This Heideggerian hermeneutic study investigates the experiences of a group of nurse leaders who were central players in attempts to develop a cluster of new Clinical Development Units (Nursing) in Australia. Due to the longitudinal nature of this study I, as the researcher, have been able to follow many of these nurses through this challenging and arduous process. In order to show respect to these participants, who discussed their own experiences with such candour, and to remain true to the philosophy on which this study is based, I have chosen to begin this chapter by disclosing relevant aspects of how I brought myself into this study and my own philosophical underpinnings. This is followed by an outline of the study, an overview of the concepts on which these Australian Clinical Development Units (Nursing) were developed and a brief introduction to the philosophical framework that underpins this study. The chapter concludes with a discussion on the organisation of this thesis.

1.1 THE RESEARCHER

1.1.1 A PERSONAL STORY

My own personal odyssey towards a PhD degree reminds me of an ancient Eastern story about a meeting of the gods. Three gods were trying to decide where to hide the ‘truth of the universe’ from humanity. The first god suggested they hide it under the deepest oceans but the others disagreed because they said that, one day, humans would make a ship capable of travelling under the water. The second suggested they hide it in the heavens however, once again, the others disagreed because they realised that, some day, people would devise a way to travel into space. The third god, who was the wisest of all, suggested they should hang the truth around the necks of every human being because people would never look there (George, 1998). And many of the myths that have been told and retold throughout the ages indicate that this is exactly what they did!
I have chosen to relate this story to you, the reader, as I believe it to be a succinct introduction to many of my own experiences during this study. I know my academic journey has, on many occasions, caused me to look at that elusive truth that hangs around my own neck. Although the truth that I have seen there may have been obvious to many of the people around me long before I saw it myself, each time I became aware of a new ‘truth’ for myself, I was startled at the clarity of vision I then held and, simultaneously, incredulous that I had never realised it before.

When I set out on this doctoral work, I was unable to identify exactly why I had chosen this area of study. ‘You must be passionate about your study,’ I was told - and yet I had never worked in Clinical Development Units, nor did I know much about them! I had worked as a diabetes educator and Clinical Nurse Consultant for over 10 years and my Bachelor Honour’s thesis had been on the experiences of people with diabetes. And yet there was a part of me that did not want to fall into the trap of being confined to a single topic area so, when the opportunity arose for me to develop a study into what was, for me, a fresh new idea, I seized the opportunity. At this time, however, I held very little passion for Clinical Development Units or any aspect of nursing leadership.

I have often said that there is a force greater than my conscious mind that is leading me along the path I need to travel in order to develop spiritually – or perhaps it is the weight of the truth that hangs around my own neck! Consequently, although blissfully unaware of my deeper motivation for choosing to study an area that would create considerable ‘extra’ work for me, I now know exactly why I made this decision. Although working as a Clinical Nurse Consultant, which is described as a ‘leadership’ position, I had never really understood what leadership in nursing truly entails – but I was about to find out.

My odyssey through the analysis of the words of these participants, the many books I read in order to write a comprehensive literature review and the frequent ‘serendipitous’ incidents I encountered on the way have formed a unique backdrop to the development of a deeper understanding of many of the ‘realities’ of nursing leadership. It is, therefore, with pride and certainty that I can now say that despite, and perhaps because of, the many hiccups along the way, this PhD has provided me with innumerable opportunities to celebrate the breadth and depth of my own human experiences and develop a new passion for my profession.

Chapter 1 - Introduction
1.1.2 MY PHILOSOPHICAL BACKGROUND

My own academic journey started later rather than earlier. Being the first in my own family to enter academic life, it was with great trepidation that, at the age of 45, I began a conversion degree offered to Registered Nurses with hospital-based certificates. At this time, I was fearful I did not have the ability to successfully complete a Bachelor degree and I worried, often in silence, about how I would be able to balance my working life and my family with the rigours of studying. Little did I know, however, that what lay ahead would deeply change both my professional and my personal ways of engaging with the world.

During my nursing training at Westminster Hospital (London) in the late 1960s, I had experienced, at first hand, the English certificate-based system of nurse training. Steeped in the old traditions, the hierarchical structure of my training hospital did not allow for any form of dissent. I, consequently, ‘knew my place’ and never questioned the opinion of my ‘seniors’, least of all the medical officers. Although going on to work as a Director of Nursing of a small nursing home in Australia during the 1970s and then, much later being appointed into a Clinical Nurse Consultant role in a large public hospital, I remained reluctant to question the ways of the world of health care.

It was left to my academic work to provoke the necessary, if rather belated, changes in my attitude towards my profession as it led me away from my previously blind faith in the scientific models of consciousness in which I had been trained, towards a holistic understanding of the human state as primarily one of an embodied and yet non-material state of consciousness that cannot be quantified by logic. Consequently, during my Bachelor degree in the mid 1990s, I became fascinated with the phenomenological and existentialist philosophies of the twentieth century, in particular that of Martin Heidegger, on whose work I based the methodology of my Bachelor Honour’s study.

My own study of Martin Heidegger’s work, as I set aside conventional logic, was one of entering into new hermeneutic meanings. It was a journey and a search for being. To say that I have ‘understood’ Heidegger would be hypocritical as I have come to agree with Steiner (1978) in: “It is not ‘understanding’ that Heidegger’s discourse solicits primarily. It is an ‘experiencing’, an acceptance of felt strangeness” (p. 18). In this way, I allowed my Bachelor Honour’s thesis to take me on a journey that would assist me in my understanding of myself as a person and as a nurse. As such, it began a process that was eventually to
bring about considerable changes in my philosophical stance towards my profession; changes that have now continued into this PhD study.

1.1.3 EXPERIENCES DURING THIS STUDY

As I look back now, I am overawed by the innocence, or perhaps naivety, with which I first engaged this PhD work. Buoyed by my recent academic awards and, rather paradoxically, fuelled by a deep-seated fear of the magnitude of the task ahead, I boasted that I could ‘knock it off’ in no time - after all, wasn’t a PhD something like a ‘big’ Honour’s thesis? The warning from many, that a PhD would irrevocably change me as a person, went unheeded. As I proceeded with the necessary formalities of obtaining ethics approval, followed by the analysis of the first round of interviews, the doubts began to build. I knew absolutely nothing about Clinical Development Units, nor leadership, for that matter! As I began to transcribe the interviews, the transcripts appeared void of much data at all. To me, they had nothing of the intensity I had found in my Honour’s study when people had discussed their emotionally charged experiences of having diabetes. Oh, why hadn’t I decided to develop a study on diabetes; something I understand in great depth?

Even so, on the surface all appeared to be going well as I continued on with the second round of interviews, my preliminary analysis and even a publication on the research so far (Atsalos & Greenwood, 2001). While my analysis could be described as an adequate representation of the words of the participants, I nevertheless knew that I was stuck at a very superficial stage that did not, as yet, display the depth of a rich hermeneutic phenomenological study. Temporary relief was, however, in sight in the shape of my literature review: it is a way of procrastinating that has been designed by the gods themselves! With circumstances forcing me to take steps to overcome my fear of writing about something ‘I knew nothing about’, I then proceeded to compose an extremely long literature review as I postponed the dreaded moment of creativity. It was this literature review, however, that was to be largely responsible for the prophesised ‘irrevocable changes’ that would take place within me. The length of time I spent studying numerous books on philosophy, management and leadership was necessary to enable me to develop a critical approach to many aspects of current leadership practices in nursing that I was, somewhat ironically, concurrently epitomizing in my own practice.
As I have been on what is often described as a ‘spiritual journey’ for some years, I have become accustomed to looking into the mirror of my own prejudices in order to develop a deeper understanding of myself. So, eventually, I began to use the words I had written in my literature review to look at my own professional practice. I was shocked at what was revealed to me in this mirror! Although I had worked as a Clinical Nurse Consultant for many years, I had never before understood my own leadership inadequacies so unambiguously.

This proved to be only the beginning. As my new understandings of myself then began to circle back towards this study, I next became aware of the changes taking place in the way I was interpreting the words of the nurse leaders who took part in this study. I was gradually becoming less judgmental of these participants. No longer creating a barrier by projecting my own fears and inadequacies as a nurse onto the participants, I was now bringing their words into my own hermeneutic circle and understanding them in the light of my new understandings of myself. Were their experiences not, after all, so similar to my own concurrent experiences as a nurse? I felt a distinct softening as I developed a deeper empathy of these participants that was, I now believe, akin to my reactions to the experiences of the participants in my previous study on the experiences of people with diabetes.

I was, in effect, consciously experiencing the wonder of the hermeneutic circle that I had discussed, in theory, in my thesis. I could so clearly see how my own circle was inexorably entwined with the circles of the other participants. While my own experiences were influencing the analysis, the words of the participants were, simultaneously, influencing my own understandings of myself as a person, as a practicing nurse and as a nurse researcher. In other words, as time had moved on, I had moved along with it, as had my understanding of the experiences of the participants. At that moment I was reminded of Heidegger, who describes our way of existing as ‘living time’, rather than ‘living in time’ (as if time were a separate entity). The changes I was experiencing could not be separated from the passage of time, as phenomena that exist in and of themselves, beyond the meaning I was attaching to them. Moreover, I was also reminded that social reality exists only within meaningful social interactions, which create the context for the development of our perceptions and interpretations of our world (Heidegger, 1962). For me, these social interactions had
occurred as I had ‘discovered’ new aspects of the experiences of the participants, previously hidden from my view, albeit within the texts.

Simultaneously, I questioned if my previously held prejudices had, in any way, been unusual. My thoughts were, and still are, that similar reactions may be common within our profession. Do we not frequently find it easier to feel empathy towards our patients than towards our own colleagues? After all, are our colleagues not better ‘targets’ for our own projections of inadequacy? This experience was, for me, the source of a very deep questioning that will undoubtedly require further action on my part before it is completely resolved.

Looking back now, I am struck by the wonder I feel at the degree of personal and professional change that I have experienced because of this study. Strange as it may seem to the reader, it was not until I had reached a point where I could not hit my head on the brick wall of procrastination any longer that my creativity returned in such a way that I can truly say my thesis began to flow. Although some of my experiences could be described as nothing less than traumatic I will, nevertheless, be forever grateful for this opportunity to catch a glimpse of some of the ‘truths’ that hang around my own neck. I now realize that I first had to turn the mirror onto myself and allow the healing of my old spiritual wounds before I was capable of listening to the words of my colleagues with the requisite degree of humility. Such understandings only enhance my gratitude to the participants who, when they shared their experiences with me in such an open and honest way, displayed a trust that I would conduct the analysis of their words with respect, honesty and courage.

It is in this way that I believe I have brought my own lived-experience as a human being and a nurse into this study. It is also in this way that I have been allowed to glimpse the everyday lives of these participants. It is not, however, one of removing my own nursing experience from the interpretation. My own lived-experience during this study has, therefore, been one of discarding my expectations; not of under-valuing my professional nursing experience.
1.2 THE STUDY

1.2.1 OUTLINE OF THE STUDY

This study follows the experiences of a small group of Australian nurse leaders over a 3½ year time frame that began soon after they agreed to take part in an initiative to develop their wards/units into designated nursing development units that were called Clinical Development Units (Nursing) (CDUs(N)). This new initiative had been developed by a Professor of Nursing with a joint appointment between the area health service and the local university to cultivate and nurture an area-wide nursing research culture. As concurrent published literature of British Nursing Development Units (NDUs) described similar aims and claimed some degree of success in this area, she set up a similar program.

A request for expressions of interest was sent out to all senior nurse managers and clinical nurses in the area health service. The Nursing Unit Managers (NUMs) and Clinical Nurse Consultants (CNCs) who were chosen to lead their existing wards/units into this new initiative first attended a specially prepared leadership program to learn more about the British NDU concepts and to hone their own leadership skills. Nine of these leaders successfully completed the course, which was spread over six months, and went on to lead their units into the official launch of this new Australian CDU(N) initiative in 1997.

Very little formal research has been conducted into the experiences of such leaders in order to study the phenomenon of nurse leadership in similar units in the United Kingdom (UK). This is despite the fact that there is evidence that the stress placed on some of the British NDU leaders is threatening the services offered (King's Fund Centre, 1994a) and even the survival of the units themselves (Greenwood, 1997). This study set out to address this deficit by developing an understanding of the lived experience of some of these Australian CDU(N) leaders. Two rounds of interviews, spanning their first two years, were originally planned for this study as this was the time when the stressors associated with CDU(N) leadership were more likely to begin to impinge. As the study progressed, however, and many of the original leaders left and were replaced by others, it became clear that the analysis of the experiences of all of these CDU(N) leaders would be greatly enhanced by a third round of interviews. This was then conducted approximately 3½ years after the first round. In total, 23 interviews were conducted with 14 people.
1.2.2 ROLE MODELS FOR THESE NEW AUSTRALIAN UNITS

The term CDU(N) and the philosophy of care adopted by this new project in Australia were based on similar units in the UK, most of which are called Nursing Development Units (NDUs). The first NDU was developed in the early 1980s by Alan Pearson at Burford, near Oxford (Johns, 1994; Pearson, 1984a, 1992). Although this was a small community hospital, it proved to be the cradle of a movement in nursing that was to spread widely throughout the UK (Neal, 1994; Redfern & Stevens, 1998; Vaughan, 1992a). Two other NDUs were to be opened within a few years: the Oxford NDU at the Radcliffe Infirmary (Pearson, Punton, & Durant, 1992; Pembrey, 1989) and the Tameside NDU near Manchester (Wright, 1991a).

The national recognition that followed the almost revolutionary changes that created these highly acclaimed centres of excellence (Salvage, 1989a; Vaughan, 1992a; Wright, 1991b), from wards that had long been plagued by low levels of staff motivation and poor nursing care, spurred others on to attempt to develop similar units, often as part of much larger projects. As these new projects sprang up, fresh titles were given to some of these units. The term Nursing Development Unit was, consequently, expanded over time to include: Clinical Development Unit (Nursing) (CDU(N)), Professorial Nursing Unit (PNU) and Practice Development Unit (PDU). It is of note that the latter differ from the other units in that they aim to incorporate disciplines other than nursing into the new philosophical approach of these units, thus expanding the concept beyond the confines of a single discipline.

The first of the large projects was developed under the umbrella of the King’s Fund Nursing Development Program, set up in London in 1989. Although this project has since wound down, it operated into the mid-1990s on both public money and private donations. It developed a large number of NDUs throughout the UK and conducted several systematic reviews, the last of which was published in 1997 (Redfern, Norman, et al., 1997). The Yorkshire Regional Health Authority (1992) and later the Institute of Nursing (1995) of the University of Leeds also developed their own program, now coordinated by the newly named Centre for the Development of Nursing Policy and Practice (2000). As this centre charges the individual organisations for its services, this scheme is largely self-funding (Alison Ferguson, personal communication, June 8, 1998). Other more recent
developments involve a similar scheme administered by the University of Northumbria at Newcastle (1998).

Similar units, called NDU, PNU, or CDU(N), have also been developed in Australia. The most well-known of these were instigated by Alan Pearson in Victoria (in the late 1980s), Bart O’Brien in Adelaide (in 1991), and Jennifer Greenwood in Western Sydney (in 1997). The academics who initiated these projects were able to provide support to the clinical nurses with funding allocated by the local area health services and the local universities.

1.2.3 THE NDU CONCEPT

Even after the development of an extensive literature review for this thesis, it remains difficult to find a simple way of distinguishing an NDU from any other innovative unit because the package of concepts described in the literature as comprising an NDU are not unique to these units. Indeed, such concepts are widely discussed in the nursing literature. There is, however, a great deal of published literature that lists the successes of many of these units. These include: improvement in nursing care (Baker & Pearson, 1992; Bamber, Johnson, Purdy, & Wright, 1989; Black, 1993; Pearson, Durand, & Punton, 1988a; Pearson, Durant, & Punton, 1989; Turner-Shaw & Bosanquet, 1993); enhancement of staff satisfaction (Bamber et al., 1989; Black, 1993; Turner-Shaw & Bosanquet, 1993); and increased patient satisfaction (Pearson et al., 1992).

As very little formal research has been conducted to date to confirm these claims, apart from some in-house publications from the King’s Fund and Leeds University Programs (in particular Black, 1993; Gerrish, 1999; Redfern, Norman, et al., 1997; Turner-Shaw & Bosanquet, 1993), these assertions are based largely on anecdotal evidence (Draper, 1996; Lorentzon, 1994). The findings of a study by Avallone and Gibbon (1998) into nurses’ perceptions of their work environment in three NDUs bring these claims into question. While their study was very small, their findings nevertheless suggest that, while some nurses expressed a high degree of satisfaction, this was not consistent over the three NDUs they surveyed. It is of particular note, however, that the earlier successes at Burford, Tameside and Oxford were judged to be credible enough to persuade the British Government and other private and public bodies to invest large sums of money in developing individual units and wide-scale programs, many of which continue to this day.
The main assumption behind the ongoing development of NDUs is that patient care cannot be improved without providing the means to expand the knowledge and skills of the nursing staff (Freeman, 1996). These units have, consequently, been described as identifiable nursing care settings that maximise the therapeutic function of nursing through commitments to improving professional nursing care and encouraging evidence-based practice (Greenwood, 1999a). While the main aim is to develop nursing practice that is patient-focused, emphasis is also placed on the development of the team, support is provided for staff development and dissemination of work through publication and networking is encouraged (Freeman, 1996; Gerrish, 1999; Greenwood, 1999a; Greenwood & Kearns, 1996; Redfern, Norman, et al., 1997; Vaughan, 1992a). All of these NDU/CDU/PDUs are led by clearly-identified clinical nurse leaders, with the recently developed Australian CDU(N) leaders being encouraged to develop a leadership style based on principles of transformational leadership (Atsalos & Greenwood, 2001; Greenwood, 2000a).

1.2.4 PHILOSOPHICAL BASIS OF THE STUDY

As I set out to investigate the experiences of a group of nurse leaders as they attempted to make changes to their existing wards or units, I knew I would require a research methodology that could interpret the meanings they developed as they progressed through these changes. A methodology that would reveal the individual phenomena as they were experienced, while still retaining a view of the ‘whole’ could not, therefore, begin with operationalized definitions. As the situation in which these participants found themselves was so unique that it will never again be repeated, neither did this study need to set out to develop a theory others could follow.

I consequently chose to base this study on the phenomenological hermeneutic philosophy of Martin Heidegger. As a hermeneutic study, it was not my intention to judge, as positive or negative, the individual views of these participants. I aimed only to listen carefully to the stories they told of their experiences and to present my own interpretation of our conversations. Accordingly, the analysis of their words marked a point where the hermeneutic circles of the 14 participants overlapped with my own as I strove to stay true to their experiences, while reinterpreting them within my own hermeneutic circle of understanding. As with the philosophy of phenomenological hermeneutics, this study does
not, therefore, purport to having discovered any new definitive ‘facts’ about human behaviour; but offers a new interpretation of some of the experiences of these participants.

Furthermore, in line with the hermeneutic recognition of the importance of questioning and supported by the claim that, “to find a new point of departure in philosophy always means being original in the sense of seeking the origins” (Inglis & Steinfeld, 2000, p. xiv), the development of this thesis incorporates the experiences of these participants into my own philosophical search for a hermeneutic framework that can render visible some of the presuppositions on which the Western conception of ‘being a nurse’ is based.

1.3 ORGANISATION OF THIS THESIS

The Heideggerian hermeneutic underpinnings of this study have informed the way this thesis has been put together. Martin Heidegger (1962) has said that we are born into a world replete with meanings that will influence our interpretations of our subsequent experiences and our personal understandings. Indeed, there is much in the stories these participants have told that resonates with our shared heritage, as citizens and as nurses. Accordingly, I chose to disclose many of the experiences of these participants, firstly, in the form of a mythological story. I believe that the positioning of this story as a preamble to this thesis not only provides the reader with an immediate raison d’être for the specific path I have taken through the literature review, but I also believe it to be a more sensitive approach to disclosing the juxtaposition of excitement and struggle, of expectation and disappointment, and of joy and pain that the participants revealed in our conversations. Myths disclose our archetypical natures by crossing all boundaries of time, sex or culture. As such, they are universal forms with which we can develop new understandings of ourselves and others. Perhaps, most importantly, myths do not set out to judge or condemn but merely to remind us of some of the more important aspects of what it is like to be human in our complex, and sometimes alien, world (Campbell, 1988).

Throughout the formulation of this thesis, I have been acutely aware of the influence of Western history and culture on what is considered ‘acceptable’ in nursing practice. The literature review, which is spread over two chapters, consequently aims to provide an historical backdrop to some of the expectations placed upon these nurse leaders as they attempted to develop their wards or units into designated centres of excellence. The first of these two chapters, Chapter 2, paints a detailed picture of the history of nursing units,
beginning with the very first NDU in Burford in Oxfordshire and ending with some of the latest units known to have been developed in Australia. As the focus of this study is on the experiences of nurse leaders, the second part of the literature review, Chapter 3, examines the relevant aspects of leadership theory uncovered from the published works of a wide variety of disciplines. This chapter concludes with a brief review of the development of nursing over the past century in order to illuminate many aspects of the dilemmas current nurse leaders face as they attempt to instigate new nursing innovations within the hierarchical milieu of the Australian health care system.

Chapter 4, which is the philosophy and methodology chapter, begins by developing this theme further as it places into context the influence of Western philosophy and culture on the use of research methodologies in health care. The remainder of Chapter 4 discusses the philosophical underpinnings of Heideggerian hermeneutic philosophy, on which the methodology of this study is based, and the ways this philosophy has influenced the analysis and, consequently, the findings of this study. This chapter concludes with details of the method I employed.

All details of the context, analysis, discussion and conclusion of this study are to be found in Chapters 5-9. Chapter 5 begins by discussing the context of this study and concludes with a brief introduction to the participants. Chapter 6, the findings chapter, incorporates quotes from our taped conversations into an extensive analysis and, as such, substantiates the themes that were tentatively introduced in the mythological tale that was told in the Preamble. Chapter 7 then develops this interpretation by further illuminating these themes in relation to the methodology of this study and previously published literature.

The final two chapters, Chapters 8 and 9, discuss the implications of the knowledge gained from the experiences of the nurses who participated in this study. These discussions, conclusions and recommendations are presented in a format that is designed to establish a relationship between the findings of this study and the arguments developed throughout this thesis.
Chapter 2

HISTORY OF NURSING UNITS

This study is based on the experiences of a group of nurse leaders as they attempted to develop their wards or units into Clinical Development Units (Nursing) (CDUs(N)) in Australia, beginning in 1997. The philosophy that underpinned the initial development of these units was adapted from an extensive nursing movement that originated in the UK in the 1980s and continues to flourish, although somewhat altered from its original form.

In order to paint a comprehensive picture of the British Nursing Development Unit (NDU) movement that these new Australian CDUs(N) attempted to emulate, this chapter describes the fundamental characteristics of the three pioneering British NDUs, situated at Burford, Oxford and Tameside. It also traces the history of this nursing movement, from its early beginnings in a small community hospital in rural England, through the heady days of establishing a high national profile, and up until the present day, as its influence is spreading around the globe. As such, this chapter takes the first step in unravelling the myth of NDU leadership that these Australian CDU(N) leaders were encouraged to adopt as their new vision for their units.

2.1 SETTING NEW STANDARDS IN NURSING LEADERSHIP

During the 1970s and 1980s, a small band of visionary nurse leaders played a very significant role in effecting significant change and disseminating a variety of new concepts that were to spread widely throughout the UK, largely through an influx of registered nurses into the tertiary sector. Although some of the most influential changes and nursing theories initially stemmed from America, it was the clinical nurses in Britain who carried the banner forward for professional nursing, referred to by Salvage (1990) as the “New Nursing” (p. 42). This story of Nursing Development Units (the precursors to subsequent Clinical Development Units, Practice Development Units and Professorial Nursing Units) begins with the work of two of these leaders: Alan Pearson and Steve Wright.
Alan Pearson is best known for having developed the first NDU at Burford Community Hospital in England, which he transformed from an outdated and grossly inefficient cottage hospital into a widely acknowledge centre of excellence. Immediately prior to his appointment at Burford, he had completed an innovative Masters degree course at Manchester University under the tutelage of Jean McFarlane (1980). Alan Pearson (personal communication, 16 August, 2001) later described his experiences during this course, which he shared with many other nurse leaders who went on to play pivotal leadership roles at the time, as akin to having had ‘the stuffing knocked out of them’ in the first year in order to build up their confidence and ideas for developing practice in the second year. The new ideas he formed at that time, in particular the series of essays he developed on clinical nursing, which were based largely on the new American and British innovations, later formed the foundation for his book ‘The Clinical Nursing Unit’ (Pearson, 1983a).

Steve Wright, who attended the same course as Pearson, was appointed at a similar time as one of the first British joint appointments in geriatric nursing at Tameside, near Manchester. Although other nurse leaders went on to contribute greatly to the expansion of the NDU movement in the UK, none were able to match the effects Pearson and Wright had on the British NDU movement. Admittedly, they incorporated concepts that had been developed by others, but their work was unique in the way that it was put together to suit their individual environments. As this literature review will show, none of the initiators of the large-scale developments of NDUs, who were to use the same name and to adopt many of the same concepts, were able to match their initial innovations. Consequently, the majority of the NDUs/PDUs/CDUs(N) that have been developed since continue to trace their lineage back to the early work of Pearson and Wright (Baker & Pearson, 1991; Gerrish, 1999; Greenwood, 1999a; Redfern, Norman, et al., 1997).

2.1.1 EARLIER INFLUENCES

The work of these two British nurses was underpinned, in large part, by new developments that came out of the United States of America in the 1970s. Consequently, before discussing the development of the three pioneering NDUs, this section will examine two aspects of professional nursing care delivery that were on the ascendancy at the same time. Not only did these models of care have a strong influence on the philosophy that underpinned the earlier NDUs, but aspects of this work continue to live on in the ways
modern NDUs are defined. The first is the work of Lydia Hall, an American nurse theorist, and the second is the development of primary nursing.

2.1.1.1 THE LOEB CENTRE

Pearson has acknowledged the considerable influence of Lydia Hall in the development of his own philosophy of care (Pearson, 1984b, 1995; Pearson et al., 1992). Hall worked as the director of the Solomon and Betty Loeb Centre, which opened at the Montefiore Hospital in the Bronx, New York in 1963. Her philosophy was then, as now, revolutionary. She pioneered the concept of ‘nursing beds’, where nursing is designated as the principle therapy and patients are admitted if their primary need is for therapeutic nursing care. As the director of the centre, she wrote the job descriptions and hired all the staff, including the medical officers (Hall, 1969; Pearson, 1984b). Her work was so unique that, during the 1970s and 1980s, the Centre was visited by hundreds of nurses from around the world, including Alan Pearson (Pearson, 1984b).

The Loeb Centre, as described by Hall in 1969, was an 80-bed unit, staffed by 44 registered nurses, deemed ‘professional nurses’. Other untrained staff were called ‘messenger attendants’ because their role entailed helping the professional nurses with “things” (Hall, 1969, p. 88), rather than people. So convinced was Hall that only registered nurses should perform professional nursing care that she said of the messenger attendants, “these people get fired if they ever try to substitute for a nurse” (Hall, 1969, p. 88). The philosophy of care adopted at the Loeb has since been described as a form of primary nursing (Baker & Pearson, 1992; Degerhammar & Wade, 1991; Griffiths & Wilson-Barnett, 1998).

Hall set up the Loeb Centre for those patients who were no longer in medical crisis but required nurturing rehabilitative nursing care (Alfano, 1971; Hall, Alfano, Rifkin, & Levine, 1975; Pearson, 1984b). She argued against the way registered nurses imitated the function of the medical staff, while also becoming their assistants. Said Hall (1969), “I guess that’s okay if nurses want to practice that way, but I wish they would stop calling themselves nurses” (p. 87). She also bemoaned the popular concept of nursing as task-orientated and its organisation as team-orientated and, in 1964, she proposed a theoretical concept of the professional nursing process. She defined ‘being a patient’ as three overlapping circles, each of which denote one aspect of the patient’s experience: Care (of the body), Cure (of the disease) and Core (of the person), all of which overlap and interact with each other (Hall, 1964; Hall, 1969).
The first of these circles, the Care, which relates exclusively to nursing, represents the intimate caring or nurturing functions of nursing that the professional nurse provides to the patient. The Cure circle where, according to Hall, the nurse probes, pokes and questions, is shared between nurses and other members of the team. The third circle, the Core, involves the therapeutic use of self as the health professional is able to assist the patient to express any feelings they may have previously denied (Hall, 1964, 1969).

Hall was heavily influenced by the work of the American nurse theorist, Martha Rogers (1970) and the psychotherapist Carl Rogers (1957, 1962), both of whom stressed the need for authenticity in the health professional-patient relationship (Marriner-Tomey, 1994). Hall encouraged her nursing staff to assist their patients to achieve their maximum potential through a process that involved learning more about themselves as people (Hall, 1969; Pearson, 1988a). She espoused a non-judgemental environment where patients could ‘be themselves’ and express their feelings openly (Hall, 1969) and where, by a therapeutic use of self, the nurses could help them to explore any anxiety they had about their illness.

An unpublished study of the longitudinal effects of admission to the Loeb Centre (Hall et al., 1975) reported success in terms of patient outcomes, nurse satisfaction and financial savings. However, in 1998 Griffiths and Wilson-Barnett published some aspects of this study and concluded that the results should “be regarded as providing only the weakest support for the benefits of the services of the Loeb Centre” (p. 1186). Although the evidence they present to support this view detracts from some of the conclusions of the original report, there is considerable evidence that Hall had a significant influence on a number of American nurses (Marriner-Tomey, 1994) and many connected with the British NDU movement (Ersser, 1997; Muetzel, 1988; Pearson, 1984b; Poirier, 1975).

Lydia Hall continued as Administrative Director of the Loeb until her death in 1969 (Marriner-Tomey, 1994), when her successor, Genrose Alfano (1971) continued her work (Poirier, 1975). In 1984, however, a very sad chapter in the history of nursing occurred when the Loeb Centre ceased to exist as a nurse-led in-patient unit, as it was converted into a nursing home. When Griffiths visited it in 1996, he was surprised to see that, even though some of the staff that had been present during Pearson’s visit in 1984 were now working as senior nurse administrators, the therapeutic nursing philosophies they had worked so closely with, and said they still believed in, were no longer visible. These nurses were now so over-burdened with paperwork that ‘the system’ had taken over as the nursing staff at the
Loeb were bereft of a strong leader (Griffiths, 1997). As Griffith asserts, the lessons to be learned are not new. The Loeb had become a victim of political pressure as financial interests were deemed paramount to good nursing care. The political reality was that none of the previously committed nurses held sufficient power to prevent the demise of this centre of excellence. As will be shown later in this chapter, this pattern was to repeat itself in Oxford in 1989.

2.1.1.2 PRIMARY NURSING

The concept of primary nursing, which developed in response to the inadequacies of the team approach, has been described as a return “to the original way of delivering nursing” (Pearson, 1988b, p. 23) and “to the concept of ‘my nurse’ and ‘my patient’” (Manthey, Ciske, Robertson, & Harris, 1970, p. 65). It was developed at the University of Minnesota Hospitals in late 1968 and first reported by Manthey et al. (1970) and Manthey and Kramer (1970). Despite the fact that primary nursing can be very demanding on nurses, it was adopted with gusto by the earlier British NDUs and, according to the literature, was instrumental in their success. Indeed, since that time, many NDUs have followed suit.

Primary nursing has been described as “advanced nursing” (Pearson, 1984c, p. 16) because primary nurses must be highly skilled. Although similar in structure to the case method, primary nursing incorporates strong components of nursing autonomy, accountability and responsibility (Baker & Pearson, 1992; Manthey et al., 1970) as primary nurses take total responsible for the care plans of their own patients (Johns, 1990a). It is a complex concept that can only be developed over time because it requires nurses to develop an effective therapeutic use of self within authentic relationships with their patients (Manthey, 1988a).

Primary nurses coordinate the care of other health professionals (Baker & Pearson, 1992) and are required to leave adequate instructions and information to allow all care to continue in their absence (Manthey, 1980; Manthey & Kramer, 1970). Consequently, much of the success of this system of care delivery has been attributed to the development of collegiality and trust between the primary nurse and the associate nurses, who carry out the care plan in the absence of the primary nurse (McMahon, 1990; Mead, 1990). In some institutions, primary nurses are contacted while off duty before any changes are made to the care plan. This occurred at the Loeb Centre (Zander, 1980), Burford (Swaffield, 1983a) and at the Oxford NDU (Tutton, 1987).
Such was the impact that primary nursing had within the first two decades following its conception that, by 1987, primary nursing developments had already taken place in Belgium, Norway, Japan and Australia as well as in the USA, Canada and the UK (Wright, 1987a). In 1988, the King’s Fund Centre in London set up the Primary Nursing Network and, within little more than a year, and with very little advertising, over 400 clinical units in the UK had become members (Ersser, Tutton, & Salvage, 1990).

Primary nursing is, however, not without its critics (Bowers, 1989; Garbett, 1993). Its success or failure is subject to the depth of understanding of the concept of the individual nurses who practice it and the strengths and weaknesses of the organizational structure in which it is implemented (Garbett, 1993; McMahon, 1996; Mills, 1995; Vaughan, 1990). It has also been noted that not all registered nurse are willing to take on the extra responsibility that primary nursing entails (Ciske, 1982). This fear of, and resistance to, ‘being responsible’ forms such barriers to professionalism that Manthey (1988b) has said that the introduction of primary nursing should be preceded by the development of a ‘safe’ environment where autonomous practice can be promoted. As this thesis will show, this is exactly what occurred in three outstanding Nursing Development Units that were developed in Britain in the 1980s.

2.1.2 THE THREE PIONEERING NDUs
This section discusses the development and achievements of the three ‘original’ NDUs at Burford, Oxford and Tameside, to which the majority of subsequent NDUs, PDUs, PNUs and CDUs(N) trace their origins.

2.1.2.1 BURFORD NURSING DEVELOPMENT UNIT
Snuggled into the picturesque Cotswold Hills of Oxfordshire in England lies the small rural town of Burford. In the late 1970s, Burford Cottage Hospital (later renamed Burford Community Hospital) was a small nine-bedded unit with orthopaedic, physiotherapy and chiropody outpatient clinics. Eighty seven percent of inpatients, mostly local residents, were over 65 years old. The staff comprised a full-time resident matron and registered and ancillary nursing staff; while medical care was provided by the local General Practitioners. Dominated by a medical-model approach, nursing care was delivered through a task-orientated system (Pearson, 1984a, 1985, 1992, 1995). When the National Health Service was reorganised and the Oxfordshire Health Authority deemed Burford Hospital to be
outdated and uneconomical the Burford community, many of whom identified closely with their local hospital, objected strongly to the proposed closure. A subsequent decision was made to keep the hospital open provided its cost-effectiveness was improved and, when the long-established matron retired in 1980, the Chief Nursing Officer for the local health authority seized the opportunity to develop the potential of nursing care (Pearson, 1985, 1992, 1995).

In 1981, Alan Pearson replaced the retiring matron, with the title ‘Nursing Officer’. His brief was to develop the nursing service at Burford. Aware that much of the drive to change nursing practice in Britain was being steered by nurse academics who were not concurrently involved in clinical care, he saw his new position as an opportunity to study the effects of the introduction of “the new norms” (Pearson, 1992, p. 7) on both service providers and recipients. Pearson, with his “‘laid-back’ style” (Flindell, 1992, p. 2) and creative thinking, brought a breath of fresh air to Burford Hospital. With no extra staff or money he began by introducing small, and yet radical, innovations that were, in a relatively short period of time, to establish a unified approach to nursing practice, management, research and education. He is also credited with having pioneered a comprehensive area health service by incorporating district nursing and health visiting services. It is clear from many of the publications of the time (for example, those of Swaffield, 1982, 1983a, 1983b, 1983c) that some of the innovations he introduced were nothing less than revolutionary to a discipline that ran largely on routine and control.

Pearson (1985) developed a systematic research-based approach to identify the effects of his proposed changes on health service provision. He employed a triangulation of methods in his before-and-after study. These included participant observation, surveys of the staff and the local population and Qualpacs, a measurement tool to assess quality of nursing care. He began with an in-depth assessment of concurrent practices at Burford. He noted, for example, that the local General Practitioners who had admitting rights to Burford Hospital displayed a “patriarchically benevolent” (p. 120) attitude towards the nurses. The nurses, whose primary concern was to get their work done according to a prescribed routine, displayed a low level of empowerment as they complained among themselves about the medical decisions while, simultaneously, displaying an unwillingness to openly question the medical officers. The patients, who were all passive recipients of care, completed the
conventional view of the idealized family: the father, mother and child trilogy, with the
doctor, nurse and patient playing their respective roles.

Alan Pearson, who was described as “an enabler” (Swaffield, 1983c, p. 14) encouraged his
staff to question their previously held attitudes to their work and their patients. While
influenced by the work of many nurse scholars, a large number of Pearson’s new
innovations were modelled on the work of Lydia Hall (Pearson, 1984b, 1995; Pearson et al.,
1992). He also introduced primary nursing to the unit and, in line with Hall’s belief that
only registered nurses perform hands on care, the ‘care assistants’ at Burford fulfilled a
similar role to the ‘messenger attendants’ at the Loeb (Griffiths & Wilson-Barnett, 1998).

In order to increase the nurses’ knowledge of contemporary nursing issues, an intensive
staff development program was introduced in an atmosphere that encouraged freedom of
expression (Pearson, 1985; Pearson et al., 1992). One of Pearson’s radical innovations
introduced at this time involved role-playing by the North West Spanner Theatre Group.
This was designed to help the nurses to introduce the nursing process by practicing their
communication skills in as realistic a situation as possible. This role-playing was followed
by lengthy discussions that allowed them to look more closely at their relationships with
their patients (Pearson, 1985; Swaffield, 1982). Simulations of how to complete a nursing
history also enabled the nurses to leave behind conventional ways of working and to
develop new skills, particularly in listening (Swaffield, 1983b, 1983c). Because of the
success of this technique, a subsequent series of role-playing scenarios included all the
health professionals working at Burford, thus improving the level of inter-disciplinary
understanding (Pearson, 1985). Although some of the new practices Pearson introduced
were “to some minds controversial” (Baker & Pearson, 1992, p. 6), they were, nevertheless,
arrived at by democratic process (Baker & Pearson, 1992), with changes made only after in-
depth discussions (Swaffield, 1983a).

In this, and other ways, the philosophy of nursing care at Burford transformed from its
previously task-orientated medical model to one that would embrace the holistic principles
of primary nursing (Pearson et al., 1992). In April 1983, there were three primary nurses at
Burford for nine inpatient beds (Swaffield, 1983a). These nurses were central to the
running of the unit as they were responsible for designing the care plans, which were based
on a detailed assessment of each patient’s normal home routine. The primary nurses, who
had 24-hour responsibility for the care of their patients (Pearson, 1983b), were then
contacted before any changes were made to these plans, by phone if necessary (Swaffield, 1983a). These care plans were then used for community nursing notes, which ensured a continuity of holistic care (Sutherland, 1991; Swaffield, 1983a, 1983b).

Patients were now being treated as partners in their own care as the nurses were encouraged to let go of a great deal of their control. Said Sue Punton, “If the patient disagrees I can’t impose my ideas on them. We share the care plan and together we list the problems and work out the goals and how to achieve them. I can point out the consequences – but the decisions are always the patient’s” (Swaffield, 1983c, p. 14). Brenda Beard, one of the registered Nurses at Burford, gave a graphic description of the ward environment when she said, “If you want an image of the nursing process, don’t think of it as a nurse neatly writing up notes. Think of a ward at 10.30am with unmade beds because some patients have chosen not to get up” (Swaffield, 1983a, p. 60). The nurses at Burford also frequently got to know their patient’s families, who were encouraged to offer solutions to problems and to suggest new innovations (Swaffield, 1983a).

The results of Pearson’s study supported his hypothesis that the changes that had been implemented were advantageous to the majority of the staff and the patients. The hospital culture was now more patient-centred, with a strong focus on nursing as the primary professional function. However, because of the small sample size, no definitive conclusions could be drawn (Pearson, 1985, 1992; Wainwright & Burnip, 1983a, 1983b). In his Doctoral thesis (1985), in a monograph (1989a) and also in his book, ‘Nursing at Burford: A Story of Change’ (1992), Pearson exemplifies his findings with direct quotes from many informal conversations recorded during the study, which leave the reader in little doubt of the depth of the changes that had taken place.

These radical changes did not go unnoticed in both the free press and the nursing journals (Pearson, 1995; Pearson et al., 1992; Swaffield, 1983d). The “fame explosion” (Pearson, 1985, p. 220) and the published case study articles (Punton, 1983; Sutherland, 1991) did much to awaken the nursing fraternity in the UK to the new innovations at Burford. Burford Hospital rapidly changed from a small cottage hospital with outmoded ideas to a working example of the way many nurses wished to practice nursing (Swaffield, 1983c). Swaffield (1983d) referred to the hospital as a unique “nursing laboratory” (p. 13) and a “powerhouse of ideas which could serve the whole nation’s nurses and build a badly needed bridge between research and everyday practice” (p. 16). These innovations proved so
popular that, by 1983, structured educational courses were being provided to nurses outside
the area on such subjects as individualised patient care, primary nursing and the
management of change (Pearson, 1995). In July of the same year, it was the focus for a
Nursing Times conference on change (Swaffield, 1983c).

Following the initial success of these radical changes, three nursing beds were established
at Burford in 1983 (Malby, 1996) and, from 1983 to 1985, Pearson conducted a funded
pilot study to evaluate the feasibility and effectiveness of these nursing beds for elderly
patients requiring rehabilitation (Pearson, 1989b, 1995; Pearson, Durand, & Punton, 1988b;
Pearson et al., 1992). Although the sample size was limited, the quality of nursing care at
Burford was shown to be significantly higher than in the control group at the acute hospital,
and at no additional cost.

For many years, the Burford NDU continued as a role model in the UK, in an effort to close
the theory-practice gap in nursing. Christopher Johns, who was appointed clinical leader
and hospital manager in 1989 (Johns, 1994), continued to introduce new innovations at
Burford. His re-evaluation of the model of practice concurrently in use, which had been
based on the Roper, Logan and Tierney model of nursing (for example Roper, 1983; Roper,
Logan, & Tierney, 1980), led him to create a new model of practice based on a “reflective
approach” (Johns, 1994, p. 18). He developed the new model, now called the Burford
Model of Practice, from a new articulation of the nurses’ own beliefs and values rather than
“what nurses already do” (p. 11). He disseminated information about this model, other on-
going developments of the unit, many new innovative educational courses and a joint
venture with the local Polytechnic via his publications (Johns, 1990a, 1990b, 1990c, 1991,
Health Authority, bereft of such innovative leaders as Pearson and Johns (who both moved
on to academic positions), it was unable to sustain its previously dynamic reputation. The
hospital was officially closed in 2000.

2.1.2.2 THE OXFORD NURSING DEVELOPMENT UNIT
Boosted by the findings of the pilot study at Burford and the promise of additional funding
from a charitable trust, Pearson and other senior nurses were able to canvas support from
the Oxfordshire Health Authority to open a new research-based nursing unit at The
Radcliffe Infirmary in September 1985. The new Oxford Nursing Development Unit also
developed from humble beginnings: Beeson Ward, an elderly care ward that had been

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closed for 6 months due to financial constraints (Pearson et al., 1992; Redfern, Norman, et al., 1997). When re-opened as an NDU, it was led by Sue Pembrey and consisted of 16 nursing beds for elderly people who required intensive nursing and rehabilitation.

This unit was unique in being the first to establish ‘nursing beds’ within an acute general hospital in Britain (Pearson et al., 1992). The fundamental difference between Beeson Ward and a more conventional ward was, consequently, that it was nursing-led and nursing-controlled, with nurturing as the chief therapy and medicine as ancillary. The physical environment of the unit was now radically changed to suit the physical, spiritual and emotional needs of the patients (Pearson et al., 1992). The stated aims of this new unit included the provision of professional therapeutic nursing care and the intention to close the gap between theory and practice by developing and researching the concurrent new nursing developments (Ersser, 1988). The basis of the NDU philosophy that Pearson had first developed at Burford remained largely unchanged (Pearson, 1995). As at the Loeb (Hall, 1969), the nursing staff of the Oxford NDU were not in uniform, likening the atmosphere to one of hosts (nurses) and guests (patients). Kinney (1987) also described how both nurses and patients were able to remove their ‘masks’ within the therapeutic relationship during such shared experiences as massage or quiet conversation, which contributed significantly towards the atmosphere of holistic healing that was nurtured on the unit.

The introduction of primary nursing, as set out by Manthey (1980) and practiced “in its pure form” (Pearson et al., 1992, p. 28), was not problem-free. As with their predecessors at Burford, many of these nurses had felt stressed and insecure when primary nursing was first introduced to the Oxford NDU. Some of them, consequently, found it difficult to develop the degree of closeness with their patients that is expected of a primary nurse. McMahon (1989) has since attributed this to the amount of change that these nurses, who had previously worked in pairs, experienced as they began to work independently and take on increased levels of responsibility. Both informal and formal peer support groups, however, were reported to have dissipated many of these reactions with McMahon reporting that “what stress there is in primary nursing is more than compensated for by the increased job satisfaction” (p. 40).

Pearson developed a new research study at the Oxford NDU in order to assess the effect of these nursing beds while, simultaneously, validating the findings of his previous study at Burford. This was conducted between 1985 and 1987. Although the sample size was, once
again, smaller than anticipated, the results confirmed improvement in patient care and cost efficiency of the new unit when compared to a similar conventional ward (Pearson et al., 1988a; Pearson et al., 1989).

So well known did this unit become that it attracted large numbers of visitors: 542 in 1988 alone (Pembrey & Punton, 1990). It was, however, the unique differences between this NDU and conventional wards that created the controversy that surrounded it, drawing both praise (from nurses and doctors) and criticism (particularly from the more conventional medical staff). Consequently, and despite its many accomplishments, success alone was not deemed the criterion for maintaining such a unique, innovative unit (Davidson, 1989). The Oxford NDU was closed down in 1989, with only six weeks notice (Sue Punton, personal communication, 3 June, 1998). This occurred in the same year that the King’s Fund Centre program opened four new NDUs in Britain. Although the reason given by the health authority was a shortage of money (Nursing Times, 1989), this experimental unit had operated under the same financial constraints as other, similar units.

Sadly, all the nurses associated with this unit were, yet again, to learn the age-old lessons of attempting nursing developments in organizations where the existing power structures are governed largely by the medical profession. While Alan Pearson (personal communication, 16 August, 2001) has related the demise of this innovative unit to a concurrent lack of strong nursing leadership, Sue Punton (personal communication, 3 June, 1998) has ascribed the closure to sabotage by some of the medical staff, who were unable to cope with the perceived loss of their power. The local Community Health Council was also said to be “very angered” (Nursing Times, 1989, p. 5). Their spokesperson saw a direct link between the decision to close the unit and the impending resignations of two consultant medical officers who had supported the unit; and accused the management of the health authority of not having “the guts to go to the (remaining) consultants and sort them out” (p. 5). Many British nursing leaders of the time, although greatly dismayed by the downfall of such an internationally renowned centre of excellence, were reported to pledge to “emerge from the setback wiser, bruised, but unabashed” (Naish, 1989, p. 13). It was not until 1994, however, that nursing beds could again be set up and evaluated in an acute hospital setting in the UK (Malby, 1996).
2.1.2.3 THE TAMESIDE NURSING DEVELOPMENT UNIT

Steve Wright, who was to become renowned for his pioneering nursing work with the elderly at Tameside, near Manchester, attended the same innovative Master’s Degree course at Manchester University as Alan Pearson (Wright, 1989). Like Pearson, Wright graduated with a strong determination to bring a new vision into nursing (Salvage, 1983a). Although they both worked primarily with the elderly and in small settings, they did not begin with identical plans for change. In contrast to Pearson, who had been appointed as ‘a last chance’ for a failing cottage hospital and had, therefore, been afforded unusual powers to make widespread changes (Alan Pearson, personal communication, 16 August, 2001), Wright was granted an academic/clinical joint appointment with clearly defined educational objectives (Wilkinson, 1983). Joint appointments, which are designed to bridge the gap between the role of the nurse academic and the expert clinical nurse who takes direct responsibility for patient care, were still in their infancy in Great Britain at this time so Wright centred his initial vision on this concept (Pearson, 1995; Salvage, 1983a; Wright, 1983). Two weeks after he commenced his new role at Tameside, he was joined by a second appointee, Sandra Mills, whom he described at one stage as his “other half” (Wright, 1983, p. 25) however it was Wright who went on to publish widely on the ensuing changes.

Prior to Wright’s appointment, this geriatric “workhouse” (Wright, 1987b, p. 10) consisted of four wards, staffed by “institutionalised” (Black, 1993, p. 21) auxiliary nurses who were unable to work anywhere else. The surroundings were described as “awful” (p. 22) and the deprivation of patients’ rights was evidenced by the lack of toilet doors, only occasionally replaced by shrunken and torn curtains that did little to conceal the occupants. When Wright attempted to bring in change, he described the situation in the unit as “highly volatile” (Wright, 1983, p. 26) as conflicts and problems arose from a resistance to change; most particularly those related to the transition from task allocation to patient allocation.

As at Burford and Beeson, an environment was created that encouraged the development of new knowledge by demonstrating that staff input was not only valued but also essential to the development of excellence in nursing practice. All of the staff were encouraged to question their own nursing values in meetings that were frequently held out of working hours; with heated debates involving nurses, doctors, patients and domestic staff (Wright, 1989, 1990). Despite the widely accepted opinion of the time, that nurses should adopt an
established theoretical model of practice, Wright set out to develop a nursing model that would be allowed ‘to grow’ in a safe environment where individual input was acknowledged (Wright, 1990). He was also keen to implement primary nursing in his unit, which he later acknowledged had enhanced the clinical credibility of the nurses (Wright, 1991c).

As these new innovations, which were gently nurtured over a five-year period, eventually required formal acknowledgment so that the aspirations of the staff could be granted new momentum, the official recognition of the unit as an NDU has been described as the next logical step (Bamber et al., 1989). Accordingly, the new Tameside Nursing Development Unit, which comprised two groups of wards at Tameside General Hospital as well as units for the elderly at two nearby hospitals, was opened in 1987 (Wright, 1987b). As previously described by Pearson at Burford, Tameside was now catapulted into the national limelight (Wright, 1990) and, by 1988, it was reported that this previously neglected ward now had a staff waiting list (Purdy, Wright, & Johnson, 1988). Tameside NDU also became famous through its staff development programs and its contributions to radio, television, journals, books and videos (Wright, 1991a). In 1992, The European Nursing Development Agency (TENDA) was established in response to calls for information and assistance from other organisations (Wright, 1992a, 1992b). Over the years, many lectures, workshops and special training programs were set up for registered nurses and care assistants. These included personal growth and awareness courses and international exchange schemes (Wright, 1991a).

Beginning in 1990, a study to evaluate the achievements of the Tameside NDU over a two-year period was funded by the Department of Health (Black, 1993). The study was largely retrospective, using a variety of methods (including questionnaires and interviews) to draw on the experiences of the staff involved in the changes. The results concurred with much that had already been written in the nursing journals, identifying significant improvements in both patient care and staff morale. The conclusions drawn credited, not only Steve Wright’s “persuasive powers … and personal vision” (p. 89), but also the substantial and durable commitment from the managers and the other clinical leaders, who had been very important (if not crucial) to the development of the NDU and its many successes. It must also be noted that this unit did not have ‘nursing beds’ until the mid 1990s (Malby, 1996),

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which may have contributed to a lower level of tension with the existing medical
hierarchical structure than that experienced by the nurses in Oxfordshire.

2.2 LARGE-SCALE NDU PROGRAMS IN THE UK

In the wake of the many successes of the Burford, Oxford and Tameside NDUs and the
increasing interest in the new innovative approaches they had spawned, two large scale
programs were set up to promote these new concepts. The first of these was administered
by the King’s Fund in London, which utilised both private and public funding to develop
and research new NDUs in the UK. Although this program wound down in the mid 1990s,
new units continue to be developed by a self-funding program maintained by the University
of Leeds. While other NDUs and PDUs have been developed, either independently (Lloyd,
1995) or by other smaller schemes (for example the University of Northumbria at
Newcastle, 1998), this section discusses some of the literature generated by these two larger
and better-known national programs.

2.2.1 KING’S FUND NURSING DEVELOPMENT PROGRAM

The London-based King’s Fund, an independent charity committed to improving health
care (Malby & Faulkner, 1998), set up its own nursing development program in 1989. This
was to be the first large-scale development of NDUs. This new program set out to
encourage clinical nursing developments in general nursing, midwifery and health visiting
through the development of further NDUs and the setting up of national NDU and primary
nursing networks (Pearson, 1995; Salvage, 1989b, 1995). It was headed by Jane Salvage, a
graduate of the same Master’s program as Pearson and Wright. Unlike Pearson and Wright,
however, Salvage had the advantage of access to a plethora of published literature on the
three pioneering NDUs to fall back on when developing this new program (Salvage, 1989a,

Many aspects of Salvage’s definition of an NDU closely mirrored those of Burford, Oxford
and Tameside, with one very noticeable difference. While the three pioneering NDUs had
aimed to develop and test new ideas and approaches, the focus of the King’s Fund team was
on replicating good practice. This was a major turning point in the history of nursing units.
Although the fledgling discipline of nursing was now better equipped to face the new
political climate of the 1990s (Page, Allsopp, & Casley, 1998), never again would the term
‘nursing units’ be linked with the same style of pioneering leadership that had so
dramatically seized the imagination of the nursing press during the heyday of the Burford, Oxford and Tameside NDUs.

Salvage (1989a) defined the term NDU as “a setting where care is given (or from which it is coordinated in the community) that aims to achieve and promote excellence in nursing” (p. 53). The primary aims of this new program were to develop nurses and nursing through workplace-based education programs; to promote the importance of valuing the staff; to encourage the active participation of patients, their families and friends in care planning; and to encourage the dissemination of any new information or nursing knowledge (Salvage, 1989a). A charitable trust agreed to provide funds to develop four NDUs in health authorities seen to be supportive of the projects. Additional small seeding grants of up to £1,000 were allocated through the King’s Fund NDU network to assist in the development of specific projects for a further 20 units (Pearson, 1995; Redfern, Norman, et al., 1997).

Steve Wright was one of the assessors who short-listed applications from 29 health authorities in England, Scotland and Wales. The units were each required to have an identifiable clinical nurse leader who was capable of steering through the necessary changes and staff who were willing to take ownership of the new project. The applications, which were largely developed by the NDU leaders themselves with little direct participation of the ward nurses (Turner-Shaw & Bosanquet, 1993), were graded on evidence of their progress and commitment to change, with the latter described as “an atmosphere of openness, trust and freedom to take risks” (Salvage, 1989a, p. 54). Although firm commitments were sought from the district health authorities to provide long-term financial support to the projects (Salvage, 1989a), it was later said that the involvement of higher management and the associated educational establishments varied considerably between the organisations (Turner-Shaw & Bosanquet, 1993).

The four successful units included two small medical units: one 15-bed ward in South London (Alderman, 1989a) and the other a 24-bedded unit in West Dorset (Alderman, 1989b). The other two units were elderly care rehabilitation units: the first, situated in Brighton (Alderman, 1989c), comprised 22 beds and the other was a 32-bed ward in Southport (Alderman, 1989d). A longitudinal study, which employed a variety of both qualitative and quantitative methods, was funded by the Department of Health to evaluate the first stage of development of these four new NDUs (Turner-Shaw & Bosanquet, 1993).
Their report substantiated previous claims to the crucial role played by the individual NDU leaders and the importance of securing the support of senior management.

In 1991, the provision of a further £3 million from the Department of Health to develop 30 more NDUs allowed innovations to be spread throughout a greater range of specialities and links to be established for dissemination of information. A large-scale evaluation of this second wave of King’s Fund NDUs was commissioned by the Department of Health in 1994. As it was too late to collect baseline data on the NDUs, the established NDUs were compared with matched units. Data was collected through a consultation seminar with the NDU stakeholders and interviews and questionnaires with NDU clinical leaders and staff. A number of journal articles (for example Christian & Redfern, 1996a, 1996b; Christian & Norman, 1998; Redfern & Murrells, 1998; Redfern, Normand, et al., 1997; Redfern & Stevens, 1998) and reports (for example King's Fund Centre, 1994b, 1995; Redfern et al., 1996; Redfern, Norman, et al., 1997) were published. Reflection on these publications indicates that, while many of these NDUs had developed new projects, there is very little data to support the anecdotal evidence of improvement in patient care (Gerrish, 1999; Nursing Standard, 1998).

In 1996, as the King’s Fund NDU scheme was drawing to a close, there were over 200 NDUs in Britain (Wright, 1996). As discussed by Redfern, Norman, et al. (1997), because the development of NDUs had been “most successful in the development of nurse-led intermediate care units for patients who have passed the acute phase of their illness” (p. 217) it was anticipated that the new developments would continue to spread to a wider variety of specialities. To this end, the King’s fund team encouraged the publication of a variety of strategies that had proved successful in developing nursing practice in these units (for example Copperman & Morrison, 1995; Evans & Griffiths, 1994; Kohner, 1994; Lathlean & Vaughan, 1997; MacGuire, 1993; MacGuire, Adair, & Botting, 1993; Marsh & Macalpine, 1995; Vaughan & Edwards, 1995).

There is, however, no published evidence that more than a handful of these units maintained the momentum over the long term. It appears that diminished access to additional funding played a major role in the demise of many of these NDUs (Healy & Shamash, 1997; Lipley, 1998). Said Lipley (1998), “when resources dried up three years on, many were forced to wind down” (p. 9). This is despite the fact that Barbara Vaughan (1996), who took over the directorship of the King’s Fund program in 1991, has stated that,
while funding was provided for research and evaluation, the King’s fund made no additional funding available for service delivery.

It is also of note that those who were intricately connected with this NDU movement have made frequent reference to the impact of national policy-making decisions in the development and survival of NDUs (for example Alderman, 1991; Garbett, 1992; Graham, 1996; King's Fund Centre, 1994a; Lipley, 1998; Mason, 1994; Turnbull, Reid, McGinley, & Shields, 1995; Vaughan, 1992b). Malby’s (1996) statement that the many “false starts were probably due to the concept being instigated before its time (as) the environment and culture … (were) not ready for such drastic change” (p. 26) further confirms the way that these units were, in many ways, held captive to the political climate of the day. Such statements also illuminate the dismal lack of functional power these NDU leaders held.

2.2.2 THE UNIVERSITY OF LEEDS PROGRAM

In 1992, Yorkshire Regional Health Authority developed an accreditation scheme of its own in order to support NDUs within the area (Malby, 1992; Yorkshire Regional Health Authority, 1992). This scheme, although short lived, gave rise to a much larger national scheme at The Institute of Nursing at the University of Leeds (1995), later to be renamed the Centre for the Development of Nursing Policy and Practice (2000), which continues to this day. This program defined an NDU as “a practice setting, which is recognised as being a ‘test bed’ or ‘laboratory’ for innovation, creativity and ‘leading edge’ practice for the organisation in which it is based and for the wider profession of nursing” (Institute of Nursing, 1995, p. 4). From the very beginning, this scheme differed, in one major respect, from its predecessor in that it emphasised the need to develop not only Nursing Development Units but also Practice Development Units (PDUs), which have a distinctly multidisciplinary focus on all aspects of leadership and care development (Gerrish, 2001; Institute of Nursing, 1995; Page et al., 1998).

While the King’s Fund relied largely on self-assessment for NDU status (Flint & Wright, 2001), this Leeds initiative utilises external facilitators to prepare the units and evaluate their level of readiness. The accreditation process is divided into various steps, on which the accreditation team provides comprehensive written feedback (Humphris, Rogers, & Moynes, 1995). Formal accreditation is not granted until the NDU is judged to have made adequate progress in each of the accreditation criteria (Gerrish, 1999). These criteria
anticipate the development of an environment that welcomes change and promotes nursing developments through ongoing nursing education and dissemination of new practice initiatives. Once again, the role of the NDU/PDU leader and the active support of management are seen as pivotal to the success of the unit. The commitments sought from the host organisation include the expectation that the unit will be supported and marketed and its activities incorporated into the organization’s strategic plans (Centre for the Development of Nursing Policy and Practice, 2000; Institute of Nursing, 1995).

All costs of accreditation are borne by the host organisation. In return, the accreditation body contracts to provide access to a supportive framework, guided by a team of expert clinical nurses and nurse academics (Centre for the Development of Nursing Policy and Practice, 2000). These project workers also guide the fledgling NDUs/PDUs through regular on-site visits and then, once the unit has been accredited, they encourage the many individual units in the network to work collaboratively and/or disseminate new knowledge (Alison Ferguson, personal communication, June 8, 1998). As accreditation is only awarded for a period of two years, funding is required on an ongoing basis if the NDU/PDU wishes to remain attached to this scheme.

2.3 NURSING UNITS IN AUSTRALIA

The development of several individual nursing units scattered around Australia, called Nursing Development Units, Professorial Nursing Units or Clinical Development Units (Nursing), was once again initiated by Alan Pearson, who had been appointed as the first Australian Professor of Nursing at Deakin University in Victoria. This section begins with a discussion of these units and some of the other individual units that have since been developed in Australia. The section concludes with a portrayal of a new initiative in Western Sydney by Jennifer Greenwood which, although short lived within the area health service, prompted the development of other CDUs(N) outside of this area health service.

2.3.1 THE DEVELOPMENT OF INDIVIDUAL AUSTRALIAN UNITS

Alan Pearson established two Professorial Nursing Units (PNU$s) in Geelong, Victoria, in 1988 and 1989. One of these was at Geelong Hospital (Baker & Pearson, 1991, 1992; Pearson & Baker, 1992) and the other was The Ernestine McKellar PNU at The Grace McKellar Centre (Crane, 1989; Donnelly, Johnson, Maloney, & O’Brien, 1990). While the latter was a rehabilitation and extended care setting, the former had a more acute care focus.
Nurses, once again, had full admission rights. The philosophy of the units reflected the needs of the patients for a supportive and homely atmosphere where they could recover from their illness and regain as much of their previous level of independence as possible. With the development of a research unit within a PNU and the provision of joint nursing appointments with Deakin University, the ground was prepared for the development of a strong nursing research culture (Baker & Pearson, 1991, 1992; Crane, 1989; Donnelly et al., 1990; Pearson & Baker, 1992).

In 1991 Bart O'Brien, who had worked at The Ernestine McKellar PNU for two years, took this philosophy to South Australia, where he developed the Julia Farr Centre NDU in Adelaide (O'Brien & Pope, 1994). This, too, strongly reflected the Burford philosophy due to his close association with Alan Pearson and additional guidance from Christopher Johns (O'Brien, 1996).

Although it appears from the literature that these units began with a great deal of promise, there is no evidence that the momentum was sustained. Alan Pearson (personal communication, 16 August, 2001) has attributed some of the problems he faced at Geelong to the difference in culture between the UK and Australia. Whereas, in the UK, his high profile and ‘celebrity’ status (as evidenced by the plethora of articles in the nursing literature and popular press) had facilitated his powers of persuasion with the local authorities, the more ‘egalitarian’ Australian climate had not provided this opportunity. Furthermore, he encountered a great deal of difficulty when he had tried to introduce the same after-hours on-call system for primary nurses. Sue Crane (1989), one of the joint appointees in Geelong, has also stated that she and her fellow joint-appointee regularly faced “a workload exceeding that which can be accommodated in a normal working week” (p. 24). In 1995, the Julia Farr Centre NDU closed “as part of Centre restructuring” (O'Brien, 1996, p. 237), while the others slowly faded into obscurity.

Despite the evidence that a number of similar units have been developed in various states of Australia, many have been short-lived. These include Bentley Lodge, which was opened in Western Australia in 1996. This NDU, which comprised a 54-bed unit for the elderly with mental illness, a day unit and a community team, has been said by Sarah Mott (personal communication, July 8, 2003), who was instrumental in developing this unit, to have failed to thrive due to the disinterest of the staff. In 1995, the NDU concept was adopted to the
local conditions of South Western Sydney by Greenwood and Kearns with the setting up of a Transcultural Nursing Development Unit (Greenwood & Kearns, 1996; McIndoe & Luck, 1997). Then, in 1996, a 29-bed psycho-geriatric unit for the elderly called Buchanan Nursing Development Unit was opened in Wallsend, New South Wales (Keatinge & Scarfe, 1998; Keatinge et al., 2000). In both of these units, despite the fact that the staff appeared to make good initial progress, once the active participation of the academic attached to each of these units was brought to an end, the formal structure of the units quickly wound down (Diana Keatinge, personal communication, January 16, 2003; Loretta Luck, personal communication, February 10, 2003).

St Vincent’s Private Hospital in Sydney hosts another unit facing considerable problems. While Kim Walker (who developed this unit) referenced literature from the British NDU movement and the Australian CDUs(N) in a recent article (Walker, 2002), he does not trace the lineage of this unit back to the British NDU movement (personal communication, January 30, 2003). He has based the development of the unit largely on nursing literature on ‘practice development’ (for example Unsworth, 2000.) It was, however, with sorrow that he also stated that the unit is now stumbling because of a loss of one of the key personnel behind this initiative and a general attrition of registered nurses.

2.3.2 DEVELOPING CLUSTERS OF CDUs(N) IN SYDNEY

2.3.2.1 Initial Development of the CDUs(N) in Western Sydney

During the mid to late 1990’s, intensive lobbying by senior nurse leaders in Western Sydney resulted in an allocation of funding towards the development of a nursing research culture within the area. Specific achievements included the establishment of four ‘clinical’ Nursing Chairs as well as financial provisions for other clinical and research based initiatives. One of these projects involved a strategic alliance between the Western Sydney Area Health Service and the University of Western Sydney Nepean (now known as the University of Western Sydney) in order to develop a network of Clinical Development Units (Nursing) (CDUs(N)) from existing wards or units (Greenwood & Gray, 1998).

Jennifer Greenwood, one of the Clinical Chairs with previous experience of developing a similar unit in South Western Sydney (Greenwood & Kearns, 1996) took responsibility for developing these CDUs(N). At this time, the area health service agreed to provide $27,500 for the initial CDU(N) leadership program and the university contributed $30,000 to
support a CDU(N) Designated Research Group. Greenwood chose the title ‘Clinical Development Unit (Nursing)’ because, as she explained, the term ‘CDU’ reflected the multidisciplinary character of contemporary health care; while the ‘N’ pointed towards the crucial role nurses would play in leading these developments (1999a). She envisaged these CDUs(N) as vehicles through which “a critical mass of seriously reflective and research-literate nurses” (Greenwood, 1999a, p. 679) could begin to tackle the perennial problem of the invisibility and disempowerment of nurses.

Greenwood maintained the primary definition of CDUs(N) as: “identifiable care settings within which nurses work to achieve and promote excellence in nursing” (1999a, p. 675) and described CDU(N) nurses as “committed to improving patient care by maximising the therapeutic function of nursing” (p. 675). However she did not agree with the concurrent UK approach, which required the staff of these units to demonstrate achievements in all of the required criteria before being recognised as NDU/CDUs. Greenwood (1999a) argued that this was not only unnecessarily expensive, but the setting up of single units as ‘flagships’ can create accusations of ‘elitism’ within the organization. It was her view that it was preferable, in due course, that all the units in the area health service should systematically work towards CDU(N) status (Greenwood, 1999a).

2.3.2.2 The First Cluster of CDUs(N)

The first cluster of nine CDUs(N) in this area health service was officially launched in September 1997. Not only was this launch described as significant in raising the profile of nursing in Western Sydney (Greenwood, 1999a), but it was followed by a flurry of both national and international publications that discussed the concurrent developments of the new network (Greenwood, 1997, 1998, 1999a, 1999b, 1999c, 2000a, 2000b, 2000c; Greenwood, Kessey, Curran, Barnard, & Forbes, 2000; Greenwood & Parsons, 2002a, 2002b).

As a distinct departure from previous NDU/PDU preparation programs in the UK, the nurse leaders of these new CDUs(N) were required to successfully complete a specially designed leadership preparation program before being given the title CDU(N). This leadership course consisted of six two-day workshops that were spread over six months. This course focused on: management of change; team building; strategic planning; time management; evaluation of care; reflective practice; and action research (Greenwood, 1999a; Greenwood & Parsons, 2002a, 2002b). By the end of this course, each leader was expected to show...
evidence of “demonstrable progress towards CDU(N) criteria” (Greenwood, 1999a, p. 678). Building on previous work done by NDU's in the UK (Freeman, 1996), these leaders set benchmarks for their own units and for the future CDUs(N) in the area by developing a round of standards, which were later published (Greenwood, 1999b). These fledgling CDU(N) leaders described their CDUs(N) as defined practice settings where the nursing staff welcomed change and had an inquiry-based approach to nursing practice. While identifying themselves as change agents who wished to develop inquiry-based approaches to practice, they simultaneously anticipated effective support from their locally-based Steering Groups Committees and tertiary resource persons.

2.3.2.3 Further Developments in Sydney

Following the initial leadership preparation course, two more CDU(N) leadership courses were held in Western Sydney. Due to the problems associated with the high attrition rate of leaders from the first wave of CDUs(N) and other problems that had been identified when only one person from each unit had attended the first course, two participants from each unit were now encouraged to attend these courses (Greenwood & Parsons, 2002b). Eight new units were also prepared at this time.

While the majority of these units had a very short life span, two of them continue to operate: one is a privately run 300-bed aged-care facility in Western Sydney (Greenwood, 1999b) and the other is a rehabilitation hospital in Northern Sydney (Forbes, 2002; Greenwood et al., 2000; Lock, 2003; Mott, 2001; Parsons & Mott, 2003; Pryor, 2001). The CDU(N) concept has since spread to other hospitals in The Northern Sydney Health Service, which now boasts CDUs(N) at 11 of their sites. While the Western Sydney Area Health Service no longer supports the CDU(N) program, CDU(N) leadership preparation courses are now run annually in Northern Sydney, with provision made for a half-time equivalent resource and support person, who is currently seconded from the University of Technology Sydney (Lesley Seaton, personal communication, September 19, 2003).

2.4 CONCLUSION

The NDU/PDU/CDU movement has now endured an array of challenges for close to a quarter of a century and it has spanned the globe from the UK to Australia, with enquiries from the United States (Kate Gerrish, personal communication, October 29, 2001). Consequently, many attempts have been made to relate the name NDU (and its derivatives)
to environments that have very little in common with the geriatric and rehabilitation settings of the original three pioneering units. Furthermore, and given the number of new units that have been set in motion since this time, it is clear from the ongoing ‘silence’ from so many units that heralded their early development with published works, that a large proportion of them must have subsequently left the fold. This assumption is partially substantiated by such publications as that of Vaughan (1997). Despite the fact that new NDUs were being developed, she stated that the overall number had remained steady. While very little has been written about the collapse of these units, largely anecdotal evidence points to a high degree of probability that, as with the Oxford NDU, many of these units have closed due to the inability of a single individual to sustain such an arduous and challenging role in a more acute setting.

While the NDU literature frequently reminds the reader that NDUs do not ‘belong’ to the NDU leader alone (Neal, 1994), time and again this literature has stressed the crucial significance of the role of the designated NDU leader (Christian & Norman, 1998; Gerrish, 1999; Malby, 1996; Redfern, Norman, et al., 1997; Turner-Shaw & Bosanquet, 1993). The following chapter has, consequently, been devoted to an examination of the leadership literature in order to set the scene for the discussion on the findings of this study, which are based on the experiences of a group of nurse leaders who had to accept their own inability to sustain the expectations that accompanied the title ‘CDU(N) leader’.

It is also of note that major changes have taken place in the political and financial strategies embraced by the discipline of management since the first NDUs were developed. Given the current reality of Australian health care, which is attempting to emulate the new management norms of the Western world, it is now likely that it will take an exceptional combination of circumstances to find an environment congenial to the transformation of an existing ward or unit into such a pinnacle of nursing excellence as the current NDU/CDU(N) movement aspires. The following chapter will, consequently, incorporate discussion on relevant aspects of Western attitudes towards leadership and management in order to develop a more in-depth explanation of some of the political realities of the ‘world’ in which these participants attempted to emulate the work of the earlier British NDU movement. This ‘world’ is then illuminated further with a discussion on the ongoing, and seemingly intractable, plight of the nursing profession, as we take our first tentative steps into the new millennium.
Chapter 3

LEADERSHIP

As this study has been based on the experiences of nurse leaders, it is essential that the discussions and conclusions presented in this thesis are supported by an understanding of leadership in its many guises. It is acknowledged, however, that the published literature on leadership is so broad and wide-ranging that it is impossible to do justice to many facets of this subject in a short literature review. Consequently, although this chapter is underpinned by an extensive evaluation of published literature from a variety of disciplines, the following discussion has been restricted to those aspects that are most pertinent to the arguments presented in the final three chapters of this thesis.

Prior to a discussion of relevant aspects of leadership theory, this chapter first examines how the Western concept of leadership has developed over time. It is anticipated that this will shed light on many of the reasons why such high expectations are held of anyone who attempts to don this title. The historical approach to this section also serves to create a backdrop to the discussion that concludes this chapter, which focuses on the development of nursing in the twentieth century and the problems nurse leaders, such as the ones featured in this study, currently face.

3.1 HISTORICAL PERSPECTIVES ON LEADERSHIP

When the nurse consultants and nurse managers who participated in this study were given the title ‘CDU(N) leader’, they each took charge of a mantle that already carried with it many preconceived connotations. The expectations associated with this new role not only related to literature from the UK NDU movement and the articles that were beginning to be published in Australia about their own fledgling project, but also to the many published ‘successes’ of the British NDUs. Behind all of the excitement and anticipation that this created in these fledgling CDU(N) leaders, there was something likely to play an even greater part in the way they perceived their new role. This was the Western preoccupation with the term ‘leader’. As will be discussed in this chapter, although understandings of this term have undergone fluctuations throughout history, the accumulation of the expectations
of the past two millennia continue to be built on in the published literature on leadership and recently developed leadership courses.

3.1.1 THE PHENOMENON OF LEADERSHIP

Leadership is a universal phenomenon that spans both time and place. Concepts of leadership have dominated human myths and legends since the ancient Egyptians formulated hieroglyphics for ‘leadership’, ‘leader’ and ‘follower’ in 3,000 BC. Not only has a large part of the study of history been the study of its leaders, but elaborate stories of hero-leaders also dominate the ancient Hindu Ramayana, the Babylonian Gilgamesh and the Icelandic Sagas. While Plato in ‘The Republic’ and Aristotle in ‘Politics’ discussed principles of leadership, Homer embodied these concepts in the heroes of ‘The Iliad’ (Bass, 1990; Burns, 1978). These stories and many others that have been told and retold throughout the ages appear as a mere drop in the ocean, however, when compared to the unprecedented surge of interest in the phenomenon of leadership in the West over the past century and the number of recent publications on the subject, most particularly within business and commerce (Sarros, Densten, & Santora, 1999).

It is relevant at this point to stop and examine the roots of the word ‘leader’ in a variety of languages in order to clarify the earlier understandings of this concept. The French, Celtic and Scottish words for ‘leader’ have developed from words that denote a head on a person’s body. This metaphor indicates a hierarchical understanding that their leaders were of greater significance and expected to have a better view, or understanding, of the situation. It is notable that, although many Europeans have an expectation that leaders are tall, many of the greatest leaders of all time have been, in reality, far from tall in stature, most notably Alexander the Great, Horatio Nelson and Napoleon Bonaparte (Adair, 1989).

In contrast, the English word for ‘leader’ comes from ‘laed’, which means a path or a road which, in turn, comes from the verb ‘laeden’, meaning to travel or to go. For the Anglo-Saxons, a leader was a person who showed the way, on land by walking ahead of the army and, at sea by navigating or steering. The metaphor of a journey is also found in the ancient Greek word ‘hegemon’ and the Roman ‘dux’. ‘Gubernator’, the Latin word for a governor, quite literally means the helmsman of a ship. Similar root words are also to be found in Egyptian, Persian and the Mashona language of Zimbabwe (Adair, 1989).
Acceptable patterns of leadership behaviour differ with time and culture. While the Egyptians attributed the qualities of authority, perception and justice to their Pharaohs in 2300 BC, the ancient Greeks were said to admire the qualities of wisdom, good judgement, justice, shrewdness, cunning and valour in their leaders (Bass, 1990). During the Renaissance, Machiavelli developed a theory of leadership that emphasised the necessity for the leader to maintain power and authority. His writings, which were later to be adopted by many European leaders, advocate the use of deceit, threat and violence when popular consent fails (Adair, 1989; Bass, 1990). In contrast, Hegel argued in ‘Philosophy of Mind’ (published in 1807) that effective leadership only develops if the leader has first served as a follower (Bass, 1990).

3.1.2 LEADERSHIP LEGACIES OF THE ANCIENT WORLD

More than two millennia have passed since the adventures of many ancient leaders were recorded and yet the multitude of similarities between these ancient texts and more modern literature appear to jump off the page. The reader is repeatedly reminded that, not only has human nature changed so little through the millennia, but that our modern understandings of effective leadership have been built on ancient beliefs and values.

As with some highly respected modern-day leaders such as Martin Luther King and Aung San Suu Kyi, many ancient Greek and Roman leaders demonstrated their strong personal convictions along with their oratory skills. Socrates, who lived in the fourth century BC was such a man. He would pretend ignorance in order to encourage others to express their own views and then expose their inconsistencies by cross-examination. Through a continuous process of questioning, a synthesis, or true understanding, was eventually arrived at by reconciling and encompassing both the thesis and the antithesis that were uncovered during the questioning (Adair, 1989; Polanyi, 1962; Popkin & Stroll, 1993). Although Socrates emphasised the need for knowledge, he also considered professional and technical competence to be prerequisites to leadership, most particularly in times of crisis. Hence, much of the post-Renaissance European desire for well-educated leaders and the influence of Western universities can be traced back to his influence (Adair, 1989).

It was Xenophon (who listened to many of Socrates arguments) who noted that, while some military leaders resorted to power and fear in order to extract obedience from their men, others were able to effect willing obedience under exceptional conditions. Although the
ancient Greeks and Romans admired such traits as boldness, physical courage and individuality, their best leaders were able to temper these tendencies in order to forge a unity of purpose that encouraged their soldiers to ‘do the impossible’ for their leader. Xenophon realised that, rather than courting popularity, such leaders were able to win the willing support of their men by sharing the dangers or hardships on an equal footing while, simultaneously, giving good direction. One of the most notable of these leaders of ancient times was Alexander the Great, who led by example when he chose to shun the privileges of his rank in order to share the privations of his men during times of crisis (Adair, 1989).

Following the recent trend of looking to traditional Eastern cultures for answers to spiritual questions, some Western leaders are returning to self-effacing styles of leadership that support mutual service (Bacon, 1993; Clegg, 1994; Senge, Kleiner, Roberts, Ross, & Smith, 1994; Wajcman, 1999). Lao-Tzu (who lived in the sixth century BC) taught freedom from attachment to worldly power and, like many other Eastern philosophical traditions, a sense of humility that is grounded in self-respect and self-confidence; thus freeing the leaders from any need for show and grandiosity in order to prove their worth (Page, 1988; Tsui-Po, 1994). Lao-Tzu’s definition of the perfect ruler, “one who governs in such a way that people are unaware that he governs them and simply believe that what happens is nature’s way” (Tsui-Po, 1994, p. 11) is now being reflected in current texts on leadership theory that stress virtues that have long been denigrated in the West as ‘soft’.

3.1.3 THE EFFECTS OF THE TECHNOLOGICAL AGE ON LEADERSHIP

Great leaps were made during the twentieth century to understand the concept of leadership in sociological terms, which paralleled the concurrent changes in values and the emphasis placed on participatory and humanistic management (Bass, 1990). The rapidity with which these changes were brought about has ensured that much remains of the glamour and awe that, throughout the millennia, have been associated with the word ‘leader’ (Toffler, 1981), whether they are now found in politics, business or academia. Prior to the twentieth century, however, evolutionary changes in attitudes towards people in leadership positions had, for the most part, come about gradually. Embedded in the feudal systems of the middle ages, with the mystical appeal of the knights and lords, was a culture that had assimilated the beliefs of pre-Roman tribes with the influence of classical Greece and the Judaeo-Christian concepts (Adair, 1989). The values of these feudal ‘leaders’ were slow to change, despite the violent surge of change during the Renaissance and the Reformation.
that dissolved the long-held European belief that the role of human beings was to fit into a hierarchical notch or fulfil a pre-ordained role in the scheme of things (Levin, 1992).

Both seventeenth century Cartesianism, which embraced the study of individual phenomena in isolation from one another and the concurrent technological advances that Toffler (1981) has called the “second-wave” (p. 35) of human civilisation contributed to the formation of a new and uniquely British concept of leadership that emphasised personal freedom within a hierarchical system. Accompanying this, the belief that natural qualities of leadership could be nurtured and developed led to the teaching of the classical virtues of justice, temperance, prudence and fortitude in the schools, universities and military academies of the British ruling classes. These beliefs, when transplanted to such colonies as Australia, were modified only by the fact that the ruggedness of the way of life encouraged the emergence of natural leaders within a more egalitarian society (Adair, 1989).

Along with the new technological innovations of the nineteenth century, the power of these gentleman leaders rapidly diminished as the new captains of industry took their place. These power brokers, hewn from the rock of the middle classes, were not subject to the long held traditions of the ruling classes and, consequently, were task orientated, viewing the working class as machines, a means to an end (Adair, 1989). Although history is replete with stories of exceptional female leaders who defied convention, the predominantly male-led Western institutions and political systems continued to ignore the leadership abilities of women. Indeed, so entrenched was the dominance of men over society that even Queen Victoria’s power has been described as illusionary as she had to feign an interest in what were deigned to be ‘feminine’ activities in order to rule (Gullickson, 2000). The backlash that resulted, however, as seen in the trade union movement, the Suffragette movement and the influx of women into positions that had long been reserved for men, was again to signal the emergence of new leaders (Adair, 1989).

One of the outcomes of the new ways of thinking that followed was that management scientists and organisational theorists began to investigate the influence of worker satisfaction on production levels and encouraged employee participation in decision making. The twentieth century, consequently, marked a time when the concept of leadership diverged from a facet of the study of history into the arena of the social sciences. This, in turn, spawned a new era of participatory and humanistic management that emphasised the importance of the human element (Marquis & Huston, 1994).
3.1.4 LEADERSHIP IN TIMES OF COMPLEXITY AND UNPREDICTABILITY

The era in which we now live marks a time when the Western concept of forward progress that developed during the industrial revolution (Toffler, 1981) now appears to many as overwhelming and unstoppable (Adair, 1989; Clancy & Webber, 1995). Even the two disastrous world wars of the twentieth century have done little to modify the notion that this forward momentum is innately beneficial (Adair, 1989). In line with the assertion that we now stand on the brink of a new epoch that is defined by a major paradigm change (Capra, 1983; Clancy & Webber, 1995; Drucker, 1993; Limerick, Cunnington, & Crowther, 1998; Luthans, 1995; Sarros et al., 1999; Toffler, 1981), strong paradoxes can be seen to coexist, even if precariously, within our Western culture (Handy, 1994).

While some continue to view organizations as machines or as big meccano sets that require constant tinkering and reassembling in order to meet specific needs (Clancy & Webber, 1995), the belief of many respected quantum physicists (Bohm & Hiley, 1993; Prigogine & Stengers, 1984) is that the traditional rationalist model of causality has been turned on its head. They state that it is no longer possible to predict the outcome of a new process simply by controlling the starting conditions. Furthermore, the long-accepted approach to dealing with change that has developed, in part, from the Cartesian legacy that everything in the world can be treated like an object (Toffler, 1981), has been reinforced by the development of technology designed to protect us from our fear of the ravages of the natural environment (Williamson, 1987). The resulting emphasis on controlling anything that is seen as ‘external’ has created a climate of reductionism and compartmentalisation (Steiner, 1978). This can clearly be seen in the world of contemporary advertising, where images of the natural environment, seen as ‘other’ and therefore able to be judged as ‘acceptable’ and ‘natural’, are combined with human technological advances in order to persuade the consumer that they have improved on nature (Williamson, 1987).

This concept of duality between ourselves and our world, which is antithetical to traditional Eastern thought, is being rejected by an increasing number of Western leaders who are questioning many of the traditional Western mores of management and leadership. An alternative, more compassionate view of the organisation has, consequently, been put forward. This view describes the organisation as a living being: a garden capable of growing, adapting and producing fruit in return for appropriate nurturing and caring (Clancy & Webber, 1995). Seen in this light, managers and employees are not separate
entities within the organisation but a part of it; as every cell is linked in the physiology of a living being.

This view is also consistent with the new world-wide paradigm shift, as being a change of emphasis from one of economic success and control of the environment to one of social responsibility (Barr & Barr, 1989; Capra, 1983; Clancy & Webber, 1995; Drucker, 1993; Limerick et al., 1998). A social justice paradigm, associated with principles of humanitarianism and equity is, essentially, policed by both personal and community awareness. Consequently, it is now widely accepted that leaders of today require flexibility, above all else, if they are to survive in a world of ever-increasing levels of complexity.

3.1.5 GENDER BIAS IN LEADERSHIP

Throughout the ages, the majority of successful military and political leaders have been men. Consequently the qualities associated with being a successful leader have, traditionally, been the so-called ‘masculine’ traits such as objectivity, drive and an authoritative manner. This has ensured that women have repeatedly been seen to lack the necessary skills and characteristics to make ‘good’ leaders (Burns, 1978; Gilligan, 1982; Ozga & Walker, 1995; Wajcman, 1999).

Although there was an influx of women into all areas of leadership during the twentieth century, many books on the subject treat women as ‘the exceptions’; indicating that leadership is primarily a male trait and that women are ‘other’. This is demonstrated in Adair’s (1989) book on ‘Great Leaders’ where women leaders are, rather condescendingly, given a whole chapter to themselves (towards the end of the book); thus emphasising the difference between what is expected of ‘great leaders’ and the successful accomplishments of an ‘insignificant’ number of women, as judged from a male-orientated perspective. Such overt gender bias is also evidenced in the actions of both men and women in leadership positions who, frequently unconsciously, ‘collude’ in subtle ways with stereotypical male and/or female behaviours of both themselves and others (Maddock & Parkin, 1993; Van Nostrand, 1993).

In reaction to this traditional gendered attitude towards leadership and in order for women to attain equal opportunities in work, the feminist authors of the 1970s minimised, or quite often denied, the differences between women and men (Wajcman, 1999). Consequently,
while many have argued that there are real differences in leadership and management styles between men and women (Bass & Avolio, 1994; Chusmir, 1985; Eisenstein, 1985; Limerick & Lingard, 1995; Shakeshaft, 1987), other authors and researchers have been unable to uncover a distinctly ‘female’ style, with the similarities between female and male leaders far outweighing the differences between women and men as groups (Bartol, 1978; Rizzo & Mendez, 1988; Statham, 1987; Wajcman, 1999). This is not to conclude that gender stereotypes are not deeply entrenched. Women have, in fact, had to adopt a style associated with male management in order to succeed. Style is, after all, an intrinsic part of the managerial job, which is, itself, gendered male (Broome, 1990; Gilligan, 1982; Linehan, 2000; Still, 1990; Wajcman, 1999). This reaction is even more evident in nursing, where the working environment is dominated by the discipline of medicine (Broom, 1989; Carpenter, 1993), which is underpinned by the more objective stance of the philosophies of empiricism and logical positivism (Greaves, 1996; Wulff, Pedersen, & Rosenberg, 1990).

Since the 1980s, many of the new leaders of the discipline of management have espoused the development of a strong cohesive culture of collective commitment. In such texts, those traits that have traditionally been described as ‘feminine’ are less likely to be associated with ‘inferiority’ (Clancy & Webber, 1995; Peters & Waterman, 1982; Wajcman, 1999). Simultaneously, as many feminist scholars and professionals are celebrating traditional female values, feelings and ways of behaving (Gilligan, 1982; Greer, 1999; Stovall, 1988; Wajcman, 1999), others are quick to disassociate women leaders from such male-oriented values as taking risks (Franks, 2000). No longer are these women prepared to feel under-valued (Cooper & Davidson, 1982), disempowered (Stovall, 1988) or suffer the excessive stress levels (Cooper & Davidson, 1982) that accompany the traditional ‘processes’ of attaining power. Professional women are, more and more, choosing to experience a connectedness to others that allows them to exercise “power with accountability” (Stovall, 1988, p. 25). According to this new orthodoxy, effective management needs to embrace the ‘softness’ of such a qualitative people-orientated approach (Wajcman, 1999). Indeed, the styles that now reflect participative, cooperative management are, generally, more closely associated with women than with men (Gilligan, 1982; Limerick et al., 1998; Ozga & Walker, 1995; Wajcman, 1999). These new wave theories of leadership and management are, however, again gendered in that they are suggesting women have a more consensual style of management than men.
3.2 THE LEADER-FOLLOWER RELATIONSHIP

The use of the word ‘leader’ always assumes the existence of a person who will be led. Consequently, while this section begins with a brief summary of the contemporary definition of leadership, it goes on to develop an understanding of some of the aspects of this two-way relationship that are most relevant to the findings of this study.

3.2.1 DEFINING LEADERSHIP

The worldwide preoccupation with leadership as both an organisational and social behaviour is such that more has been written on the subject than on any other human endeavour (Sarros et al., 1999). Despite this plethora of literature, there remains no widely accepted definition of leadership in the scholarly or popular press (Burns, 1978; Densten & Sarros, 1997; Luthans, 1995; Rost, 1994; Sarros et al., 1999), with Bass (1990) stating that many published definitions are ambiguous. Not only have attempts been made to differentiate styles of leadership on the basis of role or institutional differences, but the definition of leadership depends on the purposes to be served by this definition. As such, Bass (1990) categorises the many concepts of leadership that have been formulated to date as having been based on: a matter of personality, a matter of inducing compliance, the exercise of influence, particular behaviours, a form of persuasion, a power relation, an instrument to achieve goals, an effect of interaction, a differentiated role, the initiation of structure, and the focus of group processes, as well as combinations of these definitions.

In a similar vein, while no single model of leadership is considered universally appropriate, Clancy and Webber (1995) and Gibson, Ivancevich, and Donnelly (1979) have suggested the following variables as being important in obtaining a minimum level of leadership effectiveness: the leader’s awareness of self, the characteristics of the group, understanding individual characteristics, understanding motivation, and situational variables. Likewise, Bennis (1986) has stressed the most noticeable traits of the 90 successful leaders he studied as: the management of attention (a focus of commitment which attracts people to them), the management of meaning (the ability to communicate), the management of the self (knowing one’s skills and the ability to deploy them effectively), and the management of trust (of the group).

For the greater part of the twentieth century, leadership was considered to be little more than a characteristic of a good manager and, consequently, the literature of that time
focused on management and assessing the leadership behaviour of people in positions of administrative power (Barnum, 1994). Towards the end of the century, however, an increasing volume of authors sought to clarify the distinction between management and leadership because, as Bennis forecast in 1989, “To survive in the twenty-first century, we are going to need a new generation of leaders - leaders, not managers” (1989a, p. 7).

Chambers and Craft (1998) contrast the restrictive goals of traditional management (of ensuring that people perform their current tasks) to the aims of leadership (which include the preparation of people for the challenges of tomorrow.) Similarly, Cassidy and Koroll’s (1994) definition of management, which focuses on “organisational maintenance and routine” (p. 42) contrasts sharply with Rost’s (1994) definition of leadership as “an influence relationship between leaders and collaborators who intend real changes that reflect their mutual purposes” (p. 3). According to the new theories of leadership, this differentiation between management and leadership ensures that leadership need no longer be viewed as ‘what someone does’ (Rost, 1994). No longer is the leader seen as the person who determines the goals that others will be expected to attain. Rather, the new leader is seen as a designer of empowering environments, a steward of collective vision and a teacher in a team (Senge, 1994).

Task orientated behaviours, which focus primarily on improving performance and output, are now progressively being superseded by higher-order behaviours that emphasise attitudes, values, beliefs and needs (Bass, 1985a). In other words, while traditional management behaviour is transactional, leadership can be transformational (Parry, 1996). Bennis (1986) has described this as: “Leaders are people who do the right thing and managers are people who do things right” (p. 81). Some authors, however, have warned that, in reality, these two strands of business acumen characterise the two key functions of both transformational and transactional leadership because both leadership and management skills are relevant to effective organisational outcomes. Management without effective leadership can lack creativity and become overbearing and bureaucratic; whereas leadership without management can be overwhelmingly volatile (Marriner-Tomey, 1993).

3.2.2 THE CONCEPT OF POWER

Along with the new concepts of leadership (as the development of a mutually productive relationship), many people in management are choosing to sidestep the word ‘power’ in
favour of the less emotive term ‘influence’ to describe their own power structures. While the concepts of power and influence both relate to the ability to change the behaviour of another, in reality they are not entirely synonymous. Bass (1990) has described power as the force to attain compliance; while influence has been described by Turner (1972) as the degree of change that can be induced in another (Turner, 1972). Put another way, power is a potential force that can “be tapped and converted to influence” (Kelly, 1992, p. 280).

It is undeniable that the majority of the greatest leaders of all time have been characterised by their ability to wield considerable power and influence. Seldom, however, has history been ‘neutral’ in the judgement of such people, with the actions of Martin Luther King and John F. Kennedy, for example, most frequently described as having been directed towards ‘good’ objectives and those of Adolf Hitler or Saddam Hussein as aimed towards ‘bad’ ends (Chambers & Craft, 1998).

In contrast to such a popularised vision of power, Foucault states that power relationships are to be found everywhere in society. Within the structure of any normal relationship there will also be varying degrees of freedom of choice which, in turn, ensure that such phenomena between free individuals remain unstable and inconsistent (Foucault, 1988; McNay, 1992). Moreover, power has also been described as being embedded within the regulations, structures and relationships of an organization. Apart from the generalized acceptance of the inequalities of power within the organisational structure (which often go unquestioned), there are also many informal, unwritten rules that are shared by a number of people, frequently within the same department or cultural group. Such expectations or rituals, often defended as ‘things have always been done this way’, perpetuate existing power inequalities and can challenge new initiatives by others (Buchanan & Badham, 1999).

3.2.3 CHARISMATIC LEADERSHIP

Although the concept of charisma can be traced back to the ancient Greeks, it was first introduced into the study of leadership by the German sociologist Max Weber (1947), who developed the term from the theological concept of being endowed with divine grace. He, consequently, described charismatic leaders as highly esteemed people who are gifted with exemplary qualities. Since Weber’s original writings, this concept has been expounded upon in numerous sociological, political and psychological texts, in particular
psychoanalytical texts (Blau & Scott, 1962; Demause, 1982; Friedland, 1964; Schiffer, 1973; Schweitzer, 1984; Willner, 1968). House (1976) has also developed it into a theory, based on findings from a variety of social science disciplines. More recently, Bass (1985a) has extended this concept to include both male and female top-level executives and business leaders, in particular those whose characteristics include technical expertise and superior debating and persuasive skills (Luthans, 1995).

Discussion around this topic frequently centres on whether the leader-led relationship is grounded primarily in the magnetic power of the leader or in the subordination of the followers and the projection of their own unfulfilled needs. In situations where there is a breakdown of customary ways of doing things and a group or society is under heavy strain, such a leader can provide a symbolic solution to both internal and external conflict. Despite these arguments, it is clear that many charismatic leaders of history have frequently been viewed as champions of their times, believing passionately in their cause and speaking for the ordinary person. Both religious leaders such as Moses, Jesus and Muhammad, and political and military leaders as diverse as Joan of Arc and John F. Kennedy, have been able to capture, en masse, the imagination of the populace. They were also able to excite, motivate and activate others who, through their new awareness, were also able to develop into active leaders (Bass, 1990; Burns, 1978).

The legacy of the original leaders, however, is always moulded and adapted in more critical times (Burns, 1978). Max Weber has described this development of authority within groups or societies as three stages of a cyclical pattern: the charismatic, the rational-legal and the traditional types of authority. Although the new charismatic leader heralds an end to inertia and discontent, this period is then followed by routinization and bureaucratisation of authority, exercised through rationalised and legal institutions and practices. Gradually, however, the system evolves into precedent and custom; thus sowing the seeds for new leaders to emerge as the cycle begins again (Weber, 1947).

3.2.4 TRANSFORMATIONAL LEADERSHIP

The preparatory CDU(N) leadership course that was designed for the participants of this study was based on theoretical principles of transformational leadership. Following the current trend of holding this concept aloft as a panacea for developing leadership potential in new managers (Parry, 1996; Tichy & Devanna, 1990), many health care professionals
have written glowing accounts of this phenomenon (Barker, 1994; Barker & Young, 1994; Cassidy & Koroll, 1994; Dixon, 1999; Porter-O'Grady, 1992; Sullivan, 1998; Swansburg & Swansburg, 1999; Ward, 2002). Other authors have stated, however, that there is a considerable overlap between charismatic and transformational leadership (Sarros et al., 1999), although the latter is usually described in much broader terms (Marriner-Tomey, 1993). Some of the differences may, in many respects, be cultural. It is noteworthy that Sarros et al. (1999) have found that Australian executives view themselves as less charismatic and less emotive than their American counterparts, preferring to utilise intellectual stimulation to encourage workers to think solutions through. They have suggested that this may relate to the unique Australian history and heritage that has spawned the Australian propensity to lop the achievements and aspirations of those who are identified as ‘tall poppies’.

According to the literature, transformational leaders motivate and empower others, thus creating a work environment that is meaningful and satisfying to everyone (Bennis & Nanus, 1985; Cottingham, 1994). By building on the human need for meaning and purpose (Cottingham, 1994), they are said to provide a vision of the future that suits the purposes of all involved, are concerned with meeting the needs of the followers (including self actualisation needs) and provide opportunities for dialogue. In this way, transformational leadership transforms the leaders, the followers and the organisation as they influence each other (Burns, 1978) and the trust of everyone is preserved (Barker & Young, 1994).

Although both transformational and charismatic leaders are said to transform the followers’ original beliefs about the value of their contribution and their confidence of reaching the desired goals (Parry, 1996), Sarros and Butchatsky (1996) have described transformational leaders as appealing to the higher ideals and values of the followers. It appears, consequently, that the simultaneous enhancement of the follower’s level of self-esteem is the main factor in delineating a transformational leadership style.

In a similar vein, since Burns (1978) distinguished transformational leadership from transactional leadership, much has been written that also compares and contrasts these two models. While transactional leaders have been likened to a more pragmatic form of management that ensures objectives are achieved and deadlines are met, transformational leadership, in contrast, refers to “the intrinsic, personal style of leadership that is characteristic of visionary leaders who care about their staff and encourage them to achieve
their personal best” (Sarros et al., 1999, p. 5). Such contrasts in style, which reflect many of the comparisons made between leadership and management (as discussed previously) continue to be disseminated in countless books and articles on leadership. Bass (1985a; 1985b) has, however, suggested that many great transformational leaders of the past, such as Abraham Lincoln and John F. Kennedy, have also been transactional at times. He, therefore, modified the paradigm by proposing that transformational leadership, in fact, augments the effects of transactional leadership on the efforts, effectiveness and satisfaction of the subordinates.

3.3 LEADERSHIP IN NURSING

In contrast to the development of most other academic professions, all attempts to develop nursing as a discipline and as a profession have, by necessity, to be made against the backdrop of the traditional disempowerment of nurses and an intransigent system that ensures this situation will be perpetuated. While attempts continue to be made to develop nursing services, these are conducted largely with an eye to patient outcomes and the financial bottom line. The dismal retention rate of nurses in Australia (Jackson, Mannix, & Daly, 2001) is evidence of the ineffectiveness of these tokenistic gestures by both senior nurses and the professions that hold the reigns of power in the Australian health care system. As this thesis progresses, it will become clear that the development of these CDUs(N) followed this familiar pattern. This section places into an historical context the plight of a disempowered profession that is beginning to have access to a greater selection of theoretical works on leadership and is, consequently, awakening to the awareness that ‘things should be different.’

3.3.1 THE NIGHTINGALE LEGACY

There is no doubt that the work of Florence Nightingale (1820-1910) significantly changed the future course of nursing throughout the world. Nightingale, described as an astute political leader who was unremitting in her determination to reach her goal (Splane & Splane, 1997), developed a new nursing model that could share some aspects of power with the male-dominated medical profession (Pearson, 1983a). Although nursing had, until this time, been practiced by both men and women (Pearson, Taylor, & Coleborne, 1997), her work transformed nursing into a female-led hierarchy that was to reinforce many of the Victorian assumptions about the capabilities of women (Malone, 1997).
The plethora of literature that has been written about her is testament to her unparalleled influence in the discipline of nursing. While some have criticized her for her authoritarian stance towards nurses (Reverby, 1994), others have placed greater significance on the spiritual aspects of her work (Macrae, 1995). This apparent paradox is further exemplified by the juxtaposition of her dedicated statistical analyses (Macrae, 1995), her inductive reasoning (De Graaf, Marriner-Tomey, Mossman, & Slebodnik, 1994) and the profound spiritual insights that she developed from her study of early Christian and Eastern mystical writings (Macrae, 1995).

As a consequence of Nightingale’s work, those feminine strengths that had previously been accepted as “an important manifestation of women’s expression of love of others, and was thus integral to the female sense of self” (Reverby, 1994, p. 4), were developed in order to “find respectable work for daughters of the middling classes” (p. 6). While offering an opportunity for some women to develop independence from family in an area in which they were suited, it also provided an opportunity for the hospitals to exploit these women through the development of schools of nursing which sought a cheap labour force where altruism, sacrifice, and submission were not only expected, but demanded (Camilleri, 1997; Reverby, 1994). Furthermore, the development of a workforce comprised mainly of students meant that these nurses could more easily be manipulated within a hierarchical structure (Pembrey, 1989).

Despite the many teething problems associated with the development of nursing at this time and the rather doubtful and misguided actions of many who were associated with these reforms (Baly, 1986), great strides were made to improve the previously atrocious conditions in British hospitals. Consequently, other countries soon began to look to these new British nursing reforms in order to improve their own abysmal hospital systems. Nightingale, who had a knack of identifying leadership potential in young nurses, seized these opportunities to dispatch them around the world to places acutely in need of nursing leaders (Splane & Splane, 1997). In this way, her brand of nurse training quickly spread throughout the globe. Described as very charismatic and influential (Russell, 1990), in many of these countries, she was highly respected, even idolised (Splane & Splane, 1997).

The first of her graduate nurses to arrive in Australia took up the position of Lady Superintendent at the Sydney Infirmary in 1868. Many important changes to both nurse training and hospital administration quickly followed, in particular the enhancement of the
role of the matron, who was given total responsibility for the education and discipline of the nurses. The Nightingale model was so successful in improving nursing education and services in Australia, as in many other parts of the world, that it was to continue, virtually unchanged, for close to a century (Russell, 1990).

3.3.2 THE JOURNEY FROM HANDMAIDEN TO PROFESSIONAL

Following Nightingale, nurse leaders began to feature in health care reform in such international organizations as the Red Cross and, in 1948, in the development of the World Health Organization’s mandate on health (Pearson & Vaughan, 1990). Australian nurses, too, were prominent in the newly founded International Council of Nurses, which led nursing through the most turbulent years of the twentieth century (Splane & Splane, 1997). Despite the influence of this small band of international nurse leaders (Splane & Splane, 1997) and the fact that many of the Australian hospitals became ‘public’ institutions, the traditional religious influence on nursing and the Nightingale legacy of ‘dedication’ continued to undervalue the work of nurses as mere acts of charity or as a spiritual or religious calling (Godden, 1995). Indeed, many nurses continue to subscribe to the legacy of asceticism and total commitment through the denial of their own needs (Pearson, 1990; Vance, Talbott, McBride, & Mason, 1985).

Even the most senior nurses and matrons were severely restricted in their personal lives for a large part of the twentieth century, with many of them obliged to ‘live-in’ and frequently called out at most inopportune times of the day or night – usually by doctors. The work was gruelling and the pay was meagre and most nurses worked 10 hours a day, 6 days a week until 1938, when the 48-hour working week was introduced (Gill, 1989). Tight control of the nurses’ personal off-duty time extended well pass mid-century, with such practices as ‘lights out’ and ‘late passes’ in the nurses residences. Many practicing nurses of today clearly remember the militaristic discipline that was outwardly displayed in the wearing of stripes on caps to denote seniority of student nurses while terms such as ‘reporting for duty’ and ‘wearing civvies’ continue to be used today.

A new era of militancy among nurses did, however, emerge in Australia during the 1960s and 1970s, fuelled by poor wages and working conditions and a persistent nursing shortage. Around this period, a total of 15 governmental expert committees were commissioned to investigate the problems facing the nursing profession. The resulting changes to wages and
conditions began to attract married women and men into the profession (Russell, 1990). This new Australian militancy among nurses signalled a major parting from the previous trends to follow the traditional British line, which continued to be worn down by repeated political attacks on the British National Health Service and general mismanagement (Salvage, 1998).

As nursing practice evolved worldwide during the 1970s and 1980s, to incorporate such innovations as primary nursing (Johns, 1990b; Manthey et al., 1970; Pearson, 1988b) and the acceptance of the concept of nursing as a therapy (Pearson, 1989b), nurses were “at last starting to identify their profession” (McMahon, 1986, p. 270). The contrast between medical knowledge and the unique body of nursing knowledge were brought sharply into focus for many innovative nurse leaders of the time (McMahon, 1986; Pearson et al., 1992). Consequently, nurses in many Western countries made the individual choice to dissociate from the traditional view of the nursing profession as an extension of medicine to become “a practitioner of the discipline of nursing” (McMahon, 1986, p. 34).

Mannix and Stein (2000) have attributed the improved professional status of nurses in Australia to the work of nursing organisations and other nursing lobbying groups that have been able to influence a variety of political and health care policy decisions. Although nursing knowledge had traditionally been passed down through set textbooks and oral methods (Godden, 1995) that were, and frequently still are, dominated by the medical style of discourse (Huntington & Gilmour, 2001), beginning in the late 1960s moves were made to develop nursing as an academic discipline (Godden, 1995). While some nurses chose to acquire tertiary qualifications in education and administration, in 1967 the University of New England offered their first combined nursing and arts degree (Williams, Chaboyer, & Patterson, 2000). This movement was to culminate, from 1985 to 1993, in the transfer of all Australian basic nurse education into the tertiary sector (Russell, 1990). The impact of the move was to mean that nurse leaders and educators must immediately begin to embrace many of the standards prevailing elsewhere in academia (Worrall-Carter, 1995). Many of the new nurse academics were, for many years, unprepared and underqualified for such pressures. While expected to develop new courses and do research, they were also struggling to complete their own bachelor or master’s degrees (Godden, 1995).

Many other teething problems have beset the fledgling discipline as a result of so many changes. These include the particularly long drawn-out debate of the 1980s, as yet
unresolved, to clarify the meaning of the term ‘nursing’ (Huntington, Gilmour, & O’Connell, 1996; Lawler, 1995; Pearson, 1988a, 1996; Taylor, 1994) as well as the backbiting from those nurses who opposed the change towards tertiary education and are suspicious of their colleagues who “enjoy the intellectual challenges of nursing” (Lawler, 1995, p. vi). Indeed, such infighting may reflect the reaction of many nurses to the term ‘profession’ which is, in itself, gendered male (Davies, 1995). After all, the primary concerns of nurse leaders and their views of what constitutes ‘professional conduct’ have long been shaped by the accepted norms of medicine (Bashford, 2000): despite the fact that many of the resulting behaviours denigrate nurses. As the values that have traditionally underpinned this term, such as distancing and detachment, are at odds with many nursing values, such as caring, Davies (1995) has suggested that one of the long-term projects of nursing should be to challenge the gendered basis of this term.

3.3.3 LIVING IN A LEADERLESS POWER WARP

Traditional health care settings and practices have long maintained the power of the medical profession over all other health-care providers (Cheek, 1998; Ferguson, 1985; Walsh & Ford, 1989). This power is maintained, in large part, by the societal belief that the medical profession are privy to a special understanding of the disease process that is defined by scientific (and therefore, ‘reliable’) knowledge (Cheek, 1998; Mackay, 1989; Turner, 1987). The resulting focus on a specific organ or illness marginalizes other sources of knowledge such as nurses and ‘alternative’ health care providers. Indeed, the choice of the word alternative “indicates that these practices are ‘other’, not afforded mainframe” (Cheek, 1998, p. 86). Such a situation is further exemplified by the lack of value placed on the art of caring by the community at large (Johns, 1996c). Consequently, and despite the views of Australian authors such as Davidson, Elliott, and Daffurn (2004), that opportunities for nurses to influence health care policy are increasing, other Australian authors such as Jackson et al. (2001) call attention to the diminution in job satisfaction caused by the inability of the majority of clinical nurses to influence organisational change.

Given the dominance of the masculine world view in Western culture, nursing is constrained by being a female-dominated profession that works within the same milieu as a profession that is predominantly male-led (Carpenter, 1993; Devereux & Weiner, 1950; Freidson, 1970; Katz, 1969; Mackay, 1989; McInerney, 1998; McMahon, 1986; Pearson, 1991; Short, Sharman, & Speedy, 1993; Vance et al., 1985). Florence Nightingale
contributed significantly towards the establishment of this view of nurses in an effort to establish nursing as an occupation suited to well-bred women. In her writings, she equated nursing tasks with those of a mother looking after an infant; thus establishing a biological determinism which contributed to the subordination of nursing to the male-dominated profession of medicine (McInerney, 1998). Not only does this nurse-doctor relationship replicate the mother-father relationship in the traditional patriarchal family (Collière, 1986; Game & Pringle, 1983; Garmarnikow, 1978; Mackay, 1989; McInerney, 1998; Pearson, 1988a), but nursing is hampered by the expectation that women will remain ‘family-orientated’ at all times. This contrasts sharply with the societal expectations of men, who are stripped of their domestic identity when they enter the workforce (Wajcman, 1999). For male nurses, this picture can often be even more confusing as they are frequently prescribed ‘honorary’ female status so that others can maintain the status quo (Mackay, 1993). It has been suggested that this is one of the reasons why a large number of male nurses quickly go on to management, education or high technology positions (Fisher, 1999). The current trend in Australia, to promote a disproportionate number of men into senior nursing positions, however, can be viewed as a sociological (Carpenter, 1993) as well as a gendered problem as it continues to disadvantage the voices of women within a profession that has traditionally been considered female-based (Speedy, 2000; Speedy & Jackson, 2004; Sullivan & Whitehouse, 1996).

Such an exclusion of the voices and experiences of nurses is perpetuated by the legal system (Chiarella, 2000) and the media. Stereotypical views of nurses as handmaidens (Baker & Pearson, 1992; Greenwood, 1999d; Holloway, 1992; Mackay, 1989; Short et al., 1993; Vance et al., 1985), angels, sex symbols and dragons (Greenwood, 1999d; Holloway, 1992) and as “less empathetic to the needs of patients than doctors” (Mackay, 1989, p.46) further enhances the power of doctors at the expense of nurses (Mackay, 1989; Salvage, 1983b). Resulting behaviour patterns, now so deeply entrenched in hospital culture, are evidenced in the intimidatory doctor-nurse games (Short et al., 1993; Vaughan, 1985; Walsh & Ford, 1989). These can be witnessed in such outdated rituals as ‘the ward round’, which can appear to the uninitiated as “a cross between the freemasons, a medieval guild and the mafia” (Walsh & Ford, 1989, p. 134).

The current predicament of nursing, where large numbers of highly skilled nurses appear content to hide behind their self-erected barriers of silence (Buresh & Gordon, 2000) and

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are willing to accept a subservient role (Short et al., 1993; Tappen, 1989) is further compounded by horizontal violence and autocratic leadership styles of senior nurses which, it has been suggested, may result from their chronic disempowerment (Laurent, 2000; Taylor, 2001). Such behaviour not only fails to foster leadership among the younger nurses (Marriner, 1994; Short et al., 1993) but “it contributes to an attitude that nurses are paid to follow orders rather than to think” (Marriner, 1994, p. 55).

Organisations with rigid centralised authority structures that limit the freedom of their workers to control their work activities increase dissatisfaction, alienation and powerlessness within their workforce. This, in turn, dampens the workers’ enthusiasm to engage in discussions related to political issues or work processes. There is evidence to suggest that female nurses working in large organisations experience alienation from their work due to the restrictive structures in which they work and their consequent lack of power to make significant decisions to change their regimented work practices (Aiken & Hage, 1966; Millen, 1989; Pearlin, 1962; Turner, 1986; Winter, Sarros, & Tanewski, 1995).

The nursing profession has, consequently, attracted a large number of people “who rank low on self-esteem and initiative and higher on submissiveness and need for structure than people in other professions” (Marriner, 1994, p. 55); with many showing an unwillingness to pay the price that is required in order to attain professional status (Catalano, 2000). For many nurses, both male and female, who have chosen a profession that can allow them to emerge virtues of caring and compassion, the idea of challenging “the stifling atmosphere of an autocratic system” (Marriner, 1994, p. 55) in order to move forward in their careers can create intolerable frustration and role conflict. Marriner suggested in 1994 that the high attrition rate within the profession was directly related to this unresolved frustration.

As the millennium was drawing to a close, financial restraints were resulting in attempts to reign in spending through the enforcement of even more rigid management structures (Barker, 1994; Borbasi & Gaston, 2002; Huntington et al., 1996), which was creating ever-widening cracks in Western health care systems. While some nurse managers became more intricately involved in the business aspects of health care (Borbasi & Gaston, 2002; Marquis & Huston, 1994), others began to re-examine the core values of a profession whose history is steeped in the Nightingale tradition of duty and sacrifice and a hierarchical system that disempowers (Borbasi & Gaston, 2002; Huntington et al., 1996; Watson, 1994). This emerging new ethos can be seen to parallel the belief of many management and
leadership ‘gurus’ who state that the beliefs supporting traditional hierarchical structures, in particular the emphasis on logical decision making, are breaking down (Barker, 1994; Capra, 1983; Clancy & Webber, 1995; Rogers, 1989).

This raises new leadership issues for nurses. The recent move to the tertiary sector also highlights the need for innovative new ways to recapture and re-present the complexity and richness of accumulated nursing knowledge in a way that will be better understood by the nurses of the twenty first century. Along with the development of nursing as an academic discipline, a number of nurse leaders are consequently calling for the development of a new philosophy of nursing that can further develop and extend the basic concepts that are used by nurses (Brencick & Webster, 2000). A new nursing philosophy is required that can incorporate the tension between the universals and the singularities of nursing practice (Brencick & Webster, 2000). Based on such concepts as what it means to be a person, such a philosophy would have the potential to spiral outwards to incorporate the aspects of nursing practice that have been traditionally associated with the ‘feminine’ and, consequently, aid in the realignment of the current practices of nurses with their own espoused values.

3.4 CONCLUSION

This chapter, which completes the literature review of this thesis, has been designed to illuminate the entrenched nature of many of the problems that Australian nurses, such as the participants in this study, must face. The attitudes towards the term ‘leader’ that have developed in the Western world and the plethora of published literature on leadership, while raising the expectations of these participants, stand in stark contrast to the reality of their work as ‘nurse leaders’ in a Western health care system. Similar realisations, of the extent of the inconsistencies between attitudes towards nursing and towards other academic disciplines, confronted these participants during their leadership course as they digested the new leadership theories against the background of their own working environments.

The discussion on the development of nursing also serves as a backdrop to the beginning of the next chapter, which debates the development of research methodologies in health care, as illuminated by the philosophy that underpins this study. This is followed by an elucidation of Heideggerian hermeneutic phenomenology in relation to the methodology employed. The chapter concludes with an explanation of the method used.
Chapter 4

THE PHILOSOPHICAL FRAMEWORK

This chapter discusses the methodology and method of this study, which are derived from Heideggerian hermeneutic phenomenology. Despite the fact that hermeneutic phenomenology has been used extensively as a research methodology in nursing and other disciplines over the past two decades, many of the arguments that underpin this philosophical stance are in opposition to postures taken by those who fervently support the most dominant research methodology of contemporary Western health care: the scientific method. The philosophical viewpoint that underpins the scientific method of inquiry has developed such dominance within our society that all other traditions must frequently position and define themselves against its assumptions (Lumby, 1991; Plumwood, 1993). The first part of this chapter will, consequently, begin by placing the theoretical roots of health care and nursing research methodologies into context before proceeding to develop an in-depth discussion of the methodology of this study. The chapter then concludes with details of the method employed in this research project.

4.1 DEVELOPMENT OF RESEARCH METHODOLOGIES IN HEALTH CARE

The greater part of scientific and medical thought continues to be dominated by the rational and empirical philosophies that first developed in the seventeenth century and that denigrate the subjective and the metaphysical in order to concern themselves with observable facts (Wulff et al., 1990). Although the work of Thomas Kuhn (1970) has challenged the predominant belief of the scientific community that scientific ‘truth’ accumulates over time, the paradigm on which modern Western medicine is based retains an almost religious faith that progress is inevitable because the goals are objective and unified (Greaves, 1996). This notion reflects the broader tradition of Western thinking that reality is, in essence, a rational whole where all things will, in due course, cohere (Greaves, 1996).

As with any research methodology, the assumptions that underpin the scientific method are based on the work of some of the most celebrated philosophers of Western society. The beginnings of this method of inquiry can be found in ancient Greece (Popper, 1979), with
their all-embracing medical system. While they are renowned for their unitary theory, which provided a uniform and ontological expression of health (Greaves, 1996), the Greeks nevertheless began the Western propensity to masculinize reason by segregating it from the material world, which they viewed as less significant (Inglis & Steinfield, 2000; Lloyd, 1984; Spretnak, 1992). When the neo-platonic thinkers of the medieval period combined this view of ‘self’ (as the enduring rational mind) with the Hebraic personalization of the self within a hierarchically structured realm of influence (Levin, 1992), the stage was set for the later mechanistic standpoint that nature could only be redeemed through science (Plumwood, 1993). In the seventeenth century, Rene Descartes’ distrust of the senses, which dismissed human experiences in the world of matter, then went on to create the irrevocable split between theory and experience that led to the judgement of human experience as unreliable, naive and untrustworthy (Colaizzi, 1978; Scruton, 1984).

As the natural sciences emulated the Cartesian split between the observable and the unobservable by separating human behaviour and experience into an objective-subjective “behavior-experience polarity” (Valle & King, 1978, p. 4), experimental and quantitative methods of enquiry secured wider acceptance (Simmons, 1992; Wulff et al., 1990). With the resulting separation of the self from experience through introspective reductionism and compartmentalisation (Steiner, 1978) and the development of a mechanistic view of nature, knowledge gradually became synonymous with science or formal and analytical statements (Simmons, 1992). What has now come to be known as modern medicine built on these roots in the nineteenth century, with the systematic investigation of the structure and function of the human body and the mechanical model of disease (Wulff et al., 1990).

Despite the fact that the traditional scientific approach in quantitative research, based on a mind-body split, provides only a reductionist view that disengages people from their context (Taylor, 1993), the early nurse researchers adopted the philosophical thinking of the medical profession. Their research was centred on principles of value-free objective science, as represented by the scientific method and the biomedical model (Dickson, 1995; Mulhall, 1995). Such a limiting stance eventually proved to be incompatible with many aspects of nursing knowledge, which is so broad that it spans a large part of the spectrum of both the natural sciences and the human sciences. Consequently, the transfer of nursing education into the academic setting provided the crucial opportunity for nurses to legitimise the search for new philosophical frameworks for their research.
This search began by adopting methodological frameworks from the human sciences that incorporate description, self-reflection and interpretation in order to pursue a deeper understanding of how human beings exist and find meaning in the world (Van Manen, 1990). Phenomenology is an example of one of these research methodologies that has gained in popularity within the social sciences and nursing over the last two decades. This is not to say that these disciplines have lost sight of the theoretical issues, but that the questions they now wish to investigate have moved on to include questions of experience and meaning (Stewart & Mickunas, 1990).

Heideggerian hermeneutics has also been adopted with gusto by many within the discipline of nursing, with leading Heideggerian philosophers such as Michael Gelven (1970), George Steiner (1978) and Hubert Dreyfus (1991, 1996) influencing many contemporary nurse researchers in their interpretations of Heidegger’s work. For example, the work of Patricia Benner (1985) and Benner and Wrubel (1989) has been strongly influenced by Hubert Dreyfus; and Nancy Diekelmann owes much to the work of George Steiner (Diekelmann & Diekelmann, 1997). Australian nurses such as Annells (1996), Borbasi (1996), Koch (1994, 1995, 1996), O’Brien (2000, 2001), Taylor (1993, 1994, 1995) and Walters (1994, 1995a, 1996) have further enriched world-wide Heideggerian philosophical discussion while, simultaneously, adding greatly to the growing knowledge base of the discipline of nursing.

4.2 CHOICE OF METHODOLOGY FOR THIS STUDY

As previously discussed, as I set out on this study my aim was to gain ontological insights into the experiences of a group of CDU(N) nurse leaders and to provide a descriptive interpretive account of the understandings they developed over time. None of the quantitative strategies that entail a search for cause and effect, or even qualitative methodologies that endeavour to develop a theory, are appropriate to such a research aim. Neither are they congruent with my own personal and professional philosophical position – that human understanding goes far beyond simple theoretical concepts as it is strongly influenced by the values and beliefs that develop over time, be they conscious or unconscious.

The research methodology that I chose for this study draws on Martin Heidegger’s phenomenological ontology of Being (1962) and the long tradition of hermeneutics. This
section, consequently, begins by elucidating some of the philosophical underpinnings of phenomenology and hermeneutics before proceeding to discuss individual aspects of Martin Heidegger’s philosophy. The section concludes with a discussion of ways that Heideggerian phenomenological thought has been incorporated into the method I used in this study.

4.2.1 PHENOMENOLOGY

Although the term ‘phenomenology’ was employed in the mid-eighteenth century by Kant, it is now used to refer to a philosophical movement that developed from the work of Edmund Husserl, who introduced the term in his book ‘Ideas: a General Introduction to Pure Phenomenology’ in 1913. While Husserl, who developed the concept of life-world, followed the Cartesian tradition in the study of phenomena as they appear to consciousness (Koch, 1996), other phenomenological thinkers such as Heidegger (1889-1976), Sartre (1905-1980) and Merleau-Ponty (1908-1961), although starting from a common point, have developed their philosophies in differing directions. This diversification has ensured that there is no clearly defined school of phenomenology (Audi, 1995).

The study of phenomenology can, most succinctly, be described as the study of human experience and the way we come to understand our everyday world (Gurwitsch, 1966). In contrast to the positivist sciences, which are concerned with the exploration and theoretical explanation of consciousness as a ‘container’ that is able to fill and empty with ideas, facts, and emotions (Valle & King, 1978), phenomenological thinking describes the structures of experience in the way that they present themselves to the consciousness (Dreyfus, 1996) and poses questions of existence and meaning (Gurwitsch, 1966). There is, therefore, no recourse to theory or deduction in phenomenological thinking (Dreyfus, 1996).

4.2.2 THE HERMENEUTIC TRADITION

The term ‘hermeneutics’ is derived from the Greek word ‘hermēneia’ (interpretation) and is linked to the name of the messenger of the gods, Hermes, who interpreted their messages to humankind (Bleicher, 1980; Palmer, 1969). Hermeneutics has, consequently, been defined as “the theory or philosophy of the interpretation of meaning” (Bleicher, 1980, p. 1). While the foundations of contemporary hermeneutics originated in the early nineteenth century, its true origins have been traced back to the ancient Greek educational system and the interpretation and critique of Homer and other Greek poets. Its development as a method
for interpretation of texts resulted from the need, following the Reformation, to translate or interpret various authoritative texts under circumstances where the meaning of the original texts were either obscured or disputed. The Protestant theologian Schleiermacher (1768-1834), influenced by the traditions of transcendental philosophy and European romanticism, then developed it into a form of questioning and a new concept for the process of understanding. His genius rests in the development of a systematic foundation, fuelled by the need to prevent misunderstanding. Not only was Schleiermacher the first to attempt to analyse the process of understanding, but the stress that he placed on the linguisticity of understanding created a dividing line from the work of his predecessors and those who were to follow. Hermeneutic interpretation, an art as well as a science, became a creative reconstruction with the interpreters approximating as closely as possible the perspective of the author, while reconstructing the original creative act within themselves (Bleicher, 1980).

Dilthey, at the beginning of the twentieth century, in an attempt to find a systematic solution to the perennial question of the acceptability of subjective interpretation of the words of others, set out to develop a methodology for interpretation and understanding (Bleicher, 1980). Using sets of ‘canons’, which were designed to facilitate objective interpretations of human expressions, he drew on hermeneutics to bring out the distinctive subject matter of the text (Bernstein, 1983). The work of Martin Heidegger, however, threw into dispute Dilthey’s argument that the interpretation of a text could continue to objectively reaffirm the author’s intended meaning. His hermeneutic philosophy asserts that the interpreter is linked to the object of interpretation by preunderstandings that prevent the adoption of a neutral stance (Bleicher, 1980). Following Heidegger’s work and that of other more recent philosophers, hermeneutics has become increasingly linked with phenomenology as a research methodology.

4.2.3 THE PHILOSOPHY OF MARTIN HEIDEGGER

The influence of Martin Heidegger on modern day philosophy has been described as “an enigma” (Spiegelberg, 1976, p. 271) because, although some of his most famous works are characterised by a “weird and impressive style” (p. 273) and many of the circumstances that surround his life remain controversial (Borgmann & Mitcham, 1987; Heidegger, 1976; Inwood, 1997), his work had an immense impact on many areas of twentieth century thinking. Via his work, he has been a considerable presence in many areas of latter-day
European, Spanish-American (Spiegelberg, 1976) and Asian (Guignon, 1993) philosophy as well as such disparate areas as psychoanalytic theory, theology, ecology, rhetoric and literary theory. Likewise, his thinking has had profound influence on such phenomenological and existentialist thinkers as Gadamer, Derrida, Foucault and Bourdieu (Guignon, 1993).

4.2.3.1 HEIDEGGER’S WORK

Many have found it very difficult to categorize Martin Heidegger’s work under any single philosophical movement of the twentieth century. Most authors have classified his philosophy as phenomenological however references to his work are also to be found in textbook accounts of European existentialism, which Heidegger strongly repudiated. Heidegger identified strongly with the phenomenological movement for a significant part of his life however he omitted the word in his later writings. While he had been greatly influenced by Husserl in his early years, particularly when he worked as his assistant at Freiburg University, the foundations of their respective philosophical thoughts eventually proved to be incompatible. Consequently, it has been suggested that, because of Husserl’s prior claim to the term, Heidegger ultimately dropped all claim to the word phenomenology as his own philosophy moved further away from that of Husserl (Spiegelberg, 1976).

Heidegger set out to form a clear understanding of what it means ‘to be’. Such a philosophical aim was, indeed, ambitious as he attempted to rejuvenate Western philosophy and culture by clearing away the conceptual ‘errors’ that had dominated since the times of the ancient Greeks. His philosophising brought into question the long-held assumptions of Western thinking that had extend from Plato through to Descartes and on to contemporary scientific naturalism. In so doing, his many lectures and essays wove together the disparate historical strands of Western philosophy, drawing on the pre-Socratics, Aristotle, St. Paul, Aquinas, Kant, Hegel, Schleiermacher, Kierkegaard, Nietzsche and Husserl, among others (Guignon, 1993).

It is the change from epistemology to ontology that is central to Heideggerian hermeneutical thought as Martin Heidegger said that traditional philosophers had constantly failed to address the real issues or ask the important questions (Dreyfus, 1991; Grossmann, 1984). ‘Epistemology’, which comes from the Greek ‘episteme’ or ‘knowledge’, is the theory of knowledge while ‘ontology’, which comes from the Greek ‘on’ or ‘being’ concerns itself with being. While epistemological questions seek answers to what can be known about the
world, ontological questions are concerned with the true nature of what exists in the world (Wulff et al., 1990).

It was in his major work ‘Being and Time’ (1962), which was originally published in his native German in 1927, that Heidegger showed how much he had moved away from contemporary philosophical thinking and Husserlian phenomenology. In contrast to Husserl, Heidegger denied the notion of phenomenological reduction because we are influenced by what we do in the world, so it is not possible to bracket out our own experience (Dreyfus, 1996). He stated that, before human beings can be observers of their world, they must be dwellers in it: and thus the long-held Cartesian ‘cogito’ was transformed for all time, by ontological hermeneutic understanding, to Heidegger’s ‘Being-in-the-world’ (Crusius, 1991).

Furthermore, in his repudiation of pedantic scholarship style, Heidegger called on thinkers not merely to contemplate and debate his words, but to tread the same paths. As he said, what is most important to any thinker is what is left unsaid (Guignon, 1993). This has resulted in many diverse interpretations of his work and the adaptation of his philosophy to a research methodology for the social sciences, nursing and education.

4.2.3.2 BEING AND TIME

‘Being and Time’ is, without doubt, Heidegger’s seminal work, leaving its mark on many areas of philosophy, theology, sociology and psychology. It has been compared, in its greatness, to Hegel’s ‘Phenomenology of Spirit’, Plato’s ‘Republic’ and Kant’s ‘Critique of Reason’ (Inwood, 1997). ‘Being and Time’ not only brings together and expands on many of Heidegger’s previous works, but points the way towards his later work, which cannot be fully understood in isolation from ‘Being and Time’. Although one of the most difficult books to understand in its overall structure and somewhat obscure and original use of language (Inwood, 1997) it, nevertheless, brings “a breath of fresh air to traditional philosophical puzzles” (Guignon, 1993, p. 4).

In ‘Being and Time’, Heidegger restated the question of being and, for the first time since pre-Socrates days, Western philosophers were invited to ask “What is being, what is beingness in its Being?” (Steiner, 1978, p. 79). Heidegger (1962) argued that, although the subject of ‘Being’ is generally held to be self-evident, the “very fact that we already live in
an understanding of Being and that the meaning of Being is still veiled in darkness proves that it is necessary in principle to raise the question again” (p. 23).

He went on to oppose the dominance of epistemology within twentieth century thought (Audi, 1995) and the objective logical analysis and scientific classification that has prevented Western thinkers from expressing Being (Grossmann, 1984). Furthermore, he denied the subject-object dichotomy (Audi, 1995; Crusius, 1991) and returned us to the ontological condition: a more fundamental understanding of being than the Cartesian epistemological approach of relating the knower to the known (Dreyfus, 1991). In a similar vein, Heidegger reminded us that ‘being’ and ‘time’ are inseparable in that we ‘live time’ (Steiner, 1978).

4.2.3.3 HEIDEGGER’S BEING

Heidegger has used the German term ‘Dasein’ to describe his human ‘Being’. Dasein is not an object but a ‘happening’ and, by linking it with time, it can be likened to a ‘journeying through life.’ Dasein is also “being there” (Audi, 1995, p. 317). This ‘there’ is the world and Dasein is “human Being-in-the-world” (Crusius, 1991, p. 22) because humans are immersed in the world and this world is the root of all ontological understanding (Steiner, 1978). As Heidegger pointed out, to be human is to already understand what is meant by ‘Being’ (Dreyfus, 1991; Macann, 1993).

To Heidegger, the term ‘world’ refers, not to a geographical place but a personal world, inseparable from the self (Palmer, 1969). The composite ‘Being-in-the-world’ uses hyphens to show how each part of the term is “primordially and constantly a whole” (Heidegger, 1962, p. 65). Central to the interpretation of Dasein, the composite structure ‘Being-in-the-world’ is a priori as “the whole of the structure always comes first” (p. 65). People and their environment, therefore, are not at two distinct poles, but co-constitute each other (Dreyfus, 1991; Moss, 1978; Valle & King, 1978). As temporal Beings, while reaching out beyond themselves, they also recognise their own finitude, which is bounded by death (Smart, 1999). Heidegger’s discussion of ‘nothing’ and his interest in the immediacy of personal existence has also been likened to Eastern thought (Hirsch, 1970; Mehta, 1970), a comparison he did not reject (Smart, 1999).

Heidegger disengages what is understood by Dasein from acts of consciousness and places them within a temporal ‘world’. Unlike the Cartesian and Husserlian phenomenological
emphasis on the conscious subject, Heidegger’s Dasein cannot be interpreted as a conscious subject because consciousness is merely grounded in the temporality of Dasein, thus making the individual subject dependent on shared and social practices (Dreyfus, 1991). As Schürmann (1987) has suggested, however, he maintained some continuity with Husserl’s view of intentionality in that, because Heidegger describes Dasein as the “locality” (p. 73) of truth, “the possibilities of disclosure are always ours” (p. 73). Heidegger’s ‘knowing’ is, nevertheless, a mode of Dasein: a kind of being rather than “some mysterious leap from subject to object and back again” (Steiner, 1978, p. 83). Thrown into a world where things are ‘to hand’, there to be used, Heidegger’s Being is essentially a maker and a doer, rather than primarily a thinker.

While Western thought and, consequently, the scientific method have been based largely on the premise that we always act by applying known principles, Heidegger states that it is neither possible nor desirable to make our everyday understanding so totally explicit. He argues that we are thrown into a world that is already rich with knowing and understanding (Steiner, 1978) and the shared everyday skills and practices that we are socialised into provide the necessary conditions for us to pick up objects, to understand ourselves as subjects and to make sense of our world and of our lives (Dreyfus, 1991). These functions, necessarily, remain in the background, which he calls “the understanding of being” (Dreyfus, 1991, p. 4). These background practices operate in every function of our lives, including our use of language. We, therefore, cannot spell them out in a definitive and context-free way, but we can point out these practices and how they work to those people who already share them (Dreyfus, 1991). Hermeneutics must, therefore, always be done within a hermeneutic circle (Dreyfus, 1991).

4.2.3.4 THE HERMENEUTIC CIRCLE

Developed from the hermeneutic tool that has been used for centuries to interpret text, the term ‘hermeneutic circle’ now refers to the way humans develop understanding of themselves and their world. Heidegger (1962) reminds us that, only by leaping into the circle of understanding can we ensure “that we have a full view of Dasein’s circular being” (Heidegger, 1962, p. 363). Gadamer (1988) has described the hermeneutic circle as the “hermeneutical rule that we must understand the whole from the individual and the individual from the whole” (p. 68). Martin Heidegger, however, while retaining the concept of a circular structure of understanding, dismissed the structural confines of a
formal relationship between the individual and the whole by recognising that understanding is constantly determined by preunderstanding (Gadamer, 1988).

As no human can exist without a context, preunderstanding is Heidegger’s word for the context and culture into which we are all born, or thrown (Crusius, 1991). Humans are self-interpreting beings (Audi, 1995) who bring into their hermeneutic circle of understanding a background that dictates what is real; and a preunderstanding, which is brought into focus when interpreting a new situation (Koch, 1995). Heidegger argues, however, that while we all possess an implicit, pre-ontological understanding of the meaning of being, we lack a clear concept of it (Reeder, 1988). Interpretation of new experiences, therefore, only takes place against a backdrop of previous interpretations and meanings.

While our understanding of our world is formed from the world in which we live, we are, at the same time, developing our own world from our own experiences (Koch, 1995). This is the essence of Heidegger’s hermeneutic circle because of the movement between the shared cultural background and a specific experience during the interpretation process (Walters, 1994). Because neither consciousness nor freewill can be seen simply as a response to outside stimuli, and thinking can be described as a state of “non-willing” (Heidegger, 1959, p. 59), phenomenologists use the term ‘lived-experience’ to describe the way Dasein expresses itself in the world (Emden, 1991).

4.2.4 PHILOSOPHICAL IMPLICATIONS FOR THIS STUDY

Heidegger’s (1962) contention that ‘understanding’ and ‘interpretation’ are a priori ways of Being-in-the-world has strongly influenced the way that I, as a nurse and as a researcher, have approached the conversations I had with these participants, the analysis of their words and the subsequent development of this thesis. In line with Heideggerian phenomenological hermeneutics, the goal of the analysis was not one of presiding over or controlling the data. Nor was it one of developing scientific matter-of-fact knowledge (Reeder, 1988). There was no intention of generating a theory or of interpreting what the participants did or how they performed. Instead, the aim was to develop an ontological understanding of these nurses in their own contextual situation by interpreting shared meanings from the accounts they gave of their lived-experiences, thus preserving the details and the context of their individual experiences (Sorrell & Redmond, 1995).
When reading Heidegger, there is an almost eerie similarity between the concurrent philosophical viewpoints with which he had to grapple and those that dominated the environment of these participants. Prior to his own ontological shift, Heidegger had been immersed in a plethora of philosophical theories, including those of Edmund Husserl, which were grounded in the first-person. In other words, the starting point for previous philosophies had been a separation or a gap between the philosophers, as thinking subjects, and the objects of their thoughts (Horrocks, 1998). As previously discussed in this chapter, similar ways of thinking dominate the health care environment in which these participants worked and, as such, similar philosophical views were implicit in the understandings that underpinned their new CDU(N) project. In order for this research project to stay free of theoretical concerns and truly make contact with these participants in their “everydayness” (Heidegger, 1962, p. 421), a similar ontological shift was necessary in the design of the study to that previously taken by Heidegger.

Consequently, the starting point needed to move from the perspective of myself as the observer and the participants as people separated from their context to a focus on the world these participants described. Because of the nature of the study, this ‘world’ was the way they existed in and interacted with their everyday practice environment, which they brought into focus as they discussed their experiences. As Heidegger (1962) has stated, the new understandings they developed from their experiences in this world were formed within their own hermeneutic circles of understanding and against the background of the meanings already present in their shared social environment and their own previously developed interpretations. Had the focus of this study been on separating these nurses and their mental states from their contexts, it is highly unlikely that the richness of their world could have been brought into focus in the same way because, as discussed by Horrocks (1998), once such a detached stance has been taken, it becomes extremely difficult to bridge the gap that has been created.

Heidegger’s extension of the hermeneutic circle to an ontological expression of Dasein has been described as an understanding and caring mode of being (Reeder, 1988), with this use of the word ‘caring’ indicating that certain situations and things matter more than others. With caring as the essential requisite for coping and developing new ways of relating and maintaining connection with the environment, the fusion of thoughts, feelings and actions that can result from caring can create meaningful distinctions and provide direction for
actions (Benner & Wrubel, 1989). Such a view of the actions and motivations of these participants further posited me, as the researcher, into a position where it was easier to view the participants as self-interpreting beings (Heidegger, 1962) whose everyday ‘world’ has forged many aspects of their ways of thinking: their very ways of Being-a-nurse.

Heidegger’s re-formulation of the phenomenological method in ‘Being and Time’ has also been described as ‘caring’ in that it allowed the phenomenon of Being to show itself through an interaction between concealment and non-concealment (Levin, 1999). In this study, the words and the texts were ‘cared for’ in a similar way as all attempts were made to preserve their integrity. This is not to say that these words were not questioned. Working within the hermeneutic circle, indeed, became “a dance or interplay” (Reeder, 1988, p. 210) between the participants who wished to communicate and myself, as the one who wished to understand. In this way, the findings were ‘unhidden’ because “To speech belong the speakers, but not as cause to effect. Rather, in speech the speakers have their presencing” (Heidegger, 1977, p. 406). This has involved the utilization of insight, patience and openness in order to acquire a progressively greater and greater depth of understanding as the texts were returned to again and again because hermeneutic phenomena include both the familiar and the strange (Reeder, 1988). The journey through this study, therefore, ‘happened’ because humankind is the ‘place’ in which openness occurs (Macquarrie, 1972).

In ‘Being and Time’ (1962) Heidegger introduced two new terms: “present-at-hand” (p. 100) and “ready-to-hand” (p. 99). While the concept of present-at-hand is more congruent with the traditional philosophical stance towards objects (that we direct our internal conscious awareness towards the object of our thoughts and actions), Heidegger insisted that our interactions with our world are not underlined primarily by cognition and theory but by understandings developed from practice. To explain this, he discussed the way people use objects and tools. Although Heidegger is most famous for his description of an expert using a hammer (1962), the same concept can apply to any object or action that we are familiar with, such as driving a car. Most experienced drivers would agree that they frequently reach their destination with very little conscious memory of having changed gears or stopping at traffic lights. This is because we frequently perform such acts on automatic pilot, as if the object is transparent to us. This is the ready-to-hand mode in which we perform most of our tasks; part of our Being-in-the-world. It is only when
something unexpected happens that we apply our conscious attention to the task and switch to the present-at-hand mode.

This was another aspect of Heideggerian philosophy that underlined the analysis of this study. Despite the fact that these participants had recently attended a leadership course that had taught them many new theoretical CDU(N) concepts, in reality the understandings that underpinned their views on nursing practice would be primarily informed by their previous experiences as they had had little time to put their new theoretical understandings into practice. In other words, any new theoretical concepts introduced in the course, but not into practice, would remain present-at-hand and, consequently, would be less likely to have an immediate influence on their behaviour.

Heidegger’s work has shown that it is the underlying language that is common to, and sustained by, the shared social practices of the group that underpins the social meaning of a new experience. Because such meanings define our goals, attitudes and feelings, our understanding of these terms inevitably move in a hermeneutic circle (Heidegger, 1962; Taylor, 1971). In other words, in order to identify the meanings behind the moods or feelings that are precursors to the development of new meaning, I needed to overlie the hermeneutic circles of the participants with my own hermeneutic circle of experiences and understanding. I was facilitated in this process by the shared language that I, as a nurse who also works in the Australian health care system, held in common with these participants. Consequently, I was better equipped to question such nuances of language in words like ‘nurse’, ‘patient’ and ‘care’ and such phrases as ‘the nurse’s role’ and ‘centre of excellence’ that may have been missed by someone from a different discipline. In order to establish rigour in this process, it was then important to question my own meanings and interpretations of these words by frequent cross-reference to the text and further questioning of the participants at subsequent rounds of interviews.

While the initial analysis of this study was designed to bring order to the data by organising it into descriptive units, the interpretation began with a search for the significance of these patterns and the way such situations or actions are understood in the ‘world’ of these participants. In contrast to Descartes picture of the person as ‘a thinker’ and Husserl’s view of transcendental consciousness as self-sufficient and individual, Heidegger’s Dasein cannot operate away from the world as it is always in the background (Dreyfus 1991). Consequently, while acknowledging that this study could not begin with ‘a clean slate’,
unlike those researchers who follow Husserl’s phenomenological method, I made no attempt to bracket out my own experience. Instead, my own preunderstandings were juxtaposed with the experiences of the participants in order to enrich the subsequent analysis. This is the point where the hermeneutics circles of the participants overlapped with my own.

In the ways discussed above, the method employed in this study followed Heidegger’s own search for Dasein when he said that, we must:

choose such a way of access and such a kind of interpretation that this entity can show itself in itself and from itself … proximally and for the most part - in its average everydayness (1962, pp. 37-38).

4.3 STUDY DESIGN

4.3.1 DESCRIPTION OF THIS STUDY

This Heideggerian hermeneutic study investigated the experiences of a group of Australian nurse leaders as they attempted to develop their units into recognised centres of nursing excellence called Clinical Development Units (Nursing) (CDUs(N)). When this study began, these new CDU(N) leaders had recently completed a CDU(N) leadership preparation course and attended the official launch of their new CDUs(N). This study followed the nurse leaders of these nine CDUs(N) (or their successors) through the next 3½ years.

4.3.2 THE PARTICIPANTS

4.3.2.1 DESCRIPTION OF THE PARTICIPANTS

All of the participants who took part in this study worked as Nursing Unit Managers (NUMs) or Clinical Nurse Consultants (CNCs). Of these 14 people, 12 were in charge of the units in which they worked, while two of them worked in senior clinical positions (as CNCs) within a unit that also had a Nursing Unit Manager. Six of the participants were male and eight were female. Their nursing education had all been hospital-based; nine of them were general-trained and five worked in mental health nursing.

These 14 participants comprise the ‘original’ first-wave leaders of these CDUs(N), many of their successors and the two NUMs whose units were being led into this new CDU(N) initiative by a CNC. Although it was not possible to locate one of the first-wave CDU(N)
leaders who had left the area health service before the first round of interviews, his successor was interviewed in the second round of interviews. In order to distinguish between the experiences of the original CDU(N) leaders and their successors (whose experiences were very different), the participants who attended the first leadership course are called ‘first-wave leaders’ throughout this thesis and their successors are referred to as ‘second-wave leaders’.

4.3.2.2 RECRUITMENT OF THE PARTICIPANTS

Participant recruitment began when I requested an opportunity to talk with all of the nine CDU(N) leaders who had attended the first CDU(N) leadership course. I subsequently attended one of their meetings, which took place shortly after the completion of their leadership course. I gave them a verbal explanation of the aims of the study and a written participant information sheet and invited them to participate in this research study. Any questions they had at this time were addressed in the group setting. I then contacted them individually by telephone in order to arrange suitable appointment times for the interviews. As there was a lapse of several weeks between my attendance at their group meeting and the first round of interviews, each participant was given a second explanation of the study and the interview procedure before being asked to sign the consent form on the day of their interview.

The other participants who were recruited over time were approached individually by telephone calls to their places of work. A brief explanation was given to them on the telephone before an appointment was made for an interview. A more comprehensive explanation of the study and the interview process was provided on the day of their first interview.

4.3.3 DATA COLLECTION AND MANAGEMENT

4.3.3.1 THE INTERVIEWS

A total of 23 interviews were conducted with 14 people over a period of 3½ years. These interviews were conducted in three rounds:

1st Round – 11 interviews  Conducted in 1998 (4-6 months following the official launch).
2nd Round – 7 interviews  Conducted in 1999.
As the main aim of these interviews was to enter the world of the participants, these interviews can best be described as guided conversations (Rubin & Rubin, 1995). In line with principles of hermeneutic research, only non-directive questions were asked so as not to detract from the participants’ recollections of their own experiences. All three rounds of interviews began with similar questions, for example, ‘Can you tell me about your experiences as a CDU leader?’ and ‘Can you tell me something of your experiences since we last talked?’ Although most of the participants were able to talk at length, others required frequent prompts. Examples of such prompt questions are: ‘What does a CDU mean to you?’ and ‘Can you tell me about the reactions of some of your staff to the changes you have described?’ Other questions were asked in order to clarify my understanding of what had been said or to encourage the participant to talk further on the same topic.

The participants all chose to be interviewed at their place of work, usually in their own office. Each interview was of approximately 60 minutes in duration and was audio-taped. I also maintained a detailed reflexive journal throughout the interviews. As recommended by Koch (1994), this personal research journal was used to record notes and descriptions of the original context, relevant issues, occurrences, thoughts and observations.

4.3.3.2 TRANSCRIPTION

All of the interview tapes were transcribed verbatim. That is to say, all spoken words were transferred into written text, using a computerised word processing package. While a transcriptionist was engaged for the earlier interviews, I soon realised that I preferred to do this myself, which I did for the later interviews. For all of the earlier interviews that I had not transcribed, I set time aside to go through them myself so that I could make corrections. This also ensured that the written transcripts reflected all the ‘ums’ and ‘ahs’ and moments of silence as accurately as possible. This was done because I continually strove to increase my understanding of all of the small ‘shades’ of meaning that showed themselves during these conversations. Such a technique is consistent with the recommendations of Wellard and McKenna (2001), that qualitative researchers develop an approach that can chronicle the non-verbal as well as the spoken components of each interview.

4.3.3.3 DATA ANALYSIS

Although I made many early attempts to find an analysis procedure that could be described as having been ‘tried and tested’, they all eventually proved futile. Over time, I realised that I needed to develop a process that would not only be true to the philosophy on which
this study was based, but would also be something I could feel comfortable with. As Taylor (1994) has said, “there are many paths to the same end of phenomenology, that is, to the ‘Beingness’ of the phenomenon” (p. 55). The method of analysis that I eventually chose, like many other researchers before me, was based on my own adaptation of the plethora of literature I had read regarding phenomenological methods employed by others. Uppermost in my mind, however, were the insights I had developed from my reading of Heidegger’s own work (Heidegger, 1959, 1962, 1971a, 1971b, 1971c, 1971d, 1973a, 1973b, 1977, 1978, 1988, 2000).

The method I employed to analyse these interviews is as follows:

1. I familiarised myself with the words of the participants by reading each transcript several times in a relaxed and non-hurried way. I also replayed the tapes on several occasions, sometimes while doing menial jobs or driving the car. This allowed me to develop even deeper recognition of the voices of the participants so that, when I later sat and analysed the written transcripts, the ‘memory’ of their actual voices would ring in my ears. At this time, I also re-read the notes I had made in my reflexive journal. As discussed by Wellard and McKenna (2001), these notations reminded me of the context in which these conversations had been recorded and further deepened my understanding of some of the nuances of inflection the participants had used.

2. All of the transcripts were transferred to the computer program NUD.IST, an acronym for Non-Numerical Unstructured Data Indexing Searching and Theorising (Qualitative Solutions and Research Pty Ltd, 1996). Preliminary analysis of the transcripts then began. During this early phase of analysis, each of the three rounds of interviews was analysed separately. The transcripts, which were numbered line by line, were displayed on the computer screen and I highlighted each sentence or group of sentences that pertained to a developing theme. This process was essentially semantic and textual rather than abstract or causal (Packer, 1985). The highlighted utterances were then ‘collected’ by the computer program into ‘nodes’ that I labelled with the names of the individual themes. These nodes were then built up into a coding ‘tree’ that represented their relationship to each other.

3. Once all of the preliminary themes had been developed in this way, I was able to proceed to a ‘deeper’ level of analysis and interpretation. By comparing and contrasting the themes that had emerged, the common themes that spread over all of the sets of interviews slowly began to emerge as the hermeneutic circles of each of the participants were drawn.
into my own. My thoughts continuously flowed back and forth between the words of an individual participant and what I remembered the other participants had said. Although the earlier computer analysis now became very important as a tool to allow me to move easily between the words of the different participants and also between the different themes, I was no longer able to conduct this second phase of analysis in the same way. This ‘higher’ level of cognition, enacted within my own hermeneutic circle, now appeared to take me beyond the confines of the simplified database of a computer. This was, indeed, the point where the meanings and the experiences that the participants had described in our conversations now became ‘alive’ for me as I processed them through my own experiences of ‘being a nurse’. Even though we had all had different experiences, the similarities of our lived-experiences, which Heidegger has spoken about, now sat patiently waiting to be re-understood.

4.3.3.4 HERMENEUTIC PHENOMENOLOGICAL WRITING

Hermeneutic phenomenological descriptions and interpretations have the potential to be both insightful and compelling in their portrayal of how the world is experienced pre-reflectively. Consequently, while phenomenology can be described as providing one’s own unique orientation to lived-experience, hermeneutics, which is an interpretation of the ‘texts’ of life, is essentially a writing activity (Van Manen, 1990). When the researcher remains openly “sensitive to the subtle undertones of language, to the way language speaks when it allows the things themselves to speak” (p. 111), the resulting hermeneutic interpretations, which may engage both myth and metaphor, are at once both evocative and true to the description of the original experience. In this study, consequently, the writing process was not delayed until the final stages because listening and writing co-constituted the development of hermeneutic understanding, which spanned the entire analysis process.

The intention in hermeneutic analysis is to recapture the participants’ perspectives of their experiences (Abercrombie, Hill, & Turner, 1988), while simultaneously interpreting the concealed meanings in the phenomena (Sorrell & Redmond, 1995). Consequently, I made no distinction between explanation and understanding because hermeneutics is a process by which sense is made of our world and interpretation is the circular process that links the projection of meaning and the anticipation of understanding (Allen & Jensen, 1990). At each step along the way, whether I was ‘listening’ or ‘writing’, the hermeneutic analysis progressed as I sought the meaning of the text and linked these common meanings into
themes, as a constitutive pattern. In this way “an understanding of the whole (became) grounded in the parts, and vice versa” (Rather, 1993, p. 99).

4.3.4 VALIDITY AND AUDITABILITY

As a hermeneutic study into the experiences of these participants and the meanings they subsequently developed, the validity of this study does not relate to issues of ‘truth’ and ‘falsehood’ in regard to their disclosures; but to the conduct of the researcher. In accordance with the work of Kvale (1996) validity has, therefore, been upheld by a constant examination of ‘invalidity’, effected by a continual questioning and re-questioning of all aspects of this research in search of any misconceptions or falsifications I may have developed. Trustworthiness of the findings was then assured by meticulous attempts to reproduce the findings in this thesis in as transparent a way as possible. The trustworthiness and validity of the findings, consequently, resides to a large extent on my own credibility in the way I conducted the interviews and the craftsmanship with which I developed the analysis and findings of this study (Kvale, 1996).

In accordance with the recommendations of Guba and Lincoln (1985), consistency of data analysis is required to ensure auditability of the research process. This was facilitated by the inclusion of a “decision trail” (Koch, 1994, p. 976) in this study, which was maintained on the NUD.IST computer program (Qualitative Solutions and Research Pty Ltd, 1996) during the primary stage of the analysis process. In order to ease my access into the hermeneutic circles of the participants, I frequently referred to the personal research journal I had maintained throughout the interviews. While these entries provided a record of many aspects of the environments in which these participants worked, the taped conversations provided a record of a variety of nuances of vocal inflection, and even periods of silence, that can ‘tell a story’ in their own right (Poland & Pederson, 1998). Such aspects of ‘normal’ conversational style can be interpreted because, according to Heidegger, “there are commonalities of everyday existence that bind people-in-the-world” (Walters, 1995b, p. 496). This process was supported by frequent questioning of the decision trail.

My commitment to maintaining an ongoing critical attitude towards the findings, which ensured I would return frequently to the typed transcripts, was supported by further questioning of the participants in subsequent interviews or occasional informal discussions. During the process of analysis, and in line with principles of hermeneutic research, the
experiences of each participant were painstakingly compared to similar experiences of other participants in an attempt to disclose phenomena where ‘the parts’ reflected ‘the whole’. Furthermore, because the interviews for this study were conducted over time, it was possible to make ongoing adjustments to the ‘picture’ these people were painting of their world as the depth of my understanding of their experiences was progressively enhanced and refined. As such, I made no attempts to separate the analysis process from the rest of this study as it was seen as circular rather than linear. Indeed, even as these words are written, it continues on, and will do so until the very last word is written in this thesis, and beyond, as it is a creative act that has no end.

Finally, in order to ensure transparency of data, I took great care during the writing up of this document to ensure that all aspects of the analysis would be rendered visible to the reader by using direct quotes from the participants throughout the analysis chapter. The extended development of these themes in Chapter 7 and the discussion and the recommendations that follow in Chapters 8 and 9 are supported by numerous references to published literature from a wide variety of disciplines.

4.3.5 ETHICAL CONSIDERATIONS

Formal Ethics approval to conduct this study was granted in 1997 by the appropriate area health service ethics committee and later endorsed by the University of Western Sydney Nepean Human Ethics Committee. This study was originally designed to incorporate only the nine first-wave CDU(N) leaders over two rounds of interviews (in 1998 and 1999). Further approval was then granted in 1998 to interview the NUMs of the units where a CNC was the designated CDU(N) leader. Then, following the preliminary data analysis of the first two rounds of interviews, it was concluded that a third round of interviews may provide further insights. With additional ethics approval, this round of interviews was conducted in 2001.

All participants were given an ‘Information Sheet for Participants’ (see Appendix A), which provided a comprehensive explanation of the aims of the study, an overview of their rights, details of the interview process, a request to audiotape the interviews and the name and telephone number of myself (as the researcher) and those of my principle academic supervisor. They were informed that participation in this study was voluntary. Written consent was obtained from each participant immediately prior to commencing the
interviews (see Appendix B). It was made clear, before they signed the consent form, that if they wished to stop the tape at any time during the interview, their rights would be respected and no more questions would be asked. As no participant has, to date, withdrawn from the study, no data has been destroyed.

All participants were allocated pseudonyms so that their identity would not be recorded on the tapes or transcripts. All identifying information has been treated with absolute confidentiality and, in accordance with instructions from the Ethics committees, all tapes, transcripts, disks and diaries are to be kept in a locked cupboard for five years. It must also be noted that, because this study refers to a limited number of units, some of the identifying features of the participants have been altered in order to protect the anonymity of their disclosures. Furthermore, and again for reasons of participant confidentiality, it has been deemed necessary to limit the amount of information that is made available about each participant. In the same vein, there is a deliberate discrepancy between the pseudonyms given to the participants in Chapter 6 (the analysis chapter) and the description of the participants in Chapter 5, which refers to them only by letters of the alphabet.

4.4 CONCLUSION

This chapter has detailed the philosophical underpinnings and practical considerations of method that have been faithfully adhered to throughout the preparation and execution of this study and the formulation of this thesis. The following chapter will provide more details of the setting of the study and demographic information regarding the CDUs(N) in which these participants worked.
Chapter 5

THE CONTEXT AND THE PARTICIPANTS

This chapter is designed to provide the reader with an introduction to the ‘world’ of the participants in this study. As such, it begins with an introduction to the CDUs(N) featured in this study and their initial development. The chapter then concludes with a brief description of each of the participants.

5.1 THE CONTEXT FOR THIS STUDY

5.1.1 SETTING THE SCENE

This study relates specifically to the first cluster of nine Clinical Development Units (Nursing) (CDUs(N)) developed in a metropolitan area health service in Australia. These CDUs(N) were based on a model that had been developed in the UK, which has a well-published track record of raising the profile of nursing in specifically designated wards or units. This Australian initiative was co-sponsored by the area health service and the local university. It was developed and coordinated by a Professor of Nursing, who held a joint appointment between these two bodies.

All of these new CDUs(N) were developed from existing wards or units, spread throughout five facilities within the area health service. The geographical dispersion of these units varied, with some situated only a very short distance from each other, but with the two most distant some 40 kilometres apart. These nine units comprised one acute medical ward, three chronic long stay rehabilitation facilities, three mental health units and two ambulatory care units. Five of the nine CDUs(N) were multidisciplinary units.

The leaders of these units or wards were recruited to this CDU(N) project through a general invitation extended to the senior nurses of the area health service. Those who applied worked in managerial positions at ward level as NUMs or in senior clinical positions as CNCs. Each new CDU(N) was assigned only one CDU leader and, in all cases, this title was given to the original applicant. As the official CDU(N) leaders for their units, these...
were the people who were expected to promote the CDU(N) concepts among their staff and the broader organisation.

The participants for this study were subsequently recruited from the leaders and managers of these nine CDUs(N). The 14 people interviewed over the three rounds of interviews included first-wave CDU(N) leaders (those who had initially led their existing wards or units into this new project), many of their replacements and the managers of the two units that were being led into this CDU(N) project by a clinical nurse. During the first round of interviews, which took place approximately four to six months after the official launch of this first cluster of CDUs(N), the participants disclosed a wide variety of issues. These included: the expectations that they had held during the initial application process; their experiences during the leadership course and the official launch; their interactions with their staff and other relevant people; and their current attitudes towards the project. The second round of interviews (12-18 months later) and the third round (approximately 18 months after that) provided opportunities for those first-wave leaders who remained to discuss their more recent experiences and how these experiences had modified their previous understandings of the CDU(N) project. The incorporation of the second-wave leaders into this study then greatly enhanced the findings as they provided additional insights into what happened to these CDUs(N) over time.

5.1.2 THE DEVELOPMENT OF THESE UNITS

Once accepted into the new CDU(N) program, all of the first-wave CDU(N) leaders were required to attend a specially prepared leadership course, which was designed to provide the requisite foundation on which to develop their units into ‘centres of excellence’. It was anticipated that, once these leaders had obtained the necessary skills, they would be able to develop their units in line with the CDU(N) concepts and principles they had been taught in the course. The CDU(N) leadership course consisted of six two-day workshops. The course was held over six-months in order to allow the participants time to put their new theoretical knowledge into practice between the sessions. Specific projects and assignments were also allocated during this time to provide opportunities to apply the strategies introduced in the course.

This course focussed mainly on the CDU(N) concepts, which included strategic planning, evaluation of care, team building, time management, management of change, reflective
practice and action research. In order to develop their new CDU(N) identity, various approaches were employed. These included the development of their own CDU(N) stationery and brochures and a slideshow that was later used in seminars and presentations. By taking into account the special character of each unit, these participants began to develop projects that, although small, were significant as they capitalized on the inherent strengths of their individual units. As it was anticipated that many of these leaders may have to face difficult developmental or leadership issues, each leader was also assigned a senior nurse mentor, with whom they met regularly to reflectively dialogue the relevant issues.

Together, they formulated standards for their new CDUs(N), developed largely from the published NDU literature. Individually, they drew up strategic plans, practice development and research objectives and set benchmarks for their units; while some of them developed small quality assurance projects. One of the units utilised a small financial grant from the CDU(N) funds to develop an education program for patients and two others were able to link into academics from the local university. One of these units began a short-lived program designed to develop reflective practice skills and the other had some involvement in a research project.

The decision was made not to follow the British lead of spending considerable time developing these units before they could be granted official accreditation. This allowed the launch of the first cluster of CDUs(N) to be seen as representing the project as a whole, instead of the individual units. It was anticipated that this would reduce the possibility of claims of elitism and, consequently, allow the gradual development of this first cluster of units, while simultaneously encouraging the development of further units in the same establishments. In the absence of a drawn-out process of accreditation, the leaders of these Australian units were expected to satisfy the criteria for completion of the CDU(N) leadership course before they could proceed to the official launch of their units. None of the units ‘failed’ in this respect. Consequently, within a few months of finishing the CDU(N) leadership course, nine CDU(N) leaders went on to lead their units into the official launch of this new project.
5.1.3 FOSTERING SUPPORT

The Professor of Nursing who initiated this project, while taking responsibility for preparing the CDU(N) leaders to develop their existing units or wards into CDUs(N), simultaneously implemented various strategies to build bridges between each of these fledgling CDUs(N) and their wider organizations. She chaired meetings between the senior nurses, the appropriate medical officers, the CDU(N) leaders and other relevant parties in order to explain the new developments. In line with previous NDU experiences in the UK, provisions were also made for the development of Steering Group Committees, which would comprise the relevant CDU(N) leaders and the senior nurses and medical officers from within the institutions in which these CDUs(N) were situated. The aims of these meetings were to ‘sell’ the CDU(N) concept and provide ongoing support. Other ongoing monthly meetings were set up for the CDU(N) leaders to allow them to discuss their current issues and concerns in an atmosphere of peer support.

Small monetary grants were made available following the leadership course in order to assist each unit to develop a small project. This money was utilised to purchase specific resources or to replace nursing staff for such projects as educational programs for staff and patients and the development of research proposals. Although it was indicated, at one stage, that additional funding would be made available from the area health service in order to employ a post-doctoral fellow to support these units, this did not eventuate. One of the CDU(N) leaders did step in to liaise between the different leaders for a while but this proved to be little more than a stopgap measure. A resource nurse was employed at a later date to assist some of the second cluster of CDUs(N), however this came too late for the participants in this study.

5.1.4 COMPARISON WITH BRITISH NDU

The wards and units in which these Australian nurses worked present a dramatically different picture in terms of demographics, capacity levels and client mix to the three pioneering NDU and many of their successors in the UK. For example, the first British NDU was developed in a small community hospital where the registered nurse-patient ratio facilitated a radical rearrangement of nursing responsibilities. Such a situation was not possible in these Australian units, given the current critical shortage of trained staff. What is more, not only were the earlier NDU developed in establishments that afforded the
leaders opportunities to develop such concepts as primary nursing, therapeutic nursing and nursing beds, but a large number of the NDUs developed in the UK since this time have adopted some or all of these concepts. A similar implementation of seemingly ‘radical’ ideas requires a work environment that actively supports innovation, a substantial degree of autonomy of nursing leadership at ward level and a stable nursing workforce. It is of note that none of the participants in this current Australian study credited their own working environments with any of these characteristics.

A further sharp distinction between these Australian CDUs(N) and the original NDUs to which they trace their heritage is the role played by the person responsible for the development of the units. The earlier units were developed by nurse leaders who were present on the wards on a daily basis and were intimately involved in the everyday planning of the nursing work. In contrast, the more recently developed units, and in particular those featured in this study, were developed by more senior figures who were, in no way, involved in the everyday running of the units. Indeed, the Professor of Nursing who took responsibility for developing these Australian units held no functional power in these organisations and visited the units only occasionally.

5.2 SNAPSHOTs OF THE PARTICIPANTS

This section comprises brief descriptions of the individual participants. Each person is introduced under the unit in which they worked in order to better illuminate the leadership changes that took place within each unit over time.

CDU(N) No. 1:
Participant ‘A’ had been one of the most enthusiastic of the CDU leaders leading up to and following the CDU(N) launch. By the time of our interview, however, which occurred approximately six months after the CDU(N) launch, she had already moved on to another position. My single interview with her was conducted late in the afternoon in a quiet area of the hospital where she was now working. Although looking a little tired after her day’s work, she appeared confident and very self-assured. She remained enthusiastic about the CDU(N) concept and hoped that her decision to leave the unit would not jeopardise the development of ‘her’ CDU(N). Consequently, she was counting on Participant ‘B’, her replacement, to maintain the necessary momentum to keep this fledgling CDU(N) alive.
At the time of the first round of interviews, Participant ‘B’ had taken over the management of this ward as Acting NUM. Although very familiar with the ward, this was her first management position and she stated that she felt under considerable pressure to learn her new duties and responsibilities. Some of the pressure and stress she was working under was made evident during both of our interviews, which were conducted in her office. Not only did the door remain open for the whole time so that staff could make frequent contact if they had a problem, but the telephone also interrupted the conversations several times. She was, however, very clear about her immediate aims and objectives. She stated at her first interview that, as she wished to consolidate her knowledge of her new management role, the CDU(N) would have to take a back seat “for the time being”. She had every intention, at this time, of attending the upcoming leadership course and of maintaining her unit as a CDU(N) once her immediate concerns had been resolved. By the second interview, however, she had decided to discard the CDU(N) concept from her immediate vision for her unit and no longer intended to participate in the second leadership course.

CDU(N) No. 2:
Just prior to the establishment of the CDU(N) program, Participant ‘C’ had been promoted to the position of Nursing Unit Manager in the unit in which she had worked for some time. During our interview, she appeared quite nervous, saying she was unsure of what she “should say”. She explained that, while working as a registered nurse on the ward she had made enquiries about the newly proposed CDU(N) project however she had been thwarted in this attempt because she did not hold a management position. Soon after this she was appointed to her new position and, therefore, able to apply for CDU(N) status. During our interview her strong desire to make changes to her ward could be described as ‘passionate’. It therefore came as quite a surprise when, by the second round of interviews she, too, had resigned. Her position was vacant for some time after she left and no one continued on with the CDU(N) philosophy.

CDU(N) No. 3:
Participant ‘D’, who was interviewed on three occasions, worked as a NUM on a multidisciplinary unit. These interviews took place in his office, with the doors closed and very few interruptions. Although he often appeared quite unsure as to whether he was “doing the right thing” to live up to CDU(N) philosophy, he was very confident in his role as manager of the unit. Although he stated that he had greatly enjoyed the leadership
course, he continued to run his unit in a similar way to how he had always run it. Despite the emphasis placed on the concept of ‘leadership’ in the CDU(N) course, he made it very clear that he saw his role more as a manager than as a leader.

CDU(N) No. 4:
Participant ‘E’, who worked as the NUM of another multidisciplinary unit, was very animated as she discussed the CDU(N) concepts during the first round of interviews. She also appeared relaxed during this interview, which took place in her office, with the door closed to interruptions. She said that she had seen the CDU(N) as a way of promoting a team of which she already felt very proud. She painted a very clear vision of the needs of her staff and frequently spoke of them in glowing terms. She, too, left this position before the second round of interviews.

This vacant position was taken over by Participant ‘F’. During my first interview with her it soon became clear that there was a great deal of friction within the unit that Participant ‘E’ had not disclosed. During the second round of interviews, Participant ‘F’ appeared quite stressed when she discussed many of the problems she was having with some of her staff. Although few in number, these people were causing her considerable problems. By the time of our next interview, however, she appeared to be more relaxed in her management position and stated that things had much improved as some of her previously difficult staff had left and she had since attended one of the CDU(N) leadership courses. Although she spoke eloquently of many of the CDU(N) concepts, she had no intention at this time of identifying her unit as a CDU(N).

CDU(N) No. 5:
Participant ‘G’ worked as a CNC on a multidisciplinary unit that employs a large number of staff. Although he remained a strong believer in the individual CDU(N) concepts throughout all three rounds of interviews, over time he began to realise that the obstacles preventing the CDU(N) vision from becoming a reality in his unit were unsurmountable. He eventually resigned from his position.

Participant ‘H’, worked as a NUM on this same unit. Although not officially connected to the CDU(N) project, he was interviewed during the first round of interviews in order to discuss his experiences with the conversion of his unit into a CDU(N). Although he said that he stood behind his CNC (Participant ‘G’) in his attempts to develop the unit along
CDU(N) lines, he expressed some doubts about the validity of the overall CDU(N) concept. Both Participant ‘G’ and Participant ‘H’ had differing styles of leadership: while the official CDU(N) leader (the CNC) was trying to put his newly learned ‘leadership’ skills into practice, the NUM (Participant ‘H’) remained very management focussed. It was evident that each of them was trying very hard not to tread on the toes of the other.

CDU(N) No. 6:
Participant ‘I’ was working as a CNC in his speciality when he was asked to take responsibility for a unit experiencing difficulties. Having been placed on this unit as a change agent while the NUM was temporarily away, he said that he had been encouraged to apply for CDU(N) status for the unit by higher nursing management. While, during the first round of interviews, he discussed many of the advantages of such a move, by the second and third rounds of interviews he had become quite disillusioned and somewhat cynical about the problems he and his staff had encountered.

Participant ‘J’, who was interviewed on two occasions, was the NUM for this same unit. Away at the time of the first leadership course, he was, nevertheless, keen to maintain the CDU(N) status after Participant ‘I’ left the unit. His quiet demeanour contrasted strongly with that of Participant ‘I’. Although he appeared keen to work with the CDU(N) concepts, he frequently stated that he was unfamiliar with how to put them into practice. He later attended one of the leadership courses however, when I tried to contact him for the third round of interviews, he had already left the area health service.

CDU(N) No. 7:
Participant ‘K’ worked in both a clinical and a managerial role in a small multidisciplinary unit. Not only had she seen her previously autonomous decision-making role severely curbed over the preceding few months due to a recently introduced area-wide project, but she now felt particularly disempowered in her work and frustrated with what appeared to be an ever-increasing workload. She was only available for one interview as she left this position before the second round of interviews.

Participant ‘L’ took over from Participant ‘K’. When first appointed to this position, she had not been informed that the unit was a CDU(N). At our first interview, she said that the development of the CDU(N) was “on the backburner” as her main priorities were to “develop an efficient service”. She then attended the second CDU(N) course. Although she
spoke very highly of her experiences during this course and she made some changes on her unit that related to the CDU(N) concepts, she never called her unit a CDU(N).

CDU(N) No. 8:
The situation that Participant ‘M’ described was very similar to Participant ‘K’ as she, too, had been embroiled in similar problems over the preceding months. Although she said she had hoped that the CDU(N) program might help to extricate her from some of these problems, by the time of our interview she was already realising that her expectations would not come to fruition. So frustrated was she that she asked to have the tape switched off for approximately 15 minutes during our interview so that she could explain the exact source of her problems; these disclosures (which were not related to the CDU(N) movement) were not included in the data. She, too, eventually resigned from her position.

CDU(N) No. 9:
As one of the most enthusiastic CDU(N) leaders left his position shortly after the launch to take up a new post in the private sphere, he was not available for any of the interviews. His NUMs position was vacant for some months before being taken up by Participant ‘N’, who had come from another institution. At the time of his appointment, he was not told that the unit was a CDU(N) and, although some of his staff had been involved in many aspects of the CDU(N) planning, none of them mentioned it to him. By the time of our interview, he had learned a little about CDUs(N) and planned to attend the new leadership course. He said that he held an open mind about how he would develop his unit following the course. Although he then attended the course, by the time of the final round of interviews he had already resigned his position. He did not display any enthusiasm for the CDU(N) concept during his short tenure.

5.3 CONCLUSION

This brief introduction to the settings and the participants is followed, in the next chapter, by a detailed analysis of the findings.
Chapter 6

THE FINDINGS

This chapter discusses, in detail, the hermeneutic analysis of the 23 interviews conducted for this study. Because these interviews commenced approximately three months after the official launch of the new CDU(N) project and continued on for approximately 3½ years, it has been possible to harvest insights into a variety of the experiences of these participants. In line with the philosophical underpinnings on which the study is based, during this analysis I sought to ask questions of the data as to what it was really like for these participants, how the meanings they had brought with them into this enterprise evolved over this time and what they have taken away with them.

Because of the nature of this study, more emphasis is placed on the disclosures of the first-wave CDU(N) leaders who attended the first leadership course. While the contribution of their replacements (referred to as second-wave leaders) is vital to the development of a deeper understanding of the whole CDU(N) ‘picture’, it must be acknowledged that many of these replacements had very limited experiences within a CDU(N) context. Consequently, while knowledge gained from their interviews has been incorporated into the findings of this study, the majority of the themes are developed primarily from the experiences of the first-wave leaders.

6.1 INTRODUCTION TO THE THEMES

The findings of this study have fallen naturally into three main themes, which mirror the longitudinal nature of this research. The main themes (which are then divided into sub-themes) are: firstly, ‘Charting a New Course: Reacting to the Pressure to Change’; secondly, ‘Losing Sight of the Shore: Becoming Invisible and Forgotten’; and lastly, ‘Traversing Uncharted Waters: Losing the Dream’. It will be noted by the reader that the titles of these themes continue to reflect the tone of the mythical story in the Preamble of this thesis. This choice of arrangement is not forced; it arose spontaneously out of the words of the participants as they divulged their experiences over time, and as these words found resonance with my own understanding.
The following table lists the three major themes and associated sub-themes found in Chapter 6. It also clarifies the relationship between these themes and the new hermeneutic understandings that emerge, and are developed, in Chapter 7:

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<th>THE THEMES OF THIS STUDY</th>
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6.2 THE THEMES

6.2.1 CHARTING A NEW COURSE: REACTING TO THE PRESSURE TO CHANGE

This first theme is underscored, in large part, by the expectations the first-wave CDU(N) leaders brought with them into this new project and the new ideas they developed during the CDU(N) preparatory leadership course. Consequently, it reveals their reasons for setting out on this new adventure and how they began to enact their individual interpretations of what was expected of them during the early stages. It also reflects some of their earlier hopes and enthusiasm to initiate change in their units and to develop their leadership skills.

6.2.1.1 RIPE FOR THE PICKING:

A SEARCH FOR A NEW IDENTITY

During the first round of interviews, all of the first-wave leaders spoke about how eager they had been to partake of the quest to develop a small group of existing wards or units into CDUs(N). They had felt drawn to the promise of an exciting new adventure into the unknown. Many of them also described how they had been lured by the expectation that this new initiative would provide a haven from some of the perils they had previously had to face alone. As they signed up for the new CDU(N) program, they saw the sense of security they sought for their units mirrored in their new identity as CDUs(N).

Empowered by their own excitement, these participants talked enthusiastically about many of the theoretical concepts they had studied in their recently completed leadership course. Apart from viewing these concepts as a way of raising the standards of patient care in their units, they also spoke of their involvement with the CDUs(N) as a unique way to attain acknowledgement for their staff. As Lucy said:

[Many of the nursing staff] are bright and enthusiastic, they go and do university degrees and all that sort of stuff and, basically, they get very frustrated and tired of it because they don’t feel as if they get any recognition for all the work they do. And it’s all very well for me to go around and say to people, ‘Oh, look, you’re a wonderful little nurse’ and what have you, but it’s not scientifically based – my affection, or patting them on the head, or anything.
Denise added:

*I think that [the CDU] is exciting and that it’s actually something to turn nurses around. I think nursing is in a bit of a lull at the moment because everyone I know is dissatisfied and most people I know are looking for new jobs.*

Most of these participants talked about their wish to go beyond what is currently accepted as ‘normal’ in the Australian health care system. Their frustration with “the system” had been fed, over time, by their inability to change nursing practice. Although their job descriptions indicated that they were working in positions of ‘nursing leadership’ they were, nevertheless, forced to work within physical and managerial restraints that not only robbed them of political power within their own units, but also repeatedly sapped their enthusiasm. This is despite the fact that management pressure was simultaneously being brought to bear on all nurse leaders within the health system to make ongoing changes to their wards or units. Trevor described the all-pervasive pressure that he felt as: “*There is no doubt in my mind that there is an expectation across the board for nurses to be doing things in a more highly efficient manner.*”

The frustration these leaders felt was compounded by a nursing work force that had long-since accepted their own disempowered situation. Said Christopher:

*I guess I’d reached that point where you wonder, ‘What the heck am I doing?… How can I actually change practice?’… You can say, ‘Well, I’ve got all these great ideas. There you go,’ or you can take the opposite approach with, ‘Well, let’s look at this together…. How can we actually change this?’… but nothing would change.*

The invitation to join the new CDU(N) initiative appeared, to many of these nurse leaders, as ‘the right thing at the right time.’ Whether feeling blocked in their attempts to change practice, or acutely aware that they needed to hone their leadership skills in order to deal with urgent problems, these nurses were, as described by Alison, “*ripe for the picking.*” Their anxieties about taking on a great deal of work were, therefore, put to one side in order to seize the opportunity to solve their more demanding problems.

They were, in effect, reaching out for help to a body of people and to a new program that would by-pass previously unsuccessful sources of support. Myra, for example, discussed
how she had been forced to seek out this ‘external’ help in order to deal with the problems she was facing in her unit:

Now I'm in management, I have the opportunity to be very involved with the senior managers.... [But] the right thing for a lot of people varies, you know. Even some people who have been in management for years still think that what they know is right. And I've got to be very careful because a lot of people challenge me as well and they say, 'Oh you've got to be tough and write ‘this’ and ‘that’... and put in so-called negative reinforcers’. I keep telling them I'm not prepared to.

Many of these leaders worked in units that already functioned within a multi-disciplinary framework with a medical director. For some of the participants, this situation often discouraged nurse-led changes with which the medical director disagreed. Mired in a difficult dilemma from which she could see no easy way out, Alison, for example, was quick to reach out to what she believed to be a new source of ‘power’ in order to advance her own ideas of nursing practice:

Our outlook here is very much patient-orientated and patient-centred however we also operate [in other areas], where the quicker the bums are off the seats and people are sent home, the better. So then we get back to task orientation and, ‘Yes doctor, no doctor, three bags full, doctor’ and we're losing contact with a supportive, problem-solving primary health care model.... I mean, I've read about it, I've tried it and I've realised it works and I wanted to follow on further with it but I just got chopped off every way I could.

Steve was very open about his wish to identify with the NDU/CDU(N) movement in order to strengthen the ‘political’ position of his nursing staff within the organisation. By becoming part of an area-wide project, Steve sought to gain support for his unit, whose very existence as a ‘nursing’ team was being threatened:

Initially, I was thinking that maybe it's a good opportunity to market nursing and the team because, you see, the internal pressure on the service here is that we shouldn't be a nursing team at all.... The flavour of the moment is 'multi-disciplinary teams.' Because the team is all nursing, we're against the flow a bit and ... we're actually fighting a battle to keep the team as it is at all.... So in a sense, I've probably had that
agenda in using the CDU as a tool to maintain the team or keep it together. You know, ‘Well, you can’t just wipe us off. We’re a Clinical Development Unit.’

The first-wave leaders who were employed as CNCs faced additional problems, which the title ‘CDU(N) leader’ had the potential to solve. They had found it difficult, at times, to develop their own roles as clinical leaders in settings where they held little power to change practice because most of the nurses clarified their everyday problems with the nurse manager of the unit. Said one of these CNCs:

If you bring change into a unit, you’re going to have people who will resist it and ... there are going to be people who are actively working against you. So you’ve got to have the authority to deal with them. That’s probably the time when you need to have legitimate authority the most.

There was a clear delineation between the high expectations that the first-wave leaders held towards the NDU/CDU(N) movement and their successors. As none of the second-wave leaders had made an active choice to become part of this new initiative, they were more subdued in their expectations. This did not, however, prevent most of them from appearing keen to seize the opportunity to undertake one of the leadership courses as they wished to develop a greater degree of flexibility in their leadership styles. Linda summed this up, just prior to attending a subsequent leadership course, when she said:

The CDU course pre-reading ... has some really good principles about a leader not dictating, but needing to be comfortable with their own inner self before they can bring their leadership into any team. So, I thought it had deep philosophical principles that really go with the way I feel. So that's why I think I'll gain a lot out of it, personally and professionally.

6.2.1.2 FLYING BLIND: ATTEMPTING CHANGE BY TRIAL AND ERROR

During the leadership course, these leaders experienced periods of excitement and heightened motivation as they discussed how they could bring about radical changes to nursing practice and set new standards for others to follow. Each time they returned to their units, however, and they were faced with the reality of changing entrenched everyday practices, they felt less confident that they had all the answers. While many of them spoke
of the Professor of Nursing who was leading them into this initiative as “very enthusiastic”,
the time that she had available to spend with them was limited due her other diverse
responsibilities. Consequently, hampered by their limited knowledge of the concepts they
were trying to implement and the lack of practical examples in their immediate
environment, all they could rely on was the motivation they were developing in the
leadership course and a package of theoretical concepts. They had, in effect, to learn by
trial and error. Said Denise, “While I was trying to enthuse and excite the staff about
getting involved, I didn’t really know what we were all getting involved in. So it was pretty
much a learn-as-we-go experience for all of us.” Alison added, “In terms of the day to day
running of the place, I didn’t have a huge idea of what changes would be needed, so that
was a bit difficult and a bit frustrating as well.”

It was the CDU(N) leaders themselves who drove the changes in their units. Each one
began by developing the areas of the CDU(N) philosophy that best fitted their own
individual situations. While some set up one or two small projects, this was a time of
prolific planning for others. Buoyed by the knowledge that, in order to develop a
‘successful’ CDU(N), it was vital they should have the majority of their staff on board, they
arranged regular meetings with their staff to discuss their new ideas. In many ways, this
preliminary period proved to be the easiest. Some of them used their own lack of
knowledge as a way of encouraging participation from their staff during this very early
stage of the development of their CDU. Said Fiona:

Because I was learning as we went along, [all the staff] were kind-of at the same stage
the whole way through because, as I went to the course, I brought back the information
and shared it with them. They were kind-of up to the same stage as me without having
done the course themselves.

Myra, too, talked of how she had been able to begin to put into practice some of the ideas
she had gleaned from the course:

Doing the course was very beneficial…. It was great because [you look at how] to get
staff together, how you set ground rules and you look at the various strengths of each
individual…. [So] I was very much aware of team management because that was the
main thing in the CDU course. Whatever I did, the team must know. And I made sure
that there was a good form of communication - we had memo books to record it and a communication book.

Denise was very proud of some of the strategies she had learned from the course:

In terms of the way I do my reports now, I’m a lot more rigorous about the way I even do my data analysis and I try and put fairly comprehensive reports in about staffing and about skill mix and things like that. So, instead of just talking about it, I actually do some pretty good analysis.

In other aspects, however, they ran into unexpected pitfalls. When Lucy tried to facilitate a better use of nursing resources, she was acutely reminded of the anxiety that can be created when attempting to make changes to traditional nursing roles:

I'd just assumed that everybody knew how to do Case Management, and that it was easy. I mean,... it may not be actually 'easy' but 'you know it' and you just 'go and do it'. But one of the things that came out of it was that people didn't naturally know how to do it. It was something that I'd overlooked in that I’d said, 'You’re competent. You can go and do this.'... It was a time of quite a lot of anxiety for some of the nurses that were doing it because they were flying blind, really.

6.2.1.3 LEARNING TO WALK THE TALK: DEVELOPING NEW LEADERSHIP STYLES

For many of these participants, one of the most exciting aspects of the leadership course was the opportunity to learn more about how they conducted themselves as leaders. Although some had worked in management or leadership roles for several years, few of them had ever questioned their own leadership styles or engaged in self-reflection. Not only was reflective practice discussed in theory during the leadership course, but each course participant was also allotted an academic mentor with whom they could reflectively dialogue over the six months of the leadership preparation program. Denise was very enthusiastic about this aspect of the course:

[Before the course I had] all these ideas of how I’d like things to be but reflective practice has certainly brought them to the forefront as a CDU leader because I identified that’s what I’m actually doing. Because we were introduced to the models...
and ways of working through reflection, I actually came up with things to change the situation and to report on a situation and things like that.

Myra, a neophyte nursing leader who said she had been “desperate” to learn new leadership skills, explained how this process had begun to work for her:

_When I went for the CDU training, it gave me a little bit of ‘boldness’. Like when I saw how up front [the leaders] can be. One leader has an interest in evidence-based nursing and another one has a strength in managing people. The topic was there and [the facilitator] just drew that out from each leader. I sat there and listened to each one of them and I really did benefit from them. You see how people lead and … have different strengths; and how their strengths actually help in managing the ward._

While remaining open to critique, she had been able to learn a lot about herself:

_I discovered my own weakness and I'm in the process of dealing with that weakness as well. Because, as a leader, it is not so simple as getting things done within the unit.... You have to work externally with a lot of other people as well. It is quite political.... You have to be very articulate and very sensitive to what's going on in the higher management, to bring up issues because, otherwise, you just trample on people and you never get what you want. So, it really makes me very aware that I have weaknesses which really are, in some ways, a disadvantage to the unit. I am building on that because ‘charisma’ is definitely my, [she chuckles nervously] my weakness._

In a similar vein, Lucy described how a deeper understanding of her own leadership style had animated her approach to unit meetings:

_Whereas I would often sit and read stuff,... and I would, you know, throw away lines to people from time to time at a clinical meeting. I’d throw something in that was, you know, terribly brilliant or something - but I don't do that anymore. I sit down and actually, say, ‘Well, here's a really good article, you read this’ or ‘Here's a conference that's on’ and I'll say to one of the staff in particular, for instance, ‘Look, you need that. Do you want to go to that? That would be really interesting for you.’_
Other leaders had been encouraged, as part of their new role, to make conference and seminar presentations about their newly developing units. Christopher projected an aura of self-confidence as he described his freshly developed skills at public speaking:

*The leadership stuff has made me a bit more confident about myself and my own practice. I've presented a few times in quite large forums.... I am getting to that point where I feel confident that I have an organized way to approach some of this stuff that traditionally nurses don't talk about.*

Linda, one of the second-wave CDU(N) leaders, attended a subsequent CDU(N) leadership course. Although having initial reservations about the course, by our second interview, she had no doubts about the role the course had played in important personal and professional changes she had experienced:

*One thing that came out of it was how you can still make those difficult decisions and be really honest with people.... [For example] one of the staff members ... wanted a lot of things his way but I am strong enough now to say ‘no’ because the good of the team is much more important than the good of the individual.... I was strong enough to say, ‘No I won’t come around to what you want.’*

Linda was beginning to take some of her newly found understandings to her staff in an effort to help them to understand themselves better:

*At the moment, I’m really working on encouraging all the staff members in their individual strengths instead of competing against each other, as I think there was a lot of competition going on when I came here.... I think the shift now is more to complementing each other in that, I might be good in one thing, yet somebody else is good in another role. And that’s really difficult for some staff members to actually come to grips with.*

### 6.2.1.4 ADJUSTING THE SAILS TO CATCH THE BREEZE:

**ENCOURAGING STAFF PARTICIPATION**

During the early stages, these new CDU(N) leaders took very seriously the well-published need to bring their staff on board if their new CDUs(N) were to succeed. Prior to and immediately following all the excitement of the official launch of the first cluster of CDUs(N), the participants said that both they and many of their staff felt energised to make
changes and develop new projects. As much of this energy rapidly fizzled out, however, many of these participants soon realised that, if they wished to maintain any development within their units, they would have to make the necessary compensations themselves. From this time on, most of them can be seen to have adjusted their expectations and leadership styles to catch whatever ‘breeze’ was currently prevailing in their own units in an attempt to maintain staff motivation.

It is clear from these interviews that these leaders developed many of their new strategies for encouraging staff participation from the CDU(N) course. Their stated aim was to sensitise their staff to the proposed changes by developing an adequate degree of understanding before the changes took place. Consequently, they signalled the proposed changes in a variety of ways. Some of them began by setting new work objectives or performance measures, often through personal example or through special meetings where many aspects of the changes were discussed. In their meetings with their staff, they talked about the benefits of adopting some of the CDU(N) concepts and they distributed a variety of published materials that supported the proposed changes. They also attempted to encourage staff participation by persuading individual staff members to develop a small project of their own; projects that would be particularly pertinent to their everyday work. It remained an uphill battle, however, and they were forced to adopt new strategies. This quote from Peter is typical of what many of them talked about as they attempted to encourage their staff to appreciate their own worth and the work they had already accomplished:

You spend your time saying, ‘Wait a minute, this is a good thing. You are doing what is expected. You just don’t quite see it in that way. But this is how, if you look at it this way.’ It was just encouraging people to see what they were doing was a good and a legitimate thing.

Lucy took a slightly more pragmatic approach. While deciding to focus her attention on areas of clinical practice within her unit, she decided to hold back from criticism in order to motivate the staff to develop their own potential:

There were six clinical nurse specialists and only a couple of them did things and I thought, ‘This isn't good enough.’ So I asked them all to develop a portfolio of something of interest to them, a clinical issue that was interesting ... And in doing that,
I asked them to put together their folio with articles and information and to give in-service education on that: make themselves ‘the expert’ on the ward.

Christopher dealt with similar situations by encouraging the staff to take a reflective stance rather than trying to enforce his own agenda on the nurses in the unit:

*If someone comes to me with a problem, I'll go, ‘Okay, what have you thought about so far? What do you think might be a solution?’... My style is to try and force people to take responsibility for those decisions so that there'll be a shift in the way day-to-day clinical problems are solved.*

Such a stance began to enhance the therapeutic potential of nursing in some of these units by encouraging greater accountability in their practice. Said Fiona:

*I found that there was a lot of anecdotal and hearsay evidence of what was going on: ‘Well I remember when’ or ‘She's always like that.’ You can't set up a program of any kind ... if there is no definitive reason for why this person is at that level.... So I've asked people to put their experiences down in writing, be more accountable ... and pro-active in handing over information.*

Elizabeth, who was more relaxed following her attendance at one of the subsequent leadership courses, also said:

*[The CDU course] came [at a time when] we’d had a huge staffing turnover here, and a lot of that was traumatic. It was the wrong time, but it was a good time, too.... All roads lead to Rome but we can choose the road we want as long as we get there. So that’s the sort of perspective that we have here now. ‘OK, this is what we’ve got to do, we don’t have any choice, so how are we going to do this as a group?’*

Nevertheless, change came about very slowly. The application of strategies that are designed to develop a deeper sense of involvement was stressful for many of those leaders who tried to adopt them, particularly with those nurses who are very task-orientated. After a considerable amount of ‘trying’, Christopher sighed despondently as he said, “*In this big broad continuum of trying to get change going, we're still at the beginning, trying to get people to think and feel responsible for the work they do.*”
6.2.2 LOSING SIGHT OF THE SHORE: BECOMING INVISIBLE AND FORGOTTEN

This theme describes how, as time moved on, the many unanticipated pressures with which the first-wave participants had to contend overwhelmed the enthusiasm that had been so palpable when they had begun their journey. As the anticipated sources of support for these new CDU(N) leaders seemed to fade further from view until they became mere dots on the horizon, they described how alone and lost they felt. Furthermore, the lack of understanding of the CDU(N) concept by people in their own organisations guaranteed that the short-lived honorary status their units had received during and immediately following the official CDU(N) launch would quickly dissipate; rendering the CDUs(N) invisible within their own organisations.

Along with this ‘forgetting’ of these CDUs(N), the actions of many people within their own organisations also point to a concerted silencing of these new CDUs(N). Somewhat ironically, even the CDU(N) leaders, in their need to accomplish their goals, also appear to have attempted to silence both themselves and others. Eventually the exhaustion and uncertainty they were feeling forced them to let go of the commitments they had made to the CDU(N) movement.

6.2.2.1 OUT OF SIGHT, OUT OF MIND: BEING SILENCED

Although the first-wave CDU(N) leaders had received staunch support from the Professor of Nursing for the six months of the leadership course, once the leadership course was over, their contact with her was much less frequent. Because they were now ‘out there on their own’, they were more vulnerable than before and, consequently, were looking for tangible support from other people within their own organizations. While the rhetoric of many of the senior nurse managers and relevant medical officers indicated that they would support these CDUs(N), their lack of action had the effect of silencing these CDU(N) leaders, along with their embryonic CDU(N) program.

Once the leadership course was completed, these participants soon discovered that a major obstacle in the way of developing their CDUs(N) was the fact that no one else in their organisations had any working understanding of CDU(N) philosophy. Said Fiona, “It’s very frustrating doing something that most people don’t understand” and Christopher
Christopher later added:

[The CDU is seen as] ‘an academic thing,’ ‘a research thing.’ The feeling you get is that the prime concern [of nursing administration] is simply to have enough nurses working in the area, not to do anything glamorous. I think it was seen as something a bit glamorous and ‘out there’ and ‘what’s all that about again?’ And no real effort to see it as an alternative to the traditional ways of working. ‘Yes, research and all those sort of things; someone else does those, not the nurses on the ward.’

Despite the fact that senior executives of the area health service and academics of the university had lauded the newly created CDU(N) initiative at its inception, very few of the on-line managers followed this support through in a practical way. Said Fiona (during the first round of interviews):

We’ve got a Steering Group set up now and we’ve had two meetings. I’m hoping that it will offer some support as well. It’s still in the initial stages and I don’t think the people that are attending the meetings, like the Director of Nursing and the directors of the divisions, are completely clear what’s expected of them…. In real terms, they probably don’t see that they have any role at all in supporting the CDU apart from saying, ‘I support the CDU, what do you want me to do?’ and I say, ‘Well just put your signature on this.’ I have it in my business plan each year so I’ve signed on to it and, theoretically, they’ve signed on to it as well because they say, ‘Yes, that’s a good thing.’ But, beyond that, I don’t think that they see themselves as having any real involvement in it. It’s something that I do, and that’s fine, but I think it ends there.

Other acts of indifference that were reported included the absence from the official CDU(N) launch of many senior nurses within some of the organisations in which these CDUs(N) were located and many of the relevant senior medical officers. Some participants also described acts of overt sabotage. As explained by Peter, this occurred mainly from medical officers who not only “made it quite clear that they weren’t interested [in the CDU but also] made jokes about it…. [Some nurses had] got some-what involved [but] I think they got pushed down quite a bit or came up against brick walls.”
Consequently, like so many other aspects of their nursing work, once all the acclaim that accompanied the official launch of the new movement had died away, these participants began to realise that even the CDU(N) project itself had very quickly become ‘invisible’. Some of these leaders complained that, although they were now developing more in-depth projects, the nursing management teams of their individual hospitals were looking beyond the CDU, as if it were not there, in order to credit these individual projects to the hospital in which they worked. Peter expressed a considerable amount of frustration when he said:

*I was expected to be involved with cross-hospital activities … and every time I was involved with a project everyone wanted it…. All of a sudden, an idea that might help us with the CDU became a major hospital issue and I was under great pressure [to develop it for the whole hospital.]*

It was not that the CDU leaders showed disregard for the existing hierarchical structure of their individual establishments, in fact the opposite is true: they were looking for support from these existing structures. They were proud of the extra time and effort they had put into these projects and they wanted the unit to receive credit ‘as a CDU’. Said Fiona:

*I’s just worked out that ‘Fiona has done this as part of [her hospital]. ’ It’s not, ‘Fiona Jones, Clinical Development Unit Extraordinaire,’ type of thing. They probably just think that I would do it anyway and so I’m just getting general pats on the back because I’m doing my job well. It’s not because of being part of the CDU.*

The lack of ownership by higher management was all too evident in the interviews with the second-wave leaders who took over as the original leaders left. These words from Pat summed up the experiences of them all:

*I got a handover of what was required in the ward, what we were doing and what we were hoping to achieve. Nothing from the CDU point of view…. I wasn’t aware what CDU meant until the first pieces of paper started flowing through. I made a phone call to enquire what this was all about and they told me that this unit was actually a CDU unit. I spoke to my Director of Nursing, who had only been here for a short time, and he wasn’t aware that this was a CDU either.*
6.2.2.2 BACKED INTO A CORNER: SILENCING THE SELF

These participants, all of whom had been attracted to the CDU(N) program because they wished to obtain additional support to develop their units, can be seen in these interviews, somewhat paradoxically, to have taken the full responsibility of what they described as their new “failures” firmly onto their own shoulders. One of the participants was in no doubt that they could not fulfill the expectations of the executives of the area health service and the university without their specific support. The other participants, however, particularly during the first round of interviews, appeared ignorant of, or perhaps unwilling to become caught up in, the ‘politics’ of the traditional hospital system. Despite their disclosures about the inadequacy of the support they were receiving, the majority of them were reluctant to blame anyone who worked in a position senior to themselves. Having been backed into a corner from which they could not extricate themselves with dignity, they consequently silenced many of their anxieties of how they could, in reality, accomplish such an enormous task.

While there appeared to be a reluctance to offend the ‘people of power’ in their individual organisations, there was also a tangible lack of awareness by many of these nurses that they required any additional support from their senior managers because of their CDU(N) status. For example, although many of these participants were quick, when first asked, to say that their CDU(N) was supported by higher management at their own hospital, they then found it very difficult to describe incidences of having received such support. In fact, for many of these nurses, ‘support’ was merely the perception that they could always go and see someone if they had a problem.

Their reluctance to speak up for their own needs stretched to the Steering Group Committees, which provided none of the support for which they had been designed. This is despite the fact that they comprised some of the most prominent power brokers, both from nursing and other disciplines, within the organisations in which these CDUs(N) were situated. Although, by the time of the first interviews, there were many signs that these committees had not gotten off the ground due to a general lack of interest from higher management, many of these nurses continued to believe the promises that ‘all would be well’. Trevor, for example, remained reluctant to give up hope of an eventual solution to
this impasse as he discussed the only meeting that had occurred with senior nursing management and medical staff some five months previously:

Back in March, that was good, that was the first time a lot of people got together and really discussed the ideas behind a CDU. … Whilst we haven’t really got the Steering Committee going properly, in fact not going at all, the members of the Steering Committee know who they are.

The silence displayed by some of these participants was, at times, deafening. Trevor, for example, while telling his story in the first round of interviews, went around in circles trying to explain how some of the nurses had reacted to a particular incident. This was before he eventually admitted that they had been influenced by one of the medical officers who had taken a very negative attitude towards the CDUs(N). This same medical officer, after having ‘tolerated’ the many discussions on the proposed nursing innovations (for what may have appeared to him to be a ‘safe’ length of time) eventually took this CDU(N) leader to one side and asked, “Could we now drop the idea of [the CDUs]?” Trevor said nothing at the time to defend this new nursing initiative.

These participants were, after all, still trying to come to terms with their own ambivalence towards the commitments they had made to the CDU(N) program. Consequently, they were not only remaining silent when challenged by others but were now effectively silencing themselves. Explained Peter, “I suppose my best description at the moment is ‘ambivalence about the whole thing’. Sometimes it’s just, Oh, what's the point? It depends on the mood you’re in, I guess.” Knowing that, as time passed, it was becoming more and more difficult to cope with the pressures of being a CDU(N) leader along with their other responsibilities, in these interviews many of these participants juxtaposed their desires to maintain the momentum they had initiated on their wards with their concurrent emotional and physical exhaustion. This was expressed poignantly by Steve:

I suppose it’s more not wanting to let things down rather than a positive wanting to be part of [the CDU project]. I’m not finding a lot of benefit on the ground in being part of it. It’s just another chore sometimes. But, then, when you stand back from it and look at what’s happened, even in the short time it’s been going, it’s helped me to pull things together to make me produce things I felt I wanted to produce anyway - I’m a bit torn by it in that sense.

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For some, this ambivalence was also fuelled by a seemingly strong need to categorise the work they were doing. Said Christopher:

*After things had died down a bit and we’d started to make some changes, we’d go, ‘Is this CDU stuff.’ I think that’s part of the difficulty. Are we doing this because we want to be a CDU or are we doing it because it’s necessary? I actually played down the CDU stuff, saying, ‘No, we’ve got to refocus. We’re a clinical service. We’ve got to focus on our clinical work, not getting recognised down the other end. But if we do this, will we be recognised? But it was a little bit ambiguous, perhaps.*

6.2.2.3 UPHOLDING A ROSE-COLOURED VIEW: ATTEMPTING TO SILENCE OTHERS

So convinced were the first-wave CDU(N) leaders during the period of the leadership course that the CDU(N) concept was sound that they reframed much of the questioning of their staff as negativity. They also constructed staff criticism as being a reluctance to change, believing that they could convince their staff to fully embrace the ideas over time. They were, indeed, eager to create new projects if their CDUs(N) were to survive and prosper. Accordingly, they also regarded the more tentative ‘positive’ remarks of their staff as an endorsement of the new project. It can, consequently, be said that they were swept up by their own enthusiasm during the earlier stages to the extent that they viewed the development of their new CDUs(N) through rose-coloured spectacles, while effectively silencing open dissent.

It had been a necessary prerequisite for gaining CDU(N) status that each prospective CDU(N) leader would discuss the CDU(N) philosophy and the anticipated changes with all of the staff on the unit. It must not be forgotten, however, that while the individual CDU(N) leaders were ‘required’ to make firm commitments to the new CDU(N) program, their staff were only ‘encouraged’ to participate. Despite the high level of expectation by these CDU(N) leaders that many of the individual staff members would eventually become involved in the new CDU(N) projects, these staff members were, in fact, allowed to remain bystanders while the designated CDU(N) leader attended the preparatory leadership course and completed the assigned objectives, largely single-handed. As explained by Christopher in the third round of interviews and after much soul searching, because it was the individual CDU(N) leaders who had written the strategic plans and practice development objectives, the other nurses had never really taken ownership of the CDU(N) concept:
We’re not going to raise people’s consciousness by putting a mark on the wall and saying [CDU] without something that involves everyone…. If it was based on a business plan that I wrote, that means nothing to them…. But the CDU philosophy isn’t about that. You have to get beyond that. Having an accreditation based on an inspection type of thing is no different to having done your 25 tasks for the day. It hasn’t taken you to the next step.

During the first round of interviews, the first-wave leaders talked about the meetings they had had with their staff when they first discussed the possibility of their units becoming CDUs(N). While they described the majority of the staff as having come out in favour of the new initiative, with the more senior nursing staff appearing to be strongly in favour, they also acknowledged that some had voiced their strong disapproval. In Peter’s words, for example, “There were a couple of people who weren’t going to budge.” In all cases, however, these participants viewed the opinions of such staff members through a negative lens. Accordingly, many of them described these dissenters as ‘detractors’ for not wishing to be involved in a project that they themselves had made a commitment to and had felt very enthusiastic about. For example, Lucy said:

There were a lot of staff who were anti. One chap, who’s a fairly vocal person and tends to be the spokesperson for those anti ones, he sort of said to me, ‘Look, you know I think it’s a whole load of crap but I won’t do anything to sabotage it. I’ll watch and see what happens.’ That was because he saw he would have to do more work. He feels he comes to work and does enough work and has enough stress and stuff and has been in the business for long enough to not need to be bothered with all this high falutin’ stuff. One of the other chaps said to me, ‘I don’t get paid enough money to do all this stuff.’ And both of these people are not unpleasant people to have around…. I find it quite disappointing that they don’t want to take another step to review their practice.

It is noteworthy that Lucy had no other complaints about these same nurses as she went on to say, “but they’re not bad practitioners, you know. They’re very kind people, very gentle people.” Furthermore, Lucy later said of these same people that she had earlier called ‘anti’:
The non-believers are the ones who’ve shown the most improvement…. Particularly the crankier ones that thought it was all crap are the ones who are more tolerant of my ‘funny ways’ as they call them and my ‘silly ideas’. They go along with them because, you know, they like me…. They indulge me. They indulge me because I’m good to them.

Despite the fact that these early dissenters had now been effectively silenced, Lucy was now viewing this same silence as a sign that they were beginning to accept the CDU(N). After all, there is no evidence, from these interviews, that any of these CDU(N) leaders made any attempt to understand the reasons for this dissent, convinced as they all were that these dissenters were mistaken.

A similar dynamic may also have occurred in regard to the ‘silent majority’ of nurses on the unit who went along passively with the project rather than show dissent. Certainly, while some of the staff may have been genuinely interested in some of the new concepts, there were many who actively chose to remain silent in order to maintain pleasant relationships with the leader. Said Steve:

You know, if I'm being frank about it, the team aren't really interested much, one way or another. They'll go along with me, they'll work with me, they're a tremendous team,… that's because of the culture I've created too; but they're not overly interested in anything bar the job that has to be done.

Consequently, while these CDU(N) leaders had initially described the majority of their staff as “excited” about this new initiative, this perception must be viewed in light of the enthusiasm and commitment they were feeling during and immediately following the CDU(N) leadership course. Furthermore, the words of many of the first-wave leaders indicate that the degree of enthusiasm the staff were showing may have been, in large part, a reflection of the concurrent attitude of the designated CDU(N) leader. Fiona, for example, commented during the first round of interviews that:

It took quite a while for [the CDU concepts] to actually fit into my thinking, I guess. Because of that, it was difficult for the other staff members as they weren’t sold on how it would fit into their everyday life.
6.2.2.4 LOST AT SEA: 
FEELING ALONE

The bountiful vision fostered in the CDU(N) leadership preparatory course stands in stark contrast to the picture of loneliness the first-wave CDU(N) expressed as their CDU(N) ‘world’ began to fall apart. Long gone were the expectations that support would be forthcoming and that the comradeship they had felt during the course would be sustained. In place of the belief that they would eventually win over more and more of their staff to the benefits of CDU(N) involvement, was a resignation that this would never be so. With their individual staff members now taking less and less interest in their CDU(N), and even those who had previously appeared “excited” backing away from any involvement with the project, it became more and more obvious that the pressure to achieve sat squarely on the shoulders of the individual leaders. As Steve said: “What bothers me about the CDU is that really ‘it’s me’.”

With the pressures building from all sides and their anticipated sources of support having dried up to a trickle, these first wave leaders felt even more lost. Looking for whatever support they could find, Peter explained how they had “tried to keep in contact [with the other CDU leaders] but it was nearly impossible [so] we felt like we were doing it alone.” This meant that the effort to maintain motivation among the staff became even more tiring. Christopher appeared very despondent as he talked about the reactions of his staff to the unremitting effort he had put in during and immediately following the leadership course:

Whereas I read about the CDU stuff and see that that’s what I think nursing should be like, other people see it as something that doesn’t have to be part of their work, or part of nursing. They just come to work and do what they do and go away again.

The combination of despondency and loneliness eventually took its toll on these leaders. Fiona explained how she had transformed, from someone who had been enthusiastic and full of hope for the future of her new CDU(N), to her current feelings of bewilderment:

About two years ago I had a team and we all worked really well and that was really good. Then, when I started the CDU I felt that things were really happening, that everyone was motivated. But [some of them] have moved on and it’s been difficult. I currently feel like I just have ‘people working for me.’ I don’t feel like I have a team.
As the newly instigated modifications began to threaten their workplace routines, the resistance that many of the staff appeared to be exhibiting posed profound challenges to some of the CDU(N) leaders. Explained Christopher:

*The inertia of the status quo means that you don’t get [new] things happening. The nurses on the ward still want to know what’s in it for them or what it’s going to cost them in terms of time and effort. You know, they’re not going to connect to anything until they’ve seen the contract…. You can come back with some good ideas, a fairly clear plan, but if it’s still not where they think things should go, then there’s no support. And that means that you don’t get very far at all.*

These participants talked about an ongoing uphill battle that they had to face as the title ‘Clinical Development Unit’ was blamed for many of the professional changes that would have been required in these units, even if they had not been a CDU(N). Some of the comments that Peter, for example, had to deal with on a daily basis included, “*Why do we have to do that?”* and “*I’m sick of this change.”* He also reported that many of the staff had made it clear that they were tired of what they saw as repeated attempts to introduce “*change for change’s sake.”* As he explained, his staff had become disillusioned by their previous experiences:

*All these vogues would come in. Everyone would learn it all; they’d be forced to compulsory in-service on these things then, all of a sudden, it would all change. It wasn’t ‘in’ any longer and we weren’t going to do it anymore.*

Consequently, their staff dismissed any positive aspects of the CDU(N), which they viewed as little more than “*the latest management tool,”* with the conviction that “*it’s just another restructuring attempt; or it’s just another phase; or the latest wiz-bang voguish term that’s around at the moment.”*

Alison also disclosed some of the difficulties she was experiencing as she tried to maintain her enthusiasm in the light of ongoing criticism from some of their colleagues. She said:

*People wonder, ‘What the hell is this CDU nonsense all about.’ Because they have no concept and they say, ‘We [already] do this,’ ‘We [already] do that,’ ‘That’s nothing new.’: … I guess people say this often enough and, although I don’t believe it, it starts to chip away and have some sort of negative impression on me.*
Many of these first-wave leaders also described feelings of dejection and hopelessness. Said Steve in his second interview, “Aloneness is about feeling: ‘What’s the point in doing it all when nobody really acknowledges it; nobody cares about it.’” The temptation to opt out of the CDU(N) program, juxtaposed with the fact that they had invested a considerable amount of their own time in this project, fuelled a need to develop coping strategies in order to deal with their confusion about how they should proceed. For the majority of them, this internal conflict was easily resolved by omitting the term from their everyday language. Christopher expressed this well:

*Do you need all the staff actually knowing what a CDU is, and starting there, or do you start them off just trying to think about their work? I guess I've tried to take this softer approach. I just want people to think about what they do and, hopefully for them to see, at some point, that this fits into a framework that you can call a CDU, and that it's relevant.*

6.2.2.5 **REACHING A TURNING POINT:**

**LETTING GO OF COMMITMENT**

It appears to have been an expectation that the nurse leaders who agreed to develop their units into CDUs(N) would embrace their new title with enthusiasm, along with the package of concepts that went with the CDU(N) philosophy. During the leadership course, this is what these participants attempted to do as the CDU(N) vision, for a while, appeared to unite them in a common goal. However, even during this time, the storm clouds were beginning to amass on the horizon as they began to question the practical application of the CDU(N) concepts into their own work environments. Consequently, the completion of the leadership course (and the resulting reduction in time spent with the course coordinator) marked a turning point where their tentatively developed sense of direction quickly transformed into a weighty commitment with which they could no longer identify.

Although the term ‘Nursing Development Unit’ may be well known in nursing circles in England, none of the nurses in this current study had heard of the term until shortly before they had become involved in this new Australian initiative. Furthermore, whilst being aware of many of the individual concepts discussed in the course, few of them had studied them in any depth. Although these participants had been given information on the NDU concepts prior to making a commitment, this was not enough to develop any in-depth understanding of what being a CDU would entail. These leaders, consequently, had
problems trying to identify what the term CDU meant in practice. This lack of a concrete definition created incongruity in their understanding of what they were trying to achieve. Said Alison, “The CDU gives you a lot more work to do but it doesn’t give you a solution of how to work better.”

Repeatedly in our conversations, the participants said they were finding it difficult to identify with the CDU(N) philosophy as a ‘package’. Steve, for example, questioned if they really needed to use the title CDU(N) to make use of these individual concepts, which are available in other nursing leadership courses that were not related to NDUs or CDUs. He also said:

I suppose, in truth, I can’t clearly identify in my head what is the difference between a clinical development unit and a good team that you just call a team and you manage well. I could never separate what was different from the CDU to good quality management training.

This was further brought home to them when they tried to explain the term CDU(N) to others. For example, after Fiona had presented at a national conference she said, “I feel the whole concept of CDU just zoomed over people’s heads because they expected high powered stuff and this is just a concept.”

Like some of the other leaders who worked in multidisciplinary units, Steve’s experiences also caused him to question the use of the word ‘nursing’ in the title of these units, “I think it may be a bit insular, a ‘nursing’ development unit. A lot of the managers these days are nurses but they manage a whole raft of disciplines. We can’t just focus on one discipline.” Although this word had been added to the title as a ‘promise’ that the central focus of these new units would be on developing nursing, most of the participants chose to eliminate the word ‘nursing’ from this title in our conversations. Not only did this single word make their title exceptionally long but the word itself brought with it strong connotations that effectively alienated people from other disciplines. Christopher also described many of the unrelenting problems he encountered each time he tried to enlist the support of other health professionals in his new CDU(N) project. For example, he said:

[The title] ‘CDU Nursing’ is pretty cumbersome. And then having to answer the question from the allied health people, ‘Why is there ‘nursing’ there?’ I guess my
explanation of that was, ‘Would you not agree that, of all the bits and pieces of our service that need development, it’s how the nursing service is run?’ And they would nod, nod, nod, nod. And nothing has changed much.

Consequently, while the leadership preparation course they had attended attempted to sell the many advantages of developing a CDU, none of these participants ever fully adopted the title CDU(N) as their own. This is not to say that many of them did not try very hard to adopt this vision. Somewhat paradoxically, however, the very curriculum that was designed to assist these new CDU(N) leaders to better cope with future challenges, in reality, created unanticipated dilemmas that sorely tested their CDU(N) commitments. Shortly before she vacated her position as a CDU(N) leader Myra, for example, explained how, once the CDU(N) leadership course had awakened her to the realities of working as a nurse leader in the current Australian health care climate, she found it very difficult to return to her original ways of working. The resulting hiatus in her understanding of her leadership role now replaced her tentatively developed sense of purpose:

Having gone through the course gave me a lot of high ideals.... It really opened my eyes to a lot of areas of management and it makes me want to probe more and more and learn more and more.... I feel so frustrated. It’s either I give up the CDU and not know all those things and just be a leader like any other leader, going along with the flow of the organization, you know, if the organization wants me to move this way, I move this way.... You know [what] the strategic plan of the organization is and you accomplish what they want. Not so much of what you think the unit should have.

The new understandings that had been developed during the course soon proved their fragility as the many burdens placed on the shoulders of these participants increased. Although all of them had been prepared to work longer hours during the leadership course to complete the required assignments, once the course concluded they were overwhelmed by the combination of their new responsibilities and all of the miscellaneous everyday tasks they had previously put on hold. The effects of a chronic lack of time, which they were now experiencing, was reflected throughout all of the interviews. Said Denise, “There’s not enough time to do it all. I mean, I could do it full time for twelve months, just focusing on establishing a CDU. Like I said, anything I’ve done for the CDU, I’ve done at home.” Alison added, “I guess I’m now beginning to realize how much I’ve taken on” and Trevor concurred, “I’ve had some time off and I’m just flat out working. When you’re on your job

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unable to moderate their dilemmas, they found it difficult to continue with their attempts to embrace the title CDU(N). Even as they began to put into practice various new projects based on these individual concepts, they continued to ask themselves if their unit really was ‘a CDU’. Their commitments to the new project were, consequently, tested severely as their new CDU(N) responsibilities began to demand a heavy price from these nurses. Said Myra, “As a CDU leader, I think I’m more aware of the commitments.... Basically I’m still doing what I should be doing as a leader in any unit. Much more so. I have the pressure of knowing that I’ve got to do more, far more, to meet the criteria in the CDU plans.”

Along with their inability to develop a working understanding of the CDU(N) philosophy, the ever-present daily frustrations eventually had the inevitable affect on the commitment these leaders had made to the project. Slowly they backed away from these commitments as they thought about their daily responsibilities in terms of the CDU(N) less and less. Consequently, without ever having made a specific decision to renounce their commitments, the first-wave leaders, in different ways and at differing times, eventually felt they had little choice but to let go of their CDU(N) obligations.

In retrospect, Christopher placed some blame for the loss of direction the first-wave leaders had experienced on the decision not to follow the UK example of undertaking a formal accreditation process. In Christopher’s view, this would have given them a better chance to develop more of the CDU(N) concepts before being given an elevated title, which many people in their organisation believed they did not deserve. He also said:

One of our blunders with the original CDU idea was saying, ‘We don’t want to actually make it a tall poppy. We don’t want to set a standard you have to meet. We just want to get people to work towards this criteria.’ And maybe that’s too soft.... As we need a sense that we’ve actually achieved something, we need some more rigid criteria.

The second-wave leaders had quite different experiences. Apart from those who had been working on these units in a different capacity prior to their new appointments, the others knew nothing about the CDU(N) program. When they had been interviewed for these
positions, none of them had been told their units were designated as CDUs(N).

Consequently, these second-wave participants (who had not yet attended a CDU(N) course at the time of our first interview) expressed minimal obligation to continue a project to which their predecessors had made such a commitment. Explained Zoe, “It’s difficult to carry on somebody else’s work.” Although some of these participants, following their attendance at a subsequent leadership course, were very enthusiastic about the course itself, none of them went on to identify, in any tangible way, with the CDU(N) project. While praising the overall aims of the CDU(N) program and embracing many of the individual concepts, they expressed no commitment to take their units further as CDUs(N).

6.2.3 TRAVERSING UNCHARTED WATERS: LOSING THE DREAM

This final theme discloses some of the effects on the first-wave CDU(N) leaders of the burdens they carried as a result of the elevated vision they attempted to adopt for their units and for themselves. The expectations expressed by others during the first few months, and which they battled to integrate into their new CDU(N) leadership role, can be seen to have accompanied them over the time frame of this study as they traversed the uncharted waters of CDU(N) leadership. While many of these participants initially expressed some concern that these expectations may not come to fruition, during the first round of interviews the majority of them were clinging onto some aspects of the CDU(N) dream. In the conversations with the first-wave CDU(N) leaders who stayed long enough to participate in more than one round of interviews, however, a distinct alteration in tone became apparent over time as many of the hopes and expectations that had been evident during the earlier interviews changed to resignation and scepticism.

Consequently, throughout this theme, the images of the excitement that the first-wave leaders had felt at the beginning of their adventures are juxtaposed with the disappointment they felt as the CDU(N) dream began to fade. As time moved on and they realised that they were now lost beyond the horizon, these participants could no longer deny the fact that, with the disintegration of the sweet promise in which they had invested so many of their hopes and aspirations, they were now conscious of a raw and bitter taste.
6.2.3.1 UNDER THE SPOTLIGHT: 
LIVING WITH HIGH EXPECTATIONS

In many respects, the nine first-wave CDU(N) leaders were seen as a kind of advanced guard that would prepare the road ahead so that other nurses in the area could follow in their footsteps. Indeed, they were acutely aware of the fact that they were carrying the expectations of many people, from both the area health service and the local university. After all, the expectations that these CDU(N) leaders would accomplish something ‘very special’ for the area had been voiced by many immediately before and during the official launch. Furthermore, not only had a large sum of money been invested in the new CDU(N) project and the leadership course they had attended, but both they and their units had been the centre of attention when several power brokers from the area health service and the university community had attended the official launch of this new initiative. Denise interpreted all of this hyperbole as:

\[\text{The success of [the CDU is] carrying a lot of weight for some: for nursing, for the area and for the university. I think the stakes are fairly high, to tell the truth. Because I think that if it gets up and running, if it’s successful and impresses people and other people come on board and say, ‘I like the way you do that’ or ‘I’m impressed with that piece of literature that you’ve just presented or published’ or whatever and, um, [she falls silent for a moment.] I think the stakes are too high to let it dwindle.}\]

Many of these participants, consequently, found the resulting scrutiny very daunting as they realized their leadership abilities would now be tested. Indeed, during the first two rounds of interviews they expressed their fears that they would not be able to live up to the expectations of others. Many of the most profound expectations they expressed, however, appear to have developed during the leadership course. Myra talked about the frustration she had felt ever since she had been awoken to the possibilities of CDU(N) leadership:

\[\text{Just mixing with the other leaders and going through that course has given me a lot of courage, in a sense, to want to know more. But it has opened up so much that I want to do so much. I really want to do so much but I’ve got limited time, such limited time that I feel frustrated.}\]

During this course, they had been immersed in an atmosphere in which the term ‘CDU(N) leader’ radiated a new and exciting appeal as they simultaneously read much of the UK
NDU literature. Somewhat paradoxically, however, while the British NDU literature was a source of motivation for them, it also created considerable anxiety among some of the leaders as it raised expectations of their own future performance. Steve described this as:

*It’s put the pressure on me to do something about all of the ideas that I’ve had, whether they be in research or practice or whatever. Now you’ve got this tentative, developing CDU, you feel, ‘What do I have to do to try and meet the requirements?’*

Many of the participants took to the literature to try and answer this question, only to find that the plethora of available articles about the NDU/CDU movement further exacerbated the pressure they were experiencing. It appeared to them that the British NDU movement was staffed by highly efficient leaders, whose achievements they could not emulate. Added Christopher, “*I see articles that other NDUs produce, from the UK, and think, ‘How do they do this?’*” and Steve said, “*When I see a lot of the material on NDUs from England I throw my hat at the whole thing. I say, ‘I can’t see myself ever doing that.’ And I say, ‘Oh, God’*”

As stated previously, none of the senior nurse managers of the organisations in which these participants worked appear to have understood how much pressure these nurse leaders were under in attempting to develop, not only their units, but also their own leadership skills. They, consequently, did not let up on any of the other everyday pressures they brought to bear on these nurses. Said Peter, “*It was more, ‘What have you done?’ and ‘What can you give us?’ It had nothing to do with, ‘Isn’t this wonderful. We’ll give you this for that.’*”

All of these expectations combined to ensure that the pressure placed on their shoulders was bound to increase once the excitement of the launch dissipated and they were out there on their own and working towards meeting the goals of the UK units they had read about. Although each person dealt with their individual concerns in their own way, they all had to face the anxieties created by such high expectations and balance the many conflicting expectations, of both themselves and others, with the reality of their own situation. Some of the confusion and self-doubts this situation created are evident in this comment by Steve:

*I think it's put the pressure on to produce the goodies because part of the CDU is that you do promote what you do and explain what you do…. I don’t know whether I've gone off the path with the CDU or not but ... I've found it hard to initiate important*
things like reflective practice and stuff like that. I find it very hard to explain, oh, probably not [he hesitated] - I don't think I've changed a whole pile, you know.

And Fiona summed up the eventual conclusions of several of the other participants when she said:

Even though the course was quite interesting, not a lot of time was spent relating it back to the real world. It was all fine to be talking about doing all these wonderful things but I hardly had enough hours in the day to do my work, even before the CDU came about, let alone after it.

6.2.3.2 LEADERS NEEDING LEADERSHIP:
RESPONDING TO CHARISMA

This CDU(N) initiative was coordinated by a Professor of Nursing who was subsequently described by the participants as charismatic in the way she disseminated her CDU(N) vision. Not only did she initiate the new project, but she also worked very closely with the CDU(N) leaders throughout the initial phase, which included the leadership course. These participants developed a deep respect for her as she was seen as a nurse who had ‘achieved’ in the difficult twin worlds of health care and academia. Although they had other mentors during this time, many of these participants described her as being instrumental in the development of many aspects of their own leadership styles. However, the need for effective leadership that many of them had expressed in the earlier interviews ensured that, once the leadership course was completed, decreased access to this CDU(N) initiator and course coordinator would, once again, ensure they were bereft of a strong leader.

As described by Peter, the first-wave leaders who had attended the original leadership course were acutely aware of their ‘new leader’ as someone who “had professional authority in the sense that she was seen as the Professor and she was employed by the area health service.” Looking back at the challenges that this Professor of Nursing had set them and the responses that had flowed from such an enthusiastic well coordinated group, Steve said, “It was the stimulation that went on around each of us that was probably the most beneficial thing and [her] ability to ask hard questions … and to challenge team leaders to think about what they are doing.”
Many of these leaders talked about the way they had responded to her charismatic style, which had spurred them on to place even greater pressure on themselves to accomplish their goals. Said Christopher, “Her enthusiasm was very infectious and you got the feeling of urgency that you needed to do something.” And Lucy concurred, “I think the experience of listening to her, for me personally, was just extraordinary. I loved the course…. She’s a very inspiring person. I was a bit gob-smacked a few times.”

She was described as the person who had not only created the vision they all followed, but had also kept the momentum going during the leadership course. Explained Steve, under her direction, it was becoming a reasonably cohesive group. Her absence at later meetings had a detrimental effect on the motivation of a group who had come to rely on her leadership. At some of these meetings, “People just sat around and said, ‘What are we here for?’ There was no leadership. They literally said that, ‘What are we here for?’ ‘What’s it about?’ and ‘Where’s it going?’”

As contact with her became less frequent none of them were able to continue, on their own, what she had started. Steve later said:

But I think it was quite clear for me that it was her project… Everybody was trying to take on the concepts at the time but, once the more directive part that she was playing finished, I don’t know if too many people held ownership of it.

6.2.3.3 ACCIDENTALLY ON PURPOSE: FLOUNDERING IN A VACUUM

For the first-wave CDU(N) leaders who attended the first leadership preparatory course and shared in all the excitement that accompanied the official launch, there was a definite ‘beginning’ and ‘middle’ period to their adventures. For none of them, however, was there any form of closure. As they were dragged along by circumstances beyond their control, they attempted to allay their sense of loss by the development of a variety of coping mechanisms. Consequently, and also because of their conflicting feelings towards the CDU(N) project, their inactivity in regard to their CDUs(N) appears less of a deliberate action than it does an involuntary reaction to their loss. These first-wave leaders who remained were, in many ways, floundering in the vacuum had been created as their dream had slipped from their grasp.
For many of the first-wave participants, their CDU(N) experiences represented an intense period of their working lives; one that had created a variety of emotional reactions. The way they questioned what had gone wrong or ‘what might have been’ exemplified the loss many of them were feeling at this time. This need to question applies equally to those leaders who left early as it does to the final two first-wave leaders who remain employed in the area health service at the time of completing this thesis. For many of those leaders who chose to leave early, they took with them some regrets about having walked away from their CDUs(N) so soon after the launch. Said Denise, “I’ve sort of felt guilty because I was changing jobs in the middle of the CDU because that is my number one concern about my career move.”

The ‘what might have beens’ that the first-wave leaders talked about began with the disruption to their well-conceived plans that had been created by the diminution of their own numbers immediately following the leadership course. Those who had believed that their fellow CDU(N) leaders had made a firm commitment to the CDU(N) program were taken by surprise by the rapidity with which their numbers dwindled and their meetings began to fall apart. It was not until after many of them had left, however, that the few who remained realised how important this peer support had been in maintaining the CDU(N) momentum. Said Christopher, “I guess I probably felt more the CDU stuff when I was meeting with the other leaders.” Said Steve, “[When you] meet on a regular basis, you build a rapport as a group … you realise you’re not alone.” Steve also talked about some of the practical aspects of peer support that had been missing:

_What would have been good [is] if some sort of forum had continued where you’d hear people say, ‘Yes, it’s actually worked for me on the ground…. This is why my staff integrated this concept.’ Never found that out, you see. So you are in a bit of a vacuum. But that’s probably by nature of the people leaving as well. You know, you lost that group identity._

Although some of the second-wave leaders had begun to take part in their regular meetings, these new leaders had not, as yet, attended a leadership course and were less conversant with the CDU(N) philosophy. For the first-wave leaders, therefore, they could not take the place of those who had left: Said Steve, “In truth, I had no interest in meeting the replacements because I had no shared culture with them; meeting strangers who came along sometimes, [who were] not caring less about it.”

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As the momentum also began to slow, those leaders who were left began to feel varying degrees of disappointment that the hard work that had been put into the development of the CDUs(N), both by themselves and with others, would be wasted. Alison was very emotive when she explained how she was now worse off than before because she had come to expect more than the new program had been able to deliver: “The CDU has actually disempowered me as an individual…. You see, where I work, there’s no room for moving. You see, it has disempowered me totally.”

Also feeling intensely uncomfortable with their inability to juggle all of the competing pressures, many of them felt as if they had “failed” in their quest. Somewhat paradoxically, even while they were attempting to encourage their staff to see that what they were doing was legitimate, even if it was small, they did not grant themselves this same degree of consideration. Steve went as far as to express some feelings of guilt that they may also have disappointed the Professor of Nursing with whom they had bonded during the leadership course. “I don’t want to let the CDU initiative down. Having pushed to get acknowledged…. I don’t want to let [her] down or let the whole initiative down because I know it’s an important one.”

Fiona did not hold back as she described the consequences of the disappointment she felt. Indeed, her reactions were, arguably, the most extreme of all the participants. While describing her previously high expectations, both before and during the leadership course, our conversation was also peppered with a sense of disillusionment, which often brimmed over into projection and blame. She described how she had changed, from a person who had been very enthusiastic about all the planned new changes, to someone who now felt overwhelmed by all of the “frustrations” she felt:

I like to think that my way of thinking has changed [since the course] but I’m having trouble encouraging the other people to change their thinking. My problem is that I’m not terribly motivated myself at the moment, not with the CDU, but just with work generally. I’m finding it very difficult just to get through the day. So I find it difficult to motivate everyone else when I’m not feeling motivated myself.

She found release for some of her feelings of abandonment by overtly blaming her staff for the problems on her unit:
My lack of motivation is because I feel that I’m the only person that comes to work and gives a rat’s at all about the unit. The others just come to work, do their work and, as long as they get paid, they don’t care and they do as little work as possible.

By this time, her motivational level had dropped so low that she was looking to some of her staff to attempt to rescue her from her uncomfortable feelings:

[One of them] is really motivated, which is great because I feel inspired when he comes in to talk to me. And [another one] is good, but she’s only working here part time. But [some others], you know, they don’t [care] about anything.

As reported by one of the participants, one of the other CDU(N) leaders was described by one of his staff as having changed from a person who had been highly respected to someone who was quick to lay blame. Said Peter:

I was talking to [an RN on one of the CDUs(N)]... If something wasn’t done or [she] had a problem, she’d take it to [her CDU leader] and he’d go off his brain. So, in some ways, people started to look at [him] differently too. Some of us had known him for years and we’d seen him do great work. [He had the pressure of the CDU(N) expectations] and all the added stuff that [he was] expected to do so he started losing his temper and all sorts of things like that. And I’d sit back and think, ‘This isn’t how it was supposed to be.’

Some of the other participants coped with the conflicting feelings that accompanied their sense of loss by blaming themselves for their own inactivity. As Trevor said, “I’ve got a little bit of a block with the CDU, along with the fact that I haven’t been pro-active in running it up the flagpole.” Others coped with similar, although perhaps less overt, conflicting feelings by finding fault with their own style of leadership. Said Steve:

There’s a problem for me as an individual because I’m a bad administrator or organiser. I find, to do the CDU stuff properly, you probably need to be fairly skilful in administrative work and paperwork, and stuff like that.... Issues on the ground need to be dealt with in a proper framework and I’m very poor at that kind of planning and working.... And I probably failed as a CDU participant in the sense that I didn’t promote it. I mean, within the team, it hasn’t been mentioned for, God knows how long.
This sense of loss even stretched to some of the registered nurses on the units who, once having completed a subsequent leadership course, could no long continue as before because of the new pressures they were now placed under:

Two other nurses from the unit did the leadership course.... [One of them] ended up leaving (which was quite devastating because she was an extremely good nurse) but she just couldn’t cope anymore and then [another one] did the course and he literally left within a couple of months of finishing it. I know how he felt because he rang me up one night and actually said, ‘I’m thinking of coming back if that CDU nonsense has gone away.’ This is someone who did the leadership course.... The problem was the amount of work they ended up having to do.... When they got the mountain of work that was involved and they couldn’t give it to anyone else because no-one else would do it, they just left. Rather than say, ‘No, I won’t do this,’ they resigned. So we lost two good nurses. Rather than increase the nursing power we actually decreased it.

6.2.3.4 IN THE COLD LIGHT OF DAY: A PROMISE UNFULFILLED

In taking up the CDU(N) challenge, these first-wave leaders had, in effect, reached out to the promise of a new vision. Consequently, they had begun the leadership course with the belief that, under the guidance of an experienced educator, they would be able to focus on developing skills that would allow them to apply the NDU/CDU concepts to their own units. Said Alison, the CDU(N) course “has mushroomed my ideas of nursing.” As they read the many UK articles that were distributed to them and learned more about the history of NDUs in England, they began to identify with the promise that, if they were to develop their own units as CDUs(N) in Australia, they would become a part of an influential worldwide movement. This was succinctly captured by Trevor, “I think [everyone is] waiting out for something wonderful to happen here.” As graphically shown throughout this chapter, however, as the reality of their situation was gradually brought home to them, the CDU(N) vision gradually faded from sight until they eventually realised it had been little more than a mirage: a promise unfulfilled.

For many of the participants, the words ‘Clinical Development Units (Nursing)’ had created in their minds a picture of a closely-knit group of NUMs and CNCs that would be a source of information and support for each other. Indeed, by working closely together during the leadership course, they had frequent opportunities to share some of their anxieties and fears.
However, once the course was completed, the picture changed. As Steve described, “There was a lot of camaraderie [during the course] but it never moved beyond that.”

Consequently, while some of them began to dissolve these emotional bonds in order to concentrate on the most pressing needs of their own units, others continued to cling onto the expectations that had accompanied their feelings of camaraderie during the course. Myra, for example, who was enmeshed in a serious problem within her own unit, described how she was looking to more experienced leaders to give her some practical advice. When, however, she approached one of the other NUMs for advice, she was disillusioned when brushed off with a more ‘general’ answer. As her most pressing needs and greatest expectations had not been met, Myra then felt both confused and disillusioned as she criticised the CDU(N) program for not having “some sort of structure in the meetings” that could address the individual concerns of the leaders, such as the problems she concurrently faced in her unit. The ‘structure’ that Myra was looking for had never really been built into these meetings. She said, “There are no terms of reference…. The roles are not clearly specified. Nobody knows what they are doing.”

She also said:

[At the beginning] the CDU was alright because the items were concrete … things like the launch, the letterheads, the brochures, all that sort of thing…. I’m not complaining that we don’t have enough work because right now I’ve got a lot of work but … from the very beginning I wanted the CDU to be my support, to really give me some insight into dealing with nursing problems…. But sometimes maybe I am asking a bit too much because I’ve got to be fair with the others as well because they are not in this environment. They are in a different field and, when I sit back, I can’t expect that much from them [she hesitated] - maybe some moral support, I suppose.

Myra, like many of the other first-wave leaders, was missing the atmosphere that had existed in the leadership course where, under the leadership of a charismatic leader who was adept at tapping into their enthusiasm, they could network, disseminate new ideas and obtain peer support. Fiona agreed: “It’s like all these little plots of CDUs sparsely placed around the area and none of us see each other except for that month.” Alison expanded on this: “Once the meeting’s finished, the majority pack up their bags and shoot through…. I feel strongly that there should be a time [in the meetings] for socializing.” Alas, Alison’s
final comment on this matter soon proved to be prophetic: “This needs to be built into [the meetings] otherwise people will just skip town.”

While reminiscing on what he thought had ‘gone wrong’, Steve talked about how the atmosphere of hope and anticipation that had pervaded the heady days of the leadership course had remained unfulfilled:

The better part [of being involved with the CDU(N) project] was getting exposure to the likes of [the Professor of Nursing], talking about issues, hearing that view from a very knowledgeable source and that stimulating, challenging kind of interaction. I think that, in fact, would help better practice in units because it makes people reflect and stuff.... And I think, if that’d continued, it would have continued to challenge team leaders to think about what they are doing and how they're doing it and what they need to do to develop. In that sense, I would have been more enthused about the thing if I'd had more regular access to [the Professor] afterwards.

Christopher also said of the six-month period that encompassed the leadership course, “We were pretty naive in some ways, but we were full of enthusiasm.” As time moved on, however, many of them became more discerning regarding the reality of the promises that had been made to them. Knowing that this frequently occurred in nursing, a large part of the blame was then laid squarely on the shoulders of ‘the system’ in which they worked.

Said Steve:

It’s part of the CDU stuff that you’re acknowledged and you have an identity ... [but] one of the problems is that it is a myth: it’s not acknowledged anywhere internally in the service. You’re putting all this time into meetings and little bits and pieces. It doesn’t mean much to anybody. You know about it but, basically, that’s all. The other team members really just don’t bother with it and the organisation isn’t interested, really, except tokenistically. So you feel, ‘I’m the only one involved in this,’ which is a bit frustrating, I guess.... Having taken the initiative of applying and being accepted as a development team, that, I guess, gives you the feeling that the work you’re putting in is acknowledged somewhere, somehow. Even if it’s not necessarily on the ground or within the service itself, what you’re doing is seen to be a worthwhile endeavour.... But nobody’s taken notice of it,... which is a bit disappointing, but not surprising.
Said Peter, as he questioned the motives of those who had appeared to support the CDU(N) initiative at its inception:

*I’m not saying [the CDU] was the wrong thing.... [It gave the nurses] an opportunity to be more proactive, [to receive] recognition for doing lots of good work.... I mean, doctors prescribe medication but when it comes to therapeutic relationships, that’s nursing work.... But, as I said, it just faded away: it just crashed. People just couldn’t deal with all this other stuff that was coming in and, whilst the administration wanted the principles of the CDU,... they were [not] as supportive as they could have been.... The people from above wanted results but they weren’t there offering any support. It was demands. Again, it’s a case of what would have been a good clinical tool becoming an administrative weapon. You know, ‘What do you mean? You haven’t got this done?’... I think there was just so much pressure on the nursing staff and the CDU was just another one - and it was one they could dump.

In retrospect, some of these participants questioned if it was worth all the effort that had been put into the title CDU(N) when no one else had taken any notice, “You sometimes feel you’re doing it alone. I mean, nobody [here] gives a damn about CDUs.... In the current system, as I see it, the ward nurses are left in a powerless situation and it suits them to leave it like that,” said Christopher. Not even the academics with whom they had come into contact, or even their allotted mentors, had been able to meet their expectations. As Christopher said, “I think that [what] we are lacking is a bit of a flow on. We tried hard to establish links with academics, and we did some of that, but [because of] the staffing cuts, they haven’t been able to continue.”

Having heard of some of the problems the first-wave leaders had experienced, the second-wave leaders held back from formally adopting the title CDU(N). This was despite the fact that they attended a subsequent CDU(N) leadership course. Said Elizabeth:

*I guess we’re not really calling ourselves a CDU and, really, perhaps we couldn’t. I don’t know if we could raise a banner and say we are a CDU at all. I think we operate along the lines of a CDU which is, you know, a professional team and best practice and evidence-based and all that. But it’s more the way we work. I guess what stops me is because it would be a one-person show, basically. I don’t think the current staff would be able to realise what a CDU meant.
They did not choose to take on what some of them described as a rather “academic” and even “esoteric” title that they would, consequently, be expected to sell to their staff as well as the broader community in which they worked. Said Elizabeth:

>I think people are going to think, ‘Oh, God, Clinical Development Units. What are we developing? What does this mean?’ It sort of seems that it is something that is very intense and outside of what people normally do…. It’s a bit of an abstract term if people are to connect it to the work they do as a nurse.

As this analysis progressed over the years and I occasionally met up with some of the participants who remained, we had brief informal discussions of pertinent aspects of how the analysis was progressing. Although these conversations were not taped I could see that gradually, over time, their initial disappointments of having “failed” to achieve their goals were being replaced by a deeper disillusionment and resignation that they could not change “the system”. At the time of writing this thesis, I know of at least one of these participants who eventually left the public health system because of such disenchantment. This final quote from one of the participants during the final round of interviews portrays how the warm flush of excitement that had once motivated these nurses to make such a courageous attempt to brave the demons of the deep in search of their own golden fleece had dissipated in the cold light of day: “What is the CDU at the moment? The folder on the shelf over there. That’s probably about it.”

6.3 CONCLUSION

This chapter has highlighted many of the hopes of this small band of nurse leaders as they set out on their quest, some of the ups and downs along the way and their experiences of coping with the many problems they encountered. In the following chapter, the three major themes and the associated sub-themes that have emerged will be interpreted in light of my own understandings and the published literature.
Chapter 7

EMERGING NEW UNDERSTANDINGS

In a similar way to how the worldwide plethora of heroic stories, both ancient and modern, were born of the human experience (Campbell, 1988), our story of the Odyssey of the Great Western Land has grown out of the words and experiences of the participants in this study. As with the ancient Greek myths of Jason and Odysseus, the legends of King Arthur’s Knights of the Round Table and their search for the Holy Grail, and even the biblical search for the Promised Land, these nurse leaders set out on a quest for their own Golden Fleece. Although not as grand or as earth-shattering as many that had gone before them, their search was, nevertheless, a quest to expand the horizons of their own known world of nursing practice.

The three major themes and the sub-themes that emerged in the previous chapter, which relate to the journey these participants undertook, are further developed in this chapter in relation to published literature. As previously discussed, those involved in this Australian CDU(N) project tried to adopt many of the concepts that are closely associated with Nursing Development Units (NDUs) and Practice Development Units (PDUs) in Britain. This chapter, consequently, makes frequent use of the numerous articles, books and research reports that relate to these UK units as reference points from which to develop arguments about the NDU/CDU vision that the participants in this study attempted to follow. In addition, and in keeping with the philosophical framework on which the study is based, this discussion will also incorporate the new meanings these participants developed over time, along with many of the preunderstandings of the researcher.

This chapter has retained a Heideggerian character throughout because of the influence of Heidegger’s work on my understanding. These influences, while at times subtle, were at other times overt. The more overt influences of Heidegger’s work showed themselves when I revisited the words of the participants in order to interpret the texts in relation to the concepts that he has developed. For example, Heidegger has distinguished between ‘care’
and ‘knowing’ by describing care as an intrinsic state of Dasein. The things that we are concerned about influence our view of the world and, consequently, the way we make use of new concepts and equipment (Inwood, 1997). As I dwelt on the words of the participants, who had described the CDU(N) concepts as present-at-hand (that is to say, lying on the periphery of their everyday world), I juxtaposed my understandings of their words with Heidegger’s descriptions of how we interact with our environment.

Furthermore, Heidegger’s understanding of the way that ‘language uses us’ (Diekelmann & Diekelmann, 1997) also caused me to reflect more deeply on the way language is used as a medium rather than a tool (Palmer, 1969). As such, the language that these participants came into contact with would have informed the meanings that they developed about their CDUs(N). As I worked more closely with such aspects of Heidegger’s work, I was able, over time, to progress further into the interpretation of the words of these participants and develop deeper understandings of the influences that had informed the preunderstandings that these participants brought with them into this project and the way their understandings had changed over time. This process of interpretation was aided by ongoing informal conversations with some of the first-wave CDU(N) leaders who remained, the published literature and various other people who had been involved, both in this Australian project and other nursing units in Australia and the UK.

Many of the understandings that I developed as the process of interpretation progressed through this chapter are not ‘obvious’ at a cursory glance at this thesis. This is due, largely, to the fact that the hermeneutic circle is dynamic and, once I had merged my concurrent understandings with the published literature, the hermeneutic writing process progressed to a deeper level; thus concealing many of the nuances of understanding that had underpinned the development of these themes. Indeed, the development of understanding by Dasein has been described by Heidegger as temporal (1962), which indicates that interpretation, like language, is never static but always “on the way” (Heidegger, 1971e, p. i).

7.1 REACTING TO THE PRESSURE TO CHANGE

The first-wave CDU(N) leaders frequently spoke about the pressures they were under to instigate change. This pressure, while acting as a catalyst for their decision to become involved in the CDU(N) movement, only increased once they had agreed to develop their units into CDUs(N). In a similar vein, and somewhat paradoxically, having reacted to the
management pressure to effect change, they then felt themselves trapped by the insidious counter pressure ‘not to change’ that was emanating from a system that is dominated by the status quo. This theme, consequently, relates these experiences to the broader context of the published literature and also makes comparisons with the British NDU movement.

7.1.1 A SEARCH FOR A NEW IDENTITY

As illuminated in the previous chapter, by attempting to connect with the NDU/CDU(N) movement, the first-wave CDU(N) leaders in this study set out on a journey to find a new identity for themselves and their units. An identity that would, they believed, provide them with exciting opportunities previously denied them. Fuelled by the overwhelming pressure to make viable changes in their units, their concerns about their previous inability to change practice ensured they were “ripe for the picking” when they received the CDU(N) invitation. The expectations held out to them, that they would have the opportunity to make a fresh start with their new CDU(N) identity, in effect overrode their conflicting anxieties about taking on so much extra responsibility and additional work.

As with the early British NDU schemes (Redfern, Norman, et al., 1997; Salvage, 1989a), where a small percentage of practising nurses responded to the new initiative, only a handful of nurse leaders within this participating area health service applied for CDU(N) status for their units. The expectations the first-wave leaders took with them into this new initiative are, accordingly, particularly noteworthy as they shed new light on why this small number of nurses chose to take on this new Australian CDU(N) challenge. The majority of them acknowledged that their previously unsuccessful attempts to develop their nursing teams had left them feeling disenfranchised and disempowered. The disillusionment some of them described mirrors, in many respects, the description of work-alienation that can be felt by workers who have relinquished their autonomy and self-expression because of their perceived inability to change their work activities due to hierarchical constraints (Aiken & Hage, 1966; Winter et al., 1995). It is of note that similar feelings of disempowerment have been reported previously in organisations within the Australian health care system (Short et al., 1993).

Consequently, when a new project was suggested that bypassed their existing power structure these participants, each in their own way, saw it as a way out of their seemingly intransigent situation. Appearing to have the sincere backing of the area health service and
the local university and the close participation of a Professor of Nursing, it was an opportunity not to be missed. They believed that their eagerness was shared by many of their staff, describing them as excited about the prospect of receiving outside assistance in the development of their units. For these CDU(N) leaders, who showed overt enthusiasm for this project, the appeal of developing a working environment of which they could feel proud temporarily outweighted any qualms they may have had about the problems they would be likely to face. The decision to become part of the new CDU(N) initiative was, in large part, a way of countering the lack of control these nurses felt in all matters political, which can, as described by Seeman (1967), result from work alienation. It also sheds further light on their decision to adopt such a grand vision. As discussed by Speedy and Jackson (2004), the acquisition of knowledge, which these nurses clearly sought from this CDU(N) program, is necessary to maintain professional credibility while, simultaneously, combating disempowerment.

None of the second-wave leaders, however, echoed the same degree of enthusiasm for the CDU(N) project that these first-wave leaders had initially expressed. Consequently, their search for new meanings within a CDU(N) context appeared much less intense. Although the second-wave leaders were excited about many of the individual concepts taught in the course, none of them had any tangible plans to identify with the CDU(N) project, even after they had attended a subsequent leadership course.

Analysis of this phenomenon from a Heideggerian perspective indicates that the meaning the first-wave leaders developed before and during the course must, in some way, have held a special appeal that was not subsequently felt by their successors. With this in mind, the two aspects of their experiences they held in common with each other but not with the second-wave leaders were, firstly, the fact that they had freely chosen to undertake this difficult task. As they expressed in our conversations, their desires to find a way out of their present situation and their wish to develop their own leadership skills had been strong enough for them to commit to long hours of extra work in their own time. A second dynamic shared by no one who followed was, essentially, that they were to be pioneers in their area health service; the first to break new ground and develop a new identity for themselves and their units. Many of them, indeed, expressed a great deal of pride in their sense of ownership of the fledgling CDU(N) project during the earlier interviews. In contrast, their successors, who had different agenda for their new units, were not
experiencing any of the enthusiasm the first-wave leaders had felt as they had ridden the crest of the CDU(N) wave. These second-wave leaders, accordingly, judged the CDU(N) program with different criteria, showing reluctance to embrace a concept they had not freely chosen until they had had more time to evaluate its potential relevance and effectiveness.

7.1.2 ATTEMPTING CHANGE BY TRIAL AND ERROR

Inherent in the act of adopting the title Clinical Development Units (Nursing) was the expectation that the leaders of these units would gradually introduce the new concepts taught in the CDU(N) leadership preparation course. The first-wave leaders agreed to this with the anticipation that all the hard work that this would entail would eventually prove to be worthwhile. Due to their lack of previous experience in instigating such extensive changes, however, their attempts to sell the benefits of the new CDU(N) program to their staff can best be described as attempting change ‘by trial and error.’

These participants were well aware of the association of the term CDU(N) with the need to implement extensive change (Freeman, 1996; Greenwood, 1997, 1998, 1999a; Redfern, Norman, et al., 1997). This knowledge, even though it was the source of excitement in the early stages, nevertheless soon began to cause varying degrees of anxiety. For these fledgling CDU(N) leaders, initial relief from the prospect of the daunting task ahead of them was to come during the leadership preparation course, when they were required to complete various projects such as drawing up strategic plans and practice development objectives and setting benchmarks for their units. Not only did these tasks distract them, at least for a while, from their more long-term concerns, but the nature of the projects also ensured that it would be the CDU(N) leaders who would take prime responsibility for completing these assignments. Accordingly, these projects proceeded to schedule. This period was also marked, largely, by cordial relations with their staff and more positive attitudes towards their tentative CDUs(N). This lack of discord can also be related to the facts that, firstly, the CDU(N) leaders themselves were engaged in tasks that allowed them a high degree of control and, secondly, their staff had long accepted the necessity of such management tasks in order to satisfy the concurrent demands from higher management.

Despite the fact that the UK literature strongly recommends the early articulation of similar clearly defined aims and objectives (Freeman, 1996), these strategies had little effect on
increasing the level of involvement of the CDU(N) staff. On many of these units, the staff countered these tactics by passively accepting the changes introduced by the designated CDU leader, while offering little or no active participation. Over time, many of the nurses who had sidestepped the more disconcerting issues relating to the CDU(N) concepts during the early stages gradually began to raise a variety of seemingly minor issues. This cumulated, in many of these units, with the CDU(N) being overtly blamed as the source of their problems.

This is consistent with well-documented evidence that resistance to change will frequently surface as everyday problems and changes in behaviour patterns (Sayles, 1989). Some authors have noted that the interpersonal problems that arise during such periods of change frequently relate to the destruction of informal understandings, routines and status relationships that have developed over time (Hassard & Sharifi, 1994; Sayles, 1989; Swansburg & Swansburg, 1999). Others have also correlated such resistance to a fear of the increased responsibilities that may follow the planned changes or the fear of disturbing the stability of the work environment (Chambers & Craft, 1998). Certainly, the comments made by many of the leaders about their staff indicate that all of these complex aspects of human behaviour were coming into play as their staff attempted to cope with the new changes.

The staff resistance that many of these participants reported following the completion of the leadership course was largely misunderstood by many of these CDU(N) leaders and, accordingly, inadequately addressed in the early stages. A lack of any clear commitment to the CDU(N) by the staff on some of these units is evident in the words of the second-wave leaders who took over the management of these units. They said that they were left completely in the dark about their units being CDUs(N) for months after they had been appointed to these units. Considering these new managers were in close everyday contact with their staff, often sharing personal time over lunch or coffee, this omission by their staff could be interpreted as deliberate or, alternatively, it could be said that the concept was so inconsequential to the staff that they had not considered it worthy of mention.

Further evidence of a lack of interest by the senior nurses on these units is the contradiction in tone between one of the first-wave leaders (who vacated her position as the CDU(N) leader soon after the completion of the leadership course) and the words of her successor (who had worked as a registered nurse on the same ward during the initial development
phase.) While the original CDU(N) leader said she was confident that her successor would “keep the CDU rolling” as she had been involved in some of the earlier work and understood the basic concepts, her successor stated that she had had little to do with the preparation of the CDU and knew very little about this particular model of practice. In fact, as time moved on, she took no further steps to develop the unit further as a CDU(N).

Consequently, these CDU(N) leaders can be seen to have miscalculated the level of motivation their staff held for this new CDU(N) initiative. As some of these participants said, the primary aims of many of their staff were to complete their day’s work with as little discord as possible. Furthermore, it also appears that the staff may have chosen not to disappoint their CDU(N) leaders, who were showing enthusiasm for this project. This quote summed up the attitudes of the staff, as indicated by the words of several of the first-wave CDU(N) leaders: “They’ll go along with me, they’ll work with me.”

Many of the CDU(N) leaders also indicated that they, too, had experienced considerable ambivalence towards their CDUs(N) as the problems and pressures began to mount. Furthermore, those leaders who remained in their positions showed signs, over time, of agreeing with the earlier evaluation of some of their staff that the development of such units in the current health care climate was not possible. Consequently, it can be stated that the degree of resistance to implementing the anticipated changes increased over time for these leaders as well as their staff. Certainly, they appear to have taken up this project with a rather naive appreciation of the challenges that were ahead, which caused them to fall prey to somewhat simplistic assumptions regarding the way their staff would respond to the change process. According to Sayles (1989), this is not an unusual occurrence as very few managers or leaders are able to anticipate many of the contingencies they will eventually encounter or just how widespread the effects of change will be. Similar experiences have also been reported in the UK NDU literature (Christian & Redfern, 1996b; Redfern, Norman, et al., 1997).

As the staff of these units were not interviewed, it is difficult to obtain a more comprehensive view of the dynamics of what were occurring in these units. It is of note, however, that similar reactions to the ones reported here have been shown to be enhanced during periods of very rapid change or at times when numerous small changes have occurred within a short period of time (Tappen, 1989). Both of these situations were reported by these leaders: the adoption of the CDU(N) concept, which these participants all
agreed would involve a major change, was also seen by some of their staff as little more than “the latest management tool” to instigate yet another change in a whole series of changes. Indeed, and as previously discussed by Marriner-Tomey (1992) in a more theoretical context, the implication that some of these staff members were viewing the CDU(N) as a covert ‘tool’ to introduce what might otherwise be seen as unpalatable change also indicates a serious lack of effective vertical communication within their organisations.

It can also be seen to reflect the legacy of cynicism that, as described by Buchanan, Claydon, and Doyle (1999), has developed towards the way organisational change has been largely fashion-driven over the past two decades.

Blocked, as these CDU(N) leaders were, in their attempts to counter such charges by their staff due to their lack of operational autonomy within the organisations in which they worked, they could do little to change the attitudes of their staff. This applied even more to the Clinical Nurse Consultants (CNCs) in this study than it did to the Nursing Unit Managers (NUMs). In those units where the official CDU(N) leader was a CNC and held little management power, these CNCs expressed some frustration about their attempts to make changes without managerial authority. Comparable dynamics have been reported in the UK NDUs (Christian & Norman, 1998; Redfern, Norman, et al., 1997). While those who worked in managerial positions in the UK units reported ongoing problems as they attempted to juggle the everyday pressures of work with the need to develop new NDU projects, those who did not have any managerial responsibility for the unit often felt thwarted by their own lack of authority. This was particularly acute where the manager of their unit had not been involved in the initial development of the NDU.

It is also of note that the perceived role of the CNCs in this study was changed when these CNCs became CDU(N) leaders. As has been discussed by Gilmore (1988), any situation where the dynamics of leadership are seen to change can destabilise existing relationships. Evidence of this having occurred in at least one of these units can be seen in the words of the NUM of this unit. He stated that the nursing staff were complaining they no longer knew who was in charge and that this was beginning to affect the everyday routine. In this case, a triangular relationship was created between the CNC, the NUM and the staff. This meant that the CNC was forced to operate under the shadow of the NUM, who had previously held full responsibility for all clinical decisions on the unit. As previously described by Gilmore (1988), these same CNCs (who were now officially being called Chapter 7 – Emerging New Understanding

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‘leaders’) were bound to be compared by the staff to the recognised managers of their units. Their performance, too, was now likely to be subject to greater scrutiny by the staff and their peers than it had been before they had become CDU(N) leaders.

This study has clearly shown that these CDU(N) nurse leaders, whether CNCs or NUMs, were unable to fully understand what appeared to them as ‘staff intransigence’. This is despite the fact that they had expended enormous amounts of time and energy in an attempt to overcome staff resistance to any changes in the everyday routines of their units. Even more disconcerting is the fact that some of these participants found that the changes that had been designed to solve old problems were now creating new dilemmas that they were unable to solve. Said one of them, “the staff are now worse off than they were before” because the detractors could now say, “I told you so.” Such a situation only served to disempower those who had worked hard for the changes, as well as guaranteeing that those who had given tentative support to the new developments would, in future, be reluctant to make the same ‘mistake’ twice. Given the complex scenario playing out on these units, it is not surprising that these CDU(N) leaders all relinquish their newly-developed aspirations after a nominal period of time in favour of the relative peace and quiet of the status quo.

7.2 BECOMING INVISIBLE AND FORGOTTEN

One of the most intransigent problems these new CDUs(N) were to face involved the tendency of those who work in the Australian health care system to retain the status quo, as also described by such authors as Short et al. (1993). The power of such systems has been shown to lie in the acceptance of traditions and values that serve to protect the interests of specific groups. For as long as these values and behaviours are viewed as neutral functional constructs, the people who are most likely to benefit from them need take no part in mobilizing them because the individuals who make up the system will strive, often unconsciously, to maintain this status quo (Hardy, 1994; Salaman, 1979). Consequently, not only were these participants silenced by others who worked within this system, but they unwittingly contributed towards a complex scenario that dismissed the reality of themselves and others.
7.2.1 BEING SILENCED

Although many promises of support were made to the participants in this study, few of these assurances trickled down to them as practical support. Indeed, any verbal commitments that were made appear to have quickly dissipated as other more pressing issues took precedence. There is no doubt that the inability to obtain the commitment of the key people in their individual organisations, the lack of continuity in the mentoring program that had been designed to provide opportunities for them to ‘debrief’ during the leadership course, and their reduced access to the CDU(N) coordinator following the completion of the course, had the effect of cutting these CDU(N) leaders off from what should have been vital sources of support. This is despite the fact that, when they first agreed to take part in this new project, they had been led to believe that this area-wide initiative would have inbuilt checks and balances that would ensure ongoing support from all relevant people.

The dilemma in which these participants consequently found themselves at the end of their leadership course can, in many respects, be likened to the reality shock frequently experienced by university nurse graduates when they enter the work force; only to find that the higher ideals of nursing, as they were taught in the university, conflict with the ‘reality’ of their future working environment (Kramer, 1974; Short et al., 1993). These CDU(N) leaders, although seasoned travellers in many respects, experienced a similar reality shock, having had their hopes raised that, this time, it would be different.

Unfortunately for the profession of nursing, this is a tale of woe that has oft been repeated throughout the world. While the most prominent casualty of the NDU movement in England was Beeson Ward at Oxford, a similar situation precipitated the demise of the Loeb Centre, on which Alan Pearson had modelled his new developments at Burford. Sue Pembrey, who headed the Oxford NDU at the time of its closure, has since said that it is vitally important to educate other people in the organisation about the aims of the unit in order to dispel uncertainty and anxiety. What is more, Malby (1996) has discussed the need to secure greater public support and an openly articulated commitment from the chief executive and members of the board, as well as the full collaboration of all of the other professional disciplines. Having had many battles with powerful medical hierarchies, Sue Pembrey has been quoted as saying that it had taken “tremendous efforts … to overcome the resistance, even sabotage…. Even when an innovation is widely regarded as better it can fail because of the lack of support from key people” (Davidson, 1989, p. 18).
It must also be remembered that, not only were these Australian units introduced into the area health service almost out of nowhere and within a short space of time, but they were developed by a very small group of people with little input from the nursing and medical personnel who were responsible for the day-to-day running of the host organisations. Admittedly, as recommended in the UK literature (Christian & Redfern, 1996a; Gerrish, 1999; Redfern, Norman, et al., 1997), Steering Groups were set up to ease the passage of these new units. There was, however, a great deal of misunderstanding by the Steering Group Committee members as to their specific objectives. Furthermore, although these CDU(N) leaders had been told that ongoing support and advice would be made available by the members of these committees, only a small number of these meetings were convened.

In addition, and as also reported from the UK (Christian & Redfern, 1996b), a high turnover of those in senior management positions within the area health service and the individual hospitals in which these participants worked also meant that the new managers of these organisations would know little, if anything, about the CDU(N) project. The resulting lack of commitment to the CDU(N) program of these senior nurse managers, along with many of the senior medical officers, is evidenced in the fact that, as the individual first-wave CDU(N) leaders resigned, their replacements were not expected to carry the CDU(N) philosophy forward. Indeed, the words ‘Clinical Development Unit’ were not even mentioned in any of their employment interviews.

As discussed by Chambers and Craft (1998), the expectations that these first-wave CDU(N) leaders had been encouraged to develop had created only a temporary illusion of participatory management. The reality of the situation was brought home to them with the subsequent acts of omission, as they realized they could not make broad ranging changes due to the very limited resources and support made available to their tentative CDUs(N). According to Short et al. (1993), such a situation is typical of a clash of priorities that can occur in bureaucratic health care organisations when the needs of the minority, to provide optimal patient care, can be thwarted by the primary goals of the organization, which relate to providing more cost-effective health care. This project suffered the same fate as so many other promising schemes developed by and for nurses. While it began with the promise of developing the fullest possible range of abilities and skills these nurses had to offer, it quickly faded into obscurity. As predicted by Stewart (1994), no one appears to have recognized the waste inherent in treating staff as costly resources rather than valuable ones.
It must be remembered, however, that this study took place during a period of time when the ripples of change were being strongly felt in the established hospital culture in the area health service. The political pressure to adopt a more ‘open’ management style that correlated with contemporary management literature and the threat of ever-increasing financial restrictions was nurturing the development of a new breed of hospital manager who focused on concrete evidence of outcomes and financial accountability. Unprecedented pressures were also placed on nurse managers to find ways to juggle their more traditional responsibilities with the new management concepts. This occurred at a time when many of the senior nurse management positions had been recently trimmed and many of the senior nurses of these organizations found themselves locked in power struggles with their medical colleagues. Into the mix of conflicting emotions that such a situation would inevitably spawn, stepped four newly appointed Chairs of Nursing. As the concept of Nursing Chairs are relatively new in Australia, the development of these new positions brought with them the potential for radical change and more uncertainty as to the future of nursing in the area health service.

As human beings are seldom aware of their sub-conscious motives in complex interpersonal situations (Berne, 1964), such a situation can lead to uncertainty for any nurse who attempts to stray from the path in which they were brought up (within our patriarchal society) and the way they were trained (within a hierarchical and transactional hospital system). As discussed by such authors as Borbasi and Gaston (2002), many senior nurse managers are currently walking a precarious tightrope between the demands of higher management and their commitments to those who work closely with patients. Such nurse leaders continue to be forced, by the hierarchical organisations in which they work (Short et al., 1993), to align themselves with the masculine archetype of modern medicine in order to maintain some semblance of power (Watson, 1999). There is, consequently, little wonder that some of the senior nurses with whom these participants came into contact may have been ineffectual in understanding the needs of these CDU(N) leaders.

The situation these participants experienced is nothing new for the NDU movement as other authors have reported similar difficulties as British NDU leaders have attempted to promote the advantages of their units to senior management (Christian & Redfern, 1996b; Morrison, 1996). Gerrish (1999), in her evaluation of the Leeds program, also found that the power infrastructure of the organisations in which the individual NDUs were situated had

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considerable effect on the success of the units. The two categories of staff singled out as making a difference in this respect were nurse middle managers and senior medical staff, with many doctors described as “ambivalent” (p. viii) or even obstructive when the work of the unit was seen to have encroached on their own domain. In an edited book (Page, 1998) on the many experiences of those who developed the Seacroft Practice Development Unit in Yorkshire, Casley, Allsopp, Page, and Turner (1998) said that the development of a culture that encouraged the empowerment of all levels of staff at the expense of rigid hierarchical structures did not occur without multiple glitches. While their new approaches encouraged a flurry of cross-disciplinary activities, the team nevertheless hit a brick wall with some of the senior medical staff, who viewed their medical projects as sacrosanct and were wary of incorporating their medical research into such a context.

7.2.2 SILENCING THE SELF

Inherent in the dissolution of support these participants experienced is the way they remained silent about their own needs. This is despite the fact that they were aware that the promises made to them were not being fulfilled. This reaction to matters they perceived to be beyond their control to change is a form of self-silencing. Although it may appear very difficult for people of other professions to understand, nurses, who are poorly supported in their endeavours to improve their practice beyond what is seen as their ‘place’ or their ‘role’, most frequently accept this as normal (Buresh & Gordon, 2000; Collière, 1986).

As discussed in the literature review, our profession has long carried the legacy of its development as a predominantly female-led structure during a period of history when modern feminist thought was in its infancy. Nursing remains at a strong disadvantage in an environment where both subtle and overt pressures to conform to male stereotypes of leadership continue to be brought to bear on any women aspiring to leadership positions (Linehan, 2000; Maddock & Parkin, 1993; Morley, 1993; Speedy & Jackson, 2004; Still, 1990). Despite the fact that the gender ratio within both nursing and medicine is slowly changing, the entrenched stereotype continues to retain considerable power within our culture (Huntington et al., 1996; Stevens & Crouch, 1998).

This traditional invisibility of nurses (Buresh & Gordon, 2000; Collière, 1986), and the propensity of most nurses to put the needs of patients first (Lawler, 1991), served to further augment the dilemma of the participants in this study. Not only were their needs, as
CDU(N) leaders, excluded from the consideration of the managers of their host organisations, but the reactions of many of the participants could be described as ‘typical’ of the nursing profession, who are often described as unversed in a repertoire of suitable behaviour patterns that can demonstrate self-assurance and assertiveness (Marriner, 1994; Short et al., 1993). These participants too, although designated as leaders within their own units were, after all, ‘ordinary’ nurses (a term no longer considered derogatory since the groundbreaking work of Taylor, 1994). They were all trained in a system that, as discussed, disempowered nurses in a variety of ways and, consequently, they had never done anything that could have been seen as ‘extraordinary’ in nursing apart from their promotion into management and clinical consultancy positions. Neither had they had much previous exposure to the concepts of reflective practice (as described, for example, by Foster & Greenwood, 1998; Greenwood, 1993; Johns, 1994, 1999, 2001; Johns & Freshwater, 1998; Johns & Graham, 1994; Taylor, 2000) or spiritual intelligence (Speedy, 2004). While one characteristic of reflective practice is the conscious development of one’s own personal value system, spiritual intelligence is a way of describing such self-awareness.

Furthermore, despite the fact that reflective practice was introduced to these CDU(N) leaders during the preparatory leadership course, these nurses were forced to abandon their tentatively developed skills when they returned to an environment that did not actively encourage such practices. This stands in stark contrast to the NDUs these CDUs(N) attempted to emulate. One of the first steps for both Pearson and Wright had been to actively encourage their, up until now, disillusioned and disempowered nursing staff to articulate their own beliefs about themselves and about nursing. Decisions about changing practice were only formulated after lengthy consultation with their team; thus developing a horizontal support network, with meetings frequently held out of working hours. Such heated debates nurtured a positive attitude of cooperation and team spirit, where individual input was acknowledged and encouraged (Pearson, 1992; Wright, 1989, 1990). Not only were these NDU nursing staff encouraged to question their previously held attitudes to their work and their patients, but they were allowed a great deal more autonomy than had previously been deemed ‘appropriate’. This, in turn, nurtured their own confidence and assertiveness. They responded with a commitment that Joan Dearnley, one of the primary nurses at Burford, described as, “When the nurse has total responsibility, she’s prepared to give her absolute utmost. That’s human nature” (Swaffield, 1983c, p. 14).
Two such diametrically opposed portraits of what can occur in NDUs/CDUs(N), even though they were developed two decades apart, only serve to highlight the tremendous strides nurses can make when given functional power within a national health care system to set their own goals and re-evaluate what they are trying to achieve. Since the development of Burford, however, when Pearson took unprecedented steps to turn the tide of a declining cottage hospital, the majority of nursing units in both the UK and Australia have been developed in organisations that are built on traditional hierarchical structures. Consequently, it does not appear a coincidence that a disproportionate number of prominent nursing leaders, in particular those associated with the NDU movement in the 1980s and 1990s, appear to have been men. It is more probable their early socialization as males would have better equipped them (Gilligan, 1982) to advance their profession within the gender-based framework of a hierarchical Western health care system.

7.2.3 ATTEMPTING TO SILENCE OTHERS

The CDU(N) leaders in this study were acutely conscious of their new role as change agents for their fledgling CDUs(N). So convinced were they, at least in the initial stages, that the CDU(N) model was appropriate for their units, that they spoke as one voice in their denigration of any of their staff who openly opposed the CDU(N) concept. Many of them spoke of these staff members as “resistant to change”, with one of them placing the label “anti” on two of her most vocal staff. This is despite the fact that she simultaneously considered these two nurses to be very “kind” and “gentle” practitioners. Due to this lack of understanding of these CDU(N) leaders as to the ‘message’ that some of their more conservative staff were trying to convey to them, many of them attempted to silence the staff who considered the proposed changes unnecessary.

Such an attitude by a person in a position of power within the unit is likely to have effectively silenced other potential detractors who had not yet spoken out. After all, it was beginning to be made clear to the staff by the actions of the leaders (although not necessarily by their rhetoric) that they would be taking responsibility for the bulk of the work the CDU(N) would entail. As this involved little additional responsibility for the remaining staff, the majority of the nurses on the ward would have had nothing specific to complain about during the early stages.
While similar problems of NDU leaders who have found it very difficult to ‘sell’ the new concepts to their staff have been reported from the UK (Christian & Redfern, 1996b; Morrison, 1996), this situation does, nevertheless, shed some light on the approach some of these leaders took in attempting to implement some of the concepts they had been taught during the leadership course. It is somewhat paradoxical that, while some of them spoke of how ‘open’ they were becoming in developing their leadership skills, they were simultaneously so ‘closed’ in relation to the way they allowed their staff to express their opposition to the proposed changes. They, consequently appear to have felt the pressure to urgently develop their units along CDU(N) lines.

As discussed in the literature review, similar attitudes towards a universal necessity to implement change “for change’s sake” have taken on an aura of inevitability in the current social climate. So much so that its opponents all too frequently find themselves denigrated as ‘resistors’ (Kotter, 1985). What chance, consequently, did these leaders have of resisting this pressure, even though some of their more conservative staff were trying to warn them of the problems they would encounter? The ability to effectively introduce change has long been seen as one of the real tests of leadership (Kotter, 1985), which they were, after all, attempting to learn more about. As one of the participants said, “We were pretty naive in some ways, but we were full of enthusiasm.”

It is also of note that, while all of the first-wave leaders discussed the strategies they had used to motivate their staff to become more involved in the CDU(N) concept, none of them talked about having acknowledged their staff’s need to discuss the old ways of doing things. While this is a common error on the part of many who try to implement change, effective change will not take place if the process of transition is not allowed to occur (Bridges, 1995; Broome, 1990; Tichy & Devanna, 1990). Transition is the psychological process that takes place as people come to terms with the new situation. In sharp contrast to traditional ways of managing change, which focus on discussing the advantages of the new changes, this theory states that the focal point should be on acknowledging the grief associated with letting go of the old reality. If this loss is not adequately addressed, a “transition deficit” (Bridges, 1995, p. 22) may be created, which can trigger over-reactions to more mundane and insignificant situations at a future date.

This silencing of the needs of many of their staff to honour their long-established cultural patterns before proceeding to applaud the benefits of the proposed changes displays a lack
of understanding of the process of transition. Coupled with the previously unspoken lack of interest of the ward staff in the CDU(N) concept, it also created a deficit that was to contribute significantly to the leaders own exhaustion. Although Bridges has named the second stage in this transition process “the neutral zone” (1995, p. 34), the emotional reactions described in the literature are far from ‘neutral’ as this stage is frequently characterized by increased anxiety, confusion, self-doubt, resentment and a mixture of hope and hopelessness (Bridges, 1995), all of which are evident in the accounts of many of the first-wave leaders. It was, in fact, a time when many of these leaders as well as their staff felt ‘in limbo’ as they found themselves outside their normal comfort zones, with no one to turn to within their own units who was willing to take any responsibility for the CDU(N) they had initiated.

The discrepancy between the words and actions of the individual staff members who had attempted to voice their opposition to the CDU(N) concept and the explanations of their behaviour (as expressed by some of the CDU(N) leaders in the previous chapter) precluded any chance of reaching a mutual compromise. While some of the participants stated that some of their more ‘difficult’ staff later resigned their positions, others may have been effectively silenced as many of the participants commented, as time passed, that more and more of their staff were quietly backing away from the discussions that related to changing their normal routine.

**7.3 LOSING THE DREAM**

In the earlier interviews, the hopes and dreams of the first-wave leaders, as they embarked on their new adventure, were juxtaposed with the new understandings that were beginning to surface into their consciousness. These new understandings, which were developing out of their concurrent experiences, informed them that their previously bountiful vision was being dissolved before their eyes by the cold truth of reality. They were, consequently, caught in the dilemma of whether to continue to struggle largely unaided in their attempts to integrate their new role into their existing responsibilities (which remained unchanged) or to free themselves from this bitter-sweet dream.

As has also been shown in the findings of this study, throughout all three rounds of interviews, these first-wave leaders displayed varying degrees of emotional reactions to the stress they were feeling as they strove to live up to the expectations of others.
Consequently, this theme compares and contrasts many aspects of their dreams of breaking new ground within their own institutions with their own perceived “failure” to maintain their commitments to the CDU(N) program. As such, it also examines their relationship to the people around them and how their expectations of themselves and others played out over time.

7.3.1 FLOUNDERING IN A VACUUM

During the earlier interviews, the first-wave leaders described how they had signed up for the new CDU(N) project knowing that the peer support mechanisms that had been put in place would aid their passage from leadership course participants towards mature CDU(N) leaders. This hope was quickly snatched away from those leaders who remained due to the rapid diminution within their own ranks once the leadership course was completed. From this point on, these CDU(N) leaders began to question their newly found direction as they lost confidence in their own ability to navigate the CDU(N) path without the expected peer support. Indeed, the first round of interviews can be said to have coincided with the beginning of a turnaround for the whole of this CDU(N) program in the area health service, largely due to the swift decline in peer support for the first-wave leaders, and the resulting vacuum that was created.

Although high levels of attrition among the UK NDUs have been reported (Christian & Redfern, 1996b), these Australian figures are, nevertheless, exceptionally high as, by the second round of interviews, only two of the original nine first-wave leaders remained as CDU(N) leaders. The sense of isolation created by this rapid decline in their own numbers was further compounded by their reduced contact with the Professor of Nursing who had, until then, been their main source of support. Despite their initial zeal and hard work, this signalled a turning point as their most significant concerns began to relate to issues of survival rather than their previous pressure to develop new projects.

Even the small financial grants that allowed each unit to set up at least one new project of their choosing did little to shore up their motivation, unprepared as they were for the pressures they were experiencing. Consequently, by the first round of interviews, those who remained were struggling with the commitments they had made to the CDU(N) program. Although remaining excited about some aspects of their new projects, they also discussed their apprehension about their ability to complete the volume of work they had

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taken on with no additional resources. They described the many pressures they were under as preventing them from going forward, while their commitments to the CDU(N) initiative prevented them from going backwards.

For these participants, the high levels of motivation and sense of excitement that had spurred them on so effectively during and immediately following the leadership course were now replaced by a downward spiral of negative feedback that was uncheckable. Such a situation can be explained, in large part, by the existence of both positive and negative feedback loops within all living systems (Toffler, 1981). The term ‘positive’ refers to the way a stimulus enhances the response and ‘negative’ to the dampening down of the response. As Toffler has explained, while unregulated positive feedback can lead to total chaos as systems go out of control, negative feedback has the inbuilt potential to create stagnation. Consequently, and as so accurately predicted by Toffler, once the negative aspect of the feedback loop had effectively taken hold, no one could stop the downward pull, leading to a collapse of the whole structure. Ill equipped to cope with this intractable situation, these first-wave leaders were simultaneously drawn back into the way they had always done things.

It must not be forgotten that, while these participants were designated as leaders of change within their own units, they were simultaneously passing through their own intense learning curve during and immediately following the leadership course. Indeed, it is possible that it was the very openness to new ideas they expressed during the preparatory leadership course that left them more susceptible to some of the uncertainty that was to follow. This is despite the fact that such problems had been anticipated in the development of this course, which included theoretical sessions on reflective practice and also one-to-one sessions with a mentor, where the new leaders were encouraged to discuss any problems they were encountering. These relationship, however, were not sustained over time. While some of the participants had begun to open themselves to modifying their leadership style as a result of the earlier theoretical sessions, further gains would most likely have taken place if the practical sessions had been able to provide a more sustained nurturing environment. As some of the mentors who conducted these sessions have since been criticised for their lack of preparedness for these sessions (Greenwood & Parsons, 2002a), it is possible that the follow-on leadership courses, which were adapted to incorporate the lessons learned from
such feedback, may have been more effective in this regard. However no evidence has been uncovered that confirms if this occurred.

It was tragic for these units that the dynamics of this situation were not better anticipated as many of their concerns had been reported previously from the UK. These include the need to battle even harder than before to juggle the intense demands of their new CDU(N) leadership role (Morrison, 1996) with increased pressures of managerial work (Christian & Norman, 1998), staff anxiety and uncertainty (Christian & Redfern, 1996b), a lack of necessary resources (Pearson, 1995, 1997), attrition of staff (Gerrish & Ferguson, 2000; Pearson, 1995, 1997) and episodes of intense change within their own organisations (Christian & Redfern, 1996b; Pearson, 1995, 1997).

These first-wave CDU(N) leaders paid a heavy price for not being able to find a way of reducing their workload. Despite the fact that it has long been known that, when additional roles are incorporated into established positions, there is a serious danger of burnout (Tappen, 1989), the new theoretical knowledge that these CDU(N) leaders had gleaned from their course could not moderate the pressure they were under. As their numbers continued to dwindle and their regular meetings lost much of their practical value, many of them began to lose interest in attending. Although the places of the leaders that had left were taken up by their replacements, the lack of understanding of the NDU/CDU concepts these new people displayed meant that they were unable to shore up the rapidly dwindling motivation of those who remained. This loss of such a large proportion of the first-wave leaders within such a short period of time, and the consequent irrevocably damaged group dynamics, eventually led to the realization that the feelings of comradeship that had sustained them during the leadership course had become redundant.

7.3.2 RESPONDING TO CHARISMA

While a great deal of the literature on NDU/CDUs from both the UK (Freeman, 1996; Gerrish, 1999; Redfern, Norman, et al., 1997) and Australia (Greenwood, 1997, 1999a, 2000a) stresses the central position of the clinical leader of the individual units, very little has been said about the relationships between these clinical nurse leaders and those who take responsibility for developing and supporting the movement from their pivotal positions in either academia or nursing management. As the stated aim of the leadership course that these participants attended was to hone their own leadership skills, it is pertinent to examine
relevant aspects of their relationship with the person who not only instigated this Australian initiative but also coordinated their leadership course.

The first-wave leaders who attended the initial leadership course found the enthusiasm of the Professor of Nursing who developed and coordinated the course to be “infectious” as they strove to understand the intricacies of leading their own units towards CDU(N) status. Coupled with the disappointments they had faced in their previous attempts to introduce change, the excitement they experienced ensured they would base their plans for future projects on concepts introduced during this time. Not only did these first-wave leaders describe the CDU(N) coordinator as having a clearly defined vision for their units, but they freely attempted to adopt it as their own. The extent to which they embraced this vision during the leadership course is further exemplified by the words of those first-wave leaders who, while choosing to move on from their positions as CDU(N) leaders soon after the course, showed a strong reluctance to admit to there being substantial flaws in the project itself. In fact these same leaders displayed what could be described as an unwarranted degree of confidence that the developments they had begun would be able to continue in their absence. This contrasts with the leaders who remained for a longer period of time and eventually began to talk more freely of the inadequacies of this vision.

The experiences of these participants tie in with the literature on charismatic leaders who, although varying greatly in style, flexibility and attitudes, have great influence over their followers, who experience a magnetic emotional response (Bass, 1990; Burns, 1978; Luthans, 1995). During times of uncertainty, the novelty and the originality of the message such leaders impart serve to increase the excitement of the followers (Burns, 1978) and the group will follow such leaders for as long as they are seen to meet their needs (Byrt, 1971). Consequently, while the stated aim of the CDU(N) initiator was to assist them in the development of their own leadership skills to the point where they themselves could act as effective change agents, the results of her style of leadership also produced a new and unexpected dynamic for many of these participants, as those leaders who were left found their newly-developed enthusiasm dissipating when she was not available on such a continuous basis. They had, in fact, come to rely on her so strongly for guidance in order to meet their immediate needs that her absence created a void in the fulfilment of their expectations of their own CDU(N) leadership role.
It is well documented that charismatic people have always been around and, at times of need, some of them have taken on leadership roles. While little is known of those who fade into obscurity, a great deal is often said of those who go on to create major changes in their environment. Indeed, our modern day media appear to be obsessed with learning every little detail about those in leadership positions. It has been suggested, however, that it is not the leaders themselves who fascinate us so much in the West, but our own projections of how we feel when we are led. Although much has been written about the magnetic power of the leader, it is most likely the projection of our own unfulfilled needs that creates this inordinate and unwarranted fascination (Bass, 1990; Burns, 1978).

Although diluted from such extremes, a similar situation may have occurred with some of the leaders of the NDU/CDU movement, both in the UK and in Australia. In this study, at least, it appears that the projection of unfulfilled expectations came primarily from those nurses whose need for such a champion was greatest. What is more, it has long been known that the perceived achievements and status of people in leadership positions can have an alluring effect on those who follow them (Bass, 1990; Etzioni, 1961; Parsons, 1951; Weber, 1947). Consequently, one thing that is not clear from this study is to what extent these participants were influenced by the charismatic personality of their new ‘leader’, as opposed to the lure of the title ‘Professor’. Certainly, apart from describing her in terms that denote her charismatic qualities, these participants also displayed a sense of pride that their new project and the CDU(N) course was being coordinated by someone who “had professional authority in the sense that she was seen as the Professor” and was also described as having proven abilities and extensive experience.

As at other times when such leadership has come to the fore, and as described by Weber (1947), a leader who exuded a sense of purpose and was clearly able to articulate a new vision appeared at a time of need when these participants were psychologically ready for such a vision. It is not surprising, given the general disempowerment of nursing, that these nurses clung onto a champion, when one became available, in order to extricate themselves from the daily frustrations they were facing. Says Bass (1990), when people are experiencing uncertainty there is a greater chance they will be drawn to such a vision.

One of the saddest aspect of the early demise of these Australian units is the fact that, despite the bounty of the original CDU(N) vision and all the hard work that went into developing the units, none of the second-wave leaders who were interviewed in this study...
had retained any of the changes brought into their units by their predecessors. In other words, no one was able to sustain any of the momentum that had been developed by this charismatic leader. There is a discrepancy between Weber’s (1947) assertions, that some aspects of the changes introduced by such leaders will evolve into routine (and thus sow the seeds for new leaders to emerge as the cycle begins again) and what occurred in these units. This can be explained by the fact that, following the leadership course, this charismatic leader was not available on such a consistent basis to help these leaders to establish the CDU(N) concepts as everyday routine. Furthermore, and in line with the assertions of Porter-O'Grady (2001), because much of CDU(N) movement had reflected her own vision, the fledgling movement quickly crumbled once her leadership faded from the immediate view of the CDU(N) leaders. This is also consistent with the work of Bass (1990), who has said that followers who experience distance from such a leader are less likely to put the vision into practice.

As was also shown in this study, these first-wave CDU(N) leaders were still learning to exercise the repertoire of different leadership skills they had been taught in the course when access to their newly found champion was curtailed. If they were to continue on this path, they clearly required continuing access to someone they viewed as leading them in order to sustain their motivation. This has not been sufficiently emphasised in the NDU/CDU literature to date.

Since the heyday of the Burford, Oxford and Tameside NDUs, the NDU literature has also glossed over the significance of everyday contact between the NDU staff and the person who can be said to ‘embody’ the new vision for their unit. As was shown in this study, any influence that this charismatic leader had with the nursing staff on these units was diluted through the intents and beliefs of these fledgling CDU(N) leaders, who were still struggling to take ownership of the CDU(N) concepts. Given this situation, it is not surprising the staff on these units felt none of the “infectious” enthusiasm that had animated the first-wave CDU(N) leaders during their leadership course.

7.3.3 LIVING WITH HIGH EXPECTATIONS

The CDUs(N) featured in this study were developed as part of a strategic alliance between the area health service and the local university to raise the profile of nursing. The excitement that surrounded the development of these units culminated in the official launch
of the new program being attended by many senior figures from the area health service and the university. As the words of these participants have shown, however, a very large proportion of the weight of the expectations that accompanied this project was laid squarely on the shoulders of a handful of CNCs and NUMs. Unaware of the fact that they would not be receiving the support they had anticipated, many of these nurses consequently identified the potential they embodied in their position as CDU(N) leaders, not as a ‘possibility’, but as an ‘expectation’.

While the CDU(N) leadership course had been based on concepts that have been endorsed by the King’s Fund Centre (Freeman, 1996; Redfern, Norman, et al., 1997), such as team building, effective change management and the implementation of evidence-based nursing practice, evaluation and research, this project nevertheless set out to ‘prepare’ these CNCs and NUMs for the rigours of CDU(N) leadership within a short six-month window of opportunity. The expectation appears to be that they would emerge, after such a brief period of time, as ‘leaders’ capable of effecting considerable change. Although attempts were made to obtain additional funding for a post-doctoral fellow to support them further, this did not eventuate and, consequently, the majority of the support they had received as CDU(N) leaders during the preliminary leadership course quickly dissipated. This contrasts sharply with the King’s Fund program, which supported their NDUs for three years, and the University of Leeds program, which provides ongoing support. The downside of these British programs, however, is that the King’s Fund program had only a limited life span, and continued support from the University of Leeds program is dependent on ongoing annual payments by the management structures of the constituent hospitals.

These new CDU(N) leaders also had to contend with the expectations that accompanied their frequent association with the title ‘leader’, both during the leadership course and in public forums. As explained by Martin Heidegger, human experiences and the development of new meanings are only possible because linguistic articulation of everyday phenomena has already occurred within the everyday world of the individual (Okrent, 1992). Consequently, the strong connotations this title carries within our Western cultural heritage influenced the meanings these participants developed towards their new title ‘CDU(N) leader’. For some of these participants, in particular those who had only recently been elevated to management or leadership positions, the fusion of pride and trepidation that this new title bestowed left them even more vulnerable to feelings of failure.
The burden these expectations conferred was compounded, during the leadership course, by the literature that is associated with the term ‘NDU/CDU leader’ and the responsibilities this entails. While much of the literature that these Australian CDU(N) leaders read was internalised with a mixture of anticipation and apprehension, the frequent association of the terms NDU and CDU(N) with the expectations of ‘excellence’ (Christian & Redfern, 1996b; Greenwood, 1998, 1999a, 2000a, 2000b; Greenwood et al., 2000; Salvage, 1989a; Vaughan, 1992a, 1995; Wright, 1991b, 1992b) frequently left them feeling disempowered. The following quote from Barbara Vaughan (1995) is only one example of the British literature that painted an idealistic picture of the NDU movement in the UK, which they feared they could not emulate:

NDUs … offer an environment where scholarly enquiry, research and learning are part of everyday practice. By their very nature they foster a climate where old ideas can be tested and challenged and new ideas can be formulated and, in their turn, evaluated. Questioning becomes the norm and change is commonplace (p. 124).

Motivated by so many new expectations, and in a vain attempt to deny their own feelings of inadequacy, these participants fell into the trap of expecting more of themselves than they could realistically muster. This is evidenced by their frequent reference to their own “slow” progress. Despite the plethora of literature on managing change that states a large proportion of time and resources must be given to the earlier stages of the development cycle (Sayles, 1989; Swansburg & Swansburg, 1999), these participants felt uneasy about their lack of concrete achievements within the first few months. Similar observations have been reported in the King’s Fund literature. For example, Turner-Shaw and Bosanquet (1993) found, in their study, that it had taken much longer than any of the NDU leaders had anticipated to implement their initial plans; with the first year being described as a period of exploration and the second year as “one of increasing confidence, consolidation and clearer directions” (p. 10). Other NDU literature has confirmed that the initial period of intense activity and change within these NDUs was frequently followed by a period of relative inactivity and that the more concrete outcomes only begin to emerge after the first three years (Christian & Redfern, 1996b; Scholes, 1996a, 1996b).

These first-wave leaders nevertheless tried very hard at the beginning to develop a working understanding of themselves as ‘CDU(N) leaders’. As the meanings they associated with this new title had developed only tentatively when they were halted by subsequent
difficulties, they were unable to adequately resolve their questions about what constitutes a CDU(N). Consequently, they never fully accepted themselves as CDU(N) leaders as changes in attitude are not developed from theoretical knowledge alone (Heidegger, 1962).

After all, and as discussed, following the leadership course, the first-wave leaders began to report feelings of ambivalence that were related, at least in part, to the ambiguous messages they were receiving from the published literature and also the people around them. Berglas (1986) has stated that any ambiguity in defining the meaning of an accomplishment can lead to psychological distress, which these participants also reported. Furthermore, the internal conflicts they were experiencing regarding their own abilities to lead a Clinical Development Unit according to the published standards can be seen to have eventually led many of them towards a loss of self confidence. Such reactions have also been discussed in the published literature from the discipline of psychology. For example, and as reported by Watzlawick, Weakland, and Fisch (1974), if an individual or group of people has adopted a particular premise (as had the participants in this study in relation to the myths adopted from the British NDU movement) and their attempts to emulate the standards that go along with this premise are seen to ‘fail’, they are more likely to blame outside factors or themselves rather than examine the premise itself for any unpredictable aspects.

Similar internal conflict between fluctuating levels of confidence and self-doubt as the ones described by some of these participant have also been described by Clarkson (1994). According to Clarkson, the development of a degree of “pseudocompetency” (p. 1), while temporarily protecting the self from the admission of inadequacy (which is a characteristic behaviour pattern of some high achievers) can lead to such profound self-doubts as these people simultaneously attempt to live up to the expectations of both themselves and others. Such findings are also supported by Beckhard and Pritchard (1992) and Chambers and Craft (1998), who relate the inability to respond effectively to the demands of change to both conscious and unconscious fears of failing or appearing incompetent.

Despite the fact that the participants in this study were not chosen to lead their units towards CDU(N) status until they had satisfied the demands of a careful selection process that included an evaluation to ensure they “possessed the appropriate leadership orientation” (Greenwood & Parsons, 2002a, p. 530), a large number of them, in one way or another, went on to frustrate the expectations of this selection process. As discussed by Bond and Fiedler (2001), this is not an unusual occurrence in such stressful situations as the ones they
were to encounter because high levels of stress are highly likely to stimulate changes in behaviour patterns that cannot be anticipated in advance.

In sharp contrast to the theoretical concepts of leadership discussed in the course was the way one of the participants appears, at least in part, to have projected disappointment and disillusionment onto the staff of the unit with the words, “My lack of motivation is because I feel that I’m the only person that comes to work and gives a rat’s at all about the unit.” If this is so, such words not only echo a conscious disenchantment with ‘the system’, as discussed, but the blaming of others can reflect a personal lack of self-esteem (Kelly, 1994). Similar and dramatic effects on the sense of self-esteem of workers in bureaucratic organisations have been reported by Sarros, Tanewski, Winter, and Santora (1997) as relating to a lack of clarity in regard to the individual’s responsibilities and goals. As attempts to play the role of a victim have also been reported as characteristic of demoralised and disempowered nurses (Pike, 1997), such behaviour is a further indication of the silencing or censoring of the voice of a nurse who was trying to cope with conflicting values and responsibilities. Although this was a one-off comment, as time passed many other first-wave leaders who remained expressed a sense of betrayal that they had been let down by the very system that had elevated them.

It cannot be ignored, however, that perhaps the most poignant condemnation of this current system is that, for so long, the majority of the nurse leaders in this study remained unaware they were merely carrying the expectations of others and, therefore, blamed themselves for their perceived inability to develop their units into ‘Centres of Excellence’. It is for this reason that such situations need to be brought to the fore and discussed openly by those nurses who cherish and wish to further the development of nursing as a unique profession. In this context, it is of particular note that, although the literature has repeatedly stressed the importance of the leader in the development of a NDU/CDU (Christian & Norman, 1998; Freeman, 1996; Gerrish, 1999; Greenwood, 1999a; Redfern, Norman, et al., 1997), no discussions have been uncovered in this literature that relate to the need for such clinical leaders who have seen their units ‘fail’ to be allowed adequate opportunity to debrief from the more unpleasant aspects of their experiences and find some form of closure.
7.4 CONCLUSION

As elucidated in this chapter, the participants in this study were under considerable pressure from the moment they agreed to take on the CDU(N) mantel until they eventually slipped away quietly from their commitments. While many of them had been aware, at least in theory, of the some of the problems they were likely to face, in reality, they were ill equipped to cope with the political and social consequences of their attempts to bring about change in such a complex milieu. As Beckhard and Harris (1987) have so eloquently said:

Managing change in complex organizations is like steering a sailboat in turbulent water and stormy winds. If you’re on a course to some destination and the wind is blowing at gale force dead broadside, you have to make a number of critical choices. If you head into the wind, you’ll lose speed and direction although you probably can ride out the storm. If you let the wind carry you too far, it might blow the boat over; and if you let it go a little less far than that, it may well drive you off course. If you decide to hold rigidly to your course at all costs, you may find that the winds rip the sails or even break off the mast (p. 114).

The following chapter further illuminates some of the struggles of these participants in light of the stark realities of the world of health care.
This thesis, as an in-depth written record of the experiences of a group of nurse leaders as they set out to develop their existing wards or units into centres of excellence, discloses many of the impediments that stood in their way. Despite the plethora of literature on the development of similar units, in both the UK and Australia, such detailed explanations of the problems such nurse leaders face and how they cope with their own perceived “failures” in these contexts are not available in the published literature. Consequently, the interpretation presented in the previous chapters has focused on what was happening at ground level during this new initiative, over this period of time.

These participants had placed their trust in the fact that this project was based on the sound judgements of all who had been involved in its instigation. They were well aware that, not only had it involved a great deal of planning, but it had been initiated by a Professor of Nursing and supported by two prestigious organisations, which had made large sums of money available for this new initiative. Despite this, the project collapsed after only a very short period of time. In line with the disappointment and disenchantment these participants expressed, the question that lay partially unspoken during many of our conversations was, ‘What went wrong?’

This chapter seeks to clarify some of the answers to this question, firstly, by engaging in a deeper exploration of some of the lessons that have been learned from this attempt to adapt a package of concepts from the UK into an established Australian nursing culture and, secondly, by relating these lessons to the broader context of the Australian health care system. Many aspects of this discussion correlate with the discussion on nursing leadership in the literature review of this thesis. Consequently, it can be said that many of the difficulties that lie ahead for nurses, if we are ever to meet the high expectations that accompany the development of a mature academic discipline and an autonomous profession, have been epitomized in the experiences of the nurses in this study.
8.1 LIVING WITH A BORROWED NAME

The wide discrepancy between the environments in which these units were developed and the units from which they had taken their name contributed towards the inability of the participants in this study to take ownership of this overarching vision much beyond the duration of the leadership course. The degree of autonomy these participants were granted stands in stark contrast to the extraordinary degree of freedom Alan Pearson was allowed which, in turn, enabled him to grant a high degree of autonomy to his registered nurses. The expectation that the participants in this study would be able to follow in the footsteps of such UK units can, in hindsight, be described as tenuous at best.

Furthermore, it is not surprising that these participants struggled to understand what a CDU(N) meant to them as a cursory glance at the UK literature that attempts to define NDU's can be very confusing. Juxtaposed with claims that NDU's represent one of the most fundamental advances in the development of nursing is the acknowledgement that any attempt to identify exactly what comprises an NDU is problematic because different groups have developed various aspects of the original NDU concept (Malby, 1996). Even in the UK literature that supports the development of these units, there are many who state that there is no clearly identified definition of these units (Draper, 1996), with inconsistencies found between units in regard to the degree of satisfaction nurses experience (Avallone & Gibbon, 1998). In a similar vein, Redfern, Norman, et al., in their final report on the King’s Fund program (1997), admitted their research team had encountered difficulties when attempting to define the ‘success’ of NDU's in terms of specific outcomes. While this study demonstrated progress in new innovative approaches to care delivery, it lacked adequate data on the effects of these changes on patient care (Nursing Standard, 1998; Gerrish, 1999). They said that, while “the effects of NDU status are subtle … the more quantitative evidence suggests that the additional achievements of NDU's are quite modest” (Redfern, Norman, et al., 1997, p. 215).

It is clear from the literature that, following the development of the three pioneering NDU's, a considerable watering down (Pearson, 1997) of the aims of the original NDU concept took place. Although Pearson (1997) has stated that the large-scale developments of NDU's nevertheless presents rare opportunities for a large number of nurses to engender change in their own units, this statement does not detract from the fact that the words of those who are conceptualising and developing these new units do not always match the reality of the
nurses who deliver hands-on care. Sadly, such a redefinition of NDUs runs the risk of “diluting the ability of units to reform nursing practice” (p. 26) and again raises the question of the wisdom of perpetuating a name in units where it carries no immediate relevancy, given the degree of stress that these Australian nurses were under in trying to live up to the expectations associated with their new title of CDU(N) leader.

Draper (1996) has suggested that many of the inconsistencies between NDUs relate to the differing philosophical views of Alan Pearson and Steve Wright. While those who adopt the stance taken by Wright stress the importance of developing nurses, those following the lead of Alan Pearson are more likely to centre their philosophy on the immediate needs of the patient. While this view can be disputed on the grounds that such distinctions are frequently blurred in a caring profession such as nursing, there is yet another parting of the ways that can be more clearly defined from the literature. While the philosophical stance behind the development of many units continues to reflect the more ‘traditional’ routes developed by Pearson and Wright, a few units, in particular the ones featured in this study, have failed to implement some of the primary aims of these pioneering NDUs: the emphasis on the adoption of therapeutic nursing (often in the form of primary nursing) and an ongoing commitment to reflective practice.

Consequently, a great deal of the confusion experienced by the participants in this study and their nursing staff can also be explained by the literature that states that organisations cast clearly identifiable gender shadows (Strati, 1998). While the philosophical frameworks that supported the innovative approaches of Burford, Oxford and Tameside, with their emphasis on the importance of nurse-patient relationships and the therapeutic value of nursing, can be said to have projected a more feminine approach, the units featured in this study were developed within the strongly masculine culture of the Australian health care system. The currently espoused management concepts of health care, which were born of the cognitive approach of the scientific paradigm (Greaves, 1996), and mediated through the true/false dualism of economic rationalism (Borbasi & Gaston, 2002), fly in the face of the espoused values of the earlier NDU movement. The masculinization of the new CDU(N) initiative to fit into a largely acute care environment within the Australian health care system is indicated by the use of such terminology as “launch” (Greenwood, 2000a, p. 343), which has been described as evoking the male legend of conquest and dominance (Strati, 1998).
The inconsistency between the leadership styles most prevalent in the organisations in which the nurses in this study worked and the importance placed on the need to develop a new ‘CDU(N) style’ (based on principles of transformational leadership) with very little practical help from their mentors also served to create further uncertainty for these participants. It is of note, however, that Redfern, Norman, et al. (1997) were unable to link any single style of leadership with the success of the NDUs in their study, with the most successful units being led by people with very contrasting styles: both democratic and autocratic. As Bass (1990) has said, the definition of effective leadership is contextual and the British NDU literature indicates that, over the years, leadership styles have been adapted to fit the preferences of those who developed the new units. For example, while the leadership course these participants attended based the theoretical concepts of leadership on the model of transformational leadership, a recently developed NDU in Ireland has adopted the model of the servant-leader (Flint & Wright, 2001). These two models are, however, quite different. While transformational leaders are frequently charismatic and expected to disseminate their own vision, the servant leader, as first described by Lao-Tzu in the sixth century BC, is very self-effacing.

One weakness of many texts on leadership, and the leadership courses that have developed from this theoretical knowledge, is that they can be said to be based on a gendered view of leadership. This is because the majority of literature on management and leadership across the disciplines has focused on knowledge drawn from studies of male leaders, as reflected in the discussion of leadership at the beginning of this thesis. Although the plethora of publications on nursing leadership have, without doubt, awakened a large number of senior nurses to many of the intricacies of their roles, as with other textbooks used by nurses (Huntington & Gilmour, 2001), the framework from which these publications have been developed is riddled with an overt gender bias. It has been known for some time (following the work of such authors as Gilligan, 1982 and Lloyd, 1984) that such a one-sided view of human potential cannot be applied to both men and women alike without resulting in an overall disillusionment of the qualities of the feminine. Furthermore, what appears to be the latest mode, of searching for single definitions of effective nursing leadership (spawned, at least in part, by the propensity of Western health care systems to rely on reductionist methodologies), further polarises what is believed to be ‘good’ and what is seen as ‘bad’ leadership. Consequently, in-depth understandings of effective NDU/CDU(N) leadership cannot be developed until these issues have been adequately resolved within our profession.
Other instances where the aims of the original NDU units have been diluted can be seen in the published track records of these units in regard to developing new research studies. While one of the well-publicised aims of the NDU/PDU/CDU movement is the development and publication of research and systematic evaluation (Redfern & Murrells, 1998; Redfern, Normand, et al., 1997; Redfern & Stevens, 1998; Vaughan, 1992a), given the number of units granted these titles over the past two decades, a relatively small number of them have conducted their own research projects and many of these have been very small. In addition, those responsible for having developed these UK NDU movements sorely lack any substantial and credible research to prove these units continue to be as effective as the largely anecdotal evidence would suggest (Draper, 1996; Lorentzon, 1994). A serious lack of forward planning was demonstrated by the King’s Fund itself, when some of the data from the evaluation of their much-publicised study of the second group of King’s Fund NDU (Redfern, Norman, et al., 1997) had to be collected retrospectively.

Furthermore, these units are now situated in such diverse settings as accident and emergency (Fothergill, 1994), intensive care (Clayton & McCabe, 1991), paediatrics (Humphris et al., 1995; Lowson, 1995; Rogers, Humphris, & Moynes, 1995), midwifery (Walker, 1996), primary health care (Gooch, 1993), a haematology unit (Waterworth, Pillitteri, & Swift, 1997), a support team for people with learning difficulties (Balkizas, Morton, & Holgate, 1995), and a nurse-led outpatient service for people with anorexia nervosa (Halek, Cremin, Chandran, & Parnell, 1995). While this can be seen as a strength in that it has the potential to endow this movement with a wide range of nursing knowledge and experience, it adds to the already nebulous nature of the term NDU or CDU(N). As was shown in this study of Australian nurses, the apparent lack of clarity in explaining the defining characteristics of these units can create a great deal of confusion for anyone wishing to develop an in-depth understanding of a movement to which they are being requested to subscribe.

It cannot be denied that these nurses in Australia were at a considerable disadvantage over their British counterparts in their aims to develop a CDU(N) in line with the published NDU literature because they had no well-established NDU units in their area to provide role models. Adding to their dilemma, when they tried to define their own CDUs(N), was the fact that this package is not only borrowed from another country, but also from a health care system, which differs in many respects (Salvage, 1998). With no one involved in this new

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program having had any direct experience of working in an NDU, these nurses were forced to work from theoretical conceptions and an abstract vision. This vision, first developed in Oxfordshire and Tameside in the 1980s, had taken on such a life of its own over time that it can be said that these nurse leaders set out, at least in part, to follow a myth.

Misunderstandings of the basic NDU philosophy, as shown by one of the participants in this study who said “what is the difference between a clinical development unit and a good team that you just call a team” indicate that, what appears to be a watering down of the original NDU concept (Pearson, 1997), can also be described as attempts by some nurse leaders to ‘borrow’ the name NDU in order to seize opportunities to instigate new projects. Consequently, and in a similar way to how the nurses in this study clung on to a champion when one was made available, it can be said that it may be the needs of a disempowered profession to find a way out of a difficult dilemma that has helped to perpetuate the names NDU and CDU(N) in some organizations that have not demonstrated an openness to accept the espoused concepts of the NDU movement. Identification with the traditional NDU lineage and the achievements of Pearson, Wright and a handful of other successful NDU nurse leaders has also been shown to provide a ready-made package of development concepts as well as conferring respectability on new projects. As such, the term NDU (or its derivatives) has the potential to be used as a way of securing funding for new projects, regardless of whether the instigators of such programs intend to maintain the original NDU vision.

8.2 VISION OR MIRAGE?

The most important findings of this study relate back, in some way, to the lack of support these participants experienced following the initial six-month leadership course. The need to shelter such units until they have had adequate time to get off the ground has been discussed ad infinitum in the UK NDU literature. However, while the steps taken to support these Australian CDUs(N) were based on this literature, all of these supports quickly crumbled. Such a situation raises the question: was this venture based on a realistic vision or on a mirage?

Many people laboured under the misapprehension that the momentum initiated at the inception of this new project would be adequately sustained over time. In reality this was not effected by either the formalised hospital structures or by anyone associated with the
CDU(N) program. This was due, in large part, to the short tenure of those who had been most influential in obtaining funding for the initial development of this project, in particular those in higher executive positions within the area health service and the university community. Consequently, the additional funding required to employ a post-doctoral fellow to oversee the ongoing development of these units did not eventuate. While the participants have also stated that they were greatly disappointed by their substantially reduced access to the course coordinator following the leadership course, a continuation of such extensive ongoing support such as had occurred during the leadership course was not possible due to her other commitments as one of only four Chairs of Nursing in the area health service.

This Professor of Nursing is known to have put a considerable amount of effort into trying to bring the senior nurses and medical officers on board to support this project. While much of this support was believed, at the time, to have quickly dissipated, in retrospect, most of it appears to have been illusionary. With the exception of one of the hospitals in which these CDUs(N) were located, there was never much support for the CDU(N) program from any of the senior nurse managers within the individual hospitals. In the case of this single hospital, the CDU(N) leader reported that, while there had been strong verbal encouragement initially, this had quickly ‘fizzled out’. As far as the other units were concerned, the senior nurse managers of the institutions in which these participants worked were to demonstrate over time that, while they ‘tolerated’ the development of CDUs(N) within their organisations, they did very little to encourage or support them.

Despite the fact that the official ceremony to launch the first cluster of CDUs(N) was attended by representatives of the higher executive of the area health service and the university, very few of the senior nurse managers in the constituent hospitals and the relevant medical heads of departments attended. Not only was this a surprise to many of these participants, but it was also the source of their first disappointment. This disappointment continued with the early demise of the Steering Group Committees, which had been designed to build bridges to the people who worked in the wider organizations. Although comprising significant power brokers from these organizations, these committees quickly proved to be ineffectual. Anecdotal evidence points to the lack of interest by the members of these committees and their lack of understanding of the relevance of the CDU(N) concept. Consequently, following the official launch, little more was done to sell
the CDUs(N) to the senior nurses and medical officers of these hospitals than to rely on the individual leaders to continue to promote their own work, which had only meagre results.

While there appear to be many UK NDU’s that have, similarly, fallen by the wayside, those that have survived for any length of time all have their own stories to tell of how they protected themselves from similar problems. In the case of the Tameside NDU, for example, no attempt was made to elevate this unit to the status of NDU in the first five years. The relative anonymity of the unit, until it had taken on a momentum of its own, appears to have helped to protect the staff from both internal and external sabotage. This contrasts sharply with the CDUs(N) that featured in this study as they underwent a rather public ceremonial launch.

Largely because of the published successes of Burford and Tameside and the lessons learned from the early demise of the Oxford NDU, the King’s Fund and the University of Leeds programs made it a formal requirement that all prospective NDU’s/PDU’s have the full backing of the executives and managers of their individual organisations (Gerrish, 1999; Redfern, Norman, et al., 1997; Turner-Shaw & Bosanquet, 1993). While they have reported varying degrees of success in maintaining these commitments, the UK literature counsels against the dangers of losing this vital source of local support. The success of this strategy is also evident in two CDUs(N) that were developed in subsequent waves of this Australian scheme, and which continue to operate as CDUs(N). They are, firstly, a private aged-care facility (Greenwood, 1999b), where the Director of Nursing attended one of the initial CDU(N) leadership courses and, secondly, a public hospital operating as a rehabilitation centre in an adjacent area health service (Forbes, 2002; Greenwood et al., 2000; Lock, 2003; Mott, 2001; Parsons & Mott, 2003; Pryor, 2001). Although they both have consistent input from academics, they are also strongly endorsed by the nursing managers of their organisations. As one of these centres is incorporated into a separate area health service, other CDUs(N) have now sprung up in a number of other hospitals in that area. Anecdotal evidence from some who are currently involved with these units, however, suggests that, while there is strong verbal encouragement to develop more CDUs(N) within the area health service, these CDUs(N) are also encountering ongoing problems related to variations in the motivation of the CDU(N) leaders and their staff and fluctuations in management support (Lesley Seaton, personal communication, September 19, 2003).
The findings of this study are also a timely reminder that, while the newly developed Chairs of Nursing in the area hold great sway within the university community, they hold no functional power within the individual hospitals. Any power they yield within these institutions relates directly to the acknowledgement of their expertise. Consequently, this Professor of Nursing worked within the hospitals in which these CDUs(N) were situated at the behest of the Directors of Nursing of each organisation. Yet the early literature that was published regarding this new CDU(N) program made it clear that the development of these CDUs(N) was the responsibility of the health authority and the university, “it should not be seen as the individual responsibility of (the) clinical leader or host health facility” (Greenwood, 1999a, p. 678). This statement confirms that a precedent was set that partially by-passed the existing nursing structure within each of the constituent hospitals in respect to the development of nursing practice within these units. Furthermore, none of the publications that celebrated this new development took into account the possible sensitivities of those in administrative positions within the individual hospitals. There is anecdotal evidence that this aspect of the development of these CDUs(N) created some rifts between those who supported the new initiative and some who worked in the traditional nursing structures in the area.

Consequently, it can be said in hindsight that the CDUs(N) in this study would have been better ‘protected’ during the very fragile early stages of their development if the person who was to take on the momentous task of ensuring their survival already held adequate functional power within the host organisation and/or shared responsibility for the units with someone who held such power.

8.3 IS ANYONE REALLY LISTENING?

Despite the rhetoric within the Australian health care system that relates to the importance of implementing effective change, once these participants were won over to what may have appeared to be a radical new idea, the largely unspoken and unacknowledged pressures from the people around them to maintain the status quo became overwhelming. As previously discussed by such authors as Taylor (1997) and Short et al. (1993), the influence this status quo wields can be so insidious that few are aware of its power. Consequently, the support mechanisms developed from the experiences of UK NDUs appear, at best, to only scratch the surface of entrenched systems that have inbuilt checks and balances to maintain this rather ungainly state of equilibrium. As discussed by Wicks (1999), the many
ways in which power is wielded against practising nurses in our health care settings appear endless.

None of the participants in this study indicated that the organisations in which they worked granted them or their staff the freedom of expression that could be described as satisfying their current needs, aspirations or values, regardless of the fact that this has been described as a necessary precursor to the facilitation of real change (Burns, 1978). This is despite the well-documented evidence of a direct link between a culture that generates the acceptance of inquiry and the subsequent acceptance, by the individual, of the process of change (Beckhard & Pritchard, 1992; Bennis, 1962; Golembiewski, 1993; Kanter, 1986; Senge, 1994; Senge et al., 1994). Consequently, and despite the fact that modern theories of leadership were discussed in the CDU(N) leadership preparation course, there is no evidence that any of the staff of these Australian CDUs(N) took any long-term responsibility for the work commenced.

Such an obvious inconsistency as was shown in this study, between what is currently espoused in health care circles and what is seen to have occurred in practice, must inevitably lead to a much deeper questioning of the reasons for choosing to develop such units and their ongoing aims. This is no easy task, given the current state of chaos in health care throughout the Western world (Swansburg & Swansburg, 1999) as the more traditional attitudes of health care provision, based on a not-for-profit ethos, are being replaced by a flurry of corporatization (Kerfoot, 1997). Kermode, Emmanuel, and Brown (1994) have noted that there is a lack of positive correlation between Australian methods for measuring health care outcomes and the effectiveness of service delivery. They say,

> the reason why nationalised health care does not produce better outcomes is that the only competition which exists within the system is the competition between managers to appear to run their enterprises cost-effectively. Consequently, suppliers use their resources to produce what their superiors monitor rather than what health consumers want (p. 16).

The current need for health care organisations to compete for limited health care dollars in the political marketplace places seemingly unsurmountable pressures on practicing nurses (Borbasi & Gaston, 2002; Huntington et al., 1996; Jackson & Borbasi, 2000). It also brings with it similar problems to those that have long dogged many commercial institutions.
(Borbasi & Gaston, 2002): a blatant emphasis on management techniques and advanced technology to the detriment of the personal style of the on-line managers or their employees (Bacon, 1993; Barr & Barr, 1989; Winter et al., 1995). Seldom do these organisations demonstrate that they value their staff as much as they claim, nor do they trust them to exercise their own judgement outside of highly restrictive parameters (Stewart, 1994). Despite the fact that most employers are now beginning to speak of ‘values’ and ‘integrity,’ many employees have complained they are receiving conflicting messages about the way these fundamental ethics are implemented in their organisations (Clancy & Webber, 1995; Kent, Johnson, & Graber, 1994).

Peter Senge (1994), a well-known proponent of the ‘learning organization’, which is based on systems theory, is quick to point out that the barriers that prevent forward momentum in any organisation are created by the system as a whole, which must be taken into account before any change is planned. Underlying all human groupings are assumptions that characterise not only the society as a whole, but also the individuals who make up that society. These assumptions, which very few people challenge or question, support accepted patterns of thought, institutional mores and moral values. They are not taught in a formal way but are absorbed, as through osmosis (Goertz-Koerner & Bunkers, 1994; Senge, 1994).

Some management theorists have used the word ‘culture’ to describe this phenomenon and have defined it, in the workplace, as an infrastructure which comprises “the ceremonies and rituals which give meaning to the work environment; it encompasses the core values which leaders and subordinates hold dear” (Hassard & Sharifi, 1994, p. 134). Others have gone further by describing organisational culture, not as a mere component of the organisation, but as constituting the organisation itself (Bolman & Deal, 1991; Marquis & Huston, 1992; Smircich, 1983; Strati, 1998). As such, it is both objective and subjective as no events or aspects of the organisation can be isolated from the interpretations that the people who are involved assign to them (Strati, 1998). Over time, cultural norms such as modes of dress, language and specific work practices become entrenched and taken for granted by everyone concerned (Hassard & Sharifi, 1994). Whether realistic or unrealistic, these norms define the individual character of the organization and a high price is frequently paid by anyone who violates such expectations (Peck, 1993). Indeed, it was clearly seen in this study that the violation of traditional expectations that these units sought to establish was very quickly squashed by the status quo within these organisations.
Such a scene contrasts sharply with the work of the pioneering NDUs and some that have followed in their footsteps. Within these units, it was not just a few concepts that were changed. It was an infusion of intense effort over a long period of time that led to a change in the philosophy of care that the staff in the units espoused (Pearson, 1992). Such changes in attitude reflect a fundamental shift from single loop to double loop learning. Single-loop learning, which refers to the learner being stuck in a basic single loop of thought that is associated with routine and behavioural learning, occurs without any significant change in the underlying assumptions. Double-loop learning, on the other hand, is the process of remaining open to questioning and re-evaluating the basic objectives in terms of professionally identified values and beliefs: only this kind of thinking can truly change the basic culture of an organisation (Luthans, 1995). As such thinking was central to the values of the pioneering NDUs in the UK, attempts were made to disseminate this concept during the CDU(N) leadership course these participants undertook. However, as was so eloquently stated in one of the quotes from Myra, now that her eyes had been opened to the realities of the system in which she worked, she suffered from the frustration of knowing that she was not able to change the management culture around her. In fact her dilemma, whether to continue on her chosen path or to “give up the CDU and not know all those things and just be a leader like any other leader, going along with the flow of the organization” is strongly reminiscent of the words of Taylor (1997) when she described some of the perils of conducting reflective practice in systems resistant to change. Taylor could have been describing Myra’s evaluation of her own situation when she said “surrender and/or retreat are the only tactical alternatives if one is not to lay down and die, or become, in some other way, insensitive to the battle” (p. 24).

Furthermore, in the majority of the NDU/PDU literature, the voices of the nurses who work on these wards are seldom heard. Without clear articulation of the meanings and values these hands-on nurses have ascribed to their new units, it is impossible to develop a realistic picture of the ongoing organisational culture (Strati, 1998), and, therefore, the effects on nursing practice. Sadly, many aspects of the well-referenced British research projects into the King’s Fund (for example Redfern, Norman, et al., 1997) and Leeds University (for example Gerrish, 1999; Gerrish & Ferguson, 2000) programs were conducted or published largely in-house and most of the publications that discuss the work of these units have been written by people who have vested interests in the programs (for example Baker & Pearson, 1992; Greenwood, 1999a; Keatinge & Scarfe, 1998; McIndoe & Luck, 1997; O'Brien &
Pope, 1994). Until better evidence is forthcoming, nurses must maintain a degree of scepticism regarding the “distinctly rhetorical tone of much of this literature which seems designed to convince and proselytize rather than confirm and provide strong evidence for practice development” (Walker, 2002, p. 10).

The development of such projects as the one that featured in this study involves a great deal of emotional and financial expenditure. The collapse of any unit must, invariably, create heartaches for many. Despite the plethora of literature that celebrates the initial development of the NDUs, (for example Downey, 1994; Heenan, 1989; Kelly, James, & Buxton 1994; Salvage, 1989a) and many articles written by the staff of these units (for example Balkizas et al., 1995; Bamford, Dineen, Pritchard, & Smith, 1990; Bamford & Sparrow, 1990; Batehup & Evans, 1992; Garbett & Shephard, 1993; Gilley & Cowell, 1994; Lowson, 1995; Owen, 1995; Waterworth & Boon, 1992), many questions remain unanswered as little has been written about these units as they began to falter. While many people are only too happy to report their successes, very few of them appear willing to share with their colleagues the wealth of knowledge they have gained from their experiences once their units have ceased to function as NDU/PDU/CDUs. This poignant comment from one of the participants in the third round of interviews speaks for itself as it implores such entrepreneur nurse leaders to consider the shattered dreams their colleagues may be destined to face if they continue with this conspiracy of silence:

*I thought it might spread but it didn’t, unfortunately, it just caved in. ... I was saddened by it because I’d thought, at the time, that it might have given us a chance to do something better, or provide better patient care and give recognition to nurses. One thing nurses don’t get enough of is recognition for their work. ... And it’s actually worse today than it was when we were doing the CDU stuff. I think, four years ago, we were more optimistic. I don’t think you’d get anyone to try and start a CDU today. I think people are sadly defeated.*

8.4 CONCLUSION

This chapter has related the new understandings developed from the findings of this study to the published literature that discusses current trends of Western health care. The final chapter, which is entitled ‘Where to from here’, will further reflect on the implications of these findings and make recommendations.
Chapter 9

WHERE TO FROM HERE?

The purpose of this final chapter is to discuss the implications for nursing practice of the findings of this study. The recommendations that are made are based on the themes that were introduced in Chapter 6, the new interpretations developed in Chapter 7 and the arguments presented in Chapter 8. This chapter concludes a study that has been underpinned by Heideggerian hermeneutic phenomenology. The close relationship that was maintained with the experiences of the participants by a continuous revisiting of the transcripts during the analysis process has been sustained throughout the development of the final chapters of this thesis by continuous listening, reading and writing; thus ensuring that the ‘whole’ of this thesis continues to reflect the individual parts.

This thesis documents an episode of Australia nursing history ‘as it happened’. As a consequence, at the time the first interviews were undertaken, it was very difficult for anyone involved, including myself as the researcher, to stand back and realistically view the whole situation. As each round of interviews was conducted, it became necessary for me to reappraise the work that had gone before and a clearer picture gradually began to emerge. Reflection on my earlier article (Atsalos & Greenwood, 2001), which was published following the second round of interviews, confirms the changes that have taken place in the development of this study since that time. Such changes in my understanding, along with the advantages that frequently accompany the distance of time, have allowed me to stand back from some of the more immediate issues and gain a better understanding of what was happening at all levels within this health care system.

It appears that the old adage is indeed true: that many of today’s problems have their roots in yesterday’s solutions (Senge, 1994). Sadly, Nightingale’s solutions to the power struggles of Victorian England continue to be reflected in the everyday hierarchical and inter-disciplinary relationships of the contemporary nurse; more than a century on in time and on the opposite side of the globe. The inherent imbalances of power between the
professions that constitute the Australian health care system, a lack of support from senior nurse managers who have differing expectations and the lack of motivation of the ward nurses in these CDUs(N) have been demonstrated to have contributed to the early demise of a concept heralded by so many. Furthermore, the current political and economic climate ensured that an unexpected loss of peer support and diminished access to the CDU(N) initiator would quickly ensue.

While, in retrospect, it can be said that the early collapse of these units as CDUs(N) could have been predicted because the combination of circumstances that would lead to their demise was present from the very beginning, this is knowledge that was not available to those who developed these units. Neither does it appear to be fully understood by many who have had, or are currently experiencing, difficulties in similar units in Australia. As has been shown in these Australian CDUs(N), and as has been discussed many times in the leadership literature (Barr & Barr, 1989; Clancy & Webber, 1995; Posner & Schmidt, 1992; Sarros et al., 1999), the most difficult challenge for contemporary leaders is one of discovering new ways of aligning both personal and organisational values to achieve a synergy of outcomes. As these participants battled to implement some of the NDU/CDU nursing concepts discussed in their leadership course, their efforts were disregarded by a system that is now ruled, largely, by theories born of the world of commerce. As in so many other areas of business and commerce, conflict and confusion was re-ignited each time the rhetoric of those in leadership positions did not match the actions of the organization.

As recently discussed by Gettler (2002), an unprecedented surge of change is creating upheaval in both the private and the public sectors alike as “the forces of creative destruction mow down not only businesses but the careers of people who run them, wherever they may be” (p. 47). The participants in this study, too, became unwitting pawns in a game many people are playing but very few understand. While it must be very tempting for those in higher management positions to be ‘seen’ to be taking a determined stand to improve the status of nurses, any attempt to rely on short cuts or to tinker with existing structures within such an entrenched culture has been repeatedly demonstrated as too little or too late. Given the plight of nursing in Australia, without an overarching vision that can support deep-seated changes to the basic cultural attitudes that pervade all levels of the Australian health care system, such projects as the one featured in this study are likely,
at best, to alleviate some of the symptoms on a temporary basis, while leaving the causes untouched.

Accordingly, any nurse leaders who may wish to develop comparable projects within hierarchical systems must factor in the likelihood that they will face similar problems to the ones that unfolded for the participants in this study. As time moves on, however, new problems that the participants in this study did not encounter are likely to arise, ensuring that similar new projects will become increasingly more difficult to instigate. One factor that will impact heavily on future nursing projects is the current flight of experienced nurses from the health care system (Jackson et al., 2001) and the consequent drain on the unique knowledge base of the discipline. The strong lure of academia and the temptation to take on higher management positions is likely to further deprive those nurses who remain at the bedside of the requisite degree of direct and consistent personal contact with the small number of strong visionary leaders that the profession can boast. While it is not disputed that input from academics can greatly enhance such projects, this study has illuminated some of the pitfalls of not having a strong leader working closely with the staff on an everyday basis. Unless there is a substantial change of attitude towards hands-on nursing by the community at large, other health professionals and, indeed, nurses themselves, it is unlikely that a significant number of visionary nurse leaders will remain at the bedside in order to develop any future projects beyond the tenure of the academics instrumental in their initial development.

This study has clearly shown that it is of paramount importance for the coordinators of any new projects to be seen by the nursing staff to be facing similar problems and frustrations. As with Pearson and Wright, by working alongside the ‘ordinary nurse’, such people are more likely to gain respect as true nursing leaders; in contrast to those nurse managers whose role is seen as representing ‘the organisation’. The words of some of the nurses in this study confirm the growing anecdotal evidence that this long-established split between the clinical nurses and those who work in management now incorporates a new aspect: a clear demarcation line in the eyes of many clinical nurses between themselves (as clinical staff) and those who work solely in academic positions. The long-held scepticism towards ‘management’ is consequently now being focused on those academics that attempt to change practice without any relevant hands-on responsibility. In line with recent suggestions by Borbasi and Gaston (2002) and Borbasi, Jones, and Gaston (2004), the
findings of this study are a timely reminder that innovative Australian nurse leaders may, once again, need to be sought from clinical settings.

Given the current trend for such clinical nurses, once they have attained a leadership position, to quickly move off into management or academia, a major concern would be how to keep such visionary leaders in the clinical setting. This can be done by granting a comparable degree of autonomy to that received by Pearson and Wright to selected clinical nurse leaders and guaranteeing this for an extensive period of time. In other words, long-term concrete commitments must be made by both the organisations and the nurse leaders who develop these projects, with the latter being freed up from their other organisational responsibilities in order to concentrate on the development of the nursing team. Their other essential responsibilities would include education of other health professionals and Steering Group Committee members as to the aims of the unit and ongoing promotion of the work of the staff on the unit. Without such strategies firmly in place, history has shown that it is unlikely the new project coordinators will be able to overcome the resulting sabotage, both from within their profession and without.

The greatest challenge for the Australian health care system is to find ways to ensure the credibility of new projects in the eyes of the nursing staff who are intimately involved in these projects. As demonstrated by the three pioneering NDUs, this can be done by developing an atmosphere where questioning is encouraged. As discussed by Johns and Graham (1994), however, this will only be effective if the current work environments are adapted so that they are able to protect the integrity of staff disclosures. Despite the current upsurge in media interest in the state of the Australian health care system, no one who holds functional power within either political or health care circles appears to have come forward to take the ‘risk’ of introducing such radical and innovative approaches as were conducted at Burford. Without such a willingness to ‘trust’ that nurses are capable of steering the development of their own professional objectives, the status quo that has long held sway within the Australian health care system is likely to continue unabated.

It is of note that the frequent reference to the term ‘elitism’ in the UK NDU literature (Mangan, 1992; Manning-Barrett, 1997; Neal, 1994; Sheehan & Wright, 1995) has been reflected in recent Australian CDU(N) literature (Greenwood, 1999a). This is yet another reminder of the disempowerment of nurses at all levels of the Australian health care system, as exemplified by the fact that no similar words have been found in the literature from
Disciplines that are considered autonomous in directing their own work practices. This disempowerment is further demonstrated in the way many nurses resort to sabotaging new innovations of their peers that are likely to ‘rock the status-quo boat’. In an attempt to combat the backbiting of other nurses who are suspicious of their colleagues who, as described by Lawler (1995), enjoy intellectual challenges, this NDU/CDU(N) literature consequently appears to have confused ‘elitism’ with ‘reward’. If a culture is to be developed where nurses are willing to break new ground, some form of reward for their endeavours must be incorporated into the structure in which they work (Borbasi & Gaston, 2002). Such rewards can take the form of a greater degree of autonomy to dictate work practices, legitimate recognition for their work, inbuilt safeguards that ensure time will be set aside for networking, various incentives and financial assistance to develop new nursing programs and research projects and to disseminate the results at conferences, and concrete guarantees of ongoing support and encouragement. As was shown in this study, however, if these ‘rewards’ should be shown over time to be little more than ‘rhetoric’, the deep scepticism nurses have long held towards their management structures is likely, once again, to be projected onto the new units, viewing them as “just another restructuring attempt”.

Although there are many long drawn-out definitions of NDUs/CDUs in the published literature, the role of the pioneering NDUs can more succinctly be defined as places where nurses were encouraged to question the status quo. Despite this fact, the pioneering spirit that underlay so much of the work done at Burford, Oxford and Tameside now appears to have been replaced by a new orthodoxy: a new status quo. It is of note, in this context, that Alan Pearson has also been described as a charismatic leader (Sarah Mott, personal communication, July 8, 2003) and, as discussed by Weber in 1947, while the vision of such leaders heralds an end to discontent, their message will inevitably be mitigated by others over time. Consequently, so many of the interesting articles (such as Johns, 1990c; Kinney, 1987; Punton, 1983; Sparrow & Pearson, 1985; Sutherland, 1991; Swaffield, 1982, 1983a) that spoke to the average nurse of everyday changes in practice have now been largely replaced by publications that describe the successes of these units in more theoretical terms. The effect of these new articles, however, is to transfer the power to change practice from the hands of ‘ordinary’ nurses (who do not choose to read such articles) into the hands of their more academically minded colleagues. In this study, for example, the irrelevance of these articles to the practising nurse contributed towards the claim that, “The CDU gives you a lot more work to do but it doesn’t give you a solution of how to work better.”
Consequently, if anything is to be learned from the early literature on the British NDU movement, it is the importance of beginning new projects by assisting ordinary nurses to articulate the values that underpin their beliefs and practice; with a view to guiding them towards the development of their own philosophy of care. Similar insightful forward planning is also reflected in the works of such authors as Christopher Johns (1990c, 1996b), which discuss the necessity of transforming the philosophy of care that underpins everyday practice before wide ranging changes will take place.

What has become obvious in hindsight is the foolhardiness of expecting these CDU(N) leaders to attempt to introduce the NDU/CDU concepts as supplementary to their everyday responsibilities. A philosophy of care that underpins practice cannot be ‘added on’ to an existing philosophy of practice. The traditional culture must, instead, be gradually and gently transformed. The development of such a philosophy of care must simultaneously be reflected in shifts in the everyday reality of the environment otherwise, says Johns, “philosophies are an illusion that remind nurses of their failure to assert and live out their beliefs. What promised to be empowering becomes a constant reminder of one’s own disempowerment” (1996b, p. 41). Consequently, like the innovative British nurses whose work has been discussed in this thesis, a necessary precursor for choosing an appropriate nurse leader for future Australian developments should be their ability to assist others to articulate the values that underpin their everyday practices. This is a dramatically different view from that of adopting a preconceived package of concepts developed in a different setting. Put another way, the future choice for the fledgling Australian CDU(N) movement is whether the nurses in these units will be encouraged to use the CDU(N) concepts as tools to steer their own professional agenda or whether the CDU(N) concepts will be allowed to use the nurses as tools to achieve the expectations of others.

As has been illuminated in this study, and as described by Sarros et al. (1999), the actions of leaders frequently emanate from deeply-held values and attitudes that may only surface momentarily at the time a decision is made; thus ensuring that the values that have driven these decisions remain largely hidden. As the force of unpredictable change continues to drive organisations into less familiar territory, this can lead to leadership behaviour that is complex and confusing. In order to develop a deeper understanding of such behaviours, many authors (for example Bacon, 1993; Sarros et al., 1999) are questioning the values that underpin traditionally accepted leadership and management goals and actions.
It is now well documented in the management and leadership literature that, in order for leaders to be effective in changing deeply entrenched mores, they must first develop a deeper understanding of their own motivatory factors (Bennis, 1986; Gibson et al., 1979; Wilson & Barnacoat, 1995). This is what created such a change in the attitudes of both Alan Pearson and Steve Wright immediately before they began their pioneering work. Alan Pearson (personal communication, 16 August, 2001) has described how, immediately prior to taking up his position at Burford, they had attended an exceptional course that transformed their own understanding of themselves and their attitudes towards their profession. The fact that, from this very same course, such other outstanding nurse leaders as Jane Salvage and Barbara Vaughan also graduated with a new vision for nursing and a belief in their own abilities, reminds me strongly of Socrates’ maxim of ‘Know thyself’. A theme that is, indeed, echoed today in so much of the management literature (for example Bacon, 1993; Barr & Barr, 1989; Bennis, 1989b; Duignan & Bhindi, 1997; Kouzes & Posner, 1993; Posner & Schmidt, 1992; Sarros et al., 1999; Wilson & Barnacoat, 1995) and nursing publications on reflective practice (for example Duke & Copp, 1994; Johns, 1996c, 1998, 2001; Johns & Freshwater, 1998.)

By knowing ourselves, we can begin to truly ‘be’; and by ‘being’, we can begin to act as wise leaders. I use the term ‘wise’ consciously as I consider that while we can accumulate ‘knowledge’ from a vast variety of external sources, ‘wisdom’ develops only through ontological experience. As Bacon (1993) and Wilson and Barnacoat (1995) have said, such wisdom can teach us self-managing leadership, an essential pre-cursor to the management and leadership of others. The development of such an understanding of values-based nursing leadership would have the potential to provide immense opportunities for nurses to learn how to modify behaviour and to adapt to change in a meaningful and constructive way. While values-based behaviour “creates leaders who manage with the heart as well as the head” (Cottingham, 1994, p. 88), the empowering environments they create encourage others to work towards their full potential. Such attitudes and values not only influence the over-all goals of the organisation, but also individual perceptions of everyday situations, decisions, problems and solutions.

Leadership, in this light, becomes a paradigm-creating activity that establishes its own level of reality through everyday processes (Sarros et al., 1999). By developing a deeper belief in the value of their work, followers can be converted into leaders and leaders into change
agents, while embracing the necessary challenges to develop self-knowledge and advance spiritual growth (Bacon, 1993; Cottingham, 1994; Kelly, 1994; Kiefer & Senge, 1984). Indeed, such a pattern can be seen to have been set in motion by many visionary leaders during the latter part of the twentieth century, some of whom have been discussed in this thesis because of the relationship of their work to the NDU movement (in particular Hall, 1969; Johns, 1994; Manthey, 1980; Pearson, 1992; Wright, 1987b).

9.1 STRENGTHS, LIMITATIONS & POTENTIAL FOR FUTURE RESEARCH

The findings of this study have been strengthened by the fact that it was possible to interview some of these nurse leaders over a 3½-year time span. While it is unfortunate that some of the participants who left early were not available for further interviews, the fact that their successors were interviewed provided a more comprehensive picture of what happened to these units over time. Furthermore, interviews with the two NUMs of the units that were led into this initiative by a CNC provided a more balanced view of some of the dynamics that were playing out on these units.

A particular strength of this study is the methodological approach, which allowed for deep insights to be gleaned from the experiences of this small number of people. Findings developed from Heideggerian hermeneutic analysis can be strengthened by the considerable time that is spent by researchers as they immerse themselves in the data and, in so doing, overlap their own hermeneutic circles of understanding with those of the participants. This process was aided, in this study, by the fact that I have a strong connection, and therefore a deeper understanding, of the areas in which these participants worked.

It is of note, as discussed in the literature review of this thesis, that very little has been published to date about similar units that have failed to thrive. This is despite the fact that a large number of articles have been published about the ‘successes’ of such units during their early developmental stages. It is, consequently, anticipated that knowledge gained from the findings of this study will greatly enhance our understanding of some of the overwhelming problems that nurse leaders are likely to face in similar contexts.

It must be acknowledged that, although this study investigated the experiences of the 14 participants in this study, there are many others whose voices are not heard in this thesis. While this study has allowed this small number of people an opportunity to have a voice, it
must be left to others to articulate the opinions and experiences of the other people who have been involved in this and similar projects in order to address any unresolved questions that the findings of this study may elicit. It is also anticipated that these findings will spark considerable debate, both nationally and internationally, into the viability of such units.

This hermeneutic study investigated the experiences of a small group of people in a single Australian area health service. The findings, therefore, are specific to the context in which these people found themselves at this point in time. In order to develop broader understandings of such units, it will be necessary for further studies to be conducted into the experiences of NDU/CDU(N) leadership in a variety of health care settings. It is recommended that any future projects that set out to develop similar units should incorporate substantial research studies, which can record the experiences of all of the categories of staff involved in the project. This could include representatives of the management structures, nurse leaders, hands-on nurses and members of affiliated disciplines. Such a study would shed further light on the interplay of diverse opinions, unanticipated reactions and intricate power plays that inevitably take place when radical innovations are introduced into a traditional setting. In order to reduce the possibility of bias, it is further recommended that the researcher(s) have no direct involvement in the development of the project that they are researching.

9.2 CONCLUDING REMARKS

As discussed, despite the fact that the CDUs(N) in this study failed to thrive, there remain small pockets of CDUs(N) operating in Australia. Consequently, this fledgling Australian movement still maintains the potential for nurses to develop a uniquely Australian nursing philosophical stance. Conversely, if nurse leaders and others who hold functional power within our health care system are not prepared to learn from what has gone before, it appears highly likely that the mistakes of the past will continue to repeat themselves. If this Australian movement is to be allowed to develop its own distinctly Australian flavour, therefore, there are many lessons that must first be learned from the work of the British NDU pioneers. These lessons can, if combined with a new understanding of self-managing leadership and a concerted effort to release nurses from the tightly held constraints that are placed upon them by the expectations and influences of other professions, illuminate the values and everyday activities of the art and the science of nursing that have, traditionally, been grossly undervalued in our society.
APPENDIX A

INFORMATION SHEET FOR PARTICIPANTS

“The Lived Experience of Clinical Leadership in Clinical Development Units”

Chief Investigator: Ms. Chris Atsalos
RN., B.Hlth.Sc.(Hons), DipRSA.

Thank you for agreeing to participate in this study, which is designed to develop an understanding of the phenomena of leadership, as experienced by the clinical leaders of Clinical Development Units in the Western Sydney Area Health Service. These phenomena will be explored in the initial phase of the development of the units and again, as the Clinical Development Units (CDUs) become established.

It is anticipated that the insights gained from this research will be used to inform both the development of support mechanisms for the current Clinical Development Unit leaders in the Western Sydney Area Health Service and future CDU leadership development programs.

The study will involve two audio-taped conversation/interviews with each participant: one 3 months after the CDUs are first established and then, again, 12 months later.

The procedures involved in the study are as follows:

1. You will need to give written informed consent prior to the commencement of the study. You will retain a copy of the consent form.

2. When you agree to participate, the researcher will arrange a mutually convenient time and place for the conversation/interview.

3. The conversations between yourself and the researcher, which will take approximately 60 mins, will be audio-taped.

4. To commence the conversation, you will be asked to respond to the following: “Can you tell me about your experience of being a clinical leader in a CDU?”

5. During the conversation, you may be asked to clarify certain points.

continued overleaf
At no stage will your identity be recorded; only numeric codes identifying the institution and the person being interviewed will be recorded. Your name will not be used in any reports that emerge from this study.

All information will be treated with absolute confidentiality.

Your participation in this project is entirely voluntary and you may refuse to participate or withdraw from the study at any stage without threat of penalty. You have the right to switch off the tape recording at any time during the conversation, without giving a reason. Your decision to withdraw will be respected by the researcher.

There will be no financial or any other form of remuneration for participation.

If you have any enquires regarding this project, please feel free to contact Ms Chris Atsalos on (02) 9845 7132 or Prof. Jennifer Greenwood on (02) 9845 8029. Both can be contacted at The Nursing Professorial Unit, Westmead Hospital.

This study has been approved by the Western Sydney Area Health Service Human Research Ethics Committee.

Thank you for your participation in this project.

Participant Signature:................................................................................................

Date:.............................................................................................................................
APPENDIX B

CONSENT TO PARTICIPATE IN RESEARCH

Project Name:

“The Lived Experience of Clinical Leadership in Clinical Development Units”

I ..............................................................................................................................agree to be interviewed by Ms. Chris Atsalos (WSAHS/UWS Nepean) on the understanding that all the information divulged by me during the interview will be treated in absolute confidence and that my identity will not be revealed to anyone other that the researchers involved in this project.

I understand that the research will be carried out as described in the Information Sheet for Participants. I have read and understood this information sheet and all my questions have been answered to my satisfaction.

I give permission for Ms Chris Atsalos to record the interview using an audio tape recording device and for the results of this interview to be used in publication.

I understand that my participation in this project is entirely voluntary and that I may withdraw from the study at any stage without threat of penalty. I do not have to give a reason for the withdrawal of my consent.

I understand that participation in this project will not influence my employment conditions.

I acknowledge that I have received a copy of this form and the Information Sheet for Participants, which I have signed.

Signature of Participant: ....................................................................................................

Signature of Investigator: ....................................................................................................

Date: ..............................................................................................................................
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Nursing Leadership and Clinical Development Units: Unravelling the Myth

Christine Atsalos

Submitted for the Degree of Doctor of Philosophy

2004
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To Dr. Rene Geanellos, who facilitated some very thought-provoking discussions at our regular PhD meetings. Thank you, Rene, for your enthusiasm and your help.

To all my friends and colleagues, thank you for your ongoing support and encouragement; and a special thanks to Jann Foster, a valued friend and colleague, for being such a patient ‘sounding-board’ and also for proof-reading this thesis.

To all of the nurse leaders who participated in this study. Thank you for giving so freely of your time and discussing your experiences with such candour.

To the numerous authors and philosophers, whose works have provided a framework on which I have developed so much of my thinking during this study.

To the two funding bodies, which have greatly facilitated the development of this work. Firstly, the New South Wales Nurses Registration Board and, secondly, the University of Western Sydney, who awarded the Nepean Postgraduate Research Scholarship.

To my husband, Nick, and my two children, Sonia and John. Without the grounding your presence in my life has given me, it is unlikely I would have been able to stay so positive throughout all the travails of this academic journey.
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.

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### Abbreviations Used in This Thesis

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<tr>
<th>Abbreviation</th>
<th>Full Form</th>
<th>Description</th>
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<tbody>
<tr>
<td>CDU(N)</td>
<td>Clinical Development Unit (Nursing)</td>
<td>The name given to the Australian nursing units featured in this study. Their development was based on British NDUs.</td>
</tr>
<tr>
<td>CNC</td>
<td>Clinical Nurse Consultant</td>
<td>A senior clinical nursing position held by some of the participants in this study.</td>
</tr>
<tr>
<td>NDU</td>
<td>Nursing Development Unit</td>
<td>Designated wards or units that focus on developing nurses and nursing. The history of these units is discussed in detail in this thesis. The term NDU is the precursor of the terms CDU(N), PDU and PNU.</td>
</tr>
<tr>
<td>NUM</td>
<td>Nursing Unit Manager</td>
<td>The title given to the nurse manager who is in charge of a specific ward or unit. Some of the participants in this study worked as NUMs.</td>
</tr>
<tr>
<td>PDU</td>
<td>Practice Development Unit</td>
<td>Designated development units that incorporate disciplines other than nursing. Most of these units have been developed under the direction of the large-scale practice development programs of the University of Leeds and the University of Northumbria at Newcastle (UK).</td>
</tr>
<tr>
<td>PNU</td>
<td>Professorial Nursing Unit</td>
<td>Designated development units developed by Alan Pearson in Victoria.</td>
</tr>
<tr>
<td>UK</td>
<td>United Kingdom</td>
<td></td>
</tr>
</tbody>
</table>
STYLES USED IN THIS THESIS

Three ellipsis points (…) indicate that material has been omitted from direct quotes, either from published literature or from the interviews with the participants.

Italics have been used throughout to denote quotes from the participants.

Double inverted commas. When text is not italicised, these denote direct quotes from published literature.

Single inverted commas are used:

i. to place emphasis on a word or phrase

ii. to indicate words or phrases used in a non-conventional way

iii. to indicate the name of published and unpublished works within the text.
ABSTRACT

Australian Clinical Development Units (Nursing) (CDUs(N)) take their name from the British Nursing Development Unit (NDU) movement, which has been widely credited with introducing innovative approaches to developing nurses and nursing. A network of nine CDUs(N), which was developed and coordinated by a Professor of Nursing, was set up in an urban area health service in Australia in 1997. The aim of this project was to develop existing wards or units into centres of excellence by disseminating a new vision for Australian nurses, based on the pioneering work of the British NDU movement. Each of these CDUs(N) was led by a Nursing Unit Manager or a Clinical Nurse Consultant, who formed the first wave of CDU(N) leaders. A specially designed leadership course was spread over six months in order to prepare them for their new CDU(N) leadership role.

This research study set out to develop an understanding of the phenomena of CDU(N) leadership by interviewing these new CDU(N) leaders over time. Three rounds of interviews were conducted over 3½ years. Because many of the first wave of CDU(N) leaders left their positions between interviews, some of their replacements were also interviewed in subsequent rounds. A total of 23 interviews were conducted with 14 people. Principles of Heideggerian hermeneutic phenomenology provided a framework for the study.

Despite attempts to implement a variety of measures to nurture these CDUs(N) until they had become well established, the participants were unable to maintain the CDU(N) vision with which they had been entrusted. The unanticipated problems they encountered resulted from a rapid attrition of their peers, lack of support for their new CDUs(N) from their individual organisations, reduced access to the project coordinator and overwhelming pressure to maintain the status quo. This thesis discusses their immediate reactions to the problems they faced, the new understandings they developed over time and the regrets and disillusionment many of them retained. The recommendations made for future projects are discussed in the light of the experiences of these participants and the current Australian health care climate.
PREAMBLE

The aim of this hermeneutic study was to develop in-depth understandings of the experiences of a group of nurse leaders as they set out on a very challenging period of their lives. The following story is set in a mythological context in order to more faithfully illuminate the intensity of their experiences and many of the meanings they developed over time.

THE ODYSSEY OF THE GREAT WESTERN LAND

Once upon a time, during the final decade of the twentieth century, there lived a courageous heroine. She took on the female form of her hero, Odysseus. As such, she was known to those around her as ‘Odyssia’. Although living in The Great Western Land at the time of our story, she had been brought up in a far away country where the people spoke the same language and had very similar traditions.

‘The Great Western Land’ is the name given to a broad expanse of country that comprises many small hamlets. These hamlets, although functioning as tightly knit communities, are places where many of the people of the area go to work. While being quite autonomous in many respects, they are governed by an overarching Grand Council whose power, although largely political, also stems from the fact that it holds the purse strings for all of the hamlets. The Great Western Land also boasts a university, where many of the people who work in the hamlets have studied.

Unknown to many of its citizens, at the time of our story, The Great Western Land was about to undergo many changes. The people who sat on the Grand Council of the Hamlets and on the University Board had received a great deal of jostling by many of their important citizens, who were worried about the everyday conditions in which their people worked. These problems were made worse by the fact that power was not equally distributed within the hamlets. The largest group of people in the workforce, known as the Carers, had never received the recognition they believed they deserved and they were now beginning to bring their grievances to the fore.
This is when a decision was made to search further afield for four Grand Champions to take on the problems of this depressed group of Carers and help them to develop their own area of expertise. It was seen that this would not only boost the prestige of the Carers in the hamlets, but it would also assist the work of the Grand Council of the Hamlets and the Elders of the University to run more smoothly. These Grand Champions, who were given special rights to initiate change, were also instructed to bypass the elders of the individual hamlets by reporting directly to the Grand Council of the Hamlets and the Elders of the University. They were given the impressive title of ‘Grand Knights of the Realm’, substantial amounts of money, and set to work on the list of grievances that the citizens of the hamlets and the university had so eloquently presented. As one of these Grand Knights of the Realm, Odyssia now enters our story.

Motivated to help the people of her new land as best she knew how, Odyssia remembered the stories of people who had had similar problems in her native country. A few of them had set sail in unchartered waters in search of elusive treasures. While they had had varying degrees of success on their journeys, some had published the stories of their adventures. So exciting were these tales that they had given birth to both legends and myths! As Odyssia searched the old journals and maps that detailed these adventures, she realised they contained the answers she was seeking.

From that time on, Odyssia worked very hard to make this vision a reality for the depressed group of Carers of The Great Western Land. She drew together many people who could share their individual expertise with her and, together, they developed a magnificent plan. Odyssia told them about the story of Jason and the Golden Fleece. Like Jason, none of them knew exactly what the Golden Fleece would look like, but they quickly realised that it was magical and would bring fame and untold accolades to everyone who wore it. So, borrowing heavily from the stories of Jason and other pioneering mariners, they formed their own plans: to bring together a group of willing knights of the land and set sail in search of the prize that had proved elusive to so many who had gone before them.

Odyssia called the Grand Council of the Hamlets and the Elders of the University together and presented her plan to them. They were enamoured of the idea of winning such a rare prize – perhaps many of their own people could also write books about their own adventures. Perhaps they would even surpass the successes of the peoples of other lands!
They agreed to give their backing to Odyssia and granted her yet another purse of golden coins to assist her in her quest.

She sent out messages to all of the hamlets in the area, asking which of the most noble of the knights were willing to share the hardships of enacting her grand plan. These knights, however, must come from the community of Carers and also have access to a small ship. Although there were a large number of people in the realm who shared the title of ‘knight’, very few responded. While it is not known why many left the call unanswered, something is known of the ones who heeded her call. These brave souls had reached a point where they were tired of beating their heads against a brick wall. They knew their lives should be better – after all, isn’t that what they had been taught at the university? Despite the knowledge that what lay ahead for them would be a difficult and arduous journey, they were, nevertheless, lured to this new project by their own inner yearnings. Although they had cried out for help so many times before, only to have their calls dismissed, they saw this journey as an exciting ‘new start’.

The fact that this new endeavour was being led by one with the title of ‘Grand Knight of the Realm’ gave them additional succour as they believed they could now relax in the sure knowledge that Odyssia would safeguard them from the perils of the sea. Indeed, Odyssia was well equipped to protect her otherwise defenceless band of knights as she not only had a new purse of golden coins, but she had the backing of the Grand Council of the Hamlets and the Elders of the University. With her own newly honed coat of armour, she sharpened her swords and took steps to defend the honour of her new fleet, its captains and its crew.

These knights, who had now taken on the title of ‘captains’, comprised a very diverse group of both men and women. Some had experience of sailing small boats, while a few others had done little but paddle their feet in the shallows. One thing they all had in common, however, was the stout hearts they carried in their bosoms. Odyssia, while willing her hearty band on to victory, also feared for their safety as she knew she must prepare them well for the perilous journey ahead. Who knew where the Golden Fleece was hidden? At the very least, they would have to contend with long stretches at sea on their own, unexpected storms and perilous rocks. So Odyssia put together a very well designed training package, where she taught them all she knew about safety at sea, how to chart their course and how to motivate their crew if they began to lose heart. She even brought in many of her co-workers to share their knowledge of life on the high seas.
This period of training, which went on for six months, was a time when the captains could meet together to make their future plans and share the stories of their endeavours so far. Prior to this time, none of these plucky captains had ever witnessed any of their co-workers successful completing such a dangerous journey and, perhaps even more importantly, they had never before envisaged a time when they themselves would be asked to undertake such an adventure! Consequently, emotions ran high at some of these sessions as they shared some of their innermost hopes and their greatest fears.

While attracted to this new adventure in order to learn how to become better leaders, they also feared the fabled sea monsters, as described by other Carer leaders in stories that were not only legendary, but spine-chilling! This juxtaposition of fear and desire held sway for much of their preparations and, indeed, it was, in large part, the intensity of the excitement and the comradeship that enlivened this period for so many of them. Consequently, although they had to spend long days and nights in order to ready themselves for their new adventure, they floated along on a cloud of high hopes and soaring expectations.

Although Odyssia was aware that, when her small Armada left port, she would only be able to sail with them as far as the small group of islands that marked the outer edge of the known world, there were many in the group who envisaged her being with them for the whole journey. Such was the trust they had invested in her leadership. Simultaneously, all of these captains enjoyed a strong sense of kinship with the whole group and looked forward to the day when they could, together, sail away to claim both fame and glory.

Between their training sessions, the captains were sent back to their individual ships so that they could practice these newly found skills and motivate their crew for the journey ahead. Although those of the crew who were most scared of the high seas were rather reluctant to undergo such a perilous journey, the majority of them appeared to be energized by the thought of sharing in the glory of those captains of far-off lands who had become famous through their search for the Golden Fleece. Indeed, because of the praise they had received for all of their hard work, some of these same foreign captains had since been awarded the impressive title of Grand Knights of the Realm!

At last came the great day. In honour of its patron, it was decided that this great endeavour would, from now on, be entitled ‘The Odyssey of The Great Western Land’ and a magnificent ceremony was prepared. A special hall was hired and tea and cakes were
served! So many people attended, not the least of whom were the President and many important people from the Grand Council of the Hamlets and some Elders of the University. Rather paradoxically, while carrying with them such high expectations, these captains were largely ignored by some of the people with whom they worked. Notable by their absence from the ceremony were some of the higher-ranking officials of the individual hamlets where some of these captains worked. These captains, nevertheless, felt buoyed by the knowledge that no one less than one of the famous Grand Knights of the Realm was on their side. She was their champion and she would defend them against the demons of the deep! Furthermore, they had the support of the Grand Council, who had promised to send supply ships to tide them over for the first part of the journey. Following the many speeches, therefore, and accompanied by the sound of trumpets, this small fleet of ships was launched onto the high seas in search of the ever-elusive Golden Fleece.

There were ten ships of varying sizes that made up this small armada. Each of the captains sailed in their own ships, while Odyssia sailed in the largest and most impressive of all, the great flagship of the fleet. Towards the beginning of the journey, the ships sailed closely together so that the captains could communicate more easily. Due to the large bow of the flagship, however, this ship was soon forced to keep a greater distance from the rest of the fleet.

This did not, at this time, deter these well-motivated captains from pressing on with their preliminary plans, many of which they had devised during their preparations together. As anticipated, therefore, it was a time when everyone on board these small ships showed a great deal of frenzied preparation for the days ahead. Even though many of the charts and maps that had come from the published adventures of those of the far-off lands were, at times, rather difficult to decipher, they felt confident they could chart their own course. The captains had frequent meetings with the crew to discuss every new step along the way and to congratulate each other on their ongoing achievements in order to maintain their sense of purpose. While those of the crew who had never shown any real interest in this new adventure spent their days on routine tasks, there were others who took advantage of any available opportunity to plan a whole new colour scheme for their ship and suggest innovative new designs for their outdated flags. In this way, and with resolute hearts, they sailed away, on into the sunset!
Once they were lost beyond the horizon, however, the first storm clouds began to gather. Although they had made provision for such inclement weather, they were nevertheless taken aback that it had occurred so soon after their departure. There was little these plucky captains could do to stop their small ships from being blown off course and, try as they could, they were unable to regroup. Although some of them were able to come together for short periods, others often could not come within hailing distance at the same time. Never again were they to be able to come together as a united armada. The almighty flagship, too, had considerable problems trying to stay close to the smaller ships, as they tossed and turned in waves that occasionally rose above the tops of their masts.

As they attempted to surf these very difficult waves, many of the until-now, very healthy crew took to their bunks with bouts of seasickness, some of them never again to return to the decks. Those who had been the most fearful of the new adventure were, not unexpectedly, the first to retire. It was, however, rather a shock to these captains that those who had previously appeared to be quite steadfast in their support of this journey also chose to retire below decks so soon.

It was around this time that the captains began to realise how ‘alone’ they were as, on occasions, they were the only ones left in the wheelhouse. What a contrast this was from the times, before and during the launch, when they had appeared to have so much support from the Grand Council and the Elders of their communities. Back then, they had basked in the warmth of being the centre of attention and receiving so much appreciation. But where were these people now? These people who had lauded their efforts and given such words of encouragement to their early endeavours? Were they at hand with support ships to back them up? If they were, they were certainly nowhere to be seen. This is when the realisation struck that, if they themselves could no longer see the shore, then they must also be invisible to those from whom they had expected so much!

Although Odyssia’s flagship continued on a similar path, it, too, was only able to come close to these little ships at infrequent intervals. This was due largely to the fact that, while the design of Odyssia’s mighty ship dictated she steer a straight and steady course, the inexperienced crew on the smaller ships had to tack backwards and forwards as they learned how to adjust their sails to the prevailing winds. Although, from this greater distance, she was still able to have periodic contact with the captains of the other ships, communication became more difficult than any of them had anticipated.
With most of the crew retired to quarters, some of these captains allowed themselves to roll with the waves while others, courageously, tried even harder to steer a straight course. Those of the captains who had been the most enthusiastic for the new adventure now began to realise that their earlier sense of unity may have been, in some respects, a figment of their own inner desires. As it became more apparent that the commitment of some of their comrades might never have been as strong as they had thought, the sense of unity in the group began to dissipate. They could, perhaps, have coped without the promised supply ships if they had been able to maintain their own sense of comradeship. Now that this was broken, however, they would never know what ‘could have been’.

Many of their earlier fears, which had been repressed for as long as they had been able to experience themselves as powerful enough to overcome the elements, now began to resurface. They began to ask themselves how important this quest was to them. What meaning did it now hold for them, or their crew? As their disenchantment swelled up within their hearts, they began to lose their external sense of direction, and, perhaps more sadly, the internal motivation that had sustained them during their initial preparations. Did they really, after all, still want to be considered ‘someone special’ in their own hamlets? What was the point of ‘risking all’ if other Carers did nothing to share some of their hardships?

Feeling lost and frightened and unable to face the thought, at least in their own minds, that they may have failed in their quest, they reminisced about the times when they had been a tightly knit group with Odyssia firmly at the helm. Where was she now? Why hadn’t she sailed with them in one of their own ships? Some even expressed their, until now, undisclosed secret: that one of the reasons for agreeing to undertake this perilous journey had been the intensity of her vision. They talked about her shining suit of armour and her grand title, which had acted as umbrellas to shield them from the gruelling winter storms and the scorching summer sun. What would they now do with no one to protect them from the songs of the Sirens or to help them to slay the almighty Medusa? Unable to find one among them who held the same charisma or strength of purpose, and without a similar shining suit of armour themselves, how could they now face the many trials and tribulations that lay ahead? With no response from so many people who were beyond their reach, they began to give way to those long days and nights of exhaustion. Eventually, therefore, even

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the bravest of the captains, although still saying they intended to continue on their quest, gradually succumbed to the dream of home and a warm fire.

As these small ships limped back into harbour with their sails down, there was no one to cheer them. Sadly, the rest of the community were so busy embroiled in their own everyday concerns that they had completely forgotten about their endeavours. Those Elders of the University community and of the Grand Council of the Hamlets who had lauded their efforts at the beginning were now long gone and replaced by people who had no interest in their odyssey. In fact, no one even asked them about their adventures and, unlike some of their more fortunate predecessors of the far-off lands, no one asked them if they intended to publish their stories. It was, for this intrepid bunch, as if the last three years had been non-existent.

As everyone around them treated them as if they had never been away, some of these captains, in their own hearts, began to believe it too. They turned to thoughts more pleasant than those they had had while at sea. They were home again and among the familiar – and yet, they themselves, in many ways had changed. No one could take that away from them. They had learned something of life at sea and some of them realised that they, at some time in the more distant future, may be in a position when their experiences may be of help to other brave Carers who set out to ‘make a difference’.

Although receiving no accolades on their return, no one can say that this small band of valiant souls have failed in their quest. What would have been a failure is if no one had heeded the call; if no one had been ready to brave the monsters of the deep in search of an answer to their problems. This small band, after all, courageously set out on an unchartered course that was to bring knowledge to others, even if they themselves were unaware of it during their darkest hours.

Perhaps the time is not yet ripe; or perhaps it is not the Golden Fleece that the Carers should seek. Perhaps we should, instead, seek the knowledge that hangs around our own necks. Either way, ‘The Odyssey of The Great Western Land’ takes us one step closer to our ultimate goals and we, as nurses, can only thank those who undertook this perilous journey and so openly and honestly discussed their experiences, for the new knowledge that will be taken away by all who hear of this story.