importance of identifying strategies for establishing rigour in a feminist study, adding that in most cases feminist scholars reconceptualize evaluative criteria from qualitative research in a way that is consistent with feminist methodologies. In this study, validity is addressed by a demonstration of trustworthiness and rigour.

Many of the strategies for ensuring trustworthiness and rigour discussed by feminist researchers are concerned with issues such as: adequacy, plausibility, credibility, reflexivity, rapport, and auditability (Brayton 1997; Dallimore 2000; Rose 2001; Jackson, Clare & Mannix 2003; Olesen 2000). Hunt (1998) stresses that in feminist research the focus is on understanding the contextualised nature of experiences, and that therefore issues of rigour and trustworthiness should be embedded throughout the whole project. The following discussion centres on how rigour and trustworthiness have been addressed in this study.

Adequacy, according to Dallimore (2000), refers to how well the study reflects the voices of the participants, and how well the interpretation of the findings takes account of both the investigator and the investigated. Brayton (1997) concurs, suggesting that by recognizing the role of the researcher and the participants in the research process, the power imbalance that often exists between them is negated, so that the voices of the participants become the focus of the study. Rose (2001) believes that adequacy can be demonstrated by distinguishing between the findings derived from the participants' quotes and those defined by the researcher as interpretations of the data. Using this strategy, I have clearly described my role in the research process, and made every attempt to reflect the authentic voices of the participants, as well as differentiated between the NUMs' stories and my interpretations of the data. Olesen (2000) suggests that adequacy can be achieved by adopting innovative ways of presenting the participants' stories to ensure that data analysis does not limit their voices. In this study, this was achieved by adopting the voice-centred relational method of data analysis, which places the participants' stories at the forefront of the findings.

Credibility, according to Roberts and Taylor (2002:308), refers to the 'extent to which participants and readers of the research recognise the lived experience described in the research as similar to their own'. Roberts and Taylor argue that, if a sense of recognition is achieved, by members of a discipline when reading participants' experiences, then credibility has been achieved. Similarly, Janesick (2000:393) describes credibility as the response to the question 'Is the explanation credible?' In other words do readers consider the findings to be a reasonable interpretation of the data, bearing in mind that when exploring people's lives and experiences there is never just one interpretation. Dallimore (2000) and Rose (2001) describe credibility and plausibility as the process of making sure that the research findings are meaningful and relevant to the participants, by considering how well they reflect their real life experiences.

Grbich (1999:53) indicates that in feminist research the researcher must expose her/his position, emotions, values and view of reality and explain how these affect the interpretations and analysis of the participants' reality. This is in contrast to the process of bracketing, which is the setting aside of one's 'own

feelings and preconceived ideas regarding the experience being researched', which is the process used in many other qualitative research methodologies (Grbich 1999:169). In this study, I found that I empathised with the participants. At times their stories touched me, angered me or caused me to laugh because I am part of the context from which their stories arise. I believe that the use of a voice-centred relational approach to data analysis has assisted in translating a broad relational ontology into a procedure that facilitates the understanding of subjective meanings in cultural and interpersonal contexts. Thus, by combining a feminist methodology with a voice-centred relational approach to data analysis, credibility has been enhanced in this study.

Another strategy used to enhance both the credibility and plausibility of this study was an invitation to all the participants to verify the authenticity of their interview transcript. This is because member checks are important to ensure that the data truly reflects the participants' experiences (Lincoln & Guba 2000). All the NUMs declined to check their transcripts, stating that they did not have the time. So I sent each participant a summary of the findings and asked them for their feedback (Appendix 7), but only one NUM responded, saying that she thought I had 'hit the nail on the head, but was a bit too kind'. I took the lack of response from the other participants to be a sign that they did not disagree with my preliminary interpretation of their experiences. In addition, I asked my PhD supervisors to verify my interpretation of the data, in an effort to enhance the credibility of the findings.

Reflexivity as a strategy to ensure rigour and trustworthiness is a tenet central to all feminist research (Olesen 2000). By reflecting on one's own biases, beliefs and values, it is possible to use this self-knowledge as a resource in a feminist study (Jackson, Clare & Mannix 2003:210). Campbell and Wasco (2000) suggest that self-reflection by the researcher assists in conceptualising and conducting credible research, and helps to expose the researcher's prejudices or preferences. This is vital, as it is difficult to provide a credible interpretation of another person's reality if there is no evidence of insight into one's own reality. In this study, reflexivity played a major role at all stages of the research process. For example, I reflected on the existing literature and my

own experiences in conceptualising this study. I asked nursing colleagues to reflect on the interview questions, and then used their feedback to reflect on and refine the questions. I used a journal to record my reflections on the entire research process, from the recruitment of participants to the location and content of the interviews. Finally, I adopted a method of data analysis (Brown & Gilligan 1992) that required in depth reflections on many aspects on the NUMs' stories, as well as my reactions to them. Dallimore (2000) suggests that through reflection a feminist study can bring together subjective and objective ways of understanding reality, by acknowledging rather than ignoring the researcher's cultural beliefs and practices and by clarifying the researcher's role in the research process.

Rapport, the next criteria suggested as a means of ensuring the rigour and trustworthiness of a feminist study, refers to reducing the formality that often exists between researcher and subject when using other research paradigms (Lyons & Chipperfield 2000). In feminist studies, as already discussed, one of the overarching aims is to reduce the power differential between the researcher and the participant (Brayton 1997; Cook & Funow 1986; Jackson, Clare & Mannix 2003), and develop a non-manipulative relationship. Rapport is achieved when the participant feels at ease and the interview progresses as a mutual conversation (Lyons & Chipperfield 2000). Roberts and Taylor (2002) suggest that researchers should approach participants as people to do research *with*, not *on*, while Dallimore (2000:160) indicates that to some feminist researchers, rapport refers to the involvement of participants in every stage of the research process, including data collection, analysis and the documentation of results. However, not all feminist researchers agree on the level of rapport necessary to ensure rigorous feminist research. For example, Lyons and Chipperfield (2000:34) believe that researchers only need to build up a level of rapport consistent with the rapport one might have with a 'friendly stranger'. These authors suggest that participants may become uncomfortable if a researcher is overly friendly, or too demanding of the participants' time, as interviews can be of longer duration if the researcher interjects with personal information and anecdotes. In this study, I adopted Lyons and Chipperfield's (2003) suggestions of how to build rapport and I treated the NUMs as nursing colleagues. By this I mean that I was friendly,

without being too familiar, I listened to their stories with interest and empathy, but I did not share any of my own experiences, as I wanted their experiences to be the focus of the interviews.

Auditability, another strategy for enhancing rigour and trustworthiness, is the production of a decision trail to demonstrate consistency between the research method, processes and outcomes (Olesen 2000; Roberts & Taylor 2002). According to Schneider et al. (2003) auditability means that a reader should be able to see how the researcher's analysis and interpretation of the data has flowed from the participants' words. Similarly, Wolcott (1994) suggests that by recording all information accurately and by starting to write early, a well-documented decision trail is achieved. As previously mentioned, I kept a journal documenting all aspects of the research process, including recruitment strategies, pilot studies and interview procedures. I continued to journal throughout the data collection and analysis process, recording my impressions, comments and insights immediately following each interview and as part of the data analysis process. In these journal entries I commented on the setting, the participant and the actual interview. In addition, during the early stages of this project I also made many notes about information that I felt needed to be included in this thesis. By thus informing the reader of the processes I undertook throughout this research study, auditability has been achieved.

Finally, Stenbacka (2001:552) suggests the answer to the dilemma of how to demonstrate rigour in a feminist study is very simple: the study is valid if each participant is 'given the opportunity to speak freely according to his/her own knowledge structures'. It is my belief that the participants in this feminist study were given that opportunity, and that their stories reflect their reality within the context of the organizational culture of healthcare.

4.5 Ethical considerations

Prior to commencing this study, ethical approval was granted by the University of New England Human Research Ethics Committee, Approval Number HE02/154, and The New England Area Health (NEAH) Human Research Ethics Committee, Project Number DB119. Ethics Committees are

entrusted to ensure that research is conducted in a manner that does not harm people in any way. To achieve this the ethics committees required the submission of a detailed plan of the methods to be employed as well as a copy of the information statement, the consent form, the demographic questionnaire and the interview schedule.

In order to gain ethical approval for this study, I was asked by the New England Area Health Human Research Ethics Committee to provide them with further justification regarding the reasons why I considered a feminist paradigm to be appropriate. I was also required to revise and resubmit my proposed recruitment method. For example, I had initially intended to telephone the NUMs to invite then to participate. However the New England Area Health Human Research Ethics Committee required me to mail written invitations, and to facilitate this I was provided with a list of the NUMs employed by NEAH.

Another condition required by the New England Area Health Human Research Ethics Committee was that I gain a proportionate sample of NUMs selected from both the larger and smaller hospitals within NEAH. I found it difficult to comply with this request, as representativeness was not a study aim, nor was it consistent with a feminist design. Furthermore, I could not guarantee that I would be able to recruit the required number of NUMs from particular hospitals, considering the small population of NUMs in some hospitals and the voluntary nature of participation. However, the final number of participants was only one less than the number suggested by NEAH, and I did interview NUMs from both the larger and smaller facilities within NEAH.

Prior to the commencement of each interview, I asked participants if they had any further questions or concerns about their participation in the study. If not, they were invited to sign two consent forms. I also informed each NUM that their participation was voluntary, and they could choose to withdraw from the study at any time, and have their data destroyed, without penalty or prejudice. Finally, I was aware that if any of my questions caused the NUMs to feel distressed I had an ethical obligation to direct them to counselling

services. This information was also provided in the information sheet that the NUMs retained (Appendix 5).

Participants were informed that all data, in the form of audiotapes, transcripts, computer discs, and hard copies, would be stored in a locked filing cabinet in my office for a period of five years, and accessed only by myself and my supervisors, in accordance with the National Health and Medical Research Council of Australia (1999) guidelines. After a five-year period, the data will be destroyed, also in accordance with the guidelines.

Another ethical consideration was that many of the NUMs in NEAH work in small healthcare facilities, where there are only one or two NUM positions. I was therefore aware that confidentiality could be breached if individual workplaces were identified. In order to protect participants' identity I did not link them with any particular facility. In addition, I was also very aware of the need to maintain the confidentiality of those who participated by not identifying them to their colleagues. I found that I had to be vigilant about this aspect of confidentiality, as many of the NUMs asked me 'Have you interviewed so-and-so yet?' This was another reason why reminder letters were sent to all NUMs, and not just to those who had not yet participated. Similarly, as only a small minority of the 42 NUM positions are currently held by males, I decided not to include the gender mix data gathered in the demographic profile of participants, and to allocate them pseudonyms that do not identify gender.

A further ethical consideration for me was that I wanted to present the voices of the participants accurately, in accordance with feminist principles, so I did not originally intend to tamper with any excerpts of the narratives. However, in order to maintain confidentiality I had to remove all references to particular locations, wards or people and use pseudonyms for all participants. Throughout the data analysis chapters, I have indicated where information has been removed from participant quotes by replacing it with non-identifying information in square brackets. However, other than the removal of the identifying information, all quotes reflect the exact wording used by the NUMs.

Before embarking on this project, I also reflected on the power relationships in the research process, as this is an integral step in conceptualising a feminist study (Jackson, Clare & Mannix 2003). I did not wish to exploit the participants by just considering them as a source of data. This ethical consideration is of particular importance in feminist research and was closely linked to my decision to use the voice-centred relational approach to data analysis. Thus, I was able to ensure congruence between the principles of feminist research, the methodology, and ethical procedures by treating each participant with respect and presenting their stories as the focal point of this thesis. Discussions with my PhD supervisors regarding these ethical issues helped me to work through these concerns to my satisfaction and also to the satisfaction of the participants.

4.6 Methodological issues and limitations

One of the key methodological issues of feminist research is how to present and interpret accurately the voices of participants without distorting or manipulating their meaning (Olesen 2000). Mauthner and Doucet (1998) indicate that even when using a feminist design it is impossible to truly represent the authentic voices of the participants. They suggest that researchers should therefore address this methodological issue by striving to hear *more* of what participants say than is possible using other research designs.

Obviously, as the researcher, I had control over choice of the original topic, as well as the final decision on what to include, what to leave out, and how to present it. According to Olesen (2002) and Grbich (1999), it is vital to address these methodological issues when conducting feminist research. I therefore acknowledge that while I may have influenced the findings of this study by asking certain questions and following up on some of the NUMs' comments and not others, adopting a voice-centred relational approach to data analysis has enabled me to hear more of the NUMs' stories. Additionally, this method has also allowed my responses to the stories to become part of the research. As a nurse researching nurses, I am not unbiased, so I have included my thoughts, beliefs and values throughout this thesis, in accordance with the tenets of feminist research.

One potential methodological limitation in this study revolved around the choice of setting. I made the decision to interview the NUMs in their workplace. While this choice allowed me to observe the physical environment in which the NUMs work, it also limited the time available for the NUMs to talk to me due to their workloads, and meant that a number of the interviews were interrupted by work demands. Additionally, interviewing NUMs at work may have made them more cautious about what they told me, considering that some of the interviews were conducted in rather public places, such as staffrooms, shared offices or patient lounges. However, I believe that the benefits of talking to the NUMs in their workspace cannot be overstated.

According to Lyons and Chipperfield (2000), interviewing time-pressured workers in their own environment means they have more control over the duration and logistics of the interview. Another benefit of interviewing participants in their workspace is described by Marx (2001), who suggests that observing participants in their work location can reveal information about their power. Thus, since this study aimed to explore the construct of power within the working lives of NUMs I felt it was imperative to observe their working environment.

A final methodological issue is that the results of this study cannot be generalised to the wider population of NUMs. However, according to Roberts and Taylor (2002), some phenomena cannot be captured or understood unless qualitative methods are used. Furthermore, it was not my intention to represent NUMs as a group, or to claim that the NUMs interviewed are representative of the NUM population. Rather, the overall aim of this study was to hear the stories told by a group of NUMs, and it would not be surprising if their stories and the findings of this study resonate with the wider population of NUMs.

4.7 Conclusion

I commenced this chapter by discussing the ontology and epistemology on which this study is based. I argued, in summary, that using a qualitative feminist methodology has allowed me to explore the construct of power

embedded within the NUMs stories that might have otherwise remained hidden. This chapter has shown that congruence exists between the aims of this study, the theoretical framework and the research methodology, which will assist in hearing the NUMs' voices. I pointed out that in feminist research, the researcher is an integral part of the research process, because the researcher's beliefs and perspectives help to shape the study and the outcomes (Brayton 1997).

In this study, I have therefore identified that my own experiences of being a member of a marginalised and disempowered group has influenced my conceptualisation of this study. If a more conventional methodology had been used, my role in the research process would have remained hidden. However, by adopting a feminist perspective, and by embedding myself in this study, I argued that I am better positioned to discover how issues of powerlessness affect the NUM's role. Further to this, I suggested that the findings of feminist studies can assist in creating the conditions for the process of empowerment and emancipation to occur.

This explanation of the feminist basis for this study was followed by a justification for the research paradigm used in the study, including the voice-centred relational approach to data analysis developed by Gilligan (1982).

The chapter provided a description of the methods used in this study, detailing the setting, recruitment and sample of participants and an explanation of how the pre-pilot and pilot studies were used to clarify and refine the interview questions. This was followed by a detailed account of the procedures used to collect and analyse data. Rigour and trustworthiness were achieved in this study by using specific criteria and strategies suggested by a number of feminist researchers. Finally, a discussion of the ethical considerations, and the methodological issues and limitations of this study concluded this chapter. The next chapter, based on the first reading of the data, is one of two data analysis chapters.