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Nurse leaders' response to conflict and choice in the workplace.

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NURSE LEADERS' RESPONSE TO CONFLICT AND CHOICE
IN THE WORKPLACE

A Dissertation Presented

by

JOAN M. RILEY

Submitted to the Graduate School of the
University of Massachusetts in partial fulfillment
of the requirements for the degree of

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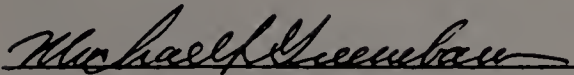
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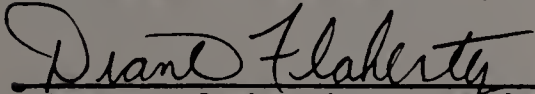
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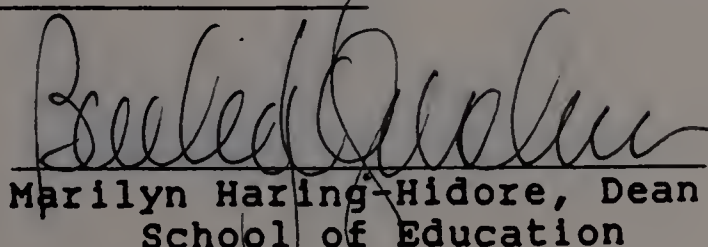
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ABSTRACT

NURSE LEADERS' RESPONSE TO CONFLICT AND CHOICE
IN THE WORKPLACE

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This study examined moral reasoning used by nurses to resolve conflict and choice in the workplace. This study also focused on how nurses saw themselves as leaders and caregivers. Ten nurse leaders were purposively selected from a large urban acute care magnet hospital. In open-ended, semi-structured interviews, each participant discussed an actual workplace conflict that they experienced, the course of action taken, and evaluation. Nurse leaders also described themselves as leaders and as caregivers. Demographic data was gathered on age, sex, educational background and career positions.

Two research questions were addressed in this study: How do nurse leaders respond to conflict and choice in the workplace? Does level of leadership influence response to

conflict and choice? Interview data were analyzed using Carol Gilligan's protocol described in the Reading Guide (Brown et al., 1988).

The results indicate that nurse leaders used justice and care voices to respond to conflict and choice in the workplace. Seven out of ten used both a justice and care voice. Three of the leaders responded with only one voice: two with only a care voice and one with only a justice voice. In this study, leadership level did not influence choice of moral voice in workplace conflict. Managers and executives both used justice and care in describing their dilemmas. Nurse leaders described three kinds of workplace conflict: organizational, interpersonal and intrapersonal.

Four themes emerged as central to how nurse leaders view themselves: the importance of relationships in the leader role; power as a piece of the leader role; the leader as a team member; standards as guides to decision-making. Nurse leaders underscored the importance of the worksetting and its influence on nursing's ethic of care. Congruence of institutional philosophy, climate, and larger administrative presence with nursing's professional care values are the contextual influences cited by the nurse leaders.

TABLE OF CONTENTS

	<u>Page</u>
ACKNOWLEDGEMENTS.....	iv
ABSTRACT.....	vi
LIST OF TABLES.....	xi
CHAPTER	
1. INTRODUCTION TO THE PROBLEM.....	1
Need and Background for the Study.....	1
Caring: A Foundation of Nursing.....	1
Research Problem.....	3
Problem Statement.....	8
Purpose of the Study.....	8
Research Questions.....	9
Significance of the Problem.....	10
Nursing and Feminist Scholarship.....	10
Leadership and Gender.....	16
Qualitative Approach to Leadership Study.....	18
Nursing Leadership.....	19
Assumptions.....	23
Working Definitions for the Study.....	24
Limitations.....	24
Organization of the Study.....	26
2. REVIEW OF THE LITERATURE.....	27
Caring as a Foundation for Nursing Practice.....	27
Leadership in Organizations.....	38
Women and Leadership.....	46
Leadership in Nursing.....	52
Moral Reasoning.....	60
Nursing and Moral Reasoning.....	73
3. METHODOLOGY.....	87
Study Design.....	88
Sample.....	88
Setting.....	90
Study Participant Protocol.....	92

Data Collection.....	95
Data Analysis.....	100
Self Descriptions of Leader Role.....	100
Leader Self Descriptions of the Caregiver Role.....	101
Workplace Conflict.....	101
Reliability.....	106
Validity.....	107
4. RESULTS AND ANALYSIS.....	111
Descriptive Characteristics of the Nurse Leaders.....	114
Leaders Describe Themselves.....	119
What Nurse Leaders Say.....	120
The Power Piece in the Leader Role.....	123
Standards As the Guide.....	125
The Importance of Relationships.....	127
Leaders as Team Members.....	128
Leaders Describe a Shift.....	131
Self-Descriptions of Caregiving in the Leadership Role.....	140
How The Health Care Delivery System Influences Caregiving.....	146
Resolving Conflicts in the Workplace.....	151
Kinds of Conflict in the Workplace.....	152
Moral Voice Considerations in Workplace Conflicts.....	160
Reading for Care.....	164
Reading for Justice.....	169
5. SUMMARY, IMPLICATIONS AND RECOMMENDATIONS.....	177
Summary.....	177
Findings.....	178
Implications for the Nursing Profession.....	180
Sphere of Influence of the Health Care Delivery System.....	182
Leadership Refocus.....	185
Moral Voice in the Workplace.....	189
Recommendations for Future Research.....	196

APPENDICES

A. LETTER TO POTENTIAL STUDY PARTICIPANTS.....200
B. INFORMED CONSENT FORM.....202
C. DEMOGRAPHIC INFORMATION FROM THE INTERVIEWEE..205
D. GILLIGAN'S REAL-LIFE MORAL CONFLICT AND
CHOICE INTERVIEW.....207
E. REAL-LIFE MORAL CONFLICT AND CHOICE INTERVIEW
ADAPTED FOR INTERVIEWING NURSE LEADERS.....209
F. ASSESSMENT OF INTERVIEW.....213
G. SELF-DESCRIPTIONS OF LEADERSHIP WORKSHEETS....215
H. MORAL CONFLICT SUMMARY WORKSHEETS.....217
I. SUMMARY CODING QUESTIONS.....229

REFERENCES.....231

LIST OF TABLES

TABLE	PAGE
1. KOHLBERG'S STAGED THEORY OF MORAL DEVELOPMENT....	63
2. TWO MORAL VOICES: CONTRASTING IMAGES.....	71
3. NURSES' MEAN PRINCIPLED MORAL REASONING SCORES ON THE DEFINING ISSUES TEST.....	77
4. STUDY PARTICIPANTS' EDUCATIONAL BACKGROUND.....	114
5. STUDY PARTICIPANTS' CAREER POSITIONS.....	116
6. SUMMARY DEMOGRAPHIC PROFILE OF NURSE LEADERS....	117
7. SELF DESCRIPTIONS OF LEADERSHIP.....	121
8. CONFLICTS EXPERIENCED BY NURSE LEADERS.....	159
9. COMPARISON OF MORAL VOICE.....	161
10. SUMMARY OF VOICE COMPARISON.....	162

CHAPTER 1

INTRODUCTION

This study is a research effort to describe the moral reasoning of nurses. The focus of the study is moral reasoning used by nurse leaders to reflect upon a conflict or dilemma that they have experienced and choose to share. The health care delivery system is the workplace setting for the nurse leaders.

Need and Background For The Study

Caring: A Foundation of Nursing

The profession of nursing faces a dilemma. On the one hand, the profession acknowledges that its values and ideals represent a human caring ethic, embedded in human responsiveness and connection as the moral foundation of nursing. On the other hand, this human caring ethic contrasts sharply with the medical ethic of rational principle, fairness and equity that objectifies, detaches and distances the professional from the subjective world of human experience (Watson and Ray, editors, 1988; Packard and Ferrara, 1988).

The medical ethic has historically prevailed in health care. The usual view in health care delivery systems is that curing of disease is the standard, the overriding goal of patient services; caring, which is the process of helping a patient maintain or attain health or die a peaceful death, is not the norm (Watson, 1988). According to Gadow (1987), care and cure are "alternative forms of commitment to patients, so sharply distinguished that one even hears them attributed to separate professions" (p.6). She proposes to reorder the hierarchical cure/care relationship in health care delivery systems. Care would be the principle or standard by which health care interventions are initiated for the patient. Care is the highest form of commitment professionals in a health care delivery system can make to patients. Cure would be one of many interventions essential to promoting the well-being of the patient. The work of Leininger, Watson and other nurse scholars support the notion that patient services, provided by health professionals in nursing and medicine, should include treatments and interventions, but would be guided by the care focus.

Nurses frequently find themselves philosophically clashing with American health care delivery systems which emphasize the curative focus over the caring

focus. This clash of values has been undermining for nurses because it contributes to self doubts about their ability to create a nursing science based on caring which would stem from a philosophy and language that reflects the nature of nursing from Florence Nightingale to the present (Munhall and Oiler, 1986). Nurses, more than other health professionals, have felt the ethical differences between care and cure issues in health care delivery systems (Gadow, 1987).

Nurse leaders are faced with a particularly difficult set of expectations because they are responsible for the work ethic practiced by the nurses they represent, while at the same time representing the dominant organizational culture of the hospital (Miller, 1989). The overall effect from these expectations has been a change in the way nursing services are managed and the way professional nurses need to be represented by their leaders. Nurse leaders are being called upon to ensure that the ethic of caring remains an essential focus of the profession of nursing, while minimizing institutional barriers that work against promotion of the ethic of care as the driving force in providing patient care (Harrison, 1990).

Research Problem

This research considers the conflict of values between nurses, who practice with a caring focus, and a health care delivery system which prioritizes a curative treatment focus. Historically, nurses working in hospitals have not controlled the decision-making processes regarding the terms of their work. Physicians and administrators see themselves as influencers over the work of nurses in hospitals (Allen, 1987).

Hospital organization charts graphically present this clash of values. In most of the different models of hospital organization charts, described in a text edited by Shortell and Kaluzny (1983), the typical schema presents a board of directors, trustees, hospital administrators and physicians in the top section. In the lower support services lines are nurses, along with the nutritionists, social services workers and other service workers. Health care service professionals, including nurses, are on the bottom of the organization chart, reflecting their lack of power and autonomy.

Patient care is the focal reason for the hospital's existence. Nurses have always described their role as

caring for and caring about patients. Nursing theorists, from Florence Nightingale to Martha Rogers to Virginia Henderson, support the concept of caring as the holding piece in nursing practice (Nyberg, 1989). As the nursing profession continues to work toward clarifying its traditional caring practice in a different era, hospitals, as health care delivery centers, have changed in significant ways.

Hospitals are changing from public, non-profit enterprises to large corporate organizational structures which are privately owned and profit oriented. In the last fifteen years, large for-profit health care delivery systems have become a dominant player in health care (MacPherson, 1989). The reason for this shift is primarily economic. Miller (1989) believes that "the health care system needs increased productivity and efficiency to deal with the astronomical rise in health care costs for consumers and the nation as a whole. Presumably, large corporate collectivities will help meet these economic goals" (p.12).

This shift has had an enormous impact on how physicians, nurses and other health care workers provide patient services. Nurses are asked to quantify in health dollars the cost of care. The productivity of

care givers is being scrutinized by new technologies such as patient classification systems which often do not measure many of nursing's caring activities (MacPherson, 1989, Ray, 1989). Nurses' view of their professional role contrasts with the health care system that "is increasingly removed from the profession's concerns and expertise" (Moccia, 1988, p. 30). The contrast between professional role and institutional goals promotes the development of nursing dilemmas in the practice setting.

This research looks at how nurses who have been educated to be care focused respond to work related conflicts in a health care delivery system that limits their care giving activities. This study centers on nurse leaders (in practice and administration) who experience dichotomous leadership expectations. These leaders are expected to represent the corporate culture of the hospital while preserving the caring ethic of nursing practice (Miller, 1989). How does the nurse leader respond to work place dilemmas that may stem from their dichotomous leadership role?

According to Huggins and Scalzi (1988), limitations in research findings are encountered when nurse researchers select a framework for an ethical practice theory of nursing that may not reflect the life

experiences of nurses in their care giver role. Specifically, they question the validity of using Kohlberg's "Justice Theory" as a framework to guide the study of moral development of nursing because it may not reflect nursing reality in the care giving role. "If an ethical base for nursing practice is built on the ethic of justice and the nurse's orientation is the ethic of care,...there will continue to be a denial of the nurse's own voice" (Huggins and Scalzi, 1988, p.46). These authors conclude that if moral dilemmas are studied in a theoretical framework that is foreign to nurses, these individuals could appear to researchers to be individuals of immature moral development.

Nokes (1989), in a review of the studies of moral reasoning in nursing, offers support for Huggins and Scalzi's perspective. In seven studies of nurses, using Rest's Defining Issues Test or Kohlberg's Moral Judgement Interview, nurses were at a relatively low level of moral reasoning. She suggests: "the consistently low level of moral reasoning in nursing and nursing students is not congruent with the nature or goals of the nursing profession" (p.174); the moral reasoning theory that guided these studies may need to be replaced by a more comprehensive theory of morality.

Problem Statement

The problem to be addressed in this study is how nurse leaders in health care delivery settings respond to nursing dilemmas they experience in their work environment. This study examines moral reasoning used by nurses to respond to conflict and choice in the workplace. Nurse leaders are increasingly faced with complex health care situations, in a changing organizational structure, that require the exercise of moral judgement. An understanding of the moral reasoning that nurse leaders use in their workplace holds promise for contribution to all nurses and the publics they serve.

Purpose Of The Study

The purpose of the study is to understand how nurses in two different levels of leadership respond to their workplace dilemmas. The purpose will be achieved by using the lens of Gilligan's Moral Orientation Theory to understand the dilemmas that nurse leaders report that they experience. Nurse leaders are increasingly faced with complex health care situations in a changing organizational structure. A research study which

proposes to describe moral reasoning used by nurse leaders in responding to real-life conflict in the workplace will contribute to the nursing profession. It is hoped that the contribution will also extend to the disciplines of psychology and women's studies. The potential for contribution provides a meaningful rationale for implementation of the study.

Research Questions

In order to examine the problem, the following questions will guide the research:

1. How do nurses in leadership positions in health care delivery systems respond to conflicts and choice in the workplace?

2. Does level of leadership influence response to conflicts and choice? This question operationalizes to: Is there a difference in conflict and choice response to workplace dilemmas for nurses in middle leadership positions (managers) than for nurses in top level leadership positions (vice presidents, directors of nursing)?

Significance Of The Problem

Nursing And Feminist Scholarship

Nursing's strengths and shortcomings, in wanting to seek recognition for its professional work ethic of caring, perhaps are intricately tied into the female experience. The work of Susan Reverby (1987) compares the evolution of the role of women with the evolution of the practice of nursing. She proposes that "nursing, as labor, began as women's work for families, friends, and community. As a form of caring, it was often taught by mother to daughter as part of female apprenticeship" (p.199). She stresses that the efforts to understand the meaning of caring cut across Western philosophy, psychological and sociological theory, and women's studies scholarship.

The logical conclusion of women's studies scholarship and theory development of caring is that caring is seen as an element in female identity. Yet, it is as a focus of professional work that caring is bonded with nursing. Caring as a professional core value for nurses takes on a different meaning than the caring that is attached as a psychological trait for women. However,

historically, women's obligation to care and nursing's position as a primarily female profession are interwoven. The recognition that nurses' work is women's work and, as such, is tied in with the traditional obligation to care, has made it very difficult for nurses to speak for their rights or to espouse a vision of caring that asserts their right to determine their professional role. As long as caring and responsibility for others, which are integral parts of nurses' work, are viewed as female qualities, they will be less valued by society (Reverby, 1987).

Contemporary feminism, supported by recent psychological and sociological theories, is providing a push for nursing. Nursing theorists, practitioners, and educators are looking at alternate feminist theories of moral development as a possible foundation for "a moral vision that is more compatible with nursing's long-standing historical and philosophical assumptions of relational caring than the rule-and-principle framework that currently constitutes the dominant strand of biomedical ethics" (Cooper, 1989, p.10). The research of Harvard educator, Carol Gilligan, on the moral development of women, has particular relevance to an ethic of caring for nursing. Nursing literature is beginning to examine Gilligan's empirical evidence that

supports the presence of a gender related perspective of care in moral deliberation. This perspective of care may provide a framework for moral deliberation that more reliably addresses the moral experience of the nurse (Cooper, 1989).

The study of moral reasoning has emerged from the field of cognitive development in psychology and education. A report by Ford and Lowry (1986) on gender differences in moral reasoning, notes that Piaget, in his major work in moral development, The Moral Judgement of the Child (1932), recognized the existence of two types of morality, a morality of good and a morality of right or duty. He said:

The relations between parents and children are certainly not only those of constraint. There is spontaneous mutual affection, which from the first prompts the child to acts of generosity and even self sacrifice, to very touching demonstrations which are in no way prescribed. And here no doubt is the starting point for the morality of good which we shall see developing alongside of the morality of right or duty, and which in some persons completely replaces it (1932, p. 193-194).

The authors state that Piaget "noted the existence of two types of morality, a morality of good and a morality of right or duty" (p. 777) but focused on the notion of justice. He said that

if the affective aspect of cooperation and reciprocity eludes interrogation, there is one notion, probably the most rational of moral notions, which seems to be the direct result of cooperation and of which the analysis can be attempted without encountering too much difficulty---we mean the notion of justice. It will therefore be on this point that most of our efforts will be directed (p.195).

Accepting the Piagetian perspective that justice is the core of morality, Kohlberg (1981) developed a stage theory of moral reasoning in the late fifties. For the next twenty years, Kohlberg validated and refined the three level/six stage model. The empirical basis for Kohlberg's work on justice reasoning was longitudinal research with a sample of eighty-four males. The study's participants were interviewed every three years. The results from Kohlberg's original work and other supporting studies concluded that moral development was sequential and related to the individual's level of cognitive development, that age and education facilitated moral development, and that his theory had universality over culture and gender (Colby and Kohlberg, 1987).

Gilligan (1982a) questioned the assumption that there is a universal standard of development and a single scale of measurement along which development differences can

be aligned as either higher or lower, or better or worse. Gilligan, through assessment of Kohlberg's work on moral development, hypothesized that there are at least two distinct considerations that individuals may use in making moral decisions: justice and care (Gilligan, 1982b). She further hypothesized that there is an association between moral orientation and gender. Men and women may use both orientations. However, Gilligan found a voice, more frequently heard from women in describing moral dilemmas, that was responsive to reasoning based on care, responsibility to others and on the continuing connection of interdependent relationships. It was not a voice framed exclusively by justice, fairness, and universal rights, as posited by Kohlberg. Gilligan believes:

Justice and care as moral perspectives are not opposites nor mirror-images of one another, with justice uncaring and care unjust. Instead, these perspectives denote different way of organizing the basic elements of moral judgement: self, others and the relationship between them" (Gilligan, 1987, p.22).

Lyons' research was "the first systematic, empirical test of these [Gilligan] hypotheses" (Lyons, 1983, p.127). The results of her study supported the hypothesis that there are two different orientations to morality: rights/justice and care/response. The study also supported the hypothesis that

individuals use two distinct modes of self-definition: a connected self, more frequently voiced by women and a separate/objective self, more frequently voiced by men. Individuals using a care/response orientation in moral decision making see moral problems as issues of relationships or of response, that is, "how to respond to others in their particular terms; resolved through the activity of care" (Lyons, 1983,p. 136).

Kohlberg and his colleagues have explored Gilligan's concept of care and its relationship to moral reasoning within the Kohlberg framework. Their analysis suggested the need for limited incorporation of the ethic of care into the Kohlberg model.

We see justice as both rational and implying an attitude of empathy. It is for this reason that we make the following proposal: i.e. that there is a dimension along which various moral dilemmas and orientations can be placed. Personal moral dilemmas and orientations of special obligation, as we have just discussed them, represent one end of this dimension and the standard hypothetical justice dilemmas and justice orientation represent the other end (Kohlberg, Levine, and Hower, 1983, p. 24-25).

Gilligan's theory calls for empirical translation of the justice/care framework into "real-life" terms. A small

number of studies have been undertaken addressing the questions of gender differences in moral reasoning across age and occupation. (Counts, 1987; Derry, 1987; Ford and Lowery, 1986; Gilligan et al, 1988; Jack and Jack, 1988; Johnston, 1985; Lyons, 1983; Langdale, 1983; Mellon, 1989; Millette, 1988; Taylor, 1989). The results of these studies confirm the presence of both orientations across the varied samples in both men and women. Women more frequently use a care orientation in describing moral dilemmas. Men more frequently use a justice orientation in describing moral dilemmas. However, the care orientation was the voice of predominance for some men and the justice orientation was the voice of predominance for some women. In Derry's study (1987), the justice orientation was the voice of predominance for both men and women in a large corporate organization.

Leadership And Gender

Research on leadership in the United States began to take on formal dimensions during World War I when the United States military organization developed screening tests for officer selections. These twentieth century leadership studies are grounded in a male domain, since women were absent from the officer ranks during World War I

and not included as study participants. Since that time, the study of leadership has followed three basic approaches: 1. the study of leader traits and behavior 2. the study of environmental factors of leadership 3. the study of situational interactions between leaders and their environment (Bass, 1981). The setting for these leadership studies has been primarily in the business environment which, until the late seventies, was a setting noted for its male dominance and lack of opportunity for women.

Leadership research has been prolific, resulting in many perspectives about the meaning of leadership. James MacGregor Burns (1978), in his book, Leadership, distinguishes one hundred-thirty different definitions of leadership in the literature. Gender became a research variable in leadership study in the late seventies and eighties. Bass (1981) reports on the relative absence of gender consideration in leadership studies, noting that "sex as a difference of consequence in the study of leadership was almost completely absent in Stogdill's (1974) review of leadership" (p. 491). Yet Stogdill's Handbook of Leadership (1974) represented a major milestone in leadership research because it undertook a systematic analysis and review of the large volume of existing research and literature on leadership.

The movement of women into the work force in the late seventies and early eighties initiated a change. The study of leadership began to include women in leadership and management positions in their focus (Bass, 1981). The methods that were used represented the traditional approach to studying leadership; that is, a quantitative positivist research model to study the additional variable of gender.

Qualitative Approach to Leadership Study

There is a volume of leadership research that has been generated around the variable of gender. Despite the large number of studies, with many different guiding philosophies and research methodologies, there is no clear consensus about the role of gender in leadership (Bass, 1981). Bass recognized the need for theory and empirical research to be integrated, each stimulating, helping and modifying the other.

Nearly all of the studies on leadership used a quantitative methodology for the research. Bryman et al., (1988) suggest that the qualitative research approach would enhance the understanding of leadership dynamics in a way that quantitative methodologies have not. By emphasizing insider perspective, dynamic situational reality, holistic focus, discovery orientation, subjective

data, and naturalistic conditions, the qualitative approach offers rich description (Duffy, 1987). Qualitative research focuses on the meaning that individuals construct out of their experiences. The assumption of the qualitative method is that meaning can be understood only by accounting for the context within which the meaning is constructed. Context involves all aspects of the experience as told by the participant, the environment in which the experience happens, the meaning constructed and the perspectives of participants constructing the meaning (Patton, 1980; Bogden and Biklen, 1982).

For this study, the context is all the aspects of a work-related moral conflict and choice that nurse leaders describe from their viewpoint. Context includes the nurses' description of the setting in which the moral conflict occurs, the meaning that is made of the conflict, and the nurses' perspective of the choices made in the moral conflict.

Nursing Leadership

Nursing leadership research, in many ways, parallels leadership research in the behavioral and social sciences. In the sixties and seventies, nurses studied their leaders' characteristics, behavior in the practice and education

settings, and situational determinants. For their conceptual frameworks, they usually used the male dominated models from the behavioral, social, and management sciences.

However, the role of the nurse leader in the hospital has changed substantially since the mid-seventies with the development of health care delivery systems as large corporate ventures (Blair, 1989; MacPherson, 1989).

"Corporate nurse leaders are taking on roles that include policy making, marketing of nursing services, economic management of multidepartments and organizations and strategic planning" (Miller, 1989, p. 13). At the same time, there has been a refocusing of nursing practice to the art and science of human caring (Leininger, 1984; Ray, 1989; Watson, 1984; Rawnsley, 1990). Nurse leaders are faced with a difficult set of expectations in balancing the caring tradition of nursing while meeting the corporate needs of the health care system for efficiency, productivity, and rational decision making (Miller, 1989).

The substantive changes in the nurse leadership role in the last decade call for understanding of how the corporate nurse leader responds to conflicts in the workplace which is characterized by shifting professional priorities and organizational demands. There is a need

for nursing leadership studies in the workplace, but with the goal of the 'theoretical-empirical' integration called for by Bass (1981). A study that looks at nurse leaders' response to workplace conflicts using a model based on Gilligan's theory may represent a response to Bass's call. The study also has the potential of increasing understanding of how nurse leaders combine their caring role with their leadership role in a changing health care delivery system.

Gender as a variable in nursing leadership has not been studied. Yet nursing is a predominately female profession. One out of every forty-four women is a nurse (Bullough and Bullough, 1984). There have been many influential women in the twentieth century who have been nurses: Lillian Wald, Margaret Sawyer, Emma Goldman, Sister Elizabeth Kenny, to name just a few. But nursing leadership has attracted neither the curiosity of social scientists, nor high positive visibility in the media. (McGee, 1984). Nurse leaders from the social science vantage point are an understudied group of females and professionals. Nurse leaders have been functioning for years in male-dominated organization models in education and health care delivery systems. The 'Consider this...' Feature in the Journal of Nursing Administration (1986) states the editor's opinion on the gender and nursing leadership issue:

A knowledge of gender influences should help nurse administrators become better leaders and group members in the various work settings required by the profession. Women, in particular, need to determine whether they can be most effective (and satisfied) with traditional female behavior in groups, or whether they need to incorporate more of the traditional male-oriented skills into their behaviors to achieve desired group and individual results (p. 4).

The role of nurse leaders, primarily female, who synthesize the caring tradition of practice, and the organizational responsibility of administration, needs further explication (Blair, 1989). The exploratory study of the response of nurse leaders to workplace dilemmas, using Gilligan's theory based model of Moral Conflict and Choice Response, will contribute to better understanding of the process of moral decision-making in complex health care delivery systems. The use of a more comprehensive theory of morality, such as Gilligan's, is supported in the nursing literature because the consistently low levels of moral reasoning of nurses under Kohlberg's theory of moral reasoning is not congruent with "either the nature or the goals of the nursing profession" (Nokes, 1989, p.174).

Assumptions

In this study, I take an assumption to be a statement which is either considered self-evident or has been satisfactorily (at least tentatively) grounded by earlier research. When assumptions are asserted before data collection, they can be questioned and measured against the data that emerges in the study. Evidence in the data will confirm valid assumptions and dispute groundless assumptions (Bogdan and Bicklen, 1982; Polit and Hungler, 1983).

The assumptions identified in this study are as follows:

1. Nurse leaders make moral decisions in their professional role.
2. Nurse leaders are able to describe reasoning used to resolve work place conflicts or dilemmas.
3. Nurse leaders use at least two ways of describing workplace conflicts. These ways are a care voice and a justice voice which are gender related but not gender specific (Gilligan, 1982; Gilligan & Antanucci, 1988; Langdale, 1983; Lyons, 1983).

With the increased complexity of health care, moral dilemmas which require a decision are faced more frequently by all health professionals (Ketefian, 1981).

Nurses can and do make moral decisions to respond to these dilemmas (Jameton, 1977).

Working Definitions for the Study

It is important to have a clear understanding of the terms central to this study in order to remain focused on the research issues. The following are the working definitions for this study.

Moral Reasoning: Moral reasoning is the active thinking processes which individuals use to construct an action response to any situation calling for a distinction between right and wrong in conduct, or responsiveness to others.

Moral dilemma: Moral dilemmas are interpersonal situations or circumstances of uncertainty in which an individual experiences moral conflict in choosing between two or more contradictory courses of action each of which expresses differences in moral judgements (McInerney, 1987; Omery, 1989).

Limitations

This is a descriptive study which focuses on hypothesis generation rather than hypothesis testing. A

qualitative methodology is used to meet this purpose. The limitations cited for this study are similar to the limitations shared by many studies using this methodology.

The limitations for this study are as follows:

1. Nurse leaders were chosen for this study by position and availability. As such, there is no assurance that they represent the entire population of nurse leaders.

2. Data was gathered using a semi-structured interview. Although reliability and validity have been addressed, it is not assumed that the interview would yield the same results in a replication of this study since an underpinning of the method is an openness to revising generalizations based on variables and dynamics of a new context (Miles and Huberman, 1984).

3. Data is analyzed, and the process of analysis is reviewed using a well developed, guiding framework. This process does not assume that the analysis is absolutely objective in that duplication of the process would leave an exact "trail of evidence".

Because of the size of the sample, the results of the this study are not for generalization to all nurse leaders. However, the ideas generated from the findings of this study may be considered as grounded work for

further study in the practice of nursing, nursing leadership, and moral reasoning.

Organization Of The Study

This study focuses on nurse leaders' response to conflict and choice in the workplace. Study participants' self-descriptions of leadership and self descriptions of caring in the leadership role will also be explored. Chapter 1 has presented the need and background for the study, problem description and significance, problem statement, purpose of the study, research questions, assumptions and limitations. Chapter 2 reviews pertinent literature to caring, leadership and moral development. Chapter 3 presents the methods and plan of action used to collect and analyze data. Chapter 4 presents the findings and analysis. Chapter 5 presents the summary, implications, and recommendations for nursing leaders as caregivers in health care delivery organizations.

CHAPTER 2

REVIEW OF THE LITERATURE

This study addresses questions relevant to the profession of nursing, the study of leadership, and the field of cognitive moral development. It extends current research in these disciplines and lays the groundwork for expanding research beyond the scope of this study. The review of the literature presented here will bring together research and literature in nursing, leadership, and cognitive development, that support the examination of nurse leaders' response to workplace conflicts.

Caring as a Foundation for Nursing Practice

Care, as a construct of nursing, is used to describe the essence of nursing practice. In the last decade, the concept of caring has become a reexamined focus in health care, nursing practice, and nursing research. Although the notions of 'care' and 'caring' have been documented throughout nursing's history, the reawakening of the caring movement began in 1976 at the American Nurses Association Convention when JoAnn Glittenberg and Madeleine Leininger presented a program on caring as the essence of nursing.

Since then, caring has been addressed and studied explicitly in nursing literature.

Madeleine Leininger has been one of the leading spokespersons for the importance of care to the practice of nursing. She began her life's work on the study of the phenomenon of care by stating her belief that nursing is derived from the concept of nurturance which comprises ideas of caring, growth, and support. She maintains that caring is the dominant intellectual, theoretical, heuristic focus of nursing practice. She believes that no other profession, historically and in the present, is so concerned and involved in caring behaviors, caring processes and caring relationships than nursing (Leininger, 1981).

Leininger (1981) acknowledged the importance of distinguishing between the generic concept of care and the concept of professional nursing care as a way to show the relationship between the two, while recognizing the greater complexity of the professional caregiving role. She defined care/caring

in a generic sense as those assistive, supportive, or facilitative acts toward or for another individual or group with evident or anticipated needs to ameliorate or improve a human condition.... I define professional nursing care as those cognitively learned humanistic and scientific modes of helping or enabling an individual, family, or community to receive personalized services through specific culturally defined or ascribed modes of

caring processes, techniques and patterns to improve or maintain a favorably healthy condition of life and death (p. 9).

Her major study focused on the cross-cultural expressions of care (Leininger, 1984). After extensive research, in thirty different cultures, on the construct of care as culturally embedded, Leininger proposed the nursing theory of Cultural Care Diversity and Universality. This theory is a meld of two positions: 1. Care is the essence of nursing and the central, dominant and unifying feature of nursing practice; 2. Care and culture are inextricably linked together and cannot be separated in nursing care actions and decisions (Leininger, 1988).

Using the lens of an anthropological viewpoint, Leininger (1981) presented six major cross cultural functions of people as assumptive premises of her theory:

1. Cross-cultural caring and care functions are critical factors for human growth, self and group actualization, human development, and survival for human cultures throughout the long history of humankind.
2. Caring activities, behaviors, and processes link human groups together in a sense of mutual interdependence and interrelatedness in order to achieve desired human tasks, maintain health, and to survive.
3. Historically, caring played an important role in protecting and maintaining humans who were ill or under the threat of illness.

4. Caring behaviors, activities and processes serve society to help prevent aspects of human misery, reality stresses, and socially disruptive conditions, and these functions are culturally based and institutionalized.

5. Cross-cultural caring promotes and sustains human qualities and attributes of people.

6. Cross-cultural caring facilitates curing modalities in health and non-health situations (pp. 95-99).

Leininger's contribution to nursing's study of the care concept is one of foundation building and facilitation for others. Her work has been a catalyst for others to further delineate and develop the concept of care in other contexts. Leininger's work supports the importance of understanding the care/cure relationship in health care delivery situations but looks to others to offer additional empirical evidence or support for the construct.

Watson (1979) articulates the concept of care from the perspective of nursing practice. She states as her belief that care is the essence of nursing and the underpinning of a philosophy and theory of the science of caring. She describes caring as the moral ideal of nursing, an end in and of itself (Gadow, 1987; Watson, 1985).

Within the scope of her Human Caring Theory, Watson(1985) describes ten carative factors that explicate essential qualities of the nurse while identifying what the

nurse does to provide care. She calls them carative factors "since they aim toward helping another person maintain or attain a high level of health or die a peaceful death. Curative factors, on the other hand, are directed toward curing a person of disease or pathology" (Watson, 1981, p. 62). Watson believes caring is a "healthogenic" practice more than curing because the practice of caring integrates scientific with humanistic knowledge to promote health and provide care to the ill. She states "a science of caring is therefore different from, but complimentary to, a science of cure" (Watson, 1981, p.63).

The ten "carative factors" from her theory are:

1. formation of a humanistic-altruistic system of values,
2. instillation of faith-hope,
3. cultivation of sensitivity to one's self and to others,
4. development of a helping-trust relationship,
5. promotion and acceptance of the expression of positive and negative feelings,
6. systematic use of creative problem solving,
7. promotion of interpersonal teaching-learning,
8. provision for a supportive, protective and/or corrective mental, physical, sociocultural and spiritual environment,
9. assistance with the gratification of human needs,
10. allowance for existential-phenomenological forces (Watson, 1985, p. 75).

Theorists' Peterson and Zderad's (1976) notion of "humanistic nursing" is supported by Watson's description of the ten carative factors in the Human Caring Theory. Peterson and Zderad believe that the phenomenon of care in nursing is intricately connected with nurturing, being nurtured, and a relationship that evolves from the process of nurturance (Smerke, 1988). Peterson and Zderad state:

In real life, nursing phenomena may be experienced from the reference points of nurturing, of being nurtured, or of the nurturing process in the "between". For instance, the nurse may describe comfort as an experience of comforting another person, the patient, as an experience of being comforted. However, while each has experienced something within himself, he also has experienced something of the "between", namely, the message or meaning of the "comfort-being-comforted" process. This essential dimension of caring is beyond and yet within the technical, procedural or interactional elements of the event. It is a quality of being that is expressed in the doing (p. 13).

The recognition and understanding of caring as a universal phenomenon has influenced the profession of nursing as it refocuses on its caring ethic. Fry (1988) believes that this has happened in several ways. She states that the primary influence has been the acknowledgement that the very nature of nursing requires and reinforces the ethic of care. A second major influence has been the development of theories of human care and care behaviors within nursing

and within the discipline of ethics. These two factors have contributed to the moral and theoretical foundations for an ethic of caring within nursing practice (Fry, 1988).

Noddings' (1984) work has contributed to an understanding of caring as a cultural moral value for nursing. She believes that caring is primarily relatedness and connectedness. Caring creates the foundation of an ethical response and "guides us in moral decisions and conduct" (p. 105). The care role in society has been obscured by a prevailing view of ethics which prioritizes rules, logic, and justification. The prevailing view contrasts with Noddings' ethic of care, which supports the notion of relationships as a priority in complex human situations. Nodding's notion of caring calls for the acknowledgment of the importance of interpersonal processes between nurses and the patient rather than contractual ones (Condon, 1988).

During the past decade, a number of empirical studies focusing on the concept of care have been undertaken. Watson et al. (1979) conducted a study of caring to identify what nurses did that indicated care from the viewpoint of a sample of patients, practicing nurses, and student nurses. The results of the survey indicated that the affective dimensions of caring were more frequently identified by practicing nurses and student nurses in their understanding of care and the physical care indicators were more frequently identified by the patients.

Benner's (1984) classic study of nurses' level of competencies in clinical nursing practice described five levels of competency: novice, advanced beginner, competent, proficient, and expert. Practicing nurses were interviewed for their descriptions of patient care situations in which they saw positive outcomes for the patient from nursing care interventions. Thirty-one competencies emerged from the data. Exemplar cases of caring reflecting Benner's model of competencies in clinical nursing practice were presented. Benner and Wrubel (1989) expanded the understanding of expert competencies by asserting that expert caring requires a greater level of involvement for the practitioner. The enabling condition of connection and concern between nurse and patient strengthen their meaning of the primacy of caring for the expert.

Gaut's (1984) research clarifies the meaning of care and proposes a theoretical description of caring. Two central questions are addressed in this study:

1. What is the usage of caring in a particular situation?
2. In order to call an action a caring action, what conditions must be met?

Gaut concludes that three conditions are required for an action to be caring:

- Condition 1: S must have knowledge about X to identify a need for care, and must know that certain things could be done to improve this situation
- Condition 2: S must choose and implement an action based on that knowledge, and intend the action to be a means for bringing about a positive change in X.
- Condition 3: The positive change must be judged solely on the basis of a 'welfare of X' criterion (pp.35-36).

Gaut (1984) presents an action-based description of caring as an intentional human enterprise in which care givers respond to the care recipient's need for a positive change. She states that there are necessary relationships for the care-giver and care-recipient within the three conditions. The first is that the intention or purpose of the chosen activity must be related to a need for care as demonstrated by the care-recipient and recognized by the care giver. Second, the caring activity must be intended to bring about a positive change to improve the care recipient's welfare. By describing the concept of care through action categories, Gaut contributed an integral part to the care-giver/care-recipient theoretical model (Nyberg, 1989).

Ray (1984) examines caring within the cultural context of the hospital, developing a classification of caring as it

related to institutions. A two phase ethnographic study was conducted in an acute care, urban hospital with 192 administrative and clinical personnel. The study focused on the following areas: descriptions of the meaning of caring in a hospital culture; identification of categories of caring within an organization; identification of dominant caring behaviors manifested within each clinical unit; and formulation of organizational caring theory. From an analysis of the respondents' descriptions of caring values, beliefs and behaviors, Ray classified the data under eight structural caring categories within the organizational culture of the hospital: political, economic, legal, technological/physiological, educational, social, spiritual/religious, and ethical.

Ray (1989) concludes that the meaning of caring is markedly influenced by the role and position a person holds, and the place within which the person works in the health care delivery system. Initially, caring is described in humanistic terms, followed by terms related to the person's position and place within the hospital. Nurse administrators generally express their notion of caring as a humanistic concept followed by an expressed need to support both the nurse and the patient directly, as well as the organization, through sound political and economic decisions. Frequently, nurse executives were in conflict between organizational goals and patient care needs.

Ray (1981) questioned that hospitals as health care delivery systems may be incongruent with professional caring because of "structured value system, economic competition, and the entrenchment of the health care settings with the medical model of diagnosis and treatment" (p.29). Nursing's caring values are submerged, leading to conflict. On the one hand, nursing claims its caring ethic and humanistic approach as the priority of its practice. On the other hand, the hospital, with its bureaucratic value system, supports the dominant medical and technological model for patient services. This results in a dilemma for nurses.

As a result of her study and an in-depth review of the literature on organizations as bureaucracies, Ray proposed the Theory of Bureaucratic Caring. This theory presents as its thesis that caring is the synthesis of humanistic, social, educational, ethical, and religious/spiritual caring (traditional) with the contemporary notion of economic, political, legal and technological caring (bureaucratic) (Ray,1989). She states:

The Theory of Bureaucratic Caring is a synthesis of the two primary components of nursing in organizations--caring and bureaucratic components that make up the functioning of complex organization systems....They make an opportunity for change from a narrow to a broad focus where management and caring views can exist, side by side, and realistically represent the transformation of health care organizations to benefit humankind (p. 40-41).

Summary:

Nursing scholars and researchers have supported and explicated theories of caring as important to the profession of nursing. A central piece of nurses' ethic of care is that nurse caregivers identify responsiveness to others' needs as a priority that is grounded in knowledge. This notion is supported by nursing research and scholarship. Caregiving, however, is influenced, contextually, by the role and position of the caregiver in the organization. Nurse leaders express a need to support the nurse, the patient and the organization. Nurse leaders are frequently in conflict over differences between the caring/responsiveness priority for patient needs and organizational goals.

Leadership in Organizations

After years of research on outstanding qualities that leaders have in common, Bennis and Nanus (1985) concluded that the overriding factor, which empowers the work force and ultimately determines which organizations succeed or fail, is the leadership of those organizations. The effort to define and measure leadership in organizations has received continuing attention since the industrial revolution. However, researchers usually study leadership

according to their individual perspective and the aspect of the phenomenon of most interest for them to focus (Yukl,1981).

An area of early interest for researchers focused on the search for traits that distinguished leaders from non-leaders. This approach was based on the assumption that leaders have identifiable physical, personality, and/or cognitive ability traits. Many studies identified differentiating traits between leaders and non-leaders in different environments, but there was little agreement across studies. Stogdill (1948) concluded that an individual does not become a leader by virtue of the possession of some combination of traits. The relationship of personal leader characteristics to characteristics, activities, and goals of the followers is relevant.

In a later review, Stogdill (1974) broadens the focus of leadership research to include the study of relationships between leadership traits and leadership effectiveness. Although additional traits of successful leaders were identified, it became clear that certain situationally dependent traits augmented leadership effectiveness but did not guarantee it. Fiedler (1967) claimed that the effectiveness of a leader is contingent upon three variables: 1. the structure of the task to be accomplished; 2. position power; 3. leader-member relations.

Another approach to studying leadership that evolved focused on describing effective leader activities and behaviors. Unlike trait theories, the behavioral approach centered primarily on leader effectiveness rather than the emergence of an individual as a leader.

The Ohio State Leadership Studies were a major contributor to the behavioral approach to studying leadership. Initiated in the late 1940's, the focus of much of the research was the identification of leadership behaviors that are instrumental for the attainment of group and organization goals. From preliminary studies, a total of 1,800 leadership behavior responses were compiled and then reduced to 150 examples that could be validated in the leadership/management literature. Additional studies showed that subordinates perceived two categories of leadership behavior:

1. "consideration" which included establishing and maintaining good relationships with subordinates.

2. "initiating structure" which included task related behaviors concerned with directing subordinates, clarifying subordinate roles, planning, coordinating, problem solving, criticizing poor work, and pressuring subordinates to perform better.

From this research, several questionnaires were developed, the most widely recognized being the Leadership Behavior Description Questionnaire (LBDQ) (Fiedler, 1974).

Another contributor to the behavioral approach in leadership study was Mintzberg (1973). He used direct observation of leader activities, and developed leadership activity categories supported by ten managerial roles. The roles of figurehead, leader, and liaison were associated with interpersonal behaviors. The roles of monitor, disseminator, and spokesman supported information processing behavior. The roles of entrepreneur, disturbance handler, resource allocator, and negotiator resulted in decision-making behaviors.

Morse and Wagner (1978) conducted a leadership study using a questionnaire with activity categories adapted from the work of Mintzberg. The results indicated that managerial effectiveness was significantly correlated with the activity categories in two different organizations. Their conclusion was that although some behaviors were common to leaders in both sites, the most essential activities differed for the two organizations. This indicated that the most important leadership activities may be organization specific.

The behavioral approach to studying leadership has been used by several researchers. However, Yukl (1981) reports that many authors have reviewed these studies and reported that neither the behavior category of consideration or initiating structure is consistently related to subordinate

performance, and the relationship between leader behavior and subordinate satisfaction is mixed.

The situational approach to leadership is one of a number of contemporary study trends in organizational theory. The underlying premise of this approach is the idea that the internal function of the organization must be consistent with the organizational goals, current technology, stability of the environment, and the needs of the individuals in the organization (Dessler, 1982).

Research into the effectiveness of situational leadership has been conducted by several researchers (Fiedler, 1967, 1974; House, 1971; Hersey and Blanchard, 1988). The researchers concluded that the effectiveness of any leadership style is related to the situational variables of leader and follower personalities, the goals to be accomplished, and the environmental conditions.

The theory of transformational leadership was presented by James MacGregor Burns (1978) in his book, Leadership. He describes the transformational leader as one who induces followers to work to achieve goals that represent the values and motivations of both the leaders in the organizations and the followers. The outcome of transformational leadership is agreement between wants and needs, aspirations and expectations, of worker and leader. "The result of

transforming leadership is a relationship of mutual stimulation and elevation that converts followers into leaders and may convert leaders into moral agents" (Burns, p.4).

Burke (1986) believes that Burns' notion of a transformational leader and Zaleznik's work on describing a leader share similarities which he selectively interprets. He says that Burns and Zaleznik both describe leaders as:

1. visionary, solitary, inspirational individuals, emotionally involved with their organization. Their work life is indistinguishable from personal life.

2. achieving commitment by inspiration; holding the whole person responsible rather than using task accountability.

3. able to engender intense feelings in followers; perceptive and accurate in identifying followers' needs.

4. able to determine and provide a mission and long term goals which, when achieved, respond to the followers' needs

5. never leaving matters as they find them; Change is their rule. (Burke, 1986, pp.66-67).

The theory of transformational leadership has been addressed by other theorists. Svrvivasta (1986) focuses on vision as a dimension of leadership, reiterating that the

leader has ideals, vision, a higher purpose as well as subordinate goals. Bennis and Nanus (1985) state that the leader's

vision...articulates a view of a realistic, credible, attractive future for the organization, a condition that is better in some important ways than now exists. A vision is a target that beckons (p. 89).

Bennis and Nanus address the importance of the leader's ability to communicate the vision to others. They caution that a vision cannot be established in an organization by edict or by use of power as coercion, but rather by leaders persuasively acting in a manner that communicates commitment to the vision with consistent actions reflecting that vision (pp.107-109).

Bennis and Nanus incorporate the notion of power in their description of leadership proposing that power is the energy source, simultaneously stimulating and supporting action. The transformative leader uses power wisely. They integrate empowerment into notion of power, saying,

[Effective leadership] is not so much the exercise of power itself as the empowerment of others. Leaders are able to translate intentions into reality by aligning the energies of the organization behind an attractive goal....These leaders lead by pulling rather than by pushing; by inspiring rather than ordering; by creating achievable, though challenging,

expectations, and rewarding progress toward them rather than by manipulating; by enabling people to use their own initiative and experiences rather than by denying or constraining their experiences and actions (p. 224-225).

Kanter (1977) includes the development of relationships or alliances with others in an organization as a source for accumulation of organizational power. She emphasizes that the importance of strong peer alliances was often neglected in the study of the accumulation of organizational power. Miller (1982) articulates a women's view of power, the crux of which is "using one's power to empower another-- increasing the other's resources, capacities, effectiveness and ability to act" (p. 2). Like Kanter, Miller believes that empowerment is also neglected from the accepted conceptualizations and definitions of power. In discussing a relational dimension of leadership, Srivastva (1986) views leaders as humanistic in their approach to people, supporting and nurturing individuals in an inclusive shared value system within an organization.

Leadership research has been prolific, resulting in the presentation of multiple perspectives about the meaning of leadership and actions of leaders. In the process of reviewing the writings of selected leadership theorists, it is reasonable to conclude that the understanding of leadership is both complex and simple. It is complex in the

difficulty of finding a precise understanding of leadership. Diebold (1984) rephrased a Chinese proverb which he believed would distinguish the leader role needed in society:

'A leader is one who, when the battle is won, leaves behind the conviction that the people did it themselves.' True leadership has the appearance of being effortless, even superfluous. It is for this reason that defining leadership qualities is often so illusory (p. 400).

The illusion of simplicity in leadership is reflected by the perspective of Bennis and Nanus (1985) on the universality of leadership. They stated:

Leadership seems to be the marshalling of skills possessed by a majority but used by a minority. But it's something that can be used by anyone, taught to everyone, denied to no one (p. 27).

Women and Leadership

With the influx of women in the work force in the late seventies and eighties, there has been a proliferation of studies of women in leadership and management positions. These studies use what has become the traditional approach to studying leadership: a quantitative research model to study a new leadership variable -- gender. Bass (1981) identifies the following categories as organizing groups in

describing leadership research that has been undertaken with gender as a variable:

1. Socialization, Sex and Leadership
2. Management and Sex Role Stereotypes
3. Male and Female Differences in Leadership Potential
4. Male and Female Differences in Leadership Style
5. Attributes of Successful Women Managers
6. Effectiveness of Women Leaders

A volume of leadership research has been generated around the variable of gender. A representative review of leadership studies on management and sex role stereotypes (Colwill, 1987; Stitt et al., 1983) and male and female differences in leadership potential and style (Dobbins, 1986; Korabik, 1985; Kushell and Newton, 1986; Stratham, 1987; Wittig, 1976) provides support for Bass's belief that there is no clear consensus about the role of gender in leadership. Bass (1981) recognized the need for theory and empirical research to be integrated, each stimulating, facilitating, and modifying the other with the goal of coming to a greater understanding of the notion of leadership that accomodates the variable of gender.

A representative review of women and leadership research indicates that serious questions remain. Muller and Cocotas (1988) believe that the health care industry may

be the prototype for understanding and changing gender roles among leaders. They state that historically, occupations and job levels in the health industry have been segregated by gender. While eighty percent of the labor force in health care delivery systems is female, only a small percent of the women are in top-level management positions. But the late eighties have brought foreshadows of changes in that the majority of the mid-level management positions are now held by women.

Muller and Cocotas (1988) conducted an exploratory study which examined the professional experiences of sixteen prominent women health executives, who functioned in traditional public and private human-service organizations with a male power structure (p.64). They chose to focus on leadership experiences of women in senior management and health policy making roles because of the paucity of data on women leaders in the health care industry. Two of their working hypotheses were:

1. Women senior health executives use different management and leadership strategies than men in organizations and in policy making settings.
2. Women senior health executives face disadvantages in the politics of power because of the prevalence of a male-dominated network and female stereotypes (p. 70).

The researchers used an open-ended interview format which was based on the methodology used by Belenky (1986) and her colleagues in their groundbreaking work, Women's Ways of Knowing. After analyzing the professional and managerial experiences described by the study participants, Muller and Cocotas concluded that the majority of women in the study viewed their management style as participative and person oriented. Half of the women said that "their style was substantively different from the authoritarian style of their male predecessors" (p. 74). At the same time that these executives cited the importance of being supportive and attentive to individual employee's needs, they also saw themselves as demanding and task oriented. "The art of management requires caring for people" was a responsive theme. However, most of the women stated that, in general, their management strategies were not gender specific.

Counts (1987), in her study, reported on the work of Gilkey and Greenhalgh(1984) at the Amos Tuck School of Business Administration at Dartmouth College. Their research focused on two different styles of negotiating, an important managerial skill, as rooted in male and female sex role orientation, not gender per se. After training experiences with young men and women negotiators, the researchers hypothesized that those predominately feminine in their orientation would:

1. characteristically conceptualize interpersonal relationships as continuous rather than episodic;
2. tend to redefine objective episodic situations as more continuous;
3. be characteristically empathic;
4. exhibit empathic tendencies in their negotiating behavior by asking questions intended to learn other parties' point of view;
5. show greater willingness, across situations, to compromise than their predominately masculine counterparts;
6. refrain from interrupting the other party during negotiations;
7. refrain from attempts to deceive the other party to gain a short term bargaining advantage (p. 6).

All hypothesis, except the fourth, were supported. Counts (1987) stated that the results of this research demonstrated that negotiators with the feminine orientation bring identifiable strengths to the negotiating process.

They [negotiators with the feminine orientation] will go to great lengths to preserve relationships, which tend to be beneficial in the long run. This stance is an asset when the relationship oriented, cooperative, and empathic behavior it spawns, elicits similar behavior from the other party and leads to constructive mutual accommodation and the preservation and enhancement of an interdependent relationship (p. 50).

After reviewing the work of several researchers (Loden, 1985; Morgan, 1986; Florisha and Goldman, 1981; Lenz and

Myerhoff, 1985) on gender-linked behavioral characteristics, Muller and Cocotas (1988) presented a descriptive contrasting compilation of typical behavior characteristics by gender:

Typical Behavior Characteristics

<u>Male</u>	<u>Female</u>
Competitive	Cooperative
Power and Control over others	Empowerment/enabling of others
Status differences accepted	Leveling of status differences
Work-family dualism	Integration of work-family
Affirmative language patterns	Qualifying language patterns
Hierarchical decision making	Consensual decision making
Rational problem solving	Intuitive and rational
Aggressive and in need of control	Empathic, lower control needs (p. 67)

They concluded that these contrasting characteristics generate conflict or dilemmas for women leaders functioning in male-dominated organizational settings. Women are caught in the dilemma of whether to emulate the normative leader behavior of the system or break traditional behavioral norms.

Leadership in Nursing

Women dominate the labor force in health care delivery systems (Caplan et al., 1984). In sheer numbers, nurses, who are overwhelmingly female, have been the dominant work group in hospitals. Historically, the profession of nursing, because it was dominated and controlled by women, gave opportunity for professional leadership roles that were not possible in other professional groups. For most of the twentieth century, nurse leaders in hospitals represented the nursing aspect of the organization which is primarily female. Nursing leadership in hospitals existed independently of men, and was not inclined to deal with the male-dominated executive leadership in hospitals (Bullough and Bullough, 1984).

Dramatic changes have occurred in health care and hospitals in the last decade (Blair, 1989; MacPherson, 1989; Ray, 1989). The transformation of health care systems, from a cottage industry to a corporate enterprise emphasizing competitive management and economic gain, challenges nursing's humanistic philosophy and theories of care, as well as nursing's administrative and clinical practice. Nurse executives, in addition to their leadership and management of the nursing aspect of the organization, now share responsibility for management of the entire health

care delivery system as "it provides various components of patient care and seeks to maintain an effective role in the broader health care system" (Blair, 1989, p. 1).

The literature and research on nursing leadership have also changed. In the early leadership studies, researchers focused on leader characteristics, leader behavior in clinical practice and education settings, and situational determinants in the hospital setting, using the male-dominated models from behavioral, social, and management sciences. A representative review of these studies indicates that nurse researchers translated the work of Ralph Stodgill, the Ohio State, and University of Rochester Leadership studies to conceptual frameworks that were the basis for studying measurable leader traits (Harris, 1968; Rim, 1965), leader actions (Shaloup, 1977) and significant personal and professional development factors for nurse influentials (Baker, 1979; Kinsey, 1985; Vance, 1978).

The following three trends are forcing a reappraisal of nursing leadership: 1. Hospitals, increasingly, have become for-profit enterprises. 2. Decentralization of nursing services represents a major change in the way nurses give care 3. Nurse executives have been promoted into vice presidencies with authority beyond the scope of nursing practice (Singleton & Nails, 1988). There is a dearth of

research around the newly emerging nurse leader role that combines the position of organization policy-maker and power holder with supporter of the caring framework of nursing practice. Singleton and Nails believe that the nurse executive will experience conflict as she "terminates her old relationship with nursing and adapts to her new scope of responsibility and interests" (p. 12).

Poulin (1984) replicated her original study (1971) of the structural and functional analysis of the nurse executive role. The purpose of the study was to determine how nurse executives viewed their positions in increasingly complex and changing organizational environments, and how the role has changed since the 1970's. Using a semi-structured interview format, participants, who were nurse executives recognized by peers for administrative competency or reputation for the progressive nature of their organization for the delivery of nursing care, responded to inquiry in three broad areas: 1. What does the nurse executive do? 2. What means are utilized in doing the job? 3. What conditions affect performance?

An analysis of the interview data from Poulin's replicated study indicated that the sharpest departure from the previous study occurred around executive role structure and function. In the original study, respondents "emphatically agreed that their sphere of responsibility

should be limited to nursing matters and opposed expansion of their role to other administrative functions. Data show an expanded role for the current participants" (p.12). This current nurse executive role encompassed a broader spectrum of responsibilities, including a coordinating role with greater decentralization of control of nursing practice, related patient-care departments, budget development, and an influencer in total institutional programming.

Poulin concluded that nurse leaders, functioning in the executive role of the organization, deal with complex patterns of interactional behaviors. Because all patient services converge on nursing, nurses integrate many diverse elements and goals on behalf of patients. Nurse executives must cope with the disparate organizational goals, while maintaining the integrity of nursing service to the patient.

Johnson's study (1989) focused on the normative power of chief executive nurses in the hospital setting. She sought to determine if there was a significant difference in the equality of power of chief executive nurses and other executives with similar titles in a complex health care delivery organization. A random sample of nurse executives (N=96) and other hospital executives (N=147) was chosen from the American Hospital Association Directory.

Using the Power Assessment Inventory for data collection and analysis, the study findings indicated a

statistically significant difference between the nurse executive and other hospital executive in overall normative power, prestige, esteem, and legitimacy of position. The nurse executive was more powerful in all of the power dimensions and was equal with other hospital executives regarding symbols of power.

Descriptive similarities and differences in the demographic profile variables of the nurse executive and hospital executive were presented:

1. "Vice President" was the most common position title for both groups.

2. The majority (96%) of the nurses group were female and the majority (84%) of the hospital executive group were male.

3. The majority of individuals in both groups reported the master's as the highest earned degree

4. Nearly half (45%) of the nurses had 400 professionals in their departments while approximately the same proportion (43%) of hospital executives had fewer than fifty individuals in their departments.

5. While both groups had been in their present positions from one to five years, the nurse executives had more years of total administrative experience.

6. Annual salary range for both groups was comparable (p. 165-166).

Johnson concluded that the findings reveal that "nurse executives are not only equal in power and responsibility of line management, but their power and responsibility exceed those of other executives at the same level of management" (p. 166). No conclusions or implications were presented by the researcher on group differences around the demographic variables of gender and human resources responsibility and management. Yet Kanter (1977), as a result of her leadership research on men and women in corporations, supported the notion that the importance of relational peer alliances was often a neglected aspect in the understanding of the accumulation of organizational power.

Marjorie Beyers (1984), the former head of the National Commission on Nursing, claimed that health care delivery systems organizational changes are a major concern for nursing leaders in hospitals. In view of the expanded role of corporate nurse leaders, Miller (1989) posited that nurse executives must re-evaluate their knowledge base to determine what leadership characteristics are most needed to meet the challenges of nursing care delivery in corporate settings (p. 13). Included in these challenges is the recognition of the importance of nurse executives to support, expand and prioritize the caring role in the institutional bureaucracy (Dunham, 1989; Nyberg, 1989; Ray, 1987; Roberts, 1990).

Miller (1989) states:

Contemporary nurse executives are being asked (or forced) to conform to a leadership model that is business oriented, competition driven and traditional in the sense of adaptation to patriarchal values and rationality....Success in nursing management and leadership roles has required at least some adaptation to these leadership patterns (p. 15).

Miller presents a contrasting analysis of organizational leadership theorists Bennis and Nanus's (1985) three major leadership contexts: commitment, complexity and credibility.

Conflict has arisen for the nurse executive around the context of commitment because there is mounting environmental pressures that nurse leaders may not be committed to their mission of caring as they assume an expanded leadership role in the health care organization. In the context of complexity, the health care system is in the throes of change more rapid and sweeping than in any previous period.

Conflict has arisen for the nurse executive in the balancing of economic productivity and quality of patient care services. The context of credibility of leadership has been challenged for nurse executives because the credibility gap between nursing leadership and caregivers has widened as the former leadership role of the director of

nursing has evolved into the nursing executive with broader corporate responsibilities (Miller, 1989, pp. 13-15; Blair, 1989).

The need for research on the expanded role of the nurse executive, which focuses on understanding the leadership characteristics, changes, or conflicts that are role related, is recognized in the literature. While the literature has acknowledged the tensions and opportunities around the expanded nursing leadership role in complex health care delivery settings, there is a gap in the empirical data that describes the dynamics of the evolving nurse leadership role in the corporate setting.

Spokespersons for the profession of nursing believe that it is appropriate "for those in nursing to devote some time and attention to the role of the nurse executive, since that individual has become increasingly significant in the leadership of health care delivery" (McClure, 1989, p. 1). The study of nurse leaders response to conflicts in their organizational environment has the potential to contribute to the understanding of models of leadership in corporate settings.

Summary

The study of leadership has evolved from a focus on characteristics and traits, to leadership styles, to

relational perspectives between leaders and others. Much of the research on women in leadership positions has focused on the shortcomings of women leaders functioning in male-oriented organizational settings and the conflicts that developed.

Using conceptual frameworks from generic leadership studies, research on nursing leaders has taken a parallel course with leadership studies. But the dramatic changes in health care delivery systems have necessitated changes in the nurse leader role. There are a few studies that have looked at the changes in the nurse leader role in the last decade. There are no studies that address how nurse leaders respond to the conflicts that have arisen from the synthesis of a professional caring role with a responsibility for organizational leadership in a changing health care delivery system.

Moral Reasoning

The understanding of the response of nurse leaders, who are primarily female, to role dilemmas or conflicts can be viewed through the lens of moral development theory. The formative constructs of moral development theory were explicated by Piaget (1965). In the first chapter of

The Moral Judgement of the Child (1965), Piaget states, "All morality consists in a system of rules, and the essence of all morality is to be sought for in the respect which the individual acquires for these rules" (p.13). Piaget's theory of moral development called for a progression from heteronomous or concrete thinking in childhood, when rules are absolutes, to autonomous, formal operational, or abstract thinking in adolescence, when there is cognitive detachment. When this occurs, the individual is able to stand outside the particular situation and make decisions from that point (Taylor, 1989).

Piaget based his research on games of marbles that children played. He acknowledged that he and his colleagues were not able to discover "a single collective game played by girls in which there were as many rules and, above all, as fine and consistent an organization and codification of these rules as in the game of marbles" [played by boys] (Piaget, p. 77). He and his colleagues believed that girls had a less developed "legal sense" than boys. Girls understood the rules but were concerned with a different sense of priorities or concerns in playing games.

Almost a quarter of a century later, Lawrence Kohlberg undertook a longitudinal study of moral development of adolescent young men. This study became the basis for Kohlberg's (1981) theory of moral development which was

built on the stages of cognitive development described by Piaget. Kohlberg postulated a theory of moral development that is based on a basic belief in the importance of moral judgement as a determinant of moral action. Kohlberg stated, "The formal operational capacity to think about thought is, in the moral realm, the capacity to think about moral judgements rather than to think about people, events and institutions" (Kohlberg, 1981, p.155). Moral dilemmas are resolved by the application of universal principles of justice which maintain the equal rights and dignity of all human beings. Each stage of moral reasoning represents an increasingly complex, objectively impartial mode of resolving hypothetical dilemmas that involve competing rights. The resolution of the dilemmas focuses on the ideal of reciprocity and equal respect for others and draws attention to problems of inequality and oppression (Reimer, Paolitto & Hersh, 1983; Taylor, 1989).

Kohlberg (1976; 1981) proposed his stage theory of moral development with three consecutive levels of moral reasoning and each level consisting of two stages, described in Table 1.

Through twenty years of longitudinal and cross-cultural study, Kohlberg (1981) maintained that his model was universal and hierarchical, with an invariant stage sequence. He believed that age and educational preparation

TABLE 1

KOHLBERG'S STAGED THEORY OF MORAL
DEVELOPMENT

Level I: Preconventional

Stage 1: Heteronomous Morality
concerned with the avoidance of
punishment and submission to power

Stage 2: Instrumental Morality
concerned primarily with right
actions that fairly meet an
individual's needs and occasionally
the needs of others

Level II: Conventional

Stage 3: Mutual Morality concerned
mutual interpersonal expectations,
relationships and interpersonal
conformity. Reasons for doing right
include the need to be a good person
in one's own eyes and those of
others.

Stage 4: Social System Morality
concerned with social system and
conscience. Right is fulfilling
obligations and duties, fixed rules
and maintaining the social order for
its own sake.

Level III: Postconventional

Stage 5: Social Contract Morality
concerned with social contract or
utility and individual rights.
Right is framed by individual
rights moderated by society or the
group. The reason for doing right is
to support the systems which do the
greatest good for the greatest
number.

Stage 6: Universal Ethical Morality
concerned with following self-chosen
ethical principles. Belief as a
rational person in the validity of
universal moral principles and a
sense of personal commitment to them
are the reasons for doing right.

facilitated moral development, and individuation and autonomy lead to more advanced moral thinking.

While there is a volume of literature that supports Kohlberg's theory, there are many people who have challenged its validity (Donenberg and Hoffman, 1988). An important concern that has been raised related to the test instrument used by Kohlberg to determine moral reasoning. The test instrument is a set of hypothetical moral dilemmas followed by open-ended questioning. The assumption was that the reasoning used to resolve hypothetical dilemmas would be the same as the reasoning used in real life situations.

Gilligan (1977) observes:

Kohlberg's dilemmas, in the hypothetical abstraction of their presentation, divest the moral actors from the history and psychology of their individual lives and separate the moral problem from the social contingencies of its possible occurrence...This insistence (for women) on the particular signifies an orientation to the dilemma and to moral problems in general that differs from any of Kohlberg's stage descriptions (pp.511-512).

Researchers report that people have used different strategies for reasoning real-life or interpersonal dilemmas than for hypothetical ones (Donnenberg and Hoffman, 1988, p. 703). They have suggested that a plausible reason for the discrepancy between real-life and hypothetical responses is that the hypothetical dilemmas developed by Kohlberg did not

represent, and were not relevant to, those faced in real-life situations (Langdale, 1983; Omery, 1985).

Many people have questioned the generalizability of Kohlberg's model because it was derived from an all-male population. Kohlberg's original work used a single sex sample of eighty-four males. While some researchers have reported the absence of sex differences in their research on moral development, others have reported the presence of sex differences in their sample populations (Lifton, 1985). When sex differences have been found, the majority of females scored in Stage 3, Mutual Morality. This stage emphasizes pleasing others for approval and avoiding hurt as a consequence of moral decisions. Males scored most often in Stage 4, Social System Morality which values a high regard for authority, fixed rules and obligations (Gilligan, 1977).

The work of Carol Gilligan (1977; 1982) pushed Kohlberg to respond to this apparent stage arrest for women. In 1982, Kohlberg first recognized that the sexes may differ in their preferential selection of issues with a stage. He recognized that the emphasis on justice does not fully reflect all that is recognized as being part of the moral domain (Kohlberg, Levine & Hower, 1983). But justice was affirmed as the central moral orientation, while refuting care as a distinct moral orientation.

Justice and care, we believe, do not represent different tracks of moral development. Piaget spoke of childhood morality as representing two moralities, not one; i.e., a morality of heteronomous respect and a morality of mutual respect. Our own work suggests that these differences represent different sub-stages within the sequential growth through Kohlberg's stages of justice reasoning. Similar to our recognition of 'Piagetian' substages within the larger context of sequential stage growth, we partially accept Gilligan's differentiation of two orientations in moral judgement...We do not believe that the growth of justice and the ethic of care represent two distinct tracts of moral stage (i.e., structural) development (Kohlberg, Levine, and Hewer, 1983, p.138-139).

The research and theorizing of Carol Gilligan have provided a major impetus for rethinking moral development theory with recognition of the need to pay attention to gender differences in theory reformulation. Gilligan's focus, after many years as a research colleague of Kohlberg, was that in choosing to describe an ethic of justice, Kohlberg postulated a model of moral development that emphasized autonomy, separation, and individuation. Acknowledged female personality traits such as a sense of responsibility and concern for others relegated women to Stage 3 in Kohlberg's model. It is paradoxical "that the very traits that have traditionally defined the 'goodness' of women, are those that mark them as deficient in moral development" (Gilligan, 1982, p.18).

Studying moral development and sense of self, Gilligan (1977; 1982) recognized that women systematically had been excluded from theory building studies, making such theories incomplete in their attempts to understand the moral development of women. She questioned the value that theorists place on detachment and separation, arguing that these are not central norms that women value for themselves and are not the most relevant measures for them. She argued that for women, the self is defined in terms of its relationships with others and judges itself in terms of its ability to care. She interpreted development as one caring for the self as well as one cares for others (Gilligan and Attanucci, 1988).

Gilligan's (1977; 1982) study of moral development led to the conceptualization of an ethic of care that recognizes a changing understanding of notions of responsibility and relationships contrasting with Kohlberg's ethic of justice that recognizes equality and reciprocity. Gilligan proposed a three stage model (which more often is taken to reflect the thinking of women) with two transitions that combined both judgement and feeling in an ethic of care and responsibility. Gilligan described hierarchical, but not invariantly sequential stages, that represent a more complete understanding between self and other, where each

transition exists as a critical assessment of the conflict between selfishness and responsibility.

In Gilligan's model, the orientation of the individual moves from self oriented to other oriented to a universal, all inclusive perspective. At Level I, Orientation to Individual Survival, an individual survives by being submissive to authority. In the first Transition, From Selfishness to Responsibility, responsibility to and for others assumes precedence over survival by submission. Attachment and connection to others appears. At Level II, Goodness as Self Sacrifice, being moral is first and foremost not hurting others, with no concern for self hurt. The priority is concordance and goodness. In the second Transition, From Goodness to Truth, responsibility shifts to include self as well as others. At Level III, The Morality of Nonviolence, moral reasoning is guided by the premise of not hurting or harming self or others. Rooted in this level of reasoning is the assumption of equality of self and others. Responsibility for care becomes the universal obligation (Gilligan, 1977; 1982; 1987).

Gilligan noted that in discussing conflicts and choices that they have, women describe dilemmas involving attempts to be responsive to themselves and others, experiencing difficulty when they are forced to choose. Women move in

their considerations to making decisions that will meet others' needs at their expense, to finding solutions that incorporate responses to the needs of both the self and others.

Lyons (1982; 1983) empirically tested Gilligan's model. She conceptualized the ethic of care and the ethic of justice. She operationalized the distinction between justice and care, contrasting a perspective of reciprocity with a perspective of response. Lyons found that although women evaluate moral conflict in terms of care and men evaluate moral conflict in terms of fairness, females and males, across the life span, both use justice and care reasoning. She related the two different moral perspectives to self definition.

Lyons (1982; 1983) evaluated study participants' mode of self definition by asking "How would you describe yourself to yourself?" Categorical analysis indicated a significant differences in the way that males and females describe themselves in their relations with others. Females more frequently defined themselves as connected, while males more frequently characterized themselves as separate. These gender-related relational descriptions crossed the life span.

Langdale (1983) supported Lyons' work. Using the Lyons' method of coding dilemma responses, Langdale compared

justice and care responses to hypothetical and real life dilemmas. Her central findings were that care and justice orientations appear in all dilemmas and appear systematically across the life cycle. Langdale found that Kohlberg's justice-oriented hypothetical Heinz dilemma, to steal or not to steal a drug for his wife, elicited significantly more justice considerations than either a hypothetical care-oriented abortion dilemma or subject-generated real-life moral dilemma. She showed that people respond to both the hypothetical Heinz and abortions dilemmas as well as real-life dilemmas predominately in terms of justice or predominately in terms of care. Her research refuted the notion that concern about justice and care arise from different kinds of moral problems. "Instead, Langdale's analysis of moral orientation indicates how the same problem can be seen in different ways" (Gilligan and Attanucci, 1988, p.76).

In Table 2, Langdale (1985) summarized the distinctions of the two moral voices embodying different conceptions of self, relationships and morality from "the continuing study of both moral voices in research following Gilligan's original identification of care as a distinct moral orientation (e.g. Gilligan, Langdale, Lyons & Murphy, 1982; Gilligan, 1982; Langdale, 1985; Lyons, 1983)" (p.73).

TABLE 2

TWO MORAL VOICES: CONTRASTING IMAGES

The Voice of Care

The Voice of Justice

Relationships

attachment	inequality
inclusion/exclusion	dominance/subordination
self and other	self vs. other
protection against isolation	impediment to autonomy
inter-relatedness assumed	inter-relatedness constructed
networks sustained by	hierarchical or contractual
activities of care-giving	relationships bound by
and response	alternatives of constraint
	and cooperation

Self

connected	separate
interdependent	autonomous
sees others in their own	sees others in self's terms
terms	

Morality/Moral Conflict

problems of detachment	problems of inequality
inclusive solutions	fair solutions
including self without	achieving equality by upholding
excluding others by	rules, carrying out role
responding to both	defined obligations
responsiveness	reciprocity
no one alone/no one hurt	rights/fairness
expand/strengthen	replace inequality with
connection	equality

Ways of Knowing

contextual, empirical	abstract, generalizing approach
approach	(objectivity, impartiality)
gain awareness of	extend to others what one would
particular situations	want for oneself(golden rule)
or needs of people	
engagement in dialogue	mirroring
join stories to transform	agreement with one person's
ideas	idea
	(p. 72)

Gilligan (1977; 1982; Gilligan and Attanucci, 1988), from her empirical investigations, has stated that an individual approaches moral conflict and choice from at least two equally valid frames: justice and care. In her view, how one constructs the conflict, how one understands the issue, and what one focuses on as relevant to the conflict are of primary importance to an individual's moral response to the conflict. She believes that the context of the problem influences how an individual constructs the problem. She describes context as "the relationships of the persons involved and their relative power to each other, where the situation takes place, who is involved, how they related, what role the person telling the story plays, how much power s/he or they have, and the personal and cultural history of the narrator" (Brown, Tappan et al., 1988, p.142).

Gilligan has suggested that moral orientation designates the type of contextual clues to which one attends. With a care orientation, which focuses on situational relationship cues for context and moral response, individuals give attention to others with whom they stand in relationship. Individuals with a justice orientation focus on objectivity and adherence to rules which are less particular, and universalistic. Justice is context-free (Blum, 1988).

The work of Carol Gilligan and her associates has made a significant contribution to the reframing of moral theory (Blum, 1988; Tronto, 1987). There still remains a need for additional empirical validation to put forth moral development theory that represents all voices. Tronto (1987) calls for the extension of the ethic of care into a full theory of care. She believes that in order to do this researchers must critically look at not only gender differences, but class, racial and ethnic differences. Recognition must be given to the limitations of gender-specific moral theory in our culture in order to fulfill the goal of conceptualizing an ethic of care as an alternative moral theory, rather than a complement to traditional moral theories grounded in justice reasoning.

Nursing and Moral Reasoning

Until recently, nursing's efforts to explore moral reasoning have focused on Kohlberg's theory of moral development. For the past decade, nursing researchers and scholars have been advocating Kohlberg's theory as the explicator of nurses' moral behavior (Omery, 1983). After a representative literature review of nursing authors, Nokes (1989) concluded,

The consensus reached by writers addressing morality in nursing was that this moral development theory [Kohlberg's] provided an appropriate framework through which to examine the moral development of registered nurses (p. 172).

Omery (1983) speculated that the prevalent use of Kohlberg's model in nursing research is probably due to several reasons. The model is easily operationalized into the nurse's research setting. The hierarchical model is ordered so that study participants will fit into one of the six stages of moral development. The model is optimistic, recognizing developmental progress toward higher levels of moral reasoning. With little acknowledgement of its limitations or "fit for nursing", nurse researchers took an easily used and readily available model of moral development and studied practitioners, students and faculty (Miller, 1984).

Murphy (1977; 1981) was the first to study moral reasoning using Kohlberg's model. The focus of her study was to determine if there were differences in moral reasoning among nurses in different positions of authority and different practice settings. Using a two-tiered sample of nurses in leadership and practice positions, her sample, (n=120), was composed of an equal number of nurses in the positions of public health supervisor, public health staff nurse, hospital head nurse, and hospital staff nurse.

Murphy's(1981) hypotheses were: 1. Higher levels of moral reasoning would be found in nurses working in public health than in hospital practice situations;

2. Higher levels of moral reasoning would be found in nurses employed in leadership positions as head nurses or public health supervisors than nurses employed in the direct care staff positions. Using Kohlberg's Moral Judgement Interview, Murphy found no significant differences in the stage of moral reasoning among the nurses in different types of practice settings and in different positions of authority. Most of the nurses in the sample (95%) were at the conventional level of moral reasoning, at Stage 3, Mutual Morality, or Stage 4, Social Systems Morality. While Murphy made several recommendations for increasing nurses' level of moral reasoning within the Kohlberg framework, there was no acknowledgement that the conventional level of moral reasoning was the predominant level for almost all females, and that nursing was a predominately female profession.

The focus of Kudzma's work (1980) was to determine if there were differences in moral reasoning due to the work environment. She studied nurses working in two different practice areas in the hospital: oncology and medical-surgical. The hypothesis of the study was that higher

levels of moral reasoning would be found in nurses working in the oncology practice area. Using Kohlberg's Moral Judgement Interview, no significant differences were found between the two groups of nurses. The nurses were predominately at the conventional level of moral reasoning for the model.

Much of the subsequent research on the moral reasoning of nurses used James Rest's Defining Issues Test (DIT). Derived from Kohlberg's theory of moral development, the DIT is a self administered, multiple-choice, objective test that asks the participant to respond to stage relevant statements based on their beliefs (Ketefian and Ormond, 1988, p.11; Nokes, 1989). The DIT furnishes two indices, the P score, representing the participants' level of principled thinking, and the D score, representing the participants' preference for principled thinking above conventional and pre-conventional reasoning. Rest (1986) presents tables with expected means of the two scores for different groups with different educational backgrounds. The sample means for high school graduates on the DIT ranged from 27 to 36. The sample means for college graduates ranged from 37 to 46.

Nokes (1989) reviewed and summarized the nursing research on moral reasoning using Rest's Defining Issues

Test that was in the literature for most of the decade of 1980's. She presented a representative review of the studies in Table 3.

TABLE 3

NURSES' MEAN PRINCIPLED MORAL REASONING SCORES ON
THE DEFINING ISSUES TEST

<u>Investigator</u>	<u>Sample</u>	<u>Results</u>
Munhall(1980)	Baccalaureate nursing students (N=305)	34.20
	Nursing faculty (N=15)	42.00
Ketefian(1981)	Baccalaureate prepared nurses (N=43)	29.02
	Technically prepared nurses (N=36)	22.47
Nokes(1985)	Staff nurses (N=150)	19.00
Felton and Parsons(1987)	Undergraduate nursing students (N=227)	25.78
	Graduate nursing students (N=111)	28.21
Frisch(1987)	Baccalaureate nursing students (N=52)	23.50- 26.00
Hilbert(1988)	Baccalaureate nursing students (N=63)	34.10 (p. 173)

Research evidence, accumulated from multiple studies which used the DIT as the methodological test instrument, supported the conclusion that students, faculty, and practitioners scored at a low level of moral reasoning which was inconsistent with their educational level. Nokes (1985) also found that length of years in the profession related negatively to moral development. Nurses who worked for more years in nursing had lower moral reasoning scores on the DIT.

Critical arguments surround the use of Kohlberg's Cognitive-Development Model as the basis for understanding moral reasoning of nurses. Nurses, reflecting the stage suspension of women, have consistently placed in a lower stage on the cognitive development model. Nurse researchers can no longer justify the use of a model of moral reasoning that is based on male experience as the standard to explain moral reasoning of members of a predominately female profession (Cooper, 1989; Miller, 1984; Nokes, 1989; Omery, 1989).

This raises the question of methodological adequacy. The validity of the use of hypothetical dilemmas devoid of real-life contextual clues has been reported as being problematic. This is in particular contrast to Gilligan's work, which focused on real-life narrative and contextual influences as descriptive pieces in understanding modes of thinking.

Models of moral reasoning that do not legitimize contextual influences as significant push nurse researchers to seek out alternative theories. Yarling and MacElmurray (1986) have sparked debate within the profession of nursing on the moral predicament of nurses in organizational settings. The authors claim that nurses are not free to be moral because of the contextual influences of the organization or health care delivery system in which they practice.

Amongst the contextual conditions that influence a nurse's response to environmental conflicts, Yarling and MacElmurry include:

1. established standards of nursing care as determined by the profession
2. consequent commitment of the nurse to the autonomy and well-being of the patient
3. responsibility of the hospital for all patients who receive care under its auspices
4. nurse's knowledge of actual or potential harm to the patient
5. divergence of the interest of the patient from the interest of the hospital or one of its power structures
6. employee status of the nurse in relation to the hospital
7. physician power structure in the hospital
8. nurse's subcollegial relation to the physician
9. vulnerability of the nurse to harmful action by the hospital as the employer (p. 64).

In her study of moral reasoning of nurses in professional practice, Omery's (1985) research recognized the importance of contextual influences in responding to moral dilemmas. Using an inductive approach, she sought to describe the composition of moral reasoning of nurses in the Intensive Care Unit when they were faced with a moral dilemma in their professional practice. Omery identified three major characteristics used by nurses in moral reasoning:

1. principles which are generalizations used by nurses to justify their decisions and direct their moral actions. Fifteen specific principles were identified with "honesty" and "responsibility" identified by all participants.

2. mediating factors which are contextual factors that influenced the nurses in their moral decision-making. The situation, legal constraints, and the nurse-physician relationship were contextual factors identified by all participants.

3. two modes of reasoning, accommodating and sovereign. Accommodating reasoners responded to the perceived norms of their identified group. Sovereign reasoners responded to self-chosen or valued moral principles even when there was potential for conflict with the group norms or principles.

Omery calls for the development of further studies to validate the three identified major characteristics of moral reasoning in different settings and different professional roles.

Application of the Gilligan model to gain understanding of the way nurses resolve institutionally based conflicts supports the notion that moral reasoning of nurses is influenced by the contextual variables of the environment in which the conflict is being analyzed. Moral is not an absolute, "but the 'best fit' solution in a conflict between the needs of the patient, institution, other health care providers, and the professional nurse" (Nokes, 1989, p.174).

There were a few research studies which looked at moral reasoning in a professional and organizational setting using Carol Gilligan's model as a theoretical framework. Participants in each of the following studies represent professional males and females, in different levels of leadership and practice, in diverse complex organizational settings.

Millette (1988) investigated the moral response of nurses (N=12) who were client advocates and nurses (N=12) who were institutional advocates. The hypotheses were that nurses reporting a preference for the client advocate role would express a moral orientation of caring, and nurses reporting a preference for the institutional advocate model would express a moral orientation of justice.

Using Gilligan's protocol for assessing moral orientation as the basis for data collection and analysis, some of Millette's study's major findings were:

1. Eleven of the twelve nurses who were client advocates expressed the mostly care or pure care orientation. One expressed the mostly justice orientation.

2. Five of twelve nurses who were institutional advocates expressed the mostly justice orientation. One was a mixed type. Six nurses expressed a mostly care orientation or pure care orientation.

Derry's research (1987) examined the kinds of moral reasoning used by managers in work-related conflicts in an organizational setting. Twenty men and twenty women were randomly selected from a Fortune 100 industrial corporation. Derry's hypotheses were: 1. There would be two distinct modes of moral reasoning (a morality of justice and a morality of care) used by managers in work-related conflicts. 2. Morality of care would be more frequently voiced by female managers and a morality of justice would be more frequently voiced by male managers. Lyons' (1983) method of coding dilemma responses in moral choice was used for data analysis. The results indicated that the justice orientation was the preferred mode of moral reasoning among the participants who described moral conflicts. Derry notes that one third of the participants indicated that they had never faced a moral conflict at work.

Counts (1987) sought to answer the question, "Are there differences in the patterns of rights and response considerations used by men and women superintendents and principals in workplace decision-making?" Educational leaders, balanced by sex and job were interviewed focusing on descriptions of self as leader, workplace dilemmas experienced, and descriptions of an important professional relationship. Data were analyzed using the Lyons' coding scheme.

Some of the major findings were:

1. Although men and women in different leadership positions used both rights and response considerations, women used more response considerations in resolving dilemmas. There was a statistically significant difference ($F=4.38$, $P<.045$) between men and women superintendents and principals in terms of response considerations in decision-making.

2. Principals used more response considerations than superintendents in their decision-making. Women principals had the highest percentage of response considerations of the four groups.

Counts' research supports the conclusion that leadership level and gender influence response to self described dilemmas in the workplace.

To analyze the self-descriptions of leadership, Counts developed a coding scheme to categorize leader descriptions

as "relational leaders", those who lead in connection with others, or as "individual" leaders, those who lead as separate from others. Both categories reflect different concepts of self-in-relationship. In one, emphasis is placed on individuality, and in the other, on relationality.

Results of the self-descriptions of leadership indicated a statistically significant difference ($F=6.55$, $P<.015$) between superintendents and principals in terms of the number of leadership self-descriptions in the individual category. Male superintendents used individual descriptors more commonly than women superintendents, although women superintendents used more than both male and female principals.

Although understanding and application of Kohlberg's moral development model has predominated in nursing literature and research, there is evidence for support of a paradigm shift to Gilligan's work as possible explicator of the nursing profession ethic of care. Cooper's (1989) position represents the shift in viewpoint. Cooper states that Gilligan's perspective of care is appropriate to nursing for the following reasons:

First, numerous nursing theories assume the essential nature of concepts of caring and relationships in human activity...

Second, supporting evidence for the use of Gilligan's ethic of care in nursing, given its gender relatedness, is found in the long association of women with nursing.

Third, a look at the history of professional nursing uncovers a strong link between nursing and Gilligan's ethic of care. This is revealed in the history of working-class nurses committed to the experience of caring within a context in which neither the commitment to relational caring nor the nurse's virtues of selflessness and obedience were valued by the dominant ideology of the time...

Fourth, Gilligan's understanding of the relationship between a perspective of care and the traditional perspective of justice provides a paradigm for a cooperative and complementary relationship between the sometimes conflicting positions of nursing and medicine in moral decision-making (p. 11).

Summary:

In this chapter I have presented a representative review of three discrete, but intersecting, bodies of literature. My rationale for doing this was for me to gain understanding and develop insights that are interrelated to the four essential pieces of this study: the nurse who is a leader who experiences conflict in a changing workplace.

Insights that have emerged from this literature review are:

1. Nurses with a care ethic as their professional focus experience conflict in their work in a cure focused health care delivery system.

2. Nurse leaders experience conflict in their leadership role in an organizational culture that prioritizes organizational goals over professional caring goals.

3. Nurse leaders are primarily female leaders who function in male-dominated health care delivery systems.

4. With Kohlberg's moral development model, many nurses, regardless of age, education, years in practice, professional role, and organizational setting have been stuck in Level II: Conventional Morality. This finding is a similar for women as a group.

5. Men and women represent concerns of care and justice in their thinking about real-life moral dilemmas.

6. Nursing literature has begun to speak of Gilligan's ethic of care and nursing's professional ethic of care as sharing common themes and concern. Research is needed to explicate the overlapping and different themes and concerns between the two.

The literature review with summary of insights supports the validity of a study of nurse leaders' response and choice to conflicts in the workplace.

CHAPTER 3

METHODOLOGY

Recent nursing research studies focusing on moral reasoning in nurses have primarily used Kohlberg's moral development theory for their conceptual framework. The choice of Kohlberg's theory has been problematic, and not to nursing or women's advantage, because that paradigm describes both groups as "stuck" in hierarchical Level II Conventional Morality at Stage 3 or Stage 4. Nurses, as well as others, are examining and evaluating other theoretical frameworks. Their purpose is to more clearly represent moral voice or orientation, and demonstrate equally valid concerns of justice and care in how individuals think real-life moral dilemmas. While there are few empirical studies in the nursing research which use Gilligan's developmental model for their conceptual framework, there has been a call within and beyond the nursing literature to empirically validate Gilligan's ethic of care as a basis for moral reasoning.

Nursing literature has presented professional reaffirmation of nursing's tradition of an ethic of care in practice. Excluded from this reaffirmation is an understanding of how nursing leaders combine the practice

ethic of care with their leadership role which has experienced broad changes and ensuing conflicts that are parallel with the changes in the health care delivery systems. This research focuses on understanding how nurse leaders respond to self-described situational conflicts. I have used Gilligan's moral reasoning model, with its recognition of the voice of care and the voice of justice as two distinct moral perspectives, for the conceptual framework as a way of understanding how nurses construct and respond to dilemmas in the workplace.

Study Design

Sample

Study participants in two levels of leadership within the hospital setting were identified. The study sample represented middle level leadership - nurse managers; and upper level nurse executives - vice presidents, nursing directors.

The nurse manager position is a key management/leadership position within the hospital organization. The nurse manager has responsibility in three major areas: patient care management, personnel management, and unit management. The nurse manager is

the practice leader in the hospital and has demonstrated clinical competence in nursing practice and management.

The nurse executive is a member of the hospital administration team, and as such, participates in policy development, long range planning and priority setting, and budget development for the the hospital. Management of human, fiscal and material resources is part of the nurse executive's responsibility.

Ten nurse leaders, in the hospital setting where they were currently working, were interviewed. Five of the nurse leaders were managers and five were executives. The following studies, which used the Gilligan framework of moral reasoning in different settings and with diverse participants, influence the sample selection for this research. Derry (1987) concluded that men and women in a large Fortune 100 industrial corporation predominately responded with a justice orientation as the preferred mode of moral reasoning to workplace conflicts. Jack and Jack's (1988) study reported three strategies for women adjusting to the professional lawyer role: emulation of the stereotype of the successful lawyer, a male role; splitting of their caring self from the lawyer self; integration of their care orientation into their legal practice. Lyons (1982; 1983) showed that the moral orientation of rights (justice) and response (care) was

found in individuals across the life cycle. However, as age increased, beginning in the late twenties, women showed increased use of an orientation of rights in their conceptualization of moral problems and conflict. In Millette's (1988) study, nurses who were client advocates generally expressed a care orientation and nurses who were institutional advocates expressed both a care and justice orientation. Counts (1987) concluded in her research that leadership level and gender influence justice and care responses of education leaders to self-described dilemmas.

This study uses Gilligan's framework of moral reasoning with a different population, ie., nurse leaders, in another setting, ie., a hospital, which is a corporate organization in the business of health care delivery.

Setting

Participants in this study were drawn from an acute care hospital in an urban setting. This institution had an average patient population of approximately 400. The hospital is a magnet hospital, which is a designated center of excellence as a health care delivery organization in the United States. A magnet hospital has

the confirmed reputation of "a good place to work and a good place to practice nursing (McClure, 1982). Kramer and Schmalenberg (1988a) reaffirm these institutions as outstanding examples of quality health care environments. They confirm the nursing leaders of these hospitals as experts in promoting and protecting values that keep their organizations as viable and dynamic institutions.

Magnet hospitals, through effective nursing leadership, appear to be dealing with critical health care and nursing issues by creating organizational conditions conducive to eliminating, for the most part, their internal nurse shortage (Kramer and Schmalenberg, 1988a). According to Kramer and Schmalenberg, nurse leaders in magnet hospitals are experts in the cultivation of values that changed their organizations into dynamic institutions. Nurse leaders, with direction and deliberation, promoted and promulgated quality care values and excellence in the nursing services in these hospitals. The hospital chosen as the setting for this study is one of the sixteen magnet hospitals that Kramer and Schmalenberg included in their study.

Study Participant Protocol

Application for permission to seek study participants from the selected setting was submitted to the Nursing Research Review Board of the the hospital. Approval was given to me through a two tiered review process in accordance with research review protocol for the hospital. This process included review and approval of the Nursing Research Review Board followed by review and approval by the Committee on Clinical Investigations.

Following approval by both committees, I was given a pool of potential participants who were nurse executives and nurse managers to select the study's sample. Because the number of executive nurse positions was limited, all executives were included in the potential sample. Because there was a greater number of nurse manager positions, a random sample of nurse managers was chosen from the manager pool.

Nurse leaders' permission to participate in the study was obtained through a two step process:

1. A letter of introduction, explanation, and request for participation was sent to the nursing leaders at the identified hospital (Appendix A). Since the focus of the study was positional/organization dilemmas, correspondence by mail and phone was through the organization setting.

2. A follow-up telephone call was given to provide additional explanation, confirmation of desire to participate, and arrangement of convenient time and place for the interview within the hospital setting.

Study participants were informed that the focus of the interview would be a moral dilemma that they had experienced and were willing to share. The interview would also focus in their self-descriptions of leadership and how they viewed themselves as care-givers in a leadership role. The length of time for the interview was critical for the participants. Most stated a limit on their time. The participants were assured that the interview would last no longer than one and one half hours. They were also assured that all information that they provided in the interview would be held in strict confidence. They were informed that they could end participation in the interview process at any time that they thought they did not want to continue.

The interviews were arranged at a time that was mutually convenient to the participant and the researcher. The participants selected the place for the interview. Their choice usually was their office or the office of a colleague. This was done so as to situate the participant in an atmosphere that would allow them

privacy and uninterrupted dialogue, conditions conducive to obtaining quality interview data (Bogdan and Taylor, 1975). While most participants limited telephone interruptions, some were unable to do this, and the telephone was the only intrusion in the interview. Written permission for participation and tape recording of the interview was obtained (Appendix B). Participants also provided demographic information (Appendix C).

All nurse executives who were contacted agreed to participate in the study. All nurse managers except one who were contacted agreed to participate. The nurse manager sample was completed from the original pool. No subjects were lost during the interview process. Given that this study was hypothesis generating, rather than hypothesis testing, the sample number of ten was sufficient because the adequacy of the description which results from data analysis was due more from the completeness of the interviews than sample size. All nurse leaders were working in their leadership role, insuring that the descriptions of conflicts or dilemmas given may reflect the moral reasoning of nurse leaders. Two pilot interviews were done to address interview bias from the researcher.

Data Collection

The method for data collection for this study was an open ended interview called "Real Life Moral Conflict and Choice Interview" (Appendix D). The purpose of the interview in a qualitative methodology is to gather descriptive data in the subjects' own words (Bogdan & Biklen, 1982). The purpose of the interview in this study was to understand the participant's representations of their experience in, and understanding of, moral conflict in their workplace. The focus of the interview is an actual moral conflict that the respondent experienced and chose to reveal, the course of action taken, and how the participant evaluates the course of action (Brown et al., 1989).

The interview protocol has been developed by Carol Gilligan and her associates at the Study Center for Gender, Education, and Human Development, at Harvard Graduate School of Education. The questions on the protocol serve as a guiding framework for the interview. The interviewer's role is to elicit the fullest description from the participant of the moral conflict. This is done by using situationally relevant, clarifying or activating questions to help the participant elaborate on the construction of the dilemma, its

resolution, and the participant's evaluation of his or her own action. The qualitative paradigm supports the premise that while the researcher has a methodology to follow, the approach used in the study must evolve as the research process continues. Individual perspective, situational variants, and environmental context are the influencers of the approach (Bogdan and Taylor, 1975).

The interview for this study was composed of three basic parts. One group of questions related to participants' descriptions of themselves as leaders. The work of Lyons (1982) supports the inclusion of self definition descriptive data. In her study, the analysis of "Describe Yourself" data explicated two modes of self definition: separate/objective and connected (p.97). Counts (1987), in her study of educational leaders, utilized self-description of leadership with superintendents and principals. Their responses were analyzed on the dimensions of individual and relational leadership.

This study utilized an interpretive framework to analyze the nurse leaders response to self-descriptions of leadership and leadership changes. The use of narrative self-descriptions of leadership allowed the research reader to discern how nurse leaders construct their understanding of themselves in a leadership role.

The two dimensions for Self-Descriptions of Leadership are defined as:

Individual Leadership Response: Self-description responses that focus on the leader as an individual, separated from those that he/she is leading. The emphasis is on individuality in the leadership role.

Relational Leadership Response: Self-description responses that focus on the leader in relation or connection with those that he/she is leading. The emphasis is on relationality with others in the leadership role.

The following phrases are illustrative of the contrast of the two orientations.

<u>Individual</u>	<u>Relational</u>
I enjoy being in a position where I make the decisions.	I prefer to have the staff come up with their own decisions about patient problems.
I set high standards for myself and my staff.	I see myself as a member of the caregiving team.
I am a role model in getting things done for my staff.	I provide a climate which encourages and facilitates the growth of each person on my staff.

In the second part of the interview, a group of questions addressed how participants viewed themselves as caregivers in a leadership role. Organizational caring themes and positional caring themes were identified. The work of Ray (1989) supports data collection around caregiver self-descriptions in the leadership role. After researching the caregiving role in health care organizations, she presented the Theory of Bureaucratic Caring. This theory is a synthesis of the two primary pieces of nursing in health care delivery organizations - a caring component and a bureaucratic component.

The major focus of the interview was the third group of questions which asked participants to describe a conflict or dilemma in their workplace where they had to make a decision and did not know what to do. Description of the conflict, choices made, implementation of their decision, and evaluation of action were the subcomponents of the dilemma description. Qualitative research is intrinsically focused on the meaning that individuals construct from their experience. Meaning making is contextually influenced by all aspects of the experience as well as the environment where the experience occurs and the perspectives of the significant persons constructing the meaning (Patton, 1980; Miles and Huberman, 1984).

For this study, ten nurse leaders in a Magnet Hospital were interviewed. They were interviewed using the Gilligan Moral Conflict and Choice Interview modified to reflect the professional role and the setting of the study sample (Appendix E). Interviews were tape recorded and transcriptions were made from the tapes. All personal names were deleted from the transcripts. Any other personally identifying information was changed. All interviews were coded and the list of names and coding was known only to the researcher. All data, i.e. tapes, verbatim transcripts, informed consents, interview assessments, are being kept in a locked cabinet to which only the researcher has access. At the completion of the this project, all tapes and written data will be destroyed.

Immediately after each interview, the researcher/interviewer completed an Interview Assessment form (Appendix F). Its purpose was to record any circumstances about the interview that may contribute to the data base but may not be included in the interview tape and transcription. Data recorded was relevant information about the interview setting, and the overall reaction of the participant to the interview or to particular parts of the interview. In qualitative research, all contextual factors, as well as underlying

individual assumptions that may influence the the study, are noted as contributing to richness and complexity in meaning making (Bogden and Biklen, 1982; Mishler, 1979).

Data Analysis

Self Descriptions of Leader Role

In order to analyze the data from the leadership interpretive schema, three readings of interview narrative focusing on self-descriptions of leadership are necessary. With the first reading, the reader reads the narrative descriptions of leadership for a sense of what the narrator is saying about him/herself as a leader. Next, using contrasting colored pencils to underline statements that represent the two different perspectives of leadership, the reader reads the text twice, listening once for the relational leadership voice and once for the individual leadership voice. Use of contrasting colored pencils allows the reader to visually identify differences in self description. Finally, the reader uses the Self-Description Leadership Worksheets (Appendix G) to record relevant pieces of text which will substantiate the reader's interpretation of the narrator's self-descriptions of leadership. Using this

protocol, the narrative texts of participants' descriptions of their leader role were read by the investigator. Summary data, leaders' primary response patterns and narrative texts describing the individual and relational leadership responses will be presented in Chapter Four.

Leader Self Descriptions of the Caregiver Role

Participants' responses to questions focusing on how nurse leaders see themselves as caregivers in the leader role were read. Analysis of leader descriptions of care focused on organizational caring themes and positional caring themes. Participants' responses were thematically analyzed around the presence of a caring component and a bureaucratic component. Narrative texts from the leaders' self-descriptions of their care giving practices in the health care delivery system will be presented.

Workplace Conflict

The dilemma interview data are analyzed through an interpretive schema called the Reading Guide Method (Brown et al., 1988). It was developed by Carol Gilligan and associates at the Study Center for Gender, Education,

and Human Development. It is used to interpret the interview text of moral conflict with the dimensions of justice and care as two moral perspectives (Brown et al., 1988).

The Reading Guide Method developed from conceptual and empirical evidence that individuals know and are able to represent conflicts or dilemmas in at least two different voices or perspectives when relating moral conflicts. An individual may indicate a preference for one voice over another. The Reading Guide provides an approach to interpreting the texts of moral conflict and choice for the relational "voices" of care and justice. It allows the reader to follow the two voices and to identify the ways in which a person chooses between them. During the readings there is considerable overlapping of self and the voices of care and justice because these dimensions are not discrete categories to be separated from the narrator (Brown, 1989).

The underlying premise of the Reading Guide Method of analysis is that an individual, speaking for the self in a narrative or story, experiences relationships both in an attachment perspective and an equality perspective. A care voice speaks of relationship in terms of attachment/detachment and

connection/disconnection, inclusion/exclusion, difference/perspective. A justice voice speaks of relationship in terms of inequality/equality, reciprocity, or lack of respect. A justice voice is concerned with standards and principles of fairness (Brown, 1989).

The Reading Guide Method calls for the reader to read the interview texts four times. Each reading is done from a different point in the process. The purpose of the first reading is to comprehend the story, as told by the narrator. The reader's goal is to understand the story, with its context: the who, what, when, where and why of the narrative (Brown and Gilligan, 1990).

The following three readings focus particularly on the ways the narrator presents self and the two voices of justice and care. In the second reading for self, the Reading Guide explains that "this reading for self makes it possible to pick up distinctions in activity and intent, reflection, motive for action, and choice-- whether it be a choice for silence, for passivity, or resistance" (Brown et al., 1989, p. 57). In the second reading of the narrative, the reader listens for "self", the voice of the "I" speaking in the story, without making interpretations for moral voice (Brown and Gilligan, 1990).

In the third and fourth reading of the story, the reader attends to the two relational voices that the Gilligan colleagues have heard in listening to narratives of conflict: a care voice and a justice voice. The care voice articulates "concerns about loving and being loved, listening and being listened to, responding and being responded to"; a justice voice reflects "a vision of equality, reciprocity and fairness among persons" (Brown and Gilligan, 1990, p.8)

After each reading for understanding the narrative, self, justice, and care, the reader fills in the Summary Worksheets (Appendix H).

The Worksheets are the documentation of narrator text as well as the place for observations and interpretive remarks. The Worksheets highlight the important move from the narrator's words to the reader's interpretation of them. They require the reader to substantiate his or her interpretation with narrative text from the interview (Brown, 1989). They become part of the audit trail of the qualitative methodology (Lincoln and Guba, 1985).

The last step in the Reading Guide Method occurs with the reader answering a set of questions about his or her understanding of self and the moral voices in the interview narrative. This is the Summary Coding

Questions (Appendix I). Data will be presented to respond to three parts of the Summary Coding Questions:

1. the presence of the moral orientations
2. the relationship between the moral orientations
3. the narrative self and its "alignment" in the conflict.

The Reading Guide (Brown et al., 1988) discusses the importance of understanding the relationship between justice and care as moral perspectives in a narrative. Individuals may know and use both moral voices but one voice can frame how a person constructs the conflict, understands the issue, and what one understands as relevant to the response. Determining the voice of predominance is part of the interpretive process and comes from the entire story, not a single passage.

Narrative texts from study participants in each level of nursing leadership will be presented in the following chapter to describe:

1. The presence of moral orientations
2. The relationship between moral orientations
 - a. The predominance of care in the narrative
 - b. The predominance of justice in the narrative
 - c. The presence of both justice and care
but neither predominates
3. The "alignment" of the narrative self with the moral conflict.

Reliability

For this study, as part of data analysis, a process of reader confirmation was undertaken. For the Reading Guide method, the process of reader confirmation is "ability of two or more readers to agree on the their interpretation and understanding of the particular interview narrative" (Brown, 1989, p. 34). The determination of reader confirmation or reliability for the Reading Guide Method, as an interpretive methodology, means that two or more readers of the narrative texts express a similar interpretation of how the self and moral voice are represented (Brown, Tappan, et al., 1989). "The establishment of such agreement among interpreters (ie., "interpretive agreement") creates a common ground for conversing about the data in question; it assumes that, within acceptable limits, both are reading the text in the same way, or interpreting the same text" (Brown, Tappan et al., 1989, p.156).

The transcripts of this study, with no identifying information, have been read by a nurse who is a faculty member, researcher, and nursing ethicist who has made a significant contribution in the nursing literature and research to understanding moral reasoning in nurses. The

reason for utilizing a confirming reader was to ascertain concurrence with the investigator's interpretation of the narrative texts. The reader prepared Summary Worksheets (Appendix H) using the Reading Guide. The investigator reviewed the transcripts with the corresponding Worksheets for each of the ten interviews. The purpose was to determine general agreement on 1. the presence of moral orientations 2. the relationship between moral orientations 3. the "alignment" of the narrative self with the moral conflict. The investigator and the reader conferred by phone and discussed differences on the three dimensions. The goal was to come to a "richer" understanding of the moral conflict from the participant's perspective by discussing differences in interpretation. A descriptive table displaying the presence and predominance of moral voice and the "alignment" of the narrative self from each of the ten interviews, as interpreted by both the investigator and the reader, is presented in Chapter 4, Table 8:

Comparison of Moral Voice.

Validity

Gilligan and her associates recognize that increased interest in the use of interpretive methodologies in

research calls for a "redefinition", in hermeneutic terms, of the meaning of validity to researchers. They have focused their validation efforts exclusively on gathering preliminary information about the construct validity of the Reading Guide and the Narrative Types (Brown, Tappan, et al., 1989). They affirm that construct validity "is crucial if we are to claim that the information our method yields about a narrative and its narrator is germane to the constructs of self and moral voice, and if differences in Narrative Types make any difference with respect to the way the individuals feel, think, and act in real life" (Brown, Tappan, et al., 1989, p.159).

The work of Cronbach and Meehl (1955/1973) supports the work of Gilligan and her associates in the process of confirming construct validity (Brown, Tappan et al., 1989). Citing the work of Cronbach and Meehl, Gilligan states that one of the central validation procedures for testing hypotheses relating to a particular construct is testing for group differences. Their method of assessment is a comparison of group differences between males and females on the dimensions of moral voice and self-definition. An assumption of Gilligan's work is that while the moral voices of justice and care are not gender specific, they are gender-related (Gilligan, 1982).

The source which Gilligan and her associates cite in assessing the construct validity of the Reading Guide method is a comparison study of group differences between adolescent males and females with respect to self and moral voice (Brown, Tappan et al., 1989). An analysis of study data around the differences in the males and females in the sample from an independent high school support:

1. With the Presence Dimension, while males and females articulated justice and care voices, there was no significant difference.
2. With the Predominance Dimension, there was a significant difference between males and females. Females articulated more frequently a care voice and males articulated more frequently a justice voice (Brown, Tappan, et al., 1989).

Recognizing that these are very preliminary findings and interpretations, Gilligan and her associates suggest that the data cited provide one piece of evidence for the presence of construct validity of the Reading Guide and Narrative Types.

The work of Rogers (1988) tested the hypothesis that there are gender differences in ego development in adolescence similar to the gender differences that Gilligan claims in moral reasoning. Rogers presents

preliminary findings of construct validity for Gilligan's gender difference hypothesis.

Correlating data from the Loevinger's Washington University Sentence Completion Test, using selected items scored for moral orientation, and Gilligan's Real Life Moral Conflict and Choice Interview, Roger's study concluded that Gilligan's gender difference hypothesis was confirmed. Males think in justice terms significantly more than females. Females think in care terms significantly more often than males. According to Rogers, this study provides more preliminary evidence for building construct validity for Gilligan's work.

Gilligan and her colleagues report that these are preliminary findings and interpretations. However, they believe that the findings and interpretations suggest that the Reading Guide and the Narrative Types used to describe moral voice "illuminate" both a gender difference and a context effect in the representation of self, justice and care in the narratives of real-life conflict and choice. They conclude, "We would argue that these data provide one piece of evidence that we can use in building our case for the construct validity of the Reading Guide" (Brown, Tappan et al., 1989, p.160).

CHAPTER 4

RESULTS AND ANALYSIS

This chapter presents the results and analysis of interview data from a research study the purpose of which was to understand how nurse leaders describe and respond to conflicts in the workplace. The findings presented here are the results of interviews with ten nurse leaders in an urban acute care magnet hospital. In discussing the interview data, results are presented in three parts. The first part will focus on the analysis and discussion of narrative texts generated from a group of questions on self-descriptions of leadership. The second part focuses on nurse leaders' descriptions of their caregiving role. The third part presents the summary data and excerpts of narrative texts which answer the study's questions: How do nurses in leadership positions respond to conflict and choice in the workplace? Does level of leadership influence response and choice?

In discussing the data, I have also identified common themes or patterns that recur among the interviews. I

recognize that the choice of patterns and themes, though supported by narrative texts, is a subjective endeavor. My interpretation of recurring themes and particular word patterns used by nurse leaders will form the basis of the meaning of leadership, caregiving, and moral conflict that I present. This study does not attempt to draw any conclusions about all nurse leaders. Rather, it seeks to explore the complex and subtle insights that ten nurse leaders reveal in their interviews. There is overlapping of some themes and patterns and I recognize the potential difficulty of excerpting some pieces of the interview transcripts with possible reduction or loss of narrator's supporting contexts and world view. One of my goals in the presentation of data analysis is to select excerpts of interview texts which include situationally relevant context variables which have sufficient narrative length to capture nurse leaders' perspectives. In order to protect the confidentiality of study participants, I have changed the names and identifying characteristics of the nurse leaders, but their voices remain unchanged.

The desired outcome of this data analysis was to create an interpretation of each of the nurse leaders' perspective on their leader role, caregiving practices in their leader role, and response to conflict and choice in their work environment. Multiple readings of the interviews with the

completion of supporting workpapers was the process used for producing a complex interpretation of the nurse leaders' stories. As discussed in Chapter 3, because I recognized the possibility of differences in analysis and interpretation of interview texts, all interview texts were read by a confirming reader. Two readers, whose goal is one comprehensive and coherent interpretation of the same interview data, test the strength of each other's inferences and interpretation with a vigorous dialogue around the questions, "How did you come to that perspective from the data?" and "What is the evidence to support your understanding?" Points of disagreement became learning opportunities in the development of the interpretation of the narrative texts.

In general an interpretive account is judged successful to the degree that it is internally consistent, that it is comprehensive of the many elements of what is to be interpreted as well as the relations among these elements, that it resolves obscurities, that it proves useful in encompassing new elements come into view (Rosenwald, 1985, p.696).

The goal of this data analysis, with the use of a confirming reader, was to create an interpretation of the nurse leaders' stories that met Rosenwald's criteria of coherence and comprehension, as well as being useful as a foundation for application to nursing practice and research.

Descriptive Characteristics of the Nurse Leaders

Ten nurse leaders in a large acute care urban hospital are the study participants. Eight nurse leaders are female and two are male. Five are managers, who are the practice leaders in the hospital, and as such, responsible for patient care management, personnel management, and unit management. Five are executives, who are members of the administrative leadership of the hospital, and as such, participate in policy development, long range planning and priority setting, and budget development for the hospital. Table 4 presents the educational background of the ten study participants.

Seven of the ten nurse leaders reported the Master of Science degree in nursing as the highest degree earned. One participant reported the Master of Public Health. One reported the Doctor of Nursing Science and one reported the hospital diploma. These nurse leaders are representative of nurses employed in this hospital in that 91% of their nurses involved in patient care services have received a Baccalaureate or higher degree. They are above the national norms for educational preparation. Nationally, the American Nurses Association's Facts About Nursing (1985) report that

TABLE 4

STUDY PARTICIPANTS' EDUCATIONAL BACKGROUND

<u>Position</u>	<u>Highest Degree Held</u>	<u>Field of Degree</u>	<u>Current Education Plans</u>
Manager	M.S.	Nursing	Selected courses
Manager	M.S.	Nursing	Doctoral Program
Manager	M.S.	Nursing	None
Manager	M.S.	Nursing	None
Manager	Hospital Diploma		None
Executive	M.S.	Nursing	Continuing Education Courses
Executive	M.S.	Nursing	Doctoral Program
Executive	M.N.	Nursing	None
Executive	M.PH.	Public Health	MBA Program
Executive	D.NSc.	Nursing	Continuing Education Courses

70% of nurses hold a diploma or Associates degree, 23% hold a Baccalaureate degree, and 7% hold a Masters and Doctorate degree. Six of the nurse leaders indicated current education plans. Three participants were currently enrolled in higher degree programs. Three participants were enrolled in selected course work.

Table 5 is a summary presentation of the career pathways of the 10 nurse leaders. There are some common characteristics. Nine of the ten leaders reported having held clinical practice positions from two to ten years. Nine nurse leaders held a clinical leadership position prior to their current leadership position. Three nurse executives held faculty positions.

Table 5 presents a composite summary of the demographic profiles of managers and executives from their Demographic Information Form (Appendix C).

It is important to note that while nurse managers and executives present the same mean years of career experience, a closer look at the information on years in their current position and organizational setting provided in the Demographic Information Form suggests some differences. Four of the nurse managers worked in

Table 5

SUMMARY DEMOGRAPHIC PROFILE OF NURSE LEADERS

	<u>Managers</u>	<u>Executives</u>
Sex:		
Female	4	4
Male	1	1
Age:		
36-40 yrs	2	2
41-45 yrs	1	0
46-50 yrs	2	2
51-55 yrs	0	1
Education:		
Doctorate in nursing	0	1
Masters degree in nursing	4	3
Masters degree in public health	0	1
Hospital diploma	1	0
Range of Years as Leader:	3 to 18 yrs	2 to 17 yrs
Mean Years as Leader:	9.1 yrs	5 yrs
Range of Years of Career Experience:	16 to 23 yrs	12 to 21 yrs
Mean Years of Career Experience:	19.4 yrs	19.4 yrs
Mean Number of Career Positions:	3.4 positions	3.4 positions

their current leadership position for ten years or less, while one reported having been a manager for 18 years. Within the nurse executive position, there were two distinct modes: a long term career role for two executives, with a mean of 15 years in the current executive position; and a newer career role for three executives with a mean of 3.7 years in the current position.

Nurse managers and executives both had held 3.7 mean career positions. A closer look at where nurse leaders were employed indicate some differences centered on the number of different organizational settings used in the course of a career. All executives moved into their current administration leadership position from other organizational settings. All managers except one followed a career pattern in their current organizational setting, moving from direct caregiver to practice leader in their current hospital. In summary, study participants, as a group, were well educated, had worked almost twenty years in nursing and had a varied career in practice, education and leadership in the profession.

Leaders Describe Themselves

This exploratory, qualitative study began by asking nurse leaders, "How would you describe yourself as a leader to yourself?" Using the interpretive schema of text analysis, described in Chapter 3, respondents described themselves in individual terms in the leader position and in relational terms in connection with others in the leader role. The following phrases taken from different narrative texts are representative responses.

Individual: I have a standard and I just run the unit...I enforce the standard.(Elaine)

You don't get to be a leader in a large hospital without having a desire for control, without wanting to make the decisions.(Nancy)

Relational: I view my role in terms of leadership...is to work quietly with people...to provide a climate that lets people use their creativity and their thinking.(Theresa)

Relationships that develop over time...It is really the key to fostering the kind of climate that you want to foster... as a leader.(Deidre)

Table 6 summarizes the leadership responses of the study participants. Nurse leaders described themselves both

individually and relationally in their leadership role. Executives and managers were similar in their responses. All managers and executives used relational responses to describe themselves as leaders, with eight out of ten using both individual and relational responses. One manager and one executive used no individual responses in their self-descriptions. Four leaders described themselves with primarily relational responses. Two leaders described themselves with a primarily individual responses. Four leaders used individual and relational responses with neither response pattern dominating.

What Nurse Leaders Say

Clare, who has been in a leadership position for ten years, provides a candid assessment of herself in this role.

In a perfect world I would like to say that I am a participatory manager. In the real world, I probably am a little right of participation. I seek a lot of information and input from the staff, but many times I make the decisions. And I would like to let them make the decisions more often, but there's something in my personal makeup, and it's gotten worse as I've gotten older. When I first started in this role, I was much more participatory. I really did have the patience to let them muddle along and make the decision, more so than I think I have today. But I see that in myself outside of work also.

TABLE 6

SELF DESCRIPTIONS OF LEADERSHIP

<u>Name</u>	<u>Position</u>	<u>Individual Response</u>	<u>Relational Response</u>	<u>Primary Response</u>
Alice	Manager	yes	yes	Neither
Robert	Manager	yes	yes	Relational
Deidre	Manager	no	yes	Relational
Clare	Manager	yes	yes	Neither
Elaine	Manager	yes	yes	Individual
Mary	Executive	yes	yes	Neither
Nancy	Executive	yes	yes	Individual
William	Executive	yes	yes	Relational
Sheila	Executive	yes	yes	Neither
Theresa	Executive	no	yes	Relational

Clare states that her goal is to be a responsive leader with her staff and let them make their own decisions. Then she speaks to what really happens: she makes more of the decisions than she thinks she should. She confirms her role of information provider, and the process that she uses to enable her staff to make decisions.

I am first and foremost a leader that believes in giving information. My staff know everything that I know. I have staff meetings...giving them information. I firmly believe that if you have information, you have a great deal of power, and that's my way of giving them power.

Similar to Clare, Mary, who has held many leadership roles, presents both relational and individual styles in her self-descriptions.

I guess I would use adjectives mostly: teambuilder, assistance developer, planner, a person who is very, very careful to give credit for any project that I happen to be leading...honest, unpretentious...I greatly enjoy working with other people and can be both a leader and a follower. My temperament is such that I'm best as an individual contributor and loner is not exactly the right word to use, because I'm not really a loner. I get great satisfaction out of working with and through people, but any question of sacrificing substance or integrity in the name of team playership, I resist. I do not wield the power that I have just for the sake of power-mongering.

Mary elaborates on her perception of the importance of power to her.

[Power is] an important piece, I think, in the way I'm perceived by others. People perceive me as very powerful, and it constantly surprises me that I actually have a lot more power than I choose to exercise.

Mary describes herself as a teambuilder who believes in the importance of recognizing and supporting those with whom she works. Yet, at the same time, she states her "temperament" is more suited for her own individual performance in the nurse leader role. Both leaders speak individually and relationally.

The Power Piece in the Leader Role

Both leaders introduce the notion of power into their self-descriptions; however, each does it differently. Mary speaks of her positional power as viewed by others, and her response to their views. "People perceive me as very powerful, and it constantly surprises me that I actually have a lot more power than I choose to exercise."

Clare's notion of the power of the leader role is to empower her staff to make decisions by providing them with information so that "you are free to make decisions because you can make informed decisions." She believes that her role of furnishing all information on patient care matters

to the staff helps them in critical decisions that surround patient care issues.

Nancy, an experienced executive, regards desire and use of power as a personal characteristic of a leader. She contrasts two perspectives: her personal belief in "all nurses-as-my-colleagues" with her view of the "nurse-leader-as-power-holder" in the organization. She speaks of the importance of "destroying" the authoritarian myth of leadership, while acknowledging power, influence and control as crucial to the role.

One of the things that is very, very important, and I guess this is part of my own leadership, I believe it so strongly, I'm not any different than most nurses. It is important for them to understand and for me to convey in a believable way that we are the same... We are professionals together. We're peers, colleagues together...For me, it's trying to get the myth of leadership destroyed.

Nancy believes that equality between peers levels out status differences in professional role. As an executive leader in the hospital, she articulates what she believes are natural characteristics of the leader role.

This hospital is an organization. In an organization, there needs to be some kind of a system that avoids chaos. The system has leaders...You don't get to be a leader in a hospital or any place without having a desire for control, without wanting to make decisions,

without wanting to be the person in control...with power, influence. That's a natural kind of characteristic, I think, of people that get into these kinds of leadership positions.

Mary, Clare, and Nancy support Bennis and Nanus' (1985) notion of power as integral to the leader role. Power as the empowerment of others is Clare's belief. The perception of positional power by others, rather than the promotion of power ownership, is described by Mary. Power as a natural characteristic that is necessary for creating order in a hierarchical system is stressed by Nancy. But in a contrasting perspective of herself, Nancy alternates her views between a more traditional notion of power, and her belief in equality between colleagues. She stresses the elimination of hierarchical levels of relationships between power-holders and others engaged in the common endeavors of caring for patients.

Standards As The Guide

In describing herself as a leader, Elaine exemplifies an individual response by placing standards as the priority in her management of patient care. She states that she "runs" all aspects of her patient care unit.

I think that I'm able to run this kind of a unit very well. And that includes patient care, managing equipment, managing products. I'm a very hands-on type leader.

She then describes how she "runs" her unit:

I have a standard and I just run the unit. I know this may sound very simplistic. I enforce the standard.... It's a challenge every day being a leader. I must say that sometimes it amazes me that it is a challenge, particularly because what the staff want you to be is their mother and perfect. And you can't, although I try. You can't, you just can't.

As a leader, Elaine says she is guided by her standards in handling patient care and staff responsibilities. She contrasts the metaphor of the perfect mother, which she believes she cannot be, with her response to the challenges of being a leader. What is not clear from her choice of metaphor is the contextual framework she brings to the leader/mother contrast. Her choice of words equates mother and perfect but does not indicate if this mother model of leadership is the standard bearer she needs on her unit or nurturer role desired by her staff.

The Importance of Relationships

The six nurse leaders who described themselves in a predominantly relational manner place primary importance on fostering good relationships in their leadership role. Deidre, who has spent half her career in positions of authority, points to the early influence of a mentor on her current leadership style. She credits the relationships that her own leaders had with her as influencing her development as a leader.

I've been developed and I have been brought along by the people who I consider top nurse leaders. I see myself as a member of a farm team, that they really promote and develop. I'm here in this position today because people have brought me along.

Encouraging others then became an integral part of her sense of leadership, as she modeled what other leaders had done with her.

I think I've mentored them without necessarily even thinking, I think that's really what I would call it, but that's really what it is, as people have done with me.

Diedre calls her style "loose leadership, without a lot of rules or policies", and places high priority on the importance of time in building strong relationships.

Relationships that develop over time are really the key, the key with patients and the key with peers and with staff and managers. It is really the key to fostering the kind of climate that you want to foster, the whole experience of being a leader on a unit.

Leaders as Team Members

Several of the leaders saw themselves as members of a team, rather than as leaders of the team. William says:

I think I'm very sharing, and I get a lot of feedback about this. I'm very much a team player. That is what I truly believe...I do believe the whole is greater than the sum of its parts, and that if I have an idea and I share it with someone, sharing it and working with somebody on it, it's going to be a much better idea. I really believe that.

Theresa, who has been a leader in practice and education, views her role as part of the leadership team, and as such, complementary to the top priorities of the hospital.

The hospital really values leadership and creativity...I view my role in terms of a member of a leadership team helping to provide a climate that lets people use their creativity and do their thinking. It makes us a much better nursing service.

She sees herself "in the service of helping to structure an environment here that permits nurses to practice as professionals", thus creating a work climate that allow professionals to practice in the kind of environment that supports, rather than directs, nurses in their provision of patient care.

Summary

The goal of the first part of these interviews is to understand how nurses see themselves as leaders. By thoughtfully discussing how they act in their leader role, what their goals are, and who and what is important to them, interesting themes that leaders spontaneously introduce begin to emerge. Common themes across the interviews suggest a composite picture of how nurse leaders see themselves.

All nurses in the study describe themselves with relational responses. Most nurses also describe themselves with individual responses. While some nurse leaders see themselves as power-holders and standard bearers, the majority of the nurses placed greater emphasis on the importance of relationships in their leader role. The relationships about which they talk are with their nursing staff, nursing peers, and administrative colleagues. The

complementary nature of relationships was underscored with those who keyed in on team membership as a part of their leadership role.

Why do nurse leaders who represent high levels of leadership in their work setting stress relationships as key to their leader role? Light is shed on this question from two points: from the nature of the profession of nursing and from some of the literature reviewed in Chapter 2. Nursing is a feminine profession, characterized by a caring, nurturing relational practice (Masson, 1985). This is a professional ideal that is promoted and developed from the earliest student days. Nurses bring these characteristics to their leader role. Another relevant consideration is what Muller and Cocotas (1988) call typical feminine behavior characteristics: cooperation, enabling of others, leveling of status differences, and intuitive consensual decision-making.

Most women differ in their orientation to power by focusing on relationship issues (Miller, 1976) and the development of alliances with others. This is an often overlooked source for the accumulation of organizational power (Kanter, 1977). Srivastva's (1986) notion of a relational dimension of leadership stresses the importance of strengthening and nurturing individuals in an inclusive, shared value system. The nurses' voices in this study

give meaning to the intersection of leadership literature with the ideals of the nursing profession.

Leaders Describe a Shift

Nurse leaders were asked to describe differences or similarities between their current leadership role and past roles or positions. Some interesting themes emerged from their descriptions of leadership role change. Nine out of the ten nurse leaders indicated that they see themselves in their current leader role in similar ways as they saw themselves in other nursing roles. Only one nurse leader saw herself acting substantially different in her current role.

There were qualitative differences in the descriptions of those who felt they had not changed, despite having held many different positions in nursing. Two executives were firm in their response of no change. Mary, who has held many different positions over her twenty-two-year career said, "No, it's absolutely the same." She adds one qualifier that supports a shift rather than a change in her leader role. "The only difference is in terms of relationships with people in other leadership roles. I would say that over the past three years I've become a little more politically astute."

Mary describes role modeling and peer collaboration as strategies she used to broaden her understanding of leadership to include "political relationships...within any large organization." For the most part, however, she believes her personal characteristics have remained the same, and are valued by people in her organization. She says, "I am a straight-shooter and I am honest and I think people realize that. I'm open, as well. I think that piece makes up for whatever political sense that I might be lacking."

Theresa, who has fewer years in leadership than she had in nursing practice, described herself as having a "quiet leadership style" that adds a much needed balance in the pressure-filled environment of a large organization. She believes that her sense of calm and her ability to be goal-oriented have been an intrinsic part of her style since "I was a new graduate, probably...and probably before." Like Mary, she also believes that these personal characteristics have contributed to her success as nurse executive in a large health care delivery system. Theresa says, "I don't feel any urgent need to try and change. I think the hospital leadership group is comfortable with my style. It's compatible with their style."

Seven nurse leaders were more explicit in their acknowledgement of growth rather than change in their leader

role. They attributed this broadening pattern to several factors, ie. a shift in priority of personal goals, a shift in tasks associated with the leadership position, development of "intuitive leadership" response associated with years of experience, and a deeper intensity and commitment to beliefs in being a leader.

Diedre believes she has "grown" in the leadership role rather than changed. She describes this growth in terms of the expectations that she has had about her investment in her nursing staff and expectations of return from the investment.

I don't think how I see myself as a leader really has changed much. I do think I have grown a lot in this position with trying to deal with feelings of vulnerability....The hardest thing for me is finding that line [between] really investing, and also knowing that they [staff] won't be here forever and they need not to be here forever. How close do you allow yourself to be and to feel, and how much do you invest in them so that you don't have this overwhelming feeling of loss if two or three of them, who you love to see every day, are going to leave...Most often, if I'm feeling badly about them leaving, I feel it's been really positive.

Alice, who has spent eighteen years in her leader role, believes that the biggest part of her job with her staff is to balance being "supportive in a global sense"

with fulfilling "my primary responsibility to make sure that patients get the care that they need." This aim has not changed but what has shifted are the mechanisms that she uses to accomplish this responsibility.

I've learned that they don't want me to be hairline fair. They want me to be, you have to be fair. That's an absolute. They want you to be absolutely fair and above-board making decisions.

Robert, who has held leadership positions in other organizations and more recently joined this hospital, describes himself as a leader who "merges a management piece and a leadership piece." He believes he has always worked from this two-pronged leadership model. But the focus and priorities of different organizational settings in which he has held leadership positions placed greater emphasis on the management piece of task accomplishment over the leadership piece which he believes focuses on staff development.

While his personal leadership model has not changed, he feels his current leadership role is unique to his present work-setting. Here, he has been able to shift some of the management pieces that are not integral to his notion of leadership and take on a greater part of what he believes the primary focus of a leader should be.

I think that what's different here is that people focus on the day to day. But then they focus on the future and they focus on staff and the development of staff. That's a really critical piece to this role as nurse manager, to develop your staff. And that is probably what should occupy most of your time in the nurse manager role.

William, who reflects on a long career in leadership, believes that the attributes he brings to his leader role - good humor, sense of calm, self confidence, and caring for people - have not changed; however, his responses to situations requiring critical leadership skills have been modified by experience. He has developed what he calls "a strong sense of intuitiveness, a strong sense of timing."

I would say I'm not that different than when I was a staff nurse or a head nurse....I think they've [leadership attributes] always been there....I think what has changed is what I've learned, with experience, how to change one's own course when dealing with a large, varied group of people....I deal with a tremendous number of people.

Like Robert, William speaks of the importance of balance in his leadership role, but chooses very different pieces to balance. He speaks of the need to balance his personal attributes with knowledge gained through professional experience.

I think that by the fact that they [personal attributes] are important to me, by the fact that I am known as a very seasoned leader--that enhances those attributes because I've always practiced them; and because I've been in a leadership role for a number of years and have not really changed my style, I think it's the experience factor that also adds to the whole picture.

Sheila believes that the professional expectations in the current health care delivery system have influenced, rather than changed, her standards.

When I came here I was just one of the many people who had talent and skill. It was humbling....I think what its done for me is it's raised my standards a great deal. I think I am much more cognizant of excellence. I expect more from people since I have come here.

Since working in her current setting, Sheila has raised her personal expectations and her expectations of others. When asked what brought this about, she said:

...the culture of the hospital. In other situations when I would have my high standards people would sometimes think they were unrealistic. But I think where patient care is concerned, you have to go for the highest standard, there is no settling. Here, that was the norm.

Nancy speaks about the relationship of her leader role to what she calls her career stage. After many years in a

career of nursing leadership, she values the freedom to develop and play with ideas that this position brings.

Obviously, you must bring to roles, positions, situations, some kind of personal characteristics. I've always been an idea person. But there was really a period of time in my career where I was more more concrete. I was much more involved and enjoyed doing. Today, I love playing with ideas.

She also views herself as an intuitive leader.

I've always thought of myself also as being much more of an intuitive kind of leader. I act intuitively. I'm always pleased when I can find some literature that eventually says, you did the right thing. There's been much more intuitive kind of behavior development from my point of view.

Only Clare, who has spent 12 years in a leadership position, acknowledges a change in how she handles decisions involving the nursing staff. In describing how she carries out her leader role she says:

...many times I make the decisions. And I would like to let them make the decisions more often, but there's something in my personal makeup, and it's gotten worse as I've gotten older. When I first started in this role, I was much more participatory. I really did have the patience to let them muddle along and make the decision, more so than I think I have today. But I see that in myself outside of work also.

Clare recognizes that the change to an more directive, individually focused style of leadership has crossed professional and personal domains. She also views her age as a mitigating factor. With her choice of words, "It's gotten worse as I've gotten older", she implies that she is not satisfied with this change but offers no insight into what she may be considering to respond to the change.

Summary

Nurses in this study believe that how they see themselves as leaders is similar to the way they saw themselves in their other nursing roles. Several leaders stated that personal characteristics remained central to their roles. They describe certain attributes that have stayed with them from their earliest experiences in nursing, and see these characteristics as important to their leadership. Their successful career in leadership has cemented their view of the enduring value of personal characteristics.

While indicating that they did not believe that they had changed over many years in organizational leadership, the nurse leaders provide some insight into how years of leadership experience has affected them. They cite a

shift in their patterns of handling job responsibilities. Moderation of expectations in professional relationships, raising rather than changing standards, separation of the leadership piece and the management piece in handling job responsibilities, and growth within professional role were put forth as influencing the shift.

Recent job expectations of the particular health care delivery system played a part in this shift. Some settings place greater emphasis on the task accomplishment of managers, while others subordinate tasks to leaders' role in strengthening and nurturing staff in a setting where individuals share common values. The research of Morse and Wagner (1978) support what the leaders say. From their study, they concluded that leadership effectiveness may be organization specific, indicating that the activities of leaders differed in different organizations.

Another factor may be involved in leaders' statements of no change. These leaders describe themselves as placing primary importance on fostering good relationships in their leader role. The importance of good relationships is a basic tenet of nursing practice across professional roles. Whether a practitioner, manager, or executive, fostering good relationships is an ideal of a feminine profession (Masson, 1985); as such, it remains a common

attribute throughout nursing. These nurse leaders confirm that fostering good relationships has remained their professional ideal over a long varied, career in nursing.

Multiple perspectives of leadership were presented in Chapter 2. The voices of nurse leaders in this study contrast with many viewpoints in the professional literature. The analysis of leaders' responses, using narrative texts, provides meanings to many notions of leadership that are contextually grounded in individual viewpoint, organizational setting, and the culture of nursing.

Self-Descriptions of Caregiving in the Leadership Role

The second part of this study focuses on how nurse leaders view themselves as caregivers. Primarily, they talk about what care meant to them in their leader role and if their notion of care is role related.

All ten nurse leaders in this study, regardless of the level of leadership, see themselves as caregivers. While acknowledging that care of patients is their overriding goal, nurse leaders state that they are not the primary caregivers to patients, but rather work towards patient care by building supportive, caring relationships with their nursing staff, peers, and administrative colleagues. Several leaders indicated that the caring

piece of their leader role which "gets played out day after day in the decisions we make" impacts on the larger hospital environment. There is the implication that these nurse leaders see themselves as the standard bearers of caregiving in the hospital. Theresa's response sums up this perspective:

I think that caring is a really important part of my leadership role and of the nurse executive position because if nurse executives don't care vehemently about what happens to patients, and what happens to nurses who care for the patients, and for their other administrative colleagues, you can't possibly have a successful caring environment in the hospital.

Clare, who has been a nurse manager for eight years, talks about supporting the nurses who are the direct caregivers.

I care for the caregivers. I take care of them in that I help them grow and develop, and support them any way that I can to grow and develop as people and as clinical experts so that they can then turn around and provide the best care possible to the patient.

When she was asked, "Is caring for the staff your priority on this unit?" she stated:

No, actually my priority is patient care and the level of practice that occurs, but I have always believed that if I care for the staff, I will get a certain

level of behavior around patient care.
Patient care will be better given by the
nurses that I've cared for.

Clare, a nurse manager, and Theresa, a nurse executive, express similar perspectives: patient care is their priority, but its accomplishment is directly related to a their caregiving function for other members of the hospital community. As nurse leaders their caregiving focus encompasses not only responsibility for patient care, but also support for others who are connected to the delivery of patient care.

Alice, a manager on a high-tech patient care unit, recognizes the impact of technology on caregiving. First, she states:

I see myself as an ardent advocate of patients, as much of an advocate as you can be while being a care provider....I think my philosophy is to try and take care of people as though they were my own.

Then she acknowledges difficulty with a caring role today because nurses are functioning in a "much more technological world." They have to try to sort out a caring role that balances the "technology required with the traditional ways of caring." As a nurse manager, how she cares is a basic part of her leadership role.

Their [the nursing staff] issues of well-being are key to my role....The most important part of my role is to repond to them when they have an issue. My expectation is there for care, my standards are there for care. But in terms of the staff, when there's a problem, they want me to fix it, or tell them why it can't be fixed, or help them fix it.

Three nurse managers view their caring role as integral to their leader role. They also weigh their own experiences as patient care providers when they examine how they align patient care with caring for their staff.

Elaine stresses that her priority is that patients receive care. Using her high standards of caregiving for measurement, she accomplishes this priority through her staff.

I'm still caring for patients when I care for the staff, only one step removed. I want the staff to care for the patient the way I would care for the patients. That sometimes is a tall order, but that's what I want.

Although she admits that it is easier to talk about care for her patients than for her staff, Elaine views herself as the facilitator for her nurses. She says:

I care about these people. I would really like to be able to facilitate their growth. If I'm going to be a good leader, in my mind, then I have to pay attention to all aspects or as many aspects of my staff as I can. I don't

think of it as caring, but it is caring for them, looking out for or helping them with their own goals.

Diedre sees caring for her staff as bound to the notion of primary nursing. In her leadership position, caring for the staff is a commitment beyond the notion of role responsibility.

I think for me it's a feeling of commitment, different from responsibility somehow. It is really because responsibility almost has a negative connotation to me. Responsibility seems too much like work, more task oriented, too much like duties. And commitment really feels more like an overall connection, feeling of wholeness. Primary nursing is very similar, their commitment to patients is really caring for patients....I have to be committed to them [nursing staff] one hundred percent even when it's not easy, and even when they're not responding to me on a day to day basis.

Diedre expands her notion of caring beyond her nursing staff to include caring for other nurse managers who are her peers.

I think there's also another caring between peers that happens. And I've seen this just recently in our nurse manager group because we have three almost new nurse managers going through those same feelings you had when you were so new. You recognize it. It's clear as day, the things that hurt them, the things they struggle with. You feel those same feelings. I've been through

this. I know this. Then I give them my story, and they feel better, at some point, that people survive.

Nancy addresses care as a professional value that she has held throughout her nursing career. She presents care primarily as a professional value, and secondly as an influence on her leader role.

I believe caring really starts with some basic values that each of us holds as an individual around people. In my role it becomes essential to instill, support, and facilitate the values of human dignity, respect, and trust...If you don't first care for yourself, if you don't have some self-esteem and identity as a person, then you are not going to be able to care for others...We can't give humanistic care to patients if we are unable to treat each other in that same way, and right from the beginning.

Nancy speaks of a humanistic notion of care that cuts through all the layers of a health care delivery system. She continues to describe how she combines her commitment to her caring piece of her leader role with her responsibilities to the organization.

My focus as an administrator is in caring, because that's what we're all about. My role has been to help people [other administrative staff] to stay focused on our mission of caring, while I'm working in budgets, marketing, strategic planning, all those wonderful, sometimes boring activities. That's the reason for doing it.

The view of the nurse leader in conflict over caring priorities with organizational priorities (Miller, 1989; Blair, 1989) is not supported by Nancy as she talks about combining the "mission of caring" with her responsibilities as a corporate leader. Rather she describes herself as a leader who knows what her professional values are, and promotes them in the daily business of organizational activities.

How the Health Care Delivery System Influences Caregiving

The review of the literature presented in Chapter 2 indicated that most hospitals have different organizational priorities than their nurses' priority of patient care (Blair, 1989; Ray, 1981). Conflicts arise in health care delivery systems between medical and technological advances and nursing's caring model of practice (Miller, 1989). Nurse leaders in this study do not support these notions⁴². All of these nurse leaders indicated that the caring practice of nurses was their institution's priority.

William explains:

I think the key issue in this hospital is the support nursing receives from all, administration, physicians, certainly patients and families...just about everyone within the hospital. There's a high degree of support for nursing. I think that's very outstanding.

When asked what that meant for him, he stated:

I think it makes one's position as a nursing leader easier because where you may feel you have to go in and really fight for support, you usually have an underlying base of support from which you can build, so that the basic support is there.

He further elaborated:

The basic premise here is that the patients are here for nursing care. The hospital is known as a nursing care institution, and therefore that becomes the focus. And if you contribute to that, there's a certain degree of respect that goes along with that because that's the mission of the institution.

Theresa contends that the success of this hospital is due to its philosophy of patient care. She compared it to different health care delivery systems where she had been a leader, and says:

It's different here. It truly is different...I don't feel like it's them and us. We do a good job caring for patients and that's what we're here for. The teaching and the research support patient care rather than patients being kind of incidental.

She went on to explain:

Caring is related to our success as a hospital. It's in our Mission Statement in terms of it being a caring, humane environment...It is an institutional priority, and that makes it easier for

nurses to fulfill the position of caring. I also believe it's a priority of the physicians who choose to practice here, rather than one of the other hospitals in the city.

Other nurse leaders agree that caring is an institutional priority as well as a nursing priority and see themselves as "care influencers" in their leadership role.

Caring is what we're all about. I mean there's no question about it. The hospital exists to care for people, and my role is to help people stay focused on that mission. (Nancy)

I see myself as not more involved with care but having more influence on care...I support that in this role philosophically and programmatically. (Sheila)

Nurse executives agree that the primary focus of patient care provides strength for their leadership and their organization as a whole. Nurse managers also confirm that their institution influenced their caregiving position. Elaine said, "To me one of the best things about working here is that we're able to take care of patients the way we think we should." She believes this is possible because she and the organization agree on care as a top priority.

Diedre takes the same position. Talking about care as a priority, she says, "I think it's institutional. It's

always been important to me and the other nurse managers...but we all seem to have the same values, the same general feelings about the hospital."

Three of the nurse managers acknowledge the importance of a larger administrative presence as an influence on the institutional priority of caregiving.

You can't have this [nurses' commitment to patient care] in a vacuum. Without the support of the Board [of Trustees], the president and administrators, and their vision and willingness to support the priority of patient care, there would not be anywhere near the fruition of what has been accomplished.(Alice)

Clare, claiming "a little bit of a historical perspective", believes that the executive leadership has been an influence in promoting patient care as an institutional priority because they have:

...always been forward thinking, which is to say, regardless of what is happening right now and while addressing what is happening right here and now, there is still thought going on about the future and where you want to be tomorrow, where you want to be next month, where you want to be next year, and how you are going to get there.

Summary

In the second part of the interview nurses talked about themselves as caregivers in their leader role. All describe themselves as caregivers, and see caregiving as an important part of their leader role. Listening to the nurses' voices talk about how they cared, for whom they cared, and why they cared suggest some common themes.

The importance of the work setting in supporting nursing's ethic of care was clearly stated. In the setting where these nurse leaders work, they believe there is only one focal point for all members of the hospital community: patient care. It is begins with the philosophy of the institution, which states its reason for existence as patient care. A climate that supports and promotes care of patients is fostered. The larger administrative presence influences retaining care of patients as an institutional priority. Nurses see caring as one part of their professional values.

Ray's (1989) work, which aimed at clarifying the meaning of caring to those who worked in hospitals, concluded that the notion of caring was markedly influenced by the role and position a person held, and the place within which the person worked in the health care delivery system. Ray's work implies conceptual differences linked

to position. The descriptions from the ten nurse leaders in this study present a different picture: one in which nurses, the health care community, and the organization have similar priorities.

The nurses in this study are careful to point out that not all institutions where they have worked support the priority of patient care, and therefore nursing care. To understand the nurse leaders highlighting differences in their workplaces, I note that the setting for nurse leaders in this study is a magnet hospital, a designated center of excellence as a health care delivery system in the United States. Nurse leaders are experts in the cultivation of patient care values in these institutions and influence the creation of an organizational milieu that supports their values (Kramer and Schmalenberg, 1988a, 1988b). The voices of nurse leaders in this study reaffirm the importance of the worksetting in promoting the care ethic of nursing.

Resolving Conflicts In The Workplace

Major changes in health care delivery systems in recent years have raised questions about the nurse leader role. There is ample evidence in literature that nurses as leaders experience conflict between organizational goals and patient care needs (Miller, 1989; Blair, 1989;

MacPherson, 1989). Because nurse executives have been promoted into vice-presidencies with authority beyond the scope of nursing practice, nurses are concerned that their institutional leaders are more committed to their bureaucratic role than to their mission of caring (Singleton and Nails, 1988). These interviews provide insights into the conflicts that nurse leaders experience in their workplace, and how they resolved these conflicts.

Kinds of Conflicts In The Workplace

All ten nurse leaders faced conflicts in their daily workplace. Participants indicated that they had thought about, and chosen, a particular conflict to share from the many that they experienced. Several of them brought more than one conflict to the interview, and chose to speak about one in particular because it was "typical" of the situations they encountered. There were other reasons given for the particular conflict described. Two leaders chose to speak about an on-going conflict and were pleased to have an opportunity to "rethink" it. Several leaders chose their particular conflict because it was a very difficult decision for them.

Some of the interviews were emotion-filled as participants described the conflict and its resolution.

All participants responded positively to the experience of sharing a self-selected conflict. Many directly expressed appreciation for the opportunity to talk about a situation that still had an emotional hold on them.

The dilemmas that nurse leaders describe seemed to follow a pattern. The first construction of the conflict centers on the problem outside of themselves, reflecting responsibilities they felt to others or to the institution. A second level of consideration of the dilemma focuses on a reinterpretation of the conflict, away from the initial construction, into a personal reconception of the conflicting responsibilities within themselves. Gilligan (1982) noted that women, in discussing different conflicts, describe dilemmas involving attempts to be responsive to themselves and others. She believes that women work to find solutions that incorporate responses to the needs of both the self and others.

Three of the nurse executives described a conflict with their institution over budget priorities or institutional policy; however, they also described an intrapersonal conflict over the values that were important to them but seemed to be in conflict with the institution. One nurse executive directly questioned whether her response to the budget-cutting conflict in her institution would force her to compromise her values around the delivery of patient care and staff relationships.

This was such a difficult time. I had examined my budget. I hadn't been asked to do that but I had examined my budget. I knew there were some positions that I could give. It became evident that really to meet the budget, I was probably going to have to drop many more positions...The conflict was, does this mean that I have to compromise the values of myself, and of the people that had really come to trust me in terms of values.(Nancy)

Another nurse stated that her dilemma was with the institution's contained response to opening a patient care situation to state and legal review.

I really felt very strongly that you get into gear and you address it, you investigate it, you open things up and look at it....They were more worried about the press, concerned with 'What if the press got wind of this'.(Theresa)

She then described her own personal conflict within the dilemma: how far, how much, and to whom should she take this situation beyond the hospital. She contrasts her values with her responsibilities to patients and the institution.

The conflict for me was being new in the system and saying, 'Were we really going to open up everything more than just this one patient care issue?' Do we really say 'Let's see what's going on here" or deal with an isolated incident. For me, it was really a lot of self evaluation of was I over-reacting because I had expertise

and consideration of what's the responsibility to all the patients that might have something happen to them. (Theresa)

William, a third nurse executive, described a conflict with the administrative leadership of the hospital over the implementation of a state regulation regarding staffing. The conflict was between the mandate of hospital administration to add overtime work-hours for nurses on a short-staffed patient care unit, and the intention of the state regulation limiting staff hours of employment. After deciding to follow the mandate of the hospital administration, William describes the evolution of the second level of conflict within himself over his personal decision to staff for minimal patient care services versus staffing for the level of patient care that he felt was necessary. William's conflict was similar to several of the dilemmas of the nurse executives. First there was a level of exterior, systems-level conflict. Then, with continuing reflection on the conflict, there was a personal, ethical struggle.

Recalling what she described as a "turning-point experience" for her, Sheila talked about a conflict with another peer professional over threats to positional authority. "My conflict was with the director of physical services who verbally assaulted me one day. I just didn't

know what to do with it." As she talked about how she planned to handle the situation, she describes a dilemma within herself to break a self-described pattern of conflict avoidance. "I think my pattern historically had been to leave when I felt uncomfortable with something. But this time I felt the need to find a resolution."

Most nurse managers described interpersonal conflicts with peers or their nursing staff, rather than conflicts with the institution itself. The nurse managers followed the pattern of two constructions of the conflict; however, they talked differently about these than did the nurse executives.

Nurse managers primarily focused on handling conflict within and amongst staff members, and with a physician colleague. Similar to executives, managers described a personal conflict, within a larger conflict, that focused on the personal values that were important to them but were being challenged in the resolution of the conflict.

Deidre described her problem with a member of her staff who was "disruptive" to other staff members. On one level she saw the conflict in terms of one individual disrupting other members of the nursing staff with her confrontive behavior, and standing in the way of effective care of the patients. On a more personal level, she weighed how far she could go in supporting this troubled

staff member before she would have "to give up on her" and sever the relationship. This action was opposed to her formulation of herself as a good leader and good cohort.

Clare, a nurse manager on a critical care unit, describes her conflict over how to handle a staff member who is "almost safe" in nursing practice. She introduces her dilemma as how to supervise a nurse whose skill level is marginal. She then immerses the conflict in her disappointment in herself because she is unable to help this staff member improve her level of clinical practice. She details a recent critical incident where this staff member's patient care was lax, bordering on making serious errors of judgement. She then asks searchingly:

How long do I keep someone who is almost safe? Do I continue to support her, waiting for something to happen, or do I terminate her? That's it exactly.

Later, after describing conditions around the staff member's employment at the hospital, she talked about the second level of her conflict.

I think what is mostly influencing me is an ego thing. I'm ashamed to say that it's real hard for me to come to grips that I can't find a way to help this character.

Clare clearly expresses the view that her own self-concept is integrally tied to successfully guiding her nurses, as well as caring for her patients.

Elaine's difficult decision was whether to openly support a physician colleague, who she views as wrongly accused of mishandling job responsibilities. As she elaborates on her story, she weaves a multifaceted conflict: Should she go against her nursing administrators, whose support she valued, but who disapproved of her actions to support the physician because of the risk involved to her? Should she speak out in support of the physician, without administrative approval, because her moral code told her she "had to do it"?

The only "should" that I thought about was that perhaps greater minds [other nurse leaders] who were perhaps more experienced in the politics of the hospital really felt I shouldn't do that...I guess I remember thinking I really didn't want to do anything to embarrass the nursing service. But I understood the ramifications of what could happen.

She decides to "stand and be counted" and write a letter of support for the physician because she believes that what was happening was wrong.

A summary of conflicts experienced by nurse leaders is presented in Table 7. All of the conflicts described by the leaders contain more than one facet and more than one consideration.

TABLE 7

CONFLICTS EXPERIENCED BY NURSE LEADERS

<u>Kind of Conflict</u>	<u>Description</u>
I. Organizational	<p>I. a. Me vs. Organization</p> <p>1. Compromise my values with shift in organization priorities</p> <p>2. Misalignment of institutional values vs. professional values</p> <p>b. Power issue</p> <p>Use/abuse of positional power in organization to respond to conflict</p>
II. Interpersonal	<p>II. a. Symmetrical</p> <p>1. Peer to peer</p> <p>2. Leader to leader</p> <p>b. Hierarchical</p> <p>Leader to staff member</p>
III. Intrapersonal	<p>III. a. Self View in Professional Role vs. Others' View</p> <p>b. Internal Agreement/Disagreement with self: I should do this vs. I believe in this</p>

Moral Voice Considerations in Workplace Conflicts

Two questions were raised in this study: How do nurse leaders respond to conflict and choice in the workplace? Does level of leadership influence response to conflict and choice? Data from interviews with ten nurse leaders were used to answer the study's questions. Table 8 presents the summary of moral voices. One finding of this study is that nurse leaders use both justice and care voices to respond to conflict and choice in a health care setting. A summary of the results indicated that seven out of ten leaders used both a care and a justice voice in their descriptions of conflict and its resolution in the workplace. Four of the leaders were managers and three of the leaders were executives. One manager and one executive did not present a justice voice in their self-descriptions of conflict but rather responded in only a care voice.

In listening for identification of the self with moral voice, one looks for nurse leaders' representations of themselves with their story of moral conflict. The reading for self provides important information about how the nurse leaders see themselves, and "picks up distinctions in activity and intent, reflection, motive for action, and choice" (Brown et al., 1988, p. 57). Table 9 also presents the summary results of the reading for self-orientation.

Nurse leaders who were predominately care focused in their moral conflict were oriented to care in their self statements. Nurse leaders who were predominately justice focused in their moral conflict were oriented to justice in their self statements. Nurse leaders with whom neither care or justice predominated were not oriented to either care or justice. These results support the work of Lyons on the relationship of moral voice to self-orientation. Focusing on leaders' accounting of themselves in their descriptions of conflict supports the self as the active knower and chooser of moral voice in their dilemmas.

TABLE 8

COMPARISON OF MORAL VOICE

<u>Name</u>	<u>Position</u>	<u>Justice Voice</u>	<u>Care Voice</u>	<u>Predominance</u>	<u>Self-Orientation</u>
Alice	Manager	no	yes	care	care
Robert	Manager	yes	yes	care	care
Diedre	Manager	yes	yes	neither	care and justice
Clare	Manager	yes	yes	neither	care and justice
Elaine	Manager	yes	yes	justice	justice
Mary	Executive	yes	yes	care	care
Nancy	Executive	yes	yes	justice	justice
William	Executive	yes	yes	care	care
Sheila	Executive	no	yes	care	care
Theresa	Executive	yes	no	justice	justice

Table 9 presents a summary of voice comparisons. Looking at moral voice dimensions by manager and executive level of leadership, leadership level does not appear to influence moral voice in workplace conflicts. In this study, managers and executives used justice and care voices in describing workplace dilemmas and their response to them. These findings confirm earlier findings that individuals approach moral conflict and choice from at least two equally valid frames: justice and care (Gilligan, 1982; Gilligan and Attanucci, 1988; Langdale, 1983; Lyons, 1982, 1983).

TABLE 9
SUMMARY OF VOICE COMPARISONS

<u>Dimension</u>	<u>Managers</u>	<u>Executives</u>	<u>Leaders as a Group</u>
Presence of Care Voice	5	4	9
Presence of Justice Voice	4	4	8
Predominance of Care Voice	2	3	5
Predominance of Justice Voice	1	2	3
Neither Voice Predominates	2	0	2

As discussed in Chapter 3, the Reading Guide (Brown et al., 1988) notes the importance of understanding the relationships between justice and care as moral perspectives in a narrative. Individuals know and use both moral voices but one voice can frame how a person constructs the conflict, understands the issue and what one understands as relevant to the response. Determining predominance is part of the interpretive process and is derived from the entire story. The reader asks, "Where do most of the considerations and concerns lie for the narrator in this story?" The narrator may begin the description of conflict with both voices but speaks with a more complete formulation with one voice as the story is elaborated. The predominant perspective is the voice that stands out as the conflict unfolds.

In this study, the care voice is predominant with two managers and three executives. The justice voice is the voice of predominance with one manager and two executives. Neither voice predominates with two of the managers.

Previous research confirmed that although men and women describe their dilemmas in both care and justice voices, the care focus is more likely to occur in women's description of moral dilemmas and the justice focus is more likely to occur in men's descriptions of moral dilemmas (Gilligan and Attanucci, 1988; Lyons, 1982). For some men

and women this pattern is reversed (Lyons, 1982). Eight women and two men participated in this study.

In the comparison of gender with the patterns of voice differences with the participants, the three leaders who used a predominately justice voice to describe their conflicts are female. One is a manager and two are executives. Of the five leaders who used care as the predominant voice, two are male. One is a manager and one is an executive.

Reading For Care

The organizing image for the care orientation as a way of thinking and responding is interdependence. "A person framing a moral dilemma from the care orientation tends to focus on the specifics of the situation and attend to the particular needs of others involved in the conflict" (Brown et al., p.95). Often the orientation draws emphasis to the welfare or well-being of others, alleviation of another's concerns or sufferings or the contextual concerns of the situation over the principles (Lyons, 1982).

For example, Sheila talks about maintaining connections and relationships with others even at the cost of personal disappointment. She talks about her response

to the person who was the source of her conflict in the workplace:

I decided that he was somebody with a very fragile ego and what I had to do to survive, even though I felt at first kind of appalled by thinking about it, that I had to support him in a way that protected his ego if I was going to survive....I remember trying to see somebody's point of view and at least understand a little bit about where he was coming from in terms of someone who's totally different and really was appalling to me. I remember thinking that there had to be a reason that he behaved that way.

Sheila works to see the antagonist's point of view, even when it is appalling to her. She seeks ways to support the individual who was the source of her personal disappointment. She expresses similar notions with her director who she believed did not react to her situation of conflict.

I really felt that I had to come up with the plan, and it had to be something that she could live with. And I felt disappointed that I had to come up with the plan. I naively assumed that if somebody had that kind of experience that they obviously have learned from it and have a lot of insight. The reality is that a lot of people don't and I think I felt disappointed that I had to come up with the answers, that it had to be me that came up with the answer, and yet make it some way feel like it was her answer.

The value of not hurting or responding to another's need is rooted in a care orientation (Brown et al., 1988).

Sheila indicates this when she says:

There are often times when I act differently than I feel because it is for a larger goal....You don't always have to be honest. You have to be honest when it matters but you can be honest with yourself and yet not always share in that honesty and openness with others because some people just can't hear it. It's not helpful to them.

Sheila's narrative descriptions support Gilligan's notion that context influences an individual's response to a moral dilemma. Gilligan believes that context in situational dilemmas shapes relationships of the individuals involved, their relative power to each other, where the situation occurs, what role the person telling the story plays, and the personal and cultural history of the narrator (Brown, Tappan et al., 1988). Sheila describes her conflict through the lens of the relationships she has with her colleague and her nursing director. She speaks of developing a response to the conflict that supports her relationships with the antagonist and her nursing director, despite her disappointment in this role. Throughout the interview, Sheila's responses indicate that it is her care perspective that seems to continually guide her.

Robert is also guided by a care voice in a conflict that arose when a "valued" staff member informed him that during her pregnancy, she did not want to care for AIDS patients. This was clearly against the stated hospital policy, and so he explained his thinking.

I did not want to see her suffer the fall-out of having to make a decision that was not in compliance with hospital policy, and get fired. I had an outstanding staff member who actually came forward way ahead of the situation to let me know what she was thinking and she would be penalized for that? or did I have to do something with it?

Robert refines his deliberations, indicating an awareness of the rules, consulting with the next highest level of leadership, and finally expressing his own thoughts.

I guess my choices were: I could ignore it, which probably wouldn't work. I could try and get them [nursing directors] to change the policy in the hospital or at least to reconsider their decision on that policy in this situation. I did that through the nursing directors. It was felt that as a group they did not want to change that policy. My last choice was to sort of let it go along and see what happened, and I knew on many units that it happened all the time, that staff protected staff.

Responding to the well-being of his "outstanding staff member", he chooses a course that emphasizes the context of the situation rather than a strict application of the hospital rule.

I could have said, 'So long, you can't do that', and referred it on to to Human Resources and washed my hands of it and said I have an employee who is refusing to take care of AIDS patients. Instead, what I chose to do was to let it just run its course and that I would see what happened....This person was very honest and upfront about it and I didn't feel she should be penalized for that.

In answering the following question, he reaffirms his belief that he handled the situation in a way that maintained the connection he wanted with "someone you value."

Some things are better off not being confronted. It's better to wait to see how the situation evolves particularly when it involves someone you value. You don't open a can of food if you're not going to eat it.

Robert seems to introduce the food metaphor to back-up his decision to wait and avoid confrontation over policy until it is necessary.

Reading for Justice

The understanding of justice as a moral orientation is based heavily on the work of Lawrence Kohlberg (1976; 1981). According to the Reading Guide (1988), the justice orientation is one that focuses on inequality or the importance of treating self and others with equal respect. Justice themes of conflicting claims include conflicts between contractual obligations, duty or commitment to others and society, including commitments to one's own values or principles (Lyons, 1982).

The key to this orientation is emphasis on the desire to be impartial. The individual, as the problem solver, tries to separate from individual interests and relationships and apply the "scales of justice" as a metaphor for justice as a moral orientation (Brown et al., 1988).

Elaine explains that "a really big conflict for me" was that she should support a physician colleague who she viewed as being wrongly accused.

Someone was being lied about and was really being railroaded a little bit; and it wasn't fair and it wasn't right. And I knew some data to prove that it wasn't right. I felt I needed to say something about that. I think that's what made it a moral dilemma. I could've kept quiet and kept my nose out of it. But I couldn't have done that.

She considers competing claims from nurse colleagues and leaders in evaluating her course of action.

The only 'should' that I thought about was that perhaps greater minds than mine who perhaps were more experienced in the politics of the hospital really felt I shouldn't do that. They felt I would really lose in the long run. I think they didn't think I was doing the right thing for nursing. I thought it was real important that I stand and be counted because I thought what was happening was wrong....I can only say that I really felt that I knew something was wrong and if I can give this information, it should be given.

The Reading Guide stresses that the justice perspective carries a way of thinking and knowing about, of applying standards and values to, the situation at hand. Nancy speaks in a justice voice when she describes her conflict over budget reductions. She weighs the competing claims of the organizational imperative of reducing the budget in a time of limited resources with her professional values related to standards of patient care.

Reducing positions is not acceptable and that's what my conflict was. The initial dilemma was my concern that we would lose the values that related to patient care. That we'd get so focused and that we would have to do this so quickly that you didn't have time to respond, keeping high standards of nursing care as a priority.

To implement a course of action Nancy underscores her commitment to her standards.

I had to find my course and then lead others to find solutions without compromising standards...I had to do it in a way that I felt the integrity of the entire system, including myself, was intact.

In evaluating this course of action, she confirms "baselines" or principles are the holding foundation for her decisions.

I come back to same thing. In life, you have some baselines, that you can compromise just so far. I think the most fortunate thing that can happen to you as a young person is to have those baselines really well ingrained, really get a solid foundation so that as you go through life you're able to make appropriate judgements without compromising the basic values.

Some individuals may know and describe both care and justice in their narratives about conflict and choice, but neither voice appears to frame the conflict or relate in such a way that one is more emphasized in the narrative (Brown et al., 1988). Both the justice and care voices are represented in the story. Both orientations justify a particular action or consideration. The narrator presents an unresolved tension between the justice and care voices.

Diedre describes the "two sides" of her conflict with a staff member who she claims is "disruptive [with] and destructive" to the other staff. While having made up her mind that "I want her gone, if I have to fire, whatever I have to do, she's gone", she admits having feelings for the individual. Severing the relationship between them was not a choice easily made.

I saw her as a very sad person and really needing support. Withdrawing support from her went against everything that seemed important to me: that everybody should have a chance, everyone can turn around, everyone can improve.

Diedre's voice changes as she weighs a course of action that she intends to take, but is not in the purview of strategies with which she is comfortable.

When I withdrew support from her, what that means to me was not being fair but being legal. All I knew was that I had to be legal, and I was going to drive her out, and I would have a management strategy that sounded too much like something they do in a business that makes widgets or something.

As she continues in the same dialogue, her tone changes again. Self-doubt over her decision to terminate the staff member contrasts with her need to be responsive to others on the patient care unit.

I felt maybe I was changing. I had a lot of conflict. Maybe this was for my advantage, but then I would look at the people she was harassing and I would see good people who would cry and could not come to me and discuss what's going on.

Both moral orientations are present in her story of conflict and response. In many ways the conflict itself seems to be which orientation will dominate. There is a sense in the narrative that she prefers the care orientation in evaluation of the conflict.

It was a very hard time for me; and it is a dilemma, in the sense that I really had a lot of personal conflict about my feelings and philosophy of caring for people, about caring for my staff...It was so hard for me to see, as a positive piece of myself, that I could just give up on somebody and yet I knew, deep in my heart, I wasn't really giving up on her.

However, Deidre operated out of the justice orientation to resolve the conflict.

It ended up that I was legal but not fair. I withdrew support from her, and what that meant to me was not being fair but being legal....I got help from the employee relations person in human resources. I wrote down as objectively as I could her behavior that was so disruptive.

Using different changes of voice, Diedre represents tension between the justice and care perspectives. She describes her story as a conflict between the two voices, She switches into a justice perspective when she plans a course of action to terminate the staff member, and to a care perspective when speaks about her relationships with the different players in the conflict.

Summary

Nurse leaders describe three kinds of conflicts in their workplace: organizational, interpersonal, and role related. The conflicts of managers were interpersonal and role related. The conflicts of executives were organizational and role related. Their self described conflicts followed a pattern: a conflict within a conflict, focusing initially on someone or something outside of themselves and a second construction of the conflict within themselves.

The two questions raised in the study were answered: Nurse leaders use care and justice voices to respond to their conflicts in their workplace. Level of leadership does not seem to influence moral voice in nurses' description of conflict and choice.

The excerpts of interviews with three managers and two executives were presented to support the findings of the

study's questions. Analysis of the narrative texts of the interviews, with interpretation from the Reading Guide, substantiated previous research claims that people represent justice and care voices in their thinking about real-life dilemmas (Gilligan, 1982; Gilligan and Attanucci, 1988; Lyons, 1982).

This study also amplifies previous research about moral reasoning in adults with the following insights that came from the voices of the ten nurse leaders.

1. More nurse leaders define their moral reasoning in terms of care for others. That this perspective predominates over justice considerations in their language and decision making is not surprising for the leaders of a profession that embraces an ethic of care.

2. Some nurse leaders speak with strong justice voices that support standards, principles and values as their guide for moral response to conflict. That nurse leaders articulate this perspective is also not surprising because of the pull toward justice decisions that comes from nurse leaders working in large health care delivery systems that are becoming "business oriented, competition driven and traditional in the sense of adaptation to patriarchal values and rationality" (Miller, 1989, p.15).

3. Neither the level of leadership responsibility or length of leadership experience can explain the choice of moral voice by nurse leaders in their descriptions of response to conflict in the workplace.

CHAPTER 5

SUMMARY, IMPLICATIONS AND RECOMMENDATIONS

Summary

This study explored how nurse leaders in a health care delivery setting respond to self described nursing dilemmas. This study examined moral reasoning used by nurses to resolve conflict and choice in the workplace. It also focused on how nurses saw themselves as leaders and caregivers.

Key insights from the literature that supported undertaking this study are the following:

1. Nurse leaders experience conflict in their leadership role in the workplace where organizational goals take priority over patient care goals.

2. Critical arguments surround the use of Kohlberg's Cognitive-Development model of justice reasoning as the basis for understanding moral reasoning of nurses. As reported in the research literature, nurses have been at a lower level of moral reasoning, that being incongruent with the philosophy and practice of nursing.

3. The possibility of Carol Gilligan's care/justice perspectives of moral development sharing common themes with nursing ethic of care has been raised.

This was an exploratory study, addressing the following questions: How do nurse leaders respond to conflicts and choice in the workplace? Does level of leadership influence response to conflict and choice? Ten study participants from middle and executive levels of leadership were selected from the nursing staff of an acute care magnet hospital.

Nurse leaders participated in interviews using the Gilligan Moral Conflict and Choice Interview modified to reflect their professional role and setting. The focus of each interview was an actual workplace conflict identified by the participants, their chosen course of action, and their evaluation. The interview also included questions designed to elicit nurses' self-descriptions of their leader and caregiving roles. Demographic data were also gathered on age, sex, educational background, and career pathway.

Findings

1. Nurse leaders describe three kinds of workplace conflict: organizational, interpersonal, and intrapersonal.

2. Nurse leaders use justice and care voices to respond to conflict and choice in the workplace. Seven out of ten used both a justice and care voice. Three of the leaders responded with only one voice: two with only a care voice, and one with only a justice voice.

3. Care is the voice of predominance with five leaders. Justice is the voice of predominance with three leaders.

4. Level of leadership level does not appear to influence moral voice. Managers and executives both use justice and care voices in describing their workplace conflicts.

5. Nurse leaders describe themselves individually and relationally in their leader role. Four nurses describe themselves in a primarily relational response pattern, emphasizing the leader role in relation to or in connection with others. Two nurses describe themselves in a primarily individual response pattern, emphasizing the leader role separate from those being led. Four leaders had no response pattern describing themselves individually and relationally.

6. Four themes emerge as central to how nurse leaders view themselves: the importance of relationships in the leader role; the leader as a team member; power as a piece of the leader role; standards as guides to decision-making.

7. Nurse leaders, as a group, advance the notion that how they see themselves as leaders is similar to the way they saw themselves in their other nursing roles. Personal characteristics were cited as the mainstay across career roles.

8. While acknowledging that they are not direct patient caregivers, nurse leaders support caregiving as an integral part of their leader role. Caring actions for their nursing staff, peers, and administrative colleagues are the mechanisms they identify for implementation.

9. Nurse leaders underscore the importance of the worksetting and its influence on nursing's ethic of care. Congruence of institutional philosophy, climate, and hospital administration with nursing's professional care values are the contextual influences cited by the leaders.

Implications For The Nursing Profession

A review of the literature found that nurse leaders experience conflict in balancing the economic productivity required by the health care system and the delivery of quality patient care services by nurses (Miller, 1989; Blair, 1989). Nurse leaders are

concerned that an expanded leadership role in the health care organization may remove them from their mission of caring. Nurse leaders face challenges to support, expand, and prioritize the caring role in the institutional bureaucracy (Dunham, 1989; Nyberg, 1989; Ray, 1987; Roberts, 1990).

The interview data from this study are not congruent with the notions advanced in the literature. It is useful to reassess the literature in light of the views articulated by the participants. In this study, it is clear that the caring practice of nurses was an institutional priority. Nurse leaders claimed that their institution supported nursing's ethic of care. In their particular hospital, patient care was the one focal point shared by all members of the hospital community. This is reflected in the philosophy of the hospital. The priority of patient care is fostered in a climate of practice that supports and promotes care of patients. The nurses in this study believe that the institutional leaders, both nursing and administrative, influence the focus of quality patient care as the goal in the health care delivery system.

These nurse leaders view caring as part of their professional values. While acknowledging that they are not the primary caregivers to patients, they see

themselves using supportive, caring relationships with their nursing staff, peers, and administrative colleagues to achieve their patient care goal. Nurse leaders described the blend of their professional care ethic and their leadership role with the absence of any conflict or dissonance between the two integral parts.

These findings become increasingly relevant to the nursing profession when the voices of the nurse leaders are placed in contrast with current themes found in the literature. The most significant challenge facing all leaders in health care systems is the development of new solutions to deal with increasing economic burden of health care (McClure, 1990). At the same time, all nursing roles in the organization must be committed to preserve and protect the quality of care given to patients (Balasco, 1990). The prevailing notion of a nurse leader is one who becomes more focused in the economic issues rather than the care-related issues, as she/he moves into executive levels of leadership in the health care system. The nursing profession should know that in this hospital, nurse leaders' actions and ideas do not support this notion. They identify the importance of caregiving and describe how they successfully integrate it into their daily work.

Sphere of Influence of the Health Care Delivery System

While the impact of the health care institution on nurse leaders descriptions of themselves as caregivers was not a direct focus in the interview, nurse leaders in this study spontaneously noted the influence of the hospital in their roles. They describe the hospital context in terms of institutional philosophy, climate of practice, and institutional leadership. Nurse leaders also recognize differences between hospitals, comparing their current work setting with their previous health care organizations. They cite their preference for their current worksetting over those in their past because of the unique institutional climate. The insight gained from nurse leaders suggest the need for additional in-depth examination of the how health care delivery systems influence and support successful caregiving practices for nurses.

It is important to note that the research presented here is limited to the realm of one setting, a magnet hospital, with certain characteristics. Magnet hospitals have reputations as "good places to work" and "good places to practice nursing" (Kramer and Schmalenberg, 1988a, p.14; 1988b). To receive the designation of a magnet hospital, the institution has a

confirmed reputation for quality nursing care practice. It meets certain criteria for retention of nursing staff, ratio of nurses to patients, proportion of registered nurses on the staff. Nurse leaders in these institutions promote and promulgate patient care values and excellence in the nursing services of the hospital.

Further examination of the influence of the health care delivery system, in settings where nurses are successful in their practice, is necessary. The words of the nurse leaders participating in this study guide the study. They say: "It's different here, it truly is different....I don't feel like it's them and us."; "The hospital is known as a nursing care institution and therefore, that becomes the focus." It is important for the nursing profession and health care delivery systems to understand what organizational factors encourage the establishment of patient care as the goal across all levels of the hospital.

Nurses in this study key their satisfaction with their professional role to the congruence of the hospital and nurses on the common goal of the delivery of quality patient care. Validating the contextual factors that enhance the congruence of institutional and professional values increases the potential of creating a model for the delivery of quality patient care

services. A model of health care delivery that meets the needs of the institution, caregivers and patients also has the potential for economic impact in systems that are struggling to deal with the burden of increasing costs of health care.

As reported in Chapter 4, the fact that this hospital setting employs 91% of its nurses with a Baccalaureate or higher degree may be a contributing factor. Other magnet hospitals report that a median of 51% of their staff nurses hold a Baccalaureate degree or are currently matriculating in Baccalaureate study (Kramer and Schmalenberg, 1988a). Educational preparation becomes more relevant when consideration is given to the American Nurses Association's Facts About Nursing report which states that 23% of practicing nurses hold a Baccalaureate degree. On the basis of reported differences in education of practicing nurses, educational preparation as a variable should be added to an in-depth study of nurse leaders in other magnet hospitals and in other kinds of health care delivery settings.

Leadership Refocus

Further examination of the characteristics that nurse leaders identify as integral to their leader role

has relevance for nursing practice. While some nurse leaders in this study see themselves as power holders and standard setters, the majority of the nurses place greater emphasis on the importance of relationships in their leader role. Their scope of significant relationships in the work setting include their nursing staff, nursing peers, and administrative colleagues.

As a result of her leadership research on men and women in corporations, Kanter (1977) supports the notion that the importance of relational peer alliances was often a neglected aspect in the understanding of the accumulation of organizational power. Others emphasize that the development of leaders who are humanistic in their approach to people, and who stress the importance of strengthening and nurturing individuals in an inclusive system is critical (Srivastva, 1986). Similar to Kanter and Srivastva's perspectives, the nurse leaders in this study view relationships as key to their leader role.

Mintzberg (1974) believes that an effective leader role augments the integration of individual needs with the organizational goals. Reflecting Mintzberg's notion, the voices of nurse leaders in this study, carry a twofold message: They speak of the high value they place in a leader role which emphasizes relationships in

their daily work. At the same time, they recognize the importance of institutional support in enhancing their work as nurse leaders. The nursing profession and health care delivery systems need to hear the message advanced by the leaders in this study.

Another insight that is gleaned from the nurses' descriptions of themselves as leaders comes from their acknowledgement of power in the leader role. Although this study did not focus on power as a dimension of leadership, nurse leaders' spontaneous discussion of power encourages further examination of power as an integral part of the leader role. They describe three notions of power: power as a natural integral characteristic used in the creation of order in a hierarchical system; positional power as perceived by others rather than the promotion of power ownership; the exercise of power serving to empower others.

Power has been defined in many ways, each reflecting the historical tradition from which it comes (Miller, 1982). Many leadership theorists and researchers include power as a dimension of leadership, while focusing on defining leadership according to their individual perspective and the aspect of the phenomenon of most interest for them (Yukl, 1981). As stated in Chapter 2, Bennis and Nanus (1985) recognize the notion

of power in leadership by proposing that power is the basic energy needed to initiate and sustain action. They broaden their understanding of power to include empowerment, describing effective leadership as "...not so much the exercise of power itself as the empowerment of individuals" (p. 224). Miller (1982) articulates a women's view of power, the crux of which is "using one's power to empower another--increasing the other's resources, capabilities, effectiveness and ability to act"(p.2). However, she believes empowering other people does not fit accepted conceptualizations and definitions of power.

Nurse leaders in this study reflect, in part, Miller (1982) and Bennis and Nanus's (1985) perspectives on empowerment. They also reflect the more traditional notion of the use of power in organizations. The contrast of viewpoints spontaneously addressed by nurse leaders of a feminine profession calls for further examination of power as an integral part of the leader role. Given the contextual changes experienced by the nurses who are moving into high level leadership roles in health care systems that are "business oriented, competition driven, and traditional in the sense of adaptation to patriarchal values" (p. 15, Miller,1989), questions that may guide further examination are: Is

there a generic notion of power for leaders in a predominately female profession? Is power used differently in different levels of leadership? By focusing first on nurse leaders who are successful in their workplace setting, the answers to these questions have the potential of understanding what is possible before addressing what is problematic. The implications from expanding the notion of power to include dimensions that reflect a feminine perspective await further articulation.

Moral Voice in the Workplace

Additional implications for the profession of nursing, as well as for the field of moral development, flow from this study of nurse leaders' responses to conflict and choice in the workplace. Looking at daily conflicts that nurse leaders experience is a useful process. It highlights the stress points that nurse leaders feel as they accomplish their daily work. It is clear from the stories of nurse leaders in this study that they make moral choices that reflect organizational, interpersonal and role-related conflicts. It is also evident that nurse leaders were able to describe a moral conflict in their workplace,

what they decided to do, and their evaluation of their course of action. That is, they were able to describe their moral reasoning used in the conflict. It is interesting to note that the nurse leaders in this study did not identify any formal professional or organizational structures within the hospital which guided or supported their decision-making. It is incumbent on nurse leaders, with the support of hospital administration, to find ways to acknowledge the existence of moral dilemmas in the workplace and set up mechanisms to examine and support their resolution. This becomes more important since nurse leaders identified goal congruence between the health care delivery system and its caregivers as an important professional value.

Questions that need further exploration are: What mechanisms can nurse leaders implement that would provide a positive, supporting environment for dealing with the daily stress points or moral conflicts that individuals experience? Are there institutional resources to support the resolution of conflict that develops when goal incongruence becomes a source of conflict? Are there educational or support resources/mechanisms for the nurse who is the direct patient caregiver?

This study sheds light on some of the kinds of conflicts that engage a nurse leader in her workrole. Patient care, which nurse leaders identified as the focal point of the whole hospital community, is directly or indirectly impacted, as nurses struggle to understand and resolve the moral dilemmas in their workplace. As health care delivery systems continue to wrestle with the difficult challenges around the effects of escalating costs on their budgets, conflict between organizational goals and caregiving goals will be heightened, even in magnet hospitals. A logical step toward supporting nurses who experience a range of moral conflicts in their workplace is the development of professional and institutional support mechanisms. The kinds of resources that may be necessary await identification through the in-depth study of diverse health care delivery settings.

It is clear from the interview data that nurse leaders use justice and care voices to respond to conflict and choice in the workplace. Seven out of the ten leaders use both a justice and care voice in their descriptions of conflict and its resolution in their work setting. Managers and executives both use justice and care voices in describing their workplace conflicts. Previous research confirmed that although

men and women describe their dilemmas in both care and justice voices, the care focus is more likely to occur in women's descriptions of moral dilemmas, and justice focus is more likely to occur in men's description of moral dilemmas (Gilligan and Attanucci, 1988; Lyons, 1982). For some men and women this pattern is reversed (Lyons, 1982). In this study, it is interesting to note that of the five leaders who use care as the predominant voice, two are male. One is a manager and one is an executive.

It is important to contrast the voices of the nurse leaders in this study with other recent studies reported in Chapter 2, because in the aggregate they have the potential of contributing to understanding how individuals respond to moral dilemmas. In Millette's (1988) study, nurses used justice and care voices, but voice differences were found between nurses who were client advocates and nurses who were institutional advocates. The care orientation was more apparent in the nurses who were client advocates. In Counts' (1987) study, level of leadership and gender were influencers in schools administrators responses to conflicts in their organizational settings. Women principals used more care response considerations than both men principals and men and women superintendants.

In Derry's (1987) study, the justice orientation was the preferred mode of moral reasoning for men and women managers in a large corporation. It is interesting to note that Derry reports that care considerations were voiced by the men and women in the corporate setting. However, they were not the dominant mode of moral reasoning, and were more frequently associated with personal dilemmas than workplace dilemmas. Derry speculates that "personal issues may be more care oriented while professional issues are related to the duties and obligations at work" (p. 98). Jack and Jack (1988) reported that care oriented lawyers reorder the hierarchy of values in the legal system and bring new viewpoints on the prized values of patriarchal structures: power, competition, and self-determination. Questions that emerge from cross comparisons of these studies and await future examination are: Do service professionals respond differently to moral conflicts than business professionals? Do the goals of the organizational enterprise moderate moral voice?

Kohlberg (1983) suggests a morality of care that pertains more to special relationships among particular persons in contrast to the more dominant universalistic principle that guides justice reasoning. Moral dilemmas

in personal or family situations may be more likely to elicit care considerations from both sexes, whereas dilemmas located in a secondary institution of society such as government or the workplace elicit justice considerations from both sexes (Friedman, 1988).

Thinking in Kohlberg's terms, care reasoning is relevant only to special relationships among "family, friends and group members" (Kohlberg, 1983, p.131). Gilligan (1977, 1982; Gilligan and Attanucci, 1988), on the other hand, suggests justice and care voices as equally valid frames for how individuals approach moral conflict in all situations. She emphasizes the importance of contextual influences in how individuals respond to moral conflict and choice.

Recognizing that institutions in society may promote justice considerations with both sexes, it is important to note that the worksetting, in this study, is a large health care delivery system which the literature describes as "business oriented, competition driven and traditional in the sense of adaptation to patriarchal values and rationality" (Miller, 1989, p.15). As such, the health care delivery system may be expected to elicit more justice responses. The nurse leaders, in this study, used both justice and care voices to respond to the dilemmas in their daily work.

An in-depth study of the relationship between nurses and their practice settings would extend the insight gained from the perspective articulated by the leaders in this study. What are the characteristics of the organizational setting that supports nurses' care and justice voices in practice? Are there other contextual influences that support nurses' voices in the health care delivery system?

The contrast in previous empirical research as well as in theory frameworks speaks to the need for further examination of how individuals respond to moral dilemmas. That nurses are able to use a care voice "in bureaucratic hospital systems that advocate teamwork, but function as a traditional hierarchy of contractual relationship" is a strength of the profession. Nurses, in their work situations, have refused "to adopt an impartial, detached posture in response to moral conflict"(Parker, 1990, p. 38-39).

Tronto (1987) suggests that the time to celebrate recognition of an ethic of care has passed. She advocates facing "squarely" the difficult task of discussing the ethic of care in terms of moral and political theory.

Although this task will be a difficult one, there is much to gain from it. Attentive to the place of caring both in concrete daily experience and in our patterns of moral thought, we might be better prepared to forge a society in which care can flourish (Tronto, p. 663).

Recommendations For Future Research

The thoughts and insights shared by the nurse leaders in this study, relevant questions raised in the literature, and Tronto's message regarding the place of a theory of care in today's society call for additional research in certain substantive areas. The research presented here is an exploratory study of how nurse leaders respond to workplace conflicts. In Chapter 1, I suggested that this study had the potential to contribute to the study of moral development, to the profession of nursing, and to the study of leadership. It can be concluded from nurse leaders' use of care and justice orientations in their workplace conflicts that the findings of this study lend support for Gilligan's theory of moral development. However, a group of studies should be undertaken to ascertain the degree to which these findings are generalizable to other nursing populations, other professions, and other adult populations.

Nurse leaders provided insights into the contextual influences in moral decision-making. These insights support Gilligan's notion that situational context impacts an individual's moral response to conflict. The congruence between nurse leaders' insights and Gilligan's notion of context call for a second group of studies to be undertaken to delineate the full range of organizational, professional, and personal contextual influences that impact on the moral reasoning used by nurses in different levels of practice and in diverse organizational settings.

This study supports that nurse leaders in certain organizational settings are able to combine organizational and caring priorities in their leader role. Future studies should examine relationships and factors that enhance or deter the successful integration of nursing's ethic of care with organizational priorities in health care delivery systems. Nurse leaders in this study do not feel caught in a clash of organizational and professional caring priorities. However, the findings of this study do not necessarily dispute views from the literature. Rather, the findings of this study of one organizational setting call for studies of diverse organizational settings. These settings should include magnet hospitals where nurses feel successful in their practice. They should also include other organizational settings where nurses

may feel caught in the clash of care priorities. The overarching goal of all of these studies would be the development of a model that reflects successful integration of the priorities of a health care delivery system with the professional imperative of care supported by nurses. The ultimate benefactor for the development of an institutional model of care would be the patient, thus advancing the views, articulated by nurses in this study, that patient care was their most important priority.

The contrast between leadership notions advanced in the literature and perspectives on leadership expressed by nurses who are leaders in a feminine profession call for a group of studies aimed at rethinking the prevailing notions of leadership. Again, the voices of nurse leaders in this study guide the direction of the reexamination. By spontaneously introducing the notions of intuition, mentoring, role related relationships, and personal characteristics as the mainstay across career roles into their self descriptions of leadership they introduce concepts which can organize future research.

I have made these suggestions to encourage research on moral reasoning, leadership and the professional ethic of care. Clearly, there are many steps to be taken. The

implications and recommendations presented in this study
press for the potential of future studies to be
actualized. It is my hope that the results of these
studies will provide bridges to support the profession of
nursing as it moves to enhance its essential position in
hospital bureaucracies and expand the understanding of
moral thinking in the complex institutions of society.

APPENDIX A

LETTER TO POTENTIAL STUDY PARTICIPANTS

Dear ,

As a nurse, I am writing to you to tell you about my research entitled, "Nurse Leaders Response to Conflict and Choice in the Work Place". Its purpose is to understand how nurse leaders respond to dilemmas they experience in their work place.

With the approval of your hospital's Nursing Research Review Committee and the Committee on Clinical Investigations, I am asking you to participate in a one hour interview designed for you to describe a dilemma or conflict that you encountered in your professional work and the choices you made around the dilemma. With the changes that have occurred in the ways that health care is delivered and managed, it is timely to explore the dilemmas that nurses are experiencing in health care systems. I will also be asking you to describe the meaning of care and leadership for you.

The interview will be tape recorded and all information from the interview will be held in strictest confidence. I will have sole access to interview tapes after transcription.

I believe this work is important and has potential to benefit nurses and patients. To further explain the project and answer any questions you may have, I will call you next week. At that time, I will ask you to indicate your willingness to participate. Research results will be shared with you if you so desire.

I look for to speaking with you. Thank you!

Sincerely,

Joan M. Riley RN, MS, EdD Cand.

APPENDIX B

SUBJECT'S NAME:

TITLE OF RESEARCH PROTOCOL: NURSE LEADERS RESPONSE
TO CONFLICT AND CHOICE IN THE WORK PLACE

PRINCIPAL INVESTIGATOR'S NAME: JOAN M. RILEY
RESEARCH PROTOCOL #:

1. PURPOSE OF THE STUDY: This study is designed to explore ways that nurse leaders respond to dilemmas in their work place.

2. PROCEDURE: With the approval of the Nursing Research Review Board of Hospital, you are being asked to participate in a one hour interview whose purpose is to understand a conflict that you experienced and are willing to share. You will be asked to describe a dilemma or conflict that you experienced in your professional work and the choices you made around the dilemma.

3. RISKS AND DISCOMFORTS: none anticipated

4. BENEFITS: There are no direct benefits to participants. However, the study may stimulate participants' thinking of how to deal with dilemmas in their work place. This study may generate new knowledge that could benefit nurses, patients, and health care delivery systems.

5. COST/PAYMENT: none

6. ALTERNATE PROCEDURE: You may choose not to participate.

7. CONFIDENTIALITY: The interview will be tape recorded and your confidentiality will be protected in the following ways. No identifying information will appear on the transcripts of the tape. All names, places, etc., will be deleted during the transcription. The researcher has sole access to the interview tapes after transcription. Tapes will be kept in a locked cabinet and will be destroyed upon completion of the research project. Short excerpts from the interview may be used for publication, professional presentation or in writing the researcher's dissertation, but these will be disguised to insure confidentiality.

You may end this interview at any time, if you desire not to continue. You may ask questions at any time during the interview.

Research results will be shared with you if you so desire.

I WISH TO RECEIVE A COPY OF THE RESEARCH RESULTS: YES NO

- CONTINUED ON NEXT PAGE-

APPENDIX C

DEMOGRAPHIC INFORMATION FROM THE INTERVIEWEE

1. EDUCATIONAL PREPARATION (including nursing education)

Institution(s)	Degree	Year Obtained	Field of Degree
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2. CURRENT EDUCATIONAL PLANS

3. CAREER PATHWAY

1. Current Position, Organizational Setting, Years Held

Past Position(s), Years Held, in Current Setting

2. Past Employment in Other Organizational Settings.

Past Position(s), Organizational Setting, Yrs Held

4. AGE RANGE

25 - 30 yrs _____ 31 - 35 yrs _____ 36 - 40yrs

41 - 45 yrs _____ 46 - 50 yrs _____ 51 - 55yrs

over 55 yrs _____

APPENDIX D

GILLIGAN'S REAL-LIFE CONFLICT AND CHOICE INTERVIEW

Transition: We've been talking about different situation in your life, and how you've thought about them. Now I'd like to ask you about a choice you've made:

All people have had the experience of being in a situation where they had to make a decision, but weren't sure of what they should do. Would you describe a situation when you faced a moral conflict and you had to make a decision, but weren't sure what you should do?

1. What was the situation? (Be sure you get a full elaboration of the story).
2. What was the conflict for you in that situation? Why was it a conflict?
3. In thinking about what to do, what did you consider? Why? Anything else that you considered?
4. What did you decide to do? What happened?
5. Do you think it was the right thing to do? Why/why not?
6. What was at stake for you in this dilemma? What was at stake for others? In general, what was at stake?
7. How did you feel about it? How did you feel about it for the other(s) involved?
8. Is there another way to see the problem (other than the way you described it)?
9. When you think back over the conflict you described, do you think you learned anything from it?
10. Do you consider the problem you described a moral problem? Why/why not?
11. What does morality mean to you? What makes something a moral problem for you?

**Note to Interviewers: Questions should follow references to judgements about the situation. Follow any references to feelings that are mentioned - e.g., Why did you feel mad or angry? Also follow moral language, i.e. should, ought. Questions should focus on: In whose terms judgements are made. Try to understand the terms of the self and the self's perspective on the terms of the other.

APPENDIX E

REAL-LIFE MORAL CONFLICT AND CHOICE INTERVIEW
Adapted for Interviewing Nurse Leaders

INTRODUCTION

Looking over the past year at work, as a nurse leader, what stands out for you?

SELF CONCEPT

How would you describe yourself as a leader, to yourself?

Is the way you describe yourself as a leader different from or similar to the way you saw yourself in your other nursing roles? If so, how? What led to the change?

MEANING OF CARE

As a nurse, what does care mean to you?

Does care have the same meaning to you now as a nurse leader that it did in your other nursing roles or positions?

If so, explain. If not, what led to the change?

All nurses have had the experience in their work where they were in a situation where they had to make a decision, but weren't sure of what they should do. Would you describe a situation here at work where you faced a moral conflict and you had to make a decision, but weren't sure what to do?

MORAL CONFLICT AND CHOICE

What was the situation? (Probe questions for full elaboration)

What was the conflict for you in the situation?

Why was it a conflict?

In thinking about what to do, what did you consider? Why?

Is there anything else you considered?

IMPLEMENTATION

What did you decide to do?

What happened?

Do you think it was the right thing? Why/why not?

What was at stake for you in this dilemma?

What was at stake for others?

In general, what was at stake?

EVALUATION

How did you feel about it

How did you feel about it for the other(s) involved?

Is there another way to see the problem (other than the way you described it)?

When you think back over the conflict you described, do you think you learned anything from it?

Is the conflict you described similar or different from conflicts you experienced in your other nurse roles?

MORAL ACTION

Do you consider the situation you described a moral problem?

Why? Why not?

What does morality mean to you?

What makes something a moral problem for you?

Does professional morality differ from personal morality for you? Why? Why not?

APPENDIX F

Assessment of Interview

At the end of the interview, the researcher answers the following questions:

1. Where did the interview take place? (Briefly describe the setting).

2. How did the informant react to the interview? Did the informant appear nervous? Were there particular questions to which the informant reacted positively or negatively?

3. Did anything unusual occur during the interview? Was the interview interrupted? If so, why and for how long?

4. Are there any additional comments you wish to make about the interview?

APPENDIX G

SELF DESCRIPTIONS OF LEADERSHIP WORKSHEETS

Case # Reader

Leadership Description Responses

Interpretation

Are the Leadership Description Responses relational? Yes No

Are the Leadership Description Responses individual? Yes No

I am not able to determine.....

Self Description of Leadership Change

Interpretation

Does narrator indicate a change in leadership? Yes No

If yes, Is it relational? Yes No Is it individual? Yes No

I am not able to determine

APPENDIX H

MORAL CONFLICT SUMMARY WORKSHEETS

I. FIRST READING - UNDERSTANDING THE STORY

A. Please Make Notes Here on the First Reading - e.g., relationships, general moral language, repeated words and themes, contradictions, and key images and metaphors.

Interpretation

B. Note All Stories and Conflicts
in Stories in the section of the
interview entitled "Moral conflict and
Choice" (please cite page numbers
where found).

Interpretation

Summary Interpretation--Conflict(s)

II. SECOND READING - SELF

A. Self and the Narrative Action - What actions does self take in the conflict?

1. Choosing self-- Does the narrator see or describe a choice? Interpretation
What is the choice? How is the choice made?

2. What is the self describing him/herself as saying and/or doing? Interpretation

3. What us self thinking or
considering or feeling?

Interpretation

B. Self in Relationship

1. What is the organizing frame
for the relationship(s)
described in the conflict?

Interpretation

C. What is at Stake for Self?

Interpretation

Summary Interpretation--Reading for Self

III. THIRD READING - CARE

A. Is the Care Voice Articulated?

Interpretation

Summary Interpretation--Care voice

B. If Care is not (Clearly) Articulated?

--What would constitute care in
this conflict?

Interpretation

C. Does Self Align with Care? How do you know?

--Is the alignment explicit or
implicit? What evidence do
you have?

Interpretation

Summary Interpretation--Self and Care Voice

IV. FOURTH READING - JUSTICE

A. Is the Justice Orientation Articulated?

--What evidence do you have?

Interpretation

Summary Interpretation--Justice Voice

B. If Justice is not (Clearly) Articulated?

--What would constitute justice
in this conflict?

Interpretation

C. Does Self Align with Justice? How do you know?

--Is the alignment explicit or
implicit? What evidence do
you have?

Interpretation

Summary Interpretation--Self and Justice Voice

V. BOTH JUSTICE AND CARE SUMMARY INTERPRETATIONS

A. The Relationship Between Moral Orientations:
Summary Interpretation

B. Alignment of Self with Moral Orientations:
Summary Interpretation

--How would you characterize the relationship between self and moral voice in this interview-narrative? Interpretation

SELF IN RELATION TO CARE AND JUSTICE: OVERALL SUMMARY
INTERPRETATION

APPENDIX I

SUMMARY CODING QUESTIONS

Case # _____ Reader _____ Narrative Type _____

I. The two moral orientations and how they are represented:
(check two)

1. Is the justice voice articulated? yes _____ no _____

2. Is the care voice articulated? yes _____ no _____

II. The relationship between the two moral orientations:
(check one)

1. Justice predominates _____

2. Care predominates _____

3. Both justice and care present, neither predominates _____

III. The Narrative Self:

1. Does the narrative self express an "alignment in the conflict? (Consider whether or not the narrator comes down on one side of his or her own values. Does the narrator perceive the values of justice or care in relation to his or her own integrity--so that compromising that set of values would be seen as losing a basic or central sense of self? Finally, this "alignment" can be determined by the narrative self rejecting the values of another.)

yes _____ no _____

2. What terms/orientation does the narrator use to frame this "alignment" in the conflict?

justice _____ care _____ both _____

*IV. Relationships:

1. What is the organizing frame for the relationships described in the conflict?

inequality/equality _____
attachment/detachment _____
both _____
neither _____

*(optional)

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