The art of clinical leadership in contemporary nursing

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For Eddie Mannix, my dearly departed father who always wanted me to have the formal education he never had
Acknowledgements

The journey to the completion of this thesis has been an interesting and largely rewarding one, providing me with the opportunity to contribute in a tangible way to contemporary nursing knowledge. While some may say it has been a long time coming, given that I am in my 35th year as a registered nurse, I take the view it was the right time for me. As many who have completed their own doctoral studies could attest, while the PhD road can be at times a solitary experience, it is a road best shared by friends and colleagues who can provide encouragement, support and sage advice. I would like to acknowledge the following people who have done that for me:

To my supervisors, Lesley Wilkes and John Daly I thank them both for their guidance, advice and encouragement throughout this project. In particular, I would like to thank Lesley as my principal supervisor for always being available, regardless of where we may have been in the world at any one time.

To those registered nurses who participated in the project, either as expert panel members, respondents to the online survey and/or as participants in the interviews, I thank sincerely. Their expertise, clinical wisdom and commitment to nursing practice and scholarship are reflected in the outcomes of this thesis.

To my friends and colleagues in the School of Nursing and Midwifery at UWS who continued to show interest in this project, from conception to development, and through to completion. Thanks to those colleagues who attended and provided feedback on my presentations at the annual Research Forum. I would like to especially thank Dr Antoinette Cotton who enthusiastically undertook a thoughtful and scholarly critique of a full draft of this thesis.

Most thanks are due to Debra Jackson, for her support, guidance, intellect and advice. Without her continued presence in my life the journey to completion of this thesis would have been more arduous.
Statement of Authentication

The work presented in this thesis is, to the best of my knowledge and belief, original except as acknowledged in the text. I hereby declare that I have not submitted this material, either in full or in part, for a degree at this or any other institution.

[Signature]
Prelude

The seeds to this project were sown in the early 2000s when I found myself hospitalised for five days in my own training hospital (a large acute tertiary referral facility in metropolitan Sydney). While I was certainly not the most acutely ill or highly dependent patient in the four bed ward, I was on bedrest and required nursing care at different times throughout the day (and night). As an experienced registered nurse I was “gobsmacked” with the nursing care I and other patients in my ward did and did not receive.

During this hospitalisation my concerns were heightened around the quality and nature of leadership and role models available in the clinical nursing arena for newly graduated or inexperienced registered nurses. Junior, less experienced registered nurses in the ward, understandably, did not possess a full range of clinical skills. However, what concerned me most was that there did not seem to be a clinical leadership presence in the area, and there was no apparent effort made to remedy this by those in clinical leadership positions. The particular clinical area had registered nurses in recognised leadership positions, including Clinical Nurse Specialists and Clinical Nurse Consultants. The ward also had a permanent Nurse Unit Manager, again a position with expectations of leadership. Nonetheless, it was apparent that the majority of the less experienced registered nurses were not being exposed and influenced by effective clinical leadership in order to help shape their day-to-day clinical practice involving direct patient care.

I continued to wonder why this situation was occurring in a profession with a long history of more experienced nurses modelling expected clinical attributes and behaviours under the apprenticeship model of hospital based nurse education. What was impeding clinical leaders from leading at the bedside? Surely, the shift to tertiary education was not the reason. Could it be the changes in patient acuity levels, changes to staff skill mix in clinical settings, the demise of team nursing in favour of total patient care, or a lack of educational preparation for those nurses in designated clinical leadership positions? I wondered if clinical leaders were being oppressed by organisational hierarchy of health care systems. After all, oppression is not an unknown concept in nursing. My wonderings about these issues around clinical leadership were ignited when calls for more effective clinical leadership were highlighted in a government report (Garling 2008) into the ills of the health system. It seemed to me a lot like “blame the victim”. The result of this interest follows.
Thesis outcomes

Series of scholarly papers


Associated relevant publications during candidature


Oral presentations

2. Clinical leadership: is it the panacea we all think? *Australian College of Mental Health Nurses Education Forum*. Cumberland Hospital, Parramatta. (2010, July).
7. The art of clinical leadership in contemporary nursing: collecting data via the online world. *School of Nursing & Midwifery Research Futures Forum*. UWS (2013, June).

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Abstract

There is little doubt that leadership is a complex process and the quality of its application can have profound effects on organisations and workplaces. As a concept, leadership has been variously depicted, defined, and discussed in the literature. In the new millennium clinical leadership has increasingly been a focus of attention in health care systems across the world, with various reports identifying enhanced clinical leadership as a solution to overcoming deficiencies in the quality of care delivered to consumers of health care services. In the complex world of health care this view is perhaps too simplistic. However, there is little doubt that clinical leadership effectiveness does have a role to play in the quality of health care delivery, regardless of the clinical setting. To this end, this study set out to explore the aesthetics of clinical leadership in contemporary nursing. A mixed-methods approach was adopted for the research, underpinned by the philosophical orientation and assumptions of critical social theory and the works of Habermas. Initially, an integrative review of the contemporary nursing literature was conducted to uncover empirical understandings of clinical leadership. Data were then collected from an online descriptive survey and conversation-style interviews with 12 registered nurses who worked in designated clinical leadership roles. The respondents to the survey were nurses from across the world, recruited via online social networks and e-learning platforms and the clinical leaders interviewed were from Australia. Quantitative data collected from the online survey were subject to descriptive analysis using SPSS software. The qualitative responses to the survey were initially subject of content analysis using aesthetic leadership dimensions. Data collected from the interviews were analysed thematically.

The findings from these three data sources are presented as part of a series of six published papers in this thesis. The integrative review revealed, from a relatively small evidence base, attributes of clinical leadership have a clinical focus, a follower/team focus or a personal qualities focus; all attributes to needed to sustain supportive workplaces. The survey results indicated that the aesthetic leadership characteristics in clinical leaders most valued included being supportive and effective communication. Taking risks and challenging processes were least likely to be evident among clinical leaders. Analysis of the narrative data collected during the research revealed that advanced practice nurses in designated clinical leadership roles embodied aesthetic leadership, reflected in a strong moral compass that
shapes their practice. The data also revealed that when clinical leaders enact aesthetic leadership they are critically self-reflective and embrace core nursing values and beliefs. Through this type of leadership they convey a visible, composed role model that has a positive effect on the nursing workplace. From subsequent synthesis of these findings, and using of the symphony orchestra as a metaphor, a model of artful clinical leadership emerged. This model offers a new and different way of conceptualising clinical leadership in contemporary nursing. Using the established notion of levels of expertise, in much the same way as has occurred clinical nursing practice, this model identifies the qualities and attributes to be an artful concertmaster in the contemporary clinical nursing world.
Chapter 1: Introduction

1.1. Framing the study

As one would expect with a doctoral level study, at the nexus of this thesis are a number of separate, yet interrelated concepts and notions. At its core are the concepts of nursing leadership, clinical leaders, the art of nursing or artful nursing, and aesthetics, all within the context of the contemporary clinical nursing world. Therefore, to frame the study, this introductory chapter introduces and briefly discusses these concepts, states the aim and significance of the study and outlines the structure of the thesis.

1.2. The art of nursing and aesthetics

Since the beginnings of modern nursing theorists have considered the art/science juxtaposition when contemplating what it is to be a nurse and all things nursing. From Nightingale’s (1859) philosophical perspective, both art and science are necessary components of effective nursing care, reflected through an holistic, caring presence underpinned by evidence-based knowledge and skills (LaSala 2009). Contemporary nursing theorists and philosophers like Benner (1984) and Watson (2001) have expanded on and contextualised Nightingale’s original views on the place of art and science in nursing practice. Although there continues to be debate on whether nursing is more science than art or vice versa, there is little opposition to the view that nursing needs both. Steeped in a practice base, and not unlike other practice-based disciplines, nursing requires a fusion of the art and science (Norman & Ryrie 2013).

As individual concepts, there is generally little confusion about what constitutes science in nursing, especially with the emergence and subsequent dominance of evidence-based practice from the latter decades of the 20th century. However, the same could not be said of the art of nursing. There has been a lack of clarity around the concept and its centrality to contemporary nursing practice, prompting nurse scholars to examine and synthesise the extant literature (Finfgeld-Connett 2008, Johnson 1994). In an effort to provide some clarity, Finfgeld-Connett (2008, p383) concludes that as a concept, the art of nursing involves nurses expertly using ‘empirical and metaphysical knowledge and values’ sensitively and creatively to
enhance patient/client well-being. Such a description reflects the inherent difficulty in
confining the art of nursing or artful nursing to a single construct. Some of this
confusion is around how “art” is thought of in a nursing context. However, as Katims
(1993) argues, “art” in nursing relates to expertly using a sound knowledge base to
apply nursing skills creatively to caregiving, rather than taking “art” to mean an artistic
object resulting from creative processes. This interpretation is true to the original
Greek word ‘techne’, meaning skilfully created (Barry & Meisiek 2010, p332). For this
artful nursing to happen, the required level of expertise necessitates professional
maturity and would not be something present in nurses less experienced in the
clinical practice setting.

Although empirical, scientific evidence-based practice has become the dominant
discourse to explain nursing practice, artful nursing and links between it and
aesthetics have been established and continue to be debated and critiqued in the
nursing literature, particularly since Carper (1978) identified aesthetics as one of the
four fundamental patterns of knowing in nursing. Derived from the original Greek word
‘aesthesis’, meaning sensory or perceptual knowledge (Koren 2010, p15), it is in
these terms that nursing philosophers and theorists have generally considered
aesthetics to mean, rather than in the context of a philosophy of art (Austgard 2006).
While Carper’s view of aesthetics as being a process of knowing, with empathy and
perception as critical elements has not gained universal support (see for example,
Duff Cloutier et al. 2007, Finfgeld-Connett 2008, Wainright 2000), it is evident that
links do exist between artful nursing and aesthetics. The artful and aesthetic aspects
of the nursing do prevail and there has been analysis and development of these
concepts in the nursing literature (see for example, Freshwater 2004, Gaydos 2003).
The involvement of human interactions and experiences in artful nursing means that,
as a concept, it is associated with the less measurable and more subjective elements
like feelings, perceptions and judgments. These subjective elements align with
aesthetics. The concept of artful nursing has been argued to encompass aesthetic
qualities of ‘balance, harmony, rhythm, tone and unity’ (Gendron 1994, p26), resulting
in nursing praxis in clinical settings that embodies a sense of harmony and felt
pleasures between nurses and patients (Holmes 1992, Kim 1993).

It is evident that artful nursing and aesthetics transcends most areas of nursing
clinical specialties from aged care (Sheets 2012) to critical care (Timmins 2011),
through to areas of nursing with less direct hands-on patient contact, such as
and leadership (Jackson et al. 2009). While there may be those who argue that it is
difficult to support the presence of artful nursing and aesthetics in non-clinical areas of nursing, there are those with a counter position, believing that nurses in education, management and leadership positions come to these positions as nurses and therefore retain, as the basis for their practice, the values and beliefs of nursing (Jeffery 2013). It is this latter position taken in this thesis.

1.3. **Contemporary leadership styles in the clinical nursing world**

Leadership has long been a taken-for-granted expectation in modern nursing, especially in clinical settings where teams of nurses are charged with the responsibility for patient/client care. As the clinical landscape has become more complex, being likened to a “perfect storm” (Hinshaw 2008; Jackson & Daly 2010), health care organisations are increasingly turning to clinical leaders. Coexisting elements contributing to this “perfect storm” in clinical workplace include workforce shortages (Juraschek et al. 2012), an ageing nursing workforce (Francis & Mills 2011), skill-mix factors (Twigg et al. 2012), and increasing patient acuity levels (Needleman 2013). Since the turn of the 21st century the quality of clinical leadership has consistently been called into question and held to account for failures in achieving positive patient/client outcomes. For example, recent reports in Australia (Garling 2008), the UK (Francis 2013) and the United States (Committee on Quality of Healthcare in America 2001) have pointed to the need for improvements in the quality and effectiveness of clinical leadership in health care. In response to these calls, health care organisations and professional bodies have offered professional development programs in clinical leadership to up-skill health professionals, especially for those in designated clinical leadership positions.

The dominant leadership model offered in these professional development programs available to nurses across the world has been transformational leadership (Martin et al. 2014), possibly as a result of the widespread adoption and adaptation of the Royal College of Nursing’s (RCN) *National Nursing Leadership Programme*, informed by the transformational leadership model and offered from the early 2000s (Millward & Bryan 2005). This dominance is also evident in the nursing leadership research, with Cummings et al. (2010) reporting in a systematic review of leadership styles in nursing that 53% of studies reviewed focused on transformational leadership. Much of this empirical research highlights the benefits of this leadership model to nursing, providing valuable insights into leadership in the nursing workplace (Hutchinson & Jackson 2013). Transformational leadership has been identified as the preferred
leadership style by nurses (Andrews et al. 2012), championed for improving job satisfaction and team performance (Braun et al. 2012), and hailed as a panacea for ensuring more effective clinical leadership. However, transformational leadership is rarely evaluated for its effectiveness in the nursing workplace (Hutchinson & Jackson 2013). Other leadership models have been considered as having the potential to improve the nursing workplace and patient outcomes. These have included servant leadership (Jackson 2008), authentic leadership (Wong & Cummings 2009), ethical leadership (Makaroff et al. 2014), and congruent leadership (Stanley 2008). The attributes of clinical leaders utilising different leadership styles vary and are presented in Chapter 2 of this thesis.

1.4. Who are the clinical leaders in nursing?

With the current emphasis in nursing practice settings on relational style leadership models such as those mentioned in the previous section it is important to consider the expectations of clinical leadership and what that may entail, particularly in designated clinical leadership roles. While clinical leaders in health care are not restricted to nurses (see for example, Leggat & Balding 2013, Nicol et al. 2014), as one of the few health professions with a physical presence in the clinical workplace 24 hours a day, seven days a week (Ennis et al. 2015), and delivering the overwhelming majority of health care (Millward & Bryan 2005), the responsibility for clinical leadership mainly rests with nurses. In many jurisdictions across the world designated clinical leadership roles have been identified within nursing career structures and while these designated roles may have different nomenclatures, a common expectation of nurses in these positions is that they are advanced practitioners in their particular clinical specialty (McNamara et al. 2011). In these advanced practice roles it is not uncommon for clinical leadership to be articulated as a specific competency or domain of practice against which the advanced practitioner’s performance is gauged (see for example, Baernholdt & Cottingham 2011, Fry et al. 2013, Gregorowski et al. 2013, Higgins et al. 2013). The expectations of clinical leadership in these roles include taking the lead for clinical practice developments, being an expert clinician and a role model for nursing staff (NSW Health 2011), guiding and coordinating multidisciplinary team activities, and taking the lead for policy development and implementation (Elliott et al. 2013). In the context of this thesis a clinical leader is a nurse who has this type of role in clinical practice.
1.5. **Aim of the study**

The study aimed to explore the aesthetics of clinical leadership in contemporary nursing.

1.6. **Significance of the study**

It is hoped this study can uncover from registered nurses what it is to be a clinical leader in contemporary nursing, and in doing so, reveal the aesthetic elements of effective clinical leadership in the nursing world. The study could offer aesthetic leadership as an alternate or additional style of leadership that sits comfortably with nursing values and beliefs. By incorporating aesthetic elements into their day-to-day activities clinical leaders may feel empowered to provide more holistic nursing leadership in a complex clinical world. For educators involved in offering clinical leadership programs the findings in the study could provide a way for them to confidently construct programs that explicitly reflect nursing values and beliefs. The study findings may also encourage professional nursing organisations and health sector employees to consider the need to strongly advocate and support clinical leadership positions in the clinical nursing world. Finally, recipients of nursing care may benefit through nurses in clinical leadership modelling clinical care that reflects the true essence of nursing practice.

1.7. **Structure of the thesis**

In line with the UWS PhD rule (Clauses 95-96) the thesis is presented for examination as a series of peer reviewed scholarly papers, as listed in the thesis outcomes (see page vi). All papers are derived from the study and were developed during the period of enrolment. The papers are integrated within an overarching discussion that serves as an introduction to the assessable work, explains the research project’s methodology, undertakes a discussion of the interdependence of the published papers and outcomes from the project, and finally, considers the implications for the nursing world of practice, education and scholarship.

Central to the study is the socio-political context in which contemporary clinical leaders practise their craft. Consequently, **Chapter one** has provided the contextual background to the study by discussing how clinical leadership is positioned and regarded in current health care organisations. The chapter has also outlined the leadership styles dominating the contemporary nursing discourse and how these styles have come to prominence in recent times. The discussion has also introduced
aesthetic leadership as an alternate leadership style suited to contemporary nursing workplaces. Finally, the chapter identified who are considered the designated clinical leaders in the current context. Chapter two is presented as the first in the series of published papers. The paper reports the findings of an integrative review that sought to uncover contemporary understandings of the defining attributes of clinical leadership in nursing. Presented as the second paper in the series, Chapter three explores the meanings of aesthetic leadership through a review of the leadership studies literature. The paper also critiques aesthetic leadership against two leadership styles specifically linked to contemporary clinical leadership in nursing. The paper concludes with a discussion of what aesthetic leadership could offer clinical leadership in the nursing workplace.

In Chapter four the philosophical assumptions and research methods for the study are outlined, first through an examination of critical social theory, with a focus on the works of Habermas, and its appropriateness to the aim and intent of the study. The chapter then outlines the mixed-methods approach taken in the study and how ethical conduct throughout research process was ensured. Finally, the chapter concludes with a discussion on how rigour, reliability and validity were established, particularly during data collection and data analysis periods of the study. Chapter five presents the third published paper that addresses the use of online social networks as avenues for research data collection.

The next three chapters present the findings from the study. Chapter six reports the findings from a mixed-method, online survey and is presented as the fourth paper in the series. In this paper aesthetic leadership was found to be multi-dimensional with the characteristics of support, communication, and the approach taken to colleagues most valued by respondents. As a style of leadership it was found to be a positive influence in the clinical nursing workplace. In Chapter seven the qualitative findings from conversation-style interviews with registered nurses who worked in designated clinical leadership roles are presented in the fifth published paper in the series. This paper showcased the explicit moral dimension of aesthetic leadership and how a strong moral compass guided the day-to-day clinical leadership activities of the participants. Chapter eight concludes the findings chapters from the study and is presented as the sixth paper in the series. This paper reports qualitative findings that resulted from subjecting narrative data from both the interviews and the online survey to analysis to uncover how aesthetic leadership is enacted by clinical leaders in the nursing workplace. The analysis of the combined narrative data revealed that when
aesthetic leadership is enacted by clinical leaders a sense of calm and order can be created, even in the most complex and chaotic clinical settings.

Chapter nine draws together the findings of the study, offering an integrated discussion and analysis of aesthetic leadership in the contemporary nursing workplace. In doing so, the discussion is framed through the metaphor of the symphony orchestra as the clinical setting and those who inhabit it. The chapter offers a new model of clinical leadership. In the latter part of the chapter conclusions are drawn from the study and a range of implications for clinical practice, leadership in nursing and nurse education are discussed. As well, limitations of the study and recommendations for further research are identified.
Chapter 2: Attributes of clinical leadership in contemporary nursing: an integrative review

2.1. Publication:


2.2. Relevance to thesis

Realistically and logically, one cannot enter into a project without knowing what has gone before. Consequently, the first paper in the series involved an extensive review of the nursing literature to ascertain how clinical leadership had been defined, described and portrayed in recent times, based on research evidence. It was notable that, despite effective clinical leadership being offered up as the panacea for the ills of the health system (and nursing), very little empirical evidence has emerged in the past decade to define and describe this particular type of leadership. The attributes of clinical leadership identified and analysed in this paper provided background for the study. In addition, the small number of research-based studies focusing on clinical leadership and reported in the nursing literature supported and reinforced the need for this current study.
Attributes of clinical leadership in contemporary nursing: An integrative review

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Abstract: Effective clinical leadership is offered as the key to healthy, functional and supportive work environments for nurses and other health professionals. However, as a concept it lacks a standard definition and is poorly understood. This paper reports on an integrative review undertaken to uncover current understanding of defining attributes of contemporary clinical leadership in nursing. Data collection involved a search of relevant electronic databases for a 10-year period. Keywords for the search were 'clinical leadership' and 'nursing'. Ten research papers met the inclusion criteria for the integrative review. Analysis of these studies indicated clinical leadership attributes had a clinical focus, a follower team focus or a personal qualities focus; attributes necessary to sustain supportive workplaces and build the capacity and resilience of nursing workforces. The small number of research-based studies yielded for the review indicates the need for further research in the area of clinical leadership.

Keywords: clinical leadership, nursing workforce, work environment, integrative review

Leadership is a concept that has been variously characterised, defined and discussed in the literature. As Curtis, de Vries, and Sheerin (2011) highlight, the many definitions of leadership reflect the various dimensions of the concept. For example, Davidson, Elliott, and Daly (2006) define leadership as a complex process involving goal setting, motivating and supporting others to work towards collectively agreed goals. This view emphasises the capacity of a leader to motivate and influence others without the need for specific management skills. Conversely, Millward and Bryan (2005) insist that traditional management skills be integrated with skills in transformational change to ensure effective clinical leadership.

A decade into the 21st Century it is becoming increasingly apparent that effective leadership is an essential element in organisations and professional bodies to ensure that they maximise the extent to which they are able to achieve their strategic objectives in a society that has been aptly described as chaotic, complex, competitive and turbulent (McLean, 2007). Effective leadership in this context is no more important than in contemporary nursing, with nursing settings and workplaces being metaphorically likened to a 'perfect storm' (Curtin, 2007; Hinshaw, 2008; Jackson & Daly, 2010; Sanford, 2007; Yoder-Wise, 2007). As Yoder-Wise (2007) describes, perfect storms are the result of the amalgamation of coexisting factors having a much greater impact together than would be the case if the same factors were to occur by chance. From a global perspective, events contributing to a perfect storm in nursing include workforce shortages (Flynn & McKeown, 2009), multi-generational workforce issues (Carver & Candela, 2008; Sherman, 2006; Wilson, Squires, Winder, Cranley, & Tourangeau, 2008), an ageing workforce (Gabrielle, Jackson, & Mannix, 2008), clinical education challenges for nursing student placements (Williams, French, & Brown, 2009), increasing patient acuity levels (Elkwall, Geditz, & Manias, 2008), staff skill mix problems (Parker, Giles, & Higgins, 2009), diminishing resources (Johnstone & Kanisaki, 2009), and evidence of poor quality of work life including escalation of workplace violence (Jackson, Clare, & Mannix, 2002).

It is within this context that the notion of clinical leadership has been offered as the panacea for overcoming the problems of the clinical world of nursing (Jackson & Watson, 2009). Clinical leadership has been linked to the provision of quality patient care services.
Attributes of clinical leadership in contemporary nursing

(Casey, McNamara, Fealy, & Geraghty, 2011; Johansson, Sandahl, & Andershed, 2010), building healthy workplaces (Cummings et al., 2008; Fealy et al., 2011; Sherman & Pross, 2010), and ensuring optimal levels of job satisfaction and wellbeing among colleagues (Alimo-Metcalfe, Alban-Metcalfe, Bradley, Maraihasan, & Samele, 2008). Effective clinical leadership is also suggested as a key to driving cultural change, including the establishment of functional work environments for all health professions, not just nursing (Jackson & Daly, 2010). For example, one of the key recommendations for nursing from the wide-ranging inquiry into the state of the New South Wales acute care health services calls for greater clinical leadership (Garling, 2008). Similarly, in the United Kingdom the Darzi Report (Department of Health, 2008) highlights effective clinical leadership as an important element in ensuring high quality health care in the National Health Service (NHS). From a global perspective, effective leadership is a paramount consideration among professional nursing organisations: the International Council of Nursing (ICN) (International Council of Nurses, 2012a) identifies leadership as one of the five core values guiding ICN activities and has, as part of its organisation, a Global Nursing Leadership Institute (International Council of Nurses, 2012b).

Even though clinical leadership has been portrayed as a solution to many of the ills of nursing, as a concept it is rarely subject to critique (Jackson & Watson, 2009), generally poorly understood and lacks a standard definition. Instead, writers describe various attributes of leadership. For example, Watson (2008) outlines characteristics of leadership to include being a pioneer, a role model, change agent and advocate. Others (for example, Casey et al., 2011; Yetman, 2008) write about clinical leadership in relation to particular issues without necessarily describing or defining what is meant by the term. Instead, there is an almost taken-for-granted stance adopted about what clinical leadership means and how it can be characterised in contemporary nursing.

The REVIEW

Aim

The aim of the review was to uncover current understandings of defining attributes or characteristics of clinical leadership by reviewing and critiquing published empirical research to synthesise the findings.

Design

An integrative review was chosen as the framework for the examination of the published literature. The rationale for choice of this approach primarily included a desire to capture empirical research that had as its focus, the characteristics of clinical leaders/leadership, irrespective of the research methods utilised. As Whittemore and Knaf1 (2005) argue, an integrative review is the only research review method that enables the inclusion of both experimental and qualitative research. The inclusiveness of this particular framework can enhance a more comprehensive understanding of a concept under examination. Like other review research designs this approach offers strategies to ensure a systematic and rigorous process (Whittemore & Knaf1, 2005).

Search methods

The process of data collection involved a search of electronic databases likely to yield relevant literature. Therefore, CINAHL, Emerald, ProQuest, Scopus and Web of Science databases were searched for a 10-year period, from January 2002–December 2011. Search alerts were set up to January 2012 to ensure all available literature was accessed. The decision to limit the search to this period was to ensure that a contemporary perspective of clinical leadership was gained through the review. The initial search term entered was 'clinical leadership', limited to appear in either the title, abstract or as a keyword of papers published in English. Next, the sample was refined and limited to 'nursing', peer-reviewed articles, reviews, research papers or case studies. The data set was then further refined by excluding duplicates, hand searching reference lists for any studies missed in the electronic search, and including only original research reports (Figure 1). We felt it was important to ensure that at least one of the...
<table>
<thead>
<tr>
<th>Study no.</th>
<th>Author/study location</th>
<th>Study design</th>
<th>Aim</th>
<th>Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Burns (2009) England</td>
<td>Phanomenology</td>
<td>Explore the concept of clinical leadership from a general practice nurse's perspective and determine nurses' clinical leadership needs</td>
<td>12 practice nurses in primary care: All female; mean age 46 years; mean length of time as practice nurse 6 years 7 months</td>
</tr>
<tr>
<td>2.</td>
<td>Carney (2009) Ireland</td>
<td>Qualitative</td>
<td>Identify how clinical leadership skills are perceived by public health nurses and the effectiveness and consequences of these skills in primary care delivery</td>
<td>20 public health nurses: Average time as public health nurse 8 years</td>
</tr>
<tr>
<td>3.</td>
<td>Cook &amp; Leaheand (2004) England</td>
<td>Ethnographic, interpretive grounded theory</td>
<td>To identify and describe the attributes of effective clinical leadership</td>
<td>4 clinical nurses. Identified by colleagues as effective clinical leaders</td>
</tr>
<tr>
<td>4.</td>
<td>Patrick et al. (2011) Canada</td>
<td>Non-experimental survey design</td>
<td>To develop a conceptual model of staff nurse clinical leadership derived from Kouris &amp; Posner's model of transformational leadership</td>
<td>480 staff nurses working in acute settings: Mean age 44.5 years; mean of 20.2 years as practicing RN</td>
</tr>
<tr>
<td>5.</td>
<td>Pepin et al. (2011)</td>
<td>Interpretive phenomenology</td>
<td>To develop a cognitive learning model of the clinical nursing leadership competency, from beginning of a nursing programme to expertise</td>
<td>32 student nurses (10th, 22nd, 13th year) 10 new RNs (12-18 months experience) 15 expert nurses (5+ years experience in a single setting &amp; considered an expert by peers)</td>
</tr>
<tr>
<td>6.</td>
<td>Stanley (2004) England</td>
<td>Mixed method approach</td>
<td>To identify the clinical leaders with a specific clinical area, to explore the appropriateness of the proposed research approach, to understand an initial exploration of the rationale behind the nomination of specific individuals as clinical nurse leaders</td>
<td>13 qualified nurses (registered nurses or registered sick children's nurses)</td>
</tr>
<tr>
<td>7.</td>
<td>Stanley (2006a) England</td>
<td>Grounded theory approach</td>
<td>To identify who the clinical leaders are and critically analyse the experience of being a clinical leader</td>
<td>50 qualified nurses: 42 from different grades involved in direct patient care; eight nominated clinical nurse leaders</td>
</tr>
<tr>
<td>8.</td>
<td>Stanley (2006b) England</td>
<td>Grounded theory approach</td>
<td>To identify who the clinical leaders are &amp; explore the experiences of clinical leadership</td>
<td>188 qualified nurses involved in direct patient care responded to questionnaire 42 qualified nurses working in either specialist or general wards 6 qualified nurses consulted by participants as clinical leaders</td>
</tr>
<tr>
<td>9.</td>
<td>Supamanee et al. (2011) Thailand</td>
<td>Qualitative exploratory</td>
<td>To explore nurses' clinical leadership competency</td>
<td>24 nurses; 31 Registered Nurses [focus groups]; 23 Nurse Administrators [interviews]</td>
</tr>
<tr>
<td>10.</td>
<td>Ziembo &amp; Monetosso (2008) Australia</td>
<td>Descriptive mixed method Survey</td>
<td>To explore leadership qualities in nurse preceptors</td>
<td>23 pre-registration nursing students in 4th semester of study</td>
</tr>
</tbody>
</table>
reviewed the six qualitative studies and four quantitative studies involving surveys. Overall, while the studies used appropriate methodological approaches, only one study (Patrick, Spence Laschinger, Wong, & Finegan, 2011) utilised a research design with sufficient strength to produce generalisable findings. Additionally, with some of the papers in the review, minor deficiencies were identified around sampling decisions (Cook & Leathard, 2004; Stanley, 2006a). However, these issues were viewed as not detracting significantly from the quality of the papers in this review. Additionally, the small sample size prompted the retention of all 10 papers in the sample, a decision that could be considered a limitation of this review.

Data abstraction and synthesis

In line with the aims of the review the characteristics of clinical leadership were extracted from the primary sources and then compared. Detailed data abstraction and synthesis resulted in the data being grouped into three categories: clinical leadership with either a 'clinical focus', a 'followership focus' or a 'personal qualities focus' (Table 2).

Further synthesis of the data sought to identify and group these specific characteristics. This process resulted in the individual characteristics in each category being incorporated into a number of key attributes (Table 3).

RESULTS

The final analysis resulted in 10 papers being included in the review. Five of the papers reflected studies conducted in England, while two reported studies from Canada, Ireland, Thailand and Australia were each the origin of one of the remaining three papers in the review (see Table 1). It should be noted that of the five English-based papers in the review, three reported different aspects of the same study (Stanley, 2004, 2006a, 2006b), thereby reducing the number of studies in the review to seven. While all the studies in the review sample produced characteristics of clinical leadership from their respective research, only two (Carney, 2009; Stanley, 2006a) developed a definition of clinical leadership from the findings of their respective studies. One Canadian study (Patrick et al., 2011) sought to develop a conceptual model of clinical leadership, linked to a model of transformational leadership. The other Canadian study (Pepin, Dubois, Girard, Tardif, & Ha, 2011) sought to conceptualise clinical nursing leadership competency as a cognitive learning model.

The sample sizes recruited into the studies included in this review ranged from relatively small numbers (N = 4) to larger numbers in studies based around survey design, up to a maximum of 480 respondents. None of the studies reported the ethnic/cultural background of respondents. Most of the studies did not report gender distribution in their samples. However, in those studies which did, the overwhelming majority of participants/respondents were female. All participants/respondents in the studies were nurses. With the exception of two studies (Pepin et al., 2011; Zilembo & Monterosso, 2008) where student nurses were recruited, the participants/respondents in the remaining studies were qualified nurses, identified in various ways including registered nurse, primary or staff nurse. Collectively, the participants/respondents in the studies selected for this review represented a wide range of nursing experiences, across a number of different clinical settings. Where indicated, participants/respondents in the studies were very experienced nurses, although only two studies (Cook & Leathard, 2004; Stanley, 2006a, 2006b) identified clinical leaders as participants. Only one of the studies (Supamane, Kairiksh, Singhakhunfu, & Turale, 2011) specifically sought the views of nurse administrators.

The majority of the papers reviewed involved qualitative research designs (N = 6) involving interviews with participants, either on an individual basis with a researcher or as part of a focus group. Overwhelmingly, purposeful sampling was a feature of recruitment into the qualitative studies. The remainder of the studies utilised a survey design as their principal method of data collection. Recruitment into these studies mainly occurred through a mail-out to potential participants who were provided with a stamped, self-addressed envelope to return the completed
### Table 2: Characteristics of Clinical Leadership - From Review Sample Papers

<table>
<thead>
<tr>
<th>Leader characteristics: Clinical focus</th>
<th>Leader characteristics: Follower/team focus</th>
<th>Leader characteristics: Personal qualities</th>
</tr>
</thead>
<tbody>
<tr>
<td>• anticipate problems and work towards preventing them</td>
<td>• acknowledge colleagues' values</td>
<td>• abiding codes of professional conduct</td>
</tr>
<tr>
<td>• circumspect and rapid thinking skills</td>
<td>• act as a key resource person</td>
<td>• adapt leadership style according to context</td>
</tr>
<tr>
<td>• clarity in decision-making</td>
<td>• act as a role model</td>
<td>• advocate</td>
</tr>
<tr>
<td>• clinical competence(^{1,2})</td>
<td>• actively listen</td>
<td>• being secure in life</td>
</tr>
<tr>
<td>• clinical decision-making skills</td>
<td>• approachable(^{1,10})</td>
<td>• consistent(^{15})</td>
</tr>
<tr>
<td>• clinical knowledge(^{1,4})</td>
<td>• bargaining skills</td>
<td>• copes well with change(^{6,8})</td>
</tr>
<tr>
<td>• clinical management skills</td>
<td>• celebrate colleagues’ achievements</td>
<td>• creativity – engaging actively with surroundings to seek new ways of working</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• duty/responsibility(^6)</td>
</tr>
<tr>
<td>• clinically competent(^{1,10})</td>
<td>• commit to patient centred care</td>
<td>• dynamic, driven(^1)</td>
</tr>
</tbody>
</table>
| • competence to practice\(^2\) | • considers relationships valuable | • emotional maturity |}

### Attributes of Clinical leadership in contemporary nursing

(Continued)
Table 2: Continued

<table>
<thead>
<tr>
<th>Leader characteristics: Clinical focus</th>
<th>Leader characteristics: Follower/team focus</th>
<th>Leader characteristics: Personal qualities</th>
</tr>
</thead>
<tbody>
<tr>
<td>- inspires confidence</td>
<td>- positive attitudes towards the nursing profession</td>
<td></td>
</tr>
<tr>
<td>- interacts with clients</td>
<td>- purposeful</td>
<td></td>
</tr>
<tr>
<td>- leading a multi-disciplinary team</td>
<td>- recognise and acknowledge own limits/ strengths</td>
<td></td>
</tr>
<tr>
<td>- legitimate, recognised, respected</td>
<td>- self-confidence</td>
<td></td>
</tr>
<tr>
<td>- manage conflicts</td>
<td>- take risks</td>
<td></td>
</tr>
<tr>
<td>- meaningful conversations</td>
<td>- take steps to develop own competencies</td>
<td></td>
</tr>
<tr>
<td>- mentoring of students and co-workers</td>
<td>- values of the aim to do good</td>
<td></td>
</tr>
<tr>
<td>- mobilise team</td>
<td>- visionary</td>
<td></td>
</tr>
<tr>
<td>- motivational skills</td>
<td>- working consciousness</td>
<td></td>
</tr>
<tr>
<td>- motivator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- motivator and developer of others</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- negotiates and support</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- openness/approachable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- participate in organisational</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- provide positive feedback</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- relationship building</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- respect from nursing and healthcare</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- supporting, well developed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- role model</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- role modelling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- sets direction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- share knowledge and help colleagues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- supporting – support staff through</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- supporting – support staff through</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- supportive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- take lead in patient/family situations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- team empowerment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- visible</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Superscript numbers indicate which of the 10 papers (Table 1) identify the particular characteristic.
Table 3: Clinical leader characteristics

<table>
<thead>
<tr>
<th>Leader characteristics: Clinical focus</th>
<th>Leader characteristics: Follower/team focus</th>
<th>Leader characteristics: Personal qualities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical competence – incorporating:</td>
<td>Effective communication skills (actively listen, engaged communication; meaningful conversations; constructive communication of factual information)</td>
<td>Positive attitudes towards the nursing profession (abiding codes of professional conduct; expressing self with confidence &amp; involvement in patient situations; working consciousness; duty/responsibility; learning enthusiasm; values of the aim to do good)</td>
</tr>
<tr>
<td>• specific clinical practice skills;</td>
<td>Role model (act as a key resource person; legitimate, recognised, respected; approachable; inspires confidence; openness/approachable; respect from nursing and healthcare team; visible)</td>
<td>Engage in reflective practice (take steps to develop own competencies; recognize and acknowledge own limits/strengths; identify own leadership style; adapt leadership style according to context)</td>
</tr>
<tr>
<td>• specific expert knowledge;</td>
<td>Supportive of colleagues (acknowledge colleagues’ values; mentor and developer of others; mentoring of students and co-workers; support staff through various situations to enhance ownership and promote learning; motivator; empower/motivate; directing and helping; guides; help others to see and understand situations from various perspectives; celebrate colleagues’ achievements; provide positive feedback)</td>
<td>Lead changes and propose different approaches from status quo (engaging actively with surroundings to seek new ways of working; challenged the status quo, were persistent and shared their new knowledge with others; having a vision for the future; visioning; copes well with change; takes risks; explores other possibilities while questioning established ways; follow through on promises; advocate)</td>
</tr>
<tr>
<td>• use evidence-based rationales;</td>
<td>Team empowerment (leading a multidisciplinary team; relationship building; human relationships; bargaining skills; considers relationships valuable; sets direction; well-developed perceptual ability to pick up and respect signals from individuals and the wider organization; develop cooperative relationships; establish therapeutic relationships; negotiate and support; share knowledge and help colleagues; initiate collaboration for quality patient-centred care; mobilise team; enhance own and team competencies; participate in organisational decision-making; manage conflicts; take lead in patient/family situations)</td>
<td>Individual inherent attributes (dynamic; driven; non-judgemental; integrity; self-confidence; being secure in life; purposeful; consistent)</td>
</tr>
<tr>
<td>• systematic, critical, circumpect &amp; rapid thinking skills</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Judy Mannix, Lesley Wilkes and John Daly

study with only four participants. The absence of one paper by Stanley (2006a) from the category reflecting a 'personal qualities focus' is noteworthy, especially as it was one of three papers reporting on the same three phase study, and reported findings from interviews with a relatively large participant group (N = 50).

Specific clinical practice skills were identified as a feature of clinical competence in all nine papers contributing to the 'clinical focus' category. This was not the case with the other characteristics comprising the clinical competence attribute. The other three characteristics concerning expert knowledge, evidence-based rationale and systematic thinking were each identified in two papers. The Thai-based study by Supamaneet al. (2011) was the only paper to feature in three of the four characteristics comprising the clinical competence attribute.

Following in-depth synthesis of the leadership characteristics drawn from the sample, it was evident that all papers in the review identified strongly with the attributes associated with a 'follower team focus'. Of the four attributes featured in this category, being supportive of colleagues was slightly more representative in the review sample, with eight of the 10 papers identifying characteristics reflecting this attribute. Effective communication skills, being a role model and empowering the team were all attributes evident in seven of the 10 papers in the review sample.

Attributes linked to leadership characteristics with a 'personal qualities focus', while apparent in nine of the papers in the review, were not strongly represented across the sample. Interestingly, engaging in reflective practice was evident only in the two Canadian-based studies (Patrick et al., 2011; Pepin et al., 2011). Characteristics demonstrating positive attitudes were more dispersed geographically, being evident in four papers from three different regions (Carney, 2009; Pepin et al., 2011; Stanley, 2004; Supamaneet al., 2011). The most common attribute in this category related to characteristics of leadership that lead change and challenge the status quo. Within the review sample, seven of the papers identified characteristics contained within this attribute. Those papers that did not identify this attribute included a study where the participants were undergraduate students (Zilembo & Montemans, 2008), the paper reporting the pilot study in the trio of papers by Stanley (2004), and the Thai-based study by Supamaneet al. (2011) which may be a result of cultural norms.

Discussion

This integrative review identified 10 research papers that met the inclusion criteria. The sample was subsequently reviewed, critiqued and the findings specific to characteristics of clinical leadership synthesised. While the aims of the studies in the review were diverse they each sought to explore aspects of clinical leadership, in line with the aim of the review. Following the extraction of relevant data from the papers it was apparent that there were a significant number of characteristics ascribed to clinical leadership, and there was a compelling uniformity of many of these findings across the review sample. Initial synthesis of the findings resulted in the evolution of three clear leadership attribute categories into which the identified characteristics fell, again with a fair degree of uniformity.

While there was uniformity of findings across the review sample, the actual size of the final sample was relatively small, especially as three of the sample was drawn from the same study (Stanley, 2004, 2006a, 2006b). This highlights the lack of an evidence base for understanding clinical leadership in nursing. The small number of research-based studies is surprising, given that the inclusion criteria span a decade where increasingly, effective leadership in the clinical context has been exposed as a critical element in the efficient and effective delivery of health care and quality patient/client care outcomes (Bowcutt, Wall, & Goolsby, 2006; Clark, 2008; Leeder, Raymond, & Greenberg, 2007; Perza, 2001). As well, the development of leadership capacity in nursing staff has been advocated as one way of overcoming recruitment and retention issues in health care (Pintar, Capuano, & Rosser, 2007; Walker, 2001). Effective leadership has been also linked to the professional
Attributes of clinical leadership in contemporary nursing

Practice behaviours of hospital-based nurses (Manojlovich, 2005), and as an integral quality in those nurses who aspire to advanced practitioner roles (Watson, 2008). Nonetheless, the sample size is a limitation of the review and does restrict somewhat the ability to generalise the findings. A further limitation restricting the findings' generalisability is the dearth of any conceptual base in the majority of the studies. Only two studies, both Canadian (Patrick et al., 2011; Pepin et al., 2011), sought to conceptualise models of different aspects of clinical leadership. Despite these restrictions the review does reveal some interesting points about how clinical leadership is constructed in contemporary nursing.

From the synthesis of the clinical leadership characteristics derived from the studies it is evident that most of the attributes reflect technical and practical skills necessary for competent clinical practice and leading a team (see Table 3). Clinical leaders who demonstrate clinical competence, possess effective communication and are supportive of colleagues have been linked to building healthy workplaces (Fealy et al., 2011; Schalk, Bijl, Halfens, Hollands, & Cummings, 2010; Sherman & Press, 2010). Studies into characteristics of healthy work environments have identified leadership as being an important component for ensuring healthy workplaces (Arwedson, Roos, & Bjorklund, 2007; Lindberg & Vingard, 2012). Those workplaces where clinical leaders lack vision and are resistant to change have been characterised as being unhealthy (Ritter, 2011). Conversely, clinical leaders who lead with integrity and engage positively in the workplace have also been shown to promote wellbeing among staff, particularly in relation to self-confidence and reduced stress levels (Alimo-Metcalfe et al., 2008).

**Conclusion**

Clearly, the importance of clinical leadership in the current health care system cannot be overstated or underestimated. Effective clinical leadership has consistently been identified as an essential component of ensuring quality care and healthy workplaces. Nonetheless, it is apparent that even with the increased emphasis on effective leadership by professional organisations and governments alike, the difficulties and problems of ineffective clinical leadership continue to impact negatively on both consumers of health care system and those who are employed in it.

In an era of evidence-based practice it is surprising that such a topical and contemporary issue in nursing is being considered on, for the most part, a narrow evidence base. The sample yielded for this integrative review indicated an emphasis on the practical and technical attributes of clinical leadership. There is little doubt that these particular attributes are clearly a necessary part of effective clinical leadership. However, it may be that, as the focus of effective leadership, they are not enough. While important links between aesthetics and leadership have been established in the wider scholarly literature there is a paucity of literature that links aesthetics with nursing leadership. If effective clinical leadership is to be put forward as the panacea for the ills of the health system may be that more emphasis needs to be placed on the aesthetic attributes of leadership, in both the nursing literature and leadership programmes offered to nurses. Further studies focussing on the aesthetics of leadership rather than the functions of leadership in a clinical nursing context are required to expand and inform our understandings of the concept of clinical leadership.

The small number of research-based studies yielded for the review also indicates the need for further research in the area of clinical leadership. Given that most of the available research has involved relatively small qualitative studies, large scale, context specific quantitative studies involving larger numbers of respondents and studies using mixed methods approaches could enhance understandings and knowledge of the concept. Finally, the global mobility of the nursing workforce means that nurses from diverse cultural backgrounds are likely to be working together in clinical settings. Therefore, research that considers cultural
perspectives of clinical leadership could also enrich our knowledge and understandings in the area.

REFERENCES


Attributes of clinical leadership in contemporary nursing


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Chapter 3:
Aesthetic leadership: its place in the clinical nursing world

3.1. Publication:


3.2. Relevance to thesis

Calls for more effective clinical leadership in healthcare environments have seen a number of different leadership models put forward as possible solutions. Among these, transformational leadership continues to dominate as the preferred model across the healthcare system. To date, despite a growing interest in the wider leadership studies literature, aesthetic leadership has not been considered among these possible solutions. In the context of this thesis it was important to undertake a critique of leadership models relevant to contemporary nursing workplaces and uncover what aesthetic leadership could offer to enhance clinical leadership in nursing. This paper presents a theoretical discussion around limitations of relevant current leadership styles and how aesthetic leadership could enhance clinical leadership in nursing workplaces.
Aesthetic Leadership: Its Place in the Clinical Nursing World

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John Daly, PhD, RN, FACN, FAAN  
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Clinical leadership has been identified as crucial to positive patient/client outcomes, across all clinical settings. In the new millennium, transformational leadership has been the dominant leadership style and in more recent times, congruent leadership theory has emerged to explain clinical leadership in nursing. This article discusses these two leadership models and identifies some of the shortcomings of them as models for clinical leadership in nursing. As a way of overcoming some of these limitations, aesthetic leadership is proposed as a style of leadership that is not antithetical to either model and reflects nursing's recognition of the validity of art and aesthetics to nursing generally. Aesthetic leadership is also proposed as a way to identify an expert clinical leader from a less experienced clinical leader, taking a similar approach to the way Benner (1984) has theorised in her staging of novice to expert clinical nurse.

INTRODUCTION

There is little doubt about the importance of clinical leadership, given the complexities of the clinical nursing world, regardless of the setting. The significance of leadership in clinical settings has been reiterated in recent reports into the failings or otherwise of various health systems around the world (Committee on Quality of Healthcare in America 2001; Francis, 2013; Garling, 2008), resulting in calls for more effective clinical leadership. Professional nursing organisations have recognised this with global organisations, such as the International Council of Nurses (2014) and Sigma Theta Tau International (2014), positioning nursing leadership development at the forefront of their activities. At a national level, nursing organisations (e.g. Australian College of Nursing, 2014; Royal College of Nursing, 2014) recognise the importance of leadership, as do discipline-specific nursing organisations. For example, the Australian College of Mental Health Nurses (2010) emphasises leadership in one of their nine standards of practice. Similarly, healthcare organisations have supported clinical leadership programmes (e.g. American Association of Colleges of Nursing, 2007; Clinical Excellence Commission, 2007), particularly for health professionals in designated clinical and non-clinical leadership positions.

Given the widespread calls for more effective clinical leadership, it is prudent to review what leadership theories and frameworks are influencing contemporary clinical leadership in nursing and what alternative leadership styles may be available for consideration. Because nurses have long recognised the epistemological and ontological validity of art and aesthetics to nursing and its practice (Finfgeld-Connett, 2008), it is worth considering if aesthetic leadership could help address some of the reported failings of leadership in the clinical practice world. Aesthetic leadership is an established theory of leadership that increasingly has gained traction in the leadership studies literature (Batthurst, Jackson, & Slater, 2010; Guillet de Monthoux, Gustafsson, & Sjostrand, 2007; Hansen, Ropo, & Sauer, 2007) but as yet, has not been considered in relation to clinical leadership in nursing.

In the new millennium, transformational leadership has dominated the nursing discourse as the preferred leadership model offered in professional development programmes (Martin, McCormack, Fitzsimmons, & Spärig, 2014), a reality also reflected somewhat in the nursing leadership research (Cummings et al., 2010). Other leadership theories and frameworks less prominent, include servant leadership, authentic leadership, transactional leadership, leadership practices and situational leadership (Cummings et al., 2010; Stanley, 2008). While these theories and frameworks can all have some application to the clinical setting, none are specific to clinical leadership. One leadership theory to emerge in relatively recent times is congruent leadership theory, proposed by Stanley (2008). This particular theory is somewhat unique in that it is specific to nursing and clinical leadership. With the domination of transformational leadership and the uniqueness of congruent leadership to clinical leadership it is reasonable to initially critique these two theories to determine why calls for effective clinical leadership continue in various reports (Francis, 2013; Garling, 2008). This article discusses aesthetic leadership as a theory for application by clinical
TRANSFORMATIONAL AND CONGRUENT LEADERSHIP THEORIES

It is clear from the leadership studies’ literature that the dominance of neo-charismatic leadership theories, including transformational leadership and charismatic leadership, go beyond nursing and healthcare areas (Dinh et al., 2014). According to Kaepers (2011), the intent of this style of leadership is for leaders to transform followers so they are aware and accepting of the organisational missions and goals. Therefore, it is not difficult to see its appeal to organisations wishing to achieve their goals. In healthcare facilities with Magnet status and those aspiring to it, transformational leadership is a fundamental component of the organisational framework (Kramer, Schnaebel, & Macguire, 2010). As a leadership model, transformational leadership is one of a number of relational styles of leadership that focus on individuals and relationships (Cummings, 2012), and not out of place in a nursing world that involves human interactions and experiences. Transformational leadership encourages leaders to be visionary, be able to inspire others to share their vision through effective communication, and empower others to lead, while leading to meet organisational priorities (Clavelle, Drenkard, Tulliar-McGuiness, & Fitzpatrick, 2012). To ensure effective transformational leadership, it is important for leaders to possess an extensive range of personal and social emotional intelligence capabilities, including behaving ethically and being able to challenge the status quo to facilitate change (Hutchinson & Hurley, 2013). As a leadership style, it has been shown to be compatible with how nurses function in their various clinical settings. For example, in the area of mental health nursing, transformational leadership processes support the collaborative involvement of consumers in care delivery (Clery, Horsfall, Deacon, & Jackson, 2011) and the development of essential interpersonal skills of nurses working in mental health settings (Blegen & Severinson, 2011). Studies in nursing have shown transformational leadership to be a style of leadership to support high job satisfaction among nurses, increased organisational commitment, enhanced role clarity, reduced workplace conflict, and lower levels of stress, anxiety and emotional exhaustion among staff (Cummings et al., 2010).

First proposed by Nicholls (1986) for business organisations, congruent leadership was adapted from the situational leadership model, and identified to occur when an appropriate leadership style is used, once an understanding is gained of aspects specifically related to the leader, the followers and the setting. Apart from the name, there are few similarities between the original congruent leadership model and the newer congruent leadership theory developed by Stanley (2006), specifically as a theory of leadership for clinical leaders. This newer theoretical proposition aligns more with authentic leadership (Hston, 2008), one of the value-based leadership models (Mumford & Fried, 2014). The foundation of Stanley’s (2006) congruent leadership theory is the way in which values and beliefs about care and nursing are reflected in and shape the activities and actions of the clinical leader. Leaders who are experts in their clinical field and who demonstrate this congruence in the clinical setting are ‘guided by their passion for care’, and seek to empower colleagues, rather than elevate their own status (Stanley, 2006, p. 139). In relation to emotional intelligence capabilities, congruent leaders require effective interpersonal and communication skills that are enacted with integrity (Hutchinson & Hurley, 2013). Another feature of the theory, is that it is derived from a study of clinical leaders who mainly were either not in a designated leadership position or not trying to lead in the clinical setting (Rolfe, 2006). Because of the relative newness of the congruent leadership theory, a search of the extant literature found no studies that have directly tested the theory. Finally, Stanley (2008) argues that congruent leadership provides a sound foundation for clinical leaders in nursing because it reflects the core values of the nursing profession and places patient-focused care as the main consideration, ahead of managers and medical officers.

Limitations of Transformational and Congruent Leadership

As in all leadership theories, some limitations or shortcomings of both transformational leadership and congruent leadership theories have been identified in the literature (see Table 1). When considering leadership in the clinical nursing context, it is not difficult to see the potential issues that could arise for clinical leaders when embracing transformational leadership as their leadership style. Stanley (2008) has argued that as a theory of leadership, transformational leadership is not a suitable theoretical foundation for developing clinical leaders in nursing. Instead, he proposes congruent leadership theory. While this may be the case, because of its relative newness, the lack of empirical evidence needs to be taken into account. Nonetheless, as a leadership theory for clinical leadership, the identified shortcomings are not particularly relevant to the clinical workplace. Findings of the research from which the congruent leadership theory was developed call into question the appropriateness of it as a leadership model outside acute hospital settings (Cameron, Harbison, Lambert, & Dickson, 2012).

AESTHETIC LEADERSHIP

Aesthetic leadership is a style of leadership that has been variously positioned in the leadership studies literature. It has been identified as one of the established leadership theories that focus on followers and their subjective views of leader qualities in the leader-follower dyad, views gained through sensory awareness and knowledge (Diob et al., 2014). Others similarly argue that aesthetic leadership is fashioned by ‘sensory knowledge and
TABLE 1

<table>
<thead>
<tr>
<th>Transformational leadership</th>
<th>Congruent leadership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Narrow representation of cultural values and beliefs (Hutchinson &amp; Jackson, 2013)</td>
<td>Similarities with authentic leadership (Stanley, 2006)</td>
</tr>
<tr>
<td>Leadership of explicit emphasis on leader integrity (Hutchinson &amp; Jackson, 2013)</td>
<td>Does not encourage change (Stanley, 2006)</td>
</tr>
<tr>
<td>More suited to nurse leaders distant from clinical areas (Hutchinson &amp; Jackson, 2013)</td>
<td>Of little use to distant leaders and managers (Stanley, 2006)</td>
</tr>
<tr>
<td>Fail to adequately address altruistic leader behaviours (Dinh et al., 2014)</td>
<td>Creativity not considered a valued attribute (Rolfé, 2006)</td>
</tr>
<tr>
<td>Lack of consideration for emotional, embodied, and aesthetic dimensions of leadership (Keevers, 2011)</td>
<td>May be more suited to clinical settings where nurses work in close proximity (Cameron et al., 2012)</td>
</tr>
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</table>

felt meaning associated with leadership phenomena’ (Hansen et al., 2007, p. 552). Hansen and colleagues also contend that a significant feature of aesthetic leadership is the way in which followers’ views about the leadership qualities of leaders are as important as the leaders’ qualities. In other words, aesthetic leaders are not self-appointed but emerge from the perceptions of colleagues (Guillet de Monthoux et al, 2007). Munro and Fried (2014) position aesthetic leadership as one of a number of ideological models of leadership that are, together with servant leadership and ethical leadership, values-oriented and focus on moral behaviours. In the organisational studies literature, aesthetic leadership has been offered as a way of enabling flow between the fields of management, administration and aesthetics in organisations, where all three fields are regarded as being of equal importance (Guillet de Monthoux et al., 2007). In this interpretation of aesthetic leadership, the management field is where visionary, action-oriented managers and economists operate and seek profits, while the administration field is occupied by those who value tradition, regulation, equality and a place for controlling costs. They go on to describe the aesthetic field as that part of the organisation where one seeks to determine what it means to provide or produce quality through ‘creative philosophizing’ (Guillet de Monthoux et al., 2007, p. 267). In some ways, the aesthetic field provides a buffer between the other two fields. Aesthetic leaders are those leaders who count on tacit knowledge, a type of knowledge that resembles sensory/aesthetic knowing, and is gained from deep inculcated know-how that defies a logical explanation (Hansen et al., 2007). Proponents of aesthetic leadership also argue that knowledge is formed, transformed and transferred through interactions and evaluations with others. This aesthetic knowledge and awareness is a way to make meaning and realities on the basis of embodied experience (Woodward & Funk, 2010) and gives leaders a variety of intellectual and emotional tools that complement conventional ways of knowing (Bathurst et al., 2010). It is also argued that aesthetic leaders need to be effective relational leaders, especially when negotiating between and with managers and administrators in an organisation (Guillet de Monthoux et al., 2007). In a review of the literature, aesthetic leadership was determined to be a style of leadership underscored by sensory, somatic and emotional awareness, and a strong moral purpose around the values of being just, fair and truthful (Katz-Buonincontro, 2011).

What Aesthetic Leadership Could Offer Clinical Leadership

It is evident from the leadership studies’ literature that leadership can be variously described, influenced by a number of factors including culture and context (Casey, McNamara, Fealy, & Geraghty, 2011). It is also evident that with the complexities of modern organisations, one particular leadership style cannot be the only model followed, regardless of the situation. Within the culture and context of the clinical nursing world, aesthetic leadership is a style of leadership that would not be out of place in supporting clinical leader-effectiveness, especially with the long held recognition of the relevance and importance of aesthetics and art to nursing practice. As a leadership model, aesthetic leadership is not anathema to either transformational leadership or congruent leadership, and could go some way to overcoming some of the identified shortcomings of these particular leadership models. All three leadership models recognise the importance of relationships in the leader-follower dyad. Aesthetic leadership, with its follower-centric position (Dinh et al., 2014), could provide a more holistic and balanced view of the leader-follower dyad if used to complement either transformational or congruent leadership models, both of which tend to focus on leader traits (Hutchinson & Jackson, 2013; Stanley, 2006).

Given calls for more effective clinical leadership, and the dominance of transformational leadership in nursing, it is evident that its place in the clinical practice world needs rethinking. The re-framing of its place does not necessarily mean discarding it as a useful leadership model. Instead, by drawing on aesthetic leadership and aesthetic processes, some of the identified shortcomings of transformational leadership as a model for clinical leadership could be overcome. By incorporating aesthetic
processes that emerge from embodied, symbolic and sensual elements shaped from one’s cultural perspective and experiences (Woodward & Funk, 2010), the cultural and moral limitations of the transformational leadership model (Hutchinson & Jackson, 2013) may not prevail. The way in which transformational leadership encourages leaders to be visionary and creative (Hansen et al., 2007) sits well with aesthetic leadership because, as Hansen and colleagues (p. 549) argue, ‘visions are sensory rich’ and ‘appeal to aesthetic senses’. Koepers (2011) contends that aesthetic transformational leadership evokes in both leaders and followers, an enthusiasm and sense of satisfaction when confronting workplace challenges.

The way in which Guillet de Monthoux et al. (2007) regard aesthetic leadership as a way of facilitating flow between management, administration and aesthetic fields could be beneficial to the clinical practice setting. In the nursing world, one could equate these different fields as management being where senior executives, including nurse leaders, operate, answerable to hospital boards/shareholders; administration where nursing administration, including nurse managers function; and the aesthetic field being the clinical practice setting, where clinical leaders provide leadership and where all necessary clinical leadership competencies may be difficult to pinpoint (Guillet de Monthoux et al., 2007).

The emergence of congruent leadership as a theory to explain the relatively unique and complex world of clinical leadership has enhanced the understanding of what is required for leadership in this context. Congruent leadership theory’s centrality of the values and beliefs of the leader (Stanley, 2006) sits well with aesthetic leadership’s focus on leaders displaying a strong moral compass (Katz-Buonsantcontro, 2011; Munford & Fried, 2014). However, the idea that clinical leaders with clinical knowledge and expertise need not be in designated leadership roles (Stanley, 2006) is contentious, especially if, as Rolfe (2006, p. 146) suggests, congruent leadership is ‘a natural way of being, rather than a skill to be taught’. This notion does not specifically take account of designated clinical leadership roles that carry with them an expectation that those positions be occupied by nurses with advanced clinical knowledge and skills in a particular clinical field.

It is perhaps useful to consider clinical leadership expertise in the same way Benner (1984) theorised levels of clinical practice expertise, from novice to expert. To be an expert clinical leader, the central ideas of congruent leadership theory around visible leader values and beliefs would need to be considered. There would also be an acknowledgement that to be an expert clinical leader, nurses would also demonstrate aesthetic leadership through a recognition and reliance on tacit knowledge: the aesthetic knowledge gained from deep indefinable know-how that defies a logical explanation (Hansen et al., 2007). It is this aesthetic knowledge that can really only be gained and utilised with the professional maturity that comes with clinical experience and high level moral maturity, reflecting developmental stages of maturity, a notion proposed by Habermas (1995). Summer (2010) describes moral maturity to be at the post-conventional level when nurses are at Benner’s expert stage, where nurses, rather than having to consciously focus on the task at hand, purposefully and skillfully use their emotions.

One could imagine expert clinical leaders engaging in these types of behaviours across all clinical nursing contexts, from community to acute settings and across discipline areas of nursing. For example, consider contemporary clinical leadership expertise in mental health nursing context. The de-institutionalisation of care for people with mental health problems to community-based care leads to changes for nursing leadership in mental health (Holm & Severinson, 2010), resulting in part in the development of specialist roles like consultant nurses and clinical nurse specialists (Bonner & McLaughlin, 2014). Clinicians occupying these specialist positions require well developed levels of skills to manage challenging clinical situations (Ennis, Høppest, & Reid-Searl, 2015), expertise that could benefit from aesthetic knowledge and professional maturity. The community-based nature of much mental health care means that clinical nurses undertake their practice in diverse and sometimes less predictable and less controlled settings. Clinical leaders in these settings may also find themselves practicing across both community and inpatient settings. Consequently, clinical leaders could benefit from the way in which aesthetic leadership can facilitate flow between management, administration and aesthetic fields involved in the delivery of mental health services.

CONCLUSION

Leadership has been referred to as being extremely complex, involving actions that are interpreted subjectively, affected by politics and all forms of communication (Block, 2014). Some writers contend that leadership is inherently aesthetic (Ackoff, 1996), a performing art (Briet-Missal, 2013, p. 279) or an embodied practice (Hansen et al., 2007, p. 554). It is evident in the clinical world of nursing that one leadership style does not fit all contexts and that the complexities of clinical nursing practice and leadership require an approach to clinical leadership that maximises the potential for positive outcomes for both recipients of nursing care and those charged with administering that care. This article has proposed that by considering aesthetic leadership in relation to clinical leaders, some of the shortcomings of both transformational leadership and congruent leadership could be overcome. At the same time, embracing aesthetic leadership as a relevant leadership model in nursing opens up the possibility of incorporating art and aesthetics into clinical leadership and recognising how an expert clinical leader might differ from other clinical leaders in nursing.

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Chapter 4: Research framework

4.1. Introduction

A primary motivation for any researcher is to seek out new insights about the world. Inherent in this quest for understanding is the pursuit of knowledge, whether it involves generating new knowledge or an expansion on what is currently known. What is important in this pursuit of knowledge is for synergies to exist between a researcher’s beliefs and assumptions about aspects of the social world and the nature of knowledge in terms of what comprises it and how it is derived. Knowledge, its acquisition and related understandings have long been central beliefs of social inquiry and as such, have been given much attention in the scholarly literature. This quest for knowledge requires the research approach taken to be located in a framework compatible with the questions being asked. As well, compatibility among the component parts of the research approach is also important, viz the methodology, data collection methods and subsequent data analysis need to sit comfortably within the chosen paradigmatic approach. It is for these reasons that philosophical orientation and assumptions of critical social theory shaped the research framework for the study. As a mode of social inquiry critical theory provides a research paradigm that liberates, and as proponents argue, overcomes the way in which the positivist and interpretivist research approaches maintain the status quo in a world that is fundamentally unfair and unjust (Grundy 1987).

This chapter begins with a brief overview of the nature of critical theory, preceding a discussion of major theoretical works of Jürgen Habermas, a contemporary philosopher and critical theorist who has had a profound influence on the development of contemporary critical theory. The theorising and analysis undertaken by Habermas on the connections between knowledge and human interests, links between the Lifeworld and the System, and his theories of communicative action and moral consciousness are outlined and discussed, especially in terms of how the current study was shaped and informed within these theoretical positions. The remainder of the chapter focuses on the research process followed in the study, including recruitment of participants, data collection and data analysis within a mixed-methods approach. Ethical processes and consideratons and methods utilised for establishing rigour, reliability and validity in the study conclude the chapter.
4.2. The nature of critical theory

Critical social inquiry operates from a set of beliefs and assumptions to emancipate people from the constraints under which they function, in a reality regarded as socially and economically based, and existing within struggles of hegemony (McCutcheon & Jung 1990). A central tenet of the critical paradigm is that no facet of social phenomena can be fully appreciated without considering the historical, cultural, economic and political context (Habermas 1972; Held 1980). One only has to consider the pressures placed on complex clinical settings from factors related to staffing (Francis & Mills 2011, Twigg et al. 2012) and increased patient acuity (Needleman 2013) to appreciate the effects of these different elements. True understanding of a situation can only be realised when there is recognition that any of these contextual components can circumvent true equity. Critical theory offers an epistemology reflecting the impact of the wider context in knowledge production. As Friere (1974, p99) argues, ‘knowing is the task of Subjects not objects’, with knowledge generated as a consequence of the active involvement of people in processes which may transform their social world. The type of knowledge generated from these processes largely depends on the interests of the individual and social groups.

With an emancipatory intent as an essential consideration, critical theorists centre on human activity and the way it influences wider social structures in shaping the social world (Ritzer 1992). Linked with this is a belief that individuals are subjective beings, able to be self-critical, self-reflective and with a capacity to act rationally (Jackson, Clare & Mannix 2003). Given these beliefs, it seemed self-evident that the philosophical assumptions of critical theory provides a way of exploring the topic, especially when one takes into account how clinical leaders are positioned in contemporary nursing and the wider health system, the expectations placed on many of them professionally by regulatory authorities (Fry et al. 2013, NSW Health 2011) and the persistent calls for more effective clinical leadership to improve health systems around the world (Garling 2008, Francis 2013). A goal of critical theorists is to create conditions that facilitate open communication by revealing covert power imbalances that restrict free discourse (Jackson et al.), ultimately resulting in an awareness of any constraints under which people exist. Related to this emancipatory intent is the belief that interconnectedness exists between social theory and social practice (Geuss 1981). Taking this interconnectedness between theory and practice into consideration throughout the project is especially useful because of the realities
of nursing being both a scholarly and a practice-based discipline. While critical theorists acknowledge the effect of historical influences on knowledge construction, there is also recognition that truth claims can be determined rationally, free of immediate ideological restrictions of a wider social milieu (Jackson et al.). For this to happen certain conditions need to be present, and for Habermas, these conditions arise in the “ideal speech situation”, a concept explored in the next section of this chapter.

### 4.3. Habermas and critical theory

Habermas, a noted contemporary critical theorist, has attempted in his writings to provide a rational critique of modern society based on the philosophical underpinnings of critical theory. According to Habermas (1972, pvii), the individual makes sense of their world and approaches the social world in three different ways, based on ‘connections between knowledge and human interests’. Habermas contends these technical, practical, and emancipatory interests serve as the basis for three different types of knowledge and three different disciplinary approaches to social inquiry. The first of these, a technical interest, gives rise to empirical-analytic sciences; the second, a practical interest, is embodied in the historical-hermeneutic sciences; and the third, an emancipatory interest, is incorporated in the approach of ‘critically oriented sciences’ (Habermas 1972, p308). It is within this emancipatory interest the critical paradigm generates knowledge that seeks to uncover and change through open communication, the inequality existing in the social world.

While acknowledging the relevance of the analytic and hermeneutic sciences Habermas (1972) contends that critical social science and its emancipatory interest goes beyond these two approaches with a methodological framework to seek freedom from constraints, cultivated by the notion of self-reflection. For Habermas self-reflection is central to conditions around generation of new knowledge and critique of ideology (Roderick 1986). It is this self-reflection that allows an individual to have critical insight into their actions, including any distortions that may exist around the process (Outhwaite 1994). In the current study interview participants revealed the importance of self-reflection in their day-to-day clinical leadership activities (see Chapter 8). From subsequent theorising, Habermas focused on linguistics as an attempt to elucidate the universal conditions under which human communication is possible, based on the concepts of communicative rationality, communicative action, and an ideal speech situation. For ideal speech to occur four validity claims need to be satisfied, these being: what is said is coherent, the content is true, what is said is
correct, and genuineness is embodied in what is said; in a context of reciprocity where the strength of argument prevails (Outhwaite p40). This concept of ideal speech provides a useful framework for the conversation-style interviews with study participants, especially as a way of trying to ensure that they are uninhibited communication acts, conducted in the context of rationality and free of distortion. For this to occur, the context and venue for the interviews also needs to be conducive to effective communication.

In the context of modernity and rationality Habermas identifies two components of society, the *Lifeworld*, the site of purposive, communicative rationality and the *System*, where formal, instrumental rationality prevails, predicated by economics and power (Hyde *et al.* 2005, Outhwaite 1994). It is in the *Lifeworld* where communicative rationality provides a basis for communicative action between individuals in a social world (Ritzer 1992). For Habermas (1987, p283), tensions arise between the *System* and the *Lifeworld* when power and money from the *System* encroach into the *Lifeworld*, resulting in a ‘colonisation of the Lifeworld’, to the detriment of communicative rationality. The *Lifeworld* is the place where nursing, with its values orientation and reflexivity is positioned, with the ideals of contemporary nursing theory concerned with contextualising illness and empowering a patient/client through encouraging participation within their cultural sphere or *Lifeworld* (Hyde *et al.*). The interactions between nurses and patients/clients in contemporary nursing practice have been reported to be more friendly and less authoritarian, and reflective of the Habermasian notion of communicative action, being free of distorted communication (Porter 1994). However, as Hyde *et al.* argue, in performing clinical work nurses rely in part on the technocratic, instrumental rationality of the *System*, along with the value-oriented rationality. The challenge for nurses is to ensure that the nursing *Lifeworld* is not colonised by the *System*. This can be difficult when by contrast, it is the *System*, with its technocratic, instrumental rationality that dominates the world of medicine (Barry *et al.* 2001). For example, in a study on nursing documentation Hyde *et al.* (p73) found that even when nurses strived to facilitate autonomy for and partnership with patients/clients, the written records reported situations like pharmacological interventions for psychological problems, indicating a ‘colonisation of the sociocultural lifeworld by the bio-technocratic system’.

To understand the discourse of the *Lifeworld* Habermas (1990) contends that validity-claims of rightness, truth, and truthfulness need to be met in order for all participants in any interaction to be satisfied, free of coercion (Sumner 2001). It is these validity-claims that provide rational criteria for ethical and aesthetic judgements, discourses
Habermas identifies, along with other types of discourses around human interests that occur in the *Lifeworld* (Outhwaite 1994). Involvement in these interactions occurs with different levels of moral maturity that Habermas (1990) contends influences the success, depth and quality of discourse. To determine the effectiveness of the discourse Habermas (1990) draws on the work of Kolberg (1981) and Selman (1980) to argue that moral development happens in three stages, and it is at the more advanced post-conventional level that communicative action occurs. Habermas (1990, p162) argues, ‘*moral action is action guided by moral insight*’, and this can only evolve at the post-conventional stage. The links between moral maturity and effective clinical leadership in nursing are discussed in *Chapter 3* and the significance of moral maturity to artful clinical leadership emerged in the findings presented in *Chapter 7* of this thesis.

4.4. The research design

Situating this research in the critical paradigm and using the theories of Habermas to frame the study enabled consideration of the socio-political, economic and cultural contexts in which nurses in clinical leadership positions practice. It also enabled notions around communication, aesthetics and morality in Habermas’ theories to guide the study. The centrality of communication and language in Habermas’ theorising was also an important consideration, especially as these concepts are vital components in any clinical nursing setting. In taking this approach to the study there was an appreciation that critical theory and related philosophical assumptions provide a framework for a study and are not something to test or apply (Jackson *et al.* 2003).

The current study’s exploratory intent to seek a richer and more complete understanding of aesthetic elements of clinical leadership in nursing required a research design with methods of data collection and analysis able to capture empirical evidence from a broad range of suitable sources. Consequently, a mixed-methods approach to data collection and data analysis was taken as it accommodates the use of at least one quantitative and one qualitative research approach in the one study (Sandelowski 2014). It has also been used effectively in different research paradigms (Giddings & Grant 2006) and as such, is compatible with the critical paradigm.

In choosing a mixed-methods design the various typologies and approaches to this type of research that have been identified and described in recent times required consideration to determine the most appropriate for the current study. These various
approaches range from four basic design types initially offered by Creswell and Plano Clark (2007), to designs that reflect some or all common core characteristics of mixed-methods research determined by Teddlie and Tashakkori (2012), and to study design based on the timing and purpose of data integration (Guest 2012). More recently, Creswell (2014) has reduced to three the number of basic mixed-methods designs, they being convergent parallel, exploratory sequential, and explanatory sequential, and added three advanced mixed-methods designs (ie, embedded, transformative, multiphase) into which the basic mixed-methods designs can be incorporated. In proposing these various designs Creswell identifies factors to consider when selecting a mixed-methods design, including the expected study outcomes, how data integration will occur and the timing of data collection, as well as practicalities around whether the study is being conducted by a single researcher or a team.

Consequently, the research study design followed a convergent parallel approach conducted within a transformative mixed-methods design, shaped by the research question and the aim of the study. Focusing on the research question to guide the study is an approach reflective of one of the nine common core characteristics of mixed-methods research delineated by Teddlie and Tashakkori (2012). In taking a convergent parallel approach both qualitative and qualitative data collection focuses on the same construct or concept (in this study, clinical leadership) and once collected, data are analysed separately, with convergence occurring in the analysis and interpretation stages (Creswell 2014). The stages of the study are shown in Figure 4.1 below.
A pragmatic view was taken to the process of data collection and analysis, beginning in Stage 1 with an integrative review of the relevant literature followed in Stage 2 by the administration of an online descriptive survey. While the survey was being administered the conversation-style, in-depth interviews commenced. Potential methodological concerns in a convergent parallel design can occur as a result of unequal sample sizes and decisions around the inclusion of an individual participant in both the in qualitative and quantitative data collection (Creswell 2014). In the current study potential unequal sample sizes are not considered problematic as the intent of the data collection is different, that is, quantitative data seeks to generalise and qualitative data seeks more in-depth information. Similarly, the involvement of participants in both the survey and an interview is not problematic because the exploratory nature of the study seeks different perspectives of clinical leadership that can be obtained from the online survey and an interview. Situating the study within a transformative framework is compatible with the emancipatory intent and philosophical assumptions of critical theory. As Andrew and Halcomb (2012) explain, a transformative approach is guided by a theoretical framework (in this case, critical theory and Habermas) that supports the integration of data from qualitative and qualitative sources during the analysis and interpretation stages of a research study.
4.5. Recruitment into the study

Recruitment into the study was determined by a number of important considerations. In the first instance it was essential that those recruited into the study were registered nurses with an interest in the nature of clinical leadership in the nursing workplace. Using convenience sampling the initial recruitment involved inviting registered nurses via e-learning platforms and online social networks to complete an online descriptive survey. For the online survey, while it was important for registered nurses to respond and complete the survey, it was not essential for them to be in clinical leadership positions. It was sufficient for them to be a registered nurse (or equivalent) and be in a position to consider a registered nurse who they regarded as a clinical leader when completing the survey. Consequently, respondents to the online survey came from different clinical settings and possessed a wide range of clinical experience. Demographics of survey respondents are reported in the paper in Chapter 6.

Participants recruited into the interview stage of data collection in the study were required to fulfil more stringent criteria. Because of this, for this part of the study, purposeful sampling was employed to recruit participants. Participants were required to be registered nurses in designated clinical leadership positions. Across the world various nomenclature have been used for these clinical leaders, including advanced practice nurse, senior charge nurse, nurse practitioner, clinical nurse consultant and nurse specialist (Christiansen et al., Vernon & Jinks 2013, Fry et al. 2013, Stoddart et al. 2014). With these various titles come agreed-upon and fairly similar domains or pillars of practice (Fry et al., Gregorowski et al. 2013), upon which competency standards or expectations are derived. For example, in New South Wales, Australia the five domains of responsibility for clinical nurse consultant are ‘clinical service and consultancy, clinical leadership, research, education and clinical services planning and management’ (NSW Health 2011). In New South Wales, Australia, where the study was located, registered nurses in such positions are required to have more than five years clinical nursing experience in a direct patient care delivery role to be eligible to apply for clinical leadership positions. As experienced registered nurses with this minimum level of experience, they had ample clinical experience and exposure to be able to contribute comprehensively to the discourse on the aesthetics and art of clinical leadership. Currency in the clinical practice setting was also important to the project, mainly because of the dynamic nature of contemporary nursing in the current health care system.
Consequently, 12 registered nurses in designated clinical leadership positions were recruited into the study. Participants worked in a number of clinical specialties including mental health, aged care, paediatrics, acute adult medical/surgical specialties, and community-based nursing. All participants had at least 10 years clinical experience, with a number of them with upwards of 25 years nursing experience. To ensure confidentiality in the conduct of the study all participants were assigned a pseudonym. The number of participants in this part of the study was determined when data saturation was reached, that is, when no new information emerged from the conversations with participants in relation to the aim of the study. When using interviews for data collection specific evidence-based guidelines around appropriate sample size were not found. However, suggestions in the literature indicate research methodology, heterogeneity of the sample and research objectives can be determining factors (Guest, Bunce & Johnson 2006). From their own analysis of data saturation of a relatively homogenous sample Guest et al. found that meta-themes emerged after six interviews and that saturation occurred within the first 12 interviews. Therefore, it was not surprising that data saturation occurred at this point, especially as there was homogeneity across the sample, viz, they were all registered nurses, all working in designated clinical leadership roles and all working in New South Wales, Australia in either the public, acute sector, community health or residential care settings.

4.6. **Collection of data**

Within the framework of the study three principal methods of data collection were utilised: first, a review of relevant, available literature; second, an on-line descriptive survey; and third, in-depth conversation style interviews with registered nurses in designated clinical leadership positions. Using these avenues for data collection relates intrinsically to the theoretical underpinnings of a critical theory methodology and facilitates a broader, deeper understanding of the complexities of contemporary clinical leadership.

**Review of the literature**

Initially, a critical review the literature was undertaken to provide a contextual background for subsequent data collection during the research. Electronic databases were accessed to yield relevant literature to uncover contemporary, empirical understandings of defining attributes of clinical leadership in nursing. An integrative review was chosen as the method to adopt for data collection as it provided a
rigorous and systematic approach (Whittemore & Knafl 2005). Details of this method are included in the published paper in Chapter 2 of this thesis.

**On-line descriptive survey**

On-line data collection for this part of the study involved the use of Qualtrics® program (http://www.qualtrics.com/research-suite/#academic), a commercial data collection software program. This program provided security of data, was relatively user-friendly and had the added capacity to permit survey data to be downloaded to other software programs for statistical analysis. The survey sought both quantitative and qualitative responses from respondents. Provision existed within the Qualtrics® software program to allow for both to occur, with a text box available for the narrative responses sought (see Chapter 5 for further details).

**Conversation-style interviews**

The process of data collection for this part of the study involved negotiation with each potential participant on a mutually agreeable time and place for the individual, semi-structured, conversation-style interview. Participants were offered a choice of a digitally-recorded face-to-face interview or if preferred, a digitally-recorded interview conducted over the telephone. The use of telephone interviews for data collection in qualitative research is not as widely accepted as is the case in quantitative research, mainly because of the inability to observe visual cues (Garbett & McCormack 2001) and the potential for participants to be distracted in their own surrounds (McCoyd & Kerson 2006). However, as Novick (2008) argues, telephone interviews can facilitate participants feeling relaxed and there is a lack of evidence to suggest that lower quality data results. In this current study, while visual cues were unobservable, there was no discernible difference in the quality of the data from the three participants interviewed by telephone and the nine participants interviewed in person.

Engaging registered nurses in designated clinical leadership roles in conversation-style interviews was a deliberate attempt to affect emancipation through the ideal speech situation (as discussed by Habermas 1972). Attempting to achieve an ideal speech situation is important because such a situation occurs in an environment of reciprocity, devoid of any unequal power relationships between the participants and the researcher. As Lather (1986) contends, reciprocity needs to be sustained to ensure the emancipatory intent of a study. A reflective journal was also utilised for the purpose of recording thoughts, feelings and ideas arising as a result of the conversations with each participant.
4.7. Data Analysis

Data collected from the literature for the integrative review were scrutinized and synthesized using accepted and rigorous methods, as reported in some detail in Chapter 2 of the thesis. The quantitative survey data were imported into Statistical Package for Social Sciences (SPSS) v.20 for management and analysis. The qualitative responses from the online survey were downloaded and initially subjected to content analysis using aesthetic leadership dimensions from the Aesthetic Leadership Scale (Polat & Oztoprak-Kavak 2011). As a method of scrutiny of qualitative data content analysis provides a systematic and objective means of quantifying and describing phenomena (Elo & Kyngas 2008), in this case, aesthetic leadership. A deductive approach to the content analysis was taken rather an inductive method because, as Elo and Kyngas explain, it is suited to an analysis where existing data is tested in a different context. The aesthetic dimensions of the Aesthetic Leadership Scale used in the current study with nurses were originally tested in a study involving school directors employed in primary and secondary schools (Polat & Oztoprak-Kavak). The details of descriptive statistical analysis, along with the nature of the content analysis of narrative responses are detailed in the paper in Chapter 6 of the thesis.

Data collected from the conversation-style interviews with registered nurses were transcribed verbatim by a professional transcription service and then checked for accuracy by the researcher against the original digital recordings. Once satisfied with the accuracy the transcribed interviews were subject to thematic analysis to search for shared patterns and meanings among the participants. This task was manually undertaken and followed accepted processes of reading, re-reading, coding, reviewing codes to generate themes (Whitehead 2011), and adopted an inductive approach to analysis and interpretation (Vaismoradi et al. 2013). The challenge for researchers during data analysis is to remain genuine to the meaning of the text, and to ensure sufficient depth in the interpretation and analysis of the data (Jackson et al. 2003). Some of the findings from the thematic analysis of these interviews are presented in the paper in Chapter 7 of this thesis. The richness of the data from these interviews was such that a decision was made to combine them with the narrative accounts offered in the online descriptive survey. Together the 12 interviews narratives and the 31 written accounts from survey respondents were combined and analysed, once again using principles of thematic analysis. Details of this process and subsequent findings are presented in Chapter 8.
4.8. Ethical processes and considerations

Research that seeks the participation of humans demands that ethical processes be adopted and followed throughout and beyond the duration of the project. The current study ensured the values and principles of ethical conduct set out by the National Health and Medical Research Council (NHMRC) (2007) were followed. In particular, the values emphasised by the NHMRC of research merit and integrity, justice, respect, and beneficence guided and informed the research process. How these values were considered and incorporated into the project are outlined in this section.

**Research merit and integrity**

To ensure the research merit and integrity of the current study a number of processes and procedures were implemented. Prior to the commencement of the study the project was subject to peer review through the Confirmation of Candidature (CoC) process, undertaken as part of the doctoral studies candidature procedures at the University of Western Sydney (UWS). In doing so, the potential benefit of the study in contributing to the current knowledge and understanding of clinical leadership in contemporary nursing was recognised. Once the merit of the project was endorsed by the CoC ethics approval was sought and granted from the University of Western Sydney (UWS) Human Research Ethics Committee (HREC) (Appendix 1). Similar ethics approval was also granted at the University of Technology, Sydney (UTS) (Appendix 2). Both universities have registered nurses enrolled in postgraduate nursing courses who were invited to be involved in the study. Following initial ethics approval an amendment to data collection strategies was lodged and approved by the UWS HREC to enable online social networks of Facebook and Twitter to be used for participant recruitment (Appendix 3). Inherent in the study was a commitment to ensure the integrity of the research, as outlined by the NHMRC (2007) guidelines. Consequently, seeking increased knowledge and understanding of clinical leadership provided motivation throughout the study, and a commitment to research honesty and accepted principles of research shaped the project. In addition, subjecting the results of the research to peer review scrutiny and subsequent publication processes throughout enhanced the project’s integrity.

**Justice**

To ensure the research was conducted in just manner it was essential that the participants involved were treated fairly. This imperative for justice was evident in a number of processes and considerations throughout the research. At both universities
an invitation in the form of an announcement was posted on e-learning platforms, accessible only to students enrolled in nursing courses. The text of the announcement directed respondents to a hyperlink (Appendix 4) where the online survey (Appendix 5) was accessible. To ensure that potential respondents to the survey were fully informed about the study a statement at the beginning of the survey directed them to the Participant Information Sheet (Appendix 6). An announcement similar to the e-platform invitation was posted on Facebook while on Twitter, a posting restricted to 140 characters was tweeted, and included a hyperlink to the online survey. These processes ensured that all potential respondents to the survey were provided with access to relevant information to be fully informed about the study. For the interview phase of the data collection, the process was free of coercion and following initial contact, potential participants were sent a Participant Information Sheet (Appendix 6) to consider their involvement.

**Beneficence**

When designing a study it is important for researchers to consider the possible benefit of the research justifies any potential risk to participants (NHMRC 2007). In the current study, all processes in the conduct of the study considered potential risks to participants. For example, for respondents to the online survey their anonymity and security of data were ensured through the use of a commercial software program that was password protected. In addition to the Participant Information Sheet initially sent to potential interview participants, their right to withdraw from the study at any time was reinforced upon receipt of the Participant Consent Form (Appendix 7) prior to the interview. While there was no direct benefit to the participants in the study, the results of the research aim to enhance the understanding of clinical leadership in nurse workplaces, a setting in which study participants practice.

**Respect**

In research involving humans it is of paramount importance that all aspects of the research processes are respectful of those involved (NHMRC 2007), whether they are anonymous respondents to a survey or participants in an interview. To ensure that this occurred in the current study a number of procedures were undertaken. Prior to the interviews participants were made aware that a professional transcription service would be engaged to transcribe the audiotapes and that they would be bound by the ethical constraints of the study, in terms of confidentiality of information. They were also assured that all data would be de-identified, included the use of pseudonyms in all publications and presentations arising from the study. Following completion of the
data collection period, the electronic data from the online survey and the interviews were stored securely on a password-protected site. Hard copies of interview transcripts, although de-identified, and signed consent forms are stored in a locked filing cabinet at UWS. All forms of data will be kept for a period of five years, before being appropriately and securely destroyed.

4.9. Establishing rigour, validity and reliability

Establishing rigour, reliability and validity are essential elements in any research study, as the degree to which this can be established in a study can position the work as credible research comprising a report of recollections and opinions from participants and respondents, as interpreted by the researcher. To remain true to a critical theory framework from a Habermasian perspective it was important to maintain an emancipatory intent throughout the study, and recognise the centrality of language and its meanings, the connection between thoughts and actions, and the importance of self-reflection for the researcher and participants (Jackson et al. 2003).

Maintaining these imperatives throughout the study involved ensuring that for those involved in the project they did so freely, in the absence of any coercion. For example, prior to the interviews participants were made aware that they could withdraw from the interview if they wished without question or adverse consequences. Those registered nurses who participated in both the survey and the interviews were informed that they were free to make contact with the researcher about aspects of the study, either by phone or email. At the completion of the interview each participant was invited to make contact if they had any further thoughts about clinical leadership, after they had the opportunity to reflect on the conversations. One participant did make contact a number of months after the interview, indicating that participation in the interview had resulted in her reflecting more on her practice and that as a result, she was more conscious of aesthetic aspects of her clinical leadership.

The evolution of an accepted standard protocol for establishing rigour in mixed-methods approaches continues (Lewis 2011). When taking a convergent parallel mixed-methods approach it is acceptable to apply critical appraisal skills from both quantitative and qualitative methods to establish validity (Creswell 2014). Lincoln and Guba’s (1985) model for establishing rigour and trustworthiness in qualitative research sets out the four criteria of credibility, dependability, confirmability and transferability. In essence, these four criteria have similarities with processes for assessing trustworthiness of quantitative data, viz, credibility being similar to internal
validity, dependability related to reliability, confirmability similar to objectivity, and transferability akin to external validity (Thomas & Magilvy 2011). Therefore, in seeking to ensure validity, reliability and rigour in the current study strategies were in place to ensure all of these criteria were satisfied.

To ensure credibility throughout the project strategies included the decision to use purposeful sampling to recruit interview participants, ensuring accuracy of the interview transcripts, and seeking confirmation of data analysis through discussions with the principal supervisor of the project. Reflexivity was also an ongoing process throughout the period of data collection and analysis. This involved maintaining a reflective journal throughout the duration of data collection and analysis. As indicated in the paper in Chapter 6 the internal validity was assured in the development and administration of the online descriptive survey by utilising and expert panel to critique the survey instrument as a whole and in particular, determine content validity of the adapted Polat and Oztoprak-Kavak (2011) ALS instrument. In addition, in the analysis of quantitative data appropriate statistical tests were applied.

Dependability and reliability are evident through an audit trail that articulates the study’s purpose, methods of data collection and analysis, and publication of these methods and findings (see Chapters 2, 5, 6, 7, & 8). This process of articulating a transparent audit trail also ensured the study’s confirmability and objectivity. Sufficient description of study processes and participants in reported findings and in this chapter make transferability possible for the qualitative aspect of the study. However, in relation external validity, generalizability of findings was not the intent of the study. Instead, the study was of exploratory nature of the study. This, along with the relatively poor response rate to the online survey restricts the potential for this to occur.
Chapter 5: Pragmatism, persistence and patience: a user perspective on strategies for data collection using popular online social networks

5.1. Publication:


5.2. Relevance to thesis

An important aspect in any research involves data collection. This paper reflects on and critiques one of the methods of data collection in this research that involved the use of the online world. The use of the internet to locate the descriptive survey lent itself to utilising the same medium to invite nurses to complete the survey. Consequently, apart from using e-learning platforms at two universities, the online social networks of Facebook and Twitter were utilised to recruit participants. These online social networks are increasingly being utilised by researchers for data collection, mainly because of accessibility to large numbers of potential participants and the low costs involved. However, this source of recruitment needs to occur in a way that retains rigour and validity in research projects.
Pragmatism, persistence and patience: A user perspective on strategies for data collection using popular online social networks

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KEYWORDS
Online survey; Online social networks; Twitter; Clinical leadership; Data collection

Summary The increasing pervasiveness of the internet and social networking globally presents new opportunities and challenges for empirical social science researchers including those in nursing. Developments in computer-mediated communication are not static and there is potential for further advances and innovation in research methods embracing this technology. The aim of this paper is to present a reflective account and critique of the use of social media as a means of data collection in a study that sought to explore the aesthetics of clinical leadership in contemporary nursing. In doing so, comparisons are drawn from using Twitter, Facebook and e-learning announcements as methods of recruitment and subsequent data collection via an online survey. The pragmatics of the Internet and online social networks as vehicles for data collection are discussed. While questions remain about best practice to safeguard the scientific integrity of these approaches and the researchers and research participants who choose to participate, the potential exists for researchers to enhance and expand research methods without compromising rigour and validity. In the interests of sharpening thinking about this means of data collection dialogue and debate are needed on a range of research aspects including but not limited to pragmatics, new requirements in research training and development, legal and ethical guidelines and strengths and limitations encountered.

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Introduction

Seeking information via the virtual world is not new. The internet has emerged as an almost taken-for-granted tool for communication, having permeated into the workplace and home environment (Giordano & Giordano, 2011; Ryan, 2013), and accessed by individuals of all ages (West & Verran, 2013). Internet users of the world-wide-web are able to access information with relative ease and speed, using various search engines and networks, particularly with the arrival of mobile devices with Internet access (Giordano & Giordano, 2011; Redfern, Ingles, Neubeck, Johnston, & Semenza, 2011). Conversely, those seeking information from Internet users can also do so with relative ease; the ways in which unsolicited invitations to complete surveys can “pop up” on computer screens reflects this and offers encouragement for researchers to consider the opportunities the Internet can provide as a way of collecting data (O’Connor, Jackson, Goldsmith, & Skirtont, 2013; Ryan, 2013). It is apparent that many researchers across a range of disciplines are exploring ways of enhancing research approaches using Internet and social media technology. Social media technologies such as online social networks (OSNs) continue to grow rapidly and are increasingly becoming one of the main methods of communication for many in the global community (Ferguson, 2013). These OSNs can serve a number of different purposes. Görnandy White (2013) identifies seven major social network categories, ranging from professional networks (e.g. LinkedIn) through to those dedicated to information sharing (e.g. Do It Yourself Community) and those designed principally to maintain social connections (e.g. Facebook and Twitter). Both Facebook and Twitter allow users to set up their own profiles, create personal contact lists, post messages, and share information including web links, videos, and photos (Heldeman et al., 2012; Hughes, Rows, Batey, & Lee, 2012). The efficiency and speed of this information sharing make these two OSNs powerful platforms for online communication. As Heldeman et al. (2012) highlight, Facebook users can actively endorse and spread posts with a single click of the “Share” function. Twitter users, unlike those using Facebook, tend to focus more on offering opinion and information rather than socialising online (Hughes et al., 2012). Accessibility to these OSNs has exploded in recent years, with figures indicating that worldwide there are around 750 million Facebook users and 100 million Twitter users (Serrano, 2011). Twitter and Facebook are consistently cited as the most popular OSNs (Antheunis, Tales, & Niehöf, 2013; Davenport, Bergman, Bergman, & Fearrington, 2014).

For those involved in research projects the potential of the internet and OSNs is significant. Regardless of the methodological approach taken, researchers can adapt traditional methods of data collection such as interviews, surveys and focus groups to an online environment (Walker, 2013). There are some advantages to using OSNs for research data collection including the possibility of being able to access a larger pool of potential study participants, and do this more economically and in less time than more traditional means such producing and distributing hardcopy surveys or questionnaires (Ahern, 2003). As well, sensitive topic areas can be more effectively researched using computer-mediated communication (East, Jackson, O’Brien, & Peters, 2008; Ryan, 2013) and anonymity afforded by online surveys can potentially improve the truthfulness of data (Contrall & Lupinacci, 2007). Research participants can also find it more convenient to engage in data collection (Valido, Jackson, & O’Brien, 2010). However, researchers taking this approach need to recognise that there are some challenges involved around establishing validity and rigour of research findings (Ahern, 2005; Walker, 2013) and issues such as social desirability (Groh, Ferrari, & Jason, 2009) and recall bias (Boone, Halligan, Mallett, Taylor & Altman, 2012). This paper aims to outline and critique the use of OSNs for data collection in a study that sought to explore the aesthetics of clinical leadership in contemporary nursing.

Background

Effective leadership in nursing has been recognised as being of global importance to the nursing profession and a key to ensuring quality health care (ICN, 2012; Mannix, Wilkes, & Daly, 2013). Wide ranging inquiries into the state of health services, conducted in both Australia and the United Kingdom in recent years, highlight the critical nature of effective clinical leadership in achieving quality patient care (Department of Health, 2008; Francis, 2013; Garling, 2008). These have resulted in recommendations for improved clinical leadership (Francis, 2013; Garling, 2008). In the clinical nursing world leadership has been offered as the solution to the problems of its workplace (Jackson & Watson, 2009), including problems associated with staff skill mix (Parker, Giles, & Higgins, 2009), shrinking resources (Johnstone & Kanitsakis, 2009), workplace wrongdoing (Jackson, Hutchinson, Peters, Luck, & Saltman, 2013) and workplace violence (Jackson, Clare, & Mannix, 2002). To this end, the International Council of Nurses (ICN) positions leadership as one of its five core values driving ICN endeaours (ICN, 2012).

In order to research international nursing issues like clinical leadership, utilising the virtual environment of the internet, and OSNs in particular, can be realistic and cost-effective ways in which to gain a global perspective from contact with nurses across the world. Increasingly, researchers in nursing and health are turning to the internet and OSNs as methods of both seeking data for and disseminating data from their research projects. In a large longitudinal study of nursing and midwifery workforces in Australia, New Zealand and the United Kingdom a dedicated website was established for data collection of a number of workforce participation measures (Huntington et al., 2009). Health-oriented OSNs have been effectively utilised in a randomised trial to promote weight loss and physical activity (Greene, Sacks, Piniewski, Kilt & Hahn, 2012). Rather than using a focused online social network, Ramo and Prochaska (2002) utilised Facebook’s paid advertising programme to recruit and survey young adults about substance use, finding it a cost-effective method of recruiting and assessing health behaviours.
Information sharing via OSNs is also increasingly evident and is becoming a focus of research in nursing and health. A study that sought to determine the effect of Twitter on disseminating information about antibiotics found that as a communication medium Twitter is a powerful tool through individuals' networks of followers and a 'culture of "retweeting"' (Scanfeld, Scanfeld, & Larson, 2010 p. 186). Similarly, Rubillard, Johnson, Hennessey, Beattie, & Illis (2013), in their study of information about dementia on Twitter, found that the majority of tweets directed readers to news and health information sites as well as discussions on recent research findings on Alzheimer's disease. Twitter, as an online micro-blogging social network, provides researchers with opportunities to access large amounts of data and determine public opinion on various issues. For example, King et al. (2013) were able to investigate reactions to the recent wide-ranging health reforms to the National Health Service (NHS) in England. By applying a streaming application programme with key words of "reforms" and "NHS" over a 12 month period the researchers collected over 120,000 tweets related to the health reforms. Subsequent analysis of the data enabled King et al. to determine tweeting trends over time, reactions to the health reforms, and who was most influential in the twitter discussions. This study by King et al. does illustrate that Twitter and similar social media platforms provide an important forum for public policy discussions.

Clearly, OSNs are gaining legitimacy as repositories for data collection. They enable researchers to access large pools of potential participants for their studies and also provide a vehicle for the dissemination of their research findings. While it is acknowledged that the use of online data collection is economical, efficient and convenient (Ahern, 2005; Hunter, 2012; Walker, 2013), concerns have been raised in the literature regarding some ethical and methodological factors around online data collection. From an ethical perspective privacy and anonymity require careful consideration. Researchers need to consider whether their research may cause potential harm or is intrusive (Eysenbach & Till, 2001), and while there are some ethical guidelines for internet research (Association of Internet Researchers, 2012), wide-ranging best practice guidelines are not apparent in the literature. As McKee (2013) argues, difficulties may arise for researchers in determining what information on social media are public and therefore a legitimate source of data, and what information, although readily accessible, may be considered private and should remain so. Engaging in research through OSNs does not ensure anonymity, as it is possible to identify individuals through email addresses and IP addresses (McKee, 2013; Walker, 2013). Therefore, if anonymity is required, researchers need to take steps to ensure it occurs. For example, as Walker (2013) suggests, using a third party to manage the research links on behalf of the researchers. Methodological concerns with online data collection that have come under scrutiny in the literature include issues around sample bias, particularly in relation to requirements for computer use and associated computer literacy for participants (Ahern, 2005; Hunter, 2012; Walker, 2013), and internal validity (Ahern, 2005), "Technophobia", described as a fear of technology, has been suggested as a factor influencing participation in online surveys (Hunter, 2012).

The study

It was with these considerations in mind that strategies for data collection via the Internet and OSNs were developed for a mixed methods study that aimed to explore the aesthetics of clinical leadership in contemporary nursing. The study sought from registered nurses their views on what it is to be a clinical leader and what aesthetic elements comprise effective clinical leadership. These views were sought initially via an online survey which was developed from two existing questionnaires, one that focused on aesthetic leadership (Polat & Öztoper-Kavak, 2011) and the other that focused on clinical leadership in nursing (Patrick, Spence-Lauinger, Wong, & Finegan, 2011). Because the aesthetic leadership questionnaire was originally developed to administer to school directors it was necessary to modify and contextualise the items to a clinical nursing context. This was undertaken systematically by one of the research team, and subsequently independently checked for clarity and accuracy by two other members of the research team. This process resulted in changes to some of the language, for example, "clinical setting" was substituted for "school". As well, the original 66 items were reduced to 32 items that focused equally on areas of a clinical leader's communication skills, support capacity, leadership approach, application, sensitivity, and honesty.

The 15 items on clinical leadership survey were not modified in any way from the original instrument (Patrick et al., 2011). The final survey tool reflected a mixed method survey design in four sections, preceded by a short introduction to the survey that included a definition of aesthetic leadership. Following a short demographic section that focused on their professional experience two sections comprising 47 items, invited a response on a five point Likert scale (strongly agree, agree, neutral, disagree, strongly disagree). A final section with a text box asked participants to give an example of aesthetic leadership from their clinical experience. Finally, the completed survey instrument was trialled by an expert panel of seven experienced registered nurses to complete and critique. In doing so, the survey was assessed for content validity and the feasibility of the instrument (Gill, Leslie, Groch, & Latour, 2013). Minor modifications to the instrument occurred as a result of their feedback.

Prior to the commencement of the data collection period in the study institutional Human Research Ethics Committee approval was sought and granted. Initially, data collection was to be confined to an invitation to registered nurses enrolled in postgraduate studies at a large metropolitan university. The invitation was posted as an announcement on the university e-learning platform, accessible only to students enrolled in nursing courses. Similar ethics approval was also granted at a second large metropolitan university using the same recruitment strategies. Before the data collection period commenced, subsequent amendments to data collection methods were approved by the ethics committee to also enable the OSNs of Facebook and Twitter be utilised for participant recruitment.
<table>
<thead>
<tr>
<th>Tweet 140 characters plus hyperlink to survey</th>
<th>Surveys pre-tweet (n)</th>
<th>Followers (n)</th>
<th>Retweets (n)</th>
<th>Retweeter followers (n)</th>
<th>Surveys 1 week post-tweet</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>48</td>
<td>218</td>
<td>8</td>
<td>2958</td>
<td>51</td>
</tr>
<tr>
<td>2 (@ 3 weeks)</td>
<td>55</td>
<td>248</td>
<td>17</td>
<td>17,990</td>
<td>62</td>
</tr>
<tr>
<td>3 (@ 13 weeks)</td>
<td>72</td>
<td>316</td>
<td>3</td>
<td>3514</td>
<td>72</td>
</tr>
<tr>
<td>4 (@ 14 weeks)</td>
<td>72</td>
<td>322</td>
<td>31</td>
<td>25,633</td>
<td>74</td>
</tr>
</tbody>
</table>

Data collection

To facilitate on-line data collection a decision was made to utilise readily accessible commercial data collection software that allowed relatively efficient data collection and with the capacity to download the completed survey responses into suitable software for data analysis. After reviewing a range of software programmes available to the research team the decision was made to use a Qualtrics® programme (http://www.qualtrics.com/research-suite/# academic), based on ease of loading the survey, security of data, and capacity to download survey data to other software programmes for statistical analysis. As well, even though completion of an online survey implies consent (Walker, 2013), it was possible to hyperlink the participant information sheet to the beginning of the survey so that respondents had the opportunity to gain more detailed information about the project, including assurances of anonymity, and contact details for the research team.

Once the survey was loaded and activated, a hyperlink was created to be included in all recruitment announcements. To ensure consistency during the data collection period one of the research team took responsibility for posting all announcements via e-learning sites, Facebook and Twitter. As O’Connor et al. (2013) suggest, by doing this rigour is enhanced in the process of data collection. Also, all recruitment announcements for the study referred to the clinical leadership in contemporary nursing. Once accessed, participants were introduced to the concept of aesthetic leadership. The initial announcements inviting registered nurses to complete the online survey occurred through the e-learning platforms at the metropolitan universities. These announcements were made when the registered nurses who were students studying locally and via distance education at the universities were most likely to access their e-learning sites. After the completion of the teaching session, and when the number of surveys being completed dropped off, recruitment via online social networks was undertaken. The notices on the OSNs were sequential, a deliberate strategy to gauge the recruitment effectiveness of Facebook and Twitter. The notice on Facebook was placed on the site of one of the research team, who, as an experienced registered nurse, had access to a relatively large network of registered nurses through “Friends’” connections. Reaction to the notice on Facebook was monitored, as well as the number of surveys being completed in the period after posting the notice.

A number of different strategies were employed when using Twitter, with the aim of maximising the number of online surveys being completed. The initial tweet (message), comprising no more than 140 characters and with the hyperlink, was posted from one of the research team’s Twitter account. Within the text of the message, a hashtag (#) preceded clinical, leadership and nursing. By doing this the message can be found by others searching in these topic areas who have not received the original tweet (O’Connor et al., 2013). At that first tweet, 218 followers received the message. Two weeks later the same message was re-posted. After a period of eight weeks a weekly posting of the same tweet was undertaken for two consecutive weeks. The final weekly post included a request for the followers to retweet (or resend) the message. This request was included to in an attempt to increase the exposure of the message to the followers of those receiving the original tweet. The responses to the four tweets are shown in Table 1.

The figures in the table above that while the number of followers initially receiving the tweet with the link to the online survey are not large, retweeting of the tweet exposes the survey to a significant number of potential participants. For example, the second tweet was retweeted by 17 followers, resulting in a potential study pool of 17,990 individuals, many of whom were likely to be nurses, given the nature of the Twitter network being accessed. By posting the message on Twitter it was also evident that nurses from across the globe were able to complete the survey, if they wished to do so. Nurses within the Twitter network were located in the United Kingdom, Europe, North America, Australia, New Zealand, small Pacific nations and Asia.

Discussion

Employing a number of different online networks for recruitment into the study did potentially expose the survey to a large number of nurses from around the world and thereby gain a global perspective of clinical leadership. In essence, the recruitment methods are contemporary, and as O’Connor et al. (2013) comments, are reflective of the more traditional snowball sampling technique. Clearly though, despite the potential participant numbers, the response rate for the survey was relatively poor. In Table 2 below the breakdown of valid surveys indicates that, with the exception of Facebook, the number of valid surveys collected is fairly consistent from Twitter and the e-learning announcements. However, given that the e-learning announcements reached no more than 1000 nurses from both universities, and the potential recruitment from Twitter exceeded 25,000 participants, the response rate was exceptionally poor.

Nonetheless, the poor response rate to this particular online survey should not be a reason to dismiss the use of OSNs as recruitment sites for scholarly research. There
Table 2: Participants by recruitment method and completed surveys.

<table>
<thead>
<tr>
<th>Recruitment method</th>
<th>Recruitment timeframe (weeks)</th>
<th>Surveys commenced (% of total)</th>
<th>Incomplete surveys (% of total)</th>
<th>Valid surveys for analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>e-learning announcement #1</td>
<td>16</td>
<td>24 (33.3)</td>
<td>3 (4.2)</td>
<td>21</td>
</tr>
<tr>
<td>e-learning announcement #2</td>
<td>16</td>
<td>23 (31.9)</td>
<td>0</td>
<td>23</td>
</tr>
<tr>
<td>Facebook</td>
<td>8</td>
<td>2 (2.8)</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Twitter</td>
<td>16</td>
<td>23 (31.9)</td>
<td>3 (4.2)</td>
<td>20</td>
</tr>
<tr>
<td>Total</td>
<td>72 (100)</td>
<td>6 (8.4)</td>
<td>6</td>
<td>66</td>
</tr>
</tbody>
</table>

may be a number of factors contributing to the response rate for this particular survey. Despite government reports (Department of Health, 2008; Garling, 2008) and professional nursing organisations (ICN, 2012) identifying clinical leadership as being a critical factor in improving the health workplace and the quality of health care, it does not necessarily follow that nurses working in clinical settings see the issue of leadership with the same interest or intensity. The focus on aesthetics did not seem to significantly affect response rates, with only a small number (n = 3) of those who accessed the survey failing to commence the survey. Rather, clinical nurses, while aware of the difficulties of the clinical workplace, may not make the links between issues of skill mix, workplace adversity and clinical leadership. Nurses working in clinical settings also may be more interested in clinical issues directly relevant to their clinical practice and patient care, and they can directly apply in their day-to-day practice. Topics of a more conceptual or theoretical perspective that cannot easily be measured against patient outcomes, such as those around leadership and management, may fall into this category.

The relatively higher response rate from nurses undertaking postgraduate studies when compared to responses from OSNs may be reflective of a couple of factors. As was the case with recruiting through e-learning platforms, posting announcements on a relevant websites can increase response rates to online surveys (Walker, 2012). Being engaged in postgraduate studies is generally indicative of a desire to gain qualifications to progress their careers, and as such, may have been more interested and inclined to access and complete a leadership survey. Conversely, nurses using OSNs may do so more for social communication and contact, rather than for increasing knowledge. Antheunis et al. (2013) found in their study on health professionals’ use of social media that 68% of respondents identified communication with colleagues as the motive for using Twitter and only 8% of respondents identified increasing knowledge as a motive. Further, 22% of respondents used Facebook for communicating with colleagues while no respondents identified it as a motive for increasing health related knowledge (Antheunis et al., 2013). This view of OSNs may be inadvertently being encouraged by nurses workplaces that restrict access to large parts of Internet, including Facebook and Twitter, and regulatory authorities being risk averse about social media (Ferguson, 2013). In some cases, as Ryan (2013) reports, regulatory authorities have suspended nurses for their Facebook activity.

The relatively low number of incomplete surveys discarded from the final sample may indicate that the content and structure of the online survey did not affect the response rate, similar to a 60% response rate being regarded as a quality measure of a survey (Johnson & Wiskar, 2012). In the majority of instances, the time taken to complete the survey was less than the 20 min timeframe suggested on the participant information sheet. However, while some participants completed the 47 item questionnaire, three of the 38 qualitative responses in the last section of the survey commented on their limited understanding of aesthetic leadership. These comments occurred despite the inclusion of a definition of aesthetic leadership at the top of the survey.

**Strategies for increasing recruitment**

Some strategies that may have enhanced a higher response rate to the online leadership survey include taking a more targeted approach to recruitment via the online social networks. In their study O’Connor et al. (2013) found that after setting up a specific Twitter account, following individuals and groups with similar interests and requesting a retweet of research related tweets, recruitment was maximised. With regards to enhancing recruitment via Facebook, establishing an open Facebook group that does not restrict membership may be effective. However, as Ryan (2013) comments, researchers need to establish clear guidelines for appropriate behaviour and monitor activity closely on the site. Taking this approach to using this online social network may become unmanageable, depending on who accesses the page, and may also be more suited to a qualitative study, rather than one with a link to an online survey.

Finally, the use of e-learning platforms for recruitment may have been improved by sending all postgraduate nursing students an email invitation with a link to the online survey, rather than limiting recruitment to announcements on the e-learning sites. Newton, Davidson, & Sanderson (2012) found with their study that email invitations to complete an online survey were an effective recruitment strategy and elicited a 21% (n = 52) response rate.

**Conclusion**

The increasing participation by nurses, largely through necessity, in computer-mediated communication such as that associated with e-health, opens the internet and OSNs as rich sites for recruitment into research that focuses on global nursing issues. While the response rate to the online survey was disappointing for the current study, the use of
online announcements and social media has the potential to maximise exposure for the collection of research data. Additional strategies that may have increased participation in the online survey include setting up a project specific Twitter account, creating a more accessible Facebook page and taking a more targeted approach to recruitment.

The practicality, simplicity and expediency of using OSNs and the Internet for conducting research cannot be understated. While the response rate was poor for this particular study, the cost of resources and labour for managing the data collection was minimal, compared to more traditional, pre-Internet and OSNs methods of data collection. However, judging the best practice to safeguard the ethical and scientific integrity of these approaches. Used judiciously these technologies can enhance and expand research methods including more creative approaches to collection of data without compromising rigour and validity. In the interests of sharpening thinking about this means of data collection dialogue and debate are needed on a range of research aspects including but not limited to pragmatics, new requirements in research training and development, legal and ethical guidelines and strengths and limitations encountered.

References


Chapter 6: Grace under fire: aesthetic leadership in clinical nursing

6.1. Publication:


6.2. Relevance to thesis

This paper presents findings from the mixed-methods online descriptive survey conducted as part of this larger study. A major part of the survey involved seeking the views from nurses on what they considered important aspects of aesthetic leadership, using an adapted version of an existing instrument. The survey also gave respondents an opportunity to offer an example of aesthetic leadership in their clinical experiences. The findings of the survey, while not generalizable, informed the study about the multi-dimensional nature of aesthetic leadership and that the clinical context shapes the particular aesthetic dimensions utilised by clinical leaders in the workplace.
Grace under fire: aesthetic leadership in clinical nursing

Judy Mannix, Lesley Wilkes and John Daly

Aims and objectives. This paper reports the results of an online descriptive survey that sought to determine nurses' perceptions of aesthetic leadership among clinical leaders in nursing.

Background. Clinical leadership has been identified as an essential component to ensuring the delivery of safe, high-quality health care. Leadership has been increasingly linked in the literature to aesthetics. However, little consideration has been given to aesthetics in relation to clinical leadership in nursing.

Design. A mixed-method, online descriptive survey.

Methods. Participants were recruited via e-learning platforms and social media. A total of 66 surveys were completed, including 31 written accounts of aesthetic leadership in practice.

Results. Aesthetic leadership characteristics in clinical leaders most valued are support, communication and the approach taken to colleagues. Taking risks and challenging processes were least likely to be evident among effective clinical leaders.

Conclusion. Aesthetic leadership is multi-dimensional and a style of leadership to positively influence the clinical workplace. Support, effective communication and taking into consideration the feelings of colleagues are important dimensions of aesthetic leadership.

Relevance to clinical practice. Aesthetic leadership represents a way for clinical leaders to create and sustain a calm and positive clinical workplace.

Keywords: aesthetic leadership, clinical leadership, mixed method, nurses, online survey

Accepted for publication: 18 April 2015

Introduction

Clinical leadership has been identified as an integral component to ensuring the delivery of safe, high-quality health care. While recognising that clinical leaders in health care are not restricted to one professional group (Howieson & Thiagarajah 2011) or a designated level within a professional group (Davidson et al. 2006), it is evident that expectations exist for nurses to fulfil the role in clinical settings. Government reports in recent years (Garling 2008,
Francis (2013) have targeted nurses in ward management positions, recommending that they refocus their roles away from administrative/management tasks to be more involved in clinical leadership. Calls for more effective clinical leadership have occurred in the absence of a standard, agreed upon definition (Howieson & Thiasarajah 2011, Mannix et al. 2013). In the contemporary context of evidence-based practice, it is apparent that those fostering the development of clinical leaders through professional development programmes focus on aspects of leadership that enhance leader competence and capacity in areas of safety and quality, patient-focused care and coordination, teambuilding and self-development (Large et al. 2005, Clinical Excellence Commission 2007).

Aspects of clinical leadership largely overlooked in the nursing literature are the less tangible aesthetic skills, shaped by sensory perceptions and experiences (Hansen et al. 2007, Bathurst et al. 2010). This has occurred despite a long held acknowledgement in nursing that along with empirics, personal knowledge and ethics, aesthetics is one of the four fundamental patterns of knowing in nursing, and integral to describing the art of nursing (Carper 1978). Even with this acknowledgement in nursing and important links between aesthetics and leadership being made in the wider leadership studies literature (Hansen et al. 2007, Bathurst et al. 2010), there is a paucity of literature that links aesthetics with nursing leadership. This may contribute to a lack of clarity around common understandings of clinical leadership, and given this, an exploration into the contribution aesthetic leadership can have in enhancing the effectiveness of clinical nurse leaders is timely.

Background

Aesthetics is not a new concept, with Baumgarten, an 18th century philosopher, arguing that aesthetic knowledge built on feelings was of equal importance to that of knowledge derived cognitively (Hansen et al. 2007). Leadership has been linked to different aesthetic theories. Bathurst et al. (2010) refer to Lagarde’s theory on aesthetics which has as its focus, how one understands the ‘existence of things’, premised on a belief that a living relationship exists between the artist, the creation and those viewing the creation. Bathurst et al. point to the theory as a way of encouraging leaders to develop different leadership strategies.

Aesthetic leadership, as a leadership model, has been described as emphasising the qualities of emotional, sensory and somatic awareness, with an interest in fostering organisational beauty and promoting moral purpose (Katz-Buonincontro 2011). Similarly, Hansen et al. (2007, p552) argue that aesthetic leadership is formed from sensory knowledge and felt meaning, derived from engaging with the senses and focusing on the experiential. The application of aesthetic leadership has been offered as a way of enabling free flow between the fields of administration, management and aesthetics, where the aesthetic field is the place for improvisation and creativity (Guillet de Monthoux et al. 2007). Using Hansen et al. (2007) and Polat and Oztokopr-Kavak (2011) state that aesthetic leadership involves leaders encouraging followers to share and embody an aesthetic vision comprising aesthetic dimensions of sensitivity, communication, appearance, approach, application, support and honesty, incorporating behaviours like concern, emotion, pleasure and criticism.

While no consensus exists around Carper’s (1978) interpretation of aesthetics, there is an accepted view that aesthetics has a place in the continuing development of nursing knowledge and practice. As Freshwater (2004, p11) argues, Carper provided a framework within which science and sensitivity can be combined to access the aesthetic evidence embedded in everyday nursing practice. It follows that everyday nursing practice includes clinical leadership activities undertaken by nurses. However, little attention has been afforded aesthetics and nursing leadership, particularly in the clinical context. Jackson et al. (2009) incorporated Carper’s patterns of knowing to develop a theory of nursing leadership. Jackson et al. identified an additional three patterns of knowing (sociopolitical, unknowing and emancipatory), joining aesthetics, ethics, personal knowledge and empirics as seven patterns of leadership knowing. By using all these seven patterns in harmony, Jackson et al. (2009, p. 153) argued that nursing leaders can engage in evidence-based leadership while demonstrating empathy, vision, respect, flexibility, morality, political strategy and transformative actions. As a style of leadership, aesthetic leadership does share some characteristics with other values-oriented styles such as servant leadership and ethical leadership (Mumford & Fried 2014), and is not antithetical to transformational leadership or congruent leadership (Mannix et al. 2015). However, aesthetic leadership overcomes the cultural and moral limitations of transformational leadership (Hutchinson & Jackson 2013) through incorporating aesthetic processes shaped from cultural and embodied experiences (Mannix et al. 2015).

An extensive search of the literature indicates a lack of empirical evidence of aesthetic leadership in clinical nursing. This paper provides results of an online descriptive survey, as part of a larger empirical study that sought to explore aesthetics in clinical leadership in nursing.
especially what nurses perceive to be important characteristics of aesthetic leadership in the clinical environment.

Aims of the study

This part of the study aimed to:
1. Determine the aesthetic leadership characteristics nurses perceive as important in their clinical leaders.
2. Ascertain from nurses the most common clinical leadership characteristics among clinical leaders.
3. Reveal clinical situations where aesthetic leadership was evident with clinical leaders.

Methods

Design

The development and administration of the online descriptive survey was conducted using validated tools and open-ended questions. This mixed-method design is a pragmatic approach taken to collect quantitative and qualitative data; the latter data source aimed at enhancing the quantitative data (Andrew & Halcomb 2012). The survey instrument consisted of four parts (see Table 1).

Quantitative section of survey

Part 1 sought demographic information from respondents about themselves and their nursing experience. Part 2 asked respondents to consider a nursing colleague they regarded as a clinical leader when answering items that focused on characteristics of aesthetic leadership. The items for this part were contextualised (with permission of the developer) from an existing and validated 31-item Aesthetic Leadership Scale (ALS) developed to measure the aesthetic leadership characteristics of school directors (Polat & Oztoprak-Kavak 2011). The ALS items addressed seven aesthetic leadership dimensions: sensitivity, approach, communication, application, support, honesty, and appearance (Polat & Oztoprak-Kavak).

A number of items in the original scale did not relate well to clinical settings or nursing and were subsequently excluded, including all three items linked to the appearance dimension, and two of three items from honesty dimension. The remaining retained items included five to seven items from each of the other five aesthetic leadership dimensions. Some items required rewording for a nursing context, for example nurses replaced teachers and clinical setting for school. This process of modification was initially undertaken by one researcher but taken over by two other team members. The final version of the adapted questionnaire comprised an even spread of the other five aesthetic dimensions identified in ALS.

As the Polat and Oztoprak-Kavak (2011) ALS was modified for context in relation to clinical relevance, the content evidence of the survey was tested using an expert panel. By doing this, the content contextualised from the original ALS was assessed to ensure that it was appropriate for its intended purpose (AERA et al. 1999). As Squires et al. (2011) highlighted, content evidence is generally the initial type of evidence sought in the assessment of an instrument. The expert panel comprised seven experienced registered nurses, a panel size acceptable for expert panels (Polit & Beck 2006). Following administration of the survey to panel members, results were analysed, indicating all seven respondents strongly agreed on all items as essential components. This provided content validity index of 1.00 (Polit & Beck 2006). The panel also assessed Part 1 of the survey tool and as a result, a third option of ‘Transgender’ was added to the Gender choices. By subjecting the survey to an expert panel, the feasibility of the instrument and its content validity were assessed (Polit & Beck 2006), thereby increasing confidence in using the instrument.

Part 3 comprised items asking respondents to again consider their identified clinical leader when answering items about general characteristics of clinical leadership. The items for this part were drawn directly from a validated Clinical Leadership Survey (CLS) developed to measure staff nurse clinical leadership (Patrick et al. 2011). No modification of items from the CLS was required. In developing the CLS, Patrick et al. considered the five leadership practice categories of challenging processes, inspiring a shared vision, enabling others, modelling behaviours and encouraging others. In both Parts 2 and 3 of the survey, respondents were given five response choices on the Likert scale, categorised and scored as ‘Strongly Agree’(5), ‘Agree’(4), ‘Neutral’(3), ‘Disagree’(2) and ‘Strongly Disagree’(1). No content validity was conducted for this part of the survey as it was used as validated by original researchers.

Table 1 Composition of online survey

<table>
<thead>
<tr>
<th>Part</th>
<th>Descriptor</th>
<th>Composition</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Demographic details</td>
<td>7 items</td>
</tr>
<tr>
<td>2</td>
<td>Aesthetic leadership survey</td>
<td>32 items</td>
</tr>
<tr>
<td>3</td>
<td>Clinical leadership survey</td>
<td>15 items</td>
</tr>
<tr>
<td>4</td>
<td>Written account of aesthetic leadership</td>
<td>Blank text box</td>
</tr>
</tbody>
</table>
Qualitative section of survey

Part 4 invited respondents to provide a brief written account of a situation in their clinical experience where aesthetic leadership was shown. Specifically, the invitation was: Briefly describe a situation in your clinical experience where aesthetic leadership was shown. Including this descriptive section provided the opportunity to interpret respondents’ understandings of aesthetic leadership in clinical practice. Adopting a qualitative descriptive approach to data analysis enables a level of interpretation that results in findings nearer to the data as it has been written, and less interpretively transformed that can occur with other qualitative research methods (Sandefur et al. 2010). A text box was available on the survey to enable respondents to type their experiences.

Sample and recruitment

Using convenience sampling, participant recruitment occurred through online invitations on two large metropolitan university restricted e-learning platforms and through online social networks of Facebook and Twitter. Registered nurses were invited to access the survey through a hyperlink contained within the invitations posted on these online sites. For example, on Twitter, with posts restricted to a maximum of 140 characters, the invitation read:

Nurses: Please help us out with a study on Clinical #leadership in contemporary #nursing (hyperlink) Please RT.

The use of social media and e-learning platforms prevented power analysis of the sample, because knowledge of total population accessed was unknown. The sample for the qualitative data was self-selecting as part of the larger survey. As such, there was no researcher control over data saturation.

Data collection

Online data collection was undertaken through Qualtrics® (http://www.qualtrics.com/research-suite/academic), a readily accessible commercial software program with capability for data download for statistical analysis. The program ensured security and confidentiality during data collection. The survey was loaded onto Qualtrics® and a hyperlink created to be included in all invitations. The link to the survey site remained open for 18 months. Details of data collection are reported elsewhere (Mannix et al. 2014).

Data analysis

The quantitative survey data were exported from Qualtrics® to Statistical Package for Social Sciences (SPSS) version 20 (Allen & Bennett 2012) for management and analysis. Descriptive analysis of each item in Parts 2 and 3 was undertaken, with frequencies tallied, means and standard deviation calculated. Cronbach’s alpha was calculated for Part 2 and Part 3 of the survey. Factor analysis of Parts 2 and 3 were attempted, but due to the small sample, the assumptions for this analysis were not met. However, these two parts had been factor analysed and dimensions formulated in the original surveys (Patrick et al. 2011, Polat & Oztoprak-Kavak 2011). Responses for each item were totalled to determine any relationship between response and age group or years of experience in nursing, using Kruskal Wallis Test (Allen & Bennett 2012). The demographics in Part 1 were presented as frequency distributions. Gender distribution was described in percentages. Qualitative responses in Part 4 were subject to manual descriptive content analysis and categorising by one researcher using the aesthetic leadership dimensions from the ALS (Polat & Oztoprak-Kavak 2011) as a framework to guide analysis. A second researcher then reviewed the findings to test for credibility and rigour. Exemplars from the qualitative data were used to augment quantitative responses.

Ethics

Institutional Human Research Ethics Committee approval (H9592) was obtained in 2012, prior to the commencement of the data collection period. Confidentiality was assured for those nurses who wished to participate in the study.

Psychometric analysis of instrument

The aim of Part 2 of the survey was to determine in an exploratory manner what a group of nurses conceptualised as characteristics of aesthetic leadership. As the sample size of respondents was not extracted from a known total accessible population and the return sample was small, it was not the intention to undertake extensive psychometric analysis. The data from the survey were used to complement another part of the study involving in-depth interviews with nurses in clinical leadership roles. Some reliability analysis was conducted in the context of the sample size.

Results

Quantitative section results

Respondents

A total of 66 respondents completed the online survey. Survey respondents were mainly females, working full time
with over 10 years nursing experience. Over half of the respondents had been in their current position for <4 years (see Table 2).

Of respondents who indicated their current position, half were currently working in clinical nursing practice. The majority of these clinical nurses identified at the level of registered nurse (36-3%, n = 20), either with that title or something similar. Twelve respondents indicated their current position at either clinical nurse specialist (n = 4) or more advanced practice level of clinical nurse consultant (n = 7). Of respondents who indicated a management role, the majority indicated a role in a clinical unit (23-6%, n = 13), for example charge nurse.

Aesthetic leadership characteristics of clinical leaders

Results indicated in Table 3 that all dimensions of the ALS have a high Cronbach’s alpha and the range of mean scores is similar to the original ALS (Polt & Orem’s-Karask)

Table 2 Demographic characteristics of survey respondents
(n = 66)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current workplace</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute hospital</td>
<td>42</td>
<td>63.6</td>
</tr>
<tr>
<td>Community</td>
<td>19</td>
<td>28.8</td>
</tr>
<tr>
<td>Residential care</td>
<td>5</td>
<td>7.6</td>
</tr>
<tr>
<td>Employment status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full time</td>
<td>50</td>
<td>74.6</td>
</tr>
<tr>
<td>Part-time</td>
<td>14</td>
<td>20.9</td>
</tr>
<tr>
<td>Casual</td>
<td>2</td>
<td>3.0</td>
</tr>
<tr>
<td>Time in current position</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;1 year</td>
<td>12</td>
<td>17.9</td>
</tr>
<tr>
<td>1-3 years</td>
<td>24</td>
<td>35.8</td>
</tr>
<tr>
<td>4-7 years</td>
<td>17</td>
<td>25.4</td>
</tr>
<tr>
<td>&gt;7 years</td>
<td>13</td>
<td>19.4</td>
</tr>
<tr>
<td>Years working in nursing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;1 year</td>
<td>2</td>
<td>3.0</td>
</tr>
<tr>
<td>1-3 years</td>
<td>6</td>
<td>9.1</td>
</tr>
<tr>
<td>4-7 years</td>
<td>4</td>
<td>6.1</td>
</tr>
<tr>
<td>8-10 years</td>
<td>9</td>
<td>13.6</td>
</tr>
<tr>
<td>&gt;10 years</td>
<td>45</td>
<td>68.2</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;25 years</td>
<td>1</td>
<td>1.5</td>
</tr>
<tr>
<td>26-35 years</td>
<td>19</td>
<td>28.8</td>
</tr>
<tr>
<td>36-45 years</td>
<td>20</td>
<td>30.3</td>
</tr>
<tr>
<td>&gt;45 years</td>
<td>26</td>
<td>39.4</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>54</td>
<td>81.8</td>
</tr>
<tr>
<td>Male</td>
<td>12</td>
<td>18.2</td>
</tr>
<tr>
<td>Current position</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical</td>
<td>33</td>
<td>50.0</td>
</tr>
<tr>
<td>Education</td>
<td>3</td>
<td>4.5</td>
</tr>
<tr>
<td>Management</td>
<td>20</td>
<td>30.3</td>
</tr>
<tr>
<td>Not specified</td>
<td>10</td>
<td>15.2</td>
</tr>
</tbody>
</table>

Table 3 Mean, standard deviation, and Cronbach's alpha scores related to aesthetic leadership dimensions

<table>
<thead>
<tr>
<th>Dimension</th>
<th>X</th>
<th>SD</th>
<th>Cronbach's alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sensitivity</td>
<td>4.15</td>
<td>0.23</td>
<td>0.86</td>
</tr>
<tr>
<td>Communication</td>
<td>4.12</td>
<td>0.19</td>
<td>0.91</td>
</tr>
<tr>
<td>Support</td>
<td>4.03</td>
<td>0.14</td>
<td>0.94</td>
</tr>
<tr>
<td>Approach</td>
<td>4.01</td>
<td>0.21</td>
<td>0.92</td>
</tr>
<tr>
<td>Application</td>
<td>3.63</td>
<td>0.20</td>
<td>0.91</td>
</tr>
</tbody>
</table>

2011). The Cronbach’s alpha for the total 32 items in the ALS was 0.98 and in conducting an item total statistic, there was little variation in the alpha scores if items were deleted. The variation was ~0.01.

Those individual items in the survey that elicited ‘strongly agree’ or ‘Agree’ responses from more than 75% of respondents and a mean >3.90 are represented in Table 4.

Of the aesthetic dimensions evenly spread across the 32-item questionnaire, only one of the seven items from the application dimension featured in the most highly rated responses. By contrast, the aesthetic dimension of support, which had the same number of items, had six of its seven responses rated highly by respondents.

Results from Kruskal-Wallis tests indicate there was no relationship between respondent age and responses (χ² = 5.21, df 4) and years of experience and responses (χ² = 6.59, df 4).

Perceptions of clinical leader behaviours

When using Patrick et al.’s 15-item CLS in Part 3, the Cronbach’s alpha score at 0.97 was higher than the 0.86 reported by Patrick et al. (2011). The results (Table 5) indicate that of the 15 items only one item, ‘taking risks’, scored a mean below 4.0 and did not elicit positive responses from at least 75% of respondents. When the leadership practice categories identified by Patrick et al. (2011) in their CLS are aligned to the results, the categories are spread throughout the table, with the exception of challenging processes. All three items from this category appear at the lower end of the table.

Qualitative responses

In Part 4, a total of 38 (57.6%) respondents provided written text. Of these, seven responses were discarded from analysis: two indicated a lack of aesthetic leadership in their area; two criticised their clinical leader’s capability; and three expressed difficulty providing an example of aesthetic leadership. The remaining 31 (47%) responses

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Table 4 Aesthetic leadership characteristics among clinical leaders

<table>
<thead>
<tr>
<th>Part 2 item number</th>
<th>In your opinion your clinical leader...</th>
<th>Descending order by mean (SD)</th>
<th>Strongly agree or agree by frequency (%)</th>
<th>Dimension</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Serves as a model</td>
<td>4.47 (0.827)</td>
<td>60 (90.9)</td>
<td>Sensitivity</td>
</tr>
<tr>
<td>26</td>
<td>Makes a difference with attitude</td>
<td>4.4 (0.749)</td>
<td>62 (93.9)</td>
<td>Approach</td>
</tr>
<tr>
<td>14</td>
<td>Uses appropriate language</td>
<td>4.39 (0.839)</td>
<td>59 (89.4)</td>
<td>Communication</td>
</tr>
<tr>
<td>7</td>
<td>Supports creativity</td>
<td>4.21 (0.851)</td>
<td>57 (86.4)</td>
<td>Support</td>
</tr>
<tr>
<td>16</td>
<td>Reflect emotions appropriately</td>
<td>4.2 (1.034)</td>
<td>56 (86.2)</td>
<td>Communication</td>
</tr>
<tr>
<td>15</td>
<td>Assures with aesthetic leadership</td>
<td>4.17 (0.841)</td>
<td>56 (86.1)</td>
<td>Support</td>
</tr>
<tr>
<td>3</td>
<td>Inspires through aesthetic leadership</td>
<td>4.14 (0.827)</td>
<td>56 (86.1)</td>
<td>Support</td>
</tr>
<tr>
<td>12</td>
<td>Uses body language well</td>
<td>4.11 (0.947)</td>
<td>58 (87.8)</td>
<td>Communication</td>
</tr>
<tr>
<td>2</td>
<td>Creates a culture to activate potential</td>
<td>4.08 (0.756)</td>
<td>52 (81.5)</td>
<td>Sensitivity</td>
</tr>
<tr>
<td>10</td>
<td>Influences beliefs with aesthetic opinions</td>
<td>4.05 (0.759)</td>
<td>52 (80.0)</td>
<td>Approach</td>
</tr>
<tr>
<td>9</td>
<td>Endeavors to encourage</td>
<td>4.05 (0.891)</td>
<td>53 (81.8)</td>
<td>Support</td>
</tr>
<tr>
<td>22</td>
<td>Facilitates aesthetics in workplace culture</td>
<td>4.02 (0.857)</td>
<td>50 (77.0)</td>
<td>Application</td>
</tr>
<tr>
<td>20</td>
<td>Is careful, responsible and practical</td>
<td>4.0 (0.666)</td>
<td>52 (80.0)</td>
<td>Approach</td>
</tr>
<tr>
<td>5</td>
<td>Is sensitive to aesthetics in environment</td>
<td>4 (0.75)</td>
<td>51 (78.4)</td>
<td>Sensitivity</td>
</tr>
<tr>
<td>11</td>
<td>Understands aesthetic expectations</td>
<td>4 (0.829)</td>
<td>51 (81.5)</td>
<td>Support</td>
</tr>
<tr>
<td>1</td>
<td>Creates an aesthetic climate in the clinical setting</td>
<td>3.97 (0.796)</td>
<td>51 (79.7)</td>
<td>Sensitivity</td>
</tr>
<tr>
<td>13</td>
<td>Is specific but pragmatic in applying aesthetics</td>
<td>3.97 (0.809)</td>
<td>49 (75.4)</td>
<td>Communication</td>
</tr>
<tr>
<td>17</td>
<td>Provides new points of view in the aesthetics of leadership</td>
<td>3.97 (0.865)</td>
<td>50 (76.9)</td>
<td>Support</td>
</tr>
<tr>
<td>19</td>
<td>Settle conflicts with an aesthetic concern</td>
<td>3.95 (0.818)</td>
<td>52 (80.0)</td>
<td>Approach</td>
</tr>
<tr>
<td>31</td>
<td>Spreads positive energy around with their lively personality</td>
<td>3.95 (1.059)</td>
<td>50 (75.7)</td>
<td>Communication</td>
</tr>
<tr>
<td>21</td>
<td>Has an aesthetic creativity</td>
<td>3.92 (0.799)</td>
<td>50 (75.7)</td>
<td>Approach</td>
</tr>
</tbody>
</table>

Table 5 General clinical leadership characteristics among clinical leaders

<table>
<thead>
<tr>
<th>Part 3 item number</th>
<th>In your opinion your clinical leader...</th>
<th>Descending order by mean (SD)</th>
<th>Strongly agree or agree by frequency (%)</th>
<th>Leadership practice category</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td>Commits to patient-centred care</td>
<td>4.63 (0.655)</td>
<td>59 (93.6)</td>
<td>Modelling behaviours</td>
</tr>
<tr>
<td>11</td>
<td>Engages in communication with colleagues</td>
<td>4.61 (0.809)</td>
<td>60 (93.7)</td>
<td>Inspiring a shared vision</td>
</tr>
<tr>
<td>12</td>
<td>Actively listens</td>
<td>4.58 (0.864)</td>
<td>61 (93.8)</td>
<td>Enabling others</td>
</tr>
<tr>
<td>5</td>
<td>Works to achieve goals</td>
<td>4.54 (0.686)</td>
<td>62 (93.5)</td>
<td>Modelling behaviours</td>
</tr>
<tr>
<td>3</td>
<td>Negotiates and supports</td>
<td>4.52 (0.793)</td>
<td>60 (92.3)</td>
<td>Inspiring a shared vision</td>
</tr>
<tr>
<td>15</td>
<td>Provides positive feedback</td>
<td>4.52 (0.868)</td>
<td>58 (89.2)</td>
<td>Encouraging others</td>
</tr>
<tr>
<td>6</td>
<td>Develops cooperative relationships</td>
<td>4.51 (0.812)</td>
<td>61 (93.9)</td>
<td>Enabling others</td>
</tr>
<tr>
<td>4</td>
<td>Follows through on promises</td>
<td>4.49 (0.773)</td>
<td>58 (89.5)</td>
<td>Modelling behaviours</td>
</tr>
<tr>
<td>2</td>
<td>Celebrates colleagues’ achievements</td>
<td>4.49 (0.812)</td>
<td>61 (93.8)</td>
<td>Encouraging others</td>
</tr>
<tr>
<td>7</td>
<td>Facilitates meaningful conversations</td>
<td>4.45 (0.811)</td>
<td>59 (90.8)</td>
<td>Inspiring a shared vision</td>
</tr>
<tr>
<td>9</td>
<td>Establishes therapeutic relationships</td>
<td>4.45 (0.830)</td>
<td>59 (90.8)</td>
<td>Enabling others</td>
</tr>
<tr>
<td>10</td>
<td>Engages in reflexive practice</td>
<td>4.44 (0.889)</td>
<td>58 (90.6)</td>
<td>Challenging processes</td>
</tr>
<tr>
<td>14</td>
<td>Acknowledges colleagues’ values</td>
<td>4.40 (0.898)</td>
<td>58 (89.3)</td>
<td>Encouraging others</td>
</tr>
<tr>
<td>8</td>
<td>Uses evidence-based rationale</td>
<td>4.37 (0.894)</td>
<td>56 (86.4)</td>
<td>Challenging processes</td>
</tr>
<tr>
<td>1</td>
<td>Takes risks</td>
<td>3.30 (1.049)</td>
<td>43 (66.1)</td>
<td>Challenging processes</td>
</tr>
</tbody>
</table>

described clinical situations where they believed aesthetic leadership was shown. Using aesthetic leadership dimensions used in the ALS (Polat & Oztropak-Kavak 2011) as a framework for analysis, these complete narratives indicated that two or three dimensions were evident when clinical leaders demonstrated aesthetic leadership. The narratives were either about direct patient care, physical aspects of the clinical setting, individual encounters with staff or interaction with the clinical nursing team. The focus of the clinical situation shaped which aesthetic leadership dimensions were evident.

Aesthetics of patient care
When focused on patient care, sensitivity of the clinical leader and approach taken in interactions with the patient were evident. As Respondent 16 reported:
I witnessed a RN take the time to put lipstick on a depressed 92 year old who was usually meticulous with grooming and presentation prior to the depression, the simple gesture enabled the patient to leave her room for the first time in 2 weeks.

Clinical setting aesthetics

For some, aesthetic leadership occurred when leaders considered the setting aesthetics. Respondent 29 recounted when both an aesthetic approach and application were evident when the nurse leader:

... included attention to the physical (hospital) environment. It needed to be welcoming and comfortable for patients and families. Wall paint colour, fresh flowers, comfortable clean modern furniture were all considered and given importance.

Aesthetics of individual encounters

All descriptors involving clinical leaders interacting with individual nurses included the communication dimension, in combination with one other aesthetic leadership dimension. Respondent 3 recounted the support received when a clinical leader:

... supported the respondent, actively listened, assisted with the job application, supported the process, continues to support even though I am working in another team.

Other descriptions highlighted the clinical leaders' approach when communicating with individual staff and patients. It was evident a clinical leader's demeanour can shape encounters in clinical settings. Of the descriptors that highlighted a leader's approach, Respondent 27 indicated the clinical leader kept calm when dealing with a disgruntled surgeon, and Respondent 9 recounted the following situation:

Clinical Leader was being challenged by a senior staff member ... able to listen and provide feedback while remaining calm and using evidence-based practice.

Aesthetic leadership with nursing teams

Situations where leadership within nursing teams were recounted highlighted the importance of the clinical leader's approach, being the only aesthetic dimension present in all 14 examples in this category. In these examples, the clinical leaders' approach was linked with the aesthetic dimensions of support (n = 6), communication (n = 5), sensitivity (n = 5) and application (n = 3). Four exemplars combined approach with more than one other aesthetic dimension. Respondent 24 described an approach that required both sensitivity and support from the clinical leader:

Recently a colleague died in a car accident. The clinical leader went out of her way to support the staff, went to the funeral, organized time post the funeral so we could debrief, reflect and enjoy each other's company. She was emotionally aware, empathetic, supportive and directed us appropriately.

Being able to combine aesthetic leadership dimensions in contemporary clinical settings can result in positive change, as evidenced through the leader's approach and application to workplace bullying.

I am not sure what aesthetic means in this context but assume it is about goodness! I have seen effective goodness in leadership in tackling extensive bullying culture by the leader putting a stop to all forms of pampering. This made a huge positive difference to the mood and culture. [Respondent 19]

Communication is also an important aesthetic dimension for clinical leaders when they approach their leadership activities, as Respondent 13 recalled:

A senior registered nurse who, despite our often chaotic clinical environment, is graceful, peaceful and confident ... approaches each patient and staff member as if they are the only person in the setting at the time, allowing time for sound communication and planning.

Discussion

While the response rate to the survey remained unknown, respondents were drawn from an ageing and experienced workforce, reflective of the current global nursing workforce demographic (AIHW 2013, International Centre for Human Resources in Nursing 2008). Respondents were mainly female; although based on current nursing workforce gender mix (AIHW), males were slightly overrepresented in the current study. Reasons for this are not apparent, however, it may be a reflection of factors around the nonclinical nature of the topic area, the overrepresentation of males in management and other nonclinical positions in nursing (AIHW), or the recruitment strategies. For an experienced and ageing workforce, it was notable that among the sample group, while the majority of respondents (68.2%, n = 45) have been nursing for more than 10 years, <20% (n = 13) of respondents had been in their current position for more than seven years. Again, reasons were not obvious but could be a reflection of the opportunities available to experienced nurses in an environment of global nursing workforce shortages (Buchan & Cadman 2005).

The various aspects of aesthetic leadership as determined by Polat and Özoğraflı-Kavak (2011) in their factor...
analysis of school directors were apparent from the survey responses. These responses are also reflected in the social science literature (Katz-Buonincontro 2011). Survey respondents indicated the aesthetic dimensions most evident and perhaps most desirable in effective clinical leaders are those around providing support, being an effective communicator and providing leadership that indicates an appreciation of how clinicians feel about clinical situations. The importance of support from clinical leaders was evident from the survey results and not surprising in the increasingly complex clinical nursing workplaces, likened to a perfect storm (Jackson & Daly 2010), where clinicians experience challenges around staffing skill mix, increasing patient acuity levels and organisational demands.

Supporting colleagues through leadership can reflect clinical leaders’ understandings of the nature of clinical nursing, especially in complex situations. Carper (1978) identified empathy and perception as critical elements in the aesthetic pattern of knowing, arguing that nurses who are skilled in these areas will have a better understanding and greater knowledge of an individual’s reality. As Hansen et al. (2007) highlighted, this aesthetic knowing is derived from a less tangible tacit knowing associated with sensory experiences around thoughts and feelings. Effective clinical leaders have been shown from study narrative accounts reported in this paper to possess these skills and be able to embody and model behaviours that produce a positive and calming influence in difficult clinical situations. These findings support those by Stanley (2006, p31) who reported that nurses identified being calm and tranquil as desirable characteristics in clinical leaders. More recently, a study found clinical leaders in mental health nursing who demonstrated calmness and confidence during a crisis positively affected the nursing workplace (Ennis et al. 2014).

It is perhaps this desire to create positive and calming clinical environments that found clinical leaders being reluctant to take risks or challenge existing processes. As identified earlier, taking risks rated as being least likely to be observed in an effective clinical leader. This reluctance to take risks is not reported in the nursing literature. Conversely, risk taking has been identified as a significant attribute of nursing leadership in different settings (Pearson et al. 2014). Another perspective to consider on this low rating of risk taking among clinical leaders could be related to gender. While the findings of studies on risk taking and gender are varied, some studies indicate women are more risk adverse and that when women replace men in senior management positions, the level of risk taking decreases (Elsaid & Ursel 2011). Sheaffer et al. (2011) found a link between masculine traits, crisis proneness and noticeable risk taking among leaders. While domination of females in the nursing workforce is acknowledged (AHW 2013), little emphasis is evident on the influence of gender on clinical leadership effectiveness in nursing. Cummings et al. (2008) called for further research into gendered behaviours of nursing leaders after completing a systematic review of factors contributing to effective nursing leadership.

Strengths and limitations

While not uncommon when surveying nursing populations (see e.g. Hutchinson et al. 2010), the sample size from the survey was small. Analysis of the quantitative survey data could have been more rigorous with a larger sample. The large number of respondents who provided narrative data enhanced the study. If the online survey was to be repeated, strategies to increase recruitment could be employed, for example, setting up a specific study Twitter account and sending individual emails via e-learning platforms (Manolix et al. 2014). Finally, given the findings around risk taking, the survey would seek to identify the gender of the clinical nurse leader considered by respondents.

Conclusion

Aesthetic leadership has been perceived in this study as multi-dimensional and a style of leadership with the potential to positively influence the clinical workplace. Effective clinical leader behaviour was reported to be less likely to involve taking risks or challenging processes, perhaps in an attempt to create a calm and positive workplace for their colleagues. Survey results revealed that support, effective communication and considering the feelings of colleagues are important dimensions of aesthetic leadership. Respondents’ narratives indicated that the particular clinical focus shapes the aesthetic dimensions used by effective clinical leaders.

Relevance to clinical practice

Aesthetic leadership offers an alternate framework of leadership for clinical leaders who aim to create and sustain a calm and positive workplace for staff to feel well supported. To encourage this, senior nursing management need to ensure that continuing education for nurse leaders engaged in clinical practice focus on offering strategies and skills that embody the aesthetic dimensions around providing support, being sensitive and communicating effectively. Nursing needs to consider the possible effect of gender on clinical leaders’ capacity to crisis manage situations in
complex clinical workplaces. Survey findings reported in this paper around risk taking highlight the necessity for nursing leadership to perhaps rethink support for leadership programmes for clinical leaders that identify taking risks as an attribute necessary for leadership effectiveness. In clinical nursing workplaces that may not be the case.

Disclosure

The authors have confirmed that all authors meet the ICMJE criteria for authorship credit (www.icmje.org/ethical_1

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References


Chapter 7: ‘Good ethics and moral standing’: a qualitative study of aesthetic leadership in clinical nursing practice

7.1. Publication:


7.2. Relevance to thesis

This paper is the first of two papers that present qualitative findings from the larger study. The focus of this paper involves gaining insights from registered nurses in designated clinical leadership roles of their views on how aesthetic leadership is embodied by clinical leaders in the workplace. Findings reported in this paper revealed that when clinical leaders embrace aesthetic leadership, with its strong moral dimension, it can have positive effects on the nursing workplace. These findings informed the development of the artful clinical leadership model presented in Chapter 9.
‘Good ethics and moral standing’: a qualitative study of aesthetic leadership in clinical nursing practice

Judy Mannix, Lesley Wilkes and John Daly

Aims and objectives. To explore how aesthetic leadership is embodied by clinical leaders in the nursing workplace.

Background. A number of different leadership styles have been developed, theorised and applied to the nursing workforce over the years. Many of these styles lack an explicit moral dimension in their identified leader attributes, due to a shift in theorising of leadership to focus on the impact of leader traits on followers. It is timely to look at aesthetic leadership, with its explicit moral dimension, as a way of improving outcomes for nurses, patients and health care organisations.

Design. Qualitative design, using conversation-style interviews with experienced registered nurses in designated clinical leadership roles.

Methods. Twelve experienced registered nurses who worked in designated clinical leadership roles participated in an individual, digitally recorded, semi-structured conversation-style interview. Narrative data were transcribed and subject to thematic analysis.

Findings. Three main themes emerged: ‘True to their beliefs’: embodying principled practice; ‘Not all policies fit every patient’: ethical leadership in ambiguous situations; and ‘Being open to people’s concerns’: providing fair and just solutions. A strong moral compass shaped and guided participants’ day-to-day clinical leadership activities.

Conclusions. Participants provided a rich narrative on how aesthetic leadership is embodied in the clinical nursing setting. It was evident that their clinical leadership is shaped and guided by a strong moral compass. By incorporating into their practice an aesthetic world-view with its strong moral purpose, participants in this study have shown how aesthetic leadership can enhance the clinical nursing workplace.

Relevance to clinical practice. Nurses in the clinical setting value clinical leaders who embrace and operate with a strong moral compass. Aesthetic leadership, with its explicit strong moral purpose, offers a way of incorporating morality into clinical leadership in the nursing workplace.
Key words: aesthetic leadership, clinical leadership, ethics, moral compass, nursing, qualitative research

Accepted for publication: 4 December 2014

Introduction and background

A number of different leadership models or styles have been developed, theorised and applied to the nursing workforce over the years, and can be categorised as either being relational styles (for example, transformational, resonant) that focus on people and relationships or task-focused styles of leadership (for example, transactional, instrumental) that concentrate on completion of tasks and meeting deadlines (Cummings 2012). While it is evident that clinical leaders do not apply one particular leadership style to all situations, preferring to mix styles (Cummings 2012), in recent years transformational leadership has been often offered as a preferred style for clinical nursing workplaces (McIntosh and Tolson 2009, McNamara et al. 2014). It has been the favoured style of leadership in clinical leadership programs offered to nurses (Martin et al. 2014) and as an essential in achieving positive organisational outcomes in health care (Leggat and Balding 2013). However, despite the increasing dominance over at least the past 15 years of this style of clinical leadership in health care, reports calling for more effective clinical leadership in health care have been produced recently in both Australia (Garling 2008) and the United Kingdom (Francis 2013).

The preference for transformational leadership and the current problems in achieving effective clinical leadership for positive outcomes highlight possible shortcomings with current leadership styles being used widely in the nursing workplace. In their critique of transformational leadership, Hutchinson and Jackson (2013, p. 11) argue that the theorising of leadership has shifted from a philosophical intent to grasp and apply the 'the values, ethics and morality' of leader attributes to theorising about how charismatic leader traits impact on followers. In nursing, there are clear expectations that nurses behave ethically and with a strong sense of morality. Nurses across the world are guided by a code of ethics that reflects the profession's commitment to respect, safeguard and advocate for the basic rights of people involved with nursing and health care (Nursing & Midwifery Board of Australia 2008). To behave ethically there is an assumption that the moral worth one assigns to their chosen actions is done so with the intention for those actions to be for the greater good (Grazi 2008). In other words, ethical behaviour is derived from a strong moral dimension.

It is perhaps timely to look for alternate styles of leadership with an explicit moral dimension as a way of improving outcomes for nurses, patients and health care organisations. One leadership style that could provide this is aesthetic leadership, a style of leadership that has been experiencing increasing attention in the wider leadership studies literature over the last decade. Aesthetic leadership has been variously described and defined as a style of leadership shaped by 'sensory knowledge and felt meaning' (Hansen, Ropo & Suter 2007, p. 552), as a way of planning and facilitating free flow between management, administration and aesthetic fields in organisations (Guillet de Monthoux et al. 2007), and a style of leadership where leaders share an aesthetic vision with followers so they too embody aesthetic meaning (Polat & Oztoprak-Kavak 2011). In her analysis of the literature to determine the relationship between aesthetic knowing and leadership Katz-Boonincontro (2011) identified four aesthetic leadership qualities, one of which was the "promotion of moral purpose", a quality encompassing values like truth, reason and being just, in order for leaders to encourage people to work together for the greater good.

The extant leadership literature in nursing is almost devoid of discussion on aesthetic leadership. This is somewhat surprising, given the seminal work of Carper (1978) in identifying aesthetics as one of the four fundamental patterns of knowing in nursing. Subsequent analysis and development of aesthetics has occurred in nursing in general (Wainwright 2000, Gaydos 2003, Freshwater 2004). Brown (1991) linked nursing's core value of caring with the art of nursing and aesthetics, arguing that the leadership role of nursing administrators can influence the enactment of this core value by other nurses. Jackson et al. (2009) proposed a theory of nursing leadership that includes Carper's patterns of knowing where nurse leaders can practice evidence-based leadership that incorporates empathy, vision, flexibility, respect, morality, political astuteness and transformative behaviours. Hujala and Rissanen (2011), in their study of organisational aesthetics and nursing management
Aesthetic leadership in clinical nursing practice

Methods
After Institutional Human Research Ethics Committee approval was granted for the study, this qualitative component of the larger, mixed-methods study was conducted over two months in 2013. For this qualitative part of the study, it was thought important by the research team to engage with experienced registered nurses who worked in designated clinical leadership roles in nursing. Registered nurses employed in designated leadership roles in clinical settings are generally regarded as advanced practitioners in their own clinical specialty (McNamara et al. 2011), guided by specific domains of practice that include expectations of competent clinical leadership (Fy et al. 2013; Gregorowski et al. 2013). Therefore, registered nurses in such roles were purposively selected and invited to participate in an individual, semi-structured conversation-style interview about aspects of clinical leadership. Specifically, the conversations with participants explored what they thought effective clinical leadership looked like in the clinical setting and the influence or otherwise of aesthetics on the clinical nursing workplace. By taking a qualitative approach to this part of the study and targeting registered nurses with appropriate experiences the study’s credibility was strengthened (Gabrielle et al. 2008). Twelve registered nurses agreed to participate in a digitally recorded interview with a member of the research team. All participants were experienced nurses with between 10–35 years’ experience, gained from diverse clinical areas including adult acute care, paediatrics, mental health, residential aged care, and community health. To further enhance the study’s rigour, one member of the team conducted all of the interviews, either face-to-face or via telephone, after participants provided informed written consent.

All interviews were conducted at a mutually agreed time and place, and lasted from 30 to 60 minutes. The number of participants was determined when data saturation was reached. All interviews were transcribed verbatim for subsequent analysis. Pseudonyms were assigned to each participant to enhance confidentiality. The principles of thematic analysis shaped the analysis of the interview transcripts. Transcripts were initially read and re-read by a member of the research team to ascertain an impression of meaning (Borbasi & Jackson 2012). An inductive approach was taken to the search, development and review of themes (Vaimorari et al. 2013). Credibility and trustworthiness of the three emergent themes were further tested by another researcher reviewing the findings to ensure the intended meaning was truly represented (Graneheim & Lundman 2004).

Findings
Three main themes focusing on ethical and moral dimensions of aesthetic leadership in clinical nursing emerged from analysis of the conversations with the participants:

- ‘True to their beliefs’: embodying principled practice;
- ‘Not all policies fit every patient’: ethical leadership in ambiguous situations;
- ‘Being open to people’s concerns’: providing fair and just solutions.

Within each of these three themes it was apparent that the participants’ own strong moral compass shaped much of their day-to-day clinical leadership.

‘True to their beliefs’: embodying principled practice
The overwhelming sense gained from the conversations with the participants was that each of them was working in nursing by choice rather than necessity, and that the way in which they conducted themselves in their day-to-day clinical practice was shaped by a strong sense of pride in and passion for nursing as a profession. They conveyed an understanding of the importance of their work as clinical leaders in contemporary nursing, believing that being critically reflective was an essential part of their practice.

A number of the participants conveyed the importance of belonging to a profession and contributing to the profession through their activities and actions. There was acknowledgment that ‘gaining knowledge and expert knowledge’ [Tony] and having ‘ties to their professional body’ were essential because as Jackie continued, clinical leaders ‘... have a vested interest in what’s happening to their profession and what’s happened over time and where it’s going in the future’. Sam valued his Masters level education because he believed that it ‘turned me from a questioning person into a critical thinker’.

It was also important ‘to have good ethics and moral standing’ [Jackie] in professional interactions in clinical settings. Some participants highlighted instances where, while not managers, clinical leaders needed to highlight inappropriate and unprofessional behaviours to nursing colleagues, such as making derogatory comments about patients or being dismissive and rude to patients and families. Sandra expressed this sense of professional pride and a moral
stance in the following situation with anxious patients and families in an Accident and Emergency department:

I’m embarrassed to be on the same side as them [nursing staff] and I sort of feel obliged to go and I’d step in and go ‘If you like, actually give me five minutes, I’m not actually working here, I’m just dropping in some papers, but I will check what they are doing and where you are’, that’s all they [patients & families] wanted.

Participants indicated the importance of being reflective about how they conduct themselves during their day-to-day clinical practice activities. To do this, clinical leaders recognised the importance of having ‘insight’ [Denise], ‘time to reflect’ [Tony], and ‘be self-aware of their weaknesses and strengths so that they can – because we all have weaknesses’ [Nola]. There was also recognition of how their practice influences those around them including colleagues, consumers of health care and the systems operating in and around the clinical setting. At the same time, there was an acknowledgement that clinical leaders can be nurses who are not necessarily in designated leadership positions, including enrolled nurses and junior registered nurses. Jackie identified an enrolled nurse as a clinical leader who was ‘a very good problem solver, she’s also reflective in her practice’.

It was also important among the participants for there to be recognition that clinical leaders are not infallible. As Barb commented, it is important ‘to be able to say, look I didn’t get that right, and look at your practice and learn from it; that is really important’. Although the participants indicated the importance of a strong leadership presence in clinical settings there was also a sense of humility among the participants, reflected by Sam when he commented, ‘you have got to know that there are many ways of doing things and sometimes your way may not be the correct way’.

Clear among the participants was a love for what they did as clinicians and a passion about nursing. Along with a passion for their work Kate felt it important to have ‘a focus and a vision of how you want things to be’, along with ‘commitment’. Indicative of this commitment, Kate continued, ‘I don’t know whether this is right or wrong, but I do stuff outside work in my own time, because I just want to get it done’. Similarly, Amy’s comments reflected passion and commitment when she said:

I’m a person – I’m quite willing to put in the hours. Like I could quite happily work 10 hours, 12 hours, that’s sort of my work style. My ethics are basically, I’m here for the patients so I’ll do what I need to do to make sure that everything is kosher I suppose, if that’s the right word.

Participants recognised the link between passion and commitment in other clinical leaders. As Denise commented, ‘she was a clinical nurse specialist, she’s a leader, very passionate about paed [paediatrics]’. Feeling connected to their job and recognising its value were also identified as important aspects of clinical leadership. As Sam explained, clinical leaders:

...have to like their job, I don’t call it passion... but they have to feel a connection where their job is something that’s important. Maybe not the most important thing in their world but it’s something that’s important to them... not something they are paid doing because they have to pay the mortgage or because they have to get out of the house, I think they have to feel some connectivity to their position so that they appreciate the value of it and then they feel the ability to share that value.

‘Not all policies fit every patient’: ethical leadership in ambiguous situations

It was apparent among the participants that there often were situations in the clinical setting that required decisions that did not necessarily comply with organisational policies and procedures. In such situations, participants relied on their explicit and implicit nursing knowledge and ontological understandings of the clinical situation. Participants also acknowledged the importance of policies to guide practice and as a part of organisational risk management, conceding that ‘sometimes you just have to eat concrete, I think because everything is black and white, there’s no shades of grey’ [Jackie] and at other times, necessary ‘to follow policies and procedures and things so that it doesn’t come to a complaint’ [Tony]. However, they indicated that, at times, it was appropriate and necessary to take on an advocacy role to contravene or challenge policy.

In such cases clinical leaders tended to prioritise the needs and best interests of the patient and their family over policy imperatives, commenting that ‘not all policies fit every patient’ [Jackie]. Jackie offered the following example:

You know, this [policy] nobody is allowed to have leave from your unit because it’s a crisis unit and their dad is upstairs dying and he’s got hours to live, then he needs to go up there, I’m sorry, I don’t care about the policies, we’ll take him up there, we’ll make sure he’s safe and we’ll sit with him and we’ll bring him back.

Similarly, Sandra recalled a clinical situation where policy imperatives were secondary to the immediate needs of and respect for the patient, his family and the needs of nursing staff. It involved a young man with cerebral
irritation, his family and policy on visiting hours. Sandra recounted that the patient's family were very involved with his ongoing care, 'feeding him, doing exercises' and settling him. Staff members requested the young man's family to leave at the end of visiting hours, 'because that's the policy, we, you know, visitors have to leave'. As Sandra commented:

why would you do that, just because it's a policy? And you know policies, they're not black and white, there's a grey area - if you want to utilise policy to your advantage you know, your work to policy you know, you've got to - it helps the patient, it helps you, because why would you want to sit there when the family are more than happy to do it, he's their son, you know. He might be 27 but he's in a vegetative state at the moment and you are never going to stop him being their child.

Participants felt that clinical leaders needed to challenge policy to protect patients' rights, affect change or achieve a resolution to clinical problems. To do this, it was important for clinical leaders to 'be prepared to step up to that mark' [Barb] and 'be articulate, because they are the future of our profession; so they need to be able to step up amongst the senior management people, they need to be able to put a case' [Fran]. At the same time, clinical leaders needed to take into consideration the skill mix of available nursing staff. Resolving clinical problems require clinical leaders to take a multi-level, strengths-based approach, as Tony expressed:

Develop those main strengths by giving them [nursing staff] support, by giving them education, by doing what they really like doing. Rather than everybody have to do exactly the same because the policy says that or because the procedure says that.

On occasions, participants revealed it was necessary for clinical leaders to challenge policies and protocols to achieve positive outcomes for patients and staff. In such situations, clinical leaders used different approaches, dependent on the circumstances. One approach was recounted by Sandra who felt it important for a patient's well being to remain in an Intensive Care Unit (ICU) rather than be transferred to a general ward. In this situation she needed to mount an argument with medical staff, stating that this required her 'to go toe to toe with them when they're doing it not right for that particular patient'. In doing so, she used existing policies and protocols to strengthen her stand, indicating to the doctor that:

as soon as they hit the ward I'm calling the MET [Medical Emergency Team] call and you're on the team...I'm going to take MET call after MET call after MET call - this patient cannot go to the ward and they'll go, OK.

Another situation where accepted protocols were challenged by a clinical leader also occurred in an ICU setting. In this case the clinical leader was keen to continue nursing a patient with critical head injuries following a motor vehicle accident. Belle recalled:

...you don't normally get a patient two days in a row... but what she requested that she could because she'd actually formed this good rapport with the family and she wanted to see certain things through.

In solving problems and resolving difficult situations the participants demonstrated that their decision-making as clinical leaders was guided by a strong moral compass. Having this confidence allows them to challenge decisions by medical staff and advocate for patients and staff.

'Being open to people's concerns': providing fair and just solutions

The capacity to provide clinical leadership with confidence, supported by a strong clinical knowledge base and a clear sense of what is right also enabled participants to be very perceptive when reading clinical situations. They were observant and intuitive, and quick to ascertain what the priorities should be in a given clinical situation. Accompanying these skills and confidence was a level of political astuteness in understanding how to facilitate change. Sandra showed this when she recounted a situation that occurred in an acute clinical setting that was experiencing problems. As she recalled:

I wrote a letter and highlighted all our issues - the OH&S problems, how the staff were feeling about it, and got every person in the department, the social workers, the medical staff - everybody signed it, no exceptions. So it was not, "you did this", it was very professionally done, I made sure it was not critical of anyone, it was just these are the issues and within 24 hours we had a meeting with the admin and someone from the union came down - they placed an ad that week and we got three new full time staff out of it.

Participants also had a clear idea of how to successfully facilitate change and implement new procedures into the clinical setting. Rather than simply imposing change, clinical leaders took an approach that involved being politically insightful with the change process, by spending time with nursing staff affected by the change and ensuring they felt safe to manage the changes. As Amy commented, 'a really big quality of a leader is empowering others rather than do as I say type mentality'.

It was also evident from the participants that they had a vision for how things should be in the clinical setting and
how to work towards particular goals. What was apparent among these clinical leaders was a sense of how to ensure other nurses shared their vision. They spoke of being ‘just being fair, being open to people’s concerns’ [Tony], the need to ‘get everyone excited so they’ll also want to work towards that same vision’ [Amy], and ‘to look at the positives and see what people can bring because they can all bring good stuff... there’s good in everybody’ [Kate].

Some of the participants recounted situations where clinical leaders enacted their vision, from an individual patient perspective through to a clinical setting standpoint. One such recollection from Belle described the vision a clinical leader had for the family of a brain-dead patient who was having treatment withdrawn and how this particular nurse orchestrated the final hours of his care:

... so on this final day she was intent on having that patient looking perfect for the family. It was all about the family coming in and seeing him, the key people in this guy’s life. And she said she wouldn’t come in, she’d diverted the monitors so she wouldn’t have to go in and peek, do anything, so that was one thing she did, guard those curtains with her life. You had people, radiologists coming through and pathologists and all sorts of doctors walking through and she was like this guard dog. You knew when they go past and the curtain’s sort of open, you know she had all her senses open, she didn’t have lunch break, morning tea break, because she just wanted to give to the family the opportunity to say goodbye.

Once treatment was withdrawn, the clinical leader’s vision was that his family be there when he died in an environment that was aesthetically appropriate. To achieve this, she manipulated the clinical environment so that ‘within that instant that whole space that patient was in was turned from a clinical space to a palliative space’ [Belle].

In the process of ensuring fair and just solutions were reached for clinical issues the participants all spoke of the importance of working with other staff in the clinical setting. To do this, participants felt that clinical leaders needed ‘to be flexible, listen to the feedback, be able to adapt’ [Sam], and have ‘good relationships, trust, be empowering and encouraging to others’ [Amy]. The importance of valuing individual members of the clinical team was also evident in the conversations with participants. This was accompanied by a strong sense of equality in their interactions with others, ‘whether it’s another nurse or patient or a doctor... I think that we’re all on the same level as a doctor, nurse, cleaner’ [Nola]. Kate also reflected this sentiment when she said, ‘the focus is, let’s work together’.

The importance of the clinical team was also reflected in the actions of Denise after three months in a new clinical area. She recalled, ‘as I got to know people I then approached my line manager and said, “this unit needs some team building, this is a fractured unit”’. The subsequent facilitation of team building days ‘was really good for the unit’. Building a cohesive team in the clinical setting was viewed as an important aspect of clinical leadership and quality patient care, so that the ‘team do the best they can’ [Nola].

Another aspect for clinical leaders to embrace when working with colleagues is to act as a resource person while remaining respectful. Clinical leaders need ‘not be driven by pride where you say “It’s my way or else”. You’ve got to leave your ego at the door’ [Sam], ‘be humble enough to say if it doesn’t work then I’m happy to do this’ [Nola] and demonstrate leadership that says, ‘it’s not just about me’ [Denise].

Discussion

Leadership effectiveness requires clinical leaders to have a clear idea of their own values (Emmons 2012) and for those values to be reflected in their actions in the clinical setting (Stanley 2014). The conversation-style interviews conducted with the 12 experienced registered nurses who worked in identified clinical leadership positions provided a rich narrative on how their own values and beliefs, guided by a clear ethical stance and strong moral compass, shaped their clinical leadership activities and affected those around them. By encompassing values that foster morality, clinical leaders who practice aesthetic leadership are positioned ideally to promote a strong moral purpose among those engaged in clinical practice, thereby encouraging teamwork and a desire to do good (Katz-Buonincontro 2011). Participants revealed that others (patients, nurses, families) responded positively to their aesthetic leadership style when it embodied a need to do the right thing in clinical situations. Guided by a strong sense of ethics and morality, participants positioned others as central to decisions that shaped their actions. It was also apparent that the ways in which these decisions were crafted were appreciated by others in the clinical setting.

The values and beliefs one holds influences the way difficult situations are managed (Wright 2013). Having values and beliefs supported by a strong moral compass allowed participants to have a clear sense of what is ethically right in ambiguous and sometimes difficult clinical situations. Because of this level of confidence, participants had the strength to speak and challenge policy when needed and also be strong and effective advocates for patients and colleagues. In clinical settings where clinical leaders, rather than show this strong ethical leadership, avoid making decisions or remain ambiguous with their responses, the consequences can have detrimental effects on the nursing workplace.

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Avoidant leadership behaviours have been shown to ‘erode the ethical character of the workplace’ and challenge nurses’ trust in an organisation to support them (Jackson et al. 2013, p. 577). Colleagues of the participants in this study trusted the decisive, ethical decision-making and leadership shown where ambiguity surrounded some clinical issues.

It was evident in this study that participants were able to encourage, inspire and empower others in the clinical setting. Participants spoke of the importance of humility and valuing colleagues for what they could contribute, rather than dictating to them through a sense of positional power. To do this consistently, leaders need to possess a strong moral compass (Wright 2013), along with the capacity to capture the attention and imagination of others in the workplace. It was also apparent that participants were at times required to be courageous when challenging the status quo to achieve positive outcomes and stay true to their own moral compass in difficult situations. This moral courage requires clinical leaders to take a stand, sometimes involving the risk of disapproval from others, and isolation (Clancy 2003). Without moral courage clinical leaders run the risk of becoming ineffective and uninspiring leaders (Horton-Deutsch & Mohr 2001), unable to advocate for patients (Kerfoot 2012) and affect a positive clinical workplace.

Strengths and limitations

The recruitment and participation of very experienced registered nurses who were engaged in designated clinical leadership roles were strengths of this part of the study, mainly because it resulted in a rich narrative on aspects of contemporary clinical leadership. Conversely, the relatively small number of participants, drawn from only one state of Australia could be considered study limitations. Nevertheless, the findings reported in this paper add to an understanding of how aesthetic leadership’s moral dimension is embodied in contemporary clinical leadership.

Conclusion

Twelve experienced registered nurses who worked in designated clinical leadership roles provided a rich narrative on how aesthetic leadership is embodied in the clinical setting. It was evident that for the participants, their clinical leadership is shaped and guided by a clear ethical stance and strong moral compass. Recognising the need for effective clinical leadership, based on coherent values and beliefs and guided by a strong moral dimension is not new in the nursing discourse. Horton-Deutsch and Mohr (2001) argued that without strong leadership, nursing fails patients both morally and ethically, and also fails to take charge of the future of the nursing profession. By embracing a leadership style that incorporates an aesthetic world-view with a strong moral purpose, participants in this study have shown how aesthetic leadership can be embodied by clinical leaders and thereby enhance the clinical nursing workplace.

Relevance to clinical practice

Current leadership styles promoted in the clinical nursing workplace have either focused on establishing effective relationships with colleagues or have a task-orientation and lack an explicit moral dimension. It is evident from the findings of this study that nurses in the clinical setting value clinical leaders who embrace and operate with a strong moral compass. Aesthetic leadership, with its explicit strong moral purpose, is one leadership style that can offer a way of incorporating morality into clinical leadership in the clinical nursing workplace.

Disclosure

The authors have confirmed that all authors meet the ICMJE criteria for authorship credit (www.icmje.org/ethical_2author.html), as follows: (1) substantial contributions to conception and design of, or acquisition of data or analysis and interpretation of data; (2) drafting the article or revising it critically for important intellectual content, and (3) final approval of the version to be published.

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References


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Chapter 8: ‘Watching an artist at work’: aesthetic leadership in clinical nursing workplaces

8.1. Publication:


8.2. Relevance to thesis

This paper reports qualitative findings that sought the views of registered nurses on how aesthetic leadership is enacted by clinical leaders in the nursing workplace. Clinical leaders were shown to positively influence the workplace by having the capacity to be self-reflective and visibly incorporate nursing values into their day-to-day practice. As well, being a visible, composed role model emerged as an important consideration for clinical leaders. While there are some commonalities with other leadership models in use in nursing, the capacity to lead with composure was uncovered as an important attribute for clinical leaders. These findings also informed the model of artful clinical leadership presented in the final chapter of this thesis.
ORIGINAL ARTICLE

‘Watching an artist at work’: aesthetic leadership in clinical nursing workplaces

Judy Mannix, Lesley Wilkes and John Daly

Aims and objectives. To explore how clinical leaders enact aesthetic leadership in clinical nursing workplaces.

Background. Clinical leadership is heralded as vital for safe and effective nursing. Different leadership styles have been applied to the clinical nursing workplace over recent years. Many of these styles lack an explicit moral dimension, instead focusing on leader qualities and developing leader competence around team building, quality and safety. Aesthetic leadership, with its explicit moral dimension, could enhance clinical leadership effectiveness and improve nursing workplaces. How aesthetic leadership is enacted in clinical nursing settings requires exploration.

Design. A qualitative design, employing conversation-style interviews with experienced registered nurses and written responses gathered from an online descriptive survey.

Methods. Narrative data were gathered from interviews with 12 registered nurses and written accounts from 31 nurses who responded to an online survey. Together, transcribed interview data and the written accounts were subject to thematic analysis.

Results. Three main themes emerged: Leading by example; ‘be seen in the clinical area’; Leading with compassion: ‘a sense of calm in a hideous shift’; and Leading through nursing values: ‘create an environment just by your being’.

Conclusions. Aesthetic leadership was shown to enhance clinical leadership activities in the nursing workplace. The capacity for clinical leaders to be self-reflective can positively influence the nursing workplace. It was apparent that clinical leader effectiveness can be enhanced with nursing values underpinning leadership activities and by being a visible, composed role model in the clinical workplace.

Relevance to clinical practice. Aesthetic leadership can enhance clinical nursing workplaces with its explicit moral purpose and strong link to nursing values. Clinical leaders who incorporate these attributes with being a visible, composed role model have the capacity to improve the working lives of nurses across a range of clinical settings.

Key words: aesthetic leadership, clinical leadership, nursing, qualitative design

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What does this paper contribute to the wider global clinical community?

- Reveals how clinical leaders can positively affect outcomes in clinical settings through their leadership skills and knowledge.
- Supports aesthetic leadership as a suitable style of leadership for clinical leaders to incorporate into their leadership practice.
- Contributes to an enhanced understanding of the importance of being visible and composed as clinical leaders.
- Reinforces the importance of nursing values in the day-to-day activities of clinical leaders.
Introduction and background

Health care systems across the world increasingly are required to provide quality health care services with seemingly fewer resources. The responsibility for providing quality health care in this environment can be collectively shared across the health workforce. However, the burden of responsibility for ensuring that quality care is produced and delivered consistently in clinical settings settle on the shoulders of clinical leaders and managers. These expectations occur in clinical workplaces that have been described metaphorically as perfect storms due to workforce shortages, staff skill mix problems, patient demands and diminishing resources (Mannix et al. 2013). Effective clinical leadership has been put forward by professional nursing organisations and government-sponsored enquiries as the remedy for the ills of the nursing workplace (Mannix et al. 2013) and has been identified as a way to increase job satisfaction among nurses (Kaddourah et al. 2013).

While transformational leadership is the dominant leadership style in nursing in recent decades (Cummings et al. 2010), it is not a style of leadership with specific application to clinical leadership (Stanley 2008). Other relational-oriented and task-oriented leadership styles have been used to a lesser extent in nursing (Cummings 2012). Of these styles, congruent leadership, proposed in recent years by Stanley (2008) is unique in that it has explicit application to clinical leadership in nursing. Many of the current leadership styles, including transformational and congruent leadership focus on leader characteristics in the leader/follower dyad (Stanley 2006, Hutchinson & Jackson 2013). In the current health care climate, it may be timely to consider a style of leadership style with a follower-centric focus to complement and overcome shortcomings in these leader-focused styles (Mannix et al. 2015a). Aesthetic leadership is one style with a follower focus (Dinh et al. 2014), described as leadership with an explicit moral dimension, and a reliance on tacit knowledge gained from largely indescribable know-how derived from sensory, emotional and somatic awareness (Mannix et al. 2015a). As well, this style of leadership sits well with nursing because nurses have for many years acknowledged the validity of aesthetics to their knowledge and practice (Fitzgerald-Connery 2008). However, the ways in which aesthetic leadership is enacted in the clinical nursing workplace is essentially unknown. This paper addresses that gap.

Methods

Following approval for the study from the Institutional Human Research Ethics Committee, this part of a larger, mixed-methods study took a qualitative approach to collect narrative data from two sources. Using convenience sampling, the first source of data involved online recruitment of nurses via e-learning platforms and online social networks to complete an online descriptive survey, details of which are reported elsewhere (Mannix et al. 2014). The online survey included an invitation to respondents to provide a written account of an experience of aesthetic leadership from a clinical leader in their clinical nursing world. Using purposive sampling, the second source of narrative data were drawn from individual, in-depth conversation-style interviews with experienced registered nurses employed in clinical leadership positions in nursing.

In all, 31 nurses who completed the online survey provided a written account of their experiences of aesthetic leadership. Twelve clinical leaders participated in a digitally recorded interview with one member of the research team. The semi-structured interviews focused on participants’ views of effective clinical leadership and the influence of aesthetics on the clinical setting. The duration of the interviews ranged between 30 to 60 minutes. As reported elsewhere (Mannix et al. 2015b), involving this number of participants was established when data saturation occurred. The study’s rigour was enhanced by having only one member of the research team conduct the interviews.

The written accounts from the survey respondents [R] and the transcribed data from interviewees [I] were subsequently combined and together were analysed following thematic analysis principles. Initially, narrative data were read by a research team member to get a sense of meaning (Borbori & Jackson 2012), followed by an inductive approach to uncover and expand themes (Vaismoradi et al. 2013). To assess trustworthiness and credibility of the three emergent themes, another researcher reviewed the findings to confirm that the intended meaning was represented truly (Graneheim & Lundman 2004).

Findings

From analysis of the narrative data, three main themes emerged to reveal how aesthetic leadership is enacted by clinical leaders in the workplace:  
• Leading by example: ‘be seen in the clinical area’  
• Leading with composure: ‘a sense of calm in a hideous shift’  
• Leading through nursing values: ‘create an environment just by your being’

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Leading by example: ‘be seen in the clinical area’

It was evident from both the conversations and the written accounts that for clinical leaders to be effective, they needed to show leadership through being involved in day-to-day activities in clinical settings. This required clinical leaders to have a physical presence in the clinical area, whether it involved, as one interviewee stated, a ‘walk through every ward’ [33], being ‘as resource person’ [66] or as one respondent wrote, ‘jump in and help do whatever she can to help me get back on track’ [R12]. The view that a clinical leader has ‘to be seen in the clinical area’ [66] and be seen ‘relating to other staff’ [19] enables them to provide support to colleagues in various situations, either to individual colleagues or collectively in the clinical workplace. In some cases, it involved supporting colleagues who was ‘doing something new that they’ve never done before’ [18], while in other situations, it involved clinical leaders encouraging staff in the workplace. For example, providing support to less experienced colleagues can have a positive effect on the nursing workplace, as one interviewee recounted:

...you build up their confidence and hopefully that then encourages them to be creative because we go through hard times in the health system. Once you get staff who are confident and feeling happy in their environment, supported in their environment, they feel valued and all that sort of thing. [R5]

Creating positive workplaces required clinical leaders to be visible and involved in activities in clinical settings. As part of this visible presence was the capacity to effectively communicate with colleagues, whether it involved ‘trying to be collaborative, to see what they think, listen to them, listen to their concerns, because a lot of the staff have different skill levels’ [18] or around nonclinical workplace issues, such as an incident of bullying reported by one respondent:

...the victim felt like she could not continue in her work in the positive way she had always performed. This clinical leader supported her by communicating, listening, debriefing and discussing moving forward with her work in a new and positive light, and enabled growth in the person who previously felt disabled in practice. [R34]

Clinical leaders also needed to have sufficient knowledge and skills to enhance workplace relations among colleagues. As interviewees remarked, ‘they colleagues need to have faith in you; they need to see you as a model ... someone to look up to, that kind of model’ [66] and ‘if you’ve got a goal or something you want to achieve, having the ability to sort of bring that across to other staff so that they also want to aspire to the same goal’ [18]. At the same time, it requires clinical leaders to respect their positional power they may have and to recognise their limitations, as one interviewee commented:

I think a good leader isn’t scared of power. They welcome difference of opinion. They welcome other ideas because a leader has got to be able to say I don’t know all the answers and sometimes I need to see outside the box. [R5]

It was also apparent that clinical leaders saw the importance of empowering colleagues and fostering teamwork in the clinical workplace. Different strategies were employed by clinical leaders to achieve this, including ‘following up with the staff, making sure that they feel safe, empowering the more junior stuff, encouraging them to ask questions’ [18], and producing a video involving staff, ‘to recognise and acknowledge the great work done as individuals and as a team’ [R4]. The importance of being involved with colleagues in the clinical setting was noted by a respondent who wrote:

My clinical leader used aesthetic leadership skills to engage his staff in frontline management work. The staff were asked what they were passionate about, what drove them crazy every day? The clinical leader then empowered the staff to improve these processes and correct issues. [R17]

Leading with composure: ‘a sense of calm in a hideous shift’

There was an awareness of the impact effective clinical leadership had on the clinical environment, especially the effect on staff demeanour. A number of interviewees spoke of a ‘sense of calmness’ [111] as an indication of effective clinical leadership. ‘This was summed up by one interviewee who commented:

I think it [good clinical leadership] has a very calming effect. You can walk on to a shift that is well led and you can also see the staff breathe a sigh of relief because the modern clinical era – in public hospitals now, the patients are so sick and there is so much that the nurses are expected to do, that if a shift is a bit out of kilter it’s just hell. [R7]

Composure from a clinical leader resulted in positive feelings from staff with reports that clinical areas, although when chaotic and busy there was a sense of a ‘harmonious place’ [18], or ‘organised chaos’ [13], and ‘even if they’ve got two MET [Medical Emergency Team] calls going at the same time it still seems controlled’ [R7]. Also evident in these busy clinical settings was a ‘sense of achievement’
getting 'a very good feeling just by walking around and seeing how people are interacting without them saying anything to you' [13], and observing nursing staff 'with smiles on their faces' [19]. These attitudes and behaviours tended to have a flow-on effect to how the clinical setting functioned, as one interviewee noted:

It [ward] just runs, it ticks over, the staff are stable, they don't have the huge turnovers, in fact, sometimes there's waiting lists to get in because they are such a good cohesive team and some of these words you know, no matter what sort of day they have they pull together, you know like it doesn't matter if that's my buzzer or I'm sitting near this phone so I'll answer it. [13]

This type of composed leadership also resulted in a heightened level of confidence among staff in the management of clinical situations. As one interviewee commented, the confidence shown by a clinical leader 'gives me confidence just to go out and do what I've been doing but with even more confidence' [111]. Effective and composed clinical leaders were able to instil confidence in colleagues and ‘foster relationships, respect and credibility’ [R10] among staff, as described in the following written account:

Clinical leader delineated hierarchy and professional divides to create an integrated clinic rehab service, brought clinicians, support and admin staff together regularly and encouraged innovation to redesign the service and support new pathways. [R23].

Similarly, leader composure was required to facilitate positive attitudes among staff in a clinical area experiencing change. In this situation:

...a number of colleagues were distressed by the challenges existing services directed at them, to justify what they were doing and why. ...established reflective practice groups to enable active discussion and feedback from each other regarding the implementation issues. In facilitating the group I provided homemade goodies, and good coffee, to enable staff to relax and enjoy the sessions as ‘separate’ to the daily demands of the job. [R6]

For those in clinical leadership roles, it was evident that they recognised the effect they could have on a clinical setting and that they needed to ‘have insight’ [110], ‘be self-aware of their weaknesses and strengths’ [15], and realise their influence. Clinical leaders can provide stability to a nursing team through their advanced knowledge and skills and are able to ‘put out the little fires before they become a big fire’ [16]. This level of insight and self-reflection was encapsulated by one interviewee who remarked:

I'm maturing as a nurse leader, I'm learning to not take other people's negativity or criticisms personally, and recognising stress and burnout in other people, and also trying to recognise it in myself, but not taking other people's negativity on. I think a positive outlook is really important ... to keep focused on what we're trying to achieve and just bring it back to why we are actually all here – working together and all these kind of things. [19]

Leading through nursing values: ‘create an environment just by your being’

The narrative accounts revealed that nursing values around caring, professionalism and collegiality were important elements in how clinical leaders demonstrated aesthetic qualities in their day-to-day practice. As was remarked, as a clinical leader ‘you should look professional, you're a leader, people look to you’ [110], and ‘the environment has a huge impact on their [patient/ stuff] sense of well-being’ [19]. Aspects of professionalism evident among clinical leaders were reflected in a number of areas, including expectations of how the clinical setting presents and how one feels when in the area. As one interviewee commented, ‘the ward looks neat, clean, tidy, calm’ [17] when a professional stance is taken by a clinical leader. A clinical environment that presents in this way can be reassuring to those entering the area, as one interviewee remarked, ‘if things look organised, then I know that someone's on the ball’ [19]. It can also foster professionalism among those working in the area, as one comment reflected:

I think when the environment's right they (nursing staff) are believed in and nurtured, I think pride in their appearance and the ward's appearance, and the aesthetic qualities follow ... I think we need to look at our appearance on the ward. What can we do? You put it in such a way to get them to own it. [15]

The way a clinical area presents can also have positive effects on staff, as one respondent recounted a situation where a clinical leader emphasised the importance of the aesthetics on staff and patient comfort. As the respondent commented, the new environment 'increased the morale of the staff and has improved patient care by both leaders and staff being positive about their surroundings' [R8]. In the absence of a professional approach from clinical leaders, it can be ‘viscally assaulting just to walk in to the ward, with so much stool on the wall, so many old notices and posters' [12] and give the appearance of being 'very cold and impersonal, just very untidy and overcrowded, a bit factory-like' [19].
It was evident that the physical appearance of any clinical setting was regarded as an important aspect to how patient care was delivered and that a professional approach from clinical leaders enhanced the patient and staff experience. It was also evident that such positive experiences can stay with nurses and shape how they behave as clinical leaders. An early nursing career experience with a dying patient was recounted by one interviewee:

I just remember the room. There was aromatherapy burning. There were low lights, flowers, family were there, music playing and it was just a very peaceful, serene environment and it was just so different from anything in the acute hospitals that I'd experienced before. We washed this lady and she was so fragile but just so lovely. The nurse was very gentle and I thought, oh, this is really nice. I thought, wow, what a privilege. How privileged I was that the family let me come in at such an important time and it just really struck me. [9]

For clinical leaders, the importance of reflective practice was evident in the way it affected their day-to-day clinical practice, especially in relation to the delivery of patient care. One interviewee reflected on how an earlier experience of observing a clinical leader affected how they approached subsequent clinical situations:

...you walk into the patient's room and it's as though it's their space now and I think you've got the ability as a nurse to create an environment just by being, your presence and the way it's just about you and you can share all that out the back and be that person for the patient. I think if when I've observed people doing that, I think that's what I want to be like. That's what I want to do, you know. [11]

Embracing nursing values around trust, equality and advocacy by clinical leaders fostered collegiality in the clinical workplace. One respondent remarked that in addition to 'being an advocate for staff and patients' [R10], clinical leaders can be a 'link between them and administration' [R10]. The importance of clinical leaders valuing colleagues and acknowledging their contributions were also reflected in the narratives. As was commented, good leaders were those nurses 'who mentored, who valued the juniors and valued education and valued the patient, and are able to transfer that information' [15], and acknowledge that 'we're all equal, we work as a team' [110]. An example of how clinical leaders can value colleagues was evident when a clinical leader acknowledged the positive difference having music in the outpatient day setting had on the environment and the mood in the department' [R7]. Establishing trusting relationships with colleagues and patients was also an important value for clinical leaders to possess, as one interviewee commented, 'if people don't like you or don't trust you, they're not going to have a bar of what you're going to say or what you're trying to bring across' [18]. Similarly, the importance of trust was emphasised by another interviewee who remarked, 'if you lose trust, you've lost everything, I think, as a clinical leader' [16].

The centrality of recipients of care shaped how clinical leaders went about their day-to-day activities in clinical areas. As one interviewee who worked in aged care commented, 'the residents should be the central point, that's what everything radiates out of, including the relatives and the doctors' [12]. Patient-centred nursing care focusing on comfort and hygiene was regarded as not only a reflection of good nursing care but also of sound clinical leadership. As evident from the narratives, when patients have their hygiene needs attended to and the area around their bed looking tidy, 'they looked cared for and that makes the patient feel better' [11]. As a result of this, these 'small details humanise the patient into a person' [R1], and these values can be retained in an evidence-based environment.

One of the ways in which clinical leaders apply their knowledge and skills to humanise patients while providing care and comfort was recounted in a narrative describing a situation where treatment was being withdrawn from a brain dead patient in an intensive care setting. The way in which the clinical leader expertly orchestrated the transition from a highly controlled setting to a palliative care space so the family could be with the patient when he died 'was just like watching an artist at work, ... comb his hair and do things so that he would resemble more like the person that he really was' [111].

**Discussion**

The findings from the combined 12 interviews and 31 written accounts reveal a rich narrative on how clinical leaders enact aesthetic leadership in the clinical nursing workplace. It was important for clinical leaders to be visible and accessible to colleagues in the clinical setting and in doing so, practise with a professionalism and competence reflective of nursing values. These findings support previous studies that have reported the positive effect leader visibility has on the nursing workplace (Gunnings et al. 2008), as well as the preference for clinical leaders to be accessible and approachable (Stanley 2014). Clinical leaders portrayed nursing values and a professional image through their actions and behaviours and in doing so, influenced colleagues' behaviours and shaped clinical outcomes. This modelling of professionalism has flow-on effects in clinical settings, especially for recipients of nursing care. As Harfield et al. (2013) report, patients have been...
shown to link nursing competence to a professional image, including how they present and they interact with patients and colleagues.

As would be expected in study involving participants from a practice-based discipline, a number of the leadership attributes to emerge from the findings had an obvious clinical focus around clinical leader competence and also reflective of the centrality of caring in nursing. Participants recounted situations where the clinical skills and knowledge of the clinical leader impacted positively on their own practice. It was also apparent that for clinical leaders to be effective, they were collegial and supportive in the workplace. Clinical leader attributes focusing on clinical competence and collegial support of followers have been reported previously (Stanley 2006, 2014, Mannix et al. 2013), but as Mannix et al. highlight, most of the attributes previously reported are indicative of the technical and practical skills and knowledge required for clinical competence and leader effectiveness.

Technical and practical knowledge and skills have been theorised by Habermas (1972) to be aspects of two of three types of cognitive interests, empirical and interpretive respectively, with critically oriented, emancipatory knowledge and cognitive interests being the third. These emancipatory interests and knowledge facilitate the rational action of self-reflection that enables an individual to critique existing systems and practices (Habermas 1972). In the current study, attributes reflective of emancipatory knowledge and interests are a feature in all three themes, especially where nursing values and beliefs shape the practice of clinical leaders. By practising self-reflection, clinical leaders have demonstrated composure in their leadership activities that insuits confidence in colleagues and facilitates a positive clinical workplace. This finding has not been previously reported in the nursing literature.

The way in which aesthetic leadership is enacted by clinical leaders as reported in this study revealed a number of attributes. A comparison of extant leadership models revealed some attributes common to other leadership models used in varying degrees in nursing (see Table 1).

From this table of leadership models, it is not surprising that aesthetic leadership shares a number of attributes with other leadership models that focus on moral behaviours and are values-oriented, such as authentic, ethical and servant leadership (Mumford & Fiedl 2014). However, it is evident that there are no similarities with transactional leadership and few similarities with transformational leadership, the most common leadership model in the nursing discourse (Cummings et al. 2010). The similarities with congruent leadership, the only leadership model specific to clinical leadership in nursing (Stanley 2006), support the
appropriateness of aesthetic leadership to clinical settings. As shown in the table, leading with composure and calmness were the only attributes not identified in any other leadership model. While these attributes are unique only to the model of aesthetic leadership, it has been found by Ennis et al. (2014) that when clinical leaders remain calm in a crisis in mental health settings, it positively contributes to clinical practice.

Strengths and limitations

One strength of this study is the number of participant narratives available for thematic analysis. Together, they provided a rich source of data on aesthetic leadership. As with other qualitative approaches to research, a limitation of the study is that the findings are not generalisable. Nonetheless, the findings of the study contribute to an understanding of how aesthetic leadership is enacted by clinical leaders in nursing.

Conclusion

The way in which aesthetic leadership was portrayed in the 45 narratives analysed for this study illustrates how effective clinical leadership can be practised in the nursing workplace. The capacity for clinical leaders to be self-reflective was shown to positively influence the nursing workplace. It was apparent that clinical leader effectiveness can be enhanced with nursing values underpinning leadership activities and by being a visible, composed role model in the clinical workplace. While some of the attributes to emerge from this study are apparent in other leadership models, leading with composure is an attribute for clinical leaders to consider in their practice.

Relevance to clinical practice

Aesthetic leadership was shown as a leadership model to enhance clinical nursing workplaces. With aesthetic leadership’s explicit moral purpose and strong link to nursing values, clinical leaders who incorporate these attributes with being a visible, composed role model have the capacity to improve the working lives of nurses across a range of clinical settings.

Contributions

Study design JM, LW, JD; Data collection and analysis JM, LW; Manuscript preparation: JM, LW, JD.

References


Chapter 9: The crucial role of the concertmaster: artful clinical leadership in the nursing world

9.1. Introduction

This study set out to better understand clinical leadership in contemporary nursing. In particular, the study sought to understand what aesthetic leadership could offer clinical leaders operating in complex and sometimes chaotic clinical practice settings. The major findings of this study, presented in the previous three chapters, reveal that aesthetic leadership does have something to offer contemporary clinical leaders. Aesthetic clinical leadership can have a positive impact on the clinical nursing workplace, and can bring a sense of order and calm to a clinical setting, regardless of whether that setting is an emergency department, a mental health unit, a palliative care ward or a community-based setting. It emerged from the findings that clinical leaders who embodied aesthetic leadership exhibited both a moral maturity and a professional maturity, developed from tacit knowledge, theoretical knowledge and advance practice skills gained as experienced clinical nurses. They demonstrated artfulness in their clinical leadership, a type of leadership that goes beyond the current models of leadership associated with clinical leadership in contemporary nursing.

Reflecting on the effect the artfulness of these professionally and morally mature clinical leaders created an imagery of a clinical setting with a sense of harmony, order and cohesiveness; similar to what you might imagine with a symphony orchestra beautifully playing a masterpiece. Making metaphorical comparisons between a clinical nursing workplace and a symphony orchestra can make it possible to enhance current understandings of clinical leadership from both theoretical and practical perspectives. The use of metaphor in the study of organisations and aesthetic leadership is evident in the literature. In studies on organisational theory jazz music has been used as a metaphor to explain how improvisation in decision-making compares with more traditional managerial approaches (Bathurst et al. 2010). Using a symphony orchestra as a metaphor has been reported in the areas of management
theory (Drucker 1996, Mintzberg 1998, 2003) and corporate executive training (Benady 2006, Snedeker 2010). Ropo and Sauer (2008) contrast the dances of a traditional waltz with modern raves to illustrate aspects of aesthetic leadership. Reasons for the use of metaphor in the study of aesthetics may be related to the way in which aesthetics and aesthetic knowledge are difficult to logically explain (Hansen et al. 2007), described as ‘one of the most intangible aspects of higher cognition’ (D’Ausilio et al. 2012, e35757).

In this chapter an integrated discussion draws together the major findings of this study and analyses what aesthetic leadership can offer contemporary nursing, using a symphony orchestra as a metaphor for the clinical practice setting and those who inhabit it. As part of the discussion, artful clinical leadership is offered as a new model of leadership for those advanced practice nurses in designated clinical leadership roles in the health system. The chapter concludes with a discussion of a range of implications for clinical practice, leadership and education in nursing, including recommendations for further research. To begin, a brief overview of the orchestra pit is presented.

9.2. The orchestra pit

Imagine a clinical setting as an orchestra pit, regardless of its physical layout or its location inside a health care facility or in a community-based setting. Similarities exist between the two settings in terms of the range of human experiences – symphony music can embrace happiness, pain, loss and success (Small 1986), as can occur in clinical settings. Like contemporary healthcare settings, a symphony orchestra comprises a number of individuals with specialist skill sets. The size of a symphony orchestra can vary but typically, comprises over 90 musicians, organised into sections, depending on their musical instrument (Kennedy & Bourne Kennedy 2007). The whole orchestra is overseen and managed by a conductor. As represented in Figure 9.1 on the next page, an orchestra has four main sections, with an occasional fifth section that may include a piano or harp. The string instruments of the violin family plus double basses is the largest section and forms the basis of the orchestra, and while the woodwind, brass and percussion sections are usually present, the instruments in these sections can vary in numbers and types, according to the performance (Spitzer & Zaslaw 2004).
If one were to transpose sections in the orchestra to groups within a clinical setting, the string section, as the largest section and the basis of the orchestra could represent nursing staff. The brass section of the orchestra, with its size and variety of instruments based on the particular repertory, could denote allied health professionals (for example, physiotherapist, radiologist, pathologist, social worker) who enter and leave the clinical setting as required. The influence doctors have on when patients/clients enter and leave a clinical setting generally sets the rhythm and pace for the setting, in much the same way as the percussion section of an orchestra. The woodwind section of the orchestra is usually located in the centre of the orchestra pit, surrounded by the other sections of the orchestra (see Figure 9.1). Within the woodwind section of the orchestra is the oboe, an instrument that has the least capacity of all instruments in the orchestra to be varied in terms of pitch. For this reason, it is the instrument against which other orchestra musicians tune their instruments (Kennedy 2015). The centrality of the woodwind section and the importance of the oboe are indicative of the significant position the patient/client (oboe) and the significant people in their lives occupy in any clinical healthcare...
setting. Patient-centred care, in conjunction with evidence-based practice, continue to shape contemporary health care delivery and related policy (Broom & Tovey 2012, van Bekkum & Hilton 2013).

The organisation of the orchestra reflects a specific hierarchy (Koivunen 2007), with each section of the orchestra having a principal musician who has responsibility for leading their section, in concert with the other three section principals and the conductor. The conductor of the symphony orchestra plays a central role in a performance as well as being involved in the overall management of orchestra. To the musicians in an orchestra the conductor is often positioned as an authority figure and regarded as the face of management in the organisation (Koivunen 2007), much like the nurse manager role can be in clinical settings. The principal of each section is generally the most accomplished musician.

Since the 18th century the principal of the string section has the additional responsibility of concertmaster – the leader of the orchestra and its performance (Spitzer & Zaslaw 2004). Located in the first violins section of the string family, the concertmaster is responsible for leading rehearsals, selecting musicians to play, ensuring all musicians are in tune, interpreting the intent of the composer and setting the tempo for other musicians to follow (Spitzer & Zaslaw). As one of the musicians, the concertmaster is in a position to lead by example (Spitzer & Zaslaw). The role of the concertmaster and its location in the string family resonates with the role of advanced practice nurses in clinical leadership roles, viz, artful clinical leaders. This role is discussed in more depth in a next section of the chapter.

9.3. **Artful clinical leadership**

Contemporary nursing workplaces are not the exclusive domain of nurses. Rather, like members of the string section in an orchestra performing a musical piece, nurses are required to work with other members of a multidisciplinary healthcare team and patients/clients to produce and follow coherent and harmonious plans of care. In the same way a musical score can determine the actions of the musicians and influence their relationships (Small 1986), patient/client management plans can mediate relationships among those health professionals providing care. To facilitate positive outcomes from these plans effective leadership is required. An effective concertmaster is well placed to do this, especially in complex clinical situations. As Spitzer and Zaslaw (2004) report, the concertmaster is central to the outcome of a performance, gaining praise if a musical piece goes well and being blamed if it goes
poorly. Recent high profile government reports (Garling 2008, Francis 2013), generated in response to failings in the healthcare system, calling for more effective clinical leadership reflect this sentiment.

This study did not set out to develop an alternate model of clinical leadership in contemporary nursing. However, as the study progressed and the findings were analysed, reflected upon and reported as a series of papers it became apparent that advanced practice nurses, particularly those in designated clinical leadership roles, practice in way that can only come with professional and moral maturity, gained from extensive clinical experience and a sound knowledge base. Expert clinical leaders bring to their practice skills and knowledge that may not be apparent in less experienced nurses who may find themselves in clinical leadership positions, either by choice or through staffing shortages. To reflect this expert level of clinical leadership a model of artful clinical leadership is presented on the next page (Figure 9.2).
Figure 9.2: Artful clinical leadership model: A concertmaster who embodies the characteristics of professional and moral maturity and applies the attributes of the 3 leadership styles as needed practices as an artful clinical leader, enacting the 4 main artful leadership qualities listed.

In this model the concertmaster is any advanced practice nurse in a designated leadership position or role. In contemporary nursing the nomenclature may vary from titles such as Clinical Nurse Consultant, Clinical Leader, Clinical Nurse Specialist, Nurse Practitioner, or Nurse Consultant. Regardless of the title, clinical leadership is an expectation, fundamental to the role. In this position and at this level or expertise a concertmaster can determine their individual leadership style and practices. If the concertmaster chooses to thoughtfully draw on, as determined by the circumstances, the critical attributes listed in the model for the three identified leadership styles (aesthetic, congruent, transformational) and embodies the characteristics listed under professional and moral maturity, their clinical leadership will be artful. However, if they
choose not to do so, they will still be a concertmaster but will not be artful clinical leaders. Concertmasters embracing artful clinical leadership will enact all four qualities listed in Figure 9.2 as part of their day-to-day leadership activities, resulting in a positive, calm and harmonious clinical setting, whether that is an inpatient setting or in the community. Whilst it may be argued that less experienced clinical leaders embody many of the attributes listed, the critical feature of this model sits with the concertmaster’s capacity to practice with sustained levels of professional and moral maturity to facilitate the appropriate application of attributes, either individually or in combination.

The notion of professional maturity is not new, reported in the psychology literature to include the traits of self-reliance and confidence (Smalzried & Remmers 1943). In the nursing literature Durgahee (1996) identified reflective practice as an important trait of nurses exhibiting professional maturity. Professional maturity has also been linked to those nurses engaged in advanced practice (Ruel & Motyka 2009), nurse practitioners (Dempster 1991), and those with a commitment to being involved in professional organisations (Armstrong et al. 2003). Advanced practice nurses demonstrate their professional maturity by engaging in the synthesis of all available data in clinical situations, practicing from an expanded theoretical and research driven knowledge base, and with the capacity to maximise available resources to optimise quality health outcomes (Ruel & Motyka). Finfgeld-Connett (2008a) identified professional maturity as one of the antecedents to caring in nursing. In doing so, she characterised professional maturity as being able to cope, possessing a strong knowledge base and being competent. In this current study these characteristics were apparent among the concertmasters who lead artfully.

It was also apparent from the study and reported in Chapter 8 that nursing values and beliefs shape the way the concertmasters practice their leadership in clinical settings. This finding supports Jeffrey’s (2013) argument that nurses involved in roles with other responsibilities like leadership, management or education remain true to their nursing values. Reflective of these nursing values and beliefs were findings that indicated among the concertmasters that there was an explicit moral dimension to their leadership practice. As reported in Chapter 7 the concertmasters interviewed were guided by a strong moral compass, indicative of a high level of moral maturity that emanates from extensive experience (Sumner 2010). Habermas (1990) contends, as previously mentioned in Chapter 4, that there are three developmental stages of moral maturity and that in the most highly developed post-conventional stage an individual is able to interact and communicate in a way that considers others
in a just and fair manner while assessing their own behaviours during the interaction. In other words, throughout the communicative action the morally mature concertmaster can participate as speaker, listener and observer (Sumner 2010), almost at an intrinsic, subconscious level, and within their Lifeworld. However, it needs to be recognised that the concertmasters’ Lifeworld is invariably imposed upon by the System when attempts are made by artful concertmasters to emancipate followers to enact patient/client-centred care within a moral and value-laden framework.

In a clinical nursing context moral maturity at this post-conventional level has been linked to Benner’s (1984) expert nurse stage where nurses have developed their ‘experiential intuition’ in clinical situations (Sumner 2010, p166), viz, tacit knowledge that can defy logical explanation. To make sense of and apply tacit knowledge to clinical situations expert nurses can use hypothetical reasoning, involving inductive and deductive logic, as the basis for critical reflection (Avis & Freshwater 2006). Possessing tacit knowledge does not dismiss or overshadow the other forms knowledge and skills held by an artful clinical leader. These artful concertmasters utilise practical, technical and critical skills and knowledge, the latter theorised by Habermas (1972) as that knowledge with an emancipatory interest or intent. In doing so, concertmasters who lead artfully demonstrate the capacity to practice with knowledge that can be evidence-based, and with an understanding of knowing how and why their actions are appropriate in a given clinical situation. Expert practice involves sometimes making decisions in clinical situations where there is insufficient research evidence and no specific procedures or policies for the application of available evidence. It is in these situations that expert practice nurses rely on critical reflection to interpret available evidence to implement an individual’s plan of care (Avis & Freshwater 2006).

Critical reflection allows for knowledge developed from experience, theory and practice to be merged to provide new insights and knowledge constructions (Rigg & Trehan 2008), something that is potentially emancipatory and empowering. Added to this, Sumner (2010) contends that at this high level of moral maturity expert nurses practice critical self-reflection, a skill that elevates critical reflection beyond reflection-in-action and reflection-on-action to a level where the individual is able to reflect on their own actions. Critical self-reflection enables individuals to truly understand their existence and take steps to change it, accepting that they are autonomous beings with the capacity for rational self-clarity and communicative lucidity (Fisher 2003). Critical self-reflection encourages empowerment and emancipation, and in relation to
artful concertmasters, allows for creativity, change and inspiring colleagues in clinical settings.

Utilising these qualities and attributes as artful clinical leaders can also enhance leadership confidence and calmness from colleagues in clinical settings. By creating order in a clinical setting, artful clinical leaders can bring a sense of harmony to nursing workplaces, in much the same way as concertmasters can for symphony orchestras. Artful clinical leaders have the capacity to lead regardless of proximity to colleagues. They are able to provide effective leadership through their advanced practice skills, which include well developed communication skills. These skills, together with an aesthetic awareness, enable concertmasters to lead by example to inspire colleagues. It was evident in the study findings that nurses had a preference for leadership by example rather than leadership by command, much like musicians in a symphony orchestra (Spitzer & Zaslaw 2004). The artfulness of their leadership can empower colleagues and facilitate positivity in clinical settings.

9.4. Implications for nursing practice, leadership and education

This study has provided a deeper understanding of how aesthetic leadership can influence the clinical nursing workplace. It is evident from the findings that a number of implications can be drawn from the study in relation to nursing practice, leadership and education. Possibly the most significant implication to be drawn from this study is how the model of artful clinical leadership provides a new and alternate way of conceptualising contemporary clinical leadership, especially for those nurses in designated leadership positions. To date, the leadership requirements for these designated leadership roles have been based around clinical leadership domains and competency standards (National CNS Competency Task Force (NACNS) 2010, NSW Health 2011) that tend to be generic and focus practical and technical skills and knowledge. Expectations for registered nurses seeking such roles tend to focus on a minimum number of years of clinical experience in the relevant clinical specialty. Leadership expectations for these roles may be detailed (see NACNS 2010) or simply be one of a number of generic selection criteria set out in a position description. In jurisdictions where designated clinical leadership positions are graded, leadership functions are differentiated according to expectations of the clinical leader’s sphere of influence, be it local, national or international (see for example, NSW Health 2011).
The artful clinical leadership model offers a detailed blueprint of attributes required by those advance practice nurses who are in or aspire to senior and sometimes more highly graded clinical leadership positions. Consideration needs to be given the notion of different levels of leadership expertise, in the much same way that nursing practice has been identified in Benner’s (1984) model from novice to expert. The concertmasters in this artful leadership model have the capacity to enhance clinical nursing workplaces and improve clinical leader effectiveness through their expert clinical leadership. The findings from this study have shown that when concertmasters practice artfully there are positive effects for those inhabiting the clinical world. The composed way in which concertmasters practice with the key attributes of aesthetic leadership can inform those providing professional development programs that target aspiring clinical leaders. The contribution of aesthetic leadership and the way in which professional maturity and moral maturity can together facilitate artfulness among clinical leaders could be important inclusions in clinical leadership education programs for nurses, including those already in clinical leadership positions.

It was apparent from the integrative review that there currently lacks an extensive evidence base about what constitutes clinical leadership in contemporary nursing. This situation exists in an environment where calls for more effective clinical leadership continue in nursing and across health care more broadly. The lack of a standard definition for clinical leadership is somewhat problematic, although not surprising, given the complexities of clinical leadership in nursing workplaces. However, of more concern from the available evidence is the focus mainly on the technical and practical skills and attributes of clinical leadership, in the absence of more critical and emancipatory attributes in clinical leadership in nursing. To date, what has been provided in the evidence addresses knowledge acquisition at the ‘knowing that’ (analytic) and the ‘knowing how’ (hermeneutic) levels, and not at the critical level of ‘knowing why’ (Terry 1997, p271). While this may be understandable in a practice-based discipline like nursing, there is a need for a greater focus on the critical, emancipatory interests of clinical leadership to ensure the continued development of nursing as a profession. To this end, education programs on clinical leadership available to nurses need to ensure that curricula include content that encourages clinical leaders to be more critically self-reflective and confident to facilitate positive outcomes in clinical settings.

In light of findings in this study education programs designed to enhance the knowledge and skills of clinical leaders also need to take a broader view of what
leadership models and theories are considered useful in the clinical nursing workplace. With continued calls for more effective clinical leadership in health care (Garling 2008, Francis 2013) and the current dominance of transformational leadership as the preferred model in professional development programs for nurses (Martin et al. 2014) it is perhaps timely to reconsider what leadership models are appropriate for leaders in clinical nursing workplaces. It has been shown in this study that aesthetic leadership is a model worth considering for clinical leaders, without discarding other more familiar and established leadership styles. By incorporating this model into the realm of clinical leadership education and practice the more leader-focused styles like transformational leadership could be complemented by the more follow-focused aesthetic leadership. The consequence of this is a more balanced approach to the leader/follower dyad in leadership practice that has been shown in this study to have positive effects on the clinical nursing workplace.

While the findings from the online survey are not generalizable, it is perhaps worth considering how gender shapes risk-taking among clinical leaders. With some literature suggesting that females in management positions are more risk adverse than their male colleagues (Elsaid & Urse 2011), and the obvious gender bias towards females in nursing (AIHW 2013), encouraging clinical leaders to take risks may be counterproductive in the clinical workplace. Although transformational leadership does incorporate a number of characteristics that focus on relationships and individuals (Cummings 2012), and could be considered to include feminine-oriented traits such as listening, empathy and being collaborative, it does identify taking risks as a desirable attribute (Clavelle & Drenkard 2012). In complex and sometimes volatile clinical nursing workplaces the positioning by survey respondents of risk-taking as being the least desirable characteristic among their clinical leaders is reflective of a desire from clinical nurses for predictability and less risk-taking in their workplaces. This desire is supported by the qualitative findings reported in previous two chapters, indicating that positive workplaces can result from having clinical leaders who can create calm clinical environments through their composed aesthetic leadership. The effects of this type of leadership on the nursing workplace reinforce the need to consider aesthetic leadership as a viable and relevant addition to existing leadership models put forward in education programs for nurses.

9.5. Limitations of the study

Within a critical framework and using a mixed-methods approach this study was able to explore what aesthetic leadership has to offer contemporary clinical leadership in
nursing. However, not unlike many research studies, there are always aspects that could have been done differently to enhance study findings. The response rate to the online descriptive survey was poor. While the use of internet as vehicle to locate and conduct the descriptive survey was cost effective and uncomplicated, and the use of online social networks exposed the survey to a large pool potential of respondents from different countries around the world, the response rate was disappointing and prevented more rigorous analysis of the data. The participants involved in the interviews during the study provided a rich source of data relevant to the aims of the study. However, the relatively small number of participants drawn from a single state in Australia could be viewed as a limitation.

9.6. Directions for further research

Like many research projects that seek greater understanding of an issue or phenomena this study has achieved what it set out to achieve. However, in doing so it has uncovered related areas that merit further inquiry, some of which have been identified in the series of publications in this thesis. Other areas of further research include:

- The online descriptive survey, despite its relatively poor response rate, yielded some interesting data. It would be worthwhile repeating this aspect of the study, with some minor modifications to the instrument and revised strategies for recruitment using online social networks. The potential exists to gain increased understandings about important aspects of clinical leadership and aesthetic leadership from nurses across world with access to online social networks.

- With the development of a new model of artful clinical leadership, further research is required to establish the consistency and rigour of the model among advanced practice nurses in clinical leadership positions in different settings and jurisdictions. This could involve considering different cultural groups, various clinical settings, and differences in interpretations of advanced practice nurses.

9.7. Concluding thoughts

This study sought to explore the art of clinical leadership in contemporary nursing. In doing so, it was hoped to add to the existing understandings about what is to be a clinical leader in the complex health care settings of the 21st century. In all, the aim of the study was met. Over the life of this study a number of interesting findings have emerged about how clinical leaders are regarded by the wider nursing workforce and
how clinical leaders practice in their role. It remains clear that clinical leadership continues to be a complex challenge for those in the role in contemporary nursing.
References


Qualtrics Research Suite. (accessed 18/4/2013 @ http://www.qualtrics.com/research-suite/#academic)


Appendices
Appendix 1: UWS HREC approval

15 May 2012

Professor Lesley Wilkes,
School of Nursing and Midwifery

Dear Lesley,

I wish to formally advise you that the Human Research Ethics Committee has approved your research proposal H9592 “The Art of Clinical Leadership in Contemporary Nursing”, until 1 June 2013 with the provision of a progress report annually and a final report on completion.

Please quote the project number and title as indicated above on all correspondence related to this project.

This protocol covers the following researchers:

Lesley Wilkes, Judith Mannix.

Yours sincerely

Dr Anne Abraham
Chair, UWS Human Research Ethics Committee

l.wilkes@uws.edu.au
99405784@student.uws.edu.au
Appendix 2: UTS HREC approval

From: Racheal Laugery [mailto:Racheal.Laugery@uts.edu.au]
Sent: Thursday, 1 November 2012 9:48 AM
To: Judy Mannix; Research Ethics
Cc: 99405784@student.uws.edu.au; John Daly; Debra Jackson; Lesley Wilkes
Subject: RE: Ethics approval

Hi Judy

Thank you for notifying us. We will send you a letter of noting soon. All the best with your research!

Kind regards

Racheal

Racheal Laugery
Research Ethics Officer
Research & Innovation Office
University of Technology, Sydney
Phone: (02) 9514 9772
Fax: (02) 9514 1244
Generic: Research.Ethics@uts.edu.au
Direct: Racheal.Laugery@uts.edu.au
Post: PO Box 123, BROADWAY NSW 2007
Location: Level 14, Building 1, Broadway Campus (CB01.14.08.04)

For all your research questions visit ask.research.uts.edu.au or call ext. 9681
Dear Sir/Madam,

I am currently enrolled in a PhD at UWS, undertaking a project about clinical leadership, that has received approval from the UWS Ethics Committee (see attached approvals). The project involves seeking participation from registered nurses and midwives to complete an online survey, and if desired, an audio-taped interview.

My supervisors are Prof Lesley Wilkes from UWS and Prof John Daly, Dean of the Faculty of Health at UTS. I am seeking approval from the UTS Ethics Committee to invite postgraduate nursing and midwifery students enrolled in courses in the Faculty of Health to access and complete the online survey, and participate in an interview if wishing to do so.

Please let me know if you require any further information.

Regards,

Judy Mannix  RN MN(Hons) | PhD student
School of Nursing and Midwifery | University of Western Sydney
Building 7 – Room 55, Campbelltown Campus
Locked Bag 1797 Penrith NSW 2751
P: 4620 3760 | F: 4620 3161 | E: j.mannix@uws.edu.au
www.uws.edu.au/nursing
Appendix 3: UWS HREC amendment approval

31 August 2012

Professor Lesley Wilkes
School of Nursing and Midwifery

Ms Judy Mannix
School of Nursing and Midwifery

Dear Lesley and Judy

H9592 - Amendment Request

The Office of Research Services has reviewed and approved your following requested amendment(s):

1. Recruitment through Twitter and Facebook

Please do not hesitate to contact me at humanethics@uws.edu.au if you require any further information.

Regards

Jillian Shute
Human Ethics Officer
Office of Research Services
Appendix 4: Invitation to participate notice

Subject: The art of clinical leadership in contemporary nursing

Dear student,

As a Registered Nurse or Registered Midwife and enrolled in a postgraduate course at the University of Western Sydney you are invited to participate in a study that is exploring aspects of clinical leadership in contemporary nursing.

Voluntary participation in the study invites you to complete an on-line survey, and if you wish, participate as well in an audio-taped interview about aspects of clinical leadership. All data collected during the study will remain confidential. The decision whether or not to participate will not prejudice your present or future relationship with the University of Western Sydney.

The project is being lead by Judy Mannix as part of her doctoral studies. If you are interested in learning more about the project or participating in the study, please click on this link: (link inserted when established).

If you have any questions or concerns about participating in the study please contact Judy Mannix via email at j.mannix@uws.edu.au.
Appendix 5: Clinical Leadership Survey

Clinical leadership in contemporary clinical nursing

Leadership in contemporary nursing has been identified as an important aspect of ensuring quality care delivery to consumers of health care. There are a number of elements and styles of effective leadership, including an aesthetic dimension. Aesthetic leadership can be regarded as:

…the process of sharing the aesthetic vision with the followers and influencing the followers to show aesthetic behaviours such as aesthetic pleasure, concern, emotion, sensitivity and criticism (Polat & Oztoprak-Kavak 2011:52).

When you complete the questionnaire you are asked to **base your responses on a nursing colleague you regard as a clinical leader**. The colleague you select may or may not be in a designated clinical leadership position. The questionnaire consists of 3 parts: the first section consists of a 32 item questionnaire that asks you to consider your nominated clinical leader when answering each statement. The second part of the survey asks you to write a response to one question that relates to aesthetic leadership in practice. Before completing the questionnaire it would be helpful to find out some information about you. To do this, please complete the section below.

*Further information about the study can be accessed at [hyperlink].*  
*Please note that by completing the survey your consent to participate in this project is implied.*

<table>
<thead>
<tr>
<th>Demographic details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current workplace (click):</td>
</tr>
<tr>
<td>Current position:</td>
</tr>
<tr>
<td>Employment status (click):</td>
</tr>
<tr>
<td>Time in current position (click):</td>
</tr>
<tr>
<td>Years working in nursing (click):</td>
</tr>
<tr>
<td>Age (click):</td>
</tr>
<tr>
<td>Gender (click):</td>
</tr>
</tbody>
</table>
**Part 1: In your opinion the nursing colleague who you regard as a clinical leader who...**

<table>
<thead>
<tr>
<th>Item</th>
<th>Characteristic or behaviour</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Creates an aesthetic climate in the clinical setting.</td>
</tr>
<tr>
<td>2</td>
<td>Creates a culture to activate the aesthetic potential in the clinical setting.</td>
</tr>
<tr>
<td>3</td>
<td>Gives inspiration to the nurses through aesthetic leadership.</td>
</tr>
<tr>
<td>4</td>
<td>Serves as a model for the nurses with her/his outlook and behaviour.</td>
</tr>
<tr>
<td>5</td>
<td>Is sensitive to the aesthetics in the environment.</td>
</tr>
<tr>
<td>6</td>
<td>Trusts her/his aesthetic feelings.</td>
</tr>
<tr>
<td>7</td>
<td>Supports creativity in the clinical setting.</td>
</tr>
<tr>
<td>8</td>
<td>Thinks that each nurse has an aesthetic potential.</td>
</tr>
<tr>
<td>9</td>
<td>Endeavours to encourage the aesthetic potential of the nurses.</td>
</tr>
<tr>
<td>10</td>
<td>Can influence the beliefs of the people around with her/his aesthetic opinions.</td>
</tr>
<tr>
<td>11</td>
<td>Tries to understand the aesthetic expectations of the nurses.</td>
</tr>
<tr>
<td>12</td>
<td>Uses body language well.</td>
</tr>
<tr>
<td>13</td>
<td>Is specific but pragmatic in applying aesthetics.</td>
</tr>
<tr>
<td>14</td>
<td>Uses appropriate language during interactions with others.</td>
</tr>
<tr>
<td>15</td>
<td>Assures the nurses with her/his aesthetic leadership.</td>
</tr>
<tr>
<td>16</td>
<td>Knows how to reflect emotions appropriately.</td>
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<td></td>
<td></td>
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<tr>
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<td>-----------------------------------------------------------------</td>
</tr>
<tr>
<td>17</td>
<td>Provides the nurses with new points of view in the aesthetics of leadership.</td>
</tr>
<tr>
<td>18</td>
<td>Is a pioneer of aesthetic leadership.</td>
</tr>
<tr>
<td>19</td>
<td>Settles conflicts with an aesthetic concern.</td>
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<tr>
<td>20</td>
<td>Is careful, responsible and practical in demonstrating aesthetic leadership.</td>
</tr>
<tr>
<td>21</td>
<td>Has an aesthetic creativity.</td>
</tr>
<tr>
<td>22</td>
<td>Facilitates aesthetics into the workplace culture.</td>
</tr>
<tr>
<td>23</td>
<td>Evokes admiration with her/his expression and style of communication.</td>
</tr>
<tr>
<td>24</td>
<td>Attaches value on artistic activities.</td>
</tr>
<tr>
<td>25</td>
<td>Endeavours to organize artistic activities.</td>
</tr>
<tr>
<td>26</td>
<td>Makes a difference with her/his attitude.</td>
</tr>
<tr>
<td>27</td>
<td>Demonstrates a style of aesthetic leadership that is compatible with practice.</td>
</tr>
<tr>
<td>28</td>
<td>Prioritizes aesthetics in the clinical setting’s social activities.</td>
</tr>
<tr>
<td>29</td>
<td>Aesthetically arranges the empty spaces in the clinical setting.</td>
</tr>
<tr>
<td>30</td>
<td>Equips the appropriate places in the clinical setting with aesthetic materials (picture, table, etc).</td>
</tr>
<tr>
<td>31</td>
<td>Spreads positive energy around with her/his lively personality and being at peace with her/himself.</td>
</tr>
<tr>
<td>32</td>
<td>Tries to get beyond the limits to find out the better in the aesthetic arrangements in the clinical setting.</td>
</tr>
</tbody>
</table>
### Part 2: In your opinion the nursing colleague who you regard as a clinical leader...

<table>
<thead>
<tr>
<th>Item</th>
<th>Characteristic or behaviour</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Takes risks</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>2</td>
<td>Celebrates colleagues’ achievements</td>
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<td>3</td>
<td>Negotiates and supports</td>
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<td>4</td>
<td>Follows through on promises</td>
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<tr>
<td>5</td>
<td>Works to achieve goals</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Develops cooperative relationships</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>7</td>
<td>Facilitates meaningful conversations</td>
<td></td>
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<tr>
<td>8</td>
<td>Uses evidence-based rationale</td>
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<tr>
<td>9</td>
<td>Establishes therapeutic relationships</td>
<td></td>
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<tr>
<td>10</td>
<td>Engages in reflective practice</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>11</td>
<td>Engages in communication with colleagues</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>12</td>
<td>Actively listens</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Commits to patient centred care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Acknowledges colleagues’ values</td>
<td></td>
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<td>15</td>
<td>Provides positive feedback</td>
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</tbody>
</table>
Part 3: Briefly describe a situation in your clinical experience where aesthetic leadership was shown.

________________________________________________________________________________________________________________

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Thank you for completing this survey.

If you would like to participate in an audio-taped interview to further discuss aspects of clinical leadership, please contact me either by phone at (02) 46203760 or email at j.mannix@uws.edu.au.
Appendix 6: Participant Information Sheet

Human Research Ethics Committee
Office of Research Services

Project ID: H9592

Participant Information Sheet

Project Title: The art of clinical leadership in contemporary nursing

Who is carrying out the study?

You are invited to participate in a study conducted by Judy Mannix, PhD candidate, School of Nursing & Midwifery, UWS; Professor Lesley Wilkes, Professor of Nursing, School of Nursing & Midwifery, UWS; and Professor John Daly, Dean, Faculty of Nursing, Midwifery & Health, UTS.

What is the study about?

The purpose of the study is to find out from current clinicians their views on aspects of clinical leadership.

What does the study involve?

You will be invited to complete an on-line survey and then, if you wish, take part in an interview with one of the researchers. The interview will cover aspects of clinical leadership and what it means to you. The interview will be recorded for transcription purposes.

How much time will the study take?

The on-line survey will take about 30 minutes to complete. The audio-taped interview will take about 30 to 40 minutes.

Will the study benefit me?

Participants of the study may or may not benefit from this process. We envisage that they will benefit by exploring aspects of clinical leadership that they may or may not have considered previously. The information gained from the analysis of the interviews will benefit future clinicians as it can provide a basis for professional and educational programs in nursing.

Will the study involve any discomfort for me?

The on-line survey and the audio-taped interview should cause you no discomfort. However, if you are uncomfortable at any time during the survey you can exit it. If you are uncomfortable during the interview it will be terminated. If necessary the interviewer can refer you to a counselling service.
How is this study being paid for?

The study is being sponsored by the University of Western Sydney.

Will anyone else know the results? How will the results be disseminated?

All aspects of the study, including results, will be confidential and only the researchers will have access to information on participants. The information we collect will be disseminated in reports, articles in peer reviewed journals and conference presentations. Participants will not be identified in any reports or publications.

Can I withdraw from the study?

Participation is entirely voluntary: you are not obliged to be involved and, if you do participate, you can withdraw at any time without giving any reason and without any consequences. There are no consequences for non-completion of the survey or the interview. You may choose to withdraw from the study at any time without penalty.

Can I tell other people about the study?

Yes, you can tell other people about the study by providing them with the Chief Investigator’s contact details. They can contact the Chief Investigator (details below) to discuss their participation in the research project and obtain an information sheet.

Consent to participate in this study:

If you agree to participate in this study, please complete the attached consent form.

What if I require further information?

When you have read this information, the member of the team conducting the interview will discuss it with you further and answer any questions you may have. If you would like to know more at any stage, please feel free to contact the research team:

Judy Mannix, PhD candidate, School of Nursing & Midwifery, UWS – (02) 4620 3760;

Professor Lesley Wilkes, Professor of Nursing, School of Nursing & Midwifery, UWS - (02) 4734 3181;

Professor John Daly, Dean, Faculty of Nursing, Midwifery & Health, UTS – (02) 9514 5045.

What if I have a complaint?

NOTE: This study has been approved by the University of Western Sydney Human Research Ethics Committee. The Approval number is [H9592]. If you have any complaints or reservations about the ethical conduct of this research, you may contact the Ethics Committee through the Office of Research Services on Tel 02-4736 0883, Fax 02-4736 0013 or email humanethics@uws.edu.au. Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.
Appendix 7: Participant Consent Form

Human Research Ethics Committee

Office of Research Services

Project ID: H9592

Participant Consent Form

This is a project specific consent form. It restricts the use of the data collected to the named project by the named investigators.

Project Title: The art of clinical leadership in contemporary nursing

I,……………………………………………….., consent to participate in the research project entitled: The art of clinical leadership in contemporary nursing.

Investigators: Judy Mannix, PhD candidate, School of Nursing & Midwifery, UWS; Professor Lesley Wilkes, Professor of Nursing, School of Nursing & Midwifery, UWS; Professor John Daly, Dean, Faculty of Health, UTS.

I acknowledge that:

I have read the participant information sheet and have been given the opportunity to discuss the information and my involvement in the project with the researcher/s.

The procedures required for the project and the time involved have been explained to me, and any questions I have about the project have been answered to my satisfaction.

I consent to being interviewed as part of this project. I recognise that the interview will be audio taped and transcribed. All tapes and transcriptions will be held securely.

I understand that my involvement is confidential and that the information gained during the study may be published but no information about me will be used in any way that reveals my identity.

I understand that I can withdraw from the study at any time, without affecting my relationship with the researcher/s now or in the future.

Date: ___________________

Signed: _______________________ Name:_________________________

Contact Phone: _____________________ Mobile: ________________________

Email Address: ___________________________________________________

Return Address: ___________________________________________________

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