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Exploring the Use of Courageous Followership in Conversations with Nurses and Their Colleagues

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EXPLORING THE USE OF COURAGEOUS FOLLOWERSHIP IN CONVERSATIONS WITH NURSES AND THEIR COLLEAGUES

A Dissertation

Presented to the Faculty of

Graduate School of Leadership & Change

Antioch University

In partial fulfillment for the degree of

DOCTOR OF PHILOSOPHY

by

Elizabeth Lynn Paxton

ORCID Scholar ID No. 0000-0001-5264-3102

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This dissertation, by Elizabeth L. Paxton, has
been approved by the committee members signed below
who recommend that it be accepted by the faculty of the
Graduate School in Leadership & Change
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DOCTOR OF PHILOSOPHY

Dissertation Committee:

Lize Booysen, DBL, Chairperson

Elizabeth Holloway, PhD

Ronald Riggio, PhD

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ABSTRACT

EXPLORING THE USE OF COURAGEOUS FOLLOWERSHIP IN CONVERSATIONS WITH NURSES AND THEIR COLLEAGUES

Elizabeth Lynn Paxton

Graduate School of Leadership & Change

Antioch University

Yellow Springs, OH

Health care is fraught with communication issues, many of which can lead to patient safety errors and toxic behaviors. Communication in a hierarchical environment has been historically challenging, especially for nurses. Courageous followership, a style of leadership first introduced in the early 1990s, is a duality of "powerful leaders supporting powerful followers" (Chaleff, 2009, p. 3). The tenets of this leadership style empower both the leader and the follower to have the courage: to assume responsibility, serve, transform, challenge, take moral action, speak up to the hierarchy, and listen to the follower. All of these actions are needed in the hierarchical health care environment to empower the staff and the leaders to speak up both for themselves and for their patients. I investigated whether nurses currently utilize the concepts of this leadership style in conversations with their colleagues. Through the use of critical incident technique, stories were collected to understand if this type of leadership is naturally occurring in conversations with nurses and their colleagues. Meaningful incidents, either positive or negative, were collected and analyzed for relevance to this topic. The research showed that positive leadership, CF concepts, and communication can influence and be beneficial to the future health care environment for both staff and patients. This dissertation is available in open access at AURA: Antioch University Repository and Archive, https://aura.antioch.edu and OhioLINK ETD Center, https://etd.ohiolink.edu

Keywords: courageous followership, leadership, communication, health care, critical incident technique

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Most of all, I would like to thank the courageous nurses that shared their stories, exposing their bravery, vulnerability, and obligation to patient safety. I am in awe of your daily courageous presence and it is an honor to call you each my colleagues. I hope that those at the bedside (RNs, RTs, MDs, Therapists) find the courage to advocate for their patients and their needs daily.

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CHAPTER I: INTRODUCTION AND SCIENTIFIC BACKGROUND OF STUDY

Health care organizations (HCOs) are often described as one of the most complex systems that exist in the world today. They are complex because of the "multilayered, connected elements" where even things as simple as communication, shared mission, and effective problem solving become increasingly difficult to navigate (Cameron & Green, 2015, p. 369). Many health care leaders are generally promoted due to their clinical expertise and lack formalized leadership training. This lack of training makes it difficult to navigate the environmental complexities and to get their followers on the correct path that leads to successful outcomes. This inability of leaders to guide their staff can produce turnover of the health care worker at the bedside, contributing to the upcoming, predicted deficits in health care staffing in the future (Groves, 2018).

Health care is currently in crisis. Today's health care struggles with everyday business challenges such as financial viability and staying current with trends. However, health care faces other obstacles like regulatory compliance, complexities with patient care, a decline of the future workforce, and the mental health of its workers. All these intricacies put additional strain and stress on health care's future well-being.

Leaders today are up against seemingly insoluble challenges. Many of these challenges are beyond the manager's and HCO's ability to control. Therefore, the leader and the organization must find ways to overcome these challenges so that patients can get the care they deserve, and the employees can practice in a safe, empowered environment. What is missing in this arena is work on helping the leader empower their staff, generally in the area of courageous followership (CF), specifically for health care leaders. Stech (2008) believed that the old ways of traditional leadership are no longer useful due to the rapid ever-changing environments in most organizations—a new paradigm needs to be suggested.

There is a gap and a limitation when separating leadership and followership development because people can be leaders and followers simultaneously, no matter their position in an organization. When an organization is only teaching leadership skills to senior level executives, follower and lower-level leaders, who can make differences at their level, are left out. If frontline staff and leaders were learning together, would they be able to affect the future of health care outcomes more effectively? There is just too much separation, whether it is for power and status or just lack of knowledge of how the leader and follower could benefit from each other. It is time that leaders and followers were treated with the same amount of dedication to their learning about leading, encouraging a symbiotic relationship of learning and empowerment. This study will explore health care complexity communication, and how courageous followership can make a difference on patient outcomes and patient care quality.

Purpose and Research Question

Purpose

The purpose of this study was to determine if health care conversations currently utilize CF tenets. As the following sections will demonstrate, CF is a form of leadership that helps the leader and the follower empower each other to be both a better and more effective leader and follower. Theory and over 50 articles with empirical data have shown that CF is valuable and can be a powerful style for leaders to possess. These same studies have indicated that CF is evident the further that one ascends the leadership (authority) ladder. CF needs to start at the frontline, and its tenets are powerful to empower the organization to meeting its outcomes, both financially and clinically.

The following section will define CF and why CF is crucial in health care conversations. The section will give a brief history of CF and close with a discussion of how CF can help the complex future of health care.

What is Courageous Followership? Courageous followership is the term used to describe the symbiotic relationship between leaders and followers. Chaleff (2009), the first researcher to add the term courageous to the concept of followership, believed that the "courageous follower can and must be the change agent for leaders" (p. 5). Chaleff further explained that he chose "the image of 'courageous follower' to build a model of followership because courage is so antithetical to the prevailing image of followers and so crucial to balancing the relationship with leaders" (p. 4).

Chaleff (2009) described seven dimensions of courageous followership to help explain the dynamics of the leader–follower relationship. The seven dimensions are the courage to assume responsibility, the courage to serve, the courage to challenge, the courage to participate in transformation, the courage to take moral action, the courage to speak to the hierarchy, and the courage to listen to followers. CF draws on the strengths of the leader and the follower to be the best that they can be for each other, therefore, benefitting the mission that they are attempting to accomplish.

When the concept of followership emerged on the leadership scene, it was met with cynicism and nonacceptance by people who could be identified by formal roles as leaders and followers. The term follower sounded derogatory to people in a follower role. Many felt that the term seemed to imply subservience and a lack of creative expression and individuality. Riggio (2014) expressed a push to "legitimize the term of follower to recognize the critical role that followers play in coproducing leaders, and to change the stereotypical views of followers and followership" (p. 17). Follower has certainly become a more acceptable term than subordinate.

The term subordinate conjures up negative thoughts and emotions among employees (Zellers et al., 2002). The etymology of the word originated in the 1590s Medieval Latin meaning "having an inferior rank" (www.etymonline.com). The word subordinate is used to describe a relationship in which the boss has control over an employee, especially a command-and-control relationship. However, Sher

(2015) defended the term, eluding that the workplace is a hierarchy and different levels of employees exist with different knowledge, experience, competencies, and expectations. Sher continued that this does not mean that the employee is inferior or has less inherent value. Leaders must have subordinates to be successful and get work in the organization accomplished. Leaders must set expectations for subordinates so that all can be successful. This definition continues to describe how the leader and the follower must rely on each other to be successful.

Why is CF Important in Health Care Conversations? Courageous followership was a new construct for the researcher at the start of this research. Because of the history of oppression that nurses have historically faced and the fact that most health care organizations are hierarchical in nature, nurses and junior medical staff have generally experienced difficulty speaking up when encountering ethical issues (Garon, 2012). Staff have experienced intimidation by fellow colleagues and leaders, making it impossible to raise an issue (O'Daniel & Rosenstein, 2008). The environment should be receptive to hearing what is going wrong. Afterall, health care workers are dealing with people's lives. If organizations made decisions and adopted the practice of using courageous followership, employees would feel more comfortable about speaking up and the quality of care would improve for patients and thus the community at large.

Kelley (2008) suggested that an entire curriculum should be developed that brings the ethical, legal, and social science tools together to equip every person with a strong, active, courageous conscience. This framework would serve health care well and provide tools to help each health care worker feel comfortable speaking up when ethical issues occur. It is time to equip leaders and followers with tools to navigate the complex world of health care, not just focus on the clinical capacity to care for a patient. Keir (2018) supported that even junior residents need this information. Having worked in an academic medical center for most of my career, I have seen medical students and residents shamed for speaking up or pointing out an error to a superior physician. These can be very uncomfortable

conversations to witness. Many junior staff are not equipped to handle these types of interactions. DiRienzo (1994) suggested training for medical staff around these kinds of conversations in the 1990s. However, these concepts have not infiltrated the health care arena some 15 years later.

Research needs to be completed on how these constructs should be taught and used amongst those of different generations. Currently, there are four generations of nurses at the bedside (Boamah et al., 2016). Studies have shown that each generation has their own way of communicating and their own way of speaking up (Knickman & Snell, 2002; McCall, 1996). Therefore, a straightforward (one size fits all) approach would not be beneficial as the only form of teaching. Styles of communication and teaching must be adapted to the multigenerational workforce.

Finally, research needs to be completed on how to connect followership and leadership into one construct instead of separate concepts. Leaders cannot exist without followers and vice versa (Baker, 2007; Chaleff, 2009; Riggio, 2014; Uhl-Bien et al., 2014). Leadership is a cause-and-effect relationship based on trust, mutual growth, and empowerment. It is time for "leadership research" to move to the next century, ensuring inclusivity and wholeness.

Research Questions

This section will state the research questions and the methodological approach for exploration. The section begins with an explanation of the research question and its relevance to the study population, briefly explore the methodological choices and their suitability for the research question, and conclude by exploring the challenges faced with the research method.

This study addressed the following research questions:

- RQ 1: What situations require bedside nurses to use CF concepts when interacting with their colleagues and leaders?
    - AIM: To understand and analyze the stories where CF concepts were used in community hospital-based nurses' interactions with their leaders and colleagues.

- RQ 2: What CF concepts are used by bedside nurses in conversations with their colleagues and leaders?
    - AIM: Through critical incident technique (CIT), gain a greater understanding of courageous followership concepts used during nursing interactions with leaders and colleagues at a community hospital.

The health care arena is fraught with complexity and challenges. Having health care workers and leaders speak to each other in different ways, such as through CF, is important to help navigate these complex environments. The purpose of this study was to understand how CF is currently being used in health care conversations.

CIT was the method of choice to answer the research questions because many times health care worker shares stories as their way of analyzing a situation (Butterfield et al., 2005; Byrne, 2001). Learning how health care workers talk to each other will help to understand how and if CF could be a useful tool for health care worker conversations. Health care relies on interpersonal relationships to convey information about the patient's history, as well as the staff's interactions with their patients and colleagues. Communication in health care accounts for over 80% of all health care errors and is the number one root cause of serious injury or death related to delay in treatment (Agarwal et al., 2010). Therefore, health care colleagues from the housekeeper to the CEO need to communicate with each other in an environment of trust and collaboration.

Challenges

There were certain challenges with this research method. It was postulated that the researcher will have a hard time gathering participants. Nurses do not like to talk about "challenging conversations." It is not always something that is done in the health care environment. Many times, nurses fear retribution or feel that they are being a tattletale. Helping them to feel comfortable having these conversations was an area of focus. Also, because the work that nurses and physicians perform is

life or death, there can be an added element of emotionality with some of these conversations. During these conversations the researcher provided equanimity, not reacting to the information provided, and reassurance that the subject's confidentiality and anonymity were maintained.

Rationale of the Study

Follower–followership can be a set of skills that balances leadership, a role within a hierarchical organization, a social construct that is integral to the leadership process, or the behaviors engaged in while interacting with leaders to meet organizational objectives (Chaleff, 2009; Kelley, 1989). Followership is a conscious action that a subordinate takes to be in synergy with a leader to accomplish goals.

As the health care environment continues to change at a rapid pace, the caregiver and their leader need to adapt to change quickly (Ead, 2015). They need to support each other and be able to have open honest communication about the challenges facing them and their patients. Heller and Van Til (1982) supported this idea stating that "leadership and followership are best seen as roles in relation to one another" (p. 406). You cannot have one without the other and expect success.

The paradigms of leadership and followership are typically studied as separate identities. However, it has been stated by many scholars that you cannot have leadership without followership (Bastardoz & Van Vugt, 2019; Chaleff, 2009; Kellerman, 2008; Kelley, 1992; Riggio et al., 2008; Van Vugt et al., 2008). So, is it also true to say that each of these identities lives within us and we pull out the side that is needed in each individual situation? Followers need courageous followership just as much as leaders do. Because in a single moment, leaders can become followers and vice versa; therefore, these concepts should not be attributed to just leaders or just followers. Rather, both need to be trained together on how these constructs can help create an interdependent relationship of growth and empowerment.

Conversations and feedback help the leader and the follower improve and grow in their abilities to lead and be successful in the organization. Positive, empowering discussions improve leader and follower relationship, especially trust in the relationship (Ramlall, 2004). When the leader and follower feel support from each other, the leader and the follower can change the health care environment for the better (Lundin & Lancaster, 1990).

Courageous Followership and the Health Care Hierarchy

The health care hierarchal structure can create a certain silence for health care providers, including leaders. Ramanujam and Rousseau (2006) discussed that silence (around medical errors) is exacerbated in health care because of status differences (personnel) inhibiting direct communication. Many staff are afraid to confront their leaders or physicians about ideas or errors because of retribution or being wrong (Rosenstein & O'Daniel, 2005). Leaders must learn to find ways to empower staff to speak and become role models themselves on speaking up.

Health care has been steeped in hierarchy going back to the days of Florence Nightingale and even earlier. The structure of the health care hierarchy makes communication extremely challenging and complex because there are layers upon layers of leaders. Heller and Van Til (1982), when considering followership as a construct, suggested that "the old order (hierarchical leader-follower relationship) no longer looks or feels right, nor holds promise for the future; yet a new order has not been found, proven or achieved consensus" (p. 409). It is possible that using the tenets of CF in the health care environment will bring that new order.

Health care organizations are typically structured and function as a hierarchy, meaning that information flows from top to bottom and most employees do not have direct, daily contact with the highest leaders of the organization. Chaleff (2016) stated that the "whole point of a hierarchy is to determine who can give orders to whom in service of the mission" (p. 2). This structure for health care keeps each practitioner in line with work that is approved by their licensing body. For example, nurses

cannot give treatments without a physician order. The hierarchical structure ensures that the nurse is not practicing outside their scope of care.

Significance of Study

This research will be applicable to leaders and followers in the health care professions, especially those that work in a health care setting, such as an acute hospital environment. However, all leaders and followers in any setting could benefit from the learnings here, as in the future, it will be crucial for all leaders and followers to be able to communicate with each other openly and honestly. The future holds many complexities and unknowns. Therefore, communication will be highly valued and needed (Garon, 2012; The Joint Commission, 2012).

The CF concept has a place in the health care leader and follower's toolkits. The largest gaps seen are the application of these concepts to the health care arena and the lack of programs to help leaders and followers develop their skills around these concepts. Focusing on courageous followership and applying it to a health care population, such as nursing, brought the biggest opportunity to contribute to the current body of research. This is certainly an area of nascent research for both nursing and health care.

In nursing there is an organization called Magnet that surveys hospitals to ensure that nurses are practicing in an environment that empowers them and supports their professional development. Shared leadership has been viewed by Magnet as the way to get the nurse's voice to be heard. However, it does not employ all the tenets of CF, especially empowering the follower to empower and support the leader. CF can fill this gap and become the shared leadership for the future. CF helps one to challenge the oppression, the unethical behaviors, and to have a voice for their patients. As a Chief Nursing Officer (CNO), this is the environment that I want my nurses to practice in. Nurses need to be heard, viewed as professionals, and to be the voice for their patients, especially when their patient's safety is in jeopardy.

Discussion of Terms and Terminology

This section contains the most common terminology that were used in this study. Many times, words can come with several meanings or meaning can be assigned based on the context. Therefore, this section is designed to clarify the various meanings that can be used for one term. The following terms will be used throughout this body of work:

- *Followers*—"subordinates who have less power, authority and influence than do their superiors and who therefore usually, but not invariably fall into line" (Kellerman, 2008, p. xix).
- *Followership*—"the study of followership involves an investigation of the nature and impact of followers and following in the leadership process" (Uhl-Bien et al., 2014, p. 7).
- *Courageous followership*—A follower who has the courage to assume responsibility for themselves and the organization, the courage to serve a leader, the courage to challenge a leader or group, the courage to transform, the courage to take moral action, the courage to speak up to the hierarchy, and the courage to listen to the follower. (Chaleff, 2009, pp. 6–7)
- *VUCA*—An acronym first established with the U.S. Army War College in the 1950s that stands for volatility, uncertainty, complexity, and ambiguity. This acronym is used to describe the complexities of the business world (Barber, 1992).
- *Critical Incident Technique*—The original definition of critical incident technique is a set of procedures for collecting direct observations of human behavior in such a way as to facilitate their potential usefulness in solving practical problems and developing broad psychological principles. The Critical Incident Technique outlines "procedures for collecting observed incidents having special significance and meeting systematically defined criteria" (Flanagan, 1954, p. 327).
    - A more current definition for critical incident technique is "a systematic, inductive, open-ended procedure for eliciting verbal or written information from participants"

(Schluter et al., 2008, p. 107). This inductive approach allows for freedom of expression for the interviewee.

- *Qualitative research*—a branch of research whose methodology aims to understand and represent the experiences and actions of people as they encounter, engage, and live through situations (Elliott et al., 1999, p. 216).
- *Meaningful interaction*—an interaction that is neither positive or negative and is important to the person sharing the event (Woo & Reeves, 2007, p. 15).
- *Registered Nurse (RN)*- the nurse may be referred to as the RN or the nurse
- *Medical Doctor (MD)*- the doctor may be referred to as the MD or physician

Methodological Approach and Researcher Positionality

Methodological Approach

Humans are social creatures. Talking is one of things that makes humans unique from other mammals. Humans tend to tell stories about their lives. Stories document our history and our learnings for the future generations. Stories give others insights into our personal worlds. These stories can help the human race relate to each other in ways that no other form of communication can accomplish.

Critical incident technique (CIT) is a form of qualitative research that relies on storytelling to get to the relevance of certain events that are important or meaningful to the ones telling the story (Flanagan, 1954; Kemppainen, 2000; Schluter et al., 2008). To understand the world in which individuals live and how they make meaning out of their interactions, research was conducted from a social constructivist lens (Creswell & Creswell, 2018). The goal is to rely on the participants' view of the interaction that they have had with their colleagues and then understand the meaning that they put around these interactions and how they view the world. To be successful, inductive interviews with broad, open-ended questions were asked so that the participant could help the researcher understand

the meaning that they associate with the interaction. Lastly, CIT encourages storytelling and sharing anecdotes which will increase the opportunity to gather detailed and rich reflections.

Choosing a research method is an arduous and personal decision. The method must be able to unearth the best answer(s) to the questions being posed. The researcher must be comfortable with using the methodology, as the researcher will spend a lot of time understanding it and attempting to make meaning of the data collected. Creswell and Creswell (2018) defined the research approach as "the plans and procedures for research that span the steps from broad assumptions to detailed methods of data collection, analysis and interpretation" (p. 3).

In line with other researchers, a modified approach to CIT was developed (Holloway & Schwartz, 2014; Norman et al., 1992; Perry, 1997). As with Holloway and Schwartz's (2014) research, the interviewees reported meaningful interactions—either positive or negative. "Meaningful" in this context is defined as meaningful to the interviewee. In a traditional positivist approach, the researcher collected both positive or negative events or incidents. Incidents that were satisfactory and/or unsatisfactory that hold special meaning for the interviewee were gathered. The participant was not influenced as to whether an incident is satisfactory or unsatisfactory; just to know why this incident was important to remember. Incidents either positive or negative helped to provide insight into the conversations. These incidents helped the researcher understand how the participant viewed the world. Byrne (2001) found that nurses needed to share both good and bad experiences to help drill down to specific behaviors. This sharing of both sides helped them to better understand what behaviors helped to make certain decisions. Kemppainen (2000) further supported the need for both satisfactory and unsatisfactory stories to help gain valuable insight to today's rapidly changing healthcare environment.

The critical incident technique is used to collect and analyze reports of behaviors in defined situations and is comparable to other forms of qualitative research methods. CIT focuses on finding solutions to practical problems versus defining phenomenon. CIT is aimed at "pinpointing facts and

reducing personal opinions, judgements and generalizations" (Kemppainen, 2000, p. 126). Kain (2003) described CIT:

> people assign meanings to their experiences, and when we group together collections of such meanings in order to make sense of the world, we engage in a kind of research, a seeking of understanding. The critical incident technique provides a systematic means for gathering the significances others attach to events, analyzing the emerging patterns, and laying out tentative conclusions for the reader's considerations. (p. 85)

CIT findings are used to support practical problem solving, especially for education and training, and to provide a knowledge base for further research topics.

The above discussion highlights the benefits of using CIT in a health care setting. CIT was the best method for answering the research questions for this study because broad, open-ended interview questions were utilized so that the participant was able to share their point of view without feeling that they were being "boxed-in" to a certain response. CIT was developed to "observe human activity that is sufficiently complete in itself to permit inferences and predictions to be made about the person performing the act" (Flanagan, 1954, p. 327). CIT also allowed the ability to gather many rich data points and points of view, and since CIT research does not start out based on any specific theory, the data was mined and analyzed for a pattern of meaning. The predictive focus of the technique has been useful in addressing practical problems noted in nursing studies utilizing CIT (Cheek et al., 1997; Cox et al., 1993; Minghella & Benson, 1995; Redfern & Norman, 1999).

Researcher Positionality

Positionality is "determined by where one stands in relation to the other" (Merriam et al., 2001, p. 411). What does the researcher know about the experience? How can the researcher strike a balance in the situation to make meaning of the situation? Realistically, the one being researched also brings their own positionality. So, positionality is about you being you and the implications of your interactions

with others. As a nurse performing research in the health care arena, I needed to be very aware of my professional position versus my scholarly position. Further discussion on my positionality for this research study will follow in Chapter III.

Proposed Research Design and Methods

Research Design

CIT involves five principles that can be modified to accommodate the purpose of the research and the research question. The five principles are (a) identifying the general aims, (b) establishing plans and specifications, (c) collecting the data, (d) analyzing the data, and (e) interpreting and reporting the results (Byrne, 2001; Fitzgerald et al., 2008; Flanagan, 1954; Hughes, 2007; Schluter et al., 2008; Urquhart et al., 2003). Proposals should be clear and concise with specifications of aim; selection of population; guidelines for observation; interpretation and classifying the incidents; and plans for analysis, interpretation, and reporting of data. The roadmap or principles of CIT really guide the researcher from start to finish, ensuring that all steps progress and conclude for the next step.

Research Methods

For this CIT research study, interviews were used to gather data. Fifty nurses were interviewed about conversations that they have had with their colleagues and leaders. Approximately one to three conversations or incidents per nurse were obtained. The data was analyzed to determine whether or not CF was present in these conversations. These interviews contained open-ended questions about conversations that were memorable to them. Information was gathered to determine why this particular conversation was meaningful for the nurse. Therefore, open-ended questions allowed the participant to speak without having to fit their answer into the question. They spoke about whatever they wished because the conversation was from their perception. The information gathered helped to understand their perception of the world as well as understand if any tenets of CF were being utilized.

Limitations and Delimitations

Limitations

As with all research studies, this study had several limitations. First, this study relied on the interviewees to recall stories that may have happened up to two years ago. Due to this time lag, some details or events of the story were difficult to recall. This lack of recall can lead scholars to question the "interviewee's credibility" (Butterfield et al., 2005, p. 488). To overcome this issue, questions were distributed ahead of time to allow the interviewee time to reflect on the conversations as recommended by certain researchers (Fitzgerald et al., 2008).

Secondly, when a shared story describes "a situation that involves no decision, act or where the participant was unaware of the information needed or suppressed, then CIT fails to be useful" (Urquhart et al., 2003, p. 65). CIT looks at specific events and the actions that led up to that event and those that occurred in that event. Therefore, a lack of action can indicate a perception of inaccuracy or making it difficult for the researcher to understand the actions that occurred.

Scope and Delimitations

A pilot study was performed before the actual research began. The pilot study gave the researcher occasion to practice interviews, coding and the opportunity to understand exactly what kind of data was needed. After the pilot study, it was identified that the nurses who were at the bedside currently provided the kinds of stories needed for the research. Therefore, nurses that were employed in an outpatient or office setting were excluded from the study. The conversations needed happen more readily at the bedside with nurses that typically have three–five years of clinical experience. Therefore, the ideal candidate was a registered nurse with three–five years of clinical experience who currently worked at the bedside in a community based acute care hospital. Nurses who did not meet the aforementioned criteria were excluded from this particular study.

The completed dissertation contains a total of five chapters. Chapter I will include the introduction and background of the study. The goal of this chapter is to establish the study purpose and research questions within the framework of any relevant epistemological and theoretical constructs. Terminology will be defined; however, discussions on the main topic and methodological framework will remain brief as further in-depth discussions are found in Chapter II and Chapter III respectively. The significance of the study is described in this section including relevance to practice, contribution to the field of study, and any positive social change. This section will end with a brief description of the following chapters.

The goal of Chapter II is to review the literature and substantiate the rationale of the conceptual framework of the study. The chapter is divided into three sections in order to discuss the potential themes. Each theme will provide a summary in terms of how the literature informs the research being proposed. The three themes that will be discussed are the complex health care environment and the challenges that leaders face daily, leading in a VUCA environment, and followership as the precursor to CF.

Chapter III is a discussion of the research design and methodology. This chapter discusses the importance of methodological fit and the rationale for using the critical incident technique approach to explore the research questions for this study. CIT's methodological fit for the topic, the sample population and saturation, coding, and analysis will able be discussed. The chapter then discusses the limitations of the study and concludes with ethical considerations in this research study.

Chapter IV will discuss the findings that were uncovered about CF in health care conversations. The research question, trended codes and themes that emerged will then be discussed. The goal of this chapter is to connect the purpose of the study, the literature review, and the conceptual framework. A discussion around trustworthiness of data will also be included. This discussion will ensure that the study followed procedures to assure that the data was accurate and the integrity intact.

Chapter V will share conclusions and recommendations. This section will share conclusions that addressed the research questions and covers all the data acquired. The recommendations will address who needs to pay attention to the results and how the results might be disseminated. There will also be a section on further recommendations, further research ideas, and my thoughts as a researcher. The final section will share the conclusion and recommendations discovered and focus on the practical applications for the health care environment.

CHAPTER II: CRITICAL REVIEW OF RELEVANT THEORY, RESEARCH, AND PRACTICE

Chapter II contains a critical review of relevant theory, research, and practice of the health care landscape, describing the unique complexities that the health care environment faces. This is followed by a description of VUCA environments, discussing and defining each word in the VUCA acronym for both the business environment and the health care environment, and finally an overview about CF and its origins in followership. Each section will describe how CF can help navigate through these environmental issues and how communication at all levels can increase patient outcomes and quality measures.

The Health Care Environment

The health care field seems to have a life of its own. It is a system of constant change in which technology, medical science, and health care consumer knowledge are advancing at rates that seem unfathomable. Many times, it is advancing so rapidly that equipment and treatments become passé after 12 months. Long gone are the days of the generalist physician or nurse. Each caregiver is specialized to one specific area of the body or disease process. Each specialty is built with its own infrastructure and services. Caregivers and leaders are required to know more, do more, manage more, and most of the time, to accomplish these things with less resources than ever before (Lee et al., 2019; McAlearney, 2006)

The face of the patient has changed. Patients with diseases that once killed them before adulthood (cystic fibrosis, cancer, pediatric heart disease) are now living into adulthood and having families of their own. Adult patients with childhood illnesses have created a need for whole new lines of medicine such as cardiologists that specialize in adult congenital heart disease and gerontologists that specialize in diseases of those older than 90. Currently, there are more aged citizens in the United States than ever in the history of the world. Researchers predict that by 2030, “61 million people will be aged 66 to 84 and 9 million people will be greater than age 84” (Knickman & Snell, 2002). These aging

patients also come with complex medical issues due to their extended lifespan. Additionally, they come with little private insurance and ways to pay for long-term care, making reimbursement for the treating facility very low and causing an overtaxing of emergency rooms and skilled nursing facilities.

Hospitals are routinely reserved for the patient that has a critical illness. Tonsillectomies, knee surgeries, and even some heart surgery can be performed on an outpatient basis. This is certainly great for the patient as they do not have the burden of an extensive hospital stay; however, it adds more complexity to the health care environment. Some of the complexities include increased handoffs leading to a loss of information, loss of safety, uncoordinated care, and a decrease in quality.

Complexities make it difficult for health care leaders to navigate the environment and lead their teams successfully. Leach (2005) stated that "an organizational leader's key challenge is to maximize the productivity and longevity of employees by cultivating their involvement and commitment" (p. 228). A clearer understanding of what complexities leaders and staff face daily is provided to help focus on the correct tools to help leaders lead more effectively in the health care environment. CF is the key to helping leaders empower their followers so that the leader, the follower, and the organization can be successful.

Background

Institute of Medicine

The Institute of Medicine (IOM) is an arm of the National Academy of Sciences. The sole job of this nonprofit, governmental entity is to improve human health. Two groundbreaking reports have been published by the IOM in the past 20 years. The first publication, *To Err is Human: Building a Safer Health System* (2000), addressed the safety of the patient in a hospital setting, specifically addressing preventable medical errors. It is a seminal piece of work, familiar to almost all leaders in health care leadership. The second work, *Crossing the Quality Chasm: A New Health System for the 21st Century*

(2001), focuses on how health care can be redesigned to foster invention and improve the delivery of care. This report is a great place to start understanding this complex, living entity called health care.

While it is not the intent of this paper to review the IOM's report, I do believe it is valuable to understand their vision. The Committee's purpose is to ensure that all

> health care constituencies—health professionals, federal and state policy makers, public and private purchasers of care, regulators, organization manager and governing boards, and consumers—are committing to a national statement of purpose for the healthcare system as a whole. In making this commitment, the parties would accept as their explicit purpose 'to continually reduce the burden of illness, injury, and disability and to improve the health and function for the people of the United States'. (IOM, 2001, p. 3)

The committee outlined six specific aims for improvement of patient care. They include the following core competencies:

- *Safe*—avoiding injuries to patients from the care that is intended to help them.
- *Effective*—providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse).
- *Patient-centered*—providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
- *Timely*—reducing waits and sometimes harmful delays for both those who receive and those who give care.
- *Efficient*—avoiding waste, including waste of equipment, supplies, ideas, and energy.
- *Equitable*—providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socio-economic status.

The committee stated that care for the patient and the environment for those that provided care would be improved if these six aims were followed. Thus, health care organizations would be able to offer safer, more coordinated care for the patient and care givers would be practicing in safer, more reliable environments ensuring less suffering and pain for the patient.

The committee further outlined 10 steps to provide some guidelines for reform. They are

- Care is customized according to the patient's needs and values.
- The patient is the source of control.
- Knowledge is shared and information flows freely.
- Decision making is evidence-based.
- Safety is a system priority.
- Transparency is necessary.
- Needs are anticipated.
- Waste is continuously decreased.
- Care is based on continuous healing relationships.
- Cooperation among clinicians is a priority. (IOM, 2001, pp. 3–4)

The health care system of today and the future has its work cut out for it. Leaders today face seemingly insurmountable challenges that are not easily solvable. Unfortunately, the challenges in the preceding paragraphs are not the only challenges that health care leaders face. Contemporary health care leadership faces certain complexities that create both prospects and predicaments (Wikstrom & Dellve, 2009).

Day-to-Day Leadership Challenges

There are six additional areas of concern for health care leaders today: (a) complexity, (b) financial, (c) nursing workforce changes, (d) leadership development, (e) incivility and oppression, and (f) communication in a hierarchical organization. These six are those that seem to erupt on the health

care scene on a daily basis, requiring the skills that healthcare leaders generally do not possess. Each challenge will be addressed individually and their impact on a leader's day-to-day work will be discussed.

Complexity

As indicated, the health care organization (HCO) is a very complex environment. Because health care is made up of so many layers that are interconnected, it is deemed a complex, adaptive system (Cameron & Green, 2015). Complex, adaptive systems do not generally have a linearity, meaning that things do not happen in a cause-and-effect manner, outcomes can be unintended, and the system cannot be understood just by examining it as a whole. Therefore, it will help to look at the system in terms of its individual entities. Because health care is a complex adaptive system even things as simple as communication, shared mission, and effective problem solving become exceptionally difficult.

Increased Regulations. Health care organizations are regulated by many oversight organizations. These organizations include

- The Joint Commission: an organization that ensures patients are cared for safely (The Joint Commission, 2008);
- Magnet: an organization that ensures that the environment is healthy and committed to the nurse's empowerment (American Nurses Credentialing Center, 2017);
- OSHA: Occupational Safety and Health Administration ensures a safe working environment (Occupational Safety and Health Administration, 2015);
- State Agencies: Department of Child Welfare (U.S. Department of Health and Human Services, 2020b), Department of the Aged (U. S. Department of Health and Human Services, 2020a), Local Fire and Police Departments, and;
- Specialty Programming Oversight: Lab services (Centers for Disease Control, 2018), Centers of Excellence (Agency for Healthcare Research and Quality, 2019).

These are only a few of the numerous regulatory bodies that oversee work in a health care environment. Sometimes, the regulatory bodies contradict each other. Meeting the standard for The Joint Commission is all that is required. For Magnet, the standard to achieve increases with each survey. As patients become sicker and care more specialized, the regulations seem to become more and more stringent. The frontline caregiver has a difficult time keeping the multitude of regulatory information straight in their minds (Allen et al., 2008).

Innovation and Technology. Medicine is extremely technological. Almost every aspect of care is automated. Prior to the 1990s, clinical notes were written out by hand. In the early 1990s, notes became automated and were reduced to "charting by exception" instead of describing what was witnessed. Many early changes in the patient's condition can get missed when charting this way (Gugerty et al., 2007).

This is not to say that technology is all bad. Noninvasive heart surgery is extraordinary. Patients are seen on an outpatient basis and go home that evening. Babies as early as 24 weeks gestation can be saved with little permanent damage, patients are living, healthy, past the age of 90. It is truly a hopeful time to be a patient and an exciting time to be a health care worker. However, all this change, especially noncommitted change, can create change fatigue for the health care worker (Ning & Jing, 2012). Ead (2015) stated that change fatigue, or the inability to sustain or enact successful change, can encourage employee absenteeism, job turnover, and dissatisfaction.

While HCOs are notorious for the amount of change present, the actual adoption of change is a slow process. Ramanujam and Rousseau (2006) reported that it takes "health care organizations approximately 17 years for research findings to be translated into practice" (p. 819). The authors cited the example that when antibiotics were invented, only 10% of physicians used them to treat illnesses despite the findings of success. The authors further suggested that evidence-based research from findings outside medicine takes even longer to implement in an HCO. McAlearney (2006) supported this

lag in implementation of research also specifically around leadership development. This lack of implementation of known practices leads HCOs to be ineffective both managerially and organizationally.

Missions, Values, and Goals. HCOs, like most businesses, function based on missions and values to reach their goals. Depending on the organization, finding the balance between achieving mission and values can create massive complexity for which group of objectives supersedes the other. "Hospital missions combine varying emphasis on clinical care, community service and outreach, teaching, research, profits, and in some cases, religious values" (Ramanujam & Rousseau, 2006, p. 813). Combining these, sometimes competing, missions and values in a supportive way is critical to the organization's success and effectiveness.

Financial Challenges

Financial viability of HCOs is a very tenuous proposition. There are many things that contribute to lower profits for HCOs. As previously stated, one thing that is contributing to health care's monetary crisis is the fact that the population is aging making the patient be on government funding longer (Agarwal et al., 2010). Government funding offers lower reimbursement to HCOs because it does not pay what private insurance pays. Many insurance companies are also making bundled payments for services. This means that the insurance company pays one price for everything so if there is a complication then the hospital will not receive additional funding to cover the extra treatment and care. This puts a tremendous strain on the care team to ensure that there are no mistakes and care is the highest quality, which are the objectives we all want for the patient's care.

Many types of surgeries have changed from being managed as outpatient procedures versus inpatient procedures. While this is good news for the insurance company and the patient, the HCO suffers because reimbursement and care is lower cost and recovery quicker, eliminating the need for an extended hospital stay. Access to services has become an issue. Waiting lists for procedures, including surgeries, mean that less people have access to the care that they need thus resulting in less revenue for

the HCO. Procedures that were once paid for are now subject to scrutiny by insurance companies and quality control regulations (Porter-O'Grady, 2003a). Menaker (2009), a physician, reported that physicians

> are placed in the ethical quandary of knowing that a patient needs care but also suspecting that there is an increasing likelihood that they will not be paid fully or at all because of stressors placed on co-pays and deductibles or patient not having insurance. (p. 340)

This type of ethical dilemma places a great deal of stress on the physician to ensure that their patients are getting the care needed. Oftentimes, the physician can exhibit signs of moral distress, such as depression, insomnia, or gastrointestinal issues because they are not able to care for the patient as they were trained (Austin et al., 2005).

Like many businesses, HCOs are being asked to do more with less (Menaker, 2009). This means there is less staff, less equipment, less resources. HCOs are being forced to cut programs or positions that have generally proven integral to running a high quality, safe HCO. The leader has less time and ability to connect with followers. All of these forms of financial cutbacks lead to staff picking up more duties, leading them to feel overworked and stressed. Many of the financial difficulties HCOs face are beyond the control of the HCO to solve. In order to meet financial goals, HCOs are forced to cut staffing and programming leading to other problems to solve.

Nursing Workforce Changes

The face of the health care workforce changes frequently. Nursing is a popular career for the young careerists who abandon it when they get married or move on to other careers. Currently the nursing shortage is one of the most challenging that leaders are facing in the history of organized health care (Knickman & Snell, 2002).

Shortage. Nursing shortages have existed since there have been nurses. Having been a nurse for 30 years, it seems that there is a major shortage every 10 years or so. However, the nursing shortage

experienced now is the worst in history (Goodwin, 2003; Haddad et al., 2020; Reineck & Furino, 2005; Snavely, 2016). Lee et al. (2019) stated that by 2020, “a large percentage of RNs in the health care workforce, including 75% of health care leaders, are projected to retire” (p. 30). Murray (2002) and Lee et al. (2019) cited a myriad of factors that are contributing to the current shortage of nurses:

- an increase in the age of registered nurses
- decreased school enrollment
- increased career opportunities for women
- changes in the health care delivery system
- nurse burnout
- aging of the population
- increased technology
- the increase of the health/wellness movement
- changes in employee’s work ethic
- influence of Generation X and dot.com workers
- scarcity of entry-level and low-wage workers

While nursing is still one of the highest paid starting salaries, many younger nurses do not feel that they are paid properly for the work that they perform (Mee & Carey, 2001). There are too many other options for young careerists for nursing to be appealing in the long run. Careers that are less taxing physically, emotionally, and mentally are available and tempting.

Short staffing can lead to burnout, medical errors, decreased patient satisfaction, and decreased employee satisfaction (Boamah et al., 2016). Staffing shortages create many problems for the nursing units. When units are short staffed, there are not always nurses to fill the gaps. This leads to nurses having to take larger than normal patient assignments. This is indeed dangerous because the patient cannot receive the care that is needed because the nurse is stretched thin. This type of situation is why

there are nursing unions and mandatory staffing ratios in many states (Boamah et al., 2016). Short staffing can lead to moral distress for the nurse because, like the physician, he does not feel that he was providing the care that the patient needed.

Travelers. One solution to the nursing shortage is the hiring of travel nurses. Travel nursing is an appealing option for younger nurses. This often involves a nurse with less than 5 years of experience leaving a permanent position at an organization to travel to different HCOs under 13-week contracts to help with staffing in understaffed units. For the nurse, it is an opportunity to see the world, make a lot of money, set their own schedules, and gain many different clinical experiences. Nurses fulfilling these contracts can make as much as triple their current earnings (Daubener, 2001). There is also a downside for the nurse. Many are not welcomed to the units by staff because the traveler makes more money than the permanent staff member, the traveler does not necessarily have to follow the rules of the unit, and they are never really part of a team.

The HCO receives various benefits and downsides from travelers. Benefits from travelers are that they fill a staffing need very quickly. Generally, they require little to no orientation. If the census slows down, you can cancel them or send them to a different unit to work. This certainly "scores points" with the permanent staff as it saves their PTO (paid time off) or floating to a different unit, which is an employee dissatisfier (Good & Bishop, 2011).

One of the biggest downsides of having travelers on staff is that the traveler is the cost. Ramanujam and Rousseau (2006) pointed out that the biggest downside is that "temporary labor further reduces the quality of a hospital's work environment and its collective problem-solving capacity" (p. 814). Travelers pay rates are expensive and generally when travelers are needed, nursing units are already paying exorbitant rates to their regular staff for overtime or bonuses to encourage work.

Porter-O'Grady (2003b) mentioned that the use of the travel nurse has grown from 1998–2003; use has more than doubled their use for the entire 20th century. The nursing leader may also have

trouble managing these employees because the travel nurse governs themselves (Porter-O'Grady, 2003a). The leader–follower relationship changes from one of direct reporting to influence. This may be a challenge for a young nurse manager who has only led by direct reporting to this point. The traveler nurse controls their salary, schedule, and practice. The staff nurse no longer has allegiance to an organization but to themselves.

However, the most disturbing thing that a nurse can exhibit during times of short staffing and constant change is a lack of passion for nursing. A nurse is trained to care for others. When that is not possible, the nurse feels that their purpose is compromised. A nurse's work is tied to their identity (Porter-O'Grady, 2003b). Therefore, with all the changes and workload increases, many leaders hear from staff that HCOs are only concerned with the money and not with the patient or staff. The nursing leader must "be able to create a sense of mission, of initiating seminal work, in a scenario of leading a strong and value-driven enterprise that keeps nursing relevant" (Porter-O'Grady, 2003b, p. 176). When leaders ignore this grief, staff can be forced to deal with moral injury, depression, and a lack of self-worth.

Leadership Development

Organizations need leaders to survive, but not just any kind of leader. Amagoh (2009) stated that "organizations with effective leaders tend to innovate, respond to changes in markets and environments, creatively address challenges, and sustain high performance" (p. 989). However, HCOs have traditionally placed little focus and resources on developing health care leaders. Porter-O'Grady (1997) stated that health care has moved into a new realm of being. The past type of leadership cannot be utilized and applied to the new health care environment.

Leader Socialization and Team Development. Hospital staff is made up of many groups of professionals: physicians, nurses, therapists, chaplains, etc. All of these groups are hired to work together as a team. Chreim et al. (2013) postulated that when different disciplines work together, they

all bring their own ways of working, their own culture, and these different disciplines must be molded together to create synergy. However, orientation to the health care environment and work is generally separated by job function. This creates fragmented teams. Ramanjam and Rousseau (2006) pointed out that each profession has its own way of orientating to work and when coming together in a new environment, they should train together. If not, this leads to confusion as to what each other's roles are and how to come together as a team for the betterment of patient care. Leaders with little education on how to lead teams find themselves facing great difficulty in effectively influencing the workforce.

Research has shown that employees that are involved in highly functioning teams are twice as likely to be engaged versus those that work alone (Buckingham & Goodall, 2019, p. 5). It is always comforting to know that someone is looking out for you during difficult clinical times, checks in on your well-being, and values your ideas and contributions. Leaders are fundamental when leading teams to success. Yet, few HCOs teach leaders how to effectively lead teams.

Succession Planning. Martin and Waring (2013) supported the belief of early, lower-level succession planning by stating that leadership should not be hoarded by the senior executives but shared amongst all levels in an organization. Nothing replaces a good mentor. Someone who is looking out for you and your success. I had the benefit of a leader that knew my goals and provided me opportunities so that I could progress from clinical manager to Chief Nursing Officer, taking her position when she retired 10 years later. In health care, this type of long-term planning, especially at the manager level, is not common.

Titzer and Shirey (2013) completed a study that revealed that 70% of hospitals do not have a succession plan in place and 38% of health care succession planning tends to focus only on senior leaders. HCOs need to invest in those that are seeking out additional experiences and retain and train them for the future.

Leadership Training. Nica (2015) voiced leadership is the most important aspect of organizational culture. As previously indicated, leadership training is not typically invested in for HCOs. In my experience, education is also the first department reduced when the organization is trying to save money. This is unfortunate because so many health care leaders lack leadership education. At times, health care tends to make claims that it is so different from other industries that evidence-based learnings are not able to be applied in the same as in other organizations. Arguably, the "product" in health care is different than other industries; however, leadership is not. McAlearney (2006) supported this notion too and stated that

> Thus, despite health care organizations' reluctance to consider evidence-based management in the same favorable light as evidence-based medicine, health care organizations can apply lessons learned about leadership development to make important strides to accelerate leadership development in health care, and better position themselves for the future. (p. 979)

Health care must break out of this siloed, self-servicing thinking so that they can move forward.

Amagoh (2009) stated that improving leadership skills "increases the effectiveness of the interpersonal process between leaders and followers, and consequently increases followers' motivations" (p. 991). HCOs must find a way to invest in leadership development for the good of the followers and the organizations. Lee et al. (2019) believed that training and development for leaders was the key to success in HCOs.

Incivility and Oppression

The hierarchical structure can create a certain silence for health care providers, including leaders. Ramanujam and Rousseau (2006) discussed that silence (around medical errors) is exacerbated in health care because of status differences (personnel) inhibiting direct communication. Many staff are afraid to confront their leaders about ideas or errors because of retribution or being wrong. Leaders

must learn to find ways to empower staff to speak up and become role models themselves on speaking up.

The topic of incivility in health care is one that I am passionate about. I am fascinated by the health care workplace culture composition. I have been a registered nurse for the past 30 years and have worked in a variety of health care environments. I have witnessed incivility in the workplace, supported uncivil behavior in others, and been uncivil to my coworkers. Thus, I have had some "hands-on" experience with the topic. I also find it difficult to separate my personal beliefs from my professional beliefs as my identity as a nurse is also part of my personal identity.

Croft and Cash (2012) studied many nurses over the years and what nurses that are bullied go through on a day-to-day basis. In order to protect themselves, many nurses leave the profession and choose to give up on their dreams of being nurses (Clausen et al., 2013; Lee et al., 2013; Oh et al., 2016). Simons (2008) performed a study of 511 registered nurses and their perceptions of bullying in the workplace. The study showed that 31% (n = 158) of respondents reported being bullied, and that bullying is a significant determinant in predicting intent to leave the organization (B = 3.1, p < .0005).

Rosenstein (2002) has also conducted significant work on incivility in the health care arena. His research concluded that the relationships that health care workers, including administrators, have with each other effects the patient outcomes. Rosenstein is quick to point out that the relationships are not just between nurses and physicians but that the nurse-to-nurse relationships also have a negative impact on the environment leading to poor patient outcomes. Regardless of the "players" incivility in the health care work environment must be addressed and resolved.

Ethics and Nursing. When nurses graduate from nursing school, they accept the tenets of the Nightingale pledge. This is a pledge that all new nurses say when getting their nursing pin. Even today, I take this pledge seriously. The pledge was written in 1893 by Florence Nightingale, who is considered the founder of modern nursing. The pledge states

> I solemnly pledge myself before God and in the presence of this assembly, to pass my life in purity and to practise my profession faithfully. I will abstain from whatever is deleterious and mischievous and will not take or knowingly administer any harmful drug. I will do all in my power to maintain and elevate the standard of my profession and will hold in confidence all personal matters committed to my keeping, and all family affairs coming to my knowledge in the practice of my calling. With loyalty will I endeavour to aid the physician in his work and devote myself to the welfare of those committed to my care. (American Nurses Association, 2015)

This pledge was considered the first code of ethics for nursing and mirrors the Hippocratic Oath, the pledge for newly graduated physicians. The essence of both oaths is to do no harm, either to patients or those that the nurse and physician work with on a routine basis.

The American Nurses Association (ANA) adopted the pledge as the *ANA Code of Ethics* in 1950. Nursing leaders created the *ANA Code of Ethics with Interpretive Standards* (2015) manual so that all nurses and nursing administrators would be familiar with the guidelines of their professional practice. The manual serves to describe the ethical values, obligations, and professional ideals of the nurse, to be the profession's nonnegotiable ethical standard, and state the nurse's commitment to society.

The manual breaks down the nurses' roles and responsibilities into nine requirements or provisions. Provisions 1, 2, and 3 and their interpretive statements are the ones that are most closely related to the work environment and state:

- **Provision 1:** The nurse practices with compassion and respect for the inherent dignity, worth, and unique attributes of every person (ANA, 2015, p. v).
    - *1.5 Relationships with colleagues and others*: The principle of respect for persons extends to all individuals with whom the nurse interacts. The nurse maintains compassionate and caring relationships with colleagues and others with a

commitment to fair treatment of individual, to integrity preserving compromise and to resolving conflict (ANA, 2015, p. 4).

- **Provision 2**: The nurse's primary commitment is to the patient, whether an individual, family, group, community, or population (ANA, 2015, p. v).
    - *2.3 Collaboration:* Collaboration intrinsically requires mutual trust, recognition, respect, transparency, shared decision making, and open communication among all who share responsibility for health outcomes (ANA, 2015, p. 6).
- **Provision 3**: The nurse promotes, advocates for and protects the rights, health and safety of the patient (ANA, 2015, p. v).
    - *3.5 Acting on questionable practice:* Nurses must be alert to and must take appropriate action in all instances of incompetent, unethical, illegal or impaired practice or actions that place the rights or best interest of the patient in jeopardy (ANA, 2015, p. 12).

These three provisions (with their interpretive statements) clearly state that nurses should not promote or tolerate bullying and should strive to be collaborative and cooperative with all caregivers that they interact with for the betterment of patient care (Lachman, 2014). A nursing executive's job is to ensure that a positive, ethical environment is the forefront to nursing practice. A positive work environment reduces the chances that a patient will be harmed and provides a safe place for nurses to practice their healing art.

Wilson and Phelps (2013) researched actions nurses take due to incivility that can affect patient care. These actions include failing to clarify orders, carrying out an order that was not in the patient's best interest, and using unfamiliar equipment without assistance. These actions can cause direct harm and even death to the patient. McNamara (2012) found that other outcomes that can occur for patients due to a nurse's exposure to being bullied are medical errors, compromises in patient safety, impaired

quality of care, and withdrawal of care. For these reasons, several health care oversight groups, such as Occupational Safety and Health Administration (OSHA; 2015) and The Joint Commission (TJC; 2008, 2012), have issued statements about solving the toxic health care environment epidemic. It is up to everyone involved in healthcare to stringently protect the health care environment so that practitioners can provide the safest, highest quality care available to care for their patients.

Dynamics of Power and Marginalization. The subject of oppressed groups comes with many preconceived notions. When I hear the phrase *oppressed groups*, I instantly think of people of the Jewish faith, Blacks, and women. These are the three groups that I traditionally associate with oppression. When starting this research; however, it had never occurred to me that nurses are considered, by some scholars, an oppressed group.

***Nurses as an Oppressed Group*.** Roberts (1983) studied nursing as an oppressed group for many years. Her hypothesis was that nursing became an oppressed group when care moved into the hospital and the hierarchical nature of medicine took over, leaving the nurse without a voice. Nurses have often been viewed as handmaidens because of their domination by medicine (McCall, 1996). Furthermore, because nursing is primarily dominated by women, and women are traditionally oppressed in society, that makes this group of female nurses doubly oppressed (DeMarco, 1997; Hutchinson et al., 2006; Miller, 1986; Roberts, 2000).

Lewin (1948) argued that groups that are marginalized exhibit self-hatred and low self-esteem. These characteristics are exhibited because the marginalized group wants to be more like the dominant culture, and therefore, the subordinate culture must reject their own characteristics causing the members to experience self-deprecation and low self-respect. Fanon (1963), when writing about postcolonial life, described conflict within the oppressed group as horizontal violence because the group is unable to revolt against the oppressor thus forcing them to take it out on the other group members.

Horizontal violence is an inherent characteristic with oppressed groups and a characteristic the nursing profession has struggled with for decades.

It is important to understand this definition of nursing as an oppressed group because the behavior of oppressed groups, in this case nurses, plays a major role in the health care environment. Griffin (2004) and Felblinger (2008) described lateral violence as nurses covertly or overtly directing their dissatisfaction inward towards each other, towards themselves, or towards those less powerful than themselves, such as nursing students, nursing assistants, or patients. This behavior allows other groups to maintain control and not be challenged by nursing as a result of the inability of nurses to join together to support each other. Cox (2003) and Daiski (2004) dually cite that this conflict and lack of support has a tremendous impact on teamwork and team satisfaction and is a major reason for nurses leaving the profession.

Hierarchical Power in Health Care. Hierarchies serve a purpose. Communication and orders flow vertically to ensure that all are performing the duties that they are trained to do. This level of communication is important in the field of health care where the stakes are a patient's life. However, hierarchical organizations create many communication issues for leaders (Keir, 2018).

In health care, there is a cultural imperialism model of medicine. The physician practices, norms, values, and beliefs are the dominant culture and established norm (Dong &Temple, 2011). Many times, the administrators generally support this belief because the physicians are the ones that bring in the money. Money is needed to keep a hospital running. Dong and Temple (2011) described that nursing can be viewed as both different and invisible and therefore is devalued and objectified by the medical staff and administrators. This imperialistic view has led to the increase of nursing unions as a way for the nursing voice to be heard by administrators with deaf ears.

Not all nursing scholars agree with the oppression of nursing theory. It has been suggested that the oppression theory describes the bullying behavior of nurses as a learned behavior and a failed

understanding that it is normalized within the organizational culture (Hutchison et al., 2006). Foucault (1977) described this power as a positive and negative force diffused throughout the organization, a network of micropower. This network allows the dominator to dominate without the workers necessarily being aware. The dominated come to believe that the dominator has the right to rule over them, subtly and legitimately (Litvin, 2002). This can lead the oppressed to feel that they cannot take actions against oppression or let their voices be heard. Furthermore, accepting the term horizontal violence, as it relates to nursing, justifies the behavior and solely blames the nurse, reinforcing the oppression of nurses. Therefore, it is up to the organizational leadership to be aware of this abuse of power and help to mitigate it and its aftereffects.

Dong and Temple (2011) suggested that nurses need to reject the status quo of oppression that is pervasive in workplace cultures and as a group make their voices stronger. Roberts (2000) also advocated that nurses need to heal from the blame of past oppression and join together to change a system that devalues the nursing voice. CF can help the nurse's voice be heard and increase their ability to serve their patients and their communities.

Facing the Future

Complexity, financial changes and constraints, nursing workforce changes, lack of leadership development, and leading in a hierarchical organization are realities that health care leaders today must deal with on a day-to-day basis. Many of these challenges are beyond the manager's and HCO's ability to control. Therefore, the leader, and in my opinion, the organization, must find ways to help leaders lead their teams to overcome these challenges so that patients can get the care that they deserve and employees can practice in a safe, empowered environment. CF can help the leader and follower improve their communication, sense of empowerment, and ability to change the organization all in service of the patient and their well-being.

Healthcare and VUCA

The environment for today's leaders is ever changing, and not necessarily in a positive way. There are constantly new and complex challenges to meet; new obstacles to overcome. This is true for the traditional business world, but for the complex health care industry, it is even more so. Change is so constant in health care that an employee could take a two-week vacation and come back to so many changes that they can be unsure as to how to perform their job.

Health care faces the financial, economic, and leadership challenges that each business experiences, but it also offers many different trials than the business world. Health care has the added complexities of patient care, regulatory restrictions, and the mental health of the practitioner to be concerned with as well (Groves, 2018). All these challenges can affect the care and outcomes that the patient receives. Unnikrishnan (2017) believed that the world of health care, with its constant changing norms and standards, painted a picture of great uncertainty and complexity and therefore fits in well in the VUCA paradigm.

In the mid-1990s, a new acronym that described the complexities in the business world arrived on the leadership scene. The term was originally coined by the U. S. Army War College and described the new world that the Cold War left behind—VUCA: volatile, uncertain, complex, and ambiguous. Barber (1992) was credited with the first use of this term after studying the leadership theories of Bennis and Namus and General Thurman. Barber and Thurman applied these terms to the conditions during the war in Afghanistan in the early 1990s. However, after September 11, 2001, "the term VUCA was subsequently adopted by strategic business leaders to describe the chaotic, turbulent, and rapidly changing business environment that has become the 'new normal'" (Lawrence, 2013, p. 3). Today, the business world is fraught with scandals, financial collapse, and poor examples of leadership. The leadership practices of the earlier century are no longer helpful or applicable.

Due to the turbulence of the health care environment, the lack of training that health care leaders seem to experience, the number of stakeholders involved, and the uncertainty of the future, leaders need all the help they can get to lead their teams into the future. New frames of thinking are required to deal with today's complex environment (Bolman & Deal, 2015). The purpose of this study is to help equip leaders with the tools that they need to ensure success in today's complex, ever-changing environment.

VUCA Dissection

Volatile Definition

Volatility brings forth images of a red-faced, easily angered person. Someone whose mood changes rapidly, from 0–50, if you will. Volatility is defined as "the nature, speed, volume, magnitude and dynamics of change" (Horney et al., 2010, p. 33). Volatility equals turbulence. Lawrence (2013) believed that turbulence (in the business world) is occurring more now than in the past.

The reason for this increased turbulence in the business world could be traced to increased connectivity, new business models, technology, and creative trade agreements (Reeves & Love, 2012). The adjectives that most commonly characterize volatility are unstable, frequent, and unpredictable. These adjectives are also used to describe change.

What is not changing in the world would be a better question than what is changing. Thinking back 10–12 years ago, texting on the phone was newer, smart phones were really coming into vogue. Now we could not live without them. Gas prices are volatile. One day gas costs $2.50/gallon and then perhaps one hour later, $2.75/gallon. Using these examples, it is easy to see volatility in the world of commerce. What does volatility look like in healthcare?

Health Care and Volatility. In health care, the first example that comes to mind is the Emergency Department (ED). If volatility equals turbulence and you want to see it in action, then come visit an ED on a Friday evening. Friday nights from about 6 pm to 3 am are some of the busiest times.

What makes it so busy? The rapid influx of patients—trauma patients, those that should have seen a doctor earlier in the week, accidents. The ED census can go from 0 patients to 30 patients in a matter of minutes, especially if there has been an incident, such as a bus crash or a crowd shooting. Sometimes EDs must set up "hallway beds" or bed spaces in the hall where lower acuity patients can be seen and receive treatments. These extra spaces allow the actual patient rooms to be able to house the more critically ill patients. Many days this rapid influx of patients can be unpredictable, frequent, and unstable as you never know when a gang fight or bus wreck will occur.

The second example is a maternity ward. This type of unit is very much like an ED. Census can go from 1 to 2 laboring patients to capacity (usually 35–40 patients) very, very quickly. No two labors are the same. Some are quick, some are very long, some are low risk, some are high risk. Once the mom delivers the baby, the census on the unit will double or more depending on how many children the mother delivered. In this type of unit, like in the ED, the change is frequent, unpredictable, and often unstable.

Volatility and Leadership. How do leaders deal with volatility? Bennett and Lemoine (2014) suggested that agility is the key to combating the volatility that leaders face. The authors noted that resources should be directed toward relieving the tension that volatility creates, and energy should be focused on developing a future of flexibility. This is exactly what should happen in a health care environment. As a health care leader, you cannot always have enough staff to meet the needs of this giant influx of patients. Leaders cope by staggering shifts of employees based on trends of admissions, call extra staff in when overloaded, and at times, divert patients to other facilities. However, new leaders can have trouble with this balance.

A new leader may overstaff, ignoring the current trends in patient census. This could lead staff to be idol and bored. Perhaps the leader over hires so that patients are seen but does not understand how to decrease staffing when the census is lower. Experienced health care leaders have learned that

agility is important when dealing with uncertain increases in patient census. While not always able to hit the exact target, they have learned to read the trends and staff accordingly.

Uncertainty Definition

Not many things in life are certain; however, the fact that things will change in life is a certainty. Codreanu (2016) discussed uncertainty in this way

> Given the incapacity to read the present through the lenses of the past, that is to sift, discern or decide it becomes obvious that the predictability of the future is more uncertain which makes forecasting extremely difficult and decision-making challenging. (p. 32)

Uncertainty fails to understand the meaning of certain outcomes. This means that uncertainty generally implies a lack of knowledge about the future and its outcomes.

In the business world, there are many uncertainties. We know that if the stock market declines, our investments will lose money. However, we do not know if the loss will occur again or what other factors could have the same outcome. We can understand the cause and effect of crime, but we certainly could not predict how, where, when, or to whom it will happen to. This lack of uncertainty makes it hard to predict the exact future.

Health Care and Uncertainty. Health care is filled with uncertainty. Afterall, medicine, while scientific, comes with a great deal of uncertainty. Doctors know that if a patient gets strep throat, then they should receive a course of antibiotics, such as penicillin. Medicine knows that penicillin kills the streptococcus pyogenes. However, the patient may be unaware if they are allergic to penicillin and, if ingested, could put them in a lethal situation of anaphylaxis—an extremely life-threatening allergy that occurs. The patient could have sought medical treatment very late in the course and the streptococcus could have already caused damage to the patient's mitral valve in the heart. So, while the treatment may be certain, the outcome is not guaranteed to be certain.

An example of uncertainty for a health care leader can be as simple as the time the health care system that I worked for changed the uniform colors of the nurses. Speaking from personal experience, this is one of the hardest changes that I have ever been involved with and would never have guessed the uncertainty it caused in the environment. Research had been completed about how the patient identified who the nurse was on the team. Opinions were gathered from patients. It was determined that consistent scrub colors would help identify team members quickly. Therefore, each discipline would have a standard color uniform. Nurses would wear solid black pants and red tops. No prints were allowed.

During this change, I worked in an 18-hospital system and led the only pediatric hospital in the health care system. Nurses at the pediatric hospital had been allowed to wear scrubs with pediatric prints on them. When the system changed scrubs to certain colors and no prints, the nurses were beside themselves.

As leaders, we knew that this change would be hard. However, we never would have predicted the uncertainty that followed. Nurses were literally grief stricken. They felt that the pediatric prints were part of their identity. As leaders, we had to call in grief counselors to help the nurses get through the change. Several nurses quit over the change; many involved their physician colleagues and patient's parents to help them "speak with leadership about the change." Unfortunately, for the staff, the change remained. However, six years later it is still the topic of many conversations.

Uncertainty and Leadership. Beyond having a crystal ball to predict the future, the leader needs information to navigate the world of uncertainty. Information is helpful to consider the issues from all angles. To address uncertainty, Lawrence (2013) suggested that leaders

> learn to look and listen beyond their functional areas of expertise to make sense of the volatility and to lead with vision. This requires leaders to communicate with all levels of employees in their organization, and to develop and demonstrate teamwork and collaboration skills. (p. 6)

Perhaps, as a leader, I should have suggested that we heard from more of the staff nurses before making this big change. But again, this outcome could not have been predicted.

Uncertainty has never been more prevalent than in today's workforce. The business environment is more complex due to the number of generational differences. Each generation has their own beliefs and social norms. The millennials come with their own amount of uncertainty. It is not uncommon for a millennial to stay in a job for a year or two before wanting a different position. Baby Boomers and Generation X and Yers do not change positions that frequently. Kinnaman (2011) described this frequent changing of jobs as emotional, and that to some millennials, long term employment makes an ethical or political statement. Rodriguez and Rodriguez (2015) further supported this belief and stated that "uncertainty over the future makes personal and organizational identity, relationships and decisions to be taken as liquid and provisional" (p. 855).

Complexity Definition

Complexity is a very common term. People generally associate complexity with science and technology. Codreanu (2016) defended this belief and postulated that the access and development of big data will continue to multiply. People are more mobile. Almost everything can be completed in some technological format creating an interconnectedness to the world and its resources that has not been available in the past.

Lawrence (2013) associated complexity with chaos. Chaos comes quickly. Leaders need to make sense of the chaos in the world. If sense cannot be made of the chaos, then the who, what, where, why, and how become virtually impossible to understand and contain. Sullivan (2012) described complexity as phenomenon that is difficult to understand and affects problems inside and outside the organization. Complexity adds to the turbulence of change and adds more difficulty to decision making.

Health Care and Complexity. The best example of complexity I can think of in science or health care is the human body. It is one of the most complicated machines in existence. It is a function of

interconnected parts that function as a whole. For instance, we cannot live without our brains or hearts. However, if any veins are severed or blocked, the body can create what is called collateral circulation. Collateral circulation is the formation of new pathways (specifically capillaries and veins) that carry blood past the blockage to the original pathway. This is a very useful skill to have so that one part of the body does not suffer or die. The body responds to the chaos and uncertainty with agility and flexibility.

Complexity and Leadership. Bennett and Lemoine (2014) suggested that the way to effectively deal with complexity is through restructuring. Restructuring simply means to effectively and efficiently address the outside world. Leaders should attempt to structure their organizations to attack the complexities in the world. Much like the body handling a block in circulation, organizations need to find new pathways that are like the old ones. Organizations should flow with complexities and not fight them (Bennett & Lemoine, 2014). This way, the organization can continue to flow without any blockages; therefore, no part is susceptible to death.

Ambiguity Definition

Ambiguity means a lack of clarity. Cause and effect of a certain situation is in doubt. There is generally not a historical precedence to explain and determine outcomes. Ambiguity is not volatile; there is not a quick change. It is not uncertain. In an uncertain situation you know the cause of the problem, and with ambiguity you do not necessarily know. Ambiguity is also not complex, it is "just a lack of understanding as to what will happen next" (Bennett & Lemoine, 2014, p. 316).

Colonel Eric Kail (2010) described ambiguity as the inability to contain a threat before it becomes lethal. In an organizational context, this means that organizations fail to bring endeavors to their full conclusion or success. Codreanu (2016) believed that ambiguity is the reason that businesses can become failures because leaders cannot deal with the inability to provide a yes or no answer to a problem. Leaders are uncomfortable with ambiguity and often time inexperienced leaders will give an

answer to just give an answer and without thinking through the consequences, which can lead to further problems.

Health Care and Ambiguity. Given that the definition is not knowing the outcome, health care and medicine is fraught with ambiguity. Physicians pride themselves on knowing the course of a disease. Most of the time, they are correct. They can predict the mortality and morbidity of the disease that they treat with great accuracy and detail. However, sometimes that one person comes along who recovers from a fatal disease with no explanation or makes it through a harrowing surgery that should have killed them. These cases always seem to leave physicians baffled and unable to explain the cause of the recovery. In my experience, it is very uncomfortable for a physician to not have the answer. Afterall, while medicine is exact, it is also a science of probability and possibility.

Ambiguity and Leadership. While ambiguity essentially means not knowing, Kinsinger and Walch (2012) suggested that the way to combat ambiguity is with agility. Leaders need to remain fluid and be able to communicate changes rapidly in their organizations. Leadership agility allows leaders to respond quickly and efficiently to any new situation that requires action (Horney et al., 2010). This agility helps leaders help their staff to adjust to changes more rapidly and efficiently.

In addition to agility, fighting ambiguity also requires clarity. The clearer the message, the more the followers will understand the mission. Clarity is about motivating people and pulling them in the right direction. The leader needs to be very clear about what the mission is, but flexible and agile to achieving the goal (Johansen & Euchner, 2013). “For clarity to emerge, people accountability, process accountability, discipline and integrity should be key ingredients. In other words, accountability plus discipline equals integrity and results in clarity” (Brown, 2014, p. 15).

Leader Development and VUCA

If the world is changing and the old ways of leadership no longer work, then what can leaders do to be successful in a VUCA environment? Drucker (1999) suggested that new paradigms for leadership

must be found stating that a leader must respond to any anomaly inside or outside the organization that affects performance. Researchers and scholars have explored many different theories and tools to assist leaders in a VUCA environment. However, the focus of this study is on those that will be most beneficial in a health care setting.

Leadership Succession and VUCA

By 2030, "millennials will comprise 75% of the workforce and their Baby Boomer parents will be high utilizers for Medicare services, decreasing the health care workforce and talent pool" (Groves, 2018, p. 4). This decrease in the workforce and talent pool will show up at the bedside, but also in the executive offices. Health care is notorious for not devoting time and planning for leadership development and succession planning. Schweyer (2009) supported this belief and stated that

> Hospitals and health care systems have devoted too little time to creating a legacy of leadership, many have no formal plans to identify and develop individuals for future roles nor do they have a transition strategy should leaders make a planned or unplanned departure. The health care industry may be unique in the enormity of the talent challenges that confront it. If there were ever a perfect storm related to talent management, it is most acute in health care. While it is true that the aging population restricts talents for all industries, it is only in health care and life sciences that it so profoundly impacts demand at the same time. (p. 13)

According to the above statements, health care will be in real crisis in the next 10 years. Health care organizations need to plan for the future now.

Schweyer (2009) completed a review of three of the top health care organizations in the United States to determine some best practices for health care succession planning in a VUCA environment. His recommendations included:

- Strong alignment between business strategy and succession management capabilities

- Substantive engagement of the board and executive teams in succession management practices
- Robust talent management metrics and ROI measures
- Rigorous talent assessment, review, and development practices
- Consistent cultivation of a leadership development culture

The author believed that if these recommendations were put into place as leaders left or were promoted, the internal replacement would be ready to take on the challenges regardless of the turbidity in the workplace.

Leadership Agility and VUCA

VUCA environments require leaders that are quick thinkers, able to adjust course quickly, and respond to followers with honesty, integrity, and grace. The leader needs to assess, reassess, and rearrange so that the organization can provide the best quality, cost, and efficiency. Agility is one of the most important characteristics a leader in a VUCA world can possess.

Agility was determined to counteract ambiguity. However, how is agility instilled in leaders? Horney et al. (2010) developed The Agile Model to assist leaders in identifying leadership agility skills. The leadership agility skills are divided up into three categories focused, fast, and flexible. Additionally, the categories are subdivided into (a) **a**nticipate change, (b) **g**enerate confidence, (c) **i**nitiate action, (d) **l**iberate thinking, and (e) **e**valuate results, each having their own characteristics. This breakdown can be especially helpful for leadership development conversations and teachings.

Codreanu (2016) discussed agility and related it to being elastic, lightweight, and reproducible. Agility is about responding quickly and creatively. Healthcare is ever changing and uncertain. Agility is necessary to navigate the daily complexities and uncertainty faced by healthcare leaders.

Leadership Advice. Instilling behaviors that combat VUCA come in many shapes and forms. Condreanu (2016) suggested three principles to help leaders. First, believe that you can make decisions.

Remember that sometimes educated guesses are ok. Second, assume accountability for your decisions. You must be accountable for ensuring that the right decisions are made. Third, be a role model. Let your leaders see what behaviors you will and will not tolerate. These sound like very basic leadership principles, ones that every leader should be following, however, many leaders seem to get caught up in the business of leading and forget about the art of leading.

Lawrence (2013) gave three suggestions for hiring in a VUCA environment. First, hire agile leaders. Structure interview questions that focus on past examples of on-the-job agility in order to hire those that already practice agility. Second, develop existing leaders to be agile leaders. Lawrence (2013) stated that training and developing VUCA leaders must be through programs that focus on developing agility, flexibility, innovation, teamwork, communication, openness to change, and other critical thinking skills. These programs must be delivered via social media and other technology to keep up with the pace of change.

Training can take a long time due to scheduling live classes, finding replacement workers for those in class, etc. Of course, electronic classes come with downsides too. Many times, people do not really pay attention and just “click” through the learning to get to the end and receive credit. Other learning platforms include scenario planning to determine what should and should not be done in certain situations and simulations. Job rotation was also suggested. Personally, I have used job rotation a lot with my staff. It gives them insight into other parts of the organization and helps with their ability to make decisions with varying information.

Third, foster an organizational culture that rewards VUCA prime behaviors and retains agile employees. This can be accomplished by adding VUCA values and attributes to performance management systems. Lawrence (2013) suggested that leaders that practice desired behaviors should receive perks, including higher salaries. He suggested that the key to offering perks is to give the employees what they would like. In other words, be agile and flexible. While I do not disagree with

those suggestions, I believe in the health care arena this would be challenging to accomplish due to the lack of flexibility often exhibited by HCOs.

VUCA environments are everywhere. Unfortunately, no business or organization is exempt from the effects of the changing environment. This includes health care. While it does not look like the environment will stabilize anytime in the future, there are things that leaders can do to navigate this environment. Clarity and agility are the two most important characteristics that leaders can possess. Agility helps navigate volatility and ambiguity, while clarity helps navigate uncertainty and complexity.

Understanding that times change, supporting and seeking the opinion of staff, providing a clear vision, and remaining agile and flexible will go a long way to becoming successful in these turbulent times. Leaders must change with the changing times. They must be comfortable with ambiguity and uncertainty. They must learn to "go with the flow" in order to be successful. CF can help empower staff, face a VUCA environment, and improve the health care landscape.

Followership

Followership, at its elemental definition, describes the actions of someone in a subordinate role. Webster's Dictionary (2019) defined followership as "the capacity or willingness to follow a leader." However, the followership concept can have many other meanings. It can be a set of skills that balances leadership, a role within a hierarchical organization, a social construct that is integral to the leadership process, or the behaviors engaged in while interacting with leaders to meet organizational objectives (Chaleff, 2009; Kelley, 1989). Followership is a conscious action that a subordinate takes to be in synergy with a leader to accomplish goals.

Riggio (2014) expressed a push to "legitimize the term of follower to recognize the critical role that followers play in co-producing leaders, and to change the stereotypical views of followers and followership" (p. 17). The term follower has gained more acceptance in the past few years. Has the leadership landscape evolved enough now to be ready for the term and concept of followership?

Followership Categories

Followership at its essence is a way for leaders and subordinates to work together for the benefit of themselves and their organization. There are several followership styles, just as there are numerous leadership styles.

Kelley

Kelley (1992, 2008) originally identified five followership styles (the terms in the parentheses were the original terms):

- **The sheep (passive):** those that are passive and let the leader do their thinking;
- **The yes-people (conformist):** they are positive but still allow the leader to do their thinking;
- **The alienated (alienated):** think for themselves but produce a lot of negative energy;
- **The pragmatics (pragmatist):** fence sitters, waiting for the next initiative to blow over, neutral affect, and;
- **The star followers (exemplary):** think for themselves, very active and have very positive energy, independent evaluators.

People can embody these styles based on the situation and their role in the organization. Just as leaders and followers can experience both roles, sometimes in a single meeting.

The Alienated (Alienated). The alienated group comprises about 15–25% of all workers (Kelley, 1992). These are the type of people who constantly seem to have a chip on their shoulder. They are negative and feel that the organization or their leader is out to get them. They are capable workers and, in fact, started out as star performers. However, something or someone along the way took advantage of them and betrayed their trust, causing them to be resentful and outwardly angry. They mistrust the leader, the organization, and themselves. Because these employees started out as star performers, resolving the source of the negativity could lead them in a positive direction. Unfortunately, that is much

easier said than done. However, if the employee and the leader can discuss the concerns, hopefully a meaningful resolution can be found. If not, this type of person may need to find other opportunities to reach happiness and fulfillment.

The Yes-People (Conformists). This group of individuals reminds me of Labrador puppies. Characteristics that they display, like Labradors, are eagerness to please their leader, high engagement, a positive can-do attitude, and obedience. Kelley (1992) believed that the cause of conformity for the yes-people, who comprise about 20–30% of a population, stems from a desire for structure, direction, and certainty, but creating their own freedom leads to fear and weakness so they seek out someone to blame their unhappiness on. There is not much of a shift for the yes-people to become star performers; these followers just need to feel comfortable and confident thinking for themselves. Sometimes, all this transformation takes is a leader that can be a mentor to help the follower begin to formulate their own ideas and speak up.

The Pragmatist (Pragmatists). Just as the word suggests, pragmatists, who make up 25–35% of the workforce, are very practical, and often this follower hugs the middle of the road (Kelley, 1992). They perform their work and often little else. Occasionally they will question the leader, but they are not willing to risk too much to do so. Kelley (1992) believed that this style is highly influenced by the leader and is often in response to an unstable organization. The pragmatist can transform into a star performer by pursuing their own personal goals and helping others to achieve their goals.

The Sheep (Passive). The sheep or passive followers comprise 5–10% of a group and rely on the leader to do their thinking for them (Kelley, 1992). They lack enthusiasm, initiative, and a sense of responsibility. Sheep are often under very controlling leaders and become passive to survive. Because the passive follower is the polar opposite to the star follower, it means that this group has a lot of work to do to ensure that they are productive members of the team.

The Star Follower (Exemplary). This is the group of high performers; the 15–30% of employees that exercise individuality, critical thinking, are actively engaged, and are innovative and imaginative (Kelley, 1992). The star follower generally excels in their job skills, has a huge network of connections, and exhibits courageous conscience with the leader and job activities. They represent enormous value to the success of the organization and the leader (Baker, 2007; Chaleff, 2009; Collinson, 2006; Kelley, 1992; Lundin & Lancaster, 1990; Roseneau, 2004). The star follower adds value to the organization by

- Focusing on the goals
- Doing a great job on critical path activities related to the goal
- Taking the initiative to increase their value to the organization
- Realizing that they add value not just by going above and beyond who they are—their experiences, ideals and dreams. (Kelley, 1992, p. 131)

The star follower is also expertly skilled at maintaining relationships with their coworkers and leaders and these relationships serve as a benefit to the organization. They see their position as that of a knitter, maximizing relationships to the benefit of the organization's best interest (Kelley, 1992). They realize that they must be part of the success of the organization for all and the organization to be successful.

Chaleff

Chaleff (2009) started writing about followership in the mid-1990s. He viewed the leader-follower relationship as a duality: influential followers supporting commanding leaders. He outlined three ways to accept our (follower) dual responsibility for our organizations and the people that they serve.

> First, followers must understand the power that they possess and learn how to use it. Secondly, followers must appreciate the value of leaders and cherish the critical contributions that they make to our endeavors. Third, followers must understand the seductiveness and pitfalls of the power of leadership. (p. 3)

Chaleff supported the belief that the follower has much to give to the leader–follower relationship. He believed that the idea of the leader's thoughts dominating the conversation was dangerous. The leader must be open to being challenged by the follower, and if this cannot happen, then the follower risks losing their creativity and unique perspective, putting the organization at risk.

Courageous Followership. Chaleff (2009) was the first researcher to add the term courageous to the concept of followership. He explained that he chose "the image of 'courageous follower' to build a model of followership because courage is so antithetical to the prevailing image of followers and so crucial to balancing the relationship with leaders" (p. 4).

Chaleff (2009) described five dimensions of courageous followership to help explain the dynamics of the leader-follower relationship. The five dimensions are

- **The courage to assume responsibility**: the follower assumes responsibility for their own growth.
- **The courage to serve**: the follower will assume new or additional responsibilities to help the organization and leader.
- **The courage to challenge**: the follower is willing to stand up and voice discomfort if the behaviors or policies conflict with the common purpose or their integrity.
- **The courage to participate in transformation**: the follower will champion the need for change and stay with the leader and group while they mutually struggle with the difficulty of real change.
- **The courage to take moral action**: the follower knows when it is time to take a stand that is different from that of the leaders.

Dixon and Westbrook (2003) performed a quantitative research study of Chaleff's five dimensions to determine if followership is evident only at lower organizational levels of an organization or is evident at all levels. The study consisted of 299 participants from 17 organizations, all levels of

employee from executive to operational or frontline staff, completing self-evaluations, through survey responses, of the five dimensions.

Dixon and Westbrook's (2003) final conclusions from the study are that the executive level understands follower behaviors the most. The executive level is able to practice this behavior and mentor it in others. The conceptualization and understanding of follower behavior decreases as it goes down the leadership scale to the frontline worker. The frontline worker has the least understanding and practice of follower behavior; therefore, the higher one goes in an organization, the more awareness and ability to foster followership occurs. Other conclusions from this work include the fact that followership is detectable at every level in an organization, followership behavior is measurable, courageous followership exists, and followership increases with every level in a hierarchy.

By 2009, Chaleff had completed more research on the above dimensions and added two additional axioms to strengthen the relationship of leaders and followers. The first dimension is the courage to speak to the hierarchy. This means that the follower gives careful thought to the sensitivities and strategies required to speak effectively to leaders in a hierarchical organization. The second-dimension courage is to listen to followers; the leader has the responsibility to support the conditions of courageous followership and to respond productively to acts of CF. When done well, the leader and the follower thrive. When done poorly, they both suffer.

Kellerman

Kellerman (2007, 2016) defined five follower styles as well. These follower styles are on a continuum from doing absolutely nothing to being passionately committed and deeply engaged. See Figure 2.1 for a diagram of these styles. The five styles are

- **isolates**: those that are completely detached from the leader, express no interest in leaders' work, maintain status quo

- **bystanders**: those that just watch, are observant and aware, disengaged, withdrawn, and support the status quo
- **participants**: those who are actively involved in work, support the leader and the organization at various times, will invest energy into work
- **activist**s: those who feel strongly, either positively or negatively about the leader, can undermine the leader
- **Diehards**: those that will die for the cause

Kellerman (2016) recognized that her typology would not be embraced by all but suggested that followers, like leaders, cannot be lumped into one group, thus the five styles. Kellerman also recognized that with these followers' styles, it is important how the follower interacts or does not interact with the leader. There is an obvious relationship between the leader and the follower.

Followership styles rely on energy and involvement with the leader and the organization. The styles are routinely mixed throughout the organization's employees. If it has been shown that diehards, star performers, and those with courageous followership perform the best, then why are leaders not exclusively hiring and empowering these employees? Kelley (2008) stated that he consistently asks executives, what mix of employees would they want to work with? Most leaders do not hire all star performers. Kelley determined that leaders believe that the star employee will grow bored or dissatisfied and leave the organization. So, to stem turnover, the leader will hire a mix of the above employees. It is so unfortunate that the leaders are ignoring the fact that employees that feel empowered to make decisions and can think independently are much happier in their roles, thus being more committed and less likely to leave the organization (Ramlall, 2004).

Bad/ineffective Followers. Nothing in life comes without a polar opposite, good and bad, hot and cold, sweet and salty, and so on. So, what is the opposite of a good follower? Just as with the perception of a bad leader, there are bad or ineffective followers. Sometimes the bad behavior is in the

eye of the beholder, sometimes it is the person themselves or the situation that they find themselves in at the time. Bad followers as those that are critical, pessimistic, uninterested, and disaffected. Many bad followers will only do work that is asked of them and not venture outside the role. Many bad followers take no accountability for their role in organizational issues. Lundin and Lancaster (1990) traced these behaviors to decreased morale, decreased self-worth, and loss of potential.

Kellerman (2008) suggested that there are two criteria that separates good followers from bad followers. First is the means or the level of engagement the follower brings, and second is the end or the motivation or self-interest. Kellerman (2008) developed five maxims to help elucidate the definition of bad and good followers based on their means and ends. The axioms range from doing nothing to help a leader, which is ineffective and unethical, to fully supporting a leader, which is helpful and ethical.

According to these definitions, bad followers are those that blindly support a bad leader, do or say nothing about an ethical situation, and oppose good leadership. There can be a variety of reasons for this bad followership behavior. Lipman-Blumen (2005) believed that sometimes the follower is unaware of how much power they possess to oppose a poor leader. Perhaps the bad follower no longer speaks up because they know that the leader will do nothing about the issue or will not even listen to the issue to begin with. Ineffective followers can lack integrity, cover up troubles, or just agree with the leader in any situation; this behavior will help the company go the wrong direction very quickly. Therefore, silence is just a way of coping for the follower. Sometimes bad followers support bad leaders out of spite or personal gain. Regardless, bad leaders rely on the support of bad followers.

Social Constructs of Followers. Carsten et al. (2010) performed a qualitative study utilizing information gathered from semi structured interviews of 31 participants across various industries and employee level. The study revealed the presence of active, proactive, and passive followers. Passive followers display behaviors, such as not thinking on their own and never challenging the status quo. The authors noted that this behavior is not uncommon in hierarchical organizations. Active followers display

obedience and loyalty, even if they are in opposition to the leader's abilities. They will, however, speak up when asked to do so. The active follower is determined to maintain a positive attitude and positive relationship with the leader. Proactive followers are more effective when they have a partnership with their leader. This group is resolute to maintain partnerships with the leader so that the mission can be advanced.

Kean et al. (2011) conducted a qualitative study to determine how community nurses view followership. The study determined that following is a complex process with a socially constructed view of leadership. The authors impart a key message for nursing leaders, a partnership between leader and follower is imperative to future success. Failure to consider difference among followers will impact the leader and the organization positively and negatively.

The Theory of the Dyad Relationship Between Follower and Leader. In followership, the leader and the follower work together to achieve a common purpose. Chaleff (2009) suggested that in successful relationships the leader and the follower are symbiotic with the purpose of the organization. As with any intimate, purposeful relationship, the follower-leaders' relationship requires trust, integrity, and the ability to give and receive feedback. The purpose of this relationship is to display mutual respect and maintain integrity to reach a common purpose. Balanced feedback from each other provides the base for honesty and mutual respect. Immature behavior is not tolerated in this relationship. With great leaders, the followers grow and mature in their leadership and vice versa. The only way to achieve this growth is through the trusting relationship of the follower and leader.

Uhl-Bien et al. (2014) expounded on the followership concept to create a followership theory. This theory is designed to understand the follower and their impact on leadership. The authors delineated that the term followership is not about general employee behaviors but how a follower acts in correlation to a leader; therefore, the term employee and follower are not the same. The authors suggest that "for a construct to qualify as followership it must be conceptualized and operationalized in

relation to leaders or the leadership process and/or in context in which individuals identify themselves in follower positions (e.g., subordinates) or as having follower identities" (p. 96).

Uhl-Bien et al. (2014) defined that the constructs in followership research should include (a) followership characteristics—how one defines and enacts followership, (b) followership behaviors—behaviors enacted from the standpoint of a follower role or in the act of following, and (c) followership outcomes—outcomes of followership characteristics and behaviors that may occur at the individual, relationship, and work-unit levels. The authors believe that because followership is its own entity, to study only leadership characteristics would make one miss out on followership characteristics because the act of followership is very different from the act of leadership. Heller and Van Til (1982) further supported this idea stating that the idea of leader and follower must be present in successful leader–follower relationships.

Uhl-Bien et al. (2014) viewed the constructs from two different perspectives. The first was looking at behaviors and characteristics as antecedents of followership and how they affect the outcomes for the individual, the leader, and the organization. Riggio (2014) stressed the importance of not just reversing the lens to solely concentrate on the follower because then the leader would get left behind. The study of follower and leader needs to be intertwined as to understand the complex relationships (Hollander, 1992). Kean et al. (2011) suggested that leadership and followership are interdependent concepts and thus leadership cannot be possible without followers.

The second perspective is the leadership process. This framework describes the outcomes achieved as leaders and followers interact with each other. It stresses the importance of the active role the leader and follower play together. It is important to look at followership in this way as it moves beyond the leader being the only one of value in the leadership dyad.

Followership and the Hierarchical Organization. Health care organizations are typically structured and function as a hierarchy, meaning that information flows from top to bottom and most

employees do not have direct, daily contact with the highest leaders of the organization. Chaleff (2016) stated that hierarchies are necessary to maintain a chain of command. Health care has been designed as a hierarchical structure since the Victorian days. The structure of the health care hierarchy makes communication extremely challenging and complex because there are so many leadership levels. For instance, the layers are generally as follows, from lowest to highest level, in medicine at an academic medical center: medical student, intern, resident, fellow, attending, chief of the department, and then chief medical officer. This is for just one department, such as general surgery. Each department or specialty has their own structure like the one just described. These levels get more complicated if there are academic appointments and when these layers are butted up against the organizational hierarchy. Heller and Van Til (1982), when considering followership as a construct, suggested that the hierarchical leader-follower relationship was outdated; however, no new type of leadership was suggested.

Communication in the Hierarchy. Chaleff (2009) distinguished between a complaint and an issue when discussing how to bring information forward in a hierarchical structure. A complaint is generally as easy as saying that "I see something wrong and it needs to be addressed." This complaint is usually addressed by one's immediate supervisor. An issue is more actionable and usually addressed by senior leadership. Chaleff suggested that when an issue is raised by a follower, time needs to be taken to present it professionally and thoughtfully. A courageous follower will act independently and provide recommendations for action to the leader. This idea supports that the follower and leader work together to find the best solutions.

Leaders are trained to mitigate risk. One of the best things that a follower can do when bringing an issue forward to the leader is to assess the risk involved. This framing will certainly garnish the attention of an astute leader. However, most perceptive leaders will also be on the lookout for new ideas that generate income and address cost containment. Ideally, one of the most important things a follower can do is educate the hierarchy who generally came up through the ranks, have a differing

background, or have just been away from where work is done for too long. Lundin and Lancaster (1990) referred to this concept as “owning the territory” or understanding how your (the follower) knowledge and expertise contribute to the whole (p. 20).

Followers’ Responsibilities in a Hierarchy. There are several things that the courageous follower needs to keep in mind when working in a hierarchical society to ensure that they are within their rights and to move the mission forward. First, the follower should remain committed and excited about the mission. A follower’s attitude can affect everyone in an organization. Everyone, regardless of position, needs to remember that each person faces various stresses in the workplace and it is in everyone’s best interest to remain positive and empathetic. Second, the follower should make positive contributions to the organization regardless of the constraints that might be present. Third, the follower needs to persist in making efforts to improve the organization. Change is never easy or quick. The leader needs support and encouragement. Keeping these points in mind, the follower can continue to make positive contributions to the organization and eventually achieve a higher position in the organization, if that is what is desired. Then once the follower is leader, they will hopefully remember these lessons and empower their followers regularly (Uhl-Bien et al., 2014).

***Followership and Nursing*.** Followership has been a concept on the leadership landscape since the late 1980s. An earlier article written by a registered nurse (Corona, 1979) implored nursing leadership to consider followership. Corona (1979) suggested that nurses should become involved in the dynamics of being a leader and a follower because nurses are both leaders and followers. During the late 1970s, this concept of followership, in my opinion, was not as rich and in-depth in meaning as it is today.

Nursing as a profession has historically had a hard time getting their voices heard by the health care team (Corona, 1979; Gunn, 1996). Corona (1979) indicated that followership is necessary as nurses begin to get their voices heard. At that time, the role of leader and follower and positive health

outcomes had not yet been correlated. However, Whitlock (2013) connected the two concluding that the interdependence between leaders and followers is required to improve the quality and safety of patient care. Guidera and Gilmore (1988) further supported that when followership supports leadership, it becomes essential to the future survival of nursing leaders.

Teaching and Encouraging Followership. As many researchers have theorized, people are both leaders and followers. Leader and follower may not be defined in formal terms, but both do exist, more often than not within the same person. Researchers have also demonstrated that followership is likely to improve training and organizational performance (Crossman & Crossman, 2011). Can followership, like leadership, be taught and encouraged? The short answer is that followership can be taught (Morris, 2014).

Lundin and Lancaster (1990) suggested four ways to encourage followership in an organization. The first is to reconceptualize the workplace. Organizations must encourage followers to be self-directed and manage themselves. This style of leadership is much more successful than intimidation. Second, institutionalize followership. Empowered followership must be role modeled on a daily basis and accepted as the norm. Third, hire and train for followership. Teach current staff problem solving, coping with change, conflict management, and the ability to give and receive feedback. Hire for independent thinking, not just performance. Finally, recognize and celebrate followership. Remove the fear of retribution and punishment and replace with rewards and encouragement.

Lippitt (1982) additionally suggested several ways to encourage followership in an organization. First, group training was recommended to set expectations and norms as support for the leader. This encourages all members of the group to be responsible for the outcomes. Second is the development of evaluations that provide feedback to both participants and celebrations for both parties when goals are met. This celebrates the positive communication that the two can share. This two-way evaluation serves as a discussion for improving the work communication and relationship. Frew (1977) created a

Leadership–Followership style instrument that could help the leader and follower to begin to understand each other's styles. Third, teach how to communicate up the hierarchy and train together as a group, do not just train the leaders. These actions all lead to shared accountability for outcomes, thus making the organization successful as a shared endeavor.

Pulling Followership Together for the Future

The above discussion traced the roots of followership from Corona (1979) to Chaleff (2009). Figure 2.2 displays a side-by-side depiction of concepts in the theories discussed and illuminates the growth in the leader-follower relationship over the 30 years of research.

Figure 2.1

A Comparison of Followership Concepts

Corona (1979, pp. 5-7)		**Kelley (1992, pp. 10-12)**	**Kellerman (2007, pp.85-86)**	**Chaleff (2009, pp.8-10)**
Leaders	**Followers**			
Studies and creates new ideas.	Test new ideas.	**Sheep**- passive and let the leader do their thinking	**Isolates-** completely detached from the leader; maintain status quo.	The courage to **assume responsibility** for one's own growth-the follower assumes responsibility.
Makes decisions.	Challenges where indicated.	**Yes -people**- positive but allow the leader to do their thinking	**Bystanders-** observant and aware but disengaged and withdrawn	The courage to **serve**- the follower will assume new or additional responsibilities
Assigns appropriate responsibilities.	Knows when to accept responsibility and carries it out.	**Alienated**- think for themselves but produce a lot of negative energy	**Participants-** actively involved in work; will invest energy	The courage to **challenge**- the follower will voice discomfort if behaviors or policies conflict with their integrity
Creates an environment of trust—resulting in freedom.	Uses freedom responsibly.	**Pragmatics-** neutral-waiting for the next initiative to blow over.	**Activists**- those who feel strongly positive or negative about the leader; undermines leader	The courage to **participate in transformation**- follower will champion the need for change and see it through with the leader
Takes risks.	Risks following.	**Star followers-** think for themselves, very active and very positive.	**Diehards**- will die for the cause; leader has full support	The courage to **take moral action**- the follower knows when it is time to take a different stance than the leaders
Is reliable.	Is trustworthy and respectful.			The courage to **speak up to the hierarchy**-the follower gives careful thought to the sensitivities and strategies required to speak effectively in a hierarchy.

Is loyal to followers.	Is loyal to leaders.			The courage to **listen to followers**- the leader has the responsibility to support the conditions of CF and respond productively to acts of CF.
Is self-confident.	Knows oneself.			
Assumes leadership position.	Follows when appropriate; uses the organizational structure.			

With all the above concepts, the interactions with the leader and follower relationship are evident. One behavior cannot be affected without affecting the other's behavior. The leader and the follower are dependent on each other to be successful. The less the leader and the follower are involved with each other, the worse the relationship seems to express itself. The more they are supporting each other, the more they flourish and the organization flourishes.

The chapter started by describing the health care arena as a VUCA environment and was followed by a discussion elucidating the many day-to-day challenges that the leader faces. The leader must rely on solid, growth producing relationships with their followers in this current environment, especially in health care where there is incivility, oppression, and a hierarchical structure, which prohibits effective communication. CF addresses all these needs while enhancing the interdependence and fluidity of the leader–follower relationship.

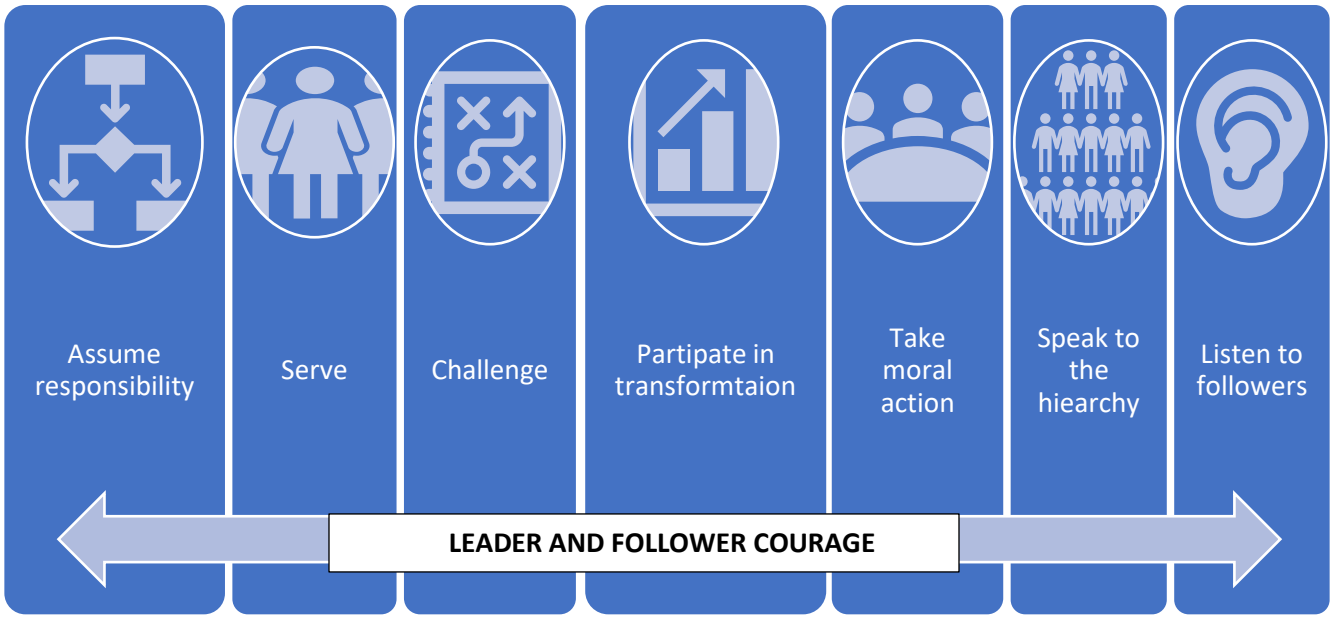
Conclusion

This chapter reviewed the health care environment and the day-to-day challenges that leaders face: complexity, financial concerns, nursing workforce changes, lack of leadership development, incivility and oppression, and the hierarchical structure of health care. A discussion of VUCA highlighted the additional threats to health care. Finally, a discussion of followership theory development during the past 30 years highlighted the importance of the leader-follower relationship, especially in an environment as ever-changing as health care. Figure 2.3 outlines the symbiosis of the leader-follower

relationship. These characteristics are not predisposed to one or the other member but must be shared by both for the good of the mission and the people. All of which take courage by both members to perform correctly.

Figure 2.2

Courage Across the Continuum of Follower and Leader



As health care organizations continue to face uncertain futures, healthcare leaders need to be able to communicate effectively with their followers. Leaders and followers must work together to meet the volatile, uncertain, complex, and ambiguous environment with less resources and more uncertainty. Leaders will need to be flexible and agile to meet the everchanging environment. Partnering with their followers to participate in the transformation, assume responsibility, and take moral action is necessary if health care is to survive.

CHAPTER III: METHOD

Humans connect with each other through words and gestures. Most people tell stories to others about their past, future, expectations, and dreams. Stories share our fears, happiness, worries, and hopes. Stories also document our history and our learnings for future generations. Many times, these stories are referred to as war stories. War stories in an operational setting are defined by Joung et al. (2006) as complex forms of examples, filled with many contextual details, insights, surprises, and drama. For this reason, many organizations are currently showing an interest in the value and power of capturing the knowledge of older more experienced members in the form of stories. The power of stories in an organization can educate, inform, change, and develop adaptive thinking within the less experienced employees (Gold et al., 2002; Mento et al., 2002; Ready, 2002).

As a social constructivist, the goal is to understand the world in which individuals live and work and what meaning people give to the incidents in their lives. This research study sought to determine the following:

- RQ 1: What situations require bedside nurses to use CF concepts when interacting with their colleagues and leaders?
- RQ 2: What CF concepts are used by bedside nurses in conversations with their colleagues and leaders?

It was important to understand the participant's view point and if these meanings can help elucidate the role of CF in the workplace. The research sought a complexity of views, not a narrow view. To be successful in gathering a complexity of views, inductive interviews were used with broad, open-ended questions so that the participants could speak freely (without restriction of closed-ended questions) and to understand the meaning that they associated with the interaction. Critical Incident Technique (CIT) was a good fit for collecting complexity of views, because it encouraged storytelling and sharing

anecdotes. Furthermore, CIT interviewing increased the ability to gather more stories and more data points.

In this chapter, CIT will be explored by first discussing a brief history and the components of CIT. The researcher's positionality will be clearly explained. Secondly, the methodology and the relevant current empirical research conducted with CIT will be discussed. Findings from the study will be included, as well as any graphic representations. Finally, the chapter reports the method of the study including participants and rationale for the years of experience for participants and data collection. It concludes with procedures for data analysis and establishing trustworthiness and credibility.

Critical Incident Technique

History

Critical Incident Technique (CIT) is a qualitative research method that has gained popularity since its inception in the early 1950s. Flanagan (1954) introduced this method of qualitative research "to observe human activity that is sufficiently complete in itself to permit inferences and predictions to be made about the person performing the act" (p. 327). The term critical incident has been used to refer to a defined event where the person involved is able to make a judgement of the positive or negative impact the incident has on the outcome of the situation (Norman et al., 1992).

CIT was first used to address military issues such as "combat leadership, pilot disorientation and bombing raid failures and supported pilot selection and training" (Hughes, 2007, p. 50). This method of research helped to determine practical problem solving through analysis of behavior. Through these studies, changes in the selection and training for the United States Air Force were improved (Keatinge, 2002).

Flanagan (1954) regarded CIT as a fluid set of principles that could be molded to fit any situation. CIT collects interactions that the interviewee has had in the form of interviews or questions. The incident discussed does not need to be dramatic, it just needs to have significance to the individual

concerned. Flanagan also stated that “an incident is critical if it makes a ‘significant contribution’, either positively or negatively to the general aim of the activity and it should be capable of being critiqued or analyzed” (p. 338).

Over the years, CIT has become a popular research method of seeking stories to explore human behavior. Beech and Norman (1995) described CIT as a flexible but focused approach to research. They further delineate CIT as a systematic, inductive, open-ended procedure for collecting direct observations of human behavior (critical incidents). Other researchers feel that CIT can assist participants by identifying solutions to practical problems as they describe, from memory, a clear and detailed recall of incidents (Keatinge, 2002).

Nursing Research and CIT

Byrne (2001) noted that CIT is useful to nursing science because it enables the nurse to understand how their role relates to the patient and their colleagues. However, Benner (1984), while a proponent of CIT in nursing research, found that it was difficult for very experienced nurses to recall everyday events. According to Benner’s Novice to Expert theory, when nurses are experts, they are no longer aware of the separate components of a system, making it difficult to interpret why they made a particular decision. This is called a “gut decision.” The nurse knew something was wrong and reacted. It is very difficult for the expert nurse to break down their decision-making process.

Byrne (2001) further found that nurses needed to share stories with both good and bad outcomes in order to drill down to specific behaviors. This sharing of both sides helped them to better understand what behaviors helped to make certain decisions. Kemppainen (2000) further supported the need for both good and bad stories to help gain valuable insight to today’s rapidly changing health care environment. The predictive focus of the technique has been useful in addressing practical problems and has been noted in nursing studies that utilize CIT (Cheek et al., 1997; Cox et al., 1993; Minghella & Benson, 1995; Redfern & Norman, 1999). This research study relied on storytelling in the form of

hearing about meaningful interactions the nurses had with their leaders and colleagues and what could be learned from these interactions. As nurses are responsible for the quality of patient care, it is supremely important that nurses' voices are heard. Hearing the nurse' stories illuminated the conversational elements of CF, such as speaking up to the hierarchy and participating in transformation. Both of these CF ideals can help improve health care quality.

Health Care Quality

What are the components of health care quality? Defined by the Institutes of Medicine (2001), health care quality is "the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge" (p. 13). Health care professionals determine success by quality indicators, such as decreased hospital acquired illnesses, increased customer satisfaction, and safety, many of which are determined by the nursing interactions with the patient (Anderson et al., 2010).

Nursing research has been examining the nurse–patient relationship for many decades. Since the early 1950s, nurse researchers have used CIT to examine clinical practice and nursing education, but not care quality specifically (Kemppainen, 2000). Grant and Hrycak (1987) were the first nursing researchers to connect nursing care to quality outcomes by using CIT. Literature has demonstrated that the quality of interaction that a provider can give a patient is one of the most significant contributions to overall health care quality (Ruben, 1993). CIT, according to Kemppainen (2000), can "provide meaningful information about the patients' experiences in health care settings and can help determine their views of health care services" (p. 1267). This connection is important to the research as courageous followership is about speaking up for the betterment of the patient and caregiver.

CIT has proven useful for analyzing the complex factors related to the delivery of nursing care services (Butterfield et al., 2009; Eriksson et al., 2016; Lewis et al., 2010; McDaniel et al., 2020; Osei-Frimpong et al., 2015; Yonas et al., 2013). CIT research can influence health care outcomes and quality.

As the health care environment and safety are all related to health care quality and outcomes, CIT can help identify areas of priority for quality improvement that will be the driving force for change in the delivery of health care. For these reasons, CIT assisted in the exploration of the research question, "Is courageous followership a key to successful provider or leader communications"?

Positionality

The research was conducted in a field where the researcher practiced professionally. Therefore, the reader needed to understand the researcher's personal views and that integrity was maintained with the research.

The researcher has been a nurse for 30 years and a nurse executive for 15 of those years. The researcher is a 54-year-old, white, heterosexual, spiritual, and liberal woman. All these factors could have influenced the research performed. The nurses that were interviewed came with varying years of nursing experience, age, sexual orientation, and diversity of race, thought, and religion. As a Chief Nursing Officer (CNO), this level of hierarchy could also create a sense of concern or intimidation in a less experienced nurse. The researcher ensured that they were viewed as a researcher and not as a health care executive.

Another facet of positionality is being an insider or outsider to the research. Merriam et al. (2001) stated that "early discussions in anthropology and sociology of outside/insider status assumed that the researcher was *either* an insider or an outsider and each status carried with it certain advantages and disadvantages" (p. 411). More recently, it has been felt that the researcher can and does fall into both categories. The researcher is an insider since they are a nurse and work in a hospital, also where the research took place. On the other hand, the researcher was also be considered to be an outsider because they are not practicing at the bedside and truly do not know what the work environment is like for staff today. This "lack of recent experience" could also have elicited concern

because the participant may have experienced anxiety that the researched just does not understand the situation, so why share their thoughts? Schluter et al. (2008) determined that

> It is impossible not to allow prior experience to inform the analysis of events which further enhances the importance of questioning the data and ensuring that accurate representations are derived from the event. Prior knowledge, when used carefully and acutely managed can enhance the study's findings and form the basis of informed and grounded research findings. (p. 113)

Self-reflection was an important awareness so that rigor and openness was maintained during all phases of research.

Components of a CIT Study

Choosing a research method can involve several steps. Not only should the method inform the philosophical assumptions, but it should also help answer the questions being posed. The method must also be comfortable to the researcher who will spend considerable effort making meaning of the data collected. Creswell and Creswell (2018) defined the research approach as "the plans and procedures for research that span the steps from broad assumptions to detailed methods of data collection, analysis and interpretation" (p. 3). There are several reasons why CIT was the research method of choice:

- It was flexible and allowed the ability to schedule at the interviewee's convenience.
- Its design enabled relatively quick gathering of information compared to an ethnography.
- It focused on real life experiences.
- It was a well-proven qualitative method with clearly defined guidelines for data collection and analysis.
- It had been proven useful in health care research.

The critical incident technique is used to collect and analyze reports of behaviors in defined situations and is comparable to other forms of qualitative research methods. CIT focuses on finding

solutions to practical problems versus defining phenomenon (Butterfield et al., 2009; McDaniel et al., 2020). CIT is aimed at investigating facts and reducing personal views, decisions, and generalities (Kemppainen, 2000). Kain (2004) described CIT

> People assign meanings to their experiences, and when we group together collections of such meanings in order to make sense of the world, we engage in a kind of research, a seeking of understanding. The critical incident technique provides a systematic means for gathering the significances others attach to events, analyzing the emerging patterns, and laying out tentative conclusions for the reader's considerations. (p. 85)

CIT findings are used to support practical problem solving, especially for education and training, and to provide a knowledge base for further research topics.

CIT involves five principles which can be modified to meet the needs of those being interviewed. The five principles are (a) identifying the general aims, (b) establish plans and specifications, (c) collecting the data, (d) analyzing the data, and (e) interpreting and reporting the results (Byrne, 2001; Fitzgerald et al., 2008; Flanagan, 1954; Hughes, 2007; Schluter et al., 2008; Urquhart et al., 2003). Proposals should be clear and concise with specifications of aim, selection of population, guidelines for observation, interpretation and classifying the incidents and plans for analysis, interpretation, and reporting of data.

Step 1: Identifying general aims

The first step in CIT is to identify the aim of the study and the research question. The study's aims will help direct the data collection and analysis (Schluter et al., 2008). This will ensure that the research questions are answered to their fullest extent.

Step 2: Establishing plans and specifications

This step involves the definition of certain types of events or incidents to be collected. In other words, making a plan for the situations to be observed/interviewed, who will be observing/interviewing,

the method of data collection, the method of data analysis, and if the Institutional Review Board would need to be included (Fitzgerald et al., 2008). This step is simply a road map for achieving success.

Step 3: Data collection

Data collection is simplified when the plan is specific and detailed. Direct observation and open-ended questionnaires are useful and popular when seeking data. Both have their advantages and disadvantages. The most common form of data collection for CIT is in-person, open-ended interviews, either individual or group, that can allow the interviewer to read non-verbal communication signs from participants and use those to further probe for in-depth responses (Schluter et al., 2008).

Butterfield, et al., (2009) suggested that the interview is the best first step, especially when information is need to be gathered from the participant's perspective. The face-to-face interview allows for the use of probing questions and follow up as needed. This type of communication is not possible with just observation, as suggested by the original CIT method (Flanagan, 1954).

Step 4: Data analysis

Once all the data is collected, it must be analyzed for meaning and provide a detailed, comprehensive, and valid description of the activity studied. Analysis of the information is an inductive classification of the information and the construction of categories, which enables the information to be described at increasing levels of specificity or transferability (Cox et al., 1993; Norman et al., 1992). There are three aspects of data analysis: (a) the frame of reference or the underlying purpose, (b) the information of categories, and (c) the general behaviors. As with most qualitative methods, data are clustered into categories and the categorization system provides an opportunity for the researcher to work at coding until he or she has an "intuitive sense of rightness" (Norman et al., 1992, p. 593). The aim is to increase the usefulness of the data without sacrificing comprehensiveness, specificity or detail.

Step 5: Interpreting and reporting

Step 5 includes interpreting and reporting out the data. Reporting should be tailored to the target audience; however, events should be unrecognizable to those hearing and reading the research (Schluter et al., 2008). Confidentiality for the research participants must be maintained to provide integrity and anonymity. The results, method of data collection, and analysis must be transparent and completely described. This ensures that the reader will be able to judge whether or not the conclusions are supported by the data (Fitzgerald et al., 2008). Chapter V will discuss conclusions and recommendations obtained from my research.

Advantages and Limitations of CIT

Advantages

Qualitative research aims "to understand and represent the experiences and actions of people as they encounter, engage, and live through situations" (Elliott et al., 1999, p. 216). Qualitative research is beneficial when little is known about the subject being researched. CIT has been described as a flexible and quick method for obtaining a large amount of information. Information is usually obtained through interviewing, either face-to-face or in groups. Some interviews can take as little as 15–20 minutes. Information can also be collected through workshops, phone interviews, or direct observation. Schluter et al. (2008) suggested that CIT was the best method to use in large organizations because of the "potential cost-benefit" it provided "by limiting the amount of time required with participants" (p. 114). This is an essential benefit when utilizing a large organization, such as an HCO.

Chell (2004) stated that CIT provided insight in real-life individual experience that assists with the identification of broader patterns of understanding. The study of unique experiences brings to light a "shared reality" (Kain, 2003, p. 82). This enables a context-rich, first-hand perspective on human activities and the significance that they bring and uniting those with the shared reality.

Limitations

Some researchers consider the term *critical* to be somewhat of a misnomer and suggest that the term be changed to *revelatory* or *significant* (New South Wales Nurses Registration Board, 1992; Norman et al., 1992). The researchers believe that the suggestion of the name change could imply that CIT can have more of a universal acceptance.

CIT lacks the theoretical underpinnings of some other qualitative methods such as phenomenology or participatory action research (Hughes, 2007). CIT binary coding is not always sufficient to deal with the nuances and levels of human experience; however, because CIT is flexible, this limitation can be overcome.

When a story shared describes a situation that involves "no decision, act or where the participant was unaware of the information needed or suppressed the information needed as a soluble problem then CIT fails to be useful" (Urquhart et al., 2003, p. 65). CIT looks at specific events and the actions that led up to that event and those that happened in that event; therefore, a lack of action can indicate a perception of inaccuracy or making it difficult for the researcher to understand the actions that occurred.

Ethical Considerations

Research with human participants requires a mechanism to protect the participants. Hughes (2007) identified the researcher's ethical responsibilities in research as

- Preserving the participant's confidentiality
- Respecting the participant's dignity
- Taking the time to explain the purpose of the study
- Explaining the exact nature of the participant's involvement
- Explaining the ways in which their responses will be handled
- Assuring the participants that their participation is voluntary

- Avoiding any kind of coercion
- Allowing the participants to leave the study at any time
- Heeding any signs of embarrassment, distress or anxiety on the part of the participant, and
- Imploring a high degree of social, cultural and linguistic sensitivity. (p. 62)

Additionally, research integrity requires the researcher to have completed the Collaborative Institutional Training Initiative (CITI) courses. These web-based modules discuss research, ethics, regulatory oversight, responsible conduct of the researcher, and the participants' rights. Studies with human participants may also require the permission of the local Institutional Review Board to ensure that the participants rights are being protected.

Chirban (1996) recommended that through "self-awareness, ethical conduct, and clarity of professional objectives, both parties may directly address their interactions and relationship" (p. 127). The author also suggested that by honestly approaching the interview without an ego, understanding one's abilities, and being genuine to the best of one's abilities, an authentic encounter can occur.

As discussed earlier in this chapter, the researcher's positionality potentially created a power dynamic for the participants. The CNO position comes with a distinct power dynamic. The participants that were interviewed, while not reporting to the researcher, were at least four to five layers down the hierarchical structure. This level of hierarchy can create a real or perceived power struggle. The participant may fear retaliation or distress when and if they reveal a disturbing event. The participants were reminded of the researcher's, confidentiality, and were ensured that if they felt uncomfortable in anyway during the interview, the interview would be stopped and they would be free to leave the study.

Method of the Study

The five phases of the critical incident study as described in Flanagan's seminal work (1954) and the interview process modeled after Holloway and Schwartz's work (2014) provided the framework for my research process, data collection and analysis. As discussed in Chapter II, I sought to understand if

the tenets of CF were used in health care conversations at the bedside between nurses and their direct supervisors or physician colleagues. As CF is a form of leadership that helps the leader and the follower to empower each other, this is a concept that will help the future of health care interactions, leading to better quality and safety outcomes in health care.

Participants

Another aspect of data collection is determining the sample size. Flanagan (1954) stated that observations become one's perceived reality when a large number of independent observers offer the same description of a behavior. Often with CIT, the number of subjects or participants needed can be difficult to determine. In qualitative research, sampling is continued until saturation, or the point in which incidents provide no new information, is reached (Mason, 2010). The observations should include a heterogeneous group of respondents, capable of reporting diverse and exhaustive descriptions from which the taxonomy of behaviors can be developed (Weisgerber et al., 1990).

Flanagan (1954) suggested that the researcher should look at the number of incidents versus the number of participants since it is the incidents that are analyzed. Researchers suggest that at least 50–100 incidents should be collected, but that the number of incidents will vary based on the complexity of the research question (Fitzgerald et al., 2008; Flanagan, 1954; Schluter et al., 2008; Twelker, 2003). For the research study, 1 to 4 incidents per person were gathered, with the mode being three per person. Therefore, 18 nurses were interviewed for a total of 50 incidents.

Participant Experience Level. Nurses' skills develop over many years. Dreyfus and Dreyfus (1980) developed a theory that for a person learning a new skill, acquisition, and development pass through five phases: novice, advanced beginner, competent, proficient, and expert. The different levels reflect three general aspects of skilled performance

- movement from reliance on abstract principles to the use of past concrete experiences as paradigms;

- a change in the learner's perception of the demand situation in which the situation is less and less a compilation of equally relevant bits and more a complete whole in which only certain parts are relevant, and;
- passage from detached observer to involved performer (Benner, 1984, p. 13).

Benner (1984) adapted this theory to nursing development. Novices are those nurses who have little to no knowledge of the environment. Advanced beginners are those nurses who have some knowledge of the environment, even if it is only through observation. Competent nurses have 2 to 3 years of experience in the same practice environment. Proficient nurses have three or more years of experience in the same setting. Experts have a deep understanding of practice, which usually comes with more experience; however, not all nurses achieve this level regardless of their years in a practice setting.

For the research, proficient nurses, those with 3 to 5 years of experience, were interviewed and included in the study. The reason for this was that at this stage of development the nurse can see the overall picture and how individual actions fit within it. Additionally, they can identify the more important elements of a situation and make decisions based on a broader perspective (Benner, 1984). Expert nurses act based on intuition and will not be able to readily identify the pieces that make up the stories, whereas those nurses with less experience are just developing their thinking. Neither the experts or the competent nurses would be able to put the pieces together in the way a proficient nurse can; thus, making the proficient nurse the ideal candidate for my research study.

During the participant recruitment stage of the study, the researcher was working in a large health care system that consisted of 51 hospitals across seven states. Nurses in the region where the researcher was currently located, Southern California, were invited to participate in the research. For ethical considerations, registered nurses at the hospital where the researcher was employed were not invited. After receiving approval from the regional hospital Institutional Review Board (IRB), email

invitations were sent to 998 registered nurses to participate. Each of these 998 registered nurses met the criteria set forth for the study.

The registered nurses that chose to participate emailed their interest to the researcher. The researcher then had a brief conversation with the participants about the study and reviewed the consent and questions that would be asked during the interview. Because the participants needed to share stories based on past experiences, a later time frame was given to aid in remembrance of the details. The initial recruitment of participants yielded five registered nurses that met the qualifications. These participants were interviewed quickly, however, recruiting the remaining participants was challenging.

The recruitment period fell during the winter holidays. Recruitment was virtually nonexistent. The world was in the midst of the COVID pandemic. During the end of 2020, Southern California was hit with a new surge of COVID patients, much worse than the surge that had occurred earlier in the year. Even after resending emails for recruitment two more times, no new participants emerged. After speaking with colleagues at the participating facilities, the researcher was informed that the nurses were tired and did not want to participate in research at this time. To tackle this concern, an addendum to the original Antioch University IRB application was amended allowing recruitment outside of the regional hospitals. Messaging for Facebook and LinkedIn were created and posted for participants. Unfortunately, this method only yielded one participant after 4 weeks and reaching out to colleagues around the country. At this point, previous participants were contacted to see if they had any friends that met the qualifications and would be willing to participate in the research study. Seeking out friends of those that had already participated yielded the additional twelve participants that were needed. Chapter IV will discuss the participant's demographics in more depth.

Interviewing

The individual interview opportunity has been determined by researchers as the most appropriate method for data collection because it allows for the greatest opportunity for discussion between the researcher and the participant (Fitzgerald et al., 2008; Hughes, 2007; Schluter et al., 2008). The direct interview allows time for the researcher and the participant to achieve the best explanation of the aims of the study and define any ambiguities. When interviewing participants, Flanagan (1954) stressed the importance of a well-informed research subject. The subject needs to understand the aims, goals, recruitment strategies, and most importantly, the anonymity of the interview and data sharing.

Flanagan (1954) determined that a successful interview was dependent on the ability of the participant to provide clear, concise descriptions of events. Vague recollection and lack of detail suggested that events may not be remembered with accuracy or clarity. Anderson and Wilson (1997) described three important pieces of information that must be included for a critical incident report to be effective and useful:

- A description of a situation that led to the incident
- The actions or behaviors of the focal person in the incident
- The results or outcomes of the behavioral actions. (p. 90)

A clear description of events that led up to the incident is important because it helps to understand why certain actions were or were not taken. The results or outcomes are important because they provide the basis for "inferences about the effectiveness of the behavior and the skills needed to enact the behavior" (Anderson & Wilson, 1997, p. 90). When all elements of a critical incident report are present, an explanation of the effectiveness of the describer's action can be made (Kemppainen, 2000).

To further drill down to the exact information that needs to be ascertained during an interview, Rous and McCormack (2006) suggested the following questions:

- What preceded and contributed to the incident?

- What did the person or people do or not do that had an effect?
- What was the outcome or the result? (p. 2)

When using CIT, how should the interviewer get to the heart of the interviewee's emotions and thoughts? Carini (1979) described an interview as a "quest or searching" for meaning and "to enter there and to dwell there" (in the mind of the interviewee) and to resonate with the interviewee's experience (p. 20). Understanding the interviewee's emotions and thoughts, the reader can have a deeper understanding and awareness of the workings of the interview and the thoughts discussed.

Interview Questions*.* The construction of questions is extremely important to the CIT process so that the interviewer can mine the needed data from the interviewee. The study design was very similar to Holloway and Schwartz (2014) who studied the interactions of students and professors. Because the authors interviewed the students versus observing their interactions, the authors had to construct certain questions to get to the heart of the matter. The authors were seeking meaningful interactions. The interactions could be positive or negative and were "meaningful and thus important to the student" to report (Holloway & Schwartz, 2014, p. 7). See Appendix A for the questions that were asked during the interviews.

Analysis and Interpretation

The interviews were video recorded through the Zoom application. Once the conversation was completed, the recording was sent to the transcription service Rev. Rev provided a written transcript. Each transcript was then broken down by each individual story or incident. The incidents were determined by each participant and then a classification scheme was created based on the interviews. Finally, a process of thematic coding was employed.

Coding

Coding, as described by Charmaz (2006), is a critical link between data collection and meaning making. Boyatzis (1998) explained that coding was developed to help with the observation of people's

behavior. Coding helps develop themes. Coding brings forth the significance and patterns in the data that become the basis for more generalized and abstract meaning making. A code is created by a researcher and signifies the purpose of patterns, categorization, and further analytical analysis. Codes allow the researcher to generate an explanatory framework, thus the ability to make meaning of the interviewee's perceptions and experience.

Data Analysis

The study used the researcher as the primary coder and a second person to validate the codes and themes. The process of verifying codes and themes increases the credibility and "the higher the concordance rate, the more credible the claims that the incidents cited are critical to the aim of the activity" (Butterfield et al., 2005, p. 486).

The first step in the analysis was to read each incident or transcript, determine the type of incident being reported, and create a classification system. As the primary coder, this step was completed by the researcher. Dr. Holloway, methodologist for this research study, reviewed the codes to determine that they were relevant to the purpose of the study and consistent with the CIT method. The incidents were loaded into the Dedoose software program for ease of analysis. At this point, an independent coder, Dr. Creech, validated and agreed to the definition of each code. For any difference of opinions, respective thoughts were discussed and consensus was used to determine the coding.

The next step in the data analysis process was to utilize Dedoose to organize the thematic codes by incident type, and look at the incident antecedents, emotions felt during and after the incident, and then any impacts from the conversation. All codes were analyzed and organized along thematic connections. Each incident was also sorted by type of incident, place of conversation, person involved, relationship length of the participants, years of practice for the RN when the conversation occurred, and whether or not the conversation altered their future practice as a nurse. Next, the relationships

between the themes were examined. In the final phase, the incidents were grouped based on the tenets of CF, looking for examples of CF in the current incidents.

Establishing Trustworthiness of the Study

CIT has been widely criticized by some scholars as having no credibility (Wason, 1994). Yet other scholars acknowledge the methodology as being very credible and incorporating a variety of checks to increase trustworthiness (Kelly, 1996; Muratbekova-Touron, 2002). In some studies, experts sorted incidents into categories then undertook an additional sort to establish category reliability (Kempainnen et al., 2001; Paterson et al., 2001). Using independent reviewers adds a level of trustworthiness and rigor to the study (Lincoln & Guba, 1985). Credibility, confirmability, dependability, and transferability build trustworthiness in qualitative research (Patton, 1999; Polit & Beck, 2012). As defined by Klenke (2008)

> Credibility looks at believability from the standpoint of the participant. Transferability looks at the extent to which results can be transferred to another setting or context. Dependability concerns whether independent researchers can obtain the same results and confirmability concerns whether the results can be corroborated or confirmed with another. (p. 38)

McDaniel et al., (2020) determined nine checks for credibility for a CIT study. These checks include looking for validity, fidelity, exhaustiveness of the data, and cross comparison of the data. The authors discuss the importance of ensuring that the data is accurate and the participant's voice and views are honored. This rigor helps tie back to the constructivist lens.

The study design and practices were designed to enhance the trustworthiness of the study. All codes were validated by an independent coder, confirming confirmability. All conversations and coding were from the view of the participant, ensuring credibility. This research is easily transferrable to another setting.

Conclusion

This chapter discussed the critical incident technique history, methodological process and how the method can be helpful in health care research. Advantages and limitations of the methodology were reviewed and explained. I shared my positionality and ethical considerations with this study. Finally, the method of the study including participants, data collection, data analysis, and establishing trustworthiness in the study were discussed. Chapter IV provides an analysis of the interviews, which includes the types and frequency of critical incidents as described by the participants.

CHAPTER IV: DATA AND FINDINGS

This chapter begins with a cursory overview of Courageous Followership (CF) and its importance in health care conversations. This research study sought to understand if CF concepts were being used in health care conversations and, if so, in what situations. Constructivist CIT was used to make meaning of the conversations that the nurses shared. The chapter will discuss the composition of the sample, with demographic data, an analysis of the interviews, including the incident type, place and person, as well as, the themes, antecedents, impacts, and outcomes. This chapter concludes with examples from the incidents that describe how they connected to the CF concepts.

Courageous Followership and Health Care

Health care is fraught with communication issues. The hierarchical structure and power differentials make it difficult for nurses to get their voices heard (Perry, 1997). However, CF can help navigate these communication issues by empowering nurses to speak up to the hierarchy, to challenge the plan of care or to take matters up the chain of command when they are unable to seek resolution at a lower level. CF can help followers and leaders be empowered to address problems, especially serious patient concerns before the potential clinical decline of the patient. Whitlock (2013) correlated that the interdependence between the leader and follower is required to improve the quality and safety of patient care. This connection is imperative to improve the quality and safety outcomes of patients in acute care settings. Health care providers must be able to talk to each other in a way where both are heard and can make a collaborative decision concerning a patient's safety.

CF provides a framework to assist health care providers with the means to courageously approach difficult situations in the health care arena. The following analysis of the interviews will demonstrate that nurses are courageously addressing patient care issues. These conversations are allowing for increased patient safety in the hospital setting.

Analysis of Interviews

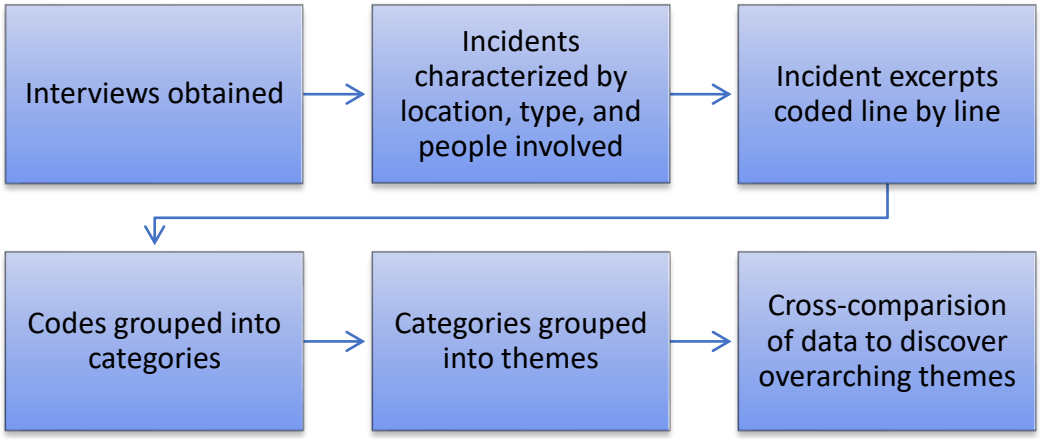
Constructivist CIT coding and analysis explores how people interact and understand their lived experiences. The incidents or conversations analyzed in this study are meaningful and memorable to the participant. The conversations contain both positive and negative data points as defined by the participant relaying the information. The researcher was unable to observe the conversations and relied on the participant's account of events. After collecting the interviews, the data analysis took place in five phases:

- Characterization of incidents by type, location, and persons involved
- Line by line emergent thematic coding of all incidents
- Codes grouped into categories
- Categories grouped into themes
- Cross-comparison of data to discover overarching themes

Each phase serves a specific purpose and required a distinct approach for exploring the data. The purpose of analyzing the conversations was to determine if CF concepts were used at the bedside and if so, in what situations. Figure 4.1 provides an overview for the CIT framework for the study.

Figure 4.1

Structure of the Study Using the CIT Framework



Critical Incidents

Participant demographics. There were three criteria for the participant's inclusion into the study. The participants had to be registered nurses, with only 3–5 years of experience, and had to currently work in an inpatient hospital setting at the bedside. Therefore, if the participant fell outside of any of the above criteria, they were excluded from the study. Recruitment was based on the above characteristics; therefore, no potential participants were excluded.

To compare the participant's demographics with the data for nurses nationally, the National Nursing Workforce Survey for 2018 was used. This survey is conducted every 2 years by the National Council of State Boards of Nursing (NCSBN) to examine the United States nursing workforce. This survey generates information on the supply of nurses in the country which is "critical to planning for sufficient numbers of adequately trained nurses and ensuring a safe and effective health care system" (NCSBN, 2021, p. 1). This data comparison allowed for understanding of any gaps in the participant pool. Refer to Table 4.1 for a comprehensive display of the participants' demographics collected and frequency of distribution for this study.

Table 4.1

Participant Demographics and Frequency (N = 18)

Demographic Category	Data	Frequency, *n* (%)
Age in years	20–29	4 (22.2)
	30–39	10 (55.6)
	40–49	2 (11.1)
	50–59	3 (16.6)
	60–69	0 (0.0)
Race	White	11 (61.2)
	Other*	7 (38.8)
	*Defined by participant as Armenian, Asian, and Latina	
Gender	Female	17 (95.0)
	Male	1 (5.0)
Experience level in years	3	4 (22.2)
	4	3 (16.6)
	5	11 (61.2)
Education level by degree	ASN	1 (5.55)
	BSN	12 (66.7)
	MSN	5 (27.8)
	DNP or PhD	0 (0.0)
Hospital type	Community	15 (83.3)
	Academic	2 (11.1)
	Teaching	1 (5.6)
Union status of hospital	Union	11 (61.1)
	Nonunion	7 (38.9)

The participants ranged in age from early twenties to late fifties. The majority (*n* = 10; 55.6%) of the participants were in their thirties (30–39). There were no participants in the 60–69 age category. The

age distribution of the participants in this study was inconsistent with the national registered nurse's data. According to Smiley et al. (2018), "the average age of the American registered nurse is 53 years old" (p. 13). My theory for this age discrepancy from the national data is that all participants lived in the Southern California area where residents are generally younger.

The participants were required to have 3–5 years of experience only at the bedside to participate in the study. This group was mostly at the five-year mark (*n* = 11; 61.2%) for length of experience as a registered nurse. Educational requirements were not determined as exclusionary criteria. None of the participants held a doctoral degree (DNP or PhD); however, two participants were in the midst of seeking a terminal degree. The educational level for this group of participants with 66.7% (*n* = 12) at the BSN level was higher than the national average of 41.7% (Smiley et al., 2018).

The participants were required to work in an acute care setting (inpatient hospital); therefore, this rate was 100% (*n* = 18). This is higher than the national average of nurses where only 55.7% of practicing nurses' primary employment setting is in an acute care hospital setting (Smiley et al., 2018). The participants mostly worked in a community hospital setting (*n* = 15; 83.3%), but those working in an academic medical center were 11.1% (*n* = 2) and 5.6% (*n* = 1) worked in a teaching hospital.

Finally, 95% (*n* = 17) of the participants for the study identified as female and 5% (*n* = 1) identified as male, which is slightly different than the national data base, which shows 90.9% of registered nurses were female and 9.1% were male, showing a slight increase in the male population nationally "for the last 2 surveys—8% in 2015 and 6.4 % in 2013" (Smiley et al., 2018, p. 13). The identified ethnicity of the participants was almost evenly distributed, 60% (*n* = 10) identified as White, while 40% (*n* = 8) identified as non-White including Armenian, Latina, and Asian. Nationally, nurses are "80.8% White and 19.2% other race" (Smiley et al., 2018, p. 11).

The participants provided a cross-sectional view of the nurses currently in acute care settings. They varied in age, education level, and experience. This provided diverse opinions about the conversations that are currently happening in acute care settings.

Incident Attributes. Out of 18 participants, 50 individual critical incidents or conversations emerged and were analyzed. The range of incidents per participant was one to four incidents with the mode being three incidents per person. The incidents were first organized by the following attributes:

- Type of conversation
- The place where that the conversation was held
- The person the conversation was held with

These attributes were chosen to determine if the courageous conversations varied by place and person. The conversations shared were with either the nurse's direct supervisor or MD colleague. Both the direct supervisor and the MD colleague, while they have no direct line authority, are both considered a leader in the healthcare hierarchy. Therefore, when the term leader is used, it could refer to either position. See Table 4.2 for an example of how the conversations were organized with the aforementioned attributes.

Table 4.2

Distribution of Incident by Characteristic (N = 50)

Distribution of Incident by characteristic	Data	Frequency, *n* (%)
Type	Clinical	38 (76.0)
	Managerial	12 (24.0)
CLINICAL (*n* = 38)		
Person	MD	38 (100.0)
Place	Nursing unit	29 (76.4)
	Phone	9 (23.6)

MANAGERIAL (*n* = 12)		
Person	Direct Supervisor	12 (100.0)
Place	Manager Office	7 (58.3)
	Nursing Unit	5 (41.7)

***Conversation type and people*.** The incidents described were categorized in to two types of conversations, clinical or managerial. Clinical conversations occurred because the nurse needed to speak with the MD about a patient concern. Managerial conversations occurred between the participant and their direct supervisor when clarifying a concern. The incident breakdown was 70% (*n* = 38) clinical and 30% (*n* = 12) managerial. It was important to determine if the incident setting made a difference in the way the leader responded to the conversation.

Conversation place. Clinical conversations were determined by two specific locales. The first locale was the inpatient nursing unit. The inpatient nursing unit could be in the patient's room, in the nursing unit hallway or at the nurse's station. These were face to face conversations with the RN participant and the physician. The second locale was described as on the phone. The phone was the described location that indicated that the nurse had placed a call to the MD. There was no face-to-face contact with the MD at any time during the phone conversation.

Managerial conversations were conducted with the nurse's direct supervisor and took place in two locales as well. The first place was in the direct supervisor's office. The second place that managerial conversations occurred was on the nursing unit; however, for managerial conversations the place was at the nurse's station of the unit as opposed to the patient's room or unit hallway. For all managerial conversations, the conversation occurred face to face.

A further discussion as to whether or not the location or person made a difference to the way the leader responded to the question will occur in the thematic analysis. The participant's responses

from each type of conversation will be compared to determine if there was a different emotional reaction to the information provided by the leader. Also, the data will determine if location made a difference to the outcome of the conversation.

Relationships. Four attributes helped describe the relationship between the two participants. Again, the clinical relationship was the participant and the MD. The managerial relationship was the participant and their direct supervisor. These attributes were chosen to express the relationship length and any change to the relationship before and after the conversation. Table 4.3 outlines the distribution and frequency of this attributes as related to the participant's conversations.

Table 4.3

Relationship Attributes (N = 50)

Conversation type	Years of relationship	Frequency, *n* (%)
Clinical (*n* = 38)	0	11 (29.2)
	1	5 (13.1)
	2	6 (15.8)
	3	5 (13.1)
	4	6 (15.8)
	5	3 (7.8)
	7	1 (2.6)
	9	1 (2.6)
Managerial (*n* = 12)	0	2 (16.8)
	1	4 (33.3)
	2	1 (8.3)
	3	3 (25.0)
	5	1 (8.3)
	10	1 (8.3)

Conversation type	Relationship **before** conversation	Frequency, *n* (%)
Clinical (*n* = 38)	Respectful	28 (73.6)
	Disrespectful	2 (5.4)
	No relationship	8 (21.0)
Managerial (*n* = 12)	Respectful	10 (83.3)

	Disrespectful	0 (0.0)
	No relationship	2 (16.7)

Conversation type	Was relationship altered **after** conversation	Frequency, *n* (%)
Clinical (*n* = 38)	Yes	29 (76.3)
	No	9 (23.7)
Managerial (*n* = 12)	Yes	10 (83.3)
	No	2 (16.7)

Conversation type	Relationship **after** conversation	Frequency, *n* (%)
Clinical (*n* = 38)	Damaged	9 (23.7)
	Improved	20 (52.6)
	Same	9 (23.7)
Managerial (*n* = 12)	Damaged	5 (41.7)
	Improved	4 (33.3)
	Same	3 (25.0)

The first attribute for the relationship category was the relationship length. How long had the participants known each other before the conversation occurred? The responses ranged from 0–10 years. The 10-year category may seem unusual for nurses with only five years of experience; however, many nurses had jobs as unit secretaries or patient technicians in the units before becoming nurses and were able to form relationships with the leaders. The relationship length was important to judge whether or not a longer relationship would influence the ease or response of the conversation.

The second attribute was the relationship that the participants had before the conversation occurred. The responses for this question were no relationship, respectful relationship or disrespectful relationship before the conversation. The majority of the clinical and managerial relationships were respectful before the conversation.

The third attribute was if the relationship was altered after the conversation. This was a yes or no answer. Interestingly, the majority of clinical and managerial conversations received a yes answer, indicating that the relationships were altered after the conversations. A “yes” response does not

indicate if the relationship was altered positively or negatively, just that there was a change in the relationship. The fourth attribute described the change.

The fourth attribute was used to describe the relationship after the conversation conclusion. The responses indicated whether the relationship was damaged, improved, or stayed the same after the conversation. Interestingly, over half of the clinical conversations improved after the conversations while the managerial conversations were almost evenly spread over damaged, improved or stayed the same. It was important to note the outcome of the conversation for the dynamics of the future relationship.

The distribution of the attributes amongst the two types of conversations was important to understand. The distribution showed whether or not there was a difference in conversation type and attribute type. The conversations in this study were centered around clinical and managerial concerns but all focused on the patient and their needs. Understanding the relationship that the participants had before and after the conversation was important to determine the leader and follower dynamics.

Thematic Analysis of Incidents

CIT relies on stories told from the perspective of the interviewee. These stories are meaningful to the participant being interviewed for a very personal reason to them. The stories were analyzed and coded line by line. This is an emergent coding approach that allows for themes to develop directly from the data (Boyatzis, 1998). The codes were conceptually grouped into categories. Finally, the categories were grouped into themes. The themes that emerged are patterns of the meaning that the participant's placed on the incident. Quotes are shared to increase the reader's understanding of the information provided related to the themes. The incidents were cross-compared to determine overarching themes. This study's components are

- Antecedents or what event led to the need for the conversation

- The emotions that were felt by the participant during the conversation
- The emotions felt by the participant after the conversation
- The impact this conversation had on the participant's future nursing career

The descriptions that the participants shared often included insights into communication barriers, leadership and clinical challenges. These overarching accounts provided the context in which to understand the meaning and relevance applied by the participants to the more refined analysis and meaning making of the critical incidents and components.

Antecedents

The primary antecedents or the events that led up to the critical incident were either clinical or managerial conversations. These conversations were between the nurse and either their MD colleague or direct supervisor. Although, all clinical conversations centered around patient care the conversations could be broken down into four secondary antecedents, and were coded in the following way: (a) validating the plan of care for the patient, (b) the clinical decline of the patient, (c) ethical dilemmas around continuing care for a patient, and (d) questioning the clinical skills of the provider (MD or RN). For the managerial conversations, three types of conversation emerged (a) annual review, (b) disciplinary, and (c) general supervisory conversation. See Table 4.4 for a breakdown of conversation primary and secondary codes and frequency.

Table 4.4

Antecedents with Themes (N = 50)

Incident type	Theme	Frequency, *n* (%)
Clinical (*n* = 38)	Validating the plan of care	23 (60.5)
	Clinical decline	8 (21.0)
	Ethical dilemma	4 (10.5)
	Questioning skills	3 (8.0)

Managerial (*n* = 12)	Disciplinary conversations	6 (50.0)
	General supervisory	3 (25.0)
	Annual review	3 (25.0)

The conversations were broken down into clinical and managerial dependent on who the nurse was speaking to and the content of the conversation. Each of the conversations brought forth important information on the leader and follower dynamics.

Clinical. The most prominent characteristic of the clinical conversation was validating the plan of care for the patient. The nurse had approached the MD or leader either directly or on the phone to ensure that the orders for patient care were indeed the correct orders or to challenge the orders as the nurse did not feel that the current orders were the correct ones for the patient at that time. The second type of clinical conversation that occurred was a conversation around the patient's clinical decline. The patient in each case had become sicker and the nurse felt the need to advocate for the patient with the MD to either get new orders or to have the patient transferred to a higher level of care.

The third characteristic seen in clinical conversations is around ethical decision making for the care of the patient. In these cases, the patients were not actively dying or in decline but the end was inevitable. These conversations were decision making conversations about the morality of continuing treatment for the patient. The fourth characteristic of clinical conversation occurred because the MD, RN or leader inferred that the patient was in decline because the "RN or MD was providing inferior care" or "had no understanding of how to perform clinically".

Managerial. Managerial conversations were identified by three characteristics. The first managerial conversation was a disciplinary conversation. In these conversations the nurse had "been called" to the leader's office to discuss a performance issue. In this case, all conversations occurred

between the nurse and their direct supervisor. The second characteristic of managerial conversations was the general supervisory conversation. These conversations were about processes on the nursing units and were between the RN and their direct supervisor. The third type of managerial conversation was grouped into a category called annual review. These conversations occurred when the nurse was receiving their annual performance review from their direct supervisor and generally was afforded feedback for a growth opportunity.

The conversations were important to separate out by topic to ensure that they could be studied by type. This separation further helped to determine if there were differences with people and place and the reaction of the participant. The conversations will be further broken down into the emotions that the nurse felt during and after the conversation and what theme was revealed with each conversation.

During the Courageous Conversations

When these conversations occurred, emotions rose to the surface for the participants. Depending on the topic, emotions that appeared were positive or negative depending on how the conversation was being handled. Positive emotions were described by the participants as those feelings that made them happy, such as, “joy, excitement, and gratitude.” Negative emotions were those feelings that are not pleasant to experience, such as, “fear, anger and hatred.” Both emotional sides are needed for a balanced emotional life (Ackerman, 2021).

The emotions that the nurses described and felt during the conversation were coded. The codes were categorized and then placed into themes. Refer to Table 4.5 for the positive and negative emotional codes that the participants described during all incidents.

Table 4.5

*Emotions Participants Felt **During** Courageous Conversations* (N = 50)

Conversation type	Emotion	Frequency, *n* (%)
Negative		
Clinical (*n* = 38)	Frustration	15 (39.4)
	Fear	12 (31.5)
	Anxiety	5 (14.1)
	Anger	1 (3.0)
	Embarrassment	1 (3.0)
	Confusion	1 (3.0)
	Incompetence	1 (3.0)
	Vulnerability	1 (3.0)
Managerial (*n* = 12)	Fear	4 (33.4)
	Frustration	2 (16.0)
	Insult	2 (16.0)
	Lack of communication	2 (16.0)
	Vulnerability	1 (6.2)
	Anger	1 (6.2)
	Anxiety	1 (6.2)
Positive		
Clinical (*n* = 38)	Feeling heard	25 (65.7)
	Relief	13 (34.3)
Managerial (*n* = 12)	Joy	4 (33.4)
	Appreciation for leader	4 (33.3)
	Confidence	4 (33.3)

Clinical conversations. The nurses reporting the incidents felt a wide range of emotions during these conversations. The majority of emotions were negative in nature. The participants felt "frustrated, fearful, nervous, vulnerable, incompetent, confused, anxious, angry and embarrassed." Participant 8 shared a conversation that she had with an MD attempting to get the plan of care validated for the patient. She expressed the fear that she had during the clinical conversation:

I had two other conversations with this MD previously. He accused me of being a terrible nurse,

> called me a liar. I felt like I couldn't respect him. I was scared of him. As a new nurse, I was very scared, very timid, very afraid to speak with him. I didn't feel my patients were safe because I couldn't speak up. I left my job shortly after this conversation.

All of the conversations in the clinical category revolved around ensuring that the patient's needs were met. Nurses "advocated and spoke up to the hierarchy" regardless of what the consequences were for them personally. However, the patient's safety was paramount. As Participant 8 stated above, "I didn't feel my patients were safe because I couldn't speak up." Patient safety means the ability to speak up to the hierarchy when there are patient safety concerns.

The participants reported "feeling heard and relief" as the two positive emotions felt with clinical concerns. "Feeling heard and relief" happened simultaneously in all cases. When the nurse brought forth a concern and the MD was able to respond to the safety concern, the nurse felt heard and relieved that the patient was receiving the help that they needed. Participant 6 stated in the response to the clinical conversation she had with an MD

> I felt so relieved because he listened to me. He took my concerns seriously. He took his time and responded to the patient's need right away. It gave me peace of mind that he actually laid his eyes on the patient. The family and I were so very thankful.

All clinical conversations revolved around the nurse seeking the correct orders for the patient's needs. The nurse in all cases but one spoke up for the patient's need regardless of the response that she was going to get from the MD. When the conversation was unsatisfactory, negative emotions, such as, "intimidation and fear" surfaced. When conversations were satisfactory, positive emotions "feeling heard and relief," were present. These positive and negative emotions led to future practice changes for the nurse's practice.

Managerial Conversations. Managerial conversations were both satisfactory and unsatisfactory resulting in positive and negative emotions. Refer to Table 4.5 for a recap of emotions felt **during** managerial conversations. Negative emotions described were "fear, frustration, being insulted,

vulnerability, guilty, feeling belittled, and not being heard." The positive emotions felt were "acceptance, appreciation of the leader and safety."

Participant 3 described the anxiety she had as her charge nurse (direct supervisor) addressed her hollering down the hall "your patient has a really high blood pressure and you didn't address it. I can't be looking over your shoulder the whole time to make sure that you are taking care of these things." This interaction occurred in front of patients and staff leading the nurse to become "very anxious and embarrassed."

Participant 17 shared a situation where he had a managerial conversation with his direct supervisor about how he was uncomfortable performing a certain task at work. He felt it was a safety issue to continue practicing the task. He felt "vulnerable" for sharing this with his leader. He felt that his supervisor ignored his concerns leading the RN to describe that he "didn't feel that I can be open and honest with her anymore. She didn't take my feelings into consideration."

A couple of participants experienced positive emotions during their courageous conversations. Participant 7 shared that she felt heard when validating the plan of care for her patient. She described the clinical conversation this way:

> He (the MD) came to the floor and actually found me. We walked to the patient's room together discussing the situation. He told me that we had lots to talk about and we would come to a plan together. This conversation made me feel more confident and stronger with my skills.

Participant 6 had a positive clinical conversation with the MD when validating the plan of care for her patient. She described her relief as the MD listened to her concerns:

> During the conversation I really felt relieved. He (the MD) really listened to me. He took his time and actually did something about it (the patient's condition) right away. He actually went upstairs and went to the patient's bedside and saw the patient. This gave me peace of mind, knowing that he had is eye on the patient and was responding to their needs.

The participants described a wide variety of emotions during these conversations. Nurses described "feeling scared, anxious or apprehensive" about bringing forth information about their patient

because they were unsure of the reaction that they would receive from their colleague. The negative emotions displayed in both types of conversations were related to "fear and anxiety." It did not matter if they were speaking with an MD colleague or direct supervisor. Conversely, the positive emotions displayed appeared to be more around the emotional growth of the participant, "joy and appreciation of leader" with the managerial conversations versus "feeling heard and relief" with the clinical conversations.

After the Courageous Conversations

As described above, the participants were asked to describe the emotions that they felt during the conversation. Additionally, they were asked to share the emotions that they felt after the conversation. The emotions felt after the conversation varied and were also coded both positive and negative. Table 4.6 displays the frequency and emotional codes felt after each clinical and managerial conversation.

Table 4.6

*Emotions Participants Felt **After** Courageous Conversations* (N = 50)

Conversation type	Emotion	Frequency, *n* (%)
Negative		
Clinical (*n* = 38)	Intimidation	10 (26.3)
	Disrespect	8 (21.4)
	Frustration	4 (10.5)
	Not being heard	4 (10.5)
	Loss of confidence	4 (10.5)
	Insulted	2 (5.2)
	Embarrassed	2 (5.2)
	Excluded	2 (5.2)
	Shocked	2 (5.2)
Managerial (*n* = 12)	Disrespect	4 (33.3)
	Frustration	3 (25.7)
	Disappointment	1 (8.0)
	Not heard	1 (8.0)

	Belittled	1 (8.0)
	Embarrassed	1 (8.0)
	Guilty	1 (8.0)
	Neutral	1 (8.0)
Positive		
Clinical (*n* = 38)	Relief	14 (36.8)
	Trust	10 (26.5)
	Respect	6 (15.9)
	Safe	2 (5.2)
	Confidence	2 (5.2)
	Felt heard	2 (5.2)
	Appreciation for MD	2 (5.2)
Managerial (*n*= 12)	Acceptance	4 (33.4)
	Appreciation for leader	4 (33.3)
	Safe	4 (33.3)

Clinical Conversations. The emotions felt after the conversations occurred were just as varied as the ones that occurred during the conversations. The negative emotions for the clinical conversations included "feeling disrespected, intimidation, frustration, loss of confidence, being excluded, embarrassed, and feeling insulted."

Participant 16 described a clinical conversation where she felt uncomfortable discharging a patient whose blood pressure was extremely high, beyond normal limits. She called the MD and got yelled at for questioning the discharge order. She ended up repeatedly calling the MD, stating "you can come discharge the patient, I don't feel comfortable." The MD eventually relented and let the patient stay another night. She said "she was extremely frustrated that the MD would not listen to her or believe her assessment." The patient in this example had a stroke that night. Thankfully, he had not been discharged home and was in the hospital so he received the care that was urgently needed.

Participant 5 describes the frustration she had with the MD after a clinical conversation that the team had had with the family of a dying patient. The RN had prepared the MD that the family was looking for "any shred of hope and not grasping that the patient was going to die". The RN believed that the MD was providing hope in a hopeless scenario.

> I was confused and frustrated because I knew how much this family was hoping for a good outcome. It was very disappointing to hear the response from the MD. It was a tragic situation for the family and there was never anything that we would be able to do to make this kid better. I felt like this was the wrong way to handle the conversation. She just shared her opinion and not medical facts. She and I discussed after the conversation with the family but she didn't understand my point of view.

Participant 14 described a clinical conversation where his patient's health declined and after his interaction with the MD he stated,

> I felt heard and I felt like he trusted my judgement. Also, I don't know if it is my experience or if that affected my communicating the needs of my patient to a physician, but I felt heard and I felt trusted and I felt like the patient had a better outcome because of the way that we worked together.

Negative emotions led to the nurse feeling unheard and unable to advocate appropriately for their patients. Nurses described feeling "vulnerable, unworthy and disrespected." When the nurse feels this way, the nurse is unable to perform their job adequately.

Positive emotions after the clinical conversations included "relief, increased respect for MD, feeling safe, trust in team and confidence in self." Participant 13 described a clinical conversation where her patient was not responding to treatment. She had called the MD to validate the plan of care and perhaps get new orders. The MD did not want to do anything differently so she had to go up the chain of command. She stated "I told him my concerns and he was very respectful and said that he appreciated me and my care. This made me feel confident because he validated my concerns."

The clinical conversations were filled with negative emotions: fear, intimidation, and self-doubt. The nurses spoke up to the hierarchy because of "an obligation and duty to keep the patient

safe—regardless if I get yelled at." The nurses felt the need to advocate for the patient. When the conversations were satisfactory the nurses felt relieved, safe and confident because they were listened to and the patient's needs were met.

Managerial Conversations. The emotions felt after the managerial conversation were also widely varied. Refer to Table 4.6 for a display of emotions **after** conversations. Negative emotions described included "frustration, disappointment, feeling belittled, and guilt." The positive emotions felt were "acceptance, appreciation for the leader, and safety."

Participant 2 described her feelings after a general supervisory conversation with her direct supervisor. The direct supervisor did not respond to the participant the way that she had hoped. This is what the participant took away from the conversation:

> I felt such a cold response. It is ingrained in my brain that this person does not care about me or about the rest of the staff. I was talking to someone that was just robotic. She was not emotionally present at all. I was so disappointed and felt a real lack of respect for her.

Participant 1 described a managerial conversation with her leader around a medication error she had made. She stated that while she was fearful during the discussion, after the discussion she "reflected on the information that she (the leader) gave me and I was so appreciative of her and my learning."

The emotions felt after the conversations varied just as widely as before the conversations. Negative emotional reactions came after the leader displayed aggressive or demeaning behavior. The negative emotions led the nurse to feel "demeaned and disrespected." Positive conversations led to the nurse "feeling heard and respected." Both positive and negative emotions helped to determine the impact on the nurse's future practice.

Impact of the Courageous Conversations

Conversations are remembered for many different reasons. The nurses felt emotions before and after the conversations. These emotions helped shape the outcome of the conversation leading to the nurse bringing forth a future practice change. One of the interview questions was "did this conversation influence your future practice as a nurse? If so, please describe." In this study, 100% (N = 50) of the conversations led to the nurse having a change in practice. The practice change that the nurses described is the primary practice change, or the first thing that they defined when relaying the conversation. Interestingly as the participants continued to talk, 100% (N = 50) of the nurses described a secondary practice change as a result of the conversation. So, both the primary and secondary practice changes are described by conversation type. Table 4.7 reviews the primary and secondary practice changes that the nurse experienced as a result of the courageous conversations. Each practice change category is ranked in order of frequency from highest to lowest occurrence reported.

Table 4.7

Primary and Secondary Practice Changes that Occurred After Courageous Conversations (N = 50)

Conversation type	Practice change-**primary**	Frequency, *n* (%)
Clinical (*n* = 38)	Speaking up to the hierarchy	22 (57.8)
	Advocate for the patient	9 (24.0)
	Confidence in clinical skills	3 (7.8)
	Become organized	1 (2.6)
	Learning new skills	1 (2.6)
	Improved documentation	1 (2.6)
	Developed empathy for MD	1 (2.6)
Managerial (n = 12)	Speaking up the hierarchy	5 (41.7)
	Asking questions	2 (16.8)
	Advocate for self	1 (8.3)
	Advocate for staff	1 (8.3)
	Build relationships	1 (8.3)
	Develop empathy for leader	1 (8.3)
	Prioritize	1 (8.3)

Conversation type	Practice change-**secondary**	Frequency, *n* (%)
Clinical (*n* = 38)	Advocate for the patient	15 (39.5)
	Speaking up to the hierarchy	9 (24.0)
	Trust instincts	5 (13.1)
	Advocate for self	3 (7.8)
	Respect team differences	3 (7.8)
	Be prepared	2 (5.2)
	Trust in team	1 (2.6)
Managerial (*n* = 12)	Appreciation of leader	3 (25.0)
	Speaking up to the hierarchy	2 (16.7)
	Advocate for self	2 (16.7)
	Listen	2 (16.7)
	Partner with leader	1 (8.3)
	Explain why	1 (8.3)
	Self-confidence	1 (8.3)

Clinical practice changes. From Table 4.7 it is evident that the primary and secondary practice changes for the clinical conversations each yielded seven practice changes. The conversations for clinical practice revolved around patient care issues. These conversations included validating the plan of care for the patient, the clinical decline of the patient, ethical dilemmas, and the questioning of clinical skills.

Primary Clinical Practice Changes. Speaking up to the hierarchy and advocating for the patient were the two practice changes highest in frequency which is not surprising when the conversations were centered around patient care. Participant 15 relayed a clinical conversation where she had to clarify orders with a MD. She was slightly anxious but stated,

> It showed me that I really needed to (raise the issue), if I really don't get the answers that I need, I need to take the next step. I didn't realize that I could go to the next level higher doctor, if I wasn't getting the response I needed to-even if it upsets the MD. This really made me change my practice. (Participant 15-Clinical conversation)

There are four practice changes that centered around the nurse improving their clinical skills: (1) increased confidence in clinical skills, (2) becoming more organized, (3) learning new skills, and (4)

increased skill in documentation. These four practice changes occurred because the MD took time to help explain the plan of care or listened to the nurse.

The final primary practice change is one that really describes the emotional growth of the nurse—developing empathy for the MD. The nurse realized during and after the conversation that the MD faces challenges that the nurse may not need to face or do not understand. The nurse has taken the time to reflect and tried to put him or herself in the MD's proverbial shoes.

Secondary Clinical Practice Changes. The secondary clinical practice changes also yielded seven distinct items. The first two were not different than the primary practice changes other than in frequency (refer to Table 4.7): advocating for the patient and speaking up to the hierarchy. The remaining five practice changes occurred after reflection on the nurse's behalf. These changes centered around the nurse's self-worth and identity as a team member. These changes were (1) trust one's instincts, (2) advocate for self, (3) respect differences of the team members, (4) be prepared when having conversations, and (5) trust in your team members.

Participant 16 described a clinical conversation with the MD where she had to clarify the plan of care. She knew that the MD would not be happy but she questioned him anyway. He agreed with her assessment. She stated that "from now on I will question orders that I am unsure of. This situation made me trust my gut."

The five changes occurred after both satisfactory and unsatisfactory conversations. If the conversation was negative from the participant's perception, the nurse learned to stick up for themselves and trust their clinical instincts. If the conversation was satisfactory, then the nurse learned trust in the team and that it was good to speak up and advocate for the patient.

Managerial Practice Changes. From Table 4. 7 it can be seen that the managerial conversations also revealed seven primary and secondary practice changes. The managerial conversations were

conversations between the nurse and their direct supervisor. The conversation types included disciplinary conversations, annual review conversations, and general managerial conversations around clinical concerns.

Primary Managerial Practice Changes. The primary practice changes from the managerial conversations yielded seven practice changes. The practice changes varied slightly from the clinical practice concerns focusing more on the relationship with the leader. The primary practice changes are (1) speaking up to the hierarchy, (2) ask questions when unsure of information, (3) advocate for staff, (4) advocate for self, (5) build relationships with team members, (6) developed empathy for leadership, and (7) prioritizing patient needs.

These practice changes showed that nurses are leaders and followers simultaneously, as the nurses needed to speak with their direct supervisor about the staff that they lead. The nurses also learned that leaders are making tough decisions and that the leader needs support during the challenging times.

Secondary Managerial Practice Changes. The secondary managerial practice changes focused on growth for the nurse and understanding their direct supervisor more empathetically. The seven secondary practice changes are (1) appreciation for leadership, (2) speaking up to the hierarchy, (3) advocating for self, (4) learning to listen, (5) partnering with leader, (6) explaining “the why” to others, and (7) increased self-confidence.

These secondary changes address the relationship that the leader and follower share and how important it is to support each other for the betterment of the mission. The nurses, who are also charge nurses, had realizations that their followers needed to rely on them so their reflections centered around how they could become better leaders and at the same time support their leader.

The primary and secondary practice changes are just as diverse as the clinical practice changes. There are some differences such as advocating for the staff (as a charge nurse would do) and explain "the why" to others. These practice changes also help the nurse become better leaders for the nurses that they lead.

While it may seem that the primary and secondary practice changes are very diverse per conversation type, the top categories are essentially the same. Primary clinical changes for clinical conversations were speaking up to the hierarchy and advocating for the patient. For the managerial conversations, the top two primary practice changes were speaking up to the hierarchy and asking questions for clarification. For the secondary practice changes, the top two clinical secondary changes were advocating for the patient and speaking up to the hierarchy. The top two secondary managerial practice changes were appreciation of leadership and speaking up to the hierarchy.

Speaking up to the hierarchy and advocating for the patient were extremely important practice changes for the nurses to develop or continue. The nurses felt that advocating for the patient and speaking up are the most important thing that a nurse can do—essentially their duty. Participant 5 described how the clinical conversation about her patient's ethical dilemma changed her practice

> I think that it just makes me feel better advocating for my patients. Even if I don't necessarily get what I want I know that I was listened to. I know that advocating for my patient is the most important thing that I can do as a nurse.

Participant 13 described a clinical conversation where she had to go up the chain of command to get help for her patient. She described what she took into her practice

> I noticed the subtle changes in the patient. Subtle signs can be indicative of hidden complications. I learned that we have to respond to those kind of things sooner rather than later. We can't ignore the signs our patients give us. It is never a bad thing to think that something is going wrong, even if it isn't. It is better to check, even if it means calling in the rapid response team (experts) and looking like a fool because nothing is wrong than to let the patient suffer. This is what I learned and will take forward.

The impact of these courageous conversations led to the nurse's future practice change. It is important to understand that the impact of the emotions that the nurse felt helped shape the nurse's future practice. When the nurse had a positive emotional experience, the nurse felt more empowered to speak up. Speaking up led to more positive patient outcomes.

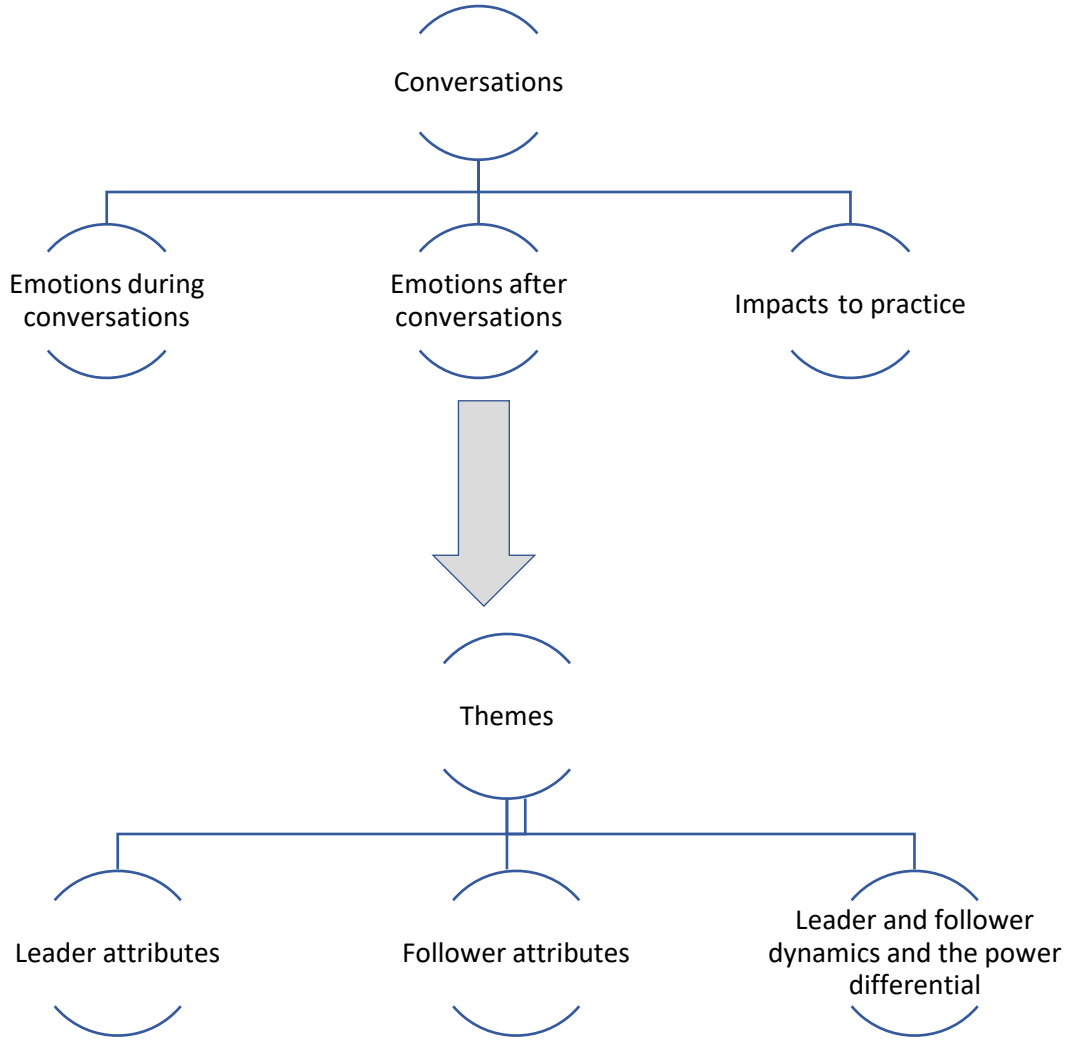
Negative emotional impacts led the nurse to "feel unheard" and caused the nurse to no longer speak up for patient safety about 25% (*n* = 12) of the time. This lack of speaking up for safety concerns when feeling intimidated was a feeling that the nurse took into their future practice. The remaining negative emotional encounters (*n* = 38; 75.0%) empowered the nurse to "advocate" and "speak up" more for their patients, as the nurse realized the orders received were not enough for patient care.

Cross Sectional Themes

The antecedents (clinical and managerial conversations) were compared with the emotions during and after the conversations, and the impacts to the nurse's practice. The cross-sectional analysis revealed three themes across all clinical and managerial conversations. The three themes are (a) follower attributes, (b) leader attributes, and (c) leader and follower dynamics and power differentials and will be discussed in the next section noting any differences and similarities. Figure 4.2 depicts the flow and development of the cross-sectional themes.

Figure 4.2

Development of Cross-sectional Themes



Follower Attributes

As discussed, CF empowers leaders and followers to be the best that they can be to enhance the success of the mission. The first theme was follower attributes. In this study, the followers were the RNs that were interviewed.

One of the demographic questions was the participant's level of professional nursing experience at the time of the conversation. This piece of information was asked to determine if the nurse had more

experience, would these conversations happen more frequently. See Table 4.8 for a display of nurse experience level during conversation.

Table 4.8

Nurse Experience Level During Conversation (N = 50)

Conversation type	RN years of experience at time of conversation	Frequency, *n* (%)
Clinical (*n* = 38)	1	8 (21.1)
	2	6 (15.7)
	3	6 (15.7)
	4	10 (26.4)
	5	8 (21.1)
Managerial (*n* = 12)	1	3 (25.0)
	2	1 (8.3)
	3	3 (25.0)
	4	4 (33.4)
	5	1 (8.3)

As the nurses shared their stories, it required them to think about their actions and feelings. The follower attributes are the result of those thoughts. Five participants (27.7%) described trusting their gut instincts to make clinical decisions. When their instincts were correct, the nurse felt "confidence, advocated for themselves and their patients, and grew as leader and/or followers." Participant 15 shared this insight from a clinical conversation

> I took away that my gut instinct was correct. As a newer nurse, going with my gut instinct was a good lesson to learn. I think because I got praise back. I was given that good feedback and realized that my gut instincts were solid and I should trust them.

Stories were shared that contained examples of how the followers grew when they received the proper attention or reaction from their leader. Followers (*n* = 6; 33.3%) described how they "matured, both professionally and emotionally" with these interactions. These positive interactions led to "professional growth, becoming involved on the unit to change clinical practice, or involvement and service to the community."

Participant 18 described a managerial conversation that caused her to rethink how she saw leadership. She explained that she is growing to respect the leaders after becoming a charge nurse. She stated,

> Well, I think that this is the first time that I have seen things from a charge nurse perspective. It gave me a different perspective of what charge nurses do and the decisions that they have to make. I have more respect for them. I understand the kind of decisions that they have to make now.

Wrong decisions by the nurse or the MD led to the nurse "feeling shame, and vulnerability." "Embarrassment" occurred when the bedside nurse suggested a course of action that was ultimately not what the MD thought was correct. However, "guilt" was the overarching emotion when the follower was not fulfilling their mission of expert patient care. Guilt because they missed a piece of care or if they could not convince the MD to use the proper course of action, then those actions ultimately led to patient compromise. One nurse shared her "feelings of guilt and letting down the team, the family, the patient, and ultimately herself" during a managerial conversation. Participant 7 shared a story about a medication error. She felt so guilty that she did not know what to do. She did not ask for help because she was "embarrassed and afraid" of the reaction that she would receive from the MD or the charge nurse. Unfortunately, the error caused irreversible damage to a patient. She stated "the guilt that I have will last forever. I will never forget the fear in the patient's eyes."

The followers described the emotions that they felt and whether the conversation helped them grow or changed the way that they felt about themselves and their practice. More negative emotions surfaced from both types of conversations, then positive emotions. (Refer to Tables 4.5 and 4.6). The follower's impact to their practice resulted in "speaking up to the hierarchy and advocating for the patients" from both positive and negative clinical and managerial conversations.

Leadership Attributes

Because the conversations involved leaders and followers, the next theme that evolved was leadership. This category subdivided itself into two subcategories as perceived by the participant,

positive leadership and ineffective leadership. Positive and ineffective leadership traits emerged with both MDs and direct supervisors.

Positive leadership traits. The participants described many characteristics of positive leadership (from their leaders) in their stories. Positive leadership was described as those comments or actions that allowed the follower to grow or have positive thoughts about the leader. Participants shared stories about how their leaders empowered them to be the best that they could be both personally and professionally. Terms like "accountability, leadership presence and support, empathy and equality" surfaced frequently in the incidents. Action items under positive leadership, where the participant "felt the leader actively supported them and their growth, were challenging their thinking, 'explaining the why' if the answer was no to a question, providing a teaching moment when an error had occurred, and affirmation from the leader for doing a good job."

Participant 1 described her direct supervisor's reaction to a disciplinary managerial conversation as follows:

> And my response was just to cry because I had been feeling close to everyone and had been very excited to be part of the team and then they went behind my back to my manager about my concern. My manager talked to me about it and she was just present with me. I didn't feel judged for showing emotions. She understood my emotions but also clarified their position. She was very neutral.

Positive leadership traits did not just come from the direct supervisor or the MD. The followers (nurses interviewed) also described positive leadership traits that they provided to their leader. Many times, they mentored their leader by "explaining a new procedure or the research behind it, empathized or supported their leaders' feelings or decisions, or approached their leader about the way the leader handled an interaction or challenged them." The follower helped the leader see where they, as the leader, could grow and learn new skills.

Participant 11 described a situation where she had a patient that was dying and what a "wonderful job the MD did explaining the process to the family." The RN provided feedback to the MD after their clinical conversation

> It was a very tough situation. If you don't explain it in the right way the family can get very frustrated. He (the MD) explained it so well. After he finished talking with the family, I told him what a great job he did and how much I learned from him. I told him that I know how hard that must be but that the family really appreciated him. I was very proud of him.

When the leader displayed positive leadership traits, the follower was able to grow and in turn help the leader grow. The leader was able to harness the positive characteristics of the follower and use them to help to move the mission forward. The positive leadership traits helped establish the trust needed between the leader and the follower.

Ineffective Leadership Traits. Ineffective leadership traits were described as those comments or actions that made the follower have a bad feeling ("fear or anxiety") or a negative emotional reaction ("self-deprecation, lack of trust"). Interactions with the MD or direct supervisor sometimes involved "yelling, intimidation, threatening body language, blaming, or belittling" the nurse. These actions led to an uncomfortable work environment as the followers described. In this environment, the nurse did not feel comfortable speaking up to the hierarchy or challenging an order, even if it was to the detriment of the patient's or their own safety. Luckily, this was the case less often rather than more often.

Ineffective leadership styles from the MD included phrases like the ones yelled at Participant 13 who called because the patient's health was declining: "don't call me now, I am busy." Additionally, Participant 3 had a similar reaction when calling an MD to report a patient's decline "why do you keep calling me? I will deal with it in the morning." Both patients in this instance were rushed to the intensive care unit after the nurses went up the chain of command to obtain the help that they needed with their patient's care. Both nurses in this case had the after effects of a negative conversation. Both felt empowered to "speak up to the hierarchy" to ensure that their patients got the care that they needed.

They did not let the negative interaction shape their future. They felt empowered to change their future.

Participants described ineffective leadership as a "lack of trust in the leader's ability to lead." Managerial conversations contained the leader's lack of communication "not explaining the why, ignoring the issue, not listening to the follower or lack of follow up around important issues." This led the followers to feel unheard and unappreciated. There were two leaders that were described as having "a lack of emotional connection, no empathy, being cold and emotionless" with their followers. All of these feelings led the follower to not want to "believe, support, or trust the leader" thus creating potential safety issues.

Participant 18 described a managerial conversation with her direct supervisor that left her feeling frustrated and belittled:

> I was so frustrated. She was talking down to me and acting like I was incompetent. Like I had no idea what I was doing. I don't know if she was just having a bad day or what, but she acted completely rude and left me feeling really bad.

Participant 2 described a managerial conversation between her and her direct supervisor that left her feeling unheard and disrespected:

> I did not feel like I was being treated as an adult. I did not feel that there was mutual respect. I felt like the conversation was very one sided and it did not matter what I said or thought. I did not feel that I could question her so I ended up just questioning myself.

Ineffective leadership can leave the nurse feeling frustrated and belittled. Leaders that are unable to communicate appropriately with their followers can miss cues about patient safety concerns. This lack of a leader's awareness around ineffective communication is a huge red flag that the leader should be aware of in the environment.

Positive and ineffective leadership traits emerged from both types of conversations. Ineffective leadership behaviors surfaced more frequently than positive ones. Positive leadership traits empowered

the nurse to “speak up to the hierarchy, advocate for their patient and feel more confident.” Ineffective leadership traits caused two reactions in the nurse: (a) “self-doubt and guilt” and a feeling that there was no point to advocate because they would not be heard or (b) “frustration” and “empowerment” to speak up. The nurses that felt frustration knew that they needed more and advocated for the patient and themselves when faced with ineffective leaders.

Leader and Follower Dynamics and the Power Differential

The way people interact on a team, specifically the leader and the follower, is key to a team’s success (Mohanty, 2018). There can be many groups of teams in a health care organization. For instance, a team can be comprised of a leader (unit manager) and the people that work on that unit, an MD and the team of nurses that they work with or those two groups of teams combined. The incidents described contained all of the above. The key to positive team dynamics is when the team works together for the best quality and safety outcomes for the patient (Logan, 2016).

Leader and Follower Dynamics. When teams work together efficiently, they become well-oiled machines, supporting each other to provide the best care. The participants described stories containing examples of positive team dynamics. Teams were described as “collaborative, respectful, and advocates for the patient and their families.” Participants described that when the team worked well, MD and RNs solved problems together, resulting in the best outcomes for the patients. RNs felt heard and respected as nurses when their MD colleagues asked for their advice and made them active participants in the health care team. RNs stated the same about the relationships with their direct supervisors. The RNs felt like being part of the team was very positive to their growth and the patient’s well-being. Trust was paramount for positive team dynamics to occur. Participants shared examples that really embodied the sentiments listed above. Participant 8 shared a clinical conversation about collaboration:

> I feel that we (MD and RN) are part of a team. I felt respected and that my knowledge and opinion on this subject was respected and not just looked down or doubted, because I am the nurse and not the doctor. I felt good that I had caught that decline in my patient and we had a

good discussion about it. (Participant 8-Clinical conversation)

Participant 4 shared a clinical conversation where she trusted her instincts to get the patient the care that they needed:

> Being able to call the doctor and say 'Hey, I notice this is going on with my patient, it is very subtle, my intuition is telling me that something is going on underneath. And to have that particular MD say 'lets get a test and make sure.' I think that being able to work collectively, I was able to get imaging done and it did show something was going on, something not obvious, but the subtle change that I noticed alerted me to it. So that provided a quick outcome and good outcomes for the patient because there was support, there was mutual respect. I felt heard and I was able to attain the orders that I needed. And the patient received the care that they needed in a very timely and efficient manner with good outcomes that did not lead to anything worse. (Participant 4-Clinical conversation)

Participant 16 shared a clinical conversation where she helped get the right orders for the patient by letting the MD know that he had written the orders for the wrong patient:

> I called the doctor to tell him about orders he had written for the wrong patient. He said 'oh my gosh. That was for a different patient. Thank you for catching that.' I felt good about clarifying the information because it didn't feel right for that patient. It was good to have that open communication with the MD-to know that he trusted me. (Participant 16-Clinical conversation)

Participant 18 described a clinical conversation where she describes the importance of collaborative relationships in the healthcare environment:

> So, in critical settings, we have to bypass these uncomfortable situations or nerve-wracking conversations because it is all about the patient. I think that your relationship with the doctors really impacts the care that the patients get so I think that it is always important to have good, collaborative relationships with the MDs. We are the eyes and ears for the MDs and they have to trust us to be on the lookout for changes with the patients. (Participant 18-Clinical conversation)

Participant 12 and Participant 4 both shared clinical conversations about the MD/RN relationship and how it is positive when both team members work together for the best of the patient:

> Sometimes there are those physicians who you can just have a very easy conversation with and then there are those where unfortunately you can definitely feel the separation of roles. But I think definitely with the MDs that I work with, my relationship with them is more comfortable. I want to say almost in a trusting way, they know me, I know them, so when I have to call them about a patient issue, it feels like (…) I am trying not to say this in a negative way but I think that sometimes when you call a physician you get the brush off. But with these physicians, I feel that

> they listen to me and trust my judgment. It feels good to know that my patients can get the care that they need. (Participant 12-Clinical conversation)
>
> I am advocating for my patient just as much as he (MD) is. We have a mutual goal, to do our best for our patients. (Participant 4-Clinical conversation)

One clinical conversation that needs to be highlighted is how the nurse felt "joy with the interaction she and the MD" had. Participant 6 described the joy she felt after bringing up a concern to the MD and the MD "took time to talk through her concern" with her. The MD explained the pathophysiology of the disease and why he decided on the particular treatment course for this patient. This participant was able to advocate for the patient and in the end used this information to help teach her colleagues when faced with this particular disease course in the future. She described not only her joy but the "pride that she had in being a nurse" and the fact that she felt "validated" that she had "chosen the right career." This example highlights how positive team dynamics and leadership support can benefit not just the patient but the entire team.

Team dynamics that are negative can stress the team to be divided and dysfunctional (Logan, 2016). Participants described negative team dynamics as "a lack of being heard or respected leading to a delay of care for the patient." Communication barriers were commonplace and mistrust was present in almost every interaction. Negative team interactions created "intimidation and betrayal." These negative team dynamics were felt both with ineffective direct supervisors and ineffective MD colleagues.

Participant 14 shared a clinical conversation with a MD around a patient safety issue and how she was not supported when she had concerns.

> I felt very frustrated and had a lot of anxiety. I was not heard and I felt that it was because I was a nurse and I didn't know what I was doing. It was a really negative environment. I felt like the patient's condition was only reliant on me. I knew that I would not receive backup or support from the MD. I could not work in that environment.

Leader and follower dynamics are key to fulfilling the mission. When the leader and follower work well together, they empower each other to the best they can be for the completion of the mission. When the leader and follower have an ineffective relationship, team dynamics are fractured and the patient ultimately suffers.

Power Differentials. Hierarchical team structures create natural power differentials. In health care, a hierarchical structure is needed so that decision making rests with the clinician that holds the highest licensure. CF respects the hierarchical structure but encourages the follower to have the courage to speak up or take moral action as needed if the decision is in conflict with the mission (Chaleff, 2009). In health care this translates to if the order the MD has given or not given threatens patient safety. This can also happen when the direct supervisor neglects to take patient safety into consideration.

Out of the 50 conversations shared, 70% (*n* = 35) were directly related to questioning or challenging orders or speaking up to the hierarchy about a patient safety issue. When the ineffective leadership characteristics above resulted in the need to speak up to the hierarchy, the nurse advocated for the patient's needs. These interactions generally resulted in fractured team dynamics and complicated patient issues leading the RN who spoke up to feel "confused, frustrated and fearful." Of the 35 conversations that had concerns of questioning orders, 80% (*n* = 28) had to be raised to the one-up, or the boss' boss. Going over someone's head, especially someone in a higher position than you can cause many bad feelings, but the nurses felt a duty and urgency to raise the issues to someone higher up. Thankfully, when concerns were brought forward positive outcomes for the patients resulted.

Participant 15 shared a situation that expressed his growth as a nurse. He had a clinical conversation with an MD about his patient. The nurse did not agree with the order:

> Last week, for the first time I just went up to the MD and told him I didn't agree with the order. I told him what I thought needed to be done. He agreed with me. The MD thanked me for

> being on top of my patient's care and for knowing what was going on. I felt like a professional at that point.

This participant did not wait for anyone to tell him how to approach this situation. He had the courage and took the responsibility himself to make a difference for his patient's care.

Participant 6 shared a clinical conversation about not being included in the patient's care discussion. He stated that

> Some of the physicians don't include me. It really frustrates me. They don't include me as a part of the team. I am the one whose spending 12 hours a day at the bedside with the patient. So, I think it is better to include me (…) have me part of the team. I just want to be respected as a team member.

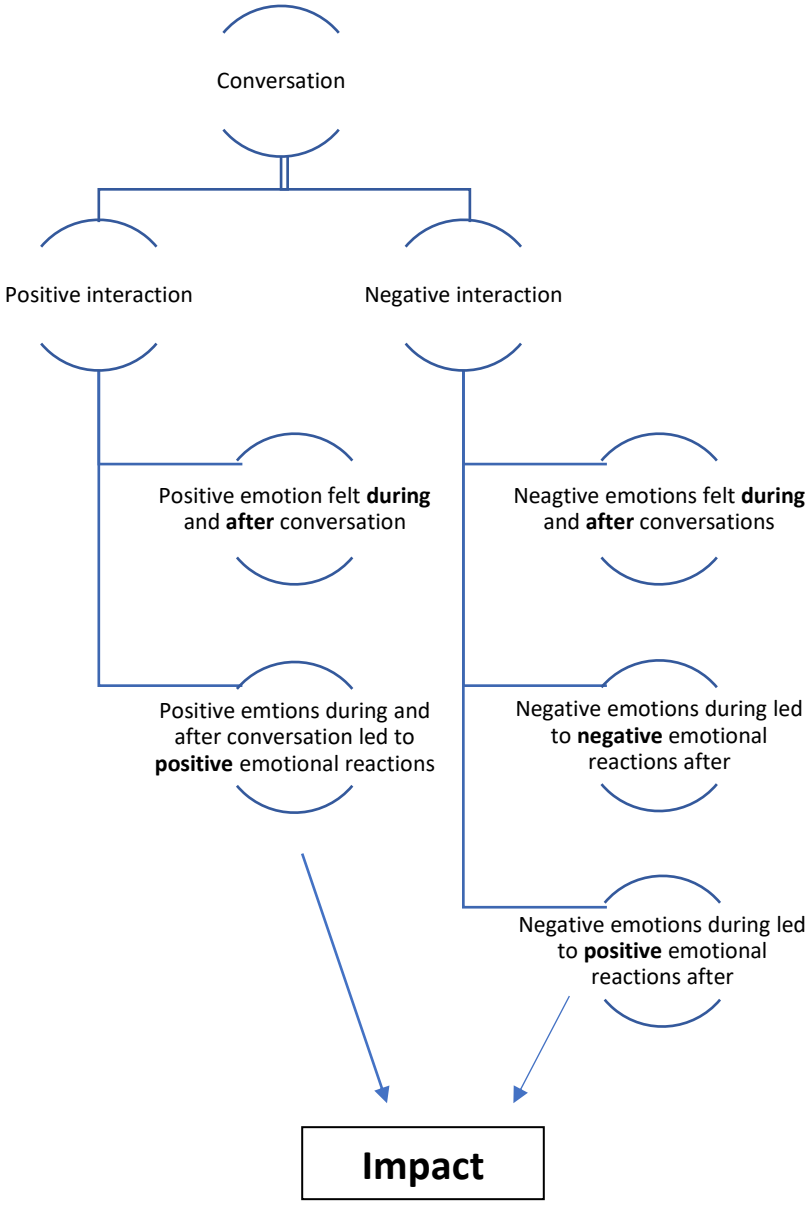
When followers in a hierarchy have problems that are not resolved at the first level, they were encouraged by their direct supervisor or leader to take those problems up the chain of command. When raising a problem to the next level goes well, nurses described feelings of "collaboration, respect and comfort." The raising of issues was not to get the first person in trouble but to seek a positive outcome for the patient. In all incidents, the respect for the leader's authority was maintained. The nurses would tell that person that they were "uncomfortable with that decision" and would be "taking the problem higher up the chain" of command. The nurses felt empowered to seek out the answer that was best for the patient's condition.

Summary of Findings

This study sought to determine if CF concepts were used in healthcare conversations between nurses and their MD colleagues or their direct supervisors. CIT was used to analyze the 50 separate incidents obtained from 18 diverse participants for the study. Refer to Figure 4.3 to see a visual of the findings of this study.

Figure 4.3

Study Analysis Flow Cycle



The conversations that the participants shared with the researcher were diverse and filled with emotions. The conversations occurred with the participant's direct supervisor or the MD that they were working with that day. The antecedents revealed seven different types of conversations, four clinical with the MD, validate the plan of care, ethical dilemma, clinical decline, and questioning clinical skills

and three managerial with the participants' direct supervisor, general supervisory, disciplinary, and annual review. Each type of conversation revealed positive and negative emotions.

Positive emotional codes included "pride, joy, increased empathy for the other person the conversation was with and relief." Negative emotional codes included "fear, anxiety, and not being heard." Nurses felt these negative emotions when bringing up patient safety issues to their physician colleagues or direct supervisors. Even though they felt "belittled or insulted", they continued to advocate for the patient's needs.

The impact of these conversations was discussed revealing that 100% (N = 18) of the nurses took the learnings from these conversations and made changes to their practice. The top two practice changes from all types of conversations were to speak up to the hierarchy and advocate for the patient's needs. Many times, these were both done in one interaction.

The codes elicited from the incident's antecedents, incidents, and impacts were compared with the incident setting and type and then developed into themes. The themes centered around follower attributes, leader attributes, follower and leader dynamics and power differentials. Each of these themes were seen across all incidents, regardless of conversation type or location. Chapter V will synthesize the data and discuss the results in relation to the research questions posed, the literature review and the conceptual framework.

CHAPTER V: DISCUSSION/INTERPRETATION OF FINDINGS, RECOMMENDATIONS, AND CONCLUSIONS

Due to the hierarchical nature of the health care structure, communication can be challenging at all levels. Garon's (2012) research demonstrated that one of the biggest challenges is the ability for health care teams to have collaborative conversations at the bedside. This study continues to validate that the ability to have collaborative conversations is still a challenge in the health care environment. When clinical communication does not happen smoothly, the patient can end up suffering from poor clinical outcomes because the nurse is afraid to raise a safety concern. A leadership concept called courageous followership (CF) helps to empower followers to serve, assume responsibility, speak up to the hierarchy, challenge orders, transform the organization, and take moral action as needed for the good of the mission (Chaleff, 2009). The mission for a healthcare organization is the continued well-being of the patient.

This research study examined the conversations of bedside nurses with 3—5 years of acute care, clinical experience. Nurses shared conversations that were meaningful to them—conversations that they remembered. The conversations were analyzed utilizing Critical Incident Technique (CIT) to determine the emotions of the nurse during and after the conversation, the themes around the conversation, and the impact to the nurse's clinical practice change after having the conversation, as well as, searching for the CF tenets in each conversation. This study sought to answer the following questions:

- RQ 1: What situations require bedside nurses to use CF concepts when interacting with their colleagues and leaders?
- RQ 2: What CF concepts are used by bedside nurses in conversations with their colleagues and leaders?

In this study, when nurses brought forth concerns to their physician colleagues or direct supervisors, they were mostly met with “fear, frustration and a feeling of not being heard.” Health care leaders need tools to help empower nurses early in their careers to speak up to the hierarchy and to advocate for their patients when there are clinical concerns or patient safety issues. These courageous clinical conversations were filled with emotions and depending on how the nurse reacted to these emotions determined the future clinical outcome of the patient.

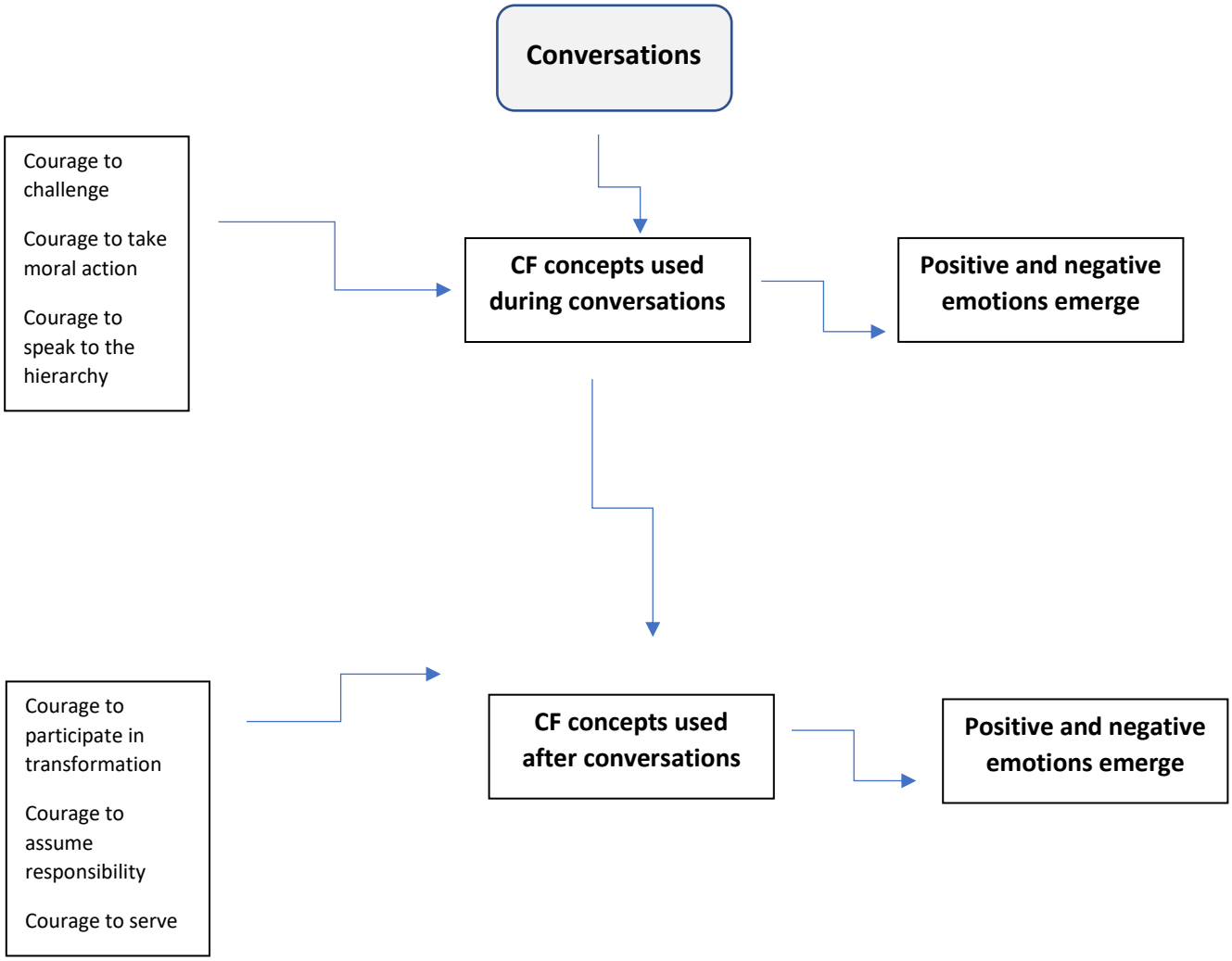
Discussion/Interpretation of Findings

This research study set out to identify if CF tenets were present in current conversations in the healthcare environment, and what situations required the use of CF concepts. The tenets of CF are (a) the courage to assume responsibility, (b) the courage to serve, (c) the courage to challenge, (d) the courage to participate in transformation, (e) the courage to take moral action, f) the courage to speak to the hierarchy, and (g) the courage to listen to followers (Chaleff, 2009).

Chaleff (personal communication, June 7, 2021), validated the actions for each of the tenets in the healthcare environment identified in this study. The incidents shared revealed many current examples of CF in the healthcare environment. Four of the six tenets emerged from the conversations, namely, (a) the courage to challenge; (b) the courage to take moral action; (c) the courage to speak up to the hierarchy; and (d) the courage to listen to followers. Three of the tenets were used after the conversations— (a) the courage to participate in transformation; (b) the courage to serve; and (c) the courage to assume responsibility. Figure 5.1 describes the analysis of the conversations in relation to the CF tenets.

Figure 5.1

Conversational Flow with CF Concepts



The following section gives brief examples of each tenet noted in the health care environment and an excerpt noted from the conversations to assist the reader with understanding the connection. The tenets are also arranged according to how they relate back to the research questions. This study supported Leach's (2005) work that leveraging follower behaviors through the use of CF can assist the leader in further accomplishing the mission, ultimately leading to improved patient outcomes.

RQ1: What situations required the nurse to use CF tenets in their conversations?

The results of this study supported Garon's (2012) and Anderson et al.'s, (2010) work, that one of the biggest challenges in health care is the ability for healthcare teams to have collaborative conversations at the bedside. The stories shared by the nurses explained that often they are "not heard,

and their thoughts are dismissed" when attempting to raise safety concerns (Rosenstein, 2002; Rosenstein & O'Daniel, 2005). This research support Butterfield et al., (2005) and Byrne (2001) findings that nurses share stories to analyze situations and understand their environments. The nurses' stories in this study helped the nurse determine future practice changes and helped the researcher analyze and understand the nurse's world.

Nurses are having to use the tenets of CF to navigate conversations with their colleagues. These courageous conversations were necessary when the nurse needed to discuss complicated patient concerns or to validate concerns with leaders. The conversations required the nurse to have the courage to advocate for their patient or themselves.

Clinical Conversations. The clinical conversations required the nurse (a) to validate the plan of care for the patient, (b) to discuss the patient's clinical decline, (c) to have a conversation about an ethical dilemma, or (d) to question the practitioner's clinical decision-making skills. In each case, the nurse was faced with a concern about the patient's safety and had the courage to speak up and advocate. All of these conversations occurred with a MD colleague and occurred on the nursing unit or by telephone.

Participant 15 described a positive clinical conversation that he had with an MD in the Emergency Department. The nurse had to clarify the plan of care for the patient.

> I had a patient that I thought was having a seizure but the MD wasn't convinced. I told the MD that I didn't think that these were the correct orders. The MD asked me why not. I explained myself. She (the MD) went into the patient's room and examined the patient again. She told me 'You were absolutely right. This patient is having a seizure. Great call!' I felt that my gut instinct was right and it felt so good to be validated. (Participant 15- Clinical conversation)

The nurse was able to have a positive clinical conversation in the nursing unit and the MD was able to go see the patient for herself and make a different clinical decision. The outcome for this patient was positive.

Trusting one's "gut instinct" or "trusting their gut," was described by the nurses throughout the interviews, which validated the research of Melin-Johansson's et al., (2017) research that described that nurses integrate both analysis and synthesis of intuition along with objective data to make clinical decisions. This knowledge is important in clinical practice to use as a support in decision making further increasing patient safety and quality.

Nurses described getting a slightly different response from the MD when the conversation was on the phone versus in person. The nurses believed that when the MD had the opportunity to see the patient and the situation, more action was taken by the MD versus on the phone. Face-to-face communication was proven in this study to be more effective to achieve the desired outcomes. The finding that face-to-face communication has better patient outcomes corroborated Baggs et al.'s (1999) research that found that face-to-face communication is associated with a lower risk of negative outcomes and greater collaboration amongst team members. However, when the MD expressed ineffective leadership ("yelling, intimidation"), the location in this study did not make a difference.

Managerial Conversations. The managerial conversations required the nurse to speak up and advocate for their patient(s). The situations that called for the nurse to use CF tenets in their conversations were (a) during disciplinary conversations, (b) during general supervisory conversations, and (c) during conversations around the nurse's annual review. All of these conversations occurred with the nurse's direct supervisor and took place in the direct supervisor's office or on the nursing unit.

Participant 2 described an ineffective managerial conversation with her direct supervisor that started out on the nursing unit. This conversation escalated and when the leader asked to go to the office the follower refused to continue the conversation because she was afraid to be alone with this leader.

> My leader came up to me on a day while I was working on the unit. She wanted to discuss an issue where I had made a mistake. While I was speaking, I could tell the she (the leader) was very uncomfortable. She was twiddling her thumbs, and trying to speak to others on the unit. Her body language told me that I was not important to her and I told her so. At that point, she

> 'woke up' and said that we could continue this conversation in her office. I said 'no, I don't want to go to your office'. We don't need to continue this conversation. It was a very disturbing conversation for me. (Participant 2- Managerial conversation)

This participant was very embarrassed that the leader attempted to have a disciplinary conversation in front of others on the nursing unit. Unfortunately, this conversation was unsatisfactory for the participant.

The places where conversations took place mattered for the participants. Face-to-face conversations with the MD or the leader were more positive and effective than phone conversations. However, ineffective behavior was present both in person and on the phone. Managerial conversations were more effective in the manager's office than out on the unit.

RQ 2: What CF concepts were used by nurses at the bedside?

The findings supported Leach's (2005) research that all CF concepts are being utilized at the bedside by nurses in conversations with their MD colleagues and direct supervisors. The use of these concepts is influenced by the emotions that the nurse felt during and after the conversation. These emotions helped to determine the nurse's future practice changes, specifically how "to speak up and advocate for their patients." When the concepts are not used or received by the other in the conversation, the nurses experienced negative emotions and self-deprecation that led to poorer patient outcomes. When the concepts were used and the other participant was receptive, trust in the team flourished and patients received the care that they needed.

Concepts Used During Conversations. The CF concepts utilized during the conversations were beneficial to the follower (nurse) being able to advocate for the patient. The four concepts that were used were (1) the courage to challenge, (2) the courage to take moral action, (3) the courage to speak up, and (4) the courage to listen to followers. The first three concepts allowed the nurse's voice to be enhanced and address the concerns that the nurse felt. All four concepts allowed the leader to listen to the follower and help the follower achieve their mission.

The Courage to Challenge. The courage to challenge allowed the nurse to give a voice to the discomfort that they felt with a view that the leader was expressing. The nurse used this concept to advocate for the patient even though it might have made the MD or direct supervisor upset with the challenge. The nurse pressed forward because it was the right thing to do.

Participant 16 shared a key example from a clinical conversation that she had with an MD. She stated,

> I remember feeling nervous before calling. I felt stupid after calling the MD, and having to call him three or four times during the night. But it felt good that I was advocating for my patient, and not letting him go home to stroke out. I learned that even when it is uncomfortable, and you know that you are going to get yelled at that the number one priority is your patient's safety and well-being. Even if that means that you get screamed at on the phone, that is fine, as long as you advocate for your patient. (Participant 16- Clinical conversation)

This nurse knew that she was going to have an unsatisfactory conversation with the MD; however, it did not deter her from doing what she needed to do to ensure that the patient got the care that they needed. This conversation supported Chaleff's (2009) research that when a leader is angry or screaming that the follower needs to maintain balance and continue to forward the mission. This nurse kept focus on what was important for the patient and did not let the leader's behavior deter her.

Participant 10 shared a managerial conversation that she had with her direct supervisor. The follower had to challenge the leader to think differently about visitation. The follower challenged the leader's moral compass.

> Patients' visitors were not allowed during COVID. However, my manager allowed some "special visitors" to see their family member in person while they were dying instead of having to use Facetime like the other patient's families. These concerns were brought forth to me and I discussed it with other colleagues. We felt that this was a favoritism issue. I brought this up to my direct supervisor and she was so insulted that we accused her of favoritism. She never followed up on our concerns and they still continue. (Participant 10-Managerial conversation)

Many times, followers have to find the courage to challenge leader's behaviors or thoughts in the environment. The follower needs true courage to remain focused on the mission and deal with the leader's behavior quietly and respectfully.

The Courage to Take Moral Action. The courage to take moral action describes the need to call in experts or refusing to follow an order for safety reasons. Participant 13 shared a clinical conversation where she had to call in the rapid response team because a newer surgeon would not listen to her recommendation. The patient ended up dying; however, the surgeon credits this nurse with the changes to his practice.

> He (the MD) was new. I kept calling him to get different orders for the patient. He didn't want to do anything different. The patient was showing subtle signs of decline. He was giving me orders that didn't make sense. I finally called in the Rapid Response team to assist. The MD was not happy. The patient died a few hours later. I had to take charge of the situation. Unfortunately, I waited too long. The MD was a newer surgeon and very unsure of himself. It has now been a few years and he shows me a great deal of respect. He isn't so lax anymore. If a nurse calls him, he is much quicker to respond. He and I have a good relationship now. (Participant 13- Clinical conversation)

This nurse made the decision to take moral action to get the patient the help that they needed. In the hierarchy, this should have been the MD's responsibility. However, the nurse felt that the patient was not getting the care that they needed and took it upon herself to change the situation. This story illustrated that miscommunication leads to poor patient outcomes, including death***,*** supporting Agarwal et al.'s, (2010) research that demonstrated that miscommunication in healthcare is the number one root cause of serious injury or death related to delay in treatment.

The Courage to Speak Up to the Hierarchy. Speaking up to the hierarchy was the most frequently used concept by nurses in this research study. When the nurse was not able to get the care that was needed for the patient, the concern had to be escalated up the chain of command. In all instances, this "going above to one's leader" was done with awareness and respect to the primary MD or leader.

By demonstrating the need to speak up to the hierarchy when safety concerns arose verified Ramanujam and Rousseau's (2006) findings that status difference between the layers in a healthcare organization, can inhibit direct communication. Participant 4 shared a clinical conversation in which she was not getting the response that she needed from the MD. She told the MD that she would be calling his boss to get further orders.

> My patient was having mini signs of a stroke. I called the MD several times to see if we could get an imaging study to confirm. He did not want to; he didn't feel that the patient needed it. He would not listen to me. Finally, I said I am uncomfortable with this and I am calling the attending. I called the attending and he agreed to order a study. The study confirmed that the patient was having a stroke. I felt bad going over his head but I felt heard and was able to attain the orders that I needed so that the patient didn't suffer further damage. It ended up being a good situation. (Participant 4- Clinical conversation)

This nurse trusted her instincts and was courageous to go up the chain of command. She spoke up to the hierarchy and her patient benefitted from her actions.

Participant 14 shared a similar clinical conversation. She did not feel comfortable with the response that she received from the first MD so she called the MD's supervisor. The outcome was beneficial for the patient.

> I felt really anxious because the patient kept constantly telling me that he was not feeling well. I repeatedly called the MD and he just blew me off. I told the charge nurse that I had called the MD and he won't listen or give me any different orders. I then called the MD's supervisor who listened to me. We transferred the patient to the ICU. I had such a sense of relief because the patient got the help that he needed. (Participant 14-Clinical conversation)

In each case, the nurse had the courage to seek out the care needed for the patient. The nurse's trusted their instincts to get what they needed for their patients.

The Courage to Listen to Followers. The courage to listen to followers ensures that the leader is listening to the follower's concerns. Chaleff's (2009) claimed that inviting creative challenge is a high level of innovative teamwork was validated in the following example. Participant 5 described a clinical conversation where she advocated for her patient. She challenged the MD but was not able to convince

the MD to give her the orders she wanted; however, she had a good conversation and in the end she felt heard. She described it as follows:

> The MD and leaders empower us to speak our mind. I wasn't afraid to say that I needed more. And I realized that there are certain things that we have to try first (treatment modalities). It was reasonable and understandable. I was just frustrated. But at least she (the MD) explained the why to me and I felt heard and appreciated. (Participant 5-Clinical conversation)

The conversations shared for this study revealed that CF tenets are currently being used in Health care conversations between nurses and their MD colleagues and direct supervisors. Courageous conversations directly impact the health care environment and the outcomes for the patients and the nurse's future practice.

CF Concepts After the Conversation. There were three CF concepts that were noted after both types of conversations. The three concepts are (1) the courage to participate in transformation, (2) the courage to serve, and (3) the courage to assume responsibility. The emotions felt after the conversations enhanced the nurse's future practice.

The Courage to Serve. The courage to serve involves entering new roles to help the organization, being as passionate as the leader and taking a stand for the leader. This finding confirmed that Leach's (2005) research that an "organizational leader's challenge to maximize the productivity and longevity of employees by cultivating their involvement and commitment" (p. 228). Participant 8 described a conversation that she had had with her direct supervisor about becoming a charge nurse for the unit. She became a charge nurse primarily for her own growth but also to help out the unit with leadership. Participant 8 shared thoughts from the managerial conversation with her leader:

> I felt really good with the conversation. She really encouraged me to grow. She was very kind and positive. She really wanted me to excel professionally. I was happy to take on this additional leadership opportunity to help her and the unit. (Participant 8-Managerial conversation)

The nurse felt very positive after the conversation with her leader and this encouraged her to take on more responsibility for both the unit and herself.

The Courage to Assume Responsibility. The courage to assume responsibility involves creating opportunities to add value to the organization and for the follower to act without permission. Participant 1 shared an example from a managerial conversation that occurred during her annual review. The managerial conversation illustrated the ability to create opportunities to fulfill her potential and maximize her value to the organization:

> She (the direct supervisor) took into consideration the fact that I took a doula class and started being a doula in the community. I did not even know that she knew that I had done that. She described everything that I have been doing on the unit and in the community to make a difference. She told me that she would allow me time to do these things in the community. (Participant 1- Managerial conversation)

This nurse was very passionate about her skills and serving her community. She had not sought the leader's permission to take on this role; she just did and was validated when her leader discussed it with her. This nurse's actions supported Chaleff's (2009) research that followers initiate action without being instructed to do so and this is a distinguishing factor of a courageous follower.

The Courage to Participate in Transformation. The courage to participate in transformation is to recognize the need for change and to participate in that change. This includes challenging the leader on abusive behavior when it occurs, as well as, modeling change for the leader. Some examples are

> I received a lot of pushback and resistance, and at one point he was yelling at me. So, I just gave him some space. He came back and apologized for his behavior and asked me about the research. I explained at what point the research (practice) should be started in the patient's trajectory. He said that he appreciated me pointing it out. We then put this into practice on the unit. (Participant 4-Clinical conversation)

> I was about a year and half in and this was the first time that I had to stick up for my patient. Usually there are times where the doctors often listen to you and hear you out and they respect whether you had a relationship professionally. But I felt like this time it stuck out to me because that was the first time that I was adamant and I told the doctor that I was uncomfortable with

> his decision and his behavior. I also told him that we could not work together like this. I think that it helped me grow professionally—sticking up for myself and my patients. He now treats me very differently-very positive. (Participant 18-Clinical conversation)
>
> I felt like she (direct supervisor) was being really aggressive with me. I felt like I needed to stick up for myself and show her how absurd she was behaving. I know that my aggressiveness was not the way to go about it (…) I know that I could have handled it differently but I wasn't going to let the nurses eat their young thing happen (…) I pulled her aside and asked her what was going on...what had I done? She was completely surprised. I told her that lots of people feel she is mean and that she talks down to everyone. She apologized and we have gotten along great ever since. She now checks in with me about her behavior frequently. It feels good to help her see how she was behaving. (Participant 18-Managerial conversation)

The nurses in these examples had the courage to make transformational change in their areas. The above examples from this study supported Chaleff's (2009) finding that in order for transformation to occur the acknowledgement of the need for change must occur. Participant 18 also validated a very important aspect of Chaleff's research; specifically, that the follower must be aware of their need to also change to assist the leader with their change.

In each case, the nurse recognized addressed the ineffective behavior of the leader. The leader accepted the criticism and used the information to participate in transformation. Each conversation resulted in a practice change for both the nurse and the other participant in the conversation.

Summary. Courageous conversations are happening in health care today. This study validated that CF concepts, first identified by Chaleff (2009), are being consistently applied to conversations by nurses with their MD colleagues and direct supervisors in the health care environment. This research also validated that these concepts are allowing the nurses to have the courage to challenge, the courage to take moral action, the courage to speak up to the hierarchy, and the courage to listen to followers during clinical and managerial conversations. The remaining three CF concepts were also validated in this research. The nurse used the courage to participate in transformation, the courage to serve, and the courage to assume responsibility after clinical and managerial conversations to help shape their future practice.

Nurses are finding the courage to challenge the status quo, allowing their voices to be heard and their patients to get the care that they need. The learnings around courageous conversations are the learnings that health care leaders need to pay attention to and take forth into their environments.

Additional Findings

The purpose of the study was to find out if courageous conversations occurred in health care and if so, what situations required such discussions. In speaking with the nurses and hearing their stories, additional findings or connections surfaced. Every courageous conversation was filled with emotions that occurred during and after the conversation. These emotions caused the nurse to reflect on the conversation. Depending on the outcome of the conversation, the nurse took learnings into their future practice.

Conversational and Emotional Findings. The managerial and clinical conversations both induced emotional responses in the nurse during and after the conversation. The emotions that the nurse felt were determined by the way the other participant reacted to the information provided. Satisfactory and unsatisfactory conversations occurred during both managerial and clinical conversations.

Satisfactory conversations evoked positive emotional responses in the nurses leading to better patient outcomes and a positive emotional response in the nurse, such as, “relief and a feeling of being heard.” The only emotional response difference between the conversations was that with positive managerial conversations the nurse reported “acceptance and appreciation of the leader.”

The findings demonstrated many instances of unsatisfactory conversations leading to poorer patient outcomes supporting McNamara’s (2012) research that showed that when a nurse is exposed to ineffective leadership behaviors compromises in patient safety occur. Unsatisfactory conversations led to patient safety concerns and negative emotions for the nurse, such as, “guilt, self-doubt, and the ability to advocate for themselves or their patient.” The negative emotions shared by the participants

supported Cox (2003) and Daiski's (2004) research that when nurses are oppressed because their voices are not heard the nurse has self-doubt and learns not to speak up for safety issues. One of the most revealing examples of the nurse's voice being oppressed comes from a clinical conversation Participant 14 discussed about her interaction with an MD colleague:

> The physician didn't listen to me. He didn't trust my judgement. I began to doubt myself and wonder why I even became a nurse. The doctor just blew me off. I called an RRT (Rapid Response) and the patient was immediately transferred to the ICU. When I took the incident up the chain of command, the next doctor called the first doctor and he (the first doctor) came in right away. Why didn't he believe me? (Participant 14-Clinical conversation)

The unsatisfactory clinical or managerial conversations occurred after the MD or leader shamed or intimidated the nurse. The negative emotions led the nurse to a feeling of "being unheard and unable to further advocate for their patient," resulting in having to go up the chain of command or withdrawing advocacy for that patient. These instances led to poor patient outcomes.

The experience level and educational level of the nurse did not affect whether or not the nurse spoke up for the patient's safety. Nurses reported that they spoke up "regardless of the consequences that they may face for speaking up." The nurses felt that reporting a patient safety concern (speaking up to the hierarchy) was "a duty" and an "obligation" of the profession. All of the nurses (100%, N = 18) reported exactly two changes in their future practice as a nurse as a result of each of the conversations shared.

Impact on Nurse's Future Practice. The conversations had an impact on the nurse's future practice. The top two practice changes for both types of conversations, clinical and managerial, were "speaking up to the hierarchy and advocating for the patient." The impact of the unsatisfactory clinical and managerial conversations additionally helped the nurse learn to "trust their gut instinct and stick up for themselves."

This study also supported Garon's (2012) research that nursing has been oppressed by the hierarchy for being both female-centered and lower on the hierarchical ladder than medicine. Participant 17 shared a story where the MD blamed him for being incompetent and "just a nurse." The nurse in this case was just trying to get the MD the results that he wanted.

> The MD came to the bedside and asked for the lab results. I had sent the blood with the RT (respiratory therapist) because they ran that test now. I explained that the results were not back yet and that the RT was running the test right then. He got mad, called me incompetent and then said I am not even sure why I am talking to you; you are just a nurse. (Participant 17-Clinical conversation)

Satisfactory managerial conversations had a practice implication not noted in the clinical conversations. The positive implications were that the nurse saw their direct supervisor in a different light. The nurses reported that the leaders have "challenging jobs and need support." The fact that the nurses in this study identified that leaders have challenging jobs and need support, validated Wikstrom and Dellve's (2009) argument that leaders in health care have extremely complex jobs.

Additionally, the research supported Corona's (1979) work that demonstrated that nurses can simultaneously be leaders and followers. The charge nurses reported that they took "learnings back from their leaders to apply with their teams." Also, all (100%, N = 18) of the satisfactory managerial conversations included the nurse sharing a learning with the leader, helping the leader to grow.

The impact on the nurses' future practices were determined by the emotions felt during and after the conversation and directly impacted the patient's trajectory. The nurses took these emotional responses both positive and negative to determine how to react to situations in the future. This is the reason that positive conversations need to occur in the health care environment.

Leader and Follower Dynamics. The research determined and supported Heller and Van Til's (1982) and Riggio's (2014) work that reciprocal follower and leader practices determine the dynamics between the leader and the follower. Additionally, this research study validated Baker (2007), Chaleff

(2009), Riggio (2014), Uhl-Bien et al.'s, (2014) research that demonstrated that leaders cannot exist without followers and vice versa. These dynamics determined the relationship between the leader and the follower and ultimately the patient's outcomes. The positive interactions improved patient outcomes and the ineffective interactions led to poorer patient outcomes.

Positive leadership practices as described by the participants, such as, "inclusion in rounds, being respected and listened to" determined the outcome of the team. These positive relational practices encouraged "MD and RN problem solving, trust and RNs feeling like active members of the health care team." When the nurses felt like valued members of the health care team, they demonstrated more willingness to speak up without fear leading to better outcomes for their patients. The study demonstrated that when followers had positive interactions with their leaders, they were more likely to participate more in achieving better patient outcomes. These interactions validated Amagoh's (2009) research that "the effectiveness of the interpersonal process between leaders and followers increases follower's motivations" (p. 991).

Conversely, ineffective practices caused negative outcomes. When the nurse was "intimidated or ignored" the leader and follower dynamics were fractured. The nurse was filled with "self-doubt and fear". When the nurse shared that they felt these characteristics, they were less likely "to speak up, feel like a member of the team, and bring safety concerns forward." This study validated the research of O'Daniel and Rosenstein (2008) that as nurses have attempted to voice their concerns over the past two centuries, they have been faced with intimidation by their medical colleagues.

Leaders and followers are a synergistic team. Their behavior effects behavior of others. Leaders need to be role modeling positive leadership for their followers. Followers need to be empowered to question leaders when orders are unclear or negative or ineffective behavior exists. This is how the health care environment and thus the patient outcomes will improve.

Power Differentials. The data from this study was consistent with the findings of Ramanujam and Rousseau (2006), who expressed that hierarchical structures create power differentials in the environment, especially with communication. This research showed that when the leader and follower dynamic was fractured or unsatisfactory, the nurse had to take the discussion to the leader's one up 80% of the time. While these interactions were "uncomfortable" for the nurse, each instance was done with respect and dignity for the other participant.

The satisfactory conversations between a leader and follower with a positive dynamic resulted in a conversation where the participants (both MD and RN) felt that their relationship improved and they both took learnings away to apply to conversations in the future. The conversations resulted in better future teamwork and collaboration. This future collaboration included education for the staff by the physicians on disease pathophysiology and becoming involved in community events together.

This research showed that courageous conversations are happening every day in health care. Nurses are bringing forth safety concerns to their MD colleagues and direct supervisors. When conversations and leader–follower dynamics are positive, trust and collaboration is built. This positive dynamic directly effects the nurse's emotions and future practice, resulting in better outcomes for the patient.

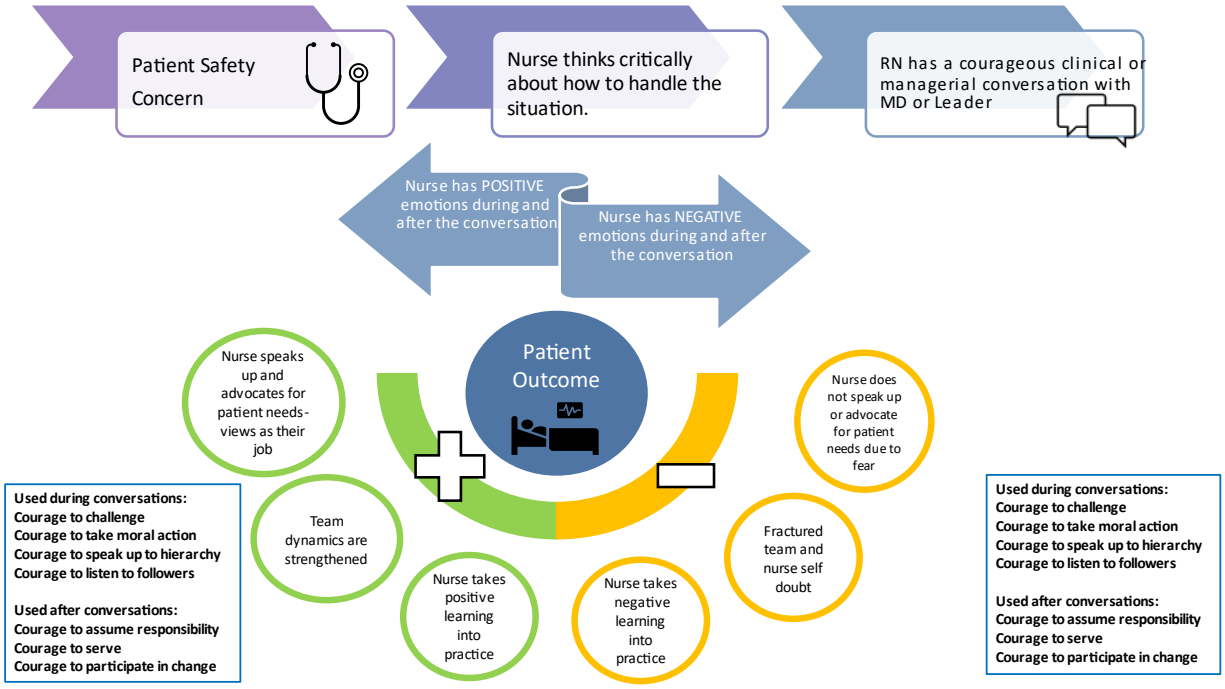
When conversations and leader–follower interactions were ineffective, trust and team dynamics were fractured. These negative events led to the nurse having "self-doubt, being afraid to bring concerns forward, and negative patient outcomes." Ensuring that conversations have satisfactory outcomes are key to positive patient outcomes and positive team interactions.

Summary. This research study demonstrated that courageous conversations are happening in the health care environment. These conversations evoked emotions in the participants and for the nurse these emotions drove their future practice. Negative emotional experiences led to negative

impacts for the patients and nurses. Positive emotional experiences led to positive patient outcomes and nurse growth. This study demonstrated that leader and follower dynamics are key to moving the organization's mission forward supporting the work completed by Chaleff (2009), Kellerman (2008), Riggio (2014), Stech (2008), and Uhl-Bien et al., (2014). Figure 5.2 gives a pictorial display of the courageous conversation and the effects on the nurse and patient.

Figure 5.2

Courageous Conversation Flow



The stories shared from the participants' perspective increased the understanding of the emotionality involved and how team dynamics can determine the nurse's action steps. CF concepts can help steer the conversation between nurses and their physician colleagues or direct supervisors in a more positive and collaborative way. The research established a foundation of empirical knowledge that can guide health care leaders to better understand and help educate those at the bedside to have more

positive communications, leading to improved patient outcomes and positive changes brought to the nurse's future practice.

Practical Applications

As outlined in Chapter II, health care is facing many daily challenges. Collaborative courageous conversations can help improve patient care because the nurse is "the eyes and the ears" at the patient's bedside 24-hours a day. Therefore, if the nurse is "silenced, ridiculed or ignored for bringing forth patient safety concerns," the patient is the one that suffers. However, this research showed that when the nurse is included as a valued member of the team and their opinion is encouraged, positive leader and follower dynamics and trust increased; thus, the positive outcomes for the patient increased. This research supported Lee et al.'s, (2013) findings that positive interactions with team members created positive outcomes for the patients.

The hierarchical structure can create silence for health care providers, including leaders, when they are not treated as contributing members of the health care team. CF is the key to enhancing communication at the bedside because it inspires the courage and permission needed for the follower to empower themselves to speak up for justice or when they have concerns that the orders for their patient may not be correct. CF also provides the courage for the follower to empower their leader to enable the success of the mission.

Leaders may be uncomfortable having their follower help support their growth; however, as the research in this study showed, sometimes the follower comes with a deeper contextual understanding of the patient, more life experiences, or more recent knowledge of best practice, than the leader and can help the leader see the growth needed in a certain situation. CF allows for the leader and the follower to become synergized with their needs for growth. Both benefit from the courage needed to move the mission forward.

Implications for Leadership and Change

Improving leadership skills and navigating change are two areas that leaders struggle with in their practice. Leaders are continually looking for ways to connect with their staff and lead them through the challenging health care landscape. CF might be just the answer to both of these concerns.

Leadership. There are four important "take-aways" from this study for leaders and leadership: (a) leaders need to recognize the important roles that followers play, (b) leaders need to be having open candid conversations with their followers, (c) leaders need to change the culture in healthcare, and (d) leaders need to allow and encourage the follower to help them grow. Courageous followership is key to these outcomes.

Leaders need to recognize that followers are important and should be considered just as valuable as the leader. This study corroborates Kellerman's (2008) and Riggio's (2014) work that validated that the follower is a valuable asset with ideas and the ability to drive change. Followers in this study were at the center of many change efforts. Followers can be driving forces for environmental change; enhancing the leader's efforts and abilities.

Leaders need to allow their followers to speak openly about safety concerns in the health care environment. In a hierarchical structure, communication is challenging and "scary." However, if leaders and followers are having "routine" conversations frequently, then when serious safety concerns arise, the task will be easier. Nurses in the study felt it a "duty and an obligation" to speak up for their patients, regardless of what the outcome was for them personally. At times they were met with "intimidation, belittling, or anger" for speaking up and yet they found the courage to forge on. When communication was effective, trust in the team was primary. This connection of effective communication and trust in team validated Menaker's (2009) research study. Leaders need to ask themselves why they may have had a negative reaction to a safety concern that was brought forth by a

follower. It is my hope that in the future, conversations do not have to be courageous just collaborative and respectful.

Leaders set the tone for the work environment. It has been said that "what the leader permits, they promote." Therefore, if leaders are not role modeling courageous conversations, then followers will probably not understand the importance of enhanced, respectful communication in the health care arena. The environment and culture need to be one of open, collaborative communication, where leaders and followers can have discussions about patient care without blaming or fear of retribution. Leaders need to be watching for the red flags of bullying and oppression as these behaviors lead to poor patient outcomes because the nurse has self-doubt and then learns not to speak up. It is only with open and direct communication that patients can be ensured that they are getting the care that they need and deserve.

Because of their complementary knowledge and professional experience, nurses can easily rotate between leader and follower in one shift. This research study validated Corona's (1979) belief that nurses are both leaders and followers in one shift. Individual nurses and the team are expected to adapt and respect each other's changing roles. This shifting between leader and follower further illustrated the need to ensure that communication is effective at all levels in the hierarchy. Nurses in this study discussed that as they had these conversations, they were able to see the positive and ineffective practices that their leaders role modeled. The participants stated that they were able to take the positive role modeling into their practice and were more alert to the ineffective practices role modeled by their leaders.

Leaders need to allow the follower to help them grow as a leader. Giving the leader feedback and helping them grow is one of the duties of the follower. Leaders need to be receptive and open to feedback from followers about their performance. Each individual comes with different life experiences

and ways to handle interactions. Leaders and followers need to be open to learn from each other. It is only then that the mission can be accomplished collaboratively.

Courageous followership encourages courageous conversations. These courageous conversations serve as a check and balance system for the environment. The follower in the hierarchical health care environment is encouraged to speak up and challenge if the values of the mission are not being supported. When done respectfully, this creates a team dynamic built on trust and collaboration, which is the environment that most leaders are searching for their teams to practice. Conversely, when not done respectfully, nurses feel demeaned and devalued and then have a harder time advocating for their patient's needs and for themselves.

Main Implications. Leaders have very challenging jobs and the identified behaviors in this research are ones that leaders need to embrace. Leaders need to be open to feedback. Leaders need to listen to their followers, even if the follower has concerns about the leader. The leader needs to accept the feedback and internalize the criticism. If the leader cannot accept the feedback, then they might be missing out on certain environmental cues from followers.

Leaders need to recognize the follower as an important and valuable member of the team. Leaders need to form collaborative and respectful relationships with followers that can promote and enhance change in the environment. When the follower is recognized and valued, the ability of the leader to perform is enhanced.

Leaders need to role model courageous conversations in the environment and change the tone in the environment to make it conducive to problem solving and positive interactions. Leaders need to be alert to bullying and oppression leading to nurses feeling unheard and becoming filled with self-doubt. When nurses feel this way, they are less likely to speak up leading to poor patient outcomes.

Leaders are key to successful leader–follower relationships. When the leader and follower are collaborative and honest, the mission is easily achieved. The leader and the follower need to empower each other to grow and achieve positive patient outcomes. CF is the key to ensuring that the leader and follower are successful.

Change. Currently, the health care community is in crisis. Financial, technological, staffing shortages, and leadership challenges abound. The average healthcare leader is unprepared to adapt to change (Porter-O'Grady, 1997). Today's leader needs to be armed with proven leadership techniques that help them and their staff navigate the everchanging environment. The leader needs to be in constant communication with the "front line" follower. The follower needs to be helping the leader be the best that they can be. It will only be together, empowering each other, that they can make a difference for the patient and bring a change forth into the environment.

Change requires patience and the courage to be different, leaving old time-worn practices behind. CF helps instill the aspects of change and respect into the leader–follower relationship. This study demonstrated that when the leader and the follower can combine forces, they make a difference in the health care environment validating Lippitt's (1982) work that found shared accountability leads to shared outcomes. They can empower each other to have more enhanced communication, trust and understanding leading to improved health care outcomes and quality for the patient.

Courageous followership encourages change throughout the hierarchical structure. This research study focused primarily on change at the follower level; however, courageous followership encourages change at all levels, especially issues of social injustice and inequity. CF encourages putting a voice to change—speaking up for moral injustice or speaking up when the leader's position is not the right thing to do (Chaleff, 2009). This research study illuminated putting a voice to change, when Participant 5 felt like she had to speak up around an ethical dilemma so that her patient and family

would be spared from further suffering. Participant 10 spoke up when she noticed her leader was allowing visitors for some patients and not for others. This situation created inequity for the other patients on the unit. These nurses were courageous enough to speak up, take moral action and change the environment.

Courageous followership encourages followers and leaders to create and embrace change. Changes can be small like instituting a new clinical practice on the unit, as Participant 4 did or as large as helping to change a leader's behavior so that they are creating a more welcoming space for conversations as Participant 18 did with her MD colleague. Imagine if a nurse was afraid to have a courageous conversation with an MD colleague when their patient is in clinical decline or an abusive situation. Nurses and physicians are bound by law and their oaths to care for patients and do no harm. Not advocating and speaking up for your patients can create moral and ethical dilemmas as well as social justice concerns, especially if the patient is in a vulnerable population.

Primary Implications. Courageous followership can change the health care landscape for leadership and change. CF encourages empowerment of the leader and the follower to be more successful. Together the leader and the follower can transform the environment.

CF promotes challenging the status quo and taking moral action to improve and change the environment. Whether the follower is helping the leader to see how they can behave differently or together how the leader and the follower change the environment for the patient, the leader and follower's positive relationship dynamics can make change in the environment.

All of these actions will improve the care that the patient receives, thus improving the patient's experience and health. That is healthcare's mission—to improve the patient's health and experience. Together, the leader and the follower can create change.

Recommendations for Action

The recommendations for action include adapting CF to the health care environment, training through story-telling and role modeling, and treating nurses as valuable members of the health care team. CF is transferable to any discipline and should be the primary training for multidisciplinary communication. As the leader and follower empower each other to communicate differently, the health care environment and the patient outcomes will drastically change for the better.

In order to comply with the IOM (2001) call for health care practitioners to provide care that is safe, effective, patient-centered, timely, efficient, and equitable enhancing bedside communication is paramount. CF has the opportunity to provide the ability for leaders and followers to empower each other by having courageous conversations to help reach the mission's goals. This study identified several recommendations how CF can become the new form of communication for health care:

- Adapt CF concepts to the health care landscape to encourage courageous conversations
- Train different disciplines on CF concepts and how to have courageous conversations together to develop multidisciplinary collaboration and trust amongst the team
    - Tell stories to highlight important conversational techniques and outcomes
    - Train leaders to role model CF in the workplace
- Appreciation for nurses as valuable team members

Adapting CF Concepts to the Health Care Landscape

Health care conversations need to be courageous and collaborative, throughout the entire team. Courageous conversations help empower those lower in the hierarchy to raise up issues to those higher up the chain. The nurses in this study showed that when a follower, lower in the organizational chain, is able to speak up, they are able to fulfill their potential and by repeatedly being courageous maximize their value to the organization.

High Reliability Organizations (HROs) are those organizations that focus on avoiding mistakes and catastrophes. HROs focus on providing a non-blaming culture so that staff can speak up for safety. Many of the characteristics of HRO practices mirror those of courageous followership such as speaking up, and deferring to expertise (PSNET, 2017). Courageous followership is a natural partner to the HRO work that most health care organizations have previously adopted. This study validated that courageous followership can help nurses enhance their voice to speak up for safety.

HROs provide highly structured guidelines to ensure success in the health care environment. In order for courageous followership to be successful in the health care arena, it will be imperative to provide stringent training and role modeling. Adapting this type of training will set the organization up for success, ensuring all are aware of the protocol for successful conversations. Supporting Kelley's (2008) work, entire curriculums need to be developed that teach courageous conversations and their importance to the environment.

Leadership and followership do not need to be considered separate leadership constructs. In health care, leaders and followers can be one in the same person. Training should not be a separate entity for leaders and for followers. It is time for leadership training and optics to move to the next century, ensuring inclusivity and wholeness.

Training for CF in the Health Care Environment

The hierarchical structure can create silence for health care providers, including leaders, when the follower is not treated as a contributing member of the health care team. Important patient information can get lost when communication is hampered. The nurses in this study created courageous conversations so that their voice and their patient's welfare did not get lost.

Employees have to be empowered to know that they will be supported by their leader to have courageous conversations. Education can only get an employee so far in the process. Employees must

feel comfortable to speak up in these challenging situations, knowing that their direct supervisor and those up the chain of command support this speaking up. Followers need to see their leaders doing the same.

Training in health care generally occurs by discipline. Very little, if any training occurs where MDs, RNs, therapists, and chaplains are all together in one room. Certainly, the direct supervisors are not present at the training sessions either. Just training the leaders will not help to ensure that communication up the hierarchy is occurring. Shared accountability leads to shared outcomes.

Because each discipline brings their own culture, the cultures must be melded together to create a new synergy. In order to instill CF into the health care environment, training around the CF principles would need to occur together. Being trained together would create the synergy needed for the betterment of patient care and positive team dynamics. Also, training together would help the team members see what each other's roles are and how to come together as a team. Training leaders and having them role model the tenets of CF is needed in the health care environment. Followers need to see the effort leaders are putting into training and improving their leadership skills and effectiveness.

Telling Stories as a Training Method. This research provided a wealth of information from stories. Health care workers like to share stories as their way of analyzing a situation (Butterfield et al., 2005; Byrne, 2001). Stories were shared that revealed that what leader and follower practices looked like, what team dynamics influenced positive and negative patient outcomes and that emotions revealed helped to determine the course for the patient's trajectory and the nurse's future practice. Stories are told because people want to share meaningful things that have happened to them. In the case of this study, the stories and the emotions that the participants felt because of what occurred during the story provided changes for the nurses' future practice.

Byrne (2001) and Kemppainen (2000) shared in their separate research studies that nurses need to share stories, with both positive and negative outcomes, to determine what specific behaviors help make certain decisions. In this research, nurses were able to share positive and negative stories to relay the conversations that they experienced. Falk (2021) stressed that stories can "reduce defensiveness, teach complicated concepts, change individuals' behavior and promote social change" (p. A 24). There are medical reasons for these behavioral changes.

Stories are processed differently from other types of information. An individual's attitudes, experiences and starting assumptions shape the way their brain interpret stories. When people have the same starting assumptions, their brains respond in similar ways to stories and synchronize more with others who share those assumptions than with those who do not (Falk, 2021). Stories give individuals the opportunity to see the world a little differently, provide motivation to care, to instill values and to change the environment. Therefore, learning together as a group can create more cooperation, a deeper way to connect with the team.

Training together as a multidisciplinary team, using stories to illustrate courageous conversations, will enhance team dynamics and help the individuals learn about their teammate's roles and responsibilities. Talking through scenarios or stories about real life situations will help create team problem solving, create empathy and build trust. Therefore, when the situation occurs in real life, the team will already know how to respond together. Training methods for instilling CF in to the health care environment need to be centered around storytelling and debriefing after courageous conversations so that all share in the learnings.

Training Leaders to Role Model Courageous Conversations. Leadership is the most important aspect of an organizational culture (Nica, 2015). Therefore, when the leader focuses on something, the followers understand that is what is important to the leader. Leaders need to understand that

communication at the bedside is the most important thing to preventing medical errors and connecting with their followers. When the leader and follower feel support from each other, the leader and the follower can change the health care environment for the better.

Leaders need to understand the importance of story-telling and training together. Just like HRO, entire training sessions for CF need to be developed for training and role modeling by senior leaders in each organization. It is only when each follower feels comfortable speaking up, that true collaborative care can be possible.

Nurses, are Valuable Members of the Team

Nurses are trained to care for others. When this ability to care for others is compromised in anyway, nurses will leave their work, unable to fulfill their mission. Participant 8 shared her need to leave a position because of the environment. This supported Simon's (2008) research that demonstrated when nurses do not feel valuable, they will leave their positions. Nurses shared stories in Chapter IV about their "inability to speak and to be regarded as valuable members of the team." Several shared how this "lack of being included, not being heard or being ridiculed" effected their "self-worth and ability to perform." When a nurse, the eyes and ears for the patient, cannot perform then the patient suffers.

Nurses should not tolerate or promote bullying and should strive to be collaborative and cooperative with all caregivers that they interact with for the betterment of the patient. McNamara (2012) discovered that when a nurse is exposed to bullying behaviors, negative outcomes such as medical errors, compromises in patient safety, impaired quality of care and withdrawal of care occur. This research validated McNamara's finding that when nurses were exposed to bullying behaviors, patient outcomes were negative. When this behavior is seen in the environment, this is a red flag for health care leaders to change the environment and model the behavior needed for positive patient

outcomes. Nurses in this study described the negative outcomes for the patient when they were "unable to be heard." One nurse left the clinical unit that she was working on because she was never regarded as a valuable member of the team not being able to speak up with her concerns. She felt that working there created a safety risk for her patients and therefore left.

Leaders need to appreciate that when nurses feel oppressed because their voices are not heard "at the table," the nurse begins to have self-doubt and learns not to speak up for safety issues. When nurses do not speak up for patient safety, patient outcomes are jeopardized. As health care leaders, empowering staff (MD and RN) to speak up when there are clinical challenges is the best communication tool a leader can teach their staff. As leaders it is our responsibility to ensure that the environment is conducive to having courageous conversations.

CF provides the opportunity for nurses to be trained to have the courage to speak up, to challenge, and to participate in change. To know that, as Participant 10 shared, "OK, this isn't enough, I need more" is an appropriate response to make to a physician when the orders do not feel like the proper ones for the patient. Nurses need to find the courage to speak up and the leaders (MD and direct supervisors) need to support them and not ridicule the nurse for speaking up.

When nurses are not treated as valuable members of the health care team by being bullied and excluded in care, negative health care outcomes: medical errors, compromises in patient safety, impaired quality of care, and withdrawal of care occur for the patient. It is time for the nurse to be viewed as a visible and valuable member of the medical team by medical staff and health care administrators. Nurses need to heal from being excluded and join together to change the system that devalues the nursing voice. CF is the key to enhancing the nurse's voice, allowing them to speak up for patient safety.

Recommendations for Further Study

Many health care leaders (both MD and RNs) have been promoted because of their clinical skills, not necessarily for their leadership acumen. This practice has continued to instill the oppression and the hierarchical mentality as opposed to the open-minded, communicative leadership needed right now in health care. Leaders need to be armed and ready to support their followers to meet today's health care challenges. This will require courage—courage from the leader and the follower to change the environment for the better.

As CF gets applied to health care leaders, further research is needed to determine if CF is the new enhanced shared leadership for nursing of the future. Shared leadership enhances the nurse's participation in creating an environment of the practice of nursing. CF gives the voice of the nurse courage to speak up and take moral action when needed. This is the level of communication that is needed at the bedside.

This research was completed on a very small sample in a localized area of the United States. The study needs to be replicated with a larger participant pool in diverse areas of the country to determine if results are similar. While the diversity of the participants was broad, the study needs to look at more male nurses, nurses with an African American, Asian, Pacific Islander, and Indigenous background to determine if there are further gender or cultural differences in the ability to have the conversations.

The study focused on nurses with only 3–5 years of experience. Studies needs to be conducted on other levels of experience as well to determine at what stage in their professional career the nurse starts to have these types of courageous conversations. Then learning can be established for the particular stage of development, before these conversations start, to enhance the nurse's understanding of the environment and how they can help shape it.

This research study was conducted at one point in the nurse's career trajectory. Studies should be completed at different stages, with different healthcare workers such as therapists, junior physicians, and other leaders to determine if the outcomes are similar. Interestingly, studies should be completed longitudinally over the life of a nurse's career to see if conversations change over the course of their career.

Different other qualitative research strategies can also be employed to further insight into courageous followership. An ethnography would be valuable to study the culture of the healthcare environment and the lived realities that the employees face. Case study review would also explore conversations over a period. Additionally, a phenomenological research study would be beneficial to identify the lived experience of courageous followership as described by the participants.

Mixed-method research would be beneficial to determine all possibilities and connections the data brings forth. For instance, adding a survey to follow up the interviews to determine the intensity of emotions felt on a 5–point Likert-type scale could be beneficial. As quantitative methods do not capture the emotions or thoughts of the participants, those methods should not be the primary methods to determine this type of research outcome. However, quantitative methods as described can add valuable insight into the research.

Personal reflection

This research was one that I really enjoyed completing. As I started as a PhD student, the research process was something that was overwhelming to me. However, the more I delved into the methodology, the more excited I got about completing this research. As a health care professional, I feel that this research will make a difference in the health care community.

I was concerned about my ability to remain non-biased with this topic. Being a nurse, I came with my own biases about nursing, MDs, direct supervisors, and the healthcare environment. Early in

the interview process, I had to remind myself that I was talking to these professionals as a researcher and not as a leader, coach, or mentor. I also had to keep my emotional reactions to myself. The more I spoke with the participants the more comfortable I became with being a researcher. Yet, sometimes when I heard stories about the way the nurse was treated or the outcome for the patient that could have been avoided, I admit that I had an emotional response and had to watch my facial reactions. I had to remind myself that I was looking for ways to help nurses, patients, and the health care environment in the future. It was important that I remained non-biased and not to lead the participant to a certain conclusion or just agree with their assessment of the situation.

I was truly shocked at the oppression that still exists for my health care colleagues. However, I was extremely proud of their courage in tackling incivility in the workplace. The courage they showed advocating for their patients on a daily basis was inspiring. The duty that they felt to heal their patients was impressive. I am so proud to call myself a nurse and it is an honor to work beside such courageous professionals.

I also had to put myself in the place of the other participant in the conversation. In a negative conversation, what led them to behave the way that they did? What had their experience been in the past to treat their colleagues like this? Did they not understand the damage that was done to the nurse and the patient? When positive conversations occurred, I was so thankful and so happy to see the growth that the nurse described in themselves and many times in the leader that they helped grow. These thoughts really drove me to get to the heart of the matter—to find a solution to drive better patient outcomes and more positive health care environments.

As a young nurse, I worked in a very toxic environment. I was taught to conduct myself with certain uncivil behaviors towards others. I had to fight to get my voice heard. Was that what happened to the other participants in these conversations? Did they not have mentors to show them how to have

conversations with others? Was it just ego? All I know is that the health care environment must change now. Nurses are leaving the profession for a multitude of reasons. The fact that they cannot advocate for the patient because their colleagues will not listen to them should not be one of the reasons.

I hope that others find this research helpful and will take the lessons learned here into their practice. It will take all of us working together to improve the health care environment. Our patients deserve the best team that they can get to heal. We owe it to them.

Conclusion

This research study sought to understand from the participant's perspective if (a) courageous conversations were happening at the bedside with nurses MD colleagues and direct supervisors, and (b) if so, what situations required the use of courageous followership concepts. Through the use of Constructivist CIT, 18 nurses were interviewed and shared stories about conversations with the MD colleagues or direct supervisors that they remembered and were meaningful to them. The stories were then coded and themed and then scanned for the use of CF concepts.

Courageous followership concepts as identified by Chaleff's (2009) research, were being used by nurses in conversations with their MD colleagues and direct supervisors. These courageous conversations happened in clinical situations when the nurse needed to speak up to the MD to validate the patient's plan of care or to challenge an order for patient care. Courageous managerial conversations are also happened with the nurse's direct supervisor when they were having annual reviews or disciplinary conversations with their follower.

This study validated that communication remains one of the biggest challenges that health care leaders face. The fact that communication in the healthcare environment is still a major problem supports the findings of the IOM (2000), Leach (2005), O'Daniel and Rosenstein (2008), and Ramanujam and Rosseau (2006). Communication up and down the hierarchical chain, collaborative communication,

and miscommunication or lack of communication due to the nursing voice being hampered continue to exist and lead to problems with patient safety, improved quality outcomes, and nurse confidence.

The outcomes of this study are significant to all leaders. Courageous followership is a model that encourages open, honest communication between leaders and followers. This is an important leadership construct so that leaders can help change the environmental culture to one where every team member is valued and their voice is heard. Courageous followership allows and encourages the leader and follower to grow together. This ensures that the mission, of positive patient care, can be met.

This study is aligned with Roberts's (1983) finding that the healthcare environment oppresses nurses when their colleagues do not listen to them and do not treat them as valuable members of the healthcare team. Nurses need to be treated with respect and valued as members of the healthcare team. This study also clearly showed that when nurses' voices are hampered, patient outcomes are poor; validating McNamara's (2012) research on nurse treatment and patient outcomes.

Courageous followership encourages change in the environment. This study noted that nurses used CF to help their leaders change their communication style, to change the clinical environment that they worked in, and to help promote social justice and equality in the larger community. The fact that nurses were using CF concepts to change the environment supported Chaleff's (2009) and Lippitt's (1982) research of the follower being empowered to change the environment. CF helps to put a voice to the change that is needed in health care.

This study also validated Kellerman's (2008) and Riggio's (2014) work that the follower needs to be considered just as important as the leader. Leaders need to recognize that the voice of the follower is important and can help drive change in the environment. Education should not be leader-centric but

inclusive of the entire team. Training leaders and followers together unites the two into a synergized team.

In order for CF to be beneficial to those in health care, the recommendation from this study is to train health care team members together to CF through storytelling. Training different leaders together supported Kelley's (2008) work to encourage courageous conversations. Storytelling encourages empathy and synergy. Falk (2021) noted that when team members learn together, they are able to communicate easier and learn from each other. This study showed that when leaders and followers shared their stories, they were able to learn from each other and understand the other's work. This shared learning gives the team the ability to handle situations easier in the future.

Courageous followership encourages open and honest communication in a hierarchical structure like health care. Leaders struggle with ensuring positive quality outcomes for their patients and strong connections with their followers. CF provides the basis for communication to address positive patient outcomes through positive communication with their followers.

Health care is in crisis. Leaders can no longer wait to change the environment. Leaders and followers need to act together to move the mission of the organization forward. The time to act is now. As leaders, our patients and staff deserve the best that we can give them. Courageous conversations are the way to empower followers and leaders to be successful.

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Appendix A: Interview Questions

The following questions helped me to better understand the point of view of the participant. Further review of my questions with my methodologist and outside expert completed my list. The questions that I asked my participants are as follows:

1. Please tell me about a specific clarifying conversation that you had with your direct supervisor or a physician whose patient you were providing care for.
2. Where did this conversation take place?
3. What led to you having this conversation?
4. What did you take away from this conversation?
5. Why do you remember this particular conversation?
6. What is your relationship with this colleague- direct supervisor, physician?
7. Please describe your relationship with this colleague before the conversation occurred.
8. How long had you known this colleague before the conversation occurred?
9. Did this conversation shift the relationship that you had with this colleague? If so, please describe.
10. How many years of practice as a nurse did you have when this conversation occurred?
11. Did this conversation influence your future practice as a nurse? If so, please describe.
12. What were you feeling during and after the incident?
13. Is there anything else that you would like for me to know about this conversation?