In command of care: clinical nurse leadership explored

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Abstract Who are the clinical nurse leaders? What are the qualities and characteristics of clinical nurse leaders? Why are they seen as clinical leaders and what might their experiences of clinical leadership be? This paper outlines a research project that sought to explore these questions. The research involved surveying registered/qualified nurses from D to H grade (n = 830) who staffed 36 clinical areas in one acute NHS Trust in the English Midlands. Only 188 questionnaires were returned, but the data proved a rich source of information about clinical leadership, the attributes of clinical leaders and who might be recognised as a clinical leader. E-grade sisters were seen as strongly associated with the role. The questionnaire was followed by interviews with 42 qualified nurses from D to H grade on four clinical areas in the same NHS Trust, and these were followed by eight further interviews with nurses identified from the interviews as clinical nurse leaders. The results demonstrate that clinical leaders appeared to be present at all nursing levels and in considerable numbers, but they were often not the most senior nurses and their approach to clinical leadership was based upon a foundation of care that was fundamental to their values and beliefs or view of nursing and care. The study also indicated that the type of clinical area had an influence on who might be seen as a clinical leader. The attributes of clinical leaders appeared to be clinical competence, clinical knowledge, approachability, motivation, empowerment, decision-making, effective communication, being a role model and visibility.

Keywords clinical leadership, nursing leadership, transformational leadership, qualitative research

Introduction
Nursing leadership has been the subject of considerable interest and in the last decade the promotion of nursing leadership has intensified as the nursing profession and National Health Service (NHS) recognised its value and promoted a greater role for nurses in the changing health service (Rafferty, 1993; DoH, 1998, 1999, 2000, 2004; Wedderburn-Tate, 1999). The Making a Difference (DoH, 1999) document established the Government’s plans to strengthen leadership within nursing, and described nurses, midwives and health visitors as ‘crucial to the Government’s plans to modernise the NHS and to improve the public’s health’ (DoH, 1999: 4). Mullally (2001: 24) suggested that, ‘good leadership is central to the delivery of the NHS plan
and strong nursing leadership is crucial if there is to be an effective nursing contribution'. The Government's change of agenda indicated that what was required was a new breed of clinical leader, 'who can establish direction and purpose, inspire, motivate and empower teams around common goals and produce real improvements in clinical practice, quality and services' (DoH, 1999: 52). As such, the demand for leadership in nursing has never been stronger (Chevannes, 2000).

The NHS Plan (DoH, 2000) took the groundwork outlined in Making a Difference (DoH, 1999) and provided greater detail for the NHS change agenda. In it, nurses were encouraged to develop new skills and roles beginning with the introduction of, 'modern matrons with authority on wards' (DoH, 2000: 82), the appointment of more nurse consultants and the establishment of an NHS Leadership Centre, dedicated to the support of leadership development throughout the NHS. There has also been a proliferation of courses and programmes (many now offered by the NHS Leadership Centre) that are specifically designed to support the development of nurse leadership and clinical nurse leadership. The RCN Clinical Leadership Development Programme (Cunningham and Kitson, 2000) and other local or regional nurse leadership programmes are examples of this proliferation.

However, if nurses are to have a significant impact on the development of clinical care and the NHS change agenda, then understanding who the clinical leaders are and the nature of clinical leadership is vital, and the absence of significant research about clinical leadership has, in part, prompted the research described below.

**Literature review – leadership and nursing**

Discussions and research related to nursing leadership are not new, although it is only in recent years that clinical nurse leadership has featured more prominently in health-related literature. The literature review began with the consultation of a wide range of journals, books, previous research papers and Government documents. These focused on leadership theories, nursing leadership, clinical leadership, ward leadership and associated topics. These were topics such as empowerment, oppression, authority, power, management, the NHS political agenda, organisational structure, organisational culture and boundaries between healthcare professionals and their relationship to leadership roles within healthcare.

The core of the literature review focused on the application of leadership to a clinical setting, and there appeared to be a wealth of literature that dealt with the role, nature and purpose of nursing leadership (Focct, 1999; McKinnon, 1999; Salvage, 1999; Shepherd, 2000; Nohre, 2001; O'Neil, 2001; Wedderburn-Tate, 2001), the value of developing and nurturing nurse leaders (Scott, 1987; Wright, 1996; Antrobus and Kitson, 1999; McKeown and Thompson, 1999; Read, 1999; Cunningham and Kitson, 2000; Faugier and Woolnough, 2001; Firth, 2001) and the characteristics of nurse leaders (McSherry and Brown, 1997; Bower, 2000; Cook, 2001b; Wedderburn-Tate, 1999; Chambers, 2002; Crouch, 2003; McCormack and Garbett, 2003). However, there was less literature and scant research that related to who the clinical leaders are and what clinical leadership might mean, although Christian and Norman, 1998; Cosens et al., 2000; Cook, 2001a, b and Lett 2002 had all initiated work in this area. The discussion of leadership is evident in a wide range of nursing literature (Antrobus and Kitson, 1999), although much is focused on leadership and management or leadership of a general nature. The literature review therefore also considered leadership perspectives from the military, teaching and business fields to ensure that a spectrum of leadership literature was employed in developing
the direction of the research. The literature related to clinical leadership is developed further in Part 2.

**Defining leadership**

Understanding the concept of leadership was pivotal to understanding the experiences of clinical nurse leaders and, as Stodgil observed (1974: 7): 'there are almost as many different definitions of leadership as there are people who have attempted to define the concept.' This research began with a plethora of literature proposing often contradictory views on the meaning of leadership. Following a considerable review of the literature, an eclectic view of leadership is proposed (supported by the writing of Stodgil, 1950; Pondy, 1978; Greenfield, 1986; Bennis et al., 1995; Kotter, 1998; Kakabadse and Kakabadse, 1999), where leadership is seen in terms of unifying people around values and then constructing the social world for others around those values and helping people get through change.

**Leadership theories**

Prior to exploring literature related to clinical leadership, clarification of the many leadership theories was also sought. Many were considered, including The Great Man Theory (Galton, 1869, cited in Morrison 1993), the Big Bang Theory (Grossman and Valiga, 2000); Trait Theory (Yoder-Wise, 1999; Grossman and Valiga, 2000); style theories (that explore how leaders behave, with leaders being described as either democratic, laissez-faire, authoritarian or dictatorial) (Norcross, 2004); Situational or Contingency Theory (Fiedler, 1967; Vroom and Yetton, 1973; House and Mitchell, 1974); and where leadership is viewed as the ability to adapt the leadership approach to complement the issue being faced or to determine the appropriate action based on the people involved and the prevailing situation (Adair, 1998).

Downs (1973), Burns (1978) and Bass (1985, 1990) described the transformational theory of leadership, which appears to be strongly associated with nursing leadership approaches (Finlay, 1998; Bowles and Bowles, 2000; Welford, 2002; Tiyer 2003). Transformational leadership grew from an attempt to tease out the distinctions between management (associated with transactional leadership) and leadership (associated with transformational leadership) (Bass, 1985, 1990). Transformational leaders are described as being connected to a process of attending to the needs of the followers, so that the interaction of each raises the motivation and energy of the other. It is about challenging the status quo, creating a vision and sharing that vision, so that the leader establishes a powerful vision, gains support for their vision and are consistently and persistently driven to maintaining momentum and empowering others (Kakabadse and Kakabadse, 1999).

Bhindi and Daugman (1997) and George (2003) describe an emerging theory, 'Authentic Leadership', where leaders are guided by 'qualities of the heart, by passion, compassion' and lead 'with purpose, meaning and values' (George, 2003: 12). All these theories were considered and explored in detail and in relation to literature about nursing leadership before embarking upon the research outlined below.

**Aim of the research, research questions**

After considerable preparatory work and the literature review, the research questions that emerged were:
Box 1

**Aim**
To identify who the clinical leaders are in a large NHS Trust in the English Midlands and to explore and critically analyse the experience of being a clinical nurse leader.

**Objectives**
The research had five significant objectives. These were:
1. To identify who the clinical leaders are.
2. To examine the qualities and characteristics of clinical nurse leaders.
3. To investigate the rationale behind the nomination of clinical nurse leaders.
4. To enquire into and critically analyse the experience of being a clinical nurse leader.
5. To explore and critically analyse the concept of leadership and clinical nurse leadership.

- Who are the clinical leaders?
- Why are they seen as clinical leaders?
- What are their experiences of clinical leadership?

In order to address these questions, an aim and a number of objectives were developed (Box 1).

**Research design**
The methodology employed in this study was fundamentally qualitative in nature, although an eclectic approach towards data collection and analysis was maintained. The two principal methods employed to generate data were a questionnaire and interviews, although casual observations were also made in the four clinical areas involved in the second and third phases of the study. Grounded theory (Glaser and Strauss, 1967; Chenitz and Swanson, 1986; Glaser, 1992; Strauss and Corbin, 1998) was considered the most appropriate approach to the study. This was because it was developed as a form of systematic enquiry that leads to the development of theories and was concerned with understanding human beings and the nature of their relationships with each other and their environment (Chenitz and Swanson, 1986; Strauss and Corbin, 1998).

The Trust recruited to the study was selected because it appeared to characterise the common features of any large acute NHS Trust. It had 1,671 qualified and 621 unqualified nursing staff at the time of the study and was made up of three large hospital sites spread across one county. The Trust was able to cater for 955 inpatients, in a wide variety of clinical specialities, and they also offered an extensive range of out-patient, diagnostic and support facilities.

Following the literature review and the selection of an appropriate NHS Trust, the study was divided into three phases (Figure 1). The first involved sending a questionnaire to qualified nurses in all the principal patient care areas of the Trust (n = 36 wards/units) (Box 2), although some qualified nursing staff were excluded, including those in midwifery, operating theatres, professional development or senior management/administration.
In total, 830 questionnaires were distributed, with 188 being returned (22.6%). The questionnaire distribution was preceded by a pilot study (Stanley, 2004), with staff in the pilot study area (paediatrics) were then excluded from the main study. The aim of the questionnaire was to identify the qualities and characteristics associated with clinical leaders and explore who the clinical leaders were in each of the clinical areas surveyed.

The second phase of the study involved interviews with a random selection of qualified nurses (D, E, F, G and H grade) in each of four identified clinical areas within the same acute NHS Trust thus far used in the study. The in-depth, semi-structured and focused interviews explored issues related to perceptions of clinical
leadership and sought to explore which staff were seen as clinical leaders in these specific clinical areas. The four clinical areas selected included a specialist area (ITU), a general medical ward, a specialist acute medical unit, and a trauma and orthopaedics ward. These areas represented inpatient wards with a range of qualified and unqualified staff, some with and some without modern matrons. The 42 participants interviewed were randomly selected and included 14 D grade, 17 E grade and 11 F, G, or H grades, including some modern matrons.

The third phase of the research involved identifying two of the clinical leaders nominated by a majority of the participants interviewed in Phase 2, from each of the four clinical areas, and interviewing them for data about their experience of being a clinical nurse leader.

**Ethical approval**

Approval was provided by the Local Research Ethics Committee (LREC) and permission to use the Trust was secured from the senior nursing manager, the head of research and development within the Trust and individual ward managers when interviews with specific clinical nurses took place. All interviews were confidential and participants were assured of their anonymity. Consent forms were used with all interviews and all the data collected was coded and stored in accordance with the Data Protection Act (1998).

**Limitations and bias**

The limitations and bias of the study were considered to be that:

- It only focused on the views of qualified nurses and nurses in direct patient care areas.
- The study took place in only one NHS Trust (although the Trust was made up of three geographically separate hospitals, each with their own unique sub-cultures).
- The researcher originally worked in the Trust when designing and planning the
research (although the researcher resigned and took a post outside the Trust as soon as the research had been approved).

- The poor questionnaire return rate was a disappointment and could be a limiting factor, but was salvaged by the wider study approach.

**Results and discussion: the questionnaire**

The questionnaire had a number of specific questions. The first sought to explore the characteristics and qualities that qualified nurses 'most' or 'least' associated with clinical leadership. Respondents were presented with a list of 42 qualities or characteristics (Table 1) and asked to put a 'tick' next to the qualities and characteristics they 'most' associated with clinical leadership and a 'cross' next to those they 'least' associated with clinical leadership. The characteristics and qualities in the list were selected from literature related to theories about transformational and transactional leadership, with attributes from each type of leadership being represented about evenly. Some of the descriptive terms in the list were made up of words that described the leadership traits identified by Grossman and Valiga (2000) and Smith (1999), and from suggestions in the pilot study.

In general, fewer respondents identified the available attributes as being related 'least' to clinical leadership, although significantly 'artistic' and 'aligning people', terms commonly associated with transformational leadership, were featured prominently as being 'least' associated with clinical leadership. It is possible that respondents understood aligning people to be associated with the management function of directing or allocating staff and took artistic at its literal meaning (e.g. an artist or painter) rather than meaning skilled and creative in general. The qualities and characteristics identified as being most or least associated with clinical leadership are presented in Table 2.

A number (n = 85) of other qualities or characteristics associated with clinical leadership were added by respondents. These included some sarcastic comments, e.g. 'manipulative' and 'unquestionable'. Most, though, represented the positive attributes of clinical leaders, suggesting that clinical leaders have current clinical practice skills (e.g. do the same thing as the staff they lead and 'mucks in and works on all levels'). Many suggestions related to interpersonal and communication skills or

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**Table 1** The 42 qualities and characteristics presented for selection as either 'most' or 'least' associated with clinical leadership

<table>
<thead>
<tr>
<th>Copes well with change</th>
<th>Motivator</th>
<th>Routine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sets direction</td>
<td>Controlling</td>
<td>Consistency</td>
</tr>
<tr>
<td>Considers relationships valuable</td>
<td>Aligning people</td>
<td>Copes well with complexity</td>
</tr>
<tr>
<td>Flexibility</td>
<td>Teacher</td>
<td>Visible</td>
</tr>
<tr>
<td>Guides</td>
<td>Mentor</td>
<td>Visionary</td>
</tr>
<tr>
<td>Sets goals and targets</td>
<td>Negotiator</td>
<td>Directing/helping</td>
</tr>
<tr>
<td>Integrity</td>
<td>Duty/responsibility</td>
<td>Reward/punishment</td>
</tr>
<tr>
<td>Inspirational</td>
<td>Calculation</td>
<td>Management experience</td>
</tr>
<tr>
<td>Critical thinker</td>
<td>Regulator</td>
<td>Counts on trust</td>
</tr>
<tr>
<td>Creative/innovative</td>
<td>Analytical</td>
<td>Resources allocation</td>
</tr>
<tr>
<td>Clinical competence</td>
<td>Administrator</td>
<td>Maintenance</td>
</tr>
<tr>
<td>Artistic</td>
<td>Conservative</td>
<td>Inspires confidence</td>
</tr>
<tr>
<td>Supportive</td>
<td>Advocate</td>
<td>Articulate</td>
</tr>
<tr>
<td>Approachable</td>
<td>Change agent</td>
<td>Just</td>
</tr>
</tbody>
</table>
Table 2  Characteristics and qualities 'most' and 'least' associated with clinical leadership

<table>
<thead>
<tr>
<th>Most</th>
<th>Least</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approachable (97.3%)</td>
<td>Controlling (78.1%)</td>
</tr>
<tr>
<td>Clinically competent (95.2%)</td>
<td>Artistic (65.5%)</td>
</tr>
<tr>
<td>Motivator (94.1%)</td>
<td>Conservative (62.2%)</td>
</tr>
<tr>
<td>Supportive (94.1%)</td>
<td>Routine (57.4%)</td>
</tr>
<tr>
<td>Inspires confidence (93.0%)</td>
<td>Calculator (47.3%)</td>
</tr>
<tr>
<td>Copes well with change (90.9%)</td>
<td>Reward/punishment (39.3%)</td>
</tr>
<tr>
<td>Flexibility (90.4%)</td>
<td>Administrator (33.5%)</td>
</tr>
<tr>
<td>Sets direction (89.3%)</td>
<td>Regulator (32.4%)</td>
</tr>
<tr>
<td>Directing and helping (88.8%)</td>
<td>Aligns people (27.1%)</td>
</tr>
<tr>
<td>Integrity (82.2%)</td>
<td>Maintenance (25.0%)</td>
</tr>
</tbody>
</table>

Attitudes appropriate for a clinical leader (e.g. 'good listener', 'hard working', 'understanding', 'honest' and 'reliable'). Some related to the clinical leader's relationship to their team or other healthcare workers (e.g. 'ability to unite a team/group' and 'looks out for the best interests of the team'), and some related to the caring aspects of the clinical leader's role (e.g. 'puts patient care first', 'compassion' and 'caring').

The questionnaire also explored the issue of who the clinical leader(s) were in each clinical area. This produced 326 nominations for clinical leaders. Some nominations were for doctors or medical consultants and one nominee was a pharmacist, with the total non-nurse-related nominations being 9.2%. The remaining 90.8% of the nominations were for F-grade junior sisters (21.7%), nurse managers (11.6%), E-grade staff nurses (11.1%), G-grade sisters (13.8%), modern matrons (12.5%) and specialist nurses, at either F, G, or H grade (8.8%). There were also a small number of nominations for D-grade staff nurses, healthcare assistants or nursing auxiliaries, a lecturer practitioner and the head of a specific nursing department (Table 3).

During the course of collating the results, it became apparent that the nomination of clinical leaders was significantly different if the nurse making the nomination worked in a specialised unit or a general ward area, as the highlighted numbers on Table 3 indicate (the clinical areas considered specialised are highlighted with an * in Box 2).

Table 3 indicates that while F-grade junior sisters received the most nominations in general and specialist clinical areas, medical officers and medical consultants, modern matrons and all levels of G-grade staff (sisters, managers and specialist nurses) are more likely to be seen as clinical leaders in specialist wards/units than in general wards. In general wards, the more numerous nominations for clinical leaders were again for F-grade junior sisters, with E-grade staff nurses being the next most likely group nominated. F-grade junior sisters, as with the pilot study results (Stanley, 2004), appeared to be highly regarded as clinical leaders. Staff in general wards also appeared to be more than twice as likely (58:G:17) to feel there were no clinical leaders (or they didn't feel able to nominate them) in their clinical areas, and while only a few respondents made 'no nominations', the stark division between specialised units and general wards was again evident.

Respondents were also questioned about why they nominated specific individuals, with most either repeating key words from the list of 42 words presented, or making statements such as: 'because she is enthusiastic, motivated, very knowledgeable, supportive, encouraging and very kind'; 'puts patient care first'; is 'a senior member of staff who is very involved in the clinical side of nursing'; or 'they are all knowledge-
Table 3  Number and type of nominations by clinical area

<table>
<thead>
<tr>
<th>Staff type</th>
<th>S</th>
<th>G</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical officer/medical consultant</td>
<td>20</td>
<td>9</td>
<td>29 (8.8%)</td>
</tr>
<tr>
<td>Modern matron</td>
<td>21</td>
<td>20</td>
<td>41 (12.5%)</td>
</tr>
<tr>
<td>G-grade sister</td>
<td>29</td>
<td>16</td>
<td>45 (13.0%)</td>
</tr>
<tr>
<td>G- or H-grade manager</td>
<td>26</td>
<td>23</td>
<td>49 (15%)</td>
</tr>
<tr>
<td>F-, G- or H-grade specialist nurse practitioner</td>
<td>21</td>
<td>8</td>
<td>29 (8.8%)</td>
</tr>
<tr>
<td>F-grade junior sister</td>
<td>32</td>
<td>39</td>
<td>71 (21.7%)</td>
</tr>
<tr>
<td>E-grade staff nurse</td>
<td>11</td>
<td>35</td>
<td>46 (14.1%)</td>
</tr>
<tr>
<td>D-grade staff nurse</td>
<td>0</td>
<td>5</td>
<td>5 (1.5%)</td>
</tr>
<tr>
<td>A- to C-grade nursing auxiliary</td>
<td>1</td>
<td>3</td>
<td>3 (0.9%)</td>
</tr>
<tr>
<td>Head of Department</td>
<td>1</td>
<td>1</td>
<td>2 (0.6%)</td>
</tr>
<tr>
<td>Lecturer practitioner</td>
<td>0</td>
<td>5</td>
<td>5 (1.5%)</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>1</td>
<td>0</td>
<td>1 (0.3%)</td>
</tr>
<tr>
<td>Total</td>
<td>162</td>
<td>164</td>
<td>326</td>
</tr>
</tbody>
</table>

Higher number = Total

Key:
S = Specialised unit (e.g. ITU, A&E)
G = General ward (e.g. Medical/surgical)

able, caring people prepared to stand up for their beliefs even if this is not the popular option.

Some respondents felt there were no clinical leaders in their clinical area, indicating this was because of a lack of staff support, low staff morale, poor motivation and a lack of empowerment, stating that this was due to a combination of staff shortages, restructuring within the Trust or individual wards, poor management structure, lack of time or simply poor leadership qualities. A total of 20 respondents made comments about there being 'no' clinical leader in their clinical area, with these individuals representing 15 separate wards. Only three respondents who made these comments came from specialist units, implying that it is staff in general wards who are more likely to be unable to identify clinical leaders.

Results: the Phase 2 interviews — clinical leadership explored

The aim of the interviews was to gather information about clinical leadership and who the clinical leaders were in specific clinical areas. Table 4 indicates the number of potential participants from each clinical area available to be interviewed, their grades and how many participants from each area were interviewed. It also indicates that, on average, 36.2% of the available participants were interviewed. Also indicated is that, while F-grade nurses and above made up only 16.3% of the potential interviewees, 26.1% of the participants in the interviews were F-grade and above. This meant that a slightly smaller representative population of D and E grades were interviewed.

Data analysis began with the transcription of each interview. Initially each interview transcript was re-read and notes made about the broad categories and key elements. A journal was used to record any significant comments or themes from each interview. These were explored and developed further with subsequent interviews. Data analysis
Table 4  Number and percentage of potential and actual participants interviewed in phase two of the research

<table>
<thead>
<tr>
<th>Grades</th>
<th>D</th>
<th>E</th>
<th>F and above</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ITU</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Available</td>
<td>12</td>
<td>17</td>
<td>8</td>
<td>37</td>
</tr>
<tr>
<td>Interviewed</td>
<td>3</td>
<td>5</td>
<td>3</td>
<td>11 (29.7%)</td>
</tr>
<tr>
<td><strong>Acute medical/gastroenterology/stroke rehabilitation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Available</td>
<td>3</td>
<td>13</td>
<td>3</td>
<td>19</td>
</tr>
<tr>
<td>Interviewed</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>7 (36.8%)</td>
</tr>
<tr>
<td><strong>Trauma and orthopaedics</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Available</td>
<td>21</td>
<td>18</td>
<td>6</td>
<td>45</td>
</tr>
<tr>
<td>Interviewed</td>
<td>7</td>
<td>5</td>
<td>4</td>
<td>16 (35.5%)</td>
</tr>
<tr>
<td><strong>General medical/cardiac/rehabilitation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Available</td>
<td>6</td>
<td>7</td>
<td>2</td>
<td>15</td>
</tr>
<tr>
<td>Interviewed</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>8 (53.3%)</td>
</tr>
<tr>
<td><strong>Total available participants (%)</strong></td>
<td>42 (36.2%)</td>
<td>55 (47.7%)</td>
<td>19 (16.3%)</td>
<td>116</td>
</tr>
<tr>
<td><strong>Total actually interviewed (%)</strong></td>
<td>14 (35.3%)</td>
<td>17 (40.4%)</td>
<td>11 (26.1%)</td>
<td>42 (36.2%)</td>
</tr>
</tbody>
</table>

continued when all 42 interviews were reviewed and copied into a Computer-Assisted Qualitative Data Analysis Software (CAQDAS) programme. In this case NVivo 2.0. The principle categories that emerged from the data were, Leadership explored, Clinical leadership, Role conflict and Who the clinical leaders are.

Leadership explored

One of the central aims of the interviews was to explore the participant’s understanding of the attributes and qualities that make good or, indeed, poor leaders. Many participants considered it a leader’s responsibility to empower people to perform better. One participant said, ‘It’s about getting the best out of people’. Most participants described leaders as guides and teachers, indicating that they should be open, approachable and get people to feel part of a team. Many suggested that leaders should provide support, motivate and be individuals they could look up to or admire. Leaders held a central role in the clinical area and were described as having drive or being assertive. Leaders were also described as being the ‘figurehead’, and ‘beacon’ in the clinical area. Effective leaders were also described as taking responsibility, communicating well, having sound knowledge, being inspirational and were considered to be ‘really approachable. . . . really looked out for you’.

Many participants (n = 34/80.9%) made reference to what they saw as poor leadership qualities and characteristics, with poor leaders being identified as gossiping or moody, not listening or lazy. One participant said poor leaders were:

Indecisive, fail to keep up with their knowledge, don’t listen to anybody, are not open to questions, ‘why do you do this?’ ‘Well we just always do it that way.’ It just doesn’t help . . . people that are ‘hidebound’ (sit down a lot) or people that have to always be right, or who are not open to questions or people that just don’t do the work . . . lazy people . . . pen pushers . . . people that sit in the office all the time.
Some poor leaders were seen as having a dictatorial attitude, having no sense of humour, being bullies or were described as ‘out of control and not aware of what was going on’. Others were unapproachable, not interested, unorganised, laid back or showed favouritism towards particular colleagues. Nurses who were poor communicators, worked to their own agendas or who ‘didn’t appear to be out there doing clinical nursing’ were also criticised.

In an effort to further understand leadership, participants were asked to describe what they saw as the difference between leadership and management. Every participant provided a perspective on this, with the consensus being that managers tended to depend on their position, title and hierarchical status, while leaders depended upon their ability to inspire people while relying on their knowledge and experience. Managers were commonly seen as having ‘more authority than a leader’ and leadership was seen as ‘not necessarily grade related... it is a quality that some people have... the ability to inspire colleagues’. This general distinction was often elaborated upon and applied to nursing specific scenarios. One participant said:

Managers are very good... unfortunately for them they are no longer clinical. They do do clinical shifts, but they are so bogged down with everything else that’s going on with CHI and NICE and all the paperwork that’s involved with it. I would say that on the shop floor as we used to say, that it was the sisters and staff nurses and there are some exceptional ones that are the leaders.

Clinical leaders appeared to be effective and respected because they had ‘some sort of belief in themselves’ or were able to stand up for what they believe. Nurses at all levels that promoted, defended or stood up for high standards of patient care were commonly identified as clinical nurse leaders and it became apparent that clinical leadership was less associated with titles, positions, grades and responsibilities and more related to the beliefs and values a nurse showed while fulfilling whatever her or his duties and responsibilities were. This perspective was summed up by one participant who said:

I think you’ve got to have respect for that person... because of the way they nurse, you identify with them, identify with the way they nurse and agree with that.

Clinical leadership attributes
The characteristics and qualities associated with clinical leadership were identified in the course of the interviews. The attributes strongly associated with clinical leadership were:

Clinical competence Related to remaining credible and competent, linked to clinical experience and the confidence others saw in the clinical leader’s ability. It meant being able to show, or to do, as well as know or teach others about clinical issues.

Clinically you need to be having some input otherwise you lose your credibility.

Clinical knowledge Identified by 40 participants (95.2%) who indicated that knowledge of nursing and in particular knowledge that related to a specific area of practice was vital. This was extended into knowing not just about clinical issues, but knowing about teamwork, how individuals worked and of interpersonal relationships.

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You've got to be knowledgeable, but you've also got to have knowledge that's applicable to the area that you work in.

You have to be a clinical expert in your field... and you have to have gone through that process from novice to expert.

**Effective communication** All the participants indicated that this was a central attribute of clinical leadership. Clinical leaders were respected if they listened, and effective communication was seen as elemental if clinical leaders who were not managers or titled leaders were to influence their colleagues.

...Extremely good at explaining things at the right level that you understand.

The ward manager has got the title and therefore they manage and are seen to be leaders because of the title, but there are other people that lead by virtue of their opinion.

**Decision maker** Many participants (69%) suggested that decision-making, not just in relation to patient care or clinical issues, but in regard to a whole host of issues was central to clinical leadership. Allied to effective decision-making was the ability to delegate and problem-solve.

**Empowerment/motivator** Many (95.2%) participants identified effective clinical leadership with being enthusiastic, able to make colleagues feel confident, supported and encouraged. It was also seen to be about empowering people to perform better, sowing a seed somewhere and letting others take the lead.

Belief in what you're doing... because I know people who are higher, at a higher level than me are not necessarily good leaders... they're not... they don't necessarily have any belief in what they're doing.

**Openness/approachable** In keeping with the questionnaire findings, all of the participants indicated that approachability and openness were seen as desirable characteristics and qualities of clinical leaders. Many participants looked for clinical leaders who, 'valued them', were 'approachable, friendly and understanding', or who were 'open, caring, knowledgeable, fair, tranquil, calm, kept secrets', or who 'you could talk to about anything'.

**Role model** Clinical leaders were identifiable because, unlike managers, they were viewed by participants as role models. Clinical leaders had their standards of care on show and other nurses indicated that it was the ability of a nurse to care effectively for their patients that made them stand out as clinical leaders.

Someone you would look up to.

People that have been inspirational or people you've thought, 'Oh that's what I really want to be like'.

**Visible** A total of 32 (76.2%) participants indicated that clinical leaders needed to be visible, available and present. Visibility meant that clinical leaders were present in the clinical area, and that they were engaged and involved in the clinical activity. Not being visible, or being unable to be involved in patient care activity was seen by some participants to place them in a difficult position, or one that weakened their clinical leadership potential.
She is an ideal clinical leader because she is very visible.

Clinical leaders were identifiable because a significant part of their role involved engaging directly in patient care and any post or role that limited contact with or relationships with patients or clients would limit their ability to act out, or live out, their values or beliefs, and limit the ability of others to recognise them as clinical leaders. It was apparent from the questionnaire results that the values and principles a clinical leader displayed were a prominent aspect in their identification and, as the interview data was analysed, it became apparent that the values and beliefs a clinical leader demonstrated were key in their being recognised as a clinical leader. The characteristics identified appeared to be a reflection of the values and beliefs the clinical leader held about care and nursing. Describing clinical leaders, one participant said, 'They’ve really got this passion and belief about what they do and why they are here.'

Who the clinical leaders are
Specific questions were addressed to participants that aimed to discover who were seen as clinical leaders. Participants indicated that clinical leaders were seen at all nursing levels and that clinical leadership often relied upon specific clinical knowledge, rather than status and position. Most participants offered either one, or commonly more than one, name of a colleague they saw as a clinical leader (Table 5). Clinical leaders were commonly selected from grades of staff that have significant client interaction, with F-grade staff being nominated with either the most and/or second most nominations, therefore F-grade staff received the most nominations. The modern matron in one area received the most nomination and in another area the most nominations were received by the G-grade ward sister. E-grade nurses received many individual nominations, but no individual E-grade received an overwhelming number.

Of the nominations made by participants, 65.8% were for nurses below the G-grade level. As such, clinical leaders were identified at all levels, from managers to nursing auxiliaries (Table 5 outlines the leadership nomination made by area and grade). When identifying clinical leaders, a number of participants also indicated that they felt clinical leadership abilities were often tied to a specific clinical area or speciality and that the ability to be an effective clinical leader was related to their knowledge of the clinical skills in that particular speciality.

Role conflict
Interviewees discussed role conflict as an extension of the distinction between leadership and management. Although not expressed by all the participants, many indicated that they found their 'managerial responsibilities were very much in conflict with one’s leadership responsibilities'. One participant said:

You get days where you have to sit here, writing out of duties, agency things, IPK’s and I know that’s all part of the administration side, but the administration side seems to take over more and more of your time...there’s more and more paper work to do...personnel issues, staffing problems and there’s just more and more paper work, letters and memos to write and it just seems to take more and more time.

These comments appeared to be particular to participants who held senior nursing posts or who were able to express an insight into the duality of their management or leadership
Table 5  Nominations for Clinical Leaders by clinical area and grade

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<td>130 Total nominees</td>
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* = Hospital manager. ** = Although nominated as an E this person was part of an Outreach Team working from the unit. Italics = Most nominations in that clinical area. Bold = Second most nominations in that clinical area.

role. There appeared to be a perception that the ‘negative side of nursing promotion is the fact there is a greater tendency to come off the shop floor’ and that this can ‘diminish your impact as a clinical leader’ and lead to considerable conflict in the process.

Clinical leaders were not selected because they had identified or articulated any vision about care. Vision was hardly mentioned. What did stand out was that clinical nurse leaders lived their beliefs and their passion about patient care. They had their values on show and were followed not because of where they were going, but because of where they stood.

Results and discussion: the Phase 3 interviews — the experience of being a clinical leader

The third and final phase of the study consisted of eight interviews with nurses nominated by participants in the second phase interviews as clinical leaders. Two nurses with the most nominations as a ‘clinical nurse leader’ in each of the four ‘wards’ were interviewed (one modern matron, two G-grade ward managers and five F-grade junior sisters).
These interviews explored the experiences of being a clinical leader. The interview data was collected and analysed in the same way as the Phase 2 interviews. All eight interviewees discussed the centrality of care to their role and their passion for ‘hands-on’ nursing. Their practice and function as clinical leaders appeared to be built on a foundation of values and beliefs, structured around their relationship with patients and the care they received.

Between them, the eight nominees had 14.6 years of nursing experience. The shortest time any participant had been qualified was 11 years, while one had been a nurse for 25 years. The mean time that the participant group had been practising nursing was 18.25 years. Five of the eight had degree-level qualifications and three had specifically studied leadership or management as part of their post-registration studies. All had undertaken a wide variety of courses following qualification and each appeared specifically qualified to work in the areas they were employed.

Clinical leadership
Initially, half the clinical leaders nominated didn’t recognise themselves as such or were surprised to have been nominated. One was ‘taken-a-back, surprised, pleasantly surprised’; another was ‘shocked actually. . . quite overwhelmed’. The four that responded in this manner were all F-grade junior sisters and it appeared that they were surprised because the focus for their role was related to patient care and not management or administrative duties. They thought other F-grade colleagues or their more senior G-grade colleagues with clear management roles would be nominated ahead of them. Shadows of the subordinate and invisible position of ‘nursing work’ and the caring role were cast across their comments (Wilkinson and Miers, 1999). Only one F-grade nominee saw clinical leadership as central to her role, saying:

I would have thought that in my role I would have been the person that would have been nominated. I am not surprised. . . that’s my role. My manager is a leader, but I see her and the staff probably see her more as a manager. . . she has to manage sickness, the off duty, the budget and although she has clinical input, that’s not predominantly her role and I see my role as looking at clinical issues. . . that’s why I’m sort of not surprised.

The two G-grade nurses and the modern matron that were also nominated indicated that they saw themselves as clinical leaders and that being a clinical leader was part of their role.

Clinical leaders’ role/focus on care
Clinical leaders described the majority of their role as being related to the delivery of ‘hands-on’ patient care. Although the two G-grade ward managers indicated that their focus was clearly a balance between their management and clinical responsibilities, one commented that she was ‘desperately, desperately trying to keep as hands on as possible’ by taking management work home or delegating part of it to other staff. The modern matron had also employed similar tactics to remain clinically focused because ‘there is a difficulty in the balance. I tend to take the management stuff home.’ because at work she wanted to be ‘where I really should be with my level of experience. . . out there on the ward.’

The F-grades had less ambiguity when describing their role. One said, ‘My role is patient care. I am accountable for everything I do for my patients. I would say that is my major role. . . being involved in the personal care of the patient.’
A number of clinical leaders described themselves as prepared for their role because of their clinical experience, which gave them credibility in their clinical field. Clinical leaders spoke passionately about their involvement in patient care and how they ‘thrived on client contact’. They saw themselves, and they felt others saw them as clinical leaders because of their ‘visibility...the fact that I am out there doing it every day’.

They described themselves as being driven by their ‘beliefs about patient care’ and they all spoke of their desire to apply and display high-quality care. They demanded of themselves and others high standards of care and described themselves as setting an example for others or acting as role models. They also recognised that clinical leadership was not related to a title or grade within the nursing hierarchy. Clinical leadership was more to do with ‘me as an individual...regardless of what my grade or title or that sort of thing’. Clinical competence and clinical knowledge, although central attributes of clinical leadership, appeared secondary to the values displayed in practice. Clinical leadership appeared to be strongly linked to what clinical leaders did and their relationship to providing high-quality patient care, rather than solely based on what they knew.

**Clinical leadership qualities**

Participants were asked why they thought they had been nominated as clinical leaders and without exception, and in keeping with the questionnaire and Phase 2 interview results, participants indicated that it was because they had sound clinical knowledge or a degree of clinical expertise, because they acted as role models for the provision of nursing care, were good communicators, approachable and visible in the clinical area. One said:

Being approachable...it’s nice to think that people can come and they aren’t worried about speaking to you...if you’re not approachable you are going to miss everything that’s going on around you...I think you’ve got to be a good role model, you’ve got to be knowledgeable at what your doing...clinical knowledge...you’ve got to be good at communication...to communicate the knowledge that you’ve got to the people that haven’t got that knowledge.

In addition to this, being fair, a good teacher, a good listener, honest, trustworthy, having some academic knowledge, being dependable, adaptable, supportive, assertive, having a good sense of humour, being a problem solver and being able to empathise with staff and patients were other characteristics and qualities associated with being seen as a clinical nurse leader.

Only one interviewee (a modern matron) mentioned objectives, and later, goal setting as part of the clinical leader’s function. This was the only conversation that came close to the issue of leaders being driven by vision. None of the other clinical leaders discussed having goals or a ‘vision’ and although looked for during the interviews, it appeared unrelated to the qualities and characteristics of clinical leadership for the majority of clinical leaders interviewed.

**Leadership insight**

In an effort to understand the clinical leader’s experience, a number of questions were asked that sought to discover the participant’s insight and understanding of leadership. Only three participants had engaged in formal or structured education about leadership and all the participants (including the three participants who had an
opportunity to 'study' leadership) felt that, although the courses had been 'valuable', much of what they had learned about clinical leadership was unrelated to their 'training' and had come from experience.

As half of the clinical leaders nominated in this study were not expecting to be nominated, it is perhaps not surprising that the majority of clinical leaders interviewed had only a basic insight into leadership theory or had not undertaken any leadership training or courses. If this is the case, in spite of considerable investment in leadership training within the nursing profession (Firth, 2002; Jasper, 2002; Moißen, 2002), could the challenges clinical leaders face offer insight?

**Challenges**
Another avenue for understanding clinical leadership related to the challenges clinical leaders faced. Exploring them proved difficult as the clinical areas and their roles within them varied significantly and the challenges appeared at first to be specific to each individual, rather than generic to clinical leadership. However, two sub-categories emerged that were common to the clinical leaders interviewed.

**Juggling everything/conflict**
First, the clinical leaders interviewed appeared to be commonly preoccupied with balancing their clinical and managerial responsibilities. 'Juggling everything' appeared to be a common and constant issue.

I see myself as having two priorities. One is the patients obviously, that's what we're here for and my second is my staff... if there is a conflict between staff requirements and patient requirements, the patient requirements come first.

Many implied that they would be happier if they didn't have to deal with the management aspects of their role.

Oh it would be wonderful... without a doubt... I'd rather not be dealing with people's salaries... with annual leave requests and monitoring sickness... I would be far more valuable out on the ward working alongside junior colleagues.

Conflict existed because management responsibilities were also seen to diminish their effectiveness as clinical leaders: 'the more management responsibility you've got the less you are visible in the clinical area... there is only so much you can do which is one of the reasons why I don't want to go any further' [with her career].

**Maintaining morale**
The second sub-category related to difficulties with 'keeping the morale of everybody high' and keeping staff motivated so that the patients continued to receive the best care. Clinical leaders commonly found themselves caught in the middle, between their managerial responsibilities and their staff and patients. They heard what staff or patients were saying about their concerns or disillusionment, but their ability to influence the health service or even their own clinical area was often limited. In keeping with the findings of Christian and Norman (1998) and Firth (2002), clinical leaders indicated that they needed to deal with their colleagues as individuals, with sensitivity and empathy, yet their increasing managerial responsibilities were becoming both burdensome and distracting from their primary role of 'getting the best care for the patient'.

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Clinical leaders spoke passionately about their high standards of care, their affinity for patient care and their recognition that keeping morale high and their colleagues motivated was one way that they could positively influence the provision of nursing care.

**Summary discussion**

The significance of the clinical leader’s beliefs and values were reinforced during the second-phase interviews. What motivated clinical nurse leaders appeared to be their passion for patient interaction and a desire to remain focused on, and directly involved with, patient care. They didn’t have deep insights into leadership, but what mattered was that they were seen as approachable, visible, clinically skilled, competent, good communicators and role models with high standards of care. Clinical leaders indicated that, at times, they faced a challenge similar to walking a tightrope. Their managerial and administrative responsibilities had to be constantly juggled and balanced with their patient care responsibilities, although this seemed to apply more as the grade of the clinical leader increased. All the clinical leaders interviewed indicated that it was their beliefs and values that kept them grounded and focused on a foundation of care that was at the heart of what they saw clinical leadership to be.

In this regard, the F-grade clinical leaders, with less duality or ambiguity in their responsibilities, offered the clearest insight into the experience of clinical nurse leadership, although not all the F-grade nominees recognised themselves as clinical leaders. They identified that clinical nurse leaders needed to nurse, both to be seen by others as clinical nurse leaders and to value their own role as leaders in their clinical area. Regardless of the clinical area, clinical leaders were most clearly identified because they continued to engage with and value core nursing work that remains central to the foundation of the nursing profession. This theme is explored further in Part 2.

**Key points**

- There are a wide variety of definitions of leadership, although clinical leadership has been only marginally addressed.
- Clinical leaders are seen as approachable, visible, clinically competent, good communicators, and role models.
- Clinical leaders are driven and identified by their values and beliefs about care.
- F-grade sisters offered the greatest insight into the experience of clinical nurse leadership.
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In command of care: clinical leadership explored

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This is an interesting, relevant and very timely account of an empirical study into clinical leadership. Although it claims to use a grounded theory (GT) approach, it appears only loosely to follow the tenets of that methodology, and might have benefited from adhering more rigidly to some of the basic principles of GT, particularly, as we shall see, the idea of theoretical sampling. Bearing in mind the ongoing debate about the use of previously published literature in GT, we might also query the extensive theoretical work and major literature review undertaken as preparation for this study, particularly since little of this work appears to feature in the discussion of the findings.

In keeping with the GT approach, the study is designed in three stages, each building on the findings of the previous one. As such, the third and final stage of eight interviews with clinical nurse leaders identified by their peers is the culmination and most important and interesting aspect of the study, and is rightly given the most prominent position in this paper. Indeed, as the author rightly points out, the first phase in particular is problematic in a number of ways, not least of which is the disappointingly low response rate of 23%. In addition, the questionnaire does not appear to have been tested for validity or reliability, and questions particularly need to be asked (although the author does not do so) about its construct and content validity. Nevertheless, it plays a useful role in selecting participants for stage two of the study, which focuses on perceptions of leadership in general, and clinical leadership in particular. Of particular significance here is the distinction made by most respondents between clinical leaders and ward managers, and (although I suspect that most of us already know this) of the conflict between the two roles within the individual. This is an issue which was developed in greater depth in stage three.

In keeping with GT methodology, stage three is the main focus of the study, and consisted of interviews with the eight nurses most often identified by their peers in stage two as clinical leaders. It was perhaps a little surprising that the author should have opted to select respondents purely according to how many of their peers nominated them, since this method of sample selection excluded some potentially interesting respondents, such as a D-grade staff nurse and a nursing assistant. Perhaps the grounded theory method of theoretical sampling would have been more appropriate in this instance.

This stage of the research identified some important and significant issues which begged for further discussion and development, but for which space presumably did
not allow. For example, a strong theme emerging from the findings was the notion that several of these identified leaders were genuinely surprised, and most had not been educationally prepared for such a role. It appears that it is personal and interpersonal qualities that are valued in clinical leaders, along with a strong commitment to hands-on nursing, which raises several issues, such as whether formal leadership training is either necessary or sufficient to produce good clinical leaders. Another theme which might have benefited from further discussion is the role-division between leadership and management. For the G-grade respondents, this issue was felt internally as they struggled to meet the demands of both aspects of their jobs. For the F-grade respondents, the internal schism was not so much of an issue. However, it would have been very interesting to have seen some exploration of the potential external role conflict that might have existed between the G-grade ward manager and the F-grade nurse identified by her peers as the clinical leader. This issue also raises other questions, such as the need for such a highly paid, highly experienced ward managers, who by their own admission are tied up in the office doing paperwork.

Finally, it is worth noting the significance of what was not raised by this study. There was no mention in the report of the currently re-emerging issue of advanced practice, nor of the nurse consultant role, nor identification of research skills as important for the clinical nurse leader, and no mention of evidence-based practice. As I said at the outset, this is an important and informative study which, despite some methodological difficulties, deserves to be read widely, but which left me wanting more.
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