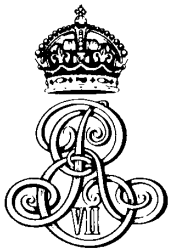

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NURSES AND LEADERSHIP

A REPORT OF THE THIRD

KING'S FUND TRANSATLANTIC SEMINAR OF NURSES

NUMBER 19

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NURSES AND LEADERSHIP

A report of the third King's Fund Transatlantic Seminar of Nurses

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CONTENTS

FOREWORD

The International Seminar of Nurses held at the King's Fund College in July 1976 was the third in the Series. There is no doubt that the question of leadership and the emergence of leaders is of paramount importance to the nursing profession in the three countries represented, Canada, United Kingdom, United States of America. Indeed this is not limited to the nursing profession. In so many walks of life today dynamic leadership seems to be missing and yet surely the need has never been more crucial than at this time.

Leadership was therefore the topic chosen for the seminar whose membership, as will be seen, was representative of the profession at the most senior levels in these three English-speaking countries. These seminars are deliberately small in membership and discussion is self-generated. Leaders at all levels need to get away from stressful situations and to experience the support generated by sharing with colleagues in similar positions common problems and hopes. Not only is there the direct advantage of meeting delegates from other countries but also the opportunity to meet senior colleagues from the same country in circumstances conducive to easy discussion and exchange of views.

One delegate of the two earlier seminars who was sadly missed was Miss Anne White CBE, whose untimely death in January 1976 robbed the seminar of one of its two founder members and the steering committee of its chairman.

The papers contained in this report, with one exception, the opening address by John Garnett CBE, were provided by the delegates. Discussion frequently took place in small groups and the reports of these discussions relating to the original papers are also included.

The report is issued in the hope that it may lead to further discussion of, and understanding about, the problems of leadership in the nursing profession today and perhaps to the emergence of new leaders to carry the profession forward in the challenging years that lie ahead.

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1978

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OBJECTIVES AND PROGRAMME

OBJECTIVES

To concentrate discussion and thinking among nurses in strategic positions in leadership and to look specifically at four areas:

- the nature of leadership
- the definition of the role and responsibility of nurses for leadership in a health care delivery system
- the emergence of leaders
- evaluation of leadership performance.

PROGRAMME

The programme followed the agreed sequence with prepared papers and discussion sessions on each topic. On the first morning, the nature of leadership was examined under the stimulating guidance of John Garnett.

The key question of the nurses' role and responsibility for leadership in a health care delivery system was accorded one whole day and two half days' work. Three speakers introduced the subject in plenary session. Three discussion groups were set up to facilitate full and detailed consideration of various situations in which nurse leadership is required: group I looked at leadership at the point of delivery of care and in nurse education; group II looked at leadership in management positions and in advisory and consultant positions; group III considered leadership in professional associations, trade unions, and in voluntary and community activities. Reports from the groups were received and further discussed in plenary session.

With the nurses' role and responsibility for leadership defined, the members of the seminar turned to consideration of the way leaders emerge and conditions conducive to such emergence in terms of selection, education and experience. Discussion in plenary session followed introductory papers by one speaker from each country. Provision had been made in the programme for the speakers to form a panel at the end of the day but discussion flowed freely and the extra time was taken for continued exchange of views.

On the last day, the difficult topic of the need for and ways of evaluating leadership performance was presented by three speakers.

The intention was for each speaker to give a critique of the papers which had been circulated previously. In this context the technique proved less satisfactory than in the research setting where it is commonly used and the seminar settled more comfortably to straight presentation and plenary discussion.

Professor Jean McFarlane rounded off the seminar with a summary which sought to integrate the theoretical presentations and their application to the nursing situation.

Brief daily meetings of the chairmen, staff members and group representatives served to keep the programme under review and to facilitate incorporation of suggested changes. A concluding session allowed for some evaluation of the seminar and for suggestions for further meetings.

1 THE NATURE OF LEADERSHIP

Opening address

John Garnett

The leadership element of management has never been more important in the United Kingdom than at the present time. It is particularly important in the area of healing and social service where people are continually having to give of themselves. If they are to give in this way they must have support and encouragement.

Leadership can be most appropriately defined as the actions necessary to call forth the gifts of each individual and to help individuals work together in teams in order to achieve the task.

The concept of leadership and the leader is so often denigrated because it is connected with old fashioned concepts of authoritarianism, paternalism, squirearchy, birth, education, and the supervisor breathing down one's neck. Yet those who have worked in organisations know from experience that a key factor in the commitment of people to their work and the extent to which they work together depends on who is the immediate leader of the group, whether it be the ward sister, the section leader of the cleaning team, or the foreman in a factory.

Considerable attention has been given to ways of developing the technical abilities of people, and explaining to them exactly what they should do in order to manage the financial and technical resources for which they are responsible. However, when it comes to helping people to involve others and to achieve their commitment to work we seem to have been highly unsuccessful. We have been caught in the crossfire of the theorists, who only wish to analyse problems and not seek the answers, and those who by studying the concepts of leaderless or autonomous groups seem to wish to deny the role of a leader at all.

The evidence however is that the role of the leader at every level becomes more and more important as organisations get bigger, particularly, as in hospitals, where there is a national structure, where unions become more widespread and where some of the old economic disciplines of the need to earn money and respect for authority have become less.

The remainder of this paper is concerned with

The leadership structure of organisations with particular reference to healing;

the training and development of the leader;

the activities a leader needs to carry out;

the operating actions necessary to make the leadership more effective;

the common aim.

STRUCTURE

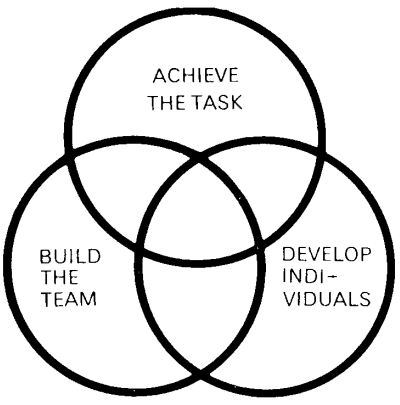
If people are to be involved they will need to work together in teams. There will therefore need to be a leader of that team who is accountable for calling forth the gifts of individuals and getting the team to achieve the task. Evidence suggests that such teams should consist of less than 18 individuals to each leader and preferably more than 2 or 3. Each team leader in his turn needs to be part of a similar sized team.

For example, at University College Hospital in 1972 the limit on healing was determined by the number of cleaning staff that could be retained. When the cleaners were organised in teams of 14 with a leader to each team the numbers that could be retained rose from 150 to the cleaning establishment of 270, and the limitation to healing was removed. Where, by the nature of shift rotas and the like, people work for different leaders at different times it is vital that each person should feel they are in a particular person's team even though they do not always work for that person.

TRAINING AND DEVELOPMENT OF THE LEADER

There has been much debate on how leaders are best selected and trained. If one <u>is</u> an effective leader one will clearly do effective leadership things. The problem however is that if you are not, how do you <u>become</u>. The evidence is that leaders become more effective by being trained to carry out leadership actions, and as a result of <u>doing</u> they become.

The simplest known concept is that the leader needs to achieve the task, build the team and develop individuals. These activities are not alternative but complementary to each other, and may be expressed as three overlapping circles as suggested by John Adair.



After: John Adair

The training, which may amount to only 12 hours input, consists of a group with an appointed leader in charge of four or five people. They are then set a task to carry out. This could be building a tower, sorting out a jigsaw puzzle, or obtaining the best possible answer to a problem in a discussion. The remaining people being trained then analyse the actions of the leader under the headings of building the team, achieving the task, and developing individuals.

It will also be necessary to discuss with the training group the most practical ways of carrying out the necessary leadership tasks which are set out in the next section.

The training period ends with an action session at which each person writes out what he is going to do to improve his leadership when he gets back to his job. These actions are monitored six months later.

THE ACTIVITIES A LEADER NEEDS TO CARRY OUT

The things that leaders need to do in order to become more effective are the very activities of all the great hospital administrators, matrons and senior physicians of the past. All those who have had the privilege of working under such people have learned these activities and no doubt thought they were always an intrinsic part in themselves. The fact is that these very simple actions need to be set out and consciously taught and trained for now more than ever. In ten simple points they are:

Do I

1 Set the task, plan the work and pace its progress

2 Make leaders accountable for teams of 4-18; give all leaders instruction in the three circles

3 Set individual targets after consulting; discuss progress with each person at least once a year

4 Design jobs and work so as to encourage the commitment of individuals or small teams

5 Delegate decisions to individuals. Where I take decisions do I consult those affected first

6 Communicate the importance of each person's job; explain decisions to help people accept them; brief team on progress, policy and people monthly

7 Train and develop people especially those under 25; make clear the rules and procedures we work with and 'have a go' at those who break them

8 Where unions are recognised, encourage joining, attendance at meetings, standing for office and speaking up for what each person believes is in the interests of the task, team and individual

9 Care about the wellbeing of people in the team; deal with grievances and attend functions

10 Monitor action; learn from successes and mistakes; regularly walk round each person's place of work, observe and listen

As an example of taking any one of these headings and putting it out more fully, let us take number 5 on decision taking.

DECISION TAKING

The leader will need to see that the necessary decisions are taken. These will need to be the best possible decisions taken at the right time and with the greatest commitment to action after the decision is taken. It is worth noting here that the most highly motivated decision is one that a man takes himself and therefore authority should be delegated wherever possible to each individual to take his own decisions. Where, however, a decision is needed that affects the group as a whole, the leader of that group will require to take the decision himself. Before doing so he will need to consult those affected to get their ideas, and after taking the decision explain to them 'why'. The only valid reason for not consulting is on those few occasions when time does not permit.

It is doubtful whether a group decision (or the consensus) is one which motivates the group. There are elements of manipulation in a decision taken this way and it is not clear who is accountable. It is usually far better for the leader first to consult those concerned, then to make up his mind, and finally to explain why and ask for people's cooperation.

In life there are three positions people can take: 'I agree', 'I disagree', and 'I don't necessarily agree but I will go along with it because somebody has got to decide, that is the leader's job, and he has bothered to ask my view and explain his decision to me'. This is the difference between management by consent and management by agreement. There is a large number of decisions about which people do not have to agree but are prepared to cooperate with, even with enthusiasm, if they feel their leader has made a sincere effort to seek their views and to get their cooperation.

The leader will obviously collect all the relevant material he can before taking a decision. However, there is a vital need not to be so bogged down by information that one no longer has the courage to take a decision. There is the grave danger of 'paralysis by analysis'.

If a leader is to take decisions at the speed necessary he will periodically make mistakes. It is for this purpose that it is important to have grievance mechanisms in organisations and people should be encouraged to use them. When the leader has made a mistake he will admit it openly, apologise, and press on with a new answer.

OPERATING ACTIONS NECESSARY TO MAKE LEADERSHIP MORE EFFECTIVE

Example is not enough to ensure effective leadership at every level. Of course one must try to practise the policies that one advocates but more is necessary. Perhaps the most important additional things to training the leader are to have an adequate method of communicating the 'what' and the 'why' to everybody in the operation, and to use the leaders at each level as the prime communicators: he who communicates is he who leads. There will be an increasing need for elected representatives to get the views of people carrying out the work to the levels where decisions are taken, but the very existence of representatives and consultative committees underlines the need for systematic communication to and through each level of leadership.

The most effective known system is that of briefing groups. Everyone in the organisation at every level is communicated with in a system which meets five principles.

1 Face to face

2 In small linked teams of between 4 and 18 people

3 Through he who is accountable for the group

4 On a regular basis

5 The matters for discussion being the 'what' and the 'why' of those matters which affect people's will to work, that is

Progress

People

Policy

Other points

Along with this 'drill' of briefing there needs to be other monitorable drills concerned with target setting, the existence of accountability charts, and walking the job at every level.

THE COMMON AIM

We can only give of our best and commit our gifts to the task if we can see a common aim running through our work. Of course we are concerned with our own earnings, our convenience and that of our families. However, the organisations which have been most successful are those where the leadership at every level has continually stressed the common aim. Whether one is cleaning the ward, washing the dishes, or driving at unearthly hours, the common aim is the service, through healing, of our fellow men and there can be no more worthwhile common aim than that.

All of us who are accountable for the leadership of an organisation will need to continually stress that common aim, and see to it that those at every level are given the drills and the encouragement to do likewise.

DISCUSSION

As a preliminary to discussion of leadership in nursing, the steering committee thought it would be helpful to look at the nature of leadership in more general terms. The lively and stimulating presentation of the introductory paper encouraged the delegates to explore the subject extensively. Wide ranging discussion was provoked and even if, at the end of the first morning, the nature of leadership was still not crystal clear, at least a multiplicity of ideas had been aired to provide a background for detailed consideration, during the rest of the week, of leadership in relation to nursing.

DEFINITION OF LEADERSHIP

Leadership was defined in the introductory paper as 'the actions necessary to call forth the gifts of each individual and to help individuals to work together in teams in order to achieve the task'.

There was little disagreement about the activities of leaders as listed in John Garnett's paper or as illustrated in the three overlapping circles of achieving the task, building the team and developing individuals, though several points were elaborated upon. The need to 'walk the job' was duly noted and the point accepted that the nature of work demands much hard, slogging routine. The leader's use of time was discussed again later in the week.

The idea that the leader is identified by his actions not his attributes raised questions throughout the seminar. Delegates asked themselves whether the personality of the leader mattered. Must a leader have integrity and idealism?

Who will be elected or followed as a leader seemed linked in people's minds to personality characteristics. The question recurred whenever selection of leaders or evaluation of leadership was under consideration. Machiavelli was said to come nearest to describing the balder truths about leadership techniques. All leaders it was suggested employ 'spies' and 'listen to gossip'. A leader's day-to-day activities might be construed as intrigue or manipulation. This was not necessarily bad or immoral. No leader could honestly say he did not employ such tactics. Florence Nightingale was quoted: 'When I entered into service here, I determined that, happen what would, I never would intrigue among the committee. Now I perceive that I do all my business by intrigue.'*

'The task' was alternatively given as 'a common goal', 'desirable goal', 'common task', 'common cause', 'common aim'. The aim might be 'good' or 'bad'. It was recognised that the common aim had to be stated in very general terms to command common support. Resources would always be limited and in considering means to achieve the generally recognised end there was room for different views about priorities or the comparative effectiveness of different approaches.

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*Harley Street Apprenticeship.

The leader should have a clear view of the common goal of the group whilst maintaining options on means of achieving the goal and remaining opportunist in advancing towards it. In helping individuals to work together in teams to achieve the task, the leader had to differentiate between the common goal of the group (for example, providing quality health care) which unites group members and the like goals of individuals (for example, for promotion, training, higher pay) which are divisive. The leader must strive to accommodate legitimate individual goals in the pursuit of the common goal.

Some delegates included the use of power and influence to achieve the common goal in their definitions of leadership. Leaders might be elected, appointed or grow out of the needs of the moment and function in formal or informal social structures. It was noted that in a formal leadership structure it was inappropriate for the leader to be elected though nomination to a short list was an acceptable practice. Leaders might rely for their influence or power on one or more of the following factors: birth, education, wealth (thought to be declining influences); authority derived from law, an hierarchical management structure or other formal social structure; position at the centre of a communication network; or such more personal factors as outstanding knowledge, enterprise, willingness to take risks and bear responsibility, skills as facilitators, or the capacity to interpret and represent the group's aims and needs.

Leaders would have different styles of leadership and different styles might be needed in different spheres of action, or in crisis/routine activities or in individual or joint leadership positions. Leaders might use a variety of tools; communication, persuasion, praise and blame, other rewards and sanctions, social pressures, exclusion from the group.

The question was raised 'Who motivates the top leaders?'. It was thought that in a large organisation leaders were motivated by a higher level of leadership. At the top the leader was motivated by internal forces, or by his followers. He had also committees, colleagues, peers and precedents to assist his internal motivation. It was noted that it was not only the 'top' leader who depended on internal motivation. The needs of leaders for support groups was also commented upon.

In the opening paper the point was made that 'it is doubtful whether a group decision (or the consensus) is one which motivates a group ... and it is not clear who is accountable.' This was seen to be of particular significance in the current context of decisions taken by a team of managers where it was possible for one of the team to back down on decisions which proved later to be unpopular.

Conflict was seen as an essential ingredient of progress. Organisations had to accommodate open discussion and differences of opinion. The leader had to listen and consult before taking decisions. It was not necessary and might not be practicable to obtain a consensus which indeed usually involves a degree of manipulation but consent to policies should be obtainable. It was part of management and part of leadership at all levels to work loyally for the success of decisions once consultation had taken place and a decision reached.

EMERGENCE OF LEADERS

Leadership talent could be developed. A small proportion of any population would show special aptitudes or none but the majority would need to, and be able to, learn leadership skills. Courses designed to change attitudes were condemned as worthless but leaders could learn what they had to do. Clear responsibility rested with leaders to give opportunities to the 'up and coming' members of the group to deputise and to gain experience 'by doing'. The importance of regular briefing at all levels was emphasised. 'Nellie' made her entrance at this point and stayed on stage for the rest of the week. 'Sitting next to Nellie' to learn the job by watching someone already doing it was thought to be useful in a leadership context - if 'Nellie' was herself a great leader. Decision-making could not be learned this way. Decision-making could be learned only by making decisions. The importance of having actually done lowly jobs oneself for at least 18 weeks consecutively received attention. A leader had to be able to say 'I know' not 'I have been told'. 'Walking the job' was also seen to contribute to this end. Involvement was said to be the key to successful learning.

ENVIRONMENTAL FACTORS

It has already been noted that different circumstances may call for different styles of leadership. Leaders have also to accommodate change and function in the world as they find it. For example Marx's maxim 'to each according to his need' was in process of realisation but when rights and duties parted company and carrots and sticks were discarded how did the leader call forth 'from each according to his ability'?

Modern methods of data-collection and processing could lead to a condition of paralysis by analysis. It was pointed out, however, that if data-collection was used as a screen for avoiding making decisions, paralysis could lead to analysis rather than the reverse.

In a number of trade unions changes had occurred in the structure. The old triangle with the general secretary at the top making decisions and instructing members to conform had been reversed. Members now instructed the union leaders.

Changes had occurred in the size of enterprises. Small might be beautiful but large might be an economic necessity. The role of leaders at every level could become more and more important as organisations increased in size. Size brought many problems in its train. It was difficult for those in lower echelons to understand what was going on. There might be great activity at the top but stagnation at the bottom where people felt unloved, unled, unwanted. A crucial question was: How many people could a leader lead? Exodus recorded that the people were ordered by tens. There were twelve disciples. Man could not expect to do better than half as well again as God. Eighteen was the maximum number of followers with whom one leader could be involved. It was essential that everyone knew who was his leader and that leaders were held responsible for each member of the team. Regular

briefing at every level allowed each man to know his target; his achievement could be monitored for progress towards the agreed goal.

EVALUATION

The problem of evaluation was virtually bypassed at this early stage of the seminar. It emerged that actions not persons were being evaluated. Effective leadership was identified by successful accomplishment of the group's common aim. Because the aim might be 'good' or 'bad' effective leadership might look different from different points of view. The importance was recognised of setting individual targets and monitoring progress towards them.

The general outline of the nature of leadership, which was sketched in during the first day of the seminar, left many questions to be discussed in the course of its application to leadership in nursing.

2 DEFINITION OF THE ROLE AND RESPONSIBILITY OF NURSES FOR LEADERSHIP

I THE NURTURANCE OF LEADERS

Dorothy J Kergin

One cannot consider the role and responsibility of nurses for leadership in the health care system without taking into account how that system is changing and the likely direction of future changes. Those who are now in key positions within the hierarchy of decision-makers, either with health services delivery or with health sciences education or research, have a responsibility to nurture those who will be tomorrow's leaders.

As members of highly industrialised countries, we are buffeted by changes that affect all realms of our activities. Toffler (1971), analyses the probable effects, on man's capacity for adaptation, of the tremendous acceleration in the rate of changes that affect all aspects of human life; accelerated changes that bring with them a sense of impermanence or transience

> 'that penetrates and tinctures our consciousness, radically affecting the way we relate to other people, to things, to the entire universe of ideas, art and values.' (p. 17)

Two important characteristics of society to which we are already subject are

1 The centrality of knowledge and the dominance of scientists, economists, computer technologists and engineers, including those who work in terms of human systems. This centrality of knowledge may involve a control of information sources, including the kinds of data that are collected.

2 An increased role of government in dealing with the problems of industrialisation and in capitalising upon the social consciousness that has accompanied recognition of these problems.

A report (Porter 1971) that examines the future of post-secondary education in the Canadian province of Ontario indicates that

> 'Already the rapidly expanding sectors of the economy are non-industrial ones, and this is likely to continue as governments at all levels assume greater responsibilities in the planning and direction of social change.' (p. 3)

In the health sector in Canada, we are well aware of subtle and not-so-subtle strategies that are redirecting health care priorities in accord with proposals contained in Lalonde (1974). This document

introduced the health field concept, describing four principal elements - human biology, environment, lifestyle, and health care organisation. One sees its influence, for instance, in the federal government's thrust into programmes in physical fitness and, in Ontario, measures to decelerate growth in the hospital sector. That the latter is not unique to Ontario is clear. In a recent issue of The Canadian Nurse, a nurse administrator from Alberta describes the dilemma of being caught between federal and provincial economic measures, that constrain the operation of nursing service departments, and rising demands for health care services (Harrison 1976). We are not being subject to winds of change, but to gusts!

If nursing is to respond to the challenges that these changes present, the profession requires leaders who are conversant with the language and concepts used by the scientists, economists, and engineers who are advisers to and often members of government policy-making bodies. At the middle management level (head nurse), the profession requires nurses who know how to use the expertise of others, including statisticians and consultants on budget and staffing as well as clinical resource personnel.

Recently, it was refreshing to read the report of a task force, commissioned by the Province of Alberta (1975) 'to prepare a framework within which the planning and coordination for the education of nursing personnel in Alberta can be carried out' (p. x): refreshing because the task force began its analyses with an examination of present and probable future demands on the health service system and from this developed its rationale for nursing education. The important changes in health services now being initiated, as summarised in the report, are

> improved and extended primary care services,
>
> increased emphasis on health promotion and maintenance, and on community and home-based care,
>
> an increased interdisciplinary health-team approach in health service delivery, and
>
> increased sophistication and specialisation in acute care settings. (pp. 23-24)

As a result of its examination of health service needs and the contribution that nursing makes (or should be expected to make), the task force developed several assumptions, upon which it based its recommendations. Among the assumptions is

> 'a need for nurses who will reach greater degrees of specialization in the provision of services, through the development and application of nursing knowledge in:
>
> a the administration of nursing-care delivery systems within hospitals and community-care settings;
>
> b the education of health personnel and consumers;
>
> c the management of people along the health/illness continuum;

d research in nursing practice.' (p. 37)

The task force thereby identifies the key points in the system in which leadership by nurses must occur. While it also follows this assumption with a recommendation that individuals be prepared for such responsibilities through masters and doctoral degree programmes, graduate education alone cannot solve the problems of leadership.

If one considers 'role' to be a set of expectations, held by significant others of the incumbent in a position, then members of the nursing profession must expect that each of its present-day leaders will develop effective strategies to deal with current restraints and reordered priorities. Harrison (1976) advises us: 'Survival in terms of maintaining the quality of patient care under tight budgetary control will be a great challenge in the months and years ahead'. Fully to reflect the challenges facing health science programmes in the university, one should add to the phrase 'quality of patient care' both 'quality of education' and 'quality of research'.

It is likely that professional organisations in most countries are wrestling with the major problem of how to assure the public that members of their profession are competent to practise, and continue to be competent throughout their professional lives. As Argyris and Schön (1974) affirm, competence requires a foundation which is essentially the capacity to learn how to learn. Because no profession is truly autonomous, these authors propose that competence in the interpersonal areas of practice is as important as competence in the more profession-specific areas of technique. (pp. 163-172) This is especially true for professions in which interaction with clients is required in order to carry out the professional tasks. In nursing, particularly in preparing nurse leaders, these three types of abilities share equal importance - self-learning ability, interpersonal skills and those skills required for effective practice. Along with responsibilities to moderate the effects of restraints on programmes and to maintain quality with shrinking resources, a major obligation of today's leaders is to nurture those who possess these three abilities as well as the potential for effective management of systems.

Educational programmes for all levels of nursing personnel should feel a strong responsibility to sensitise their students to the characteristics of effective leadership. Along with emphasis upon the three abilities mentioned above, this sensitisation should include the development in students of a strong sense of accountability for their own actions. Because of the nature of nursing practice, such learning can only occur through the joint participation of those whose primary role is teaching with those whose primary role is clinical service, for it is in the practice environment that students learn how to manage patient care within the contraints of the delivery system. In addition, clinical personnel have a right to expect that educators will ensure that graduates of the various educational programmes will

1 Know what is and how to support effective leadership (all levels of educational programmes).

2 Have beginning decision-making skills for practice in a health care organisation, including the ability to identify components of nursing care and share

responsibility for providing effective care with other team members (diploma and basic degree level education). In addition, graduates of university degree programmes should know now to assess the capabilities of others - patient, family, nursing assistant, diploma-prepared nurse and other members of the health care team - so that they can delegate, effectively those aspects of care that can be carried out appropriately by others.

3 Know how to analyse health care systems in order to identify levels of decision-making and the kinds of information that must be available in order to make decisions at various points in these systems (degree-level education).

4 Demonstrate effective leadership behaviours* (master's level education).

Along with accountability for one's own decisions and actions, leadership at any level involves a certain amount of risk-taking, including the risks involved in directly confronting others. After all, one's decisions may not lead to the outcomes that were intended, or others may not believe that the outcomes proposed are desirable. At the admission stage of basic nursing programmes, there seem to be no measures that identify those applicants who will be confident 'risk-takers', in fact, there are not effective measures that predict success in any areas, except 'academic' success. Because of this, teachers and students both have difficult tasks of evaluation. Realistic evaluation must be done as each student strives to achieve behavioural expectations that concern responsibility for self-learning and self-evaluation, accountability for one's own behaviour, individual problem-solving abilities, and participation in group problem-solving and action. Until satisfactory intake or admission measures are developed, our basic degree programmes may experience higher attrition rates as increased emphasis is placed upon demonstration of these behaviours. However, the outcome will be an increasing proportion of graduating classes with true potential for leadership.

Briefly, educators have a responsibility to describe, for students, realistic behavioural objectives that are related to leadership characteristics, to assist students to achieve these objectives, and to encourage those students for whom the expectations are unrealistic to select another career.

In the employment setting, newly graduated nurses should be challenged by similar expectations, lest these behaviours become extinguished. Nurturance must be of a type that fosters independence, not dependence; self-learning and self-direction, not prescribed learning and unquestioning adherence to procedural guides; and constructive challenge of institutional goals, not capitulation to them.

This nurturance must also be accompanied by realistic appraisals (by self, superior and others) of both strengths and limitations.

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* Since leadership behaviour is a subject of another paper and extensive discussion at the seminar, it will not be described here.

Appraisal methods need to be sensitive enough to identify when further growth of an individual in a particular organisation is no longer possible or when the individual is no longer performing competently.

Many managers find it difficult to document evidence of incompetence, for measures are frequently imprecise and subjective. As well, personnel policies are often such that they protect the incompetent as well as the competent. In universities this is called 'tenure' but the development of unionised employee groups has provided the same kind of protection in other organisations. Policies are needed that will shield the competent, innovative risk-taker from retaliation but also permit the removal from positions those individuals who have exceeded the level at which they can function competently.

Nurse leaders occupying key positions in any type of health-related organisation have one additional responsibility: to identify nurses who show promise of leadership and move (sometimes push) them forward. Through delegated responsibility, these nurses should be encouraged to test out their problem-solving and decision-making skills in more and more complex situations. Unless this is done, nursing in Canada will face a leadership crisis. Even now, we do not seem to have sufficient numbers of nurses to engage participatively in decision-making with other top organisational and governmental planners; nurses who possess a breadth of understanding of health and educational systems, a personal willingness to take risks, and an ability to analyse systems problems, combined with an ability to develop, articulate, and implement realistic solutions to these problems.

Among the reasons for this may be the fact that we have allowed the development of administrative leaders for health services and health sciences education to receive lesser priority than the development of clinical experts. A number of the latter will be found in positions as clinical specialists and university teachers. Many of these positions require minimal 'hard-nosed' decision-making and some can provide havens for those who are ready to encourage risk-taking by others from the relative safety of a non-line or non-decision-making position.

Those who are today in positions of influence with respect to the nursing profession as a whole or within health service or health sciences education programmes have two prime responsibilities.

> To provide the leadership which is needed now.
>
> To assist in the development of those who will assume the leadership tasks of the next decades.

Neither of these responsibilities can be met unless there underlies them a sound understanding of the health system, its problems, its priorities, and its future directions; along with ability to initiate strategies to achieve change. We talk much in nursing about 'practice role models'. What is needed are more, visible, articulate 'leader role models'.

REFERENCES

ALBERTINA. The Alberta task force report on nursing education. Edmonton, Alta., Ministry of Advanced Education and Manpower, 1975. pp. i-190.

ARGYRIS, Chris and SCHON, Donald A. Theory in practice: increasing professional effectiveness. San Francisco, Jossey-Bass Publishers, 1974. pp. vii-224.

HARRISON, Fernande. A contemporary dilemma in nursing administration. Canadian Nurse, vol. 62, 1976. p. 19.

ILLICH, Ivan. Medical Nemesis: the expropriation of health. London, Calder & Boyars., 1975. pp. 9-184.

LALONDE, Marc. A new perspective on the health of Canadians. Ottawa, Department of National Health and Welfare, 1974. pp. 5-76.

PORTER, John, and others. Toward 2000: the future of post-secondary education in Ontario. Toronto, McClelland and Stewart, 1971. pp. xi-176.

TOFFLER, Alvin. Future shock. New York, Bantam Books, 1971. pp. 1-561.

UNITED STATES, Public Health Service. The decanal role in baccalaureate and higher degree colleges of nursing. Washington, Division of Nursing, 1975. pp. 1-59.

WISE, Harold, and others. Making health teams work. Cambridge, Mass., Ballinger Publishing Company, 1974. pp. xiii-174.

REPORT OF DISCUSSION GROUP I

Reporter: B Champney, Members: L Besel, D J Kergin, J McFarlane, E M Reese, M E Walsh

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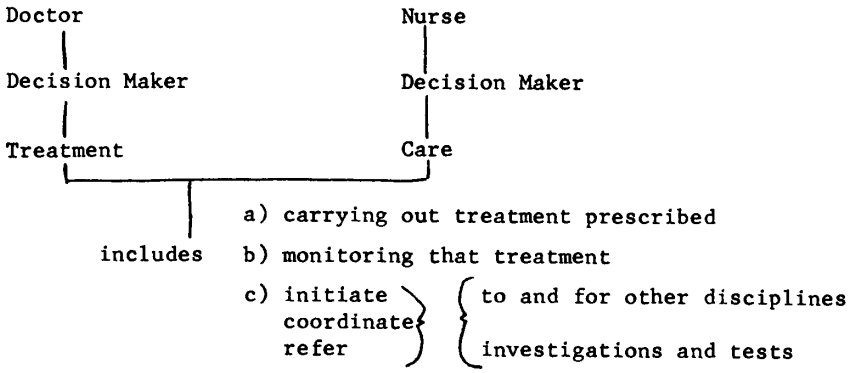
There will be different structures or patterns of leadership in different situations; for example, that in long term care will differ from that in the more acute/intensive care situation. The same structure of leadership will not be suitable for each nurse in a similar situation for it will vary at different levels; for example, head nurse/charge nurse and supervisor levels.

In the hospital situation there is more interaction of doctor and nurse as leader, for example in decision making.



Whereas in the community situation the nurse has more of the leadership role. Here, the nurse as leader, in addition to the nursing care aspect,

1 interprets and implements the medical plan of care

2 coordinates other activities, for example of other therapists

3 supports and assists the family to continue the care in her absence.

LEADERSHIP FUNCTIONS IN MANAGEMENT

1 Decision making - problem identification
gathering of data
the action, and exploration of alternative actions, with the possible outcomes

2 Assessing and evaluating staff

3 Communication skills

4 Interpersonal relationship skills

5 Task - definition
planning
personnel commitment to the task

6 Competence in the relevant clinical area to be able to exercise sapiential authority and to achieve and maintain credibility

7 Ability to supervise and evaluate performance

8 Constant search for new ideas of giving care (which might involve to some degree research studies)

TRAINING AND PREPARATION FOR LEADERSHIP AT FIRST LEVEL

If the newly qualified graduate nurse is expected to undertake leadership at this first level, she must be prepared for this before qualification, and she must have been given the opportunity to practise these skills before qualification.

Various teaching methods might be employed, but it cannot be only theoretical. She/he can learn by doing and seeing what others do in the work situation. 'Sitting next to Nellie' - the role model. But we must be careful in the selection of the role model. (Choose your Nellies with care!)

Role play - based on reality - if you have the staff with this ability. Care conference - again, based on reality - will permit an insight into another's leadership performance.

EFFECT OF POLICY AT A HIGHER LEVEL

As a leader she should be able to identify those things which will assist her in the process - and at the same time recognise the constraints.

THE LEADERSHIP RESPONSIBILITY OF THE EDUCATOR

It must be acknowledged that there is the power - for good or for evil - of those who teach.

There must be teaching for reality - perhaps another example of 'moral leadership' - but teaching for reality is essential because of the risk of increasing the discrepancy between what is practised in the clinical situation and what is taught in school.

The educator must have the power to influence change in the practice of nursing skills.

She must be able to demonstrate the importance of continuing learning and steer her students along the path.

In recognising that as an educator she can exert a great influence upon future generations of nurses, she must also appreciate that she possesses the power to determine the future professional progress and career of each student.

But - it must nor be fotgotten that educators have also to be trained for their role - and the preparation of teachers for their leadership role must not be neglected.

2 II NURSES IN MANAGEMENT POSITIONS AND AS ADVISERS AND CONSULTANTS

John Greene

In the presentation of this paper I am attempting to relate the general subject of the title to the particular aspect of leadership in management positions and in advisory or consultative posts. The paper will not be an academic exercise nor will it relate to any piece of original research. It will be based almost entirely on the author's personal experiences and impressions in a variety of management and advisory situations.

It is not possible to proceed very far without going back to the beginning of nursing in the United Kingdom and referring briefly to the development of leadership in modern nursing over the span of the last hundred and twenty years. Inevitably the Florence Nightingale era is a starting point because it was from her and from her disciples that nurses emerged as leaders in their own profession and in setting standards for the actual nursing of patients. It is unnecessary to dwell upon the early struggles, they have all been recorded elsewhere - the struggles for recognition, the struggles for training, the struggles for freedom from medical and bureaucratic domination and the establishment of nursing as a profession in its own right.

From the end of the nineteenth century until fairly recent times it was the nurses in charge of hospitals who were in the strongest position to influence and to lead opinion in nursing, and for many years there was a number of settings in which they operated:

1 the London and provincial large medical teaching hospitals;

2 the voluntary hospitals without medical school attachments built by public subscription and maintained by endowments;

3 the cottage or small hospitals built and supported by local communities;

4 the public institutions supported by local rates for the elderly and the sick poor;

5 the lunatic asylums serving large populations financed and maintained by local rates and grants from central government;

6 private institutions or hospitals run by their owners for profit;

7 hospitals managed by religious communities.

The private and public institutions on the whole did not create a setting from which nurses could emerge and develop a leadership role as these institutions were mainly managed by medical administrators. There were some exceptions where individual nurses played a dominant role.

It was perhaps the matrons of the London and provincial teaching hospitals who were in the best position to provide leadership and a great many of them have gone down in history as leaders in nursing and a powerful influence in its professional development.

In contrast to the leading nurses of the teaching hospitals were the matrons of the hundreds of small hospitals who were to a lesser but important degree establishing nursing as a profession in rural areas and small towns, and providing leadership in the actual management of hospitals by the nurses themselves. The struggles already referred to led eventually to the formation of professional organisations and to the establishment by Parliament of a statutory training and disciplinary council for nurses.

At an early stage the Association of Hospital Matrons was formed which was to exercise considerable influence in the years that followed.

The year 1946 saw the introduction of one massive piece of legislation, Great Britain - Parliament (1946), through which all the hospital services came under the direct control of the Minister of Health, with the exception of the hospital medical schools which retained a considerable degree of autonomy and independence. England was divided into fourteen regions and regional boards appointed to manage the hospital service on behalf of the government. Below the regional hospital boards were hospital management committees appointed to manage groups of hospitals on a specialist or geographical basis. The size of groups varied from one or two hospitals of, say, 100 beds each, to large groups of hospitals of two or three thousand beds. Each hospital tended to have its own matron who was directly accountable to the management committee. Exceptions were in the hospitals for the mentally ill and the mentally handicapped where a medical superintendent had a statutory function controlling all aspects of the hospital and its staff.

Despite the growing emergence of nursing as a profession there were feelings among nurses that they were in an inferior position in relation to their medical and administrative colleagues in the hospital service.

At this stage it is important to mention the development of community nursing services. Beginning in the early days as employees of private and voluntary bodies they gradually came under the control of the county authorities. An organisational feature of the transfer from private to the public sector was that they now came under the direct control of the medical officer of health.

The National Health Service Act of 1946 did not integrate all nursing services, and this meant that hospital and community nursing remained administratively apart until 1974.

The question of leadership by nurses in management positions first received serious attention when the Bradbeer committee report (1954) commended a tripartite system of administration in the hospital service in which nurses, doctors and administrators would share euqally in management decisions in the hospital service.

The recommendations, however, did not receive the attention intended and several years later the Salmon committee (1966) in taking evidence found that only lip service was paid to the concept of nurses being equals in the management of hospitals. Their roles as advisers, consultants and managers were not being recognised. Though in all situations there were exceptions, and some nurses achieved a remarkable degree of autonomy in managing nursing affairs and also in influencing other policy decisions in their hospitals, general dissatisfaction with the system remained.

The Committee on the Senior Nursing Staff Structure in the Hospital Service (Salmon) in its report published in 1966 recommended a restructuring of the nursing service in hospitals and for the first time attempted a definition of the roles and functions of nurses in the grades of ward sister and above. A key recommendation was that in large groups of hospitals nursing should be organised on a group basis and a chief nursing officer should be appointed to control and/or coordinate all nursing services in the group. The chief nursing officer should be responsible direct to the employing authority and not to any individual medical or administrative officer. Although the recommendations left it open for the chief nursing officer to control some aspects of the nursing and to coordinate others, employing authorities and nurses all accepted the concept of control rather than coordination even when the chief nursing officer was not qualified in all the branches of nursing involved. It must, however, be acknowledged that although those in teaching posts were somewhat less than enthusiastic about being controlled by a non-teacher, there is no evidence of a refusal to accept the arrangement.

Following the implementation of the Salmon committee recommendations, nurses in the hospital service became firmly established as managers of all the nursing services and nurse training in hospital groups. Below the chief nursing officer were principal nursing officers who headed divisions of midwifery, psychiatry, general nursing and nursing education.

Nurses in the community nursing services seeing the autonomy now accorded to their hospital colleagues pressed for the same status. This was achieved from the recommendations of the Mayston report (1969) which gave directors of nursing services an equivalence with their hospital colleagues and direct control over the nursing, midwifery and health visiting services in the community/public health services.

While the two new systems of nursing administration in the hospital and community services developed, the post of hospital matron gradually disappeared, but most incumbents emerged with new grades and new titles in the Salmon nursing structure. The essential change being that a great many people who had previously been in charge of their own hospitals and specialisms now became subordinate and under the control

of a top nurse manager. The top nursing managers by virtue of their structural authority became leaders of nursing in the hospital and community nursing services.

It seems a logical step to go on and mention the reorganisation of the National Health Service in 1974. Allowing for some differences in the implementation of this in England, Scotland, Wales and Northern Ireland, this was a very significant stage in the development of nursing leadership in the United Kingdom. The Act and the interpretations that flowed from it placed nurses in a position of executive authority as equals with doctors, administrators and treasurers. Decision making would be by concensus and the teams of equals would be directly accountable to the chairman and members of the health authorities at regional and area levels. However, in one important aspect equality was not achieved in that the nurse member of the team in all situations received the lowest salary and the difference between the doctor and nurse was as much as twenty per cent. A factor that could not by any standard convey the full meaning of equality and gave the impression that some members of the team were more equal than others.

Despite some feelings of inferiority as a result of the salaries structure, the potential for nurses to exercise leadership has never been greater. At the Department of Health and Social Security, the chief nursing officer occupies a position of enormous responsibility and her influence upon the whole course of health service development is well recognised by the members of her own profession, by other disciplines in the Department of Health and by the ministers responsible for health matters.

The chief nursing officer is assisted in her work by teams of nurses who function as advisers in specialised fields of nursing, in policy formation, planning, and personnel matters from which the Service receives the national guidelines that are mainly advisory but sometimes directive. It is noteworthy that the chief nursing officer is no longer regarded by the nursing profession as being subordinate to the chief medical officer at the Department.

A matter that gives satisfaction to the nursing profession is the way in which the chief nursing officer draws upon an independent advisory committee - the Standing Nursing and Midwifery Advisory Committee of the Central Health Services Council of the Department of Health and Social Security - for advice on major matters of nursing and health service policy. This Committee has in its own process of evolution emerged from being a multidisciplinary one deciding nursing policy into one in which the profession is responsible for making up its own mind and giving leadership on professional matters.

A welcome feature of the new National Health Service is the establishment of similar advisory bodies at regional and area level containing a cross-section of nurses, midwives and health visitors from all levels of the Service.

In the reorganised Service, the geographical regions in England now embrace all aspects of the Health Service. Each regional team of officers has a nurse member. It is to the regional nursing officer that all nurses in the regions look for leadership and there is no doubt that this position calls for leadership of a very high quality. A nurse in this situation has to have the confidence and approval of the several nursing staff in the operational parts of the Service. Her nursing role is primarily that of an adviser to the Regional Health Authority and to the nurses in the region, but she controls no staff other than her nursing staff officers concerned with planning, personnel and education. It is in her capacity as a nursing member in a team of equals that her influence is paramount in the nursing profession and to the Health Service, particularly in relation to the allocation of capital and revenue moneys, the selection of priorities and the monitoring of nursing activities in the region.

Below the region is the area tier of health service management, roughly one for each county in England. The Area Health Authority consists of the chairman and appointed members and an area team of officers - an administrator, a nurse, a doctor and a treasurer.

In England, the area nursing officer is in an unusual situation when compared with her counterparts in Scotland and Wales. She is like the regional nursing officer, a member of a team accountable to the chairman and elected members of the health authority, but not directly responsible for the services in the area. This function is discharged by nursing officers of the management teams of the districts, into which the areas are divided for administrative purposes. The district nursing officer is accountable to the chairman and members of the area health authority for the day to day management of the nursing services. She is monitored by the area nursing officer, but is not accountable to her. Very briefly the role of the area nursing officer is a policy forming and a monitoring one while the district nursing officer's role is mainly executive and managerial for it is she who controls and directs the divisional nursing officers in general nursing, midwifery, psychiatry, education and community nursing, and is responsible for the financial expenditure on the nursing service.

It is perhaps with the divisional nursing officer, who is responsible for a specialised branch of the service, that the real responsibility lies for the setting and maintenance of nursing standards at the actual point of delivery in the health care service. It is well to acknowledge that leadership is not the prerogative of senior nurses only at

divisional - hospital or community level

district - health district

area - area health authority/county

region - regional health authority/geographical region of England

DHSS - Department of Health and Social Security

Leadership and advice can be provided at any level of the service from the junior trained nurse at the bedside or in the patient's home, but for the purpose of this discussion only the upper five levels in the nursing structure are mentioned. For convenience I list the remaining five levels.

sector	- senior nursing officer
unit	- nursing officer
ward	- ward sister/charge nurse
basic trained grades	- staff nurse/sister's deputy state enrolled nurse

In referring to the past I have tried to illustrate that leadership in nursing could emerge from any one of the hundreds of hospital matrons. Each was an independent head of her service which ranged in size from a small cottage hospital to a large teaching hospital in London. Hospital grouping did not come about until 1948. Heads of nursing were not structurally organised until 1965 and it was not until 1974 that an integrated nursing service embracing all branches of nursing became a reality.

I return once again to the individual nurses at each of the upper levels of the nursing service.

Chief Nursing Officer DHSS

Is she leader, manager, adviser, or can she fulfil all three roles?

She is not the elected leader of nurses in England since she was appointed by a Civil Service Appointments Board without reference to the quarter of a million nurses in the country. However, the appointing body must have taken into account that she previously occupied some of the highest positions in the profession on the basis of election by nurses and would therefore be an acceptable person to occupy the highest nursing office in the country. She does not manage nurses throughout the country apart from her own personal staff of nurses.

She advises the Secretary of State and government on all nursing matters.

She provides leadership by virtue of her high office and the respect she has had to earn from members of her own profession. She is able to stand apart from nursing and party politics and act as an independent adviser on the delivery of nursing in the health care system of the country.

Regional Nursing Officer

This role can in some ways be related to that of the chief nursing officer, DHSS. She is accountable to the regional health authority for the monitoring of the nursing services in the region and she is also the regional health authority's adviser on matters of nursing and nursing education. She exercises her leadership role by virtue of her ability to persuade area nursing officers to follow a particular course of action. Through her team responsibility for the allocation of capital and revenue funds she can influence action and local policies without the necessity of having to resort to directives.

Area Nursing Officer

The leadership role in situations where district nursing officers exist is essentially a persuasive and policy making one. She can monitor the performance of the district officers but she cannot order them. This places her in a difficult position because she is accountable to the area health authority for her monitoring of the district nursing officer who is accountable to the area health authority and not to her.

District Nursing Officer Managerially responsible for the nursing services in the district, she is in a position of being able to order and control all the nursing staff in her district, irrespective of their nursing speciality. It is perhaps at the level of divisional nursing officer that the leadership role is most effective and indeed the most satisfying. The nurse is working in the speciality of her choice, she has a distinct professional affinity with all her staff and she is responsible for the standards of care delivered to patients or the level of education to nurses in training.

The leadership role of nurses in managerial and advisory positions has been in a state of constant change since modern nursing began in the nineteenth century. There has been a marked extension of an hierarchical structure extending nowadays through several stages from the individual hospital through division, district, area, region and DHSS.

It is very much open to question as to whether the standards of delivery of health care can be measured in order to show whether leadership is more effective under the present system than under previous ones.

The new hierarchy of nursing in England occupies three tiers which carry mainly advisory consultative and monitoring functions and only very marginal managerial roles. A point frequently mentioned is that those who actually manage are deprived of exercising effective leadership because they do not have sufficient control over the allocation and distribution of resources and are subject to an excess of monitoring and advice. They feel that they are left to carry out policies over which they have been unable to exercise the influence which should rightly be theirs.

I was asked in the preparation of this paper to deal with the definition of the role and responsibility of nurses for leadership in a health care delivery system. That I have not defined it must now be very clear to the reader. I hope I have conveyed some impression of the complexity of the leadership role since leadership seems no longer to be the prerogative of individuals but is in fact a responsibility shared by a great many people at different levels of our national nursing service. The aim shared by all is the delivery of a first class service to patients and to the whole community, and to the majority of nurses the question of identifying the leadership role is of secondary importance. However, there is a need for nursing leadership and the Health Service has a responsibility for developing the leadership potential of its nurses and enabling them to function at maximum level. My personal impression is that we have not yet discovered the best method for training our senior nurses as managers and advisers. It is unfortunate that nurses tend to be somewhat ashamed of their management role and hypersensitive to the criticism that in being removed from the bedside they no longer contribute to actual nursing. This conflict begins at the nursing officer level where managerial, advisory and clinical roles become identifiable as distinct elements of nursing administration. This could be one of the most influential leadership situations and I regret that we have failed in the United Kingdom to take advantage of this unique opportunity to demonstrate that all three elements are essential to leadership, to nursing, and to the delivery of health care.

REFERENCES

CENTRAL HEALTH SERVICES COUNCIL. Report of the committee on the internal administration of hospitals. (Chairman, A.F. Bradbeer.) London, H.M. Stationery Office, 1954. pp. 87.

DEPT. OF HEALTH AND SOCIAL SECURITY and SCOTTISH HOME AND HEALTH DEPT. Report of the committee on senior nursing staff structure. (Chairman, B. Salmon.) London, H.M. Stationery Office, 1966. pp. 204.

DEPT. OF HEALTH AND SOCIAL SECURITY. Working party on management structures in the local authority nursing services. (Chairman, E.L. Mayston.) London, H.M. Stationery Office, 1969. pp. 90.

GREAT BRITAIN - PARLIAMENT. National Health Service Act 1946. London, H.M. Stationery Office, 1946. pp. 93.

GREAT BRITAIN - PARLIAMENT. National Health Service Reorganisation Act 1973. London, H.M. Stationery Office, 1973. pp. 102.

REPORT OF DISCUSSION GROUP II

Reporter R C Gabrielson. Members M K Aydelotte, I C S Brown P M Friend, J Greene, J I Jones, H Labelle, W A Lloyd, S Stinson

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Discussion started by looking at the leader as consultant, adviser and manager.

The question was raised - what leadership is needed in various positions?

A group member indicated that in the UK nurses in leadership positions were selected by other than nurses - for various positions. This led to discussions about elected versus selected people for various positions in leadership in the UK. While the criterion of having been elected in a nursing organisation was not the major criterion looked at, there was agreement that this was part of the total 'track record' of achievements reviewed when assessment was being made of individuals seeking leadership positions. While there was some further discussion around the whole point, election to an office was considered relevant.

Some discussion followed about the educational preparation necessary for nurses in leadership positions in various roles - beginning with the team leader to the top executive nurse - who may have a variety of titles. The baccalaureate graduate is prepared for the team leader position. As discussion centred around the fact the professional deals with unknowns and the technical with knowns, it was felt the various executive levels in nursing should be prepared to deal primarily with unknowns and ambiguities.

Further questions were raised:

What mix is needed in leadership? What expectations do we have of leaders in nursing? Do we expect the same thing from everyone? Is this part of the problem? It was agreed it takes different kinds of knowledge for each position - and we make a mistake believing people in various leadership positions perform the same things. Do we really know <u>how</u> to train or educate for leadership?

Discussions ended with more questions than answers.

Because our charge had been to discuss the definition of the role and responsibility of nurses for leadership in a health care delivery system in management positions, as advisers, and as consultants, the group attempted to look at this.

It was felt there is a different emphasis and the functions vary of nurses in management positions or as advisers or consultants. Leadership is related to what one wants to achieve - the goals may change at various levels. The problems we see in leadership in nursing can be related to the problems in society.

The leadership role has to be developed at the ward level. As we look at the various levels of leadership, the boundaries change and at each higher level these become more diffused and complex. It is easier to identify the kind of data needed at the ward level than any other level. More options are available at each level as we go up the tiers in looking at leadership positions.

It was agreed - looking at the ward sister (head nurse) level there is a problem with this nurse relating to the health care team, so education must gear itself to focus on assisting the nurse to do this.

There was discussion about what is the attitude of nurses and non-nurses to those nurses in management positions. It was agreed - because of cultural and societal changes - there has been a denigration of nurses in management positions above the ward sister/head nurse level. Partially, this is a result of these nurses having difficulties telling others what they do and can do. Does the ward sister/head nurse view those above her as helpful and supportive? We then focused on the nurse who is called 'nursing officer' or supervisor. Has the problem been with nurses in this position? There appears to be a credibility gap between the ward sister/head nurse and the nursing officer/supervisor. Role clarification of the nursing officer/supervisor is needed. Historically decisions have been made at the ward sister/head nurse level and in the nursing office so the nursing officer/supervisor has not been making decisions and resolving problems. The question was asked - is the position of nursing officer/supervisor needed? The group responded yes - it is needed because of younger nurses put in ward sister/head nurse positions and part-time.

Is there a credibility gap between the nursing officer/supervisor and the medical staff? It was felt this was true. This problem has also been caused by the fact most nursing officers/supervisors have come from the ward sister/head nurse level and there has been a lack of self-perception and socialisation in this new role. Qualifications and role expectations should be different.

The conflict between the ward sister/head nurse and the nursing officer/supervisor may be in the decisions made. Technical nursing decisions are made by the ward sister/head nurse and the nursing officer/supervisor should <u>not</u> over-ride these clinical decisions but may over-ride management decisions.

Because of the reference to the medical staff's lack of understanding of the roles of nurses in management positions above the ward sister/head nurse level, it was felt imperative to devise ways and means of getting to the medical staff with information about the organisation of the hospital and what nursing is really doing.

It was brought to the group's attention that six or seven years ago, when some ward sisters attending a management seminar were asked to whom they were responsible, ninety per cent answered 'the medical consultant'. Lately this has been changing.

We then looked at another level in the tier of management - the directors' positions. It was indicated that, in Canada and certainly in the US, as persons in this position have become better educated and increasingly involved in top management decisions relating to the total agency - there have been casualties. Medicare has seen that the director has been fired.

It was agreed that nursing must build its power base. This is long overdue.

Example The directors could view the nursing staff as one of their power bases. The same sanctions can be applied by nursing as by medicine.

How to build a power base - what is this 'power base' - must be taught to nurses and should be incorporated in the educational programmes for all nurses in leadership positions.

All this applies to the total health care system - not just institutions.

The problems related to medicine understanding the roles of nurses in leadership positions and how these can be alleviated was stressed again. In some instances, physicians have been involved in being part of the interview team - assessing nurses who have applied for various positions. Reciprocal arrangements should have been arranged with other key positions.

There was agreement that the nursing officer/supervisor has a great deal of responsibility and must also have the authority to manage her areas. Resolution of many of the problems which have been inherent in this role lies in clarification of the role of nursing officer/supervisor - teaching the officers and developing them to function effectively.

When the question was asked - What criteria should be used in determining the length of meaningful experience in any one tier of the management structure? - there was no resolution, though it was said that the experience must be carefully evaluated and looked at in terms of its being meaningful. We need to identify the expectations of the various roles carefully and determine if the candidate has clear expectations of the role also. It is imperative we have these persons become more productive in a shorter period of time. We must review and determine what we need to teach them.

We then looked at those positions in the nursing hierarchy which are called advisory and consultative. We agreed that a consultant must be invited and the purpose of the visit clearly determined.

The advisory role was defined as coordination; analysis and synthesis; planning and priority setting. Those nurses in advisory roles need different tools - persuasion is important. It is a persuasive and facilitative role. The power of persons in this role is in monitoring and in many instances speaking for nursing with the area health authorities or a similar group.

Financial sanction is also viewed as power. The role of this person in meeting with line management is one of keeping the totality of the health care scene in its proper perspective so insulation will not occur among individuals.

Most planners are consultants. The question was asked - to what extent can the leadership potential be fully utilised to maximise the role of the adviser and consultant?

The emphasis on persuasion means the power base of the individual has to be looked at. The role is one of interpreting what must be done. Crossing of barriers in other fields is very important. Policies must be analysed and developed. Adequate input is essential and in many instances policies must be developed in the political context which exists at any given time.

The role of the adviser and consultant tends to be more indirectly related to leadership than directly related. The knowledge base must be very broad in order to have credibility. Being politically astute is essential - though it was agreed that all nurses in leadership positions needed to be politically astute.

There was a very brief discussion about participative management and this concept is now in the discussion stage in the UK. It was mentioned that this is another example of societal change and another reason why nurses in leadership positions need to learn how to deal with changes. All of these changes have implications for nursing education.

The meeting ended with this thought: personal and professional goals of nurses may change - and nurses in leadership positions should recognise that movement within various leadership roles in different settings is appropriate. This emphasises that change must be viewed in a more positive way.

2 III NURSES IN PROFESSIONAL ASSOCIATIONS AND TRADE UNIONS, AND IN VOLUNTARY COMMUNITY ACTIVITIES

Eileen M Jacobi

Nursing may have reached a plateau in its growth and development as a health profession in the United States unless opportunities for aggressive leadership are assumed. On the one hand, changes in patterns of demand for health care services and technological and scientific innovations have created a greater demand for nursing services. On the other hand, the public, the government, and other health care disciplines are reluctant to acknowledge that nurses function in primary care roles. Moreover, the recent introduction of a number of ancillary health care workers has created confusion and conflict regarding the delegation of responsibility for certain aspects of health care. These factors pose crucial problems for the profession. The expansion of the scope of nursing practice, the recognition of nurses as primary care providers, nursing's involvement in health planning activities, and the inclusion of nurse practitioners in direct fee-for-service reimbursement plans will only come about as the result of the efforts of politically and economically astute leaders in nursing.

The immediate goal of the nursing profession must be to unite nursing forces in an effort to bring about greater involvement of nurses in planning, delivering, and assuming accountability for the nursing component of health care services at the national, state, and local (community) levels. The ease with which the profession is able to accomplish this goal is dependent upon the ability of nursing's leadership to evoke a sense of harmony and balance within the profession while creating a dynamic image of nursing among other health professionals and the general public. Today, there is a need for strong moral leadership in the nursing profession.

A DEFINITION OF MORAL LEADERSHIP

Leadership is the activity of influencing people to cooperate toward the achievement of a desirable goal. In almost every industry, agency, organisation, and profession, the need for leadership has been recognised as a basic necessity for successful functioning and realisation of goals.

By and large, the increased demand for leadership has resulted from increasing functionalism and division of labour, and the complexities these phenomena have created. Problems, resulting from the aforementioned, deal mainly with satisfaction derived from group activity, job satisfaction, impersonality, and isolation of individual group members from the central purpose. Consequently, it has become the responsibility of the leader to guide and develop the individual so that he may better share in realising and achieving group ends, while obtaining a sense of self-enhancement and worthfulness.

It has been said by many that leadership is that part of the democratic society standing between 'chaos and the orderly, disciplined action of a free people'. This statement holds many truths, whether it be applied to society, in general, or to professional activities in particular.

In the professions, leadership has proved to be of necessity in organising team action towards successful achievement of previously defined aims and goals. As such, the problem of leadership has come to play an increasingly important role in the nursing profession, where it has been recognised that there is a great need for more skilled leaders.

The interpretations and connotations given to leadership have been almost as numerous as the number of leaders the world has seen. There have been strong Hitler-like leaders who have spoken, decided, and acted for a group of people - at first with their consent, and then later, with or without it. This leader has pushed aside the previously accepted morals and ethics of the group and instead has substituted his own. Here, the group is used by the leader merely as a means to an end, the feelings and wishes of the group being totally disregarded. This type of leadership may be termed 'immoral leadership'.

'Moral leadership' on the other hand, may be interpreted as a passive kind of action in which a leader facilitates the work of a group in order to achieve a specific purpose(s) defined by the group.

In 'moral leadership', the purpose of the group becomes that of advancing in new directions. The leader in this type of situation gains authority from the confidence of the group, and, in turn, must exhibit his confidence in the group and in group members. The power of the leader is used to work with the group as a whole, and not against them, while guiding and developing the individual members towards satisfaction and self-fulfilment.

The 'moral leader' should combine recognition and implications of new needs, trends, and developments while liberating, organising, and channeling the energies of the group and himself in such a way that effective action is possible. A 'moral leader' should have the ability to hypothesise, to stimulate and guide others to get the necessary facts, to analyse pertinent relationships, to make considered decisions, and to take confident action. To this end, the 'moral leader' should be a person who can successfully use the tools of human relations and one who possesses the characteristics necessary for good leadership.

Many books and articles have been written which deal with the characteristics of a good leader. Dietz (1948) believes the traits necessary for leadership are courage, the vision of a goal, an understanding of the minds and emotions of the people one is to lead, and the power to communicate a vision of the goal. (p. 152) In keeping with this, Tead (1935) believes the leader needs a sense of purpose, along with direction, integrity, technical mastery, enthusiasm, affection, friendliness, decisiveness, and intelligence. (Tead pp. 82-114) In addition, I believe the leader needs an awareness of the expectations society and his followers have of him. Therefore, in line with this he must also be aware of the ethics and morals involved in the task before himself and his group.

Perhaps, just as important as the characteristics of a leader, are the functions of the leader. It should be stressed that the leader works with his group, 'using the organisation as a means to an end... /helping/ achieve what the /group/ wants. It is the human beings themselves who are the ends'. (Tead 1935 p. 13)

The professional leader is expected to set a favourable climate to ensure the effective functioning of his leadership. This climate is described by some as 'creative, coordinated, careful, confident, and unrestricted by mores'.

Leadership in the professions, especially in the health professions, is of special importance. As a result of the growing interest of the public in professional services, the need for both a greater quality and quantity of leadership has arisen. In nursing, particularly, there is an increasing demand for quality.

A review of nursing literature reveals that numerous articles have been written which explore the concept of leadership in nursing. In the majority of these articles, nursing leadership is examined from the standpoint of the responsibilities of the leader of a nursing team which functions within an institution or an agency. The broader topics of the leadership of the nursing profession and nursing's role as a leader among other health professions remain relatively unexplored.

Very few articles examine the concept of leadership as it relates to guidance and direction of the profession as a whole. Those articles which do address this broader concept allude to the critical shortage of 'highly knowledgeable, politically astute, and skilled leaders' in nursing. (Leininger 1974 p. 29)

Even fewer articles evaluate nursing's role as a leader within the health care system. In determining the actual power base of the profession, one must examine the degree to which the profession assumes a leadership role in the delivery of health care services. As the largest group of professional workers in the health care field, nurses possess the numbers to command a key role among health professionals. However, observers are quick to point out that the health professions, in general, have failed to provide effective leadership in the resolution of many problems plaguing the health care system in the United States. It is apparent that the nursing profession, in particular, must assume a more visible and vital leadership role in the delivery of health care, if nursing is to remain a viable profession.

A critical evaluation of the profession's leadership capabilities should begin with a definition of the role and responsibility of nurses for leadership in the professional association.

LEADERSHIP OF THE NURSING PROFESSION

By its very nature, the professional association stands as the leadership mechanism of the profession. According to Merton (1958), noted sociologist, professional practitioners form an association 'to perform social functions which they cannot perform in their separate capacity as individuals'. In his paper The Functions of the Professional Association, Merton singled out three major responsibilities of an organisation of professional practitioners

1 To insure unity in action

2 To provide assistance to all practitioners in dealing with professional problems and issues, and to provide social and moral support for the individual practitioner and

3 To set and enforce rigorous standards for the profession. (Merton 1958 pp. 2-4)

Merton observed that a professional association mediates between the practitioner and the profession and its social environment. (p.4)

Given the appropriate resources (funding and manpower), the professional association serves as spokesman, mediator, crusader, innovator, etc. As Merton aptly explained, 'the professional association is a kind of organisational gadfly, stinging the profession into new and more demanding formulations of purpose.' (p. 3)

A brief review of the development of nursing in America attests to the significant role of the professional association.

The nursing profession began to gain prominence in America when nurses banded together in 1896 to seek standardisation of educational programmes, and laws to insure practitioner competency. Prior to that time, hospital committees and physicians dictated nursing duties and methods of training. In the last decade of the nineteenth century, nurses displayed a growing consciousness of the need to insure practitioner competency in order to improve nursing care. Recognising the value of organised effort, pioneer leaders proposed the formation of a nursing organisation to elevate the standards of nursing education, establish a code of ethics, and promote the interests of nurses. (Jacobi 1976 p. vii)

The establishment of the American Nurses' Association was a direct outgrowth of an interest in the professional and educational advancement of nurses. Since its founding in 1896, ANA has had a significant impact on the growth and development of the nursing profession and the quality of nursing care. Between 1896 and 1940, the American Nurses' Association took the necessary steps to secure a professional status for nurses. In the 1940s, the American Nurses' Association instituted measures to insure the adequate distribution of professional nursing services in the broader community. In the 1950s, the American Nurses' Association began to develop professional safeguards to insure

quality nursing care. In the 1960s, the American Nurses' Association identified standards for nursing education of a 'true professional calibre'. More recently, the American Nurses' Association, working through the state nurses' associations, launched a campaign to actively involve nurses in the determination of matters relevant to the delivery of nursing care to the public, and the welfare of the nurse in the employment setting. (Jacobi 1976 pp. vii-viii)

Today, the demands placed upon the leadership of professional associations are numerous. One of the most significant challenges before the leadership of the nurses' association is the need to deal with the implications of the acquisition of new knowledge and the more extensive use of technology brought about by political, social and economic changes and scientific advancements.

In 1970, Alvin Toffler, in Future Shock, predicted that, in the next three decades, millions of individuals will succumb to physiological and psychological disorientation created by an endlessly accelerating rate of change. According to Toffler, overstimulation of the human organism's physical adaptive systems and decision-making processes will trigger extreme physical and emotional distress. In the span of only six years, his predictions are being realised.

Toffler's study of change factors has great significance for the health professions, particularly nursing. Dramatic scientific and technological advancements, drastic changes in social organisations, and revolutionary alterations in social values have profound implications for nursing practice during the next 30 years.

In the next 30-50 years, it will be necessary for the nursing profession to adapt to new and different health care demands as a result of change. Nursing must become a futuristically-based profession. Nurses must begin to forecast consumer needs - to appraise past and present developments in health care and nursing, to determine significant goals and priorities desired for nursing, and to develop and initiate innovative nursing programmes aimed at satisfying projected health care needs. This process can best be achieved within the framework of the professional association, which has at its disposal appropriate mechanisms for systematic investigation.

The foremost obligation of the association's leadership is to facilitate this endeavour. It must come to grips with such questions as

1 What factors will have a significant effect on society in the next 30-50 years?

2 What is the potential impact of these factors on the health care system, in general, and the nursing profession, in particular?

3 What should be the role of the professional nurses' association in relationship to society, to the profession, and to the individual practitioner?

The prediction of health care needs and demands and the implementation of appropriate programming necessarily involve risk-taking - a willingness to make decisions, act quickly, and accept the consequences of the actions. Consequently, the association's leadership must be endowed with those qualities which will enhance and encourage the dynamic interaction of the professions toward the achievement of specific goals.

Earlier this year, twelve top executives of key businesses in the United States were polled on the characteristics they deemed necessary for effective leadership. The list of characteristics included 1) an inquiring mind, 2) the ability to make impartial decisions on the facts available, 3) an enterprising attitude toward solving problems, and 4) the capability of envisioning alternatives - each characteristic, an essential trait for leaders of the professional association. (Golightly 1976)

NURSING LEADERSHIP IN LABOUR RELATIONS

In recent years, it has also become essential that the professional association cultivate the talents of members of the profession who are adept in utilising various interpersonal and management strategies. Dr Madeleine Leininger, in an article, The Leadership Crisis in Nursing: A Critical Problem and Challenge, points out that the nursing profession must respond to changes in society's expectations of leadership. Changes in social structures, shifts in values, and differences in the psychological and political strategies of management have warranted a change from an establishment-maintenance style of leadership to a confrontation-negotiation style of leadership. (Leininger 1974)

According to Dr Leininger, 'Nurse leaders are frequently finding themselves in highly competitive and complex political situations in which open confrontation must be used to remain in the action arena'. (p. 29)

Increased unionisation of health care employees, proliferation of collective bargaining laws covering health care employees, increased organisation of other professionals, increased awareness of nurses of the need for organised action, and growing use of contracts to provide a mechanism for implementing nursing standards have stimulated a greater interest in the confrontation-negotiation approach to leadership, especially within the bargaining unit. The professional association, as the appropriate representative of nurses in the employment setting, must develop an effective economic and general welfare programme and provide guidance and assistance to those nurses functioning on labour relations teams.

Since 1946, the American Nurses' Association has implemented an economic and general welfare programme. In light of the passage of the amendments to the National Labor Relations Act, which extended the right of collective bargaining to nurses in non-profit hospitals, the leadership of the American Nurses' Association (working through state nurses' associations) has intensified efforts

1 to secure conditions of employment and a climate for practice that foster a lifetime career attachment to nursing,

2 to secure conditions of employment that will attract able persons to careers in nursing,

3 to involve nurses actively in determining the conditions of employment under which they practice, through collective action,

4 to represent nurses at their place of employment utilising collective bargaining,

5 to attain wide understanding and recognition of the scientific and social contributions of nurses to the health and welfare of the community,

6 to achieve an employment status for nurses commensurate with their preparation and qualifications and with the intellectual and technical nature of their services, and

7 to promote social, economic, and health legislation beneficial to the economic and general welfare of nurses (Flanagan 1976 p. 266).

As mentioned earlier, a critical evaluation of the profession's leadership capabilities should begin with a definition of the role and responsibility of nurses for leadership in the professional association. It is apparent from an examination of the leadership roles that the responsibilities of nurses are threefold. Working through the professional association, nursing leadership can unify nursing forces, implement plans aimed at involving more nurses in health planning activities, and facilitate the involvement of individual nurses in determining the conditions of employment under which they practice.

NURSING LEADERSHIP IN COMMUNITY ACTIVITIES

An evaluation of the profession's leadership capabilities should also include an examination of the role and responsibility of individual nurses in community activities.

The nursing profession has been called the 'conscience of the health care system'. The development of trained nursing in the United States is the direct outgrowth of the efforts of women interested in public health reform in the community. Today, two of the foremost obligations of the nurse practitioner are accountability for the quality of nursing care which is rendered and involvement in the resolution of community problems which may impinge upon maintenance of health.

According to Abraham Flexner, professionalism is characterised by a high degree of responsibility. As a professional practitioner, the nurse must assume an aggressive role in securing the necessary safeguards to insure the competency of all nursing personnel in a given community. Execution of such a role involves activities ranging from participation on peer review committees to lobbying for specific pieces of legislation.

A good example of the impact of nurses assuming an assertive role in the community was witnessed in July, 1975. Individual nurses throughout the United States joined forces to lobby Congress to override President Ford's veto of the Nurse Training Act. As a result of their efforts, Congress did override the President's veto. Consequently $2 billion can be spent on health services during the next two years, $553 million of which is earmarked for nurse training programmes.

The profession must take the necessary measures to insure the involvement of nurses in the planning for and the organisation of health care services in the community and the development of health care policies. Every nurse practitioner has an obligation to initiate or support movement within the community to improve the delivery of health care services. Moreover, nursing must address itself to continuing and intensified research and study to find better ways to utilise the skills of the nursing force. Consideration needs to be given to innovative ways in which nurses can function in promotion and maintenance of health, in the assessment of patients/clients and the supervision of nursing care in nursing homes, and in the supervision and maintenance of the chronically ill in the community.

In addition to assuming an aggressive role in promoting safeguards to insure practitioner competency and the effective utilisation of nurse practitioners, nurses must actively deal with social issues which create health problems in the community. Studies show that such conditions as overpopulation, unemployment, and pollution, to name only a few, can cause serious health problems. As responsible and well-informed citizens, nurses should assume aggressive roles in established communities of interest to deal with issues confronting the community. As early as 1907, Lavinia L Dock, a pioneer nursing leader, pointed out that nurses, as trained workers, should exercise social awareness and social activism.

In summary, many opportunities exist for nurses to assume leadership roles in the professional association and in community affairs. The responsibility of nursing's leadership is best explained metaphorically. On the doors of most council chambers are two signs. On one side of the door, the sign reads, 'pull'. On the other side of the door, the sign reads 'push'. In effect, these instructions describe the basic responsibility of leadership to take the initiative to 'push and pull' doors of opportunity open to the profession and to the occupation of nursing so that the public may be better served.

REFERENCES

DIETZ, Lena Dixon. Professional adjustments I Philadelphia. F A Davis Company, 1948.

FLANAGAN, Lyndia. compiler. One strong voice. Kansas City. American Nurses' Association, 1976

GOLIGHTLY, Henry O. Success Depends on Character. Ambassador, March 1976. pp 33-37.

JACOBI, Eileen M. Foreword. One strong voice compiled by Lyndia Flanagan. Kansas City, American Nurses' Association, 1976.

LEININGER, Madeleine. The leadership crisis in nursing: A critical problem and challenge. Journal of Nursing Administration, March-April 1974. pp 28-34.

MERTON, Robert K. The functions of the professional association. American Journal of Nursing, Vol LVIII, January 1958. Reprint.

TEAD, Ordway. The Art of leadership. New York, McGraw-Hill Book Company, 1935.

TOFFLER, Alvin. Future shock. New York, Bantam Books, 1971.

REPORT OF DISCUSSION GROUP III

Reporter M D Green, Members M E Dunn, A Emerton, E M Jacobi, H Mussallem, J M Scott, A McEwen

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INTRODUCTION

The group supported the main thesis of Eileen Jacobi's paper that the profession was in urgent need of statesmanship and moral leadership. We were of the opinion that the nurse leader should not only be the conscience of the health care system but also the keystone to that system.

In considering the definition of the role and responsibility of nurses for leadership in a health care delivery system, we did not subdivide our discussion into looking separately at the two aspects of the paper - in professional association/trade union activities and in voluntary/community activities - but tried to look at a composite whole.

Much of our time was however spent discussing the role of the professional association versus the trade union, a theme we kept on returning to throughout, but we were able to summarise our discussions under four main headings,

professional unity

changing roles in the profession

training and development of potential nurse leaders

styles of leadership

PROFESSIONAL UNITY

The need for the profession to speak as one voice was a common denominator in all our discussions. We were convinced of the need for one professional organisation, with a corporate identity, to speak on behalf of the profession, and to exert pressure and influence wherever decisions are made which affect the profession, whether locally or nationally.

The current trend of having a multitude of groups claiming to speak for nurses, if not for nursing, only enable government and other authorities to divide our role, or totally ignore our representation.

The professional association as the leader and conscience of the profession has, we considered, the collective responsibility to speak on all health care and related matters.

Therefore we decided that professional associations need to focus on the multi-purpose aspects of the profession, including the setting of high standards of professional practice, the development of the individual practitioner and the advancement of the profession in terms of status, levels of salary and conditions of practice.

We did not feel that the labour organisation role should be separated, but that it should be anticipated and a labour relations model should be developed for nursing, rather than take over the industrial model.

We considered that the professional organisation could achieve a status that would enable it to continue to fill a comprehensive role on behalf of nursing and nurses, which would not undermine the character of the organisation, which would be determined by its beliefs, purpose and professional ethic.

We deliberated the problems that existed in the United States of having one single organisation which resulted in members of the same organisation sitting across a negotiating table. Although this does not happen in the United Kingdom on salary negotiations, it is becoming more prevalent at local level during debates on conditions of work and disciplinary disputes.

The group felt there was an urgent need for the proper education and training of nurses at all levels of leadership, in negotiating and bargaining skills, and they should also be given an understanding of the management of conflict, although how the latter was to be achieved we did not decide.

The role of the trade union for nurses was discussed. We saw this as a very real threat in the present social and economic climate. We saw the chances of the general trade union movement putting money and support systems into attracting nurses into the existing unions, where often non-nurses would speak for nursing.

We considered that, if the existing trade union model was followed, it would result in the end of our professionalism, in that the major concern would be for nurses and not nursing, self-interest before service, and our professional commitment to the patient would be destroyed.

We decided that, while the present split in the profession was a reflection of social change, it was also increased because of the membership demand for value for money - and, while this is understandable, it is also difficult to quantify the spending of membership money.

The education, standard-setting role of a professional association is less overt to the membership, while the labour relations role produces positive results on salary negotiations which are seen, and sometimes appreciated, the particular employment problems of an individual nurse, when dealt with, hopefully have an immediate return, but the other aspects are equally vital. The development of nursing knowledge, influencing government and public opinion need to be explained and shown more clearly to the profession. We felt this also demonstrated a lack of leadership and awareness in the leaders, and also

insufficient education and training in nursing on the wider issues affecting society.

We also thought that the handing on of tasks to other health workers, and the dilution of the profession, resulted in the increased unionisation within nursing, and also the undermining of the essence of the profession and the altered public image of the nurse.

CHANGING ROLES IN THE PROFESSION

Not only has the nurse's role changed, and is constantly in a changing state, but so too has the nurse leader's in the nursing organisations. We considered that both nurses and nursing seemed to be constantly out of phase. We felt this was reflected in our negotiations with government. It was also thought that a stereotype of a nurse still existed in the minds of the other professionals and the public. Although we thought that the old idealised view of the ministering angel in the cap and apron had been eroded, a new public image had not been created that reflected the present changes. The need was stressed here for the leaders to develop a more healthy self-image in the profession, which will help to improve the public image.

The nurse as an advocate for the patient/client was discussed at length and it was decided that the nurse leader should, and could, play the role of patient's advocate, but that we as a profession working in a multi-disciplinary team had not got a monopoly on that role. It was therefore agreed that it should be regarded as a characteristic of the nurse's role but was interchangeable with other members of the team.

There were times, we decided, when the patient needed an additional support system, which has been demonstrated by such developments as the Patients' Association, the formalised complaints procedures and also some recent reports in the United Kingdom on mistreatment of patients.

It was considered that the nurse leader was responsible for providing an environment of care, of undertaking peer review, appraisal and programmes of quality assurance. That the professional organisation should be concerned with the advancement of knowledge and skills and the promotion of high standards of practice, and that the profession should be capable of adapting to social change and respond to the needs of the community, in the light of advances in knowledge and awareness.

As members of the major caring profession nurses have a vital part to play in policy formation in respect of health care at local and national level. They should also be members of the relevant committees concerned with health care provision and also other community and voluntary committees.

We felt, however, that nurses in general are politically naive and that many nurses had not had the training experience or wherewithal to sit on committees and take part in representation to government, and in this we considered that the academic path to doctoral degrees was

not necessarily the right one for such a role, in fact the gaining of a PhD might even militate against the effectiveness of the individual in the political representational or committee role.

TRAINING AND DEVELOPMENT OF POTENTIAL LEADERS OF ORGANISATIONS

The need to develop in all nurses a professional awareness was considered by the group to be of paramount importance, and it was agreed that this should be attempted during their basic education by the inclusion of the right balance of subject matter including the behavioural social sciences. So that they could become more knowledgeable about societal needs they should be encouraged to become sociocentric not egocentric.

There was a general consensus in the group that there was a need for the total profession to become more professionally and politically aware. We had some difficulty on method because of an agreed difference in the elite and the masses, because of achievement and ability. We considered that the leaders of the professional organisations had a responsibility to inform the membership and encourage participation, if not total involvement.

We considered that the present leaders had a definite responsibility to identify and develop leaders for the future.

We felt that they should have a good basic education plus experience, but that this should be planned.

Observation was not enough, actually working within a political setting was vital, in government departments on secondments, with state associations etc. We considered that the future generation of leaders needed to not only know the system, but also how to exploit it. They need a series of goals set and an early exposure to leadership experience.

It was also considered essential to have, within the leadership of a professional association, nurses trained in other disciplines - sociology, law, politics, economics, so that the knowledge can be utilised for the advancement of nursing.

STYLES OF LEADERSHIP

We talked at length about the different leadership roles in nursing organisation and systems and the use of manipulative skills but agreed that, in a professional organisation, leadership decisions should be based on the utilitarian model of the 'greatest good for the greatest number', but we were adamant that our leadership should always be moral - we never analysed the word moral in this context!

We were however much vexed by the problem of nurse leaders in different roles, sometimes having to make joint decisions, sometimes separate. We discussed the difference between the elected leader in the professional organisation, and other bodies, and the appointed officer.

There was consideration of the problems of making decisions in groups, for instance boards, councils or authorities, where the officer could have more knowledge and experience than the office holders or decision makers, and the need for the officer to inform and guide, but not direct. We also considered alternative forms of leadership, such as a paid president who was chief executive.

We did not, perhaps because of the make up of the group discuss the detailed characteristics of the professional organisation leader, although we agreed with Eileen Jacobi, in a private conversation, that professional associations need politically sensitive, knowledgeable and courageous individuals who are adept at the art of compromise but who are also able to stand alone, who do not need to be loved, and who can function without the approval of others.

DISCUSSION IN PLENARY SESSION

At the end of the two days devoted to the identification and discussion of the role and responsibility of the nurse for leadership in a health care system discussion continued in plenary session.

1 LEADERSHIP AT THE POINT OF DELIVERY OF CARE

Every registered nurse was seen to be potentially a leader in the setting in which she worked. The point of delivery of care was the key position if quality and quantity of care were to be provided in accordance with modern knowledge and within existing resources. In discussion of the comprehensive paper and report of Group I certain points were elaborated upon, emphasised and reviewed.

Great emphasis was placed on the need for the nurse leader to know what to do and how and why to do it in respect not only of her knowledge and technical skills but also in respect of interpersonal skills with nurse colleagues, colleagues from other disciplines, with patients, clients and their relatives.

In addition to knowing what to do now, the nurse leader had to be able to up-date her knowledge, to use research resources and adjust her performance to meet changing circumstances.

The nurse leader needed to be fiscally wise, using her budget to best advantage. She might well have difficulty balancing the quantity of service demanded against the quality of service she knew to be needed.

She had to know when to call on and how to use consultant and advisory services whether from nursing or other disciplines and how to interpret, implement and influence the policy decisions of her work place.

Much discussion arose about the nurse leader as patient advocate. The nurse had traditionally seen herself as speaking for the patients' interests. The last few years had seen a mushrooming of patient organisations, some initiated by health service personnel, others springing up spontaneously from the community. The nurse leader should use the best forces available to move towards the common goal of a good quality service. Constructive use of criticism, a keen ethical sense and a practical awareness of problems of litigation were called for from the nurse leader at the point of delivery of nursing care.

LEADERSHIP IN THE EDUCATIONAL SYSTEM

Nurses faced a complex situation. They worked not with inanimate material but with human beings reacting as individuals and often unpredictably. It was clear from earlier discussion that the nurse was expected to display leadership skills from the outset of her career as a qualified worker. The educational system might then be expected to help her to prepare for this leadership role.

Socialisation, converting a member of the public into a nurse, was said to take place during nursing education. The nursing school had to provide inspiration, role models, learning opportunities. Practice and education had to be kept in step and the student prepared for the realities of her future work. This could be done only if experience was gained in patient/client contact through the day/night, week/weekend cycle of caring. This should be not only on a one to one basis but also in planning care with groups of patients. Employers were thought not always to be happy with the products of nursing education. Nursing education did not produce a marketable product immediately upon graduation. Internship was expensive and needed to be budgeted for. Supervisors sometimes had too little experience themselves to be competent to supervise effectively.

Leaders in nursing education had to meet these challenges. Deans were gatekeepers, able to make decisions about who should come into nursing and the curriculum and experience to which students were exposed. There was some doubt about the influence the profession could bring to bear on a Dean overconcerned about academic respectability at the expense of producing a marketable product but it seemed there were sanctions available if the need to use them arose.

Faculty members had the responsibility of seeing that the environmental opportunities were used correctly, that teaching was not confined to the classrooms, that cooperative relationships were established with clinical staff. Examples were given of educational programmes where a happy blend of theory and practice and good ward and school relations had been achieved. The importance of listening to each other across the boundaries was particularly emphasised.

Faculty members had responsibility for leadership in the world of ideas and for advancing the frontiers of knowledge.

2 LEADERSHIP IN MANAGEMENT POSITIONS

A useful distinction was drawn between leadership in nursing and leadership for nursing. Both were necessary for achievement of the common goal of providing a high quality health service in the quantity needed. Leadership in nursing focussed on the point of delivery of care where there should be a partnership between the people actually giving care and the managers facilitating their work. Leadership for nursing ensured that the voice of nurses was heard at all levels where policy decisions were taken and public relations established.

A danger was seen that, under the present health care delivery systems, responsibility was being passed further and further from the point of care through failure to delegate authority with responsibility.

Nurse leaders at all levels should handle budgets. Managers had the responsibility for weighing competing demands against limited resources. The need for fiscal wisdom amongst leaders was frequently stressed. A staff member could be employed to keep monetary matters constantly under review but the leader had to be able to use the material and understand its implications. Doctors, administrators and members of the management side of negotiating bodies needed to be educated about the true cost of nursing.

Managers could be expected to set general policies in harmony with social expectations. Such expectations could rarely be met in full and public relations required continuous attention to avoid loss of public faith in the service.

Leaders were seen to exert influence through the people they met and the contacts they made outside their work. Nurse leaders could be at a disadvantage in some settings. An example was given of plans made and decisions taken in the 'smoker', a place where men met, smoked, drank, talked and played but to which women were not admitted. Contacts at the golf club were also cited.

LEADERSHIP IN CONSULTANT OR ADVISORY POSITIONS

A definition of the consultant as someone invited in for a clearly defined purpose and of the advisory role as a longer term one including the right to advise with some responsibility for coordination, planning and priority setting was used by the group without discussion.

The consultants' leadership was by virtue of specific knowledge and expertise, the need for which was recognised by the practitioner or manager. A consultant could help to identify the problem and might suggest courses of action and their probable outcome.

The adviser in his longer term position might advise on a wide range of situations. The role of adviser might be part of the function of nurse leaders, for example in work with clients or patients; in supervisory positions or in senior administrative posts. The advice might be about policy matters or action to be taken.

It was in the nature of advice that it might be rejected, though it should always be given consideration. A leader might take advice from the people likely to be affected by his decision and from others with specialised knowledge. He would weigh up the advice, which might well be conflicting, and make his decision. It would be conveyed with or without further explanation to his followers.

In the reverse position a follower might seek advice from the leader, thus using the leader as a consultant. However a follower who did not intend to take the leader's advice might be well advised not to seek it.

Colleagues of equal or differing status could examine a problem together pooling their knowledge perhaps to arrive at a 'least worst' line of action.

Usually an adviser would have greater knowledge or experience of the specific problem than the person advised. Alternatively he might have greater knowledge of the wider issues or of the setting in which the problem would have to be worked out.

The dilemma of the follower whose leader rejected his advice was not fully discussed though the question was raised did he accept the rejection or try another way to achieve what he believed to be necessary?

The dilemma of the leader whose follower rejected his advice was likewise raised but not explored. Did the leader accept the rejection and support the follower or did he insist his advice be followed? In the latter case had he abandoned his advisory role?

3 LEADERSHIP IN PROFESSIONAL ASSOCIATIONS AND TRADE UNIONS

Leadership for nursing in the professional associations and trade unions was the most emotionally charged subject raised during the seminar. Nurses in all three countries were experiencing changes in the relationship between unions and nurses. The opportunity to exchange views and discuss strategy was welcomed and fully used both in and between sessions.

The professional association was said to be the voice of the qualified nurse, or of that section of the profession in membership with the association. There could be some justification for the view that the professional association spoke for nurses, rather than nursing, since much nursing care was given by unqualified people. Was there a case for an occupational association rather than a professional one? Was this what some trade unions were offering? In most unions it was thought the people giving nursing care formed only a small proportion of the total membership so that decisions on nursing matters could be taken by people unaware of the full implications of what they did. The general feeling of the participants was that the professional associations were filling an important role which could not be filled by an occupational association or a trade union.

New ideas on nursing practice and policies should emanate from the members of the professional association. The association should enable members to plan strategy as well as policy. It should be the professional association that the government, other official bodies, other professional organisations and members of the public looked to when the views of nurses were needed. The professional association for its part should be so structured that such requests could be responded to quickly and confidently. It was pointed out that the differences between trade union and professional association aims and policies were decreasing daily. The trade unions no longer concentrated on negotiations over pay and conditions of service but were speaking on nursing policy and practice. The professional associations were becoming ever more heavily involved in negotiations, though they still referred to improved service to the public as their first priority.

There was a need for rapid preparation for nurses for their professional role. In nursing associations the staff were often had to become experts in their particular subject, consultants or staff members from other disciplines could be employed by the association but nurses versed in for example economics, law, sociology, were needed too. The staff worked with elected officers who determined policy on behalf of the members who elected them. There was a possibility of conflict here but the leadership role of the staff members depended on their success in providing reliable information on which the elected officers could take sound policy decisions.

The elected officers needed to be involved in nursing work. They could not be effective leaders unless all nurses learned something of the skills of policy making, committee work and negotiation so that their brief to their elected leaders could be realistic and so that if they in their turn became elected officers they would bring the necessary basic skills with them.

The members of the association should be fully involved so that there was no doubt in their minds that the association could meet their needs both for corporate action and as a voice to express nurses' views at all levels in the service.

Tactics presented serious problems. Examples were given of trade union members taking action to harass or intimidate members of a professional association. Once the obligation not to take sanctions which could reflect on patient care was abrogated, the professional association was at the mercy of such tactics, as it was in cases of withdrawal of labour. Much depended on the attitude of employers whether they would meet professional representatives or would listen only under the threat of industrial action.

LEADERSHIP IN THE COMMUNITY AND VOLUNTARY ORGANISATIONS

The nurse's leadership role as a member of the community and in voluntary organisations was not touched on in plenary discussion sessions.

3 I EMERGENCE OF LEADERS IN THE UNITED KINGDOM

Phyllis M Friend

INTRODUCTION AND OUTLINE

The aim of this paper is to provide a part of the background for an international discussion on problems and policies related to the emergence of leaders in nursing. The subject is a crucial one for nursing as it struggles to establish itself as a profession, and as a profession which meets the whole needs of the individual in a climate where increasingly the generalist is giving place to the specialist.

It will be of value to examine the current situation in three countries where nursing is generally accepted as having achieved professional status and to identify those problems and solutions which are common and which might, therefore, have an even wider international application.

This paper will relate to the situation in the United Kingdom, and more specifically to England. It will attempt to examine the problems of leadership in the present day and the activities of leadership in the varied organisations in which nurses work: it will refer to some of the hazards which face us in the selection of nurse leaders, the conditions which are conducive to their emergence and any special treatment which may be appropriate to their development. It will pose the question of the extent to which leadership should be equated with management and can only be exercised in an hierarchical structure. Indeed it is likely to pose more questions than it attempts to answer.

SOME PROBLEMS OF LEADERSHIP

Leaders in nursing have, over the years tended to be equated with those holding managerial or administrative positions, and as such have faced some problems of acceptance.

'Thus the new Matrons come into conflict with the lay administration and with the doctors.' (Abel Smith 1964)

'Doctors did not want nurses to be associated with management in any form.' (McCarrick 1974)

'The Area Nursing Officer is at conflict in this situation because of her need to be involved at operational district level as well as her overall policy advisory function exercised in the area management sphere.' (Flindall 1975)

These are extracts from descriptions or comments on the leadership of nursing in Britain. In a hundred years little has changed. Most people, including nurses, are not very interested in, or are actually hostile to leaders in nursing if their sphere of influence goes beyond the clinical service level. Other nurses appear to want a voice for nursing in the top echelons of the health services and in government. Why this ambivalence? What kind of people emerge from the mass of nurses to become leaders and why do they do it? Are they the right people and what conditions are conducive to their emergence? What education and experience aids or hinders the development of those who appear to have the qualities required? Who has decided on those qualities?

The first quotation above came from a description of the situation which met Miss Nightingale's trainees when they tried to take over and improve the nursing care in the hospitals to which they were appointed. The second mentions only one instance, from a barrage of vociferous criticism and even abuse, directed at the incumbents of the new nurse management posts which were set up as a result of implementation of the Report of the Committee on Senior Nursing Staff Structure (1966) in hospitals in the United Kingdom. The third is an example of the type of conflict which nurse leaders may themselves experience as they move into new spheres of activity.

There appears to be a dichotomy between the need for nurses to manage the nursing services and to be heard in high places and the need for leadership in the improvement of patient care and the maintenance of high standards in all nursing situations whatever the relationship with patient or client. The two ought not to be mutually exclusive but this is how they appear to be perceived by some observers. It would therefore seem to be necessary for nurses to examine closely the ways in which leaders emerge and to analyse the means by which they are prepared for their leadership role and to attempt to eliminate the conflict between top managers, the operational levels and the people occupied in giving personal care.

ORGANISATIONS IN WHICH NURSES WORK

In this country, with its welfare state, it is expected that nursing services will be available to the individual and his family 'from the cradle to the grave' in all fields of their activity. Nursing services range from health education to intensive therapy; they are provided in the home, at school, at work, in prison, aboard ship, in health centres, hospitals, convalescent homes and rehabilitation units. They are available to the healthy, the acutely ill, the mentally sick, the physically and mentally handicapped and the terminally ill of all ages. Nurses work both in the public and in the private sector, in health organisations, educational centres, research units, professional associations and in central government. The majority, however, function in the National Health Service and of this the largest number are concerned with patient care in hospitals, which are highly structured hierarchical organisations.

One of the important aspects of an organisation lies in its goals. Everyone in a hospital or in a community nursing service will be able to define the main goal, but with this there are also legitimate subsidiary goals such as the preparation of new health workers, career development or the conduct of research. Nevertheless the goals can become somewhat remote from the obvious and there may be an explanation of the problems surrounding nursing leaders in that their personal or corporate goals may not be those of operational staff members. Michels (1968), discusses the concept of goal displacement in a 'single purpose' organisation. This may take the members in various directions but it is easy to see that the pursuit of professional objectives, research or education could assume greater importance in the minds of the people working within the organisation. Etzioni (1964) described hospitals as multi-purpose organisations with several possible goals. If this is the preferred choice then these are clear indications that different kinds of people, differently prepared, may be necessary in order to meet the needs of each part of the organisation. Michels concluded that, amongst other things, leaders do tend to organise themselves and consolidate their own interests.

Other perspectives can be used to throw light on the actions of people in organisations but there are difficulties in trying to analyse them. Actions may depend on the meanings which individuals use to define social reality. Where a particular set of views is shared by a group of people they are institutionalised, but they are still likely to be changed by their interaction with one another. No aspect of social reality is therefore likely to remain static and it becomes necessary for continual appraisal of the perceptions and the meanings given to them by those involved. This implies a greater flexibility of approach than has been the custom in nursing. It is easy to have a tidy hierarchy and a neat organisation plan but anyone drawing up such a plan will have to appreciate that the perceptions of the people concerned and the meanings they give to them will determine how they behave and not the plan itself. One notable physician saw the new organisation for nursing described in the Salmon report as 'a charter for incompetents' (Paulley 1971). This view was perhaps somewhat extreme but nevertheless many people saw things this way. Others saw the new leadership pattern as salvation of nursing and it was expected to 'open to nurses the gateway to their own self-government'. (Revans 1966)

Whatever the problems of an hierarchical structure there can be little doubt that Salmon confirmed the position of the nurse administrator as level in responsibility with medical and general administration, equally involved with decisions concerned with policy and the management of resources, and established direct access to the employing and policy making authority. As a result nurses find themselves in a strong position in the reorganised National Health Service as equal members of management teams, with statutory right of representation on the authority and of establishing local professional advisory machinery.

The main principle underlying the reorganisation of the National Health Service was the integration of specialist and primary care services so as to ensure continuity of care for the individual and his family. The philosophy, in the management jargon of the day, is of coterminous spheres of responsibility, team working and consensus management, with a complex intermix of line management, coordination and monitoring between the various tiers of the structure. Success can only follow if in each situation goals are clearly identified and leadership established.

The influence of nurses on their own education is strong. At local level most programmes are under the control of a director of nurse education who is required to be a nurse, and others come within the nurse management structure. At national level the major statutory bodies which control nurse education are led by nurses and those which still have a non-nursing chairman have nursing majority in voting power. Their strength within the university setting, both in education and research however has still to be developed and here strong leadership will be essential.

There is a multitude of professional associations and staff organisations which speak for nurses in this country and nurses function in all of them. The major bodies have an exceedingly powerful voice and have proved to be as capable as any other discipline in representing their views to government.

The variety of situations in which a nurse may be required to exercise a leadership role is infinite. It may be among student colleagues in the introductory course, or the students' council; it may be in her relationship with an individual patient and his family; it may be at clinical level within a nursing or multidisciplinary team in a ward or health centre, or as a clinical specialist; it may be at management level within a health service structure or as a member of a professional advisory committee or a health authority; it may be as a faculty member in a university or as a pioneer in the developing field of nursing research; it may be within a government department or in an international organisation. Nursing has been referred to as 'the major caring profession' (Briggs 1972), and if it is to use its influence for the benefit of the community then a vital factor in its success must be the quality of its leadership.

ACTIVITIES OF LEADERSHIP

The basis of this discussion is the definition of leadership as the action necessary to call forth the gifts of each individual and to help individuals work together in teams to achieve the task. (Garnett 1976) The role of management has been described as the unification, coordination and welding into a team effort of human forces and directing them effectively towards a given purpose. (Brech 1965) There can be little doubt that to be effective in management it is essential to possess the skills and qualities of leadership: the question which might be posed is the degree to which, in any leadership situation it is essential to employ the activities of management.

Such activities are manifold, but they have been analysed by Brech and broken down into four constituent elements; planning, control, coordination and motivation. In the variety of situations in which a nurse may be required to exercise a leadership role it would seem that she would need to be engaged in all these activities, but not necessarily to an equivalent degree. A district nursing officer responsible for the management of a nursing service, with budgetary responsibility for several millions of pounds could only function effectively if well-versed in all the techniques of management which come within the planning and control categories; she would certainly need ability to allocate activities and coordinate teams and to inspire morale but she should derive strength from her clearly designated leadership position. A nurse specialist who may have a purely advisory role would need to call upon her special skills of motivation and communication if she is to achieve, through others, what she, with her expert knowledge knows to be the desirable goal. Perhaps the greatest challenge which faces the potential leader is to achieve leadership in a team of equals, be it of a single or a mixture of disciplines, and yet increasingly this should be the role of the nurse. Team working both in specialist and primary health services is becoming the accepted method of delivery of care and the nurse, with her unique knowledge of the total needs of the patient is frequently the appropriate person to take the lead. It is encouraging that increasingly she seems able to do this despite the traditional acceptance of the higher status of other disciplines involved.

It cannot be denied, however, that the comparative status of the professions, as seen by the general public, by other disciplines in the organisation and by the nurse herself can affect her leadership performance. Even in a country where nursing is accepted as a profession it is still new in its professional role. Leaders of nursing feel confident that there is an identifiable core of knowledge which is unique to nursing and which, in terms of patient care is nurse-prescribed and which justifies its inclusion as an academic discipline. At top management level in the National Health Service nursing has achieved equal status with medicine, and its professional voice is heard equally at government level. Nevertheless, there is a traditional and inherent subservience to the medical profession among the rank and file of nurses which can subvert and frustrate the efforts of their leaders in their attempts to establish the independence of their profession while at the same time maintaining the essential partnership with medicine without which neither can function effectively. In a period of medical manpower shortage nurse leaders at all levels will need to exercise their skill to resist pressure for nursing to undertake the role of doctor's assistant and, instead, in partnership with medical colleagues and with the support of their staff plan to adjust the professional role of the nurse to meet the changing needs of the community.

THE EMERGENCE OF NURSE LEADERS

Clearly the vitality of a profession must depend upon the quality of its leadership and its future on the extent to which potential leaders are helped and encouraged to emerge and are developed so as to be equal to the tasks of tomorrow. Questions to be posed relate to the degree to which leaders may be self-selecting, the stage at which leadership potential may be recognised, and the extent to which leadership skills are transferable to new situations.

Qualities of leadership may be easily stated in general terms, as, for example, intelligence, wisdom, insight and judgement; the ability to communicate, enlist cooperation and inspire morale; success in acquiring techniques of planning and control and in evincing those personal values and qualities of integrity, humour, courage, self-control and self-respect, which will ensure the confidence and respect of others. Successful leaders must have such qualities to a varying degree according to the style of leadership appropriate to the situation in which it is to be exercised. Thus one important factor in the consideration of the emergence of a nurse leader is the organisation in which she will expect to perform, another will be her professional competence and credibility with her colleagues and yet another her qualities of mind and personality.

We pay much lip service to the concepts of promotion planning and career development, but it must be accepted that, to a very large extent tomorrow's leaders select themselves. There may be some merit in this provided that the Peter Principle* is not allowed to operate, there is no 'hypercaninophobia'** and that our established hierarchies do permit exceptional leadership competence to make its way. Self selection alone, however, will not achieve maximum results. Despite Druckner's (1955) assertion that prediction of promotability for more than a short time ahead will at best only work with 60-70 per cent accuracy and that 'no man has a right to dispose of other people's lives and careers on probability', it would seem essential to make the attempt to recognise among today's juniors those who might have the capacity, albeit in a different organisation to become one of tomorrow's leaders and to identify leadership ability in those who have not as yet recognised it in themselves. Having done so it is for the leaders of today to accelerate the progress of their successors and assist in every way with their development.

Leadership development should take place in every nursing situation and should not necessarily be linked with promotability. A nurse, practising in her chosen field and at her chosen level can frequently exercise exactly the form of leadership which is essential to give credibility and strength to the whole organisation, whereas movement to a higher level or a different situation could take away her personal satisfaction and confidence and have exactly the reverse

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* In a hierarchy every employee tends to rise to his level of incompetence.

** Top Dog fears.

effect. Even those with only limited skills of leadership should be allowed to develop those which they do possess so that, as they remain in their posts, they may at least be prepared to meet the demands of tomorrow's job and not exercise a stultifying effect on the organisation and inhibit the efforts of their new leaders.

Thus it is for every leader by systematic appraisal, to assess the capacity and weakness of each of her team, and to provide for each member the opportunity for self-assessment. This can be done in various ways, one of which could be in the involvement of the team in the identification of goals and the setting of targets. Another could be by the use of delegation, whereby the subordinate is entrusted with authority to act and make decisions on behalf of the leader. This process has many advantages; it frees the leader to concentrate on those decisions which only she can make and speeds up the decision-making process, it engenders interest, self-confidence and job satisfaction in the subordinate as well as developing her own leadership potential. The delegation process must, however, be one which is carefully controlled and tempered to the individual ability of the subordinate who is expected to render account to the leader who remains in control and checks results. By such means can the leader be in a position to make recommendations about the career development of individual members of her team.

There are some hazards in the selection of leaders in nursing and one of these is the fact that nursing is still a predominantly women's profession. Potential leaders leave for marriage and to bring up children and, even if they do not do so, they appear to have less personal morivation to reach the top than their male colleagues. It is interesting to note that after the widespread implementation of the Salmon report the percentage of chief nursing officers who were men was 49 per cent in a profession of whom men made up only 11 per cent. (Progress on Salmon 1972) The selection process for those entering the nursing profession is not geared to the identification of potential leaders, but to their ability to function adequately in the clinical situation. Other disciplines have adopted an élitist approach as, for example, the national trainee shceme for health service administration or the administrative trainee system in the Civil Service where aspiring 'top people' will hold a good university degree, preferably from Oxford or Cambridge. Comparatively few nurses start their career in this way, although the number of entrants with a degree is increasing. Large numbers of school leavers, with university entrance qualifications, choose instead a nurse training programme which does not lead to a degree. It might, therefore, be assumed that by putting a 'service' or 'caring' function before 'higher achievement' their values are not those which will produce the motivation to progress rapidly to leadership positions. Indeed, even those who enter the profession via university programmes, and those are few in number at present, by their choice appear to indicate a deeper interest in a caring rather than a leadership role. The question could be asked as to whether some form of accelerated stream, recruited for higher academic achievement and leadership ambition should be considered and used to produce an articulate and demanding voice, or whether the very broad base of the profession should reasonably be expected to provide the necessary leadership

potential. A further hazard in the choice of future leaders is the actual process of selection. A candidate may have achieved good results in her present post and may have impressed her superiors as having good potential: but so far we have no means of objective testing which will tell us that her skills will be transferable to the new situation, nor that her new team, who in our present processes are not always consulted, will find her acceptable as their leader. We do not know that the qualities required in nurse leaders are the same as in other spheres, nor that, even if we knew, we have the right techniques to encourage them to emerge. We do not know that the most skilful bedside nurse will make the best administrator or teacher, and we rely on subjective judgements as to whom we perceive as potentially 'good' or 'bad' leaders.

SPECIAL TREATMENT FOR POTENTIAL LEADERS

In this country the Committee on Senior Nursing Staff Structure made specific proposals for preparation and selection for nursing administration and as a result a National Nursing Staff Committee was established. In 1968 this committee produced a report on management development of senior nursing staff in the hospital service and later these recommendations were extended to include staff in the community nursing services. Now all nurses in a managerial role have the opportunity to attend management courses at first, middle or senior level and at top level to join with leaders of other disciplines in commerce and industry at the Administrative Staff College or one of the business schools. In a management situation nurses have equal opportunities with their administrator and greater opportunities than their medical colleagues to develop their leadership skills.

In North America nursing has established itself in the field of higher education and the leaders tend to have been offered special treatment on the educational rather than the administrative front. Our concern now is that those nurses who wish to remain in the clinical field shall have equal opportunities to develop their leadership ability and that this shall carry a status which is essentially nursing and not borrowed either from the fields of advanced management or higher education.

It would seem that we need a three or four faced approach to finding and developing nurse leaders. Instead of emulating other professions we should analyse what we need to meet the aspirations of those who would lead in the spheres of clinical practice, administration, teaching and research, not seeking to separate the four but to make the latter three subservient to the first.

SUMMARY AND CONCLUSION

In a somewhat superficial overview of a complex situation an attempt has been made to outline the leadership activities in the various situations in which nurses find themselves in this country and to point to some of the problems which nursing faces in developing its leaders in an emerging profession which is both 'generalist' and 'specialist' in its content. The aim has not been to provide solutions but simply to contribute a basis for discussion.

Clearly our ambition must be that our leaders shall hold their own with leaders of other health professions and be able to contribute from the intimate knowledge of the needs of the individual and his family which is uniquely theirs as nurses. There is need to study how, from a common base, we can develop the differing qualities required by the clinical practitioner of nursing, the administrator, the teacher and the researcher and, by good leadership achieve a synthesis which is recognisable and accepted as the profession of nursing.

REFERENCES

ABEL SMITH, B. The hospitals 1800-1948 - A study in social administration in England and Wales. London, Heinemann Educational Books, 1964.

BRECH, E. F. L. Organisation - The framework of management. London, Longmans, 1965.

DRUCKER, P. F. The practice of management. London, Heinemann, 1955.

ETZIONO, E. Modern organisation. New Jersey, Prentice Hall, 1964.

FLINDALL, J. The organisation. Working for democracy. Nursing Times, vol. 71, 1975. p. 526.

GREAT BRITAIN. DEPARTMENT OF HEALTH AND SOCIAL SECURITY and SCOTTISH HOME AND HEALTH DEPARTMENT. Report of the committee on senior nursing staff structure. (Chairman, Brian Salmon.) London, H.M. Stationery Office, 1966.

GREAT BRITAIN. DEPARTMENT OF HEALTH AND SOCIAL SECURITY and WELSH OFFICE. Progress on Salmon. London, H.M. Stationery Office, 1972.

GREAT BRITAIN, PARLIAMENT. Report of the Committee on nursing. (Chairman, A. Briggs.) London, H.M. Stationery Office, 1972. Cmd. 5115.

MCCARRICK, H. Salmon versus the doctor. Nursing Times, vol. 70, 1974. p. 296.

MICHELS, R. Political parties. London, Free Press, 1974.

PAULLEY, J. W. Is it too late to scrap Salmon? A charter for incompetents. Nursing Times, vol. 62, 1971. pp. 212-213.

PETER, L. J. and HULL, R. The Peter principle. London, Bantam Books, 1969.

REVANS, R. W. No longer the clinical long-stop. Nursing Times, vol. 62, 1966. p. 855.

SILLS, D.L., GRUSKI and MILLER, editors. Preserving organisational goals. The sociology of organisations. London, Free Press, 1970.

3 II THE EMERGENCE OF NURSING LEADERSHIP IN THE UNITED STATES

Myrtle K Aydelotte

> 'The problem of being an executive these days is that a man can no longer be the executive in the classical sense. Traditional ways of wielding managerial power have become obsolete.'
> (Levinson 1968 p. 3)

THE LEADERSHIP CRISIS

The traditional ways with which nursing in the United States has been providing leadership is no longer adequate to handle the complex problems confronting nursing and the health care community. The small core of present nurse leaders is being taxed to the limit of their resources. Although many individuals currently occupying strategic positions are dedicated and well-meaning, they do not possess the essential knowledge and skills to deal with professional and social issues and to work toward their resolution. Unless major changes occur in both kind and amount of leadership in nursing, nursing will be seen as an ineffective social force. Two thoughtful statements have been made by Leininger (1974) and Schaefer (1973), both of whom point out that nursing, characterised by marked weakness in internal leadership, has failed to respond in ways that create social action. Both strongly advocate that nursing develop persons who can speak out thoughtfully and forcefully on health care issues, who are skilled in confrontation and negotiation, and who can propose innovative programmes. Greatly needed are informed nurses who are knowledgeable of the cultural, political, social and economic considerations which must be dealt with in policy and programme development. They also must possess the skills and attitudes necessary to meet the complexities of the relations involved.

It is imperative that attention be given to the emergence of leadership in nursing in the United States. Since nursing in the United States has had its origins in the Nightingale system and many problems in Canada and the United Kingdom are similar, a sharing of views about the emergence of leadership is useful.

PERCEPTION OF LEADERSHIP

Nursing leadership focuses upon the kind of behaviour exhibited by individuals who influence others toward the attainment of goals and objectives for which nursing as a social enterprise exists.

Leadership is defined in many ways, depending upon the particular orientation one uses in viewing it. For purposes of this paper, leadership is viewed as the exercise of will, power, influence, and insight which directs and controls others in the pursuit of a common cause. Professional nursing leadership involves groups, common purposes, and goals, and the behaviour of the leader depends upon personal, environmental, and social-situational variables. This behaviour takes place in organisational systems and involves communication, decision, politics, logic, prediction, and calculated risks. Basic to all, leadership behaviour in nursing takes place in the community where health policy is implemented.

Nursing's driving purpose is the improvement of the health status of clients and patients. To achieve this, nursing focuses on outcomes of care, evaluating the effectiveness of the delivery of practice and the efficacy of the interventions used. This relationship between the socially mandated purpose granted the professional nursing group and the purpose of nursing leadership cannot be overstressed.

Therefore, individuals in leadership positions in nursing strive toward

> improvement of the health status of the clients and patients, through the provision of care that is efficacious and satisfactory to the client or patient and the immediate social group;
>
> provision of health and nursing care that is cost-effective, accessible, and equitably distributed;
>
> the offering of programmes of nursing education that are innovative, reasonable in cost, based upon sound knowledge, future-orientated, and efficient;
>
> action in nursing and health organisations that is directed toward needs and goals of society, futuristic in orientation, and based upon up-to-date knowledge.

In order to participate and achieve these goals, individuals in positions of nursing leadership in the United States must possess the knowledge and skills with which to make decisions regarding issues; the ability to deal with new social policy and programmes, of which nurses are a part of their formulation; and to implement and evaluate the effectiveness of the programmes and policy. (Milbank Memorial Fund Commission 1968)*

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*Gives an excellent statement on education for public health, and provides many concepts and general principles applying to nursing leadership.

Opportunities for nursing leadership reside in strategic positions in organisations and groups. The settings vary. In some organisational positions, the day-to-day operation provides a basis for social interaction in which to influence the implementation of goals; whereas in other positions in the same agencies and institutions, nurses in top executive or management positions are more concerned with matters related to policy and programme development, review and evaluation; modification of programmes and policy; and allocation of total resources of the organisation and community.

Leadership positions include those of administrators, associates, and assistants; planners; supervisors; consultants; advanced clinical practitioners; nurse practitioners; faculty, and head nurses or patient care coordinators. These positions fall into two classes: those of mid-management, which are primarily concerned with the design, implementation, maintenance and evaluation of high quality nursing programmes; and a smaller core of highly strategic positions of legislative leaders, top level consultants, economic specialists, system specialists and planners.

All of these positions are important. All are needed. They are concerned with the organisation of talent and the distribution of power in relationship to others in power, power being defined as the ability to control resources, including human resources.

PRESENT LEADERSHIP RESOURCES AND NEED

The numbers of nurses currently employed in nursing leadership positions in the United States range roughly around 270 000, as the following table shows.

Position Classification	Number
Administrator or Assistant Administrator	29 752
Consultant	6 681
Supervisor	80 648
Instructor	32 657
Head Nurses	119 905
	269 643

(Source: American Nurses' Association 1974. p. 272)

These nurses are employed in hospitals, public health agencies, schools of nursing, and nursing homes. The numbers do not include the growing number of clinical nurse specialists and nurse practitioners.

A total of 25 991 nurses with a master's degree or above provide this leadership.

Degree	Number
Master's (nursing)	17 260
Master's (other than nursing)	7 625
Doctorate	1 106
	25 991

(Source: American Nurses' Association 1974. p. 272)

The Report of the Consultant Group to the Surgeon General on Nursing targeted a goal of 3000 persons to be graduated at the master's level for 1970. In 1970, 2015 graduated. Not until 1973-1974, did the number ever exceed 5000. The number currently enrolled in masters' programmes is 6342, and of this number 11.7 per cent is preparing in administration. Over the years there has been a slow growth in numbers but recently the number of fulltime students has reduced. The rate of gain has not been sufficient to meet need or the demand for persons prepared in advanced clinical nursing practice, administration, or in expanded roles of nursing practice. In 1974, 70 per cent of nursing service administrators did not have any formal education above a three-year diploma.

In a working paper for the ANA Commission on Nursing Services, Wallace has estimated that the 1980 need for nurses prepared at the doctorate level is 10,000, at the master's level 170,000; identifying the deficit to be slightly above 9000 at the doctorate level and at 145,000 at the master's level. (Wallace 1974.)

Miss Wallace's estimates have been arrived at by a professional judgment model. One of the variables considered in the model are the number and types of institutions in which they would be employed. The number of hospitals in the United States is 7174. In 1974, the average number of beds in a United States hospital was 211. The number of community hospitals over 400 beds was 506; the number of teaching hospitals approximated 400, many of which also fall in the classification of community hospitals. The current number of health centres for medical education is 114. (American Hospital Association 1975) There is a total of 293 schools of nursing offering

baccalaureate programmes in nursing; 267 institutions providing educational programmes, for graduate nurses; 86 giving master's programmes; and eight preparing nurses in a doctoral programme in nursing (Facts about Nursing, American Nurses' Association 1974). Since several of these various programmes are given in the same institution, one can state with reasonable confidence that the number of institutions offering baccalaureate education in nursing and above numbers around 350. Trying to reach a figure of the number of institutions and agencies in which nursing leadership must be available is hazardous, but the number of schools and hospitals alone approaches 7500. Not included are the various governmental agencies and services, health maintenance organisations, public health agencies, professional organisations, schools, industries, and consultant groups. The need is obvious.

BRIEF HISTORICAL NOTE ON LEADERSHIP PREPARATION

The first advanced education for nurses who were to become the teachers and administrators was given by Teachers' College, Columbia University, in 1899. The subject matter of the techniques of teaching and administration placed a premium on sound professional preparation and leadership. The aim of the course, which 'set standards for leaders in the profession', was to develop a breadth of vision, 'giving new stimulus and outlook in all directions'. (Goldmark 1928) As university schools of nursing gradually came into being, courses were offered in ward administration and supervision. Gradually courses in advanced nursing practice were added. The growth of institutions, in size and complexity, the problems of nursing care, the shortage of staff, and many other factors gave rise to recognition that management of care and administration must receive special attention. In 1949, the W K Kellog Foundation sponsored an invitational conference on the problem of nursing administration and as a result in 1951, funded a nursing service administration seminar concerned with the development of curricula in the field. During the period 1951-1959, the Foundation led a major effort in fourteen universities to educate hospital nursing service directors. (Mullane 1959)

Also in 1949, the Division of Nursing Resources (now the Division of Nursing, Department of Health, Education and Welfare) was established. The problems of nurse shortage and utilisation gave rise to public demand for their resolution. Since that time, public concern has also led to studies of supply and distribution. The report of the Surgeon General's Consultant Group on Nursing, appointed in 1961, was instrumental in bringing about the Nurse Training Act of 1964, the first comprehensive legislative aid to nurse education. The Division of Nursing, as well as other governmental units, has given great support to the development of advanced clinical nursing, research, and administration, through capitation funds, fellowships, grants-in-aid, and research funding. Although congressional support of nursing education continues, it is not enough, and not enough leaders are prepared to meet the demand and to fill the need.

PROBLEMS AND CONSTRAINTS UPON LEADERSHIP DEVELOPMENT

Four major problems or constraints are operating to hinder the emergence of leadership in nursing and are making its development more difficult. A major social revolution is taking place, transforming our industrial society into a post-industrial society, characterised by a growing negative attitude toward authority, management and leadership. (Lippitt 1973). Conflicting ideas and attitudes about the value of work, economic efficiency, nationalism, and the past normative expectations of leadership are held within sectors of society, generations and professional groups. There is increased confusion and scepticism regarding the benefit of traditional health and medical services (Wennberg 1976). There is a lack of guiding health policy and, among professionals, lack of insight into the political, social, and economic forces at work. The degree of ferment is such that new leadership patterns and techniques have not yet been tested, although suggestions have been proposed. Through the growth of collectivism, including consumerism and the feminist movement, control of power has been shifting from the traditional power centres to new centres. The conflict between past and present normative expectation of leadership, resulting from the various currents in our society, has placed great difficulties upon planners and motivators who wish to cultivate and nurture leadership.

The second constraint placed upon the emergence of nursing leadership is the role expectation of women held by society. The nursing profession continues to be made up primarily of women. Since the public image of nursing's major function is one of nurturance, which is still viewed primarily as a woman's role, the public continues to view nursing with traditionally held feminine characteristics: subordinate, servile, emotional, non-intellectual, non-competitive with men, clinging, indecisive, illogical, and unable to deal with financial matters. As changes occur in society about the roles of both men and women, serious constraints upon emergence of nursing leadership should be removed. Nurses, who are women, have their own conflicts about leadership. They are hesitant to move into assertive behaviour, and are inept and unskilled in confrontation - negotiation, so essential in our society. They are also hesitant to demand the rewards of leadership (Leininger 1974).

The third major constraint is the ambiguities within the nursing profession itself. Many issues, long identified, have not been resolved. The questions of education, credentialling, roles of practice, control of practice, relationship to the medicine profession, and the relationship of the subcultures within nursing groups are being addressed, but definitive action has been somewhat superficial. The divisiveness that exists among the profession and the slow movement on resolution of the issues suggest that there is not adequate leadership or followership among the profession. There have not yet been found innovative ways to resolve questions. The diverse interests, education, and experience of nurses themselves hinder coalescence of group effort. The ambiguity about 'who is a nurse?' is basic to the problems and issues underlying the constraint (Aydelotte 1964). The lack of action suggests lack of acceptance of purpose, mandate, and leadership.

The fourth set of constraints is a class of factors arising out of the sheer size and complexities of the organisational structures of today's society. The problem of merging, or bringing into accommodation, personal goals, professional goals, and institutional goals in the health institution is highly complex. No longer is the leader, or sets of leaders, clearly visible; consequently, potential leaders have less opportunity, as the institutions are operated, to personally identify with a mentor or model. The social distance between the talented individual and the mature leader is increased, or made to appear so, by functionaries used by the leader and by the complexities and slowness of the communication process often built in by unnecessary bureaucracy. The growth of size and complexity of the organisation has lead to marked social stratification of the system, affecting the relationships between individuals in various work groups. Unless individuals in leadership positions build structures and utilise techniques that seek out and nurture leadership, the constraint of size and complexity often makes more difficult the task of identifying and cultivating talent. The complexity requires non-classical leadership.

PREPARATION FOR LEADERSHIP

Two requisites of the leadership role are the understanding of the social, political, and economic influences affecting programmes of health care and competence in dealing with problems in the relationships of professional practitioners and those within the complex social system in which nursing operates. (American Nurses Association (n.d.),(Graves 1973)

Since the functions of leadership relate to purpose, the kinds of functions performed by a leader and the matters attended to make visible the purpose as perceived by the leader. In order to accomplish the purpose of nursing leadership described in this paper, the nurse leader requires expert knowledge. One kind of knowledge the person must possess is knowledge of nursing practice and effects of practice. This knowledge and new knowledge that she* continually accumulates are processed in making choices about goals, changes, strategies, and policies. The nursing leader cannot use techniques effectively without nursing knowledge any more than one can teach knowledge of content.

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* The use of the feminine pronoun in no way indicates a bias toward the masculine sex.

Three broad sets of knowledge are needed by the nurse leader, knowledge of nursing and nursing practice, knowledge about the realities inside and outside the organisation that affect the accomplishment of purpose; and knowledge of research methods and study which can be used to obtain or review data needed to make decisions and to influence others. The leader must assess the validity and reliability of the data given her.

The three sets of knowledge are used by the nursing leader in making real the goals, purposes and objectives of the nursing group; in creating a structure through which these are achieved; and in maintaining the group as it works to achieve goals.

Nursing knowledge is essential. The nurse leader serves as a spokesman in planning the health care programme. She is the interpreter of nursing needs and goals to the community in which she acts. She must exercise influence in obtaining funds and freedom for innovation and improvements. If she is not knowledgeable about what comprises effective practice, if she is not up-to-date on trends and issues in health care, and if she is unable to process with intellectual rigour proposals for change of practice, she cannot make gains for nursing. She must also present evidence that the changes are economically realistic.

Purposes are made operational in a particular setting. Knowledge about the institution and its operation is drawn from many disciplines, such as sociology, social psychology, political science and economics. This knowledge is used to understand the socio-psychological political system in which the nurse leader exists. It deals with the distribution of power, authority, control and culture of the setting.

Some persons may stress that the personality of the nursing leader may be most instrumental in effecting changes. Of the theories of leadership, the interaction theory is the most plausible. Its foundation resides in an understanding of organisations, groups, decision making, communications, and the political process as well as understanding one's self as a leader. Of major importance in this body of knowledge is ultimate knowledge of the health care industry and especially its political legal and economic aspects.

The nurse leader uses knowledge of the setting to build a structure that can meet the purpose of the organisation or institution effectively. Her task is the creation of strongly committed groups of individuals into cohesive units that can produce effective results. The puzzle confronting her is putting forth the combination of talent, skill, values, and environmental variables that will result in high productivity and satisfaction of individuals. In achieving structure and group cohesiveness, the leader uses knowledge about opinion and attitude formation and change. Negotiating and movement into coalition are activities based upon getting and assessing political information. The economics of proposal are based upon sound fiscal data and knowledge of forecasting. The nursing leader is able to function because her actions reside in knowledge that is sound, pertinent, and relevant.

The third set of knowledge provides the tools of research. The nurse leader forecasts and predicts; she runs risks based upon hard data. Reports and proposals include data, trends, options, and forecasts. The nurse leader is able to perform in this manner because she has knowledge of research methodology and study and uses it to design, guide and process reports and data.

To prepare leaders, two types of education are needed, formal education programmes, preparing candidates for the nursing field, at the advanced level and training, defined as 'preparation for a specific position, or for entry into, or advancement to, an identified strata of positions' (Thompson (n.d.)).*

These training programmes provide 'on-the-job preparation' and are supplementary to and supportive of the formal education. The training allows for local and regional differences and helps the person keep abreast of recent innovations.

Formal education programmes for nurse leaders at the mid-management level should lead at least to a master's degree, all of which should have courses in advanced clinical nursing and a common core in health economics, health care administration, and epidemiology and biostatistics. Programmes preparing individuals in professional nursing administration should in addition include courses in management, financing, basic disciplinary and applied research and policy analysis. For a smaller group of nurses, preparing for highly strategic positions as legislative leaders, specialists, consultants, planners, and for very large complex organisations, formal doctoral preparation especially planned is required.

Diverse educational strategies are needed to bring about the process of formal education and a more open system is needed which does not sacrifice the quality of the education. The formal education programmes for nurse leaders should make use of care courses offered other health professional students, such as medical students, health care, administrative students, and those in social work. Faculty in those disciplines must collaborate and use each other's expertise to build sound core courses to serve groups of students. (Commission on Education for Health Administration 1975)**

Forms of non-traditional study, such as external degrees and continuing education, can be used to provide training for nurse leaders on-the-job, but this type of education should be better planned, less fragmented, with a clearer understanding of its nature and

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* Thompson's paper presents critical definitions differentiating education and training. It also treats the preparation of community physicians and health administrators which has direct application to nurses. Thompson's ideas have been used in this section of the paper.

** Discussion of problems and issues in providing new approaches to the education of health administrators.

limitations. It is not a substitute for formal education. It does not give the individual a broad range of knowledge which will allow movement within the leadership field. The training will provide structured education with experience; it can be built as self paced learning through the concept of modular units, and it should draw upon a region's resources for faculty and clinical material. (Ibid)

IDENTIFICATION OF TALENT AND ITS CULTIVATION

Creativity refers to the performance of high quality of work of a particular kind, and leadership is one of the multiple types of creative talent that exists. It is a highly complex talent that possesses intellectual components, motivational characteristics, and is implemented by personality, although not a large amount is known precisely about the interaction of these three. There is little question but that inheritance and environment (life history) both influence the cultivation of creativity.

The literature on leadership and creativity suggests that the talented individual possesses identifiable characteristics. The description of such individuals include such phrases as 'the ability to see patterns in data, intellectual curiosity and thoroughness, ability to sense problems, curious, and highly observant, and original'. Intellectually, the individuals are bright and curious. They are original, possess expressional and word fluency, and are capable of giving matters broad diffused attention.

Considerable research has been done to identify the creative individual in the early years of life, in order to cultivate that talent in childhood, adolescence and young adult years. Nurturance of creativity is encouraged in the early years through the provision of a responsive environment. Such an environment provides a setting for exploration, processing of ideas and problems, and self-direction of activities. It encourages risk taking, acceptance of failure and using it positively, and the perception of work as play. The traditional sex roles are minimised.

In basic nursing courses leadership must be encouraged and the talented individual identified and given special attention. Educational strategies, which encourage thinking and self-exploration, deferred judgment, fluency and processing of ideas, should be emphasised. Students should be given the opportunity to identify realistic problems, analyse and synthesise data, hypothesise, predict and establish test options. They must be given the freedom to be self-directed and to propose their own approaches, drawing upon the real world for data. Above all the faculty and clinical nursing practice staff must recognise, accept and encourage individual differences in students.

Models and sponsors for the unusual and talented individual should be present. These students would benefit from special seminars or courses that provide the opportunity for independence of action, analysis of risk-taking and handling of failure, and development of an understanding of sex-linked problems to their own personal motivation and career plans. Too often, talented individuals must rise on their own; what is needed in the nursing culture is acceptance of the idea that planning of careers, with anticipated changes for experience and education, is acceptable and expected. Training to be assertive is needed.

Many work environments of nurses negate the development of leadership. They allow the individual nurse little freedom of decision, hemming her in with rules, regulations, policies and procedures, an environment most comfortable for the nurse who does not wish to be accountable. In the work setting, structures that are less hierarchical, which provide reduced social distance between the practitioner and leaders, allow more communication and require greater responsibility and accountability of the practitioner, may encourage leadership development. An environment that places high value on intellectual challenges in work, encourages and provides continuing training and opportunities for growth, and holds individuals to expectations of performance that demonstrate growth is most conducive to developing leadership. Several authors emphasise that after meeting the need for the basic requirements for living, individuals gain satisfaction from work that gives them a sense of autonomy, fulfilment, and a control of the results of the work itself.

Probably one of the greatest strategies is for current and emerging leaders to take as their major purpose the cultivation of talented individuals. I predict that studies of current productive leaders will show the effect of personal attention from other earlier leaders. Older successful leaders must create opportunities for the growth of the generation to follow. This is done by serving as mentors for the younger group by assisting them in career planning, job advisement, educational advisement, and counselling on personal matters that may impede progress. Above all they must be given knowledge. The young are our responsibility and only by giving them immediate and foremost attention will nursing leadership be available for the society of the future.

REFERENCES

AMERICAN HOSPITAL ASSOCIATION. Annual survey, hospital statistics. Chicago Illinois, The Association, 1975 edition.

AMERICAN NURSES' ASSOCIATION. Facts about nursing 1972-1973. Kansas City, Missouri, The Association, 1974. pp. 272.

AMERICAN NURSES' ASSOCIATION. The position, role and qualifications of the administrator of nursing services. 10 Columbus Circle, New York, The Association, no date.

AMERICAN NURSES' ASSOCIATION. Models for health care delivery: now and for the future. Papers presented at the American Academy of Nursing, Jan. 20-21 1975. Kansas City, Mo., The Association 1975. pp. 43.

AYDELOTTE, Myrtle K. Current issues in nursing. Unpublished paper prepared for joint committee of American Nurses' Association and National League for Nursing. New York, The Associations 1964.

COMMISSION ON EDUCATION FOR HEALTH ADMINISTRATION. Report: Education for health administration. Ann Arbor, Michigan, Health Administration Press, Vols I and II 1975. pp. 190 and pp. 330.

DRUCKER, Peter F. Management: tasks, responsibilities, practices. New York. Harper and Row 1974. pp. 839.

GIBB, Cecil A. Leadership The Handbook of Social Psychology Vol 4 2nd ed. Edited by LINDZEY Gardner and ARONSON Elliott. Reading, Mass. Addison-Wesley Publishing Co. 1969. pp. 694.

GOLDMARK, Josephine (Secretary) Nursing and nursing education in the United States. Report of the committee for the study of nursing education. New York. MacMillan. 1928

GRAVES, Helen Hope. Survival in the system. Journal of Nursing Administration. Vol. 3 1973. pp. 26-30.

INSTITUTE OF LIFE INSURANCE TREND ANALYSIS PROGRAM. Trend report no. 4. New York, The Institute. 1972.

KISSICK, William L. (ed). Dimensions and determinants of health policy. The Milbank Memorial Fund Quarterly. Vol. 46 part II 1966 pp. 272

LEININGER, Madeline. The leadership crisis in nursing. Journal of Nursing Administration. Vol. 4 March-April 1974. pp. 28-34.

LEVEY, Samuel and LOOMBA, Paul N. Health care administration: a managerial perspective. Philadelphia, J. B. Lippincott, 1973. pp. 621.

LEVINSON, Harry. The exceptional executive: a psychological conception. Bainbridge, Mass., Harvard University Press, 1968.

LIPPITT, Gordon L. Hospital organization in the post-industrial society. Hospital Progress.vol. 54 1973. pp. 55-64.

MILBANK MEMORIAL FUND COMMISSION. Report: Higher education for public health. (Sheps, Cecil G. Chairman) New York, Prodist 1968. pp. 218.

MULLANE, Mary K. Education for nursing service administration: an experiment in program development by fourteen universities. Battle Creek, Mich. W.K. Kellogg Foundation. 1959. pp. 242.

SCHAEFER, Marguerite J. The political and economic scene in the future of nursing. American Journal of Public Health, vol. 10. 1973 pp. 887-889.

SURGEON GENERAL'S CONSULTANT GROUP. Report: Toward quality in nursing needs and goals. United States Department of Health, Education and Welfare. Public Health Services Publication No. 992. 1963.

TAYLOR, Calvin W. Are we utilizing our creative potentials? Nursing Outlook. Vol. II. Feb. 1963. p. 10.

TAYLOR, Calvin W. (ed.) Creativity: progress and potential. New York, McGraw-Hill Book Co., 1964. pp. 241.

TAYLOR, Calvin W. and BARRON, Frank (eds.) Scientific creativity and its development. New York, John Wiley. 1963. pp. 419.

TAYLOR, Calvin W., NAHM, Helen and others. Selection and recruitment of nurses and nursing students: a review of research studies and practices. Salt Lake City, University of Utah Press, no date., pp. 91 (PHS Grant GN 6330)

THOMPSON, John D. Training and education for health service administration in England and Wales. New Haven, Conn., Yale University. no date.

WALLACE, Peggy. Estimated number of employed nurses 1973 and 1980, and estimated number needed by level of preparation. Mimeographed (working paper). Kansas City, Mo., American Nurses' Association 1974.

WENNBERG, John E. National health planning goals. Boston, Mass. Center for Analysis of Health Practices. Harvard School of Public Health. unpublished paper. 1976.

YORDY, Karl D. Regionalization of health services: current legislative directions in the United States. in SEWARD, Ernest A. The regionalization of personal health services. New York, Prodist, 1975. pp. 201-215.

3 III NURSING LEADERS IN CANADA

Ada E McEwen

'If a man reaches the top, he is not going to tell you how he really got there.' (Packard 1962)

The enigma of how leaders emerge is not easily explained, whether they be male or female. Hundreds of studies on leadership have been done beginning in the 1930s and extending up to the present time, still leaving many questions unanswered. Ralph M Stoghill (1974), considered to be one of the world's experts on leadership, read 3000 books and articles on the subject preparing his book, Handbook of Leadership. In general, the studies agree that a number of interacting factors contribute to the development of leaders. The three main factors affecting this development are considered to be personality traits and attributes of the individual, the climate of the work situation and the forces generated by the subordinates. Without contradicting this general statement, Ordway Tead (1935) sees elevation usually occurring in one of three ways. 'Leaders push themselves up. They are selected by the group. Or they are appointed by some top responsible power.' (p. 25) Others take a more pragmatic view and, in answer to the question; 'Where do leaders come from?' reply 'They will appear; the jobs will need to be done and someone will learn to do them'. (Hilberry 1952)

There is general agreement that successful leaders are not easily classified. They vary in characteristics and personality traits as widely as do unsuccessful ones. Some who do well in one situation, do poorly in another. Goble believes that 'Perhaps there are innate characteristics that make some (leaders) more qualified than others, but there is little doubt that any reasonably intelligent individual can learn to be a competent leader'. (Goble 1972 p. 4)

If leaders cannot be distinguished from followers by means of overt characteristics, they may, according to Drucker (1966), be recognised by their actions or habits. They know where time goes. Their efforts are geared to results rather than work. They recognise strengths in themselves, in their superiors, their colleagues, their subordinates and in the work situation and build on them. Priorities are set and adhered to. They are orderly and effective in their decision making, recognising that in making many decisions quickly, some will be wrong.

The difficulty in distinguishing leaders from followers is affected by other factors. The more democratic approach to administration, the teamwork approach to management and the advent of more group work situations, make the sharp distinction between leaders and

and followers less defined. In multidisciplinary teams and in group work, the leadership role may change with varying situations. Knowles (1959) sees a shifting away from the concept that the leader is the one 'who plans for, thinks for, takes responsibility for and directs other people toward the notion that the leader is primarily a convener, trainer and coordinator for the group'. (p. 12)

The continuing economic growth and increased complexity of society have created an unprecendented need for leaders in both the private and public sectors. The demand for health and health-related services has mushroomed. If there was a time when 'born leaders' could meet the demand, that time is long past. Nursing leaders are needed as nurse practitioners, educators, administrators, clinical specialists and researchers. They are needed in institutions and in community services, in universities and colleges, in health centres of industrial plants and business offices, in clinics and in homes.

When life moved at a slower pace and leaders emerged through a more normal developmental process, those who rose to the top were highly motivated, ambitious, had inquiring minds and a desire to find the answers. With the increased demand for leaders today, how does one create the climate that will stimulate individuals who may not be so inclined? Social scientists have attempted to find the answers and many theories have been proposed by people such as A H Maslow, Douglas M McGregor, Frederick Herzberg, Chris Argyris, Kurt Lewin, Rensis Likert and Fred E Fiedler, to mention only a few. Some of these will be referred to more directly later in this paper.

In addition to this basic question of motivation, the nursing profession, with a predominately female work force, has social forces to overcome more so than other professions or groups. Career advancement is affected or interrupted by marriage and family responsibilities and by inability to move to where the job opportunities would offer greater potential for leadership development. We are particularly aware of the mobility problem in a national organisation, with 80 branches separated by up to 4000 miles. Candidates for senior position vacancies are limited almost entirely to unmarried nurses. However, the situation is changing to some degree, and in recent years, we have had several instances where husbands have moved or have indicated a willingness to move to allow the wife to accept a more senior position.

Conditions conducive to the emergence of leaders will be considered in relation to the three main factors identified earlier. In spite of the difficulty in identifying individuals with leadership potential, there are inner traits that do become evident in working with individuals over a period of time that appear to contribute to successful job performance: a positive attitude toward problem solving; a willingness to try, with expectation of success; strong drives and steady persistence; the inclination to keep on trying when others give up; good judgment, self control and realistic thinking - indications of a mature personality; a marked aptitude for getting along with others. (Goble 1972 p. 48)

The climate of the work situation and the forces within the subordinates are closely intertwined. If we accept McGregor's (1960) theory that 'The individual will grow into what he is capable of becoming, provided we can create the proper conditions for his growth', (p. 192) and Maslow's theory of motivation based on the prepotent hierarchal steps culminating in self actualisation, the climate of the work situation becomes very significant. What conditions should prevail? Measurable objectives, which are challenging, are considered one of the most powerful motivating techniques of modern management. 'Men must have goals which, in their eyes merit effort and commitment; and they must believe that their efforts will win them self respect and the respect of others.' (Gardner 1961 p. 132) These objectives or goals should be clearly stated for the whole of the organisation and known and understood by all. Subordinate and supporting objectives should be developed at each level and by each individual.

The degree to which the individual will be free to carry out personal objectives within an organisation will depend on the organisational structure. A flattened pyramid structure or a decentralised administration will allow more opportunity for developing leadership potential than a centralised one. If this is not possible, smaller groups can be created within larger ones to allow opportunities for individual growth by providing greater responsibility for one's own behaviour, the opportunity to make independent decisions, the chance to develop self confidence and also to benefit from the experience of failure. The Sears Roebuck Company deliberately expanded the span of control so that one executive would have up to 40 managers reporting to him to ensure that opportunities for individual development would occur. (Packard 1962, p. 297) The degree of risk involved in this approach is directly related to the competence and leadership potential of the individuals filling the positions.

Regardless of the structure of the organisation, it may be possible to allow individuals at all levels within the organisation to have a sense of participation. The degree to which this will happen depends a great deal on the persons presently providing the leadership. Is the development of leaders one of their main objectives? Are they rewarded for their successes in achieving this objective? Do they trust their subordinates, and are they prepared to take the risk of giving them an increasing responsibility for decision making? Do they, at every level, assume the responsibility for ensuring that they can be replaced by a subordinate at least as capable as themselves?

The members of a group will, through the forces generated within that group, push up to the top the person who can best help them reach their objective. Recognition and acceptance of a common goal will determine the degree of cohesiveness of the group. The individual who is best able to 'harness' the forces within the group and direct them on this chosen course is most likely to emerge as the leader. The goals of the individual and those of the organisation will not always be in unison. The conflict that develops need not lead to destruction but can result in growth and development. Argyris (1962) sees the need for much more research to determine the 'proper mix' of individual needs and organisational demands. (p. 1)

Learning-by-seeing-and-doing is still considered the best preparation for leadership, putting a heavy responsibility on the individuals in leadership positions. Rotation through various positions can be an integral part and is considered the least expensive type of on-the-job training. The benefit gained from this experience is again dependent on the ability of the present leaders. The length of time spent in each position is important. It must be long enough to allow the individual to make a contribution, develop a sense of commitment to the responsibilities and to derive a reasonable degree of satisfaction. A short period will allow the individual to do little more than maintain the status quo, thus making little contribution towards achieving objectives, be they organisational or personal.

Salary structures and promotion policies can act as incentives or barriers to leadership development, depending on the interest of the individual and the administration of the policy. How many nurses interested in developing their potential in research or clinical nursing have found themselves accepting administrative positions, because this was and still is, in many instances, the only route for advancement? Is there opportunity for growth at the present level for those who for one reason or another do not advance?

Should conducive conditions be general or should individuals with leadership potential be selected for specific treatment? Several factors make it difficult to select specific individuals for leadership development. The difficulty in identifying individuals with leadership potential is not the least of these. The General Electric Company, which has had an extensive development programme has rejected the practice of singling out the promising candidates early and giving them the exclusive chance to progress. A study indicated that out of 143 singled out ten years earlier, only a little more than one third were fulfilling earlier promise. (Packard 1962, p. 277) The need for leaders in so many and such diverse situations in the health field and the knowledge that leadership ability is not necessarily transferrable from one situation to another support the requirement to expose as many individuals as possible to situations where they will have an opportunity to develop their potential.

Although on-the-job experience probably has the greatest impact on leadership development, continuing education programmes both within and outside the work situation appear to be a necessary adjunct, in spite of the limited evidence of their value. Fiedler (1972) reports that there have been very few studies done under controlled conditions, and those that have been done fail to show that either leadership training or experience improve organisational performance. Similarly, Jack (1971), did a study in a large diversified company where a two-week 'crash' programme in executive development had been organised. The results indicated that management attitudes were not changed by this programme and that any organisation would be well advised to survey the motivational needs of their employees before embarking on such programmes. Ingmire and Taylor (1967), studying the effectiveness of a continuing education programme in nursing developed to improve skills in administration, supervision and teaching,

found that the programme had a definite impact upon the participants' expressed attitudes and beliefs concerning leadership roles and interpersonal relations. There was a limited effect on manifest behaviour. (pp. 33-34) McGregor (1960 p. 204) suggests that correlation between formal management development programming and the actual achievements of the organisation may even be negative. Difficult as it is to measure the cost benefit, there is a general feeling that these programmes have resulted in better interpersonal relationships and created a greater sensitivity to new and better ways of doing things. Recognising the significant role that individuals in present leadership positions in the work situation play in the development of future leaders, it is abundantly clear that any training for leadership should start at the top.

In a rapidly changing and increasingly complex world, nurses need to renew themselves on an ongoing basis and acquire new knowledge and skills in their particular areas of interest. The degree to which they will grow and mature will depend on their own initiative. Development is always self development. The responsibility of the organisation is to create the climate in which this will occur. The degree to which any organisation can conduct its own training and development programmes will depend on the size and the resources available. Small groups and agencies will have the most difficulty and may have to participate in programmes conducted by large agencies. Benefit in this instance will be derived through contact with individuals in different work situations and with different backgrounds of education and experience.

Likewise, educational opportunities outside the work situation will be dependent on the size of the community and, in some instances, will be very limited regardless of the area of interest. Large metropolitan areas, university centres and centres with community colleges will present considerable choice, not only for those nurses interested in improving their clinical or research skills but also for those interested in developing interpersonal or management skills. The availability and variety of courses sponsored by nursing associations also are affected by geography.

Leadership is incorporated into curricula of schools of nursing at both the undergraduate and postgraduate levels; whether given as an independent course or not varies from school to school. Nurses interested in improving their management and administrative ability should, in addition, be encouraged to enroll in multidisciplinary seminars and short courses such as the one at the Banff School for Advanced Management, as well as in university schools of business or management science. Multidisciplinary senior management courses of three months' duration also are provided by the Federal Government. The first Canadian nurse has completed the three-month classroom portion of the Career Assignment Programme which is under Federal Government auspices. This intensive multidisciplinary programme, designed primarily for Government employees, also accepts a small number in each class from private enterprise and is the training programme for senior executive positions. Following the classroom sessions, the individuals progress through two or three special job

assignments, each of one or two years' duration before being posted to an executive position.

In discussing continuing education for leadership, one cannot overlook the phenomenon of sensitivity training in the form of T-groups that began in the 1940s. These unstructured group situations, which provide the participants with an opportunity to explore personal motivations and reactions, are designed to improve social interaction skills. Although subjected to considerable criticism, conducted under the proper conditions and direction, there is evidence that these courses have demonstrated their value. Courses have been sponsored by nursing associations in Canada for more than 15 years and at least in one province continue on an annual basis. Many nurses have taken advantage of these courses, as well as other multidisciplinary courses conducted under various auspices. With increased emphasis on group or team work at many levels in the health field, nurses should avail themselves of opportunities to improve their skills in social interaction.

The emergence of leaders is an intricate phenomenon, the complexities of which are not readily explained in spite of extensive research. There is general agreement that a number of interacting factors contribute to the development of leaders; personality traits and attributes of the individual, the climate of the work situation and the forces generated by the subordinates. Potential leaders are difficult to identify and because of this, as well as the numerous and diverse situations in which leadership is required, the conditions conducive to leadership should be general rather than specific. The work situation should provide an atmosphere that allows for personal growth and development with challenging measurable objectives to strive for.

A decentralised organisation structure offers the best opportunities for individuals to develop self confidence, experience failure and assume greater responsibility for independent decision making. The basic responsibility of the organisation is to create a climate that will stimulate self development.

On-the-job training, including rotation through different positions, contributes most to leadership development, placing a heavy responsibility on the present leaders. Their day-to-day performance and the degree to which they trust their subordinates and are prepared to give them increased responsibility make a significant impact.

The value of continuing education for leadership either inside or outside the job situation is difficult to substantiate. There is no question, however, that any leadership training should start at the top and depending on the circumstances may be unidisciplinary or multidisciplinary. Sensitivity training can be of value in developing skills of social interaction, which may be of increasing importance for group and team work.

The need for leaders in nursing, in particular, and the health field, in general, is great and shows no signs of diminishing. No doubt many more could achieve leadership positions than now do. Research efforts, no doubt, will continue. Based on the knowledge now available, we must strive to create the climate within our organisations that will stimulate more individuals to develop their leadership potential.

REFERENCES

ARGYRIS, Chris. Interpersonal competence and organisational effectiveness. Homewood, Ill. Dorsey Press, 1962.

DRUCKER, Peter. The effective executive. New York, Harper and Row, 1966.

FIEDLER, Fred E. The effects of leadership training and experience: a contingency model interpretation. Administrative Science quarterly, vol. 17, no. 4. December 1972. pp. 453-470.

GARDNER, John W. Excellence. New York, Harper and Row, 1961.

GOBLE, Frank. Excellence in leadership. American Management Association, 1972.

HILBERRY, Conrad. Growing new leaders in In search for leaders. Edited by SMITH, G.K., ERHARD, T., MACGUINEAS, C. American Association for Higher Education, Washington, D.C., 1952. pp. 92-95.

INGMIRE, Alice and TAYLOR, Calvin. The effectiveness of a leadership program in nursing. Boulder, Colorado, Western Interstate Commission for Higher Education. February, 1967.

JACK, W.R. Are management attitudes changed by "crash" executive development programs? in The Best of the Canadian Personnel Journal. Edited by PERIGOE, J.R., and HERCUS, J.F. Toronto, 1971.

KNOWLES, Malcolm. How to develop better leaders. New York, Associated Press, 1955.

MCGREGOR, Douglas M. The human side of enterprise. New York, McGraw Hill, 1960.

PACKARD, Vance. The pyramid climbers. New York, McGraw Hill, 1962.

STOGHILL, Ralph M. Handbook of leadership: a survey of theory and research. New York, Freepress, 1974.

TEAD, Ordway. The art of leadership. New York, McGraw Hill, 1935.

DISCUSSION

The emergence of nursing leaders was seen to depend on the 'gate keepers', who selected from the candidates who presented themselves and on the 'game keepers' who provided the nurturing environment.

SELECTION

If every qualified nurse is a potential leader, the 'gate keepers' hold key positions. The general opinion was that it was not necessary to introduce some form of 'élitist selection procedure'; the normal student intake should provide the necessary number of leaders of the required calibre for the wide range of leadership positions in nursing. 'Gate keepers' would need to recognise the value of preparation and experience in fields other than nursing as many bright students had been found amongst people for whom nursing was not a first choice of career. People influenced by unemployment to seek training as nurses would not necessarily be less well motivated than other students.

Selection for special grooming for leadership positions presented problems. In selecting individuals for special grooming, it was never possible to be sure whether people not chosen would have done as well as those chosen, given the same opportunities. These was a real danger of charges of favouritism where a few people were chosen for special treatment. Leaders certainly had a responsibility to see that their successors were ready for office but this did not mean choosing an individual for promotion. Posts had to be advertised and the person groomed for the post might not be selected. What was necessary was to ensure that each individual developed to the full his or her potential for leadership. Then posts could be filled from a number of applicants with suitable experience and qualities. Attention was drawn to special problems created by an expanding service when it might be appropriate consciously to develop the second best. In selection it was necessary to take the possibility of personality clashes into account. Selection procedures could be by the book but independent informal enquiries could be made.

Leaders were to some extent self selected. Those with exceptional talents would make their own way. The majority would need help to develop leadership potential. Selectors were seen as fallible and the case for providing for everyone environmental conditions conducive to personal development was accepted as of prime importance.

NURTURING LEADERS

Students would take as their role models the people from whom they learned, be they ward sisters or faculty members. Faculty members had a particular responsibility to provide intellectual leadership. There was a danger of intellectual laziness developing amongst student nurses and alienation from other social groups. Practice situations had to be provided which would call for intellectual excellence. Intellectual friendships were helpful. One delegate enlarged on the value of a senior member of staff talking with students about her experiences in national and international affairs.

Students would need opportunities to develop professional awareness, for example through involvement in and perhaps office bearing in a student nurses' organisation.

The place of formal courses in developing leadership potential was not fully discussed but reference was made to the controversial value of sensitivity training, inservice training and 'sitting next to Nellie'. What was clear was that at the end of the training period the nurse should know what she had to do in her work with patients and clients and how and why she had to do it.

Movement through a range of different positions was seen to be important. Moving sideways as well as up in the hierarchy had value for learning. Secondment for service with a professional organisation, with a local or national government department or with an international organisation could offer excellent opportunities for learning about the wider aspects of nursing and for acquiring skills of great importance for leadership positions. There could be problems of salary differences, pension rights, and friction with trade unions.

In the early stages in a new post, people would need considerable support. They could not reach peak performance instantly but would have to work up to it gradually, needing less and less support as they became familiar with the work. Of particular importance was the need to delegate authority commensurate with the responsibilities of the job. Employers should not seek to retain people who had achieved peak performance but should encourage them to widen their experience. The point was made that with too high and too steep a pyramid it was difficult to give people room to develop. Individuals should not be forever dependent on someone else preparing and stimulating them. They should start using their own initiative at an early stage. Rigid career planning was not possible or desirable but information about career possibilities should be readily available and this was crucial to independent development.

Institutional structures could be viewed as constraints or supports. As one delegate put it 'Don't kid yourself you can change the system. You will break your back; you have to learn to work with the system'. A leader had to be very conscious of the use he made of his time, never doing for people what they should do for themselves. A bureaucracy took care of routine decisions allowing leaders to devote

time to boundary areas where new decisions had to be taken. Some of these were seen as 'what if' areas where contingency plans were laid.

Nurses were not yet routinely included as experts on policy committees. A leader might find herself admitted even though she had not the expertise in the particular subject that one of her staff might have. Strategy would suggest she accepted the position seeking later to have the staff member accepted in her place. The leader needed a roster of people competent to advise on special subjects.

The importance of government and professional associations working closely together on health service matters was stressed.

Information giving was seen as a highly controlling activity whether it was to consumers, to colleagues in multidisciplinary teams or to followers.

Nurse leaders were needed for intellectual leadership; for clinical positions, for management, for public relations with consumers, for government positions, for work with nursing associations and for international officers. These positions called for many different types of leaders who had to be found from the people selected by the 'gate keepers' and nurtured by the 'game keepers'.

4 I EVALUATION OF LEADERSHIP PERFORMANCE - an American view

Jessie M Scott

Leadership may be defined as the process of influencing people, individually or in groups, to effectively accomplish organisational missions.

Fascination with leadership is as old as the Creation, and, ever since, man has wanted to understand this phenomenon. We find reference to it in the Book of Exodus, when Moses and Jethro were speaking:

> '... Moses took his seat to administer justice for the people, and from morning till evening they stood round him. Observing what labours he took on himself for the people's sake, the father-in-law of Moses said to him, "Why do you take all this on yourself for the people? Why sit here alone with the people standing round you from morning till evening," Moses answered his father-in-law, "Because the people come to me to bring their enquiries to God ..." "It is not right" the father-in-law of Moses said to him "to take this on yourself. You will tire yourself out, you and the people with you ... You cannot do it alone ... You ought to represent the people before God and bring their disputes to him. Teach them the statutes and the decisions; show them the way they must follow and what their course must be. But choose from the people at large some capable and God-fearing men, trustworthy and incorruptible, and appoint them as leaders of the people: leaders of thousands, hundreds, fifties, tens. Let these be at the service of the people ..." ' (Jerusalem Bible 1966)

Movement in our society to a democratic structure has heightened the interest, since we cannot rely on an hereditary aristocracy to provide our leaders. Everyone is potentially a leader. Leadership is found at many levels and in many places - in government, in education, in health, in unions, in giants of industry, in professions. Leaders are also found at national, state, and local levels through work, or through involvement in civic matters. Taken all together, our leaders probably number in hundreds of thousands of persons of merit, who mould opinion and take us through courses of action.

Fiedler (1967) defines leadership as 'an interpersonal relation in which power and influence are unevenly distributed, so that one person is able to direct and control the actions and behavior of others to a greater extent than they direct and control his'. Using this concept, it is apparent that personality of the leader determines, to a large extent, the degree to which he influences the behaviour of the group, because of the relationship established between the leader and the group members.

Leadership is defined by Hagen and Wolff (1961) as 'the ability to influence the behavior of others in order to accomplish the task of a group or to achieve the goals of a group while, at the same time, maintaining the integrety and morale of the group'.

And according to Tead (1935), 'leadership is the activity of influencing people to cooperate toward some goal which they come to find desirable'.

Other attempts to describe leadership bring to mind words like authority, power, and influence. It is of interest to note that Webster (1970) uses each to describe the others and as synonyms. 'Influence implies the power of persons or things to affect others; authority implies the power to command ... based on strength of character, expertness of knowledge ... made on good authority' and 'power denotes the inherent ability to rule or govern or determine.'

Along with power and influence go talent and intellect. But perhaps of even greater importance than these are the attributes of commitment and responsibility. Intellect by itself can be devoted to evil or to good; and talent can be questioned as to purpose, but commitment and responsibility broaden the concept. When individuals come into areas or positions of influence - either through their own efforts or because of timing, responsibility is required, and commitment is expected. Thus, the combination of these attributes is essential to what is identified as effective leadership.

An additional comment on the attributes of the leader is the import of a positive attitude about or toward others. It is more critical than the process. People want to feel secure. Thus the role calls for the need to introduce support and help for those affected. Another important element is the ability to analyse forces when people are interacting and not be misled by an assumption of the 'status quo'.

Evaluation of the performance of leadership means to judge or determine the worth or quality of the role. Evaluation here should focus on the system or programme, rather than on the individual.

Leadership requirements depend on the environment. Some of the factors involved include: nature and values of the organisation; type of problem and nature of the task; values of the leader and of the group; experience of the leader and group members; organisation and group culture; cultural environment of component and transcultural problems; and organisational structure.

Although the literature is replete with reports of studies of role and functions of leaders, little definitive research has been done on leadership evaluation. Perhaps this is so because of the complexity of evaluating the numerous variables impinging upon leadership performance.

For the purpose of this paper, a number of models of leadership were examined and selected for reporting and discussion, with the thought that such a presentation might provoke substantive discussion about the concept.

One way to evaluate leadership is to examine the role as depicted in Figure 1. In this instance, we see that the crux of the model is the style of leadership according to the leader's capabilities (preparation and talent) as impacted by the environment and organisational relationships. Of importance in the model are the elements of risk and power.

Power can be looked upon as a source of influence (Stodgill 1974), potential for coercion (Tannenbaum 1968), control of rewards system, or as a means to set up conflicting operations (or camps). In the latter can be observed the opportunity to influence internal decisions by outside pressures or vice versa. The use of power in this fashion and for this purpose suggests a highly sophisticated mode of operation. Depending upon one's position, it can be viewed as good or bad quite apart from outcomes.

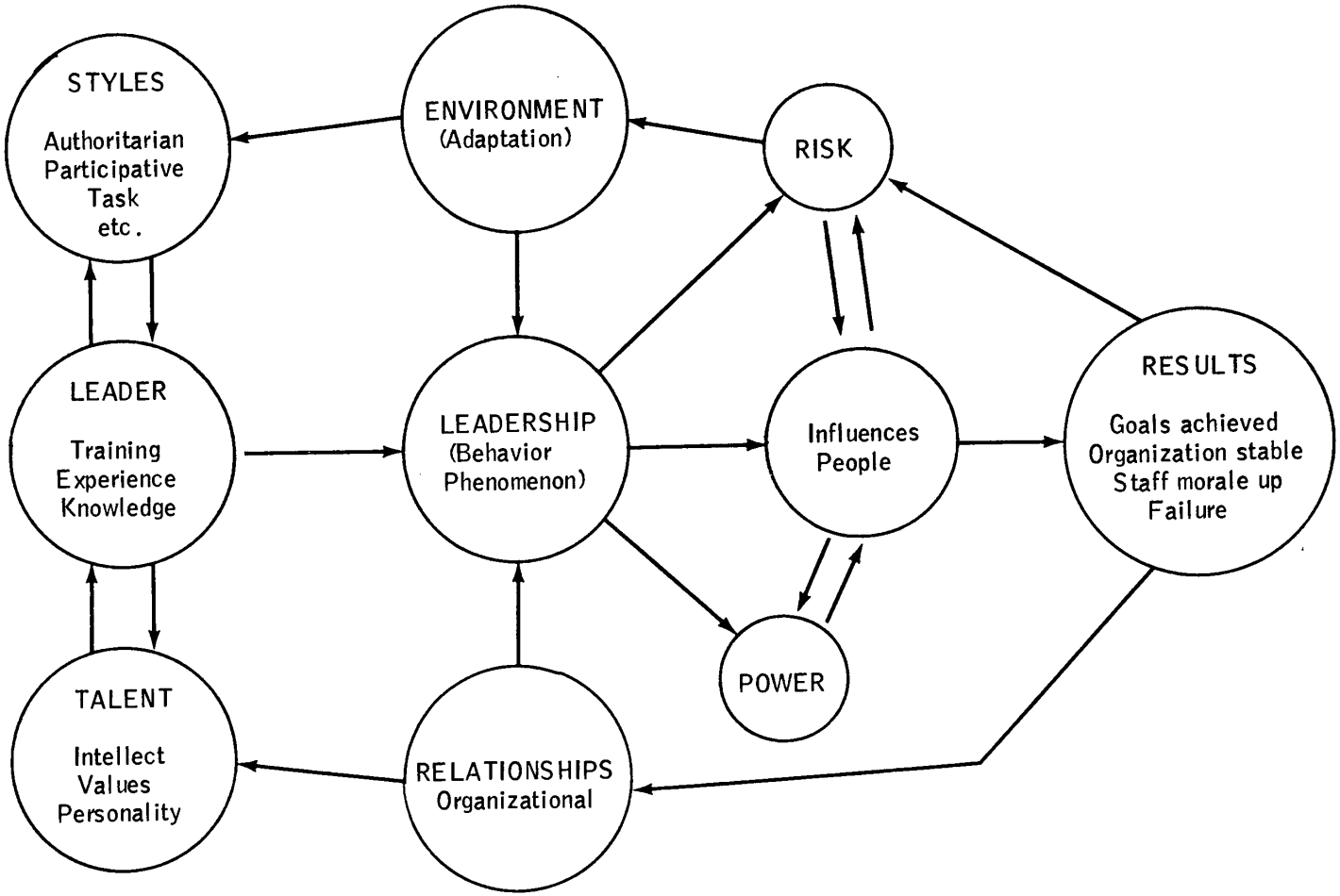
Risk involves exposing oneself to chance of loss or injury (Webster 1970). While in this model it implies taking a chance, it also means weighing in the balance the risk of failure, loss of prestige, or injury to the group. It is suggested that it is essential that the forces in the environment be known, and that the system (organisation) be thoroughly understood. Often, for leadership to be dynamic, power and risk are key elements. Again, as these are employed, commitment and responsibility are inherent.

Another way to examine leadership behaviour is found in Figure 2. Here we see that management is the process and that leadership is one of the facets, if not the key facet, of management. In this instance, leadership is shown to be part of the continuum of management of things and the development of ideas, with its share having to do with people, influence, and communications. Any examination of leadership in this model is underscored by the other facets of administration and conceptual thinking. It is a continuous flow of functions from one segment to another.

Among the various dimensions of leadership are 'task behavior' and 'relationship behavior' defined by Halpin and Winer (1959).

Figure 1

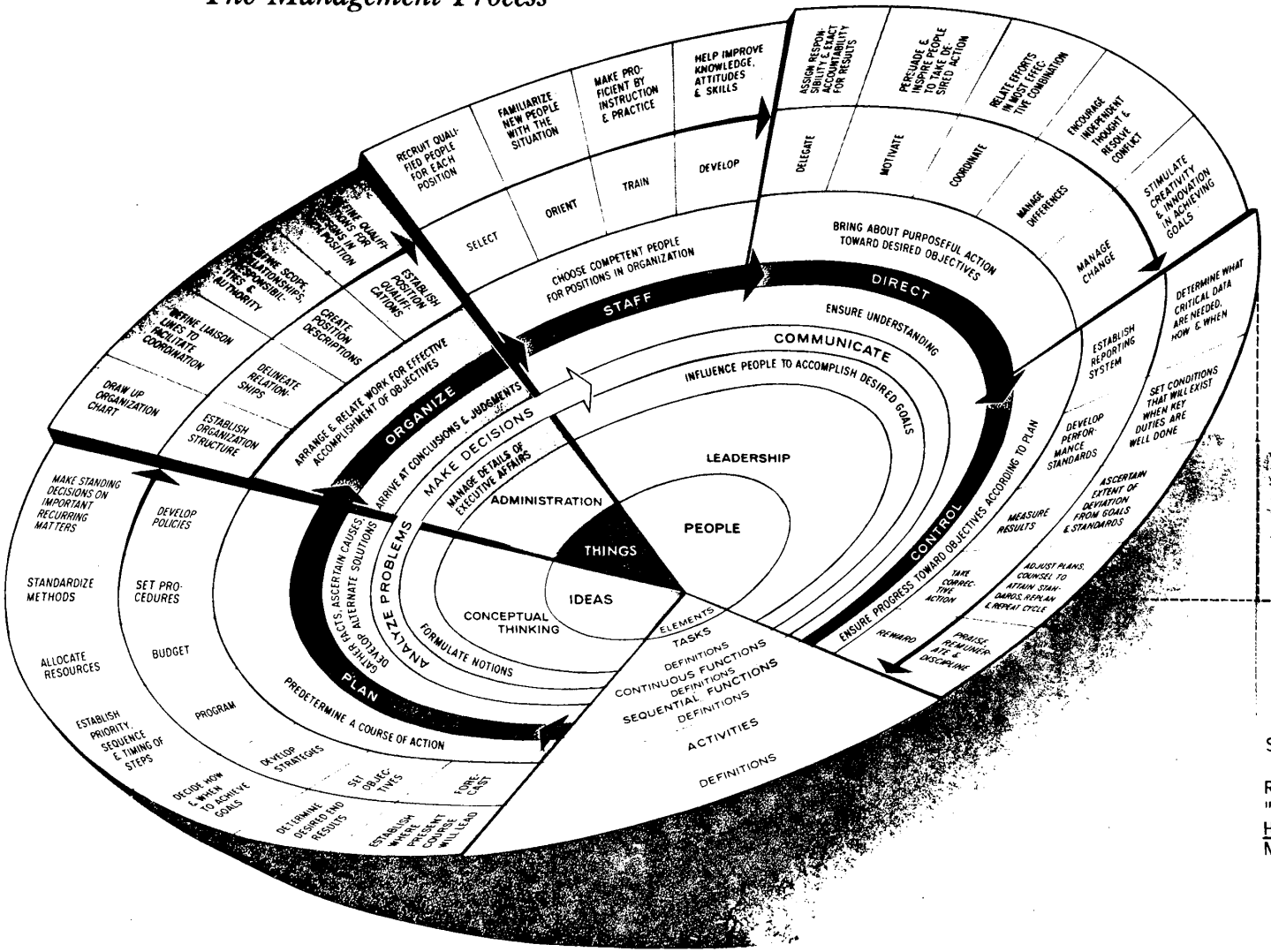
Leadership Model



Source: S. Optner, Systems Management for Business Management (Englewood Cliffs: Prentice Hall, 1971), pp 27-31.

Figure 2

The Management Process



Source:

R. Alec Mackenzie,
"The Management Process in 3-D",
Harvard Business Review,
Nov.-Dec., 1969, pp 80-87

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'task behavior: the extent to which a leader is likely to organise and define the relationships between himself and the members of his group (followers); characterized by a tendency to define the role which he expects each member of the group to assume, endeavouring to establish well-defined patterns of organization, channels of communication, and ways of getting jobs done.

relationship behavior: the extent to which a leader is likely to maintain personal relationships between himself and the members of his group (followers) in terms of socioemotional support; characterized by friendship, mutual trust, and respect for followers' ideas.'

These two dimensions can be plotted on two separate axes, as shown in Figure 3. It will be noted that the grid has a scale of 0 (low) to 9 (high) on each axis.

The styles of leadership depicted range from (9,9) 'team management', which is high in both relationship and task behaviour, to (1,1) 'impoverished management,' which exhibits a minimum degree of relationship and task behaviour.

The various zones of the managerial grid cover the complete spectrum of leadership styles as follows:

'team management' or (9,9) leadership - characterised by highly committed people working interdependently toward meeting group objectives with relationships of trust and respect;

'employee-centred' or (1,9) leadership - typified by thoughtful attention to needs of people for satisfying relationships with a comfortable friendly organization atmosphere and work tempo;

'task-centred' or (9,1) leadership - efficiency in operations results from arranging conditions of work in such a way that human elements interfere to a minimum degree;

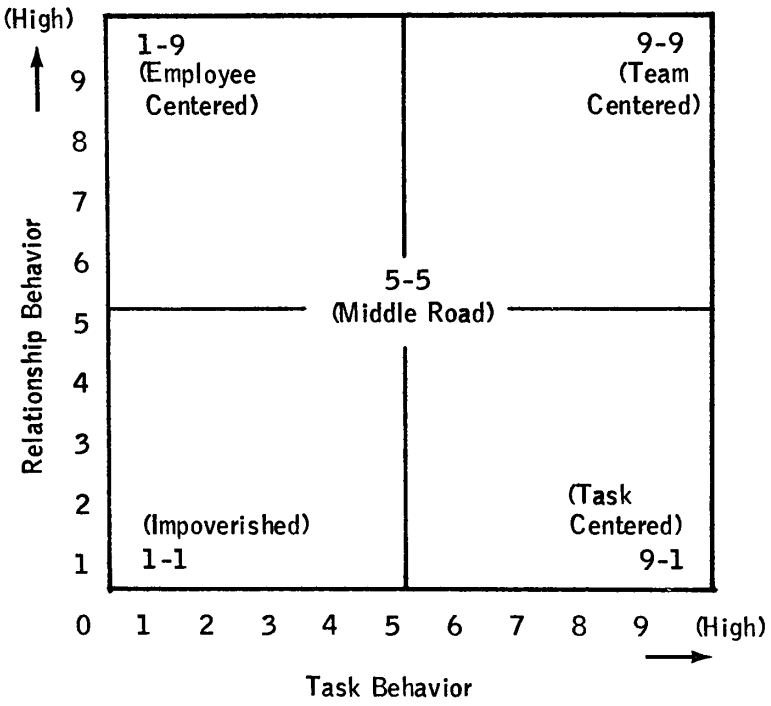
'middle of the road' or (5,5) leadership - balancing the necessity to get out work with the maintenance of satisfactory morale of people;

'impoverished' or (1,1) leadership - exertion of minimum effort to get the required work done, usually with ineffective results.

A third dimension of leadership is that of adaptability. The Tri-Dimensional Leader Effectiveness Model, (Hersey and Blanchard 1969) shown in Figure 4 integrates the 'Styles of Leadership'

Figure 3

Leadership Style Model

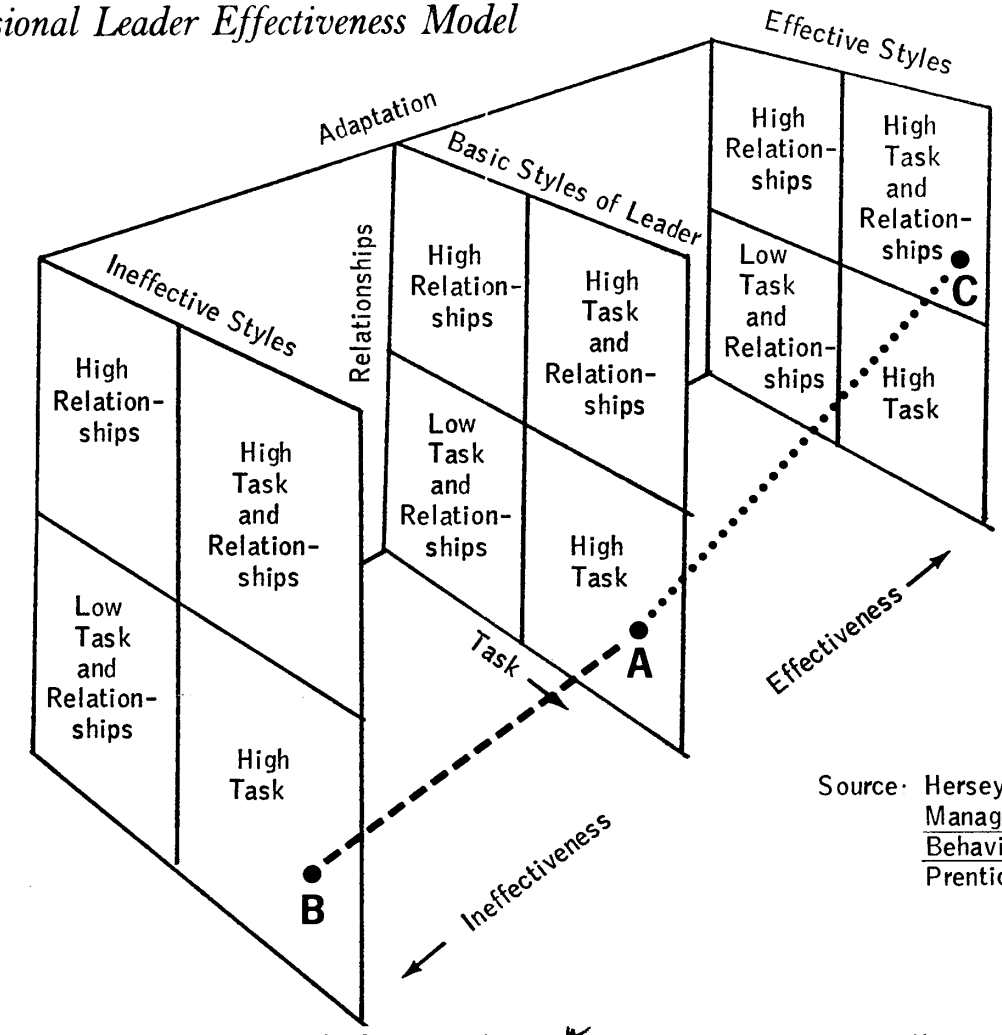


The grid has a scale of 0 (low) to nine (high) on each axis.

Source: Robert R. Black and Janes Moutow, The Managerial Grid (Houston, Texas: Gulf Publishing, 1964).

Figure 4

Tri-Dimensional Leader Effectiveness Model



Source· Hersey and Blanchard Management of Organizational Behavior (Englewood Cliffs, Prentice Hall, 1969), pp 93-120

The middle quadrants represent the four basic behavior styles: the left quadrants illustrate four basic styles when they are ineffective, as used in an inappropriate situation; and the right quadrants illustrate the four basic styles when they are effective as used in an appropriate situation.

(Figure 3) with the 'adaptability' measure of a leader to the situational demands of the dynamic environments in which he must perform.

When the leadership style adapts to a given environment measured by positive results, it is termed effective; when the style is inappropriate to a given environment and results are negative, it is termed ineffective.

Effectiveness in the Tri-Dimensional Leader Model is defined as the extent to which the goals and objectives of the organisation have been accomplished, taking into account both short and long-range goals. The assessment should consider both output or productivity measures, and the often overlooked intervening variables.

Likert (1961) has indicated these so-called 'intervening variables' that reflect the condition of the internal state of the organisation; its loyalty, motivations, and capacity for effective interaction, communication and decision-making are a crucial set of leadership factors. They have a major effect on the long-term goals of an organisation. Whereas productivity and output variables are more of a short-term influence.

If effectiveness, then, is determined by the interaction of style and environments, it would seem that any of the styles may be effective or ineffective, depending on the environment. The differences between an effective and ineffective style are often not the actual behaviour of the leader, but the appropriateness of this behaviour to the environment in which it is used. You may think of the leader's basic style as a particular stimulus, and it is the response to this stimulus which can be considered effective or ineffective.

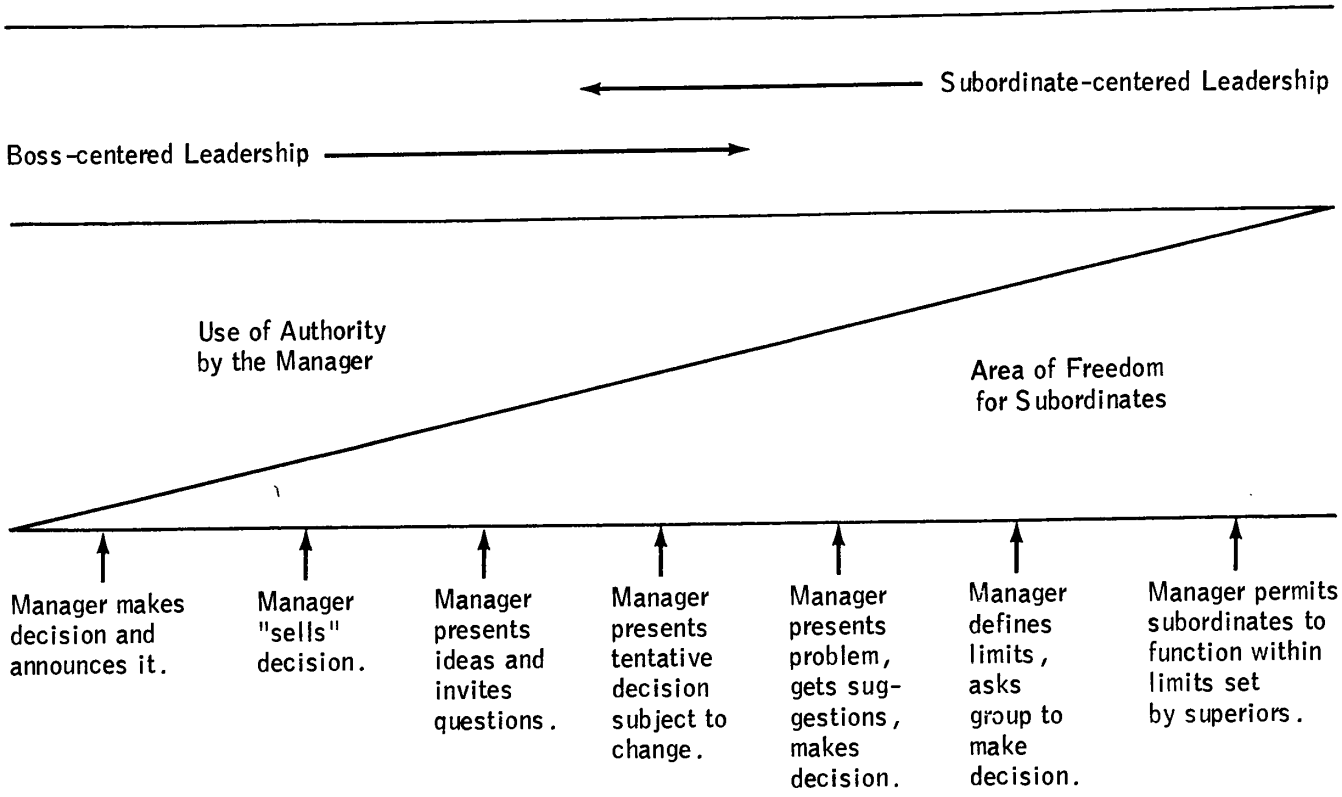
To illustrate, using the Tri-Dimensional Leader Effectiveness Model (Figure 5), let us assume that a leader newly assigned to a group adopts a high-task leadership style as shown by point A. The style may not be appropriate for this group and a given situation for a number of reasons. As a result of the inappropriate style, the group's performance may move along the dashed line to point B. Given this situation, examining the situational variables and the organisational objectives, this leader adopts a high task-high relationships style to move along the dotted line to point C. The group's performance has now become effective.

What seems most helpful in the Tri-Dimensional Effectiveness Model is that it does not suggest that there is one style better than all the others. What it does suggest is that effective leadership means that the leader can diagnose the pressures and demands in the environment and act accordingly.

This idea of variable leadership style had its roots in the continuum of leadership behaviour put forward by Tannenbaum and Schmidt (1958) in the 1950s. The pattern proposed then showed a continuum ranging from manager-centred leadership to subordinate-centred leadership, the key variable in the setting being the degree of authority or

Figure 5

Leadership Patterns Model



Source: R. Tannenbaum and W.H. Schmidt, "How to Choose a Leadership Pattern", Harvard Business Review, Vol. XXXVI, No. 2 (March-April, 1957), pp 95-101.

control retained by the leader or manager. In Figure 5, on the supervisor-centred end of the spectrum, the leader maintains a high degree of control, while on the other end the subordinates are given a high degree of control.

In 1973, Tannenbaum and Schmidt updated their model to reflect the changes occurring in society and to acknowledge 'that organisations do not exist in a vacuum'. They suggest that leadership now is more challenging, requiring greater understanding and adaptability and flexibility than previously. To their original concept, they have added power and influence as experienced in the organisational and societal environment (Figure 6).

One of the many ways currently being used to evaluate leadership is management by objectives (MOB). The purpose of this approach is to establish a method by which the objectives or goals of the organisation can be achieved, while the individual/group can meet its own goals.

In essence, the higher echelons of the organisation establish overall goals to be achieved in a certain time frame, and other levels of the organisation contribute to the achievement of these goals as appropriate, according to specific, mutually established times and targets.

This method brings into play the acknowledgement of missions of the organisation at all levels, staff and resources pertinent to the missions, the establishment of objectives and achievable goals. To make the method work, leader and subordinates meet together to set out goals, develop work plans, outline protocols, distribute resources, and establish regular periods for evaluation.

At the end of target dates, the parties involved meet - leader and group, superior and subordinate - to evaluate and discuss and perhaps set further goals.

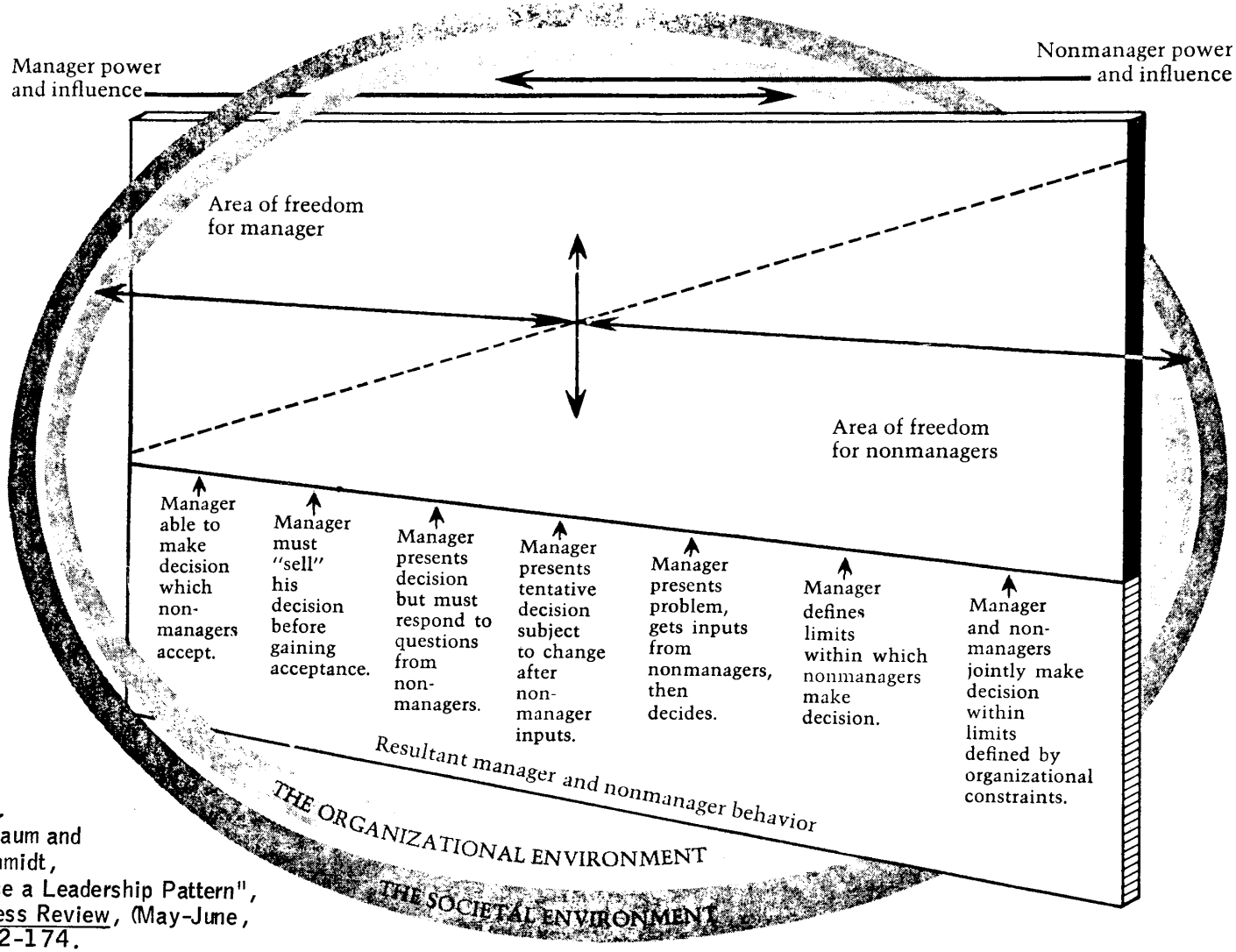
This evaluation method provides a good opportunity to assess leadership performance in that it is goal oriented, and the results are measurable according to an agreed upon plan. This approach also affords an opportunity to definitively identify failure, and to learn how 'disappointment' is handled.

In addition to staff and resources adequate to the job, the experience of the leader is crucial in the exercise of influence and stimulation of creative and productive efforts.

The style of behaviour that a leader employs as an input to his group and the corresponding output produced determines the climate of the organisation. Two such organisational climates may be described as ego defensive, resulting in stagnation, and ego acceptive, resulting in growth both of the individuals involved and of the organisation.

Figure 6

Continuum of Manager-Nonmanager Behavior



Source:
Robert Tannenbaum and Warren H. Schmidt, "How to Choose a Leadership Pattern", Harvard Business Review, (May-June, 1973), pp 162-174.

FIGURE 7

EGO DEFENSIVE			EGO ENHANCING		
INPUTS		OUTPUTS	INPUTS		OUTPUTS
Telling and Advising	D	Resenting	Emphatic Listening	A	Understanding (Reciprocated also)
Judging	E	Conforming		C	
Controlling	F	Depending	Trusting	C	Experimenting
"Hard Sell"	E	Lowered: Perceptions	Describing	E	Increased Perception and Initiative
	N	Initiative Taking Chances		P	
Punishing	S	Resentment, Hostility	Collaborative Problem-Solving	T	Creativity
"Withholding Self"	I		"Sharing Self" Risk Sharing	I	Spontaneity
	V	"Withholding Self"		N	
	E	Results in Stagnation		G	Results in Growth of Individual and Organization

Reflecting on the various forces at play in the leadership environment reminds me of one of the ambivalent features of leadership stated by Merton (1970) in his essay on 'Ambivalence of Organisational Leaders', viz. people who are to release their energies toward the attainment of goals must have a voice and a hand in shaping those goals. They must, in short, have a sense of some mastery over their own destinies. Yet, with each slice of power released by the leader - and it is power, that is, the ability to make something happen, which, in the final analysis and however broadly defined, is the core of leadership.

In small groups or organisations, it may be sufficient for the leader to be a good supervisor. However, in larger organisations he needs to be skilled both as a supervisor and as a subordinate. Likert's Linking Pin Concept, shown in Figure 8, is helpful in explaining this role.

> 'This shows that ... the capacity to exert influence upward is essential if a supervisor is to perform his functions successfully. To be effective in leading his own work group, a supervisor must be able to influence his own supervisor. He must perform the role of linking his group and/or groups to next higher hierarchical groups in the organization. This requires that his activities stress planning, acquiring and co-ordinating, as well as directing, motivating, and controlling his group.' (Likert 1961)

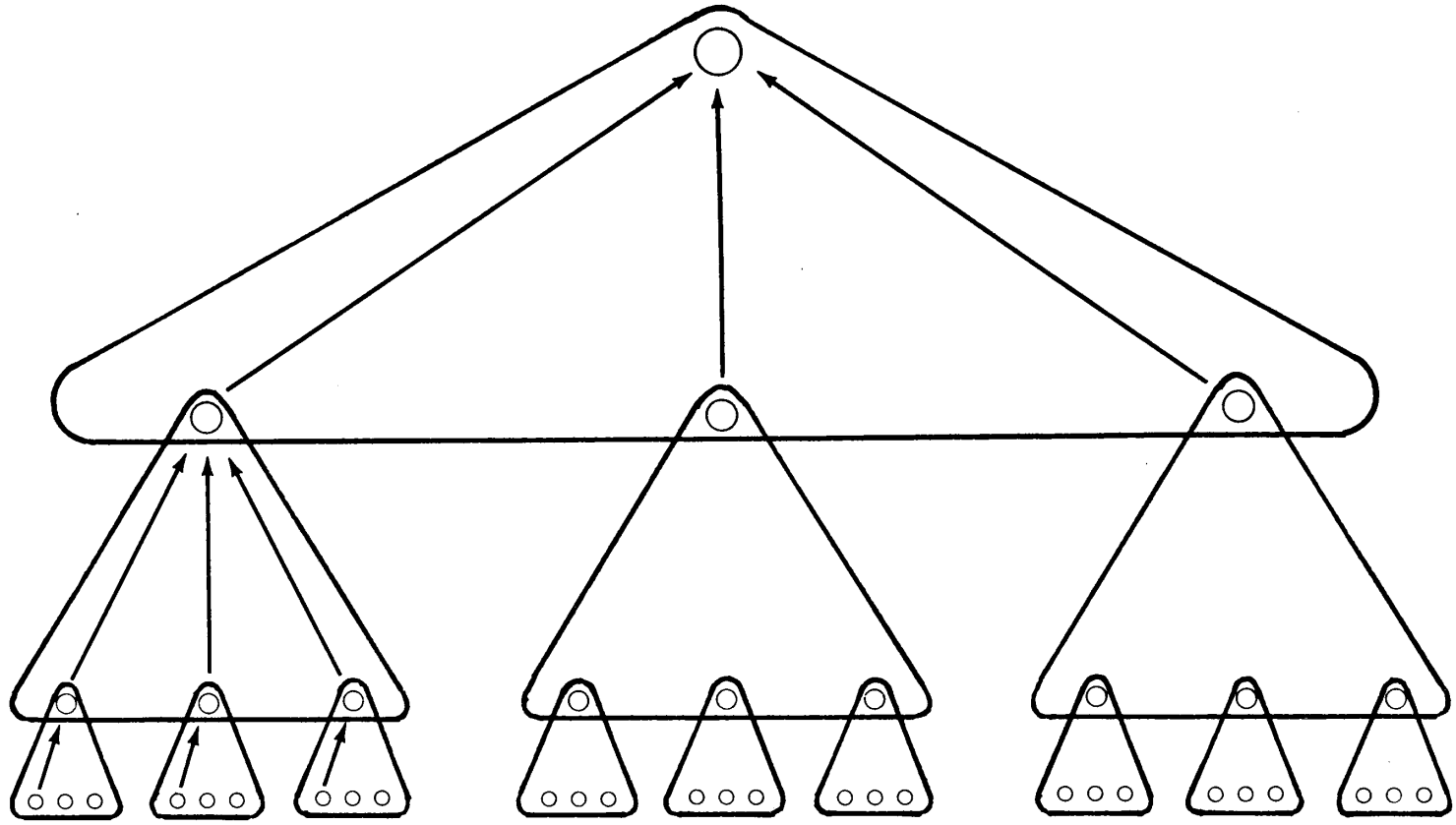
The need for systematic assessment of the leadership role has never been more urgent than it is now. In our society, as we move toward a national health programme, the importance of the nursing profession to make its voice heard is of the essence. Although each one of us can do our share, it is through our leaders that concerted action can be marshalled.

Any evaluation must speak to the systems of information and communication as they impact on the leadership role. It is through the collection, assimilation, and dissemination of information that control is exercised. And it is in the system of communication, formal and informal, inside and outside the organisation, that power is exerted.

In summary, we have examined one of the key topics of interest in nursing today - leadership. We see that there is a wide range of leadership patterns extending from authoritarian to participative. Most leadership patterns will fall somewhere between these two extremes. Reported were two dimensions of leadership style: relationship behaviour and task behaviour, as depicted by the Ohio State quadrants of leadership. A third dimension is adaptability to the needs of the situation. It is here where the leader decides which mode of leadership will best get the job done. The style of leadership the leader selects is dependent upon his understanding of the forces at work between himself, his group, the situation at hand, and the goals to be achieved.

Figure 8

Likert's Linking Pin Concept



(The arrows indicate the linking pin function)

Source: R. Likert, New Patterns of Management (New York: McGraw-Hill Book Co. 1961), p. 114.

One of the major processes involved is that of appraisal and evaluation. The leader must evaluate and, in turn, be evaluated as to overall general management/leadership qualities and performance. The models presented here (along with others) are all tools which may be employed in the process of evaluation.

The evaluation of leadership is a complete process. It involves evaluation both from inside the organisation by supervisor, staff, and colleagues working on other programmes, and from outside the organisation by colleagues, institutions, individuals, and special publics. Evaluation occurs formally and informally, and criteria vary, depending on the perspective of the evaluator.

In a recent conference hosted by the Division of Nursing in the United States Public Health Service, the concept of appraisal was discussed by Hagen (1974), who pointed out that evaluation is not to justify what is but to provide data for future decision-making - what to keep, what to discard, what to change. She indicated that a good conceptualisation of domains is essential to evaluation. Such a conceptualisation must be comprehensive and give evidence of effective or positive results of leadership role on goals or outcomes.

Useful studies would be the variables or domains to be examined, and the clear differentiation between criteria and standards. Leadership effectiveness is determined by standards set by peers, superiors, and achievement of the goals of the group. Leadership should be looked upon as an art built on scientific theory meriting scientific inquiry.

> 'Good judgement (like wisdom) requires careful appraisal of all three sides of the decision cube. Only a human computer with five sensory inputs, electro-biochemical memory core, plus a volition-laden imagination can do this. Industry hasn't been able to produce a like system yet. It is called the Model 1 Homo Sapiens.'
> W. Sidney Taylor.

REFERENCES

ARGYRIS, C. Management and organisational development. New York, McGraw Hill Book Company, 1971.

BENNETT, T.R. The leader and the process of change. New York Association Press, 1962.

DRUCKER, P.F. Managing for results. New York, Harper and Row Publishers, 1964.

DRUCKER, P.F. The effective executive. New York, Harper and Row Publishers, 1966.

FIEDLER, F.E. A theory of leadership effectiveness. New York, McGraw Hill Book Company, 1967.

GARDNER, J.W. Excellence. New York, Harper and Row Publishers, 1961.

HAGEN, E. "Conceptual issues in the appraisal of the quality of care." Report of a conference on assessment of nursing services. Washington Division of Nursing, U.S. Department of Health, Education and Welfare, Publication no. 75-40, 1974.

HAGEN, E. and WOLFF, E. Nursing leadership behavior in general hospitals. Institute of Research and Service in Nursing Education, New York, Teachers College, Columbia University, New York, 1961.

HALPIN, A and WINER, J. "A factorial study of leader behavior description 'questionnaire'" in STODGILL, R.M. and COONS, A.E. (Editors) Leader behavior: its description and measurement. Research Monograph no. 88, Columbus Bureau of Business Research, Ohio State University, 1957.

HERMAN, C.G. 'Four theories of leadership'. Journal of Nursing Administration, vol. 6, no. 5, June 1976.

HERSEY, P and BLANCHARD, K.H. Management of organizational behavior. Englewood Cliffs, Prentice Hall, 1969.

LIKERT, R. New patterns of management. New York, McGraw Hill Book Company, 1961.

MCCONNELL, T. Group leadership for self realization. New York, Petrocelli Books, 1974.

MCGREGOR, D. The human side of enterprise. New York, McGraw Hill Book Company, 1960

MERTON, R. "The ambivalence of organizational leaders: an interpretative essay" in The contradictions of leadership - a selection of speeches by James F Oates, Jr. New York, Appleton Century Crofts, 1970.

ODIORNE, G.J. "Management by objectives: antidote to future shock". Journal of Nursing Administration, vol. 5, no. 2, February, 1975.

O'DONOVAN, T.R. "Leadership dynamics". Journal of Nursing Administration, vol. 5, no. 7, September 1975.

STEVENS, B.J. The nurse as executive. Wakefield, Contemporary Publishing, 1975.

STODGILL, R.M. Handbook of leadership: a survey of theory and research. New York, Free Press, 1974.

TANNENBAUM, R. Control in organisation. New York, McGraw Hill Book Company, 1968.

TANNENBAUM, R. and SCHMIDT, W. "How to choose a leadership pattern". Harvard Business Review, March-April, 1958.

TANNENBAUM, R. and SCHMIDT, W. "How to choose a leadership pattern". Harvard Business Review, May-June, 1973.

TEAD, O. The art of leadership. New York, McGraw Hill Book Company, 1935.

The Jerusalem Bible. New York, Doubleday and Company, 1966.

Webster's new world dictionary of the American language. Second college edition. New York, 1970.

YURA, H., OZIMEK, D. and WALSH, M. Nursing leadership: theory and process. New York, Appleton Century Crofts, 1976.

4 II EVALUATION OF LEADERSHIP PERFORMANCE

Shirley M Stinson

INTRODUCTION

The intent underlying this paper is to provide a perspective for examining the topic of evaluating leadership performance, while at the same time to pinpoint some of the basic issues and problems involved in the measurement of the phenomenon of leadership. In doing so, the author has approached the topic from a generalist point of view, and upon the premise that we should be as concerned about what is not in the literature as is in it, given the apparent gap between recorded thought and practical understanding about the subject.

A preliminary note about the format. The bulk of current research on leadership is empirical in nature, Stodgill (1975), p. 5. As such, it would seem analytically respectable to develop the paper on the basis of 'traditional scientific' research proposal format*. And indeed these are the rubrics employed below - but for a different and somewhat poisonous reason: that of demonstrating the severe limitations and manifold invalidities of applying 'traditional' research mentality to the very complex phenomenon of leadership, including the business of evaluating leadership performance.

PURPOSES AND OBJECTIVES

In the strict 'scientific' sense, to suggest that the purpose of evaluating leadership performance is to maximise the efficiency and effectiveness of our health care systems is to jump the gun. We simply do not know what is the relationship between 'leadership' and health care, nor are we able to define leadership in meaningful, measurable, generalisable terms, not to mention our problems in evaluating such vitally relevant concepts as health care and patient outcomes.

In the tacit sense, however, many of us have a gnawing feeling that 'good' leadership is related to 'good' health care and 'good' patient outcomes. But is it? If yes, how? Why? Under what circumstances?

In the pre-conference materials, the question was raised 'Should we evaluate leadership performance?' It can be argued that we are in any case doing it and that the question might better be phrased, 'Should

*Based primarily on David J Fox's headings for evaluating research proposals, in Fundamentals of Research in Nursing (New York: Appleton Century Crofts, 1966), pp. 252-273.

we be evaluating it more systematically?' And from a moral stance, we might well ask, 'Given the abysmal ignorance about the basic phenomenon of leadership, and about its significance in health care, should we instead desist from evaluating leadership?' Such questions beg yet another. Suppose we had valid means for evaluating leadership performance. What to evaluate (ie objectives) and why (for what purposes) are disconcertingly difficult questions to clarify. From a practical standpoint, there is little point in evaluating if we do not have a fairly clear idea of what we are going to do with the findings, so from that standpoint evaluating leadership performance is not a sufficient objective in itself. From that point on, objectives could include evaluating leadership performance in relation to follower and/or institutional goal achievement, morale, patient care outcomes, dollar costs, publications produced, shoe leather expended (the possibilities are limitless) - and for any number of purposes. We shall come back to this point at the conclusion of the paper.

RELEVANT LITERATURE

Reference will first be made to definitions, then theories, then 'types' of leadership. A capsule overview of the current literature is then presented, followed by a beginning analysis of voids.

1. Definitions

Stodgill cites some seventy-five definitions, pointing out that 'the Oxford English Dictionary (1933) notes the appearance of the word "leader" in the English language as early as the year 1330 ... (whereas) ... the word "leadership" did not appear until about 1800' (1975, p. 7). Stodgill says, 'There are almost as many different definitions of leadership as there are persons who have attempted to define the concept' (p. 7). For purposes of detail, brevity, and clarity we have chosen to present major definitional themes and selected examples in grid form (Table I).

Bass, whom Stodgill (1975) cites in terms of the influence of leaders (p. 10), distinguishes amongst three qualities of leadership. He maintains that an individual's 'effort to change the behavior of others is attempted leadership. When the other members actually change, this ... is successful leadership. If the others are reinforced or rewarded for changing their behavior, this evoked achievement is effective leadership' (Bass 1961), pp. 120-122.

If there is a single commonality in the themes and definitions perhaps it lies in the dynamic flavour, the sense of action if not purposefulness which pervades.

Throughout the general literature one is struck by the frequent distinctions made between the concept of 'leader' and such concepts as ruler, manager, king. A Biblical phrase exemplifies the point:

'Behold, I have given him for a witness to the people, a leader and commander to the people' (Isaiah, 55:4). On the more recent side, Bennis (1968), p. 119, defines leadership in what he terms a dynamic 'agricultural' mode: 'an active method for producing conditions where people and ideas and resources can be cultivated to optimum effectiveness and growth'.

TABLE I GRID, HIGHLIGHTING SELECTED EXAMPLES OF DEFINITIONS OF 'LEADERSHIP'/IN TERMS OF STODGILL'S THEME-BASED ANALYSIS*

LS**	THEME	AUTHORS/EXAMPLES OF DEFINITIONS
1	Group Processes Focus	Chapin (1924) LS as 'a point of polarization for group co-operation.'
2	Personality and Effects	Bernard (1926) 'Any person who is more than ordinarily efficient in carrying psychosocial stimulii to others and is thus effective in conditioning collective responses may be called a leader'.
3	Inducing Compliance	Bundel (1930) 'the art of inducing others to do what one wants them to do'.
4	Exercising Influence	Stodgill (1965) 'the process (act) of influencing the activities of any organised group in its efforts towards goal setting and goal achievement'.
5	Acts/Behaviors	Shartle (1956) LS act, 'one which results in others acting or responding in a shared direction'.
6	Persuasion	Odier (1948) describes LS in terms of 'valence' of his power to affect others. Schenk (1928) differentiated between persuasion and inspiration of leaders, and threat or coercion.
7	Power Relation	French (1958) and Raven and French (1958) defined in terms of five 'power bases' including 'reward power, coercive power'.
8	Goal-Achievement Instrument	Bellows (1959) 'the process of arranging a situation so that ... (followers and leader) can achieve common goals ...'.
9	Effect on Interaction	Merton (1969) ' an interpersonal relation in which others comply because they want to, not because they have to'.
10	Differentiated Role	Sherif and Sherif (1969) LS as a (particular) role within a larger set of 'reciprocal expectations' (latter quote in Stodgill's words p. 14).
11	Initiation of Structure	Stodgill (1959) 'the initiation and maintenance of structure in expectation and interaction'.

*All content derived from Stodgill (1975, pp. 7-16). Material in quotes in the original author's wording.

**LS = Leadership.

2. Theories

In our opinion, the basic task of the theorist is to provide a cognitive approximation of reality, a blueprint from which to study reality. Roberts (1974) p. 49, states that the three central goals of science are 'explanation, prediction, and control'. Analysing the leadership theories outlined by Stodgill, we would say that the majority pertain to the task of explanation more than prediction. One could say there is quite a bit of attention given to the notion of leaders' 'control' over followers and within situations, but there would seem relatively little theory directed at 'controlling' leadership phenomena per se. Table II helps to emphasise some of the major theories if not 'threads'* which dominate the theories of the past one hundred years.

3. 'Types' of leadership

There would seem to be some overlap if not confusion between the notion of 'types' of leadership and what one might view as 'styles'; these categories are made further unclear when one introduces the concept of 'functions' of leadership. Additionally, there would seem to have been little success, and possibly insufficient effort in analysing and synthesising rigorously definitions and theories with the concepts of 'types', 'styles' and 'functions' of leadership.

In this author's view, more clarity of thought could be achieved if we would quit mixing what would seem to be apples and oranges (at minimum). For example, the function at hand may be that of providing intellectual leadership; it would seem reasonable to maintain that such leaders could conceivably have different 'styles' (democratic, autocratic, laissez-faire). Might the idea of 'types', then, be evolved on the basis of permutations and combinations of 'styles' and 'functions', to name only two variables, then expanded on the basis of contingencies such as size, immediacy of situation, etc.

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*R.R. Blake emphasises that 'Anything from a thread to a theme to a thesis to a theory ...' will do, so long as it facilitates analysis. See Readings in the Social Psychology of Education, W.W. Charters, Jr., and N.L. Gage, Eds. (Boston: Allyn and Bacon, Inc., 1963), p. xx.

TABLE II GRID, HIGHLIGHTING SELECTED EXAMPLES OF THEORIES OF LEADERSHIP, BASED ON STODGILL'S ANALYSIS*

Theories		Authors/Examples of Theoretical Emphasis
1	'Great Man'	Galton (1879), emphasis on the explanatory power of inheritance; Carlyle (1841), emphasis upon leader's having special qualities; Bernard (1926) 'trait' theory.
2	'Environmental'	Person (1928) hypothesized that the 'situation' affects 'leadership qualities' and that LS qualities are themselves derived from 'prior leadership situations'. Murphy (1941) LS 'is a function of the occasion' (Stodgill's wording, p. 18).
3	'Personal-Situational' (Interaction of ~~#~~ 1 and ~~#~~ 2)	Case (1933) maintained LS is the product of leader traits, group type, and the situation.
4	'Interaction-Expectation'	Fiedler (1967) 'The effectiveness of a given pattern of leader behavior is contingent upon the demands imposed by the situation' (Stodgill's wording, p. 21).
5	'Humanistic'	Likert (1961, 1967) emphasis upon LS as creating a situation in which both organizational productivity and human needs are met.
6	'Exchange'	Jacobs (1971) 'The group provides status and esteem satisfactions to the leader in exchange for his unique contributions to goal attainment' (Stodgill's wording, p. 23).

* All content derived from Stodgill (1975, pp. 17-23).

This 'style/function/type' confusion creates immense problems in the studying of leadership performance, for without precise distinctions being made, we may find ourselves passing value judgements upon 'styles', not 'function', and on 'types', not 'styles', and so on. On the basis of such confusion, it is interesting to return to Table II and reflect upon how much the theories have to do with the totality of the leadership phenomenon, and how much they may indeed have only to do with 'style'. Along these lines, an article by Wiley (1975) in what is not an academic journal, but is of topical relevance, advocating 'The Spaghetti Theory of Leadership', is instructive. In essence the theory revolves around the premise that 'it is much easier to pull than push a limp piece of spaghetti' (p. 6). There would seem to be quite a few unstated if not fallacious assumptions here. Firstly, might it be that pulling is 'merely' a style of leadership, not a 'theory'. Secondly, who said followers are necessarily limp? Spaghetti which is uncooked, 'natural', untreated, by whatever value judgement one might wish to label it, is indeed 'as easy' if not easier to push than to pull, for in doing the latter one might be more likely to break it, depending upon the technique. Thirdly, the notion of easier or harder is totally irrelevant if the process involved is not in any way productive.

4. Central characteristics of the current literature

Stodgill (1975) points out that the bulk of the current research literature on leadership is empirical in nature, as contrasted with the earlier emphasis upon comprehensive theory development, the consequence being that 'various issues regarded as important by the early theorists have been largely ignored by the* researcher' (p. 5).

Secondly, the empirical research which exists to date is far from conclusive. But it would seem reasonable to say that leadership phenomena involve, at minimum, three variables: leaders, followers, and situations, Stodgill (1975); Cathcart and Samovar (1970), p. 359. Applying this principle to our topic, and to the extent that all three factors are essential, one may choose to focus particularly on leaders, and/or on leadership performance, but the necessity for doing so within the context of the follower(s) and the situation(s) is inherent.

A further characteristic, somewhat related to the second, is that the interpretation 'empirical' seems to be very little connected to the notion that N can = 1.** For example, Stodgill does not cite Erik Erikson's brilliant psycho-historical analyses of Luther (1958) and Ghandi (1968), nor does he mention the incisive analysis of Barber (1968) on 'Presidential Styles' nor Manuel on 'Newton as Autocrat of Science' (1968). There would seem to be a rather abiding belief if not

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* Sic. One would gather that Stodgill has difficulty in thinking of theorists as 'researchers', a point of view decried by this author.

** For an explication of this principle see N = 1: Experimental Studies of Single Cases, by P.O. Davidson and C.G. Costello (New York: Van Nostrand Reinkold Co., 1969).

misconception that there is but one key to unlocking the mysteries of leadership: a 'new', that is recent (post-1930?), 'empirical' (N> 1), psycho-social key, to name but a few of the bits.

Thirdly, even a cursory glance at Stodgill's hundreds of references would seem adequate to substantiate the point that the research literature falls almost exclusively into the social science realm, especially in the psycho-social disciplines. As ubiquitous as 'patient needs' in the nursing literature, concepts such as group dynamics, communication, power, dependence role, exchange theory, decision-making, status, cohesion, environment, interaction, and change pervade the reported studies.

Constrictions of time, talent, and space do not permit this author to develop a comprehensive analysis of the central characteristics of the literature, but a few more would seem to be: that it is immensely fragmented; that there are very few studies replicated, and few replicable; that the assumptions underlying the use of many of the correlates studied are loose, often even not explicated; that definitions of the term 'leader' are numerous, but definitions of 'leadership' are relatively few; and that while there is considerable intellectual recognition given to the necessity to study followers, situations and leaders concomitantly, in the majority of research, there would seem to be insufficient provision for doing so.

While at first glance the above critical appraisal of the current literature might seem overly cynical, overly negative, such is not the author's intent. There has been and is much creative and exciting work in the area of leadership; but the state of the art is very much in its infancy. As such, we must treat any notions about 'evaluating leadership performance' with real reservation. That is the intent.

5. Voids

To paraphrase Phenix (1969), p. 13, 'Disciplinary studies (on leadership) tend toward academic fragmentation and a sense of academic irrelevance. (Leadership, studied) ... exclusively on a problem basis, on the other hand, tends, to degenerate into an insipid exchange of prejudices among the mutually uninformed'. Put another way, what is distinctly lacking in the literature is evidence that leadership is being systematically studied on an organised comprehensive multi-disciplinary basis. The key word here is comprehensive. There are numerous instances of psychologists working jointly with sociologists, historians working with behavioural analysts, and so on. But to our knowledge, there has been no attempt to study leadership on a systematic, truly comprehensive and concomitant, multi-disciplinary basis.

In an attempt to illustrate that the literature 'relevant' to the study of leadership logically entails the entire spectrum of disciplines, the author has chosen to employ Phenix's (1964), p.28, classification of man's 'realms' of meaning. The development of ideas/questions is

admittedly gross if not simplistic, but perhaps this beginning will serve to generate further thought:

Realm		'Relevant' Literature: Examples of Types*
I	Language (discursive: non-discursive; mathematical)	Language used about leaders and followers, by leaders and followers, in varying situations; non-discursive language as it pertains to leader and follower behaviours; mathematical formulations of expected leadership outcomes, 'sampling' of leader behaviours and populations.
II	Empirics (Life sciences; physical sciences; social sciences)	Wiggam (1931) and Dowd (1936) studied leadership from a biological perspective. Little has been studied recently by way of the 'biology' of leaders (Do they have uric acid levels?) vs followers, and in what situations; what differences are there in leaders' 'electrical fields' from the standpoint of physics, and followers? To what extent does leader input make a difference to resource allocation and utilisation and in what situations? To what extent are concepts of leadership correlated with concepts of adulthood, in what cultures and over what eras? What is the linkage between work from a psychoanalytic standpoint and leader/follower needs and behaviours? (See, eg, Bennis, 1968, pp. 103, 116).
III	Esthetics (music, visual arts of movement, (poetic) literature)	Do 'successful' leaders utilise esthetics in ways different from non-successful leaders? What kinds of structures in music, dance, art, literature distinguish 'leader' roles from followers, and in what situations? What forms does leadership take among esthetes themselves?
IV	Synoetics (intuition)	What is man's 'craft' (vs 'scientific') knowledge (Polanyi, 1958) about leadership? What sorts of differences exist between formal knowledge of leadership and 'existential' applications? Is 'charisma' a super-existential leadership phenomenon?

* 'Realm' categories developed by Phenix (p. 28) examples by Stinson.

V	Ethics	To what extent is leadership 'act' specific, if any? What should be the ethical limits in carrying out leadership research? To what extent does moral knowledge deal with 'leadership' roles as opposed, say, to peer relationships?
VI	Synoptics (philosophy; history; religion)	To what extent is the concept of leadership quantitatively and qualitatively linked with the sense of man's feeling he has choice/no choice in his own destiny? What is the human significance of leadership? Do organisations/individuals studying leadership focus sufficiently on their philosophies of leadership, ie, as a basis for determining objectives? Rustow (1968, p. 683) speaks of leadership as involving 'the recurrent interplay between private personality and public performance'. How little such 'simultaneous' knowledge do we have of leaders? Nursing leaders' ideas have been studied (eg, Allemang, 1973: Street, 1974) but there is very little way of linking 'private personality and public performance'. What are the connections, if any, between religion, healing and 'leading'? In what religious literature do the concepts of authority, leadership and 'followership' appear and what are the significant temporal comparisons, if any? What are the comparative emphases that exist about leadership from historical, religious, and philosophical standpoints in any given culture and between different slices in time?

HYPOTHESIS FORMULATION

The essential questions underlying all research are 'Does the phenomenon exist?' and to the extent that it exists, 'What is the meaning of it?'* As Fox (1966) pp. 35, 170-173 underlines, hypothesis formulation is not valid in many cases essentially when we do not know enough about a phenomenon to pose meaningful hypotheses.

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* To the author's chagrin she cannot recall the source of these questions, encountered in the literature many years ago.

So far as the practical aspects of evaluating leadership performance in the health field is concerned, the basic measurement problem revolves around the question, 'Does the person's performance make any difference?' To what, to whom, how? Should leader performance be treated as an independent variable? Dependent? If independent, what are the dependent variables? What are the indicators which are most relevant to leadership performance evaluation?

It is the author's considered viewpoint that apart from fairly 'exploratory' hypothesis-based research, a much greater quality and scope of inductive research is needed before we step heavily into hypothesis-based, deductive territory.

ASSUMPTIONS AND LIMITATIONS

Do we assume, then, that leadership 'exists'? That it is measurable in meaningful form? That we can 'do' something about our findings? That we will do something about our findings?

What are some of the assumed theoretical limits of 'leadership'? Do we talk as if 'the more the better'? Should we not concern ourselves with some normative (for the 'public good') range, for example:

Dysfunctional for Society	Functional for Society	Dysfunctional for Society
'Under-leadership'	NORMATIVE LEADERSHIP	'Over-leadership'

Was Hitler a case of 'over-leading'? Was Henry Ford? Were the Romans? In The Republic, Plato warned, 'The people always have some champion whom they set over them and nurse them into greatness ... This and no other is the root from which the tyrant springs; when he first appears he is a protector.' We would suggest that researchers make the same type of explications about their assumptions regarding followers, and situations, for it would seem logical that 'pathological' or developmental insufficiencies and excesses apply equally to all three variables.

Too, is the 'ideal type' leader assumed to be a paragon of virtue? Balzac said of humans 'Elles doivent avoir les défauts de leurs qualités/They must have the defects of their qualities'. What constitutes 'defects' and what constitutes character, eccentricity, and/or individual peculiarity in leaders, followers, and situations?

Three last points about assumptions. Homer (The Iliad) wrote:

> 'You will certainly not be able to take the lead in all things yourself, for to one man a god has given deeds of war, and to another the dance, to another the lyre and song, and in another wide-sounding Zeus puts a good mind.'

It would seem that the Fox Indians of the Central Algonkian Indians were operating on similar 'assumptions' about the nature of leadership. One can turn to Miller's (1955) analysis of leadership in this tribe in the mid-seventeenth century to see that they had different leaders for different functions: war, religion, healing, etc. It is our view that much of the current literature reflects a leadership 'in all things' mentality, not a specialist orientation.

Secondly, are we to assume that the ideal type leader 'never quits' leading? Canada Geese are ace formation flyers. According to La Rousse, the 'V' formation makes flying easiest on all but the leader. But from time to time a follower from the back comes up front to relieve the leader. Does the 'good' leader never rest?

Lastly, while there would seem to be considerable agreement in the literature that leadership phenomena entail 'voluntary' followership, there is little said as to the voluntariness of leaders. Are we to assume that the leader phenomenon is an equally voluntary one? Should we make distinctions between manifest, assumed, and extant* 'voluntarism' on the parts of leaders, followers - and situations?

Again, to touch only upon a few concerns, what are the limitations in evaluating leadership performance? Quite apart from the earlier-mentioned ethical considerations, there is the potential of 'experimental effect' in which the validity of performance can be altered by the process of measurement. Too, to the extent that being a 'true' leader means being alone at the top, there are distinct problems in establishing adequate reliability and validity of such dimensions as leader's feelings of power, interdependence, status, fears, etc, not to mention follower and situation data gathering and analysis problems. Further, one wonders what would be the cost-effectiveness of establishing systematic leadership performance evaluation schemes throughout, say, the health industry? What are the practical limitations?

RESEARCH DESIGN

Some of the thornier problems surrounding the business of evaluating leadership performance revolve around questions about research approaches and methods, populations and data analyses.

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* Wilfred Brown adds a fourth category '(theoretically) requisite', to the above three dimensions, for analysing structural characteristics in Explorations in Management (London: Heineman, 1960).

1. Approaches and methods

In one sense, whether one's evaluative approach be historical, descriptive or experimental, it can be argued that the essential question is, 'Did the performance make any difference?' for example, to the followers and/or in the situation (and/or to the leader, one might well add). As such, one is inherently into a pretest-posttest design, whether or not the data existed, do now exist in some form, or they are being created*. The advantages for data gathering potentials and problems in each of the three approaches are on a gross basis fairly obvious. Lack of sufficient data and lack of adequate means of establishing rigorous reliability and validity levels pervade all three approaches, as are problems of identification and control of relevant variables, even in the experimental case. And ethical problems permeate all three. Additionally, within all of the above lies a further question, when we talk about evaluating leadership performance, are we talking about evaluating it from a structural, process, and/or output standpoint? If the latter, what is to be regarded as 'output'?

At the risk of being simplistic, there would at minimum seem to be two basic models for evaluating leadership performance, some type of goal-attainment model, and some type of 'systems' model.** The former is extremely narrow in focus, involving relatively little measurement - and, we suspect, relatively little insight in terms of the whole. The latter is immensely complex, by definition involving the totality of the leadership phenomenon, involving relatively great range and type of measurement. Theoretically, it promises greater potential insight; yet to collect masses of data does not ensure that concomitant meaning will emerge. The minimum here would in some ways seem to be some kind of 'mix model' essentially goal-orientated in nature but with parallel attention to some of the more potent 'systems' factors, whether the latter be chosen on an inductive or deductive basis. But we must be very cautious about imposing existing models and methods on poorly-understood phenomena. What 'new' methodologies might be more valid? Prior to the onslaught of the contemporary mass of social research, Mannheim (1929) warned:

> 'For it is not to be denied that the carrying over of the methods of natural science to the social sciences gradually leads to a situation where one no longer asks what one would like to know and what will be of decisive significance for the next step in social development, but attempts only

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* These data 'tense' categories are described in principle by Fox, op cit, p. 170.

** In regard to models for evaluating, the reference by Nora Carter and Brian Wharf is instructive, although it is not directly applied to leadership. See Evaluating Social Development Programs (Toronto, Canada: The Canadian Council on Social Development, 1973) pp. 43-51.

> to deal with those complexes of facts which are measurable according to a certain already existent method. Instead of attempting to discover what is most significant with the highest degree of precision possible under the existing circumstances, one tends to be content to attribute importance to what is measurable merely because it happens to be measurable.'

On the positive side, Rustow (1968), p. 689 welcomes 'leadership' research from a methodological view, in that it is research which gives a 'single, visible focus' to the analysis of socio-political processes, which might otherwise escape study.

What should be the unit(s) of analysis in such research? Individual leaders? Individual followers? Nations? Individual organisations? And in terms of what scopes? Macroanalytical? Micro? Both?

Should one try to distinguish between 'technical' and 'professional' levels of leadership performance? In this regard Lambertsen's article is instructive in principle: technicians should deal with the knowns, the highly structured, the predictables, professionals with uncertainties requiring considerable judgement, high risk, lack of structure, extensive complexities (1968, pp. 93-94). One wonders to what extent we need 'professional' leaders to evolve goals and 'technical' leaders to achieve them. If these are valid distinctions to make, designs for evaluating leadership performance must be geared accordingly.

2. Populations, samples

In some of the empirical studies, the leader/follower subjects are university students and sometimes involve what would seem to this author to be highly artificial leadership situations. While the potential contribution which such studies could make should not be minimised, one wonders how 'representative' these samples are of the populations relevant to a group such as is gathered here.

Too, and quite apart from the problems of measuring 'informal' vs 'formal' leadership, one wonders about the limits of identifying leader populations (followers too, of course), for it would seem that our realisation that we are in the presence of a leader is often a retrospective judgement. Conversely, in terms of some populations, if we study today's 'leaders', we may well have to wait a few decades to find out which ones should be kept on the roster. Simpson (1971), p. 243, in analysing the development of nursing research states 'There has been no charismatic leader (in Britain) but a slow growth springing from a variety of sources.' Simpson strikes the author as being too modest to appreciate her own particular contributions to be able to apply her otherwise objective judgement to the question of leadership for nursing research. Yet she can also argue that nursing research is such a multivariate phenomenon that it defies 'singular' leadership, charismatic or otherwise. Might it be that in highly

complex multivariate situations such as we face in nursing research leadership is multifaceted - and with its vague and ambiguous aims, highly 'professional'* in nature?

Did Florence Nightingale have a conscious sense of leadership? Did Bedford-Fenwick? Nutting? What about our current 'leaders'?

Leadership as it pertains to health care systems logically involves the study of leadership within such groups as patients, families, unskilled health workers, board members, volunteer workers, to name a few. Is the most important target group health care professionals? Practitioners? Administrators? Teachers? Researchers? Politicians?

3. Data analysis and findings

Very briefly, we should keep in mind that data must be analysed in terms relevant to the purpose involved. Evaluating leadership performance is intrinsically interesting. But if such data are to mean anything in terms of health care systems, strenuous effort must be made to analyse and report findings such that they become means for making meaningful qualitative and quantitative decisions about the primary objects of the systems: clients, and the related factors of personnel and working environments. One further word about statistics. From her knowledge to date, this author is concerned about the prostitution of parametric statistics. A great many of the data relevant to the evaluation of leadership performance do not meet the assumptions underlying the use of ratio and interval statistics. A great many leadership performance factors are at best ordinal; in some ways, it can be argued that the majority are nominal, depending upon the purposes, objectives, and assumptions at stake. For example, 'follower satisfaction' may in some persons' views be irrelevant and/or not of equivalent weighting to group cohesiveness and/or goal emphasis. Care should be taken in these regards, or our conclusions about performance will be erroneous.

CONCLUSIONS AND RECOMMENDATIONS

With few exceptions, the generalisable conclusions one can draw from the current empirical research on leadership are few; as such, associated recommendations tend primarily to be prescriptions for further research. These statements would seem to hold true if not more so in the case of performance evaluation research. In this author's view, in futuristic terms, if one is to point to a general area of reference there are at this point in time as many if not more insights and perspectives to be gained from intuition, history and socio-philosophical thought than from empirical studies. Bennis' (1968) chapter on 'New Patterns of Leadership for Adaptive Organisations',

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* Even though some may treat it as a trade

pp. 97-123, is instructive of the latter. On a rational (vs empirical) basis, he poses crucial questions about leadership in relation to the vast 'temporariness' of our society, focussing more upon 'executive constellations' and short term 'project groups' as units of analysis, rather than upon individual leadership styles, functions, and performances per se. Empirical researchers to date have tended to rely upon 'traditional' concepts of leadership; performance evaluation as it will affect and be affected by the group gathered here should be viewed in terms which are more temporally valid. And it is in these terms that this author concludes that we should evaluate.

In the preconference material a second question was raised. 'How can individuals in leadership positions be encouraged to direct their careers when leadership criteria are not met or responsibilities of a particular position change?' This author would conclude that the most valid perspective from which to make such decisions lies not in any one mode of thought or study on leadership but in the total accumulated wisdom of man, in all the 'realms of meaning'.

REFERENCES

ALLEMANG, M.M. Nursing education in the United States and Canada 1873-1950. Unpublished doctoral dissertation. Washington, University of Washington, 1973.

BARBER, J.D. Adult identity and presidential style: the rhetorical emphasis. Daedalus 97, Summer 1968. pp. 938-968.

BASS, B.M. Some aspects of attempted, successful, and effective leadership. Journal of Applied Psychology 45, 1961. pp. 120-122. (Cited by Stodgill, 1975. p. 439.)

BENNIS, W.G. and SLATER, P.E. The temporary society. New York, Harper and Row, 1968.

BROWN, W.F. Explorations in management. London, Heineman, 1960.

CARTER, N and WHARF, B. Evaluating social development programs. Toronto, The Canadian Council on Social Development, 1973.

CATHCART, R.S. and SAMOVAR, L.A. Small group communication: a reader. Dubuque, William C. Brown, 1970.

CLAUS, K.E. and BAILEY, J.T. Power and influence in health care: a new approach to leadership. St. Louis: C.V. Mosby 1977.

DELOUGHERY, G.L. and GEBBIE, K.M. Political dynamics: impact on nurses and nursing. St. Louis. C.V. Mosby 1975.

DOWD, J. Control in human societies. New York, Appleton Century, 1936.

ERIKSON, E.H. On the nature of psycho-historical evidence: in search of Ghandi. Daedalus 97, Summer, 1968. pp. 695-730.

ERIKSON, E.H. Young man Luther. New York, Norton, 1958.

FOX, D.J. Fundamentals of research in nursing. New York, Appleton Century Croft, 1966.

LAMBERTSEN, E.C. The emerging health occupations. Nursing Forum 7, no. 1, 1968. pp. 87-97.

MANNHEIM, Karl. Ideology and Utopia. Translated by WIRTH, L. and SHILS, E. Originally published in German in 1929. New York, Attarcourt, Brace and World, n.d.

MANUEL, F.E. Newton as autocrat of science. Daedalus 97, Summer 1968. pp. 969-1001.

MILLER, W.B. Two concepts of authority. American Anthropologist 57, April 1955. pp. 271-289.

PHENIX, P. The moral imperative in contemporary American education. Perspectives in Education 2, Winter 1969. pp. 6-13.

PHENIX, P. Realms of meaning. New York, McGraw Hill, 1964.

POLANYI, M. Personal knowledge. Chicago, University of Chicago Press, 1958.

ROBERTS, M. On the nature and conditions of social science. Daedalus 103, Summer 1974. pp. 47-64.

RUSTON, D.A. Introduction to the issue 'philosophers and kings': studies in leadership. Daedalus 97, Summer 1968. pp. 683-693.

SIMPSON, H.M. Research in nursing - the first step. International Nursing Review 18, no. 3, 1971. pp. 231-247.

STODGILL, R.M. Handbook of leadership. New York, The Free Press, 1975.

STREET, M.M. Watchfires on the mountain: the life and writing of Ethel Johns. Toronto, University of Toronto Press, 1974.

WIGGAM, A.E. The biology of leadership. H.C. Metcalf's Business Leadership. New York, Pitman, 1931.

WILEY, L. The spaghetti theory of leadership. Nursing 76 6, February 1976. pp. 3, 6-7.

4 III EVALUATION OF LEADERSHIP

W Anthony Lloyd

INTRODUCTION

An attempt is made in this paper to examine the changing nature of leadership and to identify some characteristics and attributes of the leader before going on to consider the possibility and desirability of evaluation of leadership performance.

THE NATURE OF LEADERSHIP

> 'For there is no creature whose inward being is so strong that it is not greatly determined by what lies outside it.'
>
> George Eliot, Middlemarch.

There are many variables which affect human behaviour. Society used to regard inherited characteristics as predominant. Later it was recognised that family environment plays a very important part in the formation and development of character and behaviour.

It seems logical to suppose, as does Brown, (1971) that work and organisational environment is an equally important factor. Lewis (1935) describes the continuing tendency to ascribe all behaviour to the nature of the individual rather than to the individual plus his environment.

Lewin declares that Aristotelian thinking is largely the current mode:

> 'The vectors which determine an object's movements are completely determined by the object. That is, they do not depend upon the relation of the object to the environment, and they belong to that object once and for all, irrespective of the surroundings at any given time.'

Lewin then contrasts this Aristotelian attitude with that of the modern physical scientists who are always concerned to explain phenomena in terms of the object and its relationship to its environment.

If it is true that organisational environment - which is under our control - is indeed a variable affecting human behaviour, including

the behaviour of the leader, it follows that the way we design employment hierarchies and the way we set up sub-institutions within them will have specific effects.

In 1970 the Readers Digest conducted an analysis of economic conditions in the United Kingdom and the EEC. Less than 5 per cent of the working population of the United Kingdom were either self-employed or employers. If these figures are correct this means that over 90 per cent of our population are now employed in employment hierarchies.

These hierarchies, of which the United Kingdom's National Health Service is one of the largest, are growing in size and this must affect the nature of leadership at all levels within them.

A greater understanding of the nature and effects of this change is also necessary. Lack of understanding is probably at the root of the current dissatisfaction and feeling of unease with leadership performance. The fate of charisma in the modern world is an example of technological pathos. In a rationalised, bureaucratic society, marked by specific competences and seeking them in its leaders, the charismatic impact is enormously reduced. Wilson (1976) contrasts charisma in primitive societies and modern industrial societies.

In the former, charisma appears at the point where the old ways are disturbed. It evokes a rounded response to a person as saviour or divine hero which may have objective social consequences. In the latter, charisma is a residuum persisting along the margins and interstices of society. It has no objective consequences apart from the comfort or, for that matter, the entertainment of those whom it affects.

When we think of leadership in the abstract, we are inclined to think of a Lincoln or a Churchill, someone who can persuade or inspire others to do something they would not otherwise do. In this sense, leadership seems somehow mystical or unattainable for the ordinary person.

Bower (1966) claims that most system managed organisations can attract a reasonable proportion of high calibre people and develop the leaders they need for success. It does not come about automatically but it is fairly likely to happen if the system works and is followed. Bower claims that there are two reasons for believing this. First, a system managed business is not really dependent on personal leadership of an inspirational nature, desirable though such leadership always is. The various system components provide people with guide-lines for action. Individual economic and emotional self-interest will cause them to follow these guide-lines without a high order of inspirational leadership. Since they know what to do, self-government under the system will encourage them to do it. The inter-actions of system components will further stimulate their performance. Second, the requirements of business leadership, (and the delivery of health care is increasingly classified as such), are less demanding than those of great political leadership. The statesman must arouse the

people to do the unusual, the business leader need only stimulate them to do well in their chosen jobs. This does not imply that business or the running of health care services may not demand sacrifice.

Brech (1976) highlights two aspects of the impact made by the manager in action in everyday life: the 'mental' (thinking directed to judgement with an out-turn in sound decision) and the 'behavioural' (attitudes of good motivation with an end result in effective cooperation). The skill of getting people to give of their best as members of a team is one which the 'born manager' has intuitively, but which the 'made manager' must acquire, however painfully. To call this 'leadership' runs the risk of over simplying the nature of the skill and of inducing a belief in a given attitude. There is too, a glamour about 'leadership' because of its analogy with daring exploits of adventure and heroism and this all too easily blinds the manager to the very realistic and down to earth features of the human or social skills that he needs to acquire and apply.

MacGregor (1960) also stresses that among the characteristics essential to leadership are skills and attitudes which can be acquired or extensively modified through learning. These include competence in planning and initiating action, in problem solving, in keeping communication channels open and functioning effectively, in accepting responsibility and in the skills of social inter-action. Such skills are not inherited, nor is their acquisition dependent on the possession of any unique pattern of inborn characteristics.

It is unlikely that there is a single basic pattern of abilities and personality traits characteristic of all leaders. Failure is as frequent as success in moving leaders from one type of social institution to another. Even within a single institution different circumstances require different leadership characteristics. This is also true of different organisational levels. Every successful ward sister would not make a successful district nursing officer (or vice versa). Yet each may be an effective leader. On the other hand, leaders who differ notably in abilities and traits are sometimes equally successful when they succeed each other in a given situation. Within rather wide limits, weakness in certain characteristics can be compensated by strength in others. This is particularly evident in teams in which the leadership functions are, in fact, shared. The very idea of the team implies different and supplementary patterns of abilities among the members. The value of this approach is being tested, some will say to its limits, in the development of team management in the reorganised National Health Service in the United Kingdom.

It is true that the few outstanding leaders in any field have been unusually gifted people, but these pre-eminent leaders differ widely amongst themselves in their characteristics. There is no common pattern. The evidence to date does not prove the existence of a basic universal core of personal qualifications for leadership. Few of the social scientists who have worked in the field during recent years regard this as a promising possibility for further study. On the

contrary, the research during the past two decades has shown that we must look beyond the personal qualifications of the leader if we wish to understand what leadership is.

MacGregor (1960) identifies at least four major variables now known to be involved in leadership, the characteristics of the leader, the attitudes, needs, and other personal characteristics of the followers, characteristics of the organisation, such as its purpose, its structure, the nature of the tasks to be performed, the social, economic and political milieu.

'The personal characteristics required for effective performance as a leader vary depending on the other factors. This is a very important research finding. It means that leadership is not a property of the individual, but a complex relationship among these variables. The old argument over whether the leader makes history or history makes the leader is resolved by this conception. Both assertions are true within limits. The relationship between the leader and the situation is essentially circular.' (pp. 182-3) The leader requires skills and attitudes but these can be acquired by people who differ widely in their in-born traits and abilities. It does not follow that any individual can become a successful leader in a given situation. It does follow that successful leadership is not dependent on the possession of a single, universal pattern of in-born traits and abilities.

'Research findings to date suggest, then, that it is more fruitful to consider leadership as a relationship between the leader and the situation than as a universal pattern of characteristics possessed by certain people. Moreover, research studies emphasize the importance of leadership skills and attitudes which can be acquired and are, therefore, not in-born characteristics of the individual.' (MacGregor 1960, p. 185.)

Leadership should be regarded not as a rare charismatic quality impossible to define, but as a regular component of good management, capable of analysis and development in individual managers.

McFarland (1974) has suggested that charisma is a mystical, inspirational quality that some persons possess in their social relations. The charismatic leader leads by inspiring, by capturing the emotional commitment of followers and by arousing feelings of strong loyalty and driving enthusiasm. Zalesnik and Moment (1964) conclude that this kind of emotional interaction is a mass phenomenon rather than a group event in which problem solving goals and methodologies evoke rational action. Furthermore, though highly influential the charismatic leader as often as not is unaware of what he is doing. He does not, necessarily, consciously strive to bring about particular consequences.

Leadership in modern organisations is all about problem solving and group participation!

Therefore, charisma does not seem appropriate for conceptualising the leadership process in the accomplishment of work, or in the development of groups and in individual growth.

When it appears in addition to the skills and attitudes which can be acquired or modified through learning it should be regarded simply as a bonus.

SELECTION OF LEADERS AND MANAGERS

> 'Men are neither good nor bad but only good or bad in this or that position.'
>
> Chester Barnard
> The Functions of the Executive

Selection of people for leadership positions remains one of the great gambles.

To try to appraise a person's long term potential by assessment of personality or promise or anything that is not proven is akin to fortune telling and a worse gamble than to win the football pools. The more scientific the procedure - the greater the gamble.

A prodigious amount of research activity has gone into selection methods in a multiplicity of employment situations. This has produced a formidable battery of tests and interview techniques and has certainly led to a general improvement in the criteria used in selection.

It is still true however, that despite all efforts deployed on selection, human judgement in choosing the right person for a particular job continues to play a central part.

That judgment is almost wholly concerned with a comparison of the characteristics and experience of applicants with the nature of the work and the role, and is commonly exercised with little more than superficial knowledge of either.

Individual work capacity and experience varies widely and so does the work content of roles. The difficulty is that of matching one to the other - particularly as the latter is unlikely to remain static.

There has been little success in devising tests for selecting managers likely to exhibit entrepreneurial qualities, as well as basic managerial competence.

One aspect of the manager's function which deserves special emphasis is his need, not only to see the opportunity of, or need for, change within the organisation - but also to implement it.

There is a danger that the current pre-occupation with quantitative techniques in an equillibrium situation will produce only

equillibrium solutions. Analysis paralysis! The real leader needs to induce change backed by crude criteria and unsophisticated information.

To predict with any pretence of accuracy such a quality in our present state of knowledge, is impossible.

A great deal more thought and research will need to be given to ways and means of reversing the selection process when errors have been made.

CHARACTERISTICS AND ATTRIBUTES OF THE LEADER

> 'Unless the leader can get others to do as he asks or directs, he has no followers. If he can initiate action in which he induces them to join, and direct it toward chosen goals, he is their leader in the truest sense.'
>
> Dalton E. McFarland
> Management- Principles and Practices

Much diligent research has produced a wealth of information about the desirable characteristics and attributes of the manager. Most management theorists draw up lists or produce profiles. A strong correlation has been drawn in this paper between management and leadership and it is not proposed to add significantly to these lists other than to draw attention to a number of qualities of vital importance.

(i) The ability to communicate effectively

Without it any other good qualities will be negated.

(ii) Knowledge of the enterprise

For nurse-leaders this means an informed interest in the broad spectrum of health care and a detailed knowledge of nursing and nurses.

(iii) Steadiness

This is perhaps not recognised enough. Health services produce dramatic, highly coloured, emotionally charged situations. A cool head, a steady hand can produce calm and restore equillibrium.

(iv) Sound judgement

A balanced, well integrated personality usually has this, and develops it further by experience.

(v) Foresight

An aspect of judgement but important in its own right. Assessing situations and estimating future developments.

(vi) Integrity

People will not follow a person they do not trust.

(vii) Courage

This is involved in management more than people realise. Successful management is not possible without personal challenges and conflicts which require courage to sustain.

(viii) Confidence

This must be based on reality (self-knowledge), not on a conceited, unjustified pretension of competence.

(ix) Commonsense

When the manager has utilised all his professional knowledge and expertise and when he has conscientiously applied the proper personality attitudes he still needs that extra something. That indefinable something which most people recognise as commonsense.

He must know what makes things tick, what should be pursued and what left alone, what is important, what trivial, how much the people will take (pace), how groups will react. All this stems from the quality of commonsense which of all the personal attributes is the one the manager simply cannot do without.

EVALUATION

> 'Managers have to learn that de-selection is made necessary by a bad match between the person and the role, not because a person is 'no good'. Nobody is 'no good'. Nearly everybody can do some work well if the right match can be established. The whole procedure must be de-emotionalised.'
>
> Wilfred Brown
> Organisation

If the correlation between management and leadership is accepted it is possible to carry out appraisal of performance - in managerial terms. Management appraisal is to do with estimating managerial ability and performance and much is known about the techniques of manager appraisal, staff appraisal, merit ratings, staff assessment and management development. The difficulty is that the validity of the various approaches to appraisal has been seriously questioned.

Experience has shown that appraisers are reluctant to appraise and interviewers are reluctant to follow-up.

Systematic appraisal is only acceptable to most people if it is confined to reviews of past performance and the setting of performance goals for the future. Performance seems to mean most when specific goals are set.

It seems inescapable that if appraisal of this kind is to have a meaningful place in the leadership context it must be based as far as possible on present performance and not on future potential.

It also seems reasonable to suggest that 'charisma' and 'personality' must be eliminated from the appraisal. The former because it is not a pre-requisite and the latter because studies on test data of 'source traits' are not validated. It should be possible to introduce techniques for using control devices to test a manager's competence against defined performance needs in a particular post, for example, communication skills, knowledge of the enterprise, objectives of the enterprise, use of control and information systems, developing staff, initiating action etc, etc.

For some of the more intangible qualities, for example judgment, steadiness, courage and commonsense a more subjective element emerges and would of necessity involve past as well as present performance. These factors can only be judged as a cumulative record over a period of time.

This should not be a reason for 'shying-off'. When desirable managerial attributes have been formulated, appraisal may be made.

Setting the form of the appraisal would be extremely difficult though not impossible.

The appraisal could involve the manager himself, his colleagues, his subordinates and his superiors. Specialist opinion may also be sought. It would be important for the organisation to decide how much of its resources it would be prepared to devote to this activity.

Little will be done until there is acceptance of the need to evaluate leadership performance and it is in this direction that the first major push must come.

The cost to organisations of bad or inadequate performance by leaders must be immense, particularly in standards of morale, throughout the organisation. The element of 'de-selection' inherent in such a process must be faced and realistic attempts made to deal with the problem by means other than dismissal. As Wilfred Brown has pointed out 'unless people know that there is a sound process for dealing with these problems the fear of dismissal hangs over relations between managers and subordinates like a spectre'. It is hardly likely that the present tendency for appraisal ratings to have a marked affinity for the centre line will be rectified until this first step is tackled.

There must be a clear division between the appraisal system used for all staff and that used for assessing leadership performance.

The former is primarily concerned with training and development whereas the latter is concerned in addition to rectifying the mistakes of selection, not in a spirit of retribution but in the interests of everyone in the organisation and those it serves.

The means by which such a change could be implemented would need first of all to be the subject of discussion with all those in leadership positions. Their reaction may in itself be an indication of their calibre as leaders.

REFERENCES

BOWER, Marvin. The Will to Manage. New York, McGraw-Hill Book Company, 1966.

BRECH, E.F.L. Management - Its Nature and Significance. London, Pitman and Sons Ltd., 1976.

BROWN, Wilfred. Organisation. London. Heineman Education Books, 1971.

LEWIN, Kurt. A Dynamic Theory of Personality. New York, McGraw-Hill Book Company, 1935.

MCFARLAND, Dalton E. Management Principles and Practices. New York, Macmillan Publishing Co. Inc., 1974.

MCGREGOR, Douglas. The Human Side of Enterprise. New York, McGraw-Hill Book Company, 1960.

WILSON, Bryan. The Noble Savage. Berkeley, University of California Press, 1976.

ZALESNIK, Abraham and MOMENT, David. The Dynamics of Interpersonal Behaviour. Chichester, John Wiley, 1964.

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DISCUSSION

Very little is known about the validity and reliability of evaluation techniques. As one speaker put it 'we simply do not know what is the relationship between leadership and health care'.

There was therefore some hesitation amongst the delegates about attempting to evaluate leadership. Questions were raised concerning the necessity for formal evaluation, was informal evaluation not more appropriate? Did there not come a stage in professional development where self-evaluation was proper? Would constant pulling up the plant to see how the roots were growing not result in a sickly plant?

Differences between management and leadership emerged more clearly. Leadership was seen to be a multi-variant concept - a variety of relationships between the leader and the led. Managers held positions where the social structure gave them power; some were leaders as well as position holders, others were not.

In management it was proper to concentrate on evaluation of the system or programme not of individuals. There was agreement that any enterprise had to have objectives, that progress towards them could be by stages and that targets could be agreed with each group of workers. Regular evaluation offered the opportunity to talk with one's chief about the realism of targets, the various means of achieving them, about success or failure to reach them and about action to be taken where success had not been achieved. The emphasis would be on mutual interest in reaching objectives, on learning from mistakes and improving performance. Recognition of achievement, rather than monetary rewards, were proper to leadership success. Nurse leaders were said to be beset from time to time by an acute sense of failure. Much could be learned from failure and the way it was handled.

If evaluation was to take place, it was agreed that it was undesirable to evaluate the work of junior members of staff unless the work of senior staff was also evaluated. It was said that everyone needed someone to tell them what they wished they hadn't heard. Reviews from fellow members of a leadership team were useful. Team members would need to understand each other's roles.

The question of evaluation of the work of senior members of staff by junior members was raised. It was pointed out that often the two were working on different time scales. Workers at the point of delivery of care had immediate needs for the performance of their task. They would have scant patience with the documentation, committee work and long term planning which occupied the administrative grades. It was suggested by one speaker that it was leaders who were concerned about leadership. The led displayed at best lack of interest and at worst derision. Leadership implied leaders and led at different levels

fulfilling roles assigned by custom or appointment. This was seen as totally contrary to the current spread of equality and would be contested by those who no longer saw the leader as having power to define the contract without meaningful reference to the led. Another speaker felt it was becoming customary to denigrate the role of leader.

Evaluation of progress towards objectives was clearly possible; evaluation of leaders was a very different matter. The individuals concerned were professional people pursuing their chosen specialty and properly making their own judgments about priorities and practices. Respect for their personal integrity and professional knowledge was essential. No one in an administrative position could tell a specialist how to do her specialised work. What could be helpful was discussion of the context in which the work was performed, the resources available and the constraints likely to be encountered. Targets mutually set would probably be realistic and any failure to achieve them could be seen in relation to a more general situation.

The type of problems leaders dealt with seldom had 'right' answers. Often what had to be found was the 'least worse' course of action. Under these circumstances even success could look like failure. Failure, even repeated failure, should not be allowed to lead to disintegration of a personality. Realistic expectations were a necessity for the assessor and the assessed.

The effect of disease - mental or physical - on leadership performance was mentioned by a delegate. Leaders worked in positions of considerable stress; not all of them saw problems as exciting challenges. Signs of ill-health needed to be detected early and action taken to overcome the problem before it resulted in disability. Similarities with stress problems in managerial positions in other occupations were noted and the role of an occupational health service was brought out.

The importance of a positive regard for others was never more prominent than in the effective and compassionate handling of failure. Where a team was failing because a member was working beyond his level of competence that member had to be replaced. Easy transition to less onerous work for the unsuccessful leader was always difficult and could be made worse by rigid insistance on advertising all posts or by public arguments about the right to retention of particular positions. Escape systems were important enabling individuals unsuccessful with one employer to move to another without loss of face. It was noted that the UK had special problems in this respect with a nationalised health service.

Faculty members, like managers, occupied positions supported by a social structure. They too could provide leadership or occupy positions without leading. They were assessed by their peers for output in terms of published material, research and innovatory ideas and by their students in terms of the role-models they provided and the sincerity of their interest in the students themselves. Security of tenure was likely to be theirs but salary and promotion could be influenced by evaluation of their work.

Elected leaders needed to satisfy the people whom they represented and loss of office could result from failure to do so. Charismatic leadership was seen to be appropriate in crisis conditions. At least one delegate felt that the days of charismatic leadership were over. The charismatic leader retained his position by his ability to interpret and represent the aims and needs of his followers but above all success determined allegiance.

The consultant too depended on success to stay in business. He had to understand problems, offer realistic and effective suggestions for action and reliable predictions of results. Failure would result in his services no longer being sought.

Advisers and their work were perhaps the most difficult of all to assess. Their role as defined in the seminar was too complex to treat as a single entity. No method of assessing their work was considered.

Leadership in the community was largely dependent for its success on the highly controlling position of information giver. Failure to provide the information sought by the public would result in lack of credibility.

5 SUMMARY OF SEMINAR AND INTEGRATION OF THEORETICAL PRESENTATION AND ITS APPLICATION TO NURSING SITUATIONS

Jean K McFarlane

After the rich feast of 'fat things' we have enjoyed this week in the presentation of papers, in group work and in plenary and individual discussions, it seems impossible and even impertinent to attempt to summarise. In a summary, the context and richness of phrase may be lost. Perception is inevitably selective and a summary selects and modifies from the position of one's own vision. It may serve however to underline some of the important points that have been made. It may also serve to consolidate, by the pedagogic strategy of repetition, some of the things learnt during the seminar.

OBJECTIVES

Lest we forget in the sea of data in which we find ourselves, we had objectives at the beginning of the week. After consultation, our leaders stated our aims

> 'to compare developments and experiences in the three countries with a view to professional and personal benefits to members and through them to the nursing services and to publish a report for a wider audience'.

Of my own benefit in attending this seminar I have no doubt. We shall presently discuss the dissemination to the profession of what we have gained and we anticipate with pleasure the report from the King's Fund.

For this year's seminar we chose to discuss leadership, its nature, the role and responsibilities of nurses for leadership, the emergence of leaders and the evaluation of leadership performance. I would like to draw together some of these themes.

THE NATURE OF LEADERSHIP

We started on Monday with a thought provoking session with John Garnett. He gave us a definition, 'leadership consists in the actions necessary to call forth the gifts of each individual and to help the individuals work together in teams in order to achieve the task'. His definition underlines his action framework for leadership. A number of similar definitions were given by other speakers. 'Leadership is the activity of influencing people to co-operate toward

the achievement of a desirable goal.' 'Leadership is the exercise of will, power, influence and insight, which directs and controls others in the pursuit of a common cause.' 'Leadership in nursing is the kind of behaviour exhibited by individuals who influence others towards the attainment of goals and objectives for which nursing as a social enterprise exists.' 'Leadership is the process of influencing people individually and in groups to effectively accomplish organisational goals.' One speaker drew on Fiedler who looks on leadership as 'an inter-personal relation in which power and influence are unevenly distributed so that one person is able to direct and control the actions and behaviour of others to a greater extent than they direct and control his'.

Definitions given by Hagen and Wolff and Tead have a similar approach. Two speakers referred to Stodgill's monumental analysis of 3000 books and articles on leadership. One of these speakers selected eleven different leadership themes from Stodgill's analysis but the themes most frequently recurring during the week were

leadership behaviour or action;

leadership as interaction with or power, influence or authority over the led;

goals or objectives of leaders - this might be expressed in a sequence we use in another setting:

a)action; b) reaction; c) interaction; d) transaction;

the leadership situation.

Different authors place a different emphasis on each of these aspects of leadership, on the leader's behaviour, the nature of interaction, power and authority, and the goals and the factors affecting them. Because of the professional setting in which we work, the papers and discussion gave a great deal of attention to the situational variables, the setting in which leadership occurs.

I would like therefore to review our findings on the role and responsibility for nurses for leadership under these headings, taking first the situational variables.

THE ROLE AND RESPONSIBILITY FOR NURSES FOR LEADERSHIP IN A HEALTH CARE DELIVERY SYSTEM

1 The situational variables

There was general agreement that leadership positions exist in nursing at all levels of the service, in the public and private sectors, in education, in professional organisations and in research. In plenary session and in groups we considered leadership at the point of delivery of care and in the education system; in management positions and as advisers and consultants; and in professional associations, trade union activities, and voluntary and community activities. In this one can perhaps identify the larger macro-system affecting health care delivery in which the leader functions and the micro-system through which care is actually delivered.

Macro-system Emphasis was placed on the voice of the nurse being heard in places of influence - in government, in the political and economic arena, in strategic positions in organisations and groups. There was a need for members of the profession to be informed and knowledgeable about the language and concepts used by scientists, economists, and engineers, and the role of politics and government in health care. More than one speaker insisted that it is not possible to consider the role and responsibility of the leader without taking account of the changing system in which she functions and the likely direction of future changes. The group's attention was drawn to Toffler's "Future Shock" and the possible effects of rapid change in the system.

It was recognised that nursing takes place in complex political situations in which there may be open confrontation-negotiation rather than the older style of leadership in establishment maintenance. A great deal of consideration was given to the role of leadership in professional organisations. There was need for astute leadership. Group III explored this in depth and contrasted the professional model of labour relations with the industrial model.

The need for professional unity was stressed. Some of the inner stresses of the professional organisation were considered - those between the elected élite and the appointed (officer) élite. John Garnett drew attention to the very different status of officers once one makes men free - the triangle is inverted and the general secretary (once at the apex) is controlled by the membership (once at the base).

Micro-system In the micro-system, or health care delivery system, the changes which have taken place in the management structure in the United Kingdom were described with particular reference to the implementation of the Salmon Committee Report and the reorganisation of the health service. The different roles of leaders as advisers, consultants and monitors were discussed together with the different techniques of leadership associated with them, such as, persuasion, multidisciplinary consensus.

Leadership at the point of delivery of care was the cause of great concern. It was felt that standards of care were deteriorating, though due regard was given to factors such as different expectations which might contribute to this perception.

Preparation for emergence of leaders: Leadership in giving clinical care was felt to be of importance particularly in view of the changed nature of the health team, for example, the higher proportion of untrained personnel and the team's multidisciplinary nature. The staff nurse and ward sister need to take a leadership responsibility for their own actions in assessment, prescription and delivery of care and to do this assertively in the face of increasing pressure by physicians for nurses to take on a doctor's assistant role because of medical manpower shortage.

Although the importance of leadership at every level in the profession was recognised, some participants felt that leadership development of the nursing officer/supervisor grade was crucial.

Two speakers mentioned conflict and even hostility and a denigration of the management role. This could be between the nurse manager and the nurse giving care or between the manager and the physician. Whilst there should be no inherent conflict it was felt that the goals of the nurse manager should be more clearly stated in terms which could be appreciated by those in clinical positions. The relevance of their goals to the main organisational goal needs restating and clarifying.

Educational system: The role of leaders in the educational system was discussed. They were seen as 'gatekeepers', controlling entry into the profession, the curriculum, the selection of faculty members. In the American situation the graduate nurse proceeds from the 'gatekeepers' to the 'gamekeepers' and to an environment which can be negative to growth. In the United Kingdom the close relationship of practice and education in an apprenticeship system means that the student moves between the 'gatekeepers' and 'gamekeepers' and the latter may appear to be more relevant to the real goal even if the environment is sometimes negative.

2 Leadership actions

John Garnett impressed upon us the action framework of leadership. This consists in what people do and he outlined some of the activities a leader needs to carry out. These include identifying and setting the task, making leaders responsible for teams, setting targets, designing jobs, delegating decisions, communicating, training, caring, monitoring including 'walking the job'. Thus it seems that there is a leadership process (or sub-process in the management process) of identifying the aims, the strategies to achieve the aims, the team needed, their briefing, the evaluation of performance. In this process leadership skills are required. We have emphasised decision making, risk bearing, handling conflict, consultation, communications, the use of failure and success and the development of ideas.

Leadership actions therefore can be directed towards the task or goal and/or the team, towards the task or personnel. The goal must vary at different levels of leadership.

3 Interaction

It is this vital aspect of leadership, the interaction between the leader and the led that we have perhaps considered least. Many of the papers listed traits of leadership until they might have been describing the Archangel Gabriel. The good leader is knowledgeable, self-directing, aggressive, assertive, has courage, a vision, understanding, makes decisions, acts quickly, has a sense of purpose, direction, integrity, enthusiasm, affection, friendliness, is creative, decisive, intelligent, moral, does not need love. The led (and one participant asked if there must be followers) seem to be described less frequently and less eulogistically. They must have commitment, be accountable, submissive/confronting (by implication). The leadership function produces changed behaviour. But the nature of leadership is that interaction takes place and behaviour ensues (transactional) on what basis? It may be consensus about the aim and hence commitment but it may be on the basis of authority, of power (structural or personal). Etzioni designates types of power wielded in organisations - participative, coercive and so on. The elementary motivators would be financial and legal but there may also be ego involvement, self-actualising, acceptance. At least one participant was thought to be casting a longing eye back to charismatic leadership.

Even though the task be dominant the influence of a good role model may be inspirational, giving a creative quality to the interaction.

The content and nature of the interaction between the leader and the led is demonstrated in different styles of leadership. The authoritarian or democratic (Lewin), the task orientated or personnel orientated (Blake and Mantan). It was said that a positive attitude was more critical than the process.

In fact different styles of management may be required by different people for different tasks at different times. Thus certain clinical tasks may require authoritative leadership, others participative, some persuasive. Perhaps it is our historical origins in religious orders and military organisation that have given us a rather rigid approach to leadership patterns and a fear of innovations. The leader needs to be able to adapt the style of leadership.

EMERGENCE OF LEADERS

A large part of our discussions centred on education for leadership roles. No very strong case was made for selection of leaders with desirable leadership traits, though some traits were held to be inimicable to good leadership. Rather there was a concentration on training for the tasks of leadership at various levels. The nature/nurture dichotomy was discussed. Opportunities to practise leadership, modelling and educational programmes were discussed. It is possible to trace that some of our present leaders have emerged from institutions where there have been good role models, but equally many of our present leaders have had access to longer periods of post-graduate education. Attention was drawn to the lack of success of shorter periods of in-service training. Certain necessary components of knowledge were identified; nursing knowledge; organisational knowledge; knowledge of information processing techniques.

The need for support systems for the leader was also mentioned. In particular the psychological stress and physical toll exacted from leaders was examined and the need for support in success and failure was emphasised.

THE GOAL

Little has been said during the week about the precise value of the ultimate goal in nursing except that it is quality nursing care. We have avoided defining the area of our own prescriptive function and the relationship of medically prescribed tasks. We are perhaps fortunate in that nursing care of people is an objective which commands commitment to the task - to care means 'it matters to me'. It is a task which is valued in our society.

It should therefore be easy to channel that commitment to influence towards our primary goal, that is, to lead. The secondary goals of management and education and research will not in themselves command such commitment but they can be sanctified by their association and declared relationship with the primary goal. If we have doubts about the quality of care then I suggest it is our leadership which is failing to influence the team to the true goal of nursing.

Different goals and strategies in leadership exist in every part of the system.

EVALUATION

Evaluation of leadership can take place in each set of variables we have discussed, situational; leadership actions - skills; interaction; and aim (outcome).

An evaluation strategy suggests a typology of evaluation for whom? by whom? of whom? Analysis of critical incidents could provide helpful indicators. Stress was laid on the need for formal and informal systems of evaluation at every level and the difference of evaluation for formal rewards and evaluation directed towards self-knowledge was noted. Self-evaluation, peer evaluation, subordinate and superior evaluation all received mention. It was suggested that there should be escape mechanisms for failure, but that failure could result in growth and success might be as destructive as failure if inadequately managed.

CONCLUSION

In conclusion I would like to return to the goal for it is in nursing the prime motivating factor for leaders and led. On Monday the importance of restating the aim and holding it in front of the led was stressed. 'Where there is no vision the people perish'. Even in the clinical situation, the goal of caring for people may be lost in the detail of tasks and the pressure of time. The leader needs the ability to see through the demands of the moment, the true goal and we have this week stressed the need of the manager whose intermediate goal may be managing the service, to see the ultimate goal of caring. One of the prophets was told 'take the vision and write it large, that he who runs may read'. There is a need for the vision of the goal of caring to be displayed so that people who are involved in working can still see it.

We too have had a vision, painted for us in so many papers and discussions. But you will recall that some who had a vision found themselves next moment in a valley full of demons. This may be so very quickly for some of us - from this vision we return to the valley of everyday life and there will be a few demons. Of the demons it was said, 'this kind cannot be cast out except by prayer and fasting'. I think this means that we shall only bring the vision into the valley and make it a verity if we exercise the discipline of leadership. That is a continuing exercise but perhaps it ought to start right now in filling in an action slip of things we shall do when we get back.