

The art of clinical leadership in contemporary nursing

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Philosophy

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

Acknowledgements

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

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

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

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

Statement of Authentication

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



Prelude

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

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

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

Thesis outcomes

Series of scholarly papers

1. Mannix, J., Wilkes, L., & Daly, J. (2013). Attributes of clinical leadership in contemporary nursing: an integrative review. *Contemporary Nurse*, 45(1), 10-21.
2. Mannix, J., Wilkes, L., & Daly, J. (2015). Aesthetic leadership: Its place in the clinical nursing world. *Issues in Mental Health Nursing*, 36(5), 357-361.
3. Mannix, J., Wilkes, L., & Daly, J. (2014). Pragmatism, persistence and patience: A user perspective on strategies for data collection using popular online social networks. *Collegian*, 21(2), 127-133.
4. Mannix, J., Wilkes, L., & Daly, J. Grace under fire: Aesthetic leadership in clinical nursing. *Journal of Clinical Nursing*, 24, 2649-2658.
5. Mannix, J., Wilkes, L., & Daly, J. (2015). 'Good ethics and moral standing': A qualitative study of aesthetic leadership in clinical nursing practice. *Journal of Clinical Nursing*, 24, 1603-1610.
6. Mannix, J., Wilkes, L., & Daly, J. 'Watching an artist at work': Aesthetic leadership in clinical nursing workplaces. *Journal of Clinical Nursing*, 24, 3511-3518.

Associated relevant publications during candidature

1. Mannix, J., Wilkes, L., & Jackson, D. (2013). Marking out the clinical expert/clinical leader/clinical scholar: perspectives from nurses in the clinical arena. *BMC nursing*, 12(1), 12.
2. Wilkes, L., Mannix, J., & Jackson, D. (2013). Practicing nurses perspectives of clinical scholarship: a qualitative study. *BMC nursing*, 12(1), 21.
3. Daly, J., Jackson, D., Mannix, J., Davidson, P. & Hutchinson, M. (2014). The importance of clinical leadership in the hospital setting. *Journal of Healthcare Leadership*, 6, 1-9.

Oral presentations

1. The art of clinical leadership in contemporary nursing. *College of Health & Science Research Futures Postgraduate Forum*. UWS (2010, June).
2. Clinical leadership: is it the panacea we all think? *Australian College of Mental Health Nurses Education Forum*. Cumberland Hospital, Parramatta. (2010, July).
3. Clinical leadership education in nursing: what is it offering? *CASN Nursing Academic Leadership Conference*. Quebec, Canada. (2011, May).
4. Clinical leadership in nursing: What does it mean? *The RCN International Nursing Research Conference*. Harrogate, UK (2011, May).
5. The art of clinical leadership in contemporary nursing. *Research Futures Postgraduate Forum*. UWS (2011, June).
6. Attributes of clinical leadership in contemporary nursing. *School of Nursing & Midwifery Research Futures Postgraduate Forum*. UWS (2012, June).
7. The art of clinical leadership in contemporary nursing: collecting data via the online world. *School of Nursing & Midwifery Research Futures Forum*. UWS (2013, June).
8. Strategies for Data Collection and Analysis Using the Online World: Trials and Tribulations. *Sigma Theta Tau International's 25th International Nursing Research Congress*. STTI. Hong Kong. (2014, July).
9. The art of clinical leadership in contemporary nursing: insights from experienced nurses. *School of Nursing & Midwifery Research Futures Forum*. UWS (2014, October).

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Abstract

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

The findings from these three data sources are presented as part of a series of six published papers in this thesis. The integrative review revealed, from a relatively small evidence base, attributes of clinical leadership have a clinical focus, a follower/team focus or a personal qualities focus; all attributes to needed to sustain supportive workplaces. The survey results indicated that the aesthetic leadership characteristics in clinical leaders most valued included being supportive and effective communication. Taking risks and challenging processes were least likely to be evident among clinical leaders. Analysis of the narrative data collected during the research revealed that advanced practice nurses in designated clinical leadership roles embodied aesthetic leadership, reflected in a strong moral compass that

shapes their practice. The data also revealed that when clinical leaders enact aesthetic leadership they are critically self-reflective and embrace core nursing values and beliefs. Through this type of leadership they convey a visible, composed role model that has a positive effect on the nursing workplace. From subsequent synthesis of these findings, and using of the symphony orchestra as a metaphor, a model of artful clinical leadership emerged. This model offers a new and different way of conceptualising clinical leadership in contemporary nursing. Using the established notion of levels of expertise, in much the same way as has occurred clinical nursing practice, this model identifies the qualities and attributes to be an artful concertmaster in the contemporary clinical nursing world.

Chapter 1:

Introduction

1.1. Framing the study

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

1.2. The art of nursing and aesthetics

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

As individual concepts, there is generally little confusion about what constitutes science in nursing, especially with the emergence and subsequent dominance of evidence-based practice from the latter decades of the 20th century. However, the same could not be said of the art of nursing. There has been a lack of clarity around the concept and its centrality to contemporary nursing practice, prompting nurse scholars to examine and synthesise the extant literature (Fingeld-Connett 2008, Johnson 1994). In an effort to provide some clarity, Fingeld-Connett (2008, p383) concludes that as a concept, the art of nursing involves nurses expertly using '*empirical and metaphysical knowledge and values*' sensitively and creatively to

enhance patient/client well-being. Such a description reflects the inherent difficulty in confining the art of nursing or artful nursing to a single construct. Some of this confusion is around how “art” is thought of in a nursing context. However, as Katims (1993) argues, “art” in nursing relates to expertly using a sound knowledge base to apply nursing skills creatively to caregiving, rather than taking “art” to mean an artistic object resulting from creative processes. This interpretation is true to the original Greek word ‘*techne*’, meaning skilfully created (Barry & Meisiek 2010, p332). For this artful nursing to happen, the required level of expertise necessitates professional maturity and would not be something present in nurses less experienced in the clinical practice setting.

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

It is evident that artful nursing and aesthetics transcends most areas of nursing clinical specialties from aged care (Sheets 2012) to critical care (Timmins 2011), through to areas of nursing with less direct hands-on patient contact, such as education (Cleary *et al.* 2013), management (Brown 1991, Hujala & Rissanen 2011) and leadership (Jackson *et al.* 2009). While there may be those who argue that it is

difficult to support the presence of artful nursing and aesthetics in non-clinical areas of nursing, there are those with a counter position, believing that nurses in education, management and leadership positions come to these positions as nurses and therefore retain, as the basis for their practice, the values and beliefs of nursing (Jeffery 2013). It is this latter position taken in this thesis.

1.3. Contemporary leadership styles in the clinical nursing world

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

The dominant leadership model offered in these professional development programs available to nurses across the world has been transformational leadership (Martin *et al.* 2014), possibly as a result of the widespread adoption and adaptation of the Royal College of Nursing’s (RCN) *National Nursing Leadership Programme*, informed by the transformational leadership model and offered from the early 2000s (Millward & Bryan 2005). This dominance is also evident in the nursing leadership research, with Cummings *et al.* (2010) reporting in a systematic review of leadership styles in nursing that 53% of studies reviewed focused on transformational leadership. Much of this empirical research highlights the benefits of this leadership model to nursing, providing valuable insights into leadership in the nursing workplace (Hutchinson & Jackson 2013). Transformational leadership has been identified as the preferred

leadership style by nurses (Andrews *et al.* 2012), championed for improving job satisfaction and team performance (Braun *et al.* 2012), and hailed as a panacea for ensuring more effective clinical leadership. However, transformational leadership is rarely evaluated for its effectiveness in the nursing workplace (Hutchinson & Jackson 2013). Other leadership models have been considered as having the potential to improve the nursing workplace and patient outcomes. These have included servant leadership (Jackson 2008), authentic leadership (Wong & Cummings 2009), ethical leadership (Makaroff *et al.* 2014), and congruent leadership (Stanley 2008). The attributes of clinical leaders utilising different leadership styles vary and are presented in *Chapter 2* of this thesis.

1.4. Who are the clinical leaders in nursing?

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

1.5. Aim of the study

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

1.6. Significance of the study

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

1.7. Structure of the thesis

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

Central to the study is the socio-political context in which contemporary clinical leaders practise their craft. Consequently, **Chapter one** has provided the contextual background to the study by discussing how clinical leadership is positioned and regarded in current health care organisations. The chapter has also outlined the leadership styles dominating the contemporary nursing discourse and how these styles have come to prominence in recent times. The discussion has also introduced

aesthetic leadership as an alternate leadership style suited to contemporary nursing workplaces. Finally, the chapter identified who are considered the designated clinical leaders in the current context. **Chapter two** is presented as the *first* in the series of published papers. The paper reports the findings of an integrative review that sought to uncover contemporary understandings of the defining attributes of clinical leadership in nursing. Presented as the *second* paper in the series, **Chapter three** explores the meanings of aesthetic leadership through a review of the leadership studies literature. The paper also critiques aesthetic leadership against two leadership styles specifically linked to contemporary clinical leadership in nursing. The paper concludes with a discussion of what aesthetic leadership could offer clinical leadership in the nursing workplace.

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

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

aesthetic leadership is enacted by clinical leaders a sense of calm and order can be created, even in the most complex and chaotic clinical settings.

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

Chapter 2:

Attributes of clinical leadership in contemporary nursing: an integrative review

2.1. Publication:

Mannix, J., Wilkes, L. & Daly, J. (2013). Attributes of clinical leadership in contemporary nursing: An integrative review. *Contemporary Nurse* 45(1), 10-21.

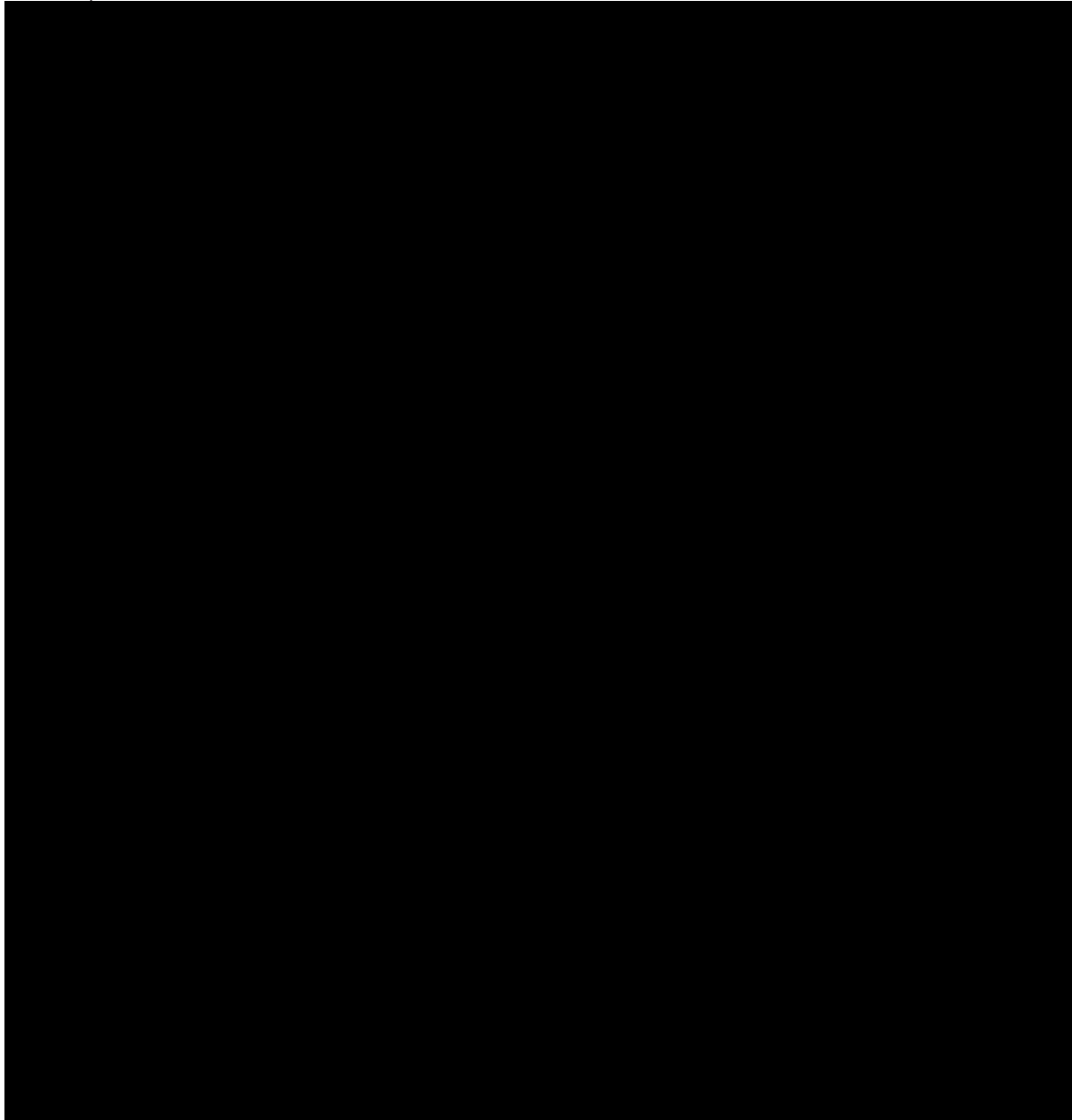
2.2. Relevance to thesis

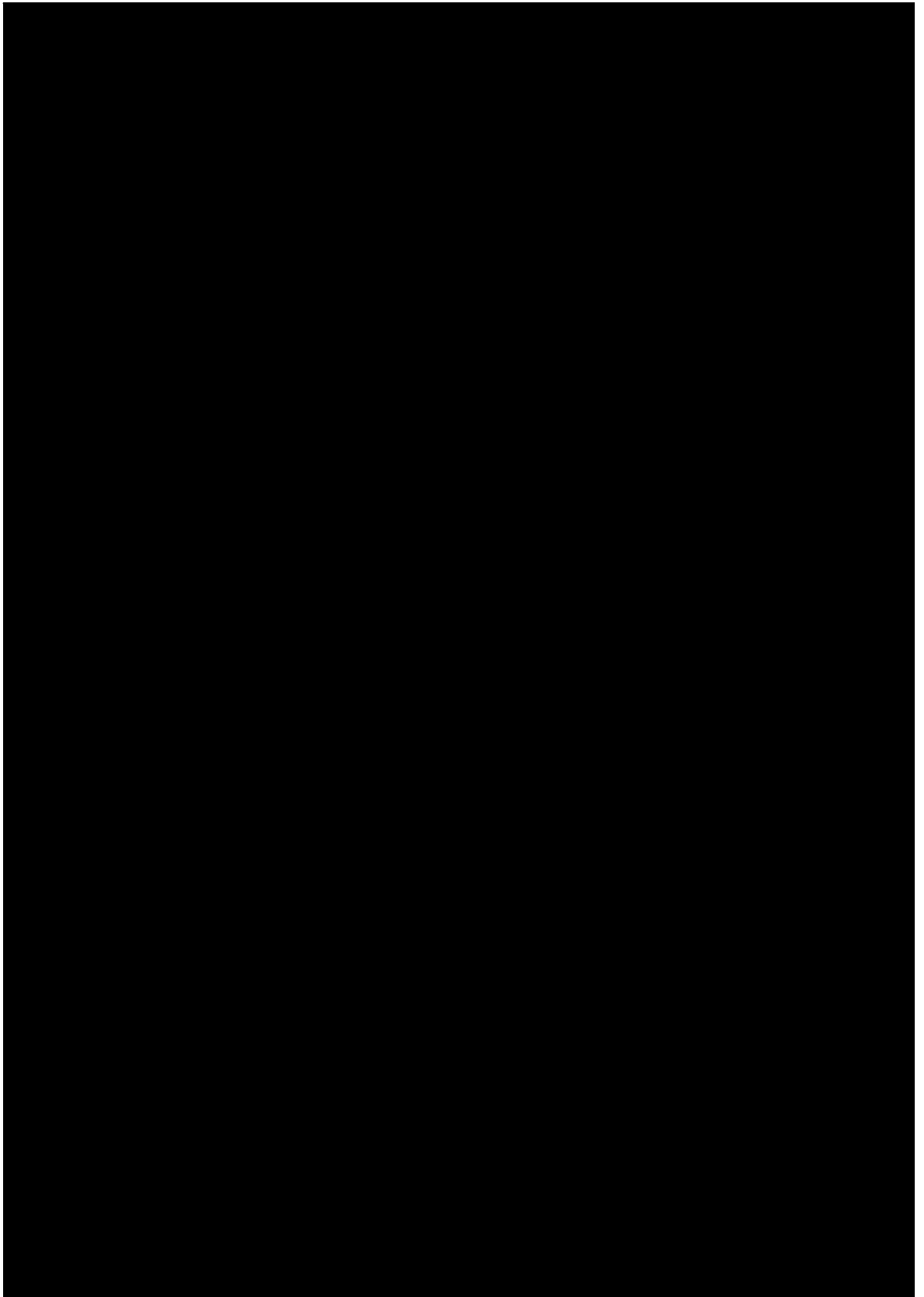
Realistically and logically, one cannot enter into a project without knowing what has gone before. Consequently, the first paper in the series involved an extensive review of the nursing literature to ascertain how clinical leadership had been defined, described and portrayed in recent times, based on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

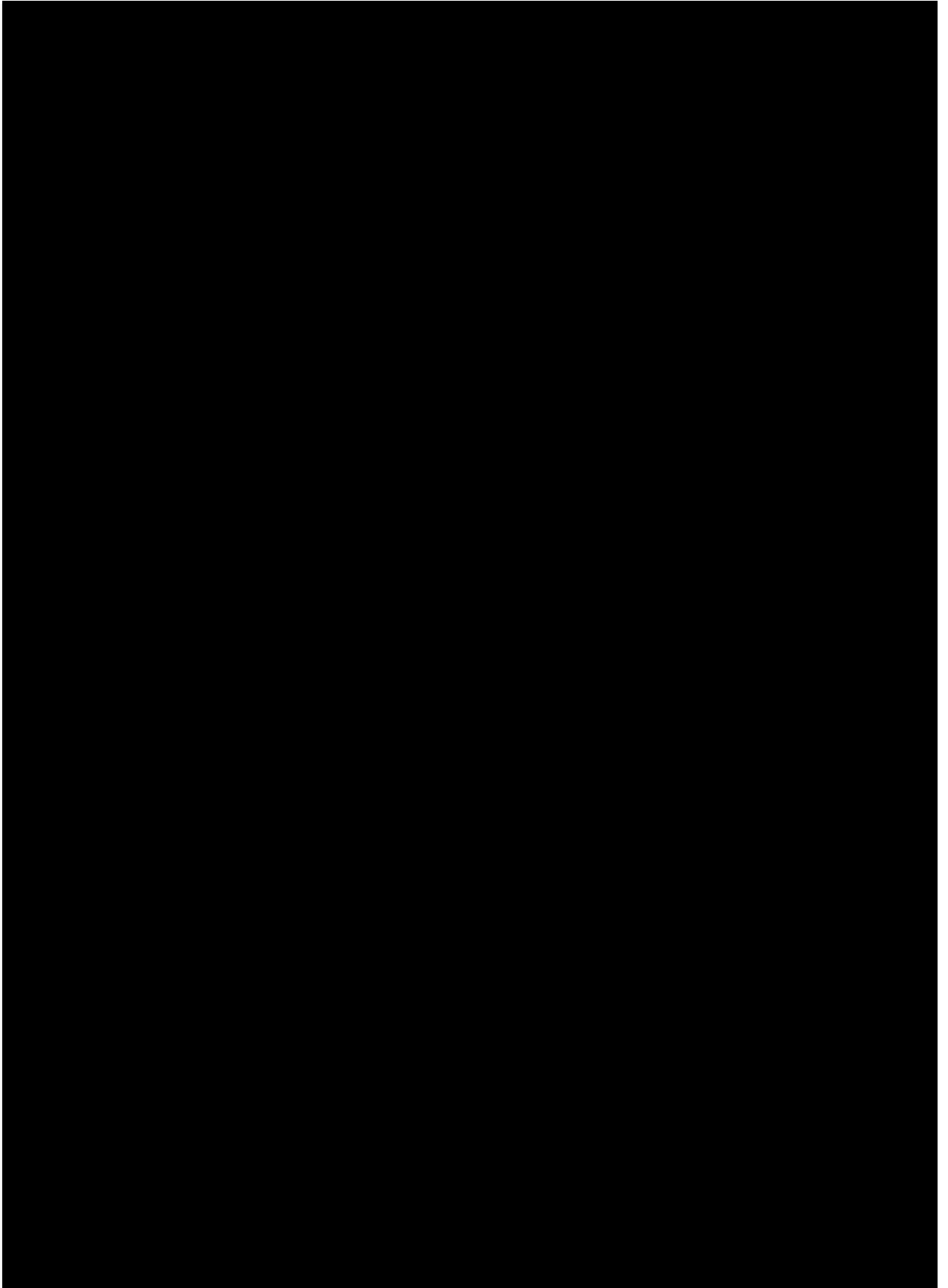
**Attributes of clinical leadership in contemporary nursing:
An integrative review**

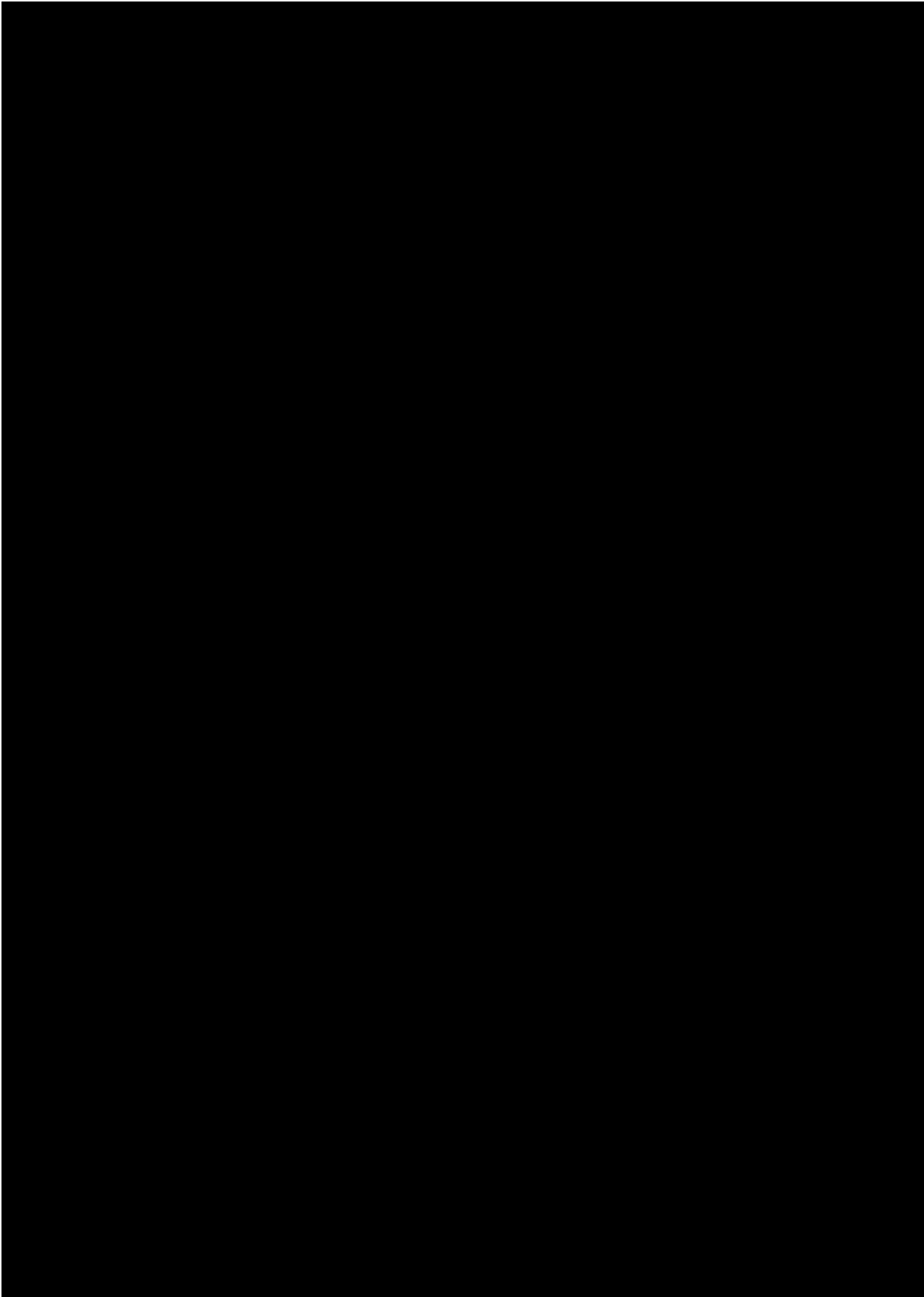
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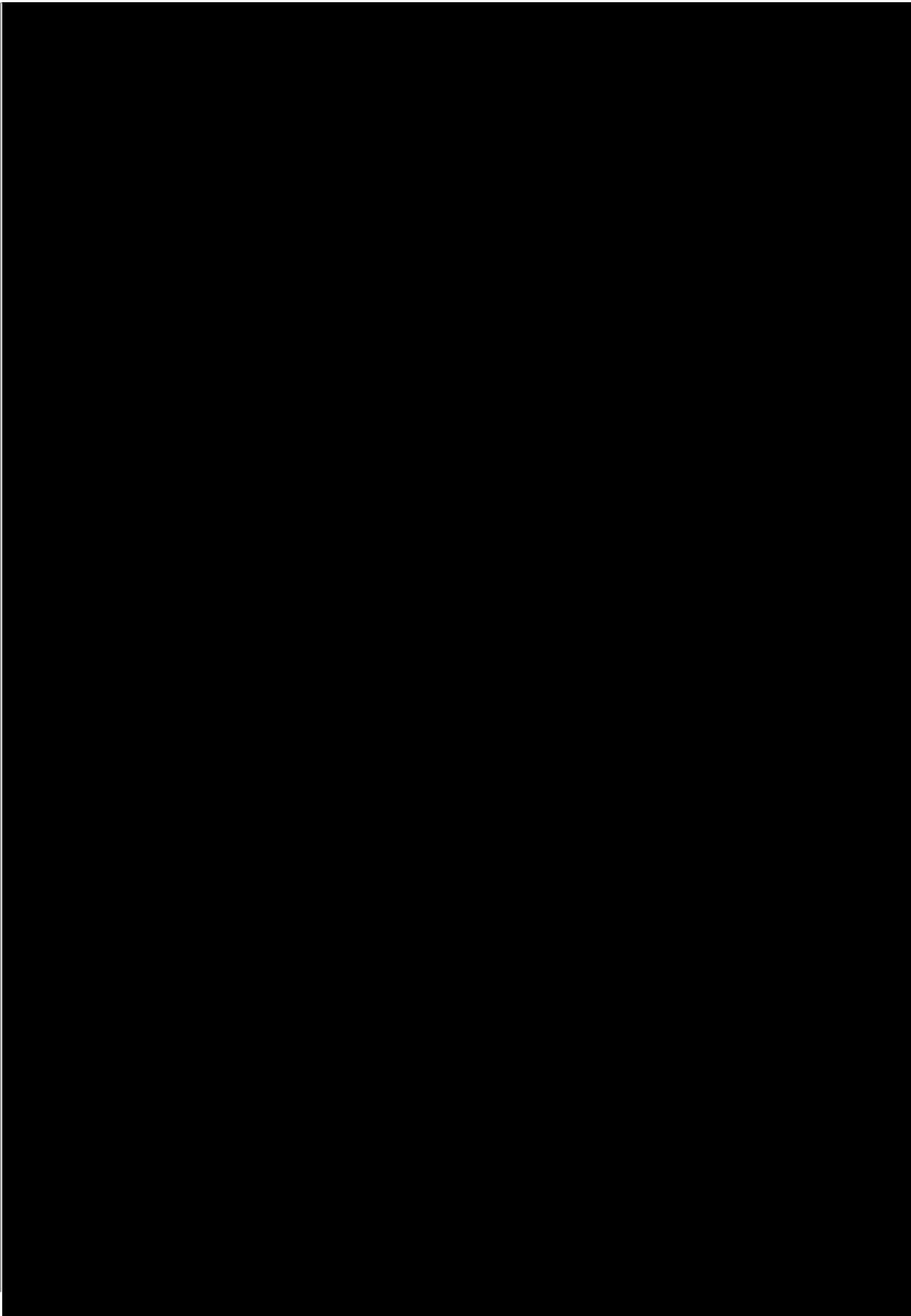
*School of Nursing and Midwifery, Campbelltown Campus, University of Western Sydney, Penrith, NSW, Australia; *Faculty of Health, University of Technology, Kuring-gai Campus, Sydney, NSW, Australia

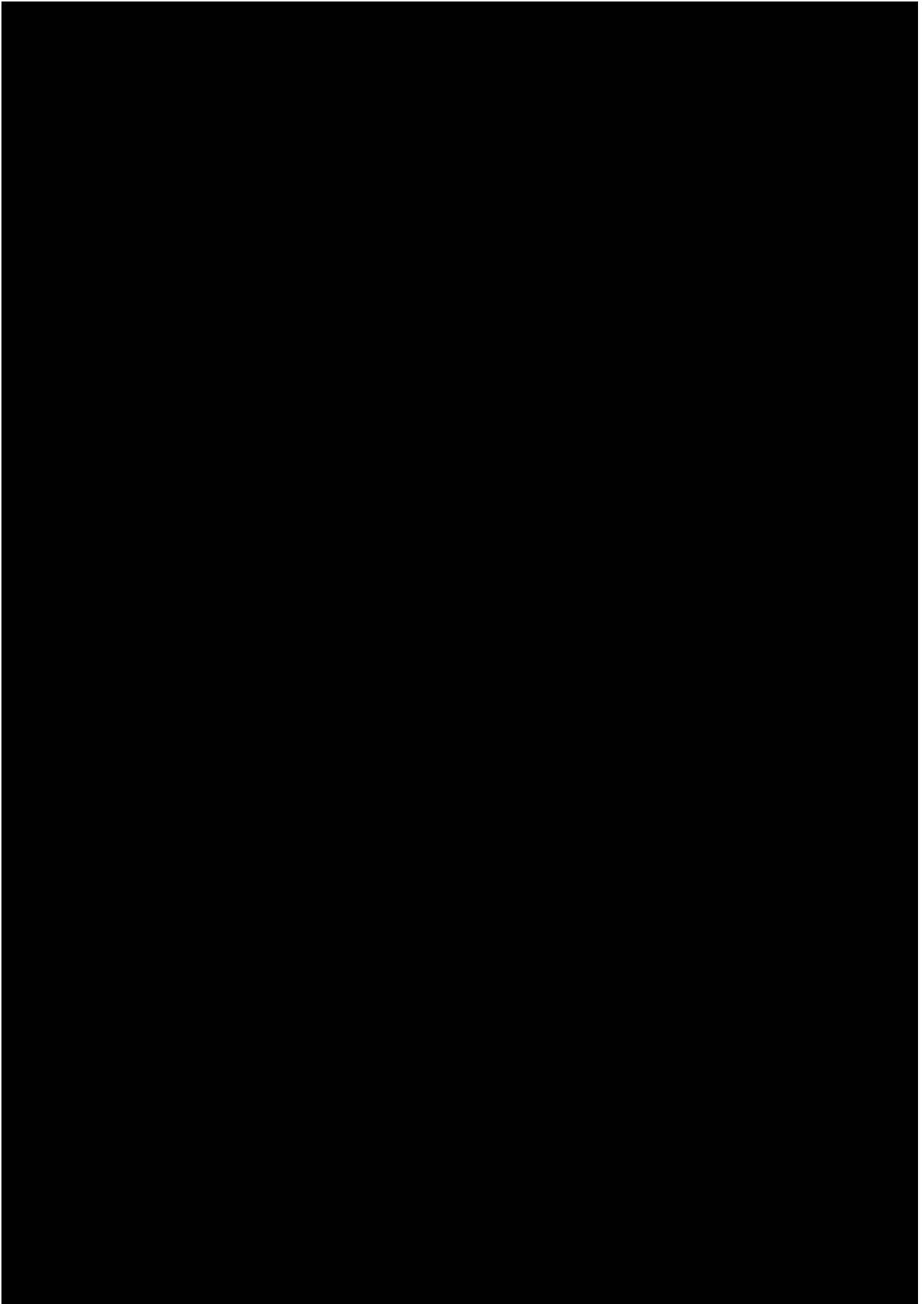


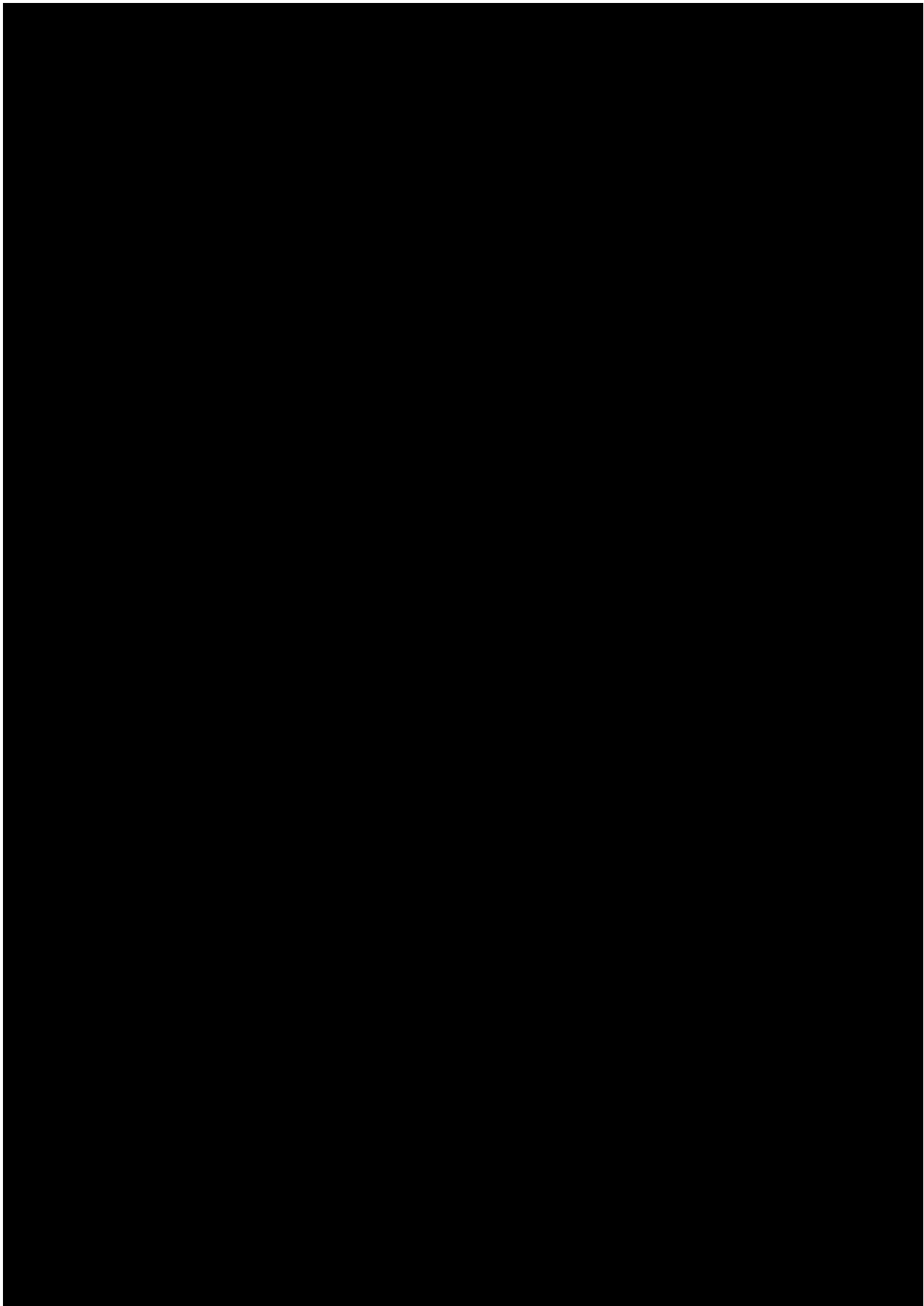


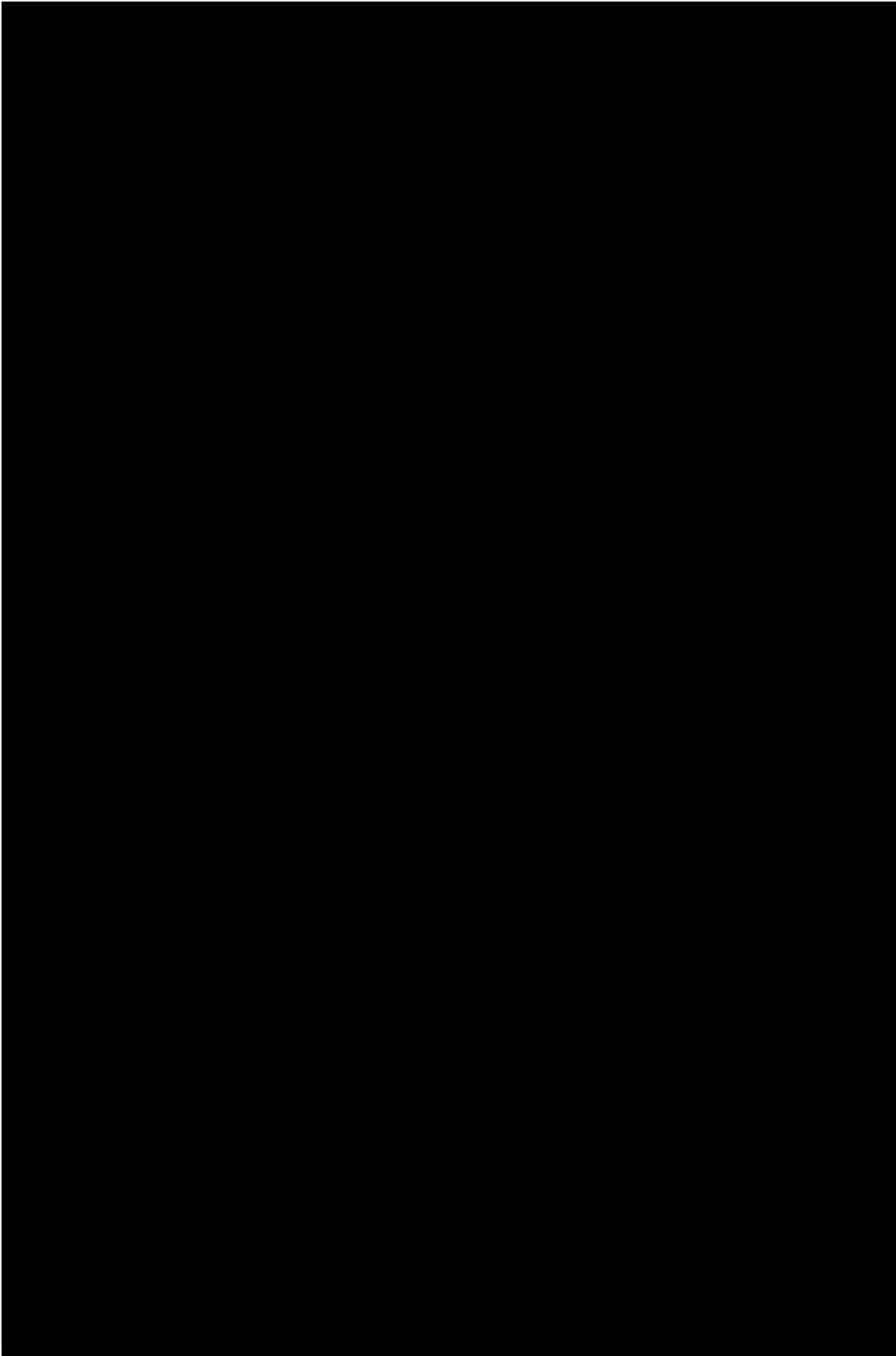


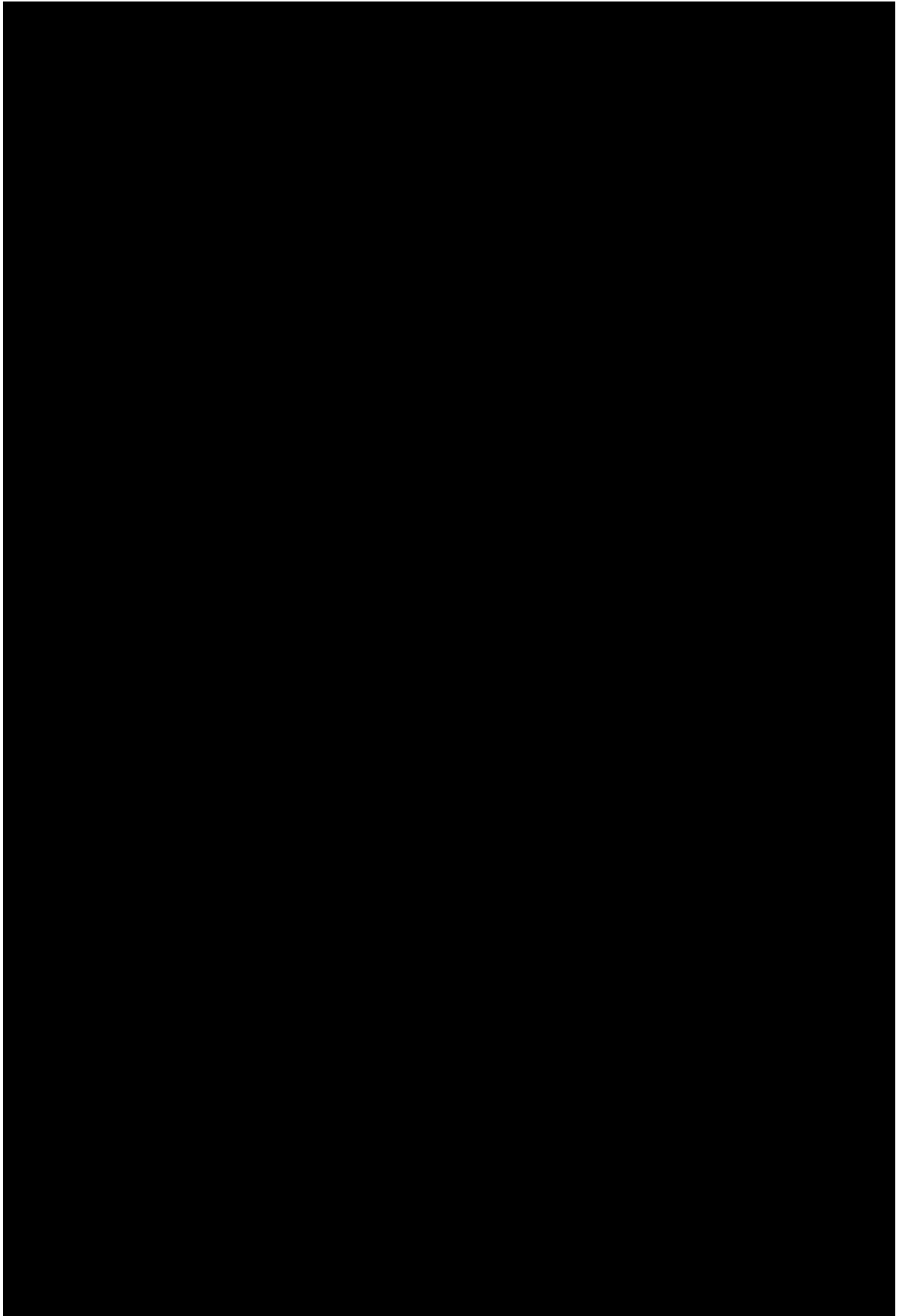


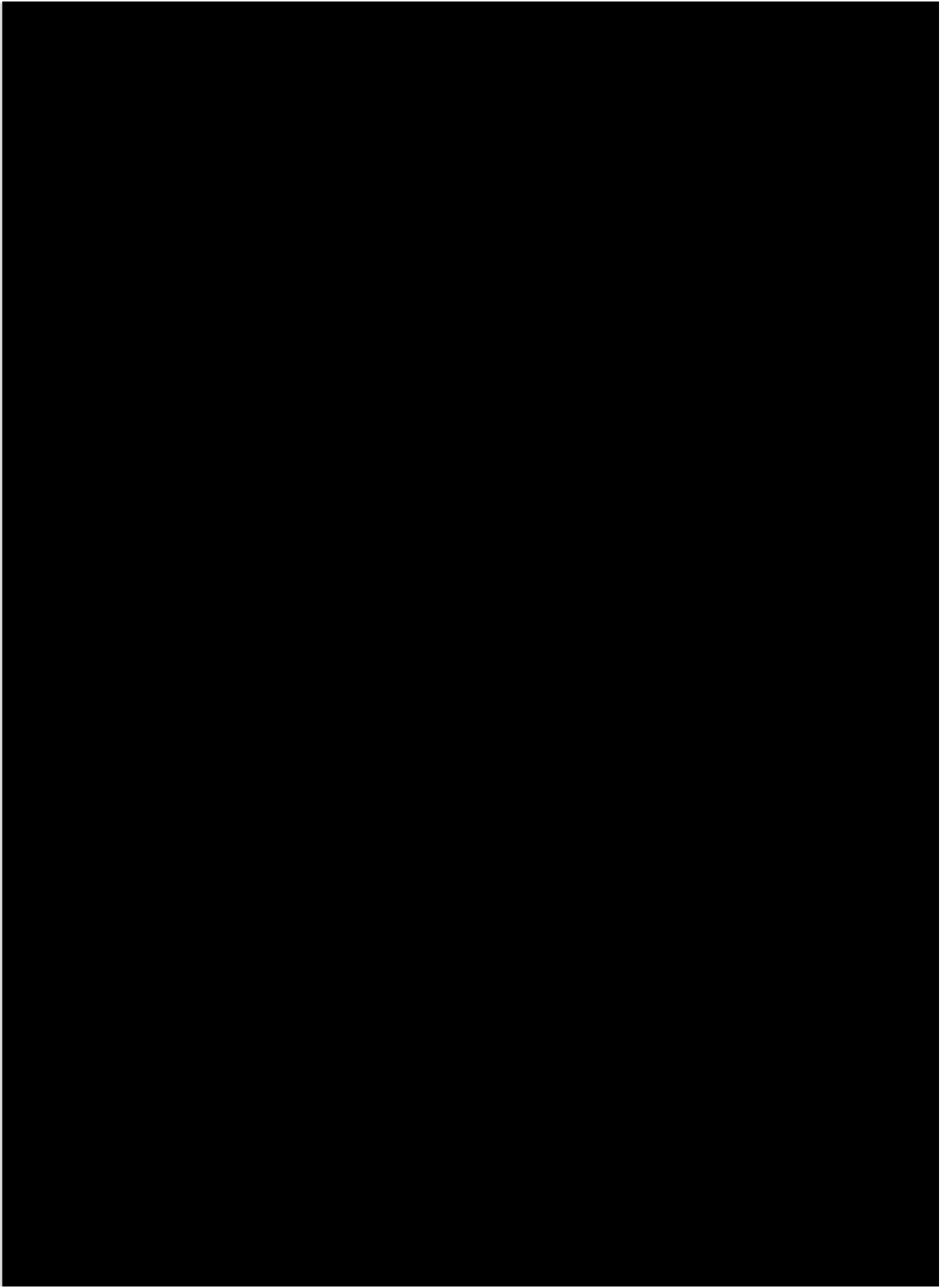


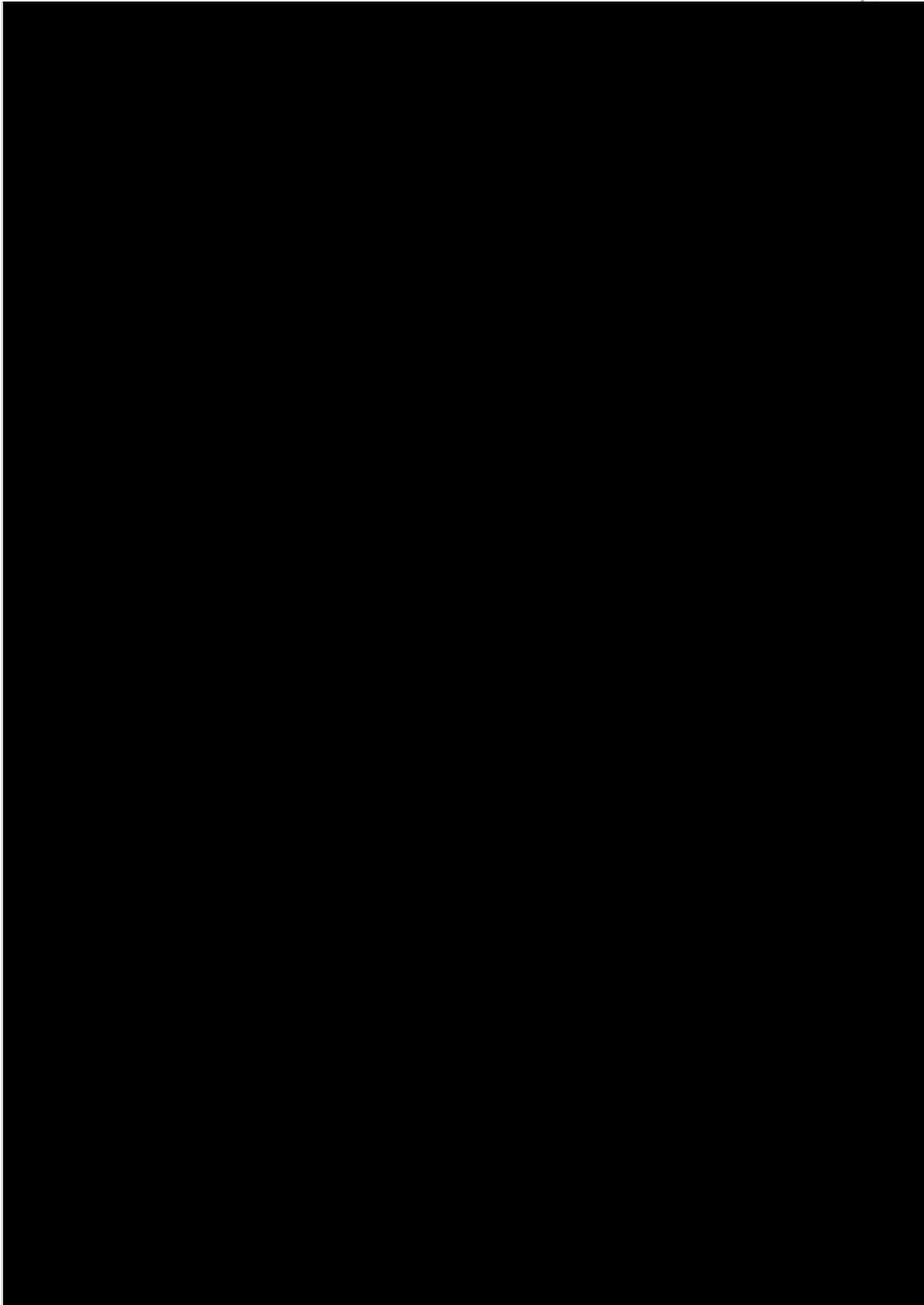












Chapter 3:

Aesthetic leadership: its place in the clinical nursing world

3.1. Publication:

Mannix, J., Wilkes, L. & Daly, J. (2015). Aesthetic leadership: its place in the clinical nursing world. *Issues in Mental Health Nursing*, 36(5), 357-361.

3.2. Relevance to thesis

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

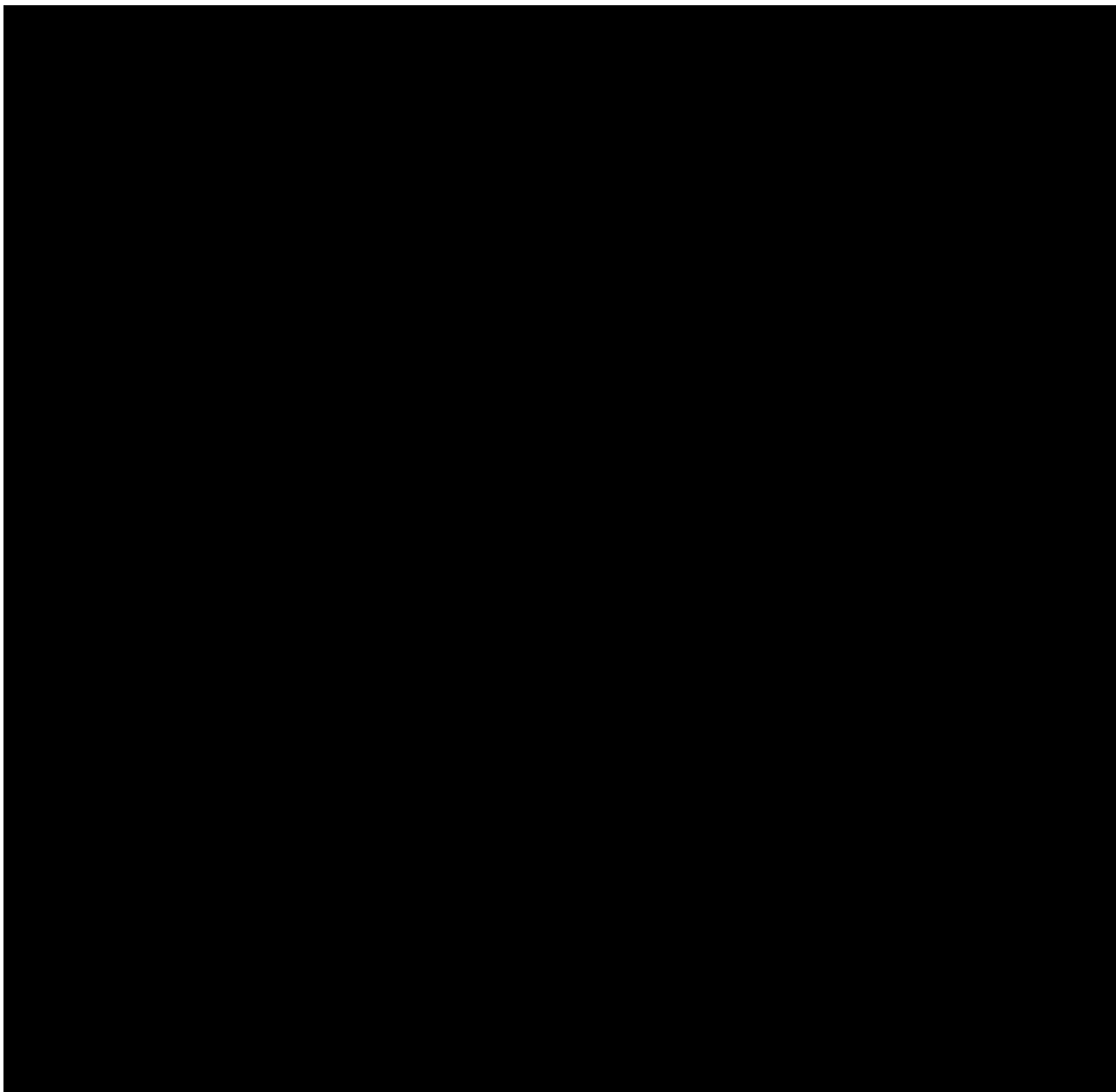
Aesthetic Leadership: Its Place in the Clinical Nursing World

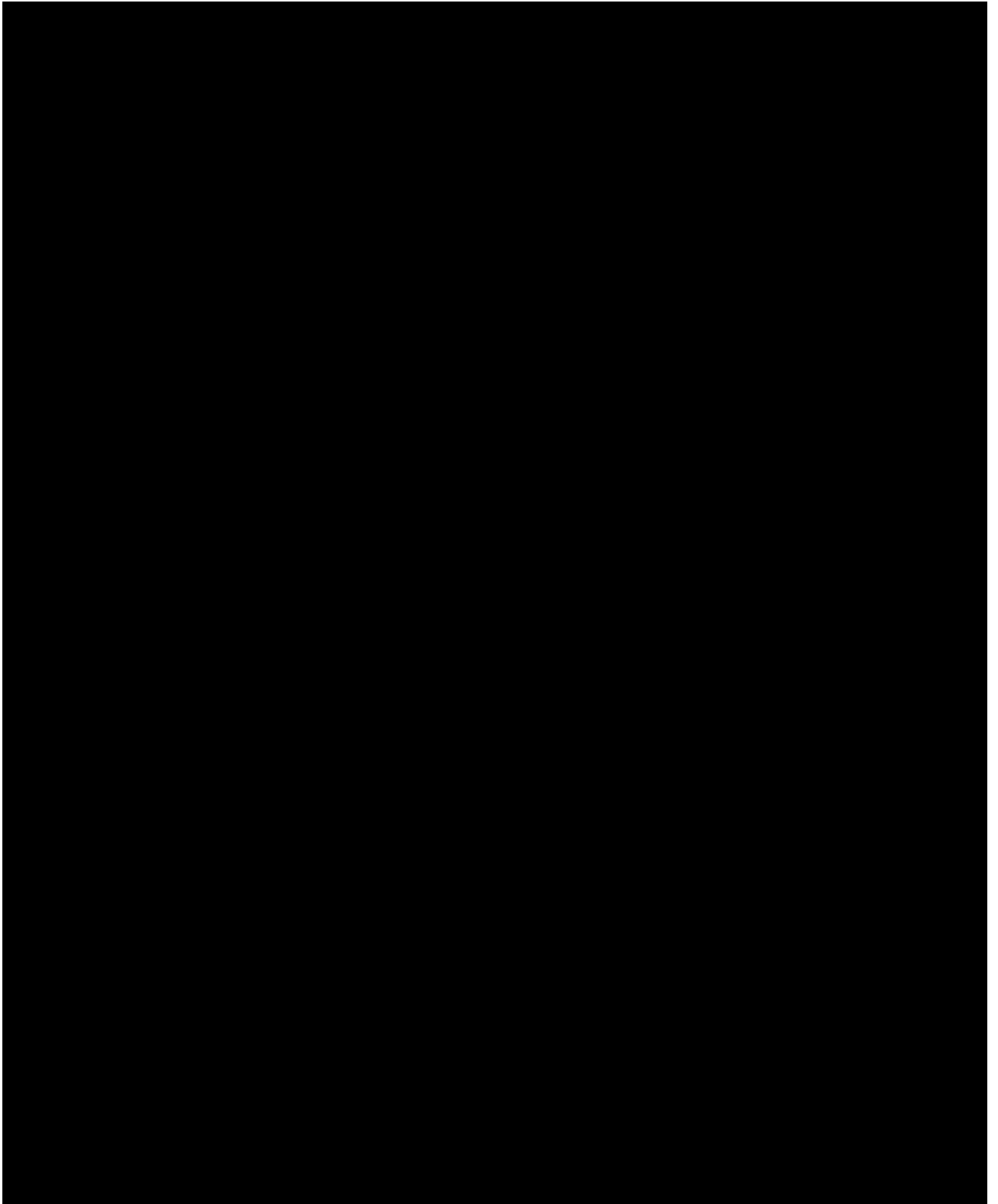
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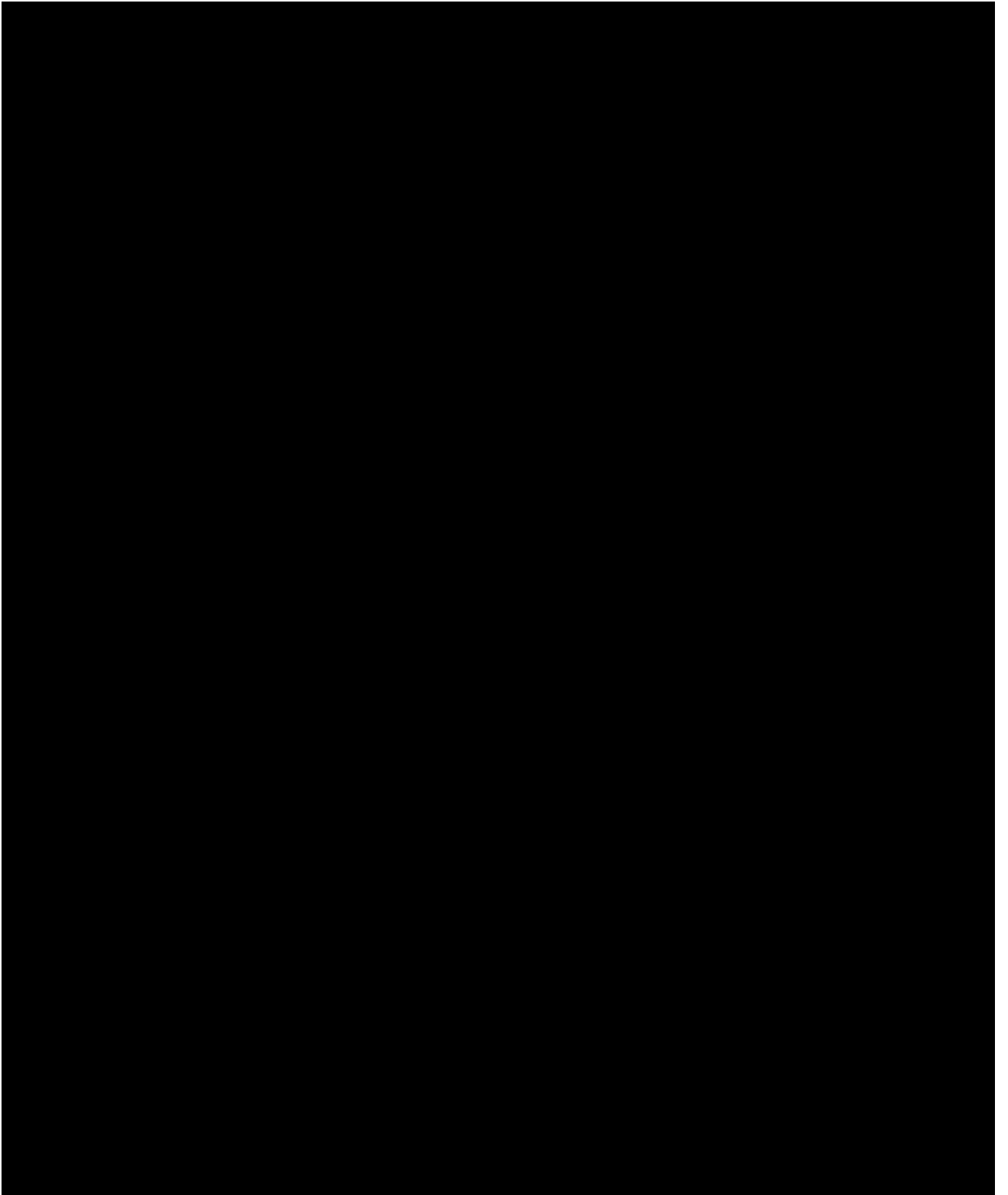
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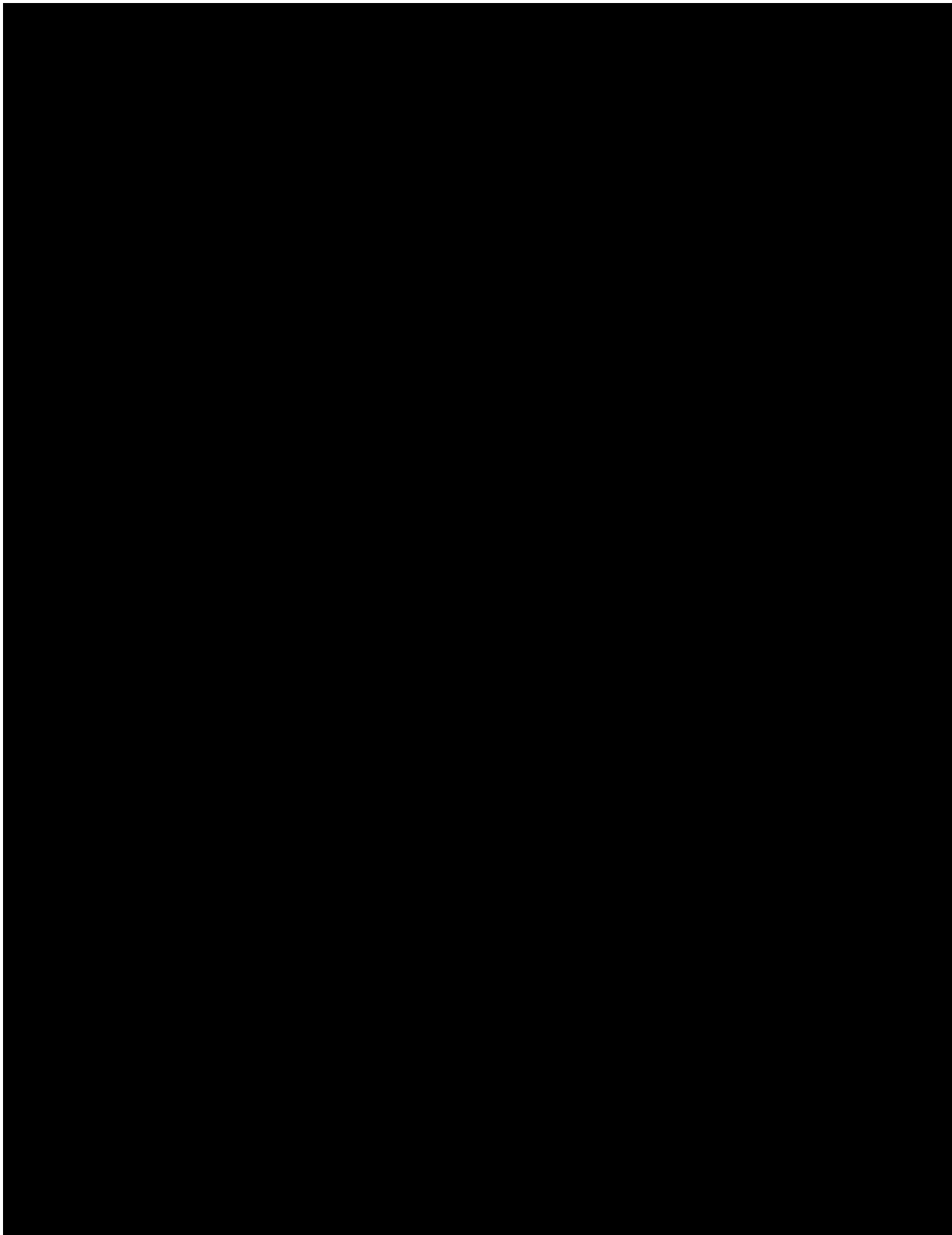
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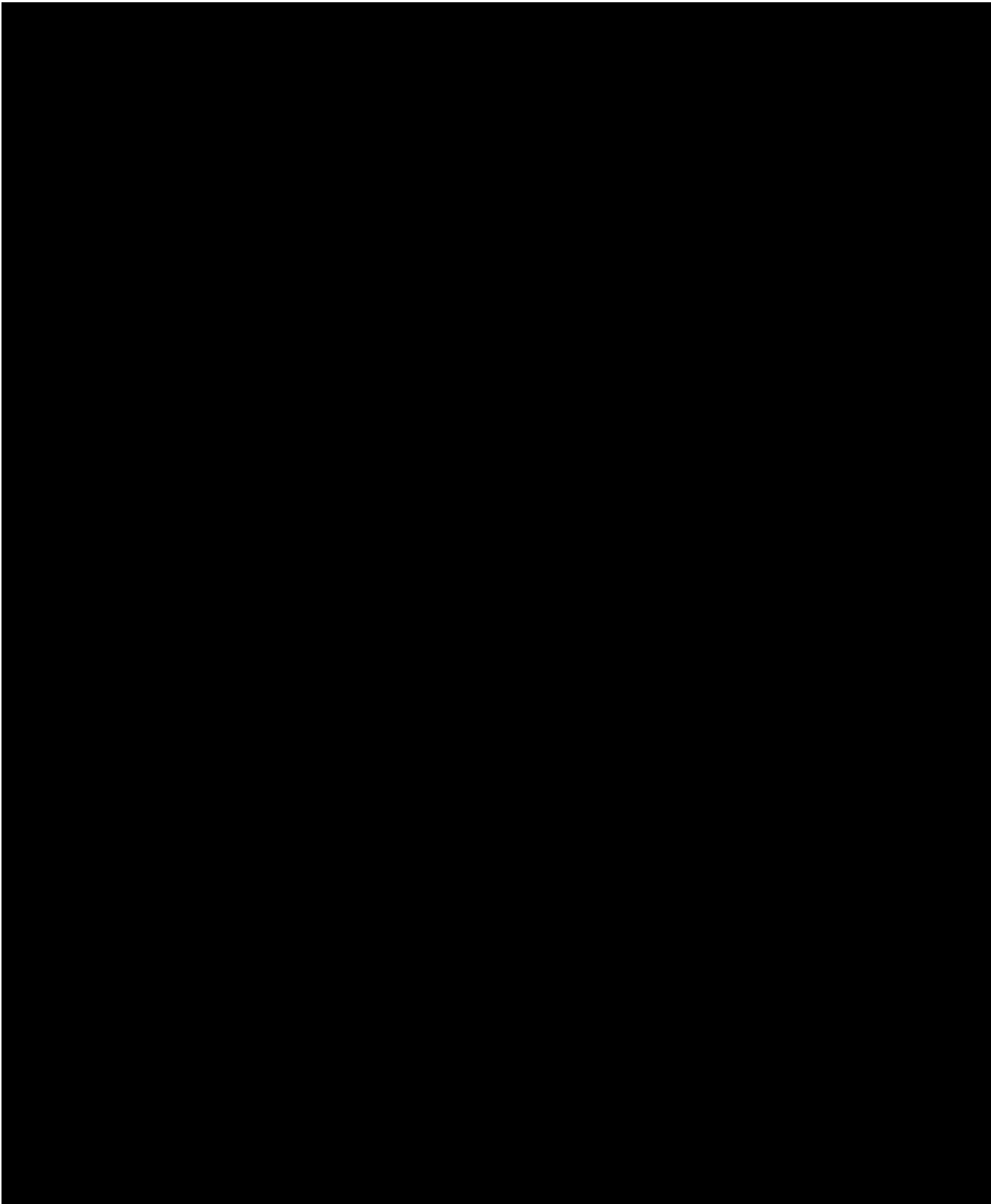
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Chapter 4:

Research framework

4.1. Introduction

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

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

4.2. The nature of critical theory

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

With an emancipatory intent as an essential consideration, critical theorists centre on human activity and the way it influences wider social structures in shaping the social world (Ritzer 1992). Linked with this is a belief that individuals are subjective beings, able to be self-critical, self-reflective and with a capacity to act rationally (Jackson, Clare & Mannix 2003). Given these beliefs, it seemed self-evident that the philosophical assumptions of critical theory provides a way of exploring the topic, especially when one takes into account how clinical leaders are positioned in contemporary nursing and the wider health system, the expectations placed on many of them professionally by regulatory authorities (Fry *et al.* 2013, NSW Health 2011) and the persistent calls for more effective clinical leadership to improve health systems around the world (Garling 2008, Francis 2013). A goal of critical theorists is to create conditions that facilitate open communication by revealing covert power imbalances that restrict free discourse (Jackson *et al.*), ultimately resulting in an awareness of any constraints under which people exist. Related to this emancipatory intent is the belief that interconnectedness exists between social theory and social practice (Geuss 1981). Taking this interconnectedness between theory and practice into consideration throughout the project is especially useful because of the realities

of nursing being both a scholarly and a practice-based discipline. While critical theorists acknowledge the effect of historical influences on knowledge construction, there is also recognition that truth claims can be determined rationally, free of immediate ideological restrictions of a wider social milieu (Jackson *et al.*). For this to happen certain conditions need to be present, and for Habermas, these conditions arise in the “ideal speech situation”, a concept explored in the next section of this chapter.

4.3. Habermas and critical theory

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

While acknowledging the relevance of the analytic and hermeneutic sciences Habermas (1972) contends that critical social science and its emancipatory interest goes beyond these two approaches with a methodological framework to seek freedom from constraints, cultivated by the notion of self-reflection. For Habermas self-reflection is central to conditions around generation of new knowledge and critique of ideology (Roderick 1986). It is this self-reflection that allows an individual to have critical insight into their actions, including any distortions that may exist around the process (Outhwaite 1994). In the current study interview participants revealed the importance of self-reflection in their day-to-day clinical leadership activities (see *Chapter 8*). From subsequent theorising, Habermas focused on linguistics as an attempt to elucidate the universal conditions under which human communication is possible, based on the concepts of communicative rationality, communicative action, and an ideal speech situation. For ideal speech to occur four validity claims need to be satisfied, these being: what is said is coherent, the content is true, what is said is

correct, and genuineness is embodied in what is said; in a context of reciprocity where the strength of argument prevails (Outhwaite p40). This concept of ideal speech provides a useful framework for the conversation-style interviews with study participants, especially as a way of trying to ensure that they are uninhibited communication acts, conducted in the context of rationality and free of distortion. For this to occur, the context and venue for the interviews also needs to be conducive to effective communication.

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

To understand the discourse of the *Lifeworld* Habermas (1990) contends that validity-claims of rightness, truth, and truthfulness need to be met in order for all participants in any interaction to be satisfied, free of coercion (Sumner 2001). It is these validity-claims that provide rational criteria for ethical and aesthetic judgements, discourses

Habermas identifies, along with other types of discourses around human interests that occur in the *Lifeworld* (Outhwaite 1994). Involvement in these interactions occurs with different levels of moral maturity that Habermas (1990) contends influences the success, depth and quality of discourse. To determine the effectiveness of the discourse Habermas (1990) draws on the work of Kolberg (1981) and Selman (1980) to argue that moral development happens in three stages, and it is at the more advanced post-conventional level that communicative action occurs. Habermas (1990, p162) argues, '*moral action is action guided by moral insight*', and this can only evolve at the post-conventional stage. The links between moral maturity and effective clinical leadership in nursing are discussed in *Chapter 3* and the significance of moral maturity to artful clinical leadership emerged in the findings presented in *Chapter 7* of this thesis.

4.4. The research design

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

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

In choosing a mixed-methods design the various typologies and approaches to this type of research that have been identified and described in recent times required consideration to determine the most appropriate for the current study. These various

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

Consequently, the research study design followed a convergent parallel approach conducted within a transformative mixed-methods design, shaped by the research question and the aim of the study. Focusing on the research question to guide the study is an approach reflective of one of the nine common core characteristics of mixed-methods research delineated by Teddlie and Tashakkori (2012). In taking a convergent parallel approach both quantitative and qualitative data collection focuses on the same construct or concept (in this study, clinical leadership) and once collected, data are analysed separately, with convergence occurring in the analysis and interpretation stages (Creswell 2014). The stages of the study are shown in Figure 4.1 below.

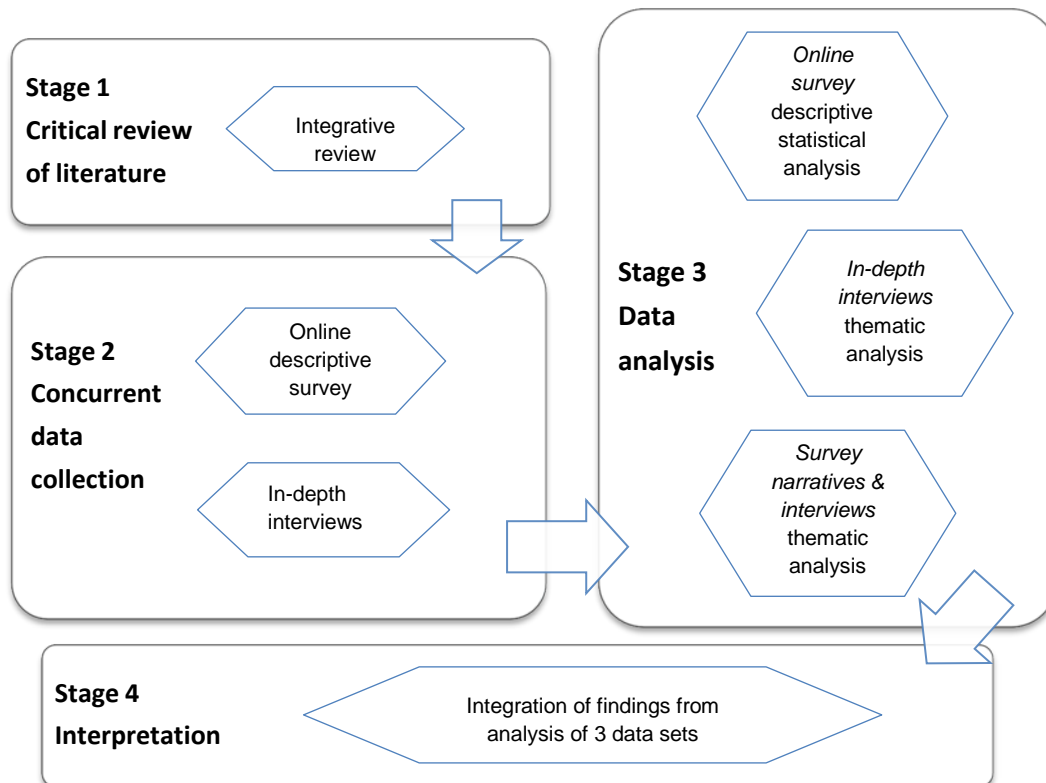


Figure 4.1: Research study design: A convergent parallel mixed-methods design within a transformative framework

A pragmatic view was taken to the process of data collection and analysis, beginning in Stage 1 with an integrative review of the relevant literature followed in Stage 2 by the administration of an online descriptive survey. While the survey was being administered the conversation-style, in-depth interviews commenced. Potential methodological concerns in a convergent parallel design can occur as a result of unequal sample sizes and decisions around the inclusion of an individual participant in both the in qualitative and quantitative data collection (Creswell 2014). In the current study potential unequal sample sizes are not considered problematic as the intent of the data collection is different, that is, quantitative data seeks to generalise and qualitative data seeks more in-depth information. Similarly, the involvement of participants in both the survey and an interview is not problematic because the exploratory nature of the study seeks different perspectives of clinical leadership that can be obtained from the online survey and an interview. Situating the study within a transformative framework is compatible with the emancipatory intent and philosophical assumptions of critical theory. As Andrew and Halcomb (2012) explain, a transformative approach is guided by a theoretical framework (in this case, critical theory and Habermas) that supports the integration of data from qualitative and qualitative sources during the analysis and interpretation stages of a research study.

4.5. Recruitment into the study

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

Participants recruited into the interview stage of data collection in the study were required to fulfil more stringent criteria. Because of this, for this part of the study, purposeful sampling was employed to recruit participants. Participants were required to be registered nurses in designated clinical leadership positions. Across the world various nomenclature have been used for these clinical leaders, including advanced practice nurse, senior charge nurse, nurse practitioner, clinical nurse consultant and nurse specialist (Christiansen *et al.*, Vernon & Jinks 2013, Fry *et al.* 2013, Stoddart *et al.* 2014). With these various titles come agreed-upon and fairly similar domains or pillars of practice (Fry *et al.*, Gregorowski *et al.* 2013), upon which competency standards or expectations are derived. For example, in New South Wales, Australia the five domains of responsibility for clinical nurse consultant are '*clinical service and consultancy, clinical leadership, research, education and clinical services planning and management*' (NSW Health 2011). In New South Wales, Australia, where the study was located, registered nurses in such positions are required to have more than five years clinical nursing experience in a direct patient care delivery role to be eligible to apply for clinical leadership positions. As experienced registered nurses with this minimum level of experience, they had ample clinical experience and exposure to be able to contribute comprehensively to the discourse on the aesthetics and art of clinical leadership. Currency in the clinical practice setting was also important to the project, mainly because of the dynamic nature of contemporary nursing in the current health care system.

Consequently, 12 registered nurses in designated clinical leadership positions were recruited into the study. Participants worked in a number of clinical specialties including mental health, aged care, paediatrics, acute adult medical/surgical specialties, and community-based nursing. All participants had at least 10 years clinical experience, with a number of them with upwards of 25 years nursing experience. To ensure confidentiality in the conduct of the study all participants were assigned a pseudonym. The number of participants in this part of the study was determined when data saturation was reached, that is, when no new information emerged from the conversations with participants in relation to the aim of the study. When using interviews for data collection specific evidence-based guidelines around appropriate sample size were not found. However, suggestions in the literature indicate research methodology, heterogeneity of the sample and research objectives can be determining factors (Guest, Bunce & Johnson 2006). From their own analysis of data saturation of a relatively homogenous sample Guest *et al.* found that meta-themes emerged after six interviews and that saturation occurred within the first 12 interviews. Therefore, it was not surprising that data saturation occurred at this point, especially as there was homogeneity across the sample, *viz*, they were all registered nurses, all working in designated clinical leadership roles and all working in New South Wales, Australia in either the public, acute sector, community health or residential care settings.

4.6. Collection of data

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

Review of the literature

Initially, a critical review the literature was undertaken to provide a contextual background for subsequent data collection during the research. Electronic databases were accessed to yield relevant literature to uncover contemporary, empirical understandings of defining attributes of clinical leadership in nursing. An integrative review was chosen as the method to adopt for data collection as it provided a

rigorous and systematic approach (Whittemore & Knafelz 2005). Details of this method are included in the published paper in *Chapter 2* of this thesis.

On-line descriptive survey

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

Conversation-style interviews

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

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

4.7. Data Analysis

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

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

4.8. Ethical processes and considerations

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

Research merit and integrity

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

Justice

To ensure the research was conducted in just manner it was essential that the participants involved were treated fairly. This imperative for justice was evident in a number of processes and considerations throughout the research. At both universities

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

Beneficence

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

Respect

In research involving humans it is of paramount importance that all aspects of the research processes are respectful of those involved (NHMRC 2007), whether they are anonymous respondents to a survey or participants in an interview. To ensure that this occurred in the current study a number of procedures were undertaken. Prior to the interviews participants were made aware that a professional transcription service would be engaged to transcribe the audiotapes and that they would be bound by the ethical constraints of the study, in terms of confidentiality of information. They were also assured that all data would be de-identified, included the use of pseudonyms in all publications and presentations arising from the study. Following completion of the

data collection period, the electronic data from the online survey and the interviews were stored securely on a password-protected site. Hard copies of interview transcripts, although de-identified, and signed consent forms are stored in a locked filing cabinet at UWS. All forms of data will be kept for a period of five years, before being appropriately and securely destroyed.

4.9. Establishing rigour, validity and reliability

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

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

The evolution of an accepted standard protocol for establishing rigour in mixed-methods approaches continues (Lewis 2011). When taking a convergent parallel mixed-methods approach it is acceptable to apply critical appraisal skills from both quantitative and qualitative methods to establish validity (Creswell 2014). Lincoln and Guba's (1985) model for establishing rigour and trustworthiness in qualitative research sets out the four criteria of credibility, dependability, confirmability and transferability. In essence, these four criteria have similarities with processes for assessing trustworthiness of quantitative data, *viz*, credibility being similar to internal

validity, dependability related to reliability, confirmability similar to objectivity, and transferability akin to external validity (Thomas & Magilvy 2011). Therefore, in seeking to ensure validity, reliability and rigour in the current study strategies were in place to ensure all of these criteria were satisfied.

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

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

Chapter 5:

Pragmatism, persistence and patience: a user perspective on strategies for data collection using popular online social networks

5.1. Publication:

Mannix, J., Wilkes, L. & Daly, J. (2014). Pragmatism, persistence and patience: A user perspective on strategies for data collection using popular online social networks. *Collegian* 21(2), 121-126.

5.2. Relevance to thesis

An important aspect in any research involves data collection. This paper reflects on and critiques one of the methods of data collection in this research that involved the use of the online world. The use of the internet to locate the descriptive survey lent itself to utilising the same medium to invite nurses to complete the survey.

Consequently, apart from using e-learning platforms at two universities, the online social networks of Facebook and Twitter were utilised to recruit participants. These online social networks are increasingly being utilised by researchers for data collection, mainly because of accessibility to large numbers of potential participants and the low costs involved. However, this source of recruitment needs to occur in a way that retains rigour and validity in research projects.



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Pragmatism, persistence and patience: A user perspective on strategies for data collection using popular online social networks



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

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Introduction

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

For those involved in research projects the potential of the internet and OSNs is significant. Regardless of the methodological approach taken, researchers can adapt traditional methods of data collection such as interviews, surveys and focus groups to an online environment (Walker, 2013). There are some advantages to using OSNs for research data collection including the possibility of being able to access a larger pool of potential study participants, and do this more economically and in less time than more traditional means such producing and distributing hardcopy surveys or questionnaires (Ahern, 2005). As well, sensitive topic areas can

be more effectively researched using computer-mediated communication (East, Jackson, O'Brien, & Peters, 2008; Ryan, 2013) and anonymity afforded by online surveys can potentially improve the truthfulness of data (Cantrell & Lupinacci, 2007). Research participants can also find it more convenient to engage in data collection (Vallido, Jackson, & O'Brien, 2010). However, researchers taking this approach need to recognise that there are some challenges involved around establishing validity and rigour of research findings (Ahern, 2005; Walker, 2013) and issues such as social desirability (Groh, Ferrari, & Jason, 2009) and recall bias (Boone, Halligan, Mallett, Taylor, & Altman, 2012). This paper aims to outline and critique the use of OSNs for data collection in a study that sought to explore the aesthetics of clinical leadership in contemporary nursing.

Background

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

In order to research international nursing issues like clinical leadership, utilising the virtual environment of the internet, and OSNs in particular, can be realistic and cost-effective ways in which to gain a global perspective from contact with nurses across the world. Increasingly, researchers in nursing and health are turning to the internet and OSNs as methods of both seeking data for and disseminating data from their research projects. In a large longitudinal study of nursing and midwifery workforces in Australia, New Zealand and the United Kingdom a dedicated website was established for data collection of a number of workforce participation measures (Huntington et al., 2009). Health-oriented OSNs have been effectively utilised in a randomised trial to promote weight loss and physical activity (Greene, Sacks, Piniewski, Kil, & Hahn, 2012). Rather than using a focused online social network, Ramo and Prochaska (2012) utilised Facebook's paid advertising programme to recruit and survey young adults about substance use, finding it a cost-effective method of recruiting and assessing health behaviours.

Information sharing via OSNs is also increasingly evident and is becoming a focus of research in nursing and health. A study that sought to determine the effect of Twitter on disseminating information about antibiotics found that as a communication medium Twitter is a powerful tool through individuals' networks of followers and a 'culture of "retweeting"' (Scanfeld, Scanfeld, & Larson, 2010 p. 186). Similarly, Robillard, Johnson, Hennessey, Beattie, & Illes (2013), in their study of information about dementia on Twitter, found that the majority of tweets directed readers to news and health information sites as well as discussions on recent research findings on Alzheimer's disease. Twitter, as an online micro-blogging social network, provides researchers with opportunities to access large amounts of data and determine public opinion to various issues. For example, King et al. (2013) were able to investigate reactions to the recent wide-ranging health reforms to the National Health Service (NHS) in England. By applying a streaming application programme with key words of 'reforms' and 'nhs' over a 12 month period the researchers collected over 120,000 tweets related to the health reforms. Subsequent analysis of the data enabled King et al. to determine tweeting trends over time, reactions to the health reforms, and who was most influential in the twitter discussions. This study by King et al. does illustrate that twitter and similar social media platforms provide an important forum for public policy discussions.

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

factor influencing participation in online surveys (Hunter, 2012).

The study

It was with these considerations in mind that strategies for data collection via the internet and OSNs were developed for a mixed methods study that aimed to explore the aesthetics of clinical leadership in contemporary nursing. The study sought from registered nurses their views on what it is to be a clinical leader and what aesthetic elements comprise effective clinical leadership. These views were sought initially via an online survey which was developed from two existing questionnaires, one that focused on aesthetic leadership (Polat & Oztoprak-Kavak, 2011) and the other that focused on clinical leadership in nursing (Patrick, Spence Laschinger, Wong, & Finegan, 2011). Because the aesthetic leadership questionnaire was originally developed to administer to school directors it was necessary to modify and contextualise the items to a clinical nursing context. This was undertaken systematically by one of the research team, and subsequently independently checked for clarity and accuracy by two other members of the research team. This process resulted in changes to some of the language, for example, "clinical setting" was substituted for "school". As well, the original 66 items were reduced to 32 items that focused equally on areas of a clinical leader's communication skills, support capacity, leadership approach, application, sensitivity, and honesty. The 15 items on clinical leadership survey were not modified in any way from the original instrument (Patrick et al., 2011). The final survey tool reflected a mixed method survey design in four sections, preceded by a short introduction to the survey that included a definition of aesthetic leadership. Following a short demographic section that focused on their professional experience two sections comprising 47 items, invited a response on a five point Likert scale (strongly agree, agree, neutral, disagree, strongly disagree). A final section with a text-box asked participants to give an example of aesthetic leadership from their clinical experience. Finally, the completed survey instrument was trialled by an expert panel of seven experienced registered nurses to complete and critique. In doing so, the survey was assessed for content validity and the feasibility of the instrument (Gill, Leslie, Grech, & Latour, 2013). Minor modifications to the instrument occurred as a result of their feedback.

Prior to the commencement of the data collection period in the study institutional Human Research Ethics Committee approval was sought and granted. Initially, data collection was to be confined to an invitation to registered nurses enrolled in postgraduate studies at a large metropolitan university. The invitation was posted as an announcement on the university e-learning platform, accessible only to students enrolled in nursing courses. Similar ethics approval was also granted at a second large metropolitan university using the same recruitment strategies. Before the data collection period commenced, subsequent amendments to data collection methods were approved by the ethics committee to also enable the OSNs of Facebook and Twitter be utilised for participant recruitment.

Table 1 Response to survey via Twitter.

Tweet 140 characters plus hyperlink to survey	Surveys pre-tweet (n)	Followers (n)	Retweets (n)	Retweeter followers (n)	Surveys 1 week post-tweet
1	48	218	8	2958	51
2 (@ 3 weeks)	55	248	17	17,990	62
3 (@ 13 weeks)	72	316	3	3514	72
4 (@ 14 weeks)	72	322	31	25,633	74

Data collection

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

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

A number of different strategies were employed when using Twitter, with the aim of maximising the number of online surveys being completed. The initial tweet (message), comprising no more than 140 characters and with the

hyperlink, was posted from one of the research team's Twitter account. Within the text of the message, a hashtag (#) preceded clinical, leadership and nursing. By doing this the message can be found by others searching in these topic areas who have not received the original tweet (O'Connor et al., 2013). At that first tweet, 218 followers received the message. Two weeks later the same message was re-posted. After a period of eight weeks a weekly posting of the same tweet was undertaken for two consecutive weeks. The final weekly post included a request for the followers to retweet (or resend) the message. This request was included to in an attempt to increase the exposure of the message to the followers of those receiving the original tweet. The responses to the four tweets are shown in Table 1.

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

Discussion

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

Nonetheless, the poor response rate to this particular online survey should not be a reason to dismiss the use of OSNs as recruitment sites for scholarly research. There

Table 2 Participants by recruitment method and completed surveys.

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

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

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

The relatively low number of incomplete surveys discarded from the final sample may indicate that the content

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

Strategies for increasing recruitment

Some strategies that may have enhanced a higher response rate to the online leadership survey include taking a more targeted approach to recruitment via the online social networks. In their study O'Connor et al. (2013) found that after setting up a specific Twitter account, following individuals and groups with similar interests and requesting a retweet of research related tweets, recruitment was maximised. With regards to enhancing recruitment via Facebook, establishing an open Facebook group that does not restrict membership may be effective. However, as Ryan (2013) comments, researchers need to establish clear guidelines for appropriate behaviour and monitor activity closely on the site. Taking this approach to using this online social network may become unmanageable, depending on who accesses the page, and may also be more suited to a qualitative study, rather than one with a link to an online survey. Finally, the use of e-learning platforms for recruitment may have been improved by sending all postgraduate nursing students an email invitation with a link to the online survey, rather than limiting recruitment to announcements on the e-learning sites. Newton, Davidson, & Sanderson (2012) found with their study that email invitations to complete an online survey were an effective recruitment strategy and elicited a 21% ($n=52$) response rate.

Conclusion

The increasing participation by nurses, largely through necessity, in computer-mediated communication such as that associated with e-health, opens the internet and OSNs as rich sites for recruitment into research that focuses on global nursing issues. While the response rate to the online survey was disappointing for the current study, the use of

online announcements and social media has the potential to maximise exposure for the collection of research data. Additional strategies that may have increased participation in the online survey include setting up a project specific Twitter account, creating a more accessible Facebook page and taking a more targeted approach to recruitment.

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

References

- Ahern, N. R. (2005). Using the internet to conduct research. *Nurse Researcher*, 13(2), 55–69.
- Antheunis, M. L., Tates, K., & Nieboer, T. E. (2013). Patients' and health professionals' use of social media in health care: Motives, barriers and expectations. *Patient Education and Counselling*, 92, 426–431.
- Association of Internet Researchers. (2012). *Ethical decision-making and Internet research*. Retrieved from: <http://www/aoir.org/reports/ethics2.pdf>
- Boone, D., Halligan, S., Mallett, S., Taylor, S. A., & Altman, D. G. (2012). Systematic review: Bias in imaging studies – the effect of manipulating clinical context, recall bias and reporting intensity. *European Radiology*, 22, 495–505.
- Cantrell, M. A., & Lupinacci, P. (2007). Methodological issues in online data collection. *Journal of Advanced Nursing*, 60(5), 544–549.
- Davenport, S. W., Bergman, S. M., Bergman, J. Z., & Fearington, M. E. (2014). Twitter versus Facebook: Exploring the role of narcissism in the motives and usage of different social media platforms. *Computers in Human Behavior*, 32, 212–220.
- Department of Health. (2008). *High quality care for all, NHS next stage review final report (The Darzi report)*. London: Department of Health.
- East, L., Jackson, D., O'Brien, L., & Peters, K. (2008). The benefits of computer-mediated communication in nursing research. *Contemporary Nurse*, 30(1), 83–88.
- Eysenbach, G., & Till, J. E. (2001). Ethical issues in qualitative research on internet communities. *British Medical Journal*, 323(10), 1103–1105.
- Ferguson, C. (2013). Editorial: It's time for the nursing profession to leverage social media. *Journal of Advanced Nursing*, 64(4), 745–747.
- Francis, R. (2013). *Report to the Mid Staffordshire NHS trust public inquiry – Executive summary*. London: The Stationary Office.
- Garling, P. (2008). *Final report of the special commission of inquiry: Acute care in NSW public hospitals, 2008 – Overview*. Sydney: NSW Government.
- Gill, F. J., Leslie, G. D., Grech, C., & Latour, J. M. (2013). Using a web-based survey tool to undertake a Delphi study: Application for nurse education research. *Nurse Education Today*, <http://dx.doi.org/10.1016/j.nedt.2013.02.016>
- Giordano, C., & Giordano, C. (2011). Health professions students' use of social media. *Journal of Allied Health*, 40(2), 78–81.
- Gormandy White, M. (2013). *What types of social networks exist?* Retrieved from: <http://socialnetworking.lovetoknow.com/What.Types.of.Social.Networks.Exist>
- Greene, J., Sacks, R., Piniewski, B., Kil, D., & Hahn, J. S. (2012). The impact of an online social network with wireless monitoring devices on physical activity and weight loss. *Journal of Primary Care & Community Health*, <http://dx.doi.org/10.1177/2150131912469546>
- Groh, D. R., Ferrari, J. R., & Jason, L. A. (2009). Self-reports of substance abusers: The impact of social desirability on social network variables. *Journal of Groups in Addiction & Recovery*, 4, 51–61.
- Heidemann, J., Klier, M., & Probst, F. (2012). Online social networks: A survey of a global phenomenon. *Computer Networks*, 56, 3866–3878.
- Hughes, D., Rowe, M., Batey, M., & Lee, A. (2012). A tale of two sites: Twitter vs. Facebook and the personality predictors of social media usage. *Computers in Human Behavior*, 28, 561–569.
- Hunter, L. (2012). Challenging the reported disadvantages of e-questionnaires and addressing methodological issues of online data collection. *Nurse Researcher*, 20(1), 11–20.
- Huntington, A., Gilmour, J., Schluter, P., Tuckett, A., Bogossian, F., & Turner, C. (2009). The internet as a research site: Establishment of a web-based longitudinal study of the nursing and midwifery workforce in three countries. *Journal of Advanced Nursing*, 65(6), 1309–1317.
- International Council of Nurses. (2012). *About ICN*. Retrieved from: <http://www.icn.ch/abouticn.htm>
- Jackson, D., & Watson, R. (2009). Editorial: Lead us not. *Journal of Clinical Nursing*, 18(14), 1961–1962.
- Jackson, D., Clare, J., & Mannix, J. (2002). Who would want to be a nurse? Violence in the workplace – A factor in recruitment and retention. *Journal of Nursing Management*, 10(1), 13–20.
- Jackson, D., Hutchinson, M., Peters, K., Luck, L., & Saltman, D. C. (2013). Understanding avoidant leadership in health care: Findings from a secondary analysis of two qualitative studies. *Journal of Nursing Management*, 21(3), 572–580.
- Johnson, T. P., & Wislar, J. S. (2012). Response rates and nonresponse errors in surveys. *Journal of American Medical Association*, 307(17), 1805–1806.
- Johnstone, M., & Kanitsaki, O. (2009). Population ageing and the politics of demographic alarmism: Implications for the nursing profession. *Australian Journal of Advanced Nursing*, 26(3), 86–92.
- King, D., Ramirez-Cano, D., Greaves, F., Vlaev, I., Beales, S., & Darzi, A. (2013). Twitter and the health reforms in the English National Health Service. *Health Policy*, 110, 291–297.
- Mannix, J., Wilkes, L., & Daly, J. (2013). Attributes of clinical leadership in contemporary nursing: An integrative review. *Contemporary Nurse*, 45(1), 10–21.
- McKee, R. (2013). Ethical issues in using social media for health and health care research. *Health Policy*, 110, 298–301.
- Newton, P. J., Davidson, P. M., & Sanderson, S. (2012). An online survey of Australian physicians reported practice with the off-label use of nebulised frusemide. *BMC Palliative Care*, 11(6). Retrieved from: <http://www.biomedcentral.com/1472-684X/11/6>
- O'Connor, A., Jackson, L., Goldsmith, L., & Skirton, H. (2013). Can I get a retweet please? Health research recruitment and the Twittersphere. *Journal of Advanced Nursing*, <http://dx.doi.org/10.1111/jan.12222>
- Parker, V., Giles, M., & Higgins, I. (2009). Challenges confronting clinicians in acute care. *Journal of Nursing Management*, 17(6), 667–678.

- Patrick, A., Spence Laschinger, H., Wong, C., & Finegan, J. (2011). Developing and testing a new measure of staff nurse clinical leadership: The clinical leadership survey. *Journal of Nursing Management, 19*.
- Polat, S., & Oztoprak-Kavak, Z. (2011). Aesthetic leadership (AL): Development and implementation of aesthetic leadership scale (ALS) of school directors. *Educational Research and Reviews, 6*(1), 50–61.
- Qualtrics Research Suite (2013). Retrieved from: <http://www.qualtrics.com/research-suite/#academic>
- Ramo, D., & Prochaska, J. J. (2012). Broad reach and targeted recruitment using Facebook for an online survey of young adult substance use. *Journal of Medical Internet Research, 14*(1), e28. <http://dx.doi.org/10.2196/jmir.1878>
- Redfern, J., Ingles, J., Neubeck, L., Johnston, S., & Semsarian, C. (2013). Tweeting our way to cardiovascular health. *Journal of the American College of Cardiology, 61*(15), 1657.
- Robillard, J. M., Johnson, T. W., Hennessey, C., Beattie, B. L., & Illes, J. (2013). Aging 2.0: Health information about Dementia on Twitter. *PLoS ONE, 8*(7), e69861. <http://dx.doi.org/10.1371/journal.pone.0069861>
- Ryan, G. (2013). Online social networks for patient involvement and recruitment in clinical research. *Nurse Researcher, 21*(1), 35–39.
- Scanfeld, D., Scanfeld, V., & Larson, E. L. (2010). Dissemination of health information through social networks: Twitter and antibiotics. *American Journal of Infection Control and Epidemiology, 38*, 182–188.
- Serrano, A. F. (2011). The social media explosion: By the numbers. *Fiscal Times*. Retrieved from: <http://www.thefiscaltimes.com/Articles/2011/09/12/The-social-media-explosion-by-the-numbers>
- Vallido, T., Jackson, D., & O'Brien, L. (2010). Nurses' management of adolescent sleep disturbance: A qualitative study. *Journal of Clinical Nursing, 19*(3–4), 324–331.
- Walker, D. (2013). The internet as a medium for health service research. Part 1. *Nurse Researcher, 20*(4), 18–21.
- West, C., & Verran, D. (2013). Something to tweet about: Incorporating social media into your nursing practice. *Transplant Journal of Australasia, 22*(1), 10–12.

Chapter 6:

Grace under fire: aesthetic leadership in clinical nursing

6.1. Publication:

Mannix, J., Wilkes, L. & Daly, J. Grace under fire: aesthetic leadership in clinical nursing. *Journal of Clinical Nursing*, 24, 2649-2658. DOI: 10.1111/jocn.12883.

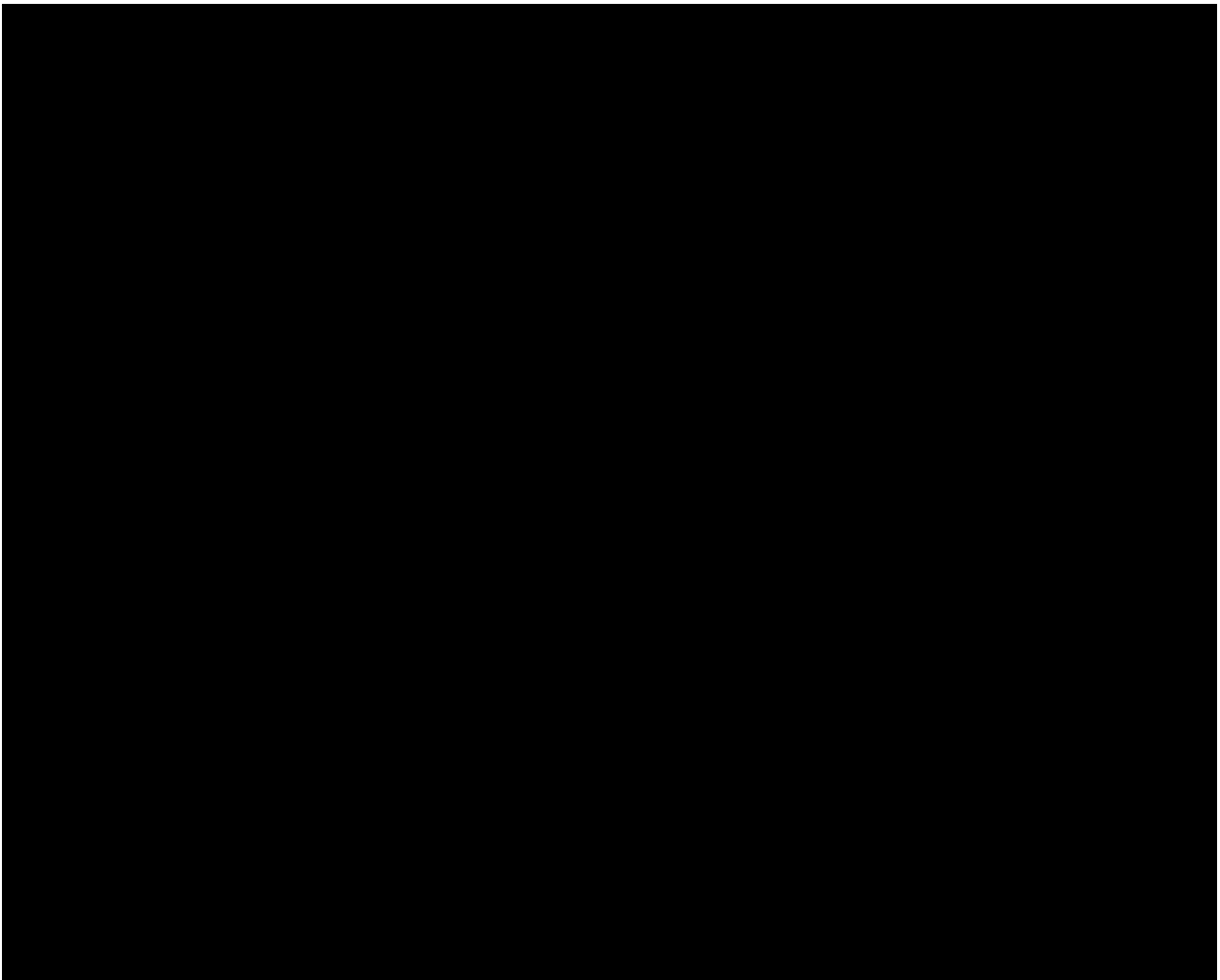
6.2. Relevance to thesis

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

ORIGINAL ARTICLE

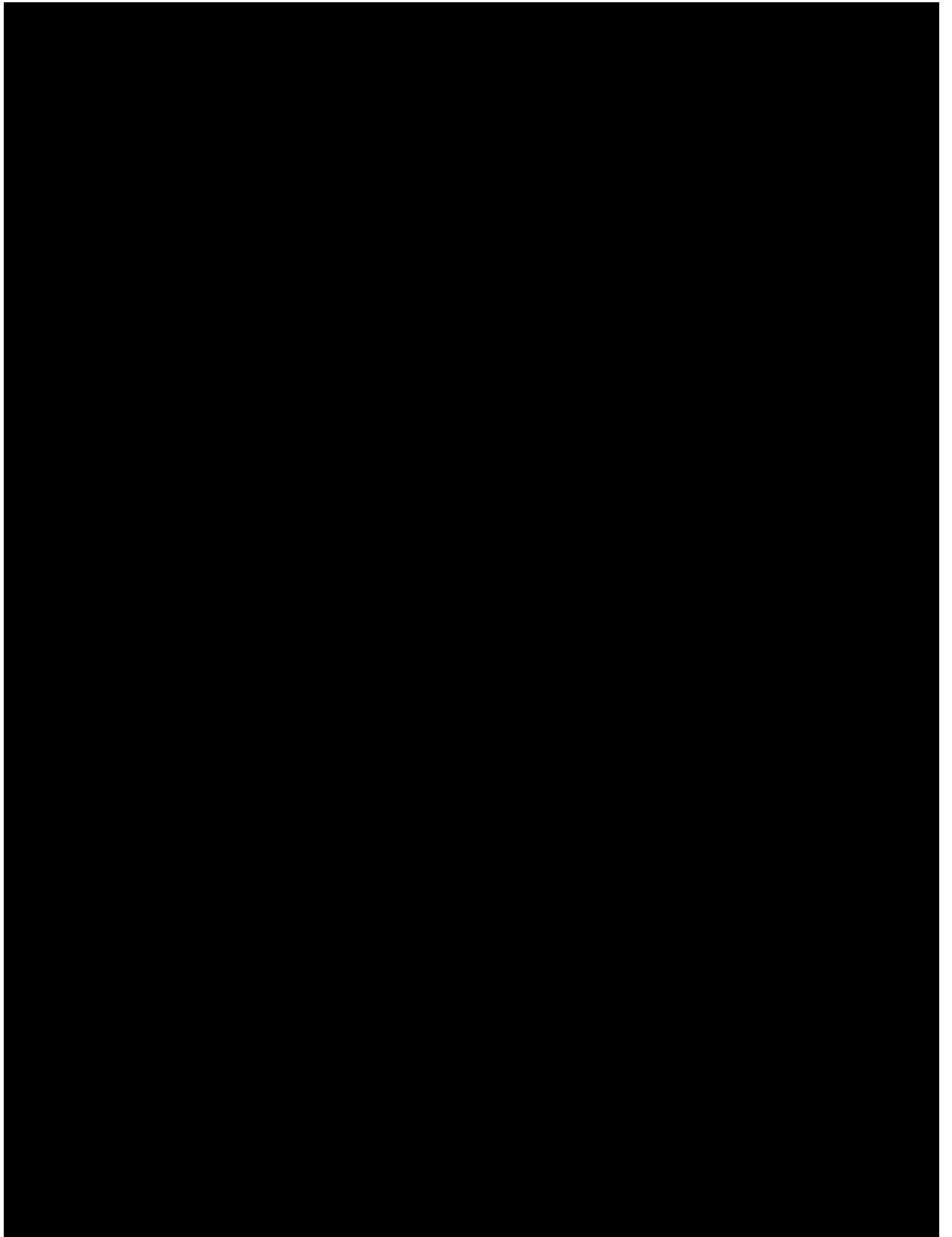
Grace under fire: aesthetic leadership in clinical nursing

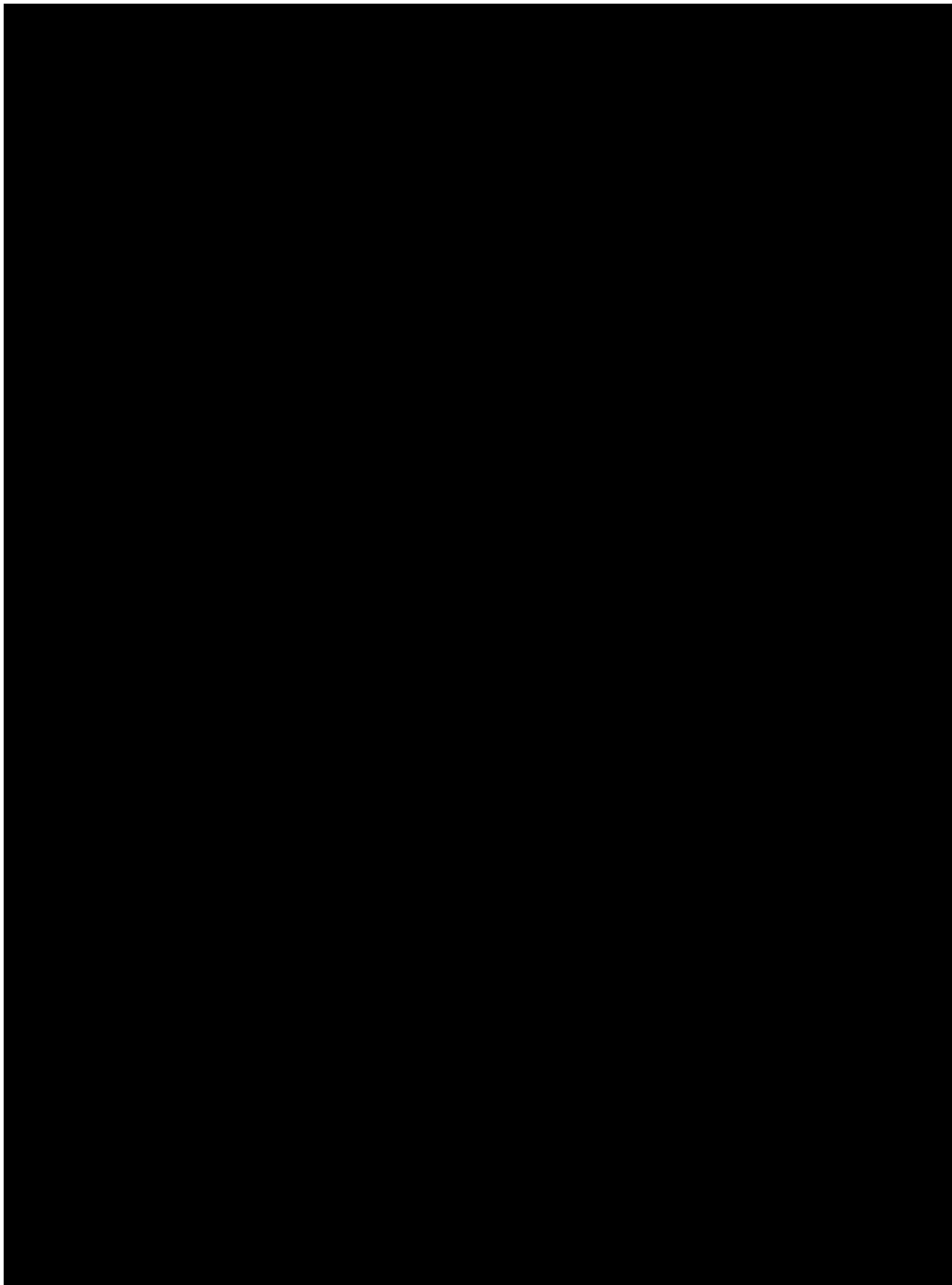
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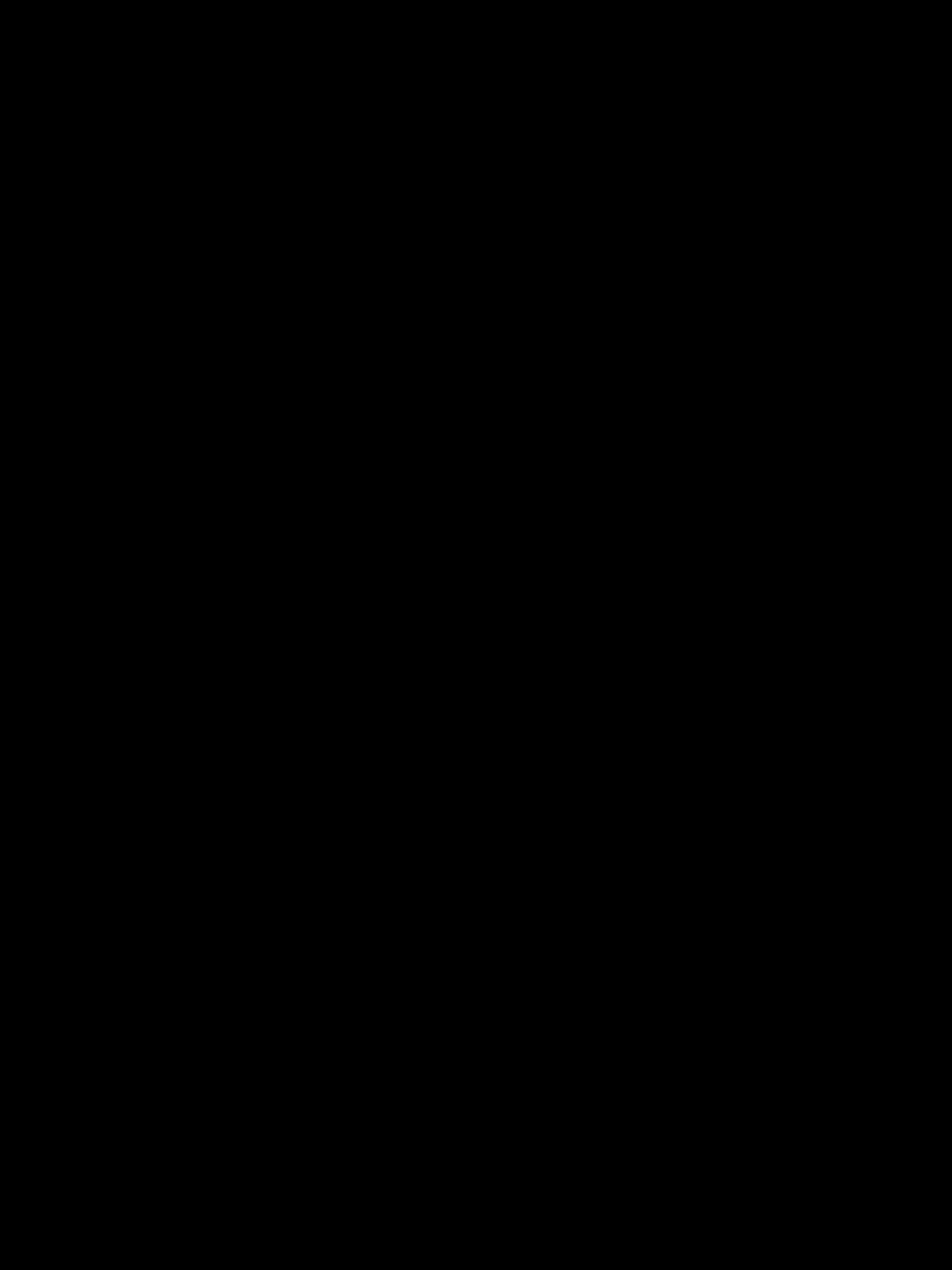


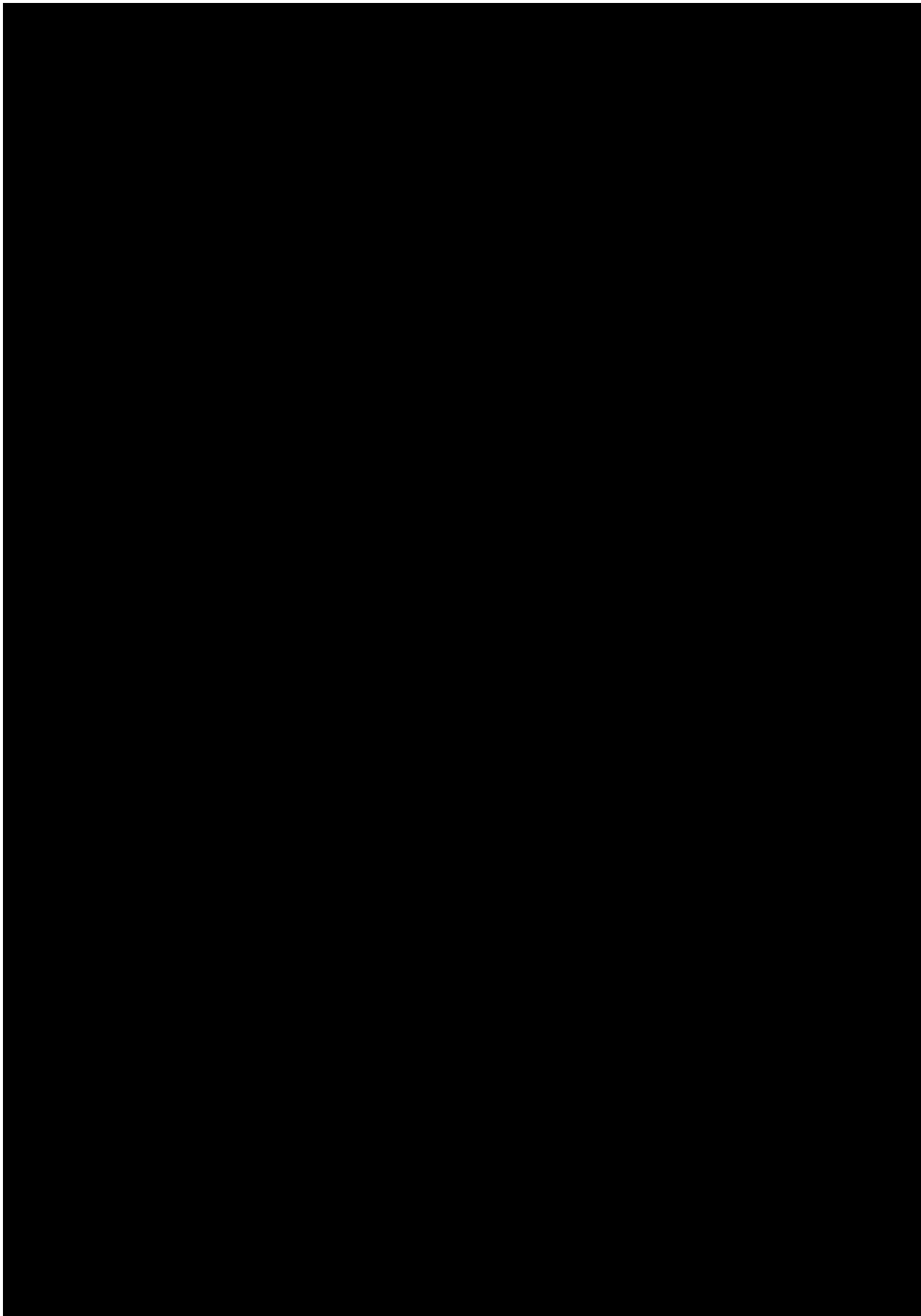
Authors: *Judy Mannix*, RN, MN, Senior Lecturer, Director, Academic Programs – Postgraduate, School of Nursing & Midwifery, University of Western Sydney, Sydney; *Lesley Wilkes*, PhD, RN, Professor of Nursing, School of Nursing & Midwifery, University of Western Sydney and Nepean Blue Mountains Local Health District, Penrith; *John Daly*, PhD, FACN, FAAN, Professor & Dean, Faculty of Health, University of Technology, Sydney, Sydney, NSW, Australia

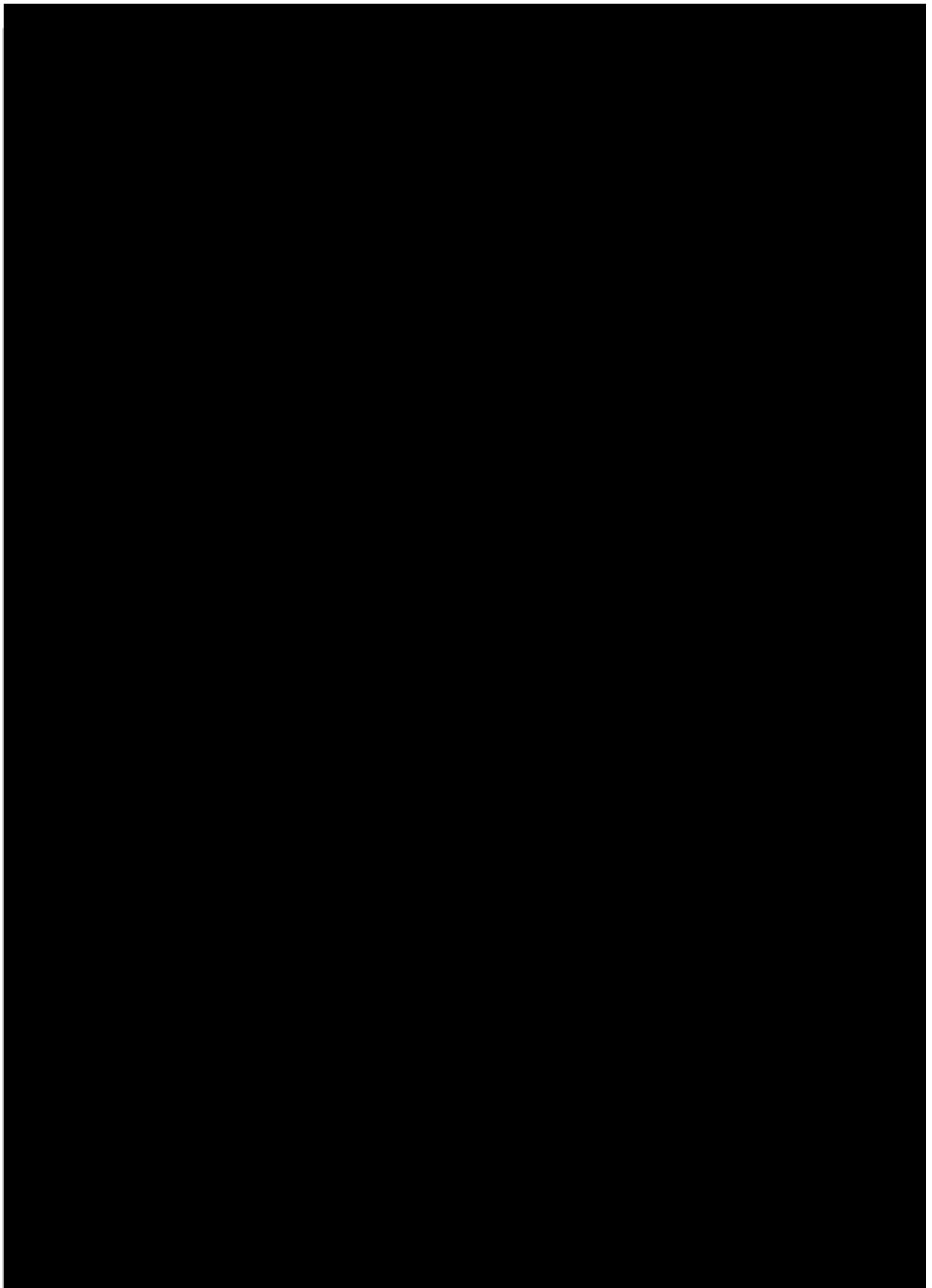
Correspondence: Judy Mannix, Senior Lecturer, Director, Academic Programs – Postgraduate, School of Nursing & Midwifery, University of Western Sydney, Locked Bag 1797, Penrith, NSW 2751, Australia. Telephone: +61 2 46203760.
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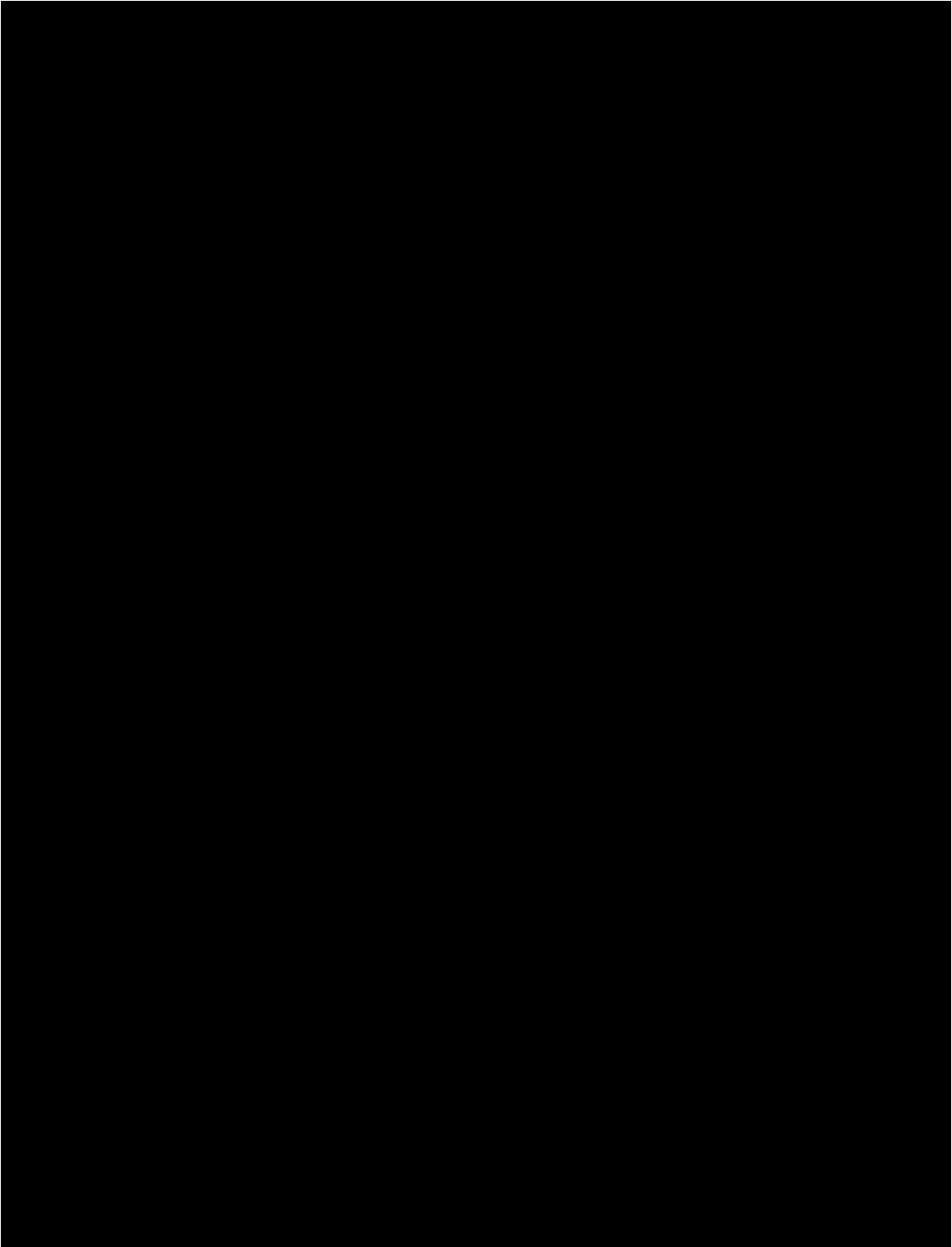


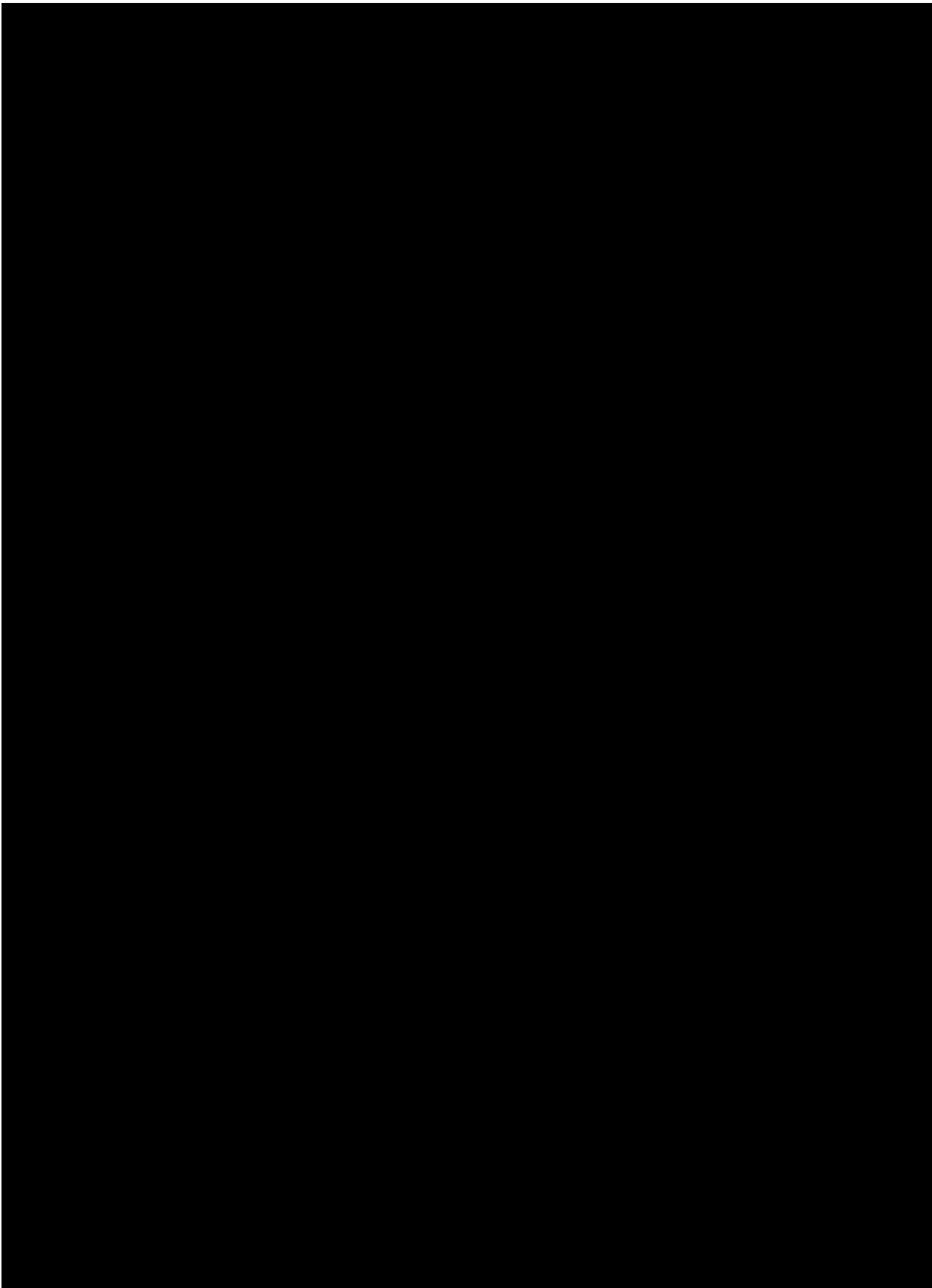


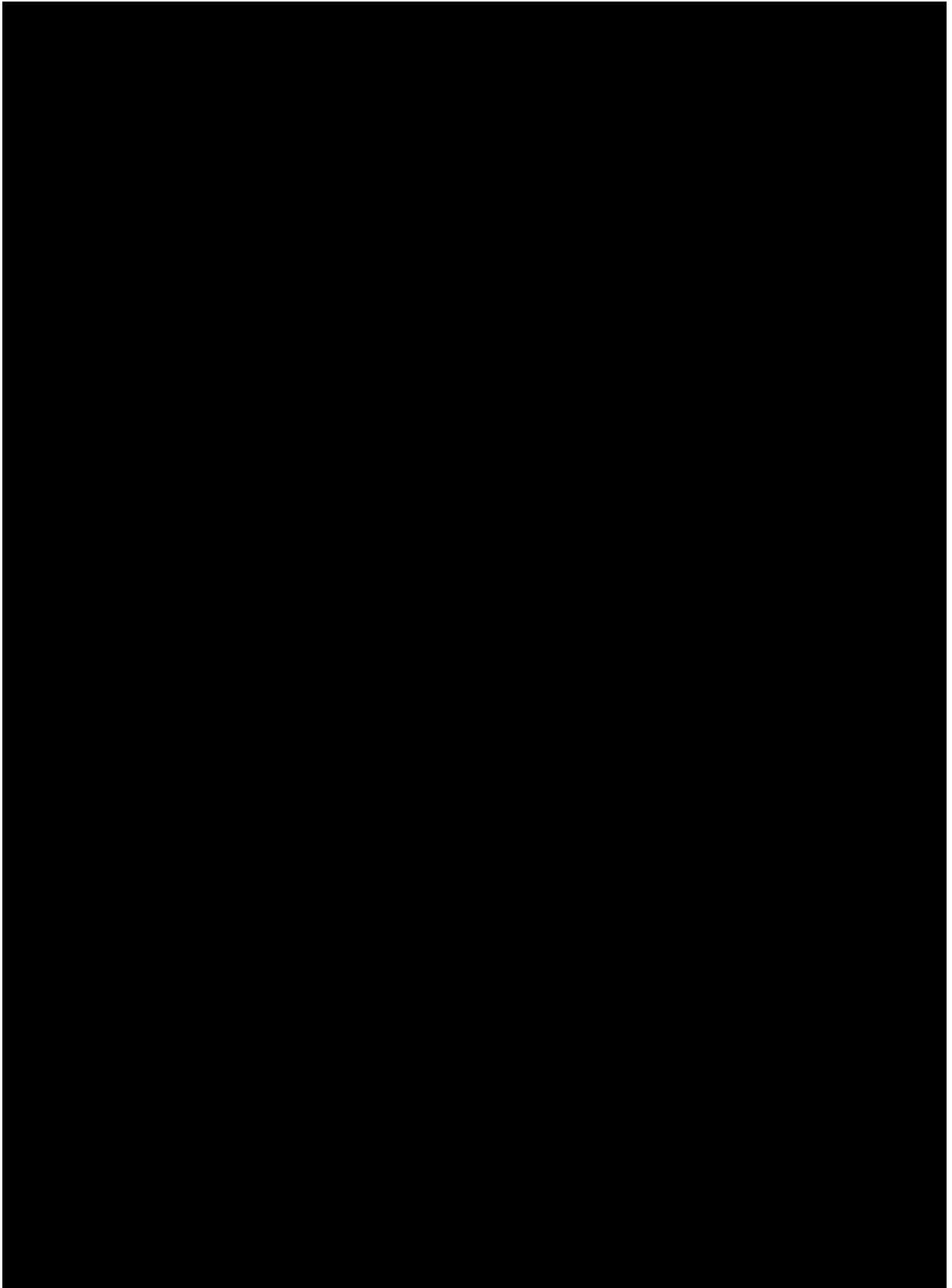


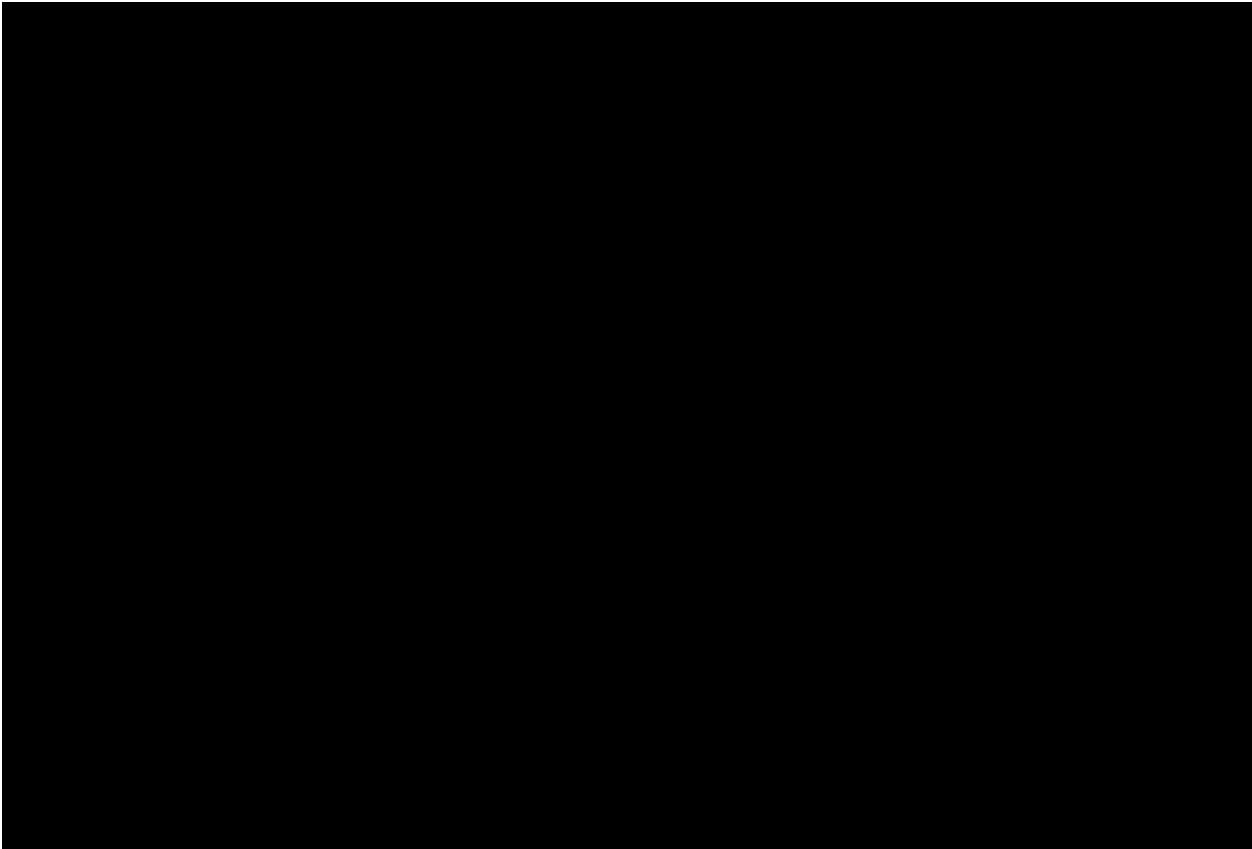












Chapter 7:

'Good ethics and moral standing': a qualitative study of aesthetic leadership in clinical nursing practice

7.1. Publication:

Mannix, J., Wilkes, L. & Daly, J. (2015). *'Good ethics and moral standing': a qualitative study of aesthetic leadership in clinical nursing practice*. *Journal of Clinical Nursing*, 24, 1603-1610. DOI: 10.1111/jocn.12761.

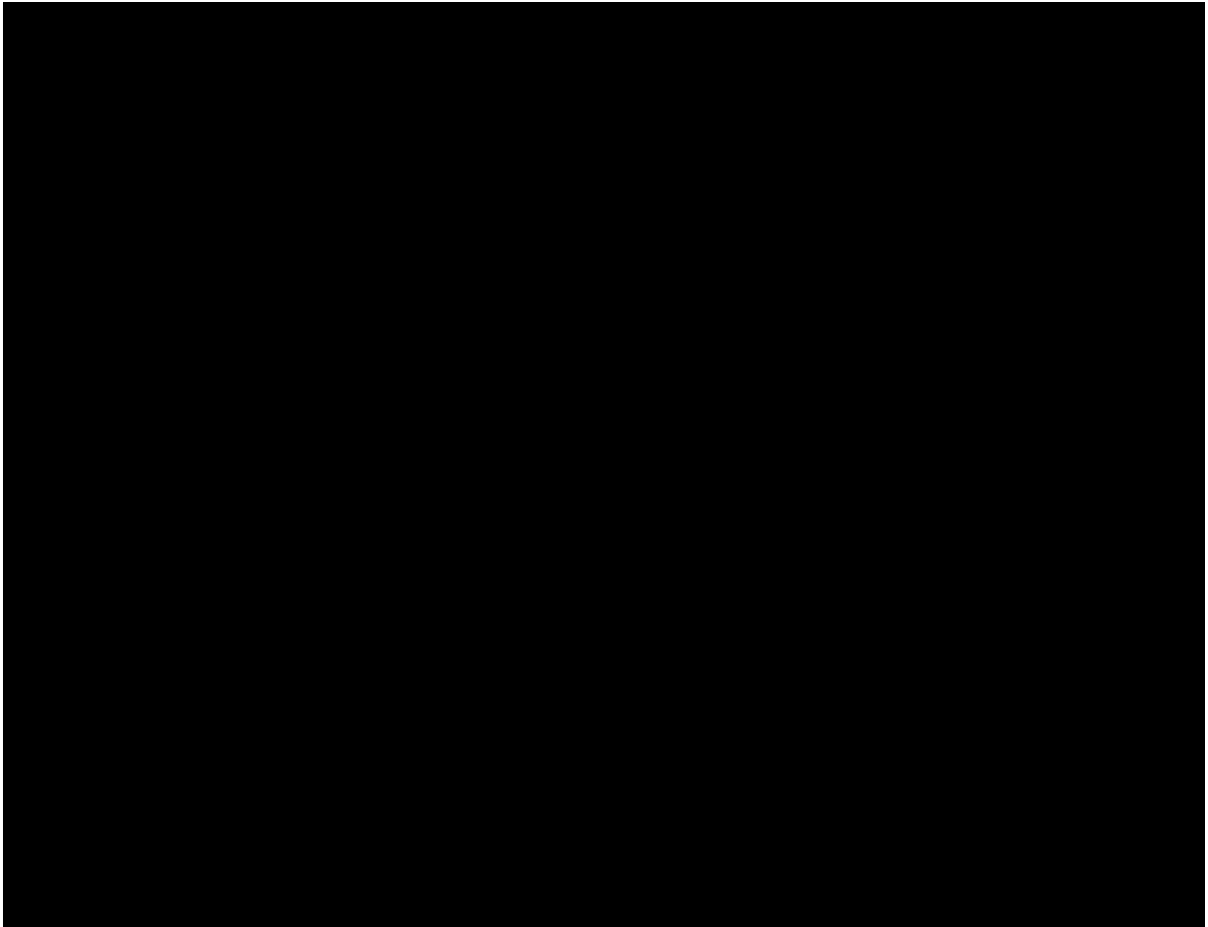
7.2. Relevance to thesis

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

ORIGINAL ARTICLE

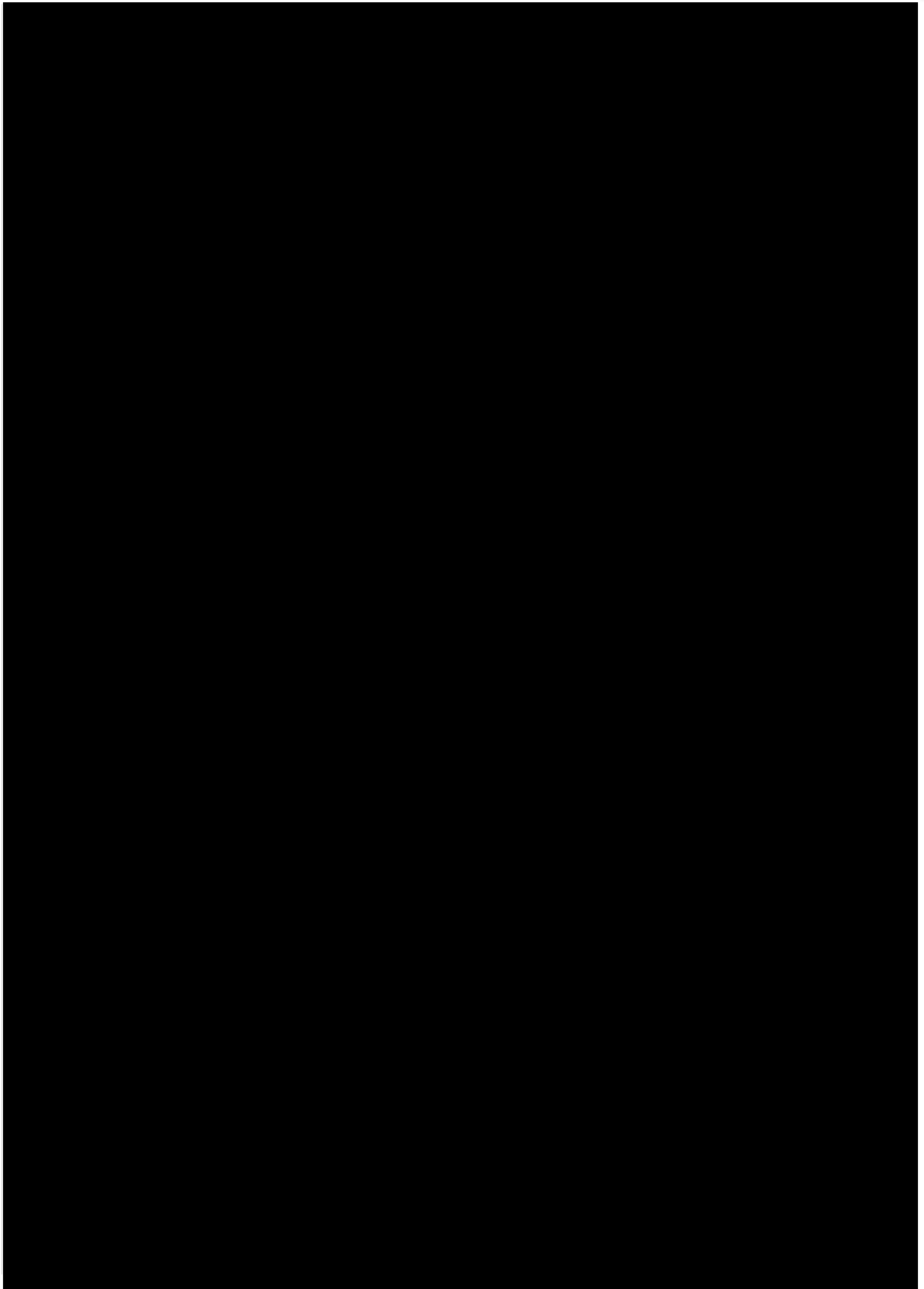
'Good ethics and moral standing': a qualitative study of aesthetic leadership in clinical nursing practice

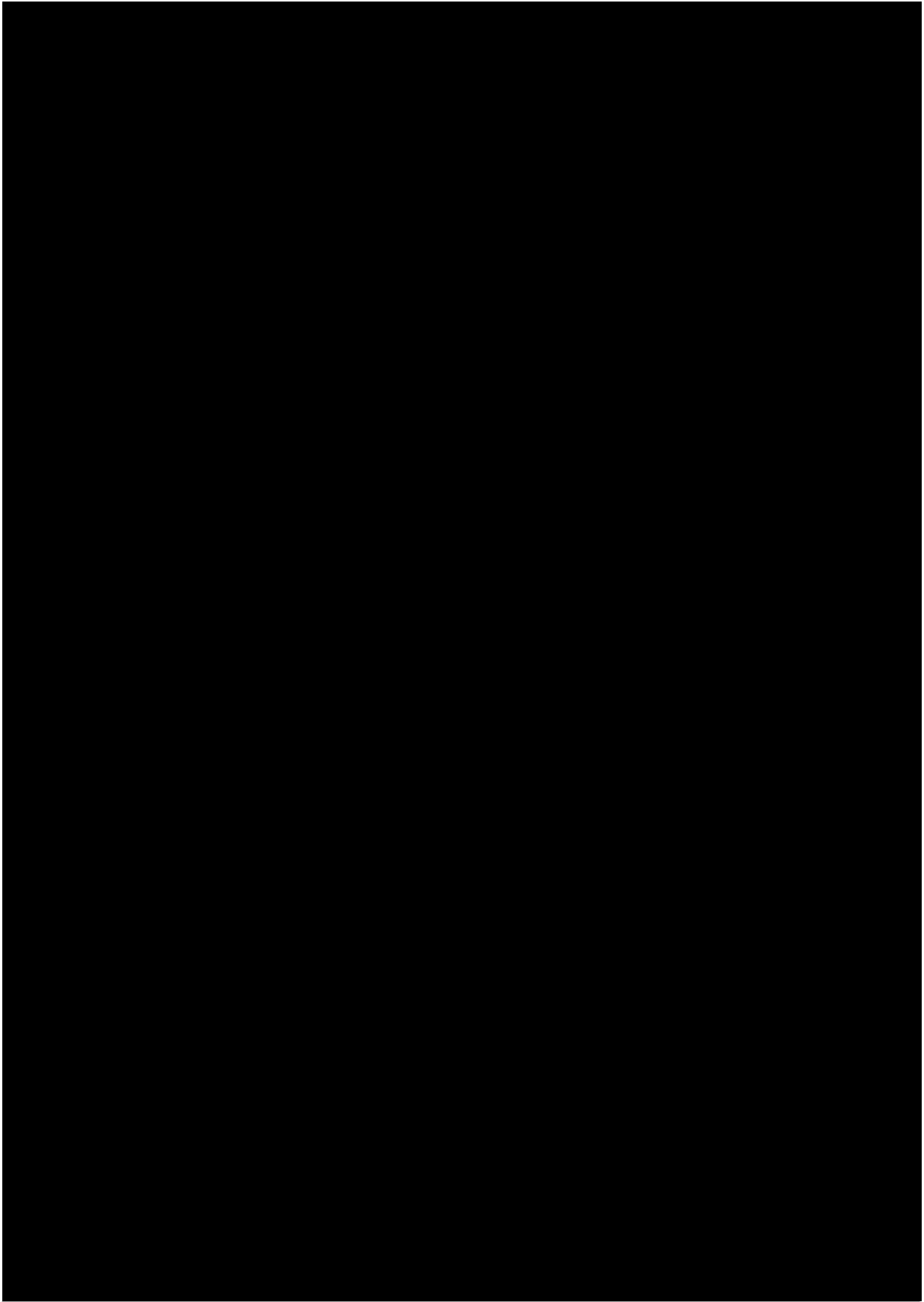
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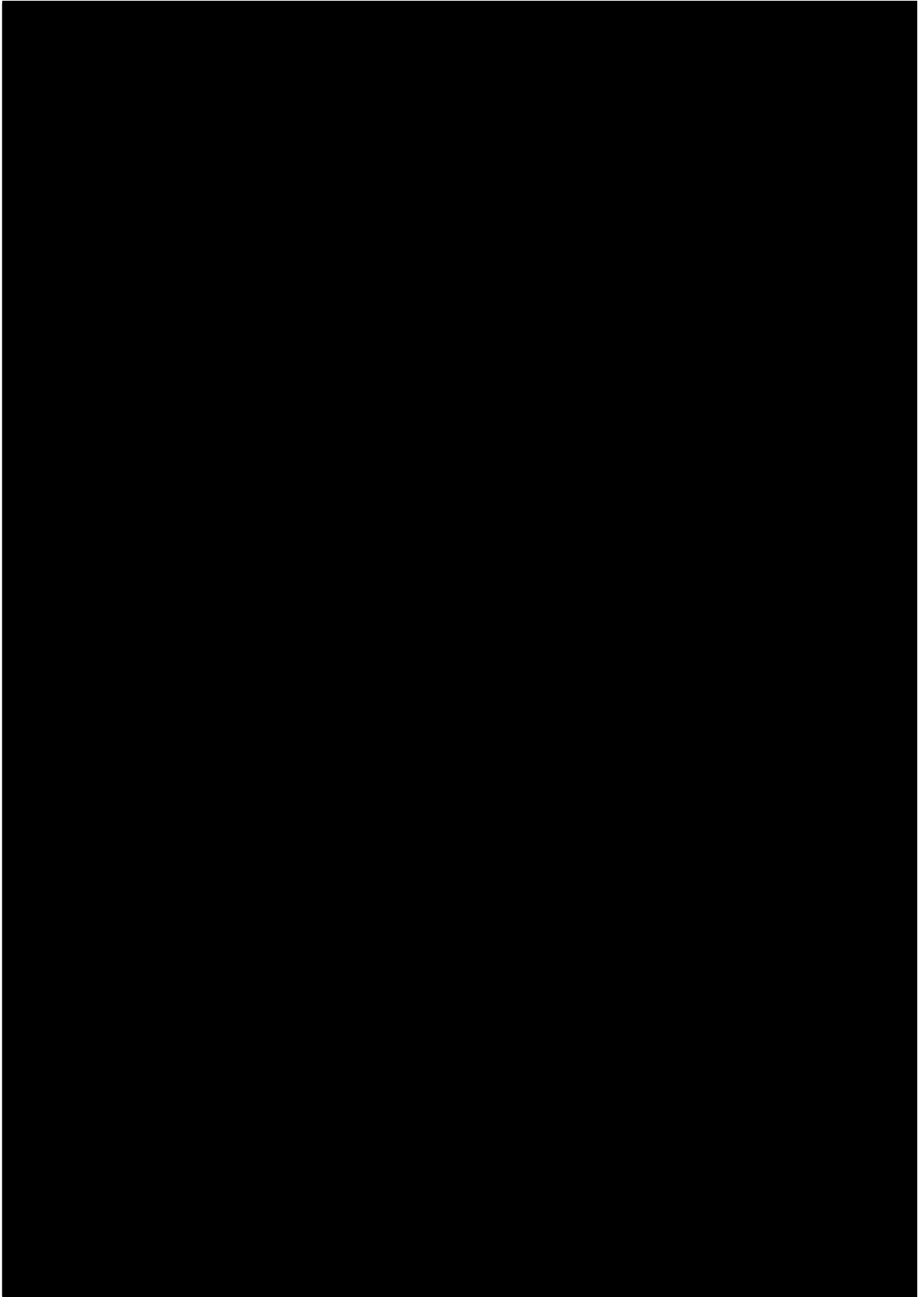


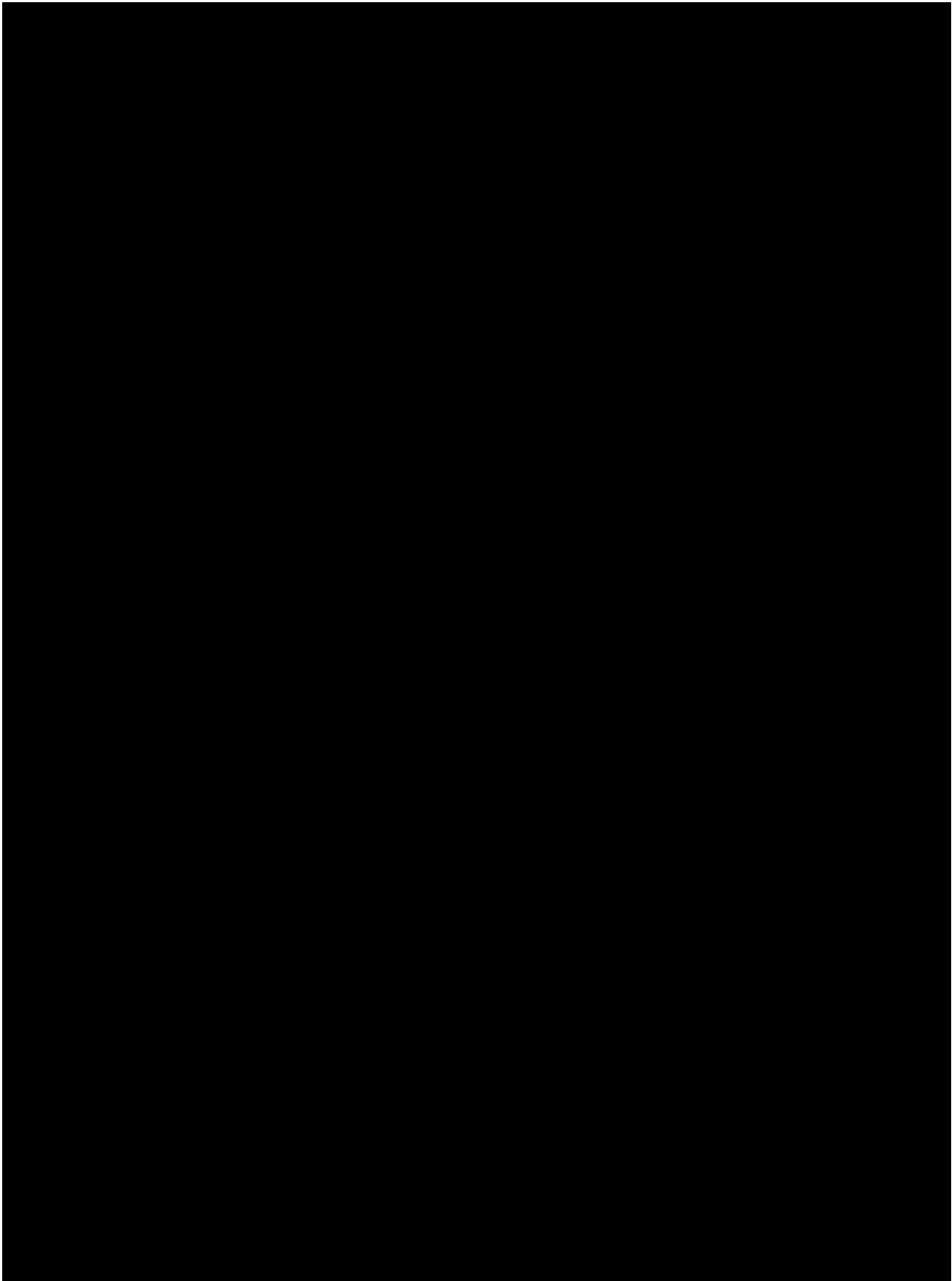
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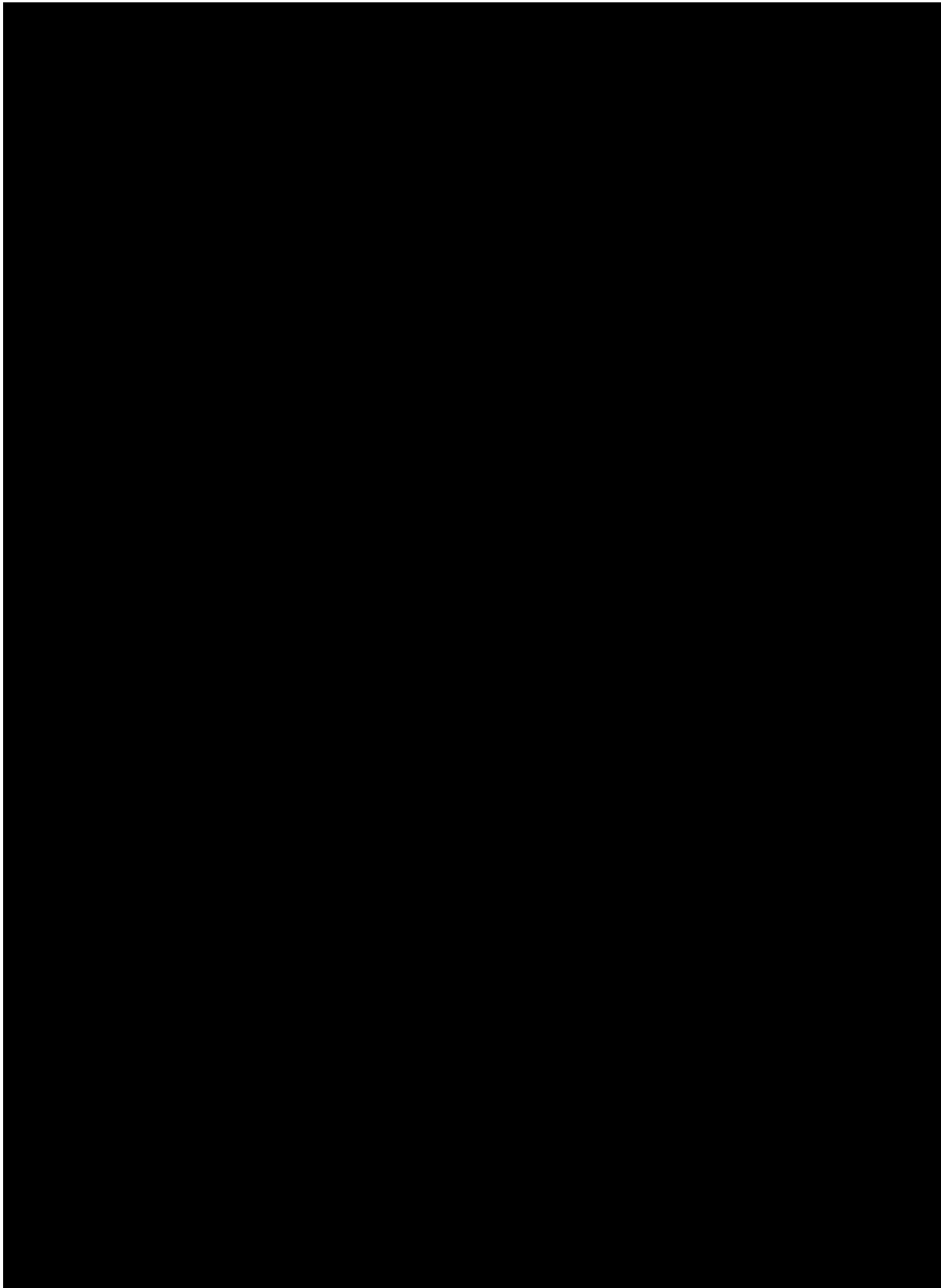
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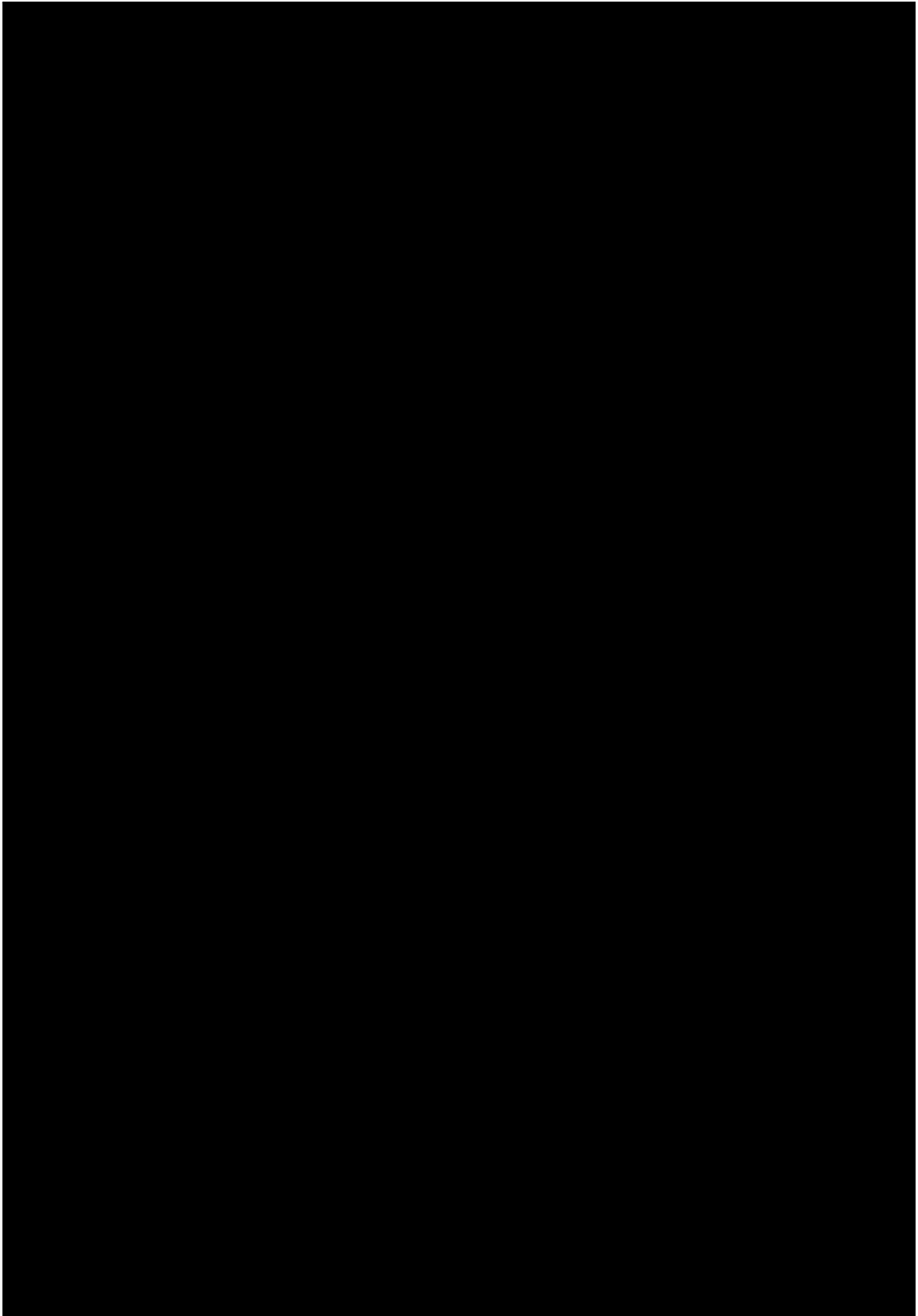


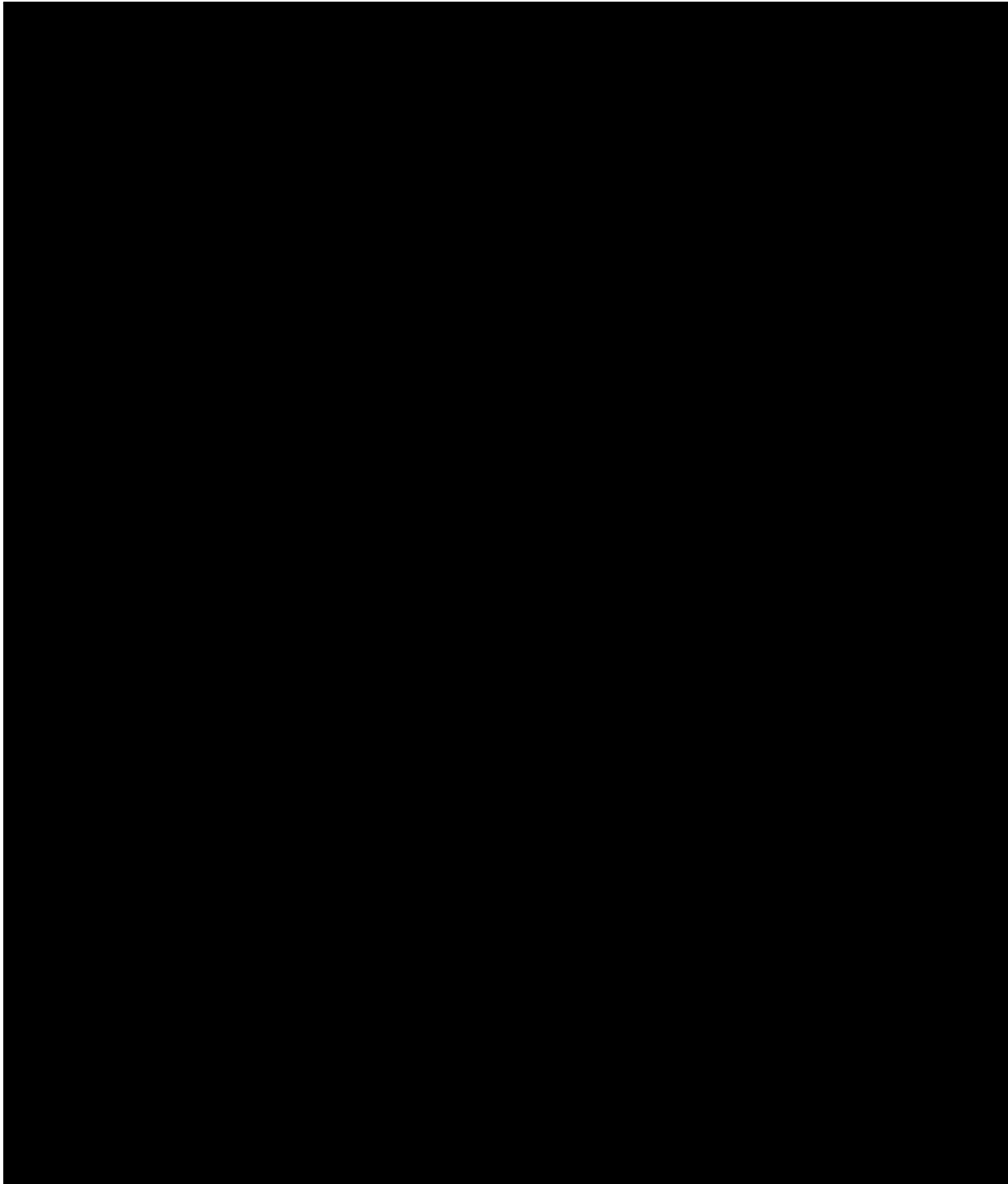












Chapter 8:

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

8.1. Publication:

Mannix, J., Wilkes, L. & Daly, J. *'Watching an artist at work': aesthetic leadership in clinical nursing workplaces. Journal of Clinical Nursing, 24, 3511-3518. DOI: 10.1111/jocn.12956.*

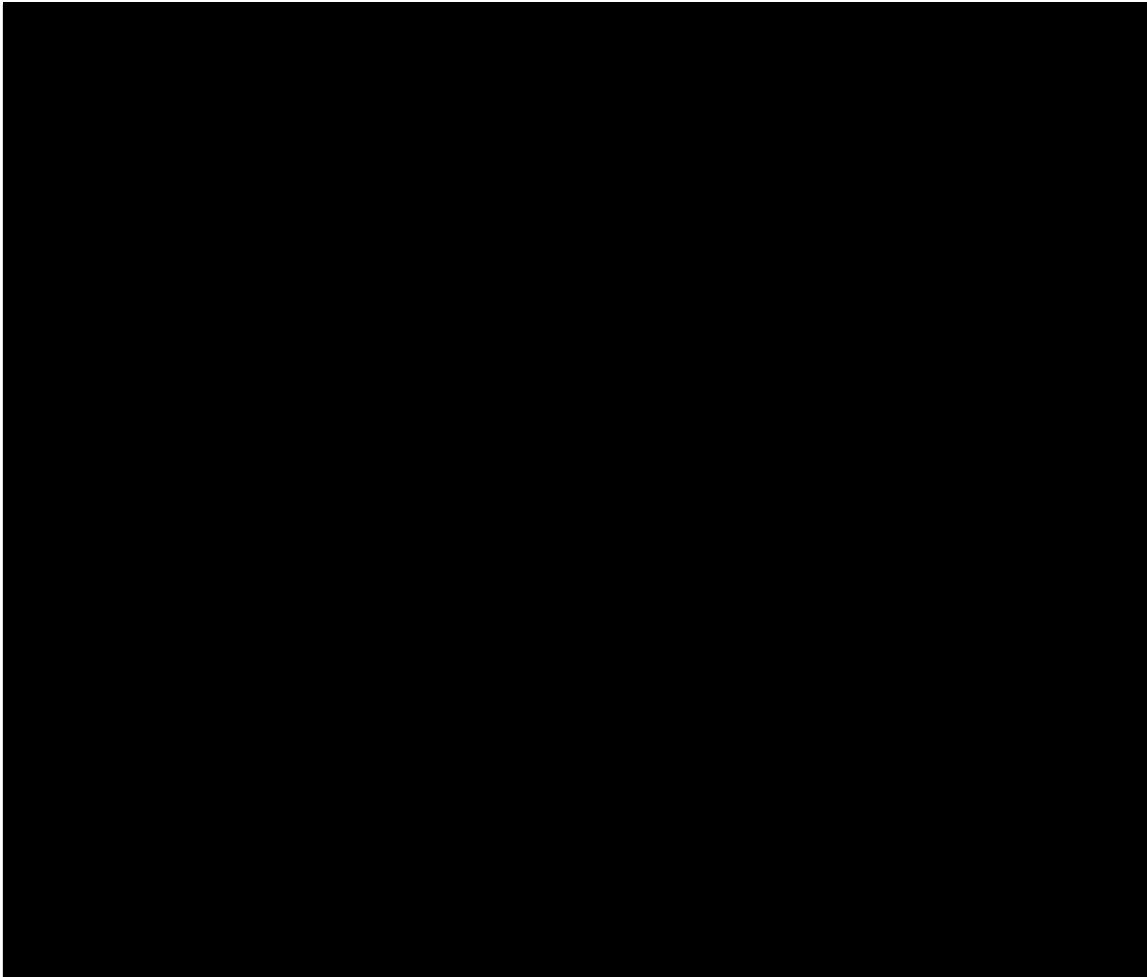
8.2. Relevance to thesis

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

ORIGINAL ARTICLE

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

Judy Mannix, Lesley Wilkes and John Daly

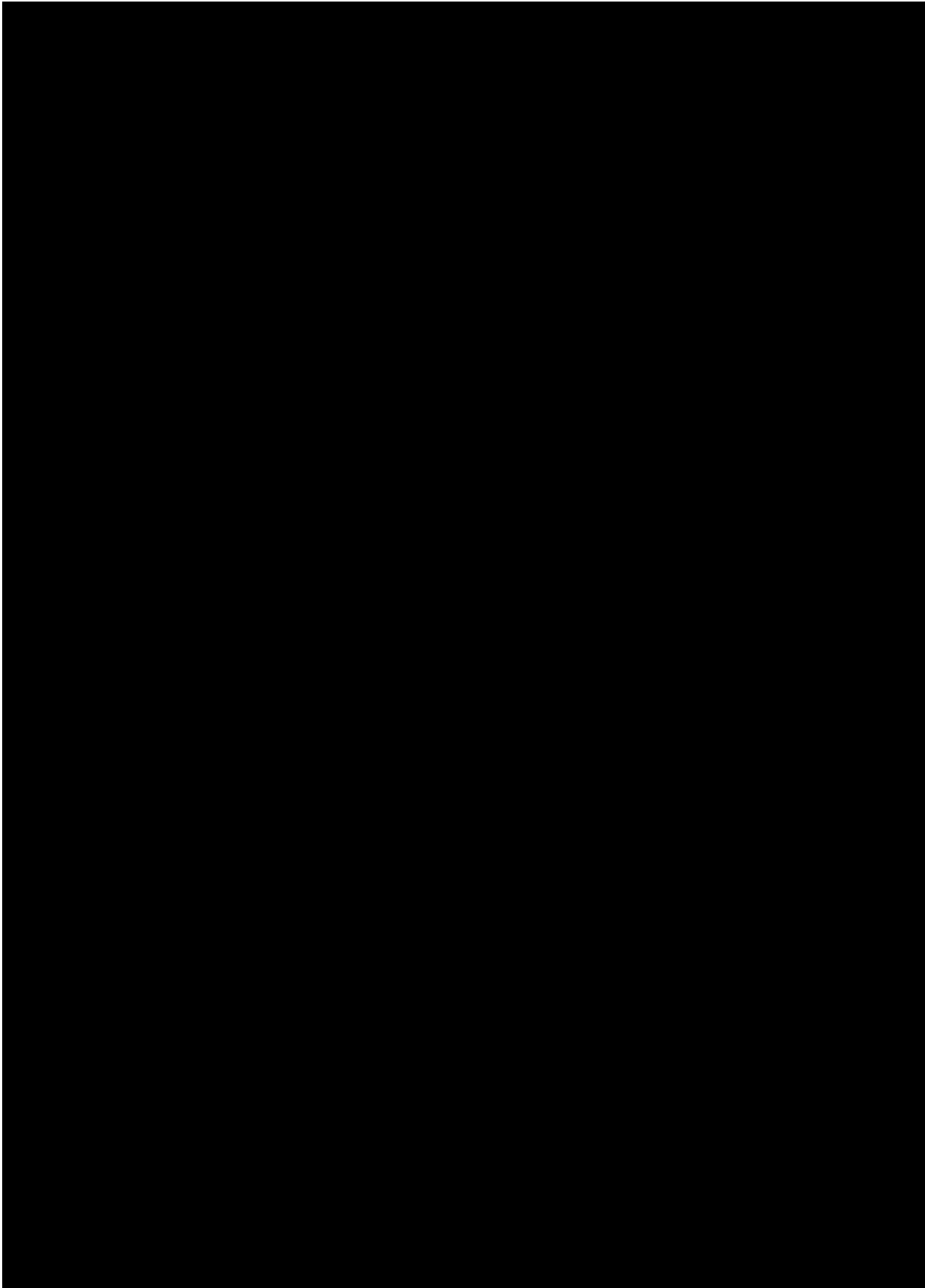


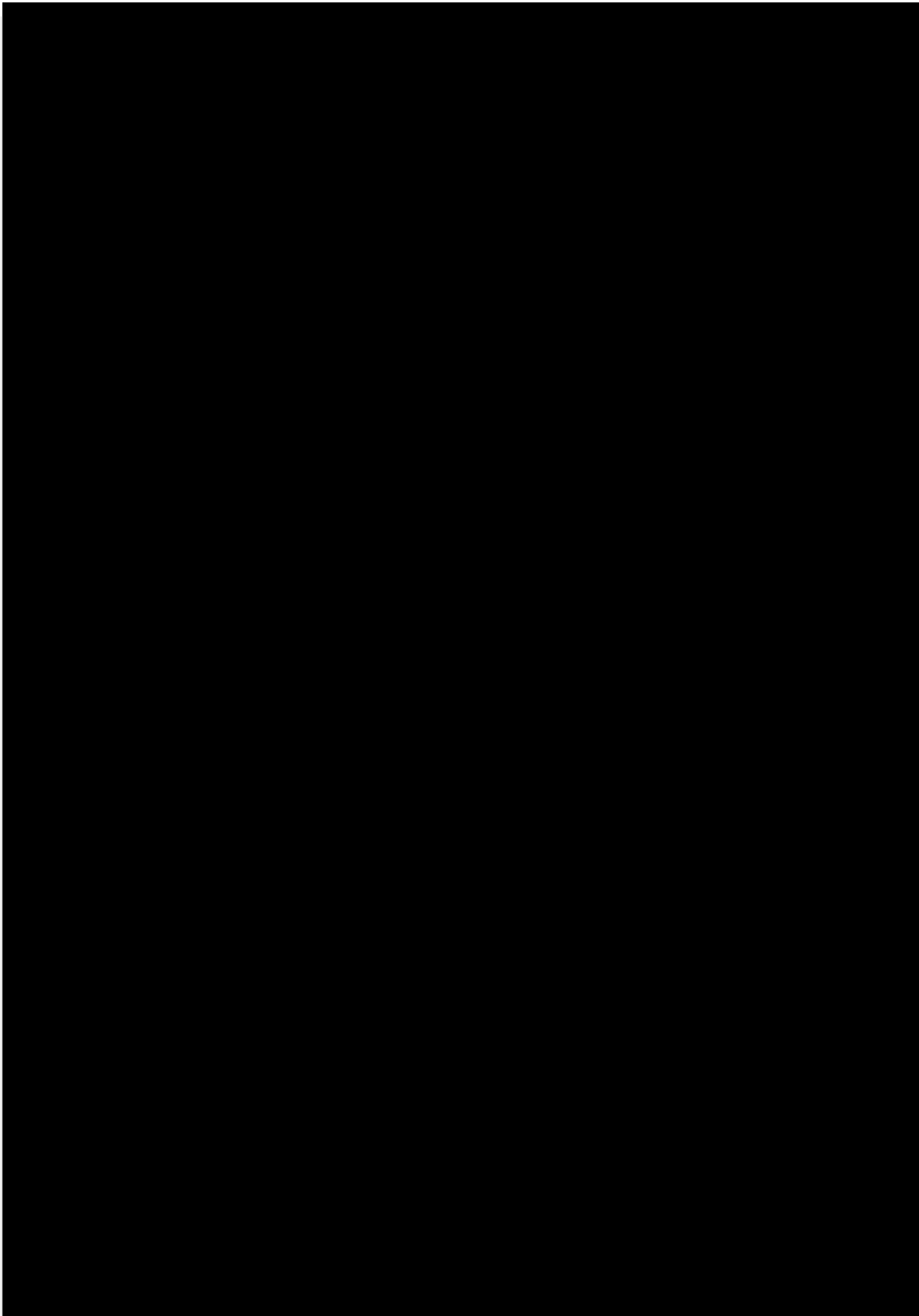
Authors: *Judy Mannix*, RN, MN, Senior Lecturer, Director of Academic Programs – Postgraduate, School of Nursing & Midwifery, University of Western Sydney, Sydney; *Lesley Wilkes*, PhD, RN, Professor of Nursing, School of Nursing & Midwifery, University of Western Sydney/Nepean Blue Mountains Local Health District, Penrith, NSW; *John Daly*, PhD, FACN, FAAN, Professor & Dean,

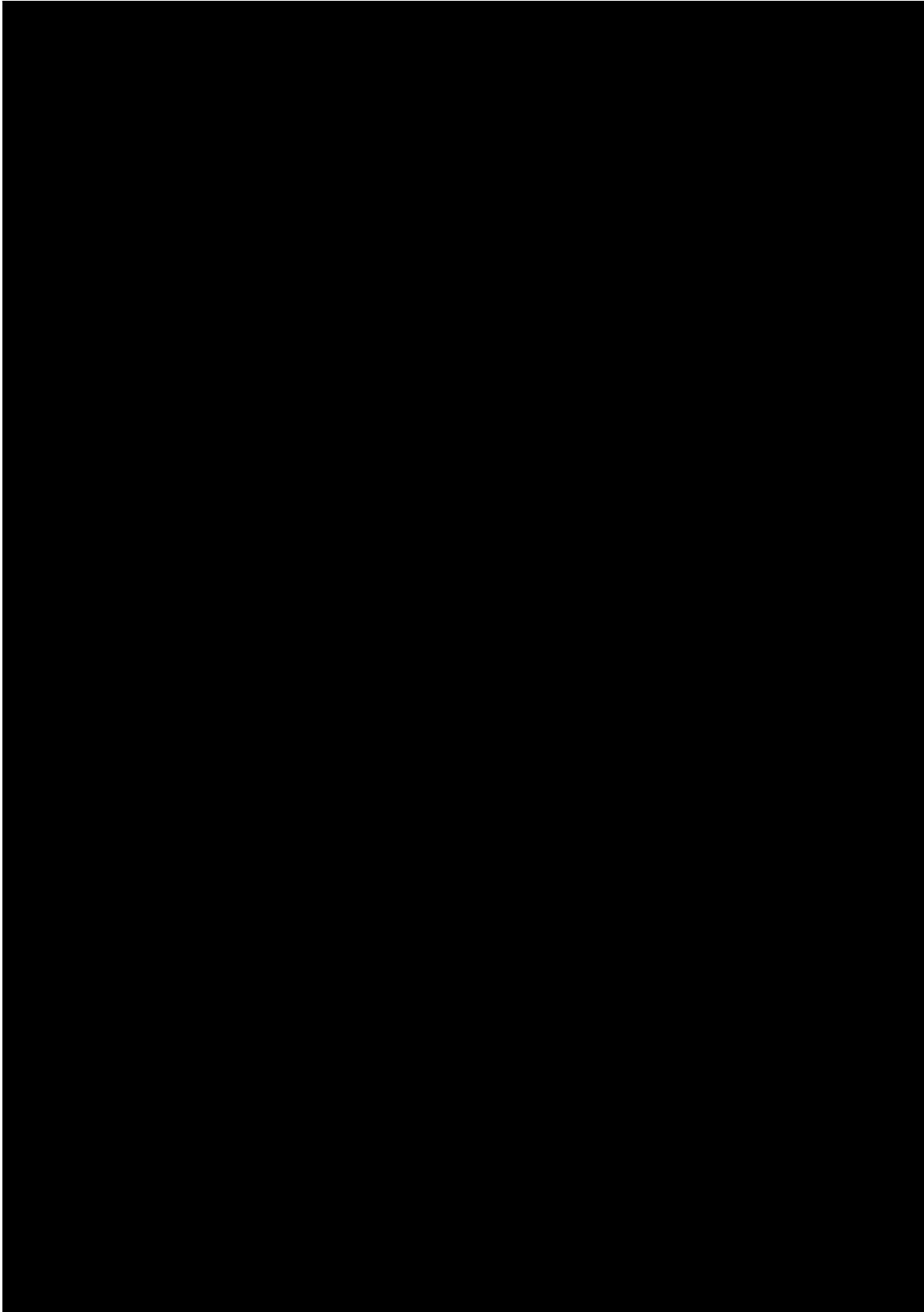
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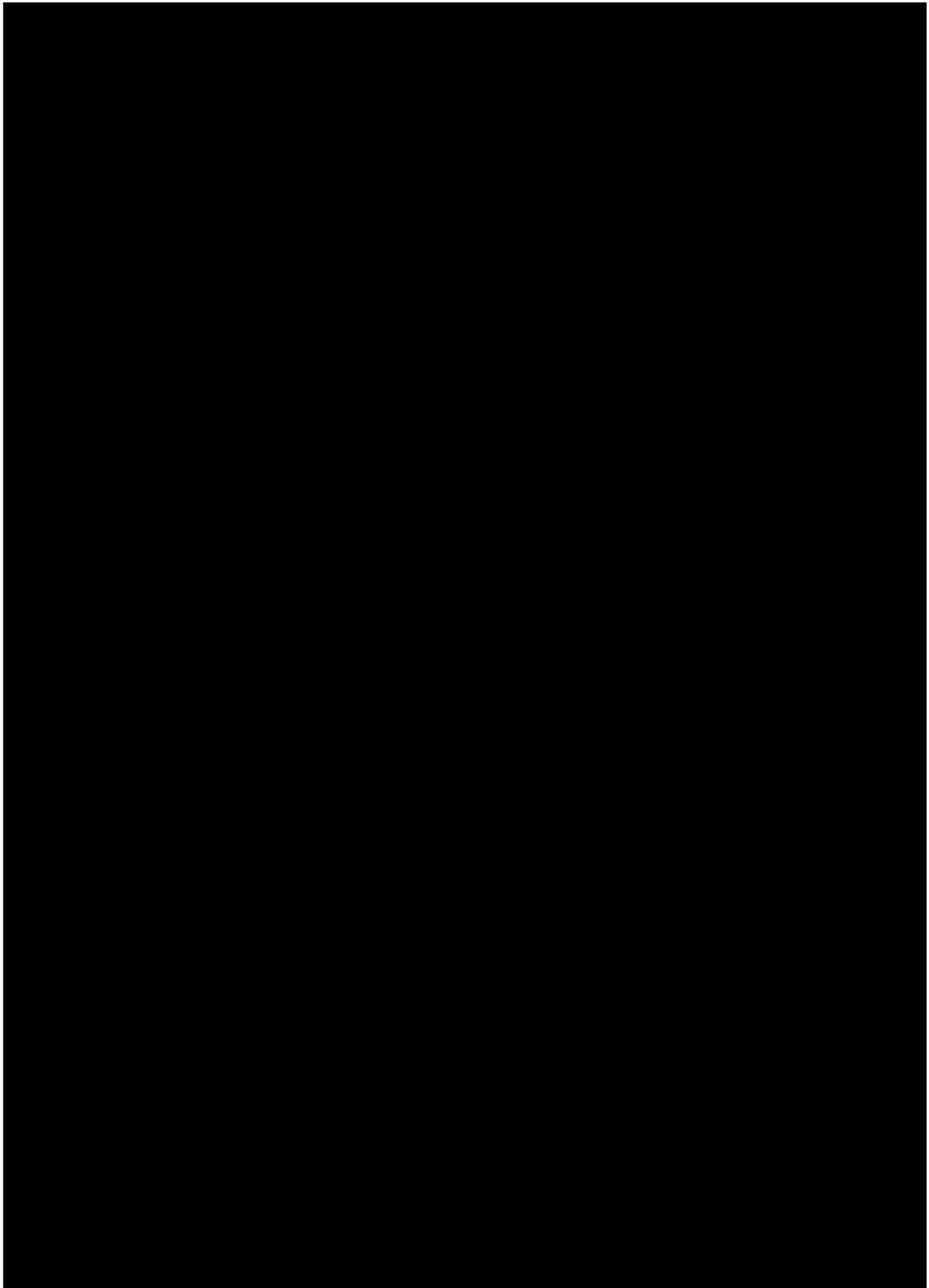
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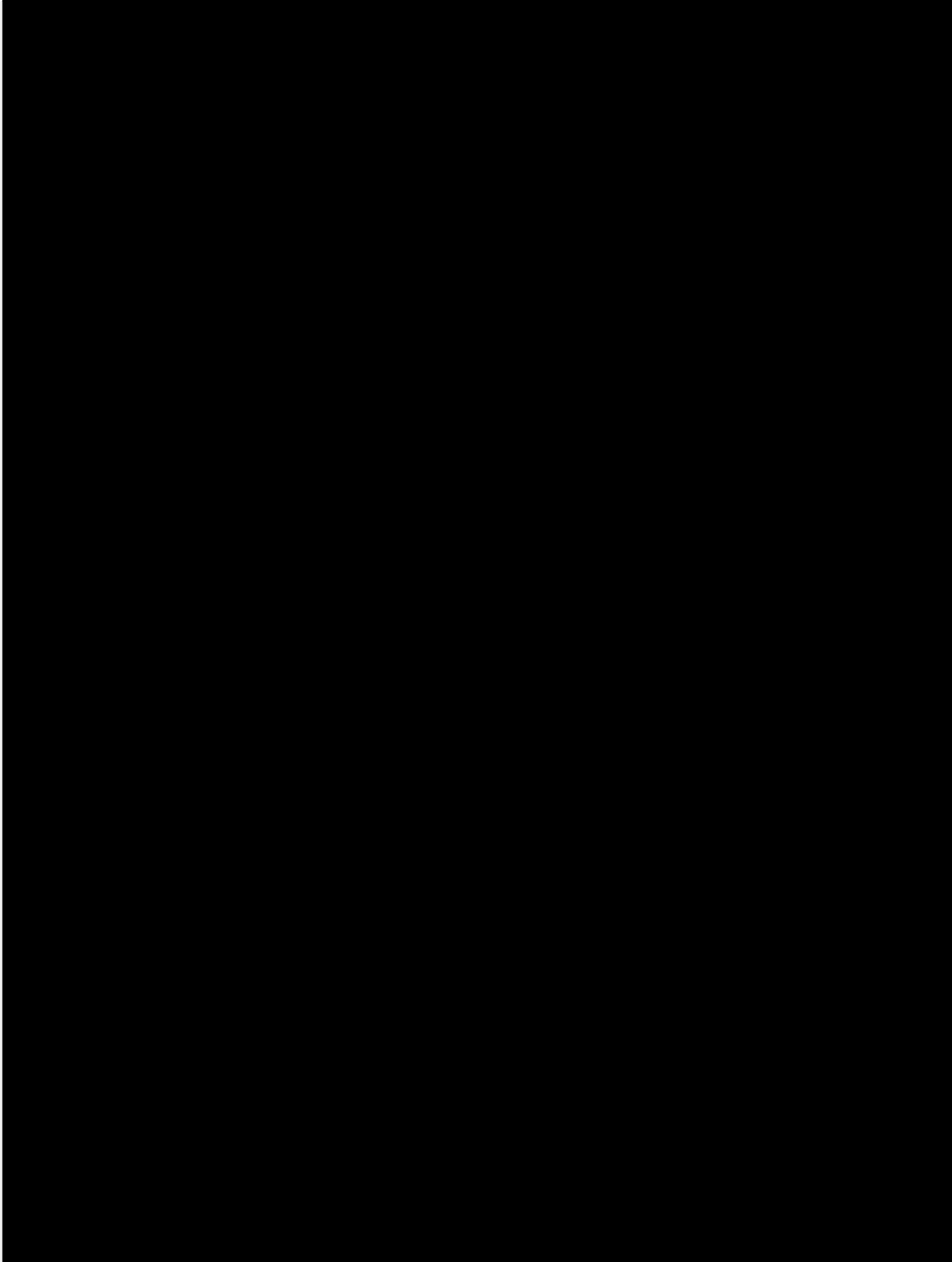
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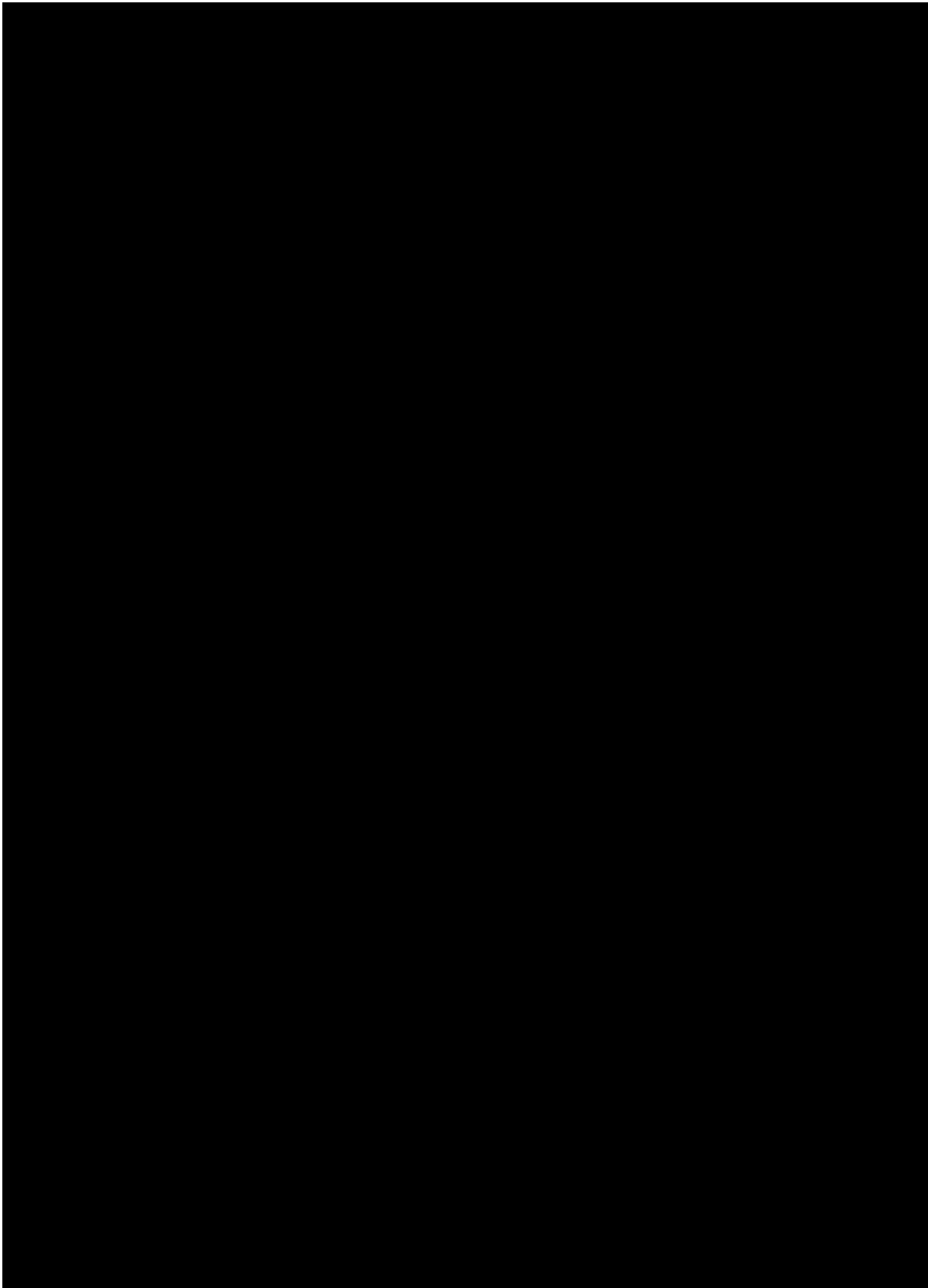


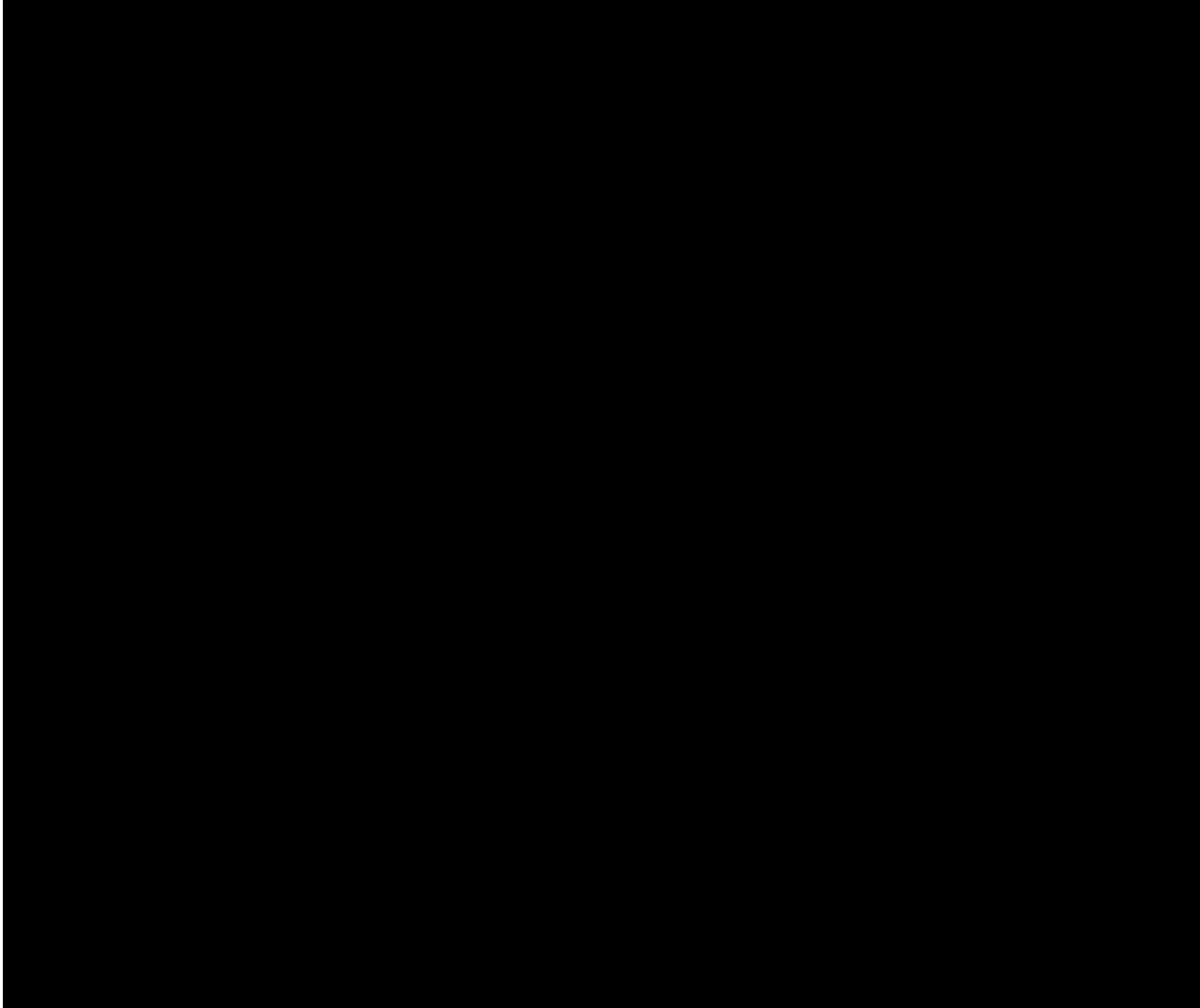












Chapter 9:

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

9.1. Introduction

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

Reflecting on the effect the artfulness of these professionally and morally mature clinical leaders created an imagery of a clinical setting with a sense of harmony, order and cohesiveness; similar to what you might imagine with a symphony orchestra beautifully playing a masterpiece. Making metaphorical comparisons between a clinical nursing workplace and a symphony orchestra can make it possible to enhance current understandings of clinical leadership from both theoretical and practical perspectives. The use of metaphor in the study of organisations and aesthetic leadership is evident in the literature. In studies on organisational theory jazz music has been used as a metaphor to explain how improvisation in decision-making compares with more traditional managerial approaches (Bathurst *et al.* 2010). Using a symphony orchestra as a metaphor has been reported in the areas of management

theory (Drucker 1996, Mintzberg 1998, 2003) and corporate executive training (Benady 2006, Snedeker 2010). Ropo and Sauer (2008) contrast the dances of a traditional waltz with modern raves to illustrate aspects of aesthetic leadership. Reasons for the use of metaphor in the study of aesthetics may be related to the way in which aesthetics and aesthetic knowledge are difficult to logically explain (Hansen *et al.* 2007), described as '*one of the most intangible aspects of higher cognition*' (D'Ausilio *et al.* 2012, e35757).

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

9.2. The orchestra pit

Imagine a clinical setting as an orchestra pit, regardless of its physical layout or its location inside a health care facility or in a community-based setting. Similarities exist between the two settings in terms of the range of human experiences – symphony music can embrace happiness, pain, loss and success (Small 1986), as can occur in clinical settings. Like contemporary healthcare settings, a symphony orchestra comprises a number of individuals with specialist skill sets. The size of a symphony orchestra can vary but typically, comprises over 90 musicians, organised into sections, depending on their musical instrument (Kennedy & Bourne Kennedy 2007). The whole orchestra is overseen and managed by a conductor. As represented in Figure 9.1 on the next page, an orchestra has four main sections, with an occasional fifth section that may include a piano or harp. The string instruments of the violin family plus double basses is the largest section and forms the basis of the orchestra, and while the woodwind, brass and percussion sections are usually present, the instruments in these sections can vary in numbers and types, according to the performance (Spitzer & Zaslav 2004).

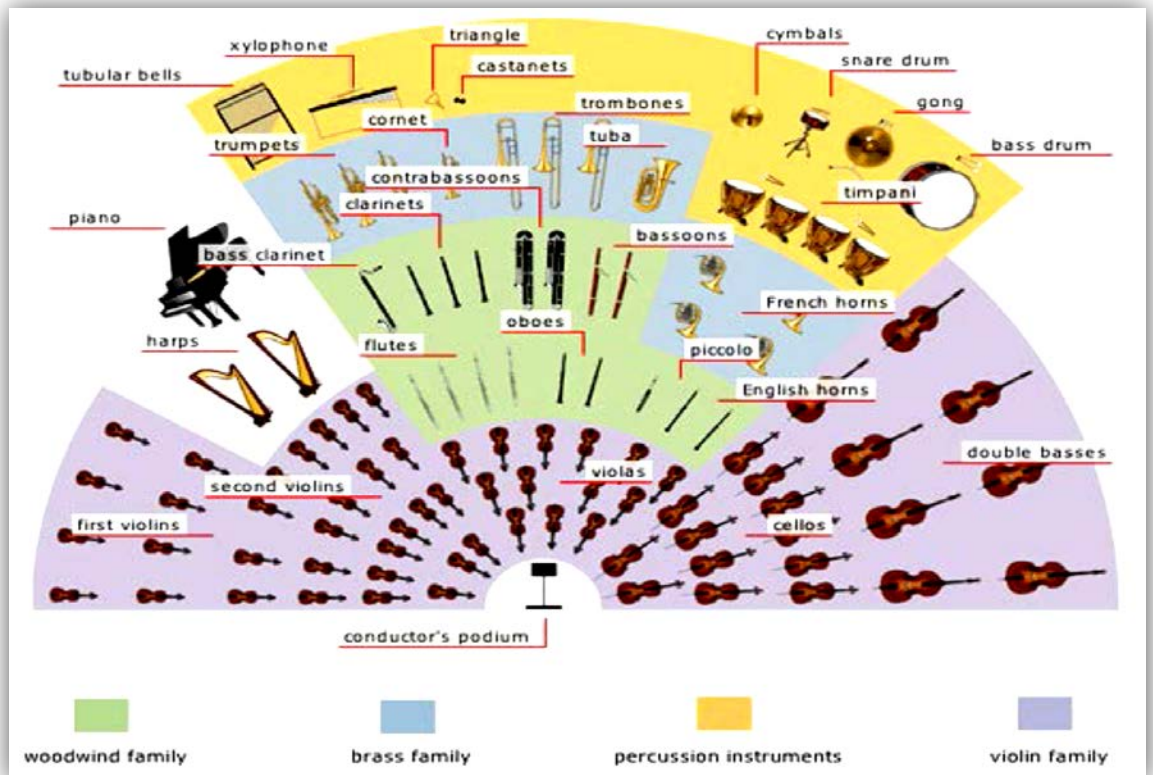


Figure 9.1: Composition of a symphony orchestra

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If one were to transpose sections in the orchestra to groups within a clinical setting, the string section, as the largest section and the basis of the orchestra could represent nursing staff. The brass section of the orchestra, with its size and variety of instruments based on the particular repertory, could denote allied health professionals (for example, physiotherapist, radiologist, pathologist, social worker) who enter and leave the clinical setting as required. The influence doctors have on when patients/clients enter and leave a clinical setting generally sets the rhythm and pace for the setting, in much the same way as the percussion section of an orchestra. The woodwind section of the orchestra is usually located in the centre of the orchestra pit, surrounded by the other sections of the orchestra (see Figure 9.1). Within the woodwind section of the orchestra is the oboe, an instrument that has the least capacity of all instruments in the orchestra to be varied in terms of pitch. For this reason, it is the instrument against which other orchestra musicians tune their instruments (Kennedy 2015). The centrality of the woodwind section and the importance of the oboe are indicative of the significant position the patient/client (oboe) and the significant people in their lives occupy in any clinical healthcare

setting. Patient-centred care, in conjunction with evidence-based practice, continue to shape contemporary health care delivery and related policy (Broom & Tovey 2012, van Bekkum & Hilton 2013).

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

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

9.3. Artful clinical leadership

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

poorly. Recent high profile government reports (Garling 2008, Francis 2013), generated in response to failings in the healthcare system, calling for more effective clinical leadership reflect this sentiment.

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

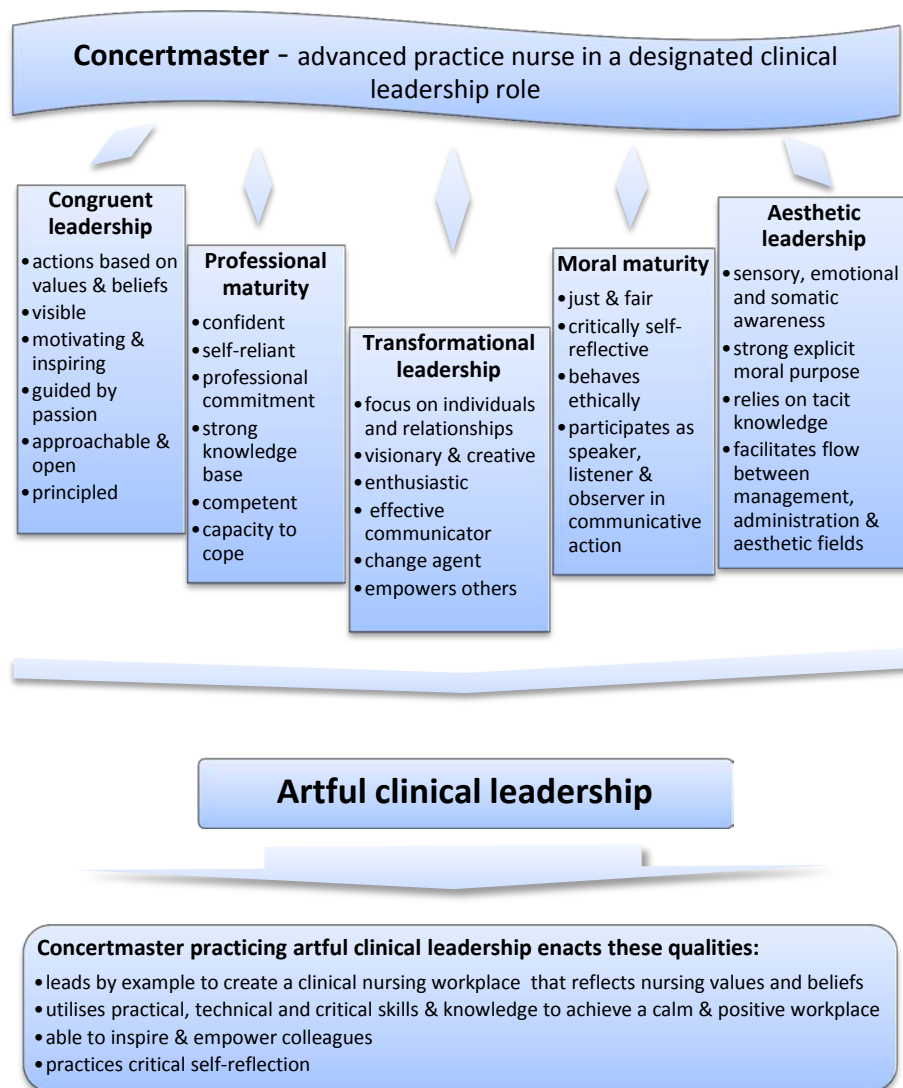


Figure 9.2: Artful clinical leadership model: A concertmaster who embodies the characteristics of professional and moral maturity and applies the attributes of the 3 leadership styles as needed practices as an artful clinical leader, enacting the 4 main artful leadership qualities listed.

In this model the concertmaster is any advanced practice nurse in a designated leadership position or role. In contemporary nursing the nomenclature may vary from titles such as Clinical Nurse Consultant, Clinical Leader, Clinical Nurse Specialist, Nurse Practitioner, or Nurse Consultant. Regardless of the title, clinical leadership is an expectation, fundamental to the role. In this position and at this level or expertise a concertmaster can determine their individual leadership style and practices. If the concertmaster chooses to thoughtfully draw on, as determined by the circumstances, the critical attributes listed in the model for the three identified leadership styles (aesthetic, congruent, transformational) and embodies the characteristics listed under professional and moral maturity, their clinical leadership will be artful. However, if they

choose not to do so, they will still be a concertmaster but will not be artful clinical leaders. Concertmasters embracing artful clinical leadership will enact all four qualities listed in Figure 9.2 as part of their day-to-day leadership activities, resulting in a positive, calm and harmonious clinical setting, whether that is an inpatient setting or in the community. Whilst it may be argued that less experienced clinical leaders embody many of the attributes listed, the critical feature of this model sits with the concertmaster's capacity to practice with sustained levels of professional and moral maturity to facilitate the appropriate application of attributes, either individually or in combination.

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

It was also apparent from the study and reported in *Chapter 8* that nursing values and beliefs shape the way the concertmasters practice their leadership in clinical settings. This finding supports Jeffrey's (2013) argument that nurses involved in roles with other responsibilities like leadership, management or education remain true to their nursing values. Reflective of these nursing values and beliefs were findings that indicated among the concertmasters that there was an explicit moral dimension to their leadership practice. As reported in *Chapter 7* the concertmasters interviewed were guided by a strong moral compass, indicative of a high level of moral maturity that emanates from extensive experience (Sumner 2010). Habermas (1990) contends, as previously mentioned in *Chapter 4*, that there are three developmental stages of moral maturity and that in the most highly developed post-conventional stage an individual is able to interact and communicate in a way that considers others

in a just and fair manner while assessing their own behaviours during the interaction. In other words, throughout the communicative action the morally mature concertmaster can participate as speaker, listener and observer (Sumner 2010), almost at an intrinsic, subconscious level, and within their *Lifeworld*. However, it needs to be recognised that the concertmasters' *Lifeworld* is invariably imposed upon by the *System* when attempts are made by artful concertmasters to emancipate followers to enact patient/client-centred care within a moral and value-laden framework.

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

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

artful concertmasters, allows for creativity, change and inspiring colleagues in clinical settings.

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

9.4. Implications for nursing practice, leadership and education

This study has provided a deeper understanding of how aesthetic leadership can influence the clinical nursing workplace. It is evident from the findings that a number of implications can be drawn from the study in relation to nursing practice, leadership and education. Possibly the most significant implication to be drawn from this study is how the model of artful clinical leadership provides a new and alternate way of conceptualising contemporary clinical leadership, especially for those nurses in designated leadership positions. To date, the leadership requirements for these designated leadership roles have been based around clinical leadership domains and competency standards (National CNS Competency Task Force (NACNS) 2010, NSW Health 2011) that tend to be generic and focus practical and technical skills and knowledge. Expectations for registered nurses seeking such roles tend to focus on a minimum number of years of clinical experience in the relevant clinical specialty. Leadership expectations for these roles may be detailed (see NACNS 2010) or simply be one of a number of generic selection criteria set out in a position description. In jurisdictions where designated clinical leadership positions are graded, leadership functions are differentiated according to expectations of the clinical leader's sphere of influence, be it local, national or international (see for example, NSW Health 2011).

The artful clinical leadership model offers a detailed blueprint of attributes required by those advance practice nurses who are in or aspire to senior and sometimes more highly graded clinical leadership positions. Consideration needs to be given the notion of different levels of leadership expertise, in the much same way that nursing practice has been identified in Benner's (1984) model from novice to expert. The concertmasters in this artful leadership model have the capacity to enhance clinical nursing workplaces and improve clinical leader effectiveness through their expert clinical leadership. The findings from this study have shown that when concertmasters practice artfully there are positive effects for those inhabiting the clinical world. The composed way in which concertmasters practice with the key attributes of aesthetic leadership can inform those providing professional development programs that target aspiring clinical leaders. The contribution of aesthetic leadership and the way in which professional maturity and moral maturity can together facilitate artfulness among clinical leaders could be important inclusions in clinical leadership education programs for nurses, including those already in clinical leadership positions.

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

In light of findings in this study education programs designed to enhance the knowledge and skills of clinical leaders also need to take a broader view of what

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

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

9.5. Limitations of the study

Within a critical framework and using a mixed-methods approach this study was able to explore what aesthetic leadership has to offer contemporary clinical leadership in

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

9.6. Directions for further research

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

- The online descriptive survey, despite its relatively poor response rate, yielded some interesting data. It would be worthwhile repeating this aspect of the study, with some minor modifications to the instrument and revised strategies for recruitment using online social networks. The potential exists to gain increased understandings about important aspects of clinical leadership and aesthetic leadership from nurses across world with access to online social networks.
- With the development of a new model of artful clinical leadership, further research is required to establish the consistency and rigour of the model among advanced practice nurses in clinical leadership positions in different settings and jurisdictions. This could involve considering different cultural groups, various clinical settings, and differences in interpretations of advanced practice nurses.

9.7. Concluding thoughts

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

how clinical leaders practice in their role. It remains clear that clinical leadership continues to be a complex challenge for those in the role in contemporary nursing.

References

- Andrew, S. & Halcomb, E. (2012). Mixed methods research. In S. Borbasi & D. Jackson (eds.), *Navigating the Maze of Research: Enhancing Nursing and Midwifery Practice* (3rd ed.). Chatswood: Elsevier.
- Andrews, D.R., Richard, D., Robinson, P., Celano, P. & Hallaron, J. (2012). The influence of staff nurse perception of leadership style on satisfaction with leadership: a cross-sectional survey of pediatric nurses. *International Journal of Nursing Studies*, 49, 1103-1111.
- Armstrong, M., Johnston, B., Bridges, R. & Gessner, B. (2003). The impact of graduate education on reading for lifelong learning. *The Journal of Continuing Education in Nursing*, 34(1), 19-25.
- Austgard, K. (2006). The aesthetic experience of nursing. *Nursing Philosophy*, 7, 11-19.
- Australian Institute of Health & Welfare (AIHW) (2013). *Nursing and midwifery workforce 2012*. National Health Workforce Series no.6. Cat. no.HWL52. Canberra: AIHW.
- Avis, M. & Freshwater, D. (2006). Evidence for practice, epistemology, and critical reflection. *Nursing Philosophy*, 7, 216-224.
- Baernholdt, M. & Cottingham, S. (2011). The Clinical Nurse Leader – new nursing role with global implications. *International Nursing Review*, 58, 74-78.
- Barry, C.A., Stevenson, F.A., Britten, N., Barber, N., & Bradley, C.P. (2001). Giving voice to the lifeworld. More humane, more effective medical care? A qualitative study of doctor–patient communication in general practice. *Social Science & Medicine*, 53(4), 487-505.
- Barry, D. & Meisiek, S. (2010). The art of leadership and its fine art show. *Leadership*, 6(3), 331-349.
- Bathurst, R., Jackson, B. & Statler, M. (2010). Leading aesthetically in uncertain times, *Leadership* 6(3), 311-330.
- Benady, A. (2006). Education: Further: State of the art in teambuilding: Playing in an orchestra: A valuable bonding exercise, or noisy embarrassment? *The Guardian*. Retrieved from <http://search.proquest.com/docview/246521869?accountid=36155>
[Accessed 14/2/2015.](#)
- Benner, P. (1984). *From Novice to Expert: Excellence and Power in Clinical Nursing*. Menlo Park, Calif: Addison-Wesley Pub.
- Braun, S., Peus, C., Weisweiler, S. & Frey, D. (2102). Transformational leadership, job satisfaction, and team performance: A multilevel mediation model of trust. *The Leadership Quarterly*, <http://dx.doi.org/10.1016/j.leaqua.2012.11.006>
- Broom, A. & Tovey, P. (2012). Patient understandings of evidence and therapeutic effectiveness. In A. Broom & J. Adams (eds.), *Evidence-based Healthcare in Context: Critical Social Science Perspectives*. Surrey, UK: Ashgate.
- Brown, C. (1991). Aesthetics in nursing administration: The art of nursing in organizations. *Nursing Administration Quarterly*, 16(1), 61-70.
- Carper, B. (1978). Fundamental patterns of knowing. *Advances in Nursing Science* 1(1), 13-23.

- Christiansen, A., Vernon, V. & Jinks, A. (2013). Perceptions of the benefits and challenges of the role of advance practice nurses in nurse-led out-of-hours care in Hong Kong: A questionnaire study. *Journal of Clinical Nursing*, 22, 1173-1181.
- Clavelle, J. & Drenkard, K. (2012). Transformational leadership practices of chief nursing officers in Magnet organizations. *Journal of Nursing Administration*, 42(4), 195-201.
- Cleary, M., Horsfall, J. & Jackson, D. (2013). Teaching mental health nursing is, at the very least, a craft, an art, and a science. *Issues in Mental Health Nursing*, 34, 136-137.
- Committee on Quality of Healthcare in America (2001). *Crossing the quality chasm: A new health system for the 21st century*. Washington, DC: Institute of Medicine. Available from: <http://www.iom.edu/Reports/2001/Crossing-the-Quality-Chasm-A-New-Health-System-for-the-21st-Century.aspx>. Accessed 21/2/2014.
- Creswell, J. (2014). *Research Design: Qualitative, Quantitative and Mixed Methods Approaches* (4th ed.). Thousand Oaks, CA; Sage.
- Creswell, J. & Plano Clark, V. (2007). *Designing and Conducting Mixed Methods Research*. Thousand Oaks, CA: Sage.
- Cummings, G. (2012). Editorial: Your leadership style – how are you working to achieve a preferred future? *Journal of Clinical Nursing*, 21, 3325-3327.
- Cummings, G., MacGregor, T., Davey, M., Lee, H., Wong, C., Lo, E., ... Stafford, E. (2010). Leadership styles and outcome patterns for the nursing workforce and work environment: A systematic review. *International Journal of Nursing Studies*, 47, 363-385.
- D'Ausilio, A., Bandino, L., Li, Y., Tokay, S., Craighero, L. *et al.* (2012). Leadership in orchestra emerges from the causal relationships of movement kinematics. *PLoS ONE*, 7(5), e35757, doi:10.1371/journal.pone.0035757.
- Dempster, J. (1991). The nurse practitioner and autonomy: Contributions to the professional maturity of nursing. *Journal of the American Academy of Nurse Practitioners*, 3(2), 75-78.
- Drucker, P.F. (1996). The shape of things to come. *Leader to Leader*, 1996(1), 12-18.
- Duff Cloutier, J., Duncan, C. & Hill Bailey, P. (2007). Locating Carper's aesthetic pattern of knowing within contemporary nursing evidence, praxis and theory. *International Journal of Nursing Education Scholarship*, 4(1), 1-11.
- Durgahee, T (1996). Promoting reflection in post-graduate nursing: A theoretical model. *Nursing Education Today*, 16, 419-426.
- Elliott, N., Higgins, A., Begley, C., Lalor, J., Sheerin, F., Coyne, I. & Murphy, K. (2013). The identification of clinical and professional leadership activities of advanced practitioners: Findings from the Specialist Clinical and Advanced Practitioner Evaluation study in Ireland. *Journal of Advanced Nursing*, 69(5), 1037-1050.
- Elo, S. & Kyngas, H. (2008). The qualitative content analysis process. *Journal of Advanced Nursing*, 62(1), 107–115.
- Elsaid, E. & Ursel, N. (2011). CEO succession, gender and risk taking. *Gender in Management: An International Journal* 26(7), 499-512.
- Ennis, G., Happell, B. & Reid-Searl, K. (2015). Clinical leadership in mental health nursing: The importance of a calm and confident approach. *Perspectives in Psychiatric Care*, 51(1), 57-62. doi: 10.1111/ppc.12070.

- Finfgeld-Connett, D. (2008). Concept synthesis of the art of nursing. *Journal of Advanced Nursing*, 62(3), 381-388.
- Finfgeld-Connett, D. (2008a). Meta-synthesis of caring in nursing. *Journal of Clinical Nursing*, 17, 196-204.
- Fisher, K. (2003). Demystifying critical reflection: Defining criteria for assessment. *Higher Education & Research Development*, 22(3), 313-325.
doi:[10.1080/0729436032000145167](https://doi.org/10.1080/0729436032000145167)
- Francis, K. L., & Mills, J. E. (2011). Sustaining and growing the rural nursing and midwifery workforce: Understanding the issues and isolating directions for the future. *Collegian*, 18(2), 55-60.
- Francis, R. (2013). *Report of the Mid Staffordshire NHS Trust Public Inquiry- Executive Summary*. London: The Stationary Office.
- Freshwater, D. (2004). Aesthetics and evidence-based practice in nursing: An oxymoron? *International Journal of Human Caring*, 8(2), 8-11.
- Friere, P. (1974). *Education: The Practice of Freedom*. London: Writers and Readers.
- Fry, M., Duffield, C., Baldwin, R., Roche, M., Stasa, H. & Solman, A. (2013). Development of a tool to describe the role of the clinical nurse consultant in Australia. *Journal of Clinical Nursing*, 22, 1531-1538.
- Garbett, R. & McCormack, B. (2001). The experience of practice development: An exploratory telephone interview study, *Journal of Clinical Nursing*, 10, 94-102.
- Garling, P. (2008). *Final Report of the Special Commission of Inquiry: Acute Care in NSW Public Hospitals, 2008 – Overview*. Sydney: NSW Government.
- Gaydos, H. (2003). The cocreative aesthetic process: A new model for aesthetics in nursing. *International Journal for Human Caring*, 7(3), 40-44.
- Gendron, D. (1994). The tapestry of care. *Advances in Nursing Science*, 17(1), 25-30.
- Geuss, R. (1981). *The Idea of Critical Theory*. Cambridge: Cambridge University Press.
- Giddings, L. & Grant, B. (2006). Mixed methods research for the novice researcher. *Contemporary Nurse*, 23, 3-11.
- Gregorowski, A., Brennan, E., Chapman, S., Gibson, F., Khair, K., May, L. & Lindsay-Waters, A. (2013). An action research study to explore the nature of the nurse consultant role in the care of children and young people. *Journal of Clinical Nursing*, 22, 201-210.
- Grundy, S. (1987). *Curriculum: Product or Praxis?* London: Falmer.
- Guest, G. (2012). Describing mixed methods research: An alternative to typologies. *Journal of Mixed Methods Research*, 7(2), 141-151.
- Guest, G, Bunce, A. & Johnson, L. (2006). How many interviews are enough? An experiment in data saturation and variability. *Field Methods*, 18(1), 59–82.
- Habermas, J. (1972). *Knowledge and Human Interests*. (trans. J. Shapiro). London: Heinemann.
- Habermas, J. (1987). *The Theory of Communicative Action. Vol. 2, Lifeworld and System: A Critique of Functionalist Reason*. Boston: Beacon Press.
- Habermas, J. (1990). *The Theory of Communicative Action and Moral Consciousness*. (trans C. Lenhart & S. Nicholson). Cambridge, MA: The MIT Press.
- Hansen, H., Ropo, A. & Sauer, E. (2007). Aesthetic leadership. *The Leadership Quarterly*, 18, 544-560.
- Held, D. (1980). *Introduction to Critical Theory*. London: Hutchinson.

- Higgins, A., Begley, C., Lalor, J., Coyne, I., Murphy, K. & Elliott, N. (2013). Factors influencing advanced practitioners' ability to enact leadership: A case study within Irish healthcare. *Journal of Nursing Management*, 22(7), 894-905.
- Hinshaw, A. (2008). Navigating the perfect storm: Balancing a culture of safety with workforce challenges. *Nursing Research*, 57(Suppl. 1), S4-S10.
- Holmes, C. (1992). The drama of nursing. *Journal of Advanced Nursing*, 17, 941-950.
- Hujala, A. & Rissanen, S. (2011). Organization aesthetics in nursing homes. *Journal of Nursing Management*, 19, 439-448.
- Hutchinson, M. & Jackson, D. (2013). Transformational leadership in nursing: Towards a more critical interpretation. *Nursing Inquiry*, 20(1), 11-22.
- Hyde, A., Treacy, M., Scott, P., Butler, M., Drennan, J., Irving, K., Byrne, A. & MacNeela, P. (2005). Modes of rationality in nursing documentation: Biology, biography and the 'voice of nursing'. *Nursing Inquiry*, 2, 66-77.
- Jackson, D. (2008). Servant leadership in nursing: A framework for developing sustainable research capacity in nursing. *Collegian*, 15, 27-33.
- Jackson, D., Clare, J. & Mannix, J. (2003). Feminist and critical approaches. In Z. Schneider, D. Elliott, C. Beanland, G. LoBiondo-Wood & J. Haber (eds.). *Nursing Research: Methods, Critical Appraisal and Utilisation* (2nd ed.). Marrickville: Elsevier.
- Jackson, D. & Daly, J. (2010). Improving the workplace: The pivotal role of nurse leaders. *Contemporary Nurse*, 36(1-2), 82-85.
- Jackson, J., Clements, P., Averill, J. & Zimbro, K. (2009). Patterns of knowing: Proposing a theory of nursing leadership. *Nursing Economics*, 27(3), 149-159.
- Jeffery, A.D. (2013). The art of nursing leadership. *Nurse Leader*, Feb, 48,51.
- Johnson, J. (1994). A dialectical examination of nursing art. *Advances in Nursing Science*, 17(1), 1-14.
- Juraschek, S.P., Zhang, X., Ranganathan, V., & Lin, V.W. (2012). United States registered nurse workforce report card and shortage forecast. *American Journal of Medical Quality*, 27(3), 241-249.
- Katims, I. (1993). Nursing as aesthetic experience and the notion of practice. *Scholarly Inquiry for Nursing Practice: An International Journal*, 7(4), 269-278.
- Kennedy, M. (2015). *The Oxford Dictionary of Music* (2nd ed.). Oxford Music Online: Oxford University Press. Retrieved from <http://www.oxfordmusiconline.com/subscriber/article/opr/t237/e7387>. Accessed 20/2/2015.
- Kennedy, M. & Bourne Kennedy, J. (2007). *The concise Oxford Dictionary of Music* (5th ed.). Oxford: Oxford University Press.
- Kim, H.S. (1993). Response to "nursing as aesthetic experience and the notion of practice". *Scholarly Inquiry for Nursing Practice: An International Journal*, 7(4), 279-282.
- Koivunen, N. (2007). The processual nature of leadership discourses. *Scandinavian Journal of Management*, 23, 285-305.
- Kolberg, L. (1981). Essays on moral development. In *The theory of communicative action and moral consciousness*. (J. Habermas (1990) trans C. Lenhart & S. Nicholson). Cambridge, MA: The MIT Press.
- Koren, L. (2010). *Which "Aesthetics" do You Mean? Ten definitions*. Point Reyes, Calif.: Imperfect Publishing.

- Kuepers, W. (2011). "Trans - + - form": Leader and followership as an embodied, emotional and aesthetic practice for creative transformation in organisations. *Leadership and Organization Development Journal*, 32(1), 20-40.
- Lather, P. (1986). Research as praxis, *Harvard Educational Review*, 56(3), 257-277.
- LaSala, C. (2009). Moral accountability and integrity in nursing practice. *Nursing Clinics of North America*, 44(4), 423-434.
- Leggat, S. & Balding, C. (2013). Achieving organisational competence for clinical leadership: The role of high performance work systems. *Journal of Health Organization and Management*, 27(3), 312-329.
- Lewis, J. (2011). Mixed methods research. In S. Jirojwong, M. Johnson & A. Welch (eds.) *Research Methods in Nursing & Midwifery: Pathways to Evidence-based Practice*. Sth Melbourne: Oxford University Press.
- Lincoln, Y. & Guba, E. (1985). *Naturalistic Inquiry*. Beverly Hills, CA: Sage.
- Makaroff, K S., Storch, J., Pauly, B., & Newton, L. (2014). Searching for ethical leadership in nursing. *Nursing ethics*, 0969733013513213. Accessed 20/12/2014.
- Martin, J., McCormack, B., Fitzsimons, D. & Spirig, R. (2014). Evaluation of leadership practices: How to develop a vision. *Journal of Research in Nursing*, 19(2), 102-115.
- McCoyd, J. & Kerson, T. (2006). Conducting intensive interviews using email: A serendipitous comparative opportunity. *Qualitative Social Work*, 5, 389-406.
- McCutcheon, G. & Jung, B. (1990). Alternative perspective on action research. *Theory into Practice*, 29(3), 144-150.
- McNamara, M., Fealy, G., Casey, M., Geraghty, R., Johnson, M., Halligan, P., Treacy, M. & Butler, M. (2011). Boundary matters: clinical leadership and the distinctive disciplinary contribution of nursing to multidisciplinary care. *Journal of Clinical Nursing*, 20, 3502-3512.
- Millward, L. & Bryan, K. (2005). Clinical leadership in health care: A position statement. *Leadership in Health Services*, 18(2), xiii-xxv.
- Mintzberg, H. (1998). Covert leadership: notes on managing professionals. *Harvard Business Review*, 76, 140-148.
- Mintzberg, H. (2003). *The Manager's Job: Folklore and Fact*. London: Routledge.
- National Clinical Nurse Specialist Competency Task Force. (2010). *CNS Core Competencies*. Philadelphia: NACNS.
- National Health and Medical Research Council [NHMRC], Australian Research Council [ARC] & Australian Vice-Chancellors' Committee. (2007 Updated May 2015). *National Statement on Ethical Conduct in Human Research*. Canberra: Commonwealth of Australia.
- Needleman, J. (2013). Increasing acuity, increasing technology and the changing demands on nurses. *Nursing Economics*, 31(4), 200.
- Nicol, E., Mohanna, K. & Cowpe, J. (2014). Perspectives on clinical leadership: A qualitative study exploring the views of senior healthcare leaders in the UK. *Journal of the Royal Society of Medicine*, 10(7), 277-286.
- Nightingale, F. (1859). *Notes on Nursing*. London: Harrison and Sons.
- Norman, I. & Ryrie, I. (2013). *The Art and Science of Mental Health Nursing: Principles and Practice*. Maidenhead: McGraw-Hill Education.
- Novick, G. (2008). Is there a bias against telephone interviews in qualitative research? *Research in Nursing & Health*, 31(4), 391-398. doi:10.1002/nur.20259

- NSW Health. (2011). *Clinical nurse consultants – domains and functions*. Information Bulletin Issued 6 June 2011. Workplace Relations and Management Branch, Sydney: NSW Government.
- Outhwaite, W. (1994). *Habermas: A Critical Introduction*. Oxford: Polity Press.
- Polat, S & Oztoprak-Kavak, Z. (2011). Aesthetic leadership (AL): Development and implementation of aesthetic leadership scale (ALS) of school directors. *Educational Research and Reviews*, 6(1), 50-61.
- Porter, S. (1994). New nursing: the road to freedom? *Journal of Advanced Nursing*, 20(2), 269-274.
- Qualtrics Research Suite. (accessed 18/4/2013 @ <http://www.qualtrics.com/research-suite/#academic>)
- Rigg, C. & Trehan, K. (2008). Critical reflection in the workplace: Is it just too difficult? *Journal of European Industrial Training*, 32(5), 374-384.
- Ritzer, G. (1992). *Contemporary Sociological Theory* (3rd ed.). New York: McGraw-Hill.
- Roderick, R. (1986). *Habermas and the Foundations of Critical Theory*. London: Macmillan.
- Ropo, A. & Sauer, E. (2008). Dances of leadership: Bridging theory and practice through an aesthetic approach. *Journal of Management & Organization*, 14, 560-572.
- Ruel, J. & Motyka, C. (2009). Advanced practice nursing: A principle-based concept analysis. *Journal of the American Academy of Nurse Practitioners*, 21, 384–392.
- Sandelowski, M. (2014). Unmixing mixed-methods research. *Research in Nursing & Health*, 37, 3-8.
- Selman, R. (1980). The growth of interpersonal understanding. In *The Theory of Communicative Action and Moral Consciousness*. (J. Habermas (1990) trans C. Lenhart & S. Nicholson). Cambridge, MA: The MIT Press.
- Sheets, D. (2012). Gerontological nursing: Developing the art and science. *The Gerontologist*, 52(6), 876-879.
- Small, C. (1986). Performance as ritual: Sketch for an enquiry into the true nature of a symphony concert. *The Sociological Review*, 34(S1), 6-32.
- Smalzried, N. & Remmers, H. (1943). A factor analysis of the Purdue Rating Scale for instructors. *Journal of Educational Psychology*, 34(6), 363-367.
- Snedeker, J. (2010). Music and book reviews: “maestro: A surprising story about leading by listening.” By Roger Nierenberg. *The Horn Call – Journal of the International Horn Society*, 41(1), 78. Retrieved from <http://search.proquest.com/docview/821009000?accountid=36155>. Accessed 20/2/2015
- Spitzer, J. & Zaslaw, N. (2004). *Birth of the Orchestra: History of an Institution*. Oxford: Oxford University Press.
- Stanley, D. (2004). Clinical leaders in paediatric nursing: A pilot study. *Paediatric Nursing*, 16(3), 39–42.
- Stanley, D. (2008). Congruent leadership: Values in action. *Journal of Nursing Management*, 16, 519-524.
- Stoddart, M., Bugge, C., Shepherd, A. & Farquharson, B. (2014). The new clinical leadership role of senior charge nurses: A mixed methods study of their views and experience. *Journal of Nursing Management*, 22, 49-59.

- Sumner, J. (2001). Caring in nursing: A different interpretation. *Journal of Advanced Nursing*, 35(6), 926-932.
- Sumner, J. (2010). Reflection and moral maturity in a nurse's caring practice: A critical perspective. *Nursing Philosophy*, 11, 159-169.
- Teddlie, C. & Tashakkori, A. (2012). Common "core" characteristics of mixed methods research: A review of critical issues and call for greater convergence. *American Behavioral Scientist*, 56(6), 774-788.
- Terry, P. (1997). Habermas and education: Knowledge, communication, discourse. *Curriculum Studies*, 5(3), 269-279.
- Thomas, E. & Magilvy, J. (2011). Qualitative rigor or research validity in qualitative research. *Journal for Specialists in Pediatric Nursing*, 16, 151-155.
- Timmins, F. (2011). Remembering the art of nursing in a technological age. *Nursing in Critical Care*, 16(4), 161-163.
- Twigg, D., Duffield, C., Bremner, A., Rapley, P., & Finn, J. (2012). Impact of skill mix variations on patient outcomes following implementation of nursing hours per patient day staffing: a retrospective study. *Journal of Advanced Nursing*, 68(12), 2710-2718.
- Vaismoradi, M., Turunen, H. & Bondas, T. (2013). Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. *Nursing & Health Sciences*, 15, 398-405.
- van Bekkum, J. & Hilton, S. (2013). The challenges of communicating research evidence in practice: Perspectives from UK health visitors and practice nurses. *BMC Nursing*, 12, 17. doi:<http://dx.doi.org/10.1186/1472-6955-12-17>.
- Wainwright, P. (2000). Towards an aesthetics in nursing. *Journal of Advanced Nursing*, 32(3): 750-756.
- Watson, J. (2001). Theory of human caring. In M.Parker (ed.) *Nursing Theories and Nursing Practice*. Philadelphia: F.A. Davis.
- Whitehead, L. (2011). Qualitative data analysis. In S. Jirojwong, M. Johnson & A. Welch (eds.) *Research Methods in Nursing & Midwifery: Pathways to Evidence-based Practice*. Sth Melbourne: Oxford University Press.
- Whittemore, R. & Knaf, K. (2005). The integrative review: updated methodology. *Journal of Advanced Nursing* 52, 546-553.
- Wong, C., & Cummings, G. (2009). Authentic leadership: A new theory for nursing or back to basics? *Journal of Health Organization and Management*, 23(5), 522-538.

Appendices

Appendix 1: UWS HREC approval

Locked Bag 1797
Penrith NSW 2751 Australia



Office of Research Services

UWS HUMAN RESEARCH ETHICS COMMITTEE

15 May 2012

Professor Lesley Wilkes,
School of Nursing and Midwifery

Dear Lesley,

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

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

This protocol covers the following researchers:

Lesley Wilkes, Judith Mannix.

[Redacted]

[Redacted]

[Redacted]

l.wilkes@uws.edu.au
99405784@student.uws.edu.au

Appendix 2: UTS HREC approval

From: Racheal Laugery [mailto:Racheal.Laugery@uts.edu.au]

Sent: Thursday, 1 November 2012 9:48 AM

To: Judy Mannix; Research Ethics

[REDACTED] John Daly; Debra Jackson; Lesley Wilkes

Subject: RE: Ethics approval

Hi Judy

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

Kind regards

Racheal

Racheal Laugery

Research Ethics Officer

Research & Innovation Office

University of Technology, Sydney

Phone: (02) 9514 9772

Fax: (02) 9514 1244

Generic: Research.Ethics@uts.edu.au

Direct: Racheal.Laugery@uts.edu.au

Web: <http://www.research.uts.edu.au/policies/restricted/ethics.html>

Post: PO Box 123, BROADWAY NSW 2007

Location: Level 14, Building 1, Broadway Campus (CB01.14.08.04)



For all your research questions visit ask.research.uts.edu.au or call ext. 9681

From: Judy Mannix [<mailto:J.MANNIX@uws.edu.au>]

Sent: Wednesday, 24 October 2012 12:12 PM

To: Research Ethics

[REDACTED] John Daly; Debra Jackson; Lesley Wilkes

Subject: Ethics approval

Dear Sir/Madam

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

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

Please let me know if you require any further information.

Regards,

Judy Mannix RN MN(Hons) | PhD student

School of Nursing and Midwifery | University of Western Sydney

Building 7 – Room 55, Campbelltown Campus

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UTS CRICOS Provider Code: 00099F

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Think. Green. Do.

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Appendix 3: UWS HREC amendment approval

Locked Bag 1797
Penrith NSW 2751 Australia



Office of Research Services

31 August 2012

Professor Lesley Wilkes
School of Nursing and Midwifery

Ms Judy Mannix
School of Nursing and Midwifery

Dear Lesley and Judy

H9592 - Amendment Request

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

- 1. Recruitment through Twitter and Facebook*

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

Regards

Jillian Shute
Human Ethics Officer
Office of Research Services

Appendix 4: Invitation to participate notice

Subject: **The art of clinical leadership in contemporary nursing**

Dear student,

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

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

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

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

Appendix 5: Clinical Leadership Survey

Clinical leadership in contemporary clinical nursing

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

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

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

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

Demographic details

Current workplace (click): acute hospital community residential care

Current position: _____

Employment status (click): fulltime part-time casual

Time in current position (click): < 1 year 1-3 years 4-7 years 8-10 years > 10 years

Years working in nursing (click): < 1 year 1-3 years 4-7 years 8-10 years > 10 years

Age (click): < 25 yrs 26-35 yrs 36-45 yrs 46-55 yrs 56-65 yrs > 65yrs

Gender (click): female male transgender

Part 1: In your opinion the nursing colleague who you regard as a clinical leader who...

Item	Characteristic or behaviour	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
1	Creates an aesthetic climate in the clinical setting.					
2	Creates a culture to activate the aesthetic potential in the clinical setting.					
3	Gives inspiration to the nurses through aesthetic leadership.					
4	Serves as a model for the nurses with her/his outlook and behaviour.					
5	Is sensitive to the aesthetics in the environment.					
6	Trusts her/his aesthetic feelings.					
7	Supports creativity in the clinical setting.					
8	Thinks that each nurse has an aesthetic potential.					
9	Endeavours to encourage the aesthetic potential of the nurses.					
10	Can influence the beliefs of the people around with her/his aesthetic opinions.					
11	Tries to understand the aesthetic expectations of the nurses.					
12	Uses body language well.					
13	Is specific but pragmatic in applying aesthetics.					
14	Uses appropriate language during interactions with others.					
15	Assures the nurses with her/his aesthetic leadership.					
16	Knows how to reflect emotions appropriately.					

17	Provides the nurses with new points of view in the aesthetics of leadership.					
18	Is a pioneer of aesthetic leadership.					
19	Settles conflicts with an aesthetic concern.					
20	Is careful, responsible and practical in demonstrating aesthetic leadership.					
21	Has an aesthetic creativity.					
22	Facilitates aesthetics into the workplace culture.					
23	Evokes admiration with her/his expression and style of communication.					
24	Attaches value on artistic activities.					
25	Endeavours to organize artistic activities.					
26	Makes a difference with her/his attitude.					
27	Demonstrates a style of aesthetic leadership that is compatible with practice.					
28	Prioritizes aesthetics in the clinical setting's social activities.					
29	Aesthetically arranges the empty spaces in the clinical setting.					
30	Equips the appropriate places in the clinical setting with aesthetic materials (picture, table, etc).					
31	Spreads positive energy around with her/his lively personality and being at peace with her/himself.					
32	Tries to get beyond the limits to find out the better in the aesthetic arrangements in the clinical setting.					

Part 2: In your opinion the nursing colleague who you regard as a clinical leader...

Item	Characteristic or behaviour	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
1	Takes risks					
2	Celebrates colleagues' achievements					
3	Negotiates and supports					
4	Follows through on promises					
5	Works to achieve goals					
6	Develops cooperative relationships					
7	Facilitates meaningful conversations					
8	Uses evidence-based rationale					
9	Establishes therapeutic relationships					
10	Engages in reflective practice					
11	Engages in communication with colleagues					
12	Actively listens					
13	Commits to patient centred care					
14	Acknowledges colleagues' values					
15	Provides positive feedback					

Part 3: Briefly describe a situation in your clinical experience where aesthetic leadership was shown.

120

Thank you for completing this survey.

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

Appendix 6: Participant Information Sheet

Human Research Ethics Committee

Office of Research Services



Project ID: H9592

Participant Information Sheet

Project Title: The art of clinical leadership in contemporary nursing

Who is carrying out the study?

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

What is the study about?

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

What does the study involve?

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

How much time will the study take?

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

Will the study benefit me?

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

Will the study involve any discomfort for me?

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

How is this study being paid for?

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

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

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

Can I withdraw from the study?

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

Can I tell other people about the study?

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

Consent to participate in this study:

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

What if I require further information?

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

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

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

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

What if I have a complaint?

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

Appendix 7: Participant Consent Form

Human Research Ethics Committee

Office of Research Services



Project ID: H9592

Participant Consent Form

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

Project Title: The art of clinical leadership in contemporary nursing

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

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

I acknowledge that:

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

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

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

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

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

Date: _____

Signed: _____

Name: _____

Contact Phone: _____

Mobile: _____

Email Address: _____

Return Address: _____