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EMPIRICAL STUDIES

Relationships influencing caring in first-line nursing leadership: A visual hermeneutic study

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Abstract

Aim: To explore and interpret relationships that influence caring in nursing leadership, in the context of Nordic municipal health care, from first-line nurse managers' perspectives.

Design and method: We chose a visual hermeneutic design. A three-stage interpretation process outlined by Drew and Guillemin, based on Rose, was used to analyse drawings and the following reflective dialogue from three focus groups, with a purposive sample of 11 first-line nurse managers. The study was conducted from February to May 2018.

Results: The findings demonstrated that first-line nurse managers struggled to balance their vision with administrative demands. Caring for patients implied caring for staff; however, they often felt as if they were drowning in contradictory demands. First-line nurse management could be a lonely position, where the first-line nurse managers longed for belonging based on increased self-awareness of their position within an organisation. Superiors' support enabled first-line nurse managers' in their primary aim of caring for patients.

Conclusion: First-line nurse managers showed deep roots to their identities as nurses. Caring for patients included caring for staff and was their main concern, despite demanding reforms and demographic changes affecting leadership. Superiors' support was important for FLNMs' self-confidence and independence in leadership, so the first-line nurse managers can enact their vision of the best possible patient care. This study adds knowledge of the significance of caring in nursing leadership and the caritative leadership theory.

Impact: In order to recognise FLNMs as vulnerable human beings and provide individual confirmation and support, a caring organisational culture is needed. FLNMs need knowledge based on caring and nursing sciences, administration and participation in formal leadership networks. These findings can serve as a foundation for developing educational programmes for nurse leaders at several organisational levels.

KEYWORDS

caring, caritative leadership, hermeneutic, municipal healthcare, nursing leadership, visual methods

INTRODUCTION

Leadership in healthcare services has traditionally been part of the nursing profession [1]. Nursing leadership involves ensuring patients receive the best possible care and seeing the alleviation of patients' suffering as the main motive for care [2-4]. Staff nurses' primary relationships are with patients; however, nurse managers must focus on working together with staff to accomplish shared visions of the best possible patient care. Further, workplace relationships are key to developing a caring culture [5], where the first-line nurse managers (FLNM) themselves have a responsibility to establish good relationships in order to lead nursing care. This study was part of a larger research project on caring in nursing leadership [6, 7].

Background

First-line nurse managers in municipal health care

This study provided perspectives from FLNMs, who are at the managerial level closest to patients and staff. FLNMs are essential in healthcare organisations [8-10] and articulate the unique role of nursing in complex, corporate healthcare systems in caring for patients [2, 4, 11-13] and facilitating organisational goals and objectives [14, 15, 16, 17]. Evidence has demonstrated FLNMs' direct impact on organisational performance where nursing leadership is connected to patient satisfaction, preventing adverse events, and alleviating suffering related to care [14-19]. Clinical presence enables FLNMs to know patients' needs; thus, their perceptions can ensure quality care [7].

FLNMs also play an important role in staff retention, satisfaction and well-being [20-23]. Having a professional, supportive, accessible and approachable leader is emphasised when building a caring culture is seen as the leader's responsibility [5, 24].

FLNMs lead municipal health care (MHC) with a rapidly growing, multimorbid older population with complex and expanded care needs [25], which indicates increased pressure on welfare capacity [26], The Nordic welfare model is financed through the tax system. MHC belongs to the primary healthcare level and provides services to anyone based on their care needs, regardless of gender, age or financial situation. Seniors receiving some form of home health care are the largest recipient group. Several reforms, strongly influenced by New Public Management, regulate a desired shift towards strengthened primary health care aimed at reduced use of hospitalisation and nursing homes [25, 27-30]. Responsibility for implementing reforms is delegated to FLNMs [31, 32], and 'being stuck in the middle' describes the daily conflict they experience [33-35], due to several, sometimes contradictory, demands [9, 36]. An increased focus on budgets may obscure emphasis on advocating and caring for patients in nursing leadership [2, 5-7, 13, 18, 37, 38]. Thus, empowering FLNMs is crucial for enabling nursing teams to deliver high-quality care, as caring administration is reminding all stakeholders of patients' suffering [2, 5, 35, 39, 40]. Supportive relationships with superiors influence job satisfaction [41], affect turnover intent among FLNMs [8, 42] and can make the FLNM position more attractive [36]. To the best of our knowledge, research is scarce on the relationships that influence caring in nursing leadership from FLNMs' perspectives; therefore, this topic requires attention.

Theoretical perspective

The theoretical perspective for caring in nursing leadership is based on the theory of caritative leadership that originated in the motive of caritas and is derived from the concept of humanistic caring and service [2]. This theory differs from other leadership theories, because caritative leadership connects caring and nursing administration. A caritative leader needs expertise in both nursing and administration, combined with competency in caring sciences, so that ministering to the patient can be implemented in leadership. A caritative leader facilitates a positive atmosphere and develops nursing care continuously, together with staff [34]. The ethos of caring in the workplace and relationships between leaders and staff are based on, and motivated by, the same interest – ministering to the patient. These relationships evolve into a culture of availability, openness and hospitality [2, 5, 43, 44].

THE STUDY

Aim

This study aimed to explore and interpret relationships that influence caring in nursing leadership, in the context of Nordic MHC, from the FLNM's perspective.

Design

The research design was qualitative, hermeneutical, using visual methods combined with focus groups.

Method

Drew and Guillemin's [45] three-stage interpretation process, based on Rose [46], was used to analyse drawings and the

following reflective dialogue from three focus groups, with a purposive sample of 11 first-line nurse managers.

Study setting and participants

The empirical foundations from our previous research were from Nordic countries [6, 7]. Even if these countries are comparable to each other, due to citizens' rights to public health care, we wanted to further explore, expand and maximise the nuances and eventual different perceptions in relation to the phenomenon 'caring' in first-line nursing leadership. A purposeful sample of FLNMs was invited to participate, holding first-line managerial positions in three Nordic welfare countries: Finland, Norway and Sweden. We conducted three focus groups, one from each country, ranging from three to five participants. FLNMs should have work experience for more than 1 year, represent both urban and rural municipalities, speak the Scandinavian language fluently and participate voluntarily (Table 1).

Data collection

We chose drawings as the main data collection method, followed by reflections as part of a focus group [47], to explore and illuminate meaning [48, 49]. Visual methods take participants seriously as knowers of their own reality and provide an opportunity to produce images that depict what might be difficult to express only in words [45, 46, 50]. Visual methods might enhance data richness, encourage reflection and improve the quality, relevance and trustworthiness of focus group interview data [50-52]. Further, interpretations of images [53] may contribute to self-reflection, add depth to dialogue and make relations more concrete [46, 50, 52-56], indicating potential as a means of supporting other qualitative methods [50].

Data were collected from February to May 2018, in quiet rooms at the participants' workplaces, at a mutually agreed upon time. Initially, participants took part in an explorative focus group on caring in nursing leadership, reported elsewhere [7]. After a break, each of the 11 participants was provided with unlined A3 paper sheets and a packet of 12 crayons. They were only encouraged to visualise their understanding of significant relationships influencing caring in nursing leadership at their workplaces, without any further instructions or questions. Subsequently, they were asked to describe their image for us and other focus group participants. This session lasted for 1.5 hours and was audio recorded. Study data included 11 drawings, 25 pages of verbatim transcripts of participants' follow-up descriptions, 34 pages of RS' (first author) interpretations and reflections of the drawings.

TABLE 1 Participant Characteristics

Age	Gender	Profession	Additional education	Time practicing as nurse	Time in a leadership position	Percentage of time resources available for administration
33–61 years Average: 50.3 years	Female	Nurse	None: 4 Nursing: 3 Administration or leadership: 4	3–37 years Average: 22.9 years	1–34 years Average: 13.3 years	FG1: 100% FG2: 20% FG3: 100%

RS and AK (third author) were present for all focus groups. RS served as moderator, led the sessions, encouraged participants to draw and facilitated an open atmosphere during reflection. AK co-moderated by being supportive and adding questions to deepen the reflections and discussions. [57, 58]

Ethical considerations

The Norwegian Centre for Research Data approved this study (NSD: 59117). Permission to conduct this study was provided by FLNMs' superiors; however, FLNMs decided on their own to participate. They received written and verbal information on the study, provided signed informed consent and were ensured of their right to withdraw from the study. We were concerned about possible harm or threats to confidentiality when using visual methodologies or sharing and discussing the drawings, or if there were possible ethical risks involved [55]. Participants were invited to discuss any ethical concerns; however, no problems were raised.

Analysis

Gadamer's [59] hermeneutic philosophy guided this study, as we strived for openness and understanding. However, Gadamer [59] does not offer a method but theorises on the subject of preunderstanding, historical awareness, the fusion of horizons and the hermeneutic circle. Thus, he emphasises the importance of becoming aware of one's preunderstanding before the process of understanding begins, and the preunderstanding will influence the emerging of a new understanding. Our preunderstanding was characterised by our range of vision at this point in life [59], shaped by our theoretical backgrounds, previous studies [6, 7] and two of the researchers' extensive experience as previous nurse leaders. We reflected upon our preunderstandings prior to data collection individually. After each session, the first author RS made notes concerning the interviews, focusing on the preunderstanding, particularly where they may have changed and discussed this with AK [60].

The analysis was iterative in the hermeneutic circle by continuous reflective and theoretical dialogues, in the research team. We searched for alternatives and returned to data in a lengthy process, allowing data to remain open to divergent interpretations. Gadamer [59] acknowledges the multiplicity of meanings, never fully revealed. As many drawings and citations as possible were included to maintain the context and allow transparency.

To guide the analysis, methods by Drew and Guillemin [45], based on Rose [46], in combination with Gbrich [56], were chosen. They describe three stages:

1. Meaning-making through participant engagement,
2. meaning-making through researcher-driven engagement and
3. meaning-making through re-contextualising [45, pp. 58-59).

Each stage is inevitably limited; they are cumulative and together provide rich and rigorous analysis. The stages, with sub-themes and themes, are described in more detail in Table 2. Drawings, interpretations and reflections were transcribed verbatim and simultaneously analysed, although understood as inextricably linked [61]. Through the drawing process, participants began to reflect on their understanding of relationships affecting leadership. This can be described as a hermeneutic spiral for gaining understanding and triangulating of data. A new horizon of understanding was gained in each phase: first, for themselves when they drew; second, as a group when explaining their drawing and reflecting upon other drawings; and third, for the researchers throughout the process. During this interpretation, our preunderstanding was challenged, making room for a new horizon of understanding.

FINDINGS

Our findings are presented in Table 2, according to the three non-linear stages of interpretation. The authors placed text-boxes in the drawings to explain them and exemplars of retrieved quotes from participants. The handwritten text on the drawings was translated into English and can be found in the stippled text boxes. Participants' drawings and scraps that were sections of the drawings are offered to illuminate the analysis.

In their drawings, participants mostly used boxes or circles as symbols for various organisational factors and structures influencing leadership. Lines, as well as one-way and two-way arrows, were used as symbols to represent relationship and communication lines. All participants had the same access to crayons and paper; however, most drawings were not very colourful, resembling sketches often seen in organisational models.

Stage 1: Struggling to balance visions and demands

Struggling to balance visions and demands was our main theme from the first stage of meaning-making from participants' perspectives, emerging from three sub-themes: 'I carry the patient in my heart in everything I do', 'when I care for staff it means I am caring for patients', and 'I am drowning in incompatible demands, where no one sees me'.

TABLE 2 The three stages of analysis according to Drew and Guillemin [45, pp. 58–59]

Stages	Analysis	Sub-themes	Themes
1. Meaning-making through participant engagement	Watching and reflecting on drawings and analysing participants' interpretations and reflections when describing their drawings ('the text')	I carry the patient in my heart in everything that I do. When I care for staff it means I am caring for patients. I am drowning in contradictory or incompatible demands, where no one sees me	Struggling to balance visions and demands
2. Meaning-making through researcher-driven engagement	Close analysis of drawings and interpretations and reflections supplemented by fieldnotes from the focus groups. We looked at the drawings and discussed them based on Rose's [46] questions. Examples of questions: 'What are the components of the drawing'? 'What relationships are established between the components of the image visually'? 'Is there more than one possible interpretation of the image'? We added questions based on Gbrich [56], such as: 'What social signifiers or signs are linked to or embedded in the image'? 'How do such signs impact and effect the image'?	Increased self-awareness of FLNMs' positions in the organisation Longing to belong FLNM as a solitary position without supportive relationship	FLNM's loneliness and longing to belong
3. Re-contextualising	We focused on theoretical and analytical explanations of our data. We reviewed the drawings and re-read the data from the two previous stages This approach is a non-linear process that goes back and forth from parts to the whole, and extends the meaning of the parts, in a hermeneutic spiral. This hermeneutic dialogue between our preunderstanding, the drawings, and the text resulted in fusion of horizons, according to Gadamer	Experiencing support and confirmation from their superiors strengthens FLNMs' confidence and independence to enact their visions of caring in leadership	Superiors' support enables FLNMs primacy of caring for patients

I carry the patient in my heart in everything I do

Professional responsibility for quality nursing care, staff and patients was described by all participants as being interrelated, as each mutually influenced the others. Therefore, these responsibilities needed equal attention. In most drawings, participants placed themselves close to or tangential to patients, patients' relatives, and staff, as drawing 1 illustrates. Relationships with patients' relatives were described as caring for the patient.

Drawing 1 (FLNM 6)

Caring for patients was identified as participants' main leadership priority, as everything they do as leaders should be based on patients' needs. Even though FLNMs were physically distant from patients and rarely met them face-to-face, they still felt connected to them. This was explained as thinking and hearing about patients and their status daily, when FLNMs met with their staff. One participant (drawing 2) visualised and described it as follows:

Drawing 2 (FLNM 9), scraps

When I care for staff it means I am caring for patients

Caring for staff and caring for patients were described as two sides of the same coin. Two participants said:

> Responsibility for patients and staff are interconnected
>
> (FLNM2, FLNM5)

FLNMs and their nursing staff shared a professional and academic foundation. Creating a caring atmosphere was understood as a managerial responsibility. For example, by creating nursing procedures together in the unit, they collaborated purposefully as they developed quality improvements in care, which also positively affected their relationships. When reflecting and working together, FLNMs were aware of their position as leaders, not one of the nurses. Leaders were described as having different, broader perspectives than staff nurses, due to their position and responsibilities. One participant said:

> When I reflect together with the staff, I need to explain to them why I think differently
>
> (FLNM2)

I am drowning in incompatible demands, where no one sees me

Participants described their workload as overwhelming, with contradictory demands and responsibilities that sometimes made it difficult to cope.

Organisational and superior levels were sometimes described as intertwined, with blurred communication lines. Superiors were defined as the managerial level of leadership closest to FLNMs, hierarchically placed between FLNMs and the top organisational level. Superiors often had a micromanagement approach, giving detailed instructions without knowing everyday details of nursing care. Instructions were described as unclear and did not provide FLNMs with all the information needed to make good decisions or solve tasks. If further questions were asked, participants stated they felt they were being troublesome. FLNMs expressed wanting warm, safe relationships with their superiors; however, this was not always the case. These relationships were often described as both physically and emotionally distant.

Some participants portrayed managerial meetings as unpredictable, due to sudden invitations where FLNMs were expected to obey and leave everything, resulting in feeling their time was not respected. Information received during these meetings was limited to what was needed to operate units, with financial themes as a recurring main agenda item, and decisions were often already made. FLNMs were expected to enforce these decisions, with few opportunities to contribute professional viewpoints or alternative solutions. Their voices were not heard. One participant stated:

> We shall by all means not exceed our budgets in any way. We are not allowed to hire extra staff to provide care to dying patients or patients who require high-level nursing care
>
> (FLNM2)

However, when a patient's condition required extra personnel, FLNMs' professional judgement of the patient's need for nursing care preceded organisational requirements of reducing costs. Organisational-level requests were described as overwhelming, visualised by using multiple one-way arrows in drawing 3.

Drawing 3 (FLNM 4)

FLNMs and superiors were together in the inner circle, where their relationship was symbolised by the only two-way arrow in the organisation, interpreted as the superior being the person to go to when the FLNM needed another opinion.

Multiple one-way arrows illustrated external demands, and tremendous pressure from the organisational level, without FLNMs' ability to influence or respond. Participants stated that orders were expected to be obeyed without question. This type of communication was described as commanding and felt like a violation, which resulted in FLNMs' irritation, sadness and feelings of not being listened to or valued as people or leaders.

> The organizational level commands us to just fix it! We have no say, and we do not request anything in return. It should certainly not be so in 2018!
>
> (FLNM 4)

Thus, some FLNMs raised their concerns, especially when decisions negatively affected patient care.

Stage 2: FLNM's loneliness and longing to belong

In the second stage of analysis – meaning-making through research-driven engagement – our main theme was FLNM's loneliness and longing to belong. It was based on two subthemes: 'Increased self-awareness of FLNMs' positions in the organisation' and 'Longing to belong'.

Increased self-awareness of FLNMs' positions in the organisation

Through visualisation and reflection, awareness of participants' positions and interpersonal relationships within the organisation arose. Analysing FLNMs' viewpoints provided valuable insight into their understanding of existing relationships. All participants except one visualised themselves in their drawing. However, their placement differed not only between focus groups, but also within groups from the same workplace, possibly indicating the unique position of each FLMN. Most participants gave themselves a central position, interpreted as seeing themselves as important to their organisation. In several drawings, everything was intertwined, without sharp lines dividing each symbol, as drawing 4 illustrates:

Drawing 4 (FLNM 8)
Overlapping circles could be understood as blurry organisations, without clear communication or relationship lines. This FLNM encircled herself around others, as if taking responsibility for 'it all', understood as a partaker. This differed from another participant's drawing (drawing 5), that placed herself as central, but with four one-way arrows pointed towards her, from the organisation, administration, patients and staff.

Drawing 5 (FLNM 6)
Although her (drawing 5) viewpoint was from the middle of the organisation, she placed, or perhaps hid herself, in a box named 'the leader's private space'. She was mostly receiving orders, interpreted from the one-way-arrows pointed towards her. One arrow passed through the 'private space', understood as her lack of engagement by taking a secluded position, subsequently affecting her ability to be genuine in encounters with patients, staff and superiors. This position was understood as being a passive spectator.

Longing to belong

All participants described support and confirmation from superiors as crucial for legitimacy and endurance and experienced this to varying degrees.

Self-awareness of leadership as a lonely position was interpreted based on participants' descriptions of feeling lonely and abandoned, though they longed to belong. Some formed informal networks with other FLNMs for mutual support and to compensate for inaccessible superiors. These networks were based on personal relationships and did not necessarily include all FLNMs. They were informal and unknown to superiors, had no formal place in the organisation and could be understood as subcultures. Where networks existed, FLNMs depicted them in their drawings.

Drawing 6a (FLNM 9), scraps
Participants strived towards good communication and relationships within the organisation; however, we identified a common discrepancy in FLNMs drawings and their statements. Drawing 3 depicts an example, where the participant has a two-way dialogue with her superior, thus illustrating her relationship and communication lines with patients, staff, and other FLNMs using one-way arrows.

One participant, with long-term leadership experience, visualised her world differently as seen in the next drawing (6b).

Drawing 6b (FLNM 9)
Her circles were equal-sized, not hierarchically composed, and interpreted as people working together. All arrows were two-way, and the circles were interconnected and affected each other. Inner strength, self-confidence and competence as a leader were highlighted as necessary to advocate for patients. Strength primarily evolved from a supportive relationship with superiors, but could also come from further education or peer networks.

Stage 3: Superiors support enables FLNM primacy of caring for patients

Based on the two previous stages, this third stage involved re-contextualising the findings [45]. In our hermeneutical approach, it is understood as fusing horizons with our theoretical perspective [2].

Participants' commitment to providing the best patient care was evident, in line with Bondas' theory of caritative leadership [2, 5, 44]. Facilitating a caring atmosphere characterised by dialogue, mutual respect and predictability positively influenced patient care. Patients were depicted in several drawings, symbolised in loving terms, as hearts. Nevertheless, reality often conflicted with their vision, and they were not able to balance administrative duties with caring for patients and staff.

Caring for patients should not be understood as FLNMs participating in direct patient care, but as made possible through caring for staff. FLNMs' clinical presence was called for when their nursing expertise was needed, or if they themselves felt a need to meet patients and relatives to verify patient care quality. Involvement and presence are in line with caritative leadership [2], which suggests that nurse leaders who combine caring with administration are able to see beyond economic concerns, can enter into caring relationships with patients and staff and see them as unique, vulnerable human beings.

FLNMs strived to be approachable and responsive to patients and staff. By being humble leaders, trusting their staff's knowledge and knowing their staff well, they were able to recognise the support their staff needed [44].

When all drawings were analysed together, most illustrated elements of hierarchical, organisational structures. Findings indicated that external management and top-down communication caused frustration; nevertheless, the drawings illustrated participants furthering similar behavioural communication with their staff. This finding is in opposition to Bondas [44], who stated that an organisation's hierarchy should be based on knowledge and understanding. The superior level seemed detached from the reality of the nursing care and driven by motives of economy and efficiency [35, 62]. Nursing and caring knowledge provides value basis for nurse leaders and provides a platform and authority for leading nursing care.

FLNMs appealed for support from their superiors; however, they were often unheard. Relationships were often described as bothersome, deficient, distant or nonexistent, resulting in loneliness in leadership. This is in line with Bondas [2], who described neglect, lack of mutual responsiveness and room for reflection as uncaring behaviours; however, our findings broadened the theory through transferability to the FLNM-superior relationship. To survive in unsupportive environments, we identified two approaches. Some FLNMs protected themselves by withdrawing to a distant position, as a spectator, which resulted in loneliness, longing to belong and feeling abandoned in leadership:

> 'To describe the relationships in my organization, it feels like I am swimming among sharks. I'm a new leader. I'm lost and not confident at all'!
>
> (FLNM3)

Others had a more active approach, being dedicated partakers, taking overall responsibility and fighting for their visions by raising concerns in order to enhance patient care. These were often experienced, more educated leaders, who recognised unformal arenas for professional exchanges of ideas, development and reflections to enhance commitment to the best patient care [2, 44].

Both partaker- and spectator-type leaders were found in the same focus group. This indicated experiences were individualised and therefore needed unique, personal attention from superiors. Partakers did not need frequent meetings or close communication with superiors, because they saw superiors as a 'safe wall' – a reliable, caring and approachable person who was there when needed. Caritative leaders can be understood as this safe wall; people who both want and dare to invite themselves to participate in everyday relationships in the unit with knowledge and caring. Findings showed that support and confirmation in the superior-FLNM relationship was pivotal for FLNMs to enact their vision of caring in leadership.

DISCUSSION

This study offered understanding of relationships influencing caring for FLNMs, in the context of NMHC. FLNMs expressed visions of providing the best possible patient care. A shared value base was at stake when external demands, often raised by superiors, challenged FLNM's ideals of nursing care. When a supportive relationship with superiors was lacking, FLNM's loneliness and longing to belong was described, which may result in a feeling of being abandoned in leadership. These leaders might not further a caring culture, as their solution was to become a spectator, as shown in our findings.

The opposite was the active partaker position, seen when support was experienced. Partakers dared to enact their visions of caring in leadership, because supportive relationships strengthen confidence and independence in leadership. We considered this a significant finding for enhanced caring in leadership. Each FLNM needs individual attention from a superior to see that superior as a support. An atmosphere of trust, personal support and two-way dialogue should characterise this relationship, so that self-confidence and independence in leadership can be nurtured and grow. However, this is rarely the reality FLNMs experienced in our study. The need to support nurse managers is crucial to how they function, as effective decision-making processes require support [39].

MHCs have been restructured due to demographic changes and major reforms; thus, leaders' responsibilities are changing [36]. Our findings must be viewed in conjunction with these changes. Our study indicated FLNM's visions of enhancing patient care often conflicted with the demands of reality. This strengthened understanding of contradictory claims can be difficult to meet [9, 36], where leaders' attention and focus was primarily directed towards administration, finances and outer structures [16, 33] with a risk of losing the patient in leadership [2, 7-9, 18, 38]. Superiors were described as essential people for participants' abilities to meet these new requirements [41].

Professional leadership with accessible and approachable leaders promotes patient safety [24]. Actively influencing administrative decisions and professional development can contribute to humanising an organisation, reflect caring values, enhance FLNMs' quality of work life [41], make FLNMs' positions more attractive and reduce turnover. Supportive superiors who confirm FLNMs are valuable can give them confidence in leadership, where they do not need to be afraid of reprisals if they make mistakes. Chisengantambu et al[39] described support as crucial to functional leadership, which in our study was described as leaders being partakers in their units, preparing the way for staff. Thus, lack of superiors' support seemed to negatively influence FLNMs; engagement, as they distanced

themselves from their units and were unapproachable to staff.

In the present study, the FLNMs asserted that superiors often communicated an expected obedience to the budget as FLNMs' primary goal in leadership. FLNMs' professional opinions as nurses were often neglected. This was in line with Nilsen, Olafsen, Steinsvåg, Halvari and Grov [63], who stated that FLNMs in MHCs described their relationships with superiors as management via email, a distant relationship, characterised by control mechanisms and lack of necessary support. If focus moves away from patients – when basic nursing care is essential to human welfare – towards saving money, patient care and nursing as an autonomous profession is threatened [12, 64, 65]. Nevertheless, findings indicated that FLNMs are deeply rooted in providing nursing care; therefore, they silently disobeyed instructions that violated their professional, moral and ethical standards (e.g. hire extra personnel for dying patients).

Kirchhoff and Karlsson [34] found that supportive superiors strengthen FLNMs' affiliation with a managerial position. If missing, they seek support from nursing staff, which weakens their managerial position, as seen in our study. Another significant consequence related to unsupportive or weak relationships with superiors was that FLNMs created informal networks for mutual support, without superiors' knowledge, understood as subcultures the organisation. They may extend the organisation's visions; however, they may also be poisoning, depending of the ethical mindset of the informal relationships. However, formal, continuous leadership networks are recommended as part of an established organisation, as they can provide FLNMs feelings of being empowered and supported [35]. When FLNMs gain leadership confidence, they extend the way they see themselves as a part of a broader perspective, especially from the perspective of patients and their families, the patient pathways [66].

Limitations

This study demonstrated interpretative rigour by following visual meaning-making in accordance with the study's aims [45]. Transparency in the analysis demonstrated how interpretations were made (Table 2, 48. We strived to be as reflexive and transparent as possible in our decisions, by offering drawings and participants' quotes [67]. To enable readers to follow our interpretation, detailed descriptions of each stage of the analysis process were provided [45, 46], including drawings and participant quotes. If visual data stand alone, there is always a risk that researchers will misinterpret the meaning behind the visuals [68]. Our choice to combine drawings with focus group dialogue was motivated by ethics, as well as striving to create a bigger picture than what could be developed by using only one method [50-52, 54, 68].

All MHCs we contacted had only female FLNMs; therefore, our participants were representative. Participants in each group knew each other and responded positively to the drawing task. Reflections concerning relationships affecting leadership were characterised by sincere interest, curiosity and involvement, strengthening the findings. Initially, participants discussed the themes based on the theoretical model [6] before they visualised their understanding, which might have influenced the findings. It may have, however, been very difficult to begin with the drawings, as the focus groups dialogues awoke participants' reflective minds.

Our coverage of three Nordic countries provided a broad perspective and strengthened the findings; however, further studies from the perspectives of the patients, their relatives, staff and superiors are needed to increase transferability to other contexts. Despite limitations, this study offered potential for qualitative understanding limited to FLNMs' perspectives in the context of NMHC, where much of the nursing care is provided as home care.

The research team consisted of nurses. RS (first author) and TB (second author) have several years' experience as leaders. All researchers have extensive qualitative research experience. RS and AK participated in the interpretation process through the drawings, text and dialogue with each other. TB verified the preliminary findings and contributed with nuances and new perspectives [49]. Throughout the process, we used conference calls to reflect upon our preunderstandings and analysis. We strived to hold our perspectives in abeyance, through ethical reflection and scientific curiosity.

CONCLUSION AND IMPLICATIONS

Our findings indicated that FLNMs are deeply rooted in their identities as nurses. Nursing leadership ideals and practices based on human dignity, love, and mercy were found in our study. Caring for patients also included caring for staff and was participants' main concern in leadership, despite wanting reforms and demographic changes. FLNMs' relationships with superiors may affect caring in leadership positively or negatively and therefore requires further attention.

While caritative leadership theory mainly focuses on relationships between leaders and staff in health care, a central finding of this study was that FLNMs themselves must experience caring and confirmation to maintain sight of patients and the nursing care within their leadership roles. The findings of this study expanded knowledge regarding the significance of caring in nursing leadership and added new knowledge to the caritative leadership theory. Continuous formal networks are recommended, as they extend the way FLNMs see themselves within a broader perspective and seem important for mutual support and reflections for improved quality care.

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CONFLICT OF INTEREST

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AUTHOR CONTRIBUTIONS

All authors have agreed on the final version and meet at least one of the following criteria recommended by the ICMJE (http://www.icmje.org/recommendations/). Substantial contributions to the conception or design of the work; or the acquisition, analysis or interpretation of data for the work; drafting the work or revising it critically for important intellectual content; and agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

ETHICAL APPROVAL

The Norwegian Centre for Research Data approved this study (NSD: 59117).

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