REFORM OF NURSING EDUCATION IN HONG KONG: A STUDY OF NURSE LEADERSHIP AND POLICY DEVELOPMENT

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ABSTRACT

Nursing education in Hong Kong has undergone major reform in recent year similar to that in some Western countries, involving the introduction of degr level preparation. This reform occurred just before Hong Kong was returned t the sovereignty of China. While a combination of complex factors contributed t the reform, the role of nurse leaders was instrumental in influencing polic development. This study investigated the role of nurse leaders in this reform an the factors influencing their effectiveness. A case study approach was used wit multiple data collection methods that included a documentary search of report newspapers, newsletters and journal articles; semi-structured interviews (n=26) c nurse leaders and policy makers; and a questionnaire survey of nurses from fiv regional hospitals in Hong Kong (n=678). The period studied extended from th first proposal for a nursing degree programme in 1985, to 1995 when 180 nursin degree places were secured.

An integrated leadership model is derived from this study that contains fou dimensions that influence leadership effectiveness: situational variables, leader power base, leaders' attributes and style, and leaders' reciprocal relationships wit followers. Data analysis indicated that nursing education reform could b conceptualised as an *evolution* process. Nurse leaders' roles focused on th acquisition of power which involved: *establishing goals, communicatin directions, increasing power through unity, increasing power through influenc empowering followers and preparing self.* Situational variables that impacted o leadership effectiveness were categorised as *inertia and facilitation.* Though th findings indicated that nurse leaders had the ability to influence nursing educatio reform to some extent, the questionnaire survey suggested that frontline nurse did not regard nurse leaders as having good leadership skills. Their evaluation o nurse leaders' effectiveness was generally negative. Furthermore, a lack o experience in the political arena and lack of unity within nursing furthe weakened nurse leaders' power. Nurse leaders' potential had not been maximised

This study expands the knowledge on leadership by providing a multidimensiona framework to comprehend or predict leadership behaviour. The findings als highlight the problems associated with nursing leadership development in Hon Kong and suggest the importance of education, positive socialisation professionalisation and power base in promoting nursing leadership development Further studies, using a prospective design, of nurse leadership in other areas ar needed to test the generalisability of these findings.

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CHAPTER ONE

INTRODUCTION

Hong Kong has experienced rapid changes in its socio-economical and political circumstances over the past 20 years, all of which have significantly affected nursing development. Among the many developments of nursing, the reform of nursing education is considered to be one of the most significant (Chan and Wong, 1999). It involved the transfer of nursing education from a hospital-based programme to degree level education in the universities. Nursing education reform has taken place in countries such as the United Kingdom (UK) and Australia with considerable success. These overseas experiences demonstrated that the efforts of nurse leaders contributed significantly to the success of the reform (American Nurses Association [ANA], 1996, p.5; Lathlean, 1988, p. 16 and McCoppin and Gardner, 1994, p.114). Nurses in Hong Kong have pursued similar reform. It was intended that all nursing education should be transferred to university degree level (College of Nursing, Hong Kong [CNHK], 1992). It was also expected by frontline nurses that nurse leaders in Hong Kong would have a great impact on the success of nursing education reform (Chan and Cheng, 1999).

The research problem

Nursing education was traditionally conducted in schools of nursing which were attached to hospitals through an apprenticeship system. Historically, the nursing profession in Hong Kong has wished to upgrade its education. The quest for nursing education reform in Hong Kong started in 1967 (Iu, 1967), but there was no follow-up action for about 30 years. It was not until 1990 that the first pre-registration degree programme was established. The

maximum intake of students was 40 each year and this number of degree places remained unchanged until 1995, when there was a further increase of 140 degree places. However, the 180 degree places allocated to nurses were minimal when compared with the 2,000 graduates per year in the hospital apprenticeship system. It was not clear why there had been little expansion in university-based nursing education.

Nursing education reform involves a change in Government policy. The literature suggested that nurse leaders were the key agents of change in nursing education policy and they played a pivotal role in the quest of nursing education reform (McCoppin and Gardner, 1994; Lathlean, 1988; Marles, 1988). However, the literature also highlighted the lack of effective leadership in nursing. Authors in Australia, the United States of America (USA) and UK claimed that nurses had generally failed to achieve a more influential leadership role in nursing professional development and policies affecting nursing were not made with adequate participation of the nursing profession itself (Irurita, 1992; Robinson, 1991; Henry, 1989; Game and Pringle, 1983). As the available literature on nursing leadership was from outside Hong Kong, the impact that nurse leaders had on nursing education reform in Hong Kong was uncertain. Little was known about how nursing education policy was formed, the role of the nurse leaders in influencing Government policy and the factors influencing its effectiveness. No studies of this kind had been undertaken in Hong Kong and there was a need to fill up this knowledge gap.

A review of leadership studies indicated that leadership has been viewed in different ways, namely: personality trait, style, an influence process, or a transactional and transformational process (Bass, 1991). Given the complexity of leadership, it was argued that leadership behaviour should be understood in the context of the social system. The broader socio-economic-political factors that influenced nursing leadership development had not been examined. Hong Kong had recently undergone great socio-political changes in the past two

decades. Whether these changes would impede or provide opportunities for nursing education reform was yet to be determined. Without an understanding of the situational factors, it would be difficult for nurse leaders to plan strategies to influence change.

Furthermore, leadership effectiveness is influenced by support from leaders' followers (Yukl, 1989). The ability of Hong Kong nurse leaders to influence nursing education policy would therefore depend on the recognition and support that they gained from their followers. However, it was not known how frontline nurses in Hong Kong perceived the effectiveness of their nurse leaders or the extent to which they supported them.

An issue raised by some nursing leadership studies was the predominant female composition of the profession. Traditionally, the stereotyped images of women and of leaders had been diametrically opposed (Martin, 1992). Though attitudes towards women as leaders were becoming more favourable, the nursing literature still suggested that nursing had weak leadership (Klenke, 1996). The true picture in Hong Kong was unknown.

Furthermore, most leadership studies have been carried out in the context of Western culture. According to Smith and Wang (1994), there was a dearth of evidence about how Chinese leaders worked in Chinese organisations. Leadership models developed in Western culture might not be applicable to Hong Kong. Little was known about the role and behaviour of Hong Kong nurse leaders and whether or not they used the same strategies to influence as nurse leaders in the West.

Purpose of the study

The purpose of this research is to investigate the process of nursing education reform in Hong Kong, the role of nurse leaders in this reform and the factors affecting their effectiveness. The research objectives are to:

1. document and analyse the process of nursing education reform;
2. identify the role of nurse leaders in nursing education reform;
3. analyse the situational factors influencing the effectiveness of nursing leadership;
4. determine the nursing leadership process and distinguish its various dimensions;
5. assess the impact of nurse leaders on nursing education reform; and
6. evaluate nurse leaders effectiveness from the perspectives of the nursing profession.

Significance of the study

This study will inform the development of nursing leadership in Hong Kong. Nurses, who form the largest group in the health service workforce and who are providing 24 hours service for the patients, are in a strong position to improve health care services. In order to achieve this, nurse leaders must be able to influence policy decisions and to shape policies related to nursing and health care. In the USA, it is an expected competency of nurse leaders as outlined by the ANA Scope and Standards of Advanced Practice Registered Nurses (ANA, 1996). The World Health Assembly has also recognised that effective nursing leadership can help in shaping health care policy and improving quality of health care (World Health Organisation [WHO], 1989). In addition, effective nursing leadership can contribute to a positive organisational climate, improved job satisfaction and nursing productivity. Ultimately, the quality of health care would be improved (Dunham and

Klafehn, 1990; Girvin, 1996 and McDaniel and Wolf, 1992). This study will provide evidence of the current status of nursing leadership in Hong Kong and help determine the direction and means by which effective leaders can be developed. By developing effective nurse leaders, it is expected that the quality of nursing care in Hong Kong will ultimately be improved.

To improve nursing leadership in Hong Kong, it is important to understand how nurse leaders have been involved in shaping the outcome of Government policy in nursing education reform and factors that would affect leadership effectiveness. Existing nursing leadership knowledge originates mainly from overseas. This study will increase understanding of the variables that influence nursing leadership effectiveness in the political context of Hong Kong. This study will also contribute to the understanding of the policy-making process and nurse leaders' role in influencing policy, to identify those leadership behaviours that are effective and those that may not be as effective. It will highlight the leadership knowledge and skills that need to be incorporated in the nursing curriculum to prepare future nurse leaders, particularly in respect of influencing policy-making and managing change.

This study will have relevance for the professional development of nursing. Schwirian (1998) claimed that one of the barriers to nursing professionalisation was the lack of effective nurse leaders. Effective leadership in nursing could contribute to the advancement of the profession by providing direction and motivating followers to work towards goals (Moloney, 1992).

An important outcome of this study will be its contribution to leadership theory development. Klenke (1996) criticised that many leadership studies merely attempting to theorise about leadership and not aiming to develop models for leadership that were useful to practitioners. Through studying of the dimensions of the nursing leadership process, a model of leadership would

then be developed. This model would be useful for understanding leadership behaviour in different settings and offer insight for developing more effective leadership strategies.

The majority of leadership studies have employed quantitative methods, but more qualitative studies in this area are recommended. Qualitative research could uncover previously unknown dimensions of leadership behaviour that quantitative research might overlook (Altieri and Elgin, 1994 and Bryman, Bresen, Beardsworth and Keil, 1988). The use of a case study approach, combining quantitative and qualitative data collection methods, provides an opportunity to study the leadership phenomenon from different perspectives. In particular, variables in the social context and nurse leaders' behaviour can be explored using such an approach. The findings of this study could increase the level of understanding about interactions among leaders, key players, and their socio-economic-political environment. It could give nurses a clearer picture of the forces that operate in a leadership environment, and provide useful insight for those in leadership positions.

Finally, the results of this study should contribute to an understanding of culture specific nurse leadership behaviours in a Chinese social environment. The results can be compared with studies from other countries, in order to examine the differences or similarities in the nursing leadership process.

Operational definitions

Nursing education reform - This term refers to the process of transferring hospital-based nurses' training to degree level education in the universities.

Leadership - The definition of leadership in this study is based on the following:

> 'An interaction between two or more members of a group that often involves a structuring or restructuring of the situation and the perceptions and expectations of the members. Leaders are agents of change - persons whose acts affect other people more than other people's acts affect them...' (Bass, 1991, p.19)

By this definition, leadership is an interpersonal relationship in which the leader employs specific strategies to influence an individual or group towards change. Also, leadership is not confined to the workplace or to an organisation. A person can be a leader, regardless of the hierarchical position or status, as long as he/she exerts more influence than another in a group.

Nurse leaders - Refers to those nurses holding senior management positions or leadership position in the health care institutions, the nursing professional organisations, the nursing statutory body, and the higher education settings; together with the nurse Legislative Councillors.

Followers - Refers to the practising nurses working in the hospitals with ranks below the General Manager (Nursing).

Stakeholders - Refers to the persons who had vested interest in nursing education, such as the medical profession, the University Grant Committee and the hospitals.

Overview of the thesis

This study investigated policy development in nursing education reform and nurse leaders' role in influencing this reform. Nursing leadership behaviour was analysed at group level rather than individual level. The study concentrated on

the period from 1985 to 1995 and on the actions taken by nurse leaders during that period. This chapter outlines the research problem, including the research aim and the significance of the study.

Chapter Two describes the context of the study, including the historical development of nursing education in Hong Kong, the impetus for nursing education reform, and its relationship to the wider policy-making process in Hong Kong. The information indicated that nursing education reform took place at a time when Hong Kong had major changes in higher education settings, health care services provision and socio-economic-political circumstances. It is followed by an outline of the process of nursing education reform in Australia and the UK. The role of nurse leaders in reform process will be analysed and the ingredients for success will be presented.

The literature review in Chapter Three provides a framework for studying leadership behaviour. The major concepts in leadership theories are discussed together with the contribution of the literature to the understanding of leadership. Studies related to nursing leadership are presented which highlighted the problem in nursing leadership development. The research methodology used in leadership study is outlined and future directions for nursing leadership research are suggested.

Chapter Four explains the framework of the study and is followed by an extended explanation of the methodology. The use of case study approach is discussed and justified. The methods of data collection and data analysis are explained in detail. This study has three distinct but inter-related foci that formed the basis of the research framework. The first was a documentary analysis to describe the process of nursing education reform. Key players involved in this process were identified and their interactions analysed. The second focus consisted of interviews to analyse the role of nurse leadership in influencing the nursing education reform, and factors affecting nurse leaders'

effectiveness. The third focus was a questionnaire survey investigating followers' perceptions of nurse leaders' performance.

Chapters Five, Six, Seven and Eight present the study findings. Chapter Five outlined the process of nursing education reform with evidence from documents and interviews to show what actually happened in the reform between 1985 to 1995. The key players in the process are identified and their interactions described. Chapter Six provides data on the situational factors that influenced nurse leaders' effectiveness. These factors are found in the health care and the socio-economic-political system. Categories classified as 'inertia' and 'facilitation' are presented and substantiated by data from interviews. Chapter Seven provides findings related to the role of nurse leaders in influencing nursing education reform. The category classified as 'evolution' is presented to describe nurse leaders' role in nursing education reform. Nurse leaders' actions were focused on the acquisition of power to influence the Government, stakeholders and followers. Chapter Eight reports the findings of the questionnaire survey which aimed to evaluate nurse leaders' effectiveness in the reform of nursing education from the perspective of the nursing profession.

Chapter Nine integrates and discusses the findings. The process of nursing education reform in Hong Kong and the role of nurse leaders in this reform is analysed. Four dimensions of the leadership process are developed and are integrated into a leadership model. Chapter Ten discusses these dimensions in light of the research, existing leadership theories and literature. Nurse leaders' contribution to the reform of nursing education is evaluated. Problems related to nursing development are highlighted.

Chapter Eleven draws the conclusions of this study. The implications of this study for leadership theory development together with directions of future research will be discussed. Recommendations for the improvement of nursing

leadership are given which focus on nursing education, professional socialisation, professionalisation and acquisition of power.

CHAPTER TWO

THE STUDY CONTEXT

Introduction

Nursing education development in Hong Kong has been influenced by changes both in Hong Kong and in other countries. This chapter outlines the development of nursing education in Hong Kong, the problems of the hospital-based nursing education, and the impetus for nursing education reform. The information will provide the background for this study. Furthermore, the process of nursing education reform in the UK and Australia will also be outlined in this chapter. These two countries were chosen for discussion because they had close relationship with Hong Kong. The role of nurse leaders in the nursing education reform and the strategies they used will be highlighted, which provides a base for comparing with what happened in Hong Kong.

Development of nursing education in Hong Kong

Nursing education in Hong Kong followed the apprenticeship system of the British model, in which nursing students were paid employees and regarded as part of the regular work force (Chan, Cheng, Lam and Ho, 1997). The first hospital in Hong Kong started to function in 1873 and as more and more hospitals were built, large numbers of nurses were recruited from Britain to staff them. These British nurses worked as nurse educators and managers in Hong Kong from 1900 to 1980 and they exerted great influence (Chan and Wong, 1999).

With the Nurses Registration Ordinance passed in 1958, the Nursing Board of Hong Kong (NBHK), the statutory body for regulating the nurses' professional training and practice, was established. Its functions were similar to that of the United Kingdom Central Council for Nursing, Midwifery, and Health Visiting (UKCC). The NBHK exercised control over the nursing curriculum by stipulating entry requirements for training, the contents and the length of time for theoretical instruction and clinical practice (Combes, 1987).

In the hospital-based system of training, there was a stipulated minimum duration of classroom study, plus specific periods of clinical placement in the required areas. The training period was three years for student nurses and they graduated as Registered Nurses (RN). All students were paid by hospitals during the training and these hospitals required that students be placed in clinical areas after fulfilling the minimal study period required by the NBHK. Gradually, nursing students became a substantial part of the nursing workforce in hospitals, the majority of which were public hospitals funded by the Government (Poon, 1983).

In 1967, a working party was formed by the NBHK to review nursing education system in Hong Kong. The working party recommended that a small number of degree places should be provided for nurses in Hong Kong to prepare them for administrative and teaching posts (Iu, 1967, p.40). However, there was no follow-up action by the NBHK on this recommendation. At that time, nursing was considered as a vocation that did not require university education.

Iu's (1967) report was the earliest documentation of a quest for change in nursing education and many years had elapsed before these recommendations were implemented. A Nursing Studies Section was established in 1980 at the Hong Kong Polytechnic (HKP, renamed as the Hong Kong Polytechnic University

[HKPU] in 1994) to provide training for nurse educators. The impetus for the establishment of the Nursing Studies Section in HKP came from the Lamb Report (Lamb, 1974). In this report, various weaknesses of the nursing education system were discussed. It was recommended that there should be a big increase in the number of qualified nurse educators to achieve a nurse educator/student ratio of 1:25, in order to improve the quality of nursing education. Until this time, nurses had been sent overseas abroad to the UK or Australia for such training. However, if the recommended ratio of the Lamb's report was to be achieved, the provision of cost-effective local opportunities for preparing nurse educators would be necessary (Yue, 1982).

In the late 1970s, there were many hurdles to establishing nursing programmes in the established university sector, therefore a polytechnic was considered a more feasible option. A Nursing Studies Section was therefore established in HKP and started to offer a programme to prepare nurse educators at professional diploma level. Since very few local nurses were qualified to teach on this programme, most members of teaching staff were recruited from abroad, e.g. from the UK, USA and Australia. These expatriate nurse academics brought with them experience of nursing education reform in their home countries. Chan and Wong (1999) commented that their teaching might have great impact on nurse educators in Hong Kong especially on the direction of nursing education reform.

Problems of hospital-based training

In the 1980s, there was a growing concern within nursing internationally as well as in Hong Kong about the inadequacy of hospital-based programmes for preparing nurses. Alderton, Wilson-Barnett, Chapman and Cox (1983) and the UKCC (1982) maintained that in hospital-based training, the teaching and learning process was directed more to the achievement of specific skills, rather

than meeting individual learners' needs for development. Furthermore, the hospital-based programme was dominated and controlled by employers, who were more concerned about workforce issues than educational issues. Nursing students were to provide a substantial proportion of hospital nursing services, while fulfilling the dual role of learners and employees. Moreover, the very limited environment of the nursing schools provided a narrow, restricted and unimaginative type of education.

There were other shortcomings of hospital-based programme. Hospital-based training functioned outside the mainstream educational system. Though a certificate (later called a diploma) was awarded to the nurses who completed the training, the qualification was not recognised by higher education settings. The failure of nursing education in Hong Kong to offer academic recognition at tertiary level, which was much valued by most young adult students, made nursing unattractive to young people (Hospital Authority Working Group on Nursing Education, 1992a). Furthermore, the economy in Hong Kong was booming in the 1980s and the job market was strong. Since nursing was regarded as a low paid and strenuous job, schools of nursing experienced increasing difficulties in recruiting students, and the dropout rate was extremely high. The student enrolment for hospital-based programmes decreased by about 20 percent from 1991 to 1992. The dropout rate increased from 9 percent in 1984 to 21 percent in 1992 and 1993 (Hospital Authority Working Group on Nursing Education, 1992a). In a survey of Form Five secondary school leavers, less than one percent of the respondents expressed a wish to enter a hospital-based nursing programme (Nursing Board of Hong Kong, 1993). These difficulties raised concern in the nursing profession, the hospitals, as well as in the Government, about the problems of hospital-based nursing programmes. One solution was to upgrade basic nursing education to degree level.

Changing role of nurses

The role of the nurse has undergone considerable changes over the last few decades. The WHO (1989) maintained that nursing should not be confined to hospitals. Nurses should provide a service for people of all ages and in both hospital and community settings. This role required that nurses should be able to promote health, prevent illness, as well as to care for the sick and disabled people. To meet these changing demands, the traditional role of the nurse as a hospital-based, disease-oriented, skilled technician responding to doctors' orders, was no longer adequate. Nurses needed to take up a more independent role in health promotion and disease prevention. Such changes demanded a better system of nursing education. Furthermore, it was proposed that a nursing programme should be able to help students develop critical thinking and problem-solving abilities (Nursing Targets Working Group, 1990). It was generally accepted that the hospital-based nurse training had been unable to prepare nurses to meet these demands.

Moreover, without higher education preparation, nurses could not function as equal partners with other health care professionals, who were educated at the tertiary level. Degree level education was considered to be an important pathway towards professionalisation of nursing. It therefore called for degree level nursing education as the minimal preparation for professional nursing practice (College of Nursing, Hong Kong, 1992; Nursing Targets Working Group, 1990 and Lam,1986).

Changes in the health care delivery system

The development of nursing education in Hong Kong has been influenced by changes in the health care delivery system. Historically, the Hong Kong

Government was responsible for the bulk of the health care burden, which was covered by taxation revenue. It supplied about 85% of all hospital beds in Hong Kong and the remaining hospital beds were provided by the private sector (Wong, 1996). To reduce Government's expenses in health care, a reform of health care system was considered necessary. Following the recommendations of the Scott Report (1985), the Hospital Authority (HA) was formed in December 1990 to take over the public hospitals previously administered by the Medical and Health Department (MHD). The aim of forming the HA was to create a new structure in which a more integrated and efficient resource management system could be established in order to cut the cost that the Government spent in health care. The HA was expected to run the public hospitals on the basis of devolved management.

The establishment of the HA brought a new look to health care services. It was independent from the Government civil service and therefore was able to adopt a management system totally different from the bureaucratic system of the Government. After the formation of the HA, there was a vigorous move to introduce new management ideas within the health care system. Nurses were expected to act as resource managers in the hospitals and to be more autonomous in their practice (Scott, 1985). This change in role expectations of nurses had implication for nursing education, which had to respond by preparing nurses for their new role in the health care system.

International influences

Since the 1980s, nursing in Hong Kong has become more internationalised and influenced by development in other parts of the world. In North America, about one-third of registered nurses were baccalaureate degree graduates. All nursing students had true student status and were considered as supernumerary when they

practise on the wards (Schwirian, 1998; McCloskey and Grace, 1997; ANA, 1996). New models of nursing education has been developed in Australia and the UK which provided Hong Kong nurses with examples of nursing education reform. In Australia, university education began in 1967 for a small number of nurses and nursing education completed its move into higher education institutes in 1993 (McCoppin and Gardner, 1994). In the UK, the Project 2000, a new system of nurse education, was implemented in 1990 (Reed and Procter, 1993).

Progress has also been achieved in Asian countries. China, for example, re-established its nursing degree programme in 1983 and by 1998, there were 13 universities offering such programmes with about 300 graduates per year (Chan and Wong, 1999). In Thailand, South Korea, Malaysia, Philippines and Japan, there has been a gradual increase in the number of degree level prepared nurses (College of Nursing, Hong Kong, 1992).

Changes in the political situation

During the past 20 years, Hong Kong had undergone great political changes. In 1984, the British and the Chinese Governments signed the Sino-British Joint Declaration. It was agreed that Hong Kong would be returned to the People's Republic of China on the 1st July 1997. Having no confidence in the future of Hong Kong, many people emigrated. In 1989, after the crackdown at Tiananmen Square on June 4, there was an even more severe brain drain from Hong Kong. As nurses were in great demand in various parts of the world, many nurses resigned from their jobs to work abroad for an overseas passport. There was a nursing workforce crisis in hospitals and the Government had to devise strategies to recruit and retain nurses.

Ever since Hong Kong became a British Colony, the purpose of university education was to prepare an elite group to work for the civil service. At the beginning of the 1980s, university degree places in Hong Kong were available to only 5 percent of the relevant student population (Postiglione and Leung, 1992). After the crackdown at Tiananmen Square in 1989, the Hong Kong Government, in an attempt to ease the unrest of society and to restore the confidence in the territory's people, announced the expansion of first-year degree places in universities from 5 percent to 18 percent in five years' time as well as upgrading all the polytechnics to universities (University Grant Committee [UGC], 1998). The expansion of degree places in higher education sector might provide an opportunity for nursing education reform.

The reform of nursing education involved a change in how the Government funded nursing education. Nursing education had all along been taking place in hospitals and was under the care of the Secretary for Health and Welfare (SHW). However, the funding of university programmes was the job of the Secretary for Education and Manpower (SE&M), who was responsible for formulating and reviewing education policy in Hong Kong. The SE&M secured funds in the Government budget, worked with the Legislative Council (LegCo) on educational issues, and oversaw the implementation of educational programmes (Howlett, 1996). When nursing education moved from hospitals into universities, both the SHW and SE&M had to be involved in the policy-making process. The way that these two Secretaries collaborated would influence the outcome of nursing education reform. Although Government was usually being described as an integrated system (Allison and Malperin, 1972), in reality, different sections in the Government had its own interests and goals. Public servants, who operated from within various government departments, tended to develop a 'territorial perspective' that had a potential for conflicts. This was referred to as 'bureaucratic politics' and resulted in 'competitive, not homogenous interests' (Allison, 1971,

p.46). The conflicts needed to be overcome for nursing education reform to be successfully implemented.

In summary, the dissatisfaction with hospital-based training, the changing role of nurses, the changes in socio-political situations set the stage for the nursing education reform. The experiences of nursing education reform from other countries inspired nurses in Hong Kong to make similar changes. The following will analyse the process of nursing education reform in the UK and Australia.

Nursing education reform in the UK

This section will discuss the nursing education development in the UK from 1960, when the first nursing degree was established in the University of Edinburgh, to 1988, the time when the Project 2000's implementation was confirmed. Before the implementation of Project 2000, the majority of nursing training was conducted in hospitals. Graduate nursing students formed only a tiny proportion of the total. Bartlett (1994) commented that the service/education link, attrition from courses, and the isolation of nursing students from the broader fields of education, were three longstanding problems identified in the apprenticeship system of training which pointed to the need for reform.

The stimulus for educational reform started at the 1960s. The Royal College of Nursing (RCN) set up a group to review the nursing education system. The RCN argued in its report (RCN, 1964) that service demands should no longer take precedence over educational needs and it proposed a nursing education reform (Davies, 1980). However, the suggestion was not supported by the General Nursing Council (GNC). The GNC responded angrily, listing achievements and gains made in nurse education since 1949 (GNC, 1965). About the same time, the government decided to take a totally different perspective, arguing that a review

of nursing management was paramount, not nursing education. Lathlean (1988) commented that the RCN report seemed to be ignored as the government had its own preoccupations.

In 1972, a Committee on Nursing, chaired by Asa Briggs, recommended a new statutory structure for nursing and midwifery, that is, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) and provided a detailed plan of educational preparation which proposed a single point of entry followed by specialisms. The UKCC came into full operation in 1983. The English National Board (ENB) was also set up to aid the Council in determining educational policy (Davies, 1985).

Processes for debating educational reform

In 1984, the UKCC devised a five-year plan in which one objective was to determine an education training policy and programme to ensure that nurses, midwives and health visitors could meet the needs of society in the 1990s and beyond. This review of educational preparation was regarded as necessary by UKCC because of demographic changes and by shifts in health care policy such as increased focus on community care and preventative measures (UKCC, 1986, 1987). Elkan and Robinson (1991) concurs that the need for reform in nursing education emerged from challenges in four main areas: education, service, recruitment and retention, and changes both in health needs and in the National Health Service (NHS). A Project Group for Project 2000, was formed in 1984 to review the nursing education system.

However, the RCN was impatient with the slow pace of the work of the UKCC. At the request of the RCN's General Secretary, Trevor Clay, it set up in December 1983 its own Commission on nursing education. The Commission had a

chairman from outside nursing, Harry Judge, Director of the Department of Educational Studies, University of Oxford (Clay, 1987). In the Commission's report (RCN, 1985), Judge vigorously argued for the wholesale move of nursing education into higher education with the associated prerequisites of supernumerary status, a broader-based common core curriculum and a simpler pattern of qualifications.

It was difficult to know how much influence the recommendations of the Commission had on the outcome of education reform. Lathlean (1988) commented that this report put pressure on the UKCC and it acted as an important catalyst for the reform. However, the RCN report caused confusion in the nursing community because it was assumed that the UKCC should take the lead in the education debate. Nevertheless, the UKCC tried to minimise the conflict. The presentation of the problems of nursing education and the suggested solutions by the Project 2000 report were almost the same as the RCN's. The main difference being the nature of the proposed relationship with higher education (Lathlean, 1988).

The report of Project 2000 was published in May 1986 with several major themes: a reorientation from hospital care to community care as the basis for basic nursing education, nursing students practising with supernumerary status, a single level of nurse registration and better preparation of nurses to deal with uncertainty and change (Bartlett, 1994 and Davies, 1995). Extensive consultation with the profession was carried out and resulted in over 2500 responses and an unprecedented level of agreement to the proposals. However, there were criticisms, for example, the trades unions were unhappy about a single level of registered practitioner and the cessation of enrolled nurses training; and the psychiatric nurses were concerned that sufficient time should be available for branch work. Though the RCN criticised about the reluctance of Project 2000 to

seek wholeheartedly a future in higher education, it put a great deal of effort in persuading those in power that Project 2000 was, in essence, the right way forward (Lathlean, 1988). Lathlean maintained that whilst the UKCC presented a very clear summary of the responses, identifying where agreement and disagreement lay, the latter was played down in many official documents so it appeared that the nursing profession had a consensus to the Project 2000 proposal.

However, doctors objected to the Project 2000 proposal. A consultant physician argued that the problems that nurses faced were not related to education, but because of unsocial hours, low pay, and poor prospects. His solution was an 18-month, ward-based training, a 'non-academic' course, run by nursing schools and cheap to organise (Davies, 1995). A medical journalist gave an account of his impressions to his doctor colleagues via the editorial pages of *The Lancet.* He mentioned that the main aim of a doctor's training is to teach the skills of diagnosis and the main aim of nurses' training is to improve a patient's comfort. The implication is that nursing did not need higher education (Davies, 1995; Dean, 1992; p.116). Nevertheless, towards the end of the 1980s, the rejection from the doctors quietened down as doctors' attention was drawn to the NHS reform.

In April 1986, the UKCC unanimously approved the Project 2000 Report. According to the Chairman of the Project Group, the consultation work undertaken within the profession facilitated overall agreement in the end (UKCC, 1986). The proposals were presented to the Ministers and officers of the four UK Health Departments in February of 1987. The Ministerial announcement was made publicly at the RCN Congress in May 1988. The introduction of the reform commenced in 1989 and it was considered as the most influential and comprehensive reform of nursing education in the UK (Lathlean, 1988). A new diploma was introduced, replacing the previous two-tier system of enrolled and

registered nurses. To obtain course validation, schools of nursing had to be integrated into an institution of higher education. The four specialist routes to qualification were replaced by a common foundation programme followed by a branch programme in the chosen specialism. Students are provided with bursary rather than a salary, and are responsible to educationalists rather than service managers (ENB, 1988; Marsland, 2000).

In the UK, policy was often initiated by the government and in turn underwritten by the Department. However, in the case of Project 2000, the initiative came largely from the UKCC, and the Government had to look at the implications for the service and ask questions about its feasibility, in manpower and cost terms. Thus there was negotiation between Government Departments and the Treasury. In an interesting illustration of the concerns of the Department of Health (DoH), one respondent (from the Department) describes that the government's decision was not based on what is good nurse education, the key question is, 'can we continue to staff the service if we bring about such radical change with its manpower implications?' (Davies, 1995, p.126). The reason why nursing education could not be all upgraded to degree level was related to resources rather than to need.

At the initial stage of the Project 2000 implementation, there were many concerns and confusions. For example, a misunderstanding of the concepts of supernumerary status, a lack of preparation for nurse educators to teach at the required level, and a lack of clarity of the role of support workers in the provision of health care (Bartlett, 1994; DoH, 1989 and Elkan and Robinson, 1991). Many recommendations and reports have been made to address these issues over the years. As time went by, many nursing schools amalgamated with universities to become nursing departments. Some Project 2000 programmes were upgraded to

degree level in which the Health Trust contracted with universities to conduct these programmes. However, some programmes were still at diploma level.

In summary, the history of policy formation in nursing education in the UK as described by Lathlean (1988) was characterised by incrementalism and the involvement of many key players. Nursing education reform was initiated by nurse leaders who were leading the professional organisations, such as Christine Chapman, Trevor Clay, Heather Williams, Margaret Green, Stanley Holders and David Jones. Amongst all the professional organisations, the RCN played an important role in pushing the reform. The RCN Commission represented an attempt by the main professional organisation to put some urgency into the debate about educational reform, and to move away from gradualism to radicalism. The establishment of the statutory body, UKCC, has served in some ways to focus responsibility for achieving educational reform (Clay, 1987).

The process of policy formation was characterised by consultation and negotiation, though there were disagreements and professional rivalry during the process. Rejection from medical doctors was evident. However, the NHS reform that took place at the same period of time diverted doctors' attention and reduced their opposition. The process of reform illustrated that nursing education was not only influenced by nurses, other stakeholders, such as doctors and government officials, had much influence on the outcome. Resource allocation was an important focus in nursing education reform. Lathlean (1988) commented that at the end of the day, the major decisions on actions related to nursing education reform were taken by Government Ministers, within any constraints placed upon them by the Treasury. The drive for efficiency and effectiveness in public services gave supremacy to the wishes of the Treasury over the desires of nurses. Davies (1995) concurred that the process of nursing education reform made one

thing abundantly clear, staffing the service takes precedence over educating the nurse.

Nursing education reform in Australia

In Australia, until the mid-1970s, basic nurse education was essentially an apprentice type training within a hospital system. In 1976, a national goal was set by the nurse leaders of the nurses' associations in a policy statement entitled 'Goals in nursing education'. It stated that all basic nurse education be conducted in Colleges of Advanced Education (McCoppin and Gardner, 1994). This was the impetus that motivated the profession to influence the federal government to move basic nurse education out of the hospital system.

The federal government responded in two ways. In 1977, the Minister for Health established a new nursing branch to advise on policy issue and matters of concern to the nursing profession. At the same year, the Minister for Education announced the appointment of a Committee of Inquiry, chaired by Dr Sidney Sax, to conduct a nation-wide inquiry into basic nurse education and make recommendations to the Commonwealth Tertiary Education Commission (CTEC) on possible development of nursing education (Martins, 1990).

From initial proposals to acceptance in principle

The Committee responded in 1978 and argued for diversity in basic nurse education. Specific recommendations were included: rationalisation and upgrading, where appropriate, of existing hospital schools of nursing; development of 'appropriate' relationships between hospital schools of nursing and higher education institutions; a limited expansion of student places in basic nursing courses to a target of some 2,000 places by 1985 at higher education

institutions; and one category of comprehensive basic preparation for nurses leading to registration (CTEC, 1982, p.107; Sax 1978, p.59).

The federal government did not respond to the Sax Report recommendations for eighteen months. The issues surrounding a non-decision, according to Martins (1990), remained shrouded in government administrative secrecy. However, McCoppin and Gardner (1994) commented that the problem might be related to the continuous objections from medical profession to nursing education reform 'while student nurses are providing service, and there is no argument that the best nurse is produced through training at the bedside...'. There were also fears from doctors that nurses would be 'over-educated' (p.100).

In June 1980, the federal Minister for Education announced that the government recommended an improvement in the standard of hospital-based training but without a major reorganisation of the total nurse training system. However, Labour's shadow Ministers for Education and Health, opposed the federal government's decision to retain the education of nurses in hospital schools. They considered the decision ran counter to the thrust of the Sax Report (Martins, 1990).

Some nurse leaders began to take up some of the claims of the new women's movement. They openly attacked the lower standard of nursing education compared with that for other health professions, by implication male-dominated medicine in particular. They linked women's issue with nursing issue and raised the nurse education reform as a public issue, a wider debate about equal opportunity of women. In 1980, the shadow ministers accused the federal government of pandering to doctors while ignoring nurses' request, because nursing is a largely female profession (McCoppin and Gardner, 1994).

The 1980 was a federal election year. The Royal Australian Nurses Federation (RANF) office mailed questionnaires to all candidates with questions on support for the transfer. The RANF suggested that the Labour party candidates were more likely than those of the Liberal or National parties to support the transfer. In facing increasing political pressure from nurses, the federal government supported a recommendation of the Sax Committee for the further development of co-operative arrangements between hospital schools of nursing and higher education institutions as a means of upgrading hospital courses (CTEC, 1984). However, the affiliation idea was not widely adopted. The nursing profession feared that this arrangement would be used by the Commonwealth to further delay its decision on the transfer of nurse education.

In May 1984, the College of Nursing rejected the CTEC's recommendations. Instead, the College called on the federal government to make a commitment to the transfer of all basic nurse education to tertiary institutions by 1990. Nursing administrators across Australia threatened not to process any further applications for hospital nursing schools until the government gave an assurance that there would be a total transfer by the specified date (Martins, 1990). The federal government was also advised that: if implemented, the CTEC's recommendations would be totally unacceptable to nurses throughout Australia. Nurses had decided that, until there was a firm government commitment to a total transfer by 1990, professional and industrial action would be taken in pursuit of this objective (College of Nursing, 1984).

In responding to representations from nursing organisations around Australia, the Ministers for Education and Health announced the establishment of an Interdepartmental Committee in May 1984 to examine the question of nurse education. The Committee examined the cost implications of the transfer, including the potential increase in the cost of providing hospital services and

related employment compared with that of the traditional delivery system (Martins, 1990).

Given that the Interdepartmental Committee was to present its report in July 1984, the nursing organisations accelerated their political pressure on federal cabinet members in the form of letters to the relevant Ministers, articles in nursing journals and in newspapers, and the appointment of a lobbyist in Canberra. The nursing organisations also recognised that the achievement of their objective required federal-state agreement and co-operation, and that it was necessary to lobby at both levels of government. Letters were forwarded to all state Premiers, Education and Health Ministers and higher education authorities, providing information and seeking their support. About the same time (June 1984), representatives of nursing organisations were given an opportunity to present their views on nurse education to the Social Policy Committee of the Australian Labour Party caucus (Martins, 1990).

In August 1984, the Interdepartmental Committee announced that there would be a complete transfer of hospital nursing training to higher education institutions. The transfer was scheduled to commence in 1985 and be completed by 1993. Subsequently, an Act relating to the grant of financial assistance to the states with respect to nursing education was assented to on 11 December 1985. It was more than forty years since the first major investigation into nursing in Australia had criticised the apprenticeship system of nurse education (Martins, 1990).

The history of nursing education reform in Australia showed that nurses initiated the reform and took political actions in shaping the outcome. McCoppin and Gardner (1994) commented that nurse leaders' effort, such as Pat Slater, Mary Patten and Sister Paulina Pilkington, contributed to the success of nursing education reform in Australia. Among the nursing leaders there was agreement

that education reform was the most significant goal to pursue. They had established a unified national stand and the nursing professional organisations led by these nurse leaders were strong and united in their quest for nursing education reform, which contributed immeasurably to its success.

Nurses in Australia used many political actions to influence government's decisions. McCoppin and Gardner (1994) maintained that one of their most effective devices was the network they built, a 'sisterhood in action', which spread in all states, and beyond to other nurses, often in strategic positions, who were interested or engaged. For example, Victorian nurses started Royal Australia Nursing Federation Special Interest Group (Nurses Action Lobby), and in South Australia, nurses formed a fairly intricate networking system across the state. Over time, those in the networks developed their political skills and influence. The nursing group had transformed into a political force and became an active political lobbying group. The internal work of persuasion and the outwardly directed political activity led by nurse leaders combined to produce the necessary political influence.

Apart from nurse leaders' contribution, Henderson (1990) commented that certain social and political factors facilitated the reform: the emergence of the women's movement; and the Labour Party election victory in 1983 that brought to power a party more sympathetic to the principle of equity in general and to the demands of women in particular. These changes provided a conduit through which nurses could channel their demands. There were other ingredients of success as identified by McCoppin and Gardner (1994): careful preparation, building support among influential groups, and recognising the time when a particular change may be acceptable. McCoppin and Gardner suggested that nurses' success in the 1990s came from judiciously uniting their chosen interests with those circumstances. Unity plus the environmental circumstances were important for success.

Comparing reform process between the UK and Australia

In describing the policy process, Mason and Leavitt (1998) suggested that the policy process began with identifying the problem and 'getting on the agenda'. Whether nursing's issues are on the agenda depends on how nurses help setting the agenda, whether the climate is right for the issue to be of interest to policy makers, and whether nursing has power to make the issue a chief priority. There were similarities and differences between nursing education reform process in UK and Australia. In both places, nursing education reform was initiated by nurse leaders. They were able to put the issue of nursing education reform on the agenda and attract some attention from the government. At both places, there were contextual factors, such as the changes in health care system or the change of the government that facilitated nurses to put forward nursing education as an important priority onto government's agenda.

Once on the agenda, Mason and Leavitt (1998) maintained that one had to find support from stakeholders and to develop strategies needed for moving the issue. The stakeholders could include those people whom the problem affected, for example, the government officials and doctors who were stakeholders. Their support is needed for influencing the government. Mason and Leavitt also suggested that establishing policy was a value-laden process. The greater numbers of power sources available to the group, the greater the potential to influence. When compared with the UK counterpart, Australian nurses undertook many more vigorous political actions in pursuing the reform. The united forces together with continuous political actions increased nurses' power base. They were able to generate support from stakeholders, such as the Shadow Government, and thus shaping the outcome of the reform. Nursing education had a complete transfer to degree level in Australia. Whereas in the UK, at the later stage of decision making, it appeared that the government was more in control of

the final decision. The value for cost-effectiveness took precedence over the value of nursing education (Davies, 1995). There were some changes in nursing education, but not the wholesale transfer to higher education. The Project 2000 was at a diploma level.

The process of nursing education reform in the UK and Australia suggested that nurse leaders played important roles in influencing the outcome of nursing education reform. Given the uniqueness of Hong Kong situation, the process of nursing education reform, the key persons involved, the nurse leaders' involvement, the contextual factors and the impact that they could exert on the reform might be different from these countries.

Summary

This chapter outlined the study context. The historical development of nursing education in Hong Kong and the impetus of nursing education reform was analysed. The information indicated that nursing education reform was not an isolated issue on the political agenda in Hong Kong. It was taken place at a time when there were tremendous changes in higher education, health care services provision and socio-economic-political circumstances and many key players would be involved in the reform. The information facilitated an understanding of the policy-making process in Hong Kong. The discussion of nursing education reform process in the UK and Australia indicated that nurse leaders played an important role in influencing nursing education reform. The experience in both places highlighted the importance of united forces and continuous political actions in shaping the outcome of nursing education reform. The following chapter is a review of literature related to leadership theories.

CHAPTER THREE

LITERATURE REVIEW

Introduction

The literature review in this chapter provides a framework for studying the behaviour of nursing leadership. Literature was searched from the citation index of *Dissertation Abstracts*; *Cumulative Index of Nursing and Allied Health Literature* (CINAHL) and MEDLINE using the keywords 'nursing education reform'; 'leader'; 'leadership'; 'nursing'; 'politics', and 'power'. The search period was from 1970 to 2000. Books and reports published from 1960 to 2000, including some classical studies of leadership, were also reviewed. This chapter starts with a discussion on various theories of leadership and the contributions of the literature to the understanding of leadership are analysed. Studies on nursing leadership are also examined. Two categories of research in nursing leadership: predicting leadership and leadership development are analysed. The research methodology used in leadership study is outlined. Future directions for leadership research are suggested.

Leadership theory

During the past 80 years, thousands of studies have been conducted on leadership and dozens of theories have been developed to describe leadership from many different perspectives (Bass, 1991). Early works focused on broad conceptualisations of leadership, such as traits or behaviour of the leader (Hersey and Blanchard, 1982a; Fiedler, 1974 and Stogdill, 1974). Contemporary research focuses on leadership as a process of influencing

others within an organisational culture and the interactive relationship of the leader and followers (Marriner-Tomey, 1993; Hoy and Miskel, 1991; Vecchio, 1991; Bennis, 1984 and House,1971).

Trait theory

The 'trait theory' assumes that leaders possess certain physical and psychological traits that determine their rise to leadership positions. It is also known as the 'great man' theory. Emphasis is placed on examining the leader's personal characteristics in an attempt to identify a set of universal leadership characteristics.

Some examples of leadership traits labelled by researchers include: energy, drive, enthusiasm, ambition, aggressiveness, decisiveness, self-assurance, emotional control, persistence, initiative, adaptability, honesty, fairness, loyalty and teaching skills (Bass, 1991 and Stogdill, 1974). Early work in this area maintained that traits were inherited, but later theories suggest that traits could be obtained through learning and experience (Gardner, 1990 and Senge, 1990).

In an attempt to distinguish which traits separate effective from ineffective leaders, Stogdill (1948) reviewed 124 trait studies of leadership that were completed between 1904 and 1947. From his survey, Stogdill found that the results varied considerably from situation to situation, and did not produce a consistent constellation of traits that characterised most leaders.

One of the major problems in trait theory is found in the methodologies employed in many of the trait studies. Klenke (1996) commented that a great deal of the research was designed to determine who would emerge as the leader in the leaderless groups. These groups were often artificially created in

contrived settings, such as laboratories, or based on observations of classrooms and other environments with limited generalisability. The limitation of this type of research is that the experimental condition may not be relevant to real-life situations. Another problem was related to the measurement tool and the sample of study. Wilson-Barnett (1980) suggested that inadequate personality description and measurement, together with a lack of homogeneity in the group studied, might be factors relating to the difficulties in establishing a definitive relationship between personality traits and leadership.

Overall, the conceptualisation of leadership as a trait proved to offer a partial explanation of what constitutes effective leadership. Trait theory expanded knowledge about leadership. However, these early studies failed to support the universal trait theory of leadership (Klenke, 1996; Marriner-Tomey, 1993 and Fiedler and Chemers, 1974). Blondel (1987) summed up the role of traits in leadership. He stated that personality of the leader did play an important part in the behaviour of leaders. However, precisely how much personality counted remained a matter for debate. Thus, while trait theory may have produced ambiguous results, traits continue to resurface as explanatory constructs to account for effective leadership. If one attempts to propose a comprehensive model of effective leadership, the traits of leaders need to be considered.

Behavioural theories

The inadequacy of the trait approach ushered in a new wave of leadership research. The 'behavioural or leadership style phase' was popular between the 1940's and the 1960's. It aimed at determining a universal leadership style consisting of the best combination of leadership behaviours.

A major line of behavioural research conducted at Ohio State University

(OSU) and the University of Michigan identified two broad dimensions of leader behaviour, labelled as 'consideration' and 'initiating structure'. Consideration includes behaviour that indicates friendship, trust, warmth, interest, and respect in the relationship between the leader and followers. Whereas initiating structure includes behaviour that delineates the relationship between the leader and the followers, and at the same time, establishes defined patterns of organisation, channels of communication and methods of procedure (Stogdill, 1974). The OSU leadership behaviour studies resulted in the development of a series of questionnaires, the Leader Behaviour Description Questionnaire (LBDQ), designed to identify initiation of structure-oriented and consideration-oriented leader behaviours.

Variations of the concepts of consideration and initiating structure leader behaviour are found in the literature related to leadership style/behaviour (Marquis and Huston, 2000; Hersey and Blanchard, 1982b; Bass and Valenzi, 1974; Fiedler and Chemers, 1974; House, Filley and Kerr, 1971; Likert, 1967 and Blake and Mouton, 1964). Terms used to describe the two dimensions of leadership behaviour varied with different researchers. Leadership with a strong concern for achievement of organisation's goals is defined in the following terms: 'initiation of structure' in Ohio State Study, 'task oriented' by Fiedler (1967), and 'in need of achievement' by McClelland (1961). Leadership with strong concern for human relation approach is defined in the following terms: 'consideration' in Ohio State Study, 'relations oriented' by Fiedler (1967) and 'concern for people' by Blake and Mouton (1978).

In this behavioural perspective, a common theme of a continuum from leader control (domination) through follower participation to follower independence is evident. The two clusters of leader behaviour (people-oriented and task-oriented) are viewed as being on a continuum, with each type of behaviour being at an opposite end. These forms of behaviour are not considered to be

mutually exclusive and may occur together.

The behavioural perspectives contrast the trait theories by suggesting that leaders are not born and leader effectiveness does not reside within the person. People can learn leadership behaviour or style. However, the behavioural approach also has weaknesses. Many of its studies relied heavily on self-reported data rather than on observations of leaders' actual behaviour in real settings. Furthermore, many studies seem to suggest that the two dimensions are orthogonal and leaders high on both dimensions are the best and most effective leaders. However, a substantial number of investigations of the impact of task and relations orientation have been mixed. Many researchers proposed that the specific behaviours effective leaders displayed were determined by situational factors which, in turn, interact with both leaders' and followers' abilities and needs. Leaders high on both initiating structure and consideration do not always obtain optimal results (Chemers, 1993; Larson, 1983; Hersey and Blanchard, 1977 and Fiedler, 1967).

As with the traits of leaders, one cannot completely understand the concept of leadership and explain effective leadership satisfactorily by considering solely the behaviour of leaders. It seems that situational factors may also have some impact on leadership behaviours and organisational effectiveness. Furthermore, it appears that most leaders did not fit a textbook picture of any one style, but rather moved dynamically along the continuum in response to each situation (Marquis and Huston, 2000). This recognition was a forerunner to situational leadership theory.

Situational theories

The 'situational theories' proposed that effective leadership could only be understood by examining variables such as the performance requirements of

the leader and followers, and the organisational structure (Marquis and Huston, 2000 and Fiedler, 1974). Among the various theories that fall into this category, Fiedler's (1967) contingency theory of leadership will be discussed as it is an influential situational approach in this category of theories.

Two leadership styles are identified in Fiedler's (1967) contingency model: task-oriented and relationship-oriented leadership. These two leader orientations are associated with the following three situational variables or contingencies:

1. leader-follower relations - the degree of confidence, trust, and respect followers have in their leaders
2. task structure - the extent to which the task performed by followers is routine or non-routine
3. position power - the leaders' authority to administer rewards and punishments and enforce compliance.

Fiedler (1967) developed the Least Preferred Co-Worker (LPC) scale to assess the degree to which people rate the co-worker, with whom they are least able to work, along a number of bipolar adjectives. Low score on the LPC scale are indicative of a task-oriented, structuring leadership style, while high scores reflect a relationship-oriented leadership and criteria of leadership effectiveness. Fiedler argued that given the critical condition, one could predict the most productive leadership style. For example, if the situation is highly favourable or unfavourable for the leader, task-oriented leadership is most effective.

The LPC scale has played a central role in the empirical research of the contingency theory. However, Bass (1991) criticised it for being unclear as to exactly what it aimed to measure. While there has been research to support

this model, findings are inconsistent (Martin, 1992). Fiedler (1967) interpreted most of the research evidence as supportive of the predictions derived from the theory, whereas others (Graen, Alvares, Orris and Martella, 1970), after re-analysing Fiedler's validation data, reach drastically different conclusions. They assert that the model lacked predictive validity. In general, Fiedler and his associates were more likely to obtain confirmatory evidence than were independent researchers.

From the above review, it seems evident that situational factors and leadership behaviours interact with each other and affect the leadership effectiveness. However, the contingency theory mainly focus on factors within an organisation, and fail to account for the environment external to the oganisation that would have potential to influence leadership behaviour.

Recent approaches in leadership studies

Situational theories add necessary complexity to leadership theory and continue to be used effectively in management. By the late 1970s, theorists began arguing that effective leadership depends on an even greater number of variables, such as social network and environment, the followers, patterns of communication, group cohesiveness and the complexities of the situations (Tappen, 1995). Efforts to integrate these variables are apparent in contemporary leadership theories. Some of the recent approaches to the study of leadership are now reviewed.

Leadership as an influence process

Leadership can be seen as an influence process. Yukl (1989, pp.251) stated that the essence of leadership was influence over people. Influence, according

to Yukl, is the effect of one party (the 'agent') over another party (the 'target'). The influence concept recognises the fact that individuals differ in the extent to which their behaviour affects the activities of a group. The notion of influence is central to the leadership concept for many theorists. Stogdill (1974, p. 10) used the influence concept in his definition of leadership: 'the process of influencing the activities of an organised group in its efforts toward goal setting and goal achievement'. According to Brewer, Ainsworth, Michael and Wynne (1984, p. 25), the process of leading involves influencing or inducing others to behave in a desired manner. Hein (1998) and Shaw (1981) also regarded leadership as a special case of social influence - the exercise of power by the occupant of a particular position in the group structure in order to change the behaviour of others to achieve a specific goal achievement. This appears to be a widely accepted viewpoint.

While the leader is the central and often the most vital part of the leadership phenomenon, followers are important and necessary factors in the equation. Bass (1960) considered leadership as an interaction between members of a group in which leaders influenced followers for the accomplishment of changes in 'motivation' or 'habits of the followers'. Three stages of leadership (when the leader's goal is to change the followers) were put forth as:

1. Attempted - when the leader can be observed attempting to change the follower.
2. Successful - the follower may actually change his/her behaviour as a consequence of the leader's efforts.
3. Effective - the follower's change may result in follower satisfaction, reward or goal attainment.

   (Bass, 1960, p.90)

Yukl (1991) also suggested that the leader was not an isolated individual in

leadership structure, but was involved with other members in a structure of responsibility differentiation and personal interaction. The performance and effectiveness of the leader might be influenced to a very high degree by the performance and interaction of the followers. However, research on how followers would influence leadership effectiveness is limited. The interaction between leaders and followers and how followers influence effectiveness of leadership should be analysed in future study.

If leadership is a form of influence, an understanding of the essence of power and politics is necessary to the understanding of leadership. Power is frequently linked with the concept of influence. Leadership power is defined as 'the demonstrated or perceived ability of an individual to change events, people and organisations' (Brewer, Ainsworth, Michael and Wynne, 1984, p.25). Sullivan and Decker (1997) maintained that the influence process involved unequal distribution of power among the leader and group members, in that the leader had the authority (legitimate power) to direct some activities of the group members, who could not similarly direct the leader. Thus power might be considered as potential influence, whereas influence is kinetic power. Successful leaders are those who can use power appropriately to achieve their goals.

Power could be obtained from various sources. French and Raven (1962) identified six sources of power, which Hersey, Blanchard and Natemeyer (1979) expanded on, yielding a typology of seven power bases: coercive power, reward power, legitimate power, expert power, referent power, information power and connection power. Stogdill (1974) identified social power as another source of power that referred to influence relationship between persons. All sources of power yield influence. Effective leaders are those who translate power into influence, understand the sources of their power and act accordingly.

Though power is important in leadership, leadership is not the same as power. Every organisation would have an individual at the top decision-making level who can exercise power simply by giving orders and making decisions. This is simple power of position and does not involve leadership. Hall (1991) argued that leadership involved a person did above and beyond the basic requirement of the position. It was the persuasion of individuals and the innovative ideas and decision-making that differentiates leadership from the sheer possession of power.

Politics is another concept closely related to influence. Politics could be defined broadly as 'influencing', or more specifically - influencing the allocation of scarce resources in the political system (Easton, 1965). The political system, as defined by Easton, comprises those identifiable and interrelated institutions and activities in a society that make authoritative allocations of values and decisions, that are binding on the society.

Power is an important concept associated with politics (Marquis and Huston, 2000). Easton (1965) commented that leaders' ability to influence the political system depended on their power. Pfeffer (1981) suggested that if power was a force, a store of potential influence through which events might be affected, politics involved those activities or behaviours through which power was developed and used in political settings. Politics involved the exercise of power to get something accomplished or to control the decision-making process. Pfeffer further explained that political activity was activity undertaken to overcome some resistance or opposition. Because political activity was focused around the acquisition and use of power, it could be distinguished from activity involved in making decisions that used bureaucratic procedures. Political activity implied the conscious effort to use force to overcome opposition in a choice situation. Power plays, or political

struggles, were often reflected in the allocation of scarce resources. In times of economic scarcity, political activity increased as individuals compete for those declining resources. As leaders were often involved in influencing the allocation of resources, leaders had to participate in political activities and to acquire power to influence.

This influence theory attempts to explain the process of leadership rather than to identify the best way to lead. The concepts of power and politics are essential elements in this theory. This theory points to the importance of studying the process of leadership, rather than just focusing on the outcome. However, there are not much empirical evidences to support this theory. There are also few studies on the process of how leaders used power to influence.

Transactional and transformational leadership

Transactional and transformational leadership has been put forward as an alternative leadership approach to the traditional theories (Marquis and Huston, 2000; Burns, 1978). This theory maintains that those behaviours associated with a leader are not limited to one person acting alone, but are part of a dynamic relationship with followers. Burns described the two basic types of leadership as 'transactional' and 'transforming'.

Transactional leadership occurs when a leader initiates a relationship with followers based on exchange. In this relationship, the leader motivates the desired follower behaviour in exchange for resource that is valued by the follower, such as, an increase in salary. Burns (1978) maintained that transactional leaders were found in traditional managers who were concerned with day-to-day operations only.

Transforming leadership, on the other hand, involves a relationship with followers that is mutually stimulating and elevating. Bass (1985) developed the concept of transformational leadership by extending House's (1977) Theory of Charismatic Leadership. Transformational leadership describes leaders in terms of articulating and focusing on a vision and mission. By raising the followers' level of awareness of designated outcomes and setting challenging goals or expectations, transformational leaders empower and motivate the followers to perform at higher levels or achieve the vision (Bass, 1985). The descriptions of the role of transformational leaders by Bass are similar to that suggested by Tichy and Ulrich (1984). They propose three roles associated with transformational leadership: the creation of a vision, mobilisation of commitment and institutionalisation of change.

Other characteristics of transformational leadership were identified by Avolio and Bass (1988, p.34): charismatic, individualised consideration and intellectual stimulation. Charisma referred to the ability to inspire followers to loyalty to a cause, a gift for seeing what is really important and a sense of mission (or vision) which is effectively articulated. Individualised consideration means the leader delegates tasks to followers to stimulate and create learning experiences, pays personal attention to followers' needs and treats each follower with respect as an individual. Intellectual stimulation occurs when leaders arouse awareness and activate problem-solving capabilities in followers, provide ideas that result in a rethinking of old ways and enable followers to look at problems from many angles.

Many authors agreed that the concept of transactional leadership was often associated with the role of manager, whereas transformational leadership was concerned with the role of the leader (Zaleznik, 1990). Bass (1985) stated that transactional leaders work within the organisational culture as it existed, but transformational leaders changed the organisational culture. Many authors

suggested that transformational leaders were needed in contemporary organisations in order to effect change (Marquis and Huston, 2000; Beecroft, 1993; McDaniel and Wolf, 1992; Dunham and Klafehn, 1990; Bennis & Nanus, 1985). According to Wolf (1993), the purpose of the leader and follower became focused through transformational leadership, unity was created and the group gained a collective purpose.

However, many management theorists, including Dunham and Klafehn (1990), Bass et al. (1987), and Tsoi (1982) expressed reservations about transformational leadership. They warned that although transformational qualities were highly desirable, these qualities had to be coupled with the more traditional transactional qualities of the day-to-day managerial role. Without transactional leadership skills, even the best transformational leader might fail to accomplish the intended mission. Further studies are needed to confirm this assumption.

Leadership as an outcome of social structure and process

Some authors criticised that conventional perspective of leadership tended to envision the leaders as belonging to an isolated organisational unit consisting only of themselves and the followers. Hall (1991) and Hunt and Larson (1975) maintained that typically the leaders was viewed as an omnipotent decision maker who was capable of analysing the situation and then selecting the one behaviour pattern most appropriate for the situation. However, this assumption failed to recognise the constraints on the leaders in their selection of leadership styles. Much research on leadership ignored the pervasive realities of organisational and social life. Leadership was heavily influenced by a number of factors, such as organisational structure, power coalitions, and environmental conditions. Hall (1991) commented that in the process of designing their own behaviour, leaders were affected by other people's

presence and preferences, and their attempts at influencing leaders' behaviour.

An alternative perspective on leadership would be to recognise explicitly that the leader occupies a position in a social network of others. Hunt and Larson (1975) suggested that leaders could be conceptualised as belonging to a larger social system than that of themselves and their followers. To understand leadership behaviour, one has to analyse how do individuals behave in given situations, and what are the constraints determining their behaviour. This social perspective of looking at leadership implies that leaders do not merely select styles of leadership to accommodate their own. Effective leaders are those who are responsive to the demands of all individuals in the social system with whom they interact and co-ordinate with. Their effectiveness may derive not only from their position with their followers, but from their position in a social-organisational structure which goes beyond their work group. In the process of dealing with others, leaders will at times be confronted with demands for certain behaviours. As a consequence, it is quite likely that the leaders' behaviour will be constrained by their social network. However, there are few studies to assess such a view of effectiveness.

In the past, much of the effort in leadership research had restricted attention to the internal aspects of leadership and ignored the broader social and competitive environment in which the organisation found itself. Hall (1991) commented that factors such as the political conditions, the socio-economic conditions, the cultural conditions, technological conditions and legal conditions that would influence leadership effectiveness were given little attention. Hunt and Larson (1975) concurred that environmental complexity might influence leadership process. When predicting leadership outcomes, there are likely significant interactions between environmental complexity and leadership process. The interactions take places at the societal, the institutional and the individual levels. Leaders have to adapt to the changing

environment. In analysing leadership effectiveness, one had to bear in mind that it depends on the interaction between leadership process and its environment. Future study on leadership should investigate how leaders adapt to the environment.

There may be numerous contextual variables associated with leadership effectiveness, but only a few has been studied. Some contextual variables may significantly influence leadership effectiveness. For example, the reform of health care system in Hong Kong may bring new direction and new ways of nursing leadership. It may be treated as important contextual factors affecting nursing leadership effectiveness.

Yukl's model of leadership

Previous review concluded that there are different approaches in conceptualising leadership. However, some researchers argued that these approaches had been fragmented. These approaches told the readers something about leadership, but not the whole story. This was in part due to narrow research, and a lack of an integrating framework (Chemers, 1993; Hunt, 1991 and Yukl, 1989). Chemers (1993) suggested that a lack of integration across theories and approaches ultimately diminished the utility of research findings for both scientists and practitioners. A successful integration should illuminate common findings and provide a platform for the next generation of theory and research. Yukl (1991) put forward an integrated model encompassing each of the important sets of variables relevant to leadership effectiveness and described the assumptions of his model as follows:

> This model is based on the assumption that organisational effectiveness, in terms of end-result variables, is mediated by a

> core set of intervening variables. These in turn are determined by a complex interaction among leader traits, power, influence, and situational variables. Leaders can directly influence intervening variables in a variety of ways, and by taking actions to make the situation more favourable. (p.268).

This model proposes that leadership behaviour interacted with leaders' personal and position power to influence the followers' attitudes and behaviour. Through working with followers and demonstrating appropriate personal skills and competence, a leader can gain referent power and other types of power. The leader's skills and traits are important factors contributing to personal power. Apart from being influenced by traits and skills, leadership behaviour is affected by situational variables. Situational variables, such as policies, rules and regulations; role expectations from superior, peers, and followers; nature of task and external environment, affect the behaviour of the leader. As different situation demands different forms of leadership, particular skills will be called for in each situation. The leader traits and skills also interact with situational variables contributing to the end-result variables. Yukl (1989)'s model seems to be quite successful in integrating the different approaches and theories of leadership. It maintains that leader behaviour is affected by a variety of factors and proposes that the leaders' traits, personal power, personal skills, and followers' interactions must be considered together in order to understand how leaders influence people.

Hall (1991) suggested several advantages of Yukl's model: it identifies the factors that could contribute or block leadership efforts; it can deal with leadership at various level within an organisation and also calls attention to end-result or outcome variables; and the model enables one to analyse leadership behaviour from different perspectives and can overcome some pitfalls of unidimensional leadership theories. This multidimensional view

could be used as an approach of this study.

Research in nursing leadership

Nursing leadership has become a popular topic in recent health literature. Meighan (1990) suggested that the increase in the importance of nursing leadership study was probably due to the turbulent environment of the health care service, where patient acuity had increased and the available number of nurses had decreased. There was a need to improve nursing leadership effectiveness. Throughout the literature in the UK, USA and Australia, the need to develop and understand nursing leadership is apparent.

Although progress had been made in the previous decades, Altieri and Elgin (1994) argued that there was a still a legacy of neglect as regards to nursing leadership studies. They reviewed the research literature on nursing leadership from the year 1960 to 1980 and found only 58 research articles. The majority of the studies were quantitative in design. In a search for studies on nursing leadership from 1980 to 1998 using CINAHL and MEDLINE, about 300 research articles were found, demonstrating an increasing number of nursing leadership studies.

Early literature focused on describing a leadership crisis in nursing and explored the reasons for weak leadership in nursing. It then moved from a concentration on the lack of nursing leaders in the late 1980s and early 1990s (Davidson and Cole, 1991; Salvage, 1989; Mackie, 1987; McCloskey and Molen, 1987; Larsen, 1983 and Leininger, 1974), through to explorations of what makes effective nurse leaders (MacPherson, 1991 and Brown, 1989) and on to finding ways of developing nurse leaders for the future (Hempstead, 1992 and Hunt, 1992). Two categories of research in nursing leadership were identified from the review: *predicting leadership*, which examines personality

characteristics and qualities that indicate leadership potential or success, and *leadership development*, which seeks the reasons that hindered nursing leadership development. These two categories of nursing leadership research will be used as a framework for discussion.

Predicting leadership

Some studies attempted to identify attributes predicting effective nursing leadership. The theories that form the framework for these studies are trait theory, behavioural theory, and transformational leadership theory. Despite the differences in theoretical frameworks and methods, many similar attributes of effective nursing leadership emerged from the literature (Altieri and Elgin, 1994). Dunham and Fisher (1990) and Murphy and DeBack (1991) carried out qualitative analysis to determine the characteristics and behaviours of nursing leaders. Both studies utilised taped interviews of a convenience sample (N=85 and N=13) of hospital nurse executives and determined that many subjects displayed similar characteristics, such as being visionary, credible, enablers, role models and able to master change. In a study of leadership quality, Smith (1985) described the qualities required by nurse leaders as abilities to think and be creative, to show initiative and imagination, to be courageous and to have stamina. Meighan (1990) looked at leadership characteristics from the perspective of staff nurses. Despite the differences in samples, the same leadership characteristics were identified in the three studies, such as having vision, exhibiting high values, communicating, motivating and risk taking.

A number of studies have investigated leadership activities. Yura (1971), in a study suggested that behaviour relating to communication, decision-making, coordination, maintaining coalition, motivating, supporting and guiding, constituted effective leadership behaviour. Yura, Ozimek, and Walsh (1991) identified five key leadership roles: deciding, communicating, relating,

influencing and facilitating. Manfredi (1996), using a descriptive study design, examined leadership activities through the use of an open-ended questionnaire to 42 nurse managers. Findings indicated that the leadership activities described by the nurse managers were congruent with the descriptions in the leadership literature, which included goals, change, influence, unity, power, growth, mentoring and vision. A qualitative study of the role of nurse leaders conducted by Coulson and Cragg (1995) was based on interviews with nurse managers in an acute hospital. It was found that establishing direction, communication, forming coalition, coaching, facilitating, directing and developing were major components of effective leadership role. Literature review concluded that effective leaders are those who establish vision and used power to influence change. Leaders acted as mentors to facilitate growth in followers.

Five studies (Martin, 1992; Garrett, 1991; Patz, Biordi and Holm, 1991; Duxbury, Armstrong, Drew and Genly, 1984 and Pryer and Distefano, 1971) examined job satisfaction in relating to leadership effectiveness with different levels of service personnel. These studies found that human management skills, such as consideration and communication, were more important to promoting job satisfaction than the clinical or fiscal abilities of the leader. Job satisfaction was positively correlated with the leadership dimension of consideration.

The relationship of head nurse leadership style to staff nurse job satisfaction was investigated by Medley and Larochelle (1995), using the leadership paradigm of transformational and transactional leadership. 122 subjects participated in the study. A correlation analysis showed a significant positive relationship between head nurses exhibiting a transformational leadership style and the job satisfaction of their staff nurses.

When attempting to identify characteristics of 'excellent' leaders, Dunham and Klafehn (1990) undertook a study of nurse leaders identified by their peers and subordinators as 'excellent' and sought to determine whether or not the skills they employed were skills associated with transformational leaders. This study demonstrated that excellent nurse executives had transformational skills and qualities and were perceived by workers to have them. Dunham-Taylor (1995) interviewed nurse executives and also identified transformational leadership as part of the composition of excellent nursing leadership. Jeska (1992) used case study method to provide a set of transformational leadership portraits. Her study demonstrated transformational leadership style could improve the effectiveness of nurse administrators in inducing change within bureaucratic organisations.

From the above literature review, it is found that the key functions of nurse leaders included: communication, establishing direction, decision making, maintaining unity, influencing, motivating and supporting. Human factors, such as consideration, were most reflective of an effective leader. Similar characteristics of transformational leadership style were identified as common characteristics of successful leaders. When evaluating nurse leaders' performance, these variables could be used as a framework for evaluation.

Leadership development

Considerable literature maintains that nursing demonstrated weak leadership. Nurses have generally failed to achieve a more influential leadership role in the delivery of health care and the professional development. It has been claimed that policies affecting nursing are not made with adequate participation of the nursing profession itself (Irurita, 1992; Henry, 1989; Marles, 1988; Lange, 1984 and Leininger, 1974). Literature suggested that the reasons for nursing's failure to produce effective leaders were embedded in its

social and political history. The gender socialisation, medical dominance and professional socialisation were considered as main factors accounting for weak nursing leadership (Irurita, 1992; Robinson, 1991; Henry, 1989 and Game and Pringle, 1983).

Nursing is still predominantly a female profession. The lack of success in obtaining influential leadership positions is influenced by the gender role socialisation. Shaver (1999) mentioned that there was still a view that women did not make such effective leaders as men. Roberts and Group (1995) in their study noted that successful leader had been depicted as male with traits emphasising aggressiveness, forceful, competitiveness and independence; characteristics that were more often associated with men than with women. Austin, Champion and Tzeng (1985) undertook a study of how the words 'nurse' and 'feminine' were perceived in thirty language/culture communities and found that the interpretation of the word 'nurse' occurred in a very similar way to the interpretation of the word 'feminine'. It was perceived as meaning 'good' and 'active' but also 'emotional' and 'weak'. The study concluded that women could not be perceived as powerful and as 'nice girls'. The stereotype image of women made it difficult for nurses to develop powerful leadership.

Furthermore, Edwards (1994) and McCurdy (1988) maintained there was also a view that women feared success and therefore underestimate their abilities and were unwilling to put themselves forward for promotion. Klenke (1996) in her study also concluded that many women felt seemingly successful was not behaving in a socially approved manner for a woman. There was a fear of demonstrating an inappropriate gender role. These traditional beliefs hindered the development of leadership in women.

Moreover, in Chinese culture, women had been socialised to develop caring and nurturing behaviour, focusing on others rather on themselves. Women

were not expected to be leaders, and as a result, competition and leadership skills were not developed or encouraged. Chan and Cheng's (1999) study of nurses in Hong Kong suggested that characteristics such as passiveness, subservience, altruism and sacrifice were culturally expected from female. Assertive and outspoken nurses had yet to be accepted by society at large. This restricted the development of leadership abilities in Chinese females. There are clearly many challenges for nurse leaders in establishing a powerful image.

Professional socialisation had been identified as another factor limiting the development of strong nursing leadership. Studies by Moloney (1992), Gardner and McCoppin (1989), and Melia (1986) found that nurses' behaviour had its roots in the Florence Nightingale tradition which encouraged submissiveness to authority and loyalty to the organisation rather than to the profession. These attitudes placed nursing in a dependent position, and encouraged behaviour patterns such as subservience, passivity and dependency. These behaviours made it difficult for nurses to develop autonomy and independence, which were essential leadership characteristics. Leininger (1974)'s study showed that passive and non-assertive leaders working in the complex health care system had failed to see needed changes and continued to function in traditional passive and non-political ways. Such behaviour had reinforced the tradition and perpetuated the behaviour. These variables had limited the performance of nurse leaders and weak nursing leadership was a consequence.

Weak nursing leadership might also be related to medical dominance in the health care system. Various reasons had been put forward to explain medical dominance. Traditionally, the nurse-doctor relationship involved the nurse giving prescribed care based upon the doctors' orders. Such convention had reinforced the image of nurses as the doctors' handmaiden and helpers.

Soothill, Mackay and Webb (1995) maintained that health care organisation focused on diagnosis and treatment of disease which was doctors' arena. Nurses were seen to be powerless with regard to diagnosis and treatment. This cure-oriented medical model influenced the division of labour in the health care settings. Doctors were seen as the leaders of the health care team and nurses and other paramedics were seen as assisting the doctors in the curing process. This contributed to the existence of medical dominance.

Nursing has always been associated with maternity and femaleness. Florence Nightingale equated the idea of being a good nurse to that of being a 'good' women and emphasised that the success of nursing depended upon the cultivation of 'feminine' character rather than on training and education (Garmarnikow, 1978). Soothill, Mackay and Webb (1995) maintained that these stereotypical images of nursing being synonymous with motherhood and femaleness fostered an image of the passive unquestioning nurse compliance to the dominant and patriarchal male doctor. It thus helped to reinforce medical dominance.

It was argued that the health care organisation resembled a microcosm of the wider society. In their studies on power relations between doctors and nurses, Garmarnikow (1978) and Willis (1983) suggested that the hierarchical structure in the health care system reflected the ideology of power relations between men, women and children within the patriarchal family. The symbolism of family: doctor/father, nurse/mother, patient/child, had been used explicitly in the definition of jobs and authority relations in health care organisations. Doctor was the in-charge of the family and the nurse as the mother providing care to the child (patient), who was dependent on the parents. The value of the male-dominated society perpetuated in the health care system.

In the hierarchical structure of the health care system, doctors have historically been involved in making nursing appointments. In Canada, for example, Keddy, Gillis, Jacobs, Burton and Rogers (1986) interviewed older nurses and found that doctors often had a great deal of influence in the selection of nurses. It reinforced the control of medicine over nursing. Gardner and McCoppin (1989), and Game and Pringle (1983) commented that even though there had been an increase in numbers of male nurses and female doctors in recent years, it had not changed the basic power relations.

In Melia's (1986) study, nurses placed a greater importance on the medical knowledge, rather than on nursing. Many nurses regarded work that has medical connection is regarded as 'prestigious work'. Nurses believed that this 'prestigious' work would assist them, in their efforts to become professionals. Some nurses were willing to submit to medicine.

The power relationship between doctors and nurses was well illustrated by Stein (1967)'s study on doctor-nurse game. Stein's study observed that when nurses knew doctor's prescribed inappropriate treatment to patient, they would try to convey this message to doctor in a subtle and indirect way, rather than telling the doctor the fact assertively. Fagin (1992) maintained that this arrangement enabled the hierarchical relationship between doctors and nurses would be managed so that nurses' recommendations and initiatives would be couched in such a way as to maintain the hierarchy and allow the attribution of decisions to doctors. This doctor-nurse game perpetuated medical dominance.

Medical dominance was also related to the difference in professional status between nursing and medicine. Medicine was recognised as a profession while nursing was not. There were many debates as to whether full professional status had been achieved in nursing and there were different interpretations on the term 'profession'. Freidson (1970) maintained that the

major criterion for making professions distinct from other occupations was that they had to have a position of legitimate control over work, that was, they had to have autonomy in their practice (p.82). Other sociologists have added the notions of self-regulation and self-identification to the definition of a profession (Etzioni, 1969).

When considering whether nursing was a profession, Freidson (1970) regarded nursing was not a profession because nurses did not have autonomy to control their practice. He commented that the dominant position of medicine frustrated any effort that the 'paraprofessionals' made towards securing full professional autonomy. Freidson maintained that 'the paraprofessional occupations usually sought professional status by creating many of the same institutions as those who possess professional status. They developed a formal standard curriculum of training, hopefully at a university. They wrote codes of ethics. They sought support for licensing or registration so as to be able to exercise control over who was allowed to do their work. But what they persistently failed to attain is full autonomy in actually performing their work. Their autonomy was only partial, being second-hand and limited by a dominant profession (p. 76)'. Etzioni (1969) labelled nursing as a 'semi-professions'. He described semi-profession as 'a group of new professions whose claim to the status of doctors and lawyers is neither fully established or fully desired. Their training was shorter, their status less legitimated. There was less autonomy from supervision or societal control than the professions (p.v)'.

As a semi-profession, nursing did not have the social prestige of being treated as equals with doctors in the health care team. Freidson (1970) maintained that the consequence of this unequal status was the paramedical occupations, such as nursing, were organised around the central established profession of medicine. Medicine became the dominant group in the health care system.

The subordination of nursing to medicine impacted on the image of nursing. Considerable literature, supported that nursing did not have a powerful image. There was still a feeling that nurses had neither scientific knowledge, nor the capacity to be independent thinkers (Mason and Leavitt, 1998; Ferguson, 1993; Clifford, 1992; Sweeney, 1990 and Boyle, 1984). Bohn (1986), Kalisch and Kalisch (1986), and Austin, Champion and Tseng (1985) examined the television images of nurses in the USA and concluded that the media portrayed nurses to be less intelligent and less rational in their behaviour, than physicians. With this powerlessness image, it would be difficult for nursing to develop strong leadership.

Another consequence of medical dominance was the development of 'oppressed group behaviour' in nursing as described by Roberts (1983). The characteristics of an oppressed group were: divisiveness, resistive to advances in nursing, lack of cohesion, a low level of participation in the professional nursing organisation, and a displaced aggression (horizontal violence) towards colleagues (Hedin, 1986; Freire, 1971). Roberts (1983) maintained that nurses formed an oppressed group because the medical profession, who had greater prestige, power and status, controlled them. The oppressed group behaviour seriously reduced the power of nurses and it affected the effectiveness of nursing leadership (Maslin-Prothero and Masterson, 1999; Boyle, 1984; Ashley, 1973; Schaefer, 1973).

In summary, the gender role socialisation coupled with nursing role socialisation and medical dominance, are important factors accounting for weak nursing leadership. Nursing does not have the professional status attributed to medicine and it projected a powerlessness image. The weak nursing leadership affected nurses' ability to influence policies related to nursing development. However, most studies on nursing leadership were

carried out in western countries, there was no study related to nursing leadership in Hong Kong. It was not known whether Hong Kong situation was the same as that in the West. There was a need to identify the situation in Hong Kong that affect nursing leadership development.

Research methods in leadership studies

Quantitative method

A review of the literature finds different methods to the study of leadership. Research on traits of leaders tends to rely heavily on the use of quantitative approach with questionnaires for the collection of data (Irurita, 1990 and Sims 1979). The advantages of using questionnaires were that they were readily available and easy to administer. Polit and Hungler (1995) commented that quantitative data derived from tests or questionnaires were often strong in terms of generalisability, control over extraneous variables and reliability of measurement.

However, weaknesses had also been identified in the use of questionnaires. Sims (1979) suggested that the use of questionnaires in leadership studies was inadequate because of the narrow scope of construct development. Because of these weaknesses, questionnaires should not be considered as an end point in themselves. Yukl (1989) also noted that factor-scaled questionnaires failed to include important items of leadership behaviour that were correlated with two or more factors. Infrequent behaviours were likely to be missed and often the context in which the behaviour appeared was also missed.

Cultural relevance also has to be taken into account when using questionnaires developed in another culture. Although common standardised instruments have made possible a great deal of comparisons across studies, questionnaires

and rating scales developed in Western countries may not be appropriate for people in other cultures. To overcome the weaknesses, it was suggested that questionnaires should be well grounded in phenomenological investigation of reality (Smith and Wang, 1994). There is also a need to pay greater attention to the steps advocated prior to questionnaire development and to ensure internal psychometric adequacy of questionnaire measures.

Furthermore, there had been many debates as to whether quantitative approach is the best research method in understanding leadership. It was argued that quantitative research methods make an epistemological assumption that the social world lent itself to objective forms of measurement (Cowman, 1993). Morse (1991b) and Leininger (1985) both argued that people were not reducible to measurable objects and did not exist independently of their historical, cultural and social context. A qualitative paradigm was therefore advocated in nursing leadership studies.

Qualitative methods

In recent years, there has been an increase in the use of qualitative approaches in leadership research. Qualitative methods are regarded as appropriate when complex factors are involved. Polit and Hungler (1995) and Bryman, Bresen, Beardsworth and Keil (1988) suggested that qualitative research was able to uncover a wider array of contextual variables that influenced leadership behaviour and were unlikely to be discovered using questionnaire survey. Orpen (1987) concurred that more qualitative research was needed in the study of leadership, as quantitative methods had limitations in dealing with situational complexities. Altieri and Elgin (1994) recommended using qualitative research to indicate the values, beliefs, and experiences of leaders, which could not be captured through quantitative analysis. Furthermore, the search for meaning and significance in the behaviours of leaders and their

followers, as well as in related events, would be aided by qualitative research (Van Maanen, 1979). The actions of people could be explained in terms of the total context in which they occurred, instead of being regarded as isolated or manipulated elements within situations.

Qualitative nursing leadership studies have increased in number in recent years. For example, Irurita (1992) used grounded theory method in studying nurse leadership in Western Australia. Brown and Hosking (1986) studied leadership in women's groups using participant observation as a principal method over a period of two years. Marshall and Stewart (1981a and 1981b), and Stewart, Smith, Blake and Wingate (1980) used a combination of lengthy interviews, as well as group discussion, when studying the nature of managerial work. House (1977) used biographic and historical analyses in studying charismatic leadership and its effects on followers. Mintzberg (1973) systematically observed five chief executive officers over a five-day period and developed managerial role categories.

Qualitative methods have advantage over quantitative method in gaining in-depth knowledge about complex contextual variables that influence leadership behaviour, and enable the interpretation of leadership actions in terms of the total context. However, Polit and Hungler (1995) pointed out that, because qualitative research was almost always based on small and unrepresentative samples, using data collection and analytic procedures that relied on subjective judgements, qualitative research might suffer in terms of reliability and generalisability.

Integrated design

Literature showed that neither quantitative nor qualitative method in isolation would truly provide an understanding of the phenomena under study (Duffy,

1987 and Haase and Myers, 1988). A recent trend in leadership study has been the integration of quantitative and qualitative approaches. Polit and Hungler (1995) suggested that qualitative and quantitative data were complementary to each other, in that they used words and numbers, the two fundamental languages of communication. The use of multiple evidence allowed the investigator to broaden the perspectives in the understanding and construction of leadership theory. The combination of qualitative and quantitative data used judiciously in a single study had the potential to 'supply each other's lack' (p.540). Polit and Hungler (1995) pointed out that when an investigator's hypothesis or model was supported by multiple and complementary types of data, the investigator could be much more confident about the validity of results. Also, Duffy (1987) and Haase and Myers (1988) maintained that since the world was complex and multidimensional, quantitative and qualitative research constituted alternative ways of viewing and interpreting the world. They suggested that the blending of quantitative and qualitative data in a single analysis led to insights into the multiple aspects of understanding the world that might be unattainable without such integration.

In acknowledging the need for the integration of research approaches in nursing, triangulation as a research strategy is proposed. Denzin (1978) defined triangulation as the combination of two or more data sources, methods, theories or investigators in the study of a single phenomenon. Various authors concurred with Denzin's interpretation of triangulation. Although these authors did not specify the kinds of data or methods that were combined, the assumption was that they were referring to triangulation of qualitative and quantitative data and methods (Kimchi, Polivka, and Stevenson, 1991; Morse, 1991a; Duffy, 1987 and Mitchell, 1986).

The integrated design has been used by nurse researchers. For example, Mitchell (1991) studied the clinical and organisational impact of multiple

changes in critical care by using a case study approach. Data were obtained through surveys, interviews, and medical record. Ferguson (1998) used quantitative survey and interview to create a description of nursing leaders, who supported autonomous practice of registered nurses in hospital settings. These studies demonstrated that the use of quantitative and qualitative data were feasible and could complement each other.

Future directions in nursing leadership research

In the future leadership study, Marquis and Huston (2000) called for a conceptual integrating framework, which tied the different approaches together and made possible the development of a comprehensive, sustaining theory of leadership. Leadership effectiveness cannot be determined from any one approach alone, but rather through the simultaneous interaction of many types of variables, such as fast-paced change, multiple decision arenas, widely dispersed players and extensive political activities. Yukl's (1991) model appears to be useful in investigating the relationship between leaders and the situational variables. However, there is little empirical evidence to support the usefulness of this model and it therefore requires further testing and investigation.

A review of nursing leadership studies showed that there was very little literature related to the impact of socio-political-cultural factors on nursing leadership (Hall, 1991; Probst, 1988; Riley, 1988 and Tsoi, 1982). It was advocated that more emphasis on the social system, the context of leadership and the leadership process was needed in the scope of leadership study, to include factors such as socialisation, work relationships and organisational influence on leadership behaviour (Tsoi, 1982). Dachler (1988) and Probst (1988) supported this view and stated that leadership could only be understood

as part of the social system, where the system itself was a part of a larger system of context, interrelated with its environment.

A methodological problem common to many leadership studies is the selection of subjects. The 'leaders' in many studies have generally been first-line supervisors, managers or military officers at lower levels of the organisation. In some nurse leadership studies, subjects involved are senior nurse managers or deans of faculty. It is difficult to make comparisons across studies, in regard to 'leaders,' 'supervisors', 'managers' and 'executives', since these positions are variously defined in different organisations, but treated as synonymous leadership positions in research. However, the skills that are needed by a first-line supervisor will be different from those of the chief nursing executive of a hospital.

Many authors have debated whether or not leadership and managerial success are the same. Gardner (1986) asserted that leadership requires more complex skills than management, and management was only one role of leadership. Some authors looked at management and leadership in terms of the functions. Manthey (1990) stated that a manager guided, directed and motivated, while a leader empowered others; therefore, every manager should be a leader. However, Holloman (1986) distinguished managers from leaders. He maintained that it was a mistake to refer to a supervisor, or a head nurse as a leader. He claimed that these individuals were in headship position, rather than leadership position.

In future leadership research study, it is essential to distinguish between leadership and management as two different functions. Also, most nurse leadership studies have involved formal leaders in the health care organisation; professional leaders were not included. Nursing is a profession and professional leaders might have different styles, strategies or characteristics

when compared with nurse executives in hospitals. Professional leaders should be taken into account in future leadership studies. As there is an increasing opportunity for nurse executives to be involved in policy-making, there is a need to focus leadership research on this group of subjects.

The last 80 years of leadership theory research has essentially been conducted in and dominated by the industrial, business, or military settings. Martin (1992) stated that nursing differed from work in industrial settings in a number of ways. The work involved in the creation of tangible products in an industrial setting is readily apparent, whereas products of nursing services, such as 'health' or 'recovery', are often ambiguous and intangible, and the work involved in the creation of these products is not always easy to quantify. Nursing leadership studies are needed to identify the unique characteristics of nurse leaders. Furthermore, all the available literature on nursing leadership is from overseas. Knowledge on nursing leadership in Hong Kong cannot be found. There is a need to fill this knowledge gap.

Previous discussion pointed out factors that influenced nursing leadership development. There is an urgent need to develop nurse leaders, as the health care environment is changing and there are new roles and expectations for nurse leaders. The input of nurses into the policy-making arena is increasingly important and desired by consumers and health care professionals alike. Future research should address questions such as:

- How do nurse leaders effect changes in the health care system?
- What are the effective ways to influence policy?
- What are the effective ways to influence followers?
- What are the situational factors influencing leaders' behaviour?
- How can leadership potential be developed?

In terms of research methodology, there is a need to increase the application of

qualitative research methods in conjunction with quantitative methods, in order to expand the focus of leadership studies and uncover a wider array of contextual variables that affect leadership behaviour. The use of triangulation with multiple methods and data sources can help to overcome the weaknesses in using quantitative or qualitative methods alone.

Summary

This chapter provided an overview of the development of leadership theory. Early leadership theories evolved from unidimensional individual-centred approaches to a multidimensional conceptualisation, which takes the individual, the group, the situation and the larger environment into account. Leadership theory was further advanced when the focus changed from leadership primarily as a top-down process to a much more bottom-up process. The influence theory extended the scope of leadership from group interactions to the interactions of the entire organisation or in the political arena. The transformational theory saw leadership as occurring at all levels of the organisation, affected by the persons involved, their situations, the followers and their influences on each other. The complexity of leadership is widely acknowledged in the literature. Given the complexity of leadership behaviour and the weaknesses identified in many leadership theories, there is no one theory that can fully explain leadership. An integrated approach to the study of leadership is therefore advocated.

Studies of nursing leadership have focused on predicting leadership and leadership development. Literature indicated that because of gender and role socialisation together with medical dominance, nursing leadership was weak. There is a need to develop effective leadership in nursing. Published literature on nurse leadership in Hong Kong is scarce. Local study is important to

develop knowledge in nursing leadership culture which takes into account the changing context of Hong Kong and is relevant to the Hong Kong Chinese. As more nurses assume new roles in policy making, a new area for nursing leadership studies emerges. The focus should be on how leaders exert influence and function in the political environment.

Previous studies used either quantitative or qualitative approaches. The use of both approaches is advocated so that data gathered by different methods can complement each other and so help to broaden the perspectives in the understanding of leadership behaviour. The following chapter will present the research framework and explain the methodology of this study.

CHAPTER FOUR

CONCEPTUAL FRAMEWORK AND METHODOLOGY

Introduction

This study used a case study approach with multiple methods of data collection to investigate the role of nurse leaders in the reform of nursing education in Hong Kong. The purpose of this chapter is to explain the conceptual framework of the study, the choice of methodology and the methods of data collection.

Conceptual framework of the study

From the discussion in previous chapters, it is concluded that nursing leadership could be one of the crucial factors in bringing about desirable change in nursing education. This study adopted a multidimensional approach in analysing leadership behaviour. Leadership effectiveness is determined by a complex interaction among various variables. The power of nurse leaders, the specific situations confronted, the characteristics of nurse leaders involved, and the nature of their relationships with followers, all affect leadership behaviour and the impact of that behaviour (Yukl, 1991).

The reform of nursing education involved a change in nursing education policy and the allocation of resources. Mason and Leavitt (1998) suggested that the policy process began with identifying the problem and putting forward an agenda to the policy-making arena. In this case, the policy-making arena was the Government. To achieve nursing education reform, nurse leaders influenced key players to put forward nursing education reform as an important agenda to the Government. This study involved identifying the key players in the Government,

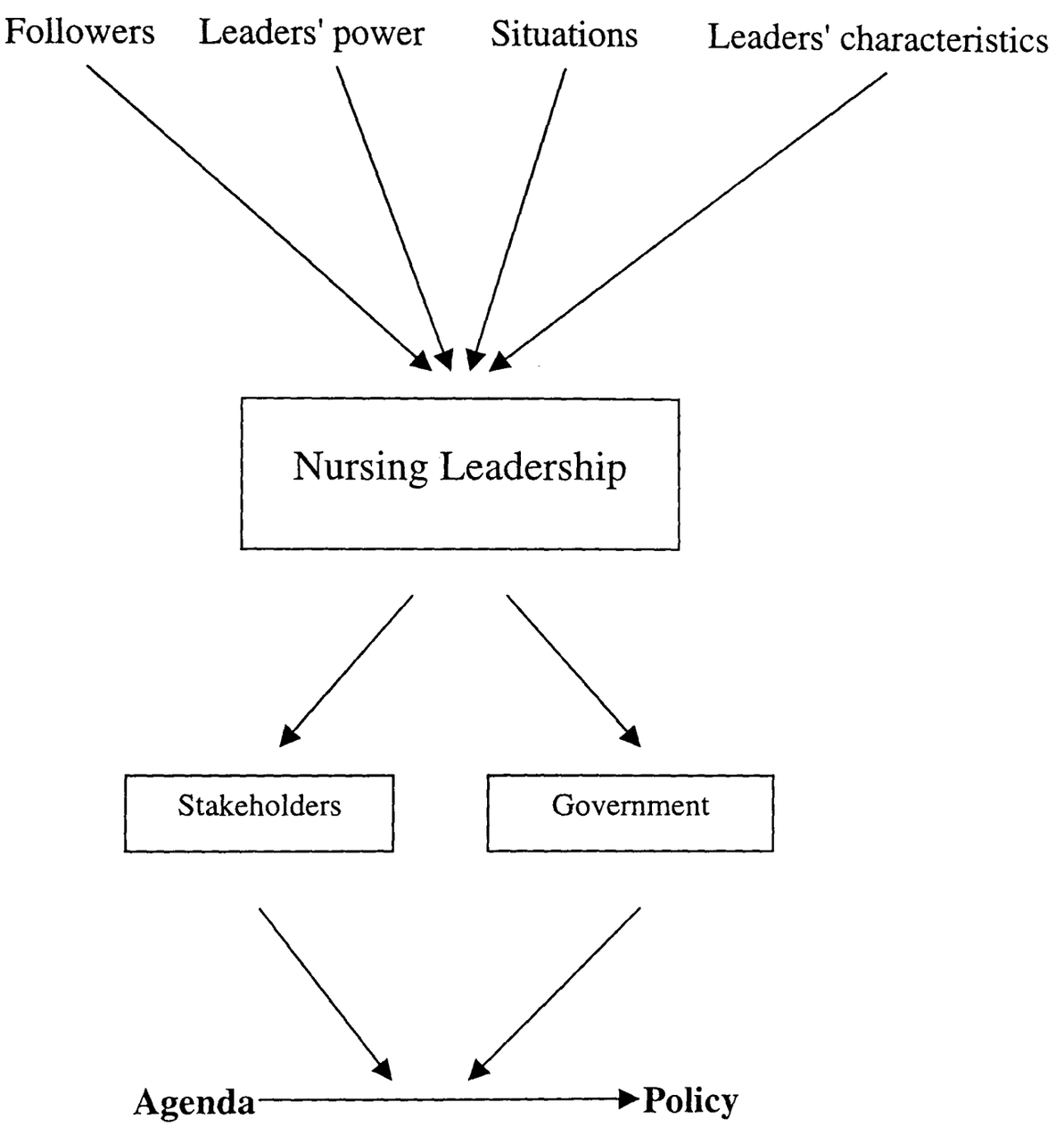
analysing how nurse leaders presented the agenda to the Government, and investigating nurse leaders' roles in influencing Government's decisions.

There are stakeholders who have influence in the nursing education reform. Mason and Leavitt (1998) suggested that support from stakeholders was important in moving the issue to make it as a priority to the Government. In the making of nursing education policy, the Government would consult stakeholders. Nurse leaders had to gain stakeholders' support to influence the Government to make and enact decisions. Stakeholders had the power to influence the outcome of nursing education reform. This study involved identifying the stakeholders and analysing nurse leaders' actions in influencing stakeholders.

Nurse leaders' effectiveness was also influenced by the support they gain from followers (Yukl, 1991). In this case, the followers were frontline nurses. The perception of followers towards nurse leaders' effectiveness would influence the support they gave to nurse leaders. The support from followers would increase nurse leaders' power. This study analysed the actions used by nurse leaders in influencing followers and examined how followers evaluated their leaders' effectiveness.

Nurse leaders' actions and interactions with key players have to be understood in light of the situational variables, as these types of interaction do not take place in isolation from one another. The environment, which includes organisational, social, cultural, political and economic aspects, would have influence on leadership effectiveness. The reform of nursing education was initiated in a period when major changes were taking place in Hong Kong's health care system and socio-political situation. These changes would have an impact on the outcome of the reform. This study sought to identify the situational factors affecting nurse leadership behaviour and to analyse how these factors influence the effectiveness of nurse leadership. The conceptual framework of the study is illustrated in figure 1.

Figure 1 Conceptual framework of the study



Methodology

Case study approach

The case study approach was used in this study. Case study approach is considered as a research methodology by Yin (1994). Yin defined case study as 'an empirical study that investigates a contemporary phenomenon within its real-life context, and in which multiple sources of evidence are used' (p.23). Woods and Catanzaro (1988, p.553) considered case study as an intensive, systematic investigation of a single individual, group, community or some other unit. It is typically conducted under naturalistic conditions, in which the investigator examines in-depth data related to background, current status, environmental characteristics and interactions. Both definitions agree that case study enabled researchers to examine a phenomenon in its context. Yin (1994) also pointed out that the deliberate act of investigating a contemporary phenomenon within its real-life context was what distinguished case study from the other research strategies.

The importance of context in case study is best summed up by Bromley (1986): 'The proper focus of a case study is not so much a *person* but is the *person in a situation*'. Context is vital for a thorough understanding of the case as 'realities are wholes that cannot be understood in isolation from their contexts' (p.25). This study was a case study of a contemporary issue 'nursing education reform in Hong Kong'. Nurse leaders' behaviour was studied in relation to the context of the health care system and the socio-economic-political culture of Hong Kong.

Defining the unit of analysis is a critical concept in case study. Yin (1993) maintained that the entire design and its potential theoretical significance were determined by the way that the unit of analysis was defined. In a case study, the unit of analysis could be a person, family, group, community, organisation, society, culture or event (Mariano, 1993). In this study the unit of analysis was an event: the reform of nursing education in Hong Kong during the period 1985 to

1995. The 'case' in this study was nursing education reform in Hong Kong and the role of nurse leaders was studied in this event.

A single-case study design was used. Yin (1994) maintained that a single-case design was justified when dealing with an extreme case. The condition might be so rare that it was worth documenting and analysing. The transfer of nursing education from hospitals to tertiary institutes had never happened in the history of nursing in Hong Kong before. This was therefore a unique situation and a single-case study was justified. In this study, the researcher examined only the global nature of the nursing leadership process. The researcher made no attempt to analyse and compare the behaviour of each nurse leader.

Some textbooks classified case study as a qualitative research method. Yin (1994) argued that case study should not be confused with qualitative research. A case study could have any mix of quantitative and qualitative evidence. This study used both quantitative and qualitative evidences from documents, interview and questionnaire survey

Rationale for using case study approach

When discussing the choices of research strategies, Yin (1994) maintained that the case study was the preferred approach when 'how' and 'why' questions were asked about a contemporary set of events, over which the investigator had little or no control (p.18). In this study, the researcher attempted to find out how nurse leaders influenced nursing education policy in Hong Kong and what factors affected leaders' behaviour. The researcher had no control over the events investigated. Nursing education reform was a contemporary phenomenon that relevant subjects were available to answer 'how' and 'why' questions. Thus case study approach was considered to be the most appropriate approach for this study when compared with other designs such as experimental, ethnographic methods or phenomenological method.

Since the behaviour of nurse leaders was not static and is strongly influenced by situational variables in the context, the case study approach allowed the researcher to examine leadership behaviour in the Hong Kong context. Situational factors, such as nursing development and social and political situation in Hong Kong could be taken into account when analysing leadership behaviour. This helped the researcher to understand the leadership process in influencing nursing education policy within its real-life context. The researcher found this useful in understanding the implications of these changes for nursing practice.

The case study design was used to arrive at a comprehensive understanding of the group under study, but this methodology could also be used to develop theories. Merriam (1988) suggested that case study was a research methodology that could both test and build theory. The findings in this study could be used to validate the existing leadership theory and to develop model to explain nurse leadership behaviour in influencing policy.

The case study approach enabled the researcher to use multiple evidences in the study of a phenomenon. Yin (1994) stated that case study's unique strength was its ability to deal with a full variety of evidence. Yin elaborated that case study relied on many of the same techniques as historical method, such as reviewing primary and secondary documents as the main sources of evidence. However, case studies also added other sources of evidence not usually included in the historian's repertoire, such as interviewing or questionnaires (p.18, 19). As case study was not limited to either quantitative or qualitative method, the opportunity to use different sources of evidence was a major strength of this approach. Yin (1994, p.42) labelled it as the development of 'converging lines of inquiry', which was a process of triangulation. The use of 'combination of methodologies in the study of the same phenomenon' (Denzin, 1978, p.291) facilitated multiple viewpoints of the same subject. It improved the accuracy and the overall quality of the data because of the increase in the details and range of the data collected over a period of time. The case study approach also produced a more holistic study than do other designs.

The case study approach helped to improve the researcher's understanding and interpretation of the phenomenon. Talbot (1995) maintained that through in-depth case descriptions or explorations, case study provided sufficient details for the reader to grasp the idiosyncrasies of the phenomenon. Mariano (1993) noted that case studies employed an intensive orientation to the phenomenon under study. A very close association between the researchers and the participants usually occurred over a long period. The researchers immersed themselves in the setting or situation and collected extensive evidence to describe and/or explain the case. Understandings that developed as an outcome of the study were often powerful and profound.

In this case study, the researcher was involved in a prolonged engagement with the subjects of the study (3 years). As a result, the researcher became familiar with, and gained an in-depth understanding of, the context within which the study was embedded. Mariano (1993, p.323) maintained that the prolonged engagement in the study gave the researcher the opportunity to 'get to know the subtleties of the situation and have the time to *peel away* layers until the core of the phenomenon emerges'. Denzin and Lincoln (1994) asserted that the pursuit of complex meanings could not be simply designed in the study or caught retrospectively, but required the continuous attention of the researcher. Such continuous attention was better sustained through an ongoing interpretation by the researcher, who was the key feature of the prolonged engagement in a case study.

Case study involved the study of a phenomenon in its context. It provided a rich description of the phenomenon under investigation. Yin (1994) stated that case studies painted a realistic picture of actual particulars in their own language. In this way, case studies communicated meaningful information to readers, thereby facilitating readers' understanding of the phenomenon. Stake (1995, p.42) supported the view that the 'thick description' or 'the particular perceptions of the actors' provided by the case study allowed the readers to decide whether or not the entity studied was applicable to their own situation.

There are increasing numbers of researchers using the case study method in studying nursing leadership. Rollison (1998) used a qualitative case study to investigate how nurse leaders perceived and actualised their leadership power and how they enacted their role in a hospital. Ferguson (1998) used a case study approach with survey and interview to create a thick description of nursing leaders that supported autonomous practice of nurses. Clifford (1998) used a multiple site case study approach with interviews to examine the impact of hospital restructuring activities on nursing leadership. Biester (1992) used single case study incorporating story telling as source of evidence to study leadership's role in organisational change. Jeska (1992) used multiple case studies to provide a descriptive account of transformational nurse leaders. These studies demonstrated that case study approach provided rich and in-depth understanding of nursing leadership in the context of the study.

Limitations of case study approach

Despite its strengths, the greatest concern about the case study approach was the limited basis of scientific generalisation. External validity, or generalisability of the results, was often viewed as problematic because of the focus of case study on a single subject (Barr, 1995; Mariano, 1993; Meier and Pugh, 1986 and Guba and Lincoln, 1981). Apart from the fact that the case selected might or might not be representative of others, there was no certainty that the results were truly representative of, or even similar to, those of the larger population (Barr, 1995).

However, Stake (1995) argued that valuable understanding could be derived from a complete and detailed knowledge of the particular in case study. He considered this knowledge as a type of generalisation and described it in terms of 'naturalistic generalisations' which referred to conclusions arrived at through personal engagement in life's affair or by vicarious experiences so well constructed that the person felt as if it happened to themselves (p.85). Yin (1994) maintained that in case study approach, the researcher's goal was to expand and generalise findings

to theories, and not to enumerate frequencies (statistical generalisation). Yin used the term 'analytic generalisation' to describe this process which carried the same meaning as 'naturalistic generalisation'.

To increase analytical generalisation in case study, Yin (1994) suggested it required clear delineation of the characteristics of the group being studied, as well as clear description of the research methods and analytic categories. Providing excerpts of rich and thick description allowed readers to judge the basis for transferability of the findings (Guba and Lincoln, 1981). Efforts were made to achieve these objectives in this study. Helco (1972) suggested that it was also important for case study research to be 'planned under the impetus of theory rather than the excrescent accumulation of whatever data happen to turn up' (p.88). This study was built upon the existing leadership theory and the researcher attempted to develop new knowledge based on the available knowledge.

The results of this study could be generalised to theory. This study, rather than reflecting the single experience of nursing education reform in Hong Kong, covered broader theoretical issues in nursing leadership, such as power is a requirement of leadership, and leadership is a reciprocal process. These issues in fact represented the building of a model of leadership process in effecting policy change. The outcome of this study could be a vehicle for examining other cases.

Method triangulation

Method triangulation is used in this study. Method triangulation refers to using dissimilar methods to generate and collect data about the same phenomenon (Hinds and Young, 1987). This study used multiple methods in data collection: document search, interviews and questionnaire survey. Polit and Hungler (1995) referred to this approach as 'integrated design', as both qualitative and quantitative methods were used to collect data. Lackey and Gates (1997) suggested that the combination of methods in a study gave a fuller description of the phenomenon. The use of multiple sources of evidence in this study allowed the researcher to

address a broader range of issues influencing the behaviour of nurse leaders. This provided a rich detailed portrait of the leadership role. Hence a more complete account of the leadership process was achieved.

The use of multiple methods in a study design could help to overcome the deficiencies that stem from any single method (Banik, 1993). Hinds and Young (1987) and Jick (1983) suggested that strengths and weaknesses of the methods tended to counterbalance one another and enhanced combined outcomes. Multiple strategies also helped to validate study findings and contribute to convergence.

In this study, the data collected from documents offered possibilities of validating the data collected from the interviews and vice versa. The survey data were also used to complement the interview data in evaluating nurse leaders' performance. By using triangulation, the researcher was much more confident about the validity of results that were supported by multiple and complementary types of data.

Difficulties in using triangulation

Several problems have been noted in the use of multiple triangulation (Morse, 1991a & b and Banik, 1993). The complexity of combining, interpreting, analysing and reporting large amounts of dissimilar data could be overwhelming. Additionally, the time necessary to implement and manage multiple methods was usually greater than when using a single method. There was also a danger of collecting a large volume of data that could not subsequently be analysed in detail. Furthermore, Duffy (1987) and Morse (1991a) stated that if the researchers did not have a full understanding of each method, triangulation might not achieve its full potential and might even increase bias.

Another difficulty faced by the researcher in using triangulation is related to the research paradigm. Dootson (1995) argued that quantitative research and qualitative research were based on different paradigms: the rationalistic and

naturalistic respectively. The rationalistic paradigm stemmed from positivism or empiricism which tried to test hypotheses and to develop theories (Powers, 1987). In the naturalistic approach, however, the researchers viewed science as a process of understanding human behaviour. They looked at the individual as a whole and believe that reality was multiple, interrelated and determined within context (Cull-Wilby and Pepin, 1987). Dootson (1995) and Phillips (1988) claimed that the philosophies of the two paradigms were too opposed to be mixed and the methodologies too different to be used together. Attempts to blend them together might cause confusion. Also, a researcher might lose sight of the differences underlying the chosen methods.

To overcome such problems, Denzin (1989) and Mitchell (1986) recommended that the research question should be clearly focused. The triangulation strategies used should be carefully considered and systematised before carrying out the study. Knalf and Breitmayer (1991) suggested that data management techniques should be designed at the outset, once the amount and kind of data were visualised. In this study, the researcher had carefully considered the strengths and weaknesses of each data collection method before deciding on the present approach. The computer software 'Ethnography' was used to organise the large amount of qualitative data, and Statistical Package for the Social Sciences (SPSS) was used to analyse quantitative data. Banik (1993) agreed that by paying the necessary attention to planning beforehand, the use of triangulation in nursing research could be optimised.

Regarding the mixing of two paradigms, some authors argued that it is possible to mix qualitative and quantitative methods, but that one paradigm would always dominate (Moccia, 1988 and Powers, 1987). In this study, the qualitative approach was the dominant paradigm that guided the analysis of data. Categories developed from the interview data were used as the main frame for data analysis and these categories were confirmed and validated by data from documents and questionnaires.

Sampling

A purposive sample was used for the interviews. Purposive sampling was referred to as 'strategic' or 'judgement' sampling (Bernard, 1988 and Pelto and Pelto, 1979). It was a non-probability sampling method in which informants were selected on the basis of the researcher's judgement. The selection was neither ad hoc nor opportunistic, rather it was guided by the researcher's theoretically and experientially informed judgements (Johnson, 1990). Honigmann (1970) described the sampling as a deliberate process in which subjects were selected by virtue of their status or previous experience, qualities, which endowed them with special knowledge that the researchers valued. The researchers used their prior knowledge to draw subjects who possessed distinctive qualifications.' (P.268)

The term 'informants' was used to describe the individuals who were in a position to give the researcher in-depth knowledge about the research topic. In purposeful sampling, the investigator used judgement to decide whether or not the informants indeed possessed the characteristics needed for the study (Morse, 1991b). This was an important aspect for the validity of the study. Mead (1953) discussed the validity of purposive sampling as opposed to the requirements of probability sampling, in which bias and sample size are critical in determining confidence in the research findings:

> 'The validity of the sample depends not so much upon the number of cases as upon the proper specification of the informant, so that he or she can be accurately placed, in terms of a very large number of variables - age, sex, life experience, political position, exact situational relationship to the investigator, and so forth. Within this extensive degree of specification, each informant is studied as a perfect example, an organic representation of his/her complete cultural experience. ' (p.646)

In this study, as the researcher had extensive experience in nursing education, she chose to interview informants who were regarded as having direct or indirect involvement in nursing education reform and who had the knowledge of the research topic. The informants were representatives of the roles and positions appropriate to the aim of this study.

Subjects for the questionnaire survey were selected by stratified random sampling. It was a variant of simple random sampling in which the population was first divided into strata or subgroups before randomisation (Polit and Hungler, 1995). The use of this method enabled the study had a representation from all grades of nurses.

Methods

Unit of analysis

The unit of analysis in this study context is defined as 'nursing education reform in Hong Kong from 1985 to 1995'. The focus is on the role of nurse leaders in nursing education reform. The period 1985 to 1995 was chosen because 1985 was the year of the initiation of nursing education reform, and 1995 was the year that the Government promised an increase in nursing degree places to 180.

Research site

The study was carried out in the context of the health care system and the political system of Hong Kong from 1985 to 1995. Data were collected from 1995 - 1997.

Case study population

The population studied included key informants who were involved in the process of nursing education reform and 1,000 front-line nurses. The key informants

were: nurse administrators in the HA, nursing academics, presidents and chairpersons of nursing professional organisations, nurse Legislative Councillors, nursing consultants from the UK, government officials, and senior administrators of higher education settings and HA Head Office. Most informants were in formal leadership positions. Leaders of nursing professional organisations were also included. These informants were chosen because all of them occupied important positions and they were considered to have significant influence on nursing education development. They were also identified as important informants from the documentary evidence. Some informants were recommended to the researcher by another informant during the interview.

Two nurse leaders from the UK were interviewed. They were chosen as subjects because they had been invited to come to Hong Kong as consultants for a number of times to advise on nursing education development. They had conducted various seminars and had written reports to support the establishment of nursing degree programmes in Hong Kong. They were considered to have great influence in nursing education reform. Interviews with these two overseas nurse leaders were conducted in London.

Stratified random sampling method was used to select subjects for the questionnaire survey. Statistics from the government showed that at the end of 1996, the RN population working under the HA, the largest employer of nurses in Hong Kong, amounted to 10,000 (Daryanani, 1996), including all Department Operations Managers (DOM)/Senior Nursing Officer (SNO), Nursing Officers (NO)/Ward Manager (WM), and RNs. Ten percent of this population, 1,000 subjects, were randomly selected for the survey from five hospitals under the Hospital Authority. This sample size enabled the study to achieve a low error factor ± 0.03 at the 95% confidence level (Wang, Fitzhugh and Westerfield, 1995). Composition of subjects were selected according to the common ranking ratio of DOM/SNO:NO/WM:RN = 1:6:20. Approximately 200 subjects were selected from each hospital. These hospitals were chosen because of their nurse training function, and also they were regional hospitals with a similar nursing work force.

Documents

The documentary approach included the examination and interpretation of data contained in official documents, such as minutes of meetings, correspondences, working party reports, annual reports, press releases, newspaper cuttings and journal articles on education and nursing from various resources. Analysis of these documents was undertaken to understand the background of the study, the process of nursing education reform, the interactions among key players, the actions taken by nurse leaders to influence policy-making process, and the extent of nurse leaders' participation in the policy-making process.

Examples of documents examined were:

- Minutes of meetings
- Correspondences
- Working Parties' reports
- Annual reports
- Governor's addresses
- Position statements
- Press release
- Newspaper cuttings
- Journal articles on education and nursing
- Newsletters.

A list of the documents reviewed in this study is presented in Appendix I. Documents belonging to the period 1985 to 1995 were obtained from various sources including the professional nursing organisations, health authorities, government departments and council and academic institutes. Such an enormous amount of information collected from various sources over a long period of time enabled the researcher to study the case from different perspectives.

Letters were sent to the authorities, departments and institutes to obtain permission for reviewing minutes or reports (Appendix II). Initial data collection involved all materials that were related to the development of nursing education in Hong Kong. As the document search actually took place alongside the interviews, many useful sources of documents were identified with the help of interviewees. Some interviewees directed the researcher to many of these relevant sources and some personally made the documents available for the researcher's perusal. As more and more detailed information was accumulated, a sharper focus was developed that directed the researcher to collect a particular document from a particular source. It was through examination of these data that the researcher studied the process of nursing education reform, the information obtained from interviewees was verified and the contextual information was validated and expanded.

Analysis of document data

All documents collected were arranged in chronological order. It helped the researcher to trace the events that happened over the period of ten years. An annotated bibliography of these documents was made. Data were grouped into four categories:

- Policy process
- Key players in the reform of nursing education
- Political actions taken by nurse leaders
- Policy outcome

Interviews

Data were collected by semi-structured interviews of a purposive sample of subjects. Data obtained from interviews helped validate the facts or opinions derived from documents. The purposes of the interviews were to explore the following questions:

- How were nurse leaders involved in making nursing education policy?
- What were their roles in the reform of nursing education?
- What were the actions used by nurse leaders to influence policy?
- How did nurse leaders influence followers?
- What were the factors that influenced nurse leaders' effectiveness in influencing policy change?

All interviews were conducted in a semi-structured manner. A set of questions was used to guide all the interviews (Appendix III). All questions were open-ended to allow the respondents to elaborate and give more individualised answers. Letters were sent to informants to obtain permission for conducting and tape-recording the interview (Appendix IV). Most subjects accepted the interviews willingly. Only three declined to be interviewed. A total of 26 subjects were interviewed. The duration of interviews ranged from one to two hours.

To eliminate errors in memory and avoid interference caused by note taking during the interview, audio recording of interviews was made. Before the interview commenced, permission for audio recording the interview was again sought from the interviewees after a full explanation of the need to do this. Confidentiality of data was also assured. Five interviewees refused to be tape-recorded, but they allowed the researcher to take notes during the interviews.

Building rapport with the interviewees was very important for creating a safe and open atmosphere in which the interviewees were willing to share their experiences (Talbot, 1995). Since the researcher was acquainted with most interviewees, the interviews usually began with a few minutes of casual and friendly talk. Then the actual interview began and the audio recorder was turned on where interviewees had agreed to it. Throughout the interview, the researcher tried to maintain eye contact with the interviewee, kept a non-judgmental attitude and avoided interrupting. The researcher also developed a healthy appreciation for silence. The skill of probing was used to clarify vague answers. Probes such as 'Could

you tell me more about...?', 'Could you explain a bit about...?', 'What do you mean by...?' were used to clarify and expand responses and explicate meaning.

The researcher conducted all the interviews so that high uniformity in the conduct of interviews was maintained. To ensure objectivity in the interpretation of data, the researcher was very careful not to impose any of her preconceived ideas or expectations as to the interview situation.

Five interviews were conducted in English, while the rest were conducted in Cantonese, the language used in interview was based on the nationality of the informants. The audio record of conversations and the notes of the interviews were then transcribed and analysed. The interviews conducted in Cantonese were transcribed and translated to English before data analysis.

Analysis of interview data

Content analysis was used to analyse interview data. This was an inductive method for analysing qualitative data. There were two planes of data analysis. The first plane was the generation of meaning from the raw data. The researcher reviewed the documents and the interview data. The data were compressed and fashioned in such a way that coherent conclusions and meaning at an initial stage could be drawn (Miles and Huberman, 1994). According to Talbot (1995), this stage is for exploring and describing. The researcher tried to gain understanding and insight about a particular phenomenon, such as how nursing education reform was initiated? Who initiated the changes? Who had the power to influence the policy-making? What were the actions used by nurse leaders to effect changes?

The next plane of data analysis was an endeavour to place the findings in context and take the social situation as the point of empirical examination. It was an extended case method approach, which required the researcher to work with the given macro structures to understand how the micro structures were shaped by the wider structures (Mitchell, 1983 and Buraway, 1991). Talbot (1995) maintains

that this stage is for discovering and explaining. Why did changes take place at a particular time? Why did the nurse leaders function in this way? What were the dimensions of nursing leadership? Were nurse leaders effective in influencing nursing education reform and why?

Data coding

The computer programme 'Ethnograph' was used to analyse the data gathered from the interviews. It is an interactive, menu-driven computer programme designed to assist the researcher with some of the mechanical aspects of data analysis. This software facilitated the management of the large amount of text-based data involved in this study. It enabled the researcher to code, recode and sort the data files into analytic categories. Coded segments of data, representing categories, might be independent or overlapping with other codes, or nested within another code in the transcribed interviews. They could be easily retrieved across all data files as single codes or as multiple codes. On demand, all examples of coded segments were made available simultaneously to the researcher for analysis. The use of the Ethnograph in a personal computer for these functions allowed the researcher to devote more time and energy to the interpretative or analytic work. The ease of retrieval encouraged early exploratory analysis at the time of data entry.

Three methods of data coding were used:

1. Substantive coding

The transcribed interviews were first entered into the Ethnography programme and printed. Each page was labelled with the file and line numbers for easy reference. The margins were used to enter the codes. The initial coding was carried out manually on printed copies of the data files on which the lines were numbered. The researcher began coding these data with what Hutchinson (1986) described as Level I codes. This referred to the substantive codes or 'in vivo'codes (Strauss, 1987, p.33), which were words used by the informants or which reflected the substance of the conversation e.g. *'liaison'*, *'apathy'*, *'coalition'*, and

'*braindrain*'. Some of the code words were chosen by the researcher by interpreting the substance of the data. An example was the term '*internal resistance*' when informants spoke of 'senior nurses rejecting the idea of degree nursing' or 'a lot of resistance coming from nurses themselves'. These initial codes were indicators of concepts developed as the researcher coded sets of indicators into categories. Glaser (1978) and Strauss (1987) recommended the use of this coding model. The codes used to identify conceptual categories were listed with definitions of their meanings in a notebook, which was referred to constantly as the codes were developed, collapsed, or rearranged, as properties of core categories became apparent.

2. Open coding

Open coding means that lines, sentences and/or paragraphs are coded for as many codes as might fit the data. About 200 codes were generated in this way. These codes fragmented the data into small segments. In open coding, a phrase or sentence, may be coded with more than one code. For example, a segment of data was coded for '*barrier*' and '*fragmented*'. Code sets were entered in the computer according to guides to '*code mapping*' on the printed files. These were changed or recoded as required (Strauss and Corbin, 1990). Example of code mapping is given in Table 1.

3. Coding for categories

The development of level II codes (Hutchinson, 1986), or categories, served to elevate data to a more abstract level. This was the stage of concept and theme development (Strauss and Corbin, 1990). Categories referred to abstractions of the phenomena observed in the data and were derived by the researcher asking questions of the data. Examples were 'What category does this incident indicate' and 'What was actually happening in the data?' (Glaser, 1978; Strauss, 1987).

Table 1 Example of code mapping

R17	Line
$strategy !communicate	
I would think of ways to present my idea	552
and plans clearly to nurses. I	553
communicate my direction in many	554
$strategy *lobby	
committees, I presented my ideas and	555
lobby committee members to support my	556
$strategy #discuss	
idea. I would discuss with them and	557
exchange ideas.	558
R21	
$barriers *resistance from medics	
We have asked medics' view on degree	221
education for nurses, most of them were	222
against this idea. All the allied health	223
professionals have their basic education	224
in tertiary institutions. Why nurses	225
cannot?	226
$barriers !poor image of nurses	
The Government does not feel the need	227
for nursing education reform. It is related	228
to the low status and poor image of nurse.	229

In this study the codes were clustered by similarities and a category scheme was developed. Some of the codes fitted into more than one category. Categories were compared with each other to ensure that they were mutually exclusive and covered the behavioural variation (Hutchinson, 1986). Subsequent transcripts were then analysed using the category scheme. In this process, some category labels were changed and subcategories developed. The categories for sorting

segments were tentative and preliminary at the beginning. Because they were flexible, they could be modified accordingly and refined until a satisfactory system is established (Glaser, 1978; Strauss, 1987). Even then, the categories remained flexible working tools; they were not rigid end products. Care was taken not to force data into categories that did not reflect the actual data. Codes were clustered into initial small categories, called sub-categories e.g. *repression, lack of unity* and *networking.* Small categories were then collapsed into larger categories e.g. *medical dominance, increasing power through unity and empowering followers.*

Seeking the core category

After the data were sorted into categories, the researcher reflected on what these clusters meant. The focus was on noting regularities in the data. The researcher then identified core themes and patterns across the data. The research questions were used to guide identifying core themes. This process continued until a comprehensive description and a general pattern of interrelated relationships evolved that could be illustrated and supported by the data. This was the stage of concept modification and theme integration. Core categories encapsulated large categories into themes, which explained the phenomena of nurse leadership behaviour. Throughout the process, memos were written to capture ideas and document recurring themes noted in the data. Memos were notations of the researcher's ideas regarding how data, codes and categories were related (Hutchinson, 1986; Melia, 1986 and Wilson, 1989). Apart from memos, diagrams were used to assist the researcher to visualise the relationships between concepts. Miles and Huberman (1994) defined diagrams as graphic representations or visual images of the relationship between concepts. Memos and diagrams assisted the researcher to move away from data to abstract thinking, then in returning to the data to ground these abstractions in reality. By sorting memos and diagrams, all the main ideas were reduced, refined, and integrated into a scheme (Hutchinson, 1986; Melia, 1986 and Wilson, 1989). Examples of core categories were: *inertia* and *evolution.*

Coding continued until saturation occurred, that is, when all levels of codes appeared completed with no new conceptual information available to indicate new codes or the expansion of existing codes. There was a sense of closure: all the data fitted into the established categories; patterns were visible; behavioural variation was described; and, behaviour in this context could be predicted (Hutchinson, 1986).

All sources of information were categorised into two classes: *documents* and *people*. *Documents* referred to the 'printed word' as in government reports, circular, minutes, files, letters, press releases, newspapers and journal articles. These sources were used for information retrieval to establish how a policy was developed and what the policy process and outcome were. *People* included individuals who were interviewed and those who had participated in the survey. These people provided personal accounts on policy implementation, policy outcome, policy evaluation and validation of interpretations of retrieved information. There was no set pattern for using documents and people. Instead, a constant cross-reference from one source to another was made. For example, when the informants claimed that they had used mass media to influence policy making, this could be validated by the documentary evidence.

Multiple methods in data collection and analysis yielded rich and diversified explanations in which *people* led to *documents* as well as to other *people*, and *documents* similarly led to *people* and to other *documents* (Martins, 1990). This method of triangulation enabled the researcher to use multiple measures in investigating a single concept. This strategy directed the researcher to collect data over time, from a variety of persons in a variety of contexts. As different types of data were used, crosschecks of accounts against one another for consistency and comparability could be made (Talbot, 1995).

Validity and reliability of qualitative data

For qualitative data obtained from documents and interviews, the argument is whether or not measures used to establish validity and reliability of quantitative research could or should be applied to qualitative research, because it is governed by a different philosophical base (Bryman, 1984). Leininger (1985) maintained that using quantitative validity and reliability for qualitative studies could result in confusion. She suggested that qualitative validity should rest upon knowing and understanding the phenomena as fully as possible, rather than on the adequacy of the measuring instrument. She also defined qualitative reliability as the extent that the phenomena under study consistently revealed meaningful and accurate truths about particular phenomena.

Recognising that threats to the credibility and trustworthiness of qualitative data were different from those of quantitative data, strategies were incorporated in the methodology to address these issues. Two separate processes, *internal* and *external criticism*, were used to establish the validity and reliability of the data collected from documents, before using them in reaching conclusions. *Internal criticism* determined the accuracy of evidence contained within the documents (Polit and Hungler, 1995). When examining evidence, the researcher asked critical questions, such as *'Is it probable that people would act in the way described by the writer? Is it physically possible for events to have occurred this quickly? '*

External criticism required that the researcher got to original and primary sources in order to minimise the chance of distortion and error and to determine the authenticity of documents. The researcher raised questions about the nature of the source: *Who wrote it? Was the writer present at the event? Where? When? Under what conditions?* Many factors were considered in answering these questions. For example, knowledge of the conditions under which a document was prepared was helpful in determining its nature and usefulness to the problem under investigation (Borg and Gall, 1989).

In this study, the researcher carefully scrutinised the documents during the data analysis process. The most important use of documents in case studies was to corroborate and augment evidence from other sources. If the documentary evidence was contradictory rather than corroboratory, the researcher must inquire further into the topic (Yin, 1994, p.87). The researcher was careful when making inferences from the documents because they were written for some specific purpose and audiences. By constantly trying to identify these conditions, the researcher was less likely to be led by documentary evidence and more likely to be critical in interpreting the contents of such evidence.

As for interview data, they were transcribed from the tapes and sent to the informants to verify the validity of the transcripts. Some informants turned down the opportunity to read the transcriptions as they regarded it as unnecessary. All of those who read the transcripts agreed that they were accurate records of the interview.

In this study the collection of data from a variety of sources aids validity and reliability because discrepancies would point up areas needing further investigation. In this study, the researcher collected data from a variety of documents and a large number of informants in order to understand the phenomena as fully as possible. The data collected through the interviews were used to validate data collected in the documents and the questionnaires and vice versa. Content validity was determined by constant referral to information in documents, to participants and experts in the field (Guba and Lincoln, 1981). Moreover, validity was enhanced by continuous data analysis during the study. Any discontinuities and contradictions of the data were further assessed. While various kinds of data were collected and analysed simultaneously in this study, any contradictions apparent in the data were further explored and validated. Furthermore, the interviews covered a 24-month period. Changes in nursing education were assessed over an extended period of time. Retrospective tracing of

historical factors was undertaken through the data gathered from interviews and by examination of documents and literature.

The researcher was cautious of the fact that she had had many years of experience in nursing and nursing education, which could contribute to the development of the researcher's own value and beliefs. A conscious attempt was made to reduce the level of bias. Bracketing of values and preconceptions was an important measure used to reduce bias (Denzin and Lincoln, 1994). In this study, the researcher tried to bracket her personal preconceptions, values and beliefs and to avoid imposing these during data collection and analysis.

In summary, the use of multiple and extensive sources, the long period covered by the data collected, the simultaneous data collection and data analysis and the bracketing, all contributed to the reliability and validity of the findings.

Questionnaire survey

Significant data of this study were obtained by a questionnaire survey. The objective of the survey was to evaluate nurse leaders' effectiveness in the reform of nursing education from the perspective of the nursing profession. The aims of the survey were to investigate nurses':

- views on the present status of nursing education
- perception on nursing leadership
- evaluation of nurse leaders behaviour.

Subjects were chosen from stratified random sampling from five regional hospitals in Hong Kong. These subjects were in the 'followers' position. They were practising nurses in the hospitals with various ranks: DOM, SNO, NO, WM and RN.

Instrument development

A questionnaire was developed by the researcher from the literature review on the behaviour and role of leader (Bass, 1991; Coulson and Cragg, 1995; Manfredi, 1996; Yura, 1971; Yura et al. 1991). Five major roles of leader behaviour were identified: *decision making, communicating, maintaining unity, generating support/motivation* and *influencing*. 39 items were formulated on the basis of the literature, which described these five major roles. Eight experts, who had experience in research or leadership, were invited to assess the face validity of the draft questionnaire. They all agreed that majority of the items were appropriate and focused data collection on the stated objectives. Some items of the initial questionnaire were deleted and some were rephrased to clarify meaning.

The final questionnaire contained 3 sections (Appendix V). Section One focused on the biographical data of the respondents. Section Two contained 6 items aiming at investigating respondents' attitudes towards the present and future development of nursing education, their perceptions about who were the nurse leaders and their support for these nurse leaders. Section Three contained 25 items aiming at investigating respondents' perceptions of the nurse leaders' power base and of the effectiveness of the nurse leaders in establishing direction, communicating with followers and producing desirable changes in nursing education policy. The items in Section Three were categorised into 5 subscales. They were:

- *Decision making* (6 items)

  Whether or not nurse leaders were able to make accurate decisions on the direction of nursing education.

- *Communication* (3 items)

  Whether or not nurse leaders were able to communicate with the followers effectively.

- *Unity* (3 items)

  Whether or not nurse leaders were able to maintain coalition within the profession.
- *Power to influence* (8 items)

  Whether or not nurse leaders had the power to influence nursing education policy.
- *Motivation and support* (3 items)

  Whether or not nurse leaders were able to motivate and support followers.

Respondents were asked to rate leaders' performance on a five point Likert scale (strongly agree=5, agree=4, no opinion=3, disagee=2 and strongly disagree=1). A mean score of 2.5 or above was considered to indicate a more positive view and a mean score below 2.5 was indicated a more negative opinion.

To ensure test-retest reliability, a test-retest study was carried out. A convenience sample of 60 subjects studying the Post-registration Diploma in Nursing - Year One at a local university was invited to take part in the test-retest study. They were excluded from the actual study. Retest was performed two weeks after the first test. The reliability coefficient of items ranged from 0.71 to 0.92. All items achieved a statistically significant reliability coefficient ($p<0.001$). Homogeneity of an instrument indicates that the instrument is consistent within itself. The most common assessment method for homogeneity is Cronbach's coefficient alpha. Alpha assesses the internal consistency of the subscales of the instrument (Talbot, 1995). The homogeneity of the subscales in the questionnaire in this study was measured. The Cronbach's Coefficient Alpha of individual categories ranged from 0.72 to 0.96, which were satisfactory (See Table 2).

A pilot study was conducted before the actual study involving 50 subjects. Another convenience sample of 50 subjects studying the Post-registration Diploma in Nursing - Year Two at a local university was invited to take part in the pilot study. These subjects were again excluded from the actual study. The subjects spent about 20 minutes on average filling in the questionnaire, which was

considered acceptable. There were no difficulties encountered by the subjects in understanding the instructions or the items.

Table 2 Results of the Cronbach's Coefficient Alpha of the subscales

Subscale	*Cronbach's Coefficient Alpha*
Decision making	0.96
Communication	0.93
Unity	0.72
Power to influence	0.97
Motivation and support	0.94

Data collection

A name list of the nursing staff was obtained from the GM(N)s of these hospitals. Subjects were chosen by stratified random sampling. Numbers were assigned to each name and the numbers were then drawn randomly. Approximately 7 SNO/DOMs, 44 NO/WMs and 148 RNs were chosen from each hospital. The total number of subjects selected included 37 SNO/DOMs, 222 NO/WMs and 741 RNs. The questionnaire was mailed to the subjects, with a stamped return envelope and a covering letter introducing the researcher and explaining the purpose of the study. Subjects were asked to return the questionnaire to the researcher in the stamped envelope provided within a period of 2 weeks.

Data analysis

Descriptive statistics were utilised to report the findings of the questionnaire. The mean, standard deviation of each item was calculated. The computer programme SPSS 8.0 for Windows was used for data analysis.

Ethical considerations

To ensure confidentiality, the subjects' and organisations' names were not used in this report. The researcher controlled all the data gained in the study and only she could have access to the data. In the debate on confidentiality, Yin (1994) considered whether or not the informants should be accurately identified in the reporting of the study. He argued that the most desirable option was to disclose the identities of the individuals. He explained that the disclosure could produce two helpful outcomes. First, the readers could be able to recall any other previous information they have learned about the same case in reading and interpreting the case report. This ability to integrate a new case study with prior research could be invaluable. Secondly, the entire case could be reviewed more readily, so that footnotes and citations could be checked and appropriate criticisms raised about the published case.

However, in this study, anonymity was necessary. Nursing education reform remained a controversial topic at the time of this report. Many informants were still in their posts. Many views given by the informants were their own and they were not speaking on behalf of their organisations, although they were in a good position to do so. Since much of the material was sensitive, anonymity of informants was justified.

As regards to subjects involved in interviews, the researcher first contacted them via letters, explaining to them the purpose and benefits of the study, the use of data and the procedures. Anonymity was assured and it was guaranteed that their identities would not be revealed in the report of the study. Their participation was voluntary and they could withdraw from the study at any time without giving an explanation. After obtaining permission, the researcher contacted the subjects via telephone to arrange a convenient time for interviews. Verbal permission was

sought from each informant for recording the interview on audiotape. It was made clear that no audio recording would take place without the subject's permission to do so. All subjects were also told they could request the tape recorder to be turned off at any time.

In respect of nursing subjects involved in the questionnaire survey, permission to use nursing subjects in the selected hospitals was obtained from the respective Hospital Chief Executives (Appendix VI). A covering letter explaining the purpose of the study and subjects' anonymity was mailed to the subjects together with the questionnaire. It was assumed that if respondents returned a completed questionnaire, their consent was voluntary.

All the documents collected in this study were accessible to the public apart from the documents of one nursing organisation. Permission from the chairperson of the organisation was gained for access to the documents covering the period from 1985 to 1995. The researcher was allowed to read the documents in the office of the nursing organisation.

Summary

This Chapter outlined the conceptual framework of this study. The methodology and methods used have been explained and a rationale provided for adopting the case study method, based on the need to obtain an in-depth understanding of nurse leadership process within its real-life context. Multiple sources of evidence were used in this study, including documents, interviews and questionnaires. The strengths of using multiple methods of data collection in producing a rich detailed portrait of the leadership process and more accurate data, have been discussed. The following chapters will present the findings of the study.

CHAPTER FIVE

FINDINGS - PROCESS OF NURSING EDUCATION REFORM

Introduction

This chapter presents the process of nursing education reform during the period 1985 to 1995. Data were collected mainly from documents and supported by interviews. Documents related to the period of study were searched from various sources, although some older documents were also used to inform the discussion. From the findings, events are traced, arranged and presented in chronological order. Code numbers are assigned to the informants to maintain anonymity. The actions taken by the nurse leaders are identified and interactions among key players are presented.

Earliest quest for nursing education reform

During the 1980s, there was a general recognition of the inadequacy of hospital-based nurse training by the nursing communities. The quest for nursing education reform was initiated by the nursing profession organisations. In 1985, the President of the Hong Kong Nurses Association (now called the College of Nursing, Hong Kong [CNHK]) spoke in public proposing a transfer of nursing education to tertiary level. She urged the Government 'to seriously consider offering nurse education programmes in universities as a means of additional input to produce more nurses' (Wei, 1985, p.78). The Association of Government Nursing Staff (AGNS), which was a nursing trade union, also proposed a complete transfer of nursing education to tertiary level ('Proposed the', 1985).

With support from the nursing professional organisations, the nursing academics of the Nursing Studies Section in the Hong Kong Polytechnic (HKP) put forward a pre-registration nursing degree curriculum to the Government in 1986. At that time, nursing did not have any representative at the Government policy-making level, any proposal to the Government had to be submitted through the Director of MHD, who was a medical doctor. The Director of MHD would then put forward the proposal to the SHW. As nursing depended on the Director to communicate with the Government, there might be blockage or distortion of messages. One informant mentioned:

> R06: I am sure that there was communication blockage. The Director of MHD would not speak on behalf of nursing. The proposal did not reach the Government.

There was opposition from MHD towards the proposal. R06: In a letter replying to the HKP's proposal for the establishment of a nursing degree programme, the Director stated that the MHD felt there was no necessity to introduce a new grade of 'degree nurse' in its establishment. He said that Hong Kong nurses were quite efficient and they did not need a degree.

Objections to nursing education reform came from other doctors as well. A senior medical officer, who refused to be named in a newspaper, said that degree education would create conflicts between graduates from hospital-based training and degree programmes ('Nursing Board', 1988).

Objections also came from some senior nurse administrators. The Nursing Director of the MHD, who was the nursing head of the public hospitals, objected nursing education reform.

> R03: The Nursing Director did not support degree education in nursing. She said that degree graduates would demand higher salaries. Degree nursing would create confusion and conflict among nurses and doctors.

The NBHK, the nursing statutory body, also objected to the reform.

> R06: When the initial proposal of the nursing degree programme was first discussed in the Education Policy Committee of the NBHK, the members were concerned that Hong Kong was not ready for nursing degree programme. The proposal was not put on the agenda for the Board meeting.

The members of the NBHK were all appointed by the Governor. At that time, the chairman of the Board was a medical doctor, the Director of MHD. It was not surprising that the NBHK objected the proposal.

Nurse leaders in the HKP and the professional organisations initiated the reform in 1985. However, consensus had not been reached and there was no united stand in the nursing profession. There was also opposition from the external groups, the doctors and the biggest employer of nurses, the MHD. The quest for nursing education reform was turned down by the Government. The first battle had been lost. The lack of internal and external support contributed to the failure.

Though the first battle was lost, some nurse leaders continued to fight for the degree programme. In an attempt to influence the Government, they adopted a number of political strategies. One of which was external consultation. In 1988, Professor Wilson-Barnett from London was invited to Hong Kong by the HKP as a consultant to look into the issue of establishing a degree programme for nurses in Hong Kong. The Council for National Academic

Awards (CNAA) from the UK was also being invited to comment on the proposed degree curriculum of the HKP. It was hoped that the Government would be more willing to accept the idea of nursing education reform if external consultants gave favourable comments. Both Professor Wilson-Barnett and the CNAA supported the establishment of the proposed degree programme in Hong Kong. In a report submitted to the Government, Professor Wilson-Barnett concluded that the degree programme was necessary for educational, professional and staffing planning reasons (Wilson-Barnett, 1988, p.1). R06: In an interview on the radio, Professor Wilson-Barnett informed the Government that if Hong Kong's nursing education system remained as it was, Hong Kong would be the only English speaking colony without a nursing degree programme. Hong Kong nurses would be seen as relatively deprived in comparison with nurses from other countries.

Mass media was used to influence. Some nurse leaders wrote and spoke to the press in support of the nursing degree programme. Mr James O'Mullan, the Principal Lecturer of the Nursing Studies Section in HKP said in a newspaper that:

> 'The development of nursing education in Hong Kong is behind other countries such as China and the Philippines. The Nursing Studies Section of HKP has proposed a degree programme for nurses but was turned down by the UPGC. They would submit the proposal again in the coming November ('No nursing', 1988)'.

In another newspaper, Mr James O'Mullan stated that:

> 'Hong Kong needs degree programme for nurses to attract more young people to join the profession. Hong Kong probably is the only British colony that has not established degree programme for nurses ('Mr. James O'Mullan', 1988)'.

In response to a doctor's and senior nurses' comments that nursing degree programme would affect the morale of existing nurses, Mr Michael Ho, the Chairperson of the AGNS (who took up the post as Legislative Councillor in 1991), said in a newspaper that a small number of graduates from degree programmes would have little effect on the interests and promotional prospects of practising nurses ('Nursing Board', 1988).

In a letter to a newspaper editor, the Education Sub-committee of AGNS called for public's support of nursing degree programme:

> 'Members of the public should be more vocal in their support of nurses' desire to be better qualified, so as to help ensure the consumers in health care are not exploited. The International Council for Nurses and American nurses have been helping China to re-establish degree programme in nursing since 1983. This puts Hong Kong behind Mainland China in respect of nursing education...('Hassan said', 1989)'.

Some senior nursing officials, who were reluctant to be identified, spoke out in support of plans for the territory's first nursing degree. All claimed that the degree nursing education would raise the standing of nursing as a profession, improve standards of care and boost morale among nurses. One nurse wrote to a newspaper stating that physiotherapists, doctors and other health care professionals all have university level education. Unless nursing has tertiary education, it could not be called a profession. A degree programme would not only raise the quality of nursing in Hong Kong, but would also boost nurses' morale ('Nursing honours', 1988).

Direct lobbying was attempted. The SHW was approached by the nursing academics in the HKP. The SHW demanded that the HKP should present more information and evidence to support the degree programme for nurses. The proposal of the HKP was revised, adding the support from Professor

Wilson Barnett (Wilson-Barnett, 1988), was submitted again to the Government in 1989. However, the MHD did not support the proposal, there was still strong objections from doctors in the Department. There was a need to identify ways to overcome this barrier.

The University and Polytechnic Grant Committee (UPGC, later changed its name to University Grant Committee [UGC] in 1994), which was responsible for funding of tertiary institutions, also did not endorse the proposal. Though UPGC was not a statutory body, it was the most significant body that influenced the development of higher education in Hong Kong.

> R26: UGC's proposals were seldom rejected by the Government. It had the financial role of administering grants. The universities they would usually listen to the advice from UGC carefully because they know that the UGC had the power over funding.

The Medical Subcommittee of the UGC was responsible for medical education in the universities and was involved in advising the Government in nursing degree programme. All members in the Medical Subcommittee were medical doctors apart from a nursing professor who join the Subcommittee in 1993. The usual procedure for policy decision making was:

> R26: When there was proposal initiated by the SE&M, the UGC would negotiate with the institutes. The Medical Subcommittee would be consulted if it was related to medical and nursing education. It would submit recommendations to the Government. The UGC would pass the reports on to the SE&M. If the Government agreed with the recommendations, the UGC would implement the proposal. It would formally write to the institutes concerning student numbers and resources.

Since the Medical Subcommittee was dominated by the doctors, it was inevitable that doctors were powerful in influencing nursing education development in universities. It was therefore important that support from this group was sought for nursing education reform.

Apart from external support, internal support was needed. Though there was no public consultation of the whole nursing profession, informal lobbying was carried out. NBHK was being lobbied by the nursing academics and the professional associations. Facing the pressure from these nurse leaders, a Working Group for a Degree Programme in Nursing was set up in 1987 by the NBHK to discuss the feasibility of introducing a degree programme. In 1989 the Working Group gave a report to the Government supporting the proposal of nursing degree for a small number of students. However, it also recommended that the existing system of hospital based nurse training should continue as it was (NBHK, 1989). Nevertheless, it was the first time that the NBHK had openly supported degree programme for nurses.

As the Statutory body gave support for degree nursing education, more direct political influence at Government level was attempted. The Legislative Council (LegCo) was a top-level law making body of the Government with the main function concerned with legislation and public expenditure (Daryanani, 1995; Postiglione and Leung, 1992). In 1988, nursing has got a seat in the LegCo representing nursing and allied health professionals. Because of the present of this member, nursing issues could be brought up directly to the LegCo and reached the Government's political agenda.

In December 1988 Mr Ronald Chow, who was a nurse and the first nurse Legislative Councillor, called for an urgent setting up of degree programmes for nurses. In a press release he said he would put this on the agenda at the LegCo meeting ('The development', 1988). In the LegCo meeting on 11

January 1989, Mr Ronald Chow raised questions asking if the Government would consider introducing nursing degree programmes in local universities to replace the training offered in hospitals and would accept that Hong Kong's existing nursing education system lags behind both well developed countries and China (Chow, 1989; 'Leaders call', 1989).

The questions were answered by the SHW that the Government had no plan at present to replace the existing system with degree level programmes based at local universities. The Government considered the present training system satisfactory. However, the Government had recently told the UPGC's Medical Sub-committee that it had no objection to the proposal of introducing a 4-year degree programme involving an annual intake of 40 students at HKP (Chow, 1989; 'No to', 1989).

This was the first time the Government stated in public that it did not object to the nursing degree programme. It seemed that a green light was given for nursing degree to go ahead. Mr O'Mullan said that, while the Government had raised no objections to nursing degree programme, the HKP had to wait for approval from the UPGC ('Decision on', 1989).

On 25 April 1990, news was released by the Government of formal approval for the running of a nursing degree programme:

> 'The HKP will introduce a 4-year full-time degree for Form 7 graduates with a maximum of 40 students' intake each year ('Approval likely', 1990)'.

On August 8, 1990, UPGC gave formal approval to the establishment of the pre-registration nursing degree programmes with 40 places given. The pre-registration degree programme started in 1990 with a 40-student intake per year. The nurses' training in schools of nursing still continued with about

2,000 students intake per year. A newspaper reported on the strong demand for these new degree programmes in nursing:

> 'New nursing programmes at HKP have drawn a strong response from women seeking degree qualifications. The nursing profession has lobbied for a nursing degree programme for a long time, saying this would help raise its professional status and promotional prospects. There were 250 applicants for the 40 places of the nursing degree programme ('Strong demand', 1990)'.

Data demonstrated that when the nursing degree programme was proposed in 1989 for the second time, more political actions were taken by nurse leaders. They also obtained support from nursing groups. At the same time, nursing got a seat in the LegCo which enabled more direct communication between nurses and the Government. All these factors might contribute to the success of nursing education reform.

The battle continued

From the early 1990s, various changes had taken place in Hong Kong, The HA was established to take over all the public hospitals from the MHD. At the same time, Hong Kong underwent rapid economic and social changes. The economy was booming and the unemployment rate was almost reaching zero percent. These changes affected societal values, as well as the values of individuals. A survey of post-secondary students in Hong Kong found that most respondents were very concerned about getting high pay jobs. They were pragmatic in the sense that they regarded studying as a way to earn more money, rather than searching for knowledge or personal cultivation. They were more attracted to profitable occupations in trade and business (Yeung, Chiu and Holbert, 1995). As nursing involved hard work and it was not a

highly paid job, it suffered from a major recruitment problem with high dropout rates. There was an acute shortage of nurses in the hospitals (Hospital Authority Working Group on Nursing Education, 1992a and b).

In an attempt to find solution to the problem of nursing manpower shortage, the Nursing Section in the HA had set up a Working Group on Nursing Education in Hong Kong to look into improvement of nursing education with a view to aid recruitment and retention of nurses. The Working Group reported that the hospital nursing schools had experienced an annual intake shortfall of over 200 student nurses in their recruitment. It recommended this unfilled training capacity be converted to degree places in universities or polytechnics from 1995 onward. It also recommended that nursing education should go into tertiary institutes in future (Hospital Authority Working Group on Nursing Education, 1992a and b). This report was submitted to the Medical Service Development Commitment (MDSC) of the HA, which was a top decision making body of HA and was supported. It was the first time the HA, the biggest employer of nurses, gave open support to the reform of nursing education.

In 1993, the Working Group on Nursing Education Policy of the NBHK recommended that the future direction in nursing education was to move towards tertiary education as soon as possible. There was a need to bridge the gap between the current hospital programme syllabi and the future goal (NBHK, 1993).

An Interdepartmental Working Group was also being sent up by the Government to look into nursing manpower issues. R02: The Group consisted of representatives from SHW, SE&M, the HA, the Finance Secretary and nursing LegCo member. In its report to the Government, it expressed support to the proposal of moving nursing education to degree level.

It appeared that at the early 1990s, there was a change in attitude towards nursing education reform. It seemed that a consensus had been reached by all nurse leaders that nursing education reform was essential. The reform was also supported by the HA and the NBHK. Although there were still objections from doctors, their voices were not as strong as before because there was acute shortage of nurses in the hospitals. Improving the standard of nursing education appeared to be one of the solutions to ease the nursing shortage problem.

However, there was still no formal announcement from the Government about the direction of nursing education development. The nursing profession continued to exert influence on the Government. In 1992, the CNHK published a position paper on the future of nursing education in Hong Kong. It recommended that in order to prepare competent and safe practitioners, a 4-year programme leading to the award of Bachelor of Nursing was required. Opportunities have to be provided to enable hospital trained RNs to upgrade their qualifications to degree level (CNHK, 1992).

Many nurse leaders spoke in public to support nursing education reform. During a nursing education seminar, Ms Wah Kit-Ying, the President of the CNHK, and Mr Michael Ho, the nursing LegCo member at that time, agreed that the present nursing education could not meet the needs of society and nurses could not deal effectively with the health problems in society. Mr Ho criticised the Government for having no long-term plan for investment and for giving the reform of nursing education very low priority ('Nurses training', 1993). In February 1993, members of the AGNS met the SE&M to discuss the finance for the nursing degree. Mr Michael Ho also met with the members of the UPGC to inquire the progress of launching the nursing degree programmes.

The turning point

The recommendations from the HA Working Group on Nursing Education and from the NBHK were forward to the Government and were endorsed by the SHW. She agreed to upgrade nursing education to degree level ('The HA', 1993). The official announcement of this support was made in the Yearly Address by the Governor. Mr Chris Patten, the Governor of Hong Kong, in a sitting of the LegCo, made a promise to give nurses more and better training by allocating an extra ten million dollars and providing 160 extra first-year first-degree places for nurses in the 1995-1998 triennium (Hong Kong Government, 1993). It was the first time in the Hong Kong history that nursing education had been an item in the Governor's address and it was also the first time that the Governor had openly supported nursing education reform.

Although there was a policy of supporting nursing degrees, problems were encountered in its implementation. Despite the Government's promise to increase the number of nursing degree places, no additional financial support was given to the universities. Without extra funding, it was not possible for the universities to establish more degree places. In December 1993, nurses still could not get the ten million dollars as promised by the Governor ('No money', 1993).

The nursing profession decided to take further action. To achieve greater influence, nurse leaders realised that united force was essential. A Task Force for Promoting Tertiary Nursing Education was initiated by the CNHK. The Task Force composed of seven nursing associations in Hong Kong with an aim to influence the Government for nursing education reform. Various political actions, such as lobbying and organising signature campaigns and petitions, were taken.

Letters were written to the UPGC. In a reply letter to the Task Force, the UPGC stated that it was concerned about the demand for degree places at the universities. The UPGC did not reach any conclusion regarding the introduction of degree programmes for the 1995-1998 triennium proposals (UPGC, 1993). Without the UPGC releasing money, it was impossible to increase nursing degree places.

The Task Force decided to upgrade its political actions. On 9 May 1994, the Task Force petitioned the Governor to fulfil his promise to grant funds for an additional 160 degree nursing places in 1995. In the press release, it stated that if the Government's promise was not kept, there would be insufficient nursing staff for the new Nethersole Hospital in Tai Po and the Northern District Hospital, due to be opened in 1996 and 1997 respectively ('Nurses Petition', 1994).

On 26 August 1994, the Task Force has a meeting with the SHW. The Secretary expressed support for degree education, but admitted that the goals could not be achieved because the Health and Welfare Branch did not have money to support the degree programme. The money should come from the Education and Manpower Branch. It appeared that the Secretary was passing the buck to another policy branch. Another reason given by the Secretary was that the Governor had 'mixed up' the 160 extra nursing degree places with the ten million dollars given to the Health and Welfare Branch for improving nurses' continuing education, though the promise to improve nursing education was still valid.

After the meeting, the Task Force arranged a press release immediately to express its dissatisfaction towards the Government ('Task Force', 1995). A series of actions were then taken. On 4 September 1994 the Task Force sent an open letter to the Governor to urge the UGC to give financial support for degree places, as promised in October 1993. A signature campaign was

carried out to collect nurses' signatures to support the quest for increasing nursing degree places and 3,000 signatures from frontline nurses were collected.

On 5 September 1994 the Task Force, armed with the three thousand signatures collected from nurses, petitioned the Governor again, urging the Government to fulfil its promise to add 160 degree places. The petition attracted media and public attention. Nurses' discontent about the Government was reported in various newspaper. On 2 October 1994 a press release from the Task Force requested the Governor to fulfil his promise ('Task Force', 1995).

Following the actions taken by the Task Force, the SE&M responded.

> R26: The SE&M gave an official reply to the Task Force on 19 October 1994, saying that the Government was still examining the financial implications...The UGC and tertiary institutions were exploring various options for expanding nursing degree programmes in 1995-1998 triennium.

On the 7 October 1994, the Government in a press release said that the UGC recommended that the University of Hong Kong (HKU) could have the pre-registration nursing degree programme in 1996 and that the Chinese University of Hong Kong (CUHK) could launch the nursing degree programme in 1995, though the decision had not been finalised ('The HKU', 1994).

However, problems were again encountered. No funding was available for the programme. It appeared that there were disagreement between two policy branches. Both the SE&M and the SHW refused to give funding.

R26: The SE&M refused to recommend funding for nursing degree programme, saying funding should come out from the Health and Welfare Branch. However, the SHW refused to give resources, it said it still needed the training resources because majority of nurses training was still taken place in hospitals. The UGC had to find resources by other means.

Political actions were continued by the Task Force which included press release and lobbying. Facing the pressure from the nursing profession, discussion between UGC and the two universities (HKU and CUHK) started. In January 1995, UGC made special arrangement with these two universities. Extra money was given by the Government to fund degree places. The CUHK would have 50 nursing degree places in 1995-1996 and HKU would have 40 places in 1996 and 60 in 1997.

R26: The two universities have no formal increase in the number of students, but they were assured that the Government would take no action if they exceeded the number. They were provided extra funding as well (65 millions for HKU and CUHK).

Outcome of the battle

In March 1995 the Financial Secretary in a LegCo meeting in moving the Second Reading of the Appropriation Bill, stated that the Government would increase the number of first-year first-degree places in nursing from 40 to 180 over three years (Hong Kong Government, 1995). The Bill was passed and the budget for nursing education was fixed. The Government finally gave extra resources to fund nursing degrees.

> R26: Since the UGC would only give financial resources for HKU to establish degree programme in 1996, the HKU would use its own resources to establish 40 degree places for nursing programme in 1995. The CUHK would have 50 places and the HKPU also increased the places of pre-registration nursing degree to 50. The number in HKU and CUHK would increase each year. By the year of 1998, there would be 180 pre-registration degree places for nurses in Hong Kong.

Therefore, in the 1995-1996 academic year, there would be 140 first-year first-degree places on the pre-registration nursing programmes. The number would further increase to 180 in the year 1998, making a total of 180 in the year 1998 ('HKU will', 1995).

Though nursing had a victory in getting some degree places, the number was small in compare with the 2,000 nurses required by the health care services per year. It constituted less than 10% of the total nurses needed per year. The Government did not have any written policy on the future development in nursing education. However, it appeared that the Government did not prepare to support a complete transfer of nursing education to degree level.

> R26: The Government did not seem to agree with a complete transfer of nursing education to degree level. A representative of the SHW said that the Government still believed it was necessary for nurses to be trained in hospitals. In the future, hospital training would still be the major mode of training

It appeared that Hong Kong nurses still had a long way to go in nursing education reform.

Policy-making process

From the review of documents, there were three stages in the quest for nursing education reform. The policy-making process began with the nurse leaders identifying the problem in nursing education and getting the issue on the political agenda. In 1985, nurse leaders from nursing professional organisations and higher education setting identified the problems of the hospital-based nursing education and proposed a nursing education reform. However, they could not get the agenda to the Government because of the obstruction from the medical profession. Also, the support from the rest of the profession was not sought. The first battle was lost.

At the end of the 1980s, nurses appeared to have a better consensus of the direction of nursing education. Many nursing groups openly supported the reform. The proposal was forwarded again to the Government at a time when there was political turmoil in Hong Kong. A small number - 40 degree places was given to nurses.

During the early 1990s, many political actions were taken by the nurse leaders in pursuing more nursing degree places. The Task Force for Promoting Tertiary Nursing Education was formed. Unity within nursing in their request was evident. Support from all nursing groups was sought and the nurse leaders were able to present the agenda to the Government for the third time. As a consequence of their actions, an additional 140 degree places were given to nurses, making it a total of 180.

Policy outcome

There were two significant policy changes in nursing education reform which resulted from the actions of nurses. The first was the establishment of the pre-registration degree programme in 1990 with 40 degree places. The second was in 1995, when the Government promised to increase degree places to 180 over three years (from 1995 to 1998) and the funding for these placed were confirmed. Table 3 shows the distribution of nursing degree places in three universities from 1990 to 1998.

Table 3 The distribution of nursing degree places in three universities

Name of university	Year 90/94	Year 95/96	Year 96/97	Year 97/98
CUHK	0	50	50	50
HKU	0	40	60	80
HKPU	40	50	50	50
Total	40	140	160	180

Key players in nursing education reform

From the document and interview data, four sets of key players were identified, namely the nurse leaders, the Hong Kong Government, the stakeholders, and the followers. Nursing leadership was demonstrated in the interactions between nurse leaders and the key players. The nurse leaders who had attempted to influence nursing education policy included:

- LegCo Councillors representing Health Care Functional Constituency
- Nurse administrators in HA (and the MHD before 1990)
- Chairpersons of the NBHK
- Senior nursing academics
- Chairpersons of the nursing professional associations.

Among the nurse leaders, there were various degree of participation in nursing education reform. The nurse leaders in the LegCo, higher education institutes and the professional nursing associations played an active role in the reform. They put forward an agenda to the Government and they used various political actions to influence nurses, stakeholders and the Government. Whereas the nurse leaders in the HA and NBHK played a more supportive role in nursing education reform.

The Government, which was a bureaucratic organisation, controlled the funding of health care services and higher education. The government officials who were involved in nursing education reform included:

- The Governor
- Members of the Legislative Council
- The SHW
- The SE&M.

To influence Government's decision making, nurses needed support from stakeholders. Stakeholders that had power to influence nursing education reform were:

- Members of the UGC
- Administrators of the HA (and the MHD before 1990)
- Administrators of the universities
- Senior doctors in the health care system
- Overseas nursing consultants

The followers, that is, the frontline nurses, were another group of key players. Nurse leaders needed support from the followers to achieve the goal of nursing education reform. Though this group was not active or visible throughout the influencing process, their support and unity was vital to nurse leaders, for example, in the signature campaign and petition to the Governor.

Political actions taken by nurse leaders

From the documentary evidence and interview data, it was found that a wide range of political actions had been taken by nurse leaders which included:

- Publishing reports and position statements
- Supporting the reform openly in seminars/conferences
- Making regular press releases
- Writing letters to the editors of newspaper
- Writing letters to the UGC
- Writing letters to the MHD
- Giving open letter to the Governor
- Raising the issue in Legislative Council
- Raising the issue in the NBHK
- Raising the issue in Medical Services Development Committee
- Meetings with Secretaries of Policy Branches
- Using overseas consultants
- Forming a Task Force
- Organising a signature campaign
- Making petition to the Governor.

Summary

In this chapter, the path of nursing education reform in Hong Kong has been traced through documentary evidence and interview data. The reform process began with the nurse leaders identifying the problem in nursing education and getting the issue on the political agenda. In Hong Kong, new policy was usually initiated by the Government. However, in the case of nursing education reform, the initiation came from the nurse leaders. Resistance was encountered from internal and external sources during the process. Nurse leaders had to use various political actions to overcome the resistance. This study showed that to effect policy change, it was important for nurse leaders to obtain consensus within the nursing profession as well as support from stakeholders.

Findings also demonstrated that nursing leadership could be regarded as a process of interaction among the key players: the Government, the stakeholders and the followers, through which the nurse leaders influenced the key players with an aim to achieve nursing education reform. To understand nursing leadership, one have to analyse the interaction between nurse leaders and the key players. This chapter described the process of nursing education reform. The following chapter presents the findings of the situational variables that influenced the behaviour of nurse leaders.

CHAPTER SIX

FINDINGS - SITUATIONAL FACTORS INFLUENCING THE EFFECTIVENSSS OF NURSING LEADERSHIP

Introduction

In this Chapter, the situational factors which were found to influence the nurse leaders' effectiveness are described. Categories were developed from analysing the interview data. Extracts of informants' transcribed interviews are included to illustrate the development of the categories and sub-categories.

Two core categories were identified: *inertia* and *facilitation*. *Inertia* is the core category describing the variables in the environment, which acted as barriers to nursing education reform. The categories which described the barriers are: medical dominance, socialisation of nurses, lack of education opportunities and weak leadership in nursing. Each of these categories has sub-categories, as illustrated in Table 4.

Facilitation is the core category describing the favourable factors of the environment that promoted nurse leaders' effectiveness in nursing education reform. Favourable factors were related to changes in the socio-economic-political environment and the health care system. This core category together with its categories and sub-categories are illustrated in Table 5. A more detailed coding scheme is presented in Appendix VII.

Table 4:

The categories and sub-categories of the core category 'Inertia'

Categories	Sub-categories
Medical dominance	Medical dominance in health care system
	Medical dominance in the Government
Socialisation of nurses	Repression
	Lack of unity
	Passive and dependent behaviour
	Poor image of nurses
Weak leadership in nursing	Weak NBHK
	Weak professional associations
	Weak academic and clinical leaders
Lack of educational opportunities	Lack of political skills
	Non-assertive behaviour

Table 5:

The categories and sub-categories of the core category 'Facilitation'

Categories	Sub-categories
Changes in political system	1997 issue
	LegCo seat
Changes in academic institutions	Increase degree numbers
	Support from Faculty of Medicine
Changes in health care system	HA formation
	Resignation of senior nurses
	Shortage of nurses

Inertia

Inertia is defined as having no ability to change or to resist change. There was reference to inertia in nursing education throughout the data. Many informants considered the progress of nursing education reform to be very slow. For example:

> R4: There is not much change in basic nursing education. Curriculum is based on practical skills, we do not encourage critical thinking skills in nurses. We still are examination oriented.

> R9: There is not much change in the hospital based nursing education, only slight amendment periodically. The theory input had increased from 41 weeks to 52 weeks, but still not enough to catch up with the needs. It is still an apprenticeship system of training. There is no direction for change.

Some informants pointed out the fundamental reason for this inertia in nursing education is the apprenticeship system of training.

> R17: The fundamental problem is the students are employees during training, service always come first, education is subservient to service. It is difficult for hospital-based nursing education to change drastically because of the manpower issue. Students are being counted as manpower in hospitals.

Medical dominance

There were many reasons accounted for 'inertia'. Medical dominance was being put forward as the major reason. 'Medical dominance' is a code word used to describe the phenomenon that the medical profession controls nursing

development. Data showed that the medical profession was the most powerful group in the health care system as well as in the Government. Doctors occupied many key positions, they therefore had the authority to control the allocation of resources. The reform of nursing education was considered to be a vehicle for nurses to become an autonomous profession, but this was suppressed by the medical profession because they did not want nurses to challenge their power.

Medical dominance in the health care system

The main reason for nurses not achieving the desired changes in nursing education was opposition by the medical profession. The medical profession had great influence on policy-making in the health care system.

> R06: The first time that we asked for a degree nursing education was in 1986. The Government rejected the proposal. The main reason was that the health care system was dominated by the doctors, who said that nurses did not need degree education. The main block was from doctors. They saw you as subordinates. A Government official, who was a doctor, told me that nurses did not need degree education.

There were difficulties when nurse leaders tried to influence policy-making because of medical dominance at the decision-making level of the health care system. One informant described the experience:

> R02: The Interdepartmental Working Group, which was set up to look at nursing education and other nursing issues, was strongly driven by medical people. Nurses were outnumbered by medical people on committees. It was very difficult to push the proposal of nursing education reform. When the report was submitted to HA,

it then went through a lot of committees which were chaired by doctors. Doctors tried to modify the report. We went through many debates that nursing education should move towards degree level. It was very difficult to go through HA because of the barrier from the doctors.

Another informant also had a similar experience.

R01: The Medical Division and Advisory Committee (MDAC), which is the highest policy-making committee in health care services was strongly driven by medical people. They were the decision makers. It was difficult to persuade them to accept that nurses need degrees.

One of the key reasons of the medical profession objected to a nursing degree being that doctors wanted to maintain their dominant positions in the health care system and they believed that well educated nurses would threaten that position.

R05: The Director of the MHD was very opposed to nursing degree. He did not want competition and rivalry within the service.

R12: The doctors would like to be the only degree holders in the health care system. Nurses have great numbers. If nurses' status increases, it would threatened their position.

Medical dominance in the Government

Apart from the health care system, it was recognised that there was great influence of the medical profession in the Government policy making arena. Although a nurse had been elected to represent the allied health care professions on LegCo, when compared with the number of doctors, nurses were still the minority at the policy-making level.

> R10: The constraint was 10% of the members in LegCo were doctors while nursing had only one member (less than 1%). Doctors had great power to influence policy making at the Government level.

> R14: The medical profession have a lot of power in influencing nursing education development. They have policy input at all levels - from health care services to the Government. Doctors outnumbered nurses on majority of the committees that were related to nursing education policy-making e.g. the MDAC, the UGC, the LegCo.

Apart from the number, doctors are more influential than nurses, because of their status.

> R01: In LegCo, there were people who would listen to doctors rather than nurses, because doctors have higher status than nurses and they had been on LegCo for a long time. When we told other LegCo members that nurses needed degree education, no one listened.

As the doctor retained the power to affect many aspects of the nurses' work, it was difficult to alter this climate of medical dominance. In the history of

nursing in Hong Kong, doctors were dominant on the NBHK and in the hospitals.

> R01: Before 1988, the NBHK was controlled by doctors. The Chairman was the Director of MHD. The nursing members were mostly from subvented hospitals. They got to that position because of their relationship with the Medical Superintendents. They had to say yes to everything the doctors said.

Doctors were involved in the performance appraisal of senior nursing staff and nursing appointments. Because of this, there was a tendency for some nurses to be obedient and to please the doctors.

> R06: Doctors are controlling the appointment of senior nursing posts in the HA. Some nurses would like to do things to please their boss, that is, the doctors, in order to survive in their positions or get promotion.

After the establishment of the HA, the medical dominance seemed to be even greater than before. Doctors occupied most senior administrative positions in the HA. At the hospital structure, nurses were lower in the hierarchy than doctors and were subordinate to doctors. It became more difficult to combat the medical dominance.

> R04: After the establishment of HA, the medical dominance seems to be even greater than the era of MHD. Doctors occupy most of the Hospital Chief Executive positions in the hospitals. Most Deputy Directors in the HA Head offices are doctors. They are controlling the resources. Although it appeared that nursing could take up more management functions in the HA, in reality it is dominated by doctors.

R06: Doctors control the HA. There are 16 Deputy Directors and the majority of them are doctors. Doctors know the system well. They have the advantages. They cut positions for nurses to create those senior posts in the clinical areas because they said clinical areas needed supervision. With the establishment of the HA, nurses are even more powerless. They are controlled by the Chiefs of Service of the units and are the lowest group in the administrative hierarchy. Nurses' voice is getting smaller.

Socialisation in nursing

Apart from medical dominance, the behaviour of nurses emerged from the data as one of the factors that caused inertia. Informants frequently commented that nurses themselves were holding nursing back. It presented a major barrier to nursing education reform. Such behaviour can be attributed to professional socialisation.

Nursing development in Hong Kong followed the Nightingale tradition which emphasised obedience to doctors and senior staff. The consequence was nurses exhibited behaviour patterns such as subservience, passivity, lack of confidence and resistance to change. A lack of unity was evident and was perceived by many informants as a major barrier to nursing development. These behaviours had been learnt and were reinforced by the hospital-based education system. The consequence of such behaviours was a poor image of nurses and weak leadership in nursing.

Repression

Repression is the category used to describe nurses' resistance to professional advancement. Inertia had been maintained, in part, by nurses themselves. Many nurses wanted to maintain the status quo and they resisted changes in nursing education. Informants described the situation as follows:

> R12: There were great resistance when the degree course for nurses was proposed. The resistance came from senior nurses.

> R20: The biggest problem is the resistance from nurses themselves It is only a very small portion of nurses who prefer change. Majority would like to maintain status quo. I feel that the block is in the nursing profession.

One of the reasons given for objecting to the degree programmes was the manpower implication.

> R01: Objection for nursing education reform mainly came from the senior nurses. They were concerned with manpower more than professional development. Manpower was their priority.

Some senior nurses were worried that degree nurses were more expensive to prepare and that they would demand higher salary.

> R05: The Nursing Director thought that if there was a broad acceptance of the pre-registration degree in nursing, it would be much more expensive to employ nurses.

Manpower and resources issues might have been used as an excuse by senior nurses for rejecting degree education. Deep down, there were potentially other reasons. They were afraid the graduate nurses might overtake their positions and they therefore felt threatened by the degree graduates. There was a lack of confidence in senior nurses. They feared that they would lose control of the valuable manpower provided by student nurses. The following comments illustrate this point:

> R04: Some senior nurses rejected the idea of tertiary education. They perceived it as a threat. They worried that they were not so knowledgeable as tertiary educated nurses.

> R13: Some senior nurse felt threatened because they were not sure about the future. They were afraid that degree nurses would threaten their job opportunity and status as well as their promotion in the future. Also if training is taken away from the hospital, they will lose control of the workforce.

Many senior nurses assumed the values prescribed by the dominant group, that is, medical doctors, by rejecting degree education for nurses. The resistance from nurses and the lack of support from internal group was regarded as the most difficult barrier to overcome.

> R12: Some members in the NBHK were very resistive to the nursing degree. They felt that the training they had received was good enough and they did not feel the need for a nursing degree. One reason for their resistance was their own security problem. They did not want their junior to be smarter than them. Others did not dare to think differently from those senior medical officers in order to maintain their relationships with the doctors, so they could

maintain their prestigious position. The resistance coming from this group of nurses was the most difficult to overcome.

Lack of unity

In the pursue of nursing education reform, nurses did not have a consensus as to what the direction should be. In spite of the large number of nurses, the image of nursing was not one of a powerful profession. Because nursing was seriously divided, it was difficult to project to the public and the Government the image of a powerful and autonomous profession. This was one of the causes of inertia.

Nurses tended to form smaller groups within this large profession and gave more loyalty to their respective group than to the nursing profession. These divisions caused a fragmented approach to the pursuance of the profession's goal. There were more than 20 nursing associations at the time of this study but these groups seldom collaborate. These behaviours might be related to nurses' socialisation process. Nurse leaders' actions to achieve nursing education reform was weakened by this lack of unity within nursing. Instead of deriving power from its size, nursing had been held back by the dividing forces operating within the profession. Examples of disharmony among different trade unions and professional organisations appeared throughout the data.

R02: Nurses have a habit of fighting against each other. We now have more than 20 professional nursing associations with vested interests. It is difficult to speak with the same voice. We have differences in opinions - the two biggest nursing associations in Hong Kong are always disagreeing with each other. It affected our strength when we bargained with the Government.

R14: There were many trade unions speaking with different voices, it is difficult for trade unions to influence if they are so divided. Nurses seldom work collaboratively. It might be related to their socialisation process. We always stepped one each others.

Because of different vested interest, data showed that that it was difficult to have consensus among nursing associations in regard to the reform of nursing education. Coalition is difficult to form.

R03: Different associations have different concerns. Each group has its own objectives and is concerned with the welfare of its group. It is difficult to form a coalition. I would like to work with other trade unions, but it is difficult if our ideologies are so different e.g. I cannot compromise with the speed of nursing education reform.

R06: There is a lack of consensus of how to move forward. We waste our time if we just ask for a small number of degree places. I have suggested that we should have a plan. Other associations preferred to do it the simple way. But we really miss the chance. There are unions that would like to compete with others and they don't compromise.

Lack of unity was not confined to nursing associations, but was also present within the nursing departments in the universities.

R05: I always felt that if the three institutions had get together, we could have this chunk of money earlier. But I understand there is tremendous rivalry between these institutions and that collaboration among them is something that probably won't come very soon. I think it's got to hold nursing back a bit.

Due to the lack of consensus in the profession, there was inadequate pressure on the HA and the Government to act for nurses. The consequence was a decrease in power and a politically weak profession. Nurse leaders had to spend extra energy to overcome these shortfalls. This made it extremely difficult for them to bring about the changes.

> R10: My honest opinion is, if the nursing associations don't get together, we are not going to have the political strength to really get nursing forward. If we can't have consensus within the profession, it is very difficult to persuade HA however well motivated they are to spend money to make a big change. They need to be sure what the professionals want.

> R04: Internally, nurses did not have a consensus about the direction for nursing education. The Government know that we had no consensus among yourselves, they turned down what we asked for and they made a less favourable proposal to us.

Passive and dependent behaviour

Another barrier to nursing education reform was related to nurses' passive and dependent behaviour. Many nurses were passive and unwilling to participate in political actions.

> R02: The whole profession is not very active politically. Political activity is very low. Most nurses were passive. They waited for someone to do things for them, they didn't see the responsibility to fight it themselves.

On the whole, the social awareness of nurses was poor. Nurses were not very interested in joining professional organisations or activities. It might be related to the socialisation process. The consequence of this passive and dependent behaviour was that nurse leaders did not get the support that was necessary.

> R03: Nurses seldom read newsletters or attend seminars. They lack social awareness. They don't see their responsibility towards their profession. It is difficult to get support and input from nurses. It was due to the socialisation process. In the past, they were not being encouraged to ask questions or to have critical thinking. I hope nurses can be more active and critical, not just waiting for the leader to give them directions.

> R16: In Hong Kong, the percentage of nurses involved in professional organisations or activities is relatively low, when compared with Australia. Only a very small percentage of nurses (less than 5%) in Hong Kong join the professional organisations. Coalition among nurses is very difficult to form.

Poor image of nurses

The subservient and passive image of nurses, together with the divisiveness of the profession, projected a poor image of nursing. This affected nursing's status and power. The fact that nurses had little influence on health policy and the Government was unwilling to invest money on nursing education might be related nursing's poor status and image.

> R06: The Government is not willing to give a lot of money for the nursing degree. It may be related to nurses' status that Government made this decision. We are not at the top of the priority list.

R21: We have asked the medics for their views on degree education for nurses. Most of them were against the idea. All the allied health professionals all get into tertiary institutions for basic education. Why can't nurses? They said that we got large numbers. I regarded that the Government did not feel the need for nurses to have degree education because of our low status.

Data also showed that nurses' image was still poor. The traditional image of nurses affected consumers' support of nursing education reform. If the public did not perceive the necessity for nurses to have degree education, it was unlikely that there would be support for nursing education reform.

R10: It is not just the problems of nurse leaders. I found that nurses are still handmaidens to the doctors. The image of nurses is poor. It is difficult to push degree education.

R04: Patients won't mind whether the nurse is a diploma or degree graduate. They just need a qualified nurse. It is difficult to get support from the public if they still have the traditional image of nurses.

Weak leadership in nursing

Many informants criticised the state of nurse leadership in Hong Kong. They spoke of having seen no evidence of 'good leadership' among nurses. It was regarded as an important factor affecting nursing education reform. Data showed that nurse leadership was weak in different areas - the NBHK, the professional organisations, academic institutes and clinical areas.

Weak NBHK

The NBHK should be the one to lead the way in nursing education. However, the Board did not provide the leadership expected and informants were not satisfied with the leadership of the Board. Data showed a lack of direction provided by the Board. It was politically weak.

> R28: The NBHK has done very little for the profession except in terms of regulations. It should play a leading role like the UKCC that initiate changes in nursing education. However, it did not have a clear direction for the future development of nursing education. Leadership was inadequate. The NBHK was not very strong politically. The members were missing the political drive. We need big changes in the Board.

> R10: In the transfer of nursing education to university, I didn't think there was a lack of wanting to move forward. They lacked the political strength to do it. The NBHK was like the old General Nursing Council in UK 30 or 40 years ago. It needed a completely fresh look at its functions, its power and its membership.

One informant commented that a reason for the NBHK's weakness was related to medical dominance and the subservience of nurses.

> R01: In the past, NBHK was controlled by nurses of ex-subvented hospitals and medical doctors. Those nurses were promoted to their positions because they supported their medical superintendents. They would not object to what the doctors said.

There was a general feelings that the NBHK provided weak leadership in the development of nursing education in Hong Kong. The problems within the

Board were related to its membership. Most of the members of the Board were senior staff from the hospitals. As members were appointed by the Governor, front-line nurses had no mechanism to monitor its work. This affected the accountability of the members and the Board was unlikely to provide strong leadership. This was one of the causes of inertia.

> R16: Many people on the Board did not have experience in higher education. When we discussed nursing education reform, that was a problem there. It limited its ability to develop direction.

> R07: There are one or two members of the NBHK who really tried, but there were members just sitting there for years and making little contribution.

Weak professional associations

Other informants commented on the strength of the professional organisations. There was a general feeling that leadership in these organisations was weak and could not provide leadership in the development of nursing education. Some informants commented on the biggest nursing professional organisation in Hong Kong.

> R14: It did not do much. The Task Force was important but the members had not maximised their influence. They did not tell the public why they needed degree nursing. What Government did depend much on public's sympathy and support. If public support was not there, there was not much pressure on Government to change.

When compared the situation of Hong Kong with overseas, it was found that professional nursing associations overseas were stronger and they performed more political actions.

> R14: When comparing Hong Kong with Australia, Australia has a stronger nursing association, the Royal Australia Nursing Federation. It has strong links with government to articulate nurses' needs. Our professional association seems to miss that link. It should be more visible because it is leading the profession. However, it now seems to be a segregated part of the profession.

One of the factors determining the ability to influence was the size of the professional nursing associations. The biggest nursing professional association had about 3,000 members. The membership size was small when compared with the total nursing population in Hong Kong - about 10,000 RNs. The strength of the association was affected by its membership size. It was also affected by the commitment of the members. If members were not committed, the associations would not have power.

> R16: The professional association should be more up-front and more vocal and should establish better relationships with the press. Problems arise because of not having enough people and time to do all that should be done. In Australia, the percentage of people joining professional organisations is higher than in Hong Kong. It might be because Hong Kong nurses are not socialised to join professional associations. They are not being encouraged to be committed to professional activities. If you can get committed people in the association as leaders, it can move faster.

Weak academic and clinical leaders

From the interview data, it is obvious that there was weak leadership in the NBHK, the professional nursing associations, the higher education settings, and the clinical areas. Weak leadership in nursing was related to nursing socialisation and a lack of opportunities to develop leadership skills. The consequence was inertia in nursing education reform. Informants commented on the situation as regards nursing leadership in academic and clinical settings.

> R10: In Hong Kong, many nurse leaders came from academic settings, academic leaders are unable to influence and break into the work situation in the hospital. In the past, we have not put in efforts to develop nursing leadership. That is why we do not have outstanding leadership in nursing.

One informant commented on the current nursing leadership situation in the hospital.

> R10: I don't see much leadership coming from the clinical field. You need a mix of nurse leaders across the hospitals and primary care settings. These people must come through strongly, believe in degree education and push it through. You need some 20 or so very able leaders in the service, who care about nursing and can handle the situation. You haven't got it yet.

Without strong nursing leaders, it would be difficult for nursing to influence nursing education reform. There was a lack of direction in nursing education development and it was difficult for nurses to influence policy-making.

> R09: There is no obvious direction in nursing education. There is no consensus. The decision is left to individual schools in the

hospitals or to nurse educators to consider. It was difficult for us to influence the Government.

Lack of learning opportunities

Nurse leaders were regarded as weak in influencing with the Government. One of the reasons was a lack of ability and knowledge. The fundamental problem was nurses' inadequate education that resulted in weak political power.

Lack of political skills in nurses

To initiate actions, nurse leaders have to confront the Government openly and negotiate professional matters. However, the inadequacy of basic nurse training and the lack of opportunities for continuing education were believed to hold nurses back in the development of political skills. Nurses did not have the power, knowledge and skills to influence.

R01: We lacked knowledge of the policy-making process and of the way in which resources were allocated. Also, we lacked the ability to bargain. When our representatives spoke to the Government officials, we could not articulate our points clearly and our response was slow. It was all because nurses do not have adequate education.

R04: When we had meetings with the Government officials, we felt inadequate because we did not have the academic qualifications that they had. It shook our confidence. However, it was not nurses' fault. The system created these nurses. The system perpetuated our ignorance.

Non-assertive behaviour

Sometimes nurses resorted to passive-aggressive behaviour instead of assertive behaviour. Nurses did not have skills to influence others. Informants commented on nurses' behaviour which was a consequence of lack of education.

> R16: Nurses sometimes were not able to explain what they wanted...Discussions between nurses and doctors were not parallel. Many times, nurses used passive-aggressive behaviour, not assertive behaviour. Nurses could not be assertive, may be it is due to their lack of confidence and the amount of education they have or it may be due to culture. Some nurses are very sensitive to doctors' suggestions as they are afraid that doctors may take over...

Facilitation

Despite all the barriers in the environment that created inertia, informants did mention factors that facilitated nursing education reform. 'Facilitation' is the core category identified which relates to the favourable factors in the environment that facilitated nurse leaders' effectiveness. These factors are related to changes in the wider society, the academic institutions and the health care system in Hong Kong.

Changes in political system

In 1984, the Sino-British Joint Declaration was signed which stated that Hong Kong would be returned to China on the 1st July 1997. The quest for nursing education reform started around that period of time. As the end of British rule was approaching, there was much uncertainty in the Hong Kong society.

People generally had very low confidence in the future. However, this political uncertainty facilitated the reform.

1997 issue

Some informants saw the return of sovereignty of Hong Kong to China and the Crackdown in Tiananmen Square on 4th June 1989 were catalyst for change. The British Government, when approaching the end of its term in Hong Kong, seemed to change its governing style a little.

> R03: In the past, the Government was dominated by senior bureaucrats who were British. They had little concern for the 'grassroot' level. However, in the past few years, the Government has been generally more open and there is now more 'grassroot' participation in politics. It makes us easier to put forward our proposal to the Government.

Two informants summarised the factors influencing nursing education reform which included political and socio-economic changes in Hong Kong and the international trend.

> R12: Because of the 1997 issue, there was high turnover rate of nurses due to emigration to other countries. The Government regarded that the number of nurses trained in the hospitals might not be able to match the turnover rate. Therefore, it considered having a nursing degree programme. So it was the political and social factors that facilitated the changes. We fought for many years without progress, until the hospitals had the need, we had this breakthrough.

R03: In the late 80s, there were many changes internationally. Degree education was established in Australia. China also started a nursing degree programmes. Even British nursing started to change. Degree level nursing education was a trend that the Government could not resist. There were also catalysts. The crackdown in Tiananmem Square in 4th June 1989 caused brain-drain in many professions, especially those with higher education. The Government then had a big increase in tertiary education places. Since nursing had asked for it, a small number then was given to nurses. It all happened in a short period of time.

LegCo seat

Before 1985, LegCo consisted of official members and appointed members only, who were from elite groups in the society, including businessmen, lawyers and doctors. After the signing of the Sino-British Joint Declaration, the Hong Kong Government started democratic reform. One of the ways was to introduce direct election in the Legislative Council. Positions for Geographical and Functional Constituencies were created. One position was established for Health Care Functional Constituency to represent nursing and allied health professionals. A nurse was elected to represent the Health Care Functional Constituency in 1988. It was the first time in the history of Hong Kong that a nurse was able to enter the policy-making arena at a high level in the Government. This ended the medical profession's monopoly in LegCo.

Since 1988, two nurses have been elected to this seat in succession. Many informants agreed that these two LegCo members had much influence on the policy outcome. It gave nurses a direct channel to contact the Government officials.

R04: When nursing had a representative in the LegCo, the channel was more direct and need not have so many turns. It made a difference The power of nursing increased by having a LegCo member representing nursing.

R24: The LegCo member could explain the need for nursing education reform to the Government officials. The contact is more direct.

Both LegCo members were chairpersons of the biggest trade union in Hong Kong. The support from the union gave the LegCo members the political power.

R03: The union had an extensive network with front line nurses. They had newsletters published every month and they organised regular seminars to discuss professional issues. In this way, information was fed to nurses promptly. The support from the members of the union and front line nurses, for example in signature campaign and in petition, put pressure on the Government to respond to the quest of nurses.

By getting into the LegCo, nurses could assert direct influence on the policy system. It was obviously an advantage when compared with the situation in the past, when no one would speak for nurses in the LegCo meetings. Informants regarded this as a significant facilitating factor.

R07: The trade unions and professional associations helped a lot in justifying the degree programme. But the turning point was the Legislative Councillor. The big thing was just at that time the functional constituency - it gave us a direct force on the LegCo.

Things had significantly changed since we had the Legislator. We can have direct contact with the Government.

Changes in academic institutions

Changes also occurred in the universities. The Government had increased degree numbers in the universities in the 1990s. As a result, universities had to develop new courses.

Increase in degree places

Because of the 1997 issue, many people left Hong Kong. There was a severe brain-drain. The Government expanded higher education in order to compensate for the manpower losses.

R15: In 1990, the government expanded higher education. Among all the health care professionals, only nurses did not have a degree. Therefore some degree places were given to nursing.

R16: In 1990, the Government increased the amount of funding to the universities. HKP and CUHK put forward proposals to UPGC. Because the number asked for was not great, the Government said yes.

Support from Faculty of Medicine

The establishment of a nursing degree received support from the Faculty of Medicine in the university. As the number of medical students was decreasing, the faculty had to establish new programme for survival. The shortage of medical students might be one of the factors that influenced the change in attitude in the Faculty of Medicine. Informants commented that:

R23: Now the pre-clinical departments are actually struggling to find students. Departments of Anatomy and Physiology are in need of more contact hours for undergraduates. They had to establish new courses in order to survive.

R05: Medical students needed to study for seven years in order to become a qualified doctor. Because of the 1997 issue, some students or their parents did not have confidence in the future of Hong Kong, they would rather select programmes that would finish in a shorter period of time.

Changes in the health care system

The HA was established in 1990 to take over all the government hospitals. Some informants mentioned that medical dominance was even greater after the establishment of HA. However, some informants had different opinions. They commented that because of decentralisation in the HA structure, some freedom was allowed.

HA formation

R10: The HA formation and the move into general management made it possible for the educators to take a hard look at nursing education. They were now in positions where they could make some changes.

R26: The setting up of HA has influenced the outcome of nursing education reform in 1995. It has brought about a new look at the manpower requirements in hospitals.

Since the establishment of the HA, nurses were given more opportunities for continuing nursing education. This decreased the barriers.

> R21: After the establishment of HA, many staff members are very keen on self-development. Many people participated in committees in hospitals. There are many initiatives, such as continuous quality improvement, cost containment. There is support from higher management in HA for nursing. These are favourable factors.

There were doctors who were more open-minded. They began to accept that nurses needed better education.

> R10: In HA, you have young doctors who support nurses. They understand the advantages of nurses having more education. They support degree education for nurses. I was quite impressed by some of the doctors. They had been to many meetings in the curriculum planning of this nursing degree. They showed a tremendous commitment. They really appreciated the contribution of nurses and what education can give. They knew that if they got people that were equally well-educated, it would have a profound effect on the standard.

Resignation of senior nurses

Many informants mentioned that nurses themselves presented the biggest barrier to nursing education reform. At the end of the 1980s, because of political instability, many senior nurses resigned or took early retirement in order to emigrate to other countries. There was a decrease in resistance from this group of nurses which contributed to the success in 1990, when 40 nursing degree places were established. Apart from that, because of the retirement of

senior nurses, many younger nurses got the opportunity to be promoted to senior positions. They were generally more proactive and willing to accept changes. There was less resistance towards nursing education reform.

R04: At that time, many senior nurses were due to retire. Their influence was reduced. Also, there were many things happening in nursing education globally, for example, in Australia, the UK and USA. It influenced people's view. Many strong opponents in nursing changed their mind at last. When there was unity, things went more smoothly.

R09: In the 1990s, there were changes in the NBHK members. As the group of former nurse administrators in the MHD resigned at the end of the 1980s, new members were appointed. There was about 70% change in the membership. The new members were able to lobby and influence decision-making at the Board level. Some new members were nurse administrators who generally supported nursing reform. The NBHK changed its stand in the early 1990s. The support from the Board contributed to the success of the reform.

One informant said:

R07: There was a also cultural change in nursing. In the past, junior nurses were not allowed to speak up directly, when they did not agree with their senior. Now it is more relaxed. We spoke up in the meetings and voiced out our requests for nursing education reform.

Shortage of nurses

In the early 1990s, there was a severe shortage of nurses in Hong Kong. The Government and the HA could no longer ignore the problem. One informant commented on the necessity for change.

> R25: In the early 1990s, there was an increasing awareness that nurses were unhappy. Many nurses resigned, including student nurses. The quality of recruitment was poor. Nurses were not vocal and assertive. It was realised that there were problems in nursing education and it had to be revitalised. If nurses kept on expressing their unhappiness and the image was poor, no one would like to join nursing. In the hospital environment, it was difficult for nurses to develop. It had to be done in the university environment. This was the way to revitalise nursing education.

On the whole, changes in the political and health care environment acted as facilitating factors that created a favourable environment for nursing education reform. Many informants believed that the success in getting the degree numbers in 1990 and 1995 was the result of a combination of multiple facilitating factors.

> R25: The establishment of degree programme in universities had got HA's support, LegCo's support and the citizens' support. Of course was also due to social and environmental factors: the poor recruitment, the technological changes, the changing health care services. All these factors facilitated changes.

R03: On the whole environmental factors played a part, such as inadequate recruitment and high turnover rate for student nurses. All these factors added up made the reform happened. Without these factors, even though we had a LegCo members, we might not have been able to get the numbers.

Summary

This chapter concluded that situational factors had both positive and negative impacts on nursing education reform. Data showed that variables acted as barriers included: medical dominance, socialisation and lack of education opportunities. As a result, nursing leadership was weak and nursing's image were poor. Despite the barriers, there were favourable factors that facilitated the effectiveness of nurse leadership. The approach of 1997 enabled nurses to gain access to the political system. The severe brain drain and the acute shortage of nurses forced the Government to expanded the number of degree places in the universities. The establishment of the HA also gave opportunities for nurses. It was the combination of various factors that facilitated nurses' success in gaining some degree places. Situational factors influenced nursing leadership effectiveness. The understanding of situational factors is important in analysing the role of nurse leaders in nursing education reform. The following chapter presents the findings of the strategies that nurse leaders used to influence.

CHAPTER SEVEN

FINDINGS - THE ROLES OF NURSE LEADERS IN NURSING EDUCATION REFORM

Introduction

In this chapter, the roles of the nurse leaders in influencing nursing education reform are described. Categories were developed from the interview data and supported by documentary evidence. Evolution is the core category used to describe the process of nursing education reform in which the role of nurse leaders were to overcome the barriers and to build new power bases, ultimately to enable growth of the nursing profession. The concept of evolution was borrowed from Darwin's theory of evolution of species. Evolution means a gradual change in the characteristics of a population of animals or plants over successful generations (Hanks, 1986). The core category 'evolution' was created to reflect nurse leaders' deliberate efforts to change the negative situation into positive situations which favoured the nursing education reform.

The evolution took place in the changing socio-political environment of Hong Kong. It was apparent that nursing education in Hong Kong could not remain stagnant and had to adjust itself and to survive in the fast changing environment. Nurse leaders attempted to influence by expanding their power base through various actions. The reform was considered as a gradual process. The coding framework of the core category 'evolution' is illustrated in Table 6. A more detailed coding scheme can be found in Appendix VII. Data from informants' transcribed interviews are presented to demonstrate the development of categories and sub-categories as they were identified.

Table 6 The categories and sub-categories of the core category 'Evolution'

Categories	Sub-categories
Establish goals	Vision Establish direction
Communicate directions	Communication with followers Communication with key players
Increase power through unity	Collectivity Collegiality
Increase power through influence	Access Networking Lobbying Increase visibility
Empower followers	Education Support and motivation
Prepare self	Leadership attributes Leadership style

Evolution

Majority of the informants realised nursing education reform was necessary to achieve growth of the profession. Actions for change were suggested.

Establish goals

Establish goals is a category describing nurse leaders' role in establishing visions and direction for change. In this way, followers could be motivated and focused to work towards the goal.

Vision

Vision, according to Tichy and Ulrich (1984) was the ability to picture some future state and described it to others so they began to share the vision. Informants mentioned the importance of having a vision in influencing nursing education reform. When leaders have vision, followers would be more focused and motivated.

> R04: A leader has to have a vision. You have to believe in the vision yourself before you can influence others. You have to strive hard for your goal. People's actions would be more focused if you have a vision. When you are a visionary leader, you will be at the forefront to guide your followers.

> R08: A leader has to determine the vision and find ways to implement the vision. You have to determine long-term plan and communicate your goal to others. People will be motivated when you have a specific goal to aim for.

Establishing direction

Establishing direction for change is an important part of leader's role. Many informants recognised leaders had to set the establish direction for change and then direct followers to pursue the goal.

> R06: We must make a decision about the future direction of nursing education. We have to have a plan before we can convince people that nursing education should go tertiary. If there is a concrete plan, we can show people the advantages of going tertiary.

R12: We have to establish direction for nursing education and communicate our direction to members, so that we can work towards the goal.

Informants had a direction that they would like to go. They all agreed that basic nursing education should be upgraded to degree level.

R12: Basic nursing education should be at baccalaureate level. In this knowledge explosion era, nurses need an educational based programme.

R06: Basic nursing education must go degree, we should not fall behind other countries.

Though there was a general agreement that nursing education should upgrade to degree level, transfer of nursing education from hospitals to tertiary institutions should take place gradually. Some informants felt that a long-term plan should be made for nursing education reform.

R09: To ask for 180 degree places is only be a part of the reform. We have to have long term plan to see how we can phase out hospital based training. I think it should be a gradual transition. I would think Hong Kong might go well on the same line as the UK or Australia. Perhaps a little way in between.

R10: We have to have a time frame and we can't move everybody to university overnight. We could use something like a ten years time frame. We can start to increase numbers in the universities and decrease number in the schools of nursing.

It was evident from documentary evidence that during the 1990s, all nurse leaders supported the transfer of nursing education to tertiary sectors. There seemed to be an agreement among nurses that change should be gradual.

Communicate directions

'Communicate directions' refers to the nurse leaders' actions in communicating their vision to others in order to influence change. Many informants emphasised that good communication skills were very important in influencing both followers and policy makers. There was emphasis on being articulate and being able to get the message across to influence policy makers, stakeholders and nursing colleagues.

Communication with followers

Communication was a way to make the vision apparent to followers and influence them to agree on the vision. It was a strategy for change. Informants tried to communicate with nurses in different ways.

> R02: These were the ways I communicated with nurses and exerted my influence. I tried to make them understand the issues and the need for change. I communicated my vision on various occasions, such as when giving an address at the graduation ceremony. I also expressed my views in newsletters published by the HA or other nursing associations. Furthermore, I discussed nursing education issues in forums organised by the CNHK.

> R20: I communicated with nurses to let them know what was happening. For example, I organised forums to communicate. I would talk to nurses during hospital visits. I would identify

opinion leaders who have the same vision as me and we sell the idea together.

Some informants explained that the purpose of communication was to influence nurses' thinking and get their support.

R06: Nurse leaders need to communicate their visions to followers so more people would accept and talk about our vision and communicate them to the policy makers. It was also a way to get support from followers.

R14: I take every opportunity to talk to people either privately or publicly. I take every opportunity to articulate, to make people discuss. It would be difficult to push the reform unless nurses recognise the need for and demand changes in education.

Communication with key players

Informants described the ways in which they communicated with the Government and stakeholders in order to exert influence and push forward nursing education reform.

R01: I wrote to the Governor and explained to him the current problem of nursing education and to demand reform. I made the same demand at the meeting of the Provisional HA. I discussed with the Chief Executive of the HA for significant issues affecting nursing education. I talked to him in different contexts, for example, in policy group or in person to give him up-to-date information. If you want support and co-operation from these key persons, you must communicate clearly the rationale for proposing such a policy change.

R11: When I was an Understudy Member of HA, I made a proposal for nursing education reform to the HA Board. I support nursing education being transferred to tertiary level. I wrote a paper on it and presented to the HA to ask for their support. It is important to explain to them the reason why nurses need degree education. I provided facts and figures to support my request.

Some informants mentioned the importance of communicating with stakeholders.

R04: I have to communicate with various key persons. In the past, nurses tended to communicate with nurses only, but that was not enough. We have to communicate with other stakeholders, such as doctors, because they have great influence on nursing education reform.

R20: I presented my views on education reform not only to nurses, but also to the Regional Advisory Committee (RAC) of the HA. This RAC included District Board members, Justices of Peace, community leaders and academics. I communicated my proposal to them and I consulted them as well. It was a way to generate support from stakeholders. They were very concerned about nursing education.

Some informants stressed the importance of assertiveness in communication.

R16: We have to be assertive in communicating to doctors about what we want. I communicated with them informally to find out what they were thinking. I explained my reasons to them and

persuaded them that it would be a good thing to let nurses have the degree programme.

R20: Doctors are ambivalent towards us, with both love and hate. They know they cannot do without us. If we can develop a more tactful and diplomatic approach, we can communicate better. The tactic is that we should be assertive rather than aggressive.

The documentary evidence also supported that nurse leaders attempted to communicate direction to different people. By communicating at different levels, it was hoped that the key players would understand the need for nursing education reform.

Increase power through unity

This category describes nurse leaders' role in acquiring power through coalition and collegial relationship with people. Nursing had got the numbers necessary to mount a considerable influence on health care policy. However, the lack of unity in nursing was one of the barriers to nursing education reform. Nurse leaders were aware of the barrier and attempted to overcome it. The coalition established in nursing could expand leaders' power base.

Collectivity

Collectivity refers to nurse leaders' actions to maintain unity and gather strength from it. Many informants recognised the importance of maintaining unity and cited evidence of success when nurses were united. Unity was a way to realise nurses' potential power.

R06: The first time we forward our proposal for nursing degree was in 1986. We forwarded a letter to the MHD, with support

from a few nursing associations. It was rejected by the MHD because there was only a small group of nurses asking for the reform. We than felt that we had to be united to make our voice stronger. Nurses should be aware of the importance of unity in influence policy.

R12: We have to be united before we can move forward. Our voice would be stronger if we are united. We have achieved something in the past because nurses were united and committed. We could not succeed without this group (Task Force for Promoting Tertiary Nursing Education).

Formation of the Task Force in 1992 was an example of forming coalition. This was the first time in the Hong Kong history that nursing professional groups worked together for nursing profession development. Informants commented on the effects of Task Force.

R04: Forming the Task Force was a good strategy to unite the profession. We had agreement within the profession and it made us stronger. We did get some degree places from our actions.

Some informants realised that it was difficult for nurses to have a single voice because of their large numbers and diversity of practice. However, they agreed that nurses had to reach a consensus on certain important issues.

R05: It may be unrealistic to think that you are going to get consensus in such a huge professional community. There are always splits. However, we have to have united voice on important issues, like the direction of nursing education. If you write something in the nursing journal and weeks later you have

another nurse writing completely opposite views, your whole credibility would be destroyed.

The reform of nursing education was more likely to be successful if followers were supportive and committed to working toward the goal. This was the power of numbers. Many informants recognised the importance of getting support from followers to strengthen the power base. One informant talked about strategies for getting support from followers:

R01: After I raised my request in the LegCo, I gave information to the AGNS and asked them to take actions to put pressure on the government. I supplied the union with information and expected to get support from members of the union. I also organised seminars for nurses to inform them what is happening and try to get support from them. This was a way to increase your power base.

Collegiality

Collegiality is a sub-category referring to the role of the leaders, which aimed at building a nurturing relationship with nursing, as well as with medical colleagues. It involved caring for colleagues, having mutual goals and trust and having collaboration rather than confrontation. Nursing could increase their unity by collegiality. It was a way to built up power base. An informant commented:

R20: Collegiality is to have mutual goals and trust. We have to have mutual goals and then we empower each other.

One informant said:

> R12: Nurses form an oppressed group. There was a lot of horizontal violence. It was not healthy at all. I always introduce this concept to students. We have to establish a collegial relationship with each other. We have to care for our colleagues. It is a way to empower the profession.

Another informant stressed the importance of respect and trust.

> R21: We have to trust and respect our colleagues. We have to respect different opinions from others. When we have meetings, we have to accept that we have different views. We have to come to terms with this philosophy.

An informant mentioned that leaders should be considerate to their followers.

> R08: We have to be considerate to your staff. As a leader, we have to build up a trusting relationship with our colleagues, in order to get their support.

Informants also maintained that it was important to collaborate with medical colleagues. Medical dominance was one of the barriers identified by the informants and it had to be overcome. Two informants spoke of the way to build collegiality with medical colleagues.

R20: I stress very much on collaboration with doctors. My belief is affiliation and interdependence. We have to build up a trusting relationship with each other. These are our weapons and power. Now some doctors already recognised us as members of the team and did not see us as subordinates. They can see that without nurses, they will not be viable.

R21: Collaboration is important in the political process. We affiliate with other medical associations, such as the Federation of Medical Association. We can reach consensus on what we are doing, since we are interdependent. We have to project a caring perspective.

An informant described her experience in working with a medical doctor in workshops. It is a form of collegiality which aimed at reducing medical dominance.

R10: One of the tactics that I have employed was conducting seminars together with a professor from the Faculty of Medicine. I realised that it was quite a good strategy to use. We suggested to the HA that it would be very useful to involve both nurses and doctors. We organised seminars with various nursing teams and doctors. The professor and I worked as a pair and we both answered the questions. People found that we gave valuable comments on the same issues from different perspectives. This was one of the strengths - we demonstrated that doctors and nurses could contribute equally.

Increase power through influence

'Increase power through influence' is a category describing the role of the nurse leaders in expanding their power base. Many aspects of the nurse leaders' roles required power if they were to succeed in achieving influence. The effective use of political strategies was found to be important in gaining power.

Access

Being able to access the political system was important in order to achieve influence. An understanding of power and of the political processes in operation within the political arena was very important.

> R01: We must understand the policy process of the Government, for example, how resources are allocated or who are the policy makers. We can then decide on the strategies needed to gain access to the policy makers and get their support.

Informant mentioned the importance of accessing the appropriate channel of communication.

> R03: You have to know the channel of communication and gain access to decision makers. You have to identify who are the decision-makers and you have to talk to decision makers. It is no use wasting your time talking to people who cannot make decisions.

An informant gave an example of accessing the right person.

> R01: When I pushed for the education reform, I demanded to have direct conversation with the Chief Secretary and the Financial Secretary. It was because they held the power in resource allocation.

Networking

Networking was defined by Marquis and Huston (2000) as establishing and using contacts to help leaders to achieve the goal. Obtaining support through networking was an important asset in gaining power. Nurses' ability to influence the Government relied on the number of nurses and the prestige of its supporters. Networking among health professionals and policy makers had widened nurse leaders' power base. Many informants discussed their networking with Government officials, administrators in the HA and nurses.

> R05: It is important to network with policy makers to get their support. I met with the SHW many times to discuss nursing education reform.

> R02: In the HA Board, there are members not belonging to nursing or medicine. They are businessmen and have no vested interest. They are the ones who can give support and see nursing as equally important with medicine. We have to establish a network with them in order to get their support.

An informant mentioned the importance of networking with both formal and informal leaders in hospitals. Informal leaders might not be so visible, but they could have considerable influence.

R04: One of the strategies is networking. We draw support from both formal and informal leaders. Formal leaders are those in senior positions in hospitals or professional associations, etc. If they support you and no one objects to your proposal publicly, the proposal will probably be accepted. Formal leaders are easy to identify. However, informal leaders are not so visible. They could be RNs in the hospitals. If they object to your proposal and spread rumours around, their influence could be great. You have to meet them in hospitals and establish networks with them. When they understand the issue, they will support you.

Networking was not confined to health care settings and government officials. It was also necessary to get the community's support for the reform. Increasing public awareness of nursing and developing a high profile in the community were strategies used by one informant. Power could be obtained by the support from public.

R01: Establishing a network within the community is also a way to influence. I am a member of the Rotary Club and Lion Club. I put forward my ideas on nursing education in these clubs' meetings. The press was usually presented in some of these meetings and reported what has been said in the media. You can participate in these clubs and get support from the public. It is important to get power from the public to push the reform.

Networking involves an exchange of activities that assist each of the network participants. An informant talked about the exchange of benefits.

R01: Sometimes, I exchanged votes with other LegCo Members. I supported their proposal by giving them my vote and in return that they supported mine. When you help them, they will help you as well.

Informants also networked with external consultants. These were consultants invited from overseas to give advice to the Government. It was a specialised networking that was unique to Hong Kong. Getting the support from consultants contribute to the success of nursing education reform.

R19: We network with external consultants from the UK who were invited by the Government to Hong Kong as advisors for nursing education reform. The names of advisors were suggested by us. We have to make sure that they would give favourable support. The use of external consultant was unique to Hong Kong that you might not be able to find in other parts of the world.

Lobbying

Lobbying is a code word to describe nurse leaders' attempts to influence someone, especially a public official, to take a desired action (Hosking and Morley,1988). When nurse leaders were engaging in lobbying behaviour, their objectives were to persuade nursing colleagues, LegCo Members and government officials to support nursing education reform. This demanded a full understanding of the issues and of the pro and con arguments propounded, not only by nursing, but also by groups opposing the nursing position. Lobbying was found to be used by informants in a variety of situations.

R04: At the HA level, there are members who are businessman and they don't have vested interest. They are the ones who support and see nursing as important as medicine. You have to lobby these people. The Government would not support degree nursing if the HA said it did not need degree nurses. There were people who still did not believe in tertiary nursing education. We discussed it in the meeting. After the meeting, we lobbied them in informal meeting, to explain to them why we had to do it this way.

R12: Strategies that were used include lobbying and personal contacts. We lobbied policy makers, the Director of MHD, and members of NBHK. We discussed the issue in the Executive Committee of the NBHK. Usually before the meetings, we already lobbied through phones about our views on certain agenda items and hoped that we would agree. We spent a lot of time in lobbying.

Successful lobbying frequently incorporates communication of critical facts and rational arguments presented to substantiate the case. Another informant talked about arguments used in lobbying.

R01: When we lobbied, we had to give good reasons to persuade others. In 1989, I discussed with the Governor the issues related to nursing. I suggested to the Governor that degree programmes for nurses could be established in HKP, as it already had a nursing section there. The Government did not need to invest lots of money for establishing degree programme, but public would benefit from it and wastage of nurses would decrease. I lobbied people in the LegCo as well. At that time, many nurse were emigrating from Hong Kong to other countries. Some of them left Hong Kong not because of political reason, but for studying and

professional advancement. If the Government wanted to retain staff, they should establish degree programmes in Hong Kong. I used these reasons to lobby the Legislative Councillors at that time.

Informants talked about the specific strategies they used in lobbying.

R02: I use kiss and kick strategy in meetings with government officials.

R03: I used broken record technique to persuade them to listen.

R14: To gain people's support, I have to know what are the selling points as well as the weaknesses, and who might oppose the policy. I will promote my idea informally. Externally I take the opportunity to talk to people in private or on public occasions. I take every opportunity to articulate the issue of nursing education reform.

Increase visibility

Most informants recognised that it was very important for the leader to become visible. Visibility was expected to increase the power bases of these informants and to increase recognition and influence.

R01: You have to raise your profile, making people in the LegCo aware whom you are representing. You have to raise your status and recognition. In all the LegCo discussions concerning health care, I appeared together with the doctors to discuss issues. It gave people an impression that we were equal partners, both contributing to the health services.

R14: We have to be visible. I took every opportunity to talk to people either privately or publicly. This was to make the issue of nursing education reform visible. Unless people outside the health care field recognise and demand changes in nursing education, it is no use just talking about it among ourselves.

Documents showed that nurse leaders did use the mass media as a way to increase visibility and influence. Three informants discussed this strategy.

R05: I talked on the radio and a lot of people could listen to my message. It is a way to achieve propaganda. I said that it was a shame that there was so much advancement going on in general education in Hong Kong, but nurses didn't seem to benefit from it.

R01: You have to develop a good relationship with the press. You have to make yourself visible in the mass media. If you are visible and come out strongly, the government officials would take your words seriously.

R03: I voiced out the request in LegCo. After I raised the issue in the meeting, I held a press conference. Then I followed it up by raising the issue again in the next LegCo meeting. In this way, the issue was visible to the public and it exerted a lot of pressure on the Government.

An informant commented that the work of the Task Force had helped a lot to increase visibility. It had put pressure on the Government.

R09: The Task Force managed to achieved publicity for the nurses' demands. If nobody had come out to speak, even though we have

> 10,000 nurses who preferred tertiary education, the Government would not know. The Task Force's actions exerted pressure on the Government. It was a force to push. We frequently brought it up in the media so the Government could not get away from it. When people asked whether nurses really wanted degree education, we could reconfirm that nurses needed the degree programme.

In the category of 'increase power through influence', all the actions that informants used were focused on the acquisition of power. Power was essential to achieve influence. It was needed to overcome the barriers.

Empower followers

This study found that the lack of learning opportunities in nursing and the socialisation process had been factors that caused passive and dependent behaviour in nursing, as well as weak nursing leadership. This was one of the barriers to evolution in nursing education reform. 'Empower followers' was put forward by many informants as nurse leaders' role which aimed to overcome these barriers.

Empowerment was defined as an interactive process that developed, built and increased power through co-operation, sharing and working together (Hawks, 1992). Synonyms for 'empowerment' include: enabling, endowing with power and or making possible (Hanks, 1986). In this study, the category 'empower followers' refers to the process of providing resources or environment to build, develop and increase the ability of the followers, in order that nursing would be more powerful. When followers were empowered, leaders could get support from followers to implement changes.

Education

Many informants regarded lack of knowledge as one of the barriers to nursing leadership development. Several informants mentioned the importance of continuing education as a form of empowerment. Nurses needed to improve their knowledge. The purpose of education is not just to increase knowledge, but also to increase confidence. Resistance to change can be reduced. Nurse leaders could have more support from followers when introducing change.

> R01: We have to empower them (the nurses). We have to educate them, give them the courage to speak up, and to move nursing forward. Nurses must learn more to broaden their knowledge. They have to be trained for decision making, and negotiation skills. After learning new things, we give chances for them to apply what they have learnt. When I implement changes, they would support me.

> R03: We have to motivate nurses to learn. I always tell them to keep on learning. They would be more confident when they have the knowledge. The profession is not very active politically. We have to organise seminars to inform them about what is happening. When they understand the issues, they will be less resistive to new ideas. It is a way to promote changes.

> R08: If staff do not have the knowledge, they will be afraid of change. After gaining knowledge, they will be more confident in themselves to implement change. We have to develop people, educate them and improve their confidence.

One of the barriers that the informants identified was the restricted environment in the hospital, that limited the development of an individual. One informant talked about the importance of providing an environment that facilitated the application of new knowledge.

> R01: People now are generally more knowledgeable. If we seclude a well-qualified person in a restricted environment, he/she cannot develop his/her potential. We have to provide a suitable environment for them to apply what they have learnt.

Support and motivation

One of the strategies leading to empowerment was to support and motivate followers to develop. Nurse informants gave examples of how they supported continuing education for nurses. They gave nurses time-off or financial support to learn.

> R09: At hospital level, I facilitate them to participate in education programmes by giving them time off. For example, even if one of my staff has to go to Australia to study for six months, I permit her to go. We try to be more open and encouraging.

> R20: We have to develop our colleagues. This year, I sent a group to the USA, another group to the UK and Australia, to let them learn from other countries. Hoping that they would apply what they have learnt and improve the service.

Informants discussed the importance of the leader's role in providing support and motivation.

R20: It is very important that the leader is a motivator. It is a way to generate support from nurses. I hope that they would support me when they have the knowledge and confidence. If there is no support and encouragement from the leader, new ideas could not be developed or implemented.

R06: When we implement changes, we have to support our staff, give them information and prepare them for change. You would then get power from their support.

Prepare self

'Prepare self' is a category used to describe informants' effort to achieve the desirable leadership attributes and style that they regarded as important for leadership. Self-development was an important role of nurse leaders.

Leadership attributes

Informants spoke about the leadership attributes needed in order to achieve influence in policy making. The starting point for being a leader was self-development. On-going self-education was required. Many informants mentioned the need to update their knowledge and skills constantly, in order to deal with the increasing demands of their roles. It was also seen to be a way to build up credibility.

R15: I have to keep on learning. Leaders must always upkeep themselves and be constantly aware of the issues going on in the health care system and society. Otherwise, there would be a gap between leaders and followers.

R09: We have to equip ourselves to be more confident when we talk about the issue e.g. I went to Australia a few years ago to observe the implementation of nursing education reform. In this way, I learnt what problems might be encountered.

R20: I studied for a Master degree in management. I have to continue to update myself for the challenges. If we want to collaborate with other health care professionals, knowledge is important. We have to demonstrate competency.

Informants also mentioned some important characteristics of effective leaders: leaders should have courage, to take risk, persistence, optimism, and the ability to exploit opportunities. They regarded these characteristics as important to leadership effectiveness.

R06: The road of nursing education reform is long. But we know we should not give up, we have to go on. You have to have courage to pursue what you would like to achieve. If it (the transfer of basic nursing education to degree level) does not happen in this era, we hope it will happen in next era.

R10: A leader must be persistent in his effort to overcome barriers in order to achieve his goal. You have to fight for what you want and not afraid of taking risk. The Government would not listen to you unless you ask for it over and over again.

R05: I am not afraid of taking risk. You have to have courage to take risk in order to change. You have to persistently finding the best way to address the issue. Otherwise you are just maintaining status quo.

Informants mentioned that an effective leader had to be able to exploit opportunities. Leaders had to be alert to the opportunities around them and be able to seize the opportunities.

> R14: It is important that we see the opportunity and work on it. The establishment of degree courses in 1990 was facilitated by environmental factors. However, there must be someone to put nursing in, otherwise it would not happen. It is important that we put in the proposal at the right time when opportunities arise.

> R20: I know the hope is here, that is why I take up this leadership position and head the change. There are opportunities right now and you have to make good use of them to advance the nursing profession.

> R14: Leaders have to know things happened around them. When opportunities arise, they can take advantage.

Despite the many barriers perceived by the informants, most of the informants had a very optimistic view about the future development of nursing. This provided the driving force for the leaders to persist in the reform of nursing education, despite all the difficulties.

> R05: Given the nursing profession regenerates itself every eight years, in eight years time, we will find everybody in the same system (tertiary education) in nursing education. Though the transitional period is very difficult, we reckon that our graduates will be gradually accepted by the majority of nurses in eight years' time.

R09: The junior staff all feel the necessity of having a degree. It is the culture to go for a degree. Things change very fast now. The trend favours tertiary education because we have the needs.

R07: I am very optimistic with regards to higher degrees. I am sure in a short time there will be many PhDs. There are many more nurses keen to upgrade their qualifications in Hong Kong. They now get the opportunity and they are taking it.

Informants were also optimistic about 1997:

R08: The development must be towards the better. You cannot maintain status quo. You must move forward with the international trend. Many people went away because of 1997, but there are people who stay. If your system is good, no matter who the government is, it does not matter. People will follow if the system is good. If nursing can prove its value, nobody can replace you.

Leadership style

Leadership style was regarded as important in influencing leadership effectiveness. An open and considerate leader was recommended by some of the informants as desirable styles of effective leaders.

R14: My leadership style is informal. I lead by example. I would not ask people to do things that I cannot do. I prefer to influence people, rather than using authority to instruct them to work. I establish the direction, and then I will try to influence others to move along that direction. I believe this informal style would work better than an authoritative style.

R21: I do not belong to autocratic style. I would not push people forcefully. Usually, I will try to persuade and invite them to participate. I am considerate to my staff and I always try to understand their feelings. To be effective, it is important to understand your staff and know their difficulties.

R07: The function of the leader is not to do it yourself. You have to talk to people to get things done. You have to make it possible for other people to do it. My philosophy is to enable people to get the work done. I see my function as to make it possible for them to do their work.

Some informants emphasised their participative style of leadership.

R22: I favoured a participative style. I would invite my staff to discuss and give opinions. We discuss and make decision together. I regard it as important to involve staff in decision-making so that they would accept the decision more readily.

Informants regarded themselves as a transformational leader.

R20: My leadership style is transformational. Charisma is important, but the most important is a clear vision. I consider myself as a visionary leader. I establish vision that would bring our nurses forward. I believe a transformational leadership style is important in effecting change.

R03: I considered myself as a transformational leader. My goal is to introduce changes in nursing profession in Hong Kong.

Summary

In this chapter, findings related to nurse leaders' roles in shaping the outcome of nursing education reform are presented. Categories that were identified as the leadership roles included: establishing goals, communicating directions, increasing power through unity, increasing power through influence, empowering followers and preparing self. These roles were centred around the acquisition of power to influence the Government, stakeholders and the followers. This study demonstrated that nursing education reform was a gradual change process. The core category of this study - evolution, reflected this process in which nurse leaders tried to overcome barriers to facilitate change. The following chapter will present the findings of the questionnaire survey.

CHAPTER EIGHT

FINDINGS - NURSE LEADERS' EFFECTIVENESS: PERSPECTIVES OF THE NURSING PROFESSION

Introduction

This chapter reports the findings of the questionnaire survey. The aim of the survey was to evaluate nurse leaders' effectiveness in the reform of nursing education from the perspective of the nursing profession. The objectives of the survey were to investigate nurses':

- views on the present status of nursing education development
- perception on nursing leadership
- evaluation of nurse leaders' behaviour.

Response rate

1,000 subjects were selected by stratified random sampling from five regional hospitals in Hong Kong. 678 subjects returned the questionnaires. The response rate of 67.8% was considered satisfactory.

Demographic data

The demographic data of the respondents are presented in Table 7. 85.4% (n=579) of the respondents were female and 14.6% (n=99) were male. The distribution reflected the gender ratio in the nursing population. The rank of the respondents and their response rate is indicated in Table 8. Table 9 presented respondents' education level, in which over half of the respondents had only the basic nursing qualifications.

Table 7 Demographic data of the respondents

	No. of subjects	Percentage (%)
Female	579	85.4
Male	99	14.6
Total	678	100.0
Age	Range: 22 - 55	
	Median: 32	
	Mean: 32.1	
Years of experience	Range: 0.5 - 32	
	Median: 9	
	Mean: 11	

Table 8 Rank of the respondents

Rank	No.	%	Response rate
RN	488	71.9	66.0%
NO/WM	175	25.9	78.8%
SNO/DOM	15	2.2	25.9%
Total	678	100.0	

Table 9 Current level of study of the respondents

Current Level of Study	No.	%
Diploma in Nursing	390	57.5
Bachelor of Nursing	253	37.3
Post-graduate Diploma	23	3.4
Master degree	12	1.8
Doctoral degree	0	0.0
Total	678	100.0

Direction of the future nursing education development

Respondents were asked to indicate their opinion as to the direction of future development in nursing education. 9.4% (n=64) believed that it should remain as hospital-based training. 79.8% (n=541) agreed that it should be transferred to tertiary institution gradually. 6.9% (n=46) agreed that nursing education should be transferred to tertiary institutions at once (See Table 10).

Table 10 Direction of future development in nursing education

	No.	%
Remain as hospital based training	64	9.4
Transfer into tertiary institution gradually	541	79.8
Transfer to tertiary institutions at once	46	6.9
Others	27	3.9
Total	678	100.0

Opinion on current nursing education

Respondents were asked to indicate their level of satisfaction with the present hospital-based system. The majority of the respondents (56.6%, n=384) disagreed and 17.7% (n=120) strongly disagreed that they were satisfied with the present hospital-based system of nursing education. Over half of the respondents disagreed and 19.0% (n=129) strongly disagreed that the current hospital-based nursing education could adequately prepare nurses for today's nursing practice (See Table 11).

Table 11 Opinion on current nursing education

	SA		A		NO		D		SD	
Items	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
1. I am satisfied with the present hospital-based system of nurse education.	4	0.6	93	13.7	77	11.4	384	56.6	120	17.7
2.The current hospital-based nurse education can adequately prepare nurses for today's nursing practice.	4	0.6	110	16.2	76	11.2	359	52.9	129	19

Recognition of nurse leaders

Who were the nurse leaders?

Respondents were asked to indicate whom they regarded as their nurse leaders in Hong Kong. They could choose more than one option. The result is presented in Table 12. Less than half (45.3%) of the respondents regarded the Senior Executive Manager (Nursing) as nurse leader and 42% the Legislative Councillor. 34.8% regarded the General Managers (Nursing) in the hospitals as nurse leaders. A small percentage of the respondents considered the Chairperson of the Nursing Board of Hong Kong as nurse leader. Very few respondents considered the Senior Planning Manager (Nursing), the Principal Nursing Officer, the Chairperson of the nursing associations/ trade unions and nurse academics to be nurse leaders. Some respondents regarded none of the above mentioned as nurse leaders. In the written comments, nine respondents regarded ward managers, nursing officers and nurse specialists in the wards as nurse leaders. One respondent stated that there was nobody in the nursing field who could be regarded as nurse leader. One respondent commented that he/she was still looking for someone, who deserved to be called a nurse leader.

Table 12 Nurse leaders in Hong Kong

	No.	%
Senior Executive Manager (Nursing) in Hospital Authority	307	45.3
Legislative Councillor elected through Health Care Constituency	285	42.0
General Managers (Nursing) in the hospitals	236	34.8
Chairperson of the Nursing Board of Hong Kong	197	29.1
Principal Nursing Officer of the Department of Health	155	22.9
Senior Planning Manager (Nursing)	146	21.5
Chairperson of nursing associations/trade unions	123	18.1
Nurse academics	13	1.9
None of the above	72	10.6
Others	33	4.9

Expressed own opinion to the nurse leaders

The respondents were asked whether or not they had expressed their opinions concerning the issue of nursing education to nurse leaders. Only 22% (n=149) said yes and 78.0% (n=529) said no.

Channels to express opinion

Those who had expressed opinions to nurse leaders were asked to indicate the channels that they had used. The channel used most often was signature campaign (14.6%, n=99). 12.7% (n=86) had talked to the nurse leaders directly and 10.5% (n=71) had expressed their opinions through trade unions or professional organisations. Few respondents, only 4% (n=27), indicated that they had written to them expressed opinions through participation in petitions or demonstrations (See Table 13). Some respondents (n=8) reported using hospital and ward meetings to express opinions to nurse leaders.

Table 13 Channels to express opinions to nurse leaders

	No.	%
Through participation in signature campaign	99	14.6
Talk to them directly	86	12.7
Through trade unions or professional organisations	71	10.5
Write to them directly	27	4.0
Through participation in petition, demonstration	14	2.1
Others	8	1.2

Reasons for not expressing opinion

Those who chose not to express their opinions to nurse leaders concerned were asked for the reasons. 55.1% (n=306) said that it was no use doing so. 21.4% (n=145) considered that channels were inadequate and 20.1% (n=136) said that they did not know the effective way to do it. A small number of respondents said that they did not have time, energy or resources to express their opinions. 4.3% (n=29) said that there was no cause for concern and 2.1% (n=14) considered that it might have adverse effects on their career (See Table 14).

Table 14 Reasons for not expressing opinion to nurse leaders concerned

	No.	%
There is no use of doing so	306	55.1
There is inadequate channel	145	21.4
I don not know the effective way to do it	136	20.1
I have no time, energy, resources	48	7.1
There is no cause for concern	29	4.3
It may have adverse effects on my career	14	2.1

In the written comments, six respondents said that there was no opportunity for them to express their opinions. One said that nurse leaders did not encourage staff to do so. One respondent wrote that nurse leaders had minimal influence over the future development of nursing education, because of medical dominance in the HA, therefore it was no use to expressing an opinion. One respondent mentioned that nurses at the frontline were not in a position to express opinions to nurse leaders directly, because the middle management would regard it as bypassing them and that the nurse would be in trouble. One commented that it was a waste of time to show support.

Ways to support the nurse leaders

Nearly half of the respondents said that they supported nurse leaders by working with them to achieve the goal. 43.7% said that they expressed their support openly in meetings with nurse leaders. A few respondents stated that they wrote to the nurse leaders to show their support. A small number of respondents reported that they supported the nurse leaders by making proposals to them and 12.7% said that they did not support the nurse leaders (See Table 15).

Table 15 Ways to support the nurse leaders

	No.	%
By working with nurse leader(s) to achieve the goal	315	46.5
Express your support openly in meetings with nurse leaders	296	43.7
Express your support by writing to the nurse leader(s)	124	18.3
By making proposal to the nurse leader(s)	120	17.7
I do not support the nurse leader(s)	86	12.7

Seven respondents said that they would vote for the nurse leader in the Legislative Council election to demonstrate support. One said that he/she showed support by joining the nursing association. Two stated that they showed support for the nurse leaders' proposal, when participating in formal meetings with them.

Evaluating nurse leaders' performance

Respondents were asked to evaluate the nurse leaders' performance by rating nurse leaders in the following areas: decision making, communication, maintain coalition within the profession, power to influence policy and motivation and support to the followers. Respondents were asked to indicate their position in relation to the items from strongly agree (SA), agree (A), no opinion (NO), disagree (D) to strongly disagree (SD). Each choice along the Likert scale was assigned a numerical value. SA=5, A=4, NO=3, D=2 and SD=1. A mean score of 2.5 was considered relatively more positive and a mean score below 2.5 was considered relatively more negative. The mean score of the subscales were rank ordered (Table 16). The subscale 'power to influence' had the highest ranking, whereas the subscale 'communication' was ranked the lowest.

Table 16 Rank ordering of subscales

Rank	Subscale	Mean
1	Power to influence	2.95
2	Decision making	2.75
3	Unity	2.70
4	Motivation and support	2.63
5	Communication	2.46

The mean and standard deviation (SD) for each item were rank ordered and presented in Table 17.

Table 17 Mean and standard deviation of each item

Rank		Item	Mean	SD
1	12	The nurse leaders have acted as the spokesperson for the nursing profession.	3.6	0.96
2	4	The nurse leaders show a willingness to make desirable changes in nursing education.	3.5	1.3
3	19	The nurse leaders maintain cordial relations with other members of the health care team.	3.3	0.84
4	20	The nurse leaders are able to relate to prominent persons in legislative, educational and governmental levels.	3.3	1.03
5	22	The nurse leaders have influenced the views and actions of co-workers and colleagues.	3.3	1
6	24	The nurse leaders have the power to influence policy making in nursing education.	3.0	1.13
7	23	The nurse leaders have taken necessary action in influencing nursing education policy.	2.9	1.04
8	6	The nurse leaders have actively invited opinions from the members.	2.9	1.03
9	15	The nurse leaders are able to decide on the actions in attaining the goals of nursing education.	2.8	1
10	17	The nurse leaders are able to convey information to nursing groups about the awareness of societal issues affecting nursing education.	2.8	0.8
11	16	The nurse leaders are able to fulfil the society's needs of nursing services.	2.7	0.96
12	25	The nurse leaders are effective in producing desirable changes in nursing education.	2.7	1.02
13	8	The nurse leaders have motivated nurses to achieve the profession's goals in nursing education.	2.6	0.96
14	10	The nurse leaders get support and cooperation from nurses for the future direction of nursing education.	2.6	0.96
15	11	The nurse leaders create coalition in nursing.	2.6	0.91
16	14	The nurse leaders have made accurate decisions in the future direction of nursing education.	2.6	0.93
17	18	The nurse leaders are able to get other members of the health care team to act for the welfare of the nursing groups.	2.6	1.04
18	21	The nurse leaders are able to bargain for needed human and monetary resources successfully.	2.5	1.04
19	13	The nurse leaders have provided adequate support to individual nurses and nursing groups in attaining the goal of nursing education.	2.4	0.9
20	1	I am satisfied with the present hospital-based system of nurse education.	2.2	0.92
21	5	The nurse leaders have adequately consulted nurses about the future direction of nursing education.	2.3	0.89
22	7	The nurse leaders have effectively communicated the future direction of nursing education clearly to nurses.	2.3	0.87
23	9	The nurse leaders effectively resolve conflicts when they occur in the nursing groups.	2.3	0.86
24	2	The current hospital-based nurse education can adequately prepare nurses for today's nursing practice.	2.0	1
25	3	The nurse leaders have established direction for the development of nursing education in Hong Kong.	2.0	1.2

Ability to make decisions

The mean score for the decision making subscale was 2.75. Although 55.3% (n=375) agreed and 2.4% (n=16) strongly agreed that the nurse leaders showed a willingness to make desirable changes in nursing education, 48% (n=325) disagreed and 8.3% (n=56) strongly disagreed that the nurse leaders had established direction for the development of nursing education in Hong Kong. This was the item that had the lowest mean score. More than half (51.9%, n=352) of the respondents disagreed and 5.9% (n=40) strongly disagreed that nurse leaders had made accurate decisions as regards the future direction of nursing education. Almost half of the respondents disagreed that nurse leaders were able to decide on the actions to take in attaining the goals of nursing education and to fulfil the society's needs of nursing services. They also disagreed that nurse leaders had taken necessary action to influence nursing education reform (See Table 18). On the whole, the evaluation of nurse leaders' ability to make decisions about the direction of nursing education was not too positive.

Ability to communicate

Respondents were asked to evaluate nurse leaders' ability to communicate to them the direction of nursing education development. The mean score of this subscale was 2.46, which ranked the lowest among all the subscales. Over half of the respondents disagreed and 13.2% (n=90) strongly disagreed that the nurse leaders have adequately consulted nurses about the future direction of nursing education. A majority of the respondents disagreed and 5% (n=34) strongly disagreed that the nurse leaders have effectively communicated the future direction of nursing education clearly to nurses. Nearly half of the respondents disagreed and 6.3% (n=43) strongly disagreed that the nurse leaders were able to convey information to nursing groups about the awareness of societal issues affecting nursing education (See Table 19).

Table 18 Nurse leaders' ability to make decisions on the direction of nursing education

	SA		A		NO		D		SD	
Items	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
3. The nurse leaders have established direction for the development of nursing education in Hong Kong.	7	1.0	190	28	100	14.7	325	48	56	8.3
4. The nurse leaders show a willingness to make desirable changes in nursing education.	16	2.4	375	55.3	102	15	143	21.1	42	6.2
14. The nurse leaders have made accurate decisions in the future direction of nursing education.	10	1.5	142	20.9	134	19.8	352	51.9	40	5.9
15. The nurse leaders are able to decide on the actions in attaining the goals of nursing education.	11	1.6	221	32.6	109	16.1	302	44.6	35	5.1
16. The nurse leaders are able to fulfil the society's needs of nursing services.	4	0.6	184	27.1	115	17.0	336	49.6	39	5.7
23. The nurse leaders have taken necessary action in influencing policy making in nursing education.	21	3.1	243	35.8	96	14.2	284	41.9	34	5.0

Table 19 Nurse leaders' ability to communicate direction to nurses

	SA		A		NO		D		SD	
Items	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
5. The nurse leaders have adequately consulted nurses about the future direction of nursing education.	7	1.0	91	13.4	85	12.6	405	59.8	90	13.2
7. The nurse leaders have effectively communicated the future direction of nursing education to nurses.	21	3.1	243	35.8	96	14.2	284	41.9	34	5.0
17. The nurse leaders are able to convey information to nursing groups about the awareness of societal issues affecting nursing education.	15	2.2	235	34.7	68	10.0	317	46.8	43	6.3

Ability to unite the profession

Respondents were also asked to evaluate nurse leaders' ability to unite the profession, as shown in Table 20. The mean score of this subscale was 2.7. More than half of the respondents (59.1%, n=401) disagreed and 10.6% (n=72) strongly disagreed that the nurse leaders effectively resolve conflicts when they occur in the nursing groups. About half (50.7%, n=344) disagreed and 6.2% (n=42) strongly disagreed that the nurse leaders create coalitions in nursing. In regard to relationships with other members, 61.5% (n=417) of the respondents agreed that nurse leaders were able to maintain cordial relations with other members of the health care team.

Table 20 Nurse leaders' ability to unite the profession

	SA		A		NO		D		SD	
Items	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
9. The nurse leaders effectively resolve conflicts when they occur in the nursing groups.	7	1.0	85	12.5	113	16.8	401	59.1	72	10.6
11. The nurse leaders create coalition in nursing.	8	1.2	133	19.6	151	22.3	344	50.7	42	6.2
19. The nurse leaders maintain cordial relations with other members of the health care system.	8	1.2	417	61.5	88	12.9	132	19.5	33	4.9

Ability to influence policy making

The mean score of this subscale was 2.95. It is the subscale in the highest ranking. More than half of the respondents agreed that the nurse leaders had acted as spokespersons for the nursing profession. This was the item that had the highest mean score in this questionnaire. Over half of the respondents agreed that they were also able to relate to prominent persons in legislative,

ıgreed that the nurse leaders had influenced the views and actions of co-ɴorkers and colleagues (See Table 21).

Table 21 Nurse leaders' ability to influence policy-making

	SA		A		NO		D		SD	
Items	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
10. The nurse leaders get support and co-operation from nurses for the future direction of nursing education.	10	1.5	161	23.7	70	10.3	399	58.9	38	5.6
12. The nurse leaders have acted as the spokespersons for the nursing profession.	47	6.9	467	69	25	3.7	112	16.5	27	3.9
18. The nurse leaders are able to get other members of the health care team to act for the welfare of nursing groups.	11	1.6	191	28.2	92	13.6	317	46.8	67	9.8
20. The nurse leaders are able to relate to prominent persons in legislative, educational and governmental levels.	21	3.1	400	59	80	11.8	133	19.6	44	6.5
21. The nurse leaders are able to bargain for needed human and monetary resources successfully.	18	2.7	146	21.5	83	12.2	351	51.8	80	11.8
22. The nurse leaders have influenced the views and actions of co-workers and colleagues.	13	1.9	382	56.4	82	12.1	168	24.8	33	4.8
24. The nurse leaders have the power to influence policy making in nursing education.	38	5.6	296	43.7	37	5.5	266	39.2	41	6
25. The nurse leaders are effective in producing desirable changes in nursing education.	17	2.5	180	26.5	90	13.3	344	50.8	47	6.9

ıbility to motivate and support

ˀhe mean score for this subscale was 2.63. Regarding the ability to motivate ınd support the followers, 55.7% (n=377) disagreed and 10.0% (n=68) ıtrongly disagreed that the nurse leaders had actively invited opinions from ıurses about the future development of nursing education. Some respondents ılso did not agree that nurse leaders had motivated nurses to achieve the profession's goals in nursing education. More than half of the respondents disagreed, 7.2% (n=49) strongly, that nurse leaders had provided adequate support to individual nurses and nursing groups in attaining the goal of nursing education (See Table 20).

Table 22 Nurse leaders' ability to motivate and support

	SA		A		NO		D		SD	
Items	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
6. The nurse leaders have actively invited opinions from the members.	6	0.9	121	17.8	206	15.6	377	55.7	68	10
8. The nurse leaders have motivated nurses to achieve the profession's goals in nursing education.	7	1	196	28.9	85	12.5	328	48.4	62	9.2
13. The nurse leaders have provided adequate support to individual nurses and nursing groups in attaining the goal of nursing education.	9	1.3	118	17.4	90	13.3	412	60.8	49	7.2

Differences in perception of nurse leaders' performance among groups

T-test was used to analyse the differences in opinion between different gender groups. ANOVA was used to test the differences in opinion among groups

ignificant differences among groups in their perception of nurse leaders' erformance.

Summary

The questionnaire survey showed that although respondents recognised that those nurses in the top administrative positions were nurse leaders, many of them did not express their opinions to nurse leaders. They did not perceive it as useful or they did not know the effective ways to do it. Respondents did not give very positive rating to nurse leaders' effectiveness, especially in the area of communication. Moreover, although respondents agreed that nurse leaders could act as spokespersons for nurses, many respondents disagreed that nurse leaders were able to establish direction for the development of nursing education. They also disagree that nurse leaders had effectively communicated the future direction of nursing education clearly to them. Furthermore, they disagreed that the nurse leaders could effectively resolve conflicts when they occur in the nursing groups. On the whole, the support and recognition for nurse leaders were low.

This chapter presents the results of the questionnaire survey. The next chapters will summarise and discuss the findings of this study with support from research literature and findings.

CHAPTER NINE

TOWARDS AN INTEGRATED LEADERSHIP MODEL

ıtroduction

he purpose of this study was to analyse the process of policy development in ursing education reform in Hong Kong and the role of nurse leadership in this :form. Data were collected from documents, interviews and questionnaire urvey. This chapter will integrate the findings and will begin with analysing the ›rocess of nursing education reform. It will be followed by a discussion on the ole of nurse leaders in the reform. The relationship among the categories dentified in this study will be illustrated. Four dimensions of the leadership ›rocess will be identified from the findings and integrated into a leadership nodel.

Γhe process of nursing education reform

Previous nursing leadership studies were limited as they mainly focused on the interaction between leaders and followers. As nurse leaders are becoming more and more involved in the political arena, leaders' interactions with key players in the political system also need to be explored. This study took a multi-actor perspective, focusing on the analysis and interpretation of nurse leaders' interactions with key players (the Government, stakeholders and followers) and their responses. It was demonstrated that nurse leaders in the LegCo, higher education settings and the professional nursing associations played an active role in pushing nursing education reform onto the political agenda. They attempted to influence policy-making through various political actions. The nurse leaders in

:alth care services and the NBHK played a supportive role in nursing education :form. Though they were not active in initiating the reform, their support was :ucial to demonstrate to the Government that nurses had consensus on the irection of nursing education development. This consensus contributed to nurse :aders' success in the reform.

Jursing education reform involved major policy changes, principally the llocation of extra resources to universities for establishing degree places and the edistribution of resources between universities and hospitals. According to Easton (1965), the political system is central to the policy-making process, naking authoritative allocations of values and decisions. In Hong Kong, the Government had the authority to make the ultimate decision on resource allocation for nursing education. The Secretary for Health and Welfare and the Secretary for Education and Manpower were the key politicians responsible for nursing education policy, along with the Governor of Hong Kong and the members of the LegCo.

Since Hong Kong was a British Colony, the Hong Kong Government was basically in a state of 'legitimacy deficit' (Postiglione and Leung, 1992, p.99). Many stakeholders were consulted in the process of policy-making. Though they were not policy makers, they had a strong influence on the Government. Stakeholders involved in nursing education reform included the HA, the medical profession, the UGC and external advisors from the UK. Among all the stakeholders, the medical profession was considered to be the most influential in nursing education reform and they generated the greatest resistance. Stakeholders' support was essential to nursing education reform.

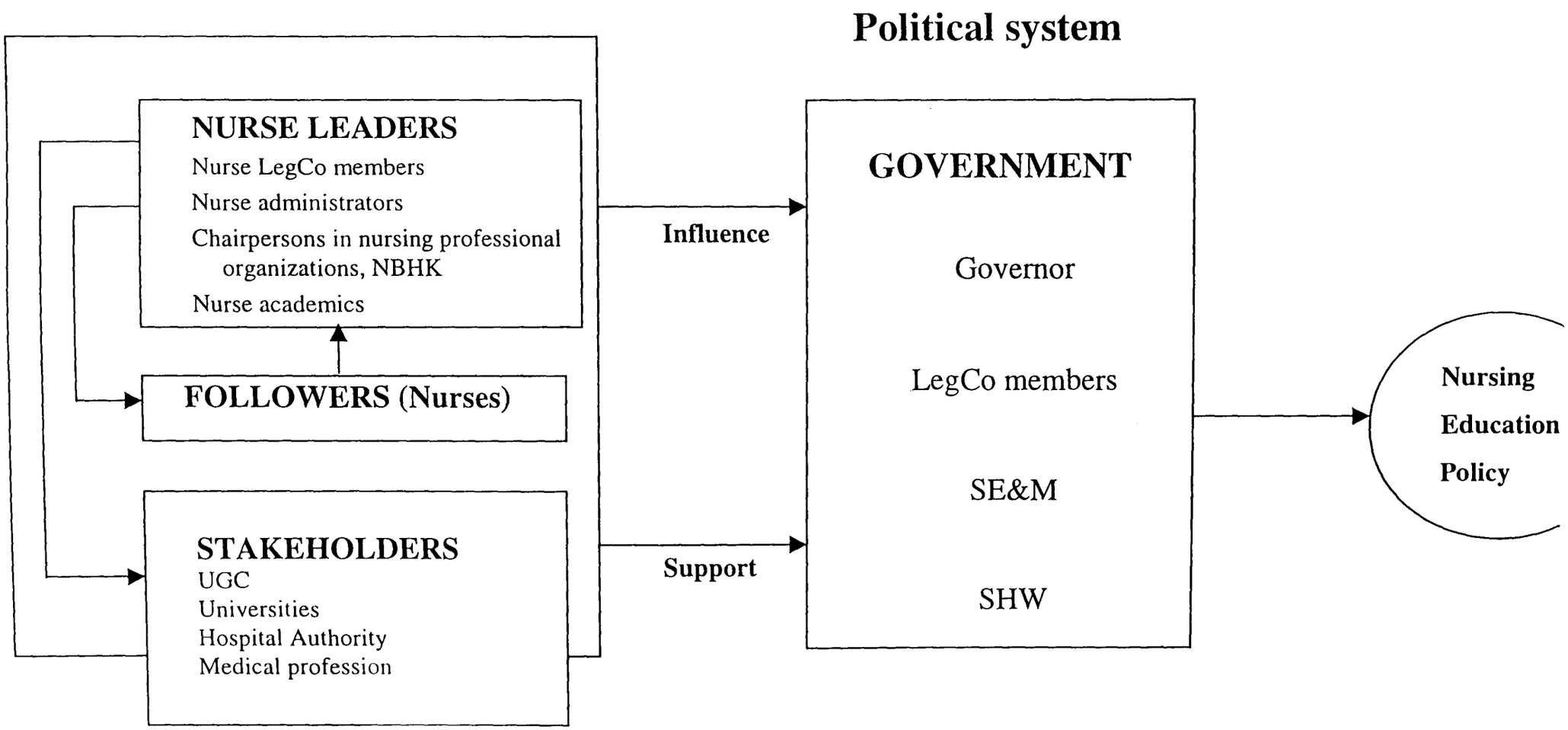
The followers who were front-line nurses played an important role in the reform. Though they were not very visible in the reform process, their support, recognition

ıd trust for their leaders were crucial to nurse leaders' success. Nurse leaders tried influence followers to obtain their support. The interview data and documentary /idence showed that they were involved in a signature campaign and petition to the ıovernment. The support from followers demonstrated unity in nursing and ıcreased nurse leaders' power base in influencing the Government.

'he process of nursing education reform was revealed in this study to have both ıternal and external foci. Internally, the focus was the relationships between nurse eaders and followers. Nurse leaders interacted with the followers to obtain their ıupport to reform nursing education. Externally, the focus was the relationships ımong nurse leaders, the Government and the stakeholders. Nurse leaders ıteracted with the Government to influence nursing education reform. They also ıteracted with stakeholders to gain their support. These relationships influenced ıurse leaders' effectiveness. Nursing leadership was demonstrated in the interaction and interrelationship among various key players.

In this study, different phases of nursing education reform can be identified. The first phase involved nurse leaders introducing change to the followers and obtaining their support. The second phase involved nurse leaders negotiating with external groups - the stakeholders, to gain their support for presenting the agenda to the political system. The third phase involved nurse leaders' forwarding the agenda to the Government and negotiating with the Government through various political actions to influence policy-making. Figure 2 illustrates nurse leaders' position and the relations among the key players in the policy-making process.

Figure 2 Nurse leaders' position in the policy-making process



ole of nurse leaders in nursing education reform

he leadership process identified in the reform of nursing education was ıaracterised by a central theme - *evolution*. There was prolonged stagnation in ırsing education and a reform of nursing education was necessary for the rofession to adapt to the changing demands of the society. Nurse leaders tried to ıfluence change by converting a negative situation to a positive one.

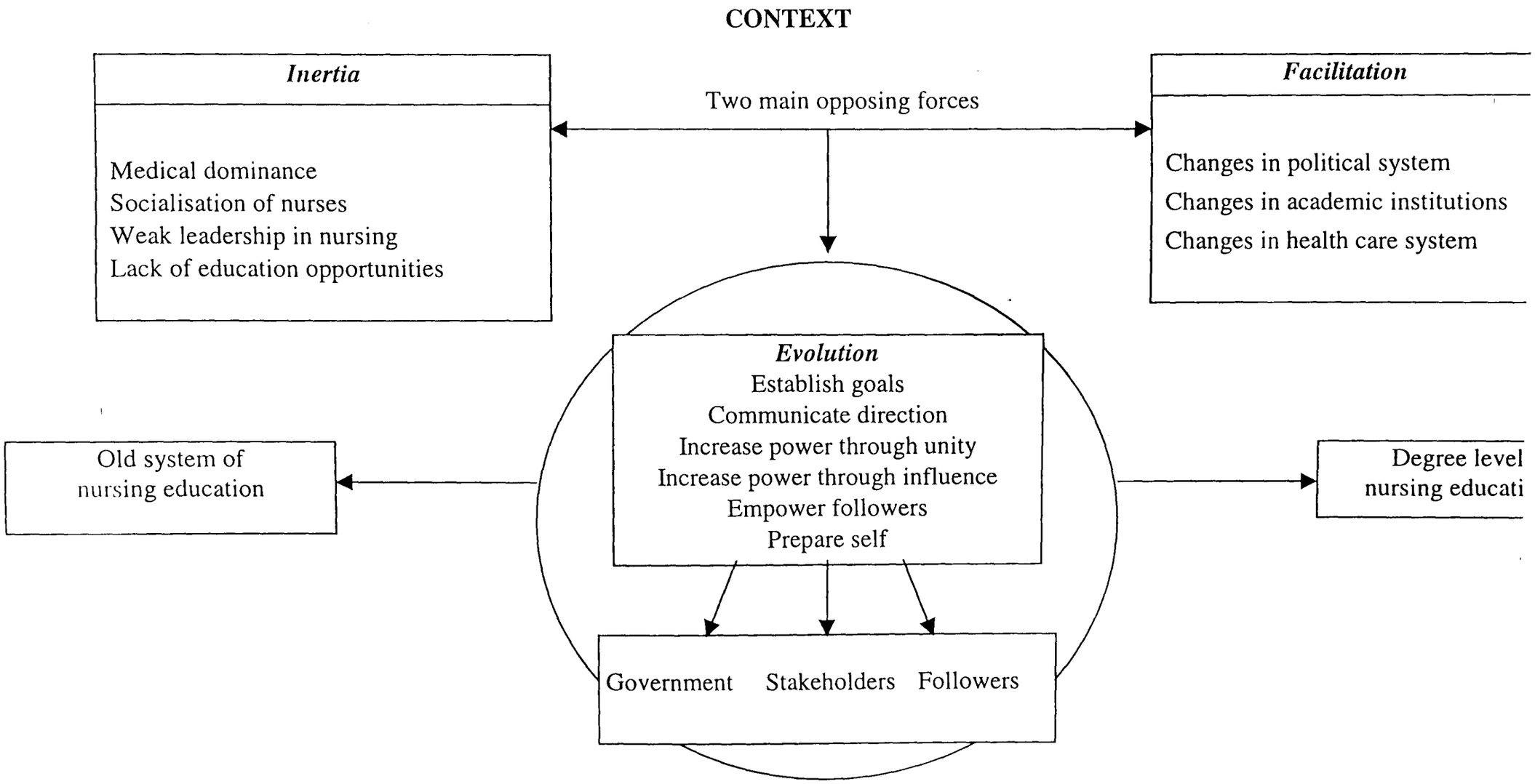
Jurse leaders performed multiple roles in this process, which included *stablishing goals, communicating directions, increasing power through unity, ncreasing power through influence, empowering followers and preparing self.* :hese roles focused on influencing the followers, stakeholders and the Jovernment. Nurse leaders had to establish goals and communicate their vision o the followers. Their actions aimed to focus attention as well as improve notivation. Support, recognition and trust from followers was then sought.

Another important role of nurse leaders was the acquisition of power. They drew on multiple power sources to achieve influence. Nurse leaders gained power by :ostering unity and collegiality among nurses. They tried to influence key players oy promoting visibility, establishing networks and engaging in lobbying. Nurse leaders also empowered followers by providing learning opportunities and building a motivating and supportive environment so followers would be equipped to work towards the vision. Furthermore, nurse leaders prepared themselves for the leadership position. They had to acquire attributes that were essential to effective leadership, such as self-development, courage, risk-taking, persistence and readiness to take opportunities. A transformational style that was people-oriented was considered by nurse leaders to be an effective leadership style in the process of change.

ıe roles of nurse leaders were found to be influenced by situational factors. [any of nurse leaders' actions were aimed at overcoming barriers. The reform of ırsing education was seen as evolutionary, which operated on the basis of two ɔnflicting forces: *facilitation and inertia.* Inertia was related to professional ɔcialisation in a health care system that was dominated by the medical rofession. Facilitation was related to changes in the wider social environment. 'he force of facilitation produced opportunities for incremental change in nursing ducation and the force of inertia created resistance to change. Nurse leaders had ɔ overcome resistance and make use of opportunities to promote nursing ducation reform.

[he process of nursing education reform in Hong Kong was evolutionary, not evolutionary. Miller (1982) considers revolutionary change occurs when an :xisting system is torn apart and replaced with something of little resemblance to he original system. In this study, nursing education reform was slow, involving gradual changes from the existing system. The inertia was cause by longstanding ɔroblems that were difficult to overcome in a short period of time. Informants ɔonsidered that a radical change in the nursing education system was not feasible. Nursing education therefore advanced incrementally and nurse leaders made this evolutionary change possible. Figure 3 illustrates the role of nurse leaders in nursing education reform and the inter-relationship among categories of the findings.

Figure 3 Evolution - role of nurse leaders in nursing education reform



owards an integrated leadership model

he second phase of analysis involved an understanding of how the nursing :adership process was shaped by the wider structures. This phase also aimed to lentify the dimensions of the process and explain why certain changes were ıking place. The categories presented in the first phase of analysis were at a escriptive level, however, as the analysis progressed, consistent elements of the ursing leadership process were identified across the categories. They were: the ituational factors affecting leadership effectiveness; nurse leaders' actions being ocused on increasing power base; reciprocal influence between leaders and ollowers; and characteristics essential to leadership effectiveness. These lements were found to be important in the leadership process. They were econceptualised as the key dimensions of the leadership process in this study:

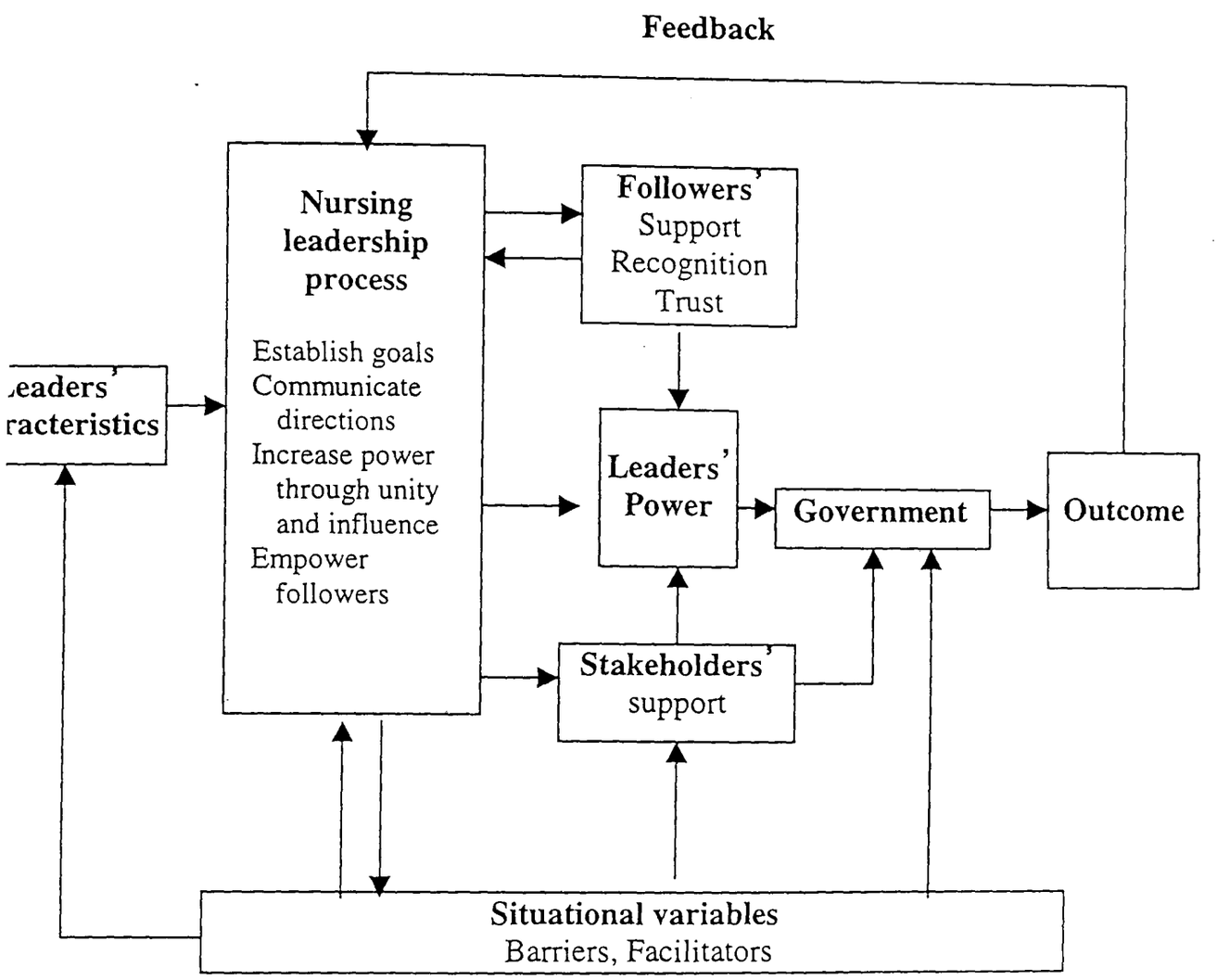
- leadership is influenced by situational variables;
- leadership focuses on the acquisition of power;
- leadership is a reciprocal process between leaders and followers; and
- leaders' characteristics influence leadership effectiveness.

These dimensions are brought together in an integrated model of leadership as illustrated in figure 4, which describes the interactions among the dimensions. The model proposes that leadership effectiveness, in terms of the outcome of the influence, is mediated by a core set of variables: the leadership process, leaders' power base, leaders' characteristics, and the situational variables. This model assumes that leadership behaviour is multidimensional, and leadership effectiveness is determined by complex interactions among the variables and key players. Situational variables can be barriers or facilitators that influence all the variables and the outcome of the influence. Leader-follower interaction is reciprocal, leaders influence followers and leadership is shaped by the support, recognition and trust from followers. The leadership process is focused on the

:quisition of power, which is influenced by leadership characteristics, situational ıriables and followers. All the variables and interactions have to be analysed to ıderstand leadership behaviour and the impact of that behaviour. The outcome f the leadership process acts as feedback to leaders about their effectiveness that 'ill modify their subsequent behaviour.

:arly leadership theories relied on a limited set of concepts, such as traits, ehaviour or situations, which are usually applicable to only one level of analysis nd involves oversimplified dichotomies, such as transactional versus ransformational, or task-oriented versus people-oriented leadership which rely on :ither-or' categories. The integrated leadership model derived from this study ncreases the number and type of variables, incorporating a more complete set of limensions that affect leadership effectiveness, and provides a more holistic view ıbout leadership behaviour. This integrated model incorporated elements found n several theories, including trait theory, behavioural theories, situational or :ontingency theories, influence process, transformational theories and Yukl's ıeadership model. Existing theories were expanded in this model by incorporating :he social system and context for leadership. This model supports Yukl's (1991) theory that leadership effectiveness is determined by a complex interaction among leaders' power, traits, influence, and situational variables. It helps to analyse factors that contribute to leadership and those that constrain leadership efforts.

Figure 4 An integrated model of leadership



Summary

This study revealed many essential roles for nurse leaders in nursing education reform. To influence change, nurse leaders established a vision and they communicated it to their followers. They built up a power base to influence key players and they empowered followers to enhance leadership effectiveness. They also prepared themselves for a leadership role by acquiring essential attributes and styles. Nurse leaders' actions focused on influencing followers, stakeholders and the Government. Based on the findings of this study, an integrated model of leadership was developed. This model proposes that leadership effectiveness is influenced by the interactions among four leadership dimensions: leadership is influenced by situational variables; leadership focuses on the acquisition of power; leadership is a reciprocal process between leaders and followers; and leaders' characteristics influence leadership effectiveness. The following chapter will analyse each dimension of the leadership process in this proposed model.

CHAPTER TEN

DIMENSIONS OF THE LEADERSHIP MODEL

Introduction

In this chapter, the four dimensions of the integrated leadership model will be discussed with reference to the findings, literature, existing leadership theories and research. Finally, nurse leaders' impact on nursing education reform in Hong Kong and their effectiveness will be evaluated.

Leadership is influenced by situational variables

In the past, leadership theories focused on situational variables in an organisation such as task structure, interaction between leader and followers, organisational structure and their effects on leadership (Riley, 1988). However, as the role of nursing leadership was not confined to health care organisations, leadership has to be understood in a wider socio-political-cultural context. In this study, leadership was examined from a broader perspective - how nurse leaders influenced change in nursing education policy in the political arena.

Previous leadership studies tended to evaluate leadership behaviour in terms of what leaders did and how it affected their followers (Fiedler, 1967). However, this study revealed that leadership effectiveness might derive not only from their position with their followers, but from their position in a social-organisational structure which went beyond their work group. Nursing leadership was influenced by a greater number of variables that included cultural, economic,

olitical and societal forces. The findings of this study support the assertion by unt and Larson (1975) that environmental complexity constrained leadership ffectiveness. However, this study also revealed that environment would facilitate eadership effectiveness if leaders could seize the opportunity. This study uggests that effective leaders are those who can analyse the situation, take the pportunities, and gather forces to overcome barriers in achieving the goal of eadership.

n the proposed nursing leadership model of this study, situational variables were elevant in three main areas: the leadership process, stakeholders and the Government. Situational variables had both positive and negative impacts on eadership effectiveness. They also influenced nurse leaders' actions. Medical dominance in the health care system and the nursing socialisation process had a negative impact on nursing leadership effectiveness. Nurse leaders had to strive to overcome the barriers. However, socio-economic and political changes in the wider society and changes in the health care system had a positive impact on nursing education reform. These influenced the Government and stakeholders' support, and enhanced leadership effectiveness.

Barriers to nursing education reform

The reform of nursing education involved a change in the mode of delivery of nursing education. Because change disrupted the homeostasis of the system, resistance was expected. This study demonstrated that nursing leadership effectiveness was constrained by barriers that were categorised as *inertia*. The barriers came from two main sources: doctors and nurses themselves. These barriers stemmed from the historical development of nursing and were not unique to Hong Kong nursing. However, these were longstanding problems that were difficult to overcome in a short period of time.

xternal resistance

octors were considered as the most important stakeholders influencing nursing lucation reform and the opposition from doctors was a major external resistance) reform. In Hong Kong, nursing has striven to become accepted as a profession ı and the reform of educational preparation has been one of the vehicles for hange. However, the early quest for a nursing degree was unsuccessful and octors were identified as the major opponents to nursing education reform. They ontrolled the decision-making process in the health care system and the political ystem, so their support was necessary to achieve any reform.

The reasons for medical dominance have been well explained by Soothill, Mackay ınd Webb (1995), Willis (1983) and Garmarnikow (1978). The situation in Hong Kong was comparable to the Western situation. Medicine was regarded as highly ntellectual, scientific and prestigious work that was looked up to and respected by :he public. Whereas nursing was concerned with 'hands-on' activities that were seen as routine, tedious, and associated with a mothering role that required little intellectual operation or education. Doctors occupied most of the senior positions in the health care system and nurses and other paramedicals were subservient to doctors.

The opposition of the medical profession to changes in nursing education has also been well documented in other countries. The major reason for such opposition was that nurses with higher qualifications had been seen as a threat to doctors' power. Many of the arguments put forth by the medical profession had centred on control and were characterised by a concern for power and domination over nursing (Davies, 1995; Gardner and McCoppin, 1989 and Parkes, 1982). Discussing the USA experience, Ashley (1976) pointed out that the medical

rofession regarded apprenticeship trained nurses easier to manage. Jolley (1989) ɔmmented that although doctors wanted a nurse capable of carrying out ɔmplicated technical skills, most did not want a colleague in the true sense of the ord as it would threaten doctors' monopoly of knowledge and power. A similar cenario was revealed by this study.

Vhen compared with other countries, the medical profession appeared to have nore control over nursing in Hong Kong. For example, until 1988 the chairman ɔf the NBHK had always been a doctor from the time it was established. Iowever, in the UK, USA or Australia, nursing statutory bodies have always been ɔntrolled by the nursing profession itself. In Hong Kong, doctors were very nfluential in the political arena as well. Many LegCo members appointed by the Government were doctors (Howlett, 1996). They therefore had great influence ɔver the Government's policy-making process.

After the establishment of the HA, there was a vigorous move to introduce management ideas and practices within the health care system. The change had brought some opportunities for nurses. However, doctors were still in control of the health care system as observed by many informants. This was reflected in the structure of HA where doctors occupied the majority of senior positions. This subordination of nursing to medicine rendered nursing powerlessness. Cheung (1994) noted that the pre-reform period in the health care system was marked by intense rivalry between administrative officers and the departmental medical professionals. The new HA structure enhanced medical professional power through the managerial subordination of nurses and other paramedical professions under them.

Furthermore, it can be argued that nurses perpetuated medical dominance. The findings suggested that nurses were not assertive enough to voice their opinions.

ven if they were dissatisfied with medical dominance, their dissatisfactions ould frequently be expressed in indirect and covert behaviour, such as that escribed in the doctor-nurse game by Stein (1967), rather than through organised ssertive and vocal actions, which were seen as disloyal to their job. A study by han and Cheng (1999) found that nurses in Hong Kong worried that being vocal n expressing their wishes would put their job at risk. Respondents in this study lso expressed this worry.

his study revealed that many senior nurses supported medical doctors in pposing nursing education reform. These findings concurred with MacPherson's 1991) assertion that historically, matrons obtained their power through their nedical colleagues. In order to secure their position, they would cling to nedicine for power and take the medical position as their point of reference. oucault (1983) argued that competition for resources leads to differential power elations as a particular group achieve access to and control of resources through exerting control over weaker groups. These power relations are then secured by he parallel emergence of a discourse that promotes these social relations as natural. The socialisation process in hospitals might help to reinforce medical dominance. Some senior nurses in this study may have accepted medical dominance as natural and unchangeable, regarding medical doctors' values as the 'right ones'. The medical dominance together with nurses' willingness to be subservient to medicine acted as barriers to nurse leaders in influencing nursing education reform.

The subordination of nursing to medicine affected nurses' image. The stereotyping of nurses as handmaidens to doctors persisted. This was considered to be one of the factors that reduced the Government and public's support for nursing education reform. The media and the public at large associated power with doctors, but seldom considered nursing or nurse leaders to be powerful

(Maslin-Prothero and Masterson, 1999). Also, when compared with other paramedical professionals, such as physiotherapists and occupational therapists, nurses had the lowest level of education in Hong Kong. Without the same level of education, it was difficult for nursing to be treated as equals in the health care team. This further affected nurses' self-esteem and confidence.

Professionalisation has been proposed as a means of enhancing nurses' status and overcoming medical dominance (Schwirian, 1998). Schwirian maintained that the drive for professionalisation in nursing has increased in intensity from the 1970s in the UK, USA and Australia. In the process of professionalisation, nurses tried to acquire the characteristics of a profession, such as upgrading nursing education to degree level. Nurses in Hong Kong followed the same path, though at a slower pace. Nursing education reform was considered as a way towards professionalisation.

However, in the quest for professionalisation, Freidson (1970) made a distinction between 'professionalism' and 'profession'. For Freidson, 'professionalism' was the means by which 'subordinate occupations claim to the public and to themselves that they have worthy tasks of service and evidence personal qualities of professionals . . . indeed the claim is to be a profession as such, if only by identification with the profession of medicine' (p.67). Professionalism, he said, seemed able to exist independently of professional status (Freidson 1970). According to Freidson, 'autonomy', was the major criterion that distinguished 'profession' from 'non-profession'. Judging by this criteria, nurses' actions that claimed to be the process of professionalisation, such as having degree level education, writing codes of ethics and establishing registration for practice (Schwirian, 1998), were no more than 'professionalism'. Nurses could not achieve full professional status because they did not have autonomy in their practice. Nurses had difficulties to function in a more autonomous position as much of their

work was still controlled by the medical profession. Therefore, nursing could only be regarded as a semi-profession. Without similar professional status to doctors, it was difficult for nurse leaders to overcome medical dominance.

Internal resistance

Apart from external resistance, there was internal resistance from nurses towards nursing education reform. The findings showed that it was nurses who opposed the reform. Inertia was attributed to the professional socialisation process within a medically dominated health care system. Together with the lack of educational opportunities, this resulted in the development of some characteristics in nurses, such as, passive and dependent behaviour, resistive to changes, lack of unity and weak leadership skills. These characteristics fitted the description of 'oppressed group behaviour' as illustrated by Roberts (1983). The survey data showed that nurses seldom participated in professional activities. Davis (1995) commented that the lack of participation in nursing associations or professional activities was related to a lack of pride in one's group and a desire not to be associated with it, an illustration of nurses rejecting nurses. This could be regarded as a form of oppressed group behaviour, characterised by nurses, as members of an oppressed group, exhibiting self-hatred and dislike for other nurses.

Another characteristic of an oppressed group was 'horizontal violence', meaning that nurses were fighting among themselves. Interview data revealed that nurses lacked consensus in nursing education development at the early stage. Informants concurred that within nursing in Hong Kong, there was a long history of divisiveness. There were more than 20 nursing groups in Hong Kong at the time of this study, but these group leaders had seldom acted cohesively. Nursing was fragmented, which was an example of horizontal violence. Nurses could not demonstrate to the Government that they were united in the stand for nursing

education reform and they could not speak with one voice. It reduced nurse leaders' power base and hindered their ability to influence. Informants regarded that this internal problem was difficult to overcome.

This lack of collective consciousness in nursing has been a common theme in Western literature over the past three decades. Compared with nurses, doctors had a stronger reputation for solidarity giving strength and focus to their cause (Ashely, 1973; Boyle, 1984; Maslin-Prothero and Masterson, 1999). Though the literature generally agreed that nursing was fragmented and weak, informants mentioned that when compared with Australia, Hong Kong nurses' participation in professional activities was relatively low. From the description by McCoppin and Gardner (1994), Australian nurses had demonstrated more solidarity than Hong Kong nurses, for example, the Federation of Australian Nurses Association, which was a coalition of nurses associations, had made nursing education reform as a goal for all nurses in Australia. However, this did not happened in Hong Kong. Informants related it to professional socialisation. Chan and Cheng (1999) concurred that Hong Kong nurses had not been encouraged to commit to professional activities during their training or at work and they regarded themselves as having inadequate knowledge and confidence. Without unity and commitment within nursing, nurse leaders lacked power to negotiate with policy makers. Thus the ability to bargain successfully was hampered. This study showed that policy-makers took advantage of the lack of general agreement within nursing by proposing a less favourable option.

The lack of preparation for leadership roles had been another factor affecting nurse leaders' effectiveness. Leadership was a topic that until recently had little presence in the nursing curriculum. Nurses therefore lacked knowledge to develop leadership skills. The Nightingale tradition of nursing practice also did not encourage leadership development. Hunt (1992) and MacPherson (1991)

argued that the culture of nursing encouraged submission to authority rather than autonomy and independence. An appropriate nursing leadership model for the development of potential leaders had also been lacking. As a result, nursing leadership was weak.

This study revealed that internal resistance from nurses was a main barrier to nursing education reform and professional socialisation and lack of learning opportunities were the causes of the problem. However, nurses' 'oppressed group behaviour' might also be a social consequence of gender socialisation. Nurses' feelings of powerlessness have been related to the social oppression of women (Garmarnikow, 1978; Game and Pringle, 1983; Willis, 1983; Gardner and McCoppin, 1989). It has also been suggested that nurses did not need higher education because it is predominantly a female profession (Davies, 1995). This might be the reason why the Government was unwilling to give resources to nurses. However, the informants in this study did not mention the gender issue. When commenting on the nursing education reform in Australia, McCoppin and Gardner (1994) maintained that the feminist movement that demanded equal opportunities for women had facilitated the implementation of nursing education reform in Australia. However, the influence of the feminist movement was not so striking in Hong Kong. It might account for the reason that the medical profession was more dominant in Hong Kong than in other countries.

In this study, 16 out of 26 informants were female. However, none of them suggested that social oppression of women were constraints to nursing education reform. The informants, for the most part, did not show an awareness of the connection between women's status and nurses' status. This study was inconclusive about the influence of gender issues in nursing education reform. However, the lack of progress in nursing education might be partly due to the external and internal resistances that were uncovered in this study and partly due

to the traditional attitude towards women in Hong Kong and the lack of awareness of inequality by nurses themselves. McCoppin and Gardner (1994) commented that to avoid the implications of gender relations in nursing education reform was to deny the reality of class and sexual oppression. It appeared that Hong Kong nurses needed to have more insight into gender issues. Nursing education reform needed to be examined in the wider context of women's issues.

Facilitators that presented opportunities

Nursing was in the midst of tremendous changes during the period of this study, both in terms of the health care system and the wider Hong Kong society. Over twenty years ago the work of Hunt and Larson (1975) failed to recognise that environment could facilitate leadership effectiveness. This study proposes that leadership effectiveness is facilitated by situational variables. Changes in the health care organisation and the socio-economic and political structure in Hong Kong provided opportunities for nurse leaders and facilitated leadership effectiveness. Effective leaders are those who could take the opportunity to facilitate the achievement of leadership goal.

Since the establishment of the HA in 1990, public hospitals had enjoyed a higher degree of autonomy in the control of their own staff and resources (Hay, 1992). Health care service delivery moved from a highly structured environment to a more diversified, decentralised, market-driven network. Because of the increased emphasis on cost containment in the health care system at that time, there was a need to foster both entrepreneurial and intrapreneurial creativity. Although the medical profession still dominated the HA, the structure of the health care system was less rigid than before. This softening of the hierarchical structure within the health care system presented opportunities for nursing to make major strides towards achieving professional autonomy. Hay (1992) mentioned that new values

were developed and assimilated in the HA, including an emphasis on new management initiatives and decentralisation. There was an emphasis on interdisciplinary collaboration and care. In this study, it was found that some younger doctors were more receptive to nursing and recognised the advantage of nurses having higher education. This reduced external resistance to nursing education reform.

Hong Kong was also facing unprecedented political changes during that period of time. Many people left Hong Kong because they had little confidence in the future after the Sino-British Joint Declaration was signed in December 1984. Steps had to be taken by the Government to restore people's confidence. One of the actions was to democratise Hong Kong's political system by introducing direct election of the members to the Legislative Council in 1988 (Leung, 1996). As a result of the creation of functional constituency elections in 1988, nursing obtained a seat on LegCo. This opened a direct channel for nursing to have input within the political system. Nurses could communicate to the Government directly and it bypassed the communication barrier imposed by the medical profession. Furthermore, the style of the colonial Government was more transparent than in the past. This facilitated nurse leaders' access to policy-makers at different stages of the policy-making process and increased the nurse leaders' abilities to influence.

This study indicated that during the 1990s, there was an acute shortage of nurses in the hospitals because of economic growth. It was felt that the establishment of nursing degree programmes would contribute to solving the manpower problem. This lessened the resistance from the Government, the HA and the medical profession to nursing education reform. At the same time, there was a massive expansion in higher education that led to an increase in the volume of degree education from 5 to 18 percent of the secondary school graduates. This decision

to expand places in higher education was referred to as 'crisis management' by Choi (1992), because it followed on the heels of the June 4 incident in 1989. Choi commented that the decision was made mainly for two reasons: to build confidence and to compensate for the tremendous emigration of talented people from Hong Kong. The increase in degree places facilitated new disciplines, such as nursing, to establish degree places in tertiary institutions. Since degree places were available and nurses had asked for them, a small number was given to nursing. The Faculties of Medicine in the universities were not so reluctant as before to accept nursing students. Facing threats to cut medical student numbers, the new nursing programme helped improve the Faculty's resources and therefore reduced resistance from doctors.

Hong Kong's experience in nursing education reform was similar to that in Australia. Social and political changes were found to help nursing education reform. For example, the expansion of higher education, and the change of government in 1983 brought to power a party more sympathetic to the principles of equity in general and to the demands of women in particular. These changes provided a conduit through which nurses could channel their demands (Henderson, 1990). In Hong Kong, the acute shortage of nurses, the increase in degree places, the socio-economic and political changes also created opportunities for nursing education reform. Without such facilitating factors, it would have been difficult for nurse leaders, no matter how skilful they were, to achieve the necessary influence. Although it did not mean that the Government and the stakeholders wholeheartedly supported nursing education reform, the fact that the Government and stakeholders would benefit from the reform lessened their resistance.

While there were factors facilitating nursing education reform, it was also important for leaders to seize the opportunities to facilitate the achievement of

their goals as pointed out by Tichy and Ulrich (1984). This study demonstrated that changes in health care organisation and the socio-economic and political structure in Hong Kong provided opportunities for nurse leaders and they were able to take the opportunities to facilitate nursing education reform.

Leadership and on the acquisition of power

The ability of nurse leaders to influence change depended on their power to make the nursing education reform a chief priority of the Government. The documentary evidence suggested that the Government did not have any fixed policy on nursing education and it appeared to be in an ambivalent position. On the one hand, the reform of nursing education had cost implications because degree places were very expensive. On the other hand, the quest from nurses created pressure on the Government. Gamson (1980) used the term 'neutrality' to describe this ambivalent position and hypothesised that in this 'neutral' position, it was more likely that the policy-maker would respond if the groups were powerful and exerting continuous political pressure. Whether nurse leaders could influence the Government's decision depended on their power base and the persistence of their actions.

When nurses demanded nursing education reform, it involved actions and collaboration of two Policy Secretaries in the Government, the SHW and SE&M. Though the Governor in 1994 agreed to give nurses extra degree places, the two Secretaries refused to give resources. There was a lack of co-ordination between the two branches. This scenario has been described by Allison (1971). Public servants from various government departments tended to develop a 'territorial perspective' that resulted in 'competitive, not homogenous interests' (p.46). To overcome this conflict, Martins (1990) suggested that government officials, each

with varying degrees of power, had to bargain and compromise. Furthermore, such bargaining and compromising could not occur without external pressure. To influence intergovernmental negotiations, nurse leaders had to exert pressure on these government officials and this depended on their use of power.

However, nurses in this study perceived themselves as powerless. The lack of cohesiveness, together with passive and dependent behaviour denied nurses power. As a result, nurse leadership was weak and nurses could not achieve the influence desired. To overcome the barriers, nurse leaders' actions were focused on the acquisition of power to increase their abilities to influence the key players in nursing education reform. Although power was an essential element in influencing, leadership was not just about 'power'. It was the exercise of power to influence to achieve a specific goal. Effective leaders are those who use power to persuade others to work towards the goal of the leaders.

Earlier leadership literature focused on power bases within an organisation (Hersey, Blanchard and Natemeyer, 1979 and Stogdill, 1974). It was apparent in this study that nurse leaders used other sources of power. The categories *increasing power through unity and increasing power through influence* described nurse leaders' actions in acquiring power. Power of unity was considered as an important power source for nurse leaders. Other power sources, such as power from connection to the political system and power from visibility, were also considered to be effective. In the past, power was viewed as coercive, dictatorial, or punitive and power sources were obtained from formal administration positions (Klenke, 1996). However, this study showed that nurse leaders exerted influence without resorting to the authority or power inherent in an employment relationship. Power obtained through non-coercive actions, such as collectivity and collegiality were also effective. Power was used as an enabling

and positive force rather than a repressive one. The following section will discuss nurse leaders' actions in acquiring power.

Power of unity

Nurses, by virtue of their very large numbers, already had latent power. However, as Schwirian (1998) commented that power in nursing was often untapped and underused. In the past, nurses had failed to realise this important source of power and used it to the profession's advantage. This study confirmed that unity was an important source of power for nurse leaders. 'Increase power through unity' was a category describing nurses leaders' role in acquiring power. Collectivity and collegiality were the key actions identified. Informants in this study generally realised that during the 1990s their professional group was fragmented and had to find ways of containing its differences when it operated publicly. Many actions that nurse leaders used were focused on obtaining consensus among the profession so that they could work collectively as a group. The formation of the Task Force for Promoting Tertiary-based Nursing Education in 1992 was evidence of 'collectivity', in which the major nursing professional associations all supported nursing education reform. The Task Force demonstrated to the Government that nursing could speak with a unified voice. Both documentary evidence and interview data supported that this nursing coalition seemed to be a strong power base and effective in influencing the Government to enact decisions to allocate the 180 degree places.

The importance of collectivity in influencing policy related to nursing development has been highlighted in the nursing literature. McCoppin and Gardner (1994) suggested that the ability of nursing organisations to establish a unified stand on the direction of nursing education was the key to successful nursing education reform in Australia. Furthermore, the experience in the UK

showed that though there was disagreement and professional rivalry during the process of nursing education reform, the drive was towards consensus (Lathlean, 1988). This study also confirmed that collectivity was an important source of power for nurse leaders. The formation of the Task Force was the first time that nursing in Hong Kong had formed such a coalition and it proved to be effective.

The development of collegiality was another strategy for increasing unity in nursing. The traditional hierarchical system in nursing made it difficult for nurses to develop collegial relationships. Many of the senior nurses who were informants in this study questioned the need for degree level nursing education. These nurses were insecure and they worried that their career prospects would be jeopardised by degree graduates. They doubted that the nurse leaders would work in their interests. To overcome the problem, nurse leaders attempted to build nurturing and trusting relationships among colleagues in order to promote unity.

The importance of collegiality as a political tool to increase the power base of nursing has been identified (Talbot, 1995 and Kalisch and Kalisch, 1983). Hein (1998) and Talbot (1995) illustrated the mechanism of collegiality. They explained that collegiality increased synergic power because the whole was greater than the sum of all the separate parts. The ability to promote collegial relationships within nursing was a way to cultivate and develop power in nurse leaders. Over a quarter a century ago, Ashley (1976) advised that if nurses could respect and care for other nurses, and there was a willingness to co-operate and collaborate, nursing would have more than enough power for controlling its practice and destiny. Collectivity and collegiality appear to work together. Effective leaders are those who inspire unity in the group to achieve collective actions.

Power derived from connection with the political system

To achieve the goal of nursing education reform, nurse leaders had to influence policy-making at the Government level. Accessing, networking, and lobbying were actions advocated by nurse leaders to build up their power base. These actions aimed at increasing public awareness of nursing issues, developing a high profile, as well as improving their ability to influence the Government.

An important access route to the political system was through nurses holding elected offices at the LegCo. When nurses first demanded degree education in the 1980s, nurse leaders lacked power because they had no access to the political arena. The turning point was the time when nursing obtained a seat in the LegCo in 1988. Both documentary and interview data indicated that the LegCo nursing members were very influential in nursing education reform. As insiders, the LegCo nursing member was able to access information that was not available to the general public and also exert influence in the LegCo. The two LegCo nursing members' contributions were crucial to achieving the reform. Furthermore, the opening up of channels for political participation in the 1990s greatly increased the political power of nurses as negotiation between nurses and the Government became direct. To be able to access the political system is an important step in influencing.

As access to the political system was available, links and networking could be established. Obtaining support from networking was an asset in gaining power. Marquis and Huston (2000) commented that in networking, interactions between persons were seen as an exchange of support or resources which each person desired. Klenke (1996) also recognised the importance of networking in facilitating the development of resources and exchange of support. In this study,

nurse leaders engaged in networking with different people, such as members of the LegCo and the HA. The support and information obtained through networking served as a power base of some significance in the LegCo. Through their network system, nurse leaders also supplied the Government and HA officials with information related to the benefits of nursing education reform. This helped to generate support from the Government and stakeholders.

One form of networking quite unique in Hong Kong was the use of external consultation. As mentioned earlier, the Colonial Government of Hong Kong was in a state of 'legitimate deficit'. In order to overcome this, it was a practice of the Government to invite overseas consultants to Hong Kong when new policies were proposed (Lau and Kuan,1988). The use of overseas consultants gave an impression to people that the Government was very objective in developing new policy. In this study, external consultants from the UK were invited by academic nurse leaders to give advice. The consultants all gave favourable support to nursing education reform in Hong Kong, which contributed to the success in the 1990s. The external consultation was considered an appropriate way of networking in the political context of Hong Kong.

As networking was established, it helped to provide opportunities for nurse leaders to lobby, which was another important influencing strategy. Both documentary and interview data revealed that nurse leaders attempted to lobby at different levels, such as with nursing colleagues, stakeholders and the Government officials. The use of lobbying in nursing was not new. For example, for many years, the American Nurses Association had employed nurse lobbyists, who engaged in intense lobbying efforts to influence policy (Moloney, 1992). The literature also supported that lobbying was a powerful tool that could be employed by a group to influence policy-making. (Roberts, 1983 and Lindblom, 1980).

This study revealed that access, networking and lobbying were useful actions for nurse leaders to acquire power in influencing nursing education reform, and these actions were interrelated. Nurse leaders had to gain access to the political system before they could establish networks with policy-makers and stakeholders. The networks they established could facilitate lobbying. The power gained from these actions was similar to connection power as described by Hersey et al. (1979). By access and networking, nurse leaders could establish connection with powerful figures in the political system and they obtained power from these connections. However, the actions used by nurse leaders in this study were greater than that of connection power. Apart from simply making connection, nurse leaders had to actively gain access and lobby the key players.

Similar to the experience in Australia, these actions were found to be powerful in exerting influence in Hong Kong. However, the Australia networking experience appeared to be more organised and formalised, groups like 'Nurses Action Lobby' and 'Political Action for Nursing Education' were formed (McCoppin and Gardner, 1994). These groups were later transformed into a force that was extremely active politically. This did not happen in Hong Kong. The Task Force became inactive after the 180 degree places were obtained. It could not substantiate its influence.

Furthermore, apart from the external consultation, the majority of the networking and lobbying activities identified by this study were not very systematically organised. For example, nursing in Hong Kong did not have a formal organised lobbying group like that found in the USA. Though networking and lobbying were found to be useful, the lack of a systematically organised group might have influenced the effectiveness of this strategy in Hong Kong.

Power from visibility

From the documentary evidence, it was noted that the earlier demand for nursing education reform had not reached the political agenda because of the blocks from doctors. To overcome this barrier, this study highlighted the use of visibility in acquiring power. For example, the nurse leaders used mass media to arouse public awareness. There was a continual flow of press releases from nursing organisations about the need to improve nursing education. The media were invited to attend significant group meetings, particularly press conferences following meetings with Government officials. Letters and articles to the various newspapers kept the general public informed of issues related to nursing education reform. Signature campaigns and petitions to the Governor were organised. The quest for nursing education reform was reported in the newspapers and discussed on the radio. The need for nurses to upgrade their education became a significant public issue that was quite visible.

Visibility was considered to be an effective strategy in the study context. Lau and Kuan (1988) pointed out that in Hong Kong, a basically closed political system, the lack of well-formed political parties, and inadequate channels of political participation had led to the emergence of unconventional politics - the non-violent unconventional pressure group. These pressure groups worked together with the free, competitive mass media enabling the groups to convey their message to the people. Lau and Kuan maintained that the joint functioning of pressure groups and the mass media was an effective means of exerting political influence on the Government. In this study, the nursing professional associations and the Task Force acted as pressure groups. Together with the use of mass media, nursing education reform became an issue that was visible to the general public, and this exerted pressure on the Government. This visibility also helped to overcome the

resistance from the medical profession. Nursing education reform was finally placed on the Government's agenda.

The findings from this study confirmed that power was a key dimension of the leadership process. However, nurse leaders' power orientation was also important. Leaders had to be willing to use their power to influence. Though Edwards (1994) stated that women had traditionally demonstrated ambivalence towards the concept of power, this study showed that nurse leaders, the majority of whom were women, recognised the importance of power and were able to achieve and manage power. The power used by nurse leaders was considered to be appropriate in the Hong Kong context. This study revealed nurse leaders' political astuteness and skills improved over a period of time. They were able to increase their power bases to influence. This was supported by the results of the questionnaire survey, which revealed that the scores of subscale 'the ability to influence policy-making' ranked the highest among all the subscales. Followers generally perceived that nurse leaders had some ability to do so and the power bases of nurse leaders were considered as non-coercive. Power of unity was considered to be an important source of power for nurse leaders and power could be an enabling force. Their power base in combination with their power orientation influenced the effectiveness of nursing leadership.

The notion that leadership was an influence process (Yukl, 1989) was demonstrated by this study. The reform of nursing education was a process that involved the exercise of power to influence the Government's policy. The nursing leadership process could be perceived as a form of political activity as it involved activities in which power was developed and used. Hosking and Morley (1988) also argued that leadership involved organising activities that represented political decision-making in its widest possible sense. Leadership was inherently a political process and the actions used by leaders were basically political actions.

To increase nursing leadership effectiveness, one important role of nurse leaders is to understand sources of power, to acquire power and to translate power into influence.

Leadership is a reciprocal process between leaders and followers

The support from followers was an important variable affecting leadership effectiveness. In the past, leadership theories imply that the relation between leaders and followers is a one-way process and followers are passive recipients of the influence (Yukl, 1989; Hersey and Blanchard, 1977 and House, 1971). However, this study revealed that leadership influence could not be regarded as merely followers' response to stimuli generated from leaders. Followers could be active participants in the leader-follower relationship. Different leadership activities had varying motivational effects on the followers and the intensity of leadership activities could influence the response. Followers' recognition and perception of leadership effectiveness influence their support to leaders. There was an element of exchange in the leader-follower relationship and leadership thus was a reciprocal process. To understand leadership, the complex interaction between leaders and followers in a specific situation has to be analysed.

This study revealed that many nurse leaders' actions were focused on influencing followers. In the traditional hierarchical system of nursing, leaders manipulated or used followers to achieve an outcome (Hedin, 1986 and Roberts, 1983). However, nurse leaders in this study tried to influence the followers by *establishing goals, communicating directions and empowering* through education and support. These were more positive ways of influencing. Many nurse leaders' actions were also focused on overcoming the barriers identified. For example, to overcome the barriers of professional socialisation and lack of opportunity for

continuing professional development, nurse leaders placed great emphasis on empowering followers. Nurse leaders provided learning opportunities, supported and motivated nurses for their continuous education. If nurses were more educated, they would be more aware of the issues, more confident in themselves and less resistant to change. They would then provide support to their leaders and leadership effectiveness could therefore be improved.

As leadership is a reciprocal process, the perception of followers' towards nurse leaders' effectiveness would influence followers' support to their leaders. This study revealed that nurse leaders and followers had different perceptions. The informants described many actions to influence followers. However, from the questionnaire survey, it was evident that followers' evaluation of nurse leaders' performance was not very positive. They did not perceive nurse leaders to have performed well in decision making, communication, maintaining coalition, influencing policy, motivating and supporting. Such perceptions matched with the fact that they seldom communicated their concern to nurse leaders. The reasons for the difference in perception will be analysed in the following section.

Evaluation of nurse leaders from the perspectives of followers

There were various factors affecting the reciprocal relationship between leaders and followers. Whether followers would support leaders' actions was influenced by their acceptance of the leaders. In this study, the nurse leaders listed in the questionnaire were those occupying senior or key positions in the LegCo, health care services, nursing professional associations and higher education settings. Although the respondents recognised them as leaders, the regard was not high. According to Yukl (1991), one prerequisite for acceptance of a leader's authority was the perceived legitimacy of the person as an occupant of the leadership position. This aspect of legitimacy depended on how the leader was selected. For

example, the Senior Executive Manager (Nursing), Senior Planning Manager (Nursing) and General Manager (Nursing) were appointed by the HA and the Chairperson of the NBHK was appointed by the Governor. The low recognition of these nurse leaders might be related to the fact that the respondents had no power in influencing these appointments. Though the nursing LegCo member was a elected one, nursing had the lowest voting rate (9.25%) in the LegCo election (Howlett, 1997). The nursing LegCo member was only supported by a minority of members in the nursing community.

Following the model of the British National Health Service, health care services in Hong Kong had been largely provided by the Government until the establishment of the HA in 1990. Nurses at a senior level were inevitably influenced by the bureaucratic traditions of the Government. Kotter (1990) suggested that large corporations tended to produce individuals who were narrow in focus and tended to avoid risk taking. These people knew little about competitive actions, but more about how to survive within organisational constraints. This view was supported by the study's interview data which revealed that many senior nurses would try to please the doctors in order to secure their position in the organisation. The top-ranking nurse in the health care service might be a senior manager but not necessarily a leader equipped to bring about change in the nursing profession. While competent at management, competence in leadership was not always present. This might be the reason why few followers recognised them as leaders. In the questionnaire survey, the item 'nurse leaders have acted as the spokesperson for the nursing profession' had the highest rating in the questionnaire reflecting a general agreement by the respondents. However, Mintzberg (1973) regarded spokesperson roles as managerial activities rather than leadership activities. Mintzberg regarded establishing direction, decision-making and communication as important roles of leaders.

Communication was regarded by many authors as essential leadership role (Martin, 1992; Garrett, 1991; Meighan, 1990 and Mintzerg, 1973). However, it was perceived by respondents as inadequate, a fact confirmed by the low ratings in the subscale 'communication' for which the mean score was below 2.5. Though other subscales, such as the abilities in decision-making, maintaining unity, and motivation had mean scores that ranging from 2.63 to 2.75, these still the lower scoring subscales. The low recognition of nurse leaders might be related to the fact that respondents perceived them as performing more of a management function rather than a leadership function. Respondents perhaps perceived that nurse leaders did not have the ability to effect change.

Evidence from the interview and documentary data revealed that the nurse LegCo members and the nurse academics, who had made the initial proposal for the degree programme, were the most influential nurses in nursing education reform. However, not many respondents recognised them as nurse leaders. The level of recognition was low when compared with other nurse leaders. Although they had put more effort into pushing for nursing education reform, their efforts might not had been well communicated to the frontline nurses. Many informants in this study mentioned that they had communicated their vision to followers. However, little documentary evidence was found to show that nurse leaders had actively communicated their actions to followers or invited followers to participate in planning actions. As mentioned earlier, the subscale 'communication' had the lowest mean score among all subscales. This limited followers' understanding of nurse leaders' actions and the recognition of nurse leaders. As a result, it was difficult for the nurse leaders to gain followers' recognition and support and the power base of leaders was consequently affected.

Recognition from followers is considered important for nurse leaders to exert influence. This was especially important in this study as the ability of nurse

leaders to influence the Government was dependent, in part, on their ability to get support from the followers. Being perceived as a leader may allow an individual to exert more influence, and thereby, more easily implement actions. Followers' recognition and support of their leaders' influence what their leaders can succeed in doing. There can be no leader in isolation. The followers must explicitly or implicitly consent to their part in the leadership-follower relationship.

In the questionnaire survey, the second highest score was the item 'nurse leaders showed a willingness to make desirable changes'. Though nurse leaders had a desire to effect change in nursing education reform, they did not have a concrete plan for the reform. For example, interview data did not indicate that nurse leaders had a plan to co-ordinate the phasing out of nursing schools and the introduction of degree places. This was supported by the findings of the survey that the item 'nurse leaders had established direction for the development of nursing education' had the lowest score among all items. Without a concrete plan of action, it was difficult to mobilise followers to achieve the vision. Manfredi (1996) and Yura, Ozimek and Walsh (1991) concurred that to be successful, leaders had to have a plan for actions and pointed out how followers could contribute to fulfilment of the vision. Also important was the mobilisation of commitment to the vision. They could then direct and motivate followers to implement those actions that contribute to the success of the vision. This study showed that nurse leaders were not able to perform well in this role.

Although nurse leaders had a desire to influence nursing education reform, the power and skills to do so were not always evident. As such, they were perceived by followers as not very capable in exercising good leadership to achieve desirable influence. Leaders 'high' in 'consideration' or 'relations oriented' and 'high' in 'initiating structure' or 'task oriented' are thought to be more effective than leaders who are 'low' in either behaviour dimension (Fiedler and Chemers, 1974

and Hersey and Blanchard, 1982b). However, even inactive, 'low' leaders could have a strong effect on followers, such as arousing intense negative feelings. This study revealed that negative feelings were aroused when followers perceived the leaders to be incapable in many aspects of the leadership role. As a result, there was a lack of support and trust towards nurse leaders.

Forming a relationship naturally involved a two-way process. Whether the followers played an active role in establishing a relationship might affect the quality of the relationship. The interview data revealed that nurses in Hong Kong were generally passive and inert in their relationship with nurse leaders. This was supported by the findings of the questionnaire survey, which demonstrated that the majority of the respondents had not expressed their opinion to the nurse leaders. This made it difficult for nurse leaders to establish a trusting relationship with the followers.

Expressing opinion to nurse leaders was regarded by Almond and Verba (1989) as a form of political participation. Chan and Cheng (1999) commented that the decision of whether or not to express opinion depended on subjects' political efficacy. This was presented when individuals believed that they had a meaningful role to play in influencing decision-making. Individuals with a high level of efficacy were likely to be participants in the political process. This study demonstrated that respondents were generally seen to have low political efficacy. They did not expect that nurse leaders would listen to what they had to say and they did not know the effective way to do it. If nurses perceived that what they did would have no effect on the outcome, then they would choose not to do anything. Many authors also agreed that the feeling of powerlessness prevented nurses' participation and that they were generally apathetic towards political participation (Boyle, 1984; Clifford, 1992; Costello-Nickitas and Mason, 1992; Roberts, 1983 and Sweeney, 1990). In this study, respondents perceived

themselves and the nurse leaders as powerless in influencing change, it was therefore less likely that they would express their opinion to nurse leaders or support them.

Leaders' abilities are important in influencing leadership effectiveness. However, this study showed that followers' qualities also had a profound impact on leadership effectiveness. The interview data revealed some followers to be passive and dependent, some were apathetic towards political participation, and some were reluctant to participate in professional activities. Though some might have the ability to do so, they were unwilling to devote their time to promote nursing development. These followers' behaviour had a negative impact on nurse leaders' performance. Without the support from followers, it was difficult for leaders to achieve the desired influence.

Although Hersey and Blanchard's (1977) and House's (1971) leadership theories also took account of leader-follower relations, the model implied a one-way, static approach to leader-follower interaction. This study revealed that leadership was a reciprocal and dynamic process. Leaders were not isolated individuals, they interacted with other members in the process of leadership. People behaved differently in their actions and reactions within the leader-follower relations. In this reciprocal process, leaders influenced followers by establishing directions, communicating visions, and empowerment. The followers influenced the effectiveness of leadership performance by their recognition, trust and support to the leaders. Many authors, such as Yukl (1991) and Stoner, Collins and Yetton (1985) also described leadership in terms of reciprocities, involving a series of exchange, such as in rewards and punishments. However, this view of interaction between leaders and followers was limiting. The exchange between leaders and followers could be more than rewards and punishment. This study demonstrated

that the reciprocal process was an exchange of motivation, support and power between leaders and followers.

As leadership effectiveness is influenced by followers' behaviour, it could be evaluated not only on the basis of how well leaders lead, but also how well followers follow. While the leader is the central and often the most vital part of the leadership phenomenon, followers are important and necessary factors in the equation. Followers' characteristics need to be taken into account in understanding leadership effectiveness. Failure to recognise interdependencies between leader and follower can have serious consequences for leadership effectiveness. However, an understanding of followers' motivation and perceptions is not enough. Leaders have to examine the characteristics of effective and ineffective followers so that they can aim to develop effective followers. The process of how followers identify and follow the leaders need to be understood. An important role of leadership in the future is to identify characteristics of effective followers and to cultivate them.

Leaders' characteristics influence leadership effectiveness

Trait theory assumes a set of common leadership characteristics in effective leaders (Stogdill, 1974). In this study it was found that leaders' characteristics related to the effectiveness of nurse leaders and were therefore an essential dimension in the leadership process. 'Prepare self' was a category that illustrated this dimension and included leadership attributes and styles that were considered important to leadership effectiveness. These characteristics appeared to be appropriate to the context of nursing education reform. Previous leadership studies suggested differences in the leadership characteristics of Eastern and Western leaders (Shaver, 1999; Klenke, 1996 and Smith and Wang, 1994), this

study revealed that nurse leaders demonstrated characteristics of effective leaders similar to those described in the Eastern and Western leadership literature (Fok, 1997; Morriner-Tomey, 1993; Ho, 1990).

Leadership attributes

Many informants in this study were generally aware that the lack of opportunity for leadership development was the cause of weak nursing leadership. They suggested that an increase in leadership knowledge and skills was important in facilitating effective leadership. They considered that to be effective, leaders had to develop themselves by learning continuously. This concept of self-development is congruent with the ancient Chinese notion of great leaders. Confucian writings described the process of becoming a leader, stating that one had first to look within self and 'verbalise intelligence of the heart', order within the self, then within the household and finally in the state and the whole world (Fok, 1997, p.22). In other words, one had to prepare oneself first before becoming a leader.

Self-development is regarded as important to leadership in the Western literature. Marriner-Tomey (1993) used the term 'self-empowerment' to describe this process, which resembled the sub-category of self-development in this study. Marriner-Tomey suggested that to be effective, contemporary nurse leaders had to be able to self-empower. Rosenbach and Taylor (1998) commented that leadership was an art, and in the art of leadership, the instrument was the self. Leadership development, then, is essentially a process of self-development, implying that leaders are not born, but that leadership can be learnt through continuous development of self. Leaders can improve their knowledge and confidence through continuous development.

Courage, persistence and risk-taking were found to be desirable qualities for nurse leaders and appeared to contribute to leadership effectiveness. Without courage, it would be difficult for nurse leaders to work for nursing education reform because they would encounter opposition and resistance from various parties. Courage was an important leadership characteristic emphasised in Lun Yu - The Analects of Confucius, the first of Four Books of Confucian Classics - that a successful leader needed courage (Ho, 1990). Courage is also considered by Smith (1985) and Altieri and Elgin (1994) to be the quality required by nurse leaders. Furthermore, courage is linked with risk-taking. Political participation is a new arena for nurse leaders and it required doing things differently or trying new things. Irurita (1992) suggested that strong leaders were not afraid of testing new models and they viewed failure as a learning process, not as something negative. Effective leaders are thus good 'experimenters' or 'innovators' who are not afraid of taking risk.

Persistence in effort was regarded as an important attribute of effective leaders and was described as a characteristic of great leaders in Chinese culture (Ho, 1990). The Task Force was very persistent in its actions for three years and it had a positive effect on the outcome of nursing education reform in Hong Kong. Persistence is also one of the characteristics of 'superleaders' identified by Bennis (1984) and referred to as the ability to stay on course regardless of the obstacles encountered. Sayles (1993) concurred that persistence was an important trait of successful leaders.

Furthermore, this study demonstrated that a leader had to exploit opportunities. A Chinese idiom stated 'great leaders were created through opportunities, but great leaders could certainly create opportunity'. That implied those who were willing to take risk were able to seize opportunities to achieve their goals and became great leaders (Ho, 1990, p16). This description of great leaders was similar to the

characteristic of transformational leadership. Tichy and Ulrich (1984) contended that transformational leaders created their own luck by seizing opportunities and knowing when to act. They agreed that to be successful, leaders needed this ability. Stewart (1982) concurred that effective leaders would recognise opportunities for choice and consider which ones they ought to take. This study revealed that there were factors facilitating nursing education reform and nurse leaders were successful in seizing the opportunities to bring about reform. To be successful, leaders have to be willing to take risk, make effective use of available resources to reverse negative situations, and create additional resources to bring about change.

Different values in Eastern and Western culture have been highlighted in literature. For example, according to Shaver (1999), innovations are important values in American culture but Asian cultures emphasise tradition more. However, this study found that innovation and change was also regarded as important in Hong Kong nursing, as reflected by the core category of the study - evolution. It was also found that attributes that were considered important in this study were common in both the Chinese and Western leadership literature. This study found no 'unique' attributes in nurse leaders. The findings supported the assertion from 'trait theory' that there might be a set of universal leadership attributes common to effective leaders.

Though some attributes identified in this study were considered as important to leadership effectiveness, none of these attributes were regarded as traits in the strictest sense. These were not something people are born with, these attributes could be learnt. It implied that effective leaders could be developed through learning. One could learn to engage in self-development, have courage, persistence and a willingness to take risk. While previous discussion concluded

that nursing leadership was weak, with learning opportunities, nurses can overcome organisational and personal barriers and learn to be better leaders.

Leadership styles

Apart from attributes, the findings demonstrated that informants adopted a leadership style that they considered appropriate. Many informants in this study regarded themselves as having an open, considerate and informal style of leadership. They appeared to be more people-oriented and regarded this style as appropriate in effecting change.

The literature also supported that a people-oriented style was more appropriate in the present health care system. In the past, nursing's military roots promoted a controlling leadership style, in order to achieve the greatest compliance with orders (Fanslow, 1984 and Meighan, 1990). Robinson (1991) and Girvin (1996) commented that the autocratic leadership style was oppressive and this hindered the advancement of nursing practice. They explained that a leader whose style encouraged two-way trust and loyalty was likely to be most effective. Nurse leaders who had people-oriented behaviour, such as direct person-to-person communication were able to enhance job satisfaction of co-workers (Garrett, 1991; Patz, Biordi and Holm, 1991; Longo and Uranker, 1987; Duxbury, Armstrong, Drew and Genly, 1984). It appeared that leaders with a people-oriented leadership style was appropriate to the context of this study.

Informants in this study exhibited characteristics of transformational leadership as described by Avolio and Bass (1988). For example, it was apparent that nurse leaders had a vision and they tried to communicate the vision to followers. They expanded their power through unity, networking and visibility and they were willing to take risk. These were characteristics of transformational leadership.

Furthermore, transformational leadership involves the provision by leaders of intellectual stimulation to arouse awareness and activate problem-solving capabilities in followers (Avolio and Bass, 1988). This is similar to the process of empowering followers, one of the emerging categories in this study. The nurse leaders in this study exhibited features of transformational leaders.

The use of a transformational leadership style seemed to be appropriate in the context of this study where there were tremendous changes in the health care system and in the wider Hong Kong society. Characteristics of transformational leadership, such as establishing vision, communication, building trust and empowerment, were essential for change. The contemporary nursing literature also suggests that transformational leadership is the desirable leadership style in the present health care system (Davidhizar, 1993; Dunham and Klafehn, 1990; Dunham-Taylor, 1995 and Tiwari, 1996). A leader who is skilful in communication, collaboration, capable of creating a collegial relationship with followers, and guiding rather than directing, might be more likely to be successful (Rosenbach and Taylor, 1998). It appeared that transformational leadership was an appropriate leadership style in this study context, when compared to the traditional approach of authority and control.

According to Burns (1978), transactional leadership occurs when a leader initiates a relationship with followers based on exchange; transformational leadership, on the other hand, involves a relationship with followers that is mutually stimulating and elevating. However, the literature does not mention elements of exchange in transformational leadership. This study showed that nurse leaders demonstrated transformational leadership, but their relationship with followers also involved exchange. For example, the followers received intangible rewards, such as support and motivation from leaders, in exchange for their willingness to carry out the leaders' vision. These rewards were useful and real. It appeared that the

exchange between followers and leaders could take different forms. It could involve material rewards for actions or, as in this study, intangibles that could enhance followers' confidence, knowledge and insight of the situation.

This study suggested that transformational leadership involved an exchange of intangible rewards between leaders and followers. Nurse leaders transformed followers by empowerment. It was much more than an exchange of intangible rewards. In transactional leadership, leaders give rewards to followers in exchange for compliance. In transformational leadership, leaders enable followers to become more confident, to use power in a more positive way, and to realise more fully their potential. Transformational leadership is not simply a form of transaction and exchange, the essence of transformation is when there are true transformations in followers, leading to transformation of the situation. The core category emerging from this study - evolution, illustrated this process.

This study identified that certain characteristics were considered important for nurse leaders. They could help distinguish leaders from non-leaders. However, it must be recognised that attributes and situational factors are both important. The effectiveness of certain leadership characteristics should be evaluated in conjunction with situational variables. For example, transformational leadership style was considered effective in this case study but it might not work in other situations. Over emphasis on personal qualities while under-emphasising situational factors might lead to erroneous decisions in selecting nurse leaders. One factor determining leadership effectiveness was the relevance of the characteristics to the needs of the situation. The functions of the leaders and demands of a particular context needed to be taken into account. Attributes and styles of the leader must be relevant to the activities and goals of the leaders. An adequate analysis of leadership involved not only a study of leaders, but also of situations. This study showed that personal characteristics of nurse leaders

influenced their effectiveness. Effective leaders are those who can adopt leadership characteristics that are appropriate to the situation. In proposing a comprehensive model of leadership, the leadership characteristics needed to be considered together with the situational demands

The impact of nurse leaders on nursing education reform

One of the objectives of this study was to assess the impact of nurse leaders on nursing education reform. This study showed that the nurse leaders in the academic institutes proposed nursing education reform in 1985 and they were able to secure 180 degree places in 1995. It could be observed that at the beginning of the reform process, nurse leaders had few political skills. However, the findings demonstrated that nurse leaders' leadership skills improved through experience. They had learnt to acquire more political skills and demonstrated increasing knowledge in influencing the Government. The actions that they used appeared to be effective in influencing change as some degree places were given to nursing. The political acumen of the nurse leaders developed incrementally and they became more effective over the period of time analysed for this study. Nurse leaders' power increased further when nurses acquired a seat in the LegCo, facilitating access to the Government, thus nurse leaders were able to grasp opportunities, focus on common goals, and gather forces to exert influence.

If leadership is seen as the interaction between leaders and followers to achieve the goal of the group, then goal achievement is an important measure of leadership effectiveness. Nurse leaders in this study were able to achieve their goal - nursing education reform, to some extent. However, the 180 degree places constituted only about 10% of the total number of nurses needed to be trained each year. This was certainly not the kind of nursing education reform wanted by

nurse leaders. Some informants expressed that basic nursing education should be all transferred to degree level. This study showed that nurse leaders had the potential to influence policy. However, their potential had not been maximised.

The failure of nurse leaders to exert more influence on nursing education reform was attributed to various barriers. The medical dominance in the health care system placed constraints on the behaviour of nurse leaders. The nursing professional socialisation inhibited greater advancement of nursing. The lack of unity in nursing and weak professional nursing association reduced nurse leaders' power. The lack of support from followers also inhibited more effective leadership. Furthermore, the lack of preparation for leadership made it difficult for nurse leaders functioning in leadership position. They lacked the essential skills to achieve greater influence. These constrains were difficult to overcome.

This study showed that political skills, such as networking and lobbying, were important for leaders to increase their power base. However, nurse leaders were not very proficient in their political skills. In comparison with Australia or the UK (Martins, 1990 and Lathlean, 1988), Hong Kong nurses leaders' political actions were not that well organised. Since nurse leaders were new to the political arena, they required more practice and experience in order to gain the skills. Apart from the nurse leaders, followers also had to see their responsibilities in supporting professional development and be active in pursuing their goals. The reluctance of many nurses to see the political dimensions of their work and their apathy towards politics rendered nurse leaders powerless.

To be effective in influencing, nurses have to speak with one voice in public. Unity was needed to pursue nursing education reform. As suggested by an informant, the nursing professional organisations in Hong Kong were not as strong as that in Australia or the UK. Though the Task Force for Promoting

Tertiary Education demonstrated united action, it was only a working group and long term collaboration among nursing groups was not demonstrated. Apart from the Task Force, there was no formal organised body or process in lobbying and the nursing professional associations had no formal links with the Government. Nurses had not demonstrated to the Government that they were a powerful group. Furthermore, the statutory body of nursing, the NBHK was weak and had long been controlled by medical doctors. Hong Kong nursing did not have a strong and proactive statutory body, such as the UKCC. Without a powerful professional nursing association, nurse leaders' ability to advance the profession was limited. Besides, the status of nursing was low and nursing was not a profession because it did not have autonomy in its practice. The power of nursing to influence the Government was thus reduced.

Nurse leaders had to be more active in the political arena to achieve change. The call for nurses to become politically active has appeared frequently in the literature since the 1970s (e.g. Chan and Cheng, 1999, Chan, 1993, Archer and Goehner, 1981 and Ashley, 1976). However, it was only recently in Hong Kong that nurses involved themselves in politics in an active way. In this study, the political participation appeared to be confined to a few nurse leaders, such as the LegCo nursing members and the nurse leaders in academic institutes, who were very active in engaging in political activities. The power of nursing was weak because only a very small number of people were actively involved in political activities.

This study found that the nursing LegCo members were very influential in nursing education reform. However, only one member represented nursing in the LegCo during each term of service. When compared with the total number of members in the LegCo - 60 (Howlett, 1997), the power of that member was limited.

Nursing representation in the highest policy making arena was therefore small. The LegCo was also dominated by doctors for a long period of time.

Although Hong Kong had a unique experience in nursing education reform, when compared with the experiences of Australia and the UK, the ingredients of success were similar. They were: establishing common goals, maintaining unity among nurses, and building support from stakeholders (McCoppin and Gardner, 1994). Also, the successful pursuit of nurses' interests depended in part on the social, political and economic circumstances. There were contextual factors, such as changes in health care system, facilitating nursing education reform. These changes provided opportunities for nurse leaders to influence the reform to some extent. However, the Hong Kong experience showed that factors in the wider environment also placed constraints on the behaviour of nurse leaders. Informants in this study did not seem aware of these factors.

In Australia, nursing education reform coincided with the government elections. Because of the size of the nursing population, nurses could influence the outcome of the election to some extent by voting for the political party that supported the reform (Martins, 1990; and McCoppin and Gardner, 1994). Nurses thus had some power to negotiate with the government. However, as mentioned earlier, Hong Kong people could not vote for a change of the Government and nurses had no influence on its status. There was a limit to the extent that nursing leaders in Hong Kong could influence the Government. During the period of the study, British rule in Hong Kong was coming to an end and therefore the Hong Kong Government was unlikely to make radical changes in nursing education.

In the process of nursing education reform in Hong Kong, it appeared that the Government was the ultimate controller of resources. The data did not reveal whole-hearted support by the Government for nursing education reform.

Nevertheless, it was difficult for the Government to ignore completely nurses' claims for educational improvement, because the actions taken by nurse leaders were quite visible and of very high profile. While a limited number of degree places were given to nurses, the majority of nurses' training remained in hospitals. However, it is certain that, if nurse leaders had not strongly presented their demand for degree level education, it would not have been possible to obtain the 180 degree places. Although the number was small, it was a significant beginning for reform in nursing education in the long run. This case study provided an example of Hong Kong citizens attempting successfully to influence the Government at a stage when the British Government was introducing some democracy in Hong Kong.

Summary

This chapter analysed and discussed the four dimensions of the integrated leadership model. This study suggests that when analysing leadership behaviour, situational factors, the power base of nurse leaders, the support from followers and leadership characteristics have to be taken into account.

This study also showed that nurse leaders had the potential to achieve more influence. However, they were constrained by their position in the health care system and the socio-political circumstances, limiting the extent to which they could influence. Nurse leaders were not effective when they first proposed the reform. In general, nurse leaders' efforts had not been considered as very effective by their followers. Nevertheless, the failure gave them some insight about leadership skills and they learnt from their experience. Leadership efficacy improved when they attempted to influence the Government again. The situational factors presented at the period of this study, such as the brain-drain

related to the 1997 issue and nurses occupying a seat in the LegCo, had created opportunities and acted as facilitators to the nurse leaders' actions. As a result, degree places for nursing were established.

The nurse leaders were generally aware of the weaknesses and they had attempted to improve themselves and their followers. Leadership was a new area for nursing development in Hong Kong and it was still in its infancy. For nursing to increase its power and have its interests represented, greater participation in politics is likely to be necessary in the future. Time is needed for nurses to develop into more mature and effective nurse leaders. Nursing education reform was the first experience of nurses attempting to influence the Government's policy. The effectiveness of nursing leadership is likely to improve if nurse leaders could learn from this positive experience. The following chapter will draw conclusions and discuss the implications of this study to leadership theory development, leadership research development and nursing leadership development in Hong Kong.

CHAPTER ELEVEN

CONCLUSIONS AND RECOMMENATIONS

Introduction

This study sought to discover, and to provide an understanding of the process of policy development in nursing education reform in Hong Kong and nurse leaders' role in influencing the reform. It also explained the interactions and the power relationship among nurse leaders, followers, stakeholders and the Government. The predominant factors influenced nurse leaders' effectiveness and the underlying reasons why nurse leaders had failed to achieve a more significant role in influencing nursing education policy were investigated. The findings contribute to a clearer understanding of the phenomenon of nursing leadership in Hong Kong. This chapter draws conclusions from the findings and considers their implications in relation to leadership theory development, leadership research and nursing leadership development in Hong Kong. Recommendations are made on strategies for improving nursing leadership effectiveness and ways in which nurses can make a more substantial contribution to nursing development. Finally, the limitations of the study are identified.

Summary of findings

This was a retrospective study which focused on the period 1985-1995 when the nursing sector, the health care delivery system, and the socio-economic and political situation in Hong Kong was in a state of turmoil. An integrated leadership model has been developed based on the findings of this study. This model proposes that leadership behaviour is multidimensional, which takes into account the interactions among key players (nurse leaders, followers,

stakeholders and the Government) and four essential dimensions of the leadership process. The dimensions are: leadership is influenced by situational variables; leadership focuses on the acquisition of power; leadership is a reciprocal process between leaders and followers; and leaders' characteristics influence leadership effectiveness.

The model proposes that all these interactions and dimensions have to be considered when evaluating leadership effectiveness. It also proposes that leadership is closely associated with contexts in the organisation and the wider social environment. Leadership effectiveness is influenced by the facilitators and constraints in the context. Effective leaders are those who can analyse the situation, overcome the barriers, and make use of the opportunity to facilitate achievement of leadership goals. The leadership process focuses on the acquisition of power; the greater number of power sources available, the greater is the ability to influence. Effective leaders are those who can acquire appropriate power to influence. Leadership is a reciprocal process between leaders and followers. Effective leaders are those who empower, motivate and support followers and in return, receive support and power from the followers. Leaders' characteristics influence leadership behaviour. To be effective, leaders have to adopt appropriate attributes and styles. These leadership characteristics can be learnt which implies individuals can become better leaders with the appropriate preparation.

This study showed that nurses, who comprised the largest group of health care professionals, had not been effective in making changes in nursing education to a level that they desired. Nurse leaders were found to be unable to fully enact their roles due to many barriers, which included socialisation of nursing in the health care system characterised by medical dominance. There was also a lack of learning opportunities for nurses. As a result, nurses developed characteristics that were unfavourable to their own development. These characteristics included fragmentation, internal conflicts, passiveness, apathy towards professional development, and non-assertiveness. These factors had a

negative impact on leadership effectiveness and led to weak leadership in nursing. Nurse leaders were unable to achieve the desirable influence and the evaluation of nurse leaders' performance from the perspective of followers was therefore negative.

Nurse leaders in this study were found to deal with the barriers and to achieve influence and advancement, through a process called *evolution*. Evolution, the core category of this leadership study, referred to the process of nursing education reform in which nurse leaders' roles were focused on transforming barriers to opportunities with an aim to influence change in the nursing education system. Nurse leaders' roles included: establishing vision and direction for change; communicating goals to others; increasing unity by collegiality and collectivity; increasing influence through access, lobbying, networking and visibility; empowering followers through education and development, and preparing self for the leadership role. The approach of 1997, the shortage of nurses and the political unrest provided opportunities for nursing education reform. Nursing education reform was related to the changes of political circumstances and nursing leadership effectiveness was facilitated by these changes. This study showed that following a long period of inertia, evolutionary changes, reflecting gradual progress in nursing education reform, had been achieved in a context of socio-political changes and expanded opportunities.

This study is unique as it is the first study of nursing leadership in Hong Kong and it focused on nurse leaders' roles in the political arena. It also contributes to a better understanding of the leadership process in the Hong Kong context. The findings of this study can inform future studies on nurse leaders' behaviour in policy-making and have important implications for leadership theory development, future leadership research and nursing leadership development.

Implications for leadership theory development

Though much has been written on leadership in the past, the literature is often very abstract and only gives superficial information about what leaders actually do. This study provides substantial data about what leaders actually did to influence nursing education policy. The integrated model formulated from the study contributes to leadership theory development by increasing understanding of the leadership process, the various dimensions influencing leadership effectiveness, and the essential roles of leaders in influencing. The knowledge gained from this study can be used to understand or predict leadership behaviour in other situations, such as how nurse leaders influence nursing structure reform in Hong Kong.

The integrated leadership model derived from this study is multidimensional. It suggests that leadership is a complex process that involves an individual's characteristics, power, and the situation. This study also suggests that the four dimensions of the leadership process (situational variables, power, reciprocal relationship, and leadership characteristics) can be substantial predictors of the outcome of leadership influence and they have to be taken into account in understanding leadership behaviour. This proposed model supports Yukl's (1991) theory that leadership behaviour is influenced by a number of variables.

Previous leadership studies tend to decontextualise leadership ignoring the cultural, economic, social or political changes. This study demonstrates that environment could impact in a positive or negative way on leadership effectiveness and that the wider environment in society influenced nursing leadership. Aspects of nursing professional socialisation and the culture of the health care system need to be considered in the understanding of nursing leadership behaviour.

Past literature focused on factors constraining leadership behaviour (Hunt and Larson, 1975), but this study proposes that situational variables can be facilitators. The contextual view advocated in the integrated model of this study encourages leaders to seek new leadership opportunities in the changing environment, as well as taking an active role in exerting influences within the constraints of the environment. It implies that to be successful, leaders have to understand the context in which they work together with the opportunities and constraints associated with the context. Leaders have to engage in 'environmental scans'. They have to see patterns or trends around them. It can help to set the vision and determine changes they like to achieve and select appropriate strategies to influence change.

This study supports Bass' (1991) assertion that leadership is an interaction process between leaders and group members. The findings also suggest that leaders influence members through their interactions. Compared with the findings of other studies by Martin (1992), Yura Ozimek and Walsh (1991), Garrett (1991) and Meighan (1990), it was found that nurse leaders in this study focused more on the acquisition of power to influence. This study proposes that leadership is a political process in which leaders use power to influence others for the allocation of resources. Hosking and Morley (1988) support this interpretation.

Although the leadership roles that are considered essential in this study are related to influencing policy in the political arena, they can be applied to different organisational settings. Dunford (1992) argued that organisations might be understood as political systems, which were sites where participants interacted in pursuit of a range of interests. For example, in health care organisations, various health care disciplines are competing for the allocation of scarce resources. Organisations, by their very nature, are political. The proposed leadership roles could help to enhance nurse leaders' effectiveness in nurses' workplace or professional organisations.

This study supports the existing arguments that leadership is a broader concept than management, and it points to ways in which leadership is different from management in purpose, activities and relationship between leaders and followers. Evolution, the central theme of the leadership process identified in this study, illustrated nurse leaders exercised power to direct change in nursing education policy. It implies that leadership is essentially about change and growth. This goes beyond a manager's function that aims at accomplishing the goal of the organisation efficiently. A successful leader is the one who can set future-oriented goals, work within the opportunities and constraints of the situation and aim at the advancement of the group.

Moreover, nurse leaders in this study focused on the acquisition and use of power to influence. The ability of nurse leaders to influence the Government depended on their power base. This could be distinguished from management activities involved in making decisions by bureaucratic procedures. Furthermore, unlike managers that are more concerned with the operational side of an organisation, nurse leaders were involved in influencing strategies. Some informants of this study did not have the legitimate power to influence as they did not have a formal position in an organisation. However, they could still influence by using other sources of power, such as unity, networking and lobbying, which were non-repressive. Leadership can be exerted beyond formal positions in an organisation. Leadership is an influence relationship whereas management is an authority relationship, based on positional power.

This study supports Yukl's (1991) model that leadership is a reciprocal process between leader and followers and there is an element of exchange in their relationship. Leaders have to develop and support followers and in turn obtain followers' support. Followers could play an active role in the leader-follower relationship. This study proposes that followers' characteristics need to be taken into account in understanding leadership effectiveness. Leadership effectiveness is influenced by followers' behaviour. It implies that leaders need to identify characteristics of effective followers and help their followers

develop these characteristics.

The roles and characteristics of nurse leaders in this study have been identified in existing literature as important elements to influence. These are common to nurse and non-nurse leaders, suggesting that there are universal leadership roles, attributes and styles across Eastern and Western culture. However, given the diversity of current Chinese societies, there is considerable scope for variation in roles and characteristics of leadership depending upon societal and organisation context. For example, this study reveals a significant leadership strategy, that is, the acquisition of power through unity. Also, the use of access, networking, lobbying and visibility were highlighted and were considered appropriate to Hong Kong's political context. However, it is not known whether these strategies will be appropriate in other Chinese societies such as in Mainland China. In studying leadership, there is a need to focus on the rapidly changing context as well as the cultural aspects of the society.

The leadership process discovered in this study and the proposed model will be useful when considering leadership development in other professions that have similar characteristics to nursing. For example, teaching, is also a female dominated semi-profession and there is a wish to upgrade teachers' qualification to degree level in Hong Kong. The problems that female professions encounter in leadership development may be similar to nurses. Furthermore, the findings of this study may be applicable to paramedical professions, such as occupational therapists and physiotherapists, who function in the same health care environment.

Implications for future leadership research

In the past, leadership theories were developed mainly in disciplines such as industry, psychology, political science and sociology. This study contributes to leadership theory from a nursing perspective. The proposed leadership

model in this study has potential application in different disciplines and settings. Before the model can be generalised, further studies are required in diverse settings.

Dimensions of the leadership model

Power is perceived as an essential dimension in the proposed leadership model. However, further research could be conducted to increase understanding of the dimension of power in nursing leadership. To be more effective in using power to influence, future studies could aim at answering the following questions:

- Will followers respond positively to a leader with power?
- What types of power will the followers accept?
- What are the most effective power sources for influencing policy?

Situational variables that were identified as being important in influencing nursing leadership development should be examined in different leadership settings. The gender issues and their impact on nurse leadership development, mentioned in overseas studies but not by the informants in this study, need to be further investigated.

The leadership characteristics identified in this study could also be explored further. Studies could be carried out to investigate whether the leadership attributes identified in this study are effective in other Chinese societies. Future studies could also focus on testing the assumption that transformational leaders are involved in exchange of intangible rewards. A people-oriented style was suggested to be an appropriate style for nurse leaders. Studies could be carried out to test this assumption. The relationship between leadership style and leadership effectiveness was not investigated in this study but may be worth examining in the political arena.

The leadership characteristics identified in this study are mainly developed from the perspective of the nurse leaders. The effectiveness of certain attributes and styles could also be evaluated from the perspective of those who work with leaders. Future studies could include other key persons, such as followers, in the evaluation of leadership attributes and styles in order to develop a better understanding of certain attributions.

Leadership effectiveness

This study suggests that to understand leadership effectiveness, the focus should be shifted from the attributes of leaders to attributes of followers. A more follower-centred approach as an alternative to the existing leader-centred approach should be adopted in leadership study to gain a better understanding of how followers could shape leadership behaviour. Studies could be carried out to identify the essential qualities of effective followers in nursing. The information could help nurse leaders to cultivate effective followers.

This study suggests nursing should develop more political leaders. Future research could focus on comparing similarities and differences between political leaders and organisational leaders in their leadership roles, styles or attributes. Furthermore, research is needed to determine the most effective leadership role in the policy-making arena. These findings could have implications for the education preparation of people who will be taking up leadership roles.

The outcome of the reform was used by this study as a criterion for evaluating the effectiveness of nurse leaders in the process of nursing education reform. However, Rosenbach and Taylor (1998) commented that the outcome of the leadership process might not be the only reliable assessment of leadership effectiveness, as the quality and worth of leadership was not measured solely in terms of achievement. Other criteria, such as the followers' effort and commitment, could be taken into account. Bass (1991) also commented that

overemphasis on goal achievement might undermine other achievements of nurse leaders, especially some variables related to transformational leadership such as improvement of group cohesiveness and satisfaction. Future study could use multiple criteria to evaluate leadership effectiveness.

Research methodology

A case study with both quantitative and qualitative methods was used to examine the research questions from different perspectives. The case study method produced a comprehensive and holistic understanding of nursing leadership behaviour in Hong Kong within its real-life context.

This study supported Denzin and Lincoln's (1994) view that complex meanings cannot be understood retrospectively, but required continuous attention through a case study. The prolonged engagement with the study participants, which is a key feature in case study, enabled the researcher to gain insights into multiple aspects of the nurse leadership process that might not be achieved without such continuous attention and engagement.

The use of multiple sources of evidence in this study: documents, interviews and questionnaires, yielded rich data that uncovered a wide array of variables influencing leadership behaviour and provided a rich detailed portrait of the leadership roles. This study demonstrated that the use of multiple sources of evidence improved the accuracy and overall quality of the data.

One of the data collection methods in this study was a questionnaire survey. Bond (1996), when describing his experience of using a questionnaire to study leadership, commented that Chinese respondents tended to choose central categories on rating scales in order not to take up extreme positions. However, this did not happen in this study. Respondents generally had an opinion on nurse leaders' behaviour. This might be related to the fact that the questionnaire was anonymous and the researcher was not a member of their

work place. The questionnaire survey used in this study that evaluated leadership performance through five sub-scales was quite successful in measuring different aspects of leadership performance. It is possible that this questionnaire may also be used to evaluate nursing leadership performance in other areas. Further development and testing of the questionnaire may be warranted.

An integrated leadership model developed from this study supported Yin's (1994) assertion that a case study method need not only be confined to descriptive study, but can also be used for theory building. Given the appropriate subject matter, context and research aims, the case study method with a multiple data collection approach is a credible methodology in leadership research that could be used to validate and build theory.

As this case study focused on nurse leaders' role in influencing the reform of nursing education, a similar method can be used to conduct research in other situations, for example, nurse leaders' role in health care reform in Hong Kong. It can increase nurses' understanding of the relationship among leadership behaviour, situations, power and followers in the political process.

The time frame of this study was from 1985 to 1995. As Hong Kong's socio-economic-political environment has been changing fast since 1997, there is a need to study the dynamics of a variable or phenomenon over time. Furthermore, given that nursing education reform is a continuing process and there is an increase in the awareness of nurse leadership development, a longitudinal study is needed to gain a better understanding of nurse leaders' behaviour over time.

Implications for nursing leadership development

Effective leadership in nursing can contribute to the advancement of professional goals and the improvement of health care services. In this study, while the potential of nurse leaders was demonstrated, this potential was not fully developed. Nursing has to determine the means of developing leaders who are able to achieve advancement in nursing. The following discussion highlights the implications of this study for nursing leadership development.

One of the barriers to nursing leadership effectiveness was the lack of opportunities for leadership development. In the past, leadership was a neglected area in the nursing curriculum and the restrictive nature of hospital-based training produced nurses with a narrow outlook. This study suggests that to improve leadership ability in nursing, nurses have to learn leadership skills. Furthermore, this study identified essential leadership roles and characteristics that are important for effective leadership and suggested that these could be developed through learning and experience. It is important to prepare future nurse leaders through education.

This study identified that professional role socialisation was a barrier to the development of nursing. Many of the problems identified at the time of this study had changed or were changing. However, many decades of exposure to the traditional culture in nursing have left their mark on a large number of nurses who are still in the workforce. These problems need to be overcome.

Due to the socialisation process, nurses generally use a passive and non-assertive style of communication, which has a negative effect on their leadership abilities. Studies showed that using an assertive communication style can help female leaders to overcome negative stereotypes commonly associated with submissiveness, weakness, and passiveness (Rosenbach & Taylor, 1998). Nurses need to develop assertive communication skills in order to be effective leaders.

One of the weaknesses of nurse leaders identified was that although they had a vision, they might not be able to communicate the vision to followers. To facilitate communication, appropriate channels should be created. Furthermore, nurse leaders did not have a clear plan for their vision. To be successful in making the vision come true, nurse leaders need a concrete plan.

Medical dominance was identified as a barrier to nursing education reform and it has to be overcome. To cultivate collaboration among health care professionals, multi-professional education is advocated, in which different student groups, for example, medical, nursing, pharmacy, and physiotherapy, undertake shared learning in their basic education (Glen, 1997). At present in Hong Kong, the education of health care professionals is undertaken separately. Doctors have long been educated in universities while nurses are mainly trained in an apprenticeship system. Students from different disciplines rarely see each other in their basic education. As a result, the learning and the work of students are divorced from each other.

The main advantage of multi-professional education is to enable students to develop mutual respect for other professional groups and a greater understanding of their professional roles (Maslin-Prothero and Masterson, 1999 and Glen, 1997). It is a way to promote positive socialisation among health care professionals and thereby reduce medical dominance. Maslin-Prothero and Masterson suggested that learning alongside medical students could help destroy the mystique of medical knowledge and power. Through such a programme, the interdependent roles of the different professions could be explored. Glen maintains that if the ideas of collaborative practice were developed in the early socialisation of health care professionals, mutual respect, understanding, and collaboration among professionals could be enhanced in practice after they graduated. A multi-professional approach in the education of health care professionals in Hong Kong may help address many of the issues identified by this study.

Professionalisation has been suggested as a means to overcome medical dominance (Schwirian, 1998). However, the previous chapter concludes that the lack of autonomy in nursing hampers nursing professionalisation. The public views nurses as subservient to doctors. To overcome this barrier, nurses have to develop their unique roles and functions. In Western countries, the literature concerned with nursing functions that are independent of the doctors is growing (Fagin, 1992). The shift of focus of health care from curing to caring, and from treatment of illness to health promotion, has given scope for nursing to expand their autonomous role (Schwirian, 1998). Nurses in Hong Kong have to consider ways to develop unique and autonomous nursing roles.

This study showed that nursing was fragmented and nurses perceived themselves as powerless to influence. Nurses in the past never projected a powerful image to the public. To increase nurse leaders' abilities in influencing, they have to develop their power base through collective work and unity.

Nurses historically did not realise the importance of political participation in implementing professional ideals. However, Tong (1994) suggested that physical access to institutionalised political power is necessary for social change. To exert greater influence, nurses have to continue to demand increased representation in the political system. Shaver (1999) maintained that politics was not an individual activity, and politicians were team players. More nurse leaders are needed in the political system to increase their influence.

Recommendations to improve nursing leadership

1. *Pre-registration nursing education in Hong Kong should be upgraded to university degree level.*

A university setting provides a less restrictive environment for nursing education, allowing space for students to develop skills, such as critical thinking and independent thinking, which are essential to leadership development.

2. *The pre-registration nursing education curriculum should have a greater focus on policy, evidence and communication to foster leadership development.*

Knowledge of the cultural, economic and political forces in the environment is required for nurses to identify key persons and plan strategies to influence Government policy. An understanding of the political and organisational context would facilitate students to analyse issues arising from the context. It is also important for nursing students to develop skills in observation, the ability to gather and interpret evidence, reflection, and judgement in relation to understanding of the context. Furthermore, nursing education programmes should aim at developing communication and assertive skills in students, which are essential for leadership development. Apart from knowledge acquisition, nursing students should be encouraged to experiment with innovations, take risks and learn in an environment of trust to ensure that leadership skills and characteristics are developed at the early stage of professional life.

3. *Education opportunities should be offered at post-registration level to prepare registered nurses to take up leadership roles.*

Education programmes can be offered at post-registration level to prepare registered nurse for a leadership role. Shaver (1999) proposed that it is preferable to recruit candidates who are sponsored by their employers to take a post-graduate leadership course, rather than accepting people who

independently applied for the courses. By having sponsorship, the candidates have an immediate need to learn and apply leadership skills. Such an approach is appropriate for developing a post-graduate level nursing leadership programme in Hong Kong.

4. *Nurses' responsibility toward the profession should be cultivated in their early period of professional socialisation through education.*

Nursing students should be encouraged to become members of nursing professional organisations and to participate in activities related to professional development. If nurses are committed to their profession and participate in professional activities, the political power of nursing can be strengthened.

5. *Hong Kong should consider a multi-professional approach in the basic education of health care professionals.*

Where university level education for different health care disciplines are well established, a multi-professional undergraduate porgramme may be feasible and an effective strategy for the future. Inter-professional collaboration may be successfully promoted and a more equal relationship between health care professionals the outcome in the long term.

6. *Nurses should be proactive in expanding their role in health promotion and illnesses prevention in the community to strengthen their unique contribution and reduce medical dominance.*

Nurses can develop a more autonomous role in community care and pilot independent practice. For example, there is an increase in the population of older people and people with chronic illnesses in Hong Kong that require nursing care in the community rather than medical treatment in the hospitals. To establish nurses' autonomous role in these areas, nurses have to develop a firm base of knowledge through research.

7. *A climate which cultivates collegiality and trust among nurses, needs to be actively promoted in nursing, for example by nurse leaders involving followers in planning and implementing actions.*

A trusting climate can help to foster a collaborative and collegial relationship between leaders and followers and overcome undesirable effects caused by the traditional hierarchial relationship in the health care system. Followers will then feel that they are respected and have the power to influence decision-making. This will promote a sense of trust between followers and leaders.

8. *Nurse leaders should work together with followers to achieve consensus on the direction of education reform.*

With a shared vision which is developed collectively, nurses will be motivated and mobilised to work towards the goal. As it was not considered feasible to have a complete transfer of nursing education to degree level in a short period of time in Hong Kong, nurse leaders have to reach agreement with the nursing community on a plan to phase out the hospital-based training and to increase university degree places.

9. *More effective channels of communication have to be created between nurse leaders and followers*

Consultative meetings could be held periodically between leaders and followers, and newsletters could be used as a channel for dissemination of information. These actions could facilitate communication and a more open and collegial relationship between nurse leaders and followers.

10. *A consortium of the nursing groups in Hong Kong should be formed to generate and direct actions with more collective power.*

Given the diversity of settings in nursing practice, it is inevitable that different professional groups are formed to represent the particular interest of their members. Nurse leaders can increase their power base by improving unity in nursing and work in a consistent way towards the goal.

11. *Nurses should adopt strategies that demonstrate to the public their contribution to health care of the community, including use of the media, community involvement and political action.*

The nursing LegCo members, by virtue of their legitimate positions, have contact with the Government so could attract media attention. They are in good position to speak on behalf of nurses. Some useful strategies include becoming part of community groups with policy interests; speaking up or writing to the media on public policy issues; and lobbying the Government officials for their support to achieve the needed changes in health care delivery. In this way, nurses' voices can be heard more frequently in the wider health care arena. Nurse leaders have to be more active in informing the public about the independent contributions of nurses in order to change the stereotype image of nurses as subservient to doctors.

12. *Nurse leaders can increase their political power by the formation of coalitions with other groups whose interests are congruent with those of nursing.*

For example, networking with Patient's Right Group, which is a consumer group, could help improve communication between professionals and consumers as well as in shaping policy around health care needs of the society.

13. *The establishment of a political action arm of Hong Kong's nursing professional organisation should be considered as a vehicle for increasing the involvement of nurses in political participation.*

Nursing in Hong Kong needs more political leaders to be team players and for this to be achieved they have to sharpen their political skills and accept the necessity of 'being political'. To increase political involvement, effective links to legislators and Government officials have to be formed as well. One of the ways is for the nursing professional organisation to have a political action arm that has the power to speak for nursing on political matters, such as the 'Nurses for Political Action' unit of the American Nurses Association. This unit communicated directly with government officials in regard to nursing

development (Marriner-Tomey, 1993). The formation of such a political action arm in Hong Kong may concentrate nursing's strength in speaking on political matters through a channel that is effective.

Nursing leadership is a new area of professional development for nurses in Hong Kong. It seems that with the increase in self-awareness and educational opportunities, nursing should be able to develop nurses who are more capable, more powerful and more willing to take up leadership roles and promote nursing professional development in the future.

Limitations of the study

This study focused primarily on the perceptions of nurses in top-level leadership positions in Hong Kong. Informal leaders, such as opinion leaders, were not included. More input from all those with whom the nurse leaders interact - peers, other health care professionals, and policy makers - would be needed for a more comprehensive study in this area.

In the questionnaire survey, respondents were asked to evaluate the performance of nurse leaders as a whole. The performance of individual leaders was not investigated. A portrait of individual leaders might have provided a more accurate picture of their performance. In-depth interviews of followers may be required to produce a more detailed evaluation.

This was a retrospective design in which parts of the data were collected from informants' self-report. The informants' recollection of past events may not have been accurate. A prospective design, with observation or field study, would have overcome the problem and provided a more accurate view of a particular nurse leader's role and function.

This study focused on nurse leadership in nursing education reform from 1985 to 1995. Replication of this study may be difficult as it was undertaken during a period of unusual change in Hong Kong. Further studies in nurse leadership and in diverse substantive areas are needed to see whether or not the findings of this study could be generalised.

Final remarks

The changes in the current health care system and the increasing demand for cost-effective health care services present new demands for nurses. Nurses are not only required to care for the patients in hospitals and the community, they also have to be able to manage resources, propose and influence health care policy. The leadership potential of nurses, the largest professional group in the health care system, should be developed and utilised more effectively.

This study identifies the key issues and problems associated with nursing leadership in Hong Kong. Recommendations are provided for the enhancement of nursing leadership development, and means for overcoming the identified problems.

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APPENDIX I

LIST OF THE DOCUMENTS REVIEWED

December, 1985	Newsletter, Association of Government Nursing Staff (AGNS): Proposal of the complete transfer of nursing education to tertiary level
February, 20 1987	Letter to the Hong Kong Polytechnic from Dr. K.L. Thong, the Director of medical and Health Department
March 18, 1988	South China Morning Post: Letter to Editor: Train nurses in university (RN C.K. Chu)
August 26, 1988	Hong Kong Standard: Board gives okay for nursing course
October 7, 1988	Ming Pao: No nursing representatives on the Provisional Hospital Authority
November 14, 1988	Hong Kong Economic Journal: Mr. James O'Mullan states that with the construction of new hospitals and expansion of existing ones, the shortfall in nurses will amount to 1800 in 1995.
December 17, 1988	Hong Kong Standard: Nursing honours degree plan gets wide support
December 18, 1988	Sing To Daily: The development of nurse education is far behind other countries
January 7, 1989	Newsletter, Association of Government Nursing Staff (AGNS), Letters to Editor: Professional standard of training needed for nurses (Rubbya Hassan, Chairman of Education Sub-committee, AGNS)
January 11, 1989	Newsletter, Association of Hong Kong Nursing Staff (AHKNS), Mr. Ronald Chow raised questions in the LegCo Meeting, vol. 17, p.16.
January 11, 1989	South China Morning Post: Leaders call for nursing overhaul
January 12, 1989	Hong Kong Standard: No to nursing degree
January 17, 1989	South China Morning Post: Support for nursing degree call
January 23, 1989	Hong Kong Standard: Decision on nursing degree in April
January 25, 1989	South China Morning Post: Letter to editor: Deserving better (Mr. T.S. Chan)

January 31, 1990	South China Morning Post: Program of training supported
April 25, 1990	South China Morning Post: Approval likely for nursing degrees
August 26, 1990	South China Morning Post: Strong demand at Polytechnic for degree courses in nursing
January 13, 1991	Hong Kong Standard: Nursing Board received 'no-confidence' vote
May, 1992	Report of the Hospital Authority Working Group on Nursing Education – Future direction of nursing education, Part I: Basic Nursing Education
July 25, 1992	Position Paper, The future of nursing education in Hong Kong' College of Nursing, Hong Kong
September 7, 1992	South China Morning Post: Nursing degree dilemma (Ms Fiona Lau)
September 9, 1992	Sing Tao Daily: UPGC urged Hong Kong Polytechnic to cancel their plan of cutting student places in the degree programme in nursing
September 30, 1992	Ming Pao: The future of degree nurses
February 8, 1993	Ming Pao: Nurses training cannot keep pace with society's needs
April 19, 1993	Hong Kong Economic Journal: Professionalization and degree education can help to improve manpower wastage
May, 1993	Report of the Hospital Authority Working Group on Nursing Education – Future direction of nursing education, Part II: Post-basic Nursing Education
May 12, 1993	Ming Pao: No money for the nursing degree programme
May 14, 1993	Education Supplement of Hong Kong Standard: LegCo plans to set up nurse degree courses
October 7, 1993	Governor's Policy Address
November 2, 1993	Ming Pao: What kind of health policy did the Government have? (Mr. Michael Ho)
November 29, 1993	Letter to the Task Force (Dr. W.H.P. Lewis, Dean Faculty of Health and Social Studies, Hong Kong Polytechnic)
November 29,1993	Letter to the Task Force (Chairman of Medical Sub-committee, University and Polytechnic Grants Committee)

December, 1993	Report of the Working Group on Education Policy of the Strategic Planning Group of the Nursing Board of Hong Kong
February, 1994	New Direction in Nursing Education: Advice of the Medical Services Development Committee
May, 1994	Newsletter, Association of Hong Kong Nursing Staff (AHKNS): The Association met the Secretary for Education and Manpower Planning to discuss the finance for nursing degree
May, 1994	Special Release, Association of Hong Kong Nursing Staff (AHKNS): The HA (Hospital Authority) promised to support nursing degree place to 200
May 9, 1994	Sing Pao, Sun Pao, Eastern Daily, ManHo Daily, Hong Kong United Daily: Nurses Petition to the Governor for more degree places
June, 1994	Work Report from November 1993 to November1994: Michael Ho met members of UPGC to inquire the progress of launching nursing degree programme
September 4, 1994	An Open Letter to the Governor to urge the UPGC to give financial support for Degree places as promised in October 1993
October 7, 1994	Ming Pao: The HKU could have degree programme for nurses in 1996
October 19, 1994	Official reply from the Government regarding tertiary nursing education
December 6,1994	Wah Kiu Daily: Michael Ho urged the Government to increase degree places for nurses
January, 1995	Newsletter, Hong Kong Society for Nursing Education: Task Force for Promoting Tertiary Nursing Education
March, 1995	The 1995-96 Budget Prosperity through consensus: The distribution of nursing degree programme 1995-98 (Second Reading of the Appropriation Bill, 1995, p.31)
March 17, 1995	Ming Pao: HKU will use its own resources to launch degree programme in 1995
December, 1995	Nursing Update HAHO Nursing Section Communiqué, Hospital Authority: Targets By the Year 2000

APPENDIX II

LETTER TO ASK PERMISSION TO REVIEW DOCUMENTS

Ms/Mr
Position
Address

PERMISSION TO REVIEW DOCUMENTS

Dear Ms/Mr _____,

I am a lecturer at the Hong Kong Polytechnic and currently enrolled for the degree of Doctor of Philosophy in Oxford Brookes University in the United Kingdom. I am researching into the issue of nurse leaders' involvement in the reform of nursing education in Hong Kong as part of my PhD thesis. I write to ask your permission to review the minutes/reports of _____. The purposes of the document review are to understand factors influencing the policy making process in nursing education and the people influencing the policy.

All the information obtained will be used in my study only and will be kept confidential. The source of the information will not be associated with the results in any way.

I hope permission would be given for me to review the documents. I hereby attach the research proposal of this study for your reference. Please contact me via phone (766 6423) for any query. I am looking forward for your reply. Thank you very much for your support in advance.

Yours sincerely,

Sally Chan
Lecturer
Nursing Studies Section
Hong Kong Polytechnic University

APPENDIX III

INTERVIEW GUIDE

Nurse leaders

What were the significant changes in nursing education policy in the past ten years?
How were changes in nursing education initiated?
Who initiated the changes in nursing education?
Why such change is necessary?
What are the factors influencing the change process?
Who are the persons that influence policy making in nursing education?
How did you participate in this change?
What are your role in the nursing education reform?
What should be the future direction of nursing education?

Government officials, officials from UPGC and tertiary institutes, politicians.

Is there any significant changes in nursing education policy in the past ten years?
How were changes in nursing education initiated?
Who initiated the changes in nursing education?
Why were changes initiated?
What are the factors influencing the change process?
What is the policy regarding the transfer of nursing education?
Who are the key persons influence the making of policy?
What should be the future direction of nursing education?

APPENDIX IV

LETTER TO ASK PERMISSION TO CONDUCT INTERVIEW

Ms/Mr
Position
Address

PERMISSION TO CONDUCT INTERVIEW

Dear Ms/Mr _____,

I am a lecturer at the Hong Kong Polytechnic and currently enrolled for the degree of Doctor of Philosophy in Oxford Brookes University in the United Kingdom. I am researching into the issue of nurse leaders' involvement in the reform of nursing education in Hong Kong as part of my PhD thesis. I write to ask your permission to conduct an interview with you. The purposes of the interview are to understand your perceptions on the present status of nursing education and the strategies that you have used to influence nurse education policy making.

The interview will be tape-recorded. All the information obtained will be used in my study only and will be kept confidential. Your name will not be associated with the results in any way.

I hope permission would be given for me to conduct the interview. I hereby attach the research proposal of this study for your reference. Please contact me via phone (766 6423) for any query. I am looking forward for your reply. Thank you very much for your support in advance.

Yours sincerely,

Sally Chan
Lecturer
Nursing Studies Section
Hong Kong Polytechnic University

APPENDIX V

QUESTIONNAIRE SURVEY ON NURSING LEADERSHIP (WITH COVER LETTER)

QUESTIONNAIRE ON NURSING LEADERSHIP

I am an Assistant Professor at the Hong Kong Polytechnic University and currently enrolled for the degree of Doctor of Philosophy in the School of Health Care Studies, Oxford Brookes University. I am researching the issue of nurse leaders' involvement in the development of nursing education in Hong Kong as part of my PhD thesis.

I would appreciate your assistance in providing me with information by filling in this questionnaire. All the information obtained will be used in my study only and will be kept confidential. You name will not be associated with the results in any way.

Thank you in anticipation for your time and interest.

Yours sincerely,

Sally Chan
Assistant Professor
Department of Health Sciences
Hong Kong Polytechnic University

Questionnaire No

QUESTIONNAIRE ON NURSING LEADERSHIP

Section 1
Please fill in your responses or circle the appropriate responses:

a. Sex
   (a) Female
   (b) Male

b. Age

c. Rank
   (1) EN
   (2) RN
   (3) NO
   (4) Ward Manager
   (5) SNO
   (6) DOM
   (7) Others (please specify)

d. Years of experience (excluding training)

e. Current Area of practice
   (1) Clinical
   (2) Education
   (3) Management
   (4) Others (please specify)

f. Place of work
   (1) Baptist
   (2) Caritas
   (3) Prince of Wales
   (4) Pamela Youde Nethersole
   (5) Princess Margaret

g. Are you taking any educational programme now?
   (a) Yes
   (b) No (Please ignore question h)

h. Current level of study
   (a) Diploma in Nursing
   (b) Bachelor of Nursing
   (c) Post-graduate Diploma
   (d) Master degree
   (e) Doctoral degree
   (f) Others (please specify)

Section 2

Please circle the appropriate response (please circle only <u>one</u> responses unless specified):

a. What do you think should be the direction of future development in nursing education?
   (1) Remain as hospital based training
   (2) Transfer nursing education into tertiary institution gradually
   (3) Stop the hospital based training at once and transfer to tertiary institutions
   (4) Others (please specify)

b. Who do you regard as the nurse leader(s) in Hong Kong? (You can choose more than one option)
   (1) The Legislative Councillor elected through Health Care Constituency
   (2) The Senior Executive Manager (Nursing) in Hospital Authority (HA)
   (3) The Senior Planning Manager (Nursing) in HA
   (4) The Principal Nursing Officer of the Department of Health
   (5) The chairperson of the Nursing Board of Hong Kong.
   (6) The General Managers (Nursing)/Chief Nursing Officers in the hospitals
   (7) The chairperson of nursing associations/trade unions (please specify the name of the association/trade union)
   (8) Nurse academics
   (9) None of the above
   (10) Others (please specify)

c. Have you ever tried to express your opinion about the future development in nursing education to the nurse leaders concerned?
   (1) Yes (please ignore question e)
   (2) No (please ignore question d)

d. What is the channel that you have used to express your opinion to the nurse leaders? (You can choose more than one options)
   (1) Write to them directly
   (2) Talk to them directly
   (3) Through trade unions or professional organisations
   (4) Through participation in signature campaign
   (5) Through participation in petition, demonstration
   (6) Others (please specify)

e. Why did you **NOT** express your opinion to the nurse leaders concerned?
   (1) There is no use of doing so
   (2) I do not know the effective way to do it
   (3) There is inadequate channel
   (4) I have no time, energy, resource
   (5) It may have adverse effects on my career
   (6) There is no cause for concern
   (7) Others (please specify)

f. In what way(s) do you support the nurse leader(s)?(You can choose more than one options)
   (1) Express your support openly in meetings with nurse leaders
   (2) Express your support by writing to the nurse leader(s)
   (3) By making proposal to the nurse leader(s)
   (4) By working with nurse leader(s) to achieve the goal
   (5) Others (please specify)

Section III

The following statements are related to the development of nursing education policy in Hong Kong. Please indicate your opinion on each of the following statements by putting a tick in the appropriate box:

5	-	Strongly agree
4	-	Agree
3	-	No opinion
2	-	Disagree
1	-	Strongly disagree

	5	4	3	2	1
1. I am satisfied with the present hospital-based system of nurse education.					
2. The current hospital-based nurse education can adequately prepare nurses for today's nursing practice.					
3. The nurse leaders have established direction for the development of nursing education in Hong Kong.					
4. The nurse leaders show a willingness to make desirable changes in nursing education.					
5. The nurse leaders have adequately consulted nurses about the future direction of nursing education.					
6. The nurse leaders have actively invited opinions from the members.					
7. The nurse leaders have effectively communicated the future direction of nursing education clearly to nurses.					
8. The nurse leaders have motivated nurses to achieve the profession's goals in nursing education.					
9. The nurse leaders effectively resolve conflicts when they occur in the nursing groups.					
10. The nurse leaders get support and cooperation from nurses for the future direction of nursing education.					
11. The nurse leaders create coalition in nursing.					
12. The nurse leaders have acted as the spokesperson for the nursing profession.					

13. The nurse leaders have provided adequate support to individual nurses and nursing groups in attaining the goal of nursing education.					
14. The nurse leaders have made accurate decisions in the future direction of nursing education.					
15. The nurse leaders are able to decide on the actions in attaining the goals of nursing education.					
16. The nurse leaders are able to fulfil the society's needs of nursing services.					
17. The nurse leaders are able to convey information to nursing groups about the awareness of societal issues affecting nursing education.					
18. The nurse leaders are able to get other members of the health care team to act for the welfare of the nursing groups.					
19. The nurse leaders maintain cordial relations with other members of the health care team.					
20. The nurse leaders are able to relate to prominent persons in legislative, educational and governmental levels.					
21. The nurse leaders are able to bargain for needed human and monetary resources successfully.					
22. The nurse leaders have influenced the views and actions of co-workers and colleagues.					
23. The nurse leaders have taken necessary action in influencing nursing education policy.					
24. The nurse leaders have the power to influence policy making in nursing education.					
25. The nurse leaders are effective in producing desirable changes in nursing education.					

END

APPENDIX VI

LETTER TO ASK PERMISSION TO CONDUCT STUDY IN HOSPITALS

Ms/Mr
Position
Address

PERMISSION TO CONDUCT STUDY IN HOSPITAL

Dear Ms/Mr _____,

I am a lecturer at the Hong Kong Polytechnic and currently enrolled for the degree of Doctor of Philosophy in Oxford Brookes University in the United Kingdom. I am researching into the issue of nurse leaders' involvement in the reform of nursing education in Hong Kong as part of my PhD thesis. I write to ask your permission to conduct a questionnaire survey on nursing staff members in your hospital. The purposes of the survey are to investigate nurses' views on the present status of nursing education and their perceptions on nurse leadership related to reform of nursing education. 160 subjects in your hospital will be invited to fill in the questionnaire. They will be chosen by random sampling from the staff name list.

All the information obtained will be used in my study only and will be kept confidential. The name of the hospital and the subjects will not be associated with the results in any way.

I hope permission would be given for me to undertake this study. I hereby attach the research proposal of this study for your reference. Please contact me via phone (766 6423) for any query. I am looking forward for your reply. Thank you very much for your support in advance.

Yours sincerely,

Sally Chan
Lecturer
Nursing Studies Section
Hong Kong Polytechnic University

APPENDIX VII

CODING SCHEME OF THE INTERVIEW DATA

Core category	Category	Sub-Category	Code
Inertia	Socialisation of nurses	Repression	environ-restrictive environment edu-nurse educators' resistance high sal-thinking graduate nurses would have high salary little change-little change in nursing education policy manpower-use manpower as a reason for objection nodirect-no direction in policy no init-nurses have no initiation for change no need-senior nurses did not feel the need for degree education no plan-to concrete plan of how to transfer resist cha-nurses resist change senior nurse-resistance from senior nurses threat-perceive degree nurses as a threst
		Lack of unity	Coalition- difficult to form coalition consensus-difficult to get consensus lacuni-lack of political strength because of lack of unity rivalrytert-rivalry between tertiary institutes rivalrygp-rivalry between nursing groups
		Passive and dependent behaviour	apathy-nurses are apathetic to politics apathproforg-nurses were not willing to join professional organisation assert-nurses are not assertive diff fed-difficult to get feedback from nurses socioaware-social awareness was poor
		Poor image of nurses	cheaplabour-students are cheap labour in hospital consumsupp-image affect consumer's support handmaiden-nurses still handmaiden prior-nursing degree was not the priority
	Weak leadership in nursing	Weak NBHK	Leadeffect-leadership was not effective in NBHK Meddomnbhk-medical dominace in NBHK Narrowfocus-narrow focus on basic nursing education Noactive-not active in pushing reform Nodirect-no direction in policy Passlearole-passive leadership role Politweak-politically weak
		Weak profession associations	Membersize-membership size is small Politweak-politically weak
		Weak academic leaders	Diffclinical-difficult to influence clinical areas Lowqual-qualification is lower than other disciplines
		Weak clinical leaders	Obsolete-danger in obsolete GM(N)post Nodirect-no direction No init-nurses have no initiation

Inertia	Lack of education opportunites	Lack of political skills	Cannot art-nurse cannot articulate their needs Lac learnopp -lack learning opportunities lac know-lack knowledge on politics lang pro-nurses have language problems No barpow-nurses have no bargaining power
		Non-assertive behaviour	Assert-nurses are not assertive Passive-aggress-nurses use passive-aggressive behaviour Sensitive-nurses sensitive to docotr's comments system cre-system creates the present state of nursing
	Medical dominance	Medical dominance in health care system	doc conMH-doctors control Mhdept doc HA-doctors' control the HA doc connur-doctors control promotion of nurses doc reject-doctors reject nursing degree doc inser-doctors felt threatened by nursing degree domcomm-doctors were dominant in committees est ha-establish ha is not favourable to nurses
		Medical dominance in the Government	diff doc-difficult to lobby doctor domcomm-doctors were dominant in LegCo outnumber-doctors outnumber nurses in policy making committees status-doctors have higher status than nurses

Core category	Category	Sub-category	Code
Facilitation	Changes in political system	1997 issue	Braindrain-braindrain in HK because of political event Catalyst-catalyst for change Turnover-high turnover rate of nurses was high
		LegCo seat	Direct-channel for influence was more direct Turn point-the establishment of LegCo seat was a turning point for nursing education reform
	Changes in academic institutions	Increase degree numbers	Expand-govt expanded degree numbers Increasfund-govt increased funding in universities
		Support from Faculty of Medicine	Decrearesist-decreased resistance Survive-Faculty of Medicine had to increase student numbers to survive
	Changes in health care system	HA formation	Diffmanpower-Ha had different manpower requirement Flexibility-more flexibility in HA
		Resignation of senior nurses	Culturchange-cultural change in nursing Decrearesist-decreased resistance
		Shortage of nurses	Poorrecruit-poor recriutment of student nurses Turnover-high turnover rate of nurses was high

Core category	Category	Subcategory	Codes
Evolution	Establish goals	Vision	Believe-believe in vision Leadvision-leader must have a vision Longterm-leaders have to establish long term goal
		Establish direction	agenda-propose agenda for discussion in legco est direct-establish direction explain-explain to people the direction goteritary-nsg education should go tertiary gratransit-transition should be gradual
	Communicate direction	Communication with followers	comm inf-communicate in informal group to get support commun-communicate with nurses at frontline constaff-staff consultation discuss-discuss with nurses in meetings commedu-communicate through education explain-explain to people the direction invit opin-invited opinions from nurses know chan-leaders have to know the communication channel publish-publish newspaper to communicate student-communicate the direction to students talk-talk to nurses
		Communication with key players	com chan-establish communication channel comm inf-communicate in informal group to get support communpol-communicate the goal to policy makers comm & supp-communicate to get support from nurses explain-explain to people the direction justify-communicate the reasons for the needs of degree education legco co-communicate the issue in legco talk depart-talk to department talk gover-talk to governor writ gover-write to governor writ report-writing report to after consultation to influence write-influence by writing papers

Evolution	Increase power through unity	Collectivity	agree-get agreement within profession consen nsg- get consensus among nurses good rel-self maintained good relationship with nurses teamwork-leaders have to work as a team with others nurses united- try to unite the profession work union-work with union
		Collegialty	caring-teach nurses caring for each others considerate-leaders have to be considerate to followers constaff-staff consultation good rel-maintained good relationship with nurses mutual-have mutual goals respect-respect each others support-support nurses trust-build up trusting relationship Conseminar- collaborate with medical staff in conducting seminars trust-build up trusting relationship collamed-collaborate with medical doc power-fight against doctors power est role-nurses must establish their role ha support-lobby for ha support overmeddom- Overcome medical dominance
	Increase power through influence	Access	know chan-leaders have to know the communication channel knowpeo-know who is the right person to approach knowpolitc-know the channel for political participation

Evolution	Increase power through influence	Networking	work union-work with union friend-better make friends than enemies get sup-get support from followers good rel- maintained good relationship with nurses liaison-leader have to liaise with the profession to get support netpub-leaders have to establish network with public suppexchange-get support by exchange with other legco members
		Lobbying	Argue-argue with people in meetings to persuade brok record-use broken record technique Concession-sometimes made concession with the authority data supp-use data to support argument debate-engage in debate about the direction of nursing education in meetings fight back-fight back if people said you were wrong form led-lobby formal leaders infor led-lobby informal leaders infor met-lobby in informal meeting ha support-lobby for ha support govtoff-lobby government official justify-use reasons to justify your argument kisskick-use kiss and kick strategy lobpub-lobby public to support nursing weak-attack doctors' weakness
		Increase visibility	Press-increase visibility on press Press rel-maintain good relationship with press Pressure-give pressure to government Publicity-use publicity to increase visibility Radio-speak on radio

Evolution	Empower followers	Education	Brainwash-brainwash nurses broadknow-broaden nurses knowledge chan appli-give chances to nurses to apply what they learn communedu-communicate direction through education programme dev lead-develop nurses as leaders edu nur-educate nurses to upkeep encourage-encourage nurses to upkeep their knowledge, equip-equip nurse with knowledge est role-nurses must establish their role faciliate-faciliate change nur ed-influence nurses through education reducresist-reduce resistance
		Support and motivation	Advocate-leaders should act a advocate for nurses chan appli-give chances to nurses to apply what they learn Motivate-motivate nurses Suppchange-support change Supportedu-support nurses in continuing education get sup-get support from followers liaison-leader have to liaise with the profession to get support speak-get support by speaking in committees supp infor-get support from informal group

Evolution	Prepare self	Leadership attributes	Self-development conselfed-leaders have to continue their own education know hk-knowledge about hk know maker-know the policy makers know nsg-knowledge about nsg know pro-know the political process poli pro-leaders must know political process under sys-have to understand the political system believe-must believe it yourself before selling it to others Courage-leader must have political courage inter free-leaders must be interest free objective-objective opportunity-able to take opportunities optimistic-must optimistic about the future Model-leader must be able to act as model Persistent-persistent in pursuing the goal preser-preservation principle-leader must have principles in himself resist temp-leaders have to resist temptation right-do what you think is right risk taking – willing to take risk self- self-discipline
		Leadership styles	accept-accept opinion of others consider-considerate to staff democrat-democratic style informal-informal leadership style modsit-modify leader style according to situation open-open to opinions participative – participative style transform-transformational leadership style understand-leaders must try to understand others feeling