ATM

Autonomy, Transparency and Management

Reform dynamics in health care: a comparative research program

Britt V. Danielsen

LEADERSHIP AND MANAGEMENT IN NURSING

Nurse Managers' experiences of leadership and management following the introduction of unitary management in Norwegian public hospitals

ATM – Skriftserie
Nr. 15 - 2008

Rokkansenteret
STEIN ROKKAN SENTER FOR FLERFAGLIGE SAMFUNNSSTUDIER

POLIS
Politikk, Organisasjon og Ledelse i
Spesialiserte kunnskapsorganisasjoner

ATM- skriftserie er en nettbasert publikasjonsserie med nyutgivelser av hovedfagsoppgaver, masteroppgaver, avhandlinger og paper som er produsert i tilknytning til ATM –prosjektet ved Rokkansenteret i perioden 2003 – 2008.

Forord

Autonomi, Transparens og Management (ATM)
Et forskningsprosjekt omkring ledelse og organisering i helsetjenestene

Ansvaret for sykehusene i Norge ble fra og med 1. januar 2002 overført fra fylkene til staten. Fem regionale helseforetak ble etablert. I tillegg er det gjennomført reformer som omfatter alt fra pasientrettigheter til finansieringsordninger til enhetlig ledelse. Formålet med ATM-prosjektet ved Rokkansenteret er å studere slike reformer og endringsprosesser i den norske helsesektoren. I studiet av de aktuelle reformene brukes de tre begrepene Autonomi, Transparens og Management.

Med AUTONOMI siktes det til ambisjonen om å etablere autonome organisasjonsenheter og resultatenheter på lavere nivå, samtidig som man sentraliserer eierskapet til stater og regioner. TRANSPARENS; her siktes det til ambisjoner om å redusere kostnader og bidra til pasientens frie valg gjennom tiltak for økt grad av gjennomsiktighet og innsyn i ressursbruk og kvalitet. Den tredje typen reformambisjoner dreier seg om å innføre MANAGEMENT – det vil si at det skal utvikles en mest mulig profesjonell og entydig lederrolle på alle nivåer i helsevesenet. Samlet sett bidrar disse reformambisjonene til et sterkt press for omstilling, samtidig som konsekvensene på det praktiske planet er tildels motstridende og uoversiktlige.

I prosjektet gjøres det analyser av ulike former for organisasjon og ledelse, blant annet med hensyn til mulige konsekvenser for effektivitet, kvalitet og legitimitet i helsetjenestene. Det gjøres sammenligninger med Sverige og Danmark med sikte på å oppnå bedre forståelse for de aktuelle endringsprosessene. Det praktiske siktemålet med prosjektet er å utvikle forskningsbasert kunnskap omkring helsevesenets struktur og historie, bidra til å forstå aktuelle endringsprosesser og hvordan reformer "virker" i praksis. Det er også et mål å bidra til kompetanseutvikling innenfor organisasjon og ledelse i helsevesenet, slik at helseinstitusjonene kan forbedre tjenesteytingen og kommunikasjonen mellom foretakene og befolkningen.

I prosjektet har det vært utviklet forskningsgrupper, nettverk og forskningsseminar der både praktikere, forskere og studenter har deltatt. Formidling av resultater fra forskningen skjer fortløpende på nettsidene til prosjektet (Se http://www.polis.no). Der formidles også resultater fra internasjonale forskningsseminarer og prosjekter der forskerne på ATM-prosjektet inngår, samt at det orienteres om åpne forskningsseminarer, formidlingsseminar og nettverksseminar.

Haldor Byrkjeflot
Prosjektleder

Britt V. Danielsen er utdannet sykepleier og har Master of Health Science, Nursing fra Deakin University, Australia 2006. Denne rapporten er en nyutgivelse av Danielsens masteroppgave som hun skrev i tilknytning til ATM – prosjektet og POLIS- seminaret. Danielsen har lang arbeidserfaring fra sykehus og kommunehelsetjeneste og arbeider i dag som høgskolelektor ved Institutt for Sykepleie, Høgskolen i Bergen.

ACKNOWLEDGEMENTS

This project could not have been realised without the assistance and support of those who have played such an important part in my research study. I wish to acknowledge and say a warm thank you to them all;

First of all I would like to thank the nurses who participated and so generously and open-mindedly gave of their experiences. Without them this research could not have been realised.

As an international student I have been so fortunate to have two supervisors; Kaye Robyn Ogle in Australia and Kirsten Fredriksen in Denmark. Thank you both so much for all your inspiration and backing, all your support and direction, your tolerance and friendliness.

Finally I would like to thank my two sons, Thorstein and Christian who supported and believed in their mother who worked full time besides these studies. Most of all I want to thank my dear husband Frank who was always there for me, who waited for me patiently when I sat by my pc so many evenings, weekends and holidays during these years, who comforted, inspired, supported and believed in me.

Many thanks to all of you for playing your important part; I could not have made it without you.

ABSTRACT

This critical ethnographic study sought to explore the experiences of nurse managers within a large public Norwegian hospital and to make space from which they could speak of their experiences. The research question sought to answer how nurse managers experience leadership and management of their profession and services after a health service reform of unitary management was introduced in public hospitals. Furthermore the research also sought to understand how this health reform has influenced nurse managers' leadership, ideals and roles and how nurse managers influenced managerial decisions in the new hospital organisation. Seven nurse managers from two hospital departments participated in field studies and individual interviews collected over a three month period.

Nurse managers reported that working pressure and required documentation had increased significantly following the introduction of the Hospital Reform. Nurse managers invested in good working environments, advocated respect and tolerance, took pride in nursing and worked strategically to develop a strong and visible nursing service. Economy and budget control had a stronger emphasis with the new reform and economic language had made its entry into the hospital world. Whilst nurse managers reported positively of experiencing improvement in cooperation and communication with the physicians the ward nurses depended entirely on a nurse at a supervisor level who could coordinate and represent the nursing services. The nurse managers on the supervisor level experienced becoming more isolated in the hospital system. The introduction of unitary management had created for them vulnerability in depending on a department manager supportive to nursing.

The study demonstrated that the new reform has implications both for individuals, for the profession of nursing and therefore also the quality of patient care delivery. Whilst nurse managers were working very hard to maximise patient care quality under the new reform further research and mechanisms for nurses to gain voice, be supported and contribute their perspectives to the new health system is required.

GLOSSARY OF TERMS

- *Assistant Department Manager* – A person with professional responsibility for the nursing or the medical services. The assistant department manager is responsible for the nursing services within the whole department and is superior to the ward nurses in the organisation.

- *Chief Physician (or chief surgeon)* – A person responsible for, or in charge of, the medical personnel and services within a medical speciality in a hospital department.

- *Department Manager (or unitary manager)* – A department manager is the only executive in the hospital department as well as the administrative superior to all personnel. The department manager has total responsibility for all budgeting and all medical, nursing and support activities within the department.

- *Hospital Reform* – A new reform on hospital ownership, organisation and management which was implemented in all public Norwegian hospitals in 2002. This reform is based on Law on Specialist Health Services of 1999 and Law on Health Enterprises of 2001.

- *Nurse Director* – The most senior nurse within a hospital organisation who was a member of the hospital executive. This position no longer exists in Norwegian public hospitals.

- *Supervisor Nurse* – A title used mainly prior to the Hospital Reform. A person in charge of the nursing services and personnel within a hospital department.

- *Two-part leadership model* – A two-part leadership model was utilised prior to the Hospital Reform where hospital departments were led by two persons being the chief physician (or chief surgeon) and the supervisor nurse.

- *Unitary management* – Unitary management indicates a model where one person is in charge of a particular hospital department. Unitary management was implemented in all hospital departments as part of the Hospital Reform.

- *Ward Nurse (or head nurse)* – A nurse responsible for, or in charge of, a single hospital ward or outpatient clinic.

TABLE OF CONTENTS PAGE

Original fornt cover
Supervisor’s Certificate.
Co-supervisor’s Certificate Statement of Authorship

1. CHAPTER ONE – INTRODUCTION

The public health care system in Norway is well developed with hospitals resembling and exhibiting the attributes of highly technological and competence based institutions. The hospitals have a central position in the Norwegian healthcare system and have experienced many reforms throughout the years in order to develop into modern well functioning hospitals.

Hospital leadership and management however, have been historically consistently controversial, according to official reports from the government. Whilst the nursing profession has had a long tradition of leadership and management of its own profession and services in Norway a new Hospital Reform was introduced in 2002 which changed the traditional two-part leadership model in hospital departments ("Law on Health Enterprises," 2001; "Law on Specialist Health Services," 1999; *Management in Hospital,* 1990; *NOU 1997:2 The Patient First! Management and Organisation in Hospital,* 1997).

Today patients have legal rights and high expectations of what they might expect from hospitalisation ("Law on Patient Rights," 1999; "Law on Specialist Health Services," 1999; *NOU 1997:2 The Patient First! Management and Organisation in Hospital,* 1997). Furthermore it is the nursing personnel at the hospital who have most contact with the patients. The organisation and management of the nursing services are therefore crucial for the quality and standards of the hospital (Holter, 1997).

1.1 Background and statement of the problem

This research has focused on nurse managers' experiences and the context of their current leadership and management in Norwegian public hospitals after a new Hospital Reform was introduced in 2002. A part of this reform was the introduction of unitary management in every hospital department which has led to changes in nurse manager positions and roles.

The research question has sought to answer how nurse managers experience leadership and management of their profession and services after unitary management was introduced in public hospitals. Furthermore the research has sought to understand how this health reform has influenced nurse managers' leadership, ideals and roles and how nurse managers influence managerial decisions in the new hospital organisation.

A multi-site critical ethnographic design has been utilised to observe and elicit the experiences of nurse managers. The intention was to contribute to engage the nurse managers in their everyday life at work as well as encouraging them in reflective processes by giving them a chance to speak and reflect on their experiences of leadership and management. It has been significant that their voice is heard rather than be either assumed or ignored and for individual nurses to gain confidence in safely voicing their opinion and contributing to current knowledge and debates.

1.1.1 A new Hospital Reform

A new reform on hospital ownership, organisation and management was implemented in all public Norwegian hospitals in 2002. This reform, called the Hospital Reform, was based on a Norwegian Public Report (NOU, 1997) regarding leadership and organisation in all public hospitals as well as a new law on Specialist Health Services ("Law on Specialist Health Services," 1999; *NOU 1997:2 The Patient First! Management and Organisation in Hospital,* 1997). In 2001 the Law on Health Enterprises was approved which resulted in regional health enterprises being established in Norway with responsibility to organise all hospitals and other health institutions within the Specialist Health Services as health enterprises ("Law on Health Enterprises," 2001). From 2002 the responsibility for the Norwegian public hospitals was transferred from the counties to central government, and the ownership was centralised to the state (Lægreid, Opedal, & Stigen, 2003; Torjesen & Gammelsæter, 2004). One of the main challenges of the reform has been balancing the autonomy of the health enterprises and the political control by central government. This reform according to Lægreid, Opedal et al. (2003, p. 7) has been "one of the most comprehensive contemporary New Public Management inspired reforms in Norway".

The new Hospital Reform presented new management principles for hospitals based on a decentralised enterprise model (Lægreid et al., 2003). As well as transferring the ownership of public hospitals from counties to state, all hospitals were organised into five regional health enterprises with local enterprises underneath. As a part of this reform a new leadership model involving unitary management was introduced in all hospital departments. Unitary management indicates a model where one person is in charge of a particular hospital department. Previously there was a two-part leadership model which included the chief physician (or chief surgeon) and the supervisor nurse (*NOU 1997:2 The Patient First! Management and Organisation in Hospital,* 1997; Torjesen & Gammelsæter, 2004).

1.1.2 New Public Management

The New Public Management (NPM) movement has swept across countries throughout the world during the last decades and most visibly been implemented in USA, Britain, New Zealand, Australia, but also in Europe including Scandinavian countries (Greve & Jespersen, 1998; Kettl, 1997; Lian, 2003). NPM is understood as a set of ideas, theories and models for governing and organising the public sector. NPM first described by Christopher Hood in 1991 has become important to describe and explain the development within the public sector in these countries. Hood (1991 in Lian 2003) described NPM as a marriage between two strong mainstreams of thought after World War II; one part consisting of new knowledge from economic theory, the other part a set of logics regarding internal organising and managing of public organisations. The first part is directed towards a liberal market orientation with increased use of market influence both internally within the public services and in relation to the private sector. The second part is related to internal organisation and management with stronger influence on organisation culture, introduction of systematic quality measurement and professional management (Lian, 2003). Greve and Jespersen (1998) stated that NPM addresses both institutional reform and administrative reform as NPM combines market mechanisms and private sector management ideas and techniques in the public sector. Most NPM reforms have been top-down reforms, however, the effect of NPM reforms

are determined when the reforms meet the professional service provision in the organisations (Greve & Jespersen, 1998).

According to Lian (2003) NPM has strongly influenced public health services in Norway. The system of free choice of hospital which was part of the Hospital Reform effectuated in 2002 represented the focus on patients and customers in the NPM ideology. Patients now have the possibility to select the hospital which they believe will offer the best treatment, for instance elective surgery, instead of having their choice limited to the local or regional hospital as earlier. The government and politicians believed it would encourage competition and increase efficiency in hospital services. The system of unitary management which is part of the Hospital Reform (Law on Specialist Health Services of 1999 and Law on Health Enterprises of 2001) emphasised the idea that strong and professional management is the key to success which is an important part of NPM (Lian, 2003).

1.1.3 Unitary management and the former two-part leadership model

The unitary manager or the department manager is now the only executive in the department as well as the administrative superior to all personnel. The department manager has total responsibility for all budgeting and all medical, nursing and support activities within the department. The intention is that one empowered manager will strengthen the leadership in each department ("Law on Specialist Health Services," 1999; *NOU 1997:2 The Patient First! Management and Organisation in Hospital,* 1997; Torjesen & Gammelsæter, 2004). According to Lian (2003) the belief has been that one strong leader striving to do his/her best will act as a catalyst within the organisation and this thought has been applied to Norwegian public hospitals.

Prior to the Hospital Reform a two-part leadership model was utilised where hospital departments were led by two persons being the chief physician (or chief surgeon) and the supervisor nurse (Normann, 2001; *NOU 1997:2 The Patient First! Management and Organisation in Hospital,* 1997). This model implied that both positions had a common responsibility for running the department, administration, budgeting and patient

outcomes. Simultaneously the chief physician was responsible for the medical personnel and services and the supervisor nurse was responsible for the nursing personnel and services. The intention was that the managing role was attended to through interaction between two persons where consensus was presupposed (Holter, 1997; Normann, 2001). Reports of experiences with this two-part leadership model have been mixed. In some hospitals this model was reported to work very well, in others the departmental leadership was unclear as the interaction and cooperation between the chief physician and the supervisor nurse did not work as intended (Normann, 2001; *NOU 1997:2 The Patient First! Management and Organisation in Hospital,* 1997).

1.1.4 Current organisation of nursing services in Norwegian public hospitals

Nursing has a long tradition of leadership and management of its own profession and services. However, over the last few years many nursing leader positions have disappeared in the Norwegian hospitals (Brandvold, 2003; Nakrem, 2004). The position as supervisor nurse has disappeared in the new organisational model of the hospitals, or where it has been maintained the position has a different role than earlier. Earlier the supervisor nurse was the ward nurses' superior and in charge of quality development and standards of the nursing services both professionally and organisationally (Berge, Mathisen, & Skogstad, 2002; Brandvold, 2003; Holter, 1997; Kristoffersen, 1996; Orvik, 2004).

In Norway most of the new unitary managers in hospital departments have a medical rather than a nursing professional background (Brandvold, 2003; Byrkjeflot, 2004b). However, it is possible for a nurse to apply for this Department Manager position as it is the background and competencies as a leader and administrator which are stated as the most important qualifications for this position (Brandvold, 2003; "Management in Hospital," 2002; *NOU 1997:2 The Patient First! Management and Organisation in Hospital,* 1997). In the new organisational model ward nurses have a direct reporting line up to the Department Manager where it is likely that this manager is a medical doctor. Many nurses and nursing managers believe that a hospital department needs a

professional nursing manager with adequate professional authority in the department team and as a professional leader of the nursing services (Berge et al., 2002; Brandvold, 2003; Nakrem, 2004; Orvik, 2004).

The Norwegian Nurses Association (NSF) has stated that nurses are natural both as professional leaders as well as administrative leaders at different levels throughout the health services. NSF supported the introduction of the Hospital Reform as they welcomed the transfer of hospitals from the counties to the state (Normann, 2003; *Statusrapport 2002*, 2003; *Statusrapport 2003*, 2004). More recently NSF has confirmed their support of unitary management, however, with a presupposition that the hospital departments are organised to ensure that nurse management on a supervisor level has real influence in the organisation (The Norwegian Nurses Association, 2005).

1.1.5 Concern with consequences for nursing

Brandvold (2003) has argued that nurse managers on a supervisor level are vital to maintain patient security and standards. She further asserted that nursing would be suppressed in the new organisation model with negative consequences in the long term unless nursing leaders continue to speak out, be distinct and brave (Brandvold, 2003). Brandvold (2003) indicated concern that lack of nursing leadership will reduce the conditions of the nursing services, and she suggested that the positions of nurse supervisors and nurse directors should be maintained to strengthen the professional leadership of nursing. It has been questioned whether traditional nursing care might get lower priority in a system which to a higher degree has efficiency as its goal (Jakobsen, 2005). Recent Norwegian research on unitary leadership and the organisation of work between doctors and nurses has shown that there is concern among nurses that they may lose influence in the new organisational model of unitary management (Sveri, 2004).

There is a worry that nurse managers no longer have a strong position in the hospital hierarchy in Norway which in the long term might influence the delivery of nursing services negatively. It is therefore important to explore and understand how nurse

managers experience leadership and management of their profession and services in hospitals under the new reform.

1.2 Purpose of the study – research question

This research project has aimed to describe and understand how nurse managers at different levels of the nursing hierarchy experience leadership and management of their profession and services after the introduction of a new health reform including unitary management in public hospitals in Norway. A further aim of this research was to understand how this health reform has influenced nurse managers' leadership, ideals and roles, and how nurse managers have influenced managerial decisions.

1.3 Significance of the research

Prior to the Hospital Reform it was routine for nursing executives to be in charge of nursing services in Norway (Berge et al., 2002; Brandvold, 2003). The research on leadership and management in nursing in Norway following this health reform is scant. The limited research in Norway has shown that nursing leaders have concentrated on running wards and clinics more than focusing on professional nursing quality and standards, and development of research in nursing (Aase, 1999; Normann, 2001). Most research related to the Hospital Reform has focused upon economic, political and enterprise level endeavours (Byrkjeflot, 2004a, 2004b; Byrkjeflot & Grønlie, 2004; Lægreid et al., 2003) rather than the experiences of nurses or impact on nursing service delivery.

As a former nurse manager myself for many years both in hospitals and municipal services, I believe it is important to study how the new Hospital Reform (Law on Specialist Health Services of 1999 and Law on Health Enterprises of 2001) has influenced the leadership, management and ideals of nurse managers and to gain knowledge about how nursing influences managerial decisions today. It is well documented that the experiences and voices of nurses are often not sought and are often unheard (Antrobus & Kitson, 1999; Brandvold, 2003). In the context of an international

shortage of nurses the position of nurse managers might also affect the number and competences of nurses in the hospital which in the long run might influence patient results negatively (Aiken, Clarke, Cheung, Sloane, & Silber, 2003; Davis, Needleman, Hand, & Aiken, 2003).

The Hospital Reform has been launched as a reform inspired by private, economic and rationalist thoughts (Lian, 2003; Nakrem, 2004; Rønning, 2004). However, the experiences of nurse managers following this new reform have not been documented. Recent research on unitary leadership and the organisation of work between doctors and nurses has shown that there is concern among nurses that they may lose influence in the new organisational model of unitary management (Sveri, 2004). This research is important as it has been argued that there is a growing concern among nurses in Norway that nurse managers have decreased their position in the hospital hierarchy following the introduction of unitary management which in the long term might influence the nursing services negatively (Berge et al., 2002; Brandvold, 2003). The experiences of nurse managers are significant from a professional viewpoint as it is important for the nursing profession to gain knowledge on how to organise nursing services and their managers.

By choosing a critical ethnographic approach in this study the intention was to engage the nurse managers in their everyday life at work and to encourage them in reflective processes concerning their experiences in leadership and management of their profession and services. The research is significant as nurse managers were given a chance to speak and reflect on their experiences in their working lives. It is important that their voice is heard as well as contributing to current knowledge and debates.

This research study is therefore significant as it aims to describe and understand how nurse managers at different levels in the nursing hierarchy experience leadership and management of their profession and services following the introduction of the Hospital Reform and unitary management in public hospitals in Norway ("Law on Health Enterprises," 2001; "Law on Specialist Health Services," 1999; *NOU 1997:2 The Patient First! Management and Organisation in Hospital,* 1997). Furthermore it seeks to understand how this health reform has influenced their leadership, ideals and roles,

and how nurses influence managerial decisions. It is important for the nursing profession to gain knowledge regarding how nurse managers experience leadership and management in the new hospital organisation as well as the influence of nurse managers into managerial decisions.

This research did not attempt to focus specifically upon gender issues however it is acknowledged that gender may influence the position of nursing in the hospital hierarchy as a vast majority of nurses are women (Holter, 1997; Statistics Norway, 2003). The intent was to explore and understand how current Norwegian nurse managers experience leadership and management as there is little research on nursing leadership in Norwegian hospitals since the Hospital Reform has been introduced.

1.4 Research design

A multi-site critical ethnographic design has been utilised to observe and elicit the experiences of nurse managers. A critical ethnographic approach was used which involves and engages the participants in the research process. Critical ethnography has developed a reflexive research approach which attempts to reveal and engage in everyday life (Hammersley, 1992; Morse & Field, 1996; Thompson & Wellard, 1999).

The research focused on the experiences of nurse managers within the departments, excluding the position of department manager who most likely would have been a physician. This higher position (unitary manager or department manager) had the total responsibility for the department and all personnel within it. Seven nurse managers were recruited from two departments within a public hospital in Norway who participated in field studies and individual in-depth semi-structured interviews which were conducted over a period of three months.

By choosing this research design the intention was to contribute to engage the nurse managers in their everyday life at work as well as giving them a chance to speak and encouraging them in reflective processes concerning their experiences in leadership and management of their profession and services.

1.5 Thesis structure

In this chapter the research question and its background has been introduced. In the following chapter a brief history and overview of traditions in nursing leadership and management in Norwegian hospitals will be introduced. Chapter three encompasses a literature review where the literature includes research studies regarding issues on leadership and management in nursing and the experiences of nurse managers. In chapter four the methodology and methods as well as ethical considerations for this research are outlined and in chapter five the findings and results are presented. In the last chapter the major findings are discussed, the study limitations outlined, directions for future research described and a conclusion to the study and findings given.

2. CHAPTER TWO – HISTORY AND TRADITIONS

The development of Norwegian public hospitals as well as a brief history and overview of traditions in nursing leadership is important to understand the contextual position and challenges most nurse managers currently encounter in their work context. This chapter briefly describes these events and issues in order to provide a context for the study.

2.1 Developments and reforms in Norwegian hospitals

The hospital as an institution for medical treatment was firmly established in Norway in the last century. Currently the modern hospital appears as a highly technological and competence based institution with a central position in the Norwegian healthcare system (*NOU 1997:2 The Patient First! Management and Organisation in Hospital,* 1997). The reform activities in the Norwegian hospital system have been described by dividing them into three periods. In the first period before 1972 the reform activities were characterised by the welfare commune and institution building. In the second period from 1972 – 2002 the reform activities were characterised by a professional political system with planning and professional autonomy prominent features, whereas the third period after the new Hospital Reform in 2002 has been characterised by a managerial system based on the idea that hospitals are transparent enterprises which are in competition with each other (Byrkjeflot & Neby, 2004). Following the Hospital Reform in 2002 five regional health enterprises were established owned by the state (Lægreid et al., 2003; Torjesen & Gammelsæter, 2004).

2.2 History and traditions in nursing leadership and management in hospitals

The Norwegian nursing tradition is built on the Nightingale tradition where central elements have been emphasis on leadership and administrative principles, hierarchies within the nursing personnel and education and training of nurses at public hospitals (Melby, 1990; Sommervold, 1997). However, the leadership traditions in Norwegian hospitals have changed in line with the development of the hospitals. According to official reports from the government, leadership and management in hospitals has been

historically consistently controversial (*Management in Hospital,* 1990*; NOU 1997:2 The Patient First! Management and Organisation in Hospital,* 1997).

2.2.1 Early history and traditions

The discussion on who should lead nurses and nursing services has been ongoing since the 1870's when the deaconess Rikke Nissen protested against male leadership at the Deaconess Institution in Christiania (Melby, 1990). According to Melby (1990) Nissen, who wrote the first Norwegian textbook in nursing, argued that nurses should lead their caring work and also be responsible for educating nurses. In 1925 the Norwegian Nurses Association established education in administration for nurses in leading positions as well as education for nursing teachers (Fause & Micaelsen, 2002; Martinsen & Wærness, 1979; Melby, 1990).

In the first half of the 20th century the hospitals were led by a trio consisting of the matron, the chief physician and the administrator. After the Second World War the hospitals expanded and developed into large and complex organisations and the demand for highly competent leadership and management increased. The earlier administrator became the managing director as the formal leader of the hospital and the chief physician was the medical leader. The managing director was often educated in business schools not necessarily with a health professional background. The hospital had a hierarchic structure with the chief physician on top with a structure adjusted to the medical world. The nursing personnel were subordinate accepting to adapt nursing to medical assessments (Berg, 1987). The supervisor nurse became the leader of the nursing services under the supervision of the chief physician (Melby, 1990; *NOU 1997:2 The Patient First! Management and Organisation in Hospital,* 1997).

2.2.2 The development following the counties' responsibility of public hospitals

The Hospital Law of 1969 made the counties responsible for the operation of hospitals and the question on how hospitals should be managed was again actualised (Fause & Micaelsen, 2002; Melby, 1990). Earlier no particular institution or authority had been

responsible for constructing and operating hospitals. The Handal Committee stated in 1971 that nurses should be administrative and professional leaders of the nursing services and the nurse director should be placed in the staff of the managing director of the hospital together with the medical director. The result was a breakthrough for nursing leadership because nurses at this point had a voice in the top level of the hospital who contributed to forming nursing policy. At the same time the nurse director and the medical director were both directly responsible for their profession and services in the hospital. This was the start of what was termed a two-part leadership model where the medical director was responsible for the medical treatment and services and the nurse director was responsible for the nursing services in the hospital. In 1975 the Mork Committee implemented this recommendation and it was ascertained that a supervisor nurse was directly subordinate to the nurse director and that the ward nurses were directly subordinate to the supervisor nurse (Fause & Micaelsen, 2002; Melby, 1990). However, the principle of two-part leadership and nurse managers' responsibilities for their own profession and services was not finally settled at this stage.

A new committee on hospital organisation was appointed and the recommendation from the Øie Committee was presented in 1981 where it was suggested that the chief physician should be the only executive in the hospital department, supervising all personnel with professional, administrative and economic responsibility. The doctors represented by the Norwegian Medical Association declared that they would defend medical leadership in the health services. This led to a strong protest from the Norwegian Nurses Association as they would not accept that the nursing service should be led and managed by another profession. "Nurses have right and duty to leadership" the union leader claimed (Melby, 1990, p. 299). Another committee was appointed, The Organisation Committee III, culminated in two-part leadership being introduced in hospital departments with the nurse director as a staff member in the hospital administration but no longer with a direct line to the supervisor nurses in the departments (Fause & Micaelsen, 2002; Melby, 1990).

According to Melby (1990) the conflict between physicians and nurses concerning who should supervise the nursing services is not only about leadership, authority and

advancement. It also affects the professional identity of nursing as well as the relationship between nursing and medicine. Melby (1990) reflected that the Norwegian Nursing Association has never officially claimed that the struggle for professional autonomy was a strategy in opposition to the oppression of women. Nevertheless professionalism in nursing could be seen as a strategy for an occupational group dominated by women to assert nursing in relation to the medical profession dominated by men (Melby, 1990). For nurses to assist doctors was important, however, it was only a small part of their job. Of most importance to nurses was caring and therefore nurses were willing to fight for autonomy both in education and in the practise field (Melby, 1990). Sommervold (1997) asserted that leadership in nursing has been a strategy for professionalism as nurses wanted to detach from the medical hierarchy. On the other hand nurses claimed their right in management of all nursing personnel including nurse assistants. Consequently nurses demonstrated a double strategy in accessing management positions with professional and managerial arguments (Sommervold, 1997).

Sommervold (1997) has described leadership in nursing from two perspectives being leadership as management and leadership as professional leadership. Leadership as management views leadership as a separate and distinct role which is vital to productivity and efficiency of the organisation. Leadership in this context is not related to a certain profession or culture. Leadership defined as professional leadership however, presupposes professional qualifications in nursing in order to hold a leading position. Sommervold (1997) believed that nurse managers have been closer to management leadership than physicians. By connecting leadership and nursing to the nursing profession professional leadership could be a strategy for nurses to obtain control and authority over nursing and its working area (Sommervold, 1997).

2.2.3 The context leading up to unitary management

The Steine Committee (1997) recommended the introduction of unitary management in hospital departments which was implemented in all public hospitals as a part of the Hospital Reform in 2002. Simultaneously the responsibility for public hospitals was

transferred from the counties to central government. The background for this latest hospital reform was mainly the urgent needs for balancing economic control with increasing demand for patient service ("Law on Health Enterprises," 2001; "Law on Specialist Health Services," 1999; *NOU 1997:2 The Patient First! Management and Organisation in Hospital,* 1997). The department manager is now the only executive in the department with responsibility for all personnel and services. Unitary management has led to a conflict between nurses and doctors regarding who is best qualified for this position. A statute was issued by the Department of Health in 2002 stating that the position as unitary manager was not attached to a certain profession ("Ledelse i sykehus," 2002). The authorities emphasised leadership as an instrument to obtain objectives with a distinct patient perspective, as in the title "patient first" (*NOU 1997:2 The Patient First! Management and Organisation in Hospital,* 1997).

The Norwegian Nurses Association (NSF) has recently published a report on nursing and leadership. The report has described expectations and responsibilities for nurse managers in a broad perspective. NSF's vision is that nurse leaders can influence future policy and contribute to the development of services in a direction to strengthen high-quality nursing and medical treatment and justice in the distribution of health resources (The Norwegian Nurses Association, 2005).

A current question surrounds unitary management as ending autonomous leadership of nursing in Norwegian hospitals. Many nurses and nursing managers believe that a hospital department needs a professional nurse manager with adequate professional authority in the department team as well as a professional leader of the nursing services (Berge et al., 2002; Brandvold, 2003; Orvik, 2004). It has also been argued that the "soft values" described in nursing and caring are at stake in meeting with the tough, economic demands which dominate the current hospital context (Berge et al., 2002; Brandvold, 2003; Nakrem, 2004).

2.3 Summary

Nursing has had a long tradition of leadership and management of its own profession and services in Norway. However, there has been a continuous disagreement between nurses and physicians on leadership and management in hospitals. The conflict between doctors and nursing concerning who should supervise the nursing services has not only been about leadership, authority and advancement. It also includes the professional identity of nursing as well as the relationship between nursing and medicine. From the 1980's the two-part leadership model was introduced in hospitals where the managing role was attended to through interaction between the chief physician and the supervisor nurse. Reports of experiences with this two-part leadership model have been mixed. By introducing a new Hospital reform in 2002 a new leadership model with unitary management was implemented in all hospital departments. The department manager is now the only executive in the department with responsibility for all personnel and services. There is concern that unitary management has put an end to autonomous leadership of nursing in Norwegian hospitals.

3. CHAPTER THREE - LITERATURE REVIEW

In this chapter relevant literature is reviewed. Initially the notions of leadership and management in nursing are briefly presented to provide a background on current thinking on leadership and management in nursing. The literature review includes research studies regarding issues on leadership and management in nursing and the experiences of nurse managers. Whilst the Norwegian research on leadership and management in nursing following the Norwegian Hospital Reform (Law on Specialist Health Services of 1999 and Law on Health Enterprises of 2001) is scant this is specifically included. In addition there have been few Norwegian studies that report of the experiences of nurse managers or that utilise a critical methodology for examining the topic of nurse management. This study is important as there are no prior critical studies to give voice to the experiences of nurse managers. Scandinavian and other international research studies are also reviewed as the Norwegian nursing is influenced by international trends and has strong cooperation with international nursing organisations (Melby, 1990; Sommervold, 1997).

3.1 Perspectives on leadership and management in nursing

"In Aristotelian terms the good leader must have *ethos, pathos* and *logos*. The *ethos* is the moral character, the source of his ability to persuade. The *pathos* is his ability to touch feelings, to move people emotionally. The *logos* is his ability to give solid reasons for an action to move people intellectually."

(Mortimer Adler cited in Zimmermann, 2002)

The definitions of the notions administration, management, and leadership which are commonly used within nursing and organisational literature are varying. The literature on management and leadership is briefly reviewed as the terms are used interchangeably in the literature. The International Council of Nurses has held that leadership is an essential component of management. Furthermore nursing leadership comprised coaching and mentoring others, and generating continuous development and quality care (International Council of Nurses, 2000).

In Norway the Steine Committee (1997) which recommended the introduction of unitary management in hospitals differentiated between administration, management

and leadership. Administration was about exercising and supervising assignments in accordance with existing laws, rules and instructions connected to a position. Management had to do with setting up objectives and identifying and choosing the most important strategies in order to accomplish these objectives, whereas leadership was about developing visions which ensured that strategies and visions are commonly embedded in the organisation's administration. Therefore management and leadership were all included in the manager's role (*NOU 1997:2 The Patient First! Management and Organisation in Hospital,* 1997).

According to Marquis and Huston (2000) leadership is held by some as one of many management functions. Others have stated that leadership requires more complex skills than management and that management was only one role of leadership, while still others distinguished between the two. Management emphasised control of costs, supplies and personnel whereas leadership emphasised increased productivity by making the best use of work force effectiveness (Marquis & Huston, 2000). A job title alone did not necessarily make a person a leader; it was the person's behaviour which determined whether he or she had the leadership skills. The manager was the person who accomplished, had the responsibility, conducted, and the one who brought things about. A leader was the person who influenced and guided opinion, direction and course of action (Marquis & Huston, 2000).

In the nursing literature Quivey (1998) asserted that the terms administration and leadership were often used as if they meant the same. Administration was closest to management being the more routine part of the job whereas leadership referred to having a certain charismatic quality. Many argue that leadership was most important as it was the relation to the employees, who represented the most valuable resource in the organisation, which was essential (Quivey, 1998).

Strand (2001) stated that leadership was not an unambiguous notion and the different leadership theories defined leadership in different ways. Strand asserted in his context model for leadership that: "Leadership as function and practice must be comprehended within the organisations, sectors and culture leaders work" (Strand, 2001, p. 11). This

understanding of leadership implied that leadership made sense and had effect within its context. The leader had both a behavioural role, telling what the leader did as well as a symbolic role, telling what the leader meant to the organisation (Strand, 2001).

Management or leadership styles are a further common concept in the nursing literature. Marquis and Huston (2002) indicated that there were two types of leaders in nursing management where the traditional manager has been seen as a transactional manager focusing upon day-to-day tasks. Transactional leadership was characterised by caretaking, examining causes, using contingency reward and was featured by conformity. The manager who was committed and had a vision was called a transformational manager who was characterised as someone who had a long-term vision, identified common values, inspired and empowered others, and paid attention to effects. The transformational leadership was seen as the future leadership style for nursing, but was recommended to be coordinated with the transactional day-to-day managerial role (Marquis & Huston, 2000). Thyer (2003) accomplished a case study by comparison of transactional and transformational leadership in a hospital ward. She found that transformational leadership is ideologically suited to nurse management and had a positive effect on communication and team development (Thyer, 2003).

It can therefore be seen that leadership and management have varied and somewhat interchangeable meanings within the current literature. Whilst many styles of leadership have been examined nursing has often been associated with transactional and transformational styles of leadership.

3.2 Nursing leadership and management

In recent years several studies connected to hospital reforms have been undertaken, however most reports have focused upon reform processes, economic, political and enterprise level endeavours (Byrkjeflot & Grønlie, 2004; Johansen, 2005). Some studies have paid attention to the processes taking place when reforms meet the practice field. These studies have especially been concerned with the traditional professional groups in hospitals who dominate the hospital field and how they have experienced and adapted to

these new reforms. There is little research in Norway that specifically focuses on nursing management in hospitals. However, there are studies that involve nursing but also encompass several other professional groups in hospitals, i.e. multidisciplinary studies (Normann, 2001; Sveri, 2004). Some studies have focused exclusively on department managers (Myhre, 2004; Nerheim, 2005).

3.2.1 Norwegian hospital studies

Aase (1999) performed a qualitative study on nurse managers in a Norwegian hospital where she interviewed seven nurse managers which represented the nursing leader group at the hospital. This was prior to the Hospital Reform of 2002. The hospital struggled with a substantial shortage of nurses and Aase (1999) found that the nurse managers were concentrating far more on operational aspects and administrating of the hospital departments and nursing care rather than working to develop the nursing profession and standards. The nurse managers in the study reported that they constantly felt pressure due to reasons of economy and budgeting and therefore paid most attention to organising hospital beds and personnel, and little time was left to think about ideals in leadership and nursing. The hospital did not have an educational or competence program for nurses. The nurse managers reported suffering from not having articulated clear aims for the nursing services at the hospital or having expressed their vision for future nursing in a document. Aase (1999) also found that nursing had low influence within and understanding of the hospital administration. The study did not suggest any reason for this result (Aase, 1999). This study confirmed other studies that the experiences and voices of nurses are often not sought or are unheard (Antrobus & Kitson, 1999; Brandvold, 2003). Several studies have shown that there is a close connection between shortages of nurses, a low nursing profile, poor leadership and organising of nursing services (Aiken, Clarke, & Sloane, 2003; Holter, 2001).

A qualitative study on nurse and physician managers was conducted in a Norwegian hospital by Normann (2001), with five supervisor nurses and five chief physicians who were all interviewed. The study focused on their experiences of management and leadership and was undertaken when the two-part leadership model was still in practice ("Law on Specialist Health Services," 1999; *NOU 1997:2 The Patient First!*

Management and Organisation in Hospital, 1997). Normann (2001) also found that the nurse managers were concentrating on the administrative routines and the running of the departments. One nurse manager expressed it like this: "The chief physician takes care of the doctors and what they do; I take care of the administration, the nurses and everything else" (Normann, 2001, p. 75). Routines such as recruiting and planning of personnel, correct placement of patients between the different wards, contact and cooperation with other departments and services was described as part of the administrative work. The nurse managers were struggling to develop the nursing services as they had little resources to do so, or they did not give it enough priority. However, the nurse managers in this study paid a great deal of attention to their subordinate personnel and were conscientious about supporting and counselling the ward nurses. The chief physicians participated actively in the clinical work to keep themselves up to date and gain respect from their fellow colleagues. Their focus was mainly directed towards medical work and little towards running of the hospital departments. This study also showed that the nurse managers were not satisfied with the cooperation they had with the chief physicians who they often experienced as autocratic. Normann (2001) explained this by the nurse managers' experience of not being properly respected and of the same standing as the chief physicians. The chief physician managers seemed to be more content on this matter (Normann, 2001). This study concentrated on the comparison between the supervisor nurses and chief physicians. The experiences and philosophy in leadership and management among the nurse managers had scant attention. However, this study identified that nurses were performing most of the administration functions for the department (Normann, 2001).

Sveri (2004) accomplished a qualitative study on unitary management which focused on how the hospital work was organised in a Norwegian hospital department and how it was influenced by the new Hospital Reform (Law on Specialist Health Services of 1999 and Law on Health Enterprises of 2001). Ten participant employees were interviewed from the same hospital department including physicians and nurses at different employment levels as well as one administrative consultant. Two of the participants were ward nurses. In this department the ward nurses had a direct reporting line to the department manager and many of the assignments and responsibilities from the former

supervisor nurse had been transferred to the ward nurses in the new organisation, for instance recruiting, planning and control of nursing personnel. Sveri (2004) found that there was a concern among the nurses that they might lose influence in this new organisational model. The ward nurses did not have a nurse manager on a higher level to consult in nursing matters. They reported that they missed this opportunity as the department manager could not meet their needs on professional nursing matters but only on managerial matters. According to Sveri (2004) the new model influenced the relationship between the professionals, physicians and nurses, where nurses had lost a direct professional reporting line upwards in the organisation as the position of nurse supervisor had disappeared. The department manager considered establishing a position for a coordinating nurse, but no decision was made at the time the study was reported.

Sveri (2004) concluded that his research demonstrated that the reform did not influence the medical treatment and nursing care in particular as this work seemed to be decoupled from the formal structure of the hospital (Meyer & Rowan, 1977). He also found that there was a concern among the nurses that they may lose influence in the new organisation. However, it is important to emphasise that only two nurses participated in this study. This research was carried out in 2003 when unitary management had been only introduced for about one year and individuals were still struggling to adjust to the new model. The results therefore were inconclusive, focused upon medical and nursing relations and paid little attention to the experiences of nurse managers (Sveri, 2004).

A further study has focused on conflicts between health professions which have emerged after the introduction of unitary management in Norwegian hospitals (Johansen, 2005). This study based its analysis on how Abbott (1988) described and understood conflicts between professionals and their jurisdiction (Abbott, 1988). Sixteen physician- and nurse managers in two Norwegian hospitals were interviewed. Johansen (2005) found that both groups agreed that in introducing unitary management it had contributed to more defined areas of responsibility and better communication. However, they disagreed on who was most competent to fill the office as the department manager. The physicians asserted that it must be a medical specialist within the department while the nurse managers emphasised formal competence in leadership and

management as a supplement to their health profession expertise. Johansen (2005) found that the different professions had adjusted to each other and practised more or less like the former two-part leadership model where the chief physicians dealt with physicians and medical treatment and the nurse managers took care of administration of the department and the nursing care. The researcher did not suggest any further reasons for this. One may ask whether the nurse managers continue to do the administrative work unacknowledged. However, this study focused more on the relations and conflicts between physician and nurse managers and less on their experiences in leadership and management (Johansen, 2005). This study identified that nurse and physician managers had more defined areas of responsibilities and had improved their communication after unitary management was introduced.

A comprehensive survey carried out by the Norwegian Work Research Institute has shown that the intensity in hospital work has increased due to higher demands of quality as well as demands on improved economic results. At the same time the nursing staff and other health care workers have been reduced. This research also revealed that 25 % of the hospital working force experienced that working pleasure was poorer and that the work environment had become less attractive (Grimsmo & Sørensen, 2004).

3.2.2 International studies on nursing leadership and management

Scandinavian and other international research studies are reviewed as Norwegian nursing is influenced by international trends and has strong cooperation with international nursing organisations (Melby, 1990; Sommervold, 1997).

Nursing leadership; between profession and management

Jespersen (2005) carried out a comprehensive case study on hospital reforms in three Danish hospitals over a three year period where studying the different health management roles was incorporated. The view on leadership and management varied between doctors and nurses as chief physicians were more concerned with professional leadership and nurse supervisors were broader orientated including both professional and management leadership. The nurse supervisors appeared as distinct leaders.

Professional nursing assignments and challenges were important as well, but for nurses the whole department organisation and personnel were important as they included interdisciplinary teamwork and economy far more in their leadership compared to chief physicians. The traditional organisation was characterised by professional autonomy and Jespersen (2005) reported that both chief physicians and supervisor nurses were strongly influenced by their health professional approaches to problems. However, after a few years influence of New Public Management (NPM) philosophy, he found that the traditional organisation form had been mixed with new NPM inspired forms characterised by general, unitary and strong leadership, and economic efficiency thinking which emphasised documented results. Jespersen (2005) characterised this organisation as a hybrid organisation.

In this context Jespersen (2005) characterised the modern nurse manager, who appeared in big hospital departments, as a hybrid leader. A hybrid leader is a generalist orientated leader who is oriented towards the profession and operates in the nurse tradition of hierarchic leadership to influence the ward nurses in order to develop and improve the quality of nursing as well as the working environment among the nursing personnel. Simultaneously the nurse supervisor is oriented towards the general management tasks regarding economic planning and controlling, developing the organisation and communicating their leadership philosophy to the administrative level of the hospital. Thus the nurse supervisor was able to establish connection between nursing and the socio-political context to position nursing (Jespersen, 2005). Other researchers have characterised this phenomenon in nursing leadership as having an internal and external focus (Antrobus & Kitson, 1999).

The importance of nursing leadership

Antrobus and Kitson (1999) performed a qualitative study in the United Kingdom with a critical, ethnographic approach where 24 nurse managers from clinical practice were interviewed. The participants were selected on their background for being recognised for their effectiveness in leading nurses. The study did not detail the area of the health services where these nurses worked. Antrobus and Kitson (1999) sought to explore the

profile of nursing leadership. From their findings, they identified a repertoire of five skills among the nurse managers:

- *A powerful influential operator*. The nurse manager works with others to empower them and creates work environments concerned with common values.
- *A strategic thinker*. The nurse manager creates meaning and establishes processes for learning.
- *A developer of nursing knowledge*. The nurse manager practises development as a process of incorporating research evidence with practice.
- *A reflexive thinker*. The nurse manager has a clear understanding of values and requires support mechanisms and processes to facilitate structured reflection.
- *A process consultant*. The nurse manager works with and through others to achieve success (Antrobus & Kitson, 1999, p. 750).

Nursing leadership was described as having both an internal and external focus. The internal focus was described as the relationship leaders develop within nursing between the clinical, management, academic and political areas to gain nursing knowledge, whereas the external focus was described as the relationship leaders establish between nursing and the socio-political context to position nursing and obtain power and influence. Antrobus and Kitson (1999) suggested that clinical nurse managers have a central role in smoothing the progress of innovation for the development of practice. Effective nurse managers combined their area of influence with clinical practice. They concluded that further investments in clinical leadership is needed as a vehicle for influencing and forming health policy (Antrobus & Kitson, 1999).

3.2.3 The importance of nursing management; recruiting and retaining nurses

Holter (2001) expressed concern for future workforce recruitment in nursing. She claimed that organisation and leadership of nursing services is very important in order to recruit and retain nursing personnel. She asserted that it is not only a question of wages and adequate staffing of nursing personnel. Holter (2001) referred to other studies within the health care services in other Western countries (cited in Aiken et al.,

2001) which have shown that where nursing services is well organised and managed, nurses have high work satisfaction and achieve respect and recognition from the other health professionals as well as from the top level in the organisation. The consequences are that they have a more stable nurse workforce and more patient satisfaction with lower rates in patient treatment complaints (Aiken et al., 2001; Holter, 2001). Holter (2001) argued that nursing leadership must develop a stronger identity and loyalty to the nursing profession and establish more visible nursing services in our health services (Holter, 2001).

Brandvold (2003) has argued that nursing leaders on a supervisor level are vital to maintain patient security and standards. She further asserted that nursing will be suppressed in the new organisation models with negative consequences in the long term unless nursing leaders continue to speak out, be distinct and brave (Brandvold, 2003). Brandvold (2003) indicated concern that lack of nursing leadership and management will reduce the conditions of the nursing services, and she suggested the positions of nurse supervisors and nurse directors should be kept to strengthen the professional leadership of nursing.

Whilst research on patient outcomes and staff skill mix is sparse some international research has shown that a lower nurse patient ratio and lack of nursing competencies influence negatively on patient results and mortality (Aiken, Clarke, Cheung et al., 2003; Davis et al., 2003). Aiken et al. (2003) accomplished a quantitative study in 168 hospitals in Pennsylvania, in the United States. They found that less nurses per patient and lack of nursing competence influenced negatively on patient results and mortality. They also found that nurses educated with a bachelor's degree or higher improved patient outcomes. The result is sensational as this study provided the first empirical evidence that the competences of nurses with a bachelor degree or higher in hospitals are connected with improved patient outcomes. These results ought to encourage employers and nurse managers to support and invest in further education for nurses to improve quality of care (Aiken, Clarke, Cheung et al., 2003). In Norway all nursing schools have educated nurses to a bachelor degree since the year 2000 (" Framework plan and regulation for 3-year nursing education in Norway," 2000).

Marquis and Huston (2000) stated that the nurse manager's role is increasingly vital to the provision of effective, quality patient care. As society and the environment change continuously nurse managers also need to be innovative, welcome change and create supportive systems for their colleagues. They argued that nurse managers need to be critical thinkers and managers in order to cope with the growing demand for nursing care (Marquis & Huston, 2000).

The International Council of Nurses (ICN) (2000) stated that nurse managers must be directly responsible for managing nursing services. ICN has held that nursing has a responsibility to coordinate and manage health services as well as contributing to health planning and policy. According to ICN (2000) the nursing profession should in all aspects of nursing be responsible for the quality and standards of nursing practice. This view is supported by the Norwegian Nurses association (International Council of Nurses, 2000; The Norwegian Nurses Association, 2005).

3.3 Summary

Earlier research on nursing and leadership in Norway has shown that nursing leaders have concentrated on running wards and clinics more than focusing on professional nursing quality and standards, and development of research in nursing. The published research does indicate that nurse managers had little influence in the hospital organisation (Aase, 1999). It has also been reported that nurse managers were performing most of the administrative functions in the departments (Aase, 1999; Normann, 2001). There was a concern among the nurses that they may lose influence in the new organisation (Sveri, 2004). Johansen's study on conflicts between health managers (2005) found that unitary management has contributed to more defined areas of responsibility and better communication between nurse- and physician managers.

Research in Denmark and Great Britain has shown that effective nurse leaders understand both politics and practice (Antrobus & Kitson, 1999; Jespersen, 2005). Other international research has shown that the position of nurse managers might also affect

the number and competences of nurses in the hospital which influences patient outcomes results negatively (Aiken, Clarke, Cheung et al., 2003; Davis et al., 2003). This research demonstrated the consequences of reducing nursing services as well as the need for strong nurse management. The International Council of Nurses has stated the importance of nurse managers' responsibility and management of the nursing services. This view is supported by the Norwegian Nurses Association (International Council of Nurses, 2000; The Norwegian Nurses Association, 2005). The literature review has demonstrated the importance of high quality nursing and well organised and managed nursing services.

This literature review has shown that nurse managers in Norwegian hospitals have had low influence in the hospital administration and have been mostly responsible for the administration function. It further indicates that nurse managers are vital to the quality and standards of the nursing services and clinical nurse managers have a central role in smoothing the progress of innovation for the development of practice. However, experiences in leadership and management in nursing following the introduction of a new Hospital Reform in Norway with unitary management are not documented.

4. CHAPTER FOUR - METHODOLOGY AND METHODS

In this chapter the methodology and research design for this study are presented as well as the methods for data collection, analysis and ethical considerations. A multi-site critical ethnographic design was utilised to observe and elicit the experiences of seven nurse managers from two hospital departments within one Norwegian hospital. The recruitment of study participants who participated in field studies and individual in-depth semi-structured interviews are described. The chapter concludes with a discussion of the validity and reliability of the research study.

4.1 Methodology

In order to describe and understand how nurse managers at different levels of the nursing hierarchy experience leadership and management after the introduction of a new health reform in Norway a critical qualitative approach was used in this study. To understand experience and the interaction between people and their environment in a complex situation a qualitative, interpretive approach was selected (Parhoo, 1997; Thompson & Wellard, 1999). Elliot (2003) stated that the phenomenon of interest in qualitative research is explored within a holistic and humanistic context and relationships or experiences are studied within the real world setting. Phenomena cannot be studied objectively, but must be studied from the individual's perspective and in the context in which they happen (Parhoo, 1997). In qualitative research the lived experiences in real settings are the objects of the study. Understanding how individuals make sense of their everyday lives is the core of this type of inquiry (Hatch, 2002). The intent is to explore human behaviours within the context of their natural occurrence (Hatch, 2002; Kvale, 1996, 1997). Analysis and interpretation are integrated in the qualitative research process of collecting data (Halvorsen, 2002; Parhoo, 1997).

4.1.1 Critical Social Science

Critical social science or critical theory is a movement in the social sciences which is often associated with the 'Frankfurt School' in Germany in the 1920s. The academic Habermas from this school has frequently been viewed as a central figure in critical

social sciences. To understand social phenomena and society critical social science has attempted to unite more or less incompatible elements of positivism, hermeneutics and Marxism. This knowledge might contribute to liberate people from suppression and dependency (Hammersley, 1992; Kim & Holter, 1995; Kristoffersen, 1996; Lewins, 1992; Street, 1991). Critical science in nursing has also often been associated philosophically and methodologically with the work of Freire who believed that people must liberate themselves and overcome a false consciousness caused by oppression (Fontana, 2004). Street (1991, p. 26) argued that "an engagement in reflective practices in nursing practice is essentially a political process because it is involved not only with understanding the world of nursing, but with changing it." As a researcher critical social science has recognised the interpretive categories in social science, and understanding the intentions and desires of the observed actors has been essential (Faye, 1975, 1987). According to Fontana (2004) critical social science provides the nursing profession the opportunity to understand its reality and take collective action to change undesirable situations. "Critical social science provides a political, economic, and historical context to oppressive realities that may have seemed predestined and promotes agency to facilitate emancipation" (Fontana, 2004, p. 99).

Critical social science is concerned with revealing existing beliefs and values which restrict or limit human freedom (Antrobus & Kitson, 1999; Hammersley, 1992). Faye (1987) held the three ideas of enlightenment, empowerment, and emancipation as the core of critical social science. However, there have been limitations as Faye (1987, p. 206) argued that "there is no single and final truth about ourselves which can definitely reveal who we are and what we ought to become". He also argued against the possibility to "set" people free. According to Thompson and Wellard (1999) the major criticisms of critical research relate to its emancipatory goals.

4.1.2 Critical ethnography

Ethnography is a way of collecting, describing and analysing ways in which human beings categorise the meaning of their world. It explores the influence or impact of culture on the lives of individuals or groups. An ethnography is generally descriptive in

orientation (Aamodt, 1991; Antrobus & Kitson, 1999; Atkinson & Hammersley, 1998; Turner & Emden, 1999).

Whilst participants' views and local information are central in traditional ethnography, critical ethnography has developed a reflexive research approach which attempts to reveal and engage in everyday life (Hammersley, 1992; Morse & Field, 1996; Thompson & Wellard, 1999). A critical ethnographic approach also intends to involve and engage the participants in the research process. Critical ethnography differs from ethnography in intent as the description is frequently informed by socialist and/or feminist politics. It moves beyond the description of ethnography and engages in more reflexive processes in qualitative research (Antrobus & Kitson, 1999; Hammersley, 1992).

4.2 Method

The critical ethnographic research design and a brief description of the study participants are outlined as well as the method of data collection and analysis.

4.2.1 Research design

A multi-site critical ethnographic design was utilised to observe and elicit the experiences of nurse managers. Seven nurse managers were recruited from two departments within a public hospital in Norway who participated in field studies and individual in-depth semi-structured interviews which were carried out over a period of three months.

Participant observation is essential for data collection in ethnography and the method combines participation in the lives of the people studied with maintaining some professional distance that allows for adequate observation and recording of data (Morse & Field, 1996). Participant observation presupposes participation and engagement as it involves studying social practices in natural settings. When doing participant observation the researcher simply cannot keep herself indifferent to what is going on (Fangen, 2004). The researcher is able to observe the society which assists in the

validation and interpretation of information provided by participants (Fangen, 2004; Morse & Field, 1996). A critical ethnographic approach engages in reflexive processes and intends to involve and engage the participants in the research process.

The purpose of the unstructured, qualitative research interview is to understand themes of the lived daily world from the subjects' own perspectives. It intends to get nuanced descriptions from the different aspects and everyday life of the person who is interviewed. The interview seeks to interpret the meaning of central themes in the life world of the subject (Kvale, 1996, 1997; Lillibridge, 1999). In qualitative research the methods of data collection are often flexible and less structured. The questions are not always prearranged or the same questions automatically asked of all respondents (Halvorsen, 2002; Parhoo, 1997). The semi-structured interview which was selected for this research, ensures that the researcher will obtain all required information while it simultaneously allows the participants freedom of responses and description to illustrate their answers (Kvale, 1996, 1997; Morse & Field, 1996). An interview guide (see appendix b) was outlined to indicate the topics and their sequence in the interview. However, a strict sequence was not adhered to as the researcher did not wish to influence the spontaneity and dynamics in the interview (Kvale, 1996, 1997).

This research focused on the experiences of nurse managers within the departments, but did not include the position of department manager who could have been a nurse but most likely would have been a physician. This higher position (unitary manager) had the total responsibility for the department and all personnel within it. This study did not attempt to focus specifically upon gender issues however it acknowledges that gender may influence the position of nursing in the hospital hierarchy as a vast majority of nurses are women (Holter, 1997; Statistics Norway, 2003).

By choosing this research design the intention was to contribute to engage the nurse managers in their everyday life at work as well as encouraging them in reflective processes concerning their experiences in leadership and management of their profession and services. The nurse managers were given a chance to speak and reflect on their experiences in their working lives. It is important that space is made for them to

speak and for the experiences of these nurses to contribute to nursing knowledge. Consistent with the critical intent of the research it is important for both individuals and nursing as a profession as individual confidence can be gained from gaining voice and nursing must have a voice in the health care system.

4.2.2 Study participants and admission to the research field

The study was undertaken in a large, public, teaching hospital in Southern Norway. The hospital administration was contacted who organised with Gatekeeper Access and assisted with hospital administration processes. The research project was presented at the Professional Nursing Leader Assembly Working Committee at the hospital, and the hospital administration invited two large departments to take part in the research in cooperation with the department managers. One large department displayed some uncertainty to be involved therefore a smaller department was invited and readily agreed to participate. Information meetings were held for potential participants within the two departments. At the end of these meetings nurse managers were invited to contact the researcher should they wish to participate and a contact telephone number and e-mail address was left with each department. No nurse managers were excluded. The first seven nurse managers who requested participation formed the study participants.

A sample of seven nurse managers from the two departments of different levels of the nursing hierarchy was utilised. This included ward nurses and nurses at supervisor level (assistant department managers) from within the two different departments in the hospital. The experiences of nurse managers included the experience of being managed by other nurses, i.e. ward nurses being managed by an assistant department manager. According to Morse (1991) a sample size of 6-8 participants is suited to exploratory, in depth qualitative research. The criterion for participation was that the nurse held a management position. The field study was restricted to two departments as including further departments would have made it difficult to gain a depth of understanding in the field and to be able to observe important aspects. Five participants were recruited from the large department, and two participants from the smaller department. In total seven nurse managers constituted the research population. Each participant received a plain language statement and verbal information that participating in the project was totally

voluntary. All participants signed the informed consent form before field studies and interviews were commenced.

4.2.3 Data collection

There were two forms of data which were collected by using both field studies and individual semi-structured interviews. All data were collected over a period of three months. The field studies and interviews were first carried out in the large department and secondly in the smaller department due to conveniences for summer vacation. Prior to the field studies the researcher had an informal meeting with each of the participants to become acquainted and to clarify eventual questions regarding the research project and data collection methods. The researcher was conscious of wearing her nurse uniform to assist with the recognition of her as a nurse and to conform to hospital hygiene standards.

Field studies

The field studies included participant observation for two days with each participating nurse manager in their work place. Nurse managers were observed in their natural working situation to enable description and understanding of their work context and their work role. The researcher kept a journal to collect data in the form of field notes that described the nurse manager's experiences, work role, environment, different statements and quotes from the nurse managers, in addition to the researcher's thoughts and reflections. In the field notes each participant was given a pseudonym in the form of a flower name only known to the researcher to protect their anonymity. Observation was temporarily ceased when the participant requested a time of non observation. This occurred on only a few occasions when the nurse participant wished to speak privately with a relative or a colleague. Participants may change their behaviour while being observed, however, inconsistencies and contradictions in the participants work role were documented by the researcher as part of the data. At the end of the day discussion was opened for a debriefing where the nurse manager could express her feelings and experience regarding participating in field studies.

Individual semi-structured interviews

In addition each participant undertook an in-depth semi-structured interview to allow them the opportunity to express their thoughts and experiences of nursing leadership and management after the new reform and how their voice is heard in the new organisation. A guide for the semi-structured interview was prepared. By accomplishing the field studies prior to the individual interviews the researcher also had the opportunity to ask the participants further about issues she had observed during the field studies. Each interview was expected to last approximately one hour to one and a half hours. The length of the semi-structured interviews, however, varied in accordance with the conversation and desire of the participants. The length of the interviews varied from 1 hour and 15 minutes to 1 hour and 50 minutes. The interviews took more of the form of a conversation as the researcher did not ask questions in the same order in each interview but followed the participants in their reflections as each interview proceeded. The interviews were carried out in the participants' work place in a room suitable for the purpose. The atmosphere was at all times good and by the end of the interviews the participants were asked if they wanted to comment on the interview or add information or aspects they thought might be important to clarify their life world as nurse managers.

After the interviews were finished and the tape turned off it was opened for a debriefing where the participants could express their feelings and experience in being interviewed and the researcher explained further procedure. Many of the nurse managers found the interview process interesting and enriching having the possibility to talk freely and openly and reflect on their experiences in their job. Each interview was audio taped and transcribed verbatim word for word by the researcher with each participant given a pseudonym as allocated in the field notes. The interview transcripts were sent to the individual participant asking for participants to validate the accuracy of the content and check the transcript for personally identifying information. In addition they were informed that they could make changes if they had any concerns with the material. Another purpose was to activate their reflexive thinking on the content of the interview. They commented mainly on their verbal talk being transcript to writing which the researcher had prepared them for. The excerpts from the participants presented in chapter five were all translated by the researcher.

4.2.4 Data analysis

The data for this study included both the researcher's journal of field notes and individual semi-structured interviews with seven nurse managers and which were analysed utilising Kvale's steps of analysing qualitative data. Kvale (1996, 1997) suggested three contexts or levels of interpretation which will be further described. Kvale's (1996, 1997) method of analysis whilst often utilised in phenomenological approaches is also frequently used in other qualitative methodologies.

The field studies provided the background of the nurse managers' natural working situation to enable description and understanding of their responsibilities and experiences as well as their work role understanding. The purpose of the analysis was to form a true picture of the understandings, intentions and values which form the basis of the persons studied (Halvorsen, 2002; Parhoo, 1997; Sivesind, 1998). In this research study Kvale's (1996, 1997) meaning condensation was selected as it is consistent with critical ethnography. A critical analysis intends to get hold of "unconscious processes, ideologies, power relationships and other expressions of dominance which entail that certain interests might be concealed at the expense of others" (Fangen, 2004, p. 187) According to Kvale (1996, 1997) meaning condensation can be applied to many qualitative methodologies.

The first steps of the analysis refer to the interview situation. Initially the participant is describing her life world and experiences in relation to the theme. Next the participant spontaneously discovers new relations and meanings during the interview. The researcher then according to Kvale (1996, 1997) condenses and interprets the sense in what the participant is saying by returning the meaning to the participant creating an opening for confirming or invalidating the interpretation. During the interviews several questions with clarifying purpose were used repeatedly and aspects from the field studies could also be validated. The interviews were transcribed verbatim word by word by the researcher and natural pauses, laughter, etc. was noted. The researcher was according to Kvale (1996, 1997) aware of decisions involved in converting oral speech

to written texts.

By interpreting the transcribed interview the material according to Kvale (1996, 1997) is going through a clarification process by eliminating surplus material and distinguishing between essential and non-essential material depending on the purpose of the study and the meaning of the interviews is being developed. Meaning condensation was selected as an approach to analysis of meaning as it is consistent with critical ethnography**.** Kvale (1996, 1997) held that meaning condensation involves a reduction of large interview texts into shorter, more concise formulations and has five stages. First the whole interview is read through to get a complete sense. Secondly the natural meaning units as expressed by the participants are decided by the researcher and in the third stage the theme that dominates a natural meaning unit is stated as simply as possible. The purpose for the researcher is to read the participant's answer and to thematise the statements from the perspective of the interviewed person as comprehended by the researcher. In the fourth stage the natural meaning units are thoroughly examined in terms of the purpose of the study which is consistent with the critical ethnographic approach. In the fifth and final stage the essential themes are bound together in a descriptive statement (Kvale, 1996, 1997).

All stages were followed as described. The themes of the meaning units were directed with respect to questions as to what the different statements told the researcher about their experiences. This involved a condensation of the expressed meanings into more and more essential meanings of the experiences in leadership and management of the nurse managers.

With regard to the interpretive work of the interview Kvale (1996, 1997) suggested three contexts or levels of interpretation; self-understanding, critical commonsense understanding, and theoretical understanding, where the two first levels were selected for this study. "Self-understanding" is what the participants actually say and describes the participants' understanding of their statements in a condensed form. The interpretation is limited within the participants' "self-understanding" and does not go beyond that. By a "critical commonsense understanding" the interpretation includes a

wider frame of understanding than that of the participants alone and extends the critical understanding of what is said by focusing on the content or the person making it to enrich the statements but within the context of a commonsense understanding (Kvale, 1996, 1997).

4.3 Ethical considerations

In qualitative research it is acknowledged that the researcher influences the research. The researcher forms a relationship to some extent with the research participants and therefore aspects of power relationships and coercion have to be considered carefully (Kvale, 1996, 1997; Turner & Emden, 1999).

Consistent with the research methodology the purpose of the research should be for the beneficence of both the participants and the larger society. The principle of informed consent is important. The participants were provided with sufficient information about the research project to enable them to make a judgement and decision as to whether they wished to participate in the research project. Participants had the right to withdraw at any time during the research project without any consequence. In addition the principle of estimated risk and harm was considered, and the welfare of the participant was weighed against the interest of science and society (Halvorsen, 2002; Solbakk, 1998; Turner, 1999).

The researcher undertook responsibility to ensure appropriate ethical standards of the research project as well to obtain approval from the relevant ethics committees (Kvale, 1996, 1997; Turner & Emden, 1999). The researcher obtained ethics approval from the Ethics Committee of Deakin University, Australia and the Committee of Research Projects, Viborg School of Nursing, Denmark (see appendix c and d). Gatekeeper Access was achieved at the hospital where the study was undertaken (see appendix e). All participants were recruited on a voluntary basis through information meetings. The researcher was not a colleague, employer or manager of potential participants and therefore participation or non-participation in this research for nurse managers and senior nurse managers did not involve any coercion or effect potential participants'

employment. Each participant was given verbal information and received a plain language statement (see appendix f). Informed consent forms were signed before the data collection commenced (see appendix g). The researcher signed the Promise of Secrecy Declaration at the hospital in which this research was conducted and was therefore also obliged to work under the Ethical Guidelines for Professional Conduct from the Norwegian Nurses Association ("Yrkesetiske retningslinjer for sykepleiere," 2001).

This research did not entail invasion of privacy. The field studies and individual in-depth interviews were organised in agreement with the participants. The field notes and interview transcripts were coded with participants allocated a pseudonym to ensure anonymity. The research project was not anticipated to expose the participants to risk or stress beyond what is encountered in their everyday life. The researcher was prepared to provide the participants with the name and contact details of an external contact person qualified in counselling should any of the participants feel uncomfortable in regard to the field study or interview. In addition the research with that participant would have ceased and any data collected would not have been utilised. However, this provision was not necessary as any distress or concern by participants was not detected.

Field notes, audiotapes and transcriptions have been kept separately from consent forms and in a locked cabinet during the research period. Upon completion of the data collection data were secured in a locked cabinet only accessible to the researcher and supervisors during the research period. All data will be kept in a locked cabinet at the School of Nursing, Viborg Campus for a minimum period of six years from the date of any publications emanating from the research.

4.4 Validity and reliability

The notions reliability, validity and generalising are closely connected and originate from quantitative research. Reliability refers to the consistency with which the results of research can be reproduced whereas validity refers to if the method provides what it is meant to study and if data collected are relevant and valid (Knizek, 1998; Kvale, 1996, 1997). In qualitative research validity is according to Morse and Field (1996)

considered by the degree to which the research findings represent reality. Other researchers have referred to validity in qualitative research as credibility or trustworthiness (Fangen, 2004). In qualitative research validity is according to Kvale (1996, 1997) superior to reliability because when validity is high the results might be trustworthy. However, high reliability does not automatically secure high validity. All aspects must be considered during the research process.

Kvale (1996, 1997) considered validity as a quality of craftsmanship and the credibility of the researcher becomes fundamental. "To validate is to check. The researcher adopts a critical outlook on the analysis, states explicitly his or her perspective on the subject matter studied and the controls applied to counter selective perceptions and biased interpretations, and in general plays the devil's advocate toward his or her own findings" (Kvale, 1996, 1997, p. 242). Validity affects all stages in the research process and is working as a quality control throughout the project (Knizek, 1998; Kvale, 1996, 1997).

Kvale (1996, 1997) underlined the importance of implementing quality in all steps of the study. He argued that to establish validity is to check, to question and to theorise through all steps of the research process. The researcher collected and transcribed all data, however, the interview transcripts were sent to the individual participant asking for participants to validate the accuracy of the content. In addition they could make changes if they had any concerns with the material, however, they did not. The research process followed all Kvale's steps of analysing qualitative data including two contexts of interpretation (Kvale, 1996, 1997).

4.5 Summary

This chapter has described the theoretical framework of critical social science and critical ethnography and the method utilised for the research study. The recruitment of participants and admission to the research field was outlined. Seven nurse managers from two hospital departments participated in field studies and individual interviews over a period of three months. All data were analysed utilising Kvale's steps of

analysing qualitative data as well as two contexts of interpretation. All ethical aspects were purposefully considered and no coercion or distress occurred. Finally issues of validity and reliability of the research study were discussed.

5. CHAPTER FIVE – RESULTS AND FINDINGS

In this chapter the findings from the study are presented. Prior to presenting the specific data a brief description of the hospital and the two hospital departments where data were collected is given. The data for this study includes both individual interviews with seven nurse managers and the researcher's journal of field notes. Both data from individual interviews and the field notes have been analysed utilising Kvale's steps of analysing qualitative data. Kvale (1996, 1997) suggested three contexts or levels of interpretation; self-understanding, critical commonsense understanding, and theoretical understanding.

The particular focus of this chapter is related to the first two levels or contexts that is self-understanding and critical common sense understanding. "Self-understanding" was what the participants actually said and describes the participants' understanding of their statements in a condensed form. This level is also combined with a "critical commonsense understanding" where the interpretation included a wider frame of understanding than of the participants alone including a critical discussion of what is said by focusing on the content to enrich the statements but within the context of a commonsense understanding (Kvale, 1996, 1997).

5.1 Introduction

The data consist of ethnographic field notes recorded by the researcher as she "shadowed" or followed each nurse manager participant at work and individual in-depth semi-structured interviews. The data were collected over a period of three months. The field studies included participant observation for two days with each participating nurse manager in their work place. Nurse managers were observed in their natural work situation to enable thick description and a deep understanding of their experiences and work role. The researcher kept a journal to collect data in the form of field notes that described the nurse manager's experiences, work role, environment and the researcher's thoughts and reflections. In addition each participant undertook an in-depth semi-structured interview to allow them the opportunity to express their thoughts and experiences of nursing leadership and management after the new reform and how their voice was heard in the new organisation. A guide for the semi-structured interview was

prepared. By accomplishing the field studies prior to the individual interviews the researcher also had the possibility to ask the participants further about issues she had observed during the field studies. Most interviews lasted approximately one and a half hours varying from 1 hour and 15 minutes to 1 hour and 50 minutes.

Thematic analysis was consistent with Kvale's meaning condensation where the purpose was to identify natural meaning units and their central themes (Kvale, 1996, 1997). The thematic analysis involved the search for and identification of common threads found throughout the interviews and supported by the field studies. The researcher's notes from the field studies corresponded well with data gained through the interviews with the participants. The excerpts from the participants are written in *Times New Roman cursive* whereas the excerpts from the researcher's field notes are written in *Arial cursive*.

The findings have been organised into four different key themes which predominantly relate to questions formed in the interview-guide;

- Experiences of responsibilities and challenges
- Leadership ideals and reflections on the role as nurse manager
- Experiences of cooperation and communication
- Possibilities for influencing managerial decisions

Within this chapter the different themes have been supplied with titles drawn from the analysis of the interviews as condensation of meaning to guide the reading and increase the depth of focus into the actual themes.

5.2 The hospital departments and organisation model

The study was undertaken in a large, public, teaching hospital in the southern part of Norway. The hospital was situated close to the centre of the city and served as both a local and a regional hospital offering many specialities of treatment. The hospital founded early in the last century had long traditions and a strong position in the region. It had been extended and renovated several times and appeared as a modern, high

technological and effective hospital with many buildings spread out as well as a huge, high-rise, central building which was constructed approximately 25 years ago. Seven nurse managers from two hospital departments situated in the central building of the hospital participated in the study. Both departments had a physical focus to the care they delivered with the specific clinical focus being the speciality of internal medicine and cardiology. The departments were situated on several floors throughout the hospital building and were both very busy departments treating mostly acute patients. One department was large containing approximately 140 hospital beds whilst the other was smaller comprising approximately 90 hospital beds. In addition both departments had outpatient clinics.

Staff within the departments comprised one general manager and two or three assistant department managers. One of the assistant department managers had responsibility for the nursing services. With regard to nursing personnel there were approximately 250 nursing staff including registered nurses and nurse assistants in the large department and approximately 160 nursing personnel in the other.

The nurse manager positions within these departments comprised assistant ward nurses, ward nurses and one assistant department manager. The ward nurse (or head nurse) was responsible for the nursing services and nursing personnel of one specific ward or outpatient clinic whereas the assistant ward nurse deputised in her absence and had special responsibility for education programmes in the ward. The position of an assistant ward nurse is not the focus of this study and therefore is not included within this study. The assistant department manager was responsible for the nursing services within the whole department and superior to the ward nurses in the organisation. Each department was headed by a department manager who reported directly to the hospital chief executive officer. Both department managers within this study had a medical background.

The larger department was organised with two assistant department managers directly responsible to the department manager. One assistant department manager was responsible for the nursing services and the other responsible for the medical services.

The ward nurses and the section chief physicians were directly subordinate to the assistant department managers and did not report to the department manager directly but via their supervisors. The medium size department was organised with one department manager and two assistant department managers who undertook professional responsibility for the medical or the nursing services respectively, but without direct responsibility for the personnel. The ward nurses and the medical leaders (similar to section chief physicians) had a direct line to the department manager whom they reported to in respect to economic matters.

5.3 Brief description of the participants

Seven nurse managers, two nurse managers at supervisor level (assistant department manager) and five ward nurses, from two hospital departments participated in this study. The formal responsibilities of the ward nurses included responsibilities for running the ward as well as being in charge of the nursing staff. The assistant department managers were responsible for the nursing services of all wards within their department and one of them were responsible for both the nursing staff and the nursing services within her department.

All participants were female with an average age of 50 years. Six of them were married, one was divorced. All participants had children. The length of experience as a nurse manager varied greatly from 9 – 22 years with the average experience being approximately 13 years. The length of experience in their current position varied from 4 – 17 years. All participants held postgraduate education qualifications in leadership and management. In addition all participants had postgraduate clinical education in different nursing specialities and/or postgraduate education in counselling.

5.4 Findings and themes

The findings have been organised into four different key themes. The different themes have been supplied with titles drawn from the analysis of the interviews as condensation of meaning to guide the reading and increase the focus into the actual themes;

- Experiences of responsibilities and challenges - *"keeping many balls in the air at the same time"*
- Leadership ideals and reflections on the role as nurse manager - *"respect, tolerance and coordinating chaos"*
- Experiences of cooperation and communication - *"good relationships and improved cooperation"*
- Possibilities for influencing managerial decisions - *"depending on a department manager in favour of nurses"*

Furthermore differentiation between the findings of the two groups of nurse managers to distinguish the differences between the ward nurses and the nurses at supervisor level (assistant department managers) in their work practices and their positions within the departments has been made.

5.4.1 Experiences of responsibilities and challenges – "keeping many balls in the air at the same time"

The ward nurses described their main responsibilities to be in charge of the nursing staff of the ward with all its complex organisation and care requirements as well as being responsible for running the ward including the economic responsibility. They expressed that their job mainly consisted of planning, coordinating and running the ward and the nursing personnel within it besides securing and developing the quality of the nursing services. They had professional responsibility for the nursing standards and training programmes for newcomers in addition to accomplishing the competence programmes for all nursing staff at the ward.

One ward nurse described the complexity of her job:

> *"It is difficult to express my job in few words, because it is in a way so complex … It is all from talking with employees to check if you have enough staff with the right competence on every shift… It is to influence the programme for our patients to make sure we can offer high quality nursing to them, not too many at the same time to be able to handle it.. In a way I feel that I catch a glimpse of everything which is going on at the ward….." (Daisy)*

Another ward nurse emphasised the importance of qualifications:

> *"It is obvious that I have to provide the nurses with the necessary competence and training…. We must bear in mind that we are taking care of seriously ill patients. The doctors are seeing the individual patient maybe five to ten minutes in total during the day and night whereas the nurses are taking care of the patients the rest of the time, so it is pretty obvious that we must be very competent nurses in order to care for them in a proper and respectable way." (Violet)*

Nurse managers emphasised that a good shift plan was essential for running the ward well. They saw the competence of the nurses on the different shifts as a condition to secure high quality nursing services. They had put great effort into developing good shift plans which they had in a data system and the long term shift plan made it possible to plot in educative programmes in the daily running of the ward.

They described their job as "keeping many balls in the air at the same time" and that they rarely could sit down calmly to concentrate on their work as they were constantly interrupted and called for. From the very moment they entered the ward in the morning they were in close contact with the nursing staff and other personnel connected to the ward to be informed about what was going on with the patients and the staff and to be able to intervene if needed. The researcher observed that the ward nurses had to be attentive to several matters at the same time and worked under great pressure. They expressed that they had a lot on their minds and they had to sort things out quickly as they were constantly pressed for time. They were often interrupted before having finished an assignment mostly due to matters regarding patients.

Placing of patients due to a high patient turnover demanded a lot of their attention as they often needed to reorganise the ward to maximise the use of the hospital beds. Some wards often experienced the trauma of having to place patients in the corridor because the patient flow was too high. Having "corridor beds" also affected the physical environment on the ward as they had to move beds around, night tables, chairs and different equipment in order to find room for additional beds. They often felt they were working in an endless chaos. They felt it was unworthy for patients and it also influenced the work environment for the nursing staff in a negative way.

The researcher also experienced the distress of corridor patients:

> *"I entered the ward early in the morning at 06.45 a.m. The corridor had subdued light and it was just before the day shift arrived. I noticed three folding screens covering hospital beds and I quickly realised that patients who had been hospitalised the last night were placed here due to lack of extra beds in the hospital rooms. One of the patients was vomiting and a nurse came to help her out. I asked myself why we still have to put up with such circumstances."*

One ward nurse expressed:

> *"[----] I really feel it is so hard to see the nurses having to work under such conditions, I think it is rather awful… I think it is terrible for the patients out there; it is unworthy for them… I find it very difficult to deal with it, and it is so unpredictable…. It nearly makes me feel sick… And to motivate the nurses when it is like that is not easy…." (Jasmine)*

However, the ward nurses expressed that they had high job satisfaction and enjoyed seeing nurses develop and succeed in their jobs. They acknowledged that filling the shift plans with competent nursing personnel was very time-consuming, tiring and quite a challenge, especially during holiday periods when they had large vacancies. The researcher observed that all ward nurses had to pay great attention to filling in vacancies in the shift plan throughout every day in which field studies were undertaken. However, the field studies took place during a holiday period where the need for extra personnel was larger than usual.

The ward nurses emphasised that personnel management had a much larger part in their daily work than what was reflected in their job description and this had increased after unitary management was introduced. Now they completed almost all procedures when employing new personnel. Earlier they took part in the interview process; the rest was completed by the supervisor nurse and the human resource department at the hospital administration. The paperwork attached to the hospital service system was also very time-consuming. They all asserted that they were extremely busy in their jobs and worked under great pressure. The researcher observed that the working pace was intense

and experienced that even taking a break for lunch was not possible every day due to an urgent and heavy work load, so often they had a sandwich in the office instead in between telephone calls and organising of different work.

The process of finding the right model in the department had taken far more time than expected especially in the largest department, and they finally decided on the new organisation chart during the last year whereas the reform was effectuated three years ago. During the process they did not know whether they would have a nurse on supervisor level or not, however, both departments decided to change the title from supervisor nurse to assistant department manager as it was important to keep a nurse manager with responsibility for the nursing services. The ward nurses believed they totally depended on having a nurse at a supervisor level as they firmly believed that they needed to have a nurse at a coordinating level position in the department in addition to someone who could lead the development of nurses professionally.

The ward nurses thought that economy and budget control had a stronger emphasis now and they were held more responsible for the ward budget which they had to account for in meetings with the department manager.

They also expressed that the communication with the unitary management was more complicated as they earlier only reported to the supervisor nurse.

When asked about the supervisor nurse one of the ward nurses responded:

> *"[----] I notice that the supervisor nurse earlier had a far more independent role when we had two-part leadership, because now she has only….. She cannot make any decisions without consulting…, well, she can of course, but she <u>needs</u> approval from the department manager. And in many ways it is getting delayed, I think. It takes longer time to get things done, which is my opinion. Another thing is that we get all information from the assistant department manager, but never directly from the department manager." (Lily)*

A positive consequence which was reported from most of the nurse managers was that the reorganisation process had forced the nursing services to become more distinct as

they needed documentation on what the nursing services represented in the department. They needed to identify what nursing is within the organisation and to document what nurses are doing. They had developed documentation and plans for the nursing services which was required for documenting an argument for the nursing services.

One nurse manager expressed:

> *"I believe it is a problem many nurses struggle with, to define and put the essence of nursing in writing, what we are doing and why we are doing it…. So I think it is good that we in a way have been forced to define what nursing is all about." (Tulip)*

A part of the hospital reform was the introduction of the enterprise model with business management ideology and hospital services. A consequence was that the ward nurses now had to buy all services they needed from the hospital services, from food to cleaning services, but they only had one choice and one price. They had to buy what the hospital service system had provided for them. They could choose neither quality nor price which many of them found unacceptable. The system was more or less the same as before, the only difference was that they believed it was more expensive and had added more paperwork. The ward nurses found that the paperwork in their job had increased immensely, most of it due to the hospital service system and the report system on wages etc. for personnel. They experienced the need for documenting consequences and writing letters when necessary had become more frequent and important. The researcher observed that the ward nurses did a great deal of paperwork during the working day and that it was piling up.

One ward nurse emphasised the importance of documentation:

> *"……. If you can't transform a problem into figures, you have a stormy passage all way long..... You <u>have to</u> have exact figures and hard facts…." (Tulip)*

Another ward nurse expressed:

> *"In my opinion the departments have increased their focus on "making money". We have to "increase our production"; these are the important words now." (Lily)*

The nurse managers expressed that for the benefit of the nursing services the model of unitary management depended on a department manager who had a positive attitude towards nursing. If not, they believed the department manager could easily change this picture.

One ward nurse expressed her view:

> *"I think that we depend on who is sitting in the leader position as a department manager, it will be very decisive for how the nursing services will turn out… If you get someone who would not back up and develop the nursing services, we would lose…." (Daisy)*

The nurses at supervisor level, the assistant department managers, described their job as being responsible for the nursing services within the department. One of them was responsible for all nursing personnel whereas the other, who was organised in the department manager's staff, had the systemic responsibility for both the nursing and the secretarial staff. Both of them explained that their job consisted of coordinating the nursing services within the department as well as supervising the ward nurses on professional nursing matters and personnel issues. The main part of their job was to influence the development of the nursing services and to implement new systems. They both reported directly to the department manager and emphasised the importance of their work in the department management group.

One nurse manager described the main focuses in her job:

> *"In a way I see two main focuses in this job; one is my work via the ward nurses on managing the running of the wards and not at least professional nursing in the wards, to find room for further development of nursing…. The other is my role in the department management group and nursing is central in both occasions." (Iris)*

The two assistant department managers considered their position to be of great importance to the nursing services and the ward nurses in the department. The staff nurse did not experience a great difference in assignments and responsibilities compared to earlier times when they had two-part leadership. The difference for her was that she

now had systemic responsibility for a personnel group who was being reorganised in their department which had demanded a great effort from her. The researcher observed little difference in their contact with the ward nurses in the two departments. The researcher noticed that both nurse managers had daily contact with the ward nurses within the department as well as individual and group meetings with them on a regular basis.

The researcher met one of the ward nurses after an individual meeting with her supervisor:

> *"We met in the corridor; she smiled and told me that the meeting was "a great relief". She had been able to talk about difficulties in the staff as well as nursing issues. She said she was very pleased to have this opportunity and she got things sorted out."*

One nurse manager described her job in the new organisation:

> *"The relationship with the ward nurses is more or less the same, even with this direct line they have to the department manager….. As the department manager has a direct line to quite many in our department, it is a matter of course that I need to support a lot to make sure that things are done. Therefore it is reasonable that I have more or less the same contact with the ward nurses and research nurses. It is the systemic responsibility which I now have for the secretarial staff which has changed my function." (Rose)*

One nurse manager expressed the importance of her position in the department:

> *"…. In the process of changing the organisation (department) the ward nurses expressed they were scared stiff that I, or the position I have, should disappear. Because they knew that they would not get access to the department manager to consult and ask different questions, to get support and feed back, as they get in relation to <u>my</u> role……both because he would have less time available and because I believe the physicians do not have that tradition. And he is a physician, and I think he would not have seen the importance of following up in the same manner. And as long as he has a different professional background, there would be many issues they could not have discussed with him….. To keep my position has been vital to them, and I also believe it has been important that we have been able to keep a gathered ward nurses group and that we have stuck together… They say that the colleague fellowship has been very important to them….. And if you haven't got somebody on top there, they would be fragmented*

out, they might get very alone, and I think it would be a very difficult role for them to cope with." (Iris)

They both communicated that they were quite happy in their jobs and enjoyed being in the forefront of matters. They admitted that a person in a job at this level might get lonesome now and then as you tended to get closer to colleagues at a ward level. They took great pleasure in seeing nurses develop and become very competent in their jobs. They experienced very busy jobs and admitted that the working pace was intense. They emphasised that the patients must be taken good care of and get the best treatment and nursing care available and consequently they needed to set the quality standards for nursing. They also emphasised that individual nursing care is essential for good quality nursing and they both worked a lot to improve nursing documentation to be able to reflect individual nursing care.

5.4.2 Leadership ideals and reflections on their role – "respect, tolerance and coordinating chaos"

All nurse managers talked frequently about the significance of respect and emphasised that respecting each other as colleagues and as patients and nurses was fundamental in their jobs.

The ward nurses worked very close to their staff. They saw themselves as coordinators in many respects and especially within the ward. They all emphasised that it was important for them to keep open and good communication with their nurses and that the nurses had confidence in them as leaders and managers.

One ward nurse expressed it like this:

"I have a leadership style which makes it necessary for me to be in close contact with, or in touch with, the persons I am in charge of. I need to see how they are doing when they are working; I need to look into their faces. I need to be there to be able to act if I see or understand that one has too much work or the opposite, I have to balance the workload as it is essential to make the ward function in a good way and that the patients are being well cared for." (Jasmine)

The researcher experienced how one of the ward nurses communicated with her staff:

> *"It was a very busy morning with many acutely sick patients having arrived during the night. She walked a round to survey the situation and communicate with the nurses. I followed her from room to room where she met the nurses helping their patients. I noticed a calm atmosphere in the ward where everybody spoke quietly and walked gently, no flurried atmosphere despite a pretty chaotic situation. I felt that the nurses were very aware of their own presence and how they appeared among the patients. It gave me a feeling that they had the situation under control."*

The ward nurses believed that their role was vital to the ward and they saw their main role to be a good coordinator for all kinds of purposes and all personnel who worked there. They saw their most important role to attend to and take care of the staff and to make the best circumstances and conditions in order to provide high quality care for the patients.

One ward nurse described her role as a coordinator:

> *"The most important role in this job is to be the coordinator between the nursing staff and what actually needs to be carried out with the responsibility included…… I believe that for me the nursing staff is the most important resource what so ever; because we can perform the most incredible for less money if we only stick together, and we can do nothing if we don't." (Tulip)*

The ward nurses were concerned about keeping high standards in nursing as well as developing nursing and saw themselves in the forefront of this work. They needed to motivate and encourage the nurses to do a good job as well as commending them when doing a good job. They emphasised that being appreciated was important for job satisfaction and it also influenced the nursing standards positively; a positive feed-back is motivating and makes you function even better.

The researcher reflected on the significance of feed-back:

> *"It had been a very busy day with less staff at work than usual. By the end of the day the ward nurse asked the staff to sit down for a minute to "talk things through" and they all agreed it had been an extraordinary day but that they had been able to handle the situation. The ward nurse responded to each of them and expressed appreciation of the good*

teamwork. I thought it was a good way of debriefing as well as giving the nurses recognition."

One ward nurse reflected on her role:

> *"As a ward nurse you are a very close and visible leader and I believe it is important that you function very well in your job and that you are able to be a "driving force". It is not always me who should come up with ideas, but sometimes I need to. Because I feel you need development and growth in the job as well as in the whole ward… that we must be…. Well, I believe we need to have something to aim for, to do the best we can all the time."…… "In my job it is important to be ahead and keep up high quality, which means that we are clever nurses, are doing a god job and are keeping up high standards of nursing." (Lily)*

One ward nurse explained the importance of feed-back:

> *"…… I believe it is essential to give them positive feed-back, both with their name and everything, that you have seen them and noticed what they are doing and how they are doing it… I believe it is very important that they feel they are seen and are valued in their job…." (Violet)*

The ward nurses talked about the significance of tolerance and to be able to accept different opinions among the staff. They worked hard for creating a good working environment where people were happy and comfortable in their jobs and with each other.

The ward nurses emphasised the importance of care and concern for the staff. They needed to be able to handle problems which occurred continuously and to be able to communicate well with their staff. They thought it was vital to have a friendly and positive working environment to be able to do a good job. They explained they needed to have a continuous focus to achieve and keep up a good working environment.

One ward nurse explained:

> *"When you have responsibility for personnel, and when things get tough for them…... you get very close when you are in this ward nurse position….. You cannot distance from it either, because…, well, when*

people do not function as human beings, they do not function as nurses either, so you simply have to find a way to make it work." (Violet)

One ward nurse expressed it like this:

"I believe that my most important task is to make the thirty persons who work here, to work well together towards a common goal." (Jasmine)

Another ward nurse said:

"I believe that my most important job is to attend to and take care of the personnel in order to make the best circumstances and conditions when caring for the patients… And then it is also about being aware of nurses who are tired or worn out, to be able to protect them from the most demanding assignments for a while if needed… it is about taking care of them to enable them to do a good job…. I also see that some nurses burn with enthusiasm where I see my job is to motivate and support them and do my best for them to contribute to the development of the nursing services." (Daisy)

A nurse manager on a supervisor level implemented her ideals in leadership to strengthen the persons she was leading. She explained that even if she had a good idea, it could only be realised through hard work of others and she believed that those who accomplish should be honoured.

She gave a definition on good leadership:

"A person told me once that the definition of good leadership was to take a step aside when you are being credited for something to make sure that those who did the job are getting the credit and praise." (Iris)

The assistant department managers both emphasised that it was important to be engaged and enthusiastic in your work and to "burn for" your work. As managers and leaders they found it important to encourage and motivate the staff and to be open for possibilities for those who want to put in extra effort to develop nursing and improve the nursing services. They saw their role as that of being a mentor, and a person the ward nurses could discuss different matters with.

One nurse manager emphasised her role in the department management group:

> *"I believe that if you are not present where the discussions take place before decisions are made, you have no real influence…. Afterwards it is useless to say what you would have preferred or that we won't have it at all, or we can't do it like this when the decision already is made…it is hopeless. Regarding decisions…, the pace on handling the different matters and statements is very fast indeed, so in a department of this size it is impossible that the expanded management group can participate in all these discussions. So I believe that being the connecting link here and getting information together with my broad knowledge on the organisation…., and bringing it into the department management group when we have these discussions, I believe it is decisive…. I experience that I have to fight for the nursing services not being run over…" (Iris)*

Both nurses on the supervisor level (assistant department managers) emphasised their role in the department management group which they thought was vital and critical for the nursing services. Having the possibility to participate in and influence all processes regarding the department in general and the nursing services especially was essential to them.

5.4.3 Experiences of cooperation and communication – "good relationships and improved cooperation"

The ward nurses experienced that the relation and cooperation between the nursing staff within the wards was very good and that they had a good working environment despite hard working days and pressure in their work situation. They emphasised the importance of having a good relationship and cooperation with the other ward nurses. It was important to confer with other ward nurses what they thought about different matters. They had regular ward nurses meetings where they could raise professional questions and discuss them properly as well as daily meetings for everyday running of the wards. The researcher sensed a friendly and open communication between the ward nurses and their supervisor nurse. They seemed to be discussing matters openly and straightforwardly in a good atmosphere. The researcher experienced frequent laughter and friendly remarks. The nurse managers expressed the need for being able to see the positive and humorous aspects of the problems and matters which arose. They also

arranged social get-togethers within the wards and between the nurse managers to get to know each other well and to be able to gather in a more relaxed setting.

One ward nurse expressed:

> *"….. You are so alone in this job, and you find your way to do things. But, it can be useful to ask a colleague how she is doing it. Maybe you spend too much time on something and less on something else. Then it is very useful to check out with the others how they think and reflect about different matters." (Jasmine)*

The researcher attended a ward nurses meeting:

> *"We were 14 persons seated around a conference table. The nurse managers were discussing different nursing matters and especially how to recruit enough qualified personnel for the summer holidays as the recruiting offices did not seem to be able to provide all of them. I was introduced but they did not seem to take any notice of me. The atmosphere was friendly and relaxed though they seemed a bit stressed over the vacancy situation."*

They also had meetings regarding professional nursing and developing the nursing services together with the assistant ward nurses to enrich the professional nursing environment. The assistant ward nurses had a special focus on professional nursing in the wards together with the research nurse on the department level. The ward nurses had individual meetings regularly with the assistant department manager which seemed to be of great importance for them. They could of course contact them informally; however, they valued to have a time of their own which was planned for.

The ward nurses believed it was important to have a good relationship and cooperation with the physicians, especially the section chief physicians or the medical leaders. Most of them thought that the cooperation worked well in general, but they seemed to be the ones who mostly took the initiative. However, occasionally it was quite challenging as the physicians seemed to be more interested in the patient treatment and not so much in how to run the ward smoothly. They were often more concerned with their research projects rather than taking a common responsibility to work out good solutions. Ward nurses experienced that the physicians expected them and the nursing staff to take part

and support them in their research projects without any additional personnel resources which made it difficult to support them.

The researcher experienced a good relationship:

> *"I had noticed the friendly tone between the ward nurse and the section chief physician. "At this ward she is taking all initiatives and I support her" he said to me with a smile. ….. Later that day I attended an informal meeting between them. We were seated in a small room without a window normally used for storing equipment, but they did not seem to take much notice of it. They needed to sort out how to organise the work with all the new personnel during the holidays. They had good eye contact and spoke to each other straight from the shoulder. They seemed to have a very good dialogue and agreed on how to solve the situation."*

The cooperation with other health professionals like the ward secretary and other secretarial staff, transport and cleaning personnel, physiotherapists, social workers and others appeared to be working very well.

The ward nurses experienced that the organisation had become more transparent and the managing personnel seemed to be more aware of and concerned about their responsibilities regarding personnel. Currently ward nurses and section chief physicians or medical leaders are equalled at the same level in the hospital organisation.
A positive aspect of the new management system was noted by the ward nurses in one department. They identified that now there was a new system for buying large medical or other equipment which they thought worked very well for everybody. If the ward needed equipment that exceeded a certain cost, the managers needed to apply for it and decisions were made in the department management group once a week. It seemed that everybody was content with this system.

In this department the ward nurses believed that the section chief physicians experienced greater changes with the reforms than the ward nurses as they as nurses had always been used to handling personnel. In the new organisation the section chief physicians had the same responsibilities regarding personnel as the ward nurses.

The assistant department managers were working via the ward nurses and thought that the cooperation between them was good and confident. They were very conscientious

not to dominate them, but wanted to contribute to make them strong, to strengthen their identity and their professional strength to be able to influence the staff in a positive manner. They had meetings weekly where they discussed different questions regarding the running of the wards as well as professional nursing matters. They also had individual meetings regularly with each ward nurse to discuss more "private" matters as well as issues regarding personnel which they thought worked very well.

A ward nurse reflected on the individual meeting with the assistant department manager:

> *"We have meetings every week where I can discuss different matters and reflect about problems I struggle with in a private room. It might be matters concerning personnel, how to manage and meet these problems or maybe more professional nursing matters…. And to have the opportunity to be allowed to learn from all her experience, she can collect from her knowledge and share with me… I would have missed it immensely if she hadn't been here." (Daisy)*

The assistant department managers both felt comfortable in the department management group and experienced that it was working well and that they were contributing to the quality of the nursing services in addition to the development and running of the departments. They thought that the controversies on the managing role both from medicine and nursing had decreased after the new organisational model had been set and that cooperation between physicians and nurses in general as well as on a managerial level had improved after unitary management had come into effect.

When asked about the cooperation with the physicians one assistant department manager replied:

> *"Yes, I believe we have good cooperation with the physicians, and that they experience it as agreeable out there among the patients. We have had quite a bit during the years, but at the moment I believe we cooperate well, but we can be even better….. It has been some argues regarding the different managing roles both for the ward nurses and the medical leaders, but it has calmed down…. We do not hear any controversies about it any longer." (Rose)*

The researcher attended an expanded department manager meeting:

> *"Approximately 20 persons were attending the meeting where the department manager was standing in the front with all nurse and medical managers seated backwards as in a classroom. I noted that nurses were mainly sitting on one side and physicians on the other. The atmosphere was formal but friendly. Most issues could be characterised as information giving and little discussion took place. However, they were discussing how to run the department through the summer holidays. I sensed a common responsibility on how to deal with the challenges."*

All nurse managers thought they were heading in the right direction as the cooperation between nurse managers and medical managers had improved and they had developed a better understanding which they explained was due to common meetings and transparent demands on both sides. They were more equal as they had similar responsibilities; they could discuss and agree on different matters. However, in the daily running of the wards the ward nurses experienced that they still had to take the main responsibility and they would have preferred that the medical managers participated to a greater extent.

The nurse managers at supervisor level experienced that their positions had become more isolated whereas earlier departments were organised in divisions where they were united and had regular meetings. After the reform the chief executive officer of the hospital had held regular meetings with the department managers, but for subordinate managers there were no meetings at a hospital level. However, they participated in a hospital management programme where leadership and management in general were discussed. They had developed their own network to compensate for discussing professional nursing matters while managerial matters were addressed in their own department.

A nurse manager expressed:

> *"..... I do feel that we have become isolated like islands so to speak…. And I believe it has to do with how the departments are organised after the new reform…. In the past we were organised in blocks or divisions, and we had somebody who we were a bit closer connected to and the supervisor nurses had their own meetings together and we supported each other and had a certain unity… Now everybody is on her own…." (Iris)*

They had established a professional nursing forum at the hospital which replaced the former supervisor nurse group. These forums which they thought were very important had the purpose of developing nursing as a profession and to arrange meetings and courses. It was the only place in the hospital where they could have common discussions and contact regarding professional nursing matters, but they emphasised that it was not a forum for discussing the management of the nursing services.

The introduction of unitary management made it clear that every department had only one manager on top level and this position had become visible for everybody in the organisation. The assistant department managers underlined the importance of close and good cooperation in the department leader group where they had developed a common understanding for all services in the department. They believed that the ward nurses had been strengthened in the new organisation as their responsibilities were more defined and that they played an important role in the department as well as being equal with the section chief physicians or the medical leaders.

5.4.4 Possibilities in influencing managerial decisions – "depending on a department manager in favour of nurses"

The ward nurses thought they had reasonable influence in the department on decisions which concerned their ward or group. They felt they had their main influence in the ward nurses meetings. But they believed their influence on managerial decisions depended on having a nurse in the department management group who could advocate and plead their cause.

One ward nurse explained:

> *"I believe that in our group as ward nurses we have good influence. We do bring up and discuss matters and are able to agree on a solution. Everybody has the opportunity to speak out and we have democratic processes…. So I believe we are influencing important decisions." (Violet)*

Simultaneously she expressed*:*

> *"…… So I believe if we didn't have a nurse manager at this level… If somebody else with a different background would be in this position as an assistant department manager, I really believe there would have been many things we would not get through at all or we would not have been listened to…. I am quite sure about that…." (Violet)*

The nurse managers on supervisor level believed their influence on the ward nurses was important and that they were respected. They also emphasised their influence on nursing and managerial matters in the department leader group.

One nurse manager explained:

> *"In order to get things through, we need someone who can be a spokesperson for the nursing services… To get resources on education and competence building, to initiate new ways in organising the nursing services….. I believe that you need someone who knows the nursing services very well and can speak directly in the department leader group…There might be different ways of doing it, but I am afraid that you might "hibernate" in your own ward if you haven't got someone who can see things across the wards….." (Rose)*

The nurse managers realised that the authority of the nurse managers had changed at the supervisor level. They worried about the different organisation models of the numerous hospital departments which had not always resulted positively for the nursing services.

One nurse manager explained:

> *"The organisation in the hospitals has changed, we have to realise the consequences… It is useless to complain about not having power and authority... We <u>have to</u> cooperate with the management in a different way than earlier as well as providing necessary influence in other ways." (Iris)*

One nurse manager reflected on having a nurse director at the hospital level:

> *"I believe we need somebody…. Somebody who can think and be the driving force in matters which are evident for the nursing services at the hospital… And when I think strategically about the future, it would have been great with a nurse director who could set up demands and requirements downwards in the organisation or give something out in the organisation… Nobody does now, we have to do everything ourselves, and therefore the departments might look very different…..And the persons*

who have got the responsibility for the nursing services have very different positions in the departments.....” (Rose)

Most of the nurse managers missed the position of the nurse director as they believed it was important to have a voice at the administrative level of the hospital. They seemed to be calm as long as one of the vice presidents had a nurse background as the nursing services employ most of the health personnel at the hospital. Currently it was expected that the chief executive demanded results and quality in the nursing services as well as the medical services, but they had not seen any reports. They also worried that the next step might be that unitary management would be introduced on the ward level which might cause greater medical dominance if the ward nurse position was at stake.

5.5 Summary

All nurse managers in this study had extensive experience as a nurse manager with the average experience being approximately 13 years. The ward nurses found that their responsibilities and assignments had increased significantly following the introduction of the new health reform including unitary management which consequently had increased their working pace and pressure. All nurse managers defined their jobs as complex and extremely busy. The nurse managers expressed that they had high job satisfaction despite the bustle and intense working pace. They experienced a friendly and good working environment which they put great effort into maintaining. The hospital service system which had been introduced as part of the enterprise model had not created acceptable and satisfying systems and services but had increased their paperwork. Economy and budget control had a stronger emphasis following the introduction of the Hospital Reform. The nurse managers at all levels had experienced improvement in cooperation and communication with the physicians and responsibilities on personnel had been formalised on both sides.

The new organisation model had encouraged their work on nursing planning and documentation which they found was important to argue for nursing services and to position nursing in the hospital organisation. The ward nurses, however, depended entirely on a nurse on a supervisor level who could coordinate and represent the nursing

services. The nurse managers on the supervisor level in these departments seemed to have a strong position within the nursing personnel as within the department management. However, they had experienced more isolation in the hospital system and saw the need for building their own network. The new reform had provided the opportunity of organising the departments in different ways. The nurse managers worried about the different organisation models at the numerous hospital departments which had not always resulted positively for the nursing services. The consequences of unitary management and possibilities for different organisation models made the nurse managers realise that they had become very dependent on a department manager who would be supportive to nursing.

6. CHAPTER SIX - DISCUSSION AND CONCLUSION

The research question in this study has sought to answer how nurse managers experience leadership and management of their profession and services after unitary management was introduced in public hospitals in Norway. Furthermore the research also has sought to understand how this health reform has influenced nurse managers' leadership, ideals and roles and how nurse managers have influenced managerial decisions in the new hospital organisation. The findings and results were presented in chapter five. This final chapter of the thesis will further discuss these findings in relation to the literature and extend the depth of discussion from a critical perspective which was the purposefully selected methodology of this study. In addition it will include clinical and professional implications of the research findings. The chapter concludes with limitations of the study, recommendations for further research and a brief study conclusion.

The data for this study included both individual interviews with seven nurse managers and the researcher's journal of field notes which have been analysed utilising Kvale's steps of analysing qualitative data which also included two levels of interpretation (Kvale, 1996, 1997). The intention with the critical ethnographic approach was to engage the nurse managers in their everyday life at work as well as encouraging them in reflective processes by proving for them an opportunity to speak and reflect on their experiences in leadership and management of their profession and services. Critical social science is concerned with revealing existing beliefs and values which restrict or limit human freedom (Antrobus & Kitson, 1999; Hammersley, 1992). According to Fontana (2004) critical science provides the nursing profession the opportunity to understand its reality and take collective action to change undesirable situations.

6.1 Theoretical perspectives and clinical explanations of the results

All nurse managers who participated in this study had extensive experience as nurse managers and therefore were able to reflect on the matters from this broad perspective as they had worked under different organisational models. The discussion is structured

to focus on the major findings of the study which are presented under each main theme and further organised in sub themes consistent with chapter five.

6.1.1 Responsibilities and challenges

Strategy - nursing on the agenda

The nurse managers in this study appeared to be working hard to improve and develop the nursing services besides having heavy operational and administrative workloads. Former studies have shown that nurse managers were concentrating far more on operational aspects and administration of the hospital departments and nursing care rather than working to develop the nursing profession and standards (Aase, 1999; Normann, 2001). However, in this study the nurse managers' strategy was to develop a strong and visible nursing service in their department. They realised that if they did not put nursing on the agenda, they could be "run over" as it took a few years to decide the organisational model in their departments. The nurse managers seemed to be very conscientious about the quality of the nursing services and the developing of nursing in their departments. The new organisation model had to some extent also forced them to become more distinct as they needed documentation on what nursing is within the organisation and to document what nurses were doing.

Good working environment – complex and busy jobs

The results of this study have shown that the nurse managers both at ward level and supervisor level had to spend more time on documentation and figures in order to create an argument for funding or resources for the nursing services. The nurse managers defined their jobs as complex and extremely busy and they felt that the working pace was intense which in their opinion had become more intense after the introduction of unitary management. Another interesting finding in this study was the experience of high job satisfaction despite the bustle and intense working pace. The nurse managers reported satisfaction in their work as well as experiencing a sense of pleasure. They also experienced laughter and humour in their work which obviously assisted them in

coping. However, they admitted that their working situation often was tiring and exhausting. A recent survey carried out by the Norwegian Work Research Institute following the Hospital Reform has shown that the intensity in hospital work has increased significantly due to higher demands of quality as well as demands on improved economic results. The survey also revealed that a great number of the hospital work force experienced that working pleasure was poorer and that the work environment had become less attractive (Grimsmo & Sørensen, 2004). With a continuously increasing working pace it is a danger that nurse managers in the long run might suffer from burn-out symptoms. Nurse managers within this study managed the hard pace by ameliorating the situation with putting great effort into creating friendly and good working environments. The nurse managers were really supporting a system to work and were trying to make quality care possible in a system that was not heeding their concerns in any way. They were not in a position to put an end to "corridor patients" or reduce the large patient turnover which needed to be resolved on a higher managerial and political level. They seemed to be accomplishing these challenges by finding day to day solutions to cope with the problems.

Documenting and developing nursing

The results of this study have shown that the nurse managers both at ward level and supervisor level had to spend more time on documentation than previously. However, the nurse managers seemed to be very conscientious about the importance of having solid plans and documentation for the nursing services and put great effort into educative programmes for nurses within the departments. The nurse managers at supervisor level (assistant department manager) emphasised that they had a vital role in the department manager group as this was the most important forum and opportunity to position nursing and improve the nursing services in the department. Their main job was to provide for the nursing services and staff as they no longer had a nurse director at the hospital to consult in nursing matters. The nurse managers at this level were concerned about nursing being dominated by medicine in the new organisation and also worried about the future of nursing with the hard economic pressures in the daily running of the departments. This is consistent with previous local findings reported by others

(Brandvold, 2003; Orvik, 2004). The strategy for managers within the current study was to develop a high quality nursing service with highly competent nurses. In order to achieve this they worked strategically to get the necessary support in the department manager group.

Additional personnel management and increased paperwork

The ward nurses emphasised that personnel management had a much larger part in their daily work than reflected in their job description and that it had increased significantly after the introduction of unitary management. With the decentralisation of personnel management the ward nurses had to take responsibility for tasks which were previously carried out by the supervisor nurse and the human resource department within the hospital administration. They also experienced an increased focus on economy and productivity. In addition the hospital service system had increased their paperwork considerably without the nurse managers experiencing increased effectiveness. These aspects might explain the increase in administrative work and assignments. The nurse managers, especially the ward nurses, complained about being constantly interrupted in their work. A great number of the administrative assignments such as reporting wages could easily be carried out by secretarial staff which would reduce the workload and give the ward nurses welcome time for supervision and development of the nursing services.

The new "economic language"

The nurse managers reflected on the increased use of economic language in the hospital, for instance "customer", "production" and "profits". In addition they reported the need for turning verbal arguments into written documentation of "exact figures and hard facts" which they did not find very suitable for nursing and therefore were difficult to "translate" into figures. According to Lian (2003) New Public Management has strongly influenced public health services in Norway and the Hospital Reform (Law on Specialist Health Services of 1999 and Law on Health Enterprises of 2001) is built on these ideas. Lian (2003, p. 198) expressed her concern for commodification in the health

services. She defined commodification as “the process by which health care is made more and more exposed to various market mechanisms, and thus turned into a kind of commodity”. Lian (2003) further held that this process represents a threat of reducing health services and in this context nursing into things where human, individual and qualitative aspects will be replaced with something more objective, rational and calculative. The nurse managers reflected upon the alarming perspective of the developing and constant focus on economic results rather than the quality of the nursing care provided and aimed for. It has earlier been reported that the “soft values” described in nursing and caring are at stake in meeting with the tough, economic demands which dominate the current hospital context (Berge et al., 2002; Brandvold, 2003; Nakrem, 2004). The nurse managers in this study could be described as practicing double communication to handle the situation. On one hand it seemed that the nurse managers needed to understand the business language when arguing for their services whereas on the other hand they seemed to be using the professional nursing language within the nursing care areas and with the nursing staff. So far the nurse managers in this study seemed to be resistant to market mechanisms. However, they worried that if the pressure continued this development might influence nursing negatively in the long run.

6.1.2 Leadership ideals and reflections on the nurse manager role

Pride in nursing – attentive and caring to staff

Marquis and Huston (2002) indicated that there were two types of leaders in nursing management where the traditional manager has been seen as a transactional manager focusing upon day-to-day tasks. The transformational manager however, was committed and had a vision and was a manager who was characterised as someone who had a long-term vision, identified common values, inspired and empowered others, and paid attention to effects (Marquis & Huston, 2000). The nurse managers in this study could be identified with the transformational type of manager on both levels. The nurse managers took pride in nursing and were concerned about keeping high standards in nursing as well as developing nursing and saw themselves in the forefront of this work but also by inspiring and empowering others. This aspect was visible both at ward nurse

level and supervisor level where they cooperated with the assistant ward nurses and the research nurse in the department on the educative programmes. All nurse managers accentuated the significance of respect and emphasised that respecting each other as colleagues and as patients and nurses was fundamental in their jobs. They were attentive and caring to their staff and talked about tolerance and advocated open and good communication. They worked hard for creating and enriching the work environment. They needed to motivate and encourage the nurses to do a good job as well as commending them when doing a good job. Thyer (2003) found that transformational leadership is ideologically suited to nurse management and had a positive effect on communication and team development which was also evident within this study. It is, however, important to emphasise that these findings cannot be generalised.

Being a powerful influential operator and a strategic thinker

The nurse managers at supervisor level (assistant department managers) appeared to have the skills of both "the powerful influential operator" and "the strategic thinker". Antrobus and Kitson (1999) identified a repertoire of skills among the nurse managers which was described in chapter three. The nurse manager as "a powerful influential operator" works with others to empower them and creates work environments concerned with common values. The nurse manager as "a strategic thinker" creates meaning and establishes processes for learning (Antrobus & Kitson, 1999). The assistant department managers saw their main role to initiate and influence the development of the nursing services and to implement new systems. They worked via the ward nurses and emphasised that individual nursing care is essential for good quality nursing and they both worked hard to improve nursing documentation in the department to be able to reflect individual nursing care.

6.1.3 Cooperation and communication

Improved cooperation and communication between nurse- and physician managers

Results from earlier Norwegian hospitals studies have shown that the relation and cooperation between the nurse managers was very good and that the nurse managers at supervisor levels were conscientious about supporting and counselling the ward nurses (Aase, 1999; Normann, 2001). The findings in this study are consistent with the published literature as it also identified good relations and cooperation between the nursing staff within the wards.

This research identified that nurse managers at all levels had experienced improvement in cooperation and communication with the chief physicians and responsibilities on personnel had been formalised on both sides. Previous hospital studies have shown that the cooperation between supervisor nurses and chief physicians did not work in a satisfactory manner and that nurse managers experienced the chief physicians as autocratic (Aase, 1999; Normann, 2001). Another study performed after the introduction of unitary management showed that nurse and physician managers had more defined areas of responsibilities and had improved their communication (Johansen, 2005). The ward nurses in this study believed that the section chief physicians possibly experienced greater changes in this respect as the ward nurses had always been used to handling personnel. All nurse managers thought they were heading in the right direction as the cooperation between nurse managers and medical managers had improved and they had developed a better understanding which could be explained by common meetings and transparent demands on both sides. However, in the daily running of the wards the ward nurses generally experienced that they still had to take the main responsibility and they would have preferred that the medical managers participated to a greater extent. The most recent report on unitary management in hospitals concluded that unitary managers (department managers) were generally satisfied with the Hospital Reform emphasising a stronger focus on management and

they experienced a positive effect on the economy of the department (Gjerberg & Sørensen, 2006). However, it was not reported how other health managers in the department experienced the new organisation.

Isolation - "a threat" to strengthening nurse leadership and management

The nurse managers at supervisor level experienced that their positions had become more isolated after the new reform and cooperation with nurse managers in other departments was no longer organised. They developed their own network to compensate for professional nursing matters while managerial matters were expected to be addressed in their own department. A professional nursing forum had been established at the hospital for developing professional nursing and meetings and courses for all nurses at the hospital were regularly arranged. The nurse managers at supervisor level had lost their former supervisor nurse group where they could discuss matters related to both the nursing profession and management of the services. Most of the nurse managers missed the former position of the nurse director of the hospital. The new nursing forum was important for developing nursing; however, they still needed a meeting place for discussing nursing leadership and management. This effect of unitary management has not previously been reported.

Previous research has shown the importance of developing a strong nursing identity and establishing more visible nursing services (Aiken et al., 2001; Holter, 2001). It is vital that nurse managers on a supervisor level do not get isolated but are able to establish formal meeting places for discussing nursing leadership and management as the health services are becoming more complex and are in constant change (Antrobus & Kitson, 1999; Brandvold, 2003; Holter, 2001). This study has shown that the nurse managers at supervisor level are only expected to discuss leadership and management in general within their department or in the hospital management programme; however, they now do not have a forum to discuss these matters from a nursing perspective.

6.1.4 Possibilities for influencing managerial decisions

The importance of having a nurse manager on a supervisor level

The introduction of unitary management structured the department so that there was only one manager on the top level. The new organisation model and the position as department manager seemed to have become visibly and prominently apparent for everybody in the organisation. This finding is interesting in relation to a new report from The Norwegian Work Research Institute which concluded that management has greater influence in the current hospital department (Gjerberg & Sørensen, 2006). Whether the new management has greater influence in the departments in this research is not evident, however, the organisation structure appears to be emphasising a stronger focus on management as a central function.

The ward nurses believed their influence on managerial decisions depended on having a nurse manager at a superior level who could coordinate, advocate, and plead their cause as well as coordinating and representing the nursing services. The nurse managers on the supervisor level appeared to have a strong position within the nursing personnel as within the department management.

Depending on the department manager supportive to nursing – oppression of nursing?

The new Hospital Reform (Law on Specialist Health Services of 1999 and Law on Health Enterprises of 2001) provided the opportunity for organising the departments in different ways. The nurse managers worried about the different organisational models at the numerous hospital departments which had not always resulted in a positive outcome for the nursing services. The consequences of unitary management and possibilities for different organisation models made the nurse managers realise that they had become very dependent on a department manager who would be supportive to nursing.

If department management continues to be dominated by the medical profession nursing would again become more attached to the medical hierarchy and thereby lose its autonomy. One could ask whether unitary management has contributed to oppression of nurse managers and the nursing profession. There has been a growing concern among nurses in Norway that nurse managers have decreased their position in the hospital hierarchy following the introduction of unitary management which in the long term might influence the nursing services negatively (Berge et al., 2002; Brandvold, 2003; Orvik, 2004). This study has shown that the nurse managers depended on a department manager who would be supportive to nursing. This new change of unitary management has not previously been identified. However, the nurse managers within this study reported that they had good influence on managerial decisions and that their department manager had a positive attitude towards nursing though they seemed to have worked very hard to achieve recognition and respect. They also worried that the next step might be that unitary management would be introduced on the ward level which might cause greater medical dominance if the ward nurse position was at stake.

The findings in this study has accentuated the importance of having a visionary and strong nurse manager on a supervisor level who can coordinate, develop and represent the nursing services. The Hospital Reform has opened different organisational models and the nurse managers worried that the future could look very different with an organisation model where nurse managers would not get central positions in the hospital departments. They also looked to other departments in their hospital where this was a reality today.

6.2 Limitations of the study

The intent of this research was to explore the experiences of nurse managers and to make space from which they could speak of their experiences. The choice of purposeful sampling with field studies and semi-structured individual interviews allowed the researcher to collect rich and in-depth information from the participants. This research did not intend to generalise, but more to explore and understand how current Norwegian nurse managers in a public hospital experienced leadership and management of their

profession and services. The results are specific to this group of nurse managers within their own context and at the time of the study. The results therefore have limited generalisation importance. The ability for nurses to gain a voice and for their experiences to be recognised, however, should not be underestimated.

Another limitation of the study was that that the analysing process was performed by the researcher alone. In quantitative methods if the results had been verified by another researcher it would have added to the validity. However the transcripts were sent to participants for them to check the understanding of the research. Further involvement of the participants in the data analysis may have further supported the research intentions. The extent to which individual nurses benefited is not something that can be quantified however nurse participants spoke positively following their interviews of having been given the opportunity to speak.

This study did not attempt to focus specifically upon gender issues; however, it acknowledged that gender may influence the position of nursing in the hospital hierarchy and that a vast majority of nurses are women.

6.3 Recommendations for further research

The consequences of unitary management and possibilities for different organisational models within the various hospital departments have resulted in different organisation of the nursing services. It is no longer a matter of course that hospital departments have a nurse manager on a supervisor level. However, more knowledge about how the nursing services and nurse management are organised and function is needed and further research in hospital departments on a larger scale is therefore recommended. It would also be beneficial to study how nurse management and organisation of the nursing services as well as the competences of nurses influence the quality and standards of the nursing services and patient outcomes.

The nurse managers in this study reflected on the constant focus on economic results rather than the quality of the nursing care provided or aimed for. With the increased use

of economic language in the hospital they worried about the consequences for quality nursing care in the long term. It would therefore be important to study how "commodification" described by Lian (2003) influences nursing in Norwegian hospitals today in addition to how the economic pressure in the hospitals is appearing in nursing. It would also be beneficial and in the interests of individual nurses and the profession to study how the working pressure affects the working conditions, personal lives and environments of nurses.

6.4 Conclusion

In this research it has been significant that the voice of the nurse manager is heard rather than be either assumed or ignored. This research has shown that nurse managers within a large public Norwegian hospital have a demanding and complex job. The working pressure and assignments have increased significantly following the introduction of unitary management. The nurse managers worked strategically to develop a strong and visible nursing service in their department. In the wake of enterprise and business management in public hospitals the emphasis on economy and budget has increased which might influence the nursing services negatively in the long term. However, the nurse managers experienced friendly and good working environments which they put great effort into maintaining. The cooperation and communication with the chief physicians had improved and responsibilities on personnel and managerial aspects had been formalised on both sides.

It was also evident that many of the major problems of nurse managers were not being resolved nor did the nurse managers have the authority or ability to influence change in this respect. Overcrowding of beds in corridors, expectations for nurses to be data collectors for medical research, lack of resources and frantic workloads were commonplace.

The consequences of unitary management and possibilities for different organisation models made it clear that the nurse managers depended on a department manager who would be supportive to nursing. The nurse managers at supervisor level experienced that their positions had become more isolated and they needed a meeting place for discussing nursing leadership and management. This effect of unitary management has not previously been identified.

This research has shown the significance of having a visionary and strong nurse manager on a supervisor level who can coordinate, develop and represent the nursing services. However, these findings cannot be generalised to other hospital departments without further research. The research has been instrumental in providing at least for some nurses an opportunity to speak and have their voice heard. It can be concluded that

whilst the introduction of unitary management has been a semi-satisfactory experience for nurse managers they are certainly aware that the change has created for them vulnerability in depending upon the personal attitudes of the departmental manager toward nursing.

REFERENCE LIST

Aamodt, A. M. (1991). Ethnography and Epistemology: Generating nursing knowledge. In J. M. Morse (Ed.), *Qualitative Nursing Research - A Contemporary Dialogue* (pp. 40-53). Newbury Park, London, New Dehli: Sage Publications, Inc.

Aase, E. L. (1999). *Fag og ledelse? Hvordan opplever sykepleieledere å være ledere, hvordan mener de at sykepleietjenesten bør ledes og hvilke forutsetninger mener de bør være tilstede for at ønsket lederskap skal utøves?* (Profession and management? How do nurse managers experience to be a manager, how do they think the nursing services should be managed and which conditions ought to be present in order to exercise desired management?) Unpublished Hovedfagsoppgave, Universitetet i Oslo, Oslo.

Abbott, A. (1988). *The System of Professions. An essay on the Division of Expert Labor*. Chicago and London: The University of Chicago Press.

Aiken, L. H., Clarke, S. P., Cheung, R. B., Sloane, D. M., & Silber, J. H. (2003). Educational Levels of Hospital Nurses and Surgical Patient Mortality. *Journal of the American Medical Association, 290*, 1617-1623.

Aiken, L. H., Clarke, S. P., & Sloane, D. M. (2003). Nursing Burnout and Patient Safety. *Journal of the American Medical Association, 289*, 549-550.

Aiken, L. H., Clarke, S. P., Sloane, D. M., Sochalski, J. A., Busse, R., Clarke, H., et al. (2001). Nurses' reports on hospital care in five countries. *Health Affairs, 20*(3), 43-53.

Antrobus, S., & Kitson, A. (1999). Nursing leadership: influencing and shaping health policy and nursing practice. *Journal of Advanced Nursing, 29 (3)*, 746-753.

Atkinson, P., & Hammersley, M. (1998). Ethnography and participant observation. In N. K. Denzin & Y. S. Lincoln (Eds.), *Strategies of Qualitative Inquiry* (pp. 110-136). Thousand Oaks, California: Sage.

Berg, O. (1987). *Medisinens logikk*. (The logic of medicine) Oslo: Universitetsforlaget AS.

Berge, A. W., Mathisen, L., & Skogstad, A. (2002). Avdelingssykepleieren - fra arbeidsleder til økonom og fagansvarlig? (The ward nurse - from working manager to economist and professional responsible?) *Sykepleien, 13*, 34-38.

Brandvold, E. B. (2003). Ledelse og organisering: Oversykepleier i en enhetlig ledelsesmodell. Muligheter og utfordringer. (Management and organising: The supervisor nurse in a unitary management model. Possibilities and challenges.) *Sykepleien, 18*, 38-45.

Byrkjeflot, H. (2004a). *Autonomy, Transparency and Management (ATM), reform programs in health care: a comparative project*. Retrieved 12-10, 2004

Byrkjeflot, H. (2004b). *The making of a health care state? An analysis of the recent hospital reform in Norway.* Bergen: Stein Rokkan Centre for Social Studies, University of Bergen.

Byrkjeflot, H., & Grønlie, T. (2004). *Det regionale helseforetaket, et overgangsfenomen i en utvikling fra velferdslokalisme til sentralstatlig styring?* (The regional health enterprise, a transitional phenomenon in a development from welfare localism to central state governing?) Bergen: Rokkansenteret og Historisk Institutt, Universitetet i Bergen.

Byrkjeflot, H., & Neby, S. (2004). *The Decentralized Path Challenged? Nordic Health Care Reforms in Comparison* (Working Paper No. 2-2004). Bergen: Stein Rokkan Centre for Social Science.

Davis, D., Needleman, J., Hand, E. E., & Aiken, L. H. (2003). Nursing Burnout and Patient Safety. *Journal of the American Medical association, 289*, 549-550.

Fangen, K. (2004). *Deltagende observasjon*. (Participating observation.) Bergen: Fagbokforlaget.

Fause, Å., & Micaelsen, A. (2002). *Et fag i kamp for livet - Sykepleiens historie i Norge*. (A profession in fight for life - The history of nursing in Norway.) Bergen: Fagbokforlaget.

Faye, B. (1975). *Social theory and political practice*. London: George Allen & Unwin Ltd.

Faye, B. (1987). *Critical Social Science*. Oxford: Polity Press.

Fontana, J. S. (2004). A Methodology for Critical Science in Nursing. *Advances in Nursing Science, 27*(2), 93-101.

Gjerberg, E., & Sørensen, B. A. (2006). *Enhetlig ledelse i sykehus*. (Unitary management in hospital.) Oslo: Arbeidsforskningsinstituttet.

Greve, C., & Jespersen, P., Kragh. (1998). *New Public Management and its Critics: Alternative Roads to Flexible Service Delivery to Citizens?* Paper presented at the European Group of Public Management, 1998.

Grimsmo, A., & Sørensen, B. A. (2004). *Null-punkt-undersøkelse i sykehus. God vakt. Arbeidsmiljø i sykehus.* (Zero-point research in hospital. Good shift. Working environment in hospital.) Oslo: Arbeidsforskningsinstituttet.

Halvorsen, K. (2002). *Forskningsmetoder for helse- og sosialfag - en innføring i samfunnsvitenskapelig metode* (2. ed.). (Research methods in health- and social sciences - an introduction to methodology in social sciences.) Oslo: Cappelen Akademisk Forlag.

Hammersley, M. (1992). Critical theory as a model for ethnography. In M. Hammersley (Ed.), *What's Wrong with Ethnography?* (pp. 96-122). London: Routledge.

Hatch, J. A. (2002). *Doing Qualitative Research in Educational Settings*. New York: State University of New York Press.

Holter, E. (1997). *Ledelse og ledere i sykehus - Administrasjon av sengeposter* (2. edition ed.). (Management and managers in hospital - administration of hospital wards.) Oslo: TANO.

Holter, I. M. (2001). En utfordring å gjøre faget synlig. (A challenge to visualise the profession of nursing.) *Sykepleien, 19*, 38-41.

International Council of Nurses. (2000). *Management of Nursing and Health Care Services*, 2000

Jakobsen, R. (2005). *Klar for fremtiden? - om kvalitet, endring og teamarbeid i sykepleieledelse* (2nd ed.). (Ready for the future? - About quality, change and taemwork in nurse management.) Oslo: Gyldendal Akademisk.

Jespersen, P., Kragh. (2005). *Mellom profession og management - Ledelse i danske sygehuse*. (Between profession and management. Management in Danish hospitals.) Copenhagen: Handelhøjskolens Forlag.

Johansen, M. S. (2005). *En studie av profesjonskonflikter i sykehus etter innføring av enhetlig ledelse.* (A study of professional conflicts in hospitals after the introduction of unitary management.) Paper presented at the NFF Conference 2005: Health sector management and organisation, Aarhus, Denmark.

Kettl, D. F. (1997). The Global Revolution in Public Management: Driving Themes, Missing Links. *Journal of Policy Analysis and Management, 16*(3), 446-462.

Kim, H. S., & Holter, I. M. (1995). Critical Theory for Science of Nursing Practice. In A. Omery, C. E. Kaspar & G. G. Page (Eds.), *In Search of Nursing Science* (pp. 205-219). London, New Dehli: SAGE Publications Inc.

Knizek, B. L. (1998). Interview - design og perspektiv. In M. Lorensen (Ed.), *Spørsmålet bestemmer metoden - Forskningsmetoder i sykepleie og andre helsefag* (pp. 33-65). (Interview - design and perspective. In M. Lorensen (Ed.) The question decides the method - Research methods in nursing science.) Oslo: Universitetsforlaget.

Kristoffersen, N. J. (1996). Sykepleiens utvikling fra oppgave og kall til yrke og selvstendig vitenskap. In N. J. Kristoffersen (Ed.), *Generell sykepleie, Fag og yrke - utvikling, verdier og kunnskap* (Vol. 1, pp. 153-238). (The development of nursing from assignment and calling to profession and independent science. In N. Kristoffersen (Ed.), General nursing, subject and profession - development, values and knowledge.) Oslo: Universitetsforlaget AS.

Kvale, S. (1996). *Interviews - An introduction to Qualitative Research Interviewing*. Thousand Oaks, London, New Dehli: SAGE Publications.

Kvale, S. (1997). *Det kvalitative forskningsintervju*. (The qualitative research interview.) Oslo: Gyldendal Akademisk.

Ledelse i sykehus, (Management in hospital.) Sosialdepartementet 1-81 (1990).

Ledelse i sykehus, Rundskriv 1-9/2002 (Management in hospital.) ,Helsedepartementet (2002).

Lewins, F. (1992). *Social Science Methodology*. Melbourne: Macmillan Education Australia.

Lian, O. S. (2003). *Når helse blir en vare*. (When health becomes a commodity.) Kristiansand S: Høyskoleforlaget AS.

Lillibridge, J. (1999). *Interviewing as a method of data collection*. Geelong: School of Nursing, Deaking University.

Lov om helseforetak m.m., (Law on Health Enterprises) Helse - og omsorgsdepartementet(2001).

Lov om pasientrettigheter, (Law on Patient Rights) Sosial- og helsedepartementet(1999).

Lov om spesialisthelsetjenesten m.m., (Law on Specialist Health Services) Sosial- og helsedepartementet(1999).

Lægreid, P., Opedal, S., & Stigen, I. M. (2003). *The Norwegian Hospital Reform - Balancing Political Control and Enterprise Autonomy* (Working Paper No. 23-2003). Bergen: Stein Rokkan Centre for Social Studies, University of Bergen.

Marquis, B. L., & Huston, C. J. (2000). *Leadership Roles and Management Functions in Nursing* (3. ed.). Philadelphia, New York, Baltimore, USA: Lippincott.

Martinsen, K., & Wærness, K. (1979). *Pleie uten omsorg? Norsk sykepleie mellom pasient og profesjon*. (Nursing without care? Norwegian nursing between the patient and the profession.) Oslo: Pax Forlag A/S.

Melby, K. (1990). *Kall og kamp. Norsk Sykepleierforbunds historie*. (Calling and fighting. The history of the Norwegian Nurses Association.) Oslo: Cappelen Forlag AS.

Meyer, J. W., & Rowan, B. (1977). Institutionalized Organisations: Formal Structure as Myth and Ceremony. *The American Journal of Sociology, 83*(2), 340-363.

Morse, J. M., & Field, P. A. (1996). *Nursing Research: The Application of Qualitative Approaches* (2. ed.). London: Chapman & Hall.

Myhre, A. M. (2004). *Omstilling til enhetlig ledelse i sykehus.* (The change to unitary management in hospital.) Unpublished Master thesis, Høgskolen i Agder, Kristiansand.

Nakrem, S. (2004). Ledelse og organisering: Moderniseringens fallgruver.(Management and organising: The pitfall of modernisation.) *Sykepleien, 6*(25th March 2004), 30-35.

Nerheim, S. T. (2005). *Hvem skal lede? - Nasjonal profesjonsdebatt og lokale erfaringer ved innføring av enhetlig ledelse i helseforetak.* (Who should manage? National debate on professions and local experiences in introducing unitary management in a health enterprise.) Unpublished Hovedfagsoppgave, Universitetet i Bergen, Bergen.

Normann, L. M. (2001). *Enhetlig todelt ledelse, kraftpotensiale eller konflikt? En deskriptiv studie av sykepleie- og legeledere i sykehus, deres ledelsesformer og oppgaver.* (Unitary two-part leadership, potential of strength or conflict? A descriptive study on nurse- and physician managers in hospital, their leadership and assignments.) Unpublished Hovedfagsoppgave, Universitetet i Oslo, Oslo.

Normann, L. M. (2003). *Om ledelse.* (About management. The Norwegian Nurses Association.) Oslo: Norsk Sykepleierforbund. Retrieved October 16, 2004, from http://www.sykepleierforbundet.no

NOU 1997:2 Pasienten først! Ledelse og organisering i sykehus, (The patient first! Management and organisation in hospital.) Sosial- og helsedepartementet 1-114 (1997).

Orvik, A. (2004). *Organisatorisk kompetanse - i sykepleie og helsefaglig samarbeid*. (Organising competence - in nursing and health professional cooperation.) Oslo: Cappelen Akademisk Forlag.

Parhoo, K. (1997). *Nursing Research: Principles, process and issues*. London: Macmillan.

Quivey, M. (1998). *Ledelse er vekst*. (Leadership is growth.) Oslo: Universitetsforlaget.

Rammeplan og forskrift for 3-årig sykepleierutdanning i Norge, (Framework plan and regulation for 3-year nursing education in Norway), Kirke-, utdannings- og forskningsdepartementet (2000).

Rønning, R. (2004). Omsorg er blitt et avvik. (Care has become deviation.) *Sykepleien, 17*, 34-35.

Sivesind, K. H. (1998). Sortering av kvalitative data. In H. Holter & R. Kalleberg (Eds.), *Kvalitative metoder i samfunnsforskning* (2nd edition ed., pp. 240-273). (Classifying qualitative data. In H. Holter & R. Kalleberg (Eds.) Qualitiative methods in social science research.) Oslo: Universitetsforlaget.

Solbakk, J. H. (1998). Etiske sider ved medisinsk og helsefaglig forskning. In M. Lorensen (Ed.), *Spørsmålet bestemmer metoden. Forskningsmetoder i sykepleie og andre helsefag* (pp. 312-332). (Ethical questions in medical and health professional research. In M. Lorensen (Ed.) The question decides the method - Research methods in nursing science.) Oslo: Universitetsforlaget.

Sommervold, W. (1997). Ledelse i sykepleien - en strategi for profesjonalisering. In H. Byrkjeflot (Ed.), *Fra styring til ledelse* (pp. 243-265). (Management in nursing - a stategy for professionalism. In H. Byrkjeflot (Ed.) From governing to management.) Bergen: Fagbokforlaget.

Statistisk Sentralbyrå. (Statistics Norway) (2003). Statistics employers - profession and gender Norway (pp. statistics on health personnel). Retrieved May 12, 2005, from http://www.ssb.no/hesospers/.

Statusrapport 2002. (2003). Oslo: The Norwegian Nurses Association.

Statusrapport 2003. (2004). Oslo: The Norwegian Nurses Association.

Strand, T. (2001). *Ledelse, organisasjon og kultur*. (Management, organisation and culture.) Bergen: Fagbokforlaget.

Street, A. (1991). *From Image to Action: Reflection in Nursing Practice*. Geelong: Deakin University Press.

Sveri, T. (2004). *Strukturer og reformer - En kvalitativ analyse av reformen "enhetlig ledelse" sett i lys av sykehusets arbeidsorganisering.* (Structures and reforms - a qualitative analysis of the reform of unitary management in light of the organisation of hospital work.) Unpublished Hovedfagsoppgave, University of Bergen, Bergen.

The Norwegian Nurses Association. (2005). *Sykepleier med lederansvar - god på fag og ledelse*. (Nurse with leadership responsibility - good at both profession and management.) Oslo: The Norwegian Nurses Association.

Thompson, P., & Wellard, S. (1999). *Get a Grip on Research: Critical and Postcritical Approaches* (Monograph). Geelong: School of Nursing, Deakin University.

Thyer, G. L. (2003). Dare to be different: transformational leadership may hold the key to reducing the nursing shortage. *Journal of Nursing Management, 11*, 73-79.

Torjesen, D. O., & Gammelsæter, H. (2004). *Management between Autonomy and Transparency in the Enterprise Hospital* (No. Working Paper 1-2004). Bergen: Stein Rokkan Centre for Social Studies.

Turner, d. S. (1999). *Ethical issues: Their impact on the research process*. Geelong: School of Nursing, Deakin University.

Turner, d. S., & Emden, C. (1999). *Interpretive Research: Practices and Challenges* (Monograph). Geelong: School of Nursing, Deakin University.

Yrkesetiske retningslinjer for sykepleiere, 2.2 (Ethical Guidelines for Nurses) The Norwegian Nurses Association (2001).

Zimmermann, P. G. (2002). *Nursing Management Secrets*. Philadelphia: Hanley & Belfus Inc., Medical Publishers.

APPENDIX A

DEMOGRAPHIC DATA – RESEARCH PERSONS

Name:_____ **Position:** _____

(The field notes and transcribed interviews will be simply coded as each participant will have a pseudonym which is kept separately from the names to aid anonymity. The purpose with name here is to be able to connect the interviews to the correct demographic data.)

1. Age

< 40 ☐

41- 50 ☐

51 – 60 ☐

> 60 ☐

2. Gender

Female ☐

Male ☐

3. Marital status

……..

4. Children

……..

5. Areas of responsibilities

Responsible for number of employees ……

Responsible for number of patients / hospital beds ……

Responsible for number of wards ……

6. Nursing education

When were you educated as a nurse, which school? ……..……

7. Further education

Do you have further education in leadership and management? Describe

……...

……...

8. Leadership and management experience

How many years have you worked as a nursing manager?

1-3 years ☐

3- 5 years ☐

5-10 years ☐

> 10 years ☐

How many years have you worked as a nursing manager at this hospital? ……..

APPENDIX B

INTERVIEW - GUIDE

Can you tell me about your areas of responsibilities and your role as a nursing leader?

What do you understand by unitary management?

How does it work in your department? Explain

The new Hospital Reform, what does it mean to you in your daily work?

What are your philosophy and values in leadership and management?

How do nurses respond to your leadership?

How do you cooperate with other nurse managers in your department?

How do you cooperate with physicians and other colleagues?

What do you think about the standards, competences and research in nursing in your

department / hospital?

How is your influence in managerial decisions in the clinic? Explain

How could nursing leadership and management be different?

What are your thoughts and wishes for the future of nursing?

Is there something else you would like to add?

APPENDIX C

DUHREC Subcommittee – Health & Behavioural Sciences
Faculty of Health & Behavioural Sciences
Burwood Campus, Burwood, Victoria 3125
Telephone 03 9251 7174 Facsimile 03 9244 6019 email jasq@deakin.edu.au

30 May, 2005

Dr Robyn Ogle
School of Nursing
BURWOOD CAMPUS

Dear Robyn,

DUHREC-H31/05: **"Nurse Managers' experience of leadership and management following the introduction of unitary management in Norwegian public hospitals"**

The amended application which was submitted by BRIT DANIELSEN was considered executively by the DUHREC-H&BS Subcommittee and has been **recommended for approval**.

The application is proceeding to the Deakin University Human Research Ethics Committee for ratification and, in the absence of any further advice, may commence.

An Annual Project Report Form has been attached which you will be required to complete in relation to this research. This should be completed and returned to the Administrative Officer to the DUHREC Subcommittee – Health & Behavioural Sciences, Burwood campus by Monday 21 November, 2005 or when the project is completed.

Good luck with the project!

Yours sincerely

For
Dr Mark Stokes (Chair)
DUHREC Subcommittee – Health & Behavioural Sciences

Cc: Ms Britt Danielsen
c/- Dr Robyn Ogle, School of Nursing

enc

H:\My Documents\Other Documents\ETHICS 2005\31-05 B Danielsen approval.doc

APPENDIX D

VIBORG AMT

Viborg School of Nursing
Viborg County
Denmark

SYGEPLEJESKOLEN
VIBORG AMT

Ethics Comitee of Research Projects, Viborg School of Nursing, Viborg County, Denmark: Den Etiske Komité for Forskningsprojekter (DEKF) ved Sygeplejeskolen i Viborg

The Ethics Comitee (DEKF) hereby states that the Comitee has processed the Ethics Application complied with the standards, laws and regulations of Danish and International Legislation concerning Ethics in Nursing Research

Name of student: Britt Viola Danielsen

☒ Approved

☐ Approved with following reservations:

☐ Not approved

☒ Addresses, language and formulations in the Danish "Almen erklæring" (Plain Language Statement) and the Danish "Samtykkeblanket" (Consent Form) are acceptable by Danish standards.

Viborg Coordinator of Master of Health Science Programme:

Kirsten Beedholm Poulsen

Chairman of the Comitee:

Birte Hedegaard Larsen

APPENDIX E

GATEKEEPER ACCESS

Please note that the name and address of the hospital is concealed to protect its anonymity

Ms Britt V. Danielsen
Nyhaugveien 11 C
5067 BERGEN

Deres ref.: Vår ref.: Bergen, 22th November 2004

Dear Britt V. Danielsen,

RE: GATEKEEPER ACCESS RESEARCH PROPOSAL ON LEADERSHIP AND MANAGEMENT IN NURSING

With regard to your letter of 15th November and previous contact with Kari Guldbrandsøy regarding your research proposal on leadership and management in nursing, we hereby accept that you will have Gatekeeper Access to accomplish your research on nursing leaders in two different clinics at our hospital.

Before you start your research, you are obliged to sign the Promise of Secrecy and make the necessary arrangements with our department.

Please contact us as soon as the ethical application is accepted to make the practical arrangements.

Sincerely

Trond Søreide
Head of section

APPENDIX F

DEAKIN UNIVERSITY HUMAN RESEARCH ETHICS COMMITTEE

PLAIN LANGUAGE STATEMENT

My name is **Britt V. Danielsen** and I am completing a Masters of Health Science Nursing degree, in the School of Nursing, Faculty of Health and Behavioural Sciences at Deakin University, Australia. The study is offered in cooperation with Viborg Campus, Nursing in Denmark. The course involves a research project which is under the **supervision** of Senior Lecturer **Kaye Robyn Ogle** in the School of Nursing, **Deakin University, Australia** and stud. Ph.D **Kirsten Fredriksen** in the School of Nursing, **Viborg Campus, Denmark.**

You are invited to participate in a research study titled: Nurse Managers' experiences of leadership and management following the introduction of unitary management in Norwegian public hospital.

The project aims to describe and understand how nurse managers at different levels in a Norwegian public hospitals experience leadership and management of their profession and services following the introduction of a changed model of management as part of the new health reform in Norway. The research further seeks to understand how this has influenced your leadership, ideals and roles and how you influence managerial decisions.

Participating in this research involves field studies, which means that I as the researcher follow you in your daily work for two days. I will observe and take notes of your activities and interactions. In addition you will be asked to take part in an individual interview which will last for one hour to one and a half hours. The interview will be arranged to take place in suitable room at your working place, and will be audio taped and later transcribed. You will be given a pseudonym, only known to the researcher, which will be kept separately from your name to assist anonymity. All data material will be kept in a safe and locked place only available to the researcher and supervisors during the research period.

If you agree to participate, you will be required to complete an informed consent form before either the field study or interview can begin.

Ethical aspects
There are no anticipated risks or stress beyond what is encountered in everyday working life through participation in this study. Should you feel uncomfortable, at any time during this research I will provide you with the name and contact details of an external support person qualified in counselling.

You are free to withdraw at any time during the study in which event your participation in the research study will immediately cease and any information obtained from you will not be utilised.

If you have any further questions regarding the study, please contact **my supervisors Kaye Robyn Ogle (Australia) on** E-mail: robyn.ogle@deakin.edu.au , telephone 00-03 9244 6132 **or Kirsten Fredriksen (Denmark)** on E-mail: kirsten-fremad@webspeed.dk , telephone 00-45 8643 2462

Data from this study will remain confidential at all times being kept in a locked cupboard and password protected on a computer. Data will be stored in a locked cabinet at Viborg Campus, Denmark for a minimum of six years from the date of any publications from this research. Following the completion of the study, outcomes of the research will be made available by the researcher Britt V. Danielsen in the form of conference reports and journal publications as well as a thesis for examination.

Should you have any concerns about the conduct of the research project please contact the Chair,
Dr. Mark Stokes, Deakin University Human Research Ethics Subcommittee – Health and Behavioural Sciences, telephone 00- (03) 9244 6865, E-mail: mark.stokes@deakin.edu.au

Or you can contact the Master Coordinator at Viborg Campus Ph.D Kirsten Beedholm, telephone 00-45 8927 3846, E-mail: kirsten.beedholm@sygeplejeskolen.com

APPENDIX G

DEAKIN UNIVERSITY HUMAN RESEARCH ETHICS COMMITTEE CONSENT FORM

I, …… of ……

hereby consent to be a subject of a human research study to be undertaken by **Britt V. Danielsen**.

I understand that the purpose of the research is to describe and understand how nurse managers at different levels in a public hospital experience leadership and management of their profession and services following the introduction of a changed model of management in Norwegian public hospitals. It further seeks to understand how this change has influenced nurse managers' leadership, ideals and roles and how they influence managerial decisions.

Participating in this research involves field studies, so that I will be observed in my daily work for two days. In addition I will take part in an individual interview which will last one hour to one and a half hours. The interview will be arranged to take place in a suitable room at my place of work. The interview will be audio taped. All data will be kept securely in a locked cabinet.

To participate in this research is totally voluntary and I am free to withdraw at any time. Should I feel uncomfortable, I will be provided with the name and contact details of an external support person qualified in counselling with whom I can talk.

I acknowledge that:

1. The aims, methods, anticipated benefits and possible hazards of the research study have been explained to me.

2. I voluntarily and freely give my consent to participation in such research study.

3. I have read the Plain Language Statement and agree to what is outlined within the statement.

4. I understand that aggregated results ***will*** be used for research purposes and may be reported in scientific and academic journals.

5. Individual results will not be released to any person except at my request and on my authorisation.

6. I am free to withdraw my consent at any time during the study, in which event my participation in the research study will immediately cease and any information obtained from me will not be used.

TITLE OF THESIS

LEADERSHIP AND MANAGEMENT IN NURSING

Nurse Managers' experiences of leadership and management following the introduction of unitary management in Norwegian public hospitals

A thesis submitted by **Britt V. Danielsen**
in partial fulfilment of the requirements for
The Degree of Master of Health Science (Nursing)

School of Nursing
Faculty of Health and Behavioural Sciences
Deakin University, Australia

June 2006

Deakin University

School of Nursing

Faculty of Health and Behavioural Sciences

Supervisor's Certificate:

I certify that the research thesis prepared by **Britt V. Danielsen**

Entitled:

Nurse Managers' experiences of leadership and management following the introduction of unitary management in Norwegian public hospitals

Being presented for the degree Master of Health Science (Nursing) satisfies the requirements of the rules for the preparation, submission and approval of Master of Health Science (Nursing) thesis as determined by the School of Nursing, Faculty of Health and Behavioural Sciences. I recommend that this research thesis be submitted to the examiners.

Signed: KRO Date: 13.06.06

Dr KATE R. OGLE

NAME AND TITLE

Deakin University

School of Nursing

Faculty of Health and Behavioural Sciences

Co-supervisor's Certificate:

I certify that the research thesis prepared by **Britt V. Danielsen**

Entitled:

Nurse Managers' experiences of leadership and management following the introduction of unitary management in Norwegian public hospitals

Being presented for the degree Master of Health Science (Nursing) satisfies the requirements of the rules for the preparation, submission and approval of Master of Health Science (Nursing) thesis as determined by the School of Nursing, Faculty of Health and Behavioural Sciences. I recommend that this research thesis be submitted to the examiners.

Signed: Date:

Kirsten Frederiksen

Lecturer, Master of Education, PhD, 130606

NAME AND TITLE

DECLARATION

I **Britt V. Danielsen** hereby declare

"Except where reference is made to the text of the thesis, this thesis contains no material published elsewhere or extracted in whole or in part from a thesis presented by me for another degree or diploma. No other person's work has been used without due acknowledgements in the main test of the thesis. This thesis has not been submitted for the award of any other degree or diploma in any other tertiary institution".

Britt V. Danielsen
SIGNATURE OF CANDIDATE

13th June, 2006
DATE

ATM – Skriftserie

Publikasjonsliste

1-2008: Rune Hallingstad: "*Regional styring i lys av foretaksorganiseringen. En sammenlignende studie av Helse Vest-Norge RHF og Helse Midt-Norge RHF".* April 2008

2 - 2008: Sturla Herfindal: "Veien frem til sykehusreformen – En studie av beslutningsprosessen bak lov om helseforetak". April 2008

3 - 2008: Lars Bjarne Klungseth: *Accessibility, Transparency and Public Choice - A study of the free choice policy within the Norwegian specialized health care system*. April 2008

4- 2008: Torgeir Sveri: *Strukturer og reformer. En kvalitativ analyse av reformen "enhetlig ledelse" sett i lys av sykehusets arbeidsorganisering.* April 2008

5- 2008: Anne – Mia Myhre: *Omstilling til enhetlig ledelse i sykehus - Påvirkning på avdelingslederrollen.* April 2008

6- 2008: Hege Johnson: *Media - vaktbikkje og pragmatisk publikumsfrier?* April 2008

7- 2008: Kari Kjos Grendahl: *Ledelse i en endringsprosess. - En studie av toppledere i fire lokale helseforetak.* April 2008

8 - 2008: Øyvind Jørgensen: *Etableringen av fritt sykehusvalg*. April 2008

9 - 2008: Odd Rune Hegrenes: *"Fra forvaltning til ledelse. En studie av topplederrekruttering i helseforetak"* April 2008-

10 - 2008: Siri Torvestad Nerheim: *Hvem skal lede? - Nasjonal profesjonsdebatt og lokale erfaringer ved innføring av enhetlig ledelse i helseforetak.* April 2008

11- 2008: Therese Svendsen: *Helseforetak og kommunikasjon - En studie av en kommunikasjonsstrategis betydning i et helseforetak.*April 2008

12 - 2008: Rune Nesdal Jonassen: *Foretaksreform, ledelse og intern informasjonsflyt i helseforetakene*. April 2008

13 --2008: Anbjørn Holme: *Det kommuniserende hospital. - En studie av informasjonsvirksomheten ved tre lokale helseforetak på Vestlandet.* April 2008

14 - 2008: Anne- Grethe Naustdal: *Sjukepleieleiaren sitt arbeid med kompetanseheving i sjukehus : sett i lys av erfaringar med sjukehusreforma.* April 2008

15 - 2008: Britt V. Danielsen: Leadership and management in nursing. Nurse managers' experiences of leadership and management following the introduction of unitary management in Norwegian public hospitals. April 2008

16 - 2008:Gunn Synnøve Dahl Reisæter: *Koordinering - Et grenseflateproblem? En studie av koordinering og samarbeid i psykisk helsevern.* April 2008

17 - 2008: Anita Vikingstad: *Foretaksreformen - Katalysator, destabilisator og diktator. En studie av strukturendringer i et lokalt foretak før og etter foretaksreformen.* April 2008

18 - 2008: Elisabeth Frisvoll: *Avdelingsledelse i norske sykehus i en reformtid - En utvikling henimot profesjonell ledelse?* April 2008

19 - 2008: Monika Alvestad Reime: *Styring og identitet. Om identitetsreguleringsprosesser i psykisk helsevern*. April 2008

20 - 2008: Robert Lohne: *"Ledelse, kommunikasjon og varsling i helseforetak"* April 2008

21 - 2008: Laila Nordstrand Berg: *"Tilpasninger og erfaringer i lederrolla i sykehus"* April 2008

22 - 2008: Kari Ilebekk: *Helsesekretærer i klinisk virksomhet. Sørlandet sykehus HF. Hvilke faktorer påvirker denne rollen? I hvilken retning endres rollen?* April 2008

23 - 2008: Borgny Botnen Aakre: *Sannhetsministerium eller kunnskapsmegler?- En studie av Nasjonalt kunnskapssenter for helsetjenesten*. April 2008

24 - 2008: Margrete Langeland: *Myndighetstilsyn eller kyndighetstilsyn? En studie av endringer i Helsetilsynets rolleutforming og rolleutøvelse i perioden 1994 – 2005.* April 2008

25 - 2008: Lene Susann Pilskog: Hva skulle læres? En casestudie av Nasjonalt lederutviklingsprogram for helseforetakene. April 2008

26 -2008: Dag Olaf Torjesen: Foretak, management og medikrati. En sektorstudie av helseforetaksreform og ledelse i den norske spesialisthelsetjenesten. April 2008

POLIS
Politikk, Organisasjon og Ledelse i
Spesialiserte kunnskapsorganisasjoner

Rokkansenteret
STEIN ROKKAN SENTER FOR FLERFAGLIGE SAMFUNNSSTUDIER