Chapter One
INTRODUCTION

No man, not even a doctor, ever gives any other definition of what a nurse should be than this – 'devoted and obedient'. This definition would do just as well for a porter. It might even do for a horse (Nightingale 1946 (1859)).

1 Introduction to the study

As I write these words, nurses in Australia and overseas are charged with the almost impossible task of providing quality nursing care in a workplace culture that does not appear to value them. While there exists a plethora of information describing the oppression and powerlessness of nurses in the healthcare context, we know little or nothing about how nurses negotiate their undervalued role in the system, or how they feel about it. This chapter provides an introduction to a study entitled 'The working world of nursing unit managers'. My overarching aim in conducting this feminist study is to explore the construct of power among one group of nurses, namely, nursing unit managers (NUMs) in a rural area health region of the New South Wales public healthcare system. My hope is that by exploring the effects of a patriarchal healthcare system on this specific group of nurses, we will learn more about how they experience their working lives.

This chapter provides background to the current role of nursing unit managers in Australia, and includes a role description of NUMs in New South Wales. Following this, I present a personal profile of myself, as I am a nurse and a part of this study, so the tone of this thesis is both passionate and personal. The chapter then outlines the purpose, aims and significance of the study. The construct of power within organizations is introduced and an overview of the theoretical framework and the methodology used to guide this project is presented. The scope of the study and a key assumption are identified, and a definition of terms used throughout this thesis is also provided. The chapter concludes with a description of the organization of the thesis.

1.1 Background to the study

In Australia, nursing unit managers (NUMs) occupy the position of first-line management in most public and private healthcare services. Their role is complex and multifaceted and, as this chapter will demonstrate, requires an intertwining of clinical and managerial responsibilities. While an abundance of studies have explored and described management roles in other professions and industries, little is known about the experiences of nurses as first-line managers. This study seeks to address this knowledge deficit by exploring the nursing unit managers' working world in the context of the Australian public healthcare system, in an effort to uncover the competing demands of being both a nurse and a manager.

In Australia, as in many other countries, NUMs replaced the senior nurse or charge nurse position of the 1980's, and with the change in title came a change in the level of responsibility (Duffield & Franks 2001). As a result, the current role of the NUM has evolved and expanded since its inception (Duffield 1989a). Today a NUM in Australia is expected to be an expert clinician as well as being responsible for the day-to-day management of a ward or clinical unit, which includes managing the human, physical and financial resources, interpreting policies, maintaining standards, and providing nursing leadership (Duffield & Franks 2001; Jones & Cheek 2003). The current role also includes responsibilities for the coordination of quality nursing care within tight budgetary constraints (Lewis 2004a). NUMs do all this in an organizational environment in which the recruitment and retention of sufficient numbers of nursing staff is a significant problem (Buchanan & Considine 2002).

According to Courtney et al. (2002), it is recognised that nursing unit managers in rural settings have an even broader role than those in metropolitan areas. Furthermore, rurally-based NUMs work in an environment where they may be isolated from peers, with reduced access to educational opportunities, and where they often have to cope with more limited services and resources than their city counterparts (Courtney et al. 2002). Thus, in today's healthcare context, competent NUMs need to be effective managers as well as expert clinicians. Herein lies a major dilemma for nursing unit managers: they are expected to perform a demanding

professional nursing role as well as demonstrate skills in administrative, financial and human resource management in a patriarchal workplace that is dogged by limited resources and staff shortages. A lack of research has meant that little is known about how NUMs' experience their day-to-day working lives, nor is anything known about the power, or lack of it, inherent in their role.

This study was designed to explore the construct of power within the working world of NUMs. The study is a progression of my passion for nursing, in that, while I love being a nurse, I have also seen and experienced the challenges, contradictions and frustrations that nurses face in the Australian healthcare system. Nurses have an entrenched image, and a traditional role, based on a set of cultural and organizational assumptions that have made it difficult for them to be accepted as equal players in the healthcare arena (Buresh & Gordon 2000; Diers 2004; Kane & Thomas 2000; Speedy 1987; Sullivan 2004). When considering the image of the nursing profession, I was struck by the enduring nature of the sentiments contained in the quote by Florence Nightingale (1946(1859)), at the beginning of this chapter. It seems to me that little has really changed for nurses since Nightingale objected to being considered 'devoted and obedient'. Daiski (2004:44) argues that nurses continue to be cast into subservient roles because they come to accept the existing power relations in healthcare as normal. Kane and Thomas (2000:19) warn that 'the oppressive nature of nursing must be transformed before nurses can be empowered'. Similarly, Des Jardin (2001:470) asserts that a nursing image based on traditional gendered assumptions 'suffocates or represses' nurses, which in turn limits their ability to fight for greater respect and recognition.

Much has been written about the gendered, subservient image of nursing and the effect this has on nurses' power and voice. For example, Darbyshire (2000:43) discusses the lack of recognition of nurses' contributions to healthcare, suggesting that healthcare organizations continue to assume that 'a nurse's role is to make coffee, not decisions'. Spence Laschinger (2004) links this lack of respect for nurses to the oppressive organizational culture of healthcare. My interest in the roles of nurses led me to investigate how the role and image of nursing within the patriarchal culture of healthcare might

impact on the power of nurses who hold management positions. In other words, while it is well known that nurses are oppressed, I was interested in exploring how this oppression might specifically impact on NUMs. While it seems logical to assume that nurses in management positions would have more status and power than other nurses, I found no evidence in the literature to support this. To provide background to this research topic, literature regarding the NUM's role, in Australia and overseas, is discussed in Chapter Two and literature regarding organizational power and the traditional image of nurses is discussed in Chapter Three.

1.1.1 The NUM's role in Australia

Nurses as managers have been known by a variety of titles since the nursing career re-structure in Australia, which occurred during the 1980s and 1990s (Duffield 1989a). The job title depended on the State or Territory in which one was employed. For example, the titles 'business unit manager' (BUM), 'clinical nurse consultant' (CNC), and 'nursing unit manager' (NUM) have all been used at one time or another to describe the role of nurses who are in charge of a ward. According to Duffield, Donoghue and Pelletier (1996:334), nurses who manage wards in New South Wales have been known as 'nursing unit managers' since 1986. Anecdotal evidence indicates that in recent years the title 'nursing unit manager' (NUM) has been adopted Australia wide. Therefore, for the sake of consistency and as this study was conducted in New South Wales, I will use this term throughout the thesis.

Following an extensive literature search, no Australian research was found that explored the construct of power within the working world of nursing unit managers. However, some researchers, in particular Duffield and colleagues (Duffield 1989a; Duffield 1989b; Duffield, Donoghue and Pelletier 1996; Duffield et al. 2001; Duffield & Franks 2001), conducted a number of quantitative studies during the 1980s and 1990s aimed at identifying the scope and responsibilities of the nursing unit manager's role. Back in the 1980s, Duffield (1989a) warned that the organizational expectations of NUMs were unrealistic. In order to better understand the power dynamics of the role, this current study seeks to explore how today's NUMs experience their role.

The early studies of the NUM's role in New South Wales focused on providing valuable data regarding the conceptualisation and scope of the role following its introduction in 1986 (Duffield 1989a; Duffield 1989b; Duffield, Donoghue and Pelletier 1996). For example, the findings of all these studies indicated that the role of a NUM was continuing to evolve and expand. This trend has meant that currently the role carries greater responsibilities for managerial and administrative tasks than ever before. The reasons for this role expansion are rooted in the changes that have occurred, and are continuing to occur, within the Australian public healthcare system (Duckett 2000). The system has had to change in response to cultural and economic trends such as an aging population, the increasing burden of chronic disease, greater consumer demand for high quality healthcare, the technology explosion, and a healthcare staff shortage (Duckett 2005; Lewis 2004a).

These factors have led governments to try and seek more economical ways of offering healthcare (Duckett 2000; Nay & Pearson 2001; Rasmussen 2004). Van Eyk, Baum and Houghton (2001) add that it is the process of rapid reform of the healthcare system in Australia that has led to confusion and uncertainty in healthcare staff who strive to deliver quality patient care in an environment characterised by constant organizational change and cost constraints. Duffield et al. (2001) and Duffield and Franks (2001) indicate that within such an environment the role of the NUM remains in transition, with little consensus regarding what the role responsibilities or functions of this position are, or should be. Several authors indicate that, as well as coordinating the provision of quality nursing care, NUMs are required to adhere to strict budgets, conduct annual staff performance reviews, report on workplace health and safety and quality assurance issues, meet the workplace educational needs of staff and deal with conflicts involving staff or patients (Duffield 1989a; Duffield 1989b; Duffield, Donoghue & Pelletier 1996; Duffield & Franks 2001).

In many healthcare settings NUMs are also required to deliver clinical nursing care, or act as a senior clinical resource person for ward staff. This is particularly the case in rural healthcare settings, where the NUM is often the senior, most experienced nurse on duty (Courtney et al. 2002; Lewis 2004b). The literature also indicates that nursing unit managers, if adequately prepared and supported, can potentially play a vital role in creating a

satisfying work environment for the nursing workforce (Jones & Cheek 2003; Mrayyan 2004; Persson & Thylefors 1999; Speedy 2001), which in turn contributes to nursing staff retention. However, Duffield and Franks (2001) indicate that there is little consensus within or between healthcare organizations in Australia regarding the scope of the role of the nursing unit manager. This is compounded by the current formal role description of NUMs, discussed in the following section.

1.1.2 The role description of NUMs in New South Wales

According to the New South Wales (NSW) Public Hospital Nurses (State) Award (2003:5), the definition of a *Nursing Unit Manager* (NUM) is 'a registered nurse in charge of a ward or unit in a hospital or health service'. The Australian Bureau of Statistics in the Australian Standard Classification of Occupations describes nurse [unit] managers as those who 'manage a hospital nursing care unit or other sub-unit of a hospital, nursing home or healthcare facility' (Australian Bureau of Statistics 2001). Anecdotally, NUMs in NSW are often responsible for more than one clinical area, ward or unit. For example, in smaller regional and rural centres, a NUM might be responsible for a maternity as well as a paediatric ward, or an accident and emergency department plus a high dependency unit. A letter that highlights the extent of the NUM's role in regional areas was published in the *Nursing Unit Managers' Society of NSW Newsletter* (2003:4), in which a NUM wrote:

> We have clinical loads as well as rosters, appraisals, Department of Health reports and monthly budget reports. I currently manage two wards...I have three non-clinical days per week (as they call it) but I still have clinical responsibilities.

This NUM wrote to ask the editor for advice regarding the classification of her job as NUM (Level One). There are three levels of NUMs recognised by the NSW Public Hospital Nurses (State) Award (2003:6). NUMs at Level One are in charge of a ward or unit of between 20-50 beds. NUMs at Level Two have responsibility for wards or units of between 50-75 beds, while Level Three NUMs have responsibility for wards or units of more than 75 beds. In 2004, the rate of pay per week ranged from $1347.50 for Level One to $1449.40

for Level Three. In comparison to other occupations, head teachers in NSW public schools earned $1411 per week, and leading senior constables in the police force earned approximately $1400 per week in 2004. Therefore, NUMs at Levels One and Two earned less than those in first-line management positions in two other service-oriented occupations that are often compared to nursing (Seymour 2003).

The NSW Public Hospital Nurses (State) Award (2003:5-6) lists the following information regarding the scope of practice and responsibilities of NUMs in NSW.

Coordination of patient services –

- *Liaison with all healthcare disciplines for the provision of services to meet patient needs.*
- *The orchestration of services to meet patient needs after discharge.*
- *Monitoring catering and transport services.*

Unit management –

- *Implementation of hospital/health service policy.*
- *Dissemination of information to all personnel.*
- *Ensuring environmental safety.*
- *Monitoring the use and maintenance of equipment.*
- *Monitoring the supply and use of stock and supplies.*
- *Monitoring cleaning services.*

Nursing Staff Management –

- *Direction, coordination and supervision of nursing activities.*
- *Training, appraisal and counselling of nursing staff.*
- *Rostering and/or allocation of nursing staff.*
- *Development and/or implementation of new nursing practice according to patient need.*

It is evident when reading this list that NUMs in NSW are responsible for far more than just the coordination of nursing activities and patient care. One

would therefore assume that they would be directly involved in the decision-making activities of the ward as well. Literature that further explores the role responsibilities of NUMs is discussed in the next chapter.

When a NUM's position is advertised in the New England Area Health (NEAH) region, which was the location of this study, the position description outlined in the information packages for potential applicants varies slightly depending on the hospital. Below is a summary of how NEAH broadly interprets the responsibilities outlined in the NSW Public Hospital Nurses (State) Award (2003) when advertising for a NUM.

Position Description – Nurse Unit Manager

Essential Criteria

- *Eligible for New South Wales Registration as Registered Nurse (List A).*
- *Tertiary qualifications in health/management or other related discipline or significant progress toward completion, or willingness to undertake same.*
- *Understanding of responsibilities under Occupational Health and Safety and Rehabilitation and the principles of Equal Employment Opportunity.*
- *Understanding of the principles of quality improvement.*
- *Computer skills, familiarity with computerized health data systems.*
- *Demonstrated team leadership skills.*
- *Minimum of (5) years post basic experience.*
- *Understanding of budget processes.*
- *Demonstrated superior communication and negotiation skills.*
- *Graduate certificate course in relevant clinical field or relevant clinical experience.*
- *Demonstrated high level of organization, conceptual and analytical skills.*
- *Demonstrated ability to manage services in a cross-cultural and multidisciplinary environment.*
- *Demonstrated ability to monitor clinical services and activity, effective management of human, physical and financial resources.*

- *Ability to develop, implement and monitor a staff development plan catering for staff and patient needs within the relevant area.*
- *Working knowledge of the Public Hospital Nurses (State) Award.*
- *Current unencumbered Driver's Licence.*

Desirable criteria

- *Knowledge of and participation in health related research.*
- *Knowledge of system-wide healthcare issues and emerging trends.*
- *Ability to handle political and professional issues sensitively and proactively.*
- *Knowledge of and participation in educational activities.*

(New England Area Health 2004)

In addition to the essential and desirable criteria, the following information is also provided by NEAH to potential applicants, to further explain the responsibilities and accountabilities of the role.

Key Performance Areas for this Position (key accountabilities)

1. *Be familiar with the budgeting process of the Health Service and its application to relevant cost centres.*
2. *Participate in the financial planning and purchasing to the relevant cost centre.*
3. *Participate in the formulation, co-ordination and evaluation of the cost centre budget.*
4. *Monitor, assess and appropriately intervene in the cost centre budget and report as necessary.*
5. *Attend Recruitment and Selection education and participate in the selection process of personnel.*
6. *Ensure adequate and appropriate staffing levels so that standards of care are maintained and unit/ward objectives are achieved and standards maintained.*
7. *Attend Performance Appraisal Workshops, appraise personnel, utilize appropriate staff and encourage their professional development.*

8. *Participate in discipline and grievance procedures as directed by the Director of Nursing.*
9. *Ensure the provision of a safe environment for patients/clients and staff.*
10. *Co-ordinate the formulation of a unit/ward-based quality program, implementation and evaluation of unit aims and objectives.*
11. *Liaise with other health professionals and functional departments.*
12. *Coordinate practice guidelines and procedure development and revision as it relates to the clinical area and relevant services.*
13. *Be aware of and/or participate in relevant professional bodies.*
14. *Be aware of the relevant awards and ensure conditions are adhered to.*
15. *Be active in the implementation of ongoing education at unit/ward level.*
16. *Participate in ongoing education programmes initiated by the Nursing Service and relevant forums.*
17. *Be involved in discussion, information and education encouraging health promotion.*
18. *Ensure written communication is legible, signed, dated and meets all legal requirements.*
19. *Organise caseload schedules in liaison with nursing/medical administration and in accordance with hospital admission/discharge protocols.*
20. *Develop business case proposals for the acquisition of equipment and other resources.*

(New England Area Health 2004)

When reading the criteria and accountabilities for the position of NUM in NEAH it is clear that potential applicants require an extensive and diverse range of skills and knowledge in order to be considered for the position. However, I found it interesting that the role responsibilities are described using words such as 'monitor, ensure and organise', rather than terms such as 'decide or control'. Speedy and Jackson (2004:56) believe that nurses are subject to 'imposed change', meaning that they are subject to, rather than a part of, the decision making processes of healthcare organizations. This lack

of power to make decisions seems to be implied in the essential criteria and key accountabilities, which lists extensive responsibilities, but do not mention the level of authority attached to the position. Rather, the role description seems to centre more on clinical coordination, liaison and monitoring tasks, than decision-making, despite one criterion that mentions a need for team leadership skills.

A review of position descriptions developed by other public healthcare service regions in NSW reveal very similar criteria. Common to all was the need to have excellent clinical skills, some post basic experience or qualifications, an ability to work in a multidisciplinary team, knowledge of quality improvement, budgetary skills, excellent communication skills, a commitment to staff development and leadership qualities (NSW Health Department 2004a). Furthermore, in a number of the positions advertised on the NSW Health website, the essential criteria includes a knowledge of, but not necessarily participation in, nursing research.

1.2 A personal profile of the researcher

I include here my personal profile because, as already mentioned, I have embedded myself throughout this thesis, because I am both a nurse and a researcher with a passion for nursing. The inclusion of this profile is also consistent with feminist research, which values the personal context and which therefore calls for the experiences and role of the researcher within a study, to be made explicit (Grbich 2004; Jackson, Clare & Mannix 2003; Olesen 2000; Roberts & Taylor 2002). Thus, in keeping with a feminist-based methodology, it is important that I locate my voice and my perspective throughout this thesis and explain my reasons for exploring the working world of NUMs.

Roberts and Taylor (2002:354) suggest that when a researcher's perspective is openly disclosed, this can assist in 'equalising power relations' between the participants and the researcher, an important consideration in all feminist research. Furthermore, by introducing myself in this chapter I will define my insider status with regard to studying nurses. Acker (2001) suggests that studies conducted by persons from the same discipline as the participants are

usually based on a strong sense of rapport, which is another means of reducing power inequalities between the researcher and the researched (Brayton 1997).

This study emerged from my desire to understand more about nurses' roles and lack of power. As a nurse I have spent many years working in a variety of wards and units, so I am part of the culture of healthcare. My interest in nurses' roles coalesced into this study after I became aware of the lack of enthusiasm many of my nursing colleagues had for applying for NUM positions. I have first-hand experience of working with a number of NUMs, but have never had the desire to become one.

Until 1999, I worked as a full-time clinician, in a variety of clinical settings in both metropolitan and rural hospitals, specialising in paediatric and critical care nursing. As a nurse, it is hardly surprising that I have always had an interest in people, as a sense of connectedness and care for others are core values in nursing (Daly, Speedy & Jackson 2006). Over the years, I developed a desire to explore nurses' relationships with each other and with their environment. This study of the working lives of NUMs brings together my passion for nursing, for research and for trying to understand nurses' lives and experiences.

During my years as a clinical nurse, the area of nursing I found most satisfying was intensive care, where I cared for critically ill patients, some of whom were donors or recipients of organ transplants. Now that I no longer have an active clinical role, I often miss it, and wish I had more time to do an occasional shift at the local hospital. I include this information, as I believe it further demonstrates my passion for my profession. However, in pursuit of my love for nursing, and while working full time on the wards, I also worked part-time as a nurse educator in a number of hospitals and technical colleges. In 1999, I was successful in gaining a position as a full-time associate lecturer in nursing at the University of New England. Since assuming this role, I have come to realise that I enjoy teaching and conducting research as much, if not more, than 'doing' nursing. I still retain my passion for clinical nursing but now strive to convey this enthusiasm to my students. Thus, in my role as a nurse in the public healthcare system, and more recently as a nursing lecturer,

I have always focused my attention on the delivery of quality patient care and I have always been aware of the challenging role of NUMs.

To further situate myself in this study I also need to describe the experiences that led me to enrol in a PhD program and conduct this study. In 2002, I gained an internal promotion to lecturer, after graduating with a Master of Nursing (Honours) degree. My Master's project examined how registered nurses assess the clinical competence of undergraduate nursing students and that study cemented my love for research and encouraged me to conduct several collaborative funded research projects, as well as to enrol in a PhD program. In conducting collaborative research with clinical colleagues, I became increasingly aware of the dissatisfaction and frustration experienced by many of them, particularly those in first-line nursing management roles. I realised that had I stayed in the public hospital system, I too, may have been tempted to move up the career ladder to NUM. I began to understand that I was fortunate to have made the move into the higher education sector, as I now feel my efforts are recognised and valued by my employing organization, feelings that were foreign to me in a traditional nursing role.

In 2003, I was awarded a NSW Minister for Education and Training Quality Teaching Award, after being encouraged by colleagues to nominate for this award, which further reinforced my love of teaching and my satisfaction with my position. During the first four years of my employment as a nurse academic, I continued to work (on a casual basis) as a registered nurse in the local hospital. Moving between the academic and clinical spheres of nursing, I became acutely aware that most of the NUMs I encountered experienced dissatisfaction in their working role. Thus, this project was born.

By drawing together a number of different concepts from the literature, I have been able to reflect on some of the challenges that I believe impact on the NUM's role. For example, I considered the well documented lack of power and status of nurses generally, particularly in developed countries such as Australia, the US the UK and Canada. In the literature this lack of power is closely linked to the traditional gendered image of nurses (Buresh & Gordon 2000; Diers 2004; Speedy 2006). I was able to better understand the relationship between nurses' roles and their oppression by exploring the

feminist literature. I also studied concepts of organizational culture and power to gain an understanding of the construct of power within management roles. Based on my extensive reading, I chose to adopt a feminist methodology to explore this topic, as I felt it was congruent with the aims of exploring the construct of power for NUMs, and it sat well with my own experiences and understandings of the working world of nurses.

In a feminist study, it is important that the researcher acknowledge why and how the study was conceptualised. Thus, in this study, I acknowledge that as the researcher, it was I who chose the topic and developed the study aims. I also decided on the research paradigm and methodology that I thought were best suited to achieving the aims of the study. However, once these decisions were made, it was important to me that I establish a relationship with each participant based on mutual respect. I approached potential participants as a fellow nurse rather than as an academic. I told each NUM that while I had never held a NUM position, I have the greatest admiration for the valuable role they play in the healthcare system. Based on my decision to use a feminist methodology, I acknowledge that my intention in researching this topic is to inspire positive change. However, I am also aware that as an academic now working outside the healthcare system, while I can encourage and support the need for change, I am not the one who should drive that change process.

I feel privileged that the NUMs who participated in this study agreed to talk to me and offer me insights into their working world. I appreciated their candour, their humour and their humanity, which is what makes their stories come alive. I have attempted to present this work as a story, with myself as the storyteller. I believe that in writing this thesis, I have done the NUMs' stories justice, and I hope that readers of this work will find their stories valuable, fascinating and illuminating.

1.3 Purpose and aims of the study

This study sought to explore the working world of nursing unit managers in an effort to uncover the construct of power within the role. Literature from Australia and overseas indicates that the role of the NUM has continued to

expand since its inception, in response to organizational changes in healthcare systems. The NUM's role description, provided in section 1.1.2, requires the incumbent to be skilled in many areas of management as well as in nursing, yet anecdotal evidence suggests that they are still promoted on the basis of their nursing expertise. For example, Brewer and Lok (1995) raise concerns that NUMs in Australia are being promoted without adequate preparation and support for a managerial position. So, while the literature indicates that NUMs have a diverse range of responsibilities, there is little research that explores how NUMs experience their role, which consists of both clinical and managerial responsibilities, in the current context of the public healthcare system in Australia.

Thus, this study set out to explore how this expansive dual role is experienced by NUMs, and specifically how the construct of power relates to the position. Bearing in mind that nursing is a strongly gendered profession which carries a traditional image of powerlessness (Kane & Thomas 2000; Speedy & Jackson 2004), the purpose of this feminist study was to gain insight into the NUMs' working world and explore whether the oppression of nurses also limits the power of the NUM. To explore the construct of power within the participants' roles, two specific aims were developed to:

- Explore what it is like to be a nursing unit manager in the context of the New South Wales public healthcare system.
- Gain insight into the participants' perceptions of the preparation and support they received for the role of NUM.

It needs to be noted that power as a construct is not explored directly via these two aims, as the concept of power carries negative connotations for many nurses (Speedy & Jackson 2004). Thus, the word 'power' has not been included either in the title of this study or in the interview questions, as I felt that the construct of power could not be effectively explored simply by asking people about it. Rather, power is to be found 'in the multilayered network of social relations' (Kuokkanen & Leino-Kilpi 2000:236), so in this study power is indirectly explored via the participants' experiences within the organizational context of the public healthcare system. A further discussion and justification

of this indirect approach to exploring the construct power is provided in Chapter Four.

1.4 Significance of the study

In the Australian context, while there has been a plethora of investigations into the education and recruitment of nurses, there is a paucity of research into nursing workforce issues from either an organizational or a feminist perspective. Thus, this current study is timely as more and more Australian scholars embrace nursing workforce research as an area worthy of academic consideration (Courtney et al. 2002; Fedoruk & Pincombe 2000; Hegney, Plank & Parker 2003; Nay & Pearson 2001; O'Brien-Pallas, Duffield & Alksnis 2004). The need to explore nurses' roles is also reinforced in the recent healthcare literature. For example, Fulop and Eastman (2004:11) call for more research into the role of clinician-managers, as they argue that studies that consider 'local practices and institutional contexts' will yield new constructs and concepts.

Concerns have also been raised by Hegney, Plank and Parker (2003:313) and West (2001:40), who argue that greater attention needs to be paid to understanding the current low morale and job dissatisfaction reported by nurses and other healthcare workers. These authors suggest that by exploring the impact of the organizational culture on healthcare professionals, workplace roles can be better understood and improvements made. Pelletier, Donoghue and Duffield (2005) indicate that it is imperative that administrators and workforce planners understand what motivates the nursing workforce to stay in their employment. Bloomfield (1998:5) also believes that in the new millennium the traditional gender-based, rigidly constructed roles that nurses occupy are 'not only outdated but also potentially harmful' to healthcare service delivery in an increasingly complex world. Similarly, Borbasi and Jackson (2005:5) call for changes to the culture of healthcare workplaces to make them more nurturing environments in which love, approval and respect all thrive.

According to Jackson, Clare and Mannix (2003:207), while feminist studies have not been popular in nursing, a feminist approach has the potential to

raise awareness of issues of voice and power, and to add to what is known about nurses' working lives in contemporary society. Furthermore, by exploring the construct of power within the NUMs' role from a feminist perspective the effects of a gendered societal image on the role are more likely to be exposed. Kane and Thomas (2000:20) believe that 'until we acknowledge linkages between professional issues and feminism, we are abdicating our role in producing change in the status quo'. Therefore, this study is significant on three levels. First, it provides insights into the construct of power within the nursing unit manager role. Second, it adds to the existing body of knowledge about nurses' experiences as first-line managers. Third, it contributes to the literature on nurses' power and voice, and potentially raises awareness of a need for policy change to inform contemporary nursing practice, specifically for nurses in management roles.

Therefore, based on concerns raised in the literature, which are discussed in more detail in Chapters Two and Three, I set out to understand more about the construct of power for NUM's within the Australian public healthcare context. This focus led me to consider whether NUMs have access to organizational power commensurate with their substantive role responsibilities. Sullivan (2004:32) discusses the powerlessness of nurses and makes the link between power and relationships, commenting that 'power is embedded in interactions with others, and contributes to or diminishes the relationship'. In this study, I suspected that the well-documented powerlessness of nurses would impact on the NUM's role and be evident in the relationships between the NUMs, the organization and other healthcare professionals. As no other studies were found that explored the workplace experiences and organizational power dynamics of nurses in management roles, either in Australia or overseas, this feminist study contributes to the existing body of knowledge.

Other authors have also indicated that further research is needed regarding the role of a NUM, if a deeper understanding of the clinician-manager role is to be gained (Duffield & Franks 2001). In an article that considers the dual role expectations of healthcare professionals who are also managers, McConnell (2002:3) reinforces concerns about the conflicts inherent in being a clinician-manager, suggesting that organizations make the classic error of assuming

that 'because people have been appointed and given appropriate titles they are suddenly managers in the true sense of the word'. McConnell's (2002) comments are not specifically aimed at nurses, but rather at all professional groups where members are required to assume managerial roles as well as maintain professional expertise. In reality, a nurse who is successful in gaining a NUM position, will tend to 'favour wearing the hat that fits best', in the same way that engineers, medical staff or lawyers who have managerial responsibilities favour their professional role (McConnell 2003:3).

A number of other authors voice similar sentiments. For example, Stanley (2002:13) suggests that a successful manager has to wear 'many hats', in order to move from one role to another and see situations from a number of perspectives. Kitchener (2000) raises concerns about the impact of role change on professional staff. This author explains that the competing ideologies of professional and administrative roles have become blurred as clinicians assume management positions. While Kitchener (2000) referred to medical doctors who become clinical directors in the UK, there is reason to suspect that nursing professionals who become managers experience similar pressures. It would seem from the literature that the position of clinician-manager in many organizational settings is ill-defined and beset by challenges and conflicts that arise from the competing demands of the role, yet this is poorly understood in the nursing literature.

While I acknowledge that the findings of this study cannot be generalised, they will contribute to what is known about the construct of power for NUMs within the organizational culture of healthcare by providing insights into how one group of NUMs experience their working lives. Thus, this study seeks to contribute to positive changes in policy and practice, by raising NUMs' awareness of the challenges inherent in their role. This knowledge will be beneficial for nursing unit managers, nursing executives and health workforce planners. In addition, I believe that the findings may also resonate with nurses generally, and lead to a greater awareness of the oppression inherent in their roles. It must be noted that according to Mosedale (2005:244), empowerment cannot be bestowed on the oppressed. Rather, it a process that can be facilitated by the creation of 'conditions favourable to empowerment'. Thus, this study seeks to contribute to the creation of such conditions.

In addition, policy changes, informed by the findings of this study, could assist in attracting and retaining senior nurses in the healthcare workforce. For example, in Australia between 1993 and 1996, nearly 17,000 nurses worked in occupations other than nursing (Duffield et al. 2004). According to these authors, who surveyed 154 nurses who were no longer working in the profession, the major reasons nurses leave nursing are linked to issues of prestige and power, in that nurses want to be valued as healthcare professionals and have autonomy in decision making and equality with other professions in healthcare. Furthermore, Duffield et al. (2004) and Pelletier, Donoghue and Duffield (2005) suggest that it is the more experienced nurses and those who have achieved a higher level of education who are more likely to leave the profession. As NUMs are generally selected on the basis of their clinical expertise, it is these senior nurses who are more likely to leave. This is a serious issue in the face of the existing nursing shortage both in Australia and worldwide (Buchanan & Considine 2002).

Several international studies have also indicated that further research into healthcare workforce issues are imperative if healthcare organizations are to deliver cost-effective quality care (McLoughlin & Leatherman 2003; Thorpe & Loo 2003b; West 2001). The biggest challenge to the delivery of quality patient care is the need to attract and retain a professional healthcare workforce (McVicar 2003). West (2001) suggests that one of the major criticisms of healthcare organizations is that they have maintained rigid hierarchical staff structures that create tensions between professional groups and within administrative structures. A similar concern is raised by Carney (2004) and Upenieks (2003) who indicate that further research into the organizational structures and processes that create and attribute power and status to certain healthcare workers, is long overdue. In a recent study by Joiner and Bartram (2004), 157 nurses in a Victorian hospital were surveyed to explore the links between social support and work empowerment. These authors concluded that:

> The lack of focus on people management is surprising considering the health care industry is labour intensive... Clearly there is a role for further management development in this sector (Joiner & Bartram 2004:62).

In summary, this feminist study, which explores the construct of power in NUMs' working lives, provides insights into how nurses in management roles cope with their role and the competing demands placed on them. The findings will inform policy and practice regarding their role within the healthcare organizational culture.

1.5 The construct of power in organizations

As previously discussed, power is used in this study as an overarching construct within which the working world of the NUM is explored. The purpose and aims of the study, set out above, were designed to explore the NUMs' experiences and provide insights into how the well-documented powerlessness of nurses' roles might impact on them. To facilitate such insights, a theory of organizational power was used as the theoretical framework to guide this study.

In trying to understand the construct of power, I encountered many and varied definitions, from Foucault's (1978) post-modern understanding of power as omnipresent, to French and Raven's (1959) five bases of power. The five bases of power, which are widely cited in the literature, are coercive power, reward power, legitimate power, referent power and expert power. Braynion (2004) reviewed a number of studies that sought to operationalise French and Raven's (1959) model. However Braynion (2004) concluded that it is difficult to use this model to analyse a lack of power, as there is no acknowledgement of the voices of those who are powerless. Furthermore, the power bases identified by French and Raven (1959) are difficult to apply to nurses, because, according to Braynion (2004:452), they are not able to be 'adapted to different cultural contexts or genders', because they are based on masculine understandings of power over others. Thus, I chose to use Kanter's (1977) theory of organizational power to guide this study, as I wanted to explore the construct of power for NUMs, who are predominantly women, within the organizational context of healthcare. Kanter's (1977) theory of power was chosen because it is more aligned with feminine understandings, which is power on behalf of others, rather than over others (Marquis & Huston 1992).

There is clear evidence in the literature that nurses lack power (Buresh & Gordon 2000; Diers 2004; Moloney 1992; Speedy & Jackson 2004) and I suspected that if the NUMs still thought of themselves as nurses, rather than managers, then they too would lack organizational power. However, definitions of power that imply control over others were rejected as a basis for understanding power for NUMs because my intention was not to determine how NUMs could gain or wield power over others, but rather to explore their working world within the construct of power. Marquis and Huston (1992:125) state that 'nurses need power', so that they can gain a fair share of organizational resources. Similarly, Huntington and Gilmour (2006:172) suggest that power flows from 'access to intertwined resources such as wealth, education, political influence and economics'. In addition, power is also a feature of workplace relationships (Emberson & Read 2000) and is evident in the interactions of workers. Cohn et al. (2005:53) suggests that by gaining a better understanding of the power struggles in healthcare, the workplace can be transformed to provide an environment that facilitates the recruitment and retention of nurses. Therefore, in trying to understand the construct of power in the NUM's role, I found that Kanter's (1977) theory of organizational power provides links to the context, relationships, resources and processes that impact on the role within the workplace, making it well suited as a theoretical framework to guide this feminist study.

Specifically, Kanter's theory (1977) considers how women fare in workplaces, by looking at how powerful and respected roles are negotiated in their working lives. Therefore, while the literature provides many definitions of power (Speedy & Jackson 2004), this study is underpinned by Kanter's (1977) theory of organizational power, to assist in understanding how the culture of healthcare and the image of nurses affect the NUMs' working lives. Furthermore, Kanter's (1977) theory of power is well suited to studies of nurses' roles, according to Spence Laschinger and Finegan (2005:7), because it 'offers a framework for creating meaningful work environments for professional nurses'.

In *Men and Women of the Corporation,* Kanter (1977) suggests that organizational power consists of formal and informal components, which are accessed via four structural determinants: opportunity, support, resources

and information. This theoretical framework, which is discussed in detail in Chapter Three, provides a means of understanding how the traditionally hierarchical nature of healthcare organizations affects the role of NUMs. Such a focus is vital in this study, as it is my contention that the ability of nurses to access power is not a feature of the individual, but of the role they occupy.

According to Kanter (1979), 'when one thinks of power, one often assumes that a person is the source of it', when in fact organizational power is actually embedded within the role construction rather than the individual. Kanter (1977) theorised that formal and informal power are both reflected in a worker's formal job description plus their access to lines of supply, information and support. As previously discussed, there is clear evidence in the literature that the nursing profession in Australia is having increasing difficulty attracting and retaining new members, so a theoretical framework that focuses on the construct of power within organizations was considered appropriate.

As feminist studies seek to uncover systemic oppression, Kanter's (1977) theory of organizational power, as a construct embedded within roles rather than in individuals, will assist in highlighting how the systemic and entrenched oppression of nurses affects NUMs. As job satisfaction is closely linked to retention in the literature, this theory was utilised as a means of contributing to the body of knowledge about nursing workforce satisfaction. The theoretical framework and literature concerning nurses' roles, image and identity within the organizational culture of healthcare are more fully discussed in Chapter Three. In summary, this framework will guide this feminist study to explore the effects of the patriarchal healthcare system on NUMs, and Kanter's (1977) theory will also underpin the implications of the findings and the suggested strategies for change, discussed in Chapter Seven.

1.6 Introduction to the methodology

In this study, a feminist methodology has been utilised to explore the construct of power within the working world of nursing unit managers, as a means of exposing their oppression, and also to focus attention on strategies to enhance their emancipation and empowerment. According to Roberts and

Taylor (2002:353), feminist methodologies are concerned with exposing issues of power and domination and also raising awareness of a need for political action to change the status quo. It will be shown in Chapter Four that the principles that underpin feminist research also allow for a greater involvement and reflexivity from the researcher than is considered appropriate using other methodologies. Thus, a more generic qualitative approach was rejected, on the grounds that issues of power and domination, within the well documented patriarchal healthcare system, would not be effectively uncovered. Furthermore, based on the literature regarding nurses' roles, image and identity, discussed in Chapter Three, a feminist approach to the research topic was chosen as the most appropriate way of acknowledging the gender-based assumptions and power inequalities that can limit nursing roles. In the following statement, Speedy (2000) argues that a greater awareness of oppression can contribute to positive change. It is this statement by Speedy that has encouraged me to examine the working world of nursing unit managers through a feminist lens:

> Nursing work in all its forms (including clinical practice, education and research), mostly undertaken by women, is affected severely by gender because of its construction and the context in which nursing is carried out. Becoming aware of such systematic oppression is the first step in changing paternalistic structures and systems that operate to disadvantage nurses, their patients and the overall healthcare system (Speedy 2000:145).

A feminist methodology seeks to unpack taken-for-granted ideas about people within historic, social and cultural contexts, and presents new ideas that challenge traditional views (Olesen 2000). In this study, a feminist approach has been used as a means of exposing the links between the experiences of NUMs, who are predominantly women, their organizational contexts, and the roles that they perform (Hunt 1998; Kane & Thomas 2000; Speedy 1987). This methodology assists in heightening awareness of cultural practices, powerlessness and oppression as factors that impact on the NUM's role.

The tenets on which feminisms are based, which are more fully discussed in Chapter Four, contribute to uncovering issues of power, and exposing embedded values and assumptions that are largely ignored within existing nursing workforce research. While the principles that guide feminist studies are not prescriptive, they define the underlying values and processes (Campbell & Wasco 2000:773; Roberts & Taylor 2002:354). For example, Olesen (2000) asserts that a feminist approach allows the researcher to consider the participants' experiences from an alternative perspective, one that begins with a consideration of the social, political and contextual causes of oppression and ends in an awareness of the need for the emancipation and empowerment of those who are oppressed. Therefore, in this study, feminist thought, methodology and methods are interwoven to demonstrate how this paradigm has informed every stage of this study. For example, the data analysis method, based on Gilligan's (1982) voice-centred relational approach which is discussed in detail in Chapter Four, was specifically chosen to interpret the NUMs' narratives, as this method allows the researcher to uncover the participants' power, voice and context.

The voice-centred relational method, grounded in feminist educational psychology, has been used by a number of feminist researchers to uncover the power, relationships and the context of participants, by attending to their voices from a number of different perspectives. Doucet and Mauthner (1998:5) discuss the use of this data analysis method, asserting that the voice-centred relational approach 'explores individual narrative accounts in terms of their relationships to the people around them and their relationships to the broader social, structural and cultural contexts in which they live'. Furthermore, these authors believe that this method, as described in Brown and Gilligan's (1992) *Listener's Guide* lends itself to adaptation to suit a variety of topics, disciplines and contexts (Doucet & Mauthner 1998). For example, Doucet and Mauthner (1998:5) suggest that it is designed to be adaptable to 'individual interpretations, adaptations, and versions of it'. Thus, in this study of the construct of power within the working lives of NUMs I have interpreted Gilligan's (1982) method to suit the aims of this study.

Finally, by adopting a feminist approach to this study, the findings have the potential to increase awareness of the organizational factors that contribute to

power inequalities for NUMs. A comprehensive justification for this choice of paradigm is provided in Chapter Four.

1.7 The scope of this study and a key assumption

In much of the literature reviewed for this study, management roles and styles are linked to concepts of leadership (Anthony et al. 2005: Borbasi & Jackson 2005; Clinton 2004; Courtney, Nash & Thornton 2004; Gabel 2002; Helgesen 2003; Speedy 2004; Tappen, Weiss & Whitehead 2004). However, due to time and work constraints within my PhD candidature, I made the choice to focus solely on the construct of power. According to Bleich (1999:4), leadership in nursing is defined as 'the use of personal traits to constructively and ethically influence patients, families and staff'. Bleich (1999) also suggests that a nurse leader must empower, motivate and inspire others. However, as I suspected that NUMs do not have sufficient organizational power to empower, motivate or inspire others, this study focuses specifically on the construct of power in the NUMs' role construction within the context of healthcare, rather than on individual leadership traits.

Fulop and Linstead (2004:191) indicate that Kanter's (1977) conception of power is ideal as a means of understanding the impact that organizational structures, processes, values and assumptions have on managers' roles. As the construct of power for NUMs within the organizational context of healthcare was the main focus of this study, an overview of organizational culture is provided in Chapter Three, as organizational power is embedded within the culture of an organization. Thus, while the theoretical underpinnings of this study are based on Kanter's (1977) theory of organizational power, an understanding of organizational culture, described by Schein (1992) was also considered necessary. While Schein's (1992) concept of organizational culture is not comprehensively discussed in this thesis, it is implicit throughout and in the strategies proposed to enhance the NUMs' access to organizational power, presented in Chapter Seven.

The major assumption on which this study is based is that nurses have a professional identity based on the value of caring at its core. This belief stems from not only my own experiences as a nurse but also from the literature,

which shows that nurses share a desire to care for those who require nursing care (Daly, Speedy & Jackson 2006). There is an abundance of literature that reinforces the concept of caring within the nursing profession (Buckenham & McGrath 1983; Fagermoen 1997; Girvin 1998; Jacobs 2001; Kuhse 1997; Thorpe & Loo 2003a). For example, caring is described by Gilmartin (2001:30) as 'the unifying domain of nursing theory and practice', with caring described as the central concept underpinning the profession's value system. Therefore, throughout this thesis, the assumption is made that the NUMs in this study retain these values as nurses and collectively strive to provide quality care for their staff and patients. It will be shown in Chapter Four that caring, as a function of nursing, is linked to the traditional feminine role of nurses. However, it is acknowledged in the literature that caring is discounted and dismissed as a goal in healthcare, because it is seen as a traditionally feminine goal within the patriarchal culture of healthcare, where curing is considered the preferred goal (Diers 2004; Kuhse 1997). Diers, however, offers a strong validation of care in nursing:

> Nursing done right is physically, emotionally and intellectually fulfilling. Many people think that nursing is simple – just take nice people and turn them loose. But to be caring, to deliver tender loving care, is exquisitely difficult (Diers 2004:158).

Despite Diers (2004) contention that caring is more than just a reflection of niceness it still remains undervalued as a goal in the healthcare context. Thus, the central assumption on which this study is based is that that nurses strive to be caring, and that caring is a strength that needs more recognition in the organizational culture of healthcare. In Chapter Three it will be clearly established that caring is central to the nursing profession, and although it requires knowledge and skill, caring remains undervalued by other healthcare professionals.

1.8 Definition of terms

The following terms have been used throughout this thesis to maintain consistency.

Registered Nurse (RN)

State and Territory authorities regulate nursing practice in Australia. These authorities are responsible for establishing and maintaining standards for safe and effective nursing practice by ensuring that nurses comply with the standards (Australian Nursing and Midwifery Council 2002). Throughout Australia, there are two tiers of nurses regulated by these statutory authorities, in most States and Territories they are called; enrolled nurse (EN) and registered nurse (RN). While both tiers of nurses work within their own scope of practice, enrolled nurses' work under the direction of registered nurses. To be eligible for registration as a nurse, the registering authority, which in NSW is the Nurses and Midwives Board of NSW, must be satisfied that the applicant has completed an approved course of study in the higher education sector, or has equivalent qualifications obtained overseas. NUMs in Australia are drawn from the ranks of registered nurses.

Nursing Unit Manager (NUM)

The term 'nursing unit manager' or NUM is now widely used throughout Australia to describe a nurse in charge of a ward or unit, as discussed earlier in this chapter. The position of NUM is called a variety of names in the international literature, such as: first-line nurse manager (FLNM) (Loo & Thorpe 2004), nurse manager (Bolton 2003; Lindholm & Uden 2001), ward manager (Wilmott 1998), head nurse (Drach-Zahavy & Dagan 2002) or clinical nurse manager (Oroviogoicoechea 1996). However, I will refer to the position by the Australian title of nursing unit manager (NUM) throughout this thesis. Participants in this study were classified as either Level One, Two or Three nursing unit managers. The difference between these three levels was described in Section 1.1.2 .

New England Area Health (NEAH)

At the time of this study, New South Wales (NSW) was divided into seventeen area health regions. Each of these areas provided semi-autonomous public healthcare to the NSW population. At the beginning of 2005, the NSW Health Department amalgamated the seventeen area health regions to create eight much larger health regions (NSW Health Department 2005). In the amalgamation, NEAH combined with the former Hunter Area Health Service,

to become Hunter New England Area Health. As the data for this study was collected in 2003, the participants were drawn only from the New England Area Health region. A more comprehensive description of the location of the study is provided in Chapter Four.

1.9 Organization of the thesis

Chapter One of this thesis has introduced the research study and provided background to the topic of interest. This chapter has also included a personal profile of the researcher in order to locate myself within this study and describe my background and intentions. The purpose and aims of the study have been presented, followed by a discussion of the significance of the study. The theoretical framework and research methodology were then introduced. Finally, the scope of the study and the key assumption were provided.

Chapter Two, a critical review of the literature, is divided into two sections. The first section reviews what is known about NUMs in Australia, focusing on the role, the demographic profile and the preparation and support of nurses as managers. This is followed by a review of the literature that describes the context of healthcare in Australia. The second section of the chapter takes a global perspective by reviewing overseas literature regarding the role of NUMs.

Chapter Three is devoted to the construct of power and presents the theoretical framework utilised in this study, which is a theory of organizational power developed by Kanter (1977). In order to explain the significance of the framework to this study I commence this section with a discussion of Kanter's (1977) theory, followed by an overview of the concept of organizational culture as a means of understanding how organizational power fits within the healthcare workplace culture. A discussion of the factors that create and mediate nurses' roles within healthcare organizations is provided, as the literature regarding nurses' image and role underpins my understandings of organizational power. Therefore, issues of image, gender, status, the professional values of nurses and societal expectations of them are discussed in detail in Chapter Three, as are influences on organizational assumptions about the role of the NUM.

Chapter Four introduces and discusses the methodology utilised in this study. The first section of the chapter describes the epistemological and ontological assumptions on which this study is based, including a justification for the choice of a feminist paradigm. Further evidence is provided of the congruence between the feminist methodology and the research topic. Following this is a justification of the voice-centred data analysis method. This chapter also provides a detailed description of the location of the study, the selection and recruitment of participants, the methods of data collection and analysis, and a discussion of rigour and trustworthiness. Finally, ethical issues and methodological limitations relevant to this study are identified and discussed.

The results of the study are presented in Chapters Five and Six. Chapter Five provides an analysis of the data based on the first reading of the transcripts, using a voice-centred relational approach. The first reading required the researcher to focus on the participants' stories as a whole, and throughout this chapter the data are organized under headings that reflect the study aims. The chapter commences with a demographic profile of the participants, followed by their stories and the study findings. Throughout this chapter, the findings are linked to the literature and the theoretical framework. The main focus of the chapter is on the participants and their stories, interwoven with my interpretations.

In Chapter Six, the data analysis continues, with the NUMs' narratives presented under headings that reflect Readings Two, Three and Four, using a voice-centred relational approach to the data. The value of these three additional readings is that they expose the relational aspects of the NUMs' lives by focusing on how they speak of themselves, their role in their working relationships and within the context of healthcare, respectively. A higher order of analysis is achieved using this approach than would have been possible using other methods of qualitative data analysis. In this Chapter, the NUMs' stories reflect their self-perceptions, their working relationships and their context, all of which further addresses the aims of the study and illuminates the construct of power embedded within their stories. I conclude Chapter Six with a reflective account of the NUMs' narratives and my observations about their working environment, based on my research journal

entries. This discussion links my observations to the findings of the study, the literature and the theoretical framework.

Chapter Seven concludes this thesis by providing a discussion of the conclusions and implications of the study. First, the findings are presented as three major conclusions, which demonstrate that the image, status and values of nurses, as opposed to managers, creates a duality that limits the NUMs' access to organizational power. This lack of organizational power is further compounded by a lack of preparation and support for the role. The conclusions are linked by the construct of organizational power. However, each one is discussed separately to show the complex interaction of factors that disempower NUMs. Second, the implications of the findings for policy and practice are discussed. Suggestions are made for changes to policy and practice, at the macro and micro levels, which could pave the way for improvements in the NUMs' image and level of power. Finally, recommendations for further research into this topic area are identified and discussed.

1.10 Conclusion

This chapter has laid the foundations for this thesis by introducing the research topic, the researcher and the background and significance of this study. The purpose and aims have been described, and the theoretical framework and methodology introduced. Finally, an overview of each chapter has been provided. The next chapter presents a review of the Australian and international literature relevant to the topic.

Chapter Two
A REVIEW OF THE LITERATURE

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2 Introduction

The preceding chapter introduced this study and summarised the contents of the thesis. This chapter provides an overview of the literature regarding the role of nursing unit managers that is relevant to the study aims, which are to: 1) explore what it is like to be a nursing unit manager in the context of the New South Wales public healthcare system; and 2) gain insight into the participants' perceptions of the preparation and support they received for the role of NUM. In order to situate this study in the current context of healthcare and to provide background for this project, literature was reviewed from a number of different disciplines and sources. The chapter commences with a description of the methods used to access the relevant literature. Following this, the chapter is organised in such a way that the topic of interest, the role of NUMs, is discussed first, followed by literature that provides background and context to their role within the Australian healthcare system. According to Wolcott (2002:96), the practice of starting a literature review with a lengthy backward look at all that has gone before, makes for 'a very boring read' and tells the reader little about the writer's scholarly abilities. Instead, Wolcott (2002) suggests immediately engaging readers with literature that is pertinent to the actual topic at hand and then introducing other literature on a need-to-know basis. I have chosen to adopt Wolcott's (2002) strategy in an effort to present a relevant, clear and concise literature review that provides sufficient depth and critical analysis to situate this study.

The literature discussed in this chapter is divided into two main sections. The first section focuses on literature that describes the role of the NUM in Australia, which includes the evolution of the role and a demographic profile of NUMs. This section also locates NUMs within the context of the Australian healthcare system, as it is vital to place them into a cultural and

organizational landscape. The first section concludes with a review of literature regarding the preparation and support of NUMs in Australia. The second section of this chapter considers the international literature regarding the role, context, and preparation of NUMs to provide a global perspective, which is then compared to the Australian literature.

2.1 Access to relevant literature

In order to gain an appropriate depth of understanding about the working world of NUMs, I accessed literature from a number of disciplines, such as nursing and management, organizational culture and organizational theory, using a variety of methods. For example, I conducted manual and electronic searches of computerised databases, library catalogues, and the World Wide Web. I used search engines such as Google, and online databases, such as the Cumulative Index to Nursing and Allied Health Literature (CINAHL), and the Clinical Information Access Program (CIAP), a health-focused database maintained by the New South Wales Health Department.

To gain access to national and international literature relevant to the topic, I used a variety of search terms, for example: nursing unit manager, nurses' roles, nurses as managers, nursing management, healthcare management, Australian healthcare context, healthcare environment, feminist methodology, power and voice, gender issues in nursing, organizational culture, organizational theory and organizational power. Key books and articles were accessed via library catalogues. As I found literature that was informative and relevant to this study, I then used the reference lists provided to lead me to further sources of information. By seeking out the literature this way, I was able to consider information from a variety of disciplines and sources that I have used to underpin the conceptualisation and development of this research project. I was also able to identify gaps in the literature that this study seeks to fill.

2.2 Section One: NUMs in Australia

In this section, the literature review explores the role of NUMs in Australia. First, the evolution of the role is presented, followed by a demographic profile of NUMs. The role within the context of the Australian healthcare system is

then discussed, as a means of situating it in the cultural, political and organizational landscape of healthcare. This is followed by a review of the literature that is relevant to the preparation and support of NUMs in Australia.

2.2.1 The evolution of the nursing unit manager's role in Australia

In the Australian healthcare system, the role of the NUM was created in 1986 to replace the earlier 'charge nurse' position (Duffield 1989a). This new role was created in response to changes that had occurred within the Australian healthcare system (Duffield 1989b). With the change in title came significant changes in the role responsibilities. Today, nursing unit managers have a significantly broader role than the charge nurses of the past, requiring a more diverse range of skills (Jones & Cheek 2003). For example, the current role of the nursing unit manager in New South Wales (NSW) is multifaceted, and the incumbent is expected to demonstrate an integration of clinical, managerial and organizational skills, combined with relevant political knowledge of the healthcare system (NSW Health Department 2004a).

Changing economic and social forces have impacted on the delivery of healthcare services in Australia (Cheung 2004), which have shaped the role of the nursing unit manager (Van Eyk, Baum & Houghton 2001). According to Duffield and Franks (2001), this is an ongoing process, as the role of the NUM continues to evolve in response to a complex mix of fiscal, socio-cultural, and political factors. More recently, Lewis (2004a:112) called for a further exploration of the role of nurses as managers, suggesting that 'contemporary management theories do not provide an adequate conceptual or practical approach for accommodating the clinician-manager role'. Fulop and Eastman (2004:1) agree, stating that 'the clinician-manager role has been surprisingly under-researched in Australia'. A further indication of the complexity and breadth of the NUM's role is evident in the following statement from Donna Diers, Professor Emerita of Yale University, School of Nursing and Adjunct Professor of the Faculty of Nursing, Midwifery and Health, University of Technology, Sydney:

> Nursing unit/ward managers are managing small businesses, often with budgets in the millions of dollars, and their budgets are set on somebody's pie-in-the-sky guesstimate (Diers 2004:325)

The focus of several early studies conducted by Duffield (1989a;1989b), Duffield, Donoghue and Pelletier (1996) and Duffield et al. (2001) was to define the scope of the role of nursing unit managers. The first of these studies, published in 1989, shortly after the introduction of the role of NUM in NSW, investigated the competencies and skills that first-line nurse managers should possess (Duffield 1989a). Using a Delphi survey of sixteen expert nursing administrators, Duffield (1989a) found that 158 competencies, out of a potential list of 168, were considered to be essential skills for NUMs. At this early developmental stage of the role of the NUM, the use of a Delphi panel to identify the responsibilities and competencies required of a NUM was an appropriate method of investigation. However, the extensive list of essential competencies identified by the panel led Duffield (1989a:30) to comment that it is 'unrealistic to expect any individual to possess all the competencies identified in the study'. Despite this, the outcomes of this study paved the way for a further exploration of the essential skills needed to be an effective NUM.

For example, in a second stage of the same study, Duffield (1989b) asked the Delphi panel to rank 20 of the 158 competencies as the most important for nursing unit managers. It is interesting that two of the top three competencies deemed vital by the panel relate to nursing skills, rather than to the managerial aspects of the NUM's role. Furthermore, competencies associated with managerial tasks, such as, decision-making, conflict resolution, quality assurance and budget control, were all ranked by the panel members towards the bottom of the list. This may be because at the time the NUM's role was still in its infancy and the panel of senior nurse administrators did not place as much importance on the managerial aspects of the role as they did on the clinical responsibilities, and anecdotally this emphasis is still reflected by many nurses' views today. In contrast, the current essential criteria for the position of NUM (NSW Health Department 2004a), provided in Chapter One, paints a different picture, as applicants are required to have competencies in a

wide range of areas such as human and physical resource management, budgeting, and staff development, as well as having expert clinical abilities (New England Area Health 2004; NSW Health Department 2004a).

The results of these early studies by Duffield (1989a;1989b) provided valuable information about the initial conceptualisation and development of the NUM role that laid the groundwork for further studies to explore how the role was experienced by NUMs within the context of the Australian healthcare system. In 1996, Duffield, Donoghue and Pelletier conducted a study that tested the list of 158 competencies identified in the 1989 study against NUMs' perceptions of the skills and knowledge they considered important in their role. These authors developed a questionnaire, based on the findings of the earlier studies, to survey just over three hundred NUMs employed in public hospitals throughout NSW. The participants were asked to indicate the importance of each competency to their role, using a Likert-type scale. The findings were presented under four headings:

- Understanding legal implications of nursing practices.
- Knowledge of care delivery systems.
- Assessing quality of care provided.
- Acting as liaison between doctor, patients, family and staff.

(Duffield, Donoghue & Pelletier 1996:338-339)

It is interesting to note that the respondents in this study identified an understanding of the legal implications of nursing practices, along with care delivery, as the two most important groups of competencies for the role (Duffield, Donoghue & Pelletier 1996). The importance placed on the legal implications of nursing practice may reflect the well-documented trend in Australian healthcare towards a more consumer orientated, litigious society (Lewis 2004a). These studies, conducted in the 1990s, highlight the inconsistencies that existed between the organizational expectations of NUMs and their strong nursing focus.

Another study involving NUMs in Australia sheds some light on a further aspect of their role. Brewer and Lok (1995) studied the link between the managerial strategies used by NUMs and nursing staff commitment to the

workplace. These authors surveyed nurses in the wards of four large teaching hospitals in Sydney, where the NUM had been continuously employed for 12 months or more. In this study, the nurses were asked to answer questions about their working relationship with the NUM of the ward in which they were employed. The findings identified that, according to the participants, NUMs are pivotal in generating nursing job satisfaction for nurses under their supervision.

Furthermore, Brewer and Lok (1995) suggested that the NUMs experience tensions when they have to combine clinical, managerial and organizational work responsibilities. According to these authors, the NUMs had invested considerable time and energy in developing expert nursing skills, and these skills were often instrumental in gaining them the NUM position in the first place. So, while it can be argued that expert nursing knowledge is achieved progressively over a number of years, producing expert nurses who 'make practice seem easy and effortless' (Paliadelis 2001:61), it is important to realise that most newly appointed NUMs are novices as managers. When appointed to the role of NUM, incumbents are expected to demonstrate organizational, budgetary and administrative skills in order to meet the demands of the position, but these new demands can potentially cause NUMs to experience tensions between the managerial and nursing aspects of their role.

While no research studies were found that qualitatively explored the working world of NUMs in Australia, several alternative sources of information were found regarding the role of NUMs. For example, in a literature review by Duffield and Franks (2001) the authors suggest that NUMs need the ability to integrate clinical knowledge with the realities of healthcare decision-making. In other words, NUMs are expected to seamlessly blend their expert nursing knowledge with managerial skills. As discussed in Chapter One, NUMs in Australia are required to have current clinical expertise relevant to the ward/unit they are to manage (New England Area Health 2004; NSW Health Department 2004a). This is because many NUMs still carry a patient load, or at the very least are expected to act as senior clinical resource persons for less experienced staff. This is particularly the case in smaller regional and rural centres (Courtney et al. 2002; Hegney, Plank & Parker 2003).

Despite the expanding role of NUMs, a lack of recognition of nurses as key players in healthcare is implied in the role description provided in Chapter One, in which NUMs are expected to assume an extensive array of responsibilities in their ward/unit, yet they lack the power to make decisions in relation to many aspects of their role. For example, anecdotally, decisions about the allocation of budgets and staffing levels for each ward are often made at a higher level, yet the NUM is responsible for adhering to the budget and providing quality care within those constraints.

Fedoruk and Pincombe (2000) raised another issue of concern for NUMs, when they examined the challenges that face nursing executives in Australia. These authors explain that in the past, demonstrations of leadership within nursing have been infrequent, causing nurses to be 'over-managed and under-led' (Fedoruk & Pincombe 2000:14). Furthermore, these authors suggest that if nurses cannot move away from their traditional, subservient role in the healthcare system, then they will not be able to take their place as active participants in redefining healthcare into the next century (Fedoruk & Pincombe 2000).

Further evidence that reinforces the need to explore the role of nurses as managers can be found in two recently published Australian textbooks. In one book, aimed at clinicians as managers, Lawson and Rotem (2004:46) make the following statement:

> The effort of [clinical] managers is affected by many forces, which often push and pull them in different directions. To understand the management function we need to become familiar with these influences.

Later in the same text the authors state that an 'essential attribute of a manager is the ability to attain, retain and use power' (Lawson & Rotem 2004:76), but to date, and to my knowledge, no studies have been conducted that have explored NUMs' working lives within the construct of power.

In another recently published textbook aimed at healthcare managers, Lewis (2004b) indicates that there is a lack of research into the role of managers in healthcare settings, particularly in rural and remote areas. Therefore, this

study, which aims to explore the working world of NUMs in regional NSW, is timely given the lack of research regarding the experiences of NUMs, who struggle with escalating responsibilities within public healthcare organizations in Australia. In summary, there is a paucity of literature that explores the experiences of nurses as managers. Hence the need for this study, which seeks to uncover some of the issues faced by this group of nurses in management roles.

2.2.2 The demographic profile of nursing unit managers in Australia

I will now turn to what is known about the demographic profile of NUMs in Australia. Few studies were found that provided a description of NUMs. However, one comparative study, conducted by Duffield et al. (2001), compared the demographic profile of NUMs in NSW in 1989 with a profile collected in 1999. Despite the 1999 sample being much smaller (n=133), than the one in 1989 (n=315), the profile did not significantly change during the ten-year interval. These authors found that the majority of NUMs were female (85.7%), in their mid- to late-thirties, with 10–11 years of experience as registered nurses before becoming NUMs. More recent data, published in the *National Review of Nursing Education*, is based on national statistical data provided by the Australian Bureau of Statistics:

> The age profile of nurse managers changed significantly between 1987 and 2001, in 1987 53% of nurse managers were under 35 years of age, compared to 14% in 2001. (Department of Education, Science & Training (DEST) & The Department of Health & Ageing 2002: 26-27)

This finding indicates that NUMs in Australia are ageing, and this is consistent with other data that describe an ageing nursing workforce in Australia (O'Brien-Pallas, Duffield & Alksnis 2004). Similarly, Clinton (2004:9) indicates that the proportion of nurses under 25 years of age in Australia declined in the decade 1986–1996, from just over 23% to 7.7%.

In addition to the problems associated with an ageing workforce, the National Review of Nursing Education presented another disturbing trend related to the profile of NUMs in Australia (Department of Education, Science &

Training (DEST) & The Department of Health & Ageing 2002). The National Review showed that NUMs worked significantly longer hours in 2001 than they did in 1987, with more than 75% of NUMs working more hours per week in 2001. The long working hours were linked to the impact of cost containment, which has, overall, led to an expansion of the NUM's role. In addition, the well-documented nursing staff shortage in Australia means that NUMs often work longer hours, and sometimes even assume a greater clinical load, in an effort to reduce the excessive clinical workloads of their staff (Jones & Cheek 2003; Hegney, Plank & Parker 2003).

Another source of demographic data regarding NUMs in NSW can be found in a recent study by Johnstone (2003), who investigated the turnover rate of NUMs. The aim of Johnstone's (2003) study was to explore the environmental, personal and work-related factors that contribute to the turnover of NUMs in NSW. To do this Johnstone (2003) surveyed 800 NUMs employed in both private and public healthcare facilities in rural and metropolitan NSW using a questionnaire developed for the project. In this study over 80% of NUMs surveyed were over the age of 40.

Johnstone (2003) found that NUMs left their jobs for two main reasons. The first was for career development, which was a positive reason for change. For example, the NUMs described moving into more senior positions, such as Assistant Director of Nursing (ADON), as a reason for leaving the NUM's role. The second major reason for leaving was negative, with many participants indicating that they experienced stress and job dissatisfaction, caused by a lack of time to do their job properly. It was not reported in the study what happened to the NUMs who left their role for this reason, as this was not a study aim.

As well as exploring NUMs' reasons for leaving, Johnstone (2003) also identified some of the reasons why NUMs chose to stay in their jobs. The reasons for staying all revolved around the respondents' belief that the role suited their skills and qualifications. They found the position satisfying and rewarding, they enjoyed the company of work colleagues, and were happy with the hours. It needs to be noted that satisfaction with the working hours may be related to the fact that NUMs in Australia do not usually do shift-

work, as they generally work Monday to Friday during business hours. An interesting aspect of this study is that out of the 800 NUMs surveyed, only 600 cited a reason for staying in their job, which means that 25% stayed, but did not provide any reason for doing so.

In both the Duffield et al. (2001) and Johnstone (2003) studies, there is evidence that NUMs do not tend to stay in one position for the duration of their career. In fact, according to both Duffield et al. (2001) and Johnstone (2003) the turnover of NUMs in NSW during the 1990's indicates that a significant number of NUMs changed jobs frequently. For example, in Johnstone's (2003) study only one third of respondents had not changed jobs in the preceding decade.

The studies described in this section (Duffield et al. 2001; Johnstone 2003), have provided a demographic profile of NUMs in NSW that is fairly consistent with national demographic data from other sources (Clinton 2004; Department of Education, Science & Training (DEST) & The Department of Health & Ageing 2002). From the limited amount of demographic data available it seems that the current trend for NUMs in Australia is that they are ageing, their turnover rate is high, and they work longer hours than at any time in the past in a role that is expanding but not clearly defined. As this study seeks to discover what it is like to be a NUM in the context of an ever changing healthcare system, the next section discusses the role of the NUM within the context of the Australian healthcare system.

2.2.3 The role of the NUM within the Australian healthcare context

Having discussed what is known about the evolution and demographics of the role of NUMs in Australia, it is now necessary to consider their position within the contextual landscape of healthcare. NUMs do not work in isolation, but within a healthcare system that consists of numerous categories of healthcare professionals, with differing goals and agendas. Thus, in order to locate the NUM within the healthcare system, I will draw on literature that explores the Australian healthcare system and workforce issues.

Observers of healthcare trends in Australia indicate that it is the push to work harder and faster, to do more with less, based on an alignment of healthcare

delivery with commercial management practices, that defines the changes occurring in Australian healthcare (Clinton & Scheiwe 1995; Duffy & Chan 2001; Hegney, Plank & Parker. 2003; Lewis 2004a; Picone 2000). Some authors suggest that a trend towards economic rationalism, combined with increased consumer expectations of healthcare services, makes it increasingly challenging to deliver quality care (Clinton & Scheiwe 1995; Duckett 2000). McLoughlin and Leatherman (2003), who reviewed the recent challenges to the delivery of quality health care in Australia, paint a gloomy picture of the future, suggesting that with an ageing population, increased consumerism, healthcare staff shortages, and a widening gap between demand and capacity the situation is unlikely to improve. A similar conclusion was reached by Nay and Pearson (2001), regarding the state of nursing within the Australian healthcare system. These authors contend that the nursing shortage is exacerbated by an increased need for nursing care, partly generated by an ageing population. This is combined with another major factor, which is the reduced number of young people choosing nursing as a career (Nay & Pearson 2001). A similar point was raised in a recently published government report (Australian Health Workforce Advisory Committee 2004), which also links the current nursing shortage in Australia to the decreased numbers of students starting and completing undergraduate nursing programs.

Jones and Cheek (2003), in a qualitative study of what nurses do every day, concluded that conflicts arise from the mismatch between the professional nursing philosophy and the reduced availability of resources. Using a purposive sample of nurses from a variety of rural and regional areas throughout Australia, interviews were conducted that focused on nurses' perceptions of the scope of nursing practice in Australia. These authors found that in response to the stress caused by a continually changing public healthcare system, nurses experienced inner conflict because of a mismatch between their desire to care for people and the need for cost containment. The participants in the study were concerned that staff shortages and heavy workloads, which are endemic in healthcare, meant that they had less time to provide the level of care they would like (Jones & Cheek 2003). The participants also acknowledged a growing need to learn more about management and leadership, conflict resolution and how to manage

workplace aggression. The authors believe that it is vital for the future of nursing in Australia that nursing managers become strong, innovative leaders who are positive role models for the nursing workforce.

Fulop and Eastman (2004) suggest that clinicians find it difficult to establish themselves as managers, because within the culture of healthcare, administrators resent health professionals adopting managerial roles and tend to blame them for budget overruns. These authors also believe that within the complex hierarchies of healthcare organizations the role of clinician–manager is poorly defined. Similarly, Pearson (2003) suggests that the ill-defined and sometimes ambiguous role of nurses in healthcare organizations warrants further investigation of their role boundaries. Pearson (2003) examined the responsibilities of nurses during patient mealtimes as an example of the challenges nurses face in defining their expertise and professional boundaries. The findings indicated that nurses are expected to assume non-nursing responsibilities, such as serving meals, when catering staff levels and budgets are cut.

In Australia in recent years, there has been a plethora of government reports, studies and reviews of nursing education and employment trends (Australian Health Ministers' Conference 2004; Australian Healthcare Summit 2003; Australian Health Workforce Advisory Committee 2004; Ellis 2002; Jones & Cheek 2003; Department of Education, Science & Training (DEST) & The Department of Health & Ageing 2002). These documents clearly link the stressors experienced by healthcare workers with constant restructuring and cost-containment strategies, which cause a reduced availability of resources and contribute to the well-documented nursing shortage (Lewis 2004a; McLoughlin & Leatherman 2003). Together, these factors create further pressures for nurses and nurse managers who stay in the system, by requiring them to work longer and harder.

Many of the government documents reviewed indicate that if nothing changes, then in the near future the system is at risk of reaching breaking point. This will culminate in an even poorer retention rate of nursing staff, leading to greater job dissatisfaction and increased stress and burnout for the remaining staff. As a result, these problems could potentially affect the

quality of nursing care provided in this country. Pelletier and Duffield (2003) recognise the need for a greater understanding of the conflicts that nurses face when they strive to reconcile cost-effectiveness with quality of care. These authors provide some valuable insights into how nursing work practices could be better understood by using a work-sampling observational methodology, which is a method of identifying how workers spend their time. These authors conclude that there is an urgent need to better understand the demands of all levels of nursing work within under-resourced healthcare environments, such as the one that exists in Australia. Similarly, Lewis (2004a) indicates that it is imperative to clarify the role of nurses and nurse managers within the constantly changing political and social landscape of healthcare in Australia.

Some further insights into the current context of healthcare in Australia can be gleaned from a report commissioned by the NSW Nurses' Association, which studied nursing workforce recruitment and retention issues. In this report Buchanan and Considine (2002) explored why nurses leave public hospitals in NSW. Using a multi-method approach that included focus groups and surveys, these authors asked 250 nurses and ex-nurses from across NSW 'Why are nurses leaving the profession?' The key finding was that changes to the healthcare system make nursing work less attractive. The participants indicated that the shift to a cost control approach means that patient care had become secondary to balancing budgets (Buchanan & Considine 2002:11). Furthermore, a focus on cost containment was also linked to increased workloads and higher levels of work stress because of higher patient acuity, in that only very sick patients, who required high levels of nursing care, were admitted to hospital. At the same time, cost containment strategies have also led to reduced numbers of nursing staff and fewer clinical resources. This situation means increased workloads for the remaining staff, causing experienced staff to leave the profession (Buchanan & Considine 2002). The findings of this report are further reinforced by those from a recently published report from the Australian Health Workforce Advisory Committee (2004:34), in which nursing staff shortages are linked to 'unsatisfactory work environment and culture, resource scarcity and increased consumer demand

for nursing services'. This report also suggests that nursing staff shortages can be linked to other factors:

> Increased attrition rates may be related to organizational factors. Experienced and highly qualified nurses have left the nursing workforce for other careers due to issues such as a lack of recognition for their work (feeling undervalued), feeling overworked and underpaid (Australian Health Workforce Advisory Committee 2004:34).

An Australian quantitative study conducted by Van Eyk, Baum and Houghton (2001), provides further insight into some of the challenges that face healthcare professionals in Australia. These authors surveyed 768 healthcare workers employed in four South Australian healthcare facilities. The findings showed that constant and complex changes to healthcare delivery in Australia have led to 'reform fatigue' in healthcare staff, contributing to stress, conflict and burnout (Van Eyk, Baum & Houghton 2001:202). While these authors did not include any information about the number of respondents who were nurses, it is logical to assume that some of the respondents were NUMs, as the sample was described as front-line clinical and managerial staff (Van Eyk, Baum & Houghton 2001). This study concluded that there is an urgent need to develop a deeper understanding of the impact of constant change on all healthcare staff if Australia is to continue to provide quality healthcare.

Duffy and Chan (2001) also studied the impact of stress on all categories of healthcare workers by comparing survey responses from staff employed in Australian and British hospitals. These researchers based their survey tool on a reduced version of the Occupational Stress Indicator (OSI), developed by Cooper (1988 cited in Duffy & Chan 2001). The results indicated that stress reduces job satisfaction in all categories of hospital staff and causes them to experience physical and mental ill health. Furthermore, Duffy and Chan (2001:237) found that in Australia the constant re-structuring of health services to become leaner and more cost effective has led to compromised levels of health and reduced quality of life for all hospital workers. These

authors also suggest that further studies into the working lives of healthcare workers would lead to a better understanding of health workplace culture.

In summary, there are limited studies that specifically relate to the NUM's role in the context of public healthcare Australia, hence the need for this study which will contribute to a deeper understanding of the experiences that underlie some of the findings of the earlier quantitative studies discussed. For example, Johnstone's (2003) findings that NUMs have a high turnover rate, and the conclusion of Duffield et al. (2001) that the NUM's role is expanding but poorly defined, suggest that NUMs are likely to experience some degree of stress and dissatisfaction in their role. Furthermore, if as discussed by Buchanan and Considine (2002) nursing work is becoming a less attractive career option, the ability of the NUM to create a positive work environment, as described by Jones and Cheek (2003), becomes more significant. Therefore, by exploring what it is like to be a NUM in the context of the public healthcare system in Australia, this feminist study will provide insight into some of the conflicts and challenges faced by NUMs. In addition, there is evidence that changes to the healthcare system have created a work environment in which NUMs suffer from a lack of preparation and support for the role. This is discussed in the following section.

2.2.4 The preparation and support of NUMs in Australia

This section reviews literature that explores the educational requirements, preparation and support of NUMs. In relation to the preparation and support of NUMs in Australia, a worrying trend was revealed in the study by Duffield et al (2001), which compared the profile of NUMs in 1999 with that of a decade earlier. A majority of the NUMs in 1999 reported that they had less access to mentoring when compared to their counterparts in 1989. Duffield et al. (2001) suggest that the lack of preparation and support for a managerial role was linked to the fact that from 1989 nurses received their basic qualifications in the higher education sector, following the relocation of nursing education to universities in 1986. These authors suggest that when nursing qualifications were gained via hospital-based training programs, more opportunities existed for nurses to go on to gain post-basic certificates, with management certificates being a popular option. However, since nursing education has moved to the higher education sector, Duffield et al. (2003)

assert that postgraduate courses have become less popular because they are more costly and time consuming than the earlier hospital-based courses. Therefore, fewer nurses are gaining management qualifications.

Waters et al. (2003), in contrast to Duffield et al (2001), suggest that university trained nurses are no less prepared than their hospital trained counterparts for managerial positions. Waters et al. (2003) reached this conclusion after surveying mentors and mentees, pre and post their participation in a formal nursing mentorship program in NSW. In this pilot program senior nurses, such as Directors of Nursing and more senior NUMs, provided mentorship to new or less experienced NUMs. The findings indicated that regardless of the extent of the educational preparation that NUMs receive, recently appointed NUMs still needed the opportunity to learn on the job from more experienced managers (Waters et al. 2003). These authors conclude that to better support NUMs in their role, formal mentoring and networking programs should be a priority, because of the well-documented benefits that arise from having access to appropriate levels of organizational support (Boucher 2001; Courtney, Nash & Montgomery 2002; Shanley 2004; Thyer 2003; Waters et al. 2003).

Similar findings are evident in the NSW Nursing Workforce Report (NSW Health Department 2001), which aimed to identify issues that impact on nursing recruitment and retention, in an effort to address the escalating nursing staff shortage in Australia. This report was based on the outcomes of an eight member Strategy Group, consisting of four members of a Ministerial Standing Committee on the Nursing Workforce and four nurse managers, two from rural and two from metropolitan settings. One of the recommendations of the Report was that NUMs needed to attend forums to 'educate, inform and provide practice examples of effective management and leadership' (NSW Health Department 2001:6). The report found that in order to better prepare NUMs, mentoring was vital, particularly to assist with the expanding administrative and managerial aspects of the job. Similarly, Chan (2001) suggests that in the current healthcare context the effectiveness of NUMs is enhanced if they work in a caring and supportive environment. In addition, a number of authors such as Jones and Cheek (2003) have recently

suggested that the educational preparation for nursing management positions remains an unmet need for Australian nurses.

In an article in The Nursing Review, Ellis (2003:6) refers to a professional development program available for NUMs, and asks *'Who are today's typical nurse unit managers?'* This author acknowledged that today's NUMs not only need expert clinical skills, but also the ability to effectively manage staff and budgets. To do this they need education and support to gain confidence and competence in these areas. Boucher (2001) believes that without appropriate training and support, clinician–managers take refuge in their clinical roles, avoiding their managerial responsibilities. Similarly, Cronenwett (2001:15) suggests that healthcare professionals are ill equipped to assume managerial roles because the focus of their education is the 'transmission of disciplinary knowledge', and not generic management skills. However, there is little incentive for NUMs in the public healthcare system to obtain a managerial qualification, as it does not provide them with any additional financial reward or status. Furthermore, it can be seen from the essential criteria for the NUM position in NSW, provided in Chapter One, that it is not compulsory to have management qualifications in order to be considered for the role. In fact, anecdotal evidence suggests that few NUMs see any benefit in pursuing such courses.

Courtney et al. (2002) believe that there is a pervasive lack of support or encouragement for NUMs to gain further education of any type, which is even more obvious in regional and rural areas, compared to metropolitan centres. As well as a lack of support, when surveying nursing executives in metropolitan, regional and rural parts of Queensland these authors found that there was a general dissatisfaction amongst senior nurses regarding the expanding roles of nurses at all levels of management. This issue was also raised by participants, in a study by Buchanan and Considine (2002), which explored why nurses in Australia leave the profession. The participants indicated that one of the reasons they had left nursing was because of concerns about the rising level of responsibility of all nurses. Particular mention was made of the increased responsibilities of NUMs in relation to record keeping and other administrative tasks. The participants felt that NUMs lacked an appropriate level of preparation and support to undertake

these additional duties. Furthermore, it was suggested that an expanding administrative load reduced the time that NUMs have to support and guide nursing staff. This finding was linked to a general sense of dissatisfaction among nurses, which contributed to poor staff retention, because NUMs were no longer able to provide adequate clinical support and assistance to less experienced nursing staff (Buchanan & Considine 2002).

In all the studies discussed in this section, the findings suggest that there is an urgent need to better prepare and support NUMs (Buchanan & Considine 2002; Chan 2001; Courtney et al. 2002; NSW Health Department 2001; Waters et al. 2003). Further evidence from the literature that supports the argument that NUMs in Australia suffer a lack of support and preparation for their role can be found in some of the studies already discussed in which inadequate preparation was linked to high turnover rates among NUMs (Duffield et al. 2001; Johnstone 2003). Such studies suggest that poor retention can be a result of inadequate preparation and support (Buchanan & Considine 2002). No further studies were found that explored the preparation and support needs of NUMs in Australia.

2.3 Section Two: NUMs from an international perspective

Research studies and other literature that describe the NUM's role from an international perspective are reviewed in this section. In particular, literature concerning the role evolution, role description, the healthcare context and their preparation and support is provided to demonstrate the links to the development of the position in Australia.

2.3.1 The evolution of the NUM's role from an international perspective

A number of international studies indicate that NUMs worldwide are assuming more responsibilities over broader areas (Apker 2002; Bolton 2003; Wilmott 1998), which is consistent with the trend in Australia, as previously discussed. For example, compared to the earlier charge nurse position, the NUM role described in the international literature requires incumbents to not only be expert clinicians, but also to have the ability to be financial gurus and innovative managers (Apker 2002; Wilmott 1998).

Oroviogoicoechea (1996) has provided an interesting summary of what was known about the evolution of the NUM's role internationally until the mid-1990's. This author considered all available literature regarding the role of the NUM, and found that the role had evolved in response to changes in the way healthcare is delivered. In particular, the NUM's role differs from the earlier charge nurse position because of a need for NUMs to organize and coordinate the activities of the ward and ensure the provision of quality patient care, as opposed to just managing nurses. Most studies reviewed by Oroviogoicoechea (1996) suggest that the clinical aspect of the role remains the most important activity from the perspective of both the NUM and the nursing staff. This author also found that when NUMs face conflicts between their professional and managerial duties, they displayed a bias toward their clinical role, by devoting more time to clinical tasks (Oroviogoicoechea 1996). In addition, it was suggested that in all healthcare organizations the NUM's position is still considered central to the delivery of quality patient care. However, despite the obvious importance of the NUM role to the provision of patient care, this author also noted a lack of consensus regarding the core managerial functions of the position. This is consistent with the findings of Duffield et al. (2001), mentioned earlier, in that NUMs in Australia do not have clear role expectations. Similarly, the literature discussed in this chapter supports Oroviogoicoechea's (1996) contention that NUMs are promoted primarily on the basis of their clinical expertise, and are generally not well prepared for the managerial role despite being expected to lead their department professionally and administratively.

In Britain, Wilmott (1998) and Bolton (2003) both conducted studies which explored the role of NUMs. Wilmott's (1998) study, which was similar to some of the early studies conducted in Australia by Duffield (1989a; 1989b) and Duffield et al. (2001), used a mixed mode method to explore the new NUM role in Britain. In the first stage of this study, a Director of Nursing and four senior nurse administrators employed by one health trust were interviewed and asked to describe the role of the NUM. This qualitative data was used to develop a questionnaire, which was then sent to 47 newly appointed NUMs. The questionnaire explored whether NUMs were satisfied with the development of their role, whether they had enough time,

knowledge and resources to perform the job effectively, and if they believed that the preparation and support they received was adequate (Wilmott 1998). Overwhelmingly the participants indicated that they experienced confusion and anxiety about their new role and they linked this to a lack of consultation about the scope and authority of the position.

Furthermore, it was found that a lack of management skills caused stress to the NUMs and their staff. For example, the NUMs often tried to counter nursing staff shortages by assuming additional clinical responsibilities themselves. This strategy left them with little time to deal with staffing problems for the next shift (Wilmott 1998), and meant that they had to take work home as they had insufficient working time to be both an effective clinician and manager, which in turn increased their stress levels. This study concluded with a warning about the stresses and challenges that result from making significant changes to nurses' roles without adequately preparing and supporting them during the change process (Wilmott 1998).

A more recent qualitative study by Bolton (2003) had a similar focus to Wilmott's (1998) study. Bolton (2003) interviewed an undisclosed number of participants to explore the challenges that British NUMs faced in one hospital in their role as managers. This study found that the NUMs were expected to demonstrate skills in human resource management, policy implementation and quality issues without any formal training in these areas. In addition, these NUMs were also expected to coordinate and direct quality patient care.

Both Wilmott (1998) and Bolton (2003) found that NUMs were unclear about the extent of their role and overwhelmed by their managerial responsibilities. Both studies also found that NUMs were expected to be effective leaders and financial managers as well as expert clinicians. The participants in both studies described a number of challenges that impacted on their ability to perform effectively in the role. For example, the coordination of quality patient care within tight financial controls, combined with a lack of time to do all that was expected of them, caused the participants to experience stress and frustration. Bolton (2003:125) suggests that one of the challenges that the NUMs faced was the inner conflict between their image of themselves as a nurse and the 'paper shuffler' image they had of managers.

Calpin-Davies (2000) suggests that gaining the skills necessary to be a successful NUM can be achieved by becoming self-reflective. In a motivational article that exhorts British NUMs to become more personally effective, this author draws attention to a large number of personal skills considered essential for becoming an effective NUM (Calpin-Davies 2000). For example, according to Calpin-Davies, NUMs need creativity and vision, integrity, congruence and an ability to control their emotions. In addition, they must radiate positive energy, believe in other people, lead balanced professional lives, transcend daily nursing issues, and be professionally proactive and patient so that they can lead nurses in new directions. However, while Calpin-Davies (2000) discusses the value of reflecting on one's practice, no specific suggestions are made regarding how NUMs could develop these attributes. In fact, it could be argued that many of the attributes described by the author are not skills at all, but are in fact beliefs, values or personal traits. I consider that based on the literature discussed in this section, the extensive list of requirements to be a NUM in Britain make the role akin to an apprenticeship for sainthood. Similarly, in Duffield's (1989a) early Australian studies it was found that the extensive list of competencies required to be an effective NUM was also an unrealistic expectation.

Descriptions of the role of the NUM from authors in the US are equally expansive. For example, Apker (2002) interviewed 18 NUMs to explore how they defined their role, what job stressors they experienced and the coping strategies they used. The findings indicated that NUMs in North America are required to hire, fire and evaluate staff performance, develop policies and procedures, control budgets, direct patient care and customer service and be advocates for nursing. One study participant described this as being a 'champion' for nursing ideas, concerns and problems (Apker 2002:78). Apker concluded that the participants suffered considerable stress as a result of overwhelming workloads and a lack of participation in decision making. This is because the NUMs had to be system coordinators, with '24-hour accountability' for what happens on their ward, yet they had little authority and minimal input into decisions that affected them, their ward and their staff (Apker 2002:77).

In another American study, Judkins and Ingram (2002) conducted a pre- and post-test survey to explore how best to protect NUMs from the stress inherent in their role. These authors evaluated NUMs' understanding of stress and 'hardiness' (Judkins & Ingram 2002:260). The authors described hardiness as a personal quality that protects people against stress by reducing negative perceptions of stressful situations. In the study, Judkins and Ingram (2002) developed a training module which linked reduced stress levels to hardiness. This module was sent to a convenient sample of 31 NUMs in four rural hospitals, with the aim of determining whether a self-directed learning package containing information about stress and hardiness would help the NUMs cope with the pressures of their job. The authors conclude that the NUMs suffered a high level of stress because of the intense daily demands of their role, in that they are expected to care for the caregivers as well as the patients. These authors feel that the participants could gain valuable skills in dealing with stress by working through the training module. Furthermore, they suggest that an assessment of hardiness levels would be a useful strategy when interviewing potential NUMs, as NUMs with a high level of hardiness are more likely to see the challenges of their job as non-threatening. In contrast to this focus on the individual, Ingersoll et al. (2002) suggests that an exploration of the organizational factors that lead to job stress is an area worthy of study.

Another study from the US by Kramer and Schmalenberg (2003) found that NUMs have an important role to play in developing, nurturing and supporting equal power relationships between different groups of healthcare professionals. The aim of this qualitative study was to identify the components of positive work relationships between healthcare professionals. One hundred and forty-six nurse managers were interviewed to obtain their perceptions of nursing staff retention, staff adequacy, autonomy and control over nursing practice. The authors found that positive relationships with other staff developed through role modelling. Kramer and Schmalenberg (2003:35) conclude that 'the responsibility falls on nurse managers to develop, nurture and support equal power relationships between nursing and medical staff', because a collegial working environment based on mutual respect is linked to job satisfaction and quality patient care.

In a study that explored the role of the NUM from a nursing staff perspective, Corser (1995) surveyed 250 registered nurses employed in one American hospital. In this study, the nurses were asked to describe their expectations of NUMs by rating the activities of NUMs from a list of 49 possibilities. The outcome showed that nurses overwhelmingly expect NUMs to retain a strong clinical presence and act as a clinical resource person by helping them with complex patient care situations. This finding is also reflected in some of the Australian and British studies previously discussed (Apker 2002; Duffield, Donoghue & Pelletier 1996; Willmot 1998). The findings of these studies indicate that NUMs globally are expected to retain a strong clinical role, as well as cope with expanding managerial responsibilities (Apker 2002; Kramer & Schmalenberg 2003; Wilmott 1998).

Also, in the US, Neuhauser (2002) conducted a study to discover what makes 'good' people stay in their jobs. Interviews were conducted with an unspecified number of senior healthcare executives throughout the US (Neuhauser 2002). This study found that NUMs play an important role in providing a positive working environment for nursing staff. As already discussed, a similar finding was made in a study by Brewer and Lok (1995), in which they contend that NUMs in Australia are vital in generating nursing job satisfaction. Furthermore, Neuhauser (2002:473) suggests that NUMs need to be more highly valued as members of the healthcare team, evidenced by the fact that 'the highest degree of agreement amongst healthcare executives interviewed relates to the importance of frontline managers'.

Parsons and Stonestreet (2003) also considered factors that contributed to the retention of nursing unit managers. These authors interviewed 28 NUMs employed in five hospitals in the southwest area of the US, and found that the most important factor in the retention of NUMs is open communication with, and accessibility to, superiors who will listen, guide and support them. Parsons and Stonestreet (2003) also support the argument made by Neuhauser (2002) that NUMs should be valued and recognised as an important part of a healthcare organization, stating that they are 'the glue that holds the hospital together' (Parsons and Stonestreet 2003:120). These authors come to the conclusion that if an organization is to deliver quality patient

care, NUMs need to be coached, mentored, supported and recognised as key players in creating a positive working environment.

According to Loo and Thorpe (2004) NUMs in Canada also struggle with role expansion. For example, the NUM's role includes many activities, such as, planning, budgeting and staffing, as well as staff development, clinical support and monitoring quality issues. In a Delphi study of occupational stress, using a panel of 41 NUMs, Loo and Thorpe (2004) found that increased job responsibilities and pressure to do more with less were the two most significant stressors for NUMs. Furthermore, the major challenges faced by the participants consisted of having to work within limited budgets, resources and staff numbers, and yet still provide quality healthcare. In another stage of the same research project the authors interviewed 26 NUMs in several regions of one Canadian province, confirming their findings that NUMs face significant challenges related to role expansion and a lack of support (Thorpe & Loo 2003b). These findings are also congruent with those from Australia, Britain and the US.

A similar picture emerges from Sweden, where two studies reveal that NUMs require competence in areas such as personnel management and administration, as well as budgeting and health economics (Lindholm & Uden 1999; Lindholm & Uden 2001). Lindholm and Uden's (2001) study investigated how 27 NUMs experienced their management role over a three-year time frame. The study consisted of two interviews with each NUM, three years apart. In this study, the NUMs described experiencing a lack of acceptance of their managerial status from other healthcare professionals, which was manifested as resistance towards their authority. Over the three years, the NUMs spoke of fighting for their right to be included and informed in the decision-making processes of the organization.

A further study by Lindholm et al. (2003) investigated Swedish NUMs' abilities to meet high work demands in a changing healthcare system. This quantitative study surveyed 205 NUMs, using a validated instrument designed to explore the relationship between job strain, job demands and self-rated health status. The findings suggested that high job demands and the lack of an effective support network could be linked to poor health in nurse

managers. These authors conclude that 'nurse managers' job demands are above the level where available support is sufficient' (Lindholm et al. 2003:513). Furthermore, these authors suggest that qualitative studies of the experiences of NUMs might capture further information about how they deal with the demands of such a broad and complex role.

Drach-Zahavy and Dagan (2002) studied the role of NUMs in Israel. These authors explored what NUMs do, by observing 48 NUMs employed in a variety of clinical settings throughout Israel. The findings suggested that most of the NUM's time was taken up with clinical care, followed by coordination of care and then administrative work (Drach-Zahavy & Dagan 2002). The picture that emerged from this study is one in which the NUMs display a management orientation more aligned with maintaining the clinical activities of the ward in which they worked. They completed administrative tasks only when they had time, preferring to involve themselves with clinical duties. These authors conclude that the NUM's role is extremely demanding because they have 24-hour-a-day responsibility for staff, operations, finances and the management of patient care (Drach-Zahavy & Dagan 2002). Despite this, these authors indicated that the NUMs neglected the managerial aspects of their role in favour of delivering patient care.

A number of other studies previously discussed also found that nursing skills were viewed by NUMs as far more important than management skills (Kramer & Schmalenberg 2003; Lindholm et al. 2003; Loo & Thorpe 2004). This is not surprising given that, historically, clinical ability was a major requirement for the charge nurse of the past to run a ward. Before the creation of the NUM's role the responsibilities for financial management, quality assurance, staff development and resource management were allocated to others, such as the matron or hospital administrator. However, the expanding role of the NUM in many developed countries now requires them to demonstrate a wide range of managerial skills in addition to having clinical expertise.

Additional literature from the UK and US adds to an understanding of the challenges faced by nurses in the transition process from nurse to manager. For example, according to a US textbook by Swansburg and Swansburg

(2002), in order to be effective, NUMs need knowledge and skills in financial management, plus the ability to make moral and ethical choices; they must be an advocate for patients, and demonstrate autonomy when threatened by authoritarian management. Furthermore, according to these authors, NUMs require effective communication skills, knowledge of political and legal forces and socio-cultural characteristics, technological and management skills, and the ability to provide staff development. When comparing this list with those described in Australian and other international studies, there are significant similarities.

From the international literature, it is clear that descriptions of the NUM's role are reasonably consistent with those of their Australian counterparts, in that NUMs are expected to have a diverse range of knowledge and skills. The literature indicates that internationally, as in Australia, the complex and multi-faceted role of the NUM remains ill defined. However, there is clear evidence that skills in human resource management, financial and policy planning, education, research, quality management, conflict resolution, political intuition, problem solving and staff empowerment, in addition to expert nursing knowledge, are all required to perform effectively in the role.

According to the findings of the Australian and international studies discussed in this chapter, to this point NUMs continue to place more importance on the nursing rather than on the managerial aspects of their role (Bolton 2003; Courtney, Nash & Montgomery 2002; Duffield, Donoghue & Pelletier 1996). Furthermore, several authors have suggested that the NUM's role is challenging because of the requirement to work within tight budgetary controls over which they have little influence (Bolton 2003; Drach-Zahavy & Dagan 2002). In order to locate the role of NUMs within an even broader frame of reference it is important to remember that the challenge of being a clinician-manager is not confined to nurses, as other healthcare professionals also face difficulties in assuming a first-line management role (Fulop & Eastman 2004). The next section situates the NUM's role into the broad context of healthcare.

2.3.2 The role of the NUM within the international healthcare context

This section provides a review of the position of the NUM within the context of healthcare internationally, compared to the Australian healthcare system which was discussed earlier in this chapter. It would appear that within many international healthcare systems that are seeking to become leaner and more efficient, NUMs have become the managerial dogsbodies, meaning that they are required to assume additional responsibilities traditionally carried out by others (Cooper et al. 2002). Duties that are now part of the NUM's role, such as budget reports, staff appraisals and conflict resolution, were once commonly performed by senior managers or clerical staff (Apker 2002; Cooper et al. 2002). Decentralisation of health services and reduced support staff numbers means that these duties are now part of the NUM's role internationally. This means that NUMs have less time to complete their work and support, educate, nurture and empower their staff. As Apker (2002:78) stated, 'most nurse managers report coming in early and leaving late', and they also experience 'a lack of appropriate organizational resources as a workload stressor'. Similarly, Manion (2005:54) warns that the demands on nurses in management positions are 'unrealistic and overwhelming'. It is because of the expanding role and corresponding increased demands placed on NUMs that they find their position stressful (Apker 2002).

As already discussed, much of the literature from Europe, the US, Canada, Britain and Australia describes the expanding role of NUMs as a response to changes and restructuring of healthcare systems over the 1980s and 1990s. For example, Mrayyan (2004) conducted an Internet survey of 600 nurses in the US, Canada and the UK to explore the role that NUMs play in nurses' experiences of work autonomy. Mrayyan comments that 'in today's health care environment the role of the nurse has become more complicated and is linked to multiple responsibilities' (Mrayyan 2004:326). The findings of Mrayyan's study showed that major changes, such as the shortage of nurses, higher patient acuity, and under-resourcing can lead to a reduction in nurses' job satisfaction and retention rates that impacts on the overall quality of patient care. Mrayyan (2004) concludes that NUMs are well placed to significantly influence nurses' job satisfaction and retention, by empowering and supporting them. Similarly, findings from two more recent studies also

conclude that NUMs are pivotal in enhancing nursing staff job satisfaction and retention (Anthony et al. 2005; Force 2005).

Concerns about the impact on nurses of constantly re-structuring healthcare systems can be found in studies by Gershon et al. (2004) and Hau (2004). These authors suggest that, globally, rapid organizational changes to healthcare funding, structures and delivery have caused a deterioration in the workplace culture that impacts on all healthcare workers. Gershon et al. (2004) considered twelve instruments that have been used to measure workers' perceptions of organizational constructs in healthcare settings. The results show that an evaluation of workers' perceptions of organizational culture is vital if healthcare workers are to reduce stress levels, and if healthcare organizations are to increase recruitment, retention and job satisfaction (Gershon et al. 2004).

Hau (2004:2) believes that in healthcare organizations, nurses' professional values and beliefs are often at odds with those of the organization. This is because nurses strive to deliver both humanistic and holistic care in organizational cultures that are increasingly constrained by managerial mindsets and fiscal limitations. Hau (2004) observed the staff on one hospital ward in Singapore for four months and then interviewed 13 nurses and one medical officer to determine how the context of healthcare impacted on their role. The findings indicated that the participants were concerned that the primary goal of the organization was cost effectiveness. They described experiencing tensions between their desire to provide quality nursing care and the need for rapid throughput of patients. Hau also makes reference to the powerlessness of nurses to influence or change the organizational culture in which they work, implying that if nurses had the power they would re-focus the goals of the organization back to the provision of quality patient care (Hau 2004). Ponte et al. (2004:174) agree, stating that 'nurses believe that the needs of patients, families and staff are less important [to the organization] than the financial goals of the institution'.

References to powerlessness within the workplace prompt further discussion of the lack of input into health policy and decision making by nurses, which can potentially impact on the role of the NUM. Decisions about healthcare

policy and the delivery of quality care are identified by several authors as areas where nurses lack input (Buresh & Gordon 2000; Diers 2004; Sullivan 2004). Another example is provided in a British study by Bolton (2003), in which a government report into healthcare management roles discounts nurses' contributions as unimportant, while medical doctors are described as playing a senior role in healthcare decision making (Bolton 2003:123). Similarly in a report on quality in healthcare in Britain, US, Australia, Canada and NZ, physicians and the public were surveyed to discover stakeholders' perceptions of quality (McLoughlin & Leatherman 2003). However, nurses perceptions were not included in the sample, implying that they are not legitimate stakeholders in the provision of quality healthcare.

Conversely, a number of studies acknowledge that nurses play a key role in the provision of quality care by achieving positive patient outcomes (Kany 2004; Stanton 2004; Tourangeau, Stone & Birnbaum 2003), and so argue that nurses should be included and consulted in decisions about healthcare. For example a report from the US *Agency for Healthcare Research and Quality* (Stanton 2004) summarises the findings of more than twenty large studies in the US that explored the relationship between nursing care, nursing staff levels and patient outcomes. Stanton (2004) found a strong relationship between the quality of care provided and adequate nursing numbers and nursing job satisfaction, indicating that nurses are indeed key stakeholders in the delivery of quality patient care.

Some authors, such as Girvin (1998), believe that the lack of leadership in nursing is a response to traditional roles that identify nurses as followers rather than leaders. While, as previously stated, a study of nursing leadership is beyond the scope of this thesis, it is thought by some that a lack of nursing leadership is the reason why nurses remain silent bystanders in health policy formulation and in decision making regarding the delivery of care (Buresh & Gordon 2000). According to Persson and Thylefors (1999), research is urgently needed to identify issues surrounding the empowerment of nurses as managers. Parsons and Stonestreet (2003) agree, believing that NUMs need more opportunities to be consulted and heard, particularly when it comes to decisions that affect their ward. Similarly, Rovin and Formella (2004:165)

suggest that a positive work environment will only be created when nurses are given appropriate authority, responsibility and respect.

In the US study by Apker (2002), it was found that a lack of participation in decision making, huge workloads and a lack of resources caused significant workplace stress for NUMs, while McConnell (2002) describes the conflicts that healthcare professionals face when promoted to managerial positions. McConnell (2002:3) places NUMs in a wider context, by explaining that all professional disciplines require members to develop professional identities, based on common values and beliefs. Therefore, when professionals are appointed to management jobs they are actually taking on a second career, for which they generally have little experience.

Similarly, Brown and McCartney (2000) found that doctors in Britain did not value management skills, even when required to take on managerial roles in healthcare settings. From the studies discussed in this section, it can be seen that NUMs also continue to value their clinical role more highly than their management responsibilities (Bolton 2003; Wilmott 1998). Many of the studies discussed in this chapter add to an understanding of the potential inner conflicts that healthcare professionals face when they assume a management role. In some ways, this is also reflected in the findings of some of the Australian research studies discussed earlier, in which the development of managerial skills was not considered a priority for NUMs (Duffield 1989a; 1989b; Duffield, Donoghue & Pelletier 1996; Waters et al. 2003).

Thus, in a healthcare system that expects NUMs to be business managers, yet does not place a high priority on preparing them for that activity, the question needs to be asked: how do they gain the skills to effectively perform this multi-faceted role? Literature that identifies the preparation and support of NUMs from an international perspective is considered next.

2.3.3 The preparation and support of NUMs from an international perspective

In order to compare what is known about the preparation and support of NUMs in Australia with that of their international counterparts, this section reviews literature that considers their education and support needs globally. Several international studies were found that explored the preparation

needed to become an effective NUM. For example, an evaluation study from the UK makes a contribution to what is known about the educational needs of NUMs in that country. Currie (1996) evaluated the impact of a management development program on NUMs and potential NUMs and found that participants believed that the program was not sensitive to the context of healthcare, as no mention was made of the potential conflicts between the nurses' professional values and managerial ideologies.

A more recent literature review by Reedy and Learmonth (2000) supports this finding when discussing management education for nurses. These authors hold a rather pessimistic view of generic management training programs offered to nurses, suggesting that they are often irrelevant to the needs of nurses as managers. Reedy and Learmonth (2000) challenge the belief that management education can transform nurses into managers, because management education programs generally do not value nursing skills, or use them as the basis for building managerial expertise (Reedy & Learmonth 2000:153). Instead, these authors suggest that many management courses actually reinforce the conflict between the nature of nursing and that of managing, thereby further alienating nurses from management roles. This conclusion helps to explain nurses' devaluation of the managerial aspects of their role, based on the difficulties they experience in combining their professional and managerial responsibilities, as described previously. Further to this, Gordon (2004) contends that nurses find management roles challenging because they lack adequate financial and business training.

In a study mentioned previously, Bolton (2003) also discussed the lack of preparation for the management aspects of the NUM role, describing this as the reason for the conflicts and contradictions in their working lives. Similarly, Wilmott's (1998) study found that British NUMs felt unsupported and unclear about the scope of their new role. For example, over 80% of respondents felt that they had not received sufficient preparation, particularly in the areas of resource and budget management. Wilmott explained that NUMs in Britain are committed to the nursing role, and as such are usually promoted on the basis of their clinical excellence, as are NUMs in Australia (Brewer & Lok 1995). Thus, without sufficient preparation and support, they flounder when asked to undertake managerial tasks, and understandably,

they invest more time and energy into the more familiar clinical role, neglecting their other duties.

In order to understand how best to prepare NUMs for their expansive role, some authors have attempted to identify the types of skills and knowledge needed. For example, in the US, both Kleinman (2003) and Fosbinder, Everson-Bates and Hendrix (2000) report on studies designed to identify the skills required for success in the NUM's role. The study by Fosbinder, Everson-Bates and Hendrix (2000) aimed to validate an interview guide based on five competency areas identified in an earlier study (Everson-Bates & Fosbinder 1994). The five competency areas were effective communication, leadership, problem solving, staff development and the ability to see the big picture. To assist in selecting applicants best suited for the NUM's role, a ten-item questionnaire was developed to aid in identifying those who could demonstrate skills in these competency areas during the selection process. Using this questionnaire, two sets of data were collected from NUMs. The first was from 22 NUMs six months after they were employed, and the second was from 19 NUMs two years after being hired. The findings indicated that problem solving in the area of conflict resolution was the single most important predictor of success, followed by an ability to see the big picture (Fosbinder, Everson-Bates & Hendrix 2000:77). The authors offered no suggestions regarding how best to develop these skills in potential NUMs.

In another study also aimed at identifying core competencies and skills needed by NUMs, Kleinman (2003) surveyed 93 senior nurse executives and 35 NUMs in the US to discover their perceptions of the skills needed to become effective NUMs. Kleinman found that all the participants agreed that NUMs needed competencies in staffing, scheduling, management and human resources as the most vital competencies. Other competencies in areas such as strategic planning, health law and operations management were ranked as less important. Kleinman (2003) also investigated how NUMs and senior nurse executives thought that the required knowledge should be gained. The NUMs who participated in the study did not consider formal postgraduate education to be important or desirable in order to perform their job competently (Kleinman 2003), believing that the required skills were best learned on the job from mentors. However, according to Kleinman, this

response may be a reflection of the experiences of most of the respondents, as most had only received on-the-job training (Kleinman 2003:456). Conversely, the need for nurses to receive adequate formal educational preparation, particularly in the area of business skills, is viewed by Crossan (2003) as a priority. Crossan suggests that 'in the long run nurses will suffer if management tasks continue to be seen as a regrettable necessity', when they are just as vital to the role as direct patient care (Crossan 2003:333).

Another perspective on the education and preparation needed by NUMs is offered by Scoble and Russell (2003:324), who suggest that in a complex healthcare system NUMs' need to be effective managers who play a major role in health and societal issues. In an attempt to identify the most appropriate way to prepare NUMs for their complex role, these authors surveyed 43 nurse leaders at a healthcare leadership conference in the US. They found that expert clinical experience remained the most desirable competency for NUMs, followed by management skills in the areas of finances and budgeting, human resource management, quality management, and management of nursing systems. However, the study offered no suggestions regarding how best to deliver this knowledge to potential NUMs. Conversely, in a text aimed at potential NUMs, Girvin (1998:x) explains that 'clinicians are best placed to manage and lead the [healthcare] service, they do, after all, know it best'. This comment seems to imply that nurses and other healthcare professionals are well suited to assume a management role. Yet, findings from a number of studies discussed earlier suggest that NUMs feel under-prepared for the managerial aspects of their role (Bolton 2003; Ingersoll et al. 2002; Lindholm & Uden 2001; Loo & Thorpe 2004; McConnell 2002; Wilmott 1998).

Other studies that have explored educational and training opportunities for NUMs were conducted in Sweden and Britain. For example, Lindholm and Uden (1999) investigated the response of a group of NUMs in Sweden to a professional development course, finding that the graduates gained valuable skills in leadership, health economy, quality assurance, ethics and research methods. Surprisingly, the findings indicated that the participants did not believe that the course content was essential knowledge for the role of NUMs, but rather the increased confidence and peer support they gained from

undertaking the course were the most valuable outcomes (Lindholm & Uden 1999:56). Further support for this finding is evident in some of the literature already discussed (Kleinman 2003; McConnell 2002), in which study participants' did not consider graduate management education to be a necessary prerequisite for successful performance in their role. It was interesting that no research literature was found that provided a positive evaluation of a management education program aimed at NUMs.

In summary, the studies discussed in this section have provided a review of the educational preparation and support available for NUMs from an international perspective. One of the reasons why there is a need to identify effective training and preparation for NUMs is because there is significant evidence in Australian and international literature of the rapid expansion of the role. After reviewing the relevant literature, it seems imperative to gain a deeper understanding of how nurses are prepared and supported for this role, if they are to take their place as empowered nursing leaders in the current context of healthcare.

When considering the literature regarding NUMs it becomes obvious that there are striking commonalities in international and Australian understandings of the role. A picture emerges of an ill-defined position that carries broad-ranging responsibilities but has little power or authority. Evidence from the literature also indicates that incumbents are inadequately prepared and supported in the role. Furthermore, the role of the NUM appears to be negatively influenced by constant changes within the organizational context of healthcare systems, which has resulted in work environments where a lack of time and resources threaten staff morale, retention and the delivery of quality patient care.

2.4 Conclusion

This chapter has provided a review of the research-based literature that situates this study contextually, and has established what is known about NUMs, both in Australia and internationally. The first section reviewed literature that examined the role, the healthcare context and the preparation and support for the NUM, from an Australian perspective. It was found that

the role of the NUM continues to expand in response to a complex mixture of socio-cultural, governmental and healthcare organizational pressures. In addition, information about the nature and context of healthcare settings suggests that constant changes aimed at cost containment create conflicts and tensions for NUMs. The literature also indicates that NUMs lack adequate preparation and support, evidenced by studies that identify an urgent need for better educational opportunities and increased mentoring and networking.

The second section of this chapter reviewed the international literature and found striking similarities between the Australian and the international role description, the healthcare context and the preparation and support of NUMs. Thus, the literature reviewed in this chapter has provided a lens through which to consider the working lives of NUMs in this study. The next chapter introduces and discusses the theoretical framework and demonstrates the relevance of the framework to this feminist research study.